Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board Meeting
Part 1 (held in Public)

Wednesday 5 February 2025

10.00am -1pm

Warrington Hospital, Trust Conference Room and Via MS Teams



Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD MEETING – PART 1 *(Held in Public)*
Wednesday 5 February 2025, 10.00am – 1pm
Trust Conference Room, Warrington Hospital

Agenda Item	Time	Agenda Item	Objective/ Desired Outcome	Process	Presenter
BM/25/02/140	**10:00**	Engagement Story – Personalised Care in Maternity	***To note***	**Presentation**	Head of Patient Experience and Inclusion Sarah Nuttie, Consultant Midwife
BM/25/02/141	**10:15**	Welcome, Apologies and Declarations of Interest	***To note***	***Verbal***	Chair
BM/25/02/142	**10:17**	Minutes and Action Log of the previous meeting held on **4 December 2024**	***For approval***	***Minutes***	Chair
BM/25/02/143	**10:20**	Matters Arising	***To note for assurance***	***Verbal***	Chair
BM/25/02/144	**10:25**	Chief Executive's Report	***For assurance***	***Report***	Chief Executive
BM/25/02/145	**10:30**	Chair's Report	***For info/update***	***Verbal***	Chair
BM/25/02/146	**10:40**	Board Assurance Framework Annual review of BAF and Risk Appetite Statement	***For approval***	***Report***	Company Secretary
BM/25/02/147	**10:50**	Maternity Incentive Scheme Yr 6 Submission	***approval***	***Report***	Director of Midwifery
Strategic aims:		QUALITY We will always put our patients first, delivering safe and effective care and an excellent patient experience		PEOPLE We will be the best place to work, with a diverse and engaged workforce that is fit for now and the future		SUSTAINABILITY We will work in partnership with others to achieve social and economic wellbeing in our communities			
BM/25/02/148	**11:00**	Integration Options Decision	**For approval**	**Report**	Chief Executive
BM/25/02/149	**11:30**	Integrated Performance Reports (IPR) and Assurance Committee Reports i) IPR Dashboard	***For assurance***	***Report***	All Executive Directors
(a)		**Quality Dashboard** **Including** Assurance Reports Quality and Assurance Committee 10.12.24, 14.01.24	***For assurance***	***Report & Presentation***	Chief Nurse, Chief Operating Officer & Deputy Chief Executive, Exec Medical Director Cliff Richards, Committee Chair
(b)		**People Dashboard** **Including**	***For assurance***	***Report***	Chief People Officer Julie Jarman, Committee Chair

(c)		Assurance Reports Strategic People Committee 18.12.24, 15.01.24			
d)		**Sustainability Dashboard -** *including Cash Support* **Including** Assurance Reports Finance and Sustainability Committee 16.12.24, 27.01.24	***For assurance***	***Report & Presentation***	Chief Finance Officer John Somers, Committee Chair
		Charitable Funds Committee Assurance Report 12.12.24	***For assurance***	***Report***	Chair Director of Communications and Engagement
Strategic aim:					
BM/25/02/150	**11:55**	Fragile Clinical Services Update	***To note for assurance***	**Report**	Chief Nurse /Executive Medical Director, Chief Operating Officer & Deputy Chief Executive
BM/25/02/151	**12:05**	Maternity & Neonatal Update Summary Report to cover: I. Monthly Maternity and Neonatal review II. MIS year 5 - 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	***To note for assurance***	***Report***	Director of Midwifery
Strategic aim:					
BM/25/02/152	**12:20**	Communications & Engagement Dashboard Report Q3	***To note for assurance***	**Report**	Director Communications & Engagement
Strategic Aim					
BM/25/02/153	**12:30**	Strategy Programme Highlight Report	***To note for assurance***	**Report**	Chief Strategy & Partnerships Officer

BM/25/02/154	**12:40**	Strategy Biannual Delivery Report	***To note for assurance***	**Report**	Chief Strategy & Partnerships Officer

Governance					
BM/25/02/155	**12:50**	Charity Commission Checklist	***To note for assurance***	**Report**	Director Communications & Engagement

SUPPLEMENTARY PAPERS for noting (see Supplementary Pack)

To Note For Assurance					
BM/25/02/156	Learning From Deaths Q2	Quality Assurance Committee Ref: QAC/24/11/201 Date: 10.12.2024 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
BM/25/02/157	Mortuary Licensed Activity Report (Including Fuller update) – Biannual Update	Quality Assurance Committee Date: 14.01.2025 Ref: QAC/25/01/214 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/25/01/158	Infection Prevention and Control Board Assurance Framework Compliance	Quality Assurance Committee Date: 14.01.2025 Ref: QAC/25/01/215 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/25/02/159	Violence Reduction Strategy	Quality Assurance Committee Date: 14.01.2025 Ref: QAC/25/01/216 Outcome: Noted	***To note for assurance***	**Report**	Chief Nurse
BM/25/02/160	Agenda for Change – Nursing & Midwifery Job Evaluation	Strategic People Committee Date: 15.01.2025 Ref: SPC/25/01/166 Outcome: Noted	***To note for assurance***	**Report**	Chief People Officer
BM/25/02/161	Digital Strategy Group Update	Finance & Sustainability Committee Date: 27.01.2024 Ref: FSC/25/01/246 Outcome: Noted	***To note for assurance***	**Report**	Executive Medical Director
BM/25/02/162	Trust Senior Management Organograms	N/A	***To note for assurance***	**Report**	Company Secretary
Closing					
BM/25/02/163	**12:55**	Review of the Meeting	To discuss	**Verbal**	Chair
BM/25/02/164		Any Other Business	To discuss	**Verbal**	Chair
Date and Time of next meeting – 10am, Wednesday 2 April 2025 – Education Centre Halton Hospital					

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

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Maternity Patient Story

Personalised care through reasonable adjustments and planning

Sarah Nuttie Consultant Midwife



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Background – Toni and Sarah

- Toni is 34 years old and this was her first pregnancy
- She was supported by her wife Sarah who had their first child at WHH in 2020
- Non smoker
- BMI- 25
- Toni is deaf and communicates with British Sign Language (BSL) and text
- Toni booked with us out of area
- Clinically low risk. However, personalised care planning needs were offered considering any reasonable adjustments required with communication and equity in accessing services
- Consultant Midwife support was put in place



Personalised offer

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- BSL interpreting services - Identified preferred interpreter in place
- Good working relationship with Deafness Resource Centre
- Flexible approach in utilising interpretation services when planning appointments.
- Alert on BadgerNet patient records highlighting **reasonable adjustments** made and detail personalised care offer
- Triangulate care between the MDT to ensure Toni was receiving the most out of her appointments, whilst making the best use of our interpretation services
- Named community midwife – Team River (enhanced community team) despite being out of area
- Text offer – Enhanced communication from Consultant Midwife and named community midwife as a safety net / additional support /signposting.
- Deafness Resource card – To support when attending for unplanned care i.e.. Triage attendance

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Deafness Resource Card



I am Deaf and use British Sign Language.

I need a BSL Interpreter for all appointments please.

My name is:.....

Please make a note on my records **"BSL Interpreter required".** Thank you.

PTO

STAFF USE ONLY

How to book a BSL Interpreter

Healthcare Providers: Contact the Deafness Resource Centre

Working Hours:

Phone: 01744 23887 Fax: 01744 611540

e.mail: communications@deafnessresourcecentre.org

Emergency out of hours ONLY: 07779 708360

Deafness Resource Centre

www.deafnessresourcecentre.org

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Birth Planning

- On call agreement with Deafness Resource Centre with preferred interpreter identified
- Interpreter to attend to provide BSL interpreting throughout labour and birth
- Postnatally – Side room was offered to allow Sarah to stay with Toni for additional support
    - identified challenges around hearing baby crying during the night as home aids are not compatable with inpatient stay.
    - Reasonable adjustment in place to offer a birthing partner to stay with person and offer side room closer to nursing station.
    - Additional offer if required is to provide designated MSW to offer additional support during inpatient stay



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Outcome

- Following induction of labour for LGA at 39+4/40 and a subsequent emergency C Section welcome **baby girl “Charlie” 9lb 4oz**

A note from Toni

“Regarding communication, the things we thought were very good were: the card you gave me for triage, the ease at which interpreter was arranged by staff, the tour of the service, the understanding of my need for my wife to be there/available (Ie sorting a private room on the ward on both occasions so that she could come and be available for interpreting and so that interpreter could be there too if needed), your communication with me via texts and your patience in person when Sarah/interpreter not available, all the midwives were really lovely and put a lot of effort into communicating.”

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Learning

- Out of area women offered **choice of care** from own community team (attached to GP) or receive care from WHH Enhanced Continuity Team River.
- **Earlier intervention** from Consultant midwife – Identified at booking appointment, now routine referral.
- SPL – To remind staff to make **reasonable adjustments** when providing unplanned care for families with additional needs, to ensure we optimise communication and understanding to support informed decision making.
- Remind staff of the resources available to them and how to **access interpretation** services.
- Continued work as a Trust to support the d/Deaf community. Efforts recently recognised in a survey carried out by Signing Solutions that support at WHH has **“significantly improved”**

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.

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust Minutes of the Trust Board Meeting – Meeting held in Public Wednesday 4 December 2024 Trust Conference Room/Via MS Teams	
Present	
Steve McGuirk (SMcG)	Chair
Michael O'Connor (MOC)	Non-Executive Director & Senior Independent Director
Julie Jarman (JJ)	Non-Executive Director
John Somers (JS)	Non-Executive Director
Jayne Downey (JD)	Non-Executive Director
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
Cliff Richards (CR)	Non-Executive Director & Deputy Chair
In Attendance	
Lucy Gardner (LG)	Chief Strategy and Partnerships Officer
Kate Henry (KH)	Director of Communications & Engagement
Ailsa Gaskill-Jones (AGJ)	Director of Midwifery
John Culshaw (JC)	Company Secretary & Associate Director of Corporate Governance
Jen McCartney (JMcC)	Head of Patient Experience and Inclusion
Lorraine Woolley (LW)	Patient
Mark Woolley (MW)	Patient's Husband
Susan Dean	Deputy Head of Patient Experience and Inclusion
Yasmin Habib	UEC Lead Nurse.
Emily Kelso	Corporate Governance and Membership Manager (minutes)
Observing	
Susan Fitzpatrick	Lead Governor – Public Governor

Agenda Ref	Agenda Item
BM/24/12/118	**Engagement Story – Support my Needs** SMcG welcomed LW to share her story to help the Trust understand and address complex needs of patents better. LW introduced herself and provided an overview of her multiple and complex medical conditions, including Charcot Marie Tooth Type 3 (Degenerative Muscle Wasting Condition). LW explained her recent ED attendance, and the communication challenges experienced during triage which resulted in her being sent to SDEC which did not have the facilities required to meet her complex needs, this meant a return

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	to ED with an extended long wait leading to deterioration of her health and wellbeing. LW described the significant impact of her hospital experience on both her physical and mental health, including a long recovery, financial worries, depression and concerns about continuing work. LW emphasised the need for improved communication from the very early stages of triage to ensure the right equipment and support were made available to patients who required them. YH provided a summary of the Trusts response and next steps, following LWs experience and the lessons learnt, the following key points were highlighted: • the importance of improving communication between hospital staff and patients to ensure that patients' needs are met effectively. An ED leaflet had since been produced for patients alerting them on how to inform staff early of any reasonable adjustments required. It was noted that charitable funds had been acquired for a screen to be installed which would dictate the content of the leaflet. • Trust wide communications to ensure staff were aware and educated on the location of equipment. This was highlighted in the local daily safety briefs for day shift and night shift staff. • Ensuring all staff are compliant with Moving and Handling training particularly the use and location of hoists • The new A&E consultant was currently reviewing pathway to ensure it was streamlined for patients with complex needs. SMcG thanked LW for presenting her story and helping the Trust to learn lessons and improve the quality of care and patient experience. AK asked if LW would be willing to review the revised pathway as an Expert by Experience, LW confirmed she would be happy to be involved in the review. **The Trust Board discussed and noted the Engagement story.**
BM/24/12/119	**Welcome, Apologies and Declarations of Interest** SMcG welcomed the Trust Board, attendees and observers to the meeting Apologies were noted as detailed above, there were no declarations of interest made. SMcG 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/24/12/120	**Minutes and Action Log of the previous meeting held on 2 October 2024** The minutes of the meeting held on 2 October 2024 were agreed as an accurate record. The Action Log was reviewed, completed actions were noted. The Board discussed the ongoing action around Health Inequalities, noting that a focused session should take place with BCHT colleagues, in the future.

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	The Trust Board approved the minutes of the meeting held on 2 October 2024 and noted the Action Log
BM/24/12/121	**Matters Arising** **The Trust Board noted that there were no matters arising.**
BM/24/12/122	**Chief Executive's Report** NK introduced the paper, which was taken as read, highlighting the following key points: • Integration work with Bridgewater was progressing well, joint Executive team meetings were now taking place weekly • PF had been appointed as joint Executive Medical Director for both organisations, from 18 November 2024. Dan Moore has been appointed as the joint Chief Operating Officer (from the 9 December 2024), both on a secondment agreement for up to two years. • It was announced in mid-November that the UK government is implementing a series of reforms to improve the NHS, including league tables, turnaround teams, rewarding performance, accountability, reducing agency staff. These reforms aim to improve the efficiency and effectiveness of the NHS, reduce waiting times, and ensure that taxpayers' money is well spent • The regional meeting focused on the ambitious NHS 10-year plan. Discussions were focused on the three key levers that will help the NHS to thrive and become more sustainable, these were; Driving care from hospital to community, Shifting from analogue to digital, Moving from treatment to prevention • Chief Midwifery Officer for England, Kate Brintworth (KB) visited the Trust on Thursday 21 November, where the midwifery team were able to showcase the Trust's investment into the maternity services. AK commented that KB had been particularly impressed with the Trusts programme to support refugee mothers, including the appointment of 3 non-clinical maternity support workers to help patents access the maternity and neonatal services available. The Board discussed the remit and purpose of CMAST. NK explained that CMAST bought Chief Executives of organisations together to ensure the coordination of effective provider response to current system and NHS priorities such as patient flow and discharge, CMAST sat as a subset of the ICB. The Board expressed their lack of clarity around the decision-making power of CMAST, NK agreed to raise at the next CMAST meeting. **The Trust Board noted the Chief Executive's Report**
BM/24/12/123	**Chair's Report** SMcG provided a verbal update on activities since the last Boad meeting, highlighting the following:

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	• Integration work was moving forward with a focus on the upcoming options appraisal. Options would be reviewed by the panel on the 17th of December • Governor elections had concluded, leaving the Trust with only one governor vacancy, he reflected on the improvements to the Trusts engagement with its members through engagement activities and the members newsletter, in line with the objectives as set out in the revised Membership Strategy. It was noted that Margaret Bamforth who had previously served as a NED for the Trust. had been elected to the Council as a public Governor for Warrington and Halton **The Trust Board noted the verbal update from the Chair.**
BM/24/12/124	**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: • No new strategic risks had been added. • There was a proposed change to the description of risk 145 following discussions at the Audit Committee where it was agreed that integration work with Bridgewater should be included as a strategic risk • There had been no changes to risk ratings • No risks had been closed or deescalated The Trust Board discussed the proposed changes to risk 145 to incorporate Integration, following robust discussion it was agreed that the proposed changes would not be approved and instead LG and JC would draft a new strategic risk to add to the BAF to incorporate the people, financial and quality risks associated with integration. The proposed new risk would be bought to the February Trust Board meeting for approval. **The Trust Board discussed and approved the changes and updates to the Board Assurance Framework with the exception of risk 145 where the proposed change to incorporate integration was not approved, instead a new integration Strategic Risk would be added to the BAF.**
BM/24/12/125	**Integrated Performance Report** NK introduced the agenda item which provided a summary of Trust performance, the report was taken as read. The Executive Team presented a set of summary slides which highlighted the KPIs within the IPR that were both failing and had special cause variation of a concerning nature. These were: **Quality:** **5. Healthcare Acquired Infections (CDI)** AK informed the board that since the last meeting rates had slowed down. The Trust remains a low outlier compared to other NW Trusts. A campaign had been launched trust wide with a focus on best practice to prevent infections and an annual plan of CDI training was in progress. **Access and Performance:** **61. Uncapped Theatre Utilisation** The Trust had achieved 79.2% in October against a target of 85% and had moved from bottom quartile to a mid-position in model hospital benchmarking over the last 6 months. The focus was on start times and cases per list in worst performing specialties as well as on the day cancellations

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	Finance and Sustainability: **72. Better Payment Practice Code** It was noted that BPPC for October was lower again due to annual leave, around half term holidays. The Board were reassured that the guidance was to be re-enforced especially at times when higher annual leave was expected. JD queried the presentation of SPC data within the IPR with some indicators showing a misrepresentation of performance. It was noted that this had been picked up internally and work was underway to review to ensure better representation of data trends and patterns. It was agreed that the issues were not associated with the integrity of data but instead the presentation. SMcG asked that a dedicated Board session on SPC date within the IPR be scheduled, particularly given the upcoming integration work it would be crucial for the NEDs to have a sound understanding of IPR data interpretation. Some inconsistencies in committee assurance reports were highlighted, it was agreed that assurance ratings would be reviewed more stringently by report authors prior to the February board meeting. JH explained that At Month 7 the revised plan was an £11m deficit. The actual deficit was £12m with the overspend being due to a shortfall in funding in relation to Industrial Action (£0.7m) and the pay award (£0.3m). **The Trust Board noted the contents of the report, and the changes to capital contingency as supported and approved by the Finance and Sustainability Committee.**
QUALITY	
BM/24/12/126	**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 overall waiting list position was improving, however there was recent deterioration in the P3 waiting list, the service remains fragile from staffing and capacity/demand profile perspectives • **Orthopaedics Fractured Neck of Femur** -prompt surgery remains an unresolved quality and performance issue. There was an emergent risk around Orthogeriatric review capacity. It was noted that some junior doctors had raised concerns, and a response had since been submitted from the Trust to the CQC • **Ear Nose and Throat Surgery** – the waiting list position had improved predominantly due to insourcing. Mitigations were in place for medical staffing challenges, currently a significant cost pressure until recruited consultants commence. • **Cardiology and Cardiorespiratory Services** - Recently entered fragile services oversight. There was a demand and capacity mismatch driven by staffing issues and increasing demand. There had been no harm identified following a deep dive.

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	• **Theatres** procedural safety had been de-escalated from Fragile Services oversight. Moving forwards the programme will report progress against plan and any further incidents bi-monthly to PSCESC and Quarterly to QAC • There were no services entering Fragile Services oversight since the last meeting JS queried the sustainability of some of these fragile services and further queried whether the ICS or CMAST had a view on how to resolve or where best to deliver these services? NK commented that the issues were around strategic commissioning and improving clinical pathways as a system rather than a single organisation, these were conversations he would have with the ICB. PF confirmed that it was the intention to roll out the systematic oversight mechanism for Fragile Services (risk 2001) at BCHFT and develop a joint paper to provide the Board with oversight of Fragile Services across both organisations. **The Trust Board: noted:** • **the current list of Fragile Services, associated clinical risk and high-level progress updates** • **the de-escalation of Theatres (Procedural Safety) out of the Fragile Services oversight program into an alternative Quality Governance reporting structure** • **the stabilised position with regards to ENT Medical Staffing, associated cost pressures and the positive consultant recruitment to reduce these**
BM/24/12/127	**Compliance Q2 Update** AK introduced the report which provided the Q2 update on the Trust's compliance with CQC regulations, including recent inspections and the progress made in addressing regulatory breaches. The following key points were highlighted: • The Trust had been accustomed to regular CQC Engagement Meetings whereby the CQC Regional Management Team who meet with the Trust Senior Team on a quarterly basis • An update was provided on the current position regarding the 4 regulatory breaches still in place due to overcrowding in the emergency department, • A Mock inspection had taken place in the ED, to prepare staff for inspections and the ongoing efforts to ensure that staff are prepared and aware of compliance requirements in the areas of safety and well led. Theatres had been chosen as the next area of focus, • Work was underway to Reduce the number of outdated policies, weekly reports were doing to the Care Groups, with full oversight via the Safety Oversight Meeting. A deep dive on policies was also being presented at the December QAC meeting AK informed the Board that there was an environmental health visit scheduled for 9th December 2024. The Trust Board discussed the progress on the Warrington kitchens refurbishment project, it was confirmed the move into the

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	new facility was scheduled for the current week. The board agreed Kitchen staff should be recognised for their patients and dedication throughout the refurbishment project, The board discussed the potential of BCHFT and WHH being inspected simultaneously by the CQC and what that would mean for the joint board. It was confirmed discussions would take place with the CQC relationship manager to discuss integration in more detail and manage expectations **The Trust Board noted the contents of the report.**
BM/24/12/128	**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. WHH Maternity Services – Compliance with Ockenden iii. Monthly Maternity Quality & Safety review iv. Maternity Self-Assessment tool v. Cheshire & Merseyside Perinatal Mortality Review Tool (PMRT) Report Q2 vi. Maternity Incentive 5-Year Update including Saving Babies Lives Care Bundle V3 Update vii. Midwifery Safe Staffing Report (SPC) Q2 viii. Avoiding Term Admissions into Neonatal Units (ATAIN) Q1 ix. Transitional Care Audit Q1 x. Review of Harm AGJ informed the Board that there were no escalations in relation to any of the reports, the Ockenden action plan had been formally closed. There were two additional items to note, which had been presented to committees these were: • Deep Dive - Review of Maternity harm events – September 2023- August 2024, presented to QAC In November 2024 • Deep Dive - Midwifery Workforce, presented to SPC in November which focused on the very low vacancy rate compared to safe staffing. The maternity incentive scheme paper had been presented at the Extraordinary Board meeting on the 29 November. The Trust was on track to complete all safety actions by the required deadline. The final report would be presented to the Trust Board at its meeting on the 5 February 2025. Results of the national maternity survey had been received, ranking the Trust in the top eight maternity services in the country and top five in seven of the ten areas. A comms plan had been developed to promote the positive news both internally and externally. KH added that another good news story around the Trusts maternity services would be circulated via social media, the Trust website and would also feature in the Warrington Guardian around the safe delivery of premature triplets via emergency section at the Trust on the 3rd of November 2024.

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	The Board of Directors noted the appended maternity reports as per national recommendations.
	PEOPLE
BM/24/12/129	**Communications & Engagement Dashboard Report Q2** KH introduced the report, it was noted that the report had been presented and discussed in detail at the Council of Governors meeting on the 14 November 2024. The following key points were highlighted: • The new Trust website accessibility analysis has shown a significant improvement from 64% to 82%, further development was underway to improve further • The Wayfinding Group was meeting regularly and a digital app to help patients navigate Trust sites was being developed. • The Expert by Experience group were helping to learn lessons and improve experiences for patients and their families, the Trust continues to recruit EbyEs and conversations were taking place with Bridgewater on expanding the programme across the two organisations SMcG queried the timeframe for moving to a single website for both BCHFT and WHH, KH confirmed that there were certain statutory requirements around published documentation for each of the sovereign organisations, and work was to be undertaken to determine the most appropriate time to join communication channels. **The Trust Board noted the update.**
	SUSTAINABILITY
BM/24/12/130	**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 Trusts commitment to shifting services from hospital to community, in line with national priorities, key indicators included the Living Well Hub in Warrington seeing over 7,500 visitors since opening and over 64,000 additional diagnostic tests being undertaken in Community Diagnostic Centre (CDC) spaces since opening of the first phase • A new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) was due to be implemented by the end of the year and an additional new pathway had recently been secured for Post Menopausal Bleeding • An update was provided on the plans for the Runcorn health and education hub, procurement was being finalised for refurbishment of the library, with a number of options within budget. The Board discussed inviting commissioner Sarah Hill to visit the Trust to showcase the community health initiatives in Runcorn and Warrington **The Trust Board noted the report.**

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BM/24/12/131	**EPRR Core Assurance Update** DM introduced the report and provided an update on the hospital's emergency (EPRR) annual assurance process for 2024-25, highlighting improvements made over the past year and the importance of continuous training and readiness for potential incidents. The key highlights taken from the report were as follows: • Following review by the ICB of the Trusts 73% compliance score an adjusted compliance score has been submitted as 68%, with 42 of the 62 standards being assessed as fully compliant, and 20 as partially compliant • The workplan was outlined to ensure the Trust continues to move towards full compliance whereby 100% of the NHS EPRR Core standards are met with full compliance • The Head of EPRR has requested an ICB led debrief to ensure learning for the next cycle is captured and embedded. • The overview of the deep dive into Cyber Security was noted The Board discussed and noted the EPRR Annual Assurance self-assessment rating as non-compliant, however recognised a significant amount of work has been put in to support progress towards partial compliance. It was further explained that where there have been partially compliant ratings, the Trust does have resilience, and work continues to fulfil the requirements in line with current legislation and guidance. JD highlighted the training gaps around EPRR assessment, DM confirmed this was an area of focus and it was hoped integration with BHCT would enable a joint approach for EPRR assessment with increased resource to support. DM confirmed he was up to date with courses and training which was part of the core assurance. The Board were informed of the programme of mock EPRR incident training, it was confirmed that NEDs would be invited to observe future mock incident training, for assurance. **The Trust Board supported and noted the EPRR annual Core Assurance Submission**
GOVERNANCE	
BM/24/12/132	**Updates to Scheme of Reservation & Delegation (SORD)** JH introduced the report which proposed the update to the Trust's SoRD. The paper provided details around the removal of the £5,000 authorisation level. This change would introduce an increased level of scrutiny by more senior staff to support a reduction in the Trust's deficit position. **The Trust Board approved the changes to the SORD.**
Supplementary Papers	
BM/24/12/133	**Director of Infection Prevention & Control Q2**
BM/24/12/134	**Learning from Experience Summary Report Q2**
BM/24/12/135	**Patient Experience 6 monthly report**
BM/24/12/136	**Guardian of Safe Working Report Q2**
BM/24/12/137	**Digital Strategy Group Update**
BM/24/12/138	**Review of the Meeting**

DRAFT

	The Trust Board discussed and agreed the meeting had been effective meeting with good discussions and challenge on agenda items
BM/24/12/139	**Any Other Business** No further business was raised. **Meeting ended at 12:30pm**
The Date and Time of the next Trust Board Meeting is Wednesday 5 February, Trust Conference Room, Warrington Hospital	

DRAFT

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TRUST BOARD

AGENDA REFERENCE	BM/25/02/142	SUBJECT:	ACTION LOG	DATE OF MEETING	05 February 2024

1. ACTIONS ON AGENDA

Minute ref	Meeting date	Item	Action	Owner	Due Date	Completed date	Progress	RAG Status
BM/24/12/124	04.12.24	Board Assurance Framework (BAF)	draft a new strategic risk to add to the BAF to incorporate, people, financial and quality risks associated with integration	JC/LG	05.02.25	05.02.2025	See agenda item **BM/25/01/146**	

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/24/12/124		Integrated Performance Report	Facilitate a dedicated Board session on SPC IPR data interpretation	Execs/JC	08.01.25	08.01.25	Session presented at January Board Development Day – SPC Data **BDD/25/01/15**	

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/25/02/144**			
SUBJECT:	**Chief Executive's Report**			
DATE OF MEETING:	4 February 2024			
AUTHOR(S):	Nikhil Khashu, Chief Executive			
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will be the best place to work with a diverse and engaged workforce that is fit for now and the future.	✓		
	SO3 We will work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	**All**			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
				✓
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report provides the Trust Board with an overview of matters on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting.			
PURPOSE: *(please select as appropriate)*	Approval	To note ✓	Decision	
RECOMMENDATION:	The Trust Board is asked to note the content of this report.			
PREVIOUSLY CONSIDERED BY:	**Committee**	Not Applicable		
	Agenda Ref.			
	Date of meeting			
	Summary of Outcome			
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full			
FOIA EXEMPTIONS APPLIED: *(if relevant)*	None			

REPORT TO BOARD OF DIRECTORS

SUBJECT	Chief Executive's Report	AGENDA REF:	BM/25/02/144

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 4 December 2024, some of which are not covered elsewhere on the agenda for this meeting.

2. KEY ELEMENTS

2.1 Integration

Since starting in post, I've said consistently that Warrington & Halton Teaching Hospitals NHS Foundation Trust (WHH) and Bridgewater Community Healthcare NHS Foundation Trust (BCH) are stronger and better together. I firmly believe this, and it is something we're working hard to achieve.

We are in a unique position to bring about transformational change – improving services and pathways for the benefit of our patients and communities. This is vital work, and we must keep it at the heart of everything we do.

We're making good progress on plans to become one single organisation, subject to the necessary NHS regulatory approvals. This change will help us achieve our ambitions and deliver the greatest benefits for our patients and staff.

Our two Boards agreed to an options appraisal process to identify the best way forward. After considering several possibilities, which included a merger, acquisitions, or a shared leadership model, and a recommendation for the acquisition of Bridgewater Community Healthcare by Warrington and Halton Teaching Hospitals will be included for approval in this same meeting, and also at the BCH Board meeting.

Bringing our organisations together in this way won't change how we are already striving to work – closely and collaboratively as one and in line with our organisational values and policies. Instead, it will enable us to formally become a single organisation, combining our talents and resources optimally and responding better to the challenges facing healthcare today and into the future.

2.2 Have your say on a future name

We have now started to think about options for a partnership name to reflect our direction of travel and we have been seeking views to make sure that we get this right as we continue with our integration plans.

The chosen name will represent our approach to joint working, now and into the future. To be fully transparent, the name we choose now will likely influence the future name of our unified organisations. So consider wisely!

It is important we start to think about this for several reasons:

- to signal that by coming together as one we are creating something new, taking the best of both organisations and being stronger for it as a result
- to help us better serve our communities and be more inclusive of all of our services (both community and hospital services, and those across broader areas)
- to communicate clearly and help us provide continuity and consistency of information for staff, patients and communities throughout this period of change
- to be used in very practical circumstances where a single partnership name would be more appropriate (for example on joint systems that are to be used across both trusts and for joint governance and leadership meetings etc).

As with anything in the NHS, there are some rules we need to bear in mind with this – the name needs to include a geographic reference to the area served by the partnership (recognising that there may be a small number of services provided outside of this immediate area). It also needs to include a word such as 'Partnership', 'Collaborative' or 'Alliance', or other such word.

To help gather views, we have created a short survey. It includes some initial naming suggestions and space for you to share any additional comments and ideas you may have. All suggestions are welcome and valued.

Thank you to everyone who has shared their views so far and there's still time to share your thoughts – please complete the survey by Sunday 9 February.

Together, we'll create something stronger than the sum of its parts: an integrated provider of outstanding community and hospital services.

2.3 Overview of Trust Performance

Appendix 1 is a snapshot dashboard overviewing Trust performance across the domains of Quality, People and Sustainability for the last full month of complete reported datasets. In this case, this is month 9 – December 2024. Further detail is provided in the Integrated Performance Dashboard, and associated Summary Report alongside the relevant Committee Assurance Reports.

2.4 Council of Governors

As NHS Foundation Trusts, our organisation has a Council of Governors, made up of elected public, staff, and partner governors. We are accountable to our local community and our Council of Governors help us to involve local people's voice in our work, share experiences and have a say in service development and delivery.

Towards the end of last year, the Trust held elections for the several public and staff constituencies and pleasing we received an unprecedented number of nominations.

Congratulations to all the successful candidates and thank you to everyone who participated in the voting process. We would also like to thank and say farewell to those Governors who have come to the end of their final term of office and those who were not re-elected.

Our governors represent their members who are residents of the communities we serve, along with the general public and their colleagues with whom they work alongside. Each governor is a Foundation Trust member and is elected through a member nomination and vote.

We are extremely well served across our organisations by individuals who have a wealth of knowledge, skills, and experience. Our respective Council of Governors provide invaluable oversight of our organisations and work alongside our Boards of Directors. The role is a voluntary one and they each give up their time freely in support of our two organisations.

I had the privilege of meeting the majority of our new Governors, alongside existing Governors, and the New Governor Induction Day in early January, and know they are fantastic ambassadors for our respective organisations and the wider NHS. It is a great pleasure and privilege for me to work alongside such committed and ardent advocates of our respective organisations. They each bring with them experience of working in the public and private sectors and are motivated by shared ambition to make things the best they can be for our patients and their families.

As we continue to work towards becoming a single organisation, I know that our governor's role will be invaluable to help us drive progress forward. I have no doubt that they will be supporting us to review and develop the systems and processes that underpin this significant undertaking. This is an exciting opportunity to really make things better for our patients and our staff, while also making our services stronger and more resilient.

2.5 Maternity Services

Towards the end of 2024, we received the wonderful news that our maternity services at Warrington Hospital had been named in the top 10 in the CQC's annual national maternity survey findings.

The results capture what women who gave birth in February 2024 felt about the care they received while pregnant, in hospital during and after labour, and once at home in the weeks following the arrival of their baby. The survey is split into four sections which ask questions about antenatal care, labour and birth, postnatal care, and complaints.

As is always the case with these findings, we know there will be areas of improvement to focus on, and a detailed action plan for further progress will be shared later in the year.

However, it would be remiss of me not to shine a light on the news that WHH has been highlighted nationally as a positive outlier, and one of eight Trusts across the country whose results were rated 'better than expected', one of two in the North West, and the only one in Cheshire and Merseyside. This is a significant achievement.

I speak on behalf of everyone when I say how proud we are of the entire team, because the results are based on the experience of the families we care for – which is ultimately the most important factor for us to measure ourselves on. It's incredibly heartening to see all the work being done across the service and the changes that have been made are making a real and tangible difference.

Well done to all involved.

2.6 Getting our patients home

We held a Multi-Agency Discharge Event (MaDE) from Monday 16 December to Tuesday 31 December 2024, and the MaDE for Christmas campaign was our most successful yet. Thank

you to everyone across WHH and BCH who worked so hard and put the energy in to support getting people home for Christmas.

During the event we saw an increase in average weekday discharges from 70 per day to 83, which is an increase of over 18%. A special shout out goes to Ward A6 who hit the top of the improvement chart with a whopping 127% increase in discharges, followed by B19 at 81% and A8 at 63%.

We know that the winter period continues to be challenging, and we will continue to work closely together across our acute and community services to support discharge planning, get people home and free up beds in our hospitals.

2.7 Making our workplaces more inclusive and accessible

International Day of Persons with Disabilities was held on 3 December 2024, and acted as a reminder for us to take stock of what more we can do to promote the rights and wellbeing of people living with disabilities as well as looking at how far we have come in making our workplaces more accessible and inclusive.

The Trust is proud to have achieved Disability Confident Leader accreditation. This is a government initiative which supports employers to embrace the talents of disabled people in the workplace through an inclusive approach to recruiting staff with disabilities and supporting adjustments which can help people with disabilities (also known as reasonable adjustments).

The Trust also has well established staff networks which also support and celebrate the contribution of colleagues with disabilities and long-term health conditions, including physical or mental, hidden or visible.

2.8 Local News

Liverpool Place Announcement

It was announced that following the departure of Claire Wilson, Mark Bakewell has taken up the post of Executive Director of Finance for NHS Cheshire and Merseyside on an interim basis. Mark has a very strong finance background and extensive first-hand knowledge and experience of the financial landscape across Cheshire and Merseyside having previously held the post of Deputy Director of Finance prior to taking up the post of Liverpool Place Director.

For Liverpool Place, it is incredibly important that there continues to be strong leadership across all areas, and it has therefore been agreed - for an interim period - to divide the role into three distinct portfolios, with agreed leadership as follows:

1. **Urgent Care Recovery Programme.** Leigh Thompson, currently Director of Partnerships and Transformation at Merseycare, will undertake this role on a seconded basis for the next 6 months.

2. **Liverpool Clinical Services Review.** It has been agreed that for an interim period, Anthony Middleton and his team will provide the leadership, support and oversight of this programme as it progresses.

3. **Place Based Team leadership** - In addition to his role as Place Director for Halton, Tony Leo has agreed to take on other elements of the role of Interim Place Director role for Liverpool, working closely with Liverpool City Council and other partners to ensure effective healthcare for communities across the city.

Devolution Update

You may be aware that the government published its White Paper on Devolution on 16 December 2024.

Cheshire and Warrington is one of the areas that has been recognised to join the Devolution Priority Programme. The Council Leaders of Cheshire West and Chester, Cheshire East Councils and Warrington will 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.

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

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

2.13 Special Days/Weeks for professional groups

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

December

- National Grief Awareness Week
- International Day of Persons with Disabilities
- Disability History Month

January

- Dry January
- National Obesity Awareness Week
- Cervical Cancer Prevention Week
- Holocaust Memorial Day

2.14 Employee Recognition

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

You Made A Difference Award (December 2024): Rachael Dent, Endoscopy

The winners of the December 2024 You Made a Difference Award is Rachael Dent for going above and beyond to help a patient locate their biopsy results following a delay.
On locating the results Rachael emailed them immediately to the patient's gastro consultant at Leighton followed up with a phone call to ensure that they had been received. Rachael then proceeded to call the patient to ensure they were kept up to date with what was happening. The nomination stated "I had spent months stressing that they had been lost because nobody I spoke to could tell me exactly where they were and if my gastro doctor

had seen them. Rachael spent a lot of time talking to me, calming me down and reassuring me it would get resolved, which it did, I cannot thank her enough. She is a star."

Further Recognition – Chief Executives Cards:

Nikhil Khashu, Chief Executive intended to specifically and personally recognise the contributions of the following colleagues via a handwritten thank you card:

- CT Team
- Learning & Development Team
- Theatre Recovery Team, Warrington

You Made A Difference Award (January 2025): Gemma Jenkins - Histology Operational Manager

The winner of the January 2025 You Made A Difference Award is Gemma Jenkins for going gone above and beyond to improve the lab which was registered as a "fragile service" when Gemma commenced her role during Christmas 2023.
She has gone above and beyond to improve the lab, hire staff, bring the workforce together, bring services back from other hospitals to ours and improve result turnaround times. The lab is no longer registered as a fragile service, and it has been proven that we have the quickest turnaround of patient results in the North west of England. She is always at the forefront of the team, helping with all jobs great and small and always approachable no matter how busy she maybe. The nominator felt that Gemma is an inspiration to the team, and all of this has ensured our patients are receiving the very best service from our hospital in a time when they need reliable and timely results and treatment.

Chief Executive's Award (January 2025): Kevin Burke & Harry Winn-Harrison, Security

Kevin Burke & Harry Winn-Harrison will be recognised as January's Chief Executive Award winners for their quick thinking and actions when they came across an incident at the front of the Emergency Department where a patient was declaring that they had been poisoned along with a strong smell of chemicals, the patient then attempted to enter the rear of an ambulance at which point Kevin & Harry apprehended the individual without any concerns for their own safety.
Following the apprehension of the individual a major incident was declared. The actions of Kevin & Harry were selfless and showed great dedication to both their colleagues and the organisation.

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

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

- ICU and surgical team following a complimentary letter received from a patient
- A&E following a complimentary letter
- A&E, Resus and AMU following a complimentary letter
- Radiology, Mr Chalga and Dr Razzaq following a complimentary letter

Further Recognition – Chief Executives Cards:

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

- Paula Chattington, Consultant in diabetes & endocrinology

- Gina Coldrick, Trust Executive Offices
- Kirsty Watmough, Diabetes Team
- Harry Routledge, Estates & Facilities
- Jamie Kennah, Estates & Facilities
- Kenin Burke, Security
- Harry Wynn-Harrison, Security

2.15 Signed under Seal

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

- IT Relocation & Refurbishment Works

3 MEETINGS ATTENDED

The following is a summary of key external stakeholder meetings I have attended in December 2024 and January 2025 since the last Trust Board meeting:

- Linda Buckley Managing Director, CMAST Provider Alliance
- Graham Urwin, Chief Executive Cheshire & Merseyside Integrated Care Board
- Webinar with Amanda Pritchard and Secretary of State
- Interview with Warrington Guardian
- New Hospitals strategic oversight group
- Merseyside Mental Health, Learning Disabilities and Community (MHLDC) Provider Collaboration Chief Executive Forum
- Carl Marsh, ICB Place Director
- PRAXIS Peter Ridley
- Steve Broomhead, CEO Warrington Borough Council
- Cheshire & Merseyside CEO Providers
- ICB Regional Roadshow
- Chris Douglas, Cheshire & Merseyside Director of Nursing & Care
- Professor Tim Briggs, Chair. Getting it Right First Time (GIRFT)
- Charlotte Nicholls MP
- Superintendent Adam Ross, Area Commander Warrington Police

4 RECOMMENDATIONS

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

5 APPENDICES

Appendix 1: CEO Dashboard – Month 9 (December 2024)
Appendix 2: CMAST Board Update (December 2024 & January 2025)

Appendix 1 - CEO Dashboard Month 9 – December 2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Quality

Operational Performance

Indicator	Target	Actual	SPC
Diagnostic 6 Weeks	95.00%	88.93%	F
RTT 18 Weeks	92.00%	59.47%	F
RTT 52+ Weeks	0	1163	F
A&E % patients seen within 4 hours	> 75.00%	63.21%	F
A&E % waiting longer than 12 hours	< 2.00%	22.44%	F
Cancer 28 Day Faster Diagnostic Standard	75.00%	74.50%	?
Cancer 62 Day Wait	85.00%	72.10%	F
Ambulance Handovers within 60 mins	100%	84.75%	F
Discharge Summaries 24 hours	95.00%	89.79%	F
Cancelled Operations – 28 days	0	1	?
Super Stranded Patients	Trajectory	131	No SPC
Uncapped Theatre Utilisation	85.00%	81.00%	F
Capped Theatre Utilisation	85.00%	75.80%	F

Quality of Care

Indicator	Target	Actual	SPC
Incidents open over 40 days	0	10	F
Sepsis Screening Emergency	90.00%	52.00%	F
Sepsis Screening Inpatients	90.00%	60.00%	F
Sepsis Antibiotics Emergency	90.00%	52.00%	F
Sepsis Antibiotics Inpatient	90.00%	100.00%	F
Inpatient Falls	20.00% reduction	43	?
VTE	95.49%	93.65%	?
Pressure Ulcers	10.00% reduction	17	?
Medication Reconciliation (24 hrs)	80.00%	48.00%	F
Complaints over 6 months	0	2	?
Healthcare Infections - MRSA	0	1 YTD	P
Healthcare Infections - MSSA	N/A	26 YTD	No SPC
Healthcare Infections – CDI (cumulative)	Less than 61 (2024/25)	70 YTD	?
Healthcare Infections - E. coli (cumulative)	Less than 80 (2024/25)	78 YTD	?
Healthcare Infections – Klebsiella (cumulative)	Less than 29 (2024/25)	22 YTD	?
Healthcare Infections - P. aeruginosa (cumulative)	Less than 11 (2024/35)	8 YTD	?
Maternity Postpartum Haemorrhage >1500ml	Less than 3.7%	4.10%	?
MUST nutritional assessment completion	85%	64.16%	F

Sustainability

Finance

Indicator	Target	Actual	SPC
Income & Expenditure (£m)	-£1.25	-£2.34	No SPC
Capital Spend (£m)	£12.36	£7.49	?
Cash Balance (£m)	£4.63	£15.68	No SPC
Better Practice Payment Code (£m)	95%	86%	F
CIP In Year Delivered (£m)	£11.66	£11.36	P
CIP Forecast (Recurrent) (£m)	£11.36	£8.94	?
Agency Ceiling	Less than 3.7%	1.4%	P

People

Workforce

Indicator	Target	Actual	SPC
Supporting Attendance	Less than 4.20%	5.82%	F
Retention	85.00%	87.17%	P
Core/Mandatory Training	85.00%	90.00%	P
PDR Compliance	85.00%	79.81%	F

Strategy

- The **Living Well Hub in Warrington has seen over 9,300 visitors** attend since the doors opened in mid-March 2024. Around 50% of these attendances have been people "dropping in" to the hub to access a service, and the remainder have been for pre-booked appointments. The Hub now has its own social media account to help raise the profile and share information about new and existing services with the local population.
- **Over 68,000 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 **new pathway for paediatric respiratory diagnosis** in CDC Phase 2 (Runcorn Shopping City) is now live and work has also commenced to implement a new gynaecology bleeding pathway utilising the new CDC spaces.
- Work continues with the **integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital Trust**. An options appraisal for the legal mechanism of integration is ongoing with outcome expected to be presented to WHH and Bridgewater Boards in early February. All workstreams are progressing with previously agreed priorities and detailed delivery plans are in development.
- **The Urgent and Emergency Care System Improvement Programme continues**. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly. Referrals to the Same Day Emergency Care (SDEC) unit have increased and are consistently above target (currently over 1,100 attendances per month). ED attendances are down by 3% compared to the same period last year. Although the Emergency department remains extremely busy, and patients are still being nursed on the corridor, the time spent there has reduced significantly.

CMAST Leadership Board
Update to Boards December

CMAST Leadership Board met on 6th December discussing a number of system issues as follows:

The Leadership Board were joined by Trust Chairs for a quarterly update on programme deliverables which covered outputs for the first half of the financial year. A summary of progress to date can be found here. These updates were both noted and widely celebrated by those present.

The Board also received an update on recent system discussions and was asked to feedback, outside of the meeting, on the suggestion that there could be one provider collaborative within C&M. Board feedback was particularly sought on anticipated benefits and any areas which should be subject to wider exploration.

Update papers were also provided on the following areas:

- System financial report
- System performance update

CMAST Leadership Board
Update to Boards January

CMAST Leadership Board met on 10th January discussing a number of system issues as follows:

The Leadership Board were joined by the ICB Medical Director, Rowan Pritchard Jones, to understand the ICB's requirement to begin discussions and to govern approaches to decommissioning services and/or reducing clinical variation. Following a wide ranging conversation the value of at least one provider voice supporting and contributing to the development of these proposals was agreed. This will be taken forward by the ICB.

Mark Bakewell, interim Director of Finance for the ICB, provided an update on the current and aggregate ICS financial position and the moving parts and assumptions being taken into the planning round for 2025/6. This was shared with the Leadership Board in the absence of any published planning guidance (at that time) and was done with the intent of shaping thinking and preparation for activities to come.

Next Linda Buckley, CMAST Managing Director, provided an overview of the current activity within the sector associated with RTT and the apportionment of these volumes between NHS and Independent Sector providers. Further detail was shared on the specialist mix and caseload and discussions took place on the policy direction in this space and the volumes arising from case mix.

Finally, Ann Marr provided the group with an update on feedback from CMAST members on the merits or otherwise of establishing a different approach to provider collaboration within C&M and the proposals from the ICB that a small working group would be established, including the ICB, in order to agree and define some principles and parameters for this work before discussions could be progressed or taken forward. It was expected that this work will start in late January / February.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/02/146**	
SUBJECT:	**Board Assurance Framework** **Annual Review of Board Assurance Framework & Risk Appetite Statement**	
DATE OF MEETING:	5 February 2025	
AUTHOR(S):	Emily Kelso, Corporate Governance & Membership Manager	
EXECUTIVE DIRECTOR SPONSOR:	Nikhil Khashu, Chief Executive	
LINK TO STRATEGIC OBJECTIVE: ***(Please select as appropriate)***	SO1 We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF):	All	

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	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):*

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:

	• It is being proposed that one new strategic risk relating to integration is added to the BAF • There are no changes to the descriptions of any current risks • There has been one update to risk ratings, this is to risk 115, which has been reduced from 16 to 12, given the improved position of nursing establishment. • No target risk ratings or risk appetites have changed • No risks have been closed or deescalated Key updates to existing risk; controls, assurances and gaps are detailed within section 2.6 of the report. Detailed individual strategic risk reports are included as **Appendix 1.** **Annual Review of Board Assurance Framework & Risk Appetite Statement** **During 2024/25:** • One new strategic risk has been added (should the proposed integration risk be approved by Trust Board) • Two risk descriptions were updated, these are risks 1757 and 224 • The risk rating of three risks were updated. These were Risk 115 during Q4 was reduced from 16 to 9 and Risk 1134 during Q2 was reduced from 20 to 12, in addition the rating of risk 1157 was reduced from 20 to 9. • The risk appetite for 3 of the trust strategic risks were updated following committee deep dives. These were, Risk 224 from cautious to open, Risk 1215 from minimal to open • Following committee Deep Dives the target risk rating of 3 of the trusts strategic risks were updated. These were **Risk 134** from 10 (5Lx4C) to 12 (4Lx3C), **Risk 1114** from 6 (2Lx3C) to 5 (1Lx5C) and **Risk 1898** from 4 (L1xC4) to 9 (3Lx3C) • Risk 1757 was deescalated The Trust has an overall Risk Appetite Statement **(Appendix 2)** which is required to be reviewed and approved annually by the Trust Board. For the financial year 2025/26 there are no proposed changes to the WHH risk appetite statement.		
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 addition of the new integration strategic risk integration • Note the annual review of the amendments made to the Strategic Risk Register in financial year 2024/25 • Note the work undertaken via committee Deep Dives throughout 2024/25 to assign appropriate risk appetites to each of the Trusts strategic risk and align those to the target risk scores. • Note the status of those risks monitored by committees through the Corporate Risk Register • Approve the WHH Risk Appetite Statement 2025/26	
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/25/02/146

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
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) ↓	Minimal	QAC
1114	EMD	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	16 (L4xC4) ↔	Minimal	FSC
1372	EMD	If the Trust is unable to procure a new Electronic Patient Record, then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	16 (L4xC4) ↔	Cautious	FSC
1898	CSPO	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	16 (L4xC4) ↔	Seek	FSC
125	COO	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	15 (L3xC5) ↔	Open	EMT

145	CSPO	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	12 (L3xC4) ⟷	Open	EMT
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	12 (L3xC4) ⟷	Open	SPC
TBA	CSPO	***Proposed NEW Integration Risk*** *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, ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, 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

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 Bridgewater Community Healthcare NHS Foundation Trust.

2.1.1 Proposed 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, ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, potentially impacting both Trusts' decision-making and service management.

2.1.2 Proposed new risk rating:

It is proposed that the risk is given a current risk scoring of **9 (3Lx3C).**

Full details of the proposed new risk including associated controls, assurances, gaps and recommendations/actions are provided in **Appendix 1.**

2.2 Amendment to risk ratings

Since the last meeting there has been one change to risk ratings. This change was approved by the Quality Assurance Committee at its meeting 14 January 2025.

Risk 115 around nursing establishment was reduced from **16 (L6 x C4)** to **12 (L3 x C4).** This is a result of the improved position in registered nursing vacancies along with decreases in registered nurse and healthcare support worker turnover. Full details on controls and assurances are included within **Appendix 1.**

2.3 Amendments to descriptions

There have been no amendments to risk descriptions.

2.4 De-escalation of risks

No strategic risks have been closed or deescalated.

2.5 Risk appetite

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

2.6 Existing risks - updates

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

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
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** • 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 2025 • 2023/24 position was in line with original plans and with the reported likely forecast throughout the year. 2024/25 Month 9 position was in line with the forecast. • 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. **Assurances** • 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 **Control and Assurance Gaps** • Implementing PWC recommendations including decrease in bank rates from 13/01/2025 • There is a risk that NHSE will not approve the maximum request. Mitigations to this could include, using capital cash to fund revenue spend, negotiating with the ICS to transact any negative year end cash adjustments to early 2025/26 and delay of payments to creditors	**20 (L5x4C)**	none ⟷
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.	**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	**12 (L3xC4)**	Risk rating was reduced following january

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 10.28 % in November 2024 • Overall CHPPD sustained between 7.8-7.9 in Q3. • Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 13.98% in November 2024 **Gaps** • 444 Red Flags reported in November compared to 368 August 2024- 76 Red Flags were linked to difficulties in providing enhanced care. • Between June – October 2024 over 1200 patients were admitted to WHH with a mental health condition		QAC meeting.
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	**Controls:** 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. **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	**16 (L4xC4)**	None ⟷
125	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	**Controls** • Additional bids generated and submitted nationally to address some of the backlog issues for example LED lighting **Assurance** • Future capital porgramme bids reviewed by senior team and prioritised • Following an environmental health inspection, upgrades to the Warrington kitchen facilities have been completied in October 2024. Phase 3 now commenced Recommendation Completed: • Upgrade Warrington kitchen facilities 29.11.24	**15 (L3xC5)**	none ⟷
1134	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the	**Sickness Absence** The rolling 12-month sickness absence rate is 5.74% as at November 2024 and is showing a slight increase from September which is reflective of seasonal trend with an increase in coughs, colds, flu and covid. Target remains 4.2% however following a recent benchmaking exercise across	**12 (L3xC4)**	None ⟷

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
	financial risk associated with temporary staffing and reliance on agency staff	the C&M region, this target is under consideration as it is one of the lowest targets in the region. **Assurance** • The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 2.94% % in November 2024. **Turnover and Attraction** Turnover in November 2024 remains below target at 12% and is showing an improving variation. Turnover of permanent staff in November 2024 was 11.16% which was below Trust target which is 13%. Retirements are reducing, with relocation the fastest growing reason for people leaving. Work/life balance remains the main reason for leaving. The Trust's November 2024 vacancy rate has significantly reduced to 7.50%, the Trust, target is 9%. This significant reducition is reflective of the Trust's current vigorous scruitiny of vacancies through the ECF panel **Controls** • 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. • 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% **Assurances** • 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 worknig requests enabling greater understanding/scrunity. **Temporary Staffing spend** Bank and Agency reliance in November 2024 was 13.8% . The Trust target is 9%. Bank reliance has slightly reduced to 12.6% and agency reliance continues to decrease to 1.8%. **Controls**		

Risk ID	Strategic Risk	Update since last Risk review	Current Risk Rating	Impact of update on risk rating
		• Bank reliance is driven by the Trusts plan to reduce overall reliance on agency workers. The contingent workforce remains part of safe care. 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.		

3 ANNUAL REVIIEW OF THE STRATEGIC RISK REGISTER - BAF

Detailed in this section is a review of the updates made to the Strategic Risk Register during the financial year 2024/25 up to an including this meeting (5 February 2025)

3.1 New Risks (2024/25)

During Financial Year 2024/25 no new risks were added during Q1 – Q3. However as detailed in this report (section 2.1) it is proposed to add a new risk relating to integration.

3.1.1 Proposed New Integration Risk

Following discussion at the Trust Board meeting December 2024, the board rejected the proposal to amend the description of risk 145 to include integration. Instead, it was agreed a new strategic risk would be introduced to the Board Assurance Framework, as detailed in section 2.1.2 of this report.

ID	Risk description	Rating	Executive Lead
TBA	*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, ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, potentially impacting both Trusts' decision-making and service management.*	9 (3Lx3C)	CSPO

3.2 Amendments to risk ratings during 2024/25

During Financial Year 2024/25 the ratings of **three** risks have been updated, given the reduction in the rating of Risk 1757 from 20 to 9, the decision was made to deescalate the risk during Q3. Movement in each of the strategic risk ratings are detailed below:

Risk ID	Exec Lead	Risk Description	Current Rating Q4 2024/25	Q3 2024/25	Q2 2024/25	Q1 2024/25
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) ↔	20 (L5xC4) ↔	20 (L5xC4) ↔	20 (L5xC4)
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) ↔	20 (L5xC4) ↔	20 (L5xC4) ↔	20 (L5xC4)
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) ↔	20 (L5xC4) ↔	20 (L5xC4) ↔	20 (L5xC4)
1757	CPO	If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety		**Risk De-escalated** 9 (3Lx3C) ↓	20 (L5xC4) ↔	20 (L5xC4)
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) ↔	20 (L5xC4) ↔	20 (L5xC4) ↔	20 (L5xC4)
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) ↓	16 (L4xC4) ↔	16 (L4xC4) ↔	16 (L4xC4)
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) ↔	16 (L4xC4) ↔	16 (L4xC4) ↔	16 (L4xC4)
1372	EMD	If the Trust is unable to procure a new Electronic Patient Record, then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	16 (L4xC4) ↔	16 (L4xC4) ↔	16 (L4xC4) ↔	16 (L4xC4)
1898	CSPO	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	16 (L4xC4) ↔	16 (L4xC4) ↔	16 (L4xC4) ↔	16 (L4xC4)
125	COO	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	15 (L3xC5) ↔	15 (L3xC5) ↔	15 (L3xC5) ↔	15 (L3xC5)
145	CSPO	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative	12 (L3xC4) ↔	12 (L3xC4) ↔	12 (L3xC4) ↔	12 (L3xC4)

Risk ID	Exec Lead	Risk Description	Current Rating Q4 2024/25	Q3 2024/25	Q2 2024/25	Q1 2024/25
		impacts on patient care, reputation and financial position.				
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	12 (L3xC4) ⟷	12 (L3xC4) ⟷	12 (L3xC4) ↓	20 (L4xC5)
TBA	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, ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, potentially impacting both Trusts' decision-making and service management.*	9 (L3x3L)			

3.3 Amendments to Risk Descriptions:

During the financial year 2024/25, there have amendments to the descriptions of two of the Trusts strategic risks, details of these changes are provided below:

3.3.1 Risk 1757

Quarter 2

From: *If we fail to effectively plan for and manage industrial action caused by Trade Unions taking strike action then this could result in significant workforce gaps which would negatively impact service delivery and patient safety*

To: If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services.

Quarter 3

From: *If industrial action continues to take place, then workforce availability and wellbeing may be negatively impacted affecting delivery of services*

To: *If GP collective action continues to take place, then operational delivery may be negatively impacted affecting delivery of services.*

3.3.2 Risk 224

Quarter 3

From: *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.*

To: 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.

3.4 De-escalation of Risks

During Q3 of the 2024/25 financial year, the Board approved the de-escalation of risk 1757, given that the remaining risk related to the operational impact of the GP collective action, the only remaining assurance gap.

The risk is now monitored through QAC via the Corporate Risk Register and ownership has moved from the Executive Medical Director and Chief People Officer to the Executive Medical Director only, with operational ownership from the Trusts Emergency Preparedness, Resilience and Response Lead.

3.5 Committee Deep Dives of Risk Appetites and Target Risk Ratings

Each of the monitoring committees undertook a Deep Dive of their assigned strategic risks during Q2 2024/25. The aim of the Deep Dives was to review the risk details including agreeing individual risk appetites for each of the Trusts strategic risks and to align target risk ratings to the agreed risk appetites.

3.5.1 Key changes to risk appetites following committee Deep Dives:

Following the Deep Dive discussion at the Quality Assurance Committee on 9 July 2025, the risk appetite of two risks were updated.

- **Risk 224** – The risk appetite was amended from **Cautious** to **Open** as it more accurately reflected the actions taken and controls in place to improve the position, such as the introduction of the LLP and boarding.
- **Risk 1215** – The risk appetite was amended from **Minimal** to **Open**, due to the willingness to consider all potential delivery options while also providing an acceptable level of reward.

3.5.2 Key changes to target risk ratings following committee Deep Dives.

Following the Deep Dive discussion and the Finance and Sustainability Committee on the 26 June 2024, the target risk ratings of three risks were updated.

- **Risk 134 -** The target risk rating was increased from 10 (5Lx4C) to 12 (4Lx3C) to better align with the agreed risk appetite of **Open**
- **Risk 1114 -** The target risk rating reduced from 6 (2Lx3C) to 5 (1Lx5C) to better align with the agreed risk appetite of **Minimal.**
- **Risk 1898 –** The target risk rating increased from 4 (L1xC4) to 9 (3Lx3C) to better align with the agreed risk appetite of **Seek.**

BAF reports to committees and Trust Board now include a unique risk appetite for each strategic risk, these are assigned based on the risk appetite matrix recommended by The Good Governance Institute.

4. RISK APPETITE STATEMENT

The Trust Board is required to review and approve the risk appetite statement on an annual basis.

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

There are no proposed changes to the Trust Risk Appetite Statement to take forward into 2025/25. See **Appendix 2** for the current and proposed 2025/26 WHH Risk Appetite Statement.

5. CORPORATE RISK REGISTER

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

Risks on the Corporate Risk Register may be escalated or de-escalated to or from the Strategic Risk Register as appropriate. A Corporate Risk Register report is presented to the Risk Review Group

The Corporate Risks are also monitored at the appropriate Board Committees

The current Corporate Risk Register is included as **Appendix 3** for noting.

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 addition of the new strategic risk relating to integration
- Note the annual review of the amendments made to the Strategic Risk Register in financial year 2024/25
- Note the work undertaken via committee Deep Dives throughout 2024/25 to assign appropriate risk appetites to each of the Trusts strategic risk and align those to the target risk scores.
- Note the status of those risks monitored by committees through the Corporate Risk Register
- Approve the WHH Risk Appetite Statement 2025/26

Appendix 1

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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

Risk ID	Executive Lead	Risk Description	Strategic Objective at Risk	Current Rating	Target Rating	Risk Appetite	Monitoring Committee
224	COO	If there are capacity constraints in the Emergency Department, Local Authority, Private Provider and Primary Care capacity; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four-hour emergency access standard and have patients waiting more than 12 hours in the department from time of arrival resulting in an overcrowded Emergency Department.	1	20 (L5xC4)	8 (L2xC4)	Open	Quality Assurance Committee
1215	COO	If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans.	1	20 (L4xC5)	6 (L3xC2)	Open	Quality Assurance Committee
134	CFO	If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton	3	20 (L5xC4)	12 (L4xC3)	Open	Finance & Sustainability Committee
2001	EMD	If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards.	1	20 (L5xC4)	6 (L2 xC3)	Minimal	Quality Assurance Committee
115	CN	If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	1	↓ 12 (L3xC4)	8 (L2xC4)	Minimal	Quality Assurance Committee
1114	EMD	If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations.	1	16 (L4xC4)	5 (1x5)	Minimal	Finance & Sustainability Committee
1372	EMD	If the Trust is unable to procure a new Electronic Patient Record then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety	3	16 (L4xC4)	8 (L2xC4)	Cautious	Finance & Sustainability Committee

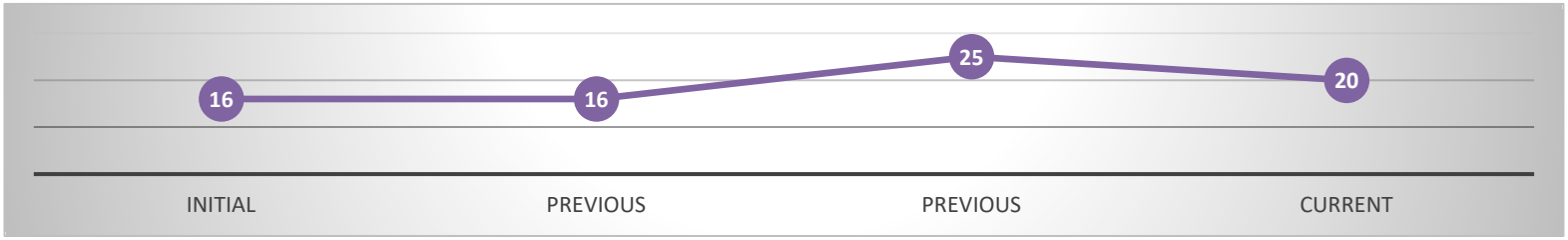
1898	CSPO	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.	3	16 (L4xC4)	9 (3x3)	Seek	Finance & Sustainability Committee
125	COO	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns	1	15 (L3xC5)	10 (L2xC5)	Open	Executive Management Team
145	CSPO	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position.	3	12 (L3xC4)	8 (L4xC2)	Open	Executive Management Team
1134	CPO	If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	2	12 (L3xC4)	8 (L2xC4)	Open	Strategic People Committee
TBC	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, ensure long-term sustainability (Triple Aim Duty) and mitigate risks associated with shared Board roles, 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

- Regular Trust Wide Capacity meetings led by the Tactical Manager for the day
- Discharge Lounge/Patient Flow Team/Silver Command
- ED Escalation processes/intentional rounding with ED Consultant and Nurse in charge.
- Private Ambulance Transport to complement patient providers in and out of hours
- Frailty Assessment Unit FAU/ operational 5 days per week.
- Gynae Assessment Unit (GAU) and Paediatric Assessment Unit (PAU) operational 7 days per week.
- Relaunch of the deflection policy for minor injury patients overnight, where appropriate.
- Enhanced Paediatric ED opened in May 2021 that encompasses a larger footprint & more cubicle space. This supports compliance with RCEM guidance.
- Co-located minors area adjacent to the SDEC centre and ED ambulatory signed off to allow for a UTC type model on the Warrington site. Became operational April 24.
- Increase IMC provided by the system such as the opening of the additional bedded capacity
- Increase IMC at home
- Integrated Discharge Team – Daily huddle between hospital discharge team and the hospital social care team now in place.
- Same Day Emergency Care Centre (SDEC) completed July 2022.
- Co-located and upgraded Minor Injuries nit.
- Meetings with senior leaders from the ICB and Local Authority to review and discharge taking place weekly.
- Monitoring of utilisation of internal UC system i.e. GPAU, ED Ambulatory throughput. Reports monitored via Unplanned Care Group, ED & KPI Meetings
- Additional Senior Manager on call support a weekends
- Senior Dr at Triage Function
- CT scanner co-located in the main body of the ED department in 2023.
- Phlebotomy business case approved to support earlier decision making and flow in AMU to support flow out of the ED for acute medical patients.
- Winter planning in place to identify additional community and Trust based capacity to support expected activity levels for winter
- Virtual frailty ward, live from 1st February 2023, in line with national planning. This will help reduce admissions from care home to A&E
- Additional Nurse Staffing paper to support increases in the substantive workforce and manage escalation areas supported by the Trust Board
- On a daily basis the Trust utilises the SHREWD Resilience system to inform tactical and strategic site decision making in relation to flow and occupancy.
- Introduction of the new Manchester Triage Process from 14th April 2024 to support reduced overcrowding in ED and improve clinical quality and patient experience

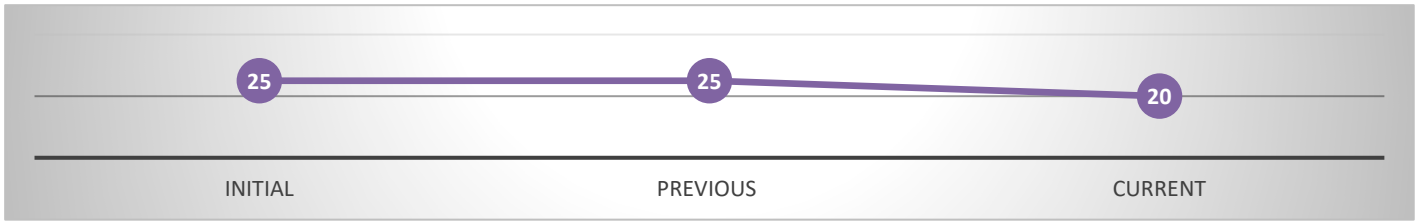
	• Winter escalation capacity (ward A10 & bay of 6 on Ward B4) planned to be open in Winter 2024/25 to support flow and urgent care • The Performance Improvement & Oversight Group has been established in place of the ED Improvement Gorup and is the oversight group for the performance of the Urgent & Emergency Care System Improvement Group • The Performance Improvement & Oversight Group reports to the Finance & Sustainability Committee **Assurances** • System actions agreed supporting the Winter Plan • Redeveloped ED 'at a glance' dashboard • Trust implemented NHS 111 allowing for directly bookable ED appointments • Integrated discharge Team in place • Respiratory Ambulatory Care Facility agreed. • Royal College Emergency Medicine Resetting ED Care guidance received, acted upon and achieved • Non-Elective flow activity now above 2019/20 activity levels for type 1 & 3 • Same Day Emergency Care Centre (SDEC) opened July 2022 • Plans to reduce length of stay for criteria to reside patients using SAFER methodology. • Following closure of the Lilycross facility at the end of May 2023, additional capacity has opened in Statham Manor, Grapenhall Manor and Oak Meadow. This replacement capacity is open and operational. • As a result of national urgent care tiering (Warrington placed in Tier 1), the Trust continue working with ECIST to support a service improvement programme. • Continuous flow commenced on 8th October 2023. • Triage and streaming test of change commenced in November 2023 to improve productivity and utilisation of assessment areas to support lowering ED occupancy. • Transition to type 5 SDEC reporting went live on 1st November 2023. This will support improvements in streaming and data to allow the organisation to plan access and flow more robustly. • Reconfiguration of the ED footprint took place on 8th November 2023, to create a new ED admission area. This will support the reductions in 12-hour time in department as referenced in the Tier 1 urgent care metrics. • As part of being in tier 1 urgent care, the Trust and wider system were supported by Newton to undertake a place diagnostic on capacity and demand. The outcome has instigated a project to help improve flow, reduce attendances and thus lower bed occupancy. • Urgent & Emergency Care System Improvement Group established in May 2024. The aim of the Group is to deliver the opportunities identified by the Newton work. It covers 5 workstreams with system partners to improve urgent care performance and eradicate corridor care. This programme of work feeds into the ICB Urgent Care programme of work. • Review of the ED footprint being undertaken to identify opportunities to increase capacity and improve efficiency. • Updated nursing documentation to include risk assessment for when patient is cared for in an escalation space/corridor
Assurance Gaps	**Gaps in Controls** • Ongoing industrial action across a number of staffing groups including junior medical staff. **Gaps in Assurances** • Increase growth of higher acuity in types 1 & 3 as a result of population need and lack of access to Primary Care

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Continued Escalation of Breaches and Patients Requiring Admission	Escalation of 4 hours quality standard and 12-hour decision to admit emergency access standard.	Escalation per ed safety escalation via Bed Meeting, Tactical Command and SMOC (out of hours) and Executive on Call.	Bowman, Karen	31/03/2025 (ongoing)	
Ongoing Monitoring of the Emergency Access Standard	ED Insight report daily SITREP report National report and benchmarking outcome UEC north dashboard Robust ongoing monitoring	Ongoing monitoring of risk via daily report SITREP, Daily Capacity and Demand report from 4* daily bed meetings.	Bowman, Karen	31/03/2025 (ongoing)	

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

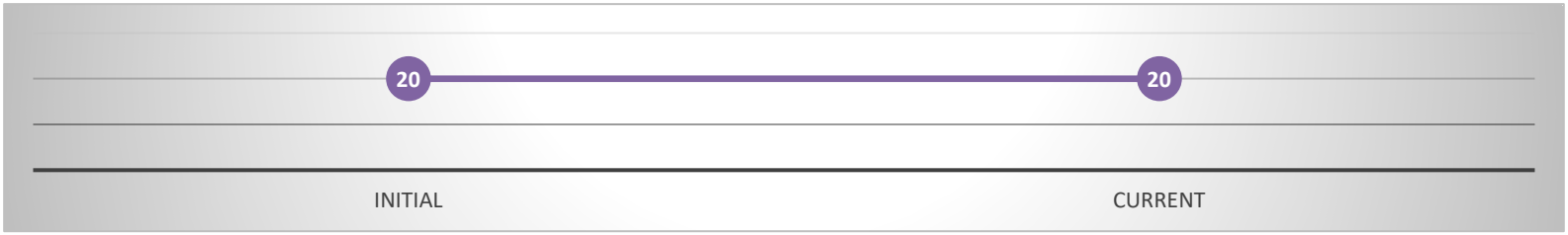
Risk ID	1215	**Executive Lead**	Chief Operating Officer	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If the Trust does not have sufficient capacity (theatres, 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. • . • Recruitment to Dom Care ICAHT & Discharge Team posts agreed with the System Sustainability Group for the workplan for 2023/24 • Workforce is continually reviewed to ensure that all wards and teams are staffed safely. • Live dashboards and weekly activity reporting in place to ensure oversight and transparency of Trust recovery, via the Performance Review Group and weekly PTL meetings • Deployment of modular build at the Halton site to provide additional pre-operative assessment capacity in support of elective recovery • The Halton site developed as a cold elective site to protect it from cancelations as a result of urgent care pressures. • Capacity identified and being utilised with appropriate independent sector providers • Capital build approved via the national Target Investment Fund (TIF) of the development of the Halton site. The outcome of this project will increase diagnostic & elective capacity for the Trust in the form of an additional Endoscopy room, a 5th Theatre as CSTM, a day case unit and increased CT and MR capacity, due Spring 2025 (all phases to be complete) • Weekly theatre scheduling to ensure listing of patients in line with national guidance, with the support and guidance of Cheshire and Merseyside Productive Partners • Bioquell Pods deployed in ICU in March 2021 to support flow and IPC compliance. This will help reduce instances of having to escalate capacity to the Main Theatre at the Warrington site. • Continue to specifically focus on and monitor patients waiting greater than 52 weeks & 65weeks • Continue to ensure urgent cancers are prioritised in line with national guidance • Workforce pay incentives reviewed to create additional capacity in non-contracted work time e.g. evening and weekends. • Continued use of Insourcing and outsourcing providers (NHS approved contractors) in 2024/2025 to support 65 & 78-week target. Following approval by Execs. • Ongoing validation of the trust waiting lists to improve data quality **Assurances** • All elective patients have been clinically reviewed and categorised in line with national guidance. • New working arrangements are in place to maximise capacity whilst operating in line with IPC guidance. • Post Anaesthetic Care Unit (PACU) operational from January 2021				

	• New Clinical Treatment Suite opened in the Nightingale Building in May 2022 to support the reduction in chronic pain waiting lists an increase theatre capacity to support restoration and recovery. • Same Day Emergency Care Centre (SDEC) opened in August 2022 • Bioquell Pods in ED live and operational • Harm and waiting lists reported to Quality Assurance Committee, Finance & Sustainability Committee and Patient Safety & Clinical Effectiveness Sub-Committee. • Respiratory nursing business case approved to support step down of respiratory patients from ICU to B18 earlier in their care pathway thus creating ICU capacity to support planned care • Reviewing workforce pay incentives to create additional capacity in non-contracted work time e.g. evening and weekends. This links to the MIAA WLI Review & recent review of the rate card payments • Regular meetings and communication with the ICB and primary care GP's to inform them with recovery progress within the organisation and to highlight/address any identified problems. • Participation in the national 'My Planned Care' scheme to support and inform patient waiting time status and support safe management of waiting lists • Productivity Improvement Oversight Group (from May 2024) in place to deliver the GIRFT/Efficiency programme to increase theatre and outpatient productivity and utilisation • The Trust has been confirmed as the regional diagnostic hub to support the reduction of local and system waiting lists. • New CT and MR scanner replacement to be undertaken in 2023/24 • CDC phase 1 gone live in July 2023. CDC phase 3 including CT & MRI due to open in spring 2025 • Trust Board support for additional use of independent sector to treat all outpatients in 65-week wait cohort. The Trust Board supported £4.6m for third party providers to treat all 78 & 65 waiters by the end of September 2024 & significantly reduce 52-week waiters. Monthly reporting to the Finance and Sustainability Committee. • Regional funding secured to support reduction in the echocardiogram waiting list. This is with third party providers and commenced on 1st November 2023.
Controls & Assurance Gaps	• Capacity challenge with social workers to keep on top of demand and necessary patient assessments. • Estates work is required to complete the development of the Elective Centre at Halton and the reconfiguration of the day case facility. • Limited bed base within A5 elective footprint on the Warrington site. • Workforce capacity challenges in the medical workforce

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

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 • CEO led improvement meeting (inc finance & improvement) now take place three times per month • Procurement/tender waiver training in place • TIF funding relates to the Halton Elective Centre, and this has now been approved (£9.2m capital over 3 years) • Latest guidance from MIAA Counter Fraud Team circulated • Counter Fraud campaign took place for national anti-fraud week in November 2023 and is planned for w/c 18/11/24 • Revised approach to GIRFT/ improvement/ CIP. Leadership from Executive Medical Director and joint reporting to FSC introduced. • Appointed GIRFT Finance Lead and 5 PAs allocated. • Appointed Head of Improvement • Financial strategy developed to support improvement in financial sustainability. 2022-2027 Financial Strategy approved by the Trust Board in May 2022 • High Level 5 year plan presented to the Finance & Sustainability Committee in April 2024 • CDC phase 1 & 2 complete. Phase 3 to be completed by 31st March 2025 • Capital Plans for 2024/25 approved by the Trust Board in March 2024. 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 2025 • 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 9 position was in line with the forecast. • New process introduced that any new revenue spend must be submitted to the Executive Team and/or Trust Board for approval as appropriate. Approval will only be provided if it is self-funding or relating to patient/staff safety and consideration whether CIP has been fully identified. • In addition, new revenue spend to support activity targets is approved by Executives/ Trust Board only when the cost does not exceed tariff, all internal options have been considered (WLI, productivity) and no mutual aid is available • Introduced process for oversight of unfunded and partially funded cost pressures via routine reporting to the Executive Team and the FSC with Deep Dive at FSC on highest cost • Cheshire & Merseyside ICS 3 year financial strategy and recovery plan submitted in September 2023 • Tightening controls of non-pay expenditure with executive review of catalogue spend and implemented cease option to purchase some items • 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.				

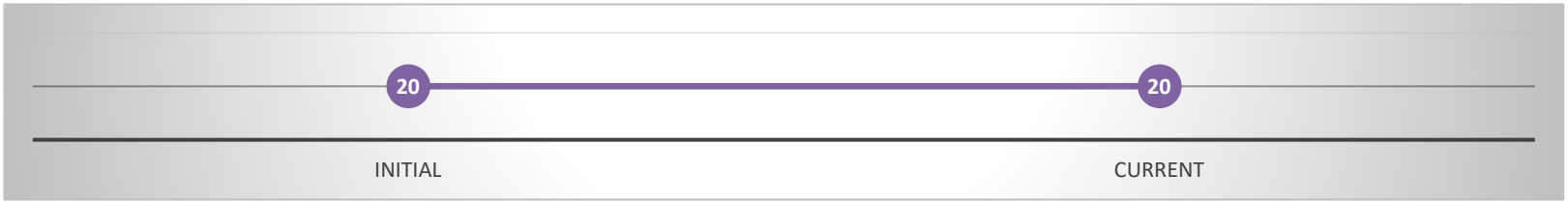
	• Enhanced ECF meetings in place with Chief Executive sign off, with ICS attendance. Bridgewater Community Healthcare NHS FT invited to attend. • Urgent & Emergency Care System Improvement (UECSIP) Lead with Place support • Introduced system of escalation where capital paperwork has not been produced by Q1 • Executive Review of CIP gap and unfunded cost pressures. • Review of non-recurrent CIP and move to recurrent if possible • Fortnightly Executive led meeting to monitor spend on WLI/ Insourcing/ LLP to support 65 & 52 Week recovery. • review of Nurse variable pay – 3 times per week • Weekly review of medic variable pay • PWC action tracker in place – monitored through Execs • PWC support to review theatre opportunities, grip & control nad coolaboration, with weekly feedback meetings during November 2024 • FICC weekly meetings ICS & PWC and the 4 Trusts in mandated support to review and challenge process on improving finacial position **Assurances** • Achieved ICS control total in 2022/23 • The 23/24 the control total was exceeded by the stretch target set by the ICS. The Trust has highlighted the level of risk throughout the year. • Delivered 2023/24 Capital Plan • Unqualified audit opinion (2023/24) submitted on time • Completed MIAA Governance Checklist received by Audit Committee • Monthly Report to Executive Team Meeting and FRG highlights the number of retrospective waivers compared to the previous year, the number of staff trained and the number of staff who have received training but not followed the correct process. • Refresher training offered to those who undertook training over 12 months ago but then submitted a retrospective waiver • Capital is reported monthly to FSC detailing all schemes above £500k monitoring underspends against plan and expected end date. This is in line with MIAA recommendations. • Changes to WTE have been reviewed by the Finance & Sustainability Committee during the year and the Trust has seen a significant reduction in agency with an increase in bank and substantive staff. The 2024/25 challenge is to keep agency to below the 3.2% ceiling and reduce bank. Month 8 agency is 1.2% • C&M ICS have indicated that there should be a 2% reduction in staffing in the 2024/25 plan in line with the 5% CIP target • HFMA self-assessment completed and audited. • We have allocated CIP targets for 2024/25 including additional 2% reduction on non-clinical staffing and an additional 1% in second half of the year • Richard Barker/Graham Urwin Letter re: financial controls received. All actions received by the Finance & Sustainability Committee and the Trust Board. Response has been provided. • Continue to work with the system through the Warrington System Sustainability Group and One Halton to support system priorities and long-term sustainability. • Key financial controls review 2023/24 received substantial assurance for general ledgers and high assurance for accounts receivable and treasury management. • System-wide diagnostic undertaken to quantify the operational opportunities to improve UEC effectiveness and efficiency across Warrington & Halton to provide clarity of operational and financial opportunities and outcomes by organisation. • Final 2024/25 Operational Plan has been submitted in June 2024 • Quarterly reports to be submitted to the Finance & Sustainability Committee to review the cash position • Replied to the National Team to confirm enhanced control for pay and non-pay are in place and adhered to in line with cash support requirements • In November 2024 submitted revised risk adjusted forecast with £8.6m variance from the control total, following full review of CIP, cost pressures, IA and pay award
Control & Assurance Gaps:	• Non-recurrent and unidentified CIP, and high-risk schemes, presents a risk to in-year and future year financial position. • No external funding support for Halton Healthy New Town or Warrington Hospital new build. • Risk of unforeseen costs and under delivery of activity and income due to further Industrial action / Acuity of patients / NCTR / growth in ED attendance • Availability of social care to support the current super stranded position (currently c22% of bed base). Estimated annual cost of circa £11m • Additional capacity opened across the Trust supported in part by non-recurrent funds. This presents a risk to sustainability as capacity is funded part year only • Additional capacity remained open in quarter 1 closed in June 2024. • Required to deliver additional activity within existing resources whereby funding will be lost if activity not delivered within PbR • Risk to financial freedoms as the Trust has a deficit plan & requires cash support • Achieving 104% of 19/20 in core capacity is key to delivery of GIRFT/ CIP

	• Agency is 1.2% of pay bill YTP (ceiling is 3.2%) • Implementing PWC recommendations including decrease in bank rates from 13/01/2025 • There 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

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

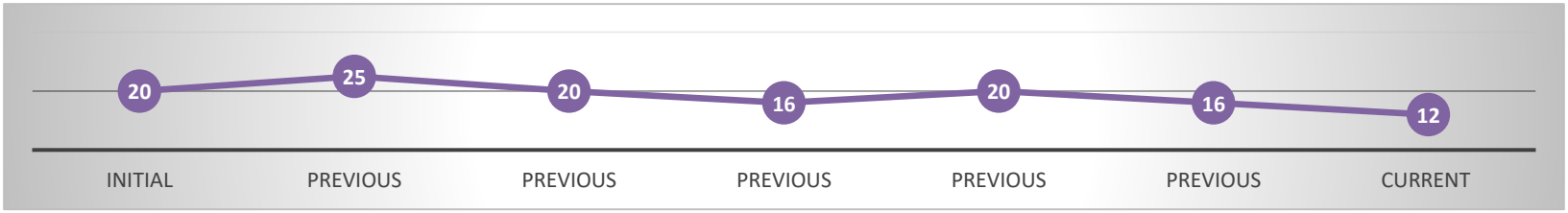
Warrington and Halton Teaching Hospitals NHS Foundation Trust

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 standardised Fragile Service Reports to Patient Safety and Clinical Effectiveness Subcommittee (PSCESC) • • Escalation to Quality Assurance Committee via PSCESC escalation reports Bi-monthly Fragile Services report to Trust Board				
Assurance Gaps	•Capacity constraints impinging on Fragile services (Staffing, theatres, diagnostics, outpatients, bed base) •Ongoing industrial action •Increasing demand				

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date

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 3 times a week
- Bi-annual acuity reviews completed with analysis of results to ensure establishment levels align to dependency and acuity.
- Twice daily review of red flag data to identify staffing, patient acuity and dependency across all clinical areas with movement off staff and consideration of skill mix to ensure safe staffing levels.
- Temporary staffing requested via NHS Professionals, process in place to fill shifts via bank prior to escalation to agency request via agreed Agency Managed Service
- Staff numbers and skill mix recorded daily on Gold Command report for transparency of clinical decision making.
- Workforce Review Group in place to monitor progress against recruitment and retention planning across the Trust.
- Agency reduction plan in place
- Local workforce plans in place for Emergency Department and Maternity with additional support from Executive Team
- Local recruitment in place targeting ED and Endoscopy who have had recent investment / establishment increases.
- Open advert for RN/HCSW recruitment
- Quarterly recruitment events in place
- Sickness absence being manged in line with Trust policy.
- Monthly Cost Pressure Clinics in place reviewing sickness management/recruitment/skill mix/supernumerary status/maternity leave cover plans

Assurances

- Increase in registered nursing establishment in the Emergency Department, 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 10.28 % in November 2024
- Overall CHPPD sustained between 7.8-7.9 in Q3.
- Healthcare Support Worker turnover has decreased from 16.42% in January 2023 to 13.98% in November 2024
- Quarterly recruitment events for RN and continuous advert with regular shortlisting and interviews for HCA Vacancy,
- Support and guidance to student nurses from the beginning of their training to qualifying through the STEPP programme. 35 students recruited in Summer 2024 who commenced in post in Q3.
- Cost avoidance of £2,088,871m (end November 2024) from agency managed service contract started August 2022

	• International Nurse recruitment: Final cohort (11 staff) in post, pause for WHH in programme, pastoral care and retention is focus. • Part of the Cheshire and Mersey staff Retention Forum to share and benchmark retention plans and receive support from ICS Retention Lead • Minimum staffing levels agreed for every ward, analysis of monthly shift fill completed with mitigation plans in place and reported to Trust Board bi-monthly. • Site Manager and Matron on site until 8pm (Warrington and Halton site) on weekends • Rolling recruitment for RN and HCA posts, weekly interviews • Leaver data is closely monitored, and the Board have supported a position of over recruitment to enable replacement of leavers in a timely manner. • Internal Transfer process in place for staff to support retention. • Nurse Staffing and Clinical Outcomes Group provides a forum through which nurse staffing and clinical outcomes data sets could be reviewed and triangulated to highlight wards or departments at risk. • Increased cohort of Care Support worker Development Programme (CSWDs) 12x CSWDs commenced Q3 with 4 x 12 cohorts planned for 2025. • The number of wards achieving 90% fill rate increased to 23 wards in November 2024 from 17 in December 2023.
Assurance Gaps	• Increased operational capacity and demand results in the need to open additional areas to provide patient care, increasing the staffing need e.g. Treatment/MDT rooms on B14, B19; accelerated transfers and boarding out of hours – Beds were opened in escalation areas 88 times in November 2024 • 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 • Partially funded revenue requests • Time to post when recruiting new staff. • 444 Red Flags reported in November compared to 368 August 2024- 76 Red Flags were linked to difficulties in providing enhanced care. • Between June – October 2024 over 1200 patients were admitted to WHH with a mental health condition

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Focus upon the Workforce Strategy to proactively retain, fill and review vacancies alongside care need. To include succession planning and staff opportunities.	Assurance of Workforce Strategy progress through the Workforce Review Group and associated workplans.	Workforce Review Group to provide updates on specified workstreams to the Quality Assurance Committee and Strategic People Committee as part of the staffing report, ahead of submission to the Board of Directors. This will include: • Domestic and international nursing recruitment – complete? • Position and plans for staff retention. • Planning for the future – succession planning and staff development. • 6/12 establishment reviews. • Triangulation of staffing position alongside patient safety measures.	Chief Nurse	19/10/24	November 2024

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:** • [DSPT Standard(s): 1.3.5] & 1.3.6] Risks for Cyber on Trust's risk register in line of national requirements of the Data Security Protection Toolkit (DSPT) & NHS England • [DSPT Standard(s): 1.3.5] & 1.3.6] Digital Governance Structure including bi-weekly structured Senior Leadership Team meetings, monthly Risk Register Reviews, monthly Budget Meetings (where CIP and cost pressures are reviewed), Information Governance and Records Sub-Committee, Service Delivery Group with escalations to the Quality Assurance Committee and Finance Sustainability Committee. The high level Quality Assurance Committee report provides assurance against all key security measures (i.e. Risks/GDPR/Data Security & Protection Toolkit/Data Incidents/Audit Actions/IG training figures). • [DSPT Standard(s): 9.4.5] Digital annual IT audit plan inclusive of ever-present overarching Data Security & Protection Toolkit baseline and final report, with MIAA Management response with progress monitored at the Trust Audit Committee. • Trust benchmarking activities including Use of Resources reviews (Model Hospital). • New updated ITHealth Assurance Dashboard is live, monthly external network penetration testing is now in place using NHS England's VMS service and BitSight security score is live. • Approval of the subsequent Annual Prioritised Capital Investment Plan as managed via the Trust Capital Management Committee. • Digital Services have implemented all national guidance regarding Log4J vulnerabilities highlighted by NHS Digital • WHHT return for assurance re cyber security to NHS England • [DSPT Standard(s): 7.1.4] Active core member C&M ICB Cyber Core Group, C&M ICB Cyber Security Group and the Cyber Associates Network (CAN) • Outcome of the third Phishing exercise by NHS England, communications have been sent out to staff members who entered details for awareness. **Controls:** • [DSPT Standard(s): 1.3.5, 7.1.2. 7.1.3, 7.2.1, 7.2.2 & 7.3.2] **Digital Operations Governance** including supplier management, product management, cyber management, Business Continuity And Disaster Recovery Governance and customer relationship management with CBUs (e.g. The Events Planning Group) and an Information Security Management System (ISMS) based upon the principles of ISO27001 security standard. • [DSPT Standard(s): 9.5.1] **Digital Change Management** regime including including the Digital Development Group, the WHH Change Advisory Group, The Digital Transformation Group, Trust communication channels (e.g. the Events Planning Group) and structured Capital Planning submissions. • **Trust Data Quality** Policy and Procedures (e.g. Data Corrections in response to end user advice) plus supporting **EPR Training** regime for new starters including doctor's rotation and annual mandatory training. • External NHS England approved Cyber Training for the Trust Exec Board • [DSPT Standard(s): 8.3.1, 8.3.2, 8.3.3] The use of automatic patching software to rollout security updates to devices. • Existing external network traffic is monitored by NHS Digital for both HSCN & Internet links. • [DSPT Standard(s): 7.3.4] Secondary secure backup at Halton Data Centre				

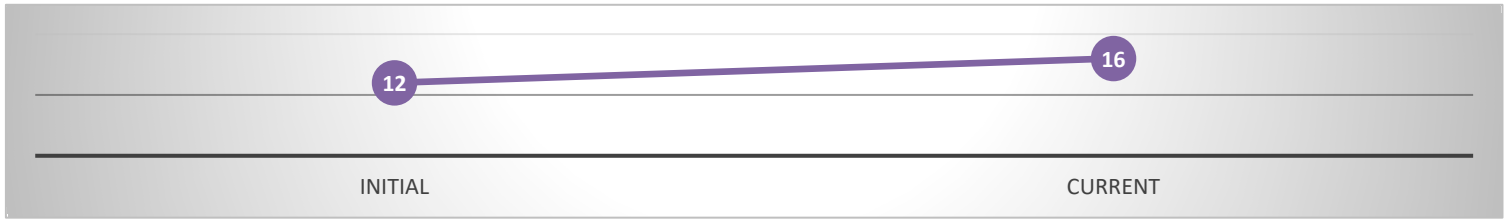
	• [DSPT Standard(s): 9.6.5] Remote devices no longer bypassing the web proxy • New Phishing exercise by NHS England has been arranged for 24/25 • [DSPT Standard(s): 8.4.1, 9.6.6] Local device (PC & laptop) based firewalls now enabled • Vulnerability identified by Dedalus obtaining elevated SQL access to data in ORMIS has been patched • [DSPT Standard(s): 4.5.3] MFA active on new starters for NHSMail • [DSPT Standard(s): 8.1.4 & 8.4.2] MUSE migrated to new server
Assurance Gaps	**Gaps In Assurance:** • Achieving 98% standards of mandated compliance with DSPT, incorporating CE+ (moderate assurance given by MIAA for the standards audited and substantial in respect of the veracity of the self-assessment (23/24). • 24/25 DSPT has been aligned to the new Cyber Assurance Framework. No Trust is expected to be compliant until 2030. **Gaps In Controls:** • No real-time early warning of zero-day attacks due to the lack of network pattern matching software. • Ability to mitigate cyber configuration of nationally provided systems (e.g. ESR) and non-Microsoft devices (that meet a clinical need). • Using generic logins staff usernames and passwords are stored in browser when selecting "remember me" • [DSPT Standard(s): 4.2.3 & 4.4.1] No dedicated logging tool to pull all key logs together and provide useable alerts. • [DSPT Standard(s): 8.3.6] Lack of process to check antivirus/MDE alerts in console. MIAA to review processes and tools • [DSPT Standard(s): 4.4.2] Administrator accounts still have access to the Internet & email, although only used when required (SIRO approved process, best solution between operational vs security). • [DSPT Standard(s): 8.1.4 & 8.4.2] Using unsupported software SharePoint 2010 for the Hub • No controls in place for Bluetooth connectivity. Would be difficult to implement. • [DSPT Standard(s): 8.1.2] Data Loss Protection (DLP) is currently disabled until the ePO service is upgraded on the server, stopping read-only access of USB devices • [DSPT Standard(s): 4.5.3] MFA on limited number of systems • [DSPT Standard(s): 8.3.4] Limited 24/7 dedicated cyber cover • SmartSheets (cloud-based) currently does not have an attachment scanning service to scan for potential virus payloads, it's on their roadmap, but no confirmed date • CISCO network requires a hardware refresh • [DSPT Standard(s): 8.1.4] Version 7 of Clinisys Ice is end of life • [DSPT Standard(s): 9.3.8] Lack of an automated Medical device / Internet of Things asset register and vulnerability scanning • [DSPT Standard(s): 4.1.2] No Privilege Access Management (PAM) in place for Domain Admin/Admin accounts • [DSPT Standard(s): 7.3.4 & 7.3.5] Backup storage being end of life and out of support • Weak cyber controls in the supply chain (3rd party vendors), could that filter down and affect the Trust network.

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Support for Windows Server 2003 has now ceased and Windows Server 2008 becomes unsupported from January 2020. As a consequence, Microsoft will no longer provide security updates or technical support for these operating systems. Consequently, any server or system reliant on Windows Server 2003 and Windows Server 2008 (from Jan 2020) presents a cyber-security risk to the Trust. We either need to migrate or decommission the unsupported	Migrate all 2003 and 2008 servers to 2016.	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	31/01/25	

Windows Server 2003 and Windows 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 Digital Analytics and CBU have completed their duplication review. Meeting to be arranged to discuss how we will move the reports into Solus. The meeting will primarily cover testing, assurances and processes. 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.	Waterfield, Tracie	31/01/25	
Multifactor authorisation (MFA) review of Trust critical systems	Multifactor authorisation (MFA) review of Trust critical systems as data has shown that majority of cyber attacks can be prevented within 20 minutes of the initial attack starting with MFA compared to organisations who don't use MFA.	Create a document that details the Trust's critical systems and contact the vendors to inquire whether they have Multi-Factor Authentication (MFA) and, if not, where it is on their roadmap. Digital Services have submitted a capital bid for NHSE Cyber Risk Reduction Programme to fund for 1 year Privilege Access Management for the Trust elevated window accounts to help protect accounts that have administrator rights either the Trust network or Trust systems. Waiting on feedback from NHSE.	Deacon, Stephen	31/03/2025	
Review Digital BCP Documentation	Review Digital BCP Documentation	Review Digital BCP Documentation, after the recent unplanned downtime of clinical systems. MIAA to audit the new documentation in November 24	Deacon, Stephen	30/11/2024	02/12/24
Attend the C&M Cyber Desktop Exercise	Attend the C&M Cyber Desktop Exercise	Attend the C&M Cyber Desktop Exercise with NHS England in September 24 (Has been delayed until the end of November 24)	Deacon, Stephen	30/11/2024	21/11/24
Perform Cyber Assurance Service (CAS) with NHS England	Perform Cyber Assurance Service (CAS) with NHS England	Engage with NHS England and their 3rd part for onboarding to be cyber	Deacon, Stephen	31/12/2024	30/12/24

		assed by the Cyber Assurance Service (CAS). Current status: Accepted and completing the onboarding documentation.			
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.	Waterfield, Tracie	30/10/2026	

Board Assurance Framework

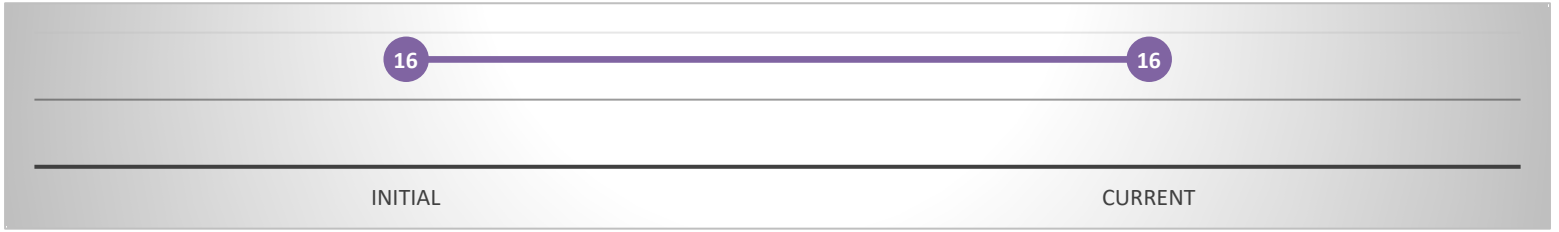
Risk ID	1372	**Executive Lead**	Executive Medical Director	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust is unable to procure a new Electronic Patient Record then 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			**Initial**	12 (L3 xC4)
				Current	16 (L4xC4)
				Target	8 (L2 xC4)
Risk Appetite	**Cautious –** Preference for safe delivery options that have a low degree of inherent risk and only a limited reward potential.				
Risk Movement					
Assurance Details	**Assurance:** Clear reporting line from EPR Project Group via escalation/assurance route through Digital Strategy Group, FSC and Trust Board) • Regular, documented conference calls with the ICS and NHSE – external partners supportive of managed convergence relaunch with partner Trust. • Program Governance and PMO function refreshed and improved following lessons learnt exercise • EPR project group has oversight on state of readiness for deployment and associated risks **Controls:** • Contract in place for a 3 (+2) year tactical Lorenzo contract in support of time required to complete the procurement and deployment of a new EPR • Trust financial modelling includes 5-year Lorenzo costs • ICB Executive Leads 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				
Assurance Gaps	**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 • Deficit in programme year 3 • Further assurance required regarding state of readiness for implementation				

Board Assurance Framework

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Ensure ICS and NHSE Digital leadership sighted and supportive of procurement approach	Ensure ICS and NHSE FDIB leadership fully sighted and remain supportive of procurement approach including Tender format Ensure NHSE FD leadership remain supportive of approach to managing new convergence guidance	Ongoing engagement with ICS and NHSE FDIB leadership	Fitzsimmons, Paul	01/2/2025	
Develop plan to manage risk posed by coterminous LIMS implementation	To ensure the Trust has a plan to ensure is in a position to deploy EPR and LIMS over similar timeframes	Plan to mitigate for potential coterminous implementation of LIMS	Poulter, Tom	01/2/2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID:	1898	**Executive Lead:**	Chief Strategy and Partnerships Officer	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities				
Risk Description:	If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions.			**Initial**	16 (L4xC4)
				Current	16 (L4xC4)
				Target	9 (L3 xC3)
Risk Appetite	**Seek** - Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).				
Risk Movement					

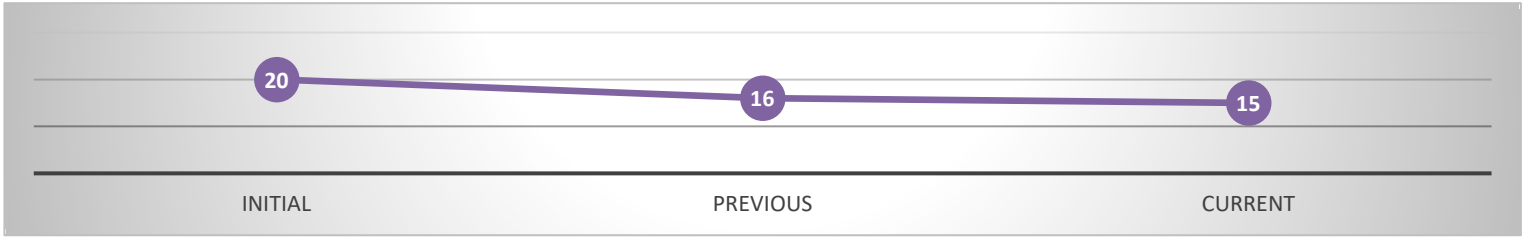
Control & Assurance Details	**Controls**
	• Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance
	• Estates 10 year capital programe which is updated annually as a result of the 6 facet survey and any capital works that have been carried out
	• Estates strategy incorporating options and enablers for new hospitals plans complete
	• External funding sought to enable estates developments which support delivery of new hospitals plans and estates strategy
	• All partners, including MPs, Councils, Education Providers, Place Partners and ICB supportive of our new hospitals plans
	• Financial and economic cases for new hospitals to be updated and funding options explored
	• WHH not included in Phase 3. Programme now termed New Hospital Programme (NHOP) recently reviewed by government, WHH are unlikely to receive funding before 2040.
	
	Assurances
	• DoH launched Health Infrastructure Programme (HIP) announcing a £2.8b investment. WHH not included in the first 2 phases of investment. Phase 3 of the HIP announced. WHH submitted an Expression of Interest (EOI) in September 2021. WHH assessed & submitted by Cheshire & Merseyside ICS to regional and national NHSE/I team as the top priority for the New Hospital Build Programme in C&M.
	• Funding secured to deliver:
	  ○ Community Diagnostics Centre,
	  ○ Additional theatre ward and endoscopy capacity at Halton
	  ○ Community Hubs in Runcorn and Warrington
	• Initial business cases for Estates priorities drafted
	• Estates strategy refreshed and approved
	• Regular oversight meetings with partners, to support profile of need for investment, re-established
	
	Developing scope for work required to create phased new hospital plan for the Warrington site				

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

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Phased redevelopment plan	Develop phased redevelopment plan with support from architects and cost advisors	Funding reallocation supported by Trust Board. Formally reallocate funding via CPG and FSC. Commission/appoint team to develop plan. Awaiting release of funding prior to commencing work	Lucy Gardner	30.03.2025	
Continue to raise profile and importance of need for new hospitals in Warrington and Halton.	Partners to attend new hospitals oversight meeting and raise case of need via appropriate channels.	Ensure meetings and appropriate updates take place.	Lucy Gardner	31.03.2025	

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Risk ID	125	**Executive Lead**	Chief Operating Officer	**Rating**	
Strategic Objective	**Strategic Objective 1:** We will… Always put our patients first delivering safe and effective care and an excellent patient experience.				
Risk Description	If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns			**Initial**	20 (L5xC4)
				Current	15 (L3xC5)
				Target	10 (L2xC5)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls** • Annual capital funding is allocated to mandated and statutory estates projects • The estates team operate a Planned Maintenance Program (PPM) • The estates team operate a reactive maintenance process via the Computer aided facilities mananagement software (CAFMS) • Six Facet survey – condition appraisal of estate (annually) which informs a prioritised schedule for managing backlog maintenance • Prioritised schemes communicated to the capital programme and report monthly provided • Estates 10 year capital program which is updated annually as a result of the 6 facet survey and any capital works that have been carried out • Capital Planning Group and associated capital funding allocation process • Estate strategy 2024-2029 which addresses several backlog issues to reduce future costs and to develop both the Warrington and Halton sites with available capital funding • Additional bids generated and submitted nationally to address some of the backlog issues for example LED lighting **Assurance** • Health and safety sub committee acts as an esclation point for issues • Estates and Facilities Health, Safety and Risk Group – managing health and safety issues and monitoring risk registers • Non funded capital schemes are risk rated and monitoired through the above group • Fire Safety Group – monitors fire safety issues across the trust • PLACE assessment with subsequent action plan produced, implemented and monitored • Capital Planning Group – determine how the trust capital is spent and supportive of bids submitted • Future capital porgramme bids reviewed by senior team and prioritised • Cleanliness monitoring identifies estates issues that are addressed through the CAFMS system • Ventilation Group – gives assurance on the appropriate levels of trustwide ventilation in particular approves upgrades and new installations • Operational and Safety groups linked to Health Technical Memorandum (HTM) that identify compliance issues and put in place actions to reduce any resultant risk • Completed a formal Reinforce autoclave aerated concrete (RAAC) survey across whole estate. Small extension building identified as having RAAC present. • Confirmation from NHSE of funding to take the necessary remedial action to eradicate RAAC on the small extension and the roof has now been replaced. • Following an environmental health inspection, upgrades to the Warrington kitchen facilities have been completied in October 2024. Phase 3 now commenced				

	• Establishment of the Tactical Estates Group (TEG), reporting to the Capital Planning Group, to help support efficient decision making relating to estate allocation. • Associate Director of Estates & Facilities and Director of Strategy & Partnerships represents the Trust on ICB Estates meetings from an operational and strategic perspective • Funding identified in the 2024/25 Capital Plan to Support refurbishment of another patient lift on the Warrington Site to improve operational efficiency to commence in november 2024. • Plans are in development to undertake roof repairs to pathology as part of the backlog maintenance plan for 2024/25.
Assurance Gaps	• Limited capital funding to address entire backlog • Estates staffing - as maintenance (reactive and planned) increase due to limited backlog funding or new national standards, staff are asked to do more, with less and the estates maintenance team is currently under resourced and further impacted by non clinical CIP target. • Accessibility – some equipment is not accessible for maintenance due to age and design. Without a permanent decant ward this proves difficult to overcome • Cost pressures – unfunded elements of unforseen and emergency maintenance in I&E budget • Threat to the delivery of capital schemes due to the lenghty process to obtain full design costs in an uncertain market. • Delays in approvals of PO resulting in risk to compliance and delivery of standards • Implications of the intergration programme not yet clear

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

Board Assurance Framework

Warrington and Halton Teaching Hospitals NHS Foundation Trust

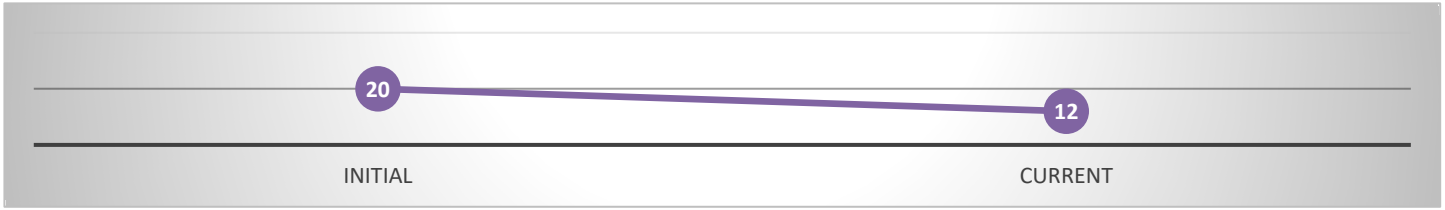
Risk ID	145	**Executive Lead**	Chief Strategy and Partnerships Officer	**Rating**	
Strategic Objective	**Strategic Objective 3:** We will...Work in partnership with others to achieve social and economic wellbeing in our communities.				
Risk Description	If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcomes for our patient population, possible negative impacts on patient care, reputation and financial position.			**Initial**	20 (L5xC4)
				Current	12 (L3xC4)
				Target	8 (L4xC2)
Risk Appetite	**Open:** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.				
Risk Movement					
Assurance Details	**Controls** • The board has developed the Trust's strategy and governance for delivery of the strategy to ensure that all risks are escalated promptly and proactively managed. • The Trust has developed effective clinical networking and integrated partnership arrangements. • Council and Place Teams in both Warrington & Halton supportive of development of new hospitals. • Strategic Outline Cases (SOC) for both new hospital developments approved by the Trust Board and both CCGs. Formally supported by wider partners through both Warrington & Halton Health & Wellbeing Boards, Warrington Health Scrutiny and Halton Health Policy & Performance Board. • Clinical strategies at Specialty level are refreshed annunallly • Bid for targetted investment fund (TIF) to further develop the elective offer at Halton has been approved. • Pathology – Draft outline business case for pathology reconfiguration across Cheshire & Merseyside has been approved. Currently options for further development do not include any option where WHH is a hub. All options proposed include Essential Services Labs (ESL) at WHH. Detailed feedback provided by the Trust included in strategic outline business case to ensure quality standards and turnaround time are sustained for proposed ESLs. • Refreshed programme for pathology collaboration shared by the Cheshire & Mersey Pathology Network. The first phase is to develop an outline business case for the hub model expected by the end of October 2024. • CSPO invited to be a member and the health representative on both Runcorn and Warrington Town Deal Boards, tasked with planning for the investment of £25m (each) to regenerate Runcorn Old Town and Warrington Town Centre. Warrington Town Deal Board has now taken responsibility for the UK Shared Prosperity Fund allocation. • Town Deal plan for Warrington approved. Included the proposed provision of a Health & Wellbeing hub in the town centre and a Health & Social Care Academy. £22.1m funding approved for the Town investment plan, including £3.1m for the Health & Wellbeing Hub and £1m for the Health & Social Care Academy. Health & Social Care Academy opened. • Health & Wellbeing Hub (Living Well Hub) opened in March 2024 • Town Deal plan for Runcorn approved by the Government securing c£23m, including c£3m for Health Education Hub in Runcorn. Full Business Case for Health & Education Hub approved by Government. • Strategy refresh completed and updated strategy for 2023/24 – 2024/25 approved by the Trust Board. • WHH commenced a focussed programme of work on addressing health inequalities, the green agenda, and our role as an anchor institution. Initial work recognised as the exemplary within Cheshire & Merseyside. • Consistent Trust representation within Cheshire & Merseyside ICS.				

	• Trust representation on place-based Boards within both Warrington & Halton. Trust continues to inform placed based strategies to ensure the Trust's priorities are reflected. • Funding received from One Public Estate to support progression of the Halton site redevelopment and a full review of the public sector estate in Warrington. Both reviews have been completed. • Formal partnerships developed with key educational partners to enable tailored education & training and research opportunities. • CSPO co-led sessions to ensure CMAST providers priorities (including WHH) are appropriately reflected in ICB 5 Year joint forward plan. • Trust Estates priorities now also reflected in the ICB infrastructure plan • Adaptive Reserve Fund created with Warrington Place partners • Discussions with neighbouring Trust to accelerate collaboration taking place • Joint Executive Team meetings & programme of collaboration established with Bridgewater Community Healthcare NHS FT **Assurances** • Regular Strategy updates are provided to the Council of Governors & Trust Board • Funding secured via Halton Borough Council and Liverpool City Region Town Centre Fund to provide some services within Shopping City in Runcorn. This contributes to a potential phased approach to delivering reconfiguration of the Halton site. Matched investment approved by the Trust Board to enable delivery of Ophthalmology, Audiology & Dietetics services. Halton Health Hub in Shopping City opened in November 2022. • In February 2021 the Government White Paper, "Integration and Innovation: working together to improve health and social care for all - The Department of Health and Social Care's legislative proposals for a Health and Care Bill" was published. • Pace of pathology collaboration no longer poses a such significant risk to service delivery for WHH as challenges within histopathology are being addressed via mutual aid and recruitment. • National funding secured for a single Laboratory Information Management System (LIMS) for Cheshire & Merseyside. Draft business case approved by the Trust Board in June 2024. • Detailed work commenced, supported by external consultants, to help address no criteria to reside & enable admission avoidance. • The Trust has been selected as a site for one of two endoscopy hubs in Cheshire & Merseyside. Endoscopy Hub – opened September 2024 • CDC phase 2 including ultrasound, spirometry, sleep studies, audiology & phlebotomy opened in Halton Health Hub in December 2023 • CDC phase 3 including CT & MRI due to open in spring 2025
Assurance Gaps	• Self assessments of both Warrington & Halton place based governance development indicate that Halton is 'emerging' (stage 2 of 4) and Warrington is established (stage 3 of 4). There is a requirement to further develop as places to ensure both boroughs can benefit from potential future autonomy. • Trust's capacity to deliver significant number of capital projects

Recommendation	Action Description	Actions Required	Responsible Officer	Deadline Date	Completion Date
Actively participate in and contribute to the development of integrated care partnerships at Place & provider collaboratives at regional level.	Participate in meetings and influence new governance development.	Participate in meetings and influence new governance development.	Lucy Gardner	30/04/2025	
Ensure sufficient capacity to deliver increased number of capital projects	Agree funding mechanisms for gaps identified.	Interim arrangements to support delivery given lack of available funding	Lucy Gardner & Dan Moore	30/04/2025	

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 5.74% as at November 2024 and is showing a slight increase from September which is reflective of seasonal trend with an increase in coughs, colds, flu and covid. Target remains 4.2% however following a recent benchmaking exercise across the C&M region, this target is under consideration as it is one of the lowest targets in the region. **Controls** • Supporting Attendance Policy implemented in February 2022 and reviewed post 6 months implementation, updated policy implemented April 2023. • Supporting Attendance clinics held in partnership with HR Business Partners and CBU areas to provide an overview of policy, associated paperwork and interventions to support managers. • Support continues within areas of high sickness and low compliance WBC figures. Providing coaching support to managers, compliance audits and communication campaigns focusing on staff to ensure they have a WBC so their wellbeing is supported. • Occupational Health and Wellbeing triangulation meetings with HR colleagues to review and progress individual cases under the formal stages Supporting Attendance Management. • Focused welcome back conversation recording and internal audit • Following an MIAA Audit, the HR team have worked with CBUs to develop an audit framework to provide greater assurance regarding compliance with the Supporting Attendance policy by managers. • Sickness absence, turnover and attraction workstreams have been reviewed in line with the ICBletter and action plans updated to ensure all actions from the letter have been considered. **Assurance** • The Trusts wellbeing offers continue to be well utilised, supporting people to remain in work. The Trust has received national recognition from NHS Employers for our Check In Conversation, and local recognition for our Health and Wellbeing Hub. • The Trust has seen a significant improvement in long term sickness absence rates since the full implementation and transition on to the new Supporting Attendance policy reducing from 4.39% in April 2022 to 2.94% % in November 2024. • Pilot took place in maternity services where WBC compliance improved from 20% to 85% and is now cited as a best practice case study by NHSE • Pro-active health interventions offered to support staff to remain well including cardiac clinic and wellbeing day with referrals to smoking cessation, G.P.'s and counsellors as appropriate. Well attended by staff. • As a result of the sickness absence data analysis undertaken by the People Health and Wellbeing Group, OH have identified a trend that is emerging for new starters, particularly those new to the NHS, who are being referred to OH within their first year of employment. The HRBP team are carrying out a review of new starters within				

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

Turnover and Attraction

Turnover in November 2024 remains below target at 12% and is showing an improving variation. Turnover of permanent staff in November 2024 was 11.16% which was below Trust target whichis 13%.

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

The Trust's November 2024 vacancy rate has significantly reduced to 7.50%, the Trust, target is 9%. This significant reducition is reflective of the Trust's current vigorous scruitiny of vacancies through the ECF panel.

Controls

- Exit Interview process - collation and analysis of data captured enables themes to be identified and targeted actions implemented. This information is available on the Trust Workforce Information Dashboard for all managers to review.
- Further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process.
- Rugby League Cares have been supporting WHH since July 2021 and have been working in areas offering drop-in sessions and tailored programmes to support teams and individuals to keep well in work
- Grief and Menopause cafes implemented to support individuals
- Social media accounts have been created to support recruitment attraction across a number of social media platforms
- Financial wellbeing resources have been implemented to support the workforce and retention including Wagestream
- A dedicated area to supporting Agile/Flexible working is available on the extranet, and 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 worknig 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%

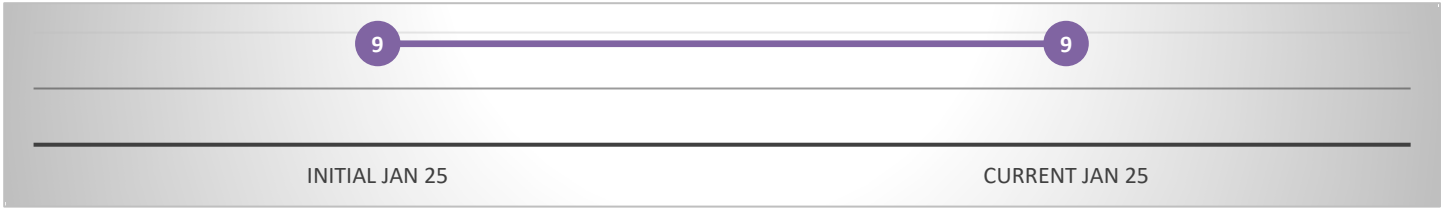
	Temporary Staffing and Agency spend Bank and Agency reliance in November 2024 was 13.8% . The Trust target is 9%. Bank reliance has slightly reduced to 12.6% and agency reliance continues to decrease to 1.8%. **Controls** • Bank reliance is driven by the Trusts plan to reduce overall reliance on agency 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: ○ 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	Carl Roberts	31.03.2025	

		• Develop an approach to how WHH staff request flexible/agile working – thus enabling further oversight of requests			
Review of Exit Interview Process to Support Improvement of Completion Rates	As part of the Delve OD programme within the People Directorate there is a further review of the leavers process is underway with the development of a SOP for stay conversations and an options appraisal review of the current exit interview process.	• Develop SOP for Stay Conversations • Develop Options Appraisal for exit interview process to inform future approach. Depending on the option agreed will determine future actions to address exit interview compliance.	Laura Hilton	31.03.25	
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	TBA	**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, 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				

Recommendation	**Action Description**	**Actions Required**	**Responsible Officer**	**Deadline Date**	**Completion Date**

Board Assurance Framework – Proposed New Risk Integration

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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.

Appendix 3 - Corporate Risk Register Quality Assurance Committee January 2025

ID	Risk description	Opened	Review date	Rating (initial)	Rating (current)	Department admitted	Monitoring Committee	Monitoring Sub Committee	Strategic Objective	Manager responsible for risk
184	If there is no future investment in improving the physical condition of the ward kitchens then the Trust will be unable to comply with food safety legislation resulting in potential local authority enforcement action and/or patient food borne illness and reputational damage.	16/11/2021	06/01/2025	16	16	Corporate Support Services	Quality & Assurance Committee	Estates Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.	Beech, Kieran
421	If there is no future investment in hospital ventilation then the built environment may not be fit for purpose in relation to compliance with HTM resulting in possible loss of several clinical services and non compliance with HTM.	18/08/2022	13/01/2025	16	16	Corporate Support Services	Quality & Assurance Committee	Health & Safety and Well Being Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.	Beech, Kieran
423	If lifts are not maintained and replaced at end of lifecycle then there may be preventable occurrences of lifts breaking down resulting in reputational damage, negative financial impact, operational challenges and possible staff and patient safety issues. See gaps in assurance section for actual service disruption caused.	14/07/2022	06/01/2025	16	16	Corporate Support Services	Quality & Assurance Committee	Risk Review Group	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.	Beech, Kieran
1048	If the Trust does not have the appropriate workforce within Urology then the service capacity will not be able to meet current demand across all points of delivery, which will increase backlogs, overall waiting times and cause potential delays in diagnosis and treatment.	21/10/2019	28/02/2025	20	↑16	Surgical Specialties	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.	Rogers, Ceri Louise
1503	If the underground pipework and backup manifolds fail then this will affect the supply of piped medical oxygen resulting in the potential loss of service provision to the whole site.	02/09/2021	06/01/2025	15	10	Corporate Support Services	Quality & Assurance Committee	Health & Safety and Well Being Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.	Beech, Kieran
1547	If policies (including strategy, policy, guidelines, SOPS, Pathways) are not reviewed and updated in line with best practice and legal requirements in a timely manner then staff may not be following best practice and may be non compliant with legal obligations This will cause increased risk of harm to patients, staff and the organisations.	03/11/2021	18/01/2025	9	16	Corporate Support Services	Quality & Assurance Committee	Patient Experience Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.	Umbers, Catherine
1749	If ED Nursing Vacancies continue to be above 25%, despite extensive recruitment, then we will not be able to safely staff the ED Department with sufficient numbers of suitably qualified, skilled and experienced nurses to meet the needs of patients in the Emergency Department. This will impact the ability to comply with regulation 18 (1) in relation to safe staffing numbers.	18/10/2022	30/12/2024	20	20	Urgent and Emergency Care	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.	Habib, Yasmin
1757	If GP collective action continues to take place, then operational delivery may be negatively impacted affecting delivery of services.	31/10/2022	03/03/2025	16	9	Corporate Support Services	Quality & Assurance Committee	Operational People Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.	Clint, Rachel

1797	If there is not an electronic process to list patients (from ICE to Lorenzo to ORMIS) then there is requirement for administrative staff to enter in patient listing information into the Theatre system (ORMIS) which could cause potential errors in the TCI listing and incorrect surgery.	13/12/2022	29/11/2024	25	15	Digestive Diseases	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.	Alsop, Melanie
1805	If the Trust does not achieve a 20% reduction in pressure ulcers then this may adversely impact on patient length of stay, mobility, pain, experience of care and resulting in the Trust not meeting the WHH Quality Priority for hospital acquired pressure ulcers	22/12/2022	31/03/2025	12	12	Corporate Support Services	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.	Howard, Debbi
1939	If the Trust implements the Accelerated Transfer SOP which includes the boarding of patients in extremis. Then there may be an additional patients on ACCU, A4, A6, A7, A8, A10, B14, B18, C20, C21, K25 for accelerated transfers/boarding and A9, B12 and B19 for boarding only. Resulting in a decompression of ED and a reduction to risks for patient in ED balanced against risks of additional patients in escalated inpatient wards e.g. disturbed sleep for patients or different call bell arrangements may increase the risk of slips, trips and falls and a potential adverse impact of patient experience e.g. privacy and dignity.	18/07/2023	30/09/2024	12	12	Corporate Support Services	Quality & Assurance Committee	Patient Safety & Effectiveness Sub-Committee	Strategic Objective 1: We will .. Always put our patients first through high quality, safe care and an excellent patient experience.	Fennell, Tracy

Appendix 3: Corporate Risk Register Strategic People Committee January 2025

ID	Risk description	Opened	Review date	Rating (initial)	Rating (current)	Department admitted	Monitoring Committee	Monitoring Sub Committee	Strategic Objective	Manager responsible for risk
199	If the Trust are not able recruit into vacancies then this will increase time to hire and result in high expenditure on temporary / agency staffing exceeding budget.	01/04/2018	31/03/2025	20	16	Corporate Support Services	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.	Roberts, Carl
200	If there continue to be high levels of sickness above the trust target then this will cause staffing shortages resulting in an impact to service delivery, and risk financial targets for temporary staffing / agency spend	01/04/2018	31/03/2025	12	15	Corporate Support Services	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.	Hilton, Laura
1051	If there are operational issue which result in non-compliance with Induction Policy and Temporary Staffing Policy, then the Trust will not be compliant with inductions for staff and there will be risks to the safe delivery of services if staff are not correctly inducted to the organisation.	23/10/2019	31/03/2025	12	12	Corporate Support Services	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.	Roberts, Carl
1758	If appraisals are not undertaken by Managers, then there could be a negative impact on staff engagement causing a decrease in Staff Survey scores, increased turnover and failure of succession planning	31/10/2022	31/03/2025	12	6	Corporate Support Services	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.	Patel, Rebecca
1759	If the organisation fails to effectively manage the use of agency and temporary staffing then this could result in financial overspend on agency / temporary staffing and also impact staff engagement for substantive staff	31/10/2022	31/03/2025	12	12	Corporate Support Services	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.	Roberts, Carl
1760	If the NHS pay award does not support the increase in cost of living or the real living wage then staff may not be able to afford to come to work or be able to provide for themselves or their families, causing an increase in staff absence and also a negative impact on recruitment and retention	31/10/2022	31/03/2025	12	4	Corporate Support Services	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.	Patel, Rebecca
1764	If workforce turnover does not meet the Trust target of 13% then this will result in increase in agency / temporary staffing costs as well as a negative impact on engagement of substantive staff and thus staff survey results	31/10/2022	31/03/2025	12	12	Corporate Support Services	Strategic People Committee	Operational People Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.	Roberts, Carl
1893	If there is a lack of uptake in Equality, Diversity and Inclusion (EDI) learning and development provisions then there will be a failure to equip our workforce with the EDI knowledge and skills for the organisation to meet its requirements under the Public Sector Equality Duty, Armed Forces Act 2021 and Human Rights Act 1998. Resulting in an inability to meet the Trust's equality related strategic objectives.	05/05/2023	31/01/2025	12	9↓	Corporate Support Services	Strategic People Committee	Workforce Sub-Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.	Patel, Rebecca
2103	If the Trust does not reduce the disparate amount of bullying and harassment towards staff with specific protected characteristics compared with others, then there may be an increase in staff harm, poor wellbeing and employee relations activities.	21/03/2024	24/01/2025	12	12	Corporate Support Services	Strategic People Committee	Workforce Sub-Committee	Strategic Objective 2: We will .. Be the best place to work with a diverse, engaged workforce that is fit for the future.	Patel, Rebecca

Appendix 3: Corporate Risk Register - Finance and Sustainability Committee January 2025

ID	Risk description	Opened	Review date	Rating (initial)	Rating (current)	Department admitted	Monitoring Committee	Monitoring Sub Committee	Strategic Objective	Manager responsible for risk
2099	If the Trust does not achieve the assumed target activity of 104% for 2024/25, then there is a risk that the £10m ERF (included in the operational plan) will be clawed back increasing the Trust financial deficit, posing a significant risk to the Trust financial position. There could also be a reduction in contract income for the activity under PBR.	15/03/2024	31/03/2025	12	12	Corporate Support Services	Finance & Sustainability Committee	Financial Resources Group (FRG)	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.	Hurst, Jane
2100	If the Trust does not adequately identify the full balance of CIP schemes recurrently from a target of £19.4m. This will pose a significant risk to the Trust achieving its control total in 2024/25 and 2025/26	15/03/2024	31/03/2025	12	12	Corporate Support Services	Finance & Sustainability Committee	Financial Resources Group (FRG)	Strategic Objective 3: We will .. Work in partnership to design and provide high quality, financially sustainable services.	Hurst, Jane

Maternity Incentive Scheme Year 6 (MIS) Compliance Report

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board
5th February 2025
Ailsa Gaskill-Jones, Director of Midwifery

The 10 Maternity Safety Actions

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Safety Action 1: Use of the National Perinatal Mortality Review Tool
- Safety Action 2: Submitting data to the Maternity Services Data Set
- Safety Action 3: Transitional care services to minimise separation of mothers and babies
- Safety Action 4: Effective systems of clinical workforce planning
- Safety Action 5: Effective system of midwifery workforce planning
- Safety Action 6: Demonstrating compliance with Saving Babies Lives Care Bundle v3
- Safety Action 7: Listen to women, parents and families using maternity and neonatal services with users
- Safety Action 8: Multi professional maternity Core Competency Framework Version 2 training
- Safety Action 9: Board Assurance for maternity and neonatal safety and quality issues.
- Safety Action 10: Reporting of all qualifying cases to HSIB/MNSI and NHS Resolution Early Notification Scheme

MIS Year 6 - background

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- The 10 safety actions for the year six MIS scheme were first published by NHS Resolution (NHSR) on 2 April 2024.
- The reporting period for MIS Year 6 is to 30th November 2024.
- NHSR reporting deadline for the Board declaration of compliance with all 10 standards is 12 noon on 3 March 2025.
- Update reports describing compliance against the standards have been shared monthly with the Quality Assurance Committee and bi-monthly to Trust Board.
- 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).
- 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 NHSR.

External assurance process:

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Cheshire & Mersey LMNS have reviewed the evidence uploaded to the NHS Futures portal for MIS year 6 Safety Actions 3 – 9.
- Findings of the review team were shared with the LMNS Assurance Board on 27th January 2025
- WHH Compliance level agreed by LMNS Assurance Board
  - 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

External assurance process:

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Safety Action 1 - Use of the National Perinatal Mortality Review Tool – 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

Internal assurance process:

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Date	Action
April 2024 – January 2025	Presentation of position to Quality Assurance Committee (monthly)
April 2024 – January 2025	Presentation of position to Trust Board (Bi-monthly)
4th February 2025	Review with Chief Nurse / Deputy Chief Executive
4th February 2025	Review and sign off with Chief Executive
5th February 2025	Present MIS evidence and presentation to Trust Board
5th February 2025	Final sign off by Chief Executive (Board Notification Form)

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
1a	All eligible perinatal deaths should be notified to MBRRACE UK within seven working days.	Validation by NHSR to cross reference data from MBRRACE-UK for standards a, b and c	100% of cases reported and surveillance completed within the timescales.	*Compliant*
1b	For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.		100% of cases have been reviewed within the 2-month timescale. Bereavement Midwife supports parents to submit questions and comments to the PMRT case review.	*Compliant*
1c	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 and published within six months.		100% of all deaths of babies have been reviewed using PMRT by a multi professional team as per the standard.. A PMRT draft report has been generated within 4 months and the report published within 6 months.	*Compliant*
1d	Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.	Q3 & Q4 2023/24 PMRT Reports reported to QAC and Trust Board confirm that the required standards a), b) and c) have been met.	Q4 2023-24 PMRT report to QAC May 2024, Trust Board June 2024 Q1 2024-2025 PMRT report to QAC 13/08/24 Trust Board October 2024	*Compliant*

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
1	Trust Boards to assure themselves that at least 10 out of 11 MSDS-only (see technical guidance) Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024. Final data for July 2024 will be published during October 2024	The "Clinical Negligence Scheme for Trusts: Scorecard" July 2024 evidencing achievement of 12/12 Quality Improvement Metrics		*Compliant*
2	July 2024 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001).			*Compliant*

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?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
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	Transitional Care (TC) Guideline Q4 23/24 TC report to QAC June 2024, Trust Board August 2024 Q1 24/25 TC report to QAC September 2024, Trust Board October 2024 Minutes of meeting Q4 23/24 ATAIN report to QAC June 2024, Trust Board August 2024 Q1 24/25 ATAIN report to QAC October 2024, Trust Board December 2024 Minutes of Patient Safety champion meeting 22/11/24 including position in relation to Transitional Care	The Transitional Care Guideline covers:- *evidence of neonatal involvement in care planning *admission criteria *staffing model *quarterly audits *babies 34+0 and above Transitional Care Reports to Trust Board inclusive of action plans. ATAIN meetings demonstrating a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks.	*Compliant* *Confirmation received LMNS assured by evidence*
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.			*Compliant* *Confirmation received LMNS assured by evidence*

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
a	Obstetric medical workforce – Trust to ensure:- 1. criteria is met for employing short-term (2 weeks or less) locum doctors in Obstetrics and gynaecology on tier 2 or 3 (middle grade rotas) 2. Implementation of RCOG guidance on engagement of long-term locums and provide assurance they have evidence of compliance or action plan to address shortfall 3. Implementation of RCOG guidance on compensatory rest 4. Monitoring of compliance of consultant attendance for the clinical situations listed in the RCOG workforce document 'Roles and Responsibilities'	Audit of short-term and long-term locums Compensatory rest SOP Monthly Audit of compliance Report to Board 29th November 2024 reporting position in relation to: • Short term locum doctors in obstetrics and gynaecology	Monitoring of criteria compliance for short-term and long-term locums is in place. Consultant attendance continues to be monitored on a monthly basis	*Compliant* *Confirmation received LMNS assured by evidence*
b	Anaesthetic medical workforce – Trust to ensure:- A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and have clear lines of communication to the supervising anaesthetist consultant	Labour Ward Anaesthetic Staffing Policy ACSA Accreditation Anaesthetic staffing rota April-October 2024 Report to Board 29th November 2024 reporting availability of a duty anaesthetist to support the obstetric unit	Anaesthetic staffing guideline in place	*Compliant* *Confirmation received LMNS assured by evidence*

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard ….. continued

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

	Required Standard	Evidence / Comments	RAG
c	Neonatal medical workforce – Trust to ensure:- The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing.	Report to Board 29th November 2024 reporting position in relation to: • Compliance of the neonatal medical workforce meeting British Association of Perinatal Medicine (BAPM) standards and Neonatal Workforce Action Plan November 2024 • Compliance of the neonatal nursing workforce meeting BAPM standards and Neonatal Nurse Staffing Report November 2024	*Compliant* *Confirmation received LMNS assured by evidence*
d	Neonatal nursing workforce – Trust to ensure: The Neonatal Unit meets the British Association of Perinatal Medicine (BAPM) neonatal nursing standards		*Compliant* *Confirmation received LMNS assured by evidence*

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
a	A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.	Midwifery summary safe staffing report 20/12/23, 15/05/24, 21/08/24, 20/11/24 – reported to Strategic People Committee and to Trust Board Workforce deep dive reported to Strategic People Committee November 2024 and Trust Board December 2024 Maternity and Neonatal workforce plan 2024-2025 Maternity & Neonatal update to Trust Board 05/06/24, 02/10/24 Minutes of Patient Safety Champion Meeting 22/11/2024 including presentation of Workforce deep dive	Midwifery Summary Safe Staffing Report to Trust Board evidencing:- *midwifery coordinator in charge of labour ward must have supernumerary status to 2 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. *the maternity service has robust escalation processes to manage short falls in staffing level during periods of high acuity. *the midwife: birth ratio	*Compliant* *Confirmation received LMNS assured by evidence*
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.			

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle V3

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
1	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.	Evidence for all 6 elements of SBLCBv.3 uploaded to new national implementation tool. MIS Report to Trust Board:- 05/06/2024 07/08/2024 02/10/2024 Q1 review – 96% Q2 review – 96% Q3 review – 100%	Final validation by LMNS in December 2024 confirmed 100% of the 6 elements of SBLv3 have been implemented and deemed 'CNST Met'. Monitoring is ongoing to ensure ongoing compliance with the care bundle and achieve stretch ambitions.	*Compliant* *Confirmation received LMNS assured by evidence*

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
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.	WHH MNVP Workplan 2024-25 MNVP chair role description MNVP TOR approved 04/10/24 WHH CQC Maternity Survey WHH CQC Maternity Survey – action plan Patient Safety Champion Meeting 22/11/24 Presentation to MNVP 17/1/2025	2024 CQC Maternity Survey published November 2024. Overview shared with MNVP at following MNVP meet (17/1/2024). Draft action plan being developed. Agenda item for next MNVP meeting April 2025.	*Compliant* *Confirmation received LMNS assured by evidence*
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.			*Compliant* *Confirmation received LMNS assured by evidence*

Safety action 8: Can you evidence the following 3 elements of local training plans and ‘in-house’, one day multi professional training?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

	Required Standard	Evidence	Comments	RAG
1	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 A local training plan is in place for implementation of Version 2 of the Core Competency Framework.	Training Compliance Report – 30/08/24, 30/09/24, 31/10/24 Mandatory Training Exception Report October 2024 SIM reports	Full compliance with training requirements demonstrated via Training Compliance Reports Annual mandatory PROMPT	*Compliant* *Confirmation received LMNS assured by evidence*

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?

Warrington and Halton Teaching Hospitals NHS Foundation Trust

	Required Standard	Evidence / Comments	RAG
a	All Trust requirements of the PQSM must be fully embedded.	Maternity and neonatal team update – DOM 9/11/24 Overview of perinatal quality surveillance Nov 24 WHAM update 05/02/24, 05/04/24, 20/08/24 Maternity & NN safety champions infographic – updated Aug 24 October 2024 Board paper– August Maternity Quality & Safety (Q&S) Update, September Q&S Midwifery Staffing Annual Workforce Plan Q1 2024-25, MIS Yr 5 and Yr 6 August 2024 Trust Board Minutes 02/10/24 October 2024 Board – Transitional Care Q1 2024-25 PP Lessons Learnt – MSOG WHH 31/07/24 Template presentation to facilitate discussions with staff Workforce plan 2024-25 Women's and Children's CBU governance meeting minutes – 26/04/24, 04/10/24 (reconvened September meeting) Engagement – feedback sessions with staff following a case involving death of a baby Email from DoM demonstrating staff engagement with a schedule of ideas sessions Narrative from WHH Pelvic Health Specialist Midwife PPH Study day agenda 02/02/24 Perinatal Quad – BSC Meeting 08/10/24 minutes Maternity & Neonatal Quality Review – includes PLCP Culture Workplan WHH EBM 24/11/24 MIS Yr6 final evidence submission DoM team updates Overview to Trust Board 29/11/2024	*Compliant* *Confirmation received LMNS assured by evidence Compliant*
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 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

	Required Standard	Evidence / Comments	RAG
a	Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.	All cases that have met or are thought to meet the MNSI reporting criteria have been reported to MNSI. All qualifying EN cases have been reported to NHSR EN Scheme. Integrated Governance Quality Lead for Women's and Children's CBU will continue to share MNSI updates and quarterly review meetings through Patient Safety Oversight Meeting to ensure Chief Nurse and board oversight is maintained. MNSI position reported monthly to Quality Assurance Committee wef October 2024	*Compliant*
b	Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.		*Compliant*
c	For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.		*Compliant*

Next steps:

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Deadline	Action
5th February 2025	Trust Board to confirm they are satisfied the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance.
17th February 2025	Board Notification Form signed by WHH Chief Executive and submitted to ICB
3rd March 2025	Board Notification Form countersigned by C&M ICB Chief Executive and returned to provider
3rd March 2025	Final submission of Board Notification Form to NHSR

List of Supporting Evidence

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Safety Action 1	Safety Action 2
• PMRT Q3 Oct-Dec 23 report to QAC • PMRT Q4 Jan-Mar 24 report to QAC • PMRT Q1 Apr-Jun 24 report to QAC • Email from MBRRACE-UK 31/1/2025	• The “Clinical Negligence Scheme for Trusts: Scorecard” July 2024 evidencing achievement of 12/12 Quality Improvement Metrics
Safety Action 3	**Safety Action 4**
• Transitional Care (TC) Guideline • Q4 23/24 TC report to QAC June 2024, Trust Board August 2024 • Q1 24/25 TC report to QAC September 2024, Trust Board October 2024 • Minutes of meeting • Q4 23/24 ATAIN report to QAC June 2024, Trust Board August 2024 • Q1 24/25 ATAIN report to QAC October 2024, Trust Board December 2024 • Minutes of Patient Safety champion meeting 22/11/24 including position in relation to Transitional Care	• Short-term and long-term locums – audit • Compensatory Rest SOP • GMC action plan • Obstetric workforce - consultant presence audit April-October 2024 • ACSA accreditation • Anaesthetic rota April-October 2024 • Ockenden 2 IEA02 – Action response report • EBM Trust Board final evidence submission for MIS Yr 6 29.11.24 • Neonatal workforce action plan November 2024 • Neonatal nurse staffing action plan November 2024

List of Supporting Evidence...continued

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Safety Action 5

- WHH report to Trust Board Final evidence submission for MIS Yr6
- Patient safety champion meeting 22/11/24
- Workforce deep dive November 2024
- Midwifery summary safe staffing report 20/12/23, 15/05/24, 21/08/24, 20/11/24 – reported to Strategic People Committee
- Maternity and Neonatal workforce plan 2024-2025
- Maternity & Neonatal update to Trust Board 05/06/24, 02/10/24
- Minutes of Patient Safety Champion Meeting 22/1//2024 including presentation of Workforce deep dive

Safety Action 6

MIS Yr6 Report to QAC:-
- 5 June 2024
- 7 August 2024
- 2 October 2024

MIS Yr6 Report to TB:-
- 5 June 2024
- 7 August 2024
- 2 October 2024

LMNS Quarterly assurance meeting record
- 31/05/2024
- 04/09/2024

Completed SBLv3 tool –
- Q1 24/25 final review
- Q2 24/25 final review

Safety Action 7

- WHH MNVP Workplan 2024-25
- MNVP chair role description
- MNVP TOR approved 04/10/24
- WHH CQC Maternity Survey & action plan
- Patient Safety Champion Meeting 22/11/24
- Maternity & Neonatal Quality Review – August 24
- Quality Assurance Committee Minutes 12/11/24
- Feedback received following candle lit walk at Walton Gardens
- MNVP engagement with groups and charities
- MNVP supporting candle lit walk at Walton Gardens
- Example of reimbursement for volunteer expenses
- Confirmation from Finance Dept of funding for MNVP Chair infrastructure

Safety Action 8

- Training compliance report – 30/08/24, 30/09/24, 31/10/24
- Mandatory Training Exception Report October 2024
- SIM report

List of Supporting Evidence...continued

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Safety Action 9

- Maternity and neonatal team update – DOM 9/11/24
- Overview of perinatal quality surveillance Nov 24
- October Board – Ockenden position
- WHAM update 05/02/24, 05/04/24, 20/08/24
- Maternity & NN safety champions infographic – updated Aug 24
- October Board – August Maternity Quality & Safety Update
- October Board – Midwifery Staffing Annual Workforce Plan Q1 2024-25
- October Board – Maternity & Neonatal overview
- October Board – MIS Yr 5 and Yr 6 August 2024
- Trust Board Minutes 02/10/24
- October Board – Transitional Care Q1 2024-25
- PP Lessons Learnt – MSOG WHH 31/07/24
- Template presentation to facilitate discussions with staff
- October Board – September Maternity Quality & Safety Update
- Workforce plan 2024-25
- Quality Paper QAC – Sep 24, Oct 24
- Women's and Children's CBU governance meeting minutes – 26/04/24, 04/10/24 (reconvened September meeting)
- Engagement – feedback sessions with staff following a case involving death of a baby
- Email from DoM demonstrating staff engagement with a schedule of ideas sessions
- Narrative from WHH Pelvic Health Specialist Midwife
- PPH Study day agenda 02/02/24
- Perinatal Quad – BSC Meeting 08/10/24 minutes
- Maternity & Neonatal Quality Review – includes PLCP Culture Workplan
- WHH EBM 24/11/24 MIS Yr6 final evidence submission
- DoM team updates 2024

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Thank you

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/02/148 i**	
SUBJECT:	**Better Care Together Integration Programme – Options appraisal recommendation**	
DATE OF MEETING:	5th February 2025	
AUTHOR(S):	Lucy Gardner, Chief Strategy & Partnerships Officer	
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): (***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. **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 **2001** If the Trust is unable to mitigate for the challenges faced by its Fragile services, then the Trust may not be able to deliver these services to the required standard with resulting potential for clinical harm and a failure to achieve constitutional standards. **115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care.	

	1114 If we see increasing demands upon current cyber defence resources and increasing reliance on unfit/end-of-life digital infrastructure solutions then we may be unable to provide essential and effective Digital and Cyber Security service functions with an increased risk of successful cyber-attacks, disruption of clinical and non-clinical services and a potential failure to meet statutory obligations. **1372** If the Trust is unable to procure a new Electronic Patient Record, then then the Trust may have to continue with its current suboptimal EPR or return to paper systems triggering a reduction in operational productivity, reporting functionality and possible risk to patient safety **1898** If we are unable to secure sufficient funding to implement the plan for new hospital facilities, then we may not be able to meet all the requisite estates standards and recommendations and be unable to provide an appropriate environment for high quality and effective patient care and a positive patient and staff experience. Furthermore, this may result in unsustainable growth in backlog maintenance and a requirement to invest in short term solutions. **125** If the hospital estate is not sufficiently funded to enable appropriate maintenance and development, then there will be an increase in capital required to bring the estate to an appropriate condition and subsequent increase in backlog maintenance costs, which may mean a reduction in estates and facilities compliance and possible patient safety concerns **145** If the Trust does not deliver our strategic vision, including two new hospitals and influence sufficiently within the Cheshire & Merseyside Integrated Care System (ICS) and beyond, then the Trust may not be able to provide high quality sustainable services resulting in a potential inability to provide the best outcome for our patient population, possible negative impacts on patient care, reputation and financial position. **1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff
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	**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 purpose of this report is to present the recommended option to legally integrate Bridgewater Community Healthcare NHSFT (BCH) and Warrington and Halton Teaching Hospitals NHSFT (WHH) for approval by both organisations' Trust Boards. BCH and WHH agreed with the Integrated Care Board (ICB) in April 2024 that the two organisations need to integrate in order to improve care for patients and support clinical and financial sustainability of services. A detailed, robust and transparent options appraisal process has been undertaken to provide a recommended option to legally integrate the two organisations. Members of both executive teams and Trust Boards have been engaged throughout the process and approved aspects of the process as appropriate. Partners have been engaged and NHS England (NHSE) have supported and endorsed the process. The options appraisal process is purely about the legal mechanism for integration and is an enabler to transformational change to improve service delivery. Approval of the recommended option is the start of the NHSE transaction process Option 6, the acquisition of BCH by WHH is the recommended option, following the detailed process. Both Trust Boards are asked to approve the recommended option. Option 6 enables delivery of broadly the same high levels of patient, staff and financial benefits as options 5 and 7.			

	Option 6 provides the best value for money and does not present significant delivery risks against the Department of Health and Social Care's (DHSC) risk assessment process. If both Trust Boards approve the recommended option, the key next step is to share our draft milestone plan and associated draft transaction timetable with NHSE, which would commence the transaction process. The draft timeline proposes that we would become a single organisation in April 2027. Clinical pathway improvements and the integration of corporate services are expected to deliver ahead of completion of the legal transaction.		
PURPOSE: ***(please select as appropriate)***	**Approval** ✓	**To note**	**Decision** ✓
RECOMMENDATION:	It is recommended that Warrington and Halton Teaching Hospitals NHSFT Trust Board approve the recommended option of Warrington and Halton Teaching Hospitals NHSFT acquiring Bridgewater Community Healthcare NHSFT. In approving the recommended option the Trust Board commits to commencing the formal NHSE transaction process. In considering approval of the recommended option Board members need to consider their legal obligations, including the duty to collaborate and NHS Code of Governance.		
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		

Better Care Together Options Appraisal Recommendation

1. Executive summary

The purpose of this report is to present the recommended option to legally integrate Bridgewater Community Healthcare NHSFT (BCH) and Warrington and Halton Teaching Hospitals NHSFT (WHH) for approval by both organisations' Trust Boards.

BCH and WHH agreed with the Integrated Care Board (ICB) in April 2024 that the two organisations need to integrate in order to improve care for patients and support clinical and financial sustainability of services.

A detailed, robust and transparent options appraisal process has been undertaken to provide a recommended option to legally integrate the two organisations. Members of both executive teams and Trust Boards have been engaged throughout the process and approved aspects of the process as appropriate. Partners have been engaged and NHS England (NHSE) have supported and endorsed the process.

The options appraisal process is purely about the legal mechanism for integration and is an enabler to transformational change to improve service delivery. Approval of the recommended option is the start of the NHSE transaction process

Option 6, the acquisition of BCH by WHH is the recommended option, following the detailed process. Both Trust Boards are asked to approve the recommended option.

Option 6 enables delivery of broadly the same high levels of patient, staff and financial benefits as options 5 and 7. Option 6 provides the best value for money and does not present significant delivery risks against the Department of Health and Social Care's (DHSC) risk assessment process.

If both Trust Boards approve the recommended option, the key next step is to share our draft milestone plan and associated draft transaction timetable with NHSE, which would commence the transaction process. The draft timeline proposes that we would become a single organisation in April 2027.

Clinical pathway improvements and the integration of corporate services are expected to deliver ahead of completion of the legal transaction.

2. Purpose

The purpose of this report is to present the recommended option to legally integrate Bridgewater Community Healthcare NHSFT (BCH) and Warrington and Halton Teaching Hospitals NHSFT (WHH) for approval by both organisations' Trust Boards.

The report will clearly outline the context to our integration and the decision required on legal process. It will outline the overall integration programme and the transaction process as an integral part of the programme.

It will provide an overview of the options appraisal itself before recommending to both Boards that they approve the option unanimously recommended by the panel appointed by both Boards.

Finally, the paper will summarise next steps.

3. Context

BCH and WHH have previously explored integration, driven by the need to improve services for the shared population we serve and to deliver clinical and financial sustainability.

On 16th April 2024 the CEOs and Chairs of both Trusts met with Graham Urwin, CEO Cheshire and Merseyside ICB. Graham wrote to both Trusts on 22nd April, confirming the agreement in principle made in the meeting, which was that BCH and WHH need to vertically integrate.

Following the meeting on 16th April BCH and WHH commenced a programme of integration. The two CEOs agreed a memorandum of understanding (MoU), which set out a series of initial principles for the programme. The initial MoU is included at appendix 1.

On 4th September 2024, both Trust Boards met together for the first joint Board development session. In this session both Boards reviewed the content of the MoU with further points of clarity and considerations of how we work together. The MoU and 20 additional points identified were therefore condensed into 5 key points describing how we will work together to simplify the expectations going forward. Material changes since the original MoU were noted including the known departure of the organisations' CEOs. These 5 points were formally approved and adopted by both Trust Boards independently in October 2024. This document is included at appendix 2.

A series of other documents were approved at our October 2024 Boards, reflective of the progress we had made together, including:

- Our Strategic Case for Change (appendix 3)
- Our communications principles and key messages (appendix 4)
- Our joint programme branding (appendix 5)

Our draft milestone plan and risk and gain share agreement were shared at these Board meetings for information as both had been previously approved at our Joint executive team meeting.

Within our approved strategic case for change we state that "We hope to become a single organisation as soon as possible", which reflects the discussion and agreement at the joint Board development session. A key action agreed at our joint Board development session in September 2024 was therefore to progress, as a priority, an options appraisal to help determine the most appropriate legal mechanism for us to integrate and become a single organisation.

In October 2024 we further demonstrated our commitment to integration by appointing a joint CEO, Nikhil Khashu, who started in post on 1st November. The Joint CEO role has been followed by two more joint executive posts, our shared Executive Medical Director and Chief Operating Officer.

4. Process

The options appraisal process aimed to:

- Identify options, including legal mechanisms, to bring our organisations together to support and enable integration
- Develop and agree a shortlist of options
- Evaluate the shortlist of options against agreed criteria
- Recommend an option, based on the evaluation
- Put the recommendation to both Boards for review and approval

If the approved option is a transaction, the options appraisal will then be included within a strategic case. The strategic case would be developed over an estimated 6 months and would also require approval by both Boards and NHSE.

If the strategic case is approved by NHSE a full business case will be developed – this is where the detail of everything comes together, e.g. joint clinical strategy, clinical benefits, detailed costs and financial benefits. The full business case will take an estimated 12 months to develop and would also require approval by both Trust Boards and NHSE.

Patients, staff, partners and governors will be engaged throughout the integration programme. Prior to the completion of the transaction, governors will be required to confirm that a robust process has been followed, in accordance with NHSE transactions guidance.

The options appraisal process is purely about the legal mechanism for integration and is an enabler to transformational change to improve service delivery. Approval of the recommended option is the start of the transaction process. Figure 1 below shows how a decision on organisational form and delivery of future organisational form is integral to delivery of clinical, workforce and financial benefits of integration.

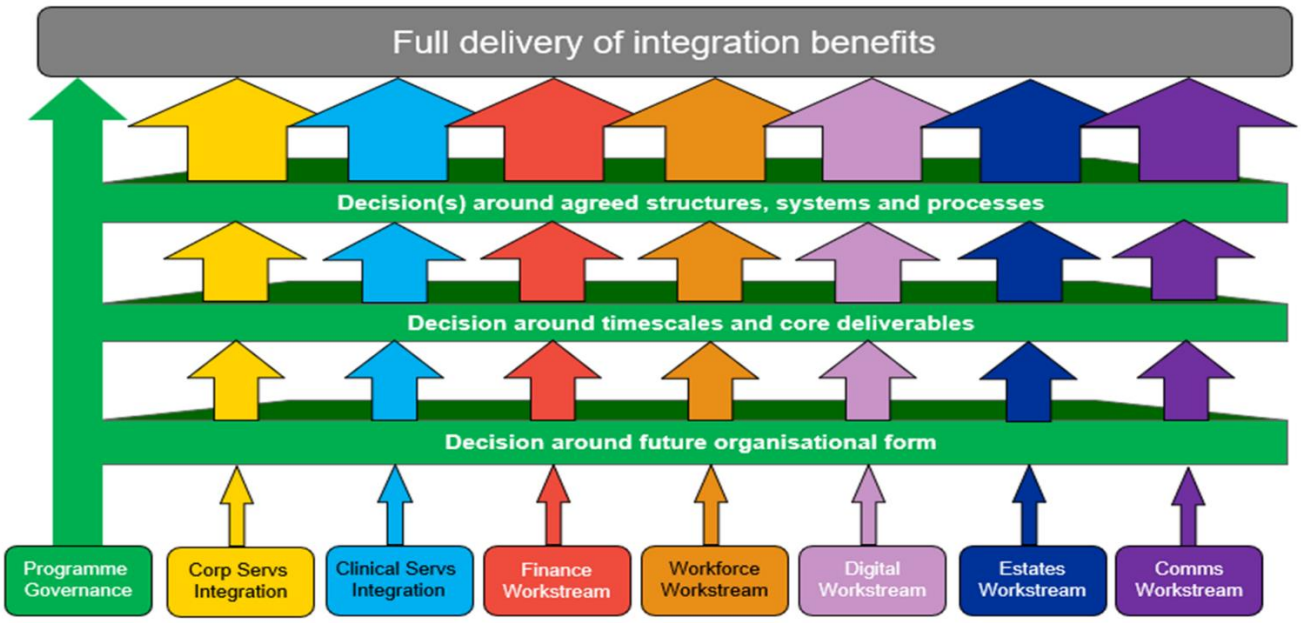


Figure 1: Interdependency between organisational form and integration benefits

Our joint options appraisal process has been detailed, transparent and robust. The process, criteria and weightings were agreed by both Boards and executive teams and endorsed by NHSE. We have adopted previously successful transactions' learning and best practice.

The full options appraisal timetable, which was agreed at the joint executive team meeting on 15th October 2024, is included at appendix 6.

In summary the process included the following key steps:

- Development and agreement of timetable
- Development and approval of long list of options
- Appraisal of long list of options to provide shortlist
- Review and approval of shortlist
- Development and approval of criteria and weightings, against which to score shortlisted options
- Development and approval of guide and detailed evidence and information pack to support panel members to score shortlisted options
- Agreement on panel members
- Independent evaluation and scoring of each shortlisted option against agreed criteria by each of the panel members
- Collation of scores
- Dedicated workshop with panel members to review collated scores and agree a recommended option
- Recommended option and scores shared with all Board members
- Recommended option proposed to both Boards for approval

All executives, key partners, including Local Authority, ICB, voluntary sector and primary care colleagues, and NHSE contributed to the detailed evidence and information pack used to support the evaluation of options. The detailed evidence and information pack is included at appendix 7.

Board members were engaged throughout the process and feedback informed the process, for example merger was included in the shortlist for detailed options appraisal following discussion at a joint Board session in November.

All Board members were given opportunities to suggest membership of the panel. Feedback from members of the Boards resulted in, for example, both Chief Nurses and Senior Independent Directors being included on the panel. The final panel was approved by both Chairs and our joint CEO.

To ensure a fair and thorough process, the options appraisal panel was made up of 10 executive and non-executive Board members – equally representing both organisations. The membership of the panel is detailed in appendix 8.

The panel considered detailed information and evidence, scoring each option against 19 criteria grouped into six key areas:

- Patient impact and benefits
- Patient care sustainability
- Workforce and culture
- Financial sustainability and value for money
- Strategic alignment
- Deliverability

The detailed scores and outcome of the options appraisal process are outlined in section 5 below.

5. Options appraisal

The panel members independently assessed and scored the four approved shortlisted options, which were:

Option 4: Shared leadership with joint operational governance

Option 5: Merger of BCH and WHH
Option 6: Acquisition of BCH by WHH
Option 7: Acquisition of WHH by BCH

All scores were then combined to provide final scores and weighted scores for each option, against the agreed criteria and weightings.

The key outcomes of the appraisal process, as agreed by the panel on 17th December are as follows:

- All 10 panel members scored option 6, acquisition of BCH by WHH, the highest
- Option 6 has a total weighted score of 2337 vs the next highest score of 1937 for option 7, acquisition of WHH by BCH
- Option 6 scored higher than or equal to option 7 on every one of the 19 criteria
- The process has been agreed by both Boards, supported by NHSE and has been detailed, transparent and robust
- **In the panel meeting on 17th December option 6 was therefore confirmed as the recommended option.**

The total scores and weighted scores for each of the four shortlisted options against each of the 19 agreed criteria are provided in the table below. The full spreadsheet, including scores from each panel member, has been shared with all panel members. For ease of reading, the below table, figure 2, is also included as appendix 9.

Strategic Case: Selection Criteria and Scoring Template		Total Scores (Unweighted)				Total Scores (Weighted)			
		Option 4	Option 5	Option 6	Option 7	Option 4	Option 5	Option 6	Option 7
CSF	Area to consider	Shared leadership with joint operational governance	Merger of BCH and WHH	Acquisition of BCH by WHH	Acquisition of WHH by BCH	Shared leadership with joint operational governance	Merger of BCH and WHH	Acquisition of BCH by WHH	Acquisition of WHH by BCH
Patient Impact & Benefits	Impact on safety and quality of care.	18	26	34	30	90	130	170	150
	Impact on patient and service user experience.	20	27	34	29	80	108	136	116
	Impact on long-term health outcomes.	19	28	35	30	57	84	105	90
Patient Care Sustainability	Enables delivery of shared strategic clinical objectives	17	31	36	34	85	155	180	170
	Helps support/improve fragile services across both/either organisation	16	30	35	32	48	90	105	96
	Impact on performance outcomes.	16	29	35	31	64	116	140	124
Financial Sustainability and Value for Money	Delivery of financial benefits	11	30	30	30	44	120	120	120
	Cost of implementation.	30	0	20	11	120	0	80	44
	Sustainability of individual providers and the overall health and care system.	12	31	34	32	48	124	136	128
Workforce and Culture impact	Enables development and implementation of a joint Workforce Strategy/People Plan.	18	32	38	33	72	128	152	132
	Impact on staff satisfaction and well-being.	13	26	29	23	65	130	145	115
	Impact on culture and local identity. Including, attractiveness of option from our local communities' points of view.	11	25	34	27	33	75	102	81
Strategic Alignment	Supports the delivery of the ICB Long-term plan	13	34	38	36	39	102	114	108
	Supports the development of integrated working	17	33	37	35	51	99	111	105
	Enables delivery of system-wide estates and digital strategies.	14	34	38	38	42	102	114	114
Deliverability	Can be delivered within a realistic timescale.	39	0	30	21	156	0	120	84
	Trusts have the capability and capacity to deliver the integration	24	20	27	17	96	80	108	68
	Likely to pass the DHSC risk assessment process	0	20	29	10	0	100	145	50
	Minimises adverse impact on BAU.	18	14	18	14	54	42	54	42
		326	**470**	**611**	**513**	**1244**	**1785**	**2337**	**1937**

Figure 2: Options appraisal scores

The full evidence and information pack, used by panel members to support their evaluation and scoring of each shortlisted option, is included at appendix 7. Some key points contained within the detailed pack which are pertinent to the panel's scoring and recommendation are summarised below:

Option 6, acquisition of BCH by WHH
Option 6 ranked 1st in both weighted and unweighted scores.

In terms of patient impact and benefits, full integration of services under option 6, would formally bring community and hospital staff together to enhance the community service offer and deliver streamlined pathways which are likely to lead to improved long term health outcomes. Also

enabling our system's strategic journey from provider to community as per the 10 year plan. The patient benefits for option 6 are likely to be broadly the same as for option 7.

Option 6 delivers broadly the same staffing benefits as options 5 and 7. Option 6 would facilitate the development of a single workforce with improved opportunities for career development through shared training and educational resources, new roles and challenges supporting development and retention. These changes will help with filling workforce gaps, reducing agency staffing and premium rates through integrated teams, particularly in support of fragile services. All options may bring concerns for staff as all options involve significant change. Both organisations are committed to supporting staff and we will follow our own policies, as well as NHSE's transactions guidance and legal processes as appropriate, to ensure clarity, compliance and fairness.

Financially, option 6 is likely to deliver a similar level of financial benefits to options 5 and 7, as a result of full integration of services. The cost of the transaction in both options 6 and 7 is likely to be c£2m, which is less than the cost of a merger and less than the likely benefits. The latest benchmarking by NHSE suggests that there is as much as £7m of financial improvement opportunity available across both organisations through reduced corporate service costs. Option 6 is likely to cost less than option 7 to implement due to the requirement to for example transfer less contracts and staff. Therefore option 6 presents the best value for money.

Both options 6 and 7 are likely to take c24 months in order to complete the transaction. There are some key differences between the two acquisition options in terms of deliverability, with reference to Department of Health and Social Care's (DHSC's) risk assessment process, which is a key component of the transaction process. Key DHSC risk assessment questions and any potential risks are summarised below.

- Are there concerns regarding management capability and capacity to execute the transaction?
  WHH currently has a full and stable Trust Board/Leadership team and therefore would not flag as a risk to DHSC if option 6 is chosen as the recommended option.
- What is the scale of the transaction, with reference to the gross assets, income and/or consideration attributable to the transaction as a proportion of that of the Trust?
  Under option 6, the transaction would involve a £350m organisation growing by 29% to become a £450m organisation. This would not flag as a risk to DHSC.
- Are there concerns relating to the quality or operational performance of either Trust, including the direction of travel?
  Under option 6, the transaction would involve an organisation classified as CQC good overall acquiring an organisation classified as requires improvement. This would not flag as a risk to DHSC.
- Are there concerns relating to the financial management of either Trust, including the direction of travel?
  Under option 6, the transaction would involve an organisation with a financial deficit acquiring an organisation with a stable financial position. This is likely to flag as a risk to DHSC.

Option 7, acquisition of WHH by BCH
Option 7 ranked 2nd in both weighted and unweighted scores.

In terms of patient impact and benefits, full integration of services under option 7, would formally bring community and hospital staff together to enhance the community service offer and deliver streamlined pathways which are likely to lead to improved long term health outcomes. Also enabling our system's strategic journey from provider to community as per the 10 year plan. The patient benefits for option 7 are likely to be broadly the same as for option 6.

Option 7 delivers broadly the same staffing benefits as options 5 and 6. Option 7 would facilitate the development of a single workforce with improved opportunities for career development through shared training and educational resources, new roles and challenges supporting development and retention. These changes will help with filling workforce gaps, reducing agency staffing and premium rates through integrated teams, particularly in support of fragile services. All options may bring concerns for staff as all options involve significant change. Both organisations are committed to supporting staff and we will follow our own policies, as well as NHSE's transactions guidance and legal processes as appropriate, to ensure clarity, compliance and fairness.

Financially, option 7 is likely to deliver a similar level of financial benefits to options 5 and 6, as a result of full integration of services. The cost of the transaction in both options 6 and 7 is likely to be c£2m, which is less than the cost of a merger and less than the likely benefits. The latest benchmarking by NHSE suggests that there is as much as £7m of financial improvement opportunity available across both organisations through reduced corporate service costs. Option 7 is likely to cost more than option 6 to implement due to the requirement to for example transfer more contracts and staff. Therefore option 7 presents better value for money than options 4 and 5 but less value for money than option 6.

Both options 6 and 7 are likely to take c24 months in order to complete the transaction. There are some key differences between the two acquisition options in terms of deliverability, with reference to Department of Health and Social Care's (DHSC's) risk assessment process, which is a key component of the transaction process. Key DHSC risk assessment questions and any potential risks are summarised below.

- Are there concerns regarding management capability and capacity to execute the transaction?
  BCH currently has no substantive Medical Director or COO and the Chair has recently announced her intention to retire. This leaves the current substantive Trust Board/Leadership team depleted and is likely to flag as a risk to DHSC if option 7 is chosen as the recommended option.
- Are there concerns relating to the financial management of either Trust, including the direction of travel?
  Under option 7, the transaction would involve an organisation with a stable financial position acquiring an organisation with a financial deficit. This would not flag as a risk to DHSC.
- What is the scale of the transaction, with reference to the gross assets, income and/or consideration attributable to the transaction as a proportion of that of the Trust?
  Under option 7, the transaction would involve a £100m organisation growing by 350% to become a £450m organisation. This is likely to flag as a risk to DHSC.
- Are there concerns relating to the quality or operational performance of either Trust, including the direction of travel?
  Under option 7, the transaction would involve an organisation classified as CQC requires improvement overall acquiring an organisation classified as good. This is likely to flag as a risk to DHSC.

Option 5, merger of BCH and WHH

Option 5 ranked 3rd in both weighted and unweighted scores.

In terms of patient impact and benefits, full integration of services under option 5, would formally bring community and hospital staff together to enhance the community service offer and deliver streamlined pathways which are likely to lead to improved long term health outcomes. Also enabling our system's strategic journey from provider to community as per the 10 year plan. However, option 5 is likely to have the longest timeframe to implement and therefore maximises any period of unsettlement for staff and potentially delays the delivery of patient benefits.

Option 5 delivers broadly the same staffing benefits as options 6 and 7. Option 5 would facilitate the development of a single workforce with improved opportunities for career development through shared training and educational resources, new roles and challenges supporting development and retention. These changes will help with filling workforce gaps, reducing agency staffing and premium rates through integrated teams, particularly in support of fragile services. All options may bring concerns for staff as all options involve significant change. Both organisations are committed to supporting staff and we will follow our own policies, as well as NHSE's transactions guidance and legal processes as appropriate, to ensure clarity, compliance and fairness. The length and complexity of the process for option 5 may disrupt workforce experience, reducing satisfaction.

Financially, option 5 is likely to deliver a similar level of financial benefits to options 6 and 7, as a result of full integration of services. However, option 5 is likely to be the costliest to implement, with estimated implementation costs of the transaction of at least £3m and it therefore presents less value for money than options 6 and 7.

Option 5 requires the dissolution of 2 organisations in order to create one new single entity. This is arguably the most complex of the options that involve moving to a single combined organisation. NHSE have suggested that this option would likely take a minimum of 24 months to complete, but more likely closer to 36 months.

Option 4, shared leadership and operational governance

Option 4 scored the lowest both in weighted and unweighted scores and scored significantly lower than the next lowest scoring option, which was option 5, merger of BCH and WHH.

In terms of patient impact and benefits, whilst option 4 allows for closer working and sharing of best practice, it is unlikely to support larger-scale sustainable improvements in quality of care. It provides limited continuity of care/carer as referrals between individual providers would still be required and lack of resilience for smaller services would continue.

Financially, whilst option 4 is likely the least costly to implement, an estimated £0.5m, it is very unlikely to deliver significant benefits, either clinical or financial. It therefore does not present good value for money.

From a staff perspective, although option 4 may bring least worry and concern about jobs, rightly or wrongly, since the workforce of the two organisations wouldn't be fully integrated, it would provide less opportunity to improve the overall workforce, support talent management and reduce gaps and agency usage than other options.

From a public point of view – one legal entity/organisation at the end of this process is a clearer outcome. The public view the NHS as one organisation, and don't fully understand the complexities of different providers. For this reason, option 4 could be perceived as least favourable.

Option 4 is likely the quickest to deliver, with an estimated implementation timeline of 6-12 months. However, complex governance arrangements will be required to manage joint decision making under this option.

Insight from NHS England suggests that the shared leadership option creates complex and challenging shared governance in the short-term and in the longer-term generally leads to either:

a) an agreed de-coupling of the arrangements, or

b) full integration via a merger or acquisition within 3 years.

6. Recommendation

It is recommended that both Bridgewater Community Healthcare NHSFT Trust Board and Warrington and Halton Teaching Hospitals NHSFT Trust Board approve the recommended option of Warrington and Halton Teaching Hospitals NHSFT acquiring Bridgewater Community Healthcare NHSFT.

In approving the recommended option both Trust Boards commit to commencing the formal NHSE transaction process.

7. Next steps

If both Trust Boards approve the recommended option, the immediate next step is to share our decision, along with a draft transaction timeline, with NHSE to seek their support to commence the transaction process.

Our updated integration milestone plan and associated draft transaction timeline is included at appendix 10. Some key points are summarised below.

- Draft timeline proposes a single organisation from 1st April 2027.
- This is in line with advice from NHSE and will require us to work at pace.
- The draft timeline assumes development of joint strategies, including a service level clinical strategy in 2025/26.
- Clinical pathway improvements are expected to deliver ahead of completion of the legal transaction.
- Corporate services integration is expected to deliver ahead of completion of the legal transaction.
- The first step in the transaction process is to develop the strategic case, it is estimated that this will take 6 months. It will require significant progress to be made across all workstreams.
- We intend to submit a detailed resource request to the ICB, which will evidence the resource we have committed and ask for funding to address the gaps. Any delay to allocation of resource needed will delay the programme.
- Our resource request will include funding for consultancy and legal support, as subject matter experts and to provide independent assurance.
- Our full business case will demonstrate that the benefits we will deliver will outweigh investment required.

8. List of appendices

1. Initial MoU
2. How we will work together
3. Strategic case for change
4. Communications principles and key messages
5. Joint programme branding
6. Options appraisal timeline
7. Evidence and information pack
8. Panel membership
9. Options appraisal scores table
10. Draft milestone plan and transaction timeline

Memorandum of Understanding

- Our system is not clinically and financially sustainable and we must significantly improve our use of resources. All parties have recognised the sub-optimal working that exists, caused by silo working, fragmentation, and lack of co-ordination. Evidence demonstrates that alignment of management of the system is necessary to effectively address and optimise the use of resources and outcomes for patients and staff.

- We have identified significant opportunities to improve things for both our patients and staff working at the front line and are launching a programme of work to deliver integrated and collaborative models of care between Warrington and Halton Hospital NHS Foundation Trust and Bridgewater Community NHS Foundation Trust.

- We recognise the potential risks associated with these plans, in terms of staff anxiety and the potential for cumbersome governance. The overriding aim of delivery of a sustainable system for patients and staff will require focus and leadership to mitigate risks and take people with us.

- The programme must focus on a Warrington and Halton solution and involve the seven local Primary Care Networks and the two Local Authorities.

- To achieve the objectives, the programme will focus on the place-based clinical integration of services and production of a co-designed clinical strategy for the places/partnership, with organisational forms/models being developed to create the environment, leadership and governance for high-quality clinical services to thrive.

1. We will follow the ‘ask’ of the ICB in the best interests of the C&M system as a whole.
2. Together, we will be a/behave as a single organisation by mid-2026 at the very latest; much sooner if possible
3. The integration journey will be driven by a balanced programme of clinical and non-clinical integration, which will engage Primary Care and Local Authorities and will ensure we stay true to the requirement that form follows function.
4. A single Trust Board will be created, supported by the appointment of a single Chair, single Chief Executive and single Leadership Team (not necessarily at the same time or in any pre-determined/’conventional’ sequence).
5. In the interim, we will aim to appoint a joint Board and joint working across Trusts will be encouraged.
6. Given the fact that both organisations are foundation trusts, the unification of the Council(s) of Governors will also be important.
7. Together, we will take specialist advice on the options available to integrate our services, governance and potentially organisations. The mechanism to deliver the above needs to be legal, timely, and will represent best value for public-money ensuring that the form follows function.

8. We will have two initial primary objectives: 1) to achieve UEC Recovery and 2) ensure effective use of resources.
9. Terminology is powerful and important to people in both organisations. Recognising their differences in any number of domains, both trusts will engage in the integration work from a position of parity, and this will be termed as a ‘coming together’ of both organisations – hospital and community services – and will not be, or be considered as being, a takeover of one organisation by the other, regardless of the technical mechanism deployed.
10. Both organisations share the ambition for more care to be delivered in the community, closer to peoples’ homes.
11. The transition needs to be managed with sensitivity and be respectful of professional circumstances as well as employment law from the outset. This is true for staff at all levels.
12. The programme of integration will be operationally led by Lucy Gardner supported by Mark Charman, on behalf of both organisations.
13. The ICB will be represented by Carl Marsh, Place Director (Warrington) on behalf of both Warrington and Halton Places (which will be considered on an equal basis).

14. This programme of change will be delivered by both Executive Teams empowered to be working together. Individualised and personalised career conversations will take place between each member of each Executive Team and their respective Chief Executive to fully understand their personal aspirations and expectations (alongside their concerns and anxieties) as part of this process.
15. Executives will be asked to engage with their opposite number to begin to set out the opportunities for all forms of collaboration and integration within their portfolio.
16. Data will be shared freely between organisations to understand the underlying financial positions of both Trusts, the drivers of the WHH deficit, each Trust's non-recurrent income, CIP plans, corporate and support service structures, as well as current operational plans.
17. We will establish a joint vacancy control process with immediate effect.
18. We will jointly manage our assets including our balance sheet, cash and leases.

Better Care Together integration programme

How we will work together

At the Board to Board away day held on 4 September 2024, we collaboratively came up with a list of expected ways of working for us all to adopt as we increasingly work and behave as one organisation.

There were 20 points identified, with many commonalities and some overlap. As a result, we have condensed down to five key points:

1. We will be person centred, keeping patients and staff at the heart of everything we do. We share a common goal to make things better for the people of Warrington and Halton and beyond, including those accessing our services in other boroughs
2. As we share the same unifying purpose, we will assume each of us has the best of intentions and we won't judge people on their worst day. This is essential if we are to be able to express any concerns safely.
3. We're one team and we need one consistent message – the language we use is important. It will be positive, simple, and non-judgemental, and we will avoid using words like 'merger' and 'acquisition' where they are not needed.
4. We value and actively seek diverse thinking to help us make better decisions. While we may change our minds or learn new information, we won't go back on decisions lightly or in isolation. We won't say yes and agree to something when we really mean no.
5. We will treat each other with kindness and respect, being open and transparent so that we can build and maintain trust. We will share our expertise and relevant information freely. We will hold ourselves to account for how we work together.

Communications principles and key messages

11 September 2024

DRAFT v0.2

Communications and engagement principles

The NHS has several well-established communication principles. Communication should be clear and accessible, always putting people at the forefront. Avoid jargon, use plain English, and tailor the message to each audience.

1. Clarity and trust

With the need to engage a broad audience, clarity and trust are essential to achieving our communication goals. Alongside the ‘Seven Cs of effective communication’ — clear, concise, concrete, correct, coherent, complete, and courteous — our messaging about Better Care Together must be strongly aligned with our key messages and personalised for different audiences. We must be open and honest in line with our values to help build trust, communicating as much as we can, as soon as we can.

2. Compassionate and reassuring language

Change can often feel unsettling. A new partnership, like this one, may raise concerns about forced changes or, in the worst case, job security. Our language should reassure both colleagues and patients that they play a vital role in our mission and that we are working with them and for them, not against them. We should select language that resonates with each audience, avoiding a one-size-fits-all approach. For internal communications with staff, consistency in language across both organisations is imperative.

3. Aspirational yet realistic

Our language should inspire hope and a sense of purpose, using active terms like "building", "strengthening", "combining", and "flourishing" to convey positivity, dynamism, and purpose. While Better Care Together is ambitious, aimed at long-term sustainability for our colleagues and patients, our communication must strike a balance between being aspirational and realistic. We should communicate our goals and processes in a way that is inspiring, beneficial, and grounded in reality.

4. Accessible and timely

Information about Better Care Together should be available in various formats to ensure that all audiences can access it in the way that suits them best. Urgent or important information must be communicated internally within both organisations at the same time. Less important information should be timed to be issued as closely together as possible. We commit to communicating internally with our staff before we communicate externally, so that staff hear news from us first, and not from external sources.

5. Start with people

Collaborative and meaningful partnerships should start with people and focus on what really matters to our communities and staff. There are clear benefits to working in partnership with people and communities:

- better decisions are made about service changes and how money is spent
- reduced risks of legal challenges
- improved safety, experience and performance
- helps address health inequalities by understanding communities' needs and developing solutions with them.

It is about shaping a sustainable future for the NHS that meets people's needs and aspirations. We commit to effective engagement with staff, stakeholders and communities, including people with lived experience.

6. Close the loop

Clear and consistent communication is essential for effective engagement. Beyond encouraging staff and patients to voice their opinions, our communications and engagement activity should also 'close the loop', clearly demonstrating how their input has influenced the outcomes of this new way of working together. This applies not only when feedback has been implemented but also when we cannot make changes in line with the feedback received.

Key messages

The narrative and key messages are fundamental to all communication activity relating to our integration programme. They will form the basis of our communication with different stakeholder groups and will be tailored for specific audience and different communication channels/formats.

In line with our communications and engagement principles, the key messages need to:

- be **repeated often** so that they become embedded in people's minds
- be **simple and memorable** so that they can be recalled and repeated

The messages have been produced using the '27/9/3' model of message development. Each set of key messages are no more than 27 words, which can be said in nine seconds and contain three messages. This model is based on US research which that found:

- the average length of a quote in print media is 27 words
- the duration of a sound bite in broadcast media is nine seconds
- the average number of messages carried is three

Key message grid:

	Key message 1 (why) **We want to provide better care together**	Key message 2 (what) **We are joining forces and working as one**	Key message 3 (how) **With shared leadership, we are integrating our services**	23 words
Supporting messages	Warrington and Halton need strong and resilient clinical services	Together we will improve healthcare services for our communities	We [will] have a joint CEO and shared executive team	
	Our healthcare system must be sustainable for the future	We'll involve staff, partners and people with lived experience	We've established an integration programme called Better Care Together	
	We can achieve more together for patients and staff	We will work and behave as a single organisation	We need your support to make it a success	
	27 words	27 words	27 words	

Shorter narrative:

We want to provide better care together, so we are joining forces and working as one. With planned shared leadership, we are integrating our services.

Longer narrative:

We want to provide better care together. 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.

We are joining forces and working as one. Together we will improve healthcare services for our communities. We'll involve our staff, partners and people with lived experience, and we will work and behave as a single organisation.

With planned shared leadership, we are integrating our services. We will have a joint chief executive and a shared executive team. We've established an integration programme called Better Care Together and we need your support to make it a success.

Integration branding proposal v2

For approval at Board meetings
taking place on 2/3 October 2024

Integrating hospital and community services provided by Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust

The ask

- After exploring partnership branding options, it was agreed at the Board to Board meeting held in September that we need to undertake further engagement work with staff, patients and the public about future partnership (and ultimately organisation) names.
- This work is ongoing and will take some time to engage and seek a wide range of views.
- In the meantime, and as we are progressing with integration plans, a proposal to brand the integration programme as ‘Better Care Together’ is being put forward for approval.
- As previously, any branding developments must:
  - Meet NHS Identity Guidelines, which help to ensure clarity for the public and staff
  - Be developed internally – no external design / agency spend
  - Be approved through the governance processes being established (at this point in time, both Boards)
  - Be implemented in a cost effective way

The proposal

- To brand the integration programme ‘Better Care Together’, using the graphic below:



- As per NHS identity guidelines, two NHS logos must not appear on the same page – this is confusing for the public and dilutes the strength of the NHS identity.
- For all materials relating to the integration programme, a single NHS lozenge will be used, accompanied with the Better Care Together graphic, and the following descriptor text:

Integrating community and hospital services provided by
Bridgewater Community Healthcare NHS Foundation Trust and
Warrington and Halton Teaching Hospitals NHS Foundation Trust

An example


DRAFT v3
NHS
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

Potential sensitivities

- As we increasingly work and behave as one single organisation, we will need a branding solution for very practical matters which will need to be managed sensitively
- Examples include:
  - Email signatures / lanyards for joint postholders e.g. CEO and potentially some exec directors – can't be seen to align to one organisation more than the other
  - Templates for joint BAU communications channels e.g. one CEO-led Team Brief across both organisations rather than two
- Additionally, and as we plan to become a single organisation (subject to options appraisal and approval etc), we will need to demonstrate engagement activity being undertaken and feedback being considered about the organisation's name
- This work will also require us to find a solution for services provided outside of Warrington and Halton, e.g. Bridgewater's dental services and WHH's breast screening service

Progress and next steps

- Discussed at Exec to Exec Meeting - 16 July 2024
- Discussed at Board to Board – 4 September
- Revised following feedback and discussed at Exec to Exec meeting – 17 September
- For approval at Bridgewater and WHH Board meetings – 2 and 3 October
- Implement alongside communication of key messages for the programme
- Seek views on partnership name / future organisation name via both organisations' channels, including from staff, stakeholders, governors, patients and the public, e.g. WHH's Experts by Experience and Bridgewater's equivalent
- Share findings at future Exec to Exec and Board to Board meetings for decision

Options appraisal - timetable

Action	Action No.	Milestone	Work Required	Contributors	Deadline	Forum
Agree Timetable	1.1	Develop proposed timetable for options appraisal	Review national guidance on process to be followed, plan actions/milestones that must be completed and deadlines in relation to approval forums	LG & JP	14.10.2024	N/A
	1.2	Develop the long list for options appraisal	Review similar options appraisals, Trusts' strategies and regional context	LG & JP	14.10.2024	N/A
	1.3	Confirm timetable for completion of options appraisal	Review proposed timetable, provide any feedback and approve	Executive Teams	15.10.2024	Better Care Together Programme Board
Develop and Approve Long List	2.1	Present and finalise long list for options appraisal		LG & JP	15.10.2024	Better Care Together Programme Board
	2.2	Approve long list for options appraisal		Executive Teams	COP 17.10.2024	Virtual
Develop and Approve Shortlist	3.1	Appraise long list options to identify shortlist	Review the advantages and disadvantages of each long list option	LG, LZ & JP Corporate Governance	25.10.2024	N/A
	3.2	Circulate shortlist for options appraisal for comments		LG, LZ & JP	25.10.2024	Virtual
	3.3	Provide comments on the shortlist		Executive Teams	COP 29.10.2024	Virtual
	3.4	Update shortlist in response to feedback		JP	31.10.2025	N/A
	3.5	Approve shortlist		Executive Teams	05.11.2024	Executive Team Meeting
	3.6	Share shortlist with both Trust Boards		LG	06.11.2024	Joint Board Development

Action	Action No.	Milestone	Work Required	Contributors	Deadline	Forum
Undertake Options Appraisal	4.1	Develop draft scoring criteria for options appraisal	Review NHSE guidance and examples from other similar organisations, amend to reflect our own strategies and develop appropriate scoring criteria for our organisations	LG, LZ & JP Stephen Bennett	15.11.2024	N/A
	4.2	Agree scoring panel		Trust Chairs CEO	19.11.2024	Better Care Together Programme Board Follow-up email to Chairs
	4.3	Endorse draft scoring criteria, acknowledging amends may be made based on exec review, NED discussion and informed by evidence gathering	Initial draft shared at BCT Executive Delivery Group 5.11.2024, weighting of staff impact increased based on feedback	Executive Teams	19.11.2024	Better Care Together Programme Board
	4.4	Deliver sessions with the Non-Executive Directors on the options appraisal process and clinical services integration		LG, Paul Fitzsimmons	28.11.2024/29.11.2024	Dedicated sessions
	4.5	For each option provide evidence and information against scoring criteria to develop an evidence and information evaluation pack	Following advice from NHSE, partners to input on key relevant areas e.g. alignment to ICB Long term plan. NHSE to provide advice as required.	Integration team Corporate Governance Workstream SROs Key partners NHSE	28.11.2024	Virtual Workstream meetings Meeting with partners
	4.6	Update panel guide		LZ	28.11.2024	
	4.7	Share WIP evidence and information evaluation packs with the workstream groups for review, contribution and verification	Workstreams to review the detail of evidence scoring packs relevant to their area, contribute detail to these packs and verify the detail is correct	Workstream SROs	W/c 18.11.2024 and 25.11.2024	Workstream meetings
	4.8	Approving scoring criteria		Executive Teams	03.12.2024	Better Care Together Executive Delivery Group
	4.9	Final review of evidence and information evaluation pack		Executive teams	03.12.2024	Better Care Together Executive Delivery Group
	4.10	Review of panel guide		Executive teams	03.12.2024	Better Care Together Executive Delivery Group
	4.11	Incorporate any final amends from Executive teams into evidence and information evaluation pack and approve virtually		Integration team Executive teams	06.12.2024	Virtually
	4.12	Incorporate any final amends from Executive teams into panel guide and approve virtually		Integration team Executive teams	06.12.2024	Virtually
	4.13	Circulate evidence and information evaluation pack to the scoring panel, alongwith guide		LG	10.12.2024	N/A
	4.14	Deliver options appraisal scoring workshop and undertake scoring assessment of each option	Scoring panel to review all options and score against agreed criteria. As per guidance assessment will need to demonstrate impact on patients, finances, workforce and other stakeholders	Scoring panel	17.12.2024	Dedicated workshop
	4.15	Circulation of options appraisal following completion of scoring assessment to both Boards	Ideally by 24.12.2024, latest by 08.01.2025	Integration team	08.01.2025	N/A
	4.16	Review options appraisal and recommendation		Trust Boards	16.01.2025	Joint Board development session
	4.17	Finalise options appraisal	Update options appraisal in response to discussion at joint Board development session	Integration team	24.01.2025	
	4.18	Formal approval of preferred option by both Boards		Trust Boards	05.02.2025/ 06.02.2025	Trust Boards

Better Care Together Options Appraisal Information and Evidence Pack

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Critical Success Factor (CSF) - Patient Impact & Benefits

Area to Consider: Impact on Safety and Quality of Care

Information in this section has been provided and verified by the following sources:

- NHS England guidance
- The Better Care Together Clinical and Operational workstream
- Place partners
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Development/implementation of an improved clinical governance framework, including Patient Safety Incident Response Framework (PSIRF) and improved patient safety incident reporting.
- Effective Board oversight of safety and quality standards.
- Development of end-to-end clinical pathways.

CSF - Patient Impact & Benefits - Impact on Safety and Quality of Care - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options.

Option 4 **Shared leadership with joint operational governance**	Option 5 **A merger between WHH and BCH**	Option 6 **Acquistion of BCH by WHH**	Option 7 **Acquistion of WHH by BCH**
Allows for closer working and sharing of best practice with regards to patient safety incidents, although two separate organisations will remain.	Full integration would facilitate implementation of a single clinical governance framework including Patient Safety Incident Response Framework (PSIRF), developing and maintaining joint patient safety incident response policies and plans and full learning from incidents occurring throughout the whole patient pathway.	Full integration would facilitate implementation of a single clinical governance framework including Patient Safety Incident Response Framework (PSIRF), developing and maintaining joint patient safety incident response policies and plans and full learning from incidents occurring throughout the whole patient pathway.	Full integration would facilitate implementation of a single clinical governance framework including Patient Safety Incident Response Framework (PSIRF), developing and maintaining joint patient safety incident response policies and plans and full learning from incidents occurring throughout the whole patient pathway.
Supports the standardisation of quality standards across Warrington and Halton.	Supports the standardisation of quality standards across Warrington and Halton.	Supports the standardisation of quality standards across Warrington and Halton.	Supports the standardisation of quality standards across Warrington and Halton.
Likely to be a simpler process around the 'transaction' therefore minimising distractions for leadership teams around safety and quality	Creation of a single team and set of processes overseeing clinical governance will enable consistency and clarity at all times.	Creation of a single team and set of processes overseeing clinical governance will enable consistency and clarity at all times.	Creation of a single team and set of processes overseeing clinical governance will enable consistency and clarity at all times.
	Single reporting processes would be in place which will support simplicity and clarity of information.	Single reporting processes would be in place which will support simplicity and clarity of information.	Single reporting processes would be in place which will support simplicity and clarity of information.
	Simplified decision making allowing for maximum agility to respond to emerging issues/incidents.	Simplified decision making allowing for maximum agility to respond to emerging issues/incidents.	Simplified decision making allowing for maximum agility to respond to emerging issues/incidents.
	More effective Board oversight than provided by option 4.	More effective Board oversight than provided by option 4.	More effective Board oversight than provided by option 4.
	Improved system working leading to better, safer and less fragmented clinical pathways.	Improved system working leading to better, safer and less fragmented clinical pathways.	Improved system working leading to better, safer and less fragmented clinical pathways.

CSF - Patient Impact & Benefits - Impact on Safety and Quality of Care - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Ineffective or insufficient Board oversight due to increased distance between leaders and frontline (as advised by NHSE).	Likely to be the most complex and resource intensive process around the 'transaction' therefore maximising distractions for leadership teams around safety and quality.	Likely to be a complex and resource intensive process around the 'transaction' creating distractions for leadership teams around safety and quality however this option is less disruptive than option 5.	Likely to be a complex and resource intensive process around the 'transaction' creating distractions for leadership teams around safety and quality however this option is less disruptive than option 5.
Potential for fragmented and siloed reporting.	More costly than other options therefore quality and safety improvements may become less affordable.		
Convoluted decision making can reduce agility to respond to certain emerging situations within individual organisations.	Potent to retain less corporate/clinical memory due to higher risk of staff leaving due to prolonged uncertainty.		
Likely that separate clinical governance teams will continue to exist within the individual organisations, creating a potential lack of consistency and clarity.			
Lack of longevity as option 4 is unlikely to support larger-scale, sustainable improvements in quality and co-production.			
Collaborative programmes may be more difficult to deliver, e.g. virtual wards currently struggle due to the different values and working practices.			

CSF - Patient Impact & Benefits

Area to Consider: Impact on Patient and Service User Experience

Information in this section has been provided and verified by the following sources:

- The Better Care Together Clinical and Operational workstream
- Place partners
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Delivery of improved clinical services.
- Continuity of care and carer for patients and service users.
- Improved patient experience through increased location options and timing of appointments to minimise patient travel and fatigue

CSF - Patient Impact & Benefits - Impact on Patient and Service User Experience - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Increased opportunities to deliver WHH services closer to home and in MDT clinics/community hubs and/or BCH services in an acute setting. Although there would be a requirement for Memorandum of Understandings or Service Level Agreements to be in place to underpin any agreements and greater opportunities are likely to be possible with options 5, 6 & 7.	Maximises the opportunities to deliver WHH services closer to home and in MDT clinics/community hubs and/or BCH services in an acute setting without the requirement for Memorandums of Understandings or Service Level Agreements between the individual organisations.	Maximises the opportunities to deliver WHH services closer to home and in MDT clinics/community Hubs and/or BCH services in an acute setting without the requirement for Memorandums of Understandings or Service Level Agreements between the individual organisations.	Maximises the opportunities to deliver WHH services closer to home and in MDT clinics/community hubs and/or BCH services in an acute setting without the requirement for Memorandums of Understandings or Service Level Agreements between the individual organisations.
Improved collaboration and multidisciplinary communication could support more streamlined patient pathways and improved services although not likely to be as streamlined as options 5, 6 & 7.	Full integration will improve multidisciplinary communication and support the development of more streamlined, seamless patient pathways and therefore improved services.	Full integration will improve multidisciplinary communication and support the development of more streamlined, seamless patient pathways and therefore improved services.	Full integration will improve multidisciplinary communication and support the development of more streamlined, seamless patient pathways and therefore improved services.
Likely to have the shortest implementation timeframes, minimising any period of unsettlement for staff which may in turn lead to less issues with retention of workforce and continuity of care compared to other options.	Will provide complete continuity of care/carer as this option removes the requirement for referrals between individual providers.	Will provide complete continuity of care/carer as this option removes the requirement for referrals between individual providers.	Will provide complete continuity of care/carer as this option removes the requirement for referrals between individual providers.
	Will help to build resilience for smaller services around resources.	Will help to build resilience for smaller services around resources.	Will help to build resilience for smaller services around resources.

CSF - Patient Impact & Benefits - Impact on Patient and Service User Experience - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options

Option 4 **Shared leadership with joint operational governance**	Option 5 **A merger between WHH and BCH**	Option 6 **Acquistion of BCH by WHH**	Option 7 **Acquistion of WHH by BCH**
Provides limited continuity of care/carer as referrals between individual providers would still be required.	Likely to have longest timeframe to implement and therefore maximises any period of unsettlement for staff which may in turn lead to issues with retention of workforce and continuity of care.	This option is likely to have a longer timeframe to implement than option 4 and therefore increases any period of unsettlement for staff which may in turn lead to issues with retention of workforce and continuity of care however the timeframe is likely to be shorter than option 5.	This option is likely to have a longer timeframe to implement than option 4 and therefore increases any period of unsettlement for staff which may in turn lead to issues with retention of workforce and continuity of care however the timeframe is likely to be shorter than option 5.
Continued lack of resilience for smaller services unable to derive benefits of full integration that are more prevalent with other options.			
Generally more fragmented option.			

CSF - Patient Impact & Benefits

Area to Consider: Impact on Long-Term Health Outcomes

Information in this section has been provided and verified by the following sources:

- The Better Care Together Clinical and Operational workstream
- The Better Care Together Integration Team

Things to consider – how this option will support:

- A shift of care towards community services and away from hospitals.
- A shift of care towards prevention.
- More effective management of chronic, long-term conditions away from an acute setting.

CSF - Patient Impact & Benefits - Impact on Long-Term Health Outcomes - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options

Option 4 **Shared leadership with joint operational governance**	Option 5 **A merger between WHH and BCH**	Option 6 **Acquistion of BCH by WHH**	Option 7 **Acquistion of WHH by BCH**
Closer collaboration and shared leadership will help identify opportunities to move more services away from a hospital setting, where appropriate.	Full integration will significantly help identify opportunities to move more services away from a hospital setting, where appropriate.	Full integration will significantly help identify opportunities to move more services away from a hospital setting, where appropriate.	Full integration will significantly help identify opportunities to move more services away from a hospital setting, where appropriate.
Closer collaboration between clinical services will enhance understanding of hospital staff around opportunities to deliver more services out in community settings, although ability to deliver changes to services is limited due to separate operational, clinical and leadership teams.	Full integration between clinical services will formally bring together community and hospital staff working in connected services. This will create significant opportunities to deliver more services in community settings.	Full integration between clinical services will formally bring together community and hospital staff working in connected services. This will create significant opportunities to deliver more services in community settings.	Full integration between clinical services will formally bring together community and hospital staff working in connected services. This will create significant opportunities to deliver more services in community settings.
	Streamlined pathways are likely to improve compliance with healthcare and lead to improved long-term outcomes.	Streamlined pathways are likely to improve compliance with healthcare and lead to improved long-term outcomes.	Streamlined pathways are likely to improve compliance with healthcare and lead to improved long-term outcomes.

CSF - Patient Impact & Benefits - Impact on Long-Term Health Outcomes - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Transforming services from reactive to preventative models requires significant capacity and resource within operational and clinical teams. This is less likely to be available under option 4 due to limited opportunity to free up resources.	Transforming services from reactive to preventative models requires significant capacity and resource within operational and clinical teams. This is however more likely to be available under this option than under option 4 due to increased opportunities to free up resources.	Transforming services from reactive to preventative models requires significant capacity and resource within operational and clinical teams. This is however more likely to be available under this option than under option 4 due to increased opportunities to free up resources.	Transforming services from reactive to preventative models requires significant capacity and resource within operational and clinical teams. This is however more likely to be available under this option than under option 4 due to increased opportunities to free up resources.

CSF – Patient Care Sustainability

Area to Consider: Enables Delivery of Shared Strategic Clinical Objectives

Information in this section has been provided and verified by the following sources:

- NHS England guidance
- The Better Care Together Clinical and Operational workstream
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Development of shared objectives for population served.
- Improved sharing of resources to deliver clinical services.

CSF – Patient Care Sustainability - Enables Delivery of Shared Strategic Clinical Objectives - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Improved strategic alignment between providers (as advised by NHSE).	Creates full strategic alignment as a single provider.	Creates full strategic alignment as a single provider.	Creates full strategic alignment as a single provider.
Facilitates sharing of best practice to deliver clinical objectives.	Facilitates sharing of best practice to develop and deliver shared clinical objectives.	Facilitates sharing of best practice to develop and deliver shared clinical objectives.	Facilitates sharing of best practice to develop and deliver shared clinical objectives.
Provides a potential catalyst for service change and improvement across both organisations.	Provides a catalyst for service change and improvement across both organisations.	Provides a catalyst for service change and improvement across both organisations.	Provides a catalyst for service change and improvement across both organisations.
Creates opportunities to share resources (estate, equipment etc.), although not as easily as with other options.	Enables the development of sustainable services by sharing skills and resources and attracting new staff.	Enables the development of sustainable services by sharing skills and resources and attracting new staff.	Enables the development of sustainable services by sharing skills and resources and attracting new staff.
	Facilitates the development of a single clinical strategy.	Facilitates the development of a single clinical strategy.	Facilitates the development of a single clinical strategy

CSF – Patient Care Sustainability - Enables Delivery of Shared Strategic Clinical Objectives - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
There is no clear and agreed clinical case for change, evidenced on a national level.	Potential loss of specific strategic focus on community services due to acute pressures and priorities.	Potential loss of specific strategic focus on community services due to acute pressures and priorities.	Potential loss of specific strategic focus on community services due to acute pressures and priorities.
Potentially conflicting priorities of acute and community clinical strategies at sub-Board level.			
Complex governance arrangements may present operational risk to delivering clinical objectives.			

CSF – Patient Care Sustainability

Area to Consider: Helps Support/Improve Fragile Services Across Both/Either Organisation

Information in this section has been provided and verified by the following sources:

- The Better Care Together Clinical and Operational workstream
- Place partners
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Strengthening of fragile services.

CSF – Patient Care Sustainability - Helps Support/Improve Fragile Services Across Both/Either Organisation - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options

Option 4 **Shared leadership with joint operational governance**	Option 5 **A merger between WHH and BCH**	Option 6 **Acquistion of BCH by WHH**	Option 7 **Acquistion of WHH by BCH**
Will help develop a shared understanding of fragile services leading to increased support.	Will help develop a shared understanding of fragile services leading to increased support.	Will help develop a shared understanding of fragile services leading to increased support.	Will help develop a shared understanding of fragile services leading to increased support.
Supports the development of sustainable services through having improved access to other specialist skills and resources.	A single organisation has the ability to deploy specialist skills and resources to areas of highest need and therefore more easily provide support to ensure sustainable services.	A single organisation has the ability to deploy specialist skills and resources to areas of highest need and therefore more easily provide support to ensure sustainable services.	A single organisation has the ability to deploy specialist skills and resources to areas of highest need and therefore more easily provide support to ensure sustainable services.
	A single set of Board priorities and risks should ensure focus on smaller or fragile services.	A single set of Board priorities and risks should ensure focus on smaller or fragile services.	A single set of Board priorities and risks should ensure focus on smaller or fragile services.
	More joined up clinical pathways across a single integrated organisation is likely to directly increase capacity and capability of small and fragile services.	More joined up clinical pathways across a single integrated organisation is likely to directly increase capacity and capability of small and fragile services.	More joined up clinical pathways across a single integrated organisation is likely to directly increase capacity and capability of small and fragile services.
	There will be improved resilience for smaller or fragile services as part of a much larger organisation.	There will be improved resilience for smaller or fragile services as part of a much larger organisation.	There will be improved resilience for smaller or fragile services as part of a much larger organisation.
	A larger organisation may be seen as more attractive and support recruitment to fragile services.	A larger organisation may be seen as more attractive and support recruitment to fragile services.	A larger organisation may be seen as more attractive and support recruitment to fragile services.

CSF – Patient Care Sustainability - Helps Support/Improve Fragile Services Across Both/Either Organisation - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Conflict of Board priorities could lead to under funding and a negative impact on smaller or fragile services.	The length of time required to complete the transaction may prolong the period of service disruption and potentially create a loss of focus on fragile services.	The length of time required to complete the transaction may prolong the period of service disruption and potentially create a loss of focus on fragile services. This is less of a risk in option 6 and 7 than option 5.	The length of time required to complete the transaction may prolong the period of service disruption and potentially create a loss of focus on fragile services. This is less of a risk in option 6 and 7 than option 5.
Fragmented clinical pathways across two individual organisations is unlikely to directly increase capacity and capability of small and fragile services.	Potentially creates challenges around diverting scarce resources away from other services to specifically support fragile services.	Potentially creates challenges around diverting scarce resources away from other services to specifically support fragile services.	Potentially creates challenges around diverting scarce resources away from other services to specifically support fragile services.
Lack of resilience for smaller or fragile services as they will remain separate and siloed operationally.			
Small clinical teams within the separate organisations may continue to struggle to recruit and find meeting demand difficult, e.g. Dermatology.			
Potential for different processes for identifying and supporting fragile services in each organisation.			

CSF – Patient Care Sustainability

Area to Consider: Impact on Performance Outcomes

Information in this section has been provided and verified by the following sources:

- The Better Care Together Clinical and Operational workstream
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Improved efficiency through GIRFT programme.
- Improved (reduced) waiting times.
- Availability of management and leadership capacity to drive performance improvements.

CSF – Patient Care Sustainability - Impact on Performance Outcomes - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Creates opportunities to share best practice between the two organisations and shared learning which may improve performance.	Fully integrated service lines create much greater opportunities to implement improvement and enables GIRFT.	Fully integrated service lines create much greater opportunities to implement improvement and enables GIRFT.	Fully integrated service lines create much greater opportunities to implement improvement and enables GIRFT.
A shared Executive team would give greater insight into individual Trust performance and issues.	Sharing of best practice will happen much more routinely.	Sharing of best practice will happen much more routinely.	Sharing of best practice will happen much more routinely.
Opportunities to implement best clinical practice across pathways however this will potentially be limited by a lack of full service line integration.	A single integrated organisation will have a clear focus on specific performance issues and challenges.	A single integrated organisation will have a clear focus on specific performance issues and challenges.	A single integrated organisation will have a clear focus on specific performance issues and challenges.
	The organisation would be able to identify and respond more quickly to performance issues through single, integrated reporting, governance and performance management processes.	The organisation would be able to identify and respond more quickly to performance issues through single, integrated reporting, governance and performance management processes.	The organisation would be able to identify and respond more quickly to performance issues through single, integrated reporting, governance and performance management processes.
	Having a single, fully integrated organisation makes it more likely that senior capacity will be available to lead/support improvement.	Having a single, fully integrated organisation makes it more likely that senior capacity will be available to lead/support improvement.	Having a single, fully integrated organisation makes it more likely that senior capacity will be available to lead/support improvement.

CSF – Patient Care Sustainability - Impact on Performance Outcomes - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Operational risk in relation to making quick improvements due to potentially complex governance changes.	None identified.	None identified.	None identified.
Insufficient senior capacity to lead/support improvement.			
Risk around fragmented and siloed reporting and convoluted decision making.			
Potentially conflicting priorities of acute and community clinical performance targets.			
Separate and different operational processes and policies within each Trust could hinder the pace of any improvement programme.			

CSF – Financial Sustainability and Value for Money

Area to Consider: Delivery of Financial Benefits

Information in this section has been provided and verified by the following sources:

- WHH and BCH Finances Team
- Knowledge and Evidence Team information searches
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Improved sharing of resources to deliver all services.
- Ability to reduce operational overhead costs:
    - BCH current overhead costs (as per NCC):
      Estates – 8.75%
      Other overheads – 22%
    - WHH current overhead costs (as per NCC):
      Estates – 7.5%
      Other overheads – 17.4%
- Ability to deliver financial efficiencies through clinical pathway improvements.
- The latest benchmarking by NHSE suggests that there is as much as £7m of financial improvement opportunity available across both organisations through reduced corporate service costs (overheads)

CSF – Financial Sustainability and Value for Money - Delivery of Financial Benefits - Detail and Evidence

N.B – points highlighted in purple are the same across the options.

Option 4 **Shared leadership with joint operational governance**	Option 5 **A merger between WHH and BCH**	Option 6 **Acquistion of BCH by WHH**	Option 7 **Acquistion of WHH by BCH**
Option 4 would not create the conditions to deliver significant overhead cost reductions as two individual organisations would remain in place. Potential financial benefits of option 4 are likely to be limited to a reduction in Executive Director/Board positions in the move to a single senior leadership model alongside some possible contract alignment to reduce non-pay costs	Option 5 would see both organisations coming together to form a new single entity. This would require a single leadership structure and also a single set of corporate services to support therefore the opportunities to deliver financial benefits via this option are likely to be maximised.	Option 6 would see both organisations coming together to form a new single entity. This would require a single leadership structure and also a single set of corporate services to support therefore the opportunities to deliver financial benefits via this option are likely to be maximised.	Option 7 would see both organisations coming together to form a new single entity. This would require a single leadership structure and also a single set of corporate services to support therefore the opportunities to deliver financial benefits via this option are likely to be maximised.

CSF – Financial Sustainability and Value for Money

Area to Consider: Cost of Implementation

Information in this section has been provided and verified by the following sources:

- NHSE Mergers and Acquisitions Team
- Knowledge and Evidence Team information searches
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Minimal costs of completing any required legal 'transaction'.
- Minimal costs of sustaining a new model moving forwards.

CSF – Financial Sustainability and Value for Money - Cost of Implementation - Detail and Evidence

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Legal/professional costs of mobilising option 4 would be minimal (<£0.5m) as this option does not require dissolution of one of the providers or the creation of a new entity. However, under this option each Trust would remain a separate organisation meaning that formal governance arrangements such as Service Level Agreements and recharges will be required when utilising the other Trust's services or estate. For example WHH utilising BCH's Dermatology service to provide inpatient reviews for WHH patients or BCH delivering services out of WHH community locations.	Yeovil District Hospital NHS FT and the old Somerset NHS FT merged on 1 April 2023 to form Somerset NHS Foundation Trust. Costs of the transaction up to the point of merger were £3.1m. The figure of £3m to complete the transaction required under this option has been validated as realistic by the NHSE national team.	As part of the acquisition process of Bedford Hospital NHS Trust by Luton and Dunstable University Hospital NHS Foundation Trust, the short-term integration costs have been identified as £2.5m. The acquisition of Southport & Ormskirk NHS Trust by St Helens and Knowsley NHST cost circa £1.5m in legal fees and project management costs. The figure of between £1-2m to complete the transaction required under this option has been validated as realistic by the NHSE national team.	As part of the acquisition process of Bedford Hospital NHS Trust by Luton and Dunstable University Hospital NHS Foundation Trust, the short-term integration costs have been identified as £2.5m. The acquisition of Southport & Ormskirk NHS Trust by St Helens and Knowsley NHST cost circa £1.5m in legal fees and project management costs. The figure of between £1-2m to complete the transaction required under this option has been validated as realistic by the NHSE national team. Option 7 is likely to cost a little more than option 6 to implement due to the requirement to for example transfer more contracts and staff.

CSF – Financial Sustainability and Value for Money

Area to Consider: Sustainability of Individual Providers and the Overall Health and Care System

Information in this section has been provided and verified by the following sources:

- Knowledge and Evidence Team information searches
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Medium to long-term financial sustainability of the organisations through the ability to maximise financial benefits and minimise operating costs in the future.

CSF – Financial Sustainability and Value for Money - Sustainability of Individual Providers and the Overall Health and Care System Detail and Evidence

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
It is unlikely that option 4 would significantly support the overall sustainability of the individual providers due to the projected low level of financial benefits that would likely be delivered.	Given that option 5 would facilitate the maximum opportunities to deliver recurrent financial improvement, it is likely that this option would significantly support the overall ongoing sustainability of the new provider organisation.	Given that option 6 would facilitate the maximum opportunities to deliver recurrent financial improvement, it is likely that this option would significantly support the overall ongoing sustainability of the new provider organisation.	Given that option 7 would facilitate the maximum opportunities to deliver recurrent financial improvement, it is likely that this option would significantly support the overall ongoing sustainability of the new provider organisation.

CSF – Workforce and Culture Impact

Area to Consider: Enables Development and Implementation of a Joint Workforce Strategy/People Plan

Information in this section has been provided and verified by the following sources:

- The Better Care Together Clinical and Operational workstream
- The Better Care Together Workforce workstream
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Improved opportunities for staff to learn, develop and progress their careers.
- Improved ability to fill 'hard to recruit' roles and reduced reliance on temporary staffing.

CSF – Workforce and Culture Impact - Enables Development and Implementation of a Joint Workforce Strategy/People Plan - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Option 4 would support improved workforce collaboration between the two organisations.	Option 5 would facilitate the development of a single workforce with improved opportunities for career development through shared training and educational resources, new roles and challenges supporting development and retention. These changes will help with filling workforce gaps, reducing agency staffing and premium rates through integrated teams, particularly in support of fragile services. Examples include district/community nursing and UCR teams who could support the UEC system work or the integration of midwifery and health visiting teams.	Option 6 would facilitate the development of a single workforce with improved opportunities for career development through shared training and educational resources, new roles and challenges supporting development and retention. These changes will help with filling workforce gaps, reducing agency staffing and premium rates through integrated teams, particularly in support of fragile services. Examples include district/community nursing and UCR teams who could support the UEC system work or the integration of midwifery and health visiting teams.	Option 7 would facilitate the development of a single workforce with improved opportunities for career development through shared training and educational resources, new roles and challenges supporting development and retention. These changes will help with filling workforce gaps, reducing agency staffing and premium rates through integrated teams, particularly in support of fragile services. Examples include district/community nursing and UCR teams who could support the UEC system work or the integration of midwifery and health visiting teams.
	Enables the establishment of rotation agreements for most staff groups and roles to improve capacity and capability and offer new development opportunities for staff.	Enables the establishment of rotation agreements for most staff groups and roles to improve capacity and capability and offer new development opportunities for staff.	Enables the establishment of rotation agreements for most staff groups and roles to improve capacity and capability and offer new development opportunities for staff.
Potential to establish rotation agreements for some staff groups and specific roles to improve capacity and capability and offer new development opportunities for staff.	Provides the ability to have a joint workforce strategy, harmonising policies (where possible), procedures and systems, reducing inefficiencies	Provides the ability to have a joint workforce strategy, harmonising policies (where possible), procedures and systems, reducing inefficiencies	Provides the ability to have a joint workforce strategy, harmonising policies (where possible), procedures and systems, reducing inefficiencies
	Aligned workforce equality, diversity and inclusion reporting.	Aligned workforce equality, diversity and inclusion reporting.	Aligned workforce equality, diversity and inclusion reporting.

Limited or no Transfer of Undertakings (TUPE) to take place. Reducing the number of transactional activities required.	Aligning staff side arrangements supports a unified partnership and engagement approach.	Unified staff side arrangements.	Unified staff side arrangements.
	A unified vision streamlines workforce planning, career development and succession planning, nurturing shared ownership among staff.	Joint oversight and delivery of services with a single reporting process for teams.	Joint oversight and delivery of services with a single reporting process for teams.
	Resource combining improves efficiency, positively impacting the National People Plan.	BCH staff gain access to WHH resources systems and development opportunities, supporting retention and succession planning.	WHH's staff will gain access to BCH's resources systems and development opportunities, supporting retention and succession planning.
		Due to the existing workforce establishment in BCH there would likely to be fewer transactional processes (TUPE) due to workforce numbers allowing for strategy implementation to not be impacted.	

CSF – Workforce and Culture Impact - Enables Development and Implementation of a Joint Workforce Strategy/People Plan - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options.

Option 4 **Shared leadership with joint operational governance**	Option 5 **A merger between WHH and BCH**	Option 6 **Acquistion of BCH by WHH**	Option 7 **Acquistion of WHH by BCH**
Remaining as two seperate legal entities would mean that each organisation would be likely to have separate workforce priorities and potentially prevent the development of a single/joint workforce strategy.	Cultural change programmes will be needed post-merger to support integration.	Cultural change programmes will be needed post-acquisition to support integration.	Cultural change programmes will be needed post-acquisition to support integration.
As separate organisation there will be a requirement to continue with separate national information submissions e.g. PWR.	Changes in data reporting could alter workforce metrics, potentially affecting benchmarks (e.g. benchmarking would change from 'community' to 'acute & acute and 'community').	Changes in data reporting could alter workforce metrics, potentially affecting benchmarks (e.g. benchmarking would change from 'community' to 'acute & acute and 'community'). .	Changes in data reporting could alter workforce metrics, potentially affecting benchmarks (e.g. benchmarking would change from 'community' to 'acute & acute and community').
Separate staff side involvement and consultations may lead to differing policies and terms and conditions for staff.	Mergers may create leadership challenges and decision-making delays, affecting workforce strategy implementation.		
Potential inequalities in career progression, pay bands or resources across the separate organisations.	Partnership working and industrial action may strain employee relations activity.		
Dual equality, diversity and inclusion strategies and reporting will be required, increasing inefficiencies.			

CSF – Workforce and Culture Impact

Area to Consider: Impact on Staff Satisfaction and Wellbeing

Information in this section has been provided and verified by the following sources:

- NHS England guidance
- The Better Care Together Clinical and Operational workstream
- The Better Care Together Workforce workstream
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Greater resilience within the overall workforce.
- Improved staff retention.

CSF – Workforce and Culture Impact - Impact on Staff Satisfaction and Wellbeing - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options.

Option 4 **Shared leadership with joint operational governance**	Option 5 **A merger between WHH and BCH**	Option 6 **Acquistion of BCH by WHH**	Option 7 **Acquistion of WHH by BCH**
There are likely to be existing staff in both organisations who would prefer to retain employment with either BCH or WHH individually. Option 4 would enable that as both individual organisations would continue to exist and employ their own staff.	The workforce of the two organisations will be fully integrated therefore providing opportunities to improve the overall workforce and support talent management, reduce gaps, agency usage and premium costs.	The workforce of the two organisations will be fully integrated therefore providing opportunities to improve the overall workforce and support talent management, reduce gaps, agency usage and premium costs.	The workforce of the two organisations will be fully integrated therefore providing opportunities to improve the overall workforce and support talent management, reduce gaps, agency usage and premium costs.
Staff satisfaction may not be impacted due to staff feeling 'secure' with separate identities and processes.	A newly formed Foundation Trust would create a fresh identity, avoiding one workforce to feel a loss of legacy over the other.	Will provide opportunities for contract alignment and service efficiency, standardised policies (where possible) and systems to reduce complexity.	Will provide opportunities for contract alignment and service efficiency standardised policies (where possible) and systems to reduce complexity.
Improved communication and engagement channels could foster collaboration between both organisations workforce and PLACE/system level colleagues (C&M/GM/L&SC).	Pooled resources may enhance wellbeing services, including flexible working opportunities.	BCH staff will gain access to WHH's wellbeing resources, enhancing support available to staff.	WHH's staff gain access to BCH's wellbeing resources, enhancing support available to staff.
Potential to share staff health and wellbeing provisions, though limited by procurement rules and guidance.	Collaboration between community and acute workforce would lead to enhanced care delivery, efficiencies and experience.	Cultural continuity benefits WHHs circa. 5000 staff	Cultural continuity benefits BCHs circa. 1700 staff.
	Expanded career pathways and leadership roles may improve staff satisfaction.	BCH staff will gain access to WHH's Occupational Health and Wellbeing service, providing a higher specification service and cost efficiency in the long-term with services run in-house.	

		Due to the existing workforce establishment in BCH there would likely to be fewer transactional processes (TUPE) allowing for strategy implementation to not be impacted.	

CSF – Workforce and Culture Impact - Impact on Staff Satisfaction and Wellbeing - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Under option 4 the workforce of the two organisations will not be fully integrated, providing less opportunity to improve the overall workforce, support talent management, reduce gaps, agency usage and premium costs than with other options.	There are likely to be existing staff in both organisations who would prefer to retain employment with either BCH or WHH individually. Under option 5 this would not be possible.	There are likely to be existing staff in both organisations who would prefer to retain employment with either BCH or WHH individually. Under option 6 this would not be possible.	There are likely to be existing staff in both organisations who would prefer to retain employment with either BCH or WHH individually. Under option 7 this would not be possible.
Cultural differences and lack of harmonisation may impact morale, engagement and wellbeing.	The length and complexity of the process may disrupt workforce experience, reducing satisfaction.	Likely to be a complex process however would be less disruptive than option 5.	Likely to be a complex process however would be less disruptive than option 5.
Shared governance might not resolve pre-existing satisfaction issues, risking employee relations activity.	Job insecurity could lead to increased staff turnover during the merger process, impacting retention, talent management and succession planning.	Staff would have different terms and conditions based on TUPE.	Staff would have different terms and conditions based on TUPE.
Joint/shared post holders may face wellbeing pressures managing across both organisations.	Extensive communication/engagement would be required to prevent staff feeling overwhelmed or unsupported, creating additional workload.	BCH staff may feel disempowered, affecting morale.	WHH staff may feel disempowered, affecting morale.
		Cultural misalignment and unfamiliar practices may lower satisfaction.	Cultural misalignment and unfamiliar practices may lower satisfaction.
		Adapting to WHH systems could impact BCH staff wellbeing (positive or negative).	Adapting to BCH systems could impact WHH staff wellbeing (positive or negative).
		Risk of increased employee relations activity.	Risk of increased employee relations activity.
			Due to the existing workforce establishment at WHH there would likely to be more transactional processes (TUPE) which could have an impact on strategy implementation.

CSF – Workforce and Culture Impact

Area to Consider: Impact on Culture and Local Identity, Including Attractiveness of Option from our Local Communities Points of View

Information in this section has been provided and verified by the following sources:

- The Better Care Together Workforce workstream
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Improved attractiveness of future organisation(s) as an employer of choice for our local population.

CSF – Workforce and Culture Impact - Impact on Culture and Local Identity, Including Attractiveness of Option from our Local Communities Points of View - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
From a staff perspective, option 4 may bring least worry and concern about jobs, rightly or wrongly, as two organisations would still need to be run.	A larger organisation may attract higher quality talent, aiming to improve productivity, efficiency, economies of scale and improve retention and attraction.	A larger organisation may attract higher quality talent, aiming to improve productivity, efficiency, economies of scale and improve retention and attraction.	A larger organisation may attract higher quality talent, aiming to improve productivity, efficiency, economies of scale and improve retention and attraction.
Would provide opportunities to attract staff with the ability to collaboratively work with both community and acute services.	Creation of combined roles which would attract existing or new staff to advance development within the new organisation.	Creation of combined roles which would attract existing or new staff to advance development within the new organisation.	Creation of combined roles which would attract existing or new staff to advance development within the new organisation.
More enhanced collaboration for existing staff, enhancing a culture of shared working under joint leadership and governance.	Supports the workforce's ability to deliver the Better Care Together 'case for change' bringing community and acute services together (Home, Community, Hospital).	Supports the workforce's ability to deliver the Better Care Together 'case for change' bringing community and acute services together (Home, Community, Hospital).	Supports the workforce's ability to deliver the Better Care Together 'case for change' bringing community and acute services together (Home, Community, Hospital).
Supports the workforce's ability to deliver the Better Care Together 'case for change' bringing community and acute services together (Home, Community, Hospital). Recognising option 4 may not have as great an impact as option 5/6/7 due to being two sovereign organisations.	As one organisation there would be the ability to complete one Staff Survey and People Pulse with combined benchmarking comparisons.	As one organisation there would be the ability to complete one Staff Survey and People Pulse with combined benchmarking comparisons.	As one organisation there would be the ability to complete one Staff Survey and People Pulse with combined benchmarking comparisons.
	As a larger organisation the new Foundation Trust would be one of the largest employers within the local boroughs with opportunities to have a greater impact on workforce health inequalities as an anchor institute.	As a larger organisation the Trust would be one of the largest employers within the local boroughs with opportunities to have a greater impact on workforce health inequalities as an anchor institute.	As a larger organisation the Trust would be one of the largest employers within the local boroughs with opportunities to have a greater impact on workforce health inequalities as an anchor institute.
	Opportunities to attract new staff/students with a mix of community and acute career pathways.	Ability to attract staff to the organisation by externally being recognised for equality, diversity and inclusion achievements and clinical accreditations.	Ability to attract staff to the organisation by externally being recognised for equality, diversity and inclusion achievements and clinical accreditations.

	The newly formed Foundation Trust would attain the accreditations of both organisations through discussions with external partners, e.g. Navajo Charter Mark, Anti-Racist Organisation.	Opportunities to increase the workforce profile through the lens of diversity due to the nature of roles within WHH – evidence suggests this could bring more diverse decision-making.	Opportunities to increase the workforce profile through the lens of diversity due to the nature of roles within BCH – evidence suggests this could bring more diverse decision-making.
		WHH holds a certificate of sponsorship which would allow BCH to access this and support attraction and retention.	

CSF – Workforce and Culture Impact - Impact on Culture and Local Identity, Including Attractiveness of Option from our Local Communities Points of View - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
From a public point of view one legal entity/organisation at the end of this process is a clearer outcome. The public view the NHS as one organisation, and don't fully understand the complexities of different providers. For this reason, option 4 could be perceived as least favourable.	From a staff perspective, option 5 may bring a level of concern amongst staff and the public about job losses, rightly or wrongly.	From a staff perspective, option 6 may bring a level of concern amongst staff and the public about job losses, rightly or wrongly.	From a staff perspective, option 7 may bring a level of concern amongst staff and the public about job losses, rightly or wrongly.
As separate organisations there would be a requirement to run two applications for external accreditations, producing inefficiencies and costs.	Potential impact on WHH's ambition to achieve 'university' status which may impact on local identity as a training provider for students as the new Foundation Trust would need to highlight its ability to retain this status.	Option 6 gives the perception of one organisation being more important than the other.	Option 7 gives the perception of one organisation being more important than the other.
For staff attraction there can be a negative impact for staff applying to either organisation due to perceived lack of direction and inequalities.	Due to the timely nature and complexity of mergers this could have a negative impact on the existing cultures within both organisations due to perceived inequalities during the change process.	Option 6 may create a perception of failure of BCH (the organisation being acquired under this option), and impact patients perception in those services resulting in an erosion of confidence; and for the staff an impact on loyalty and commitment.	Option 7 may create a perception of failure of WHH (the organisation being acquired under this option), and impact patients perception in those services resulting in an erosion of confidence; and for the staff an impact on loyalty and commitment.
Impact on staff feeling a sense of "belonging" due to a confusion around branding and perception.			
Separate recruitment systems would be in place which may impact staff applying for role, e.g. WHH utilise Trac and Bridgewater utilise NHS Jobs.		Resistance to change from staff being acquired by WHH could have an impact on the culture in the new organisation (during and post integration).	Resistance to change from staff being acquired by BCH could have an impact on the culture in the new organisation (during and post integration).

Separate reporting would need to remain in place, e.g. Staff Survey. This would delay collaboration and provide different benchmarking data.		Perceived impact on culture for staff applying for community focused healthcare roles with a perceived viewpoint that acute care is the direction of the organisation.	Potential impact on WHH's ambition to achieve 'university' status which may impact on local identity as a training provider for students as BCH is not a 'Teaching' hospital.
Both organisations would be required to have certificates of sponsorship, currently BCH does not have this in place which may impact international recruitment and attraction..			BCH does not currently hold a certificate of sponsorship which could impact on staff being acquired from WHH, specifically from international recruitment pathways.
Both organisations would be required to have certificates of sponsorship, currently BCH does not have this in place which may impact international recruitment and attraction.			There is a risk to external accreditations being retained by WHH and not by BCH, for example, Anti-Racist Organisation, potentially impacting attraction in the future

CSF – Strategic Alignment

Information in this section has been provided and verified by the following sources:

- Review of the NHS Cheshire and Merseyside strategy
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Alignment to NHS Cheshire and Merseyside Joint Forward View 2024-29 Strategic Objectives:
    - Tackling health inequalities.
    - Improving outcomes on population health.
    - Enhance quality, productivity and value for money.
    - Support broader social and economic development.

CSF – Strategic Alignment - Supports the delivery of the ICB Long-Term Plan - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options.

Option 4 **Shared leadership with joint operational governance**	Option 5 **A merger between WHH and BCH**	Option 6 **Acquistion of BCH by WHH**	Option 7 **Acquistion of WHH by BCH**
Option 4 would potentially provide improved access to community sites for WHH and acute sites for BCH (to support work to reduce health inequalities), although this would likely require contracts and Service Level Agreements in place between the two organisations.	Option 5 would provide improved access to community sites for WHH and acute sites for BCH. This can support work to reduce health inequalities by putting service delivery in the right place (more local where appropriate).	Option 6 would provide improved access to community sites for WHH and acute sites for BCH. This can support work to reduce health inequalities by putting service delivery in the right place (more local where appropriate).	Option 7 would provide improved access to community sites for WHH and acute sites for BCH. This can support work to reduce health inequalities by putting service delivery in the right place (more local where appropriate).
This option would also encourage closer working between clinical services from community and acute teams to help improve patient outcomes.	This option would see the full integration of clinical services to improve patient outcomes and service delivery, with shorter waiting times, a more streamlined patient journey through the joining up of services and better experience for patients accessing community and hospital healthcare services. An example would be the UEC system improvement work.	This option would see the full integration of clinical services to improve patient outcomes and service delivery, with shorter waiting times, a more streamlined patient journey through the joining up of services and better experience for patients accessing community and hospital healthcare services. An example would be the UEC system improvement work.	This option would see the full integration of clinical services to improve patient outcomes and service delivery, with shorter waiting times, a more streamlined patient journey through the joining up of services and better experience for patients accessing community and hospital healthcare services. An example would be the UEC system improvement work.
It would be expected that there would be quality, productivity and value for money benefits delivered as a result of this option, however, these would likely be less than the benefits delivered through other options involving full integration.	It would be expected that there would be significant quality, productivity and value for money benefits delivered as a result of this option. For example through single contracts and consolidation of corporate functions.	It would be expected that there would be significant quality, productivity and value for money benefits delivered as a result of this option. For example through single contracts and consolidation of corporate functions.	It would be expected that there would be significant quality, productivity and value for money benefits delivered as a result of this option. For example through single contracts and consolidation of corporate functions.

CSF – Strategic Alignment - Supports the delivery of the ICB Long-Term Plan - Risks and Disadvantages

None identified for any of the options.

CSF – Strategic Alignment

Area to Consider: Supports the Development of Integrated Working

Information in this section has been provided and verified by the following sources:

- The Better Care Together Clinical and Operational workstream
- The Better Care Together Communications workstream
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Improved alignment of clinical pathways, systems and processes.
- Improved alignment of corporate functions, systems and processes.
- Creation of a sense of positivity about the future of our organisation(s)amongst our local population.
- Impact on patient and public viewpoints for the organisation and access to treatment.

CSF – Strategic Alignment - Supports the Development of Integrated Working - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options.

Option 4	Option 5	Option 6	Option 7
Shared leadership with joint operational governance	**A merger between WHH and BCH**	**Acquistion of BCH by WHH**	**Acquistion of WHH by BCH**
Option 4 would see improved alignment of clinical pathways and corporate functions for improved quality, efficiency, and performance, albeit short of the benefits of full integration.	Option 5 would see both organisations coming together to form a new single entity. This would require a single operational/clinical service structure, a single set of corporate services to support those services and a single leadership structure. This option fully supports the development of integrated working.	Option 6 would see both organisations coming together to form a new single entity. This would require a single operational/clinical service structure, a single set of corporate services to support those services and a single leadership structure. This option fully supports the development of integrated working.	Option 7 would see both organisations coming together to form a new single entity. This would require a single operational/clinical service structure, a single set of corporate services to support those services and a single leadership structure. This option fully supports the development of integrated working.
	Commissioned contracts will be easier to align under a single organisation.	Commissioned contracts will be easier to align under a single organisation.	Commissioned contracts will be easier to align under a single organisation.
	Option 5, 6 and 7 deliver simplified governance, one Board, Council of Governors (including CQC, ICO, NHS Resolution and other regulatory bodies registration), one set of reporting requirements, one financial ledger – resulting in improved clarity and efficiencies.	Option 5, 6 and 7 deliver simplified governance, one Board, Council of Governors (including CQC, ICO, NHS Resolution and other regulatory bodies registration), one set of reporting requirements, one financial ledger – resulting in improved clarity and efficiencies.	Option 5, 6 and 7 deliver simplified governance, one Board, Council of Governors (including CQC, ICO, NHS Resolution and other regulatory bodies registration), one set of reporting requirements, one financial ledger – resulting in improved clarity and efficiencies.
	One larger organisation can build a stronger reputation and have a stronger single voice in the health and care system.	One larger organisation can build a stronger reputation and have a stronger single voice in the health and care system.	One larger organisation can build a stronger reputation and have a stronger single voice in the health and care system.

	It was agreed that all options need to end up with an organisation that has a new name – in order to more accurately reflect being an integrated provider of acute and community services. This was seen as important in uniting people behind a new direction or travel, and in helping to mitigate risk of disengaging and demoralising people in an organisation being acquired.	It was agreed that all options need to end up with an organisation that has a new name – in order to more accurately reflect being an integrated provider of acute and community services. This was seen as important in uniting people behind a new direction or travel, and in helping to mitigate risk of disengaging and demoralising people in an organisation being acquired.	It was agreed that all options need to end up with an organisation that has a new name – in order to more accurately reflect being an integrated provider of acute and community services. This was seen as important in uniting people behind a new direction or travel, and in helping to mitigate risk of disengaging and demoralising people in an organisation being acquired.
	Option 5 would bring one website, one point of contact for PALS/complaints/switchboard etc, which helps with simplified public messaging.	Option 6 would bring one website, one point of contact for PALS/complaints/switchboard etc, which helps with simplified public messaging.	Option 7 would bring one website, one point of contact for PALS/complaints/switchboard etc, which helps with simplified public messaging.
	Option 5 gives the perception of the two organisations as equals.	The public tend to know their GP and local hospital and are perhaps less clear on the role of community providers.	
	One single organisation would be perceived to be better by local residents.		

CSF – Strategic Alignment - Supports the Development of Integrated Working - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Option 4 does not involve full integration and therefore does not directly support the development of integrated working, however, it does promote improved collaboration between the two organisations, which is likely to deliver some operational and strategic benefits.	Option 5 requires the dissolution of 2 organisations in order to create one new single entity, which is a more complex process to achieve integrated working.	Option 6 gives the perception of one organisation being more important than the other	Option7 gives the perception of one organisation being more important than the other.
Commissioned contracts may be difficult to align for different organisations.			The public tend to know their GP and local hospital and are perhaps less clear on the role of community providers.
From a public point of view – one legal entity/organisation at the end of this process is a clearer outcome. The public view the NHS as one organisation, and don't fully understand the complexities of different providers. For this reason, option 4 could be perceived as least favourable.			
Risk of perception of waste/poor value for money running two organisations instead of one.			

CSF – Strategic Alignment

Area to Consider: Enables Delivery of System-Wide Estates and Digital Strategies

Information in this section has been provided and verified by the following sources:

- The Better Care Together Estates Workstream
- The Better Care Together Digital Workstream
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Delivery of system-wide estates strategy
- Delivery of system-wide digital strategy

CSF – Strategic Alignment - Enables Delivery of System-Wide Estates and Digital Strategies - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Would allow the Trust to work together more effectively to optimise core estate, for example easier governance around improving utilisation of fallow sessions in either organisation assets and portfolios.	Would enable more effective optimisation of core estate – i.e. unified room booking systems for corporate and clinical estate across the portfolio, removing layers of current governance.	Would enable more effective optimisation of core estate – i.e. unified room booking systems for corporate and clinical estate across the portfolio, removing layers of current governance.	Would enable more effective optimisation of core estate – i.e. unified room booking systems for corporate and clinical estate across the portfolio, removing layers of current governance.
Trusts could undertake some facilities management/estates contracting opportunities more easily (i.e. one Trust delivering services for both).	Improved opportunities to develop a cohesive strategy between secondary and community estate assets across our place.	Improved opportunities to develop a cohesive strategy between secondary and community estate assets across our place.	Improved opportunities to develop a cohesive strategy between secondary and community estate assets across our place.
Enables easier retention of organisational memory/sector expertise.	Greater scope for negotiating improved benefits through contracting/procurement opportunities.	Greater scope for negotiating improved benefits through contracting/procurement opportunities.	Greater scope for negotiating improved benefits through contracting/procurement opportunities.
Minimal changes to the current operational models of the Estates departments and the joint model would allow a transition to take place across a longer timescale, reducing disruption in the departments.	Easier to implement an integrated strategic workforce plan to align the working locations of staff across our catchment.	Easier to implement an integrated strategic workforce plan to align the working locations of staff across our catchment.	Easier to implement an integrated strategic workforce plan to align the working locations of staff across our catchment.
	Would enable creation of a single Estates team across the organisation	Would enable creation of a single Estates team across the organisation	Would enable creation of a single Estates team across the organisation
	Options 5, 6 & 7 would enable full integration of our Digital services, creating the opportunity for convergence of digital infrastructure and information systems. With these options, several corporate systems used for HR, Finance, Procurement, Payroll, Risk Management, BI/reporting could be consolidated, providing both commercial cost	Options 5, 6 & 7 would enable full integration of our Digital services, creating the opportunity for convergence of digital infrastructure and information systems. With these options, several corporate systems used for HR, Finance, Procurement, Payroll, Risk Management, BI/reporting could be consolidated, providing both commercial cost	Options 5, 6 & 7 would enable full integration of our Digital services, creating the opportunity for convergence of digital infrastructure and information systems. With these options, several corporate systems used for HR, Finance, Procurement, Payroll, Risk Management, BI/reporting could be consolidated, providing both commercial cost

	savings and reduced management and support overhead costs.	savings and reduced management and support overhead costs.	savings and reduced management and support overhead costs.
	Options 5, 6 & 7 would be better aligned to the strategic direction for Digital at national and regional level.	Options 5, 6 & 7 would be better aligned to the strategic direction for Digital at national and regional level.	Options 5, 6 & 7 would be better aligned to the strategic direction for Digital at national and regional level.

CSF – Strategic Alignment - Enables Delivery of System-Wide Estates and Digital Strategies - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Doesn't maximise opportunities for attracting funding across a joint secondary care/community care estate.	More difficult to ensure that organisational memory/expertise is retained through the transition to a single organisation	More difficult to ensure that organisational memory/expertise is retained through the transition to a single organisation	More difficult to ensure that organisational memory/expertise is retained through the transition to a single organisation
From a staff base there may be missed opportunities to undertake strategic workforce planning and improve resilience across both Trusts, for example, opportunities around co-location are difficult to realise.	A longer period of transition will be required to combine the operational models of the Estates departments.	A longer period of transition will be required to combine the operational models of the Estates departments	A longer period of transition will be required to combine the operational models of the Estates department.
Still a requirement for resource to support independence of statutory and operational reporting			
There would still be a requirement to ensure robust governance in place where sharing assets and facilities, e.g. Service Level Agreements would continue to be drafted to ensure clinical compliance etc.			
Option 4 would provide significantly less benefits from a Digital perspective, as although some resources could be pooled and some efficiencies could be made with regards to system management and support overheads, this would be limited due to need to maintain specific systems and sovereignty of organisation level data, security and information governance etc.			

Option 4 would be the least preferable of the options in terms of alignment to the strategic direction for Digital at national and regional level.			

CSF – Deliverability

Area to Consider: Can be Delivered within a Realistic Timescale

Information in this section has been provided and verified by the following sources:

- NHS England Acquisitions and Mergers Team
- Knowledge and Evidence team information searches
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Ensure the length of time required to achieve the preferred future state is kept to a minimum.

CSF – Deliverability - Can be Delivered within a Realistic Timescale - Detail and Evidence

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Option 4 requires no changes to organisational form and therefore should be deliverable within 12 months, possibly within 6 months, once a new joint leadership team and governance structure has been agreed and put in place. The timescale of 6 to 12 months to complete the structural changes required under this option has been validated as realistic by the NHSE national team.	Delivery of option 5 will require the dissolution of the two existing organisations and the creation of a brand new legal entity. This is arguably the most complex of the options that involve moving to a single combined organisation. NHS England have suggested that this option would likely take a minimum of 24 months to complete, but more likely closer to 36 months. There was a recent merger between Yeovil District Hospital NHS Foundation Trust and the old Somerset NHS Foundation Trust, this was a merger between an acute and a community Trust. The two organisations officially merged after 2 years (on 1 April 2023) to form Somerset NHS Foundation Trust. The timescale of 24 to 36 months to complete the transaction required under this option has been validated as realistic by the NHSE national team.	Delivery of option 6 will require the dissolution of BCH in its current form but would not require a new legal entity to be created. Whilst this is more complex and time-consuming than option 4, it is less complex and time-consuming than option 5. NHS England have suggested that this option would likely take between 18 and 24 months to complete. 2gether NHS Foundation Trust acquired Gloucestershire Care Services NHS Trust, which involved acute and community services. The proposed merger was announced in September 2017, after the Boards of both Trusts agreed plans to work towards joining together. While the merger was technically an acquisition, it was treated as a merger by both parties. Gloucestershire Health and Care NHS Foundation Trust formed 2 years later in October 2019. The timescale of 18 - 24 months to complete the transaction required under this option has been validated as realistic by the NHSE national team.	Delivery of option 6 will require the dissolution of BCH in its current form but would not require a new legal entity to be created. Whilst this is more complex and time-consuming than option 4, it is less complex and time-consuming than option 5. NHS England have suggested that this option would likely take between 18 and 24 months to complete. 2gether NHS Foundation Trust acquired Gloucestershire Care Services NHS Trust, which involved acute and community services. The proposed merger was announced in September 2017, after the Boards of both Trusts agreed plans to work towards joining together. While the merger was technically an acquisition, it was treated as a merger by both parties. Gloucestershire Health and Care NHS Foundation Trust formed 2 years later in October 2019. The timescale of 18 - 24 months to complete the transaction required under this option has been validated as realistic by the NHSE national team.

			It is likely that option 7 will take a little longer than option 6 as for example there should be more contracts and staff to transfer.

CSF – Deliverability

Area to Consider: Trusts have the Capability and Capacity to Deliver the Integration

Information in this section has been provided and verified by the following sources:

- The Better Care Together Clinical and Operational workstream
- NHS England Acquisitions and Mergers Team
- NHS England Statutory Transactions guidance
- The Better Care Together Integration Team

Things to consider – how this option will support:

- The capability of the respective Trust Boards and senior leadership teams to oversee and deliver the option.
- The capacity of the respective Trust Boards and senior leadership teams to oversee and deliver the option.

CSF – Deliverability - Trusts have the Capability and Capacity to Deliver the Integration - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Option 4 requires limited additional capacity to deliver the required change as the existing organisational form of the two individual organisations will continue to exist, albeit they will closely co-exist.	Key question as part of DHSC risk assessment: Are there concerns regarding management capability and capacity to execute the transaction? WHH currently has a full and stable Trust Board/Leadership team to be able to oversee a merger of the two organisations and therefore it would not flag as a risk to DHSC if option 5 is chosen as the preferred option.	Key question as part of DHSC risk assessment: Are there concerns regarding management capability and capacity to execute the transaction? WHH currently has a full and stable Trust Board/Leadership team and therefore would not flag as a risk to DHSC if option 6 is chosen as the preferred option. Option 6 would require the least operational capacity of options 5, 6 and 7 due to the reduced number of contracts requiring transfer.	None identified.

CSF – Deliverability - Trusts have the Capability and Capacity to Deliver the Integration - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options.

Option 4 **Shared leadership with joint operational governance**	Option 5 **A merger between WHH and BCH**	Option 6 **Acquistion of BCH by WHH**	Option 7 **Acquistion of WHH by BCH**
Key question as part of DHSC risk assessment: Are there concerns regarding management capability and capacity to execute the transaction? Complex governance arrangements will be required to manage joint decision making under this option. This will require significant capacity at senior level to lead and manage beyond the initial 'transaction date.'	Options 5, 6 and 7 are all likely to require significant additional programme management, transformation and operational capacity to deliver due to the scale of the change required. Option 5 would require the most operational capacity of all options due to the need to transfer contracts of almost 7,000 staff and novate all contracts from both existing organisations across to a new legal entity.	Options 5, 6 and 7 are all likely to require significant additional programme management, transformation and operational capacity to deliver due to the scale of the change required.	Options 5, 6 and 7 are all likely to require significant additional programme management, transformation and operational capacity to deliver due to the scale of the change required. Key question as part of DHSC risk assessment: Are there concerns regarding management capability and capacity to execute the transaction? BCH currently has no substantive Medical Director or COO and the Chair has recently publicly announced her intention to retire. This leaves the current substantive Trust Board/Leadership team depleted and is likely to flag as a risk to DHSC if option 7 is chosen as the preferred option. Option 7 would require more operational capacity than option 6 due to the need to transfer more contracts.

CSF – Deliverability

Area to Consider: Likely to Pass the DHSC Risk Assessment Process

Information in this section has been provided and verified by the following sources:

- NHS England Statutory Transactions guidance
- NHS England Mergers and Acquisitions Team
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Minimising the risk of the proposed future state being rejected following risk assessment by the Department of Health and Social Care

CSF – Deliverability - Likely to Pass the DHSC Risk Assessment Process - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Option 4 would not require formal approval by DHSC or the Secretary of State.	None identified.	Key questions as part of DHSC risk assessment: What is the scale of the transaction, with reference to the gross assets, income and/or consideration attributable to the transaction as a proportion of that of the Trust? Under option 6, the transaction would involve a £350m organisation growing by 29% to become a £450m organisation. This would not flag as a risk to DHSC.	Key question as part of DHSC risk assessment: Are there concerns relating to the financial management of either Trust, including the direction of travel? Under option 7, the transaction would involve an organisation with a stable financial position acquiring an organisation with a financial deficit. This would not flag as a risk to DHSC.
		Key questions as part of DHSC risk assessment: Are there concerns relating to the quality or operational performance of either Trust, including the direction of travel? Under option 6, the transaction would involve an organisation classified as CQC good overall acquiring an organisation classified as requires improvement. This would not flag as a risk to DHSC.	

CSF – Deliverability - Likely to Pass the DHSC Risk Assessment Process - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options.

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Insight from NHS England suggests that the shared leadership option creates complex and challenging shared governance in the short-term and in the longer-term generally leads to either: a) an agreed de-coupling of the arrangements, or b) full integration via a merger or acquisition within 3 years.	NHS England has advised that DHSC would be relatively agnostic about merger (option 5) vs acquisition (option 6 or 7). The difference between merger and acquisition is more to do with detailed practical considerations which is more in NHSE's domain than DHSC's (i.e. merger is legally more complex and is more expensive but does have the debatable benefit of starting with a relatively clean slate). It would tilt DHSC's value for money economic model slightly in favour of acquisition, but DHSC is mostly concerned with the views of local MPs and any public concerns and perception. The other main difference for merger would depend on the makeup of the Board in a merger i.e. because the whole board would have to be appointed to the new organisation and new governance determined, there might be some uncertainty about continuity and track record.	Key question as part of DHSC risk assessment: Are there concerns relating to the financial management of either Trust, including the direction of travel? Under option 6, the transaction would involve an organisation with a financial deficit acquiring an organisation with a stable financial position. This is likely to flag as a risk to DHSC.	Key question as part of DHSC risk assessment: What is the scale of the transaction, with reference to the gross assets, income and/or consideration attributable to the transaction as a proportion of that of the Trust? Under option 7, the transaction would involve a £100m organisation growing by 350% to become a £450m organisation. This is likely to flag as a risk to DHSC.
			Key question as part of DHSC risk assessment: Are there concerns relating to the quality or operational performance of either Trust, including the direction of travel? Under option 7, the transaction would involve an organisation classified as CQC requires improvement overall acquiring an organisation classified

	So DHSC would likely be more concerned about a trust rated Requires Improvement acquiring a trust rated Good by the CQC, and a smaller community service provider taking on larger and higher risk services provided by an acute organisation. All of that is mitigatable if there is a strong justification and clarity around governance and leadership but would take some convincing.		as good. This is likely to flag as a risk to DHSC.

CSF – Deliverability

Area to Consider: Minimises adverse impact on BAU

Information in this section has been provided and verified by the following sources:

- The Better Care Together Clinical and Operational workstream
- The Better Care Together Integration Team

Things to consider – how this option will support:

- Minimising the disruption caused to staff, services and patients/service users during the period of the integration programme/transaction.

CSF – Deliverability - Minimises adverse impact on BAU - Opportunities and Advantages

N.B – points highlighted in purple are the same across the options

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
Option 4 would have less of a negative impact on BAU compared to the other options as there would be little or no direct change to any of the existing clinical / operational or corporate teams within each of the individual organisations and no staff or non-pay contracts to transfer to another organisation	None identified.	Under option 6, it is likely that the existing governance policies within WHH or BCH would be adopted and therefore cause less disruption in terms of any requirement to develop and agree new governance structures and processes. Option 6 would likely create less operational disruption than options 5 and 7 due to having less BCH staff contracts and non-pay contracts to transfer across to WHH.	Under option 7, it is likely that the existing governance policies within WHH or BCH would be adopted and therefore cause less disruption in terms of any requirement to develop and agree new governance structures and processes.

CSF – Deliverability - Minimises adverse impact on BAU - Risks and Disadvantages

N.B – points highlighted in purple are the same across the options

Option 4 Shared leadership with joint operational governance	Option 5 A merger between WHH and BCH	Option 6 Acquistion of BCH by WHH	Option 7 Acquistion of WHH by BCH
There is potential for some organisational decision making to become slower or less agile due to complex joint governance processes.	There is potential for some organisational decision making to become slower or less agile in the short-term as a new single set of governance processes are developed and embedded.	Option 6 would likely create a degree of disruption to day to day operations of both individual organisations as there would be multiple teams being brought together to form single services. The likely timeframes would also mean that some of this impact would be seen across a longer period, although this is likely to be less than with option 5.	Option 7 would likely create a degree of disruption to day to day operations of both individual organisations as there would be multiple teams being brought together to form single services. The likely timeframes would also mean that some of this impact would be seen across a longer period, although this is likely to be less than with option 5.
Staff may remain unsettled following the 'transaction' point due to ongoing challenges around complex governance and a perception that option 4 may eventually lead to a different option in future.	Due to the complex and lengthy nature of the transaction required for option 5, it is likely that this option would have the most significant impact on business as usual operations and processes for both individual providers out of options 5, 6 and 7. For example, individual teams may be required to hold vacancies for longer as the process for developing a new single team structure is followed. This may put greater strain on those teams as they continue to deliver services on a day to day basis.		Option 7 would likely create more operational disruption than option 6 due to having more WHH staff contracts and non-pay contracts to transfer across to BCH.
Insight from NHSE suggests that the shared leadership option creates complex and challenging shared governance in the short-term and in the longer-term generally leads to either:	A prolonged period of unsettlement for staff may lead to issues with retention of workforce and continuity of care.		

a) an agreed de-coupling of the arrangements, or b) full integration via a merger or acquisition within 3 years. - A prolonged period of unsettlement for staff may lead to issues with retention of workforce and continuity of care.			

Total scores and weighted scores for all options

Strategic Case: Selection Criteria and Scoring Template

		Total Scores (Unweighted)				Total Scores (Weighted)			
		Option 4	Option 5	Option 6	Option 7	Option 4	Option 5	Option 6	Option 7
CSF	**Area to consider**	**Shared leadership with joint operational governance**	**Merger of BCH and WHH**	**Acquisition of BCH by WHH**	**Acquisition of WHH by BCH**	**Shared leadership with joint operational governance**	**Merger of BCH and WHH**	**Acquisition of BCH by WHH**	**Acquisition of WHH by BCH**
Patient Impact & Benefits	Impact on safety and quality of care.	18	26	34	30	90	130	170	150
	Impact on patient and service user experience.	20	27	34	29	80	108	136	116
	Impact on long-term health outcomes.	19	28	35	30	57	84	105	90
Patient Care Sustainability	Enables delivery of shared strategic clinical objectives	17	31	36	34	85	155	180	170
	Helps support/improve fragile services across both/either organisation	16	30	35	32	48	90	105	96
	Impact on performance outcomes.	16	29	35	31	64	116	140	124
Financial Sustainability and Value for Money	Delivery of financial benefits	11	30	30	30	44	120	120	120
	Cost of implementation.	30	0	20	11	120	0	80	44
	Sustainability of individual providers and the overall health and care system.	12	31	34	32	48	124	136	128
Workforce and Culture impact	Enables development and implementation of a joint Workforce Strategy/People Plan.	18	32	38	33	72	128	152	132
	Impact on staff satisfaction and well-being.	13	26	29	23	65	130	145	115
	Impact on culture and local identity. Including, attractiveness of option from our local communities' points of view.	11	25	34	27	33	75	102	81
Strategic Alignment	Supports the delivery of the ICB Long-term plan	13	34	38	36	39	102	114	108
	Supports the development of integrated working	17	33	37	35	51	99	111	105
	Enables delivery of system-wide estates and digital strategies.	14	34	38	38	42	102	114	114
Deliverability	Can be delivered within a realistic timescale.	39	0	30	21	156	0	120	84
	Trusts have the capability and capacity to deliver the integration	24	20	27	17	96	80	108	68
	Likely to pass the DHSC risk assessment process	0	20	29	10	0	100	145	50
	Minimises adverse impact on BAU.	18	14	18	14	54	42	54	42
		326	**470**	**611**	**513**	**1244**	**1785**	**2337**	**1937**

DRAFT INTEGRATION TIMELINE

MILESTONES	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
	2024							2025												2026												2027													
STRATEGIC PROGRAMME MANAGEMENT																																											
Establishment of Programme Governance																																											
Establishment of workstreams																																											
Data sharing agreement in place																																											
Develop and agree risk gain share agreement																																											
Develop programme risk register																																											
Develop programme benefits tracker																																											
Develop programme financial benefits tracker																																											
Develop strategic case for change *																																											
Complete appraisal of different legal and organisation options *																																											
Develop shared clinical strategy *																																											
Develop shared overall strategy *																																											
WORKSTREAMS																																											
Clinical & Operational Services Integration																																											
Develop Clinical services integration milestone plan and prioritisation*																																											
Integration of Priority services (Paed Audiology, Intermediate Care/Padgate, UEC, Dermatology)*																																											
Complete Widnes UTC Review*																																											
Integration of Medical and Clinical structures and operational management for patient and productivity benefit																																											
Integration of Clinical Support Services*																																											
Agree strategy for fully integrated clinical pathways to deliver improvements to patient care and experience *																																											
Integration of clinical services and pathways*																																											
Stakeholder Engagement and potential Public Consultation for any Service Change *																																											
Corporate Services Integration																																											
Collate information around all key systems, operational processes and external contracts/services for both organisations																																											
Agree phased workforce plans for each corporate function																																											
Implementation of Target Operating Model																																											
Alignment of processes and systems																																											
Organisational identity and team integration*																																											
Finance																																											
Develop high level 5 year financial strategy*																																											
Review all contracts and draft agreement of principles for transferring contracts*																																											
Rationalisation and alignment of all external contracts and SLAs*																																											
Single Financial Ledger																																											
Workforce																																											
Sign off Joint Vacancy Review and Management Framework.																																											
Sign off Integrated Organisational Change Framework.																																											
Single ESR system in place																																											
Organisational development programme of focussed support																																											
Estates																																											
Complete Review of all Trust sites to identify opportunities for cost savings*																																											
Identify opportunities for service relocation to and from WHH/BCH sites*																																											
Implementation of a single FM Service delivery model																																											
Rationalisation and alignment of all FM contracts and SLAs*																																											
Digital																																											
Define and agree plan for digital system architecture integration *																																											
Provide digital user environment conducive to integration																																											
Seek opportunities for integrated digital procurement *																																											
Define a common suite of products to use for end user hardware																																											
Align digital strategies *																																											
Communications and engagement																																											
Finalise and begin implementing integration communications and engagement plan, including approach to joint branding*																																											
Introduce regular internal and external comms re integration*																																											
Clinical governance and corporate nursing																																											
Develop a shared risk register																																											
Develop single incident reporting and risk management process																																											
Align clinical policies																																											
Corporate governance																																											
Establish joint executive team meetings																																											
Develop and agree Partnership/management agreement																																											
Establish joint committee																																											
Establish committees in common																																											
IF A TRANSACTION IS REQUIRED																																											
ORGANISATION DESIGN																																											
Agree and implement leadership team structure																																											
Sign-off future clinical structure and corporate functions structures																																											
Implementation of clinical and operational structures																																											
STRATEGIC CASE																																											

	Develop and sign-off Heads of Terms
	Develop patient benefits
	Financial modelling to support strategic case
	Complete Strategic Case
	WHH +BCH Board approval to develop Full Business Case
	NHSE approval to proceed to Full Business Case
	FULL BUSINESS CASE
	Complete Financial modelling to support Full business case
	Benefits case
	Quality governance review
	Financial governance review
	Due diligence
	Heads of Terms
	Transaction agreement
	Board certification
	Management letter of representation
	Complete Full Business Case
	Internal FBC Review and Board approval to submit to NHSE
	Trusts submit FBC, Heads of Terms and other information required under the NHS Oversight Framework to NHS England for review and approval
	CONSULTATION PROCESS
	Complete Public, staff and stakeholder engagement and consultation
	APPROVALS
	WHH secures Board of Directors approval for the Integration
	BCH secures Board of Directors approval for the Integration
	Trusts secure Council of Governors approval for the Integration
	Trusts submit a joint application in respect of the Transaction to NHS England with accompanying documents.
	NHS England approves the Integration
	CQC registration of enlarged FT
	Go-live
	Post transaction implementation plan delivered
	PLEASE NOTE: Milestones with an * will be delivered in partnership with external stakeholders

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS

AGENDA REFERENCE:	**BM/25/02/149**	
SUBJECT:	**Integrated Performance Report**	
DATE OF MEETING:	5 February 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, in part as a consequence of the COVID-19 pandemic; then the Trust may not be able to provide timely patient discharge, have reduced capacity to admit patients safely, meet the four hour emergency access standard and incur recordable 12 hour Decision to Admit (DTA) breaches. This may result in a potential impact to quality and patient safety. **#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) as a consequence of the COVID-19 pandemic then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards. **#1275** If we do not prevent nosocomial Covid-19 infection, then we may cause harm to our patients, staff and visitors, which can result in extending length of inpatient stay, staff absence, additional treatment costs and potential litigation. **#134** If the Trust's services are not financially sustainable then it is likely to restrict the Trust's ability to make decisions and invest; and impact the ability to provide local services for the residents of Warrington & Halton. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	

<table>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td>
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 76 IPR indicators which have been placed into the following categories based on SPC/Making Data Count “Assurance” and “Variation” principles and performance.

Table 1 sets out the “Assurance” and “Variation” of all indicators, of these, there are <u>2 indicators that are both failing and have special cause variation of a concerning nature</u>, these are:

Quality:
• 23. Sepsis % screening for all emergency patients (NEW)
Finance and Sustainability:
• 72. Better Payment Practice Code

At Month 7 there were 3 failing and declining indicators, however 2 of these indicators now have normal variation or are no longer consistently failing, so have been removed from the top category. These indicators are included below:
• 5.Healthcare Acquired Infections (CDI)
• 61. Uncapped Theatre Utilisation

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
</td></tr>
</table>

	have not been offset as in previous months and PwC consultancy costs. The latest submitted risk adjusted forecast is £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.		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to: 1. Approve cash support of up to £5.166m from NHSE for March 2025. 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.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Finance + Sustainability Committee	
	Agenda Ref.	FSC/25/01/240 FSC/25/01/245	
	Date of meeting	27/01/2025	
	Summary of Outcome	Cash support application supported for approval at Trust Board. Submission of forecast capital position in line with plan supported and approved. Changes to the capital contingency supported and approved.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Integrated Performance Report	AGENDA REF:	BM/25/02/149

1. BACKGROUND/CONTEXT

1.1 IPR Indicators

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

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

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

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

2. KEY ELEMENTS

2.1 Making Data Count Assurance and Variation Categories

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

Table 1: KPIs by Assurance and Variation Categories

	Special Variation of a Concerning Nature	Common Cause Variation	Special Variation of an Improving Nature	No SPC/Not Enough Datapoints/NA
Consistently Fails the Target (based on the last 7 months)	**CONSISTENTLY FAILING TARGET & DECLINING PERFORMANCE** **Quality** 23. Sepsis - % screening for all emergency patients **(52% - 90% target)** ↓ **Finance & Sustainability** 72. Better Payment Practice Code ***(86% - 95% target)***	**CONSISTENTLY FAILING TARGET & VARYING PERFORMANCE** **Quality** 1.Incidents ↓ 13. Medication Safety - Reconciliation within 24 hours 21. Friends and Family (ED and UCC) 22. Mixed Sex Accommodation Breaches (ITU Only) 24. Sepsis - % screening for all inpatients 25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1h of diagnosis 26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1h of diagnosis 27. Ward Moves between 10pm and 6am **A&P** 33. Referral to treatment Open Pathways ↓ 35. A&E Wait Times - % patients waiting under 4 hours 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 **NEW** 41. Ambulance Handovers within 15 minutes 42. Ambulance Handovers within 30 minutes 44. Discharge Summaries - % sent within 24hrs 61. Uncapped Theatre Utilisation ↑ 62. Capped Theatre Utilisation 76. A&E 4 hour wait (including WUTC)	**CONSISTENTLY FAILING TARGET & IMPROVING PERFORMANCE** **Quality** 31. MUST nutritional assessment completion **A&P** 32. Diagnostic Waiting Times 6 Weeks 34. RTT - Number of patients waiting 52+ weeks 43. Ambulance Handovers within 60 minutes **Workforce** 63. Supporting Attendance 66. Bank and Agency Reliance 68. PDR	**CONSISTENTLY FAILING TARGET & NO SPC**
Inconsistently Passes/Fails the Target	**INCONSISTENTLY PASSING TARGET & DECLINING PERFORMANCE** **Quality** 19. Complaints open over 6 months ↓ **Finance & Sustainability** 71. Capital Programme	**INCONSISTENTLY PASSING TARGET & VARYING PERFORMANCE** **Quality** 5. Healthcare Acquired Infections (CDI) ↑ 6. Healthcare Acquired Infections (Ecoli) 7. Healthcare Acquired Infections (Klebsiella) 8. Healthcare Acquired Infections (PA) 10. VTE Assessment 11. Inpatient Falls & harm levels 12. Pressure Ulcers 15. Staffing Care Hours per patient day (CHPPD)	**INCONSISTENTLY PASSING TARGET & IMPROVING PERFORMANCE** **Quality** **A&P** 45. Discharge Summaries - Number NOT sent in 7 days **Finance** 74. Cost Improvement Programme (recurrent forecast) – In year performance to date	**INCONSISTENTLY PASSING TARGET & NO SPC**

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

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

Areas exceeding the target and continuously maintaining/improving performance

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

⬆ Improved category from previous IPR
⬇ Declined category from previous IPR

2.2 IPR Update

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

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

2.3 Financial Update

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

At the beginning of the financial year Cheshire & Merseyside ICS set the Trust a control total of £27.8m deficit (including a £3m integration stretch target). In month 6 the Trust was allocated deficit support funding of £16.458m therefore reducing the Trust deficit plan from £27.8m to £11.3m. The latest submitted risk adjusted forecast is £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. This is due to the following risk areas:

- CIP delivery including the £3m integration stretch target.
- Funding for the pay award – the Trust has been allocated funding associated with the pay award however this has left a shortfall compared to the total cost.
- Funding for industrial action – there is a shortfall in funding compared to the cost and loss of income from industrial action to date.
- PwC costs and other cost pressures – cost pressures up to month 8 were offset with underspends, however this was not possible in month 9. 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 October is £15.7m, of which, £1.8m is related to capital creditors. The Trust has been allocated a share (£16.458m) of the £150m deficit support provided to the Cheshire and Merseyside ICS and the Trust has received £12.4m of this year to date.

Given the planned deficit for 2024/25 the Trust is in receipt of cash support. A total of £19.39m has been received to date of which £12.145m relates to 2024/25. Further cash support was not required in Q3 following the receipt of the deficit support and pay award funding however cash support is required in March 2025. The Finance and Sustainability Committee discussed and supported the March 2025 application for cash support from NHSE. The Trust Board is asked to approve up to £5.166m cash support for March 2025. Should the cash no longer be required there is no commitment to draw down, however, once the value has been requested an increase is not possible.

CIP

At 31 December 2024, the Trust has delivered a CIP of £11.4m against a target of £11.7m, therefore £0.3m off plan. It should be noted that the delivery year to date has been mainly achieved from central items and reduction in non-clinical posts. The 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. The current level of identified recurrent CIP is £12.7m.

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 9 is £7.5m which is £2.3m below the Trust plan of £9.8m. This is due to timing and is expected to catch up later in the year. The Finance and Sustainability Committee discussed and supported the 2024/25 forecast position continuing to be in line with plan. 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 9		**182**
Proposed changes in month		
VAT Recovered		**58**
Requests supported at CPG 10.1.25		
Comms cabinet improvement phase 1 of 3 addendum	-13	
Warrington comms cabinet environment addendum	-6	
Network refresh underspend to fund the overspend in above scheme	6	
Sub Total		**-13**
Emergency schemes:		
Ground Tractor	-11	
OPD Scopes	-19	
Sub Total		**-30**
Contingency as at end of month 9		**197**

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 £5.166m from NHSE for March 2025.
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	10	Dec-24		8	Nov-24	F
2	Duty of Candour (serious incidents)	100.00%	100.00%	Dec-24		100.00%	Nov-24	P
3	Healthcare Acquired Infections (MRSA)	0	0	Dec-24		0	Nov-24	P
4	Healthcare Acquired Infections (MSSA)	No threshold set	0	Dec-24		1	Nov-24	No SPC
5	Healthcare Acquired Infections (CDI)	Less than 36 for 2023/24	6	Dec-24		2	Nov-24	?
6	Healthcare Acquired Infections (Ecoli)	Less than 54 for 2023/24	9	Dec-24		5	Nov-24	?
7	Healthcare Acquired Infections (Klebsiella)	Less than 18 - annual	1	Dec-24		2	Nov-24	?
8	Healthcare Acquired Infections (PA)	Less than 2 - annual	1	Dec-24		1	Nov-24	?
9	Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks	No target set	0	Dec-24		0	Nov-24	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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10	VTE Assessment	95.00% (quarterly position)	93.65%	Dec-24		95.00%	Nov-24	
11	Inpatient Falls & harm levels	20% or more decrease from previous year	43	Dec-24		35	Nov-24	
12	Pressure Ulcers	10% reduction	17	Dec-24		12	Nov-24	
13	Medication Safety Reconciliation within 24 hours	80.00%	48.00%	Dec-24		42.00%	Nov-24	F
14	Staffing - Average Fill Rate	90.00%	97.77%	Dec-24		90.43%	Nov-24	P
15	Staffing - Care Hours Per Patient Day (CHPPD)	7.9	7.4	Dec-24		7.57	Nov-24	
16	Mortality ratio - HSMR	No target set	90.79	Dec-24		90.11	Nov-24	No SPC
17	Mortality ratio - SHMI	No target set	97.98	Dec-24	H	96.84	Nov-24	No SPC
18	NICE Compliance	90.00%	94.00%	Dec-24	H	94.13%	Nov-24	P
19	Complaints	Zero complaints open over 6 months old/in the backlog	2	Dec-24	H	2	Nov-24	

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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20	Friends and Family (Inpatients & Day cases)	95.00%	98.00%	Dec-24		96.00%	Nov-24	P
21	Friends and Family (ED and UCC)	87.00%	72.00%	Dec-24		73.00%	Nov-24	F
22	Mixed Sex Accommodation Breaches (ITU Only)	0	14	Dec-24		21	Nov-24	F
23	Sepsis - % screening for all emergency patients.	90.00%	52.00%	Dec-24	L	54.00%	Nov-24	F
24	Sepsis - % screening for all inpatients	90.00%	60.00%	Dec-24		78.00%	Nov-24	F
25	Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag	90.00%	52.00%	Dec-24		65.00%	Nov-24	F
26	Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis	90.00%	100.00%	Dec-24		85.00%	Nov-24	F
27	Ward Moves between 10:00pm and 06:00am, for patients with an alert	0	12	Dec-24		2	Nov-24	F
28	Acute Kidney Injury	Less than previous month	152	Dec-24		134	Nov-24	P
29	Maternity Postpartum Haemorrhage	3.70%	4.10%	Dec-24		3.90%	Nov-24	?

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

30	Fractured Neck of Femur (% of patients treated in line with Best Practice Tariff (BPT))	Best Practice Tariff	14%	Dec-24		39%	Nov-24	No SPC
31	MUST nutritional assessment completion	above > 85%	64.16%	Dec-24	H	72%	Nov-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	ACCESS & PERFORMANCE	Plan/Target	Actual	Period	Variation	Actual	Period	
32	Diagnostic Waiting Times 6 Weeks	95.00%	88.93%	Dec-24	H	88.10%	Nov-24	F
33	Referral to treatment Open Pathways	92.00%	59.47%	Dec-24		59.54%	Nov-24	F
34	RTT - Number of patients waiting 52+ weeks	0	1163	Dec-24	L	1135	Nov-24	F
35	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (excluding WUTC).	75%	63.21%	Dec-24		63%	Nov-24	F
76	A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge (including WUTC).	75%	67.65%	Dec-24		68%	Nov-24	F
36	A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge.	2% or less	22.44%	Dec-24		17.9%	Nov-24	F
37	Average time in department ED	No Target	389	Dec-24		356	Nov-24	No SPC
38	28 Day Faster Cancer Diagnosis Standard	75%	74.50%	Nov-24		71.60%	Oct-24	F
39	Cancer 31 Day Wait	96%	98.60%	Nov-24		98.60%	Oct-24	P

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%	72.10%	Nov-24		76.70%	Oct-24	F
41	Ambulance Handovers within 15 minutes	65%	33.40%	Dec-24		39.76%	Nov-24	F
42	Ambulance Handovers within 30 minutes	95%	68.24%	Dec-24		73.98%	Nov-24	F
43	Ambulance Handovers within 60 minutes	100%	84.75%	Dec-24	H	92.14%	Nov-24	F
44	Discharge Summaries - % sent within 24hrs	95%	89.79%	Dec-24		90.11%	Nov-24	F
45	Discharge Summaries - Number NOT sent within 7 days	0	0	Dec-24	L	0	Nov-24	?
46	Cancelled Operations on the day for a non-clinical reason Please note: Validation for this indicators was in progress at the time of reporting.	Less than 2%	1.14%	Dec-24	H	0.46%	Nov-24	P
47	Cancelled Operations on the day for a non-clinical reason - Not offered a date for readmission within 28 days of the cancellation Please note: Validation for this indicators was in progress at the time of reporting.	0	1	Dec-24		5	Nov-24	?
48	Urgent Operations Cancelled for 2nd Time	0	0	Dec-24		0	Nov-24	P
49	Super Stranded Patients	Trajectory	131	Dec-24		128	Nov-24	No SPC

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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Special Cause Variation of a concerning nature.



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Consistently fails the target*

*based on the last 6 datapoints/months

50	No Criteria to Reside (NCTR)	No Target set	206	Dec-24		170	Nov-24	No SPC
51	Elective Recovery Activity (Grouped SPCs)	104% (aggregate) % activity is against activity in the same month in 2019/20	NA	NA	No SPC	NA	NA	No SPC
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	0%	90%	Dec-24		86%	Nov-24	?
55	Patients seen in the Fracture Clinic within 72 hours	95%	96.70%	Dec-24		96%	Nov-24	?
56	% patients referred to long COVID service not assessed within 15 weeks	No Target set	0	Dec-24	No SPC	0	Nov-24	No SPC
57	Type 5 attendances	No Target set	1296	Dec-24	H	1321	Nov-24	No SPC
58	Reduction in Outpatient Follow Ups compared to 19/20 activity	No Target set	90%	Dec-24		86%	Nov-24	No SPC
59	% Patients discharged to their usual place of residence	No Current Threshold	96%	Dec-24	H	95%	Nov-24	No SPC
60	Virtual Appointments	No Target set	20%	Dec-24	H	19%	Nov-24	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

61	Uncapped Theatre Utilisation	85%	81.00%	Dec-24		84%	Nov-24	F
62	Capped Theatre Utilisation	85%	75.80%	Dec-24		76%	Nov-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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*based on the last 6 datapoints/months

		Latest				Previous		Assurance
	WORKFORCE	**Plan/Target**	**Actual**	**Period**	**Variation**	**Actual**	**Period**	
63	Supporting Attendance	4.20%	5.82%	Dec-24	L	5.74%	Nov-24	F
64	Retention	85.00%	87.17%	Dec-24	H	87.05%	Nov-24	P
65	Turnover	Below 13%	12%	Dec-24	L	12%	Nov-24	P
66	Bank and Agency Reliance	9% or Below	13.78%	Dec-24	L	13.82%	Nov-24	F
67	Core/Mandatory Training	85.00%	90.00%	Dec-24	H	90.10%	Nov-24	P
68	PDR	85.00%	79.81%	Dec-24	H	80.42%	Nov-24	F

Statistical Process Control - Assurance & Variation

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Appendix 1

Key:



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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)	-£1.25	-£2.34	Dec-24	No SPC	-1.24	Nov-24	No SPC
70	Cash Balance (£m)	£4.63	£15.68	Dec-24	No SPC	16.19	Nov-24	No SPC
71	Capital Programme (£m)	£12.36	£7.49	Dec-24	L	£6.76	Nov-24	?
72	Better Payment Practice Code	95%	86%	Dec-24	L	78%	Nov-24	F
73	Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date (£m)	£11.66	£11.36	Dec-24	H	9.72	Nov-24	P
74	Cost Improvement Programme (recurrent) – In year performance to date (£m)	£11.36	£8.94	Dec-24	H	9.72	Nov-24	?
75	Agency Ceiling	Less than 3.2%	1.4%	Dec-24	L	1%	Nov-24	P

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key: SOF System Oversight Framework; CQC Care Quality Commission; RR116

Quality Improvement - Trust Position

Appendix 2

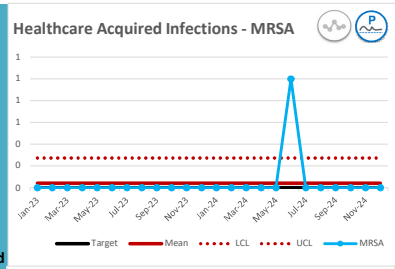
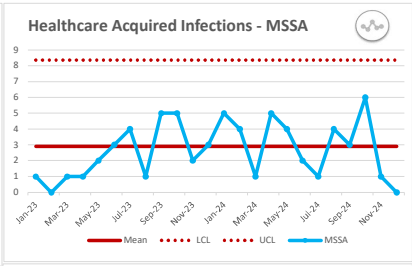
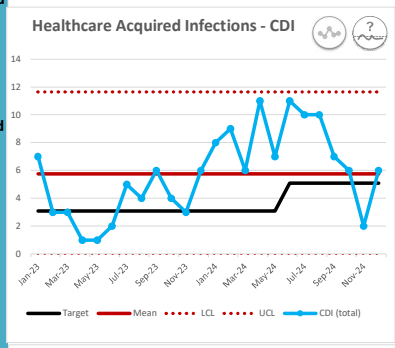
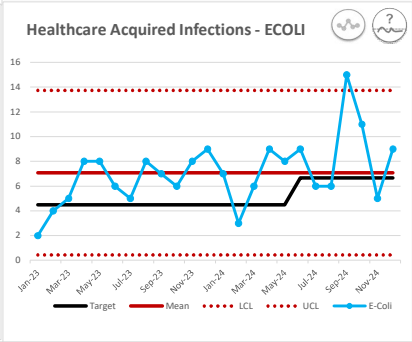
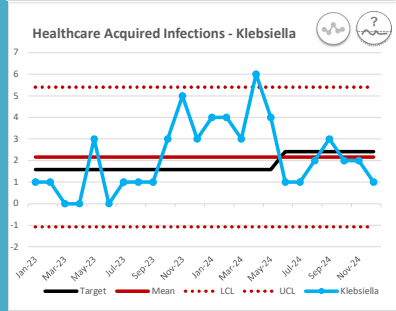
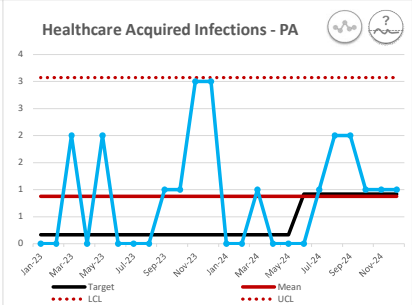
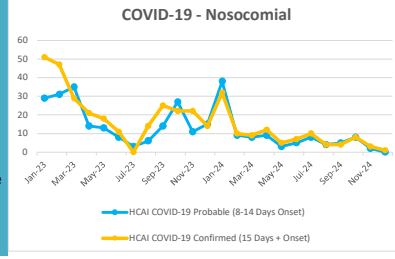
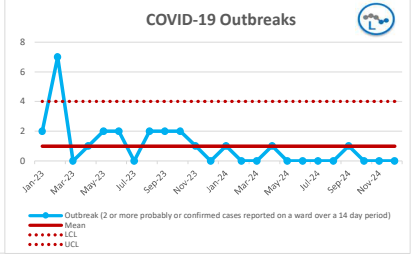
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
1. Incidents (over 40 days) **Target: ZERO Open incidents outside 40 day timeframe and ZERO Never Events**	Open Incidents - 40 Days; Total Incidents Reported by month; Total PSIIs recorded in month; Serious Incidents / PSII Actions Breached; Never Events; Qty of 'prevention of future death orders'	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause variation of a concerning nature.**	**There were 2 PSIIs reported in December 2024 both relating to delays in cancer diagnosis. One relating failure to recognise deterioration.** **There were 10 incidents open over 40-days at the time of reporting these were in the Planned Care Group.** **There was 1 breached patient safety incident investigation actions at the time of reporting. These relate to policies that are going through the ratification process.** **There have been no never events reported since April 2024.**	**A weekly governance dashboard is overseen by the Executive Team monitoring trends of reporting alongside triangulation of incidents, complaints, claims and inquests.** **Incidents overdue 40 days- An overdue incident report is sent daily to the triumvirates for the relevant areas, and this work is being prioritised.** **The Medical Director is leading a priority improvement work relating to tracking of cancer delays.** **Datix system alerts at an additional lower threshold (30 days) to enable further support to be provided and this will be monitored closely.** **PSII's** **Weekly monitoring continues through the weekly Executive Led Safety Oversight Meeting with appropriate escalation to the Care Group leads.**
There were 10 incidents over 40 days old.				
2. Duty of Candour (serious incidents) **Target: 100%**	Duty of Candour (DoC) - Moderate Incidents; Duty of Candour (DoC) - Serious Incidents	**Assurance: The Trust consistently passes the target.** **Variation: Common Cause (Normal) variation.**	**WHH has maintained 100% compliant with Duty of Candour requirements throughout the year.**	**Weekly monitoring is maintained to ensure that compliance continues to be sustained. Oversight continues through the weekly Executive Led Safety Oversight Meeting.**
The Trust achieved 100% for Duty of Candour in month.				

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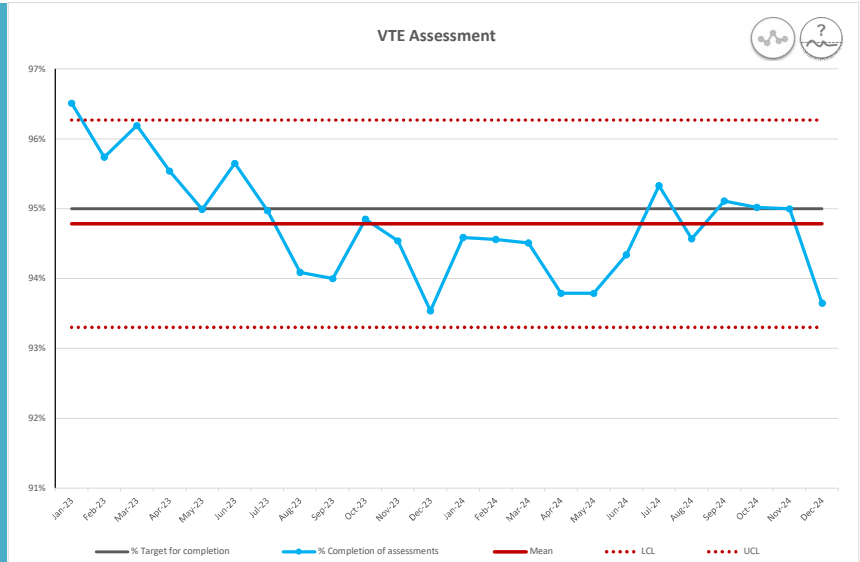
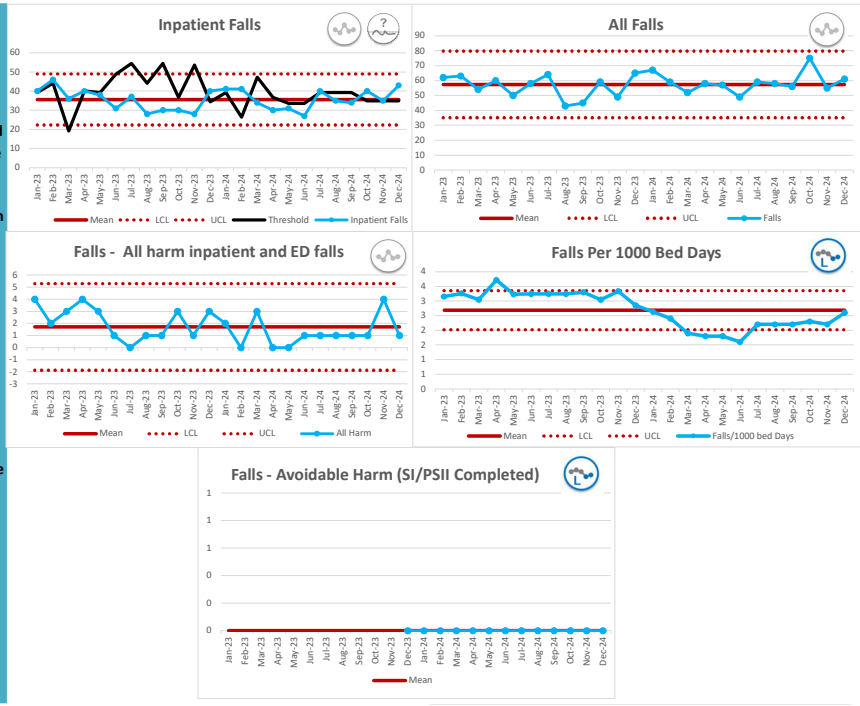
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
3. Healthcare Acquired Infections (MRSA) Target: ZERO 4. Healthcare Acquired Infections (MSSA) Annual threshold: NA 5. Healthcare Acquired Infections (CDI) Annual threshold: 61 6. Healthcare Acquired Infections (Ecoli) Annual threshold: 80 7. Healthcare Acquired Infections (Klebsiella) Annual threshold: 29 8. Healthcare Acquired Infections (PA) Annual threshold: 11	MRSA cases YTD - annual threshold exceeded by 1 MSSA 26 cases YTD - no threshold set CDI 70 cases YTD - annual threshold exceeded by 9 cases E. coli 78 cases YTD - annual threshold exceeded by 0 Klebsiella spp. 22 cases YTD - annual threshold exceeded by 0 P. aeruginosa 8 cases YTD - annual threshold exceeded by 0	     	(MRSA) Assurance: The Trust consistently passes the target. Variation: Variation: Common Cause (Normal) variation. (CDI) Assurance: The Trust inconsistently passes/fails the target. (CDI) Variation: Variation: Common Cause (Normal) variation. (ECOLI) Assurance: The Trust inconsistently passes/fails the target. (ECOLI) Variation: Variation: Common Cause (Normal) variation. (K) Assurance: The Trust consistently fails the target (K) Variation: Special cause variation of a concerning nature. (PA) Assurance: The Trust inconsistently passes/fails the target. (PA) Variation: Common Cause (Normal) variation.	Regional/national increase in C. difficile cases. UKHSA has declared the rise in cases as a national standard incident. One ward outbreak of C Difficile, control measures implemented, outbreak has since been declared closed. Reduction in MSSA and Klebsiella cases in December. WHH Trust is not flagging as an outlier on cases/rates of infection with the exception of C Difficile where WHH is considered a low outlier. There are multiple primary sources for reported infections, some are deep seated infections and felt to be unavoidable.	MRSA: MSSA: An increase in ANTT assessors driving compliance with ANTT training and competency assessments. ANTT eLearning presentation updated. There is a focus on IV device care bundle with an agreed ongoing audit schedule to provide assurance on compliance with the bundle and care of invasive devices. CDI: CDI Prevention Action Plan in place. Brilliant Basics Campaign continues which includes education across all staff groups. A system-wide seminar on CDI is being hosted in Quarter 4 - agenda to be finalised. Deep dive of 2023/24 cases and thematic analysis completed, no new learning identified. Senior Nursing Leadership Team undertaking IPC visits and spot checks. Efficacy MDT audits commenced from October 2024. MDT Review Meetings are aligned to PSIRF, Swarm Huddles commenced for all hospital onset healthcare associated cases. Trust-wide deep cleaning programme commenced. Review of National Action Plan on Antimicrobial Stewardship in progress. ECOLI: Klebsiella: Pseudomonas aeruginosa: Revision and relaunch of the GNBSI Prevention Group, medical staff membership from both Planned and Unplanned Care has been requested.
9. Healthcare Acquired Infections COVID-19 Hospital Onset & Outbreaks (No Target)	0 in month COVID-19 outbreak. Covid-19: 0 day 8-14 cases probable healthcare associated cases in month. 1 day 15+ cases definite healthcare associated in month.	 	(C19) Assurance: N/A - No target. (C19) Variation: Special cause variation of an improving nature		

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10. VTE Assessment **Target: 95% (quarterly position)**		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause Variation.	VTE Risk Assessment (RA) performance target in December 2024 was below the mandatory threshold of 95% at 93.65%. There is no single identified cause for this reduction.	Non-completion of VTE risk assessments data is on the GIRFT In-patient Ward Productivity Dashboard which is displayed on ward level e-whiteboards. This is to encourage the completion of outstanding risk assessments in real time. This data can be drilled down at the ward level daily, for identification of those patients who do not have an up-to-date risk assessment. VTE Risk Assessments Dashboard is now live on LION Dashboard and the link has been included as a standing agenda item at the monthly Clinical Business Units (CBUs) Governance Meetings from October 2024. The Thrombosis Group monitors the data trends and oversees completion of the CBUs Improvement Plans.
The Trust did not achieve the required target at 93.65% for VTE assessments in month.				
11. Inpatient Falls & harm levels **Target: decrease from 23/24 (418 Inpatient Falls in 2023/24)**		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause Variation.	There has been a slight increase in the number of falls per 1000 bed days (2.6). 1 fall resulted in moderate harm to a patient. The completion of timely Risk Assessments is emerging as a new theme. Information to support the accurate completion of risk assessments has been discussed with staff and has been circulated regularly at Trust-wide Safety Brief.	January 2025's monthly hot topic was falls/deconditioning. Falls information will be shared with wards and departments. Enhanced care was safety hot topic in "The Week." In January. The WHH falls information leaflet has been revised and is awaiting approval prior to the use and circulation. Plan to promote the updated falls information leaflet once approved. Falls Policy update to be completed and ratified in Quarter 4 following which the bedside eyesight vision check will be launched Trust wide. There has been supporting information sent to all wards reminding them of the need to complete timely Risk Assessments. Compliance will be tracked via the monthly Compliance Meetings with the Deputy Chief Nurse/Director of Governance. All falls improvement actions are tracked via the Harm Free Care Meeting.
61 total falls were reported in month. 43 of these were inpatient falls. **There was 1 fall(s) in month with harm.** **There were 671 total falls in 2023/24. There have been 528 total falls YTD in 2024/25.** **We are expecting a 5% increase in falls from last year.** **There were 418 inpatient falls in 2023/24. There have been 315 inpatient falls YTD in 2024/25.** **We are expecting a 0% increase in falls from last year.**				

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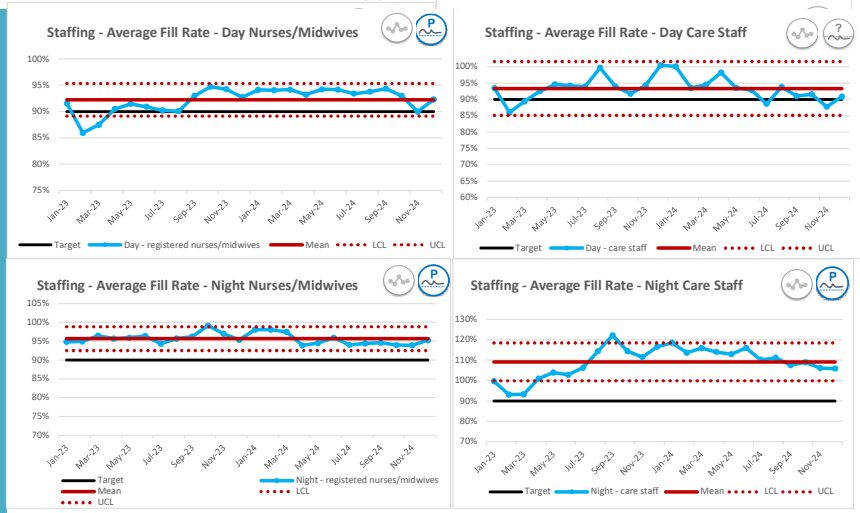
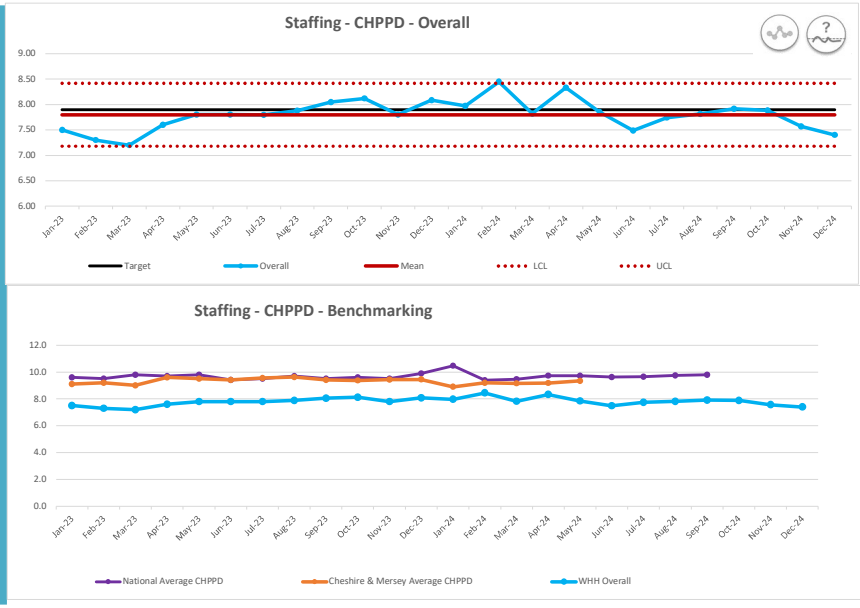
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
12. Pressure Ulcers (Category 2 and above) **Target: 10% reduction based on 2023/24**	Pressure Ulcers - Category 2 and above Pressure Ulcers - Category 2 Pressure Ulcers - Category 3 Pressure Ulcers - Category 4 Community Acquired Pressure Ulcers	**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (Normal) variation.**	**In December 2024, there were 17 category 2 pressure ulcers. Five of which were device related pressure ulcers (O2 straps, NIV mask, convene, NG tube and patient's own wrist splint).** **There was no single theme identified for the remaining 12 pressure ulcers. Broad themes include deconditioned patients who are frail, timeliness of Risk Assessments, timely use of appropriate mattresses, sheering of heels on bed sheets and patients declining pressure relieving intervention.** **There were 0 category 3 pressure ulcers and 0 Category 4 pressure ulcers in December 2024.**	**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. Minimum category 3 and above will have an MDT review completed.** **3. Improvement plans in place for both Unplanned Care and Planned Care Groups overseen by the Associate Chief Nurses.** **4. Compliance Meetings reviewing pressure ulcer prevention care plan completions has commenced with the Deputy Chief Nurse from Quarter 3.** **5. Trail of heel films to prevent sheering to heels.** **6. Review of training for all staff.** **7.Validation training for all ward based senior nurses.**
There were 17 hospital acquired category 2 pressure ulcers, 0 Category 3 pressure ulcers and 0 Category 4 ulcers in month. **There were 38 community aquired pressure ulcers in month.**				
13. Medication Safety **Reconciliation within 24 hours Target: 80%**	Medication Safety - Reconciliation - 24 hours Medication Safety - Reconciliation - Overall Medication Safety - Controlled Drug Incidents Internal Medication Safety - Incidents with Harm	**Assurance: The Trust consistently fails the target.** **Variation: Common Cause (Normal) variation.**	**In December WHH did not meet this target although there is an improving trend. Pharmacy staffing position improving but an increase sickness and annual leave across the month of December impacted performance.** **Controlled drug incidents: there is no target for this metric. There were 25 controlled drug incidents in December 2024, with administration (n=7) and running balance errors (liquid medicines) (n=4) being the most reported subcategories. No specific themes or trends identified.** **Incidents causing harm: there is no target for this metric. One incident causing moderate harm was reported in December 2024. This was a documentation error that led to missed VTE prophylaxis resulting in hospital-acquired VTE.**	**Ongoing training of new Pharmacists. Two additional Pharmacists started on 6 January 2025. Only two vacancies remain in the Pharmacist establishment. Staff are in pipeline for these positions one with start date to be confirmed, one with a start date of March 2025.** **Medicines reconciliation (MR) improvement action plan in place, overseen at Pharmacy Specialty Governance Meeting. Work underway to implement MR completion by midwives for antenatal women. Reviews of all patients with LOS >72 hours who do not receive MR is 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 developed through the medicine's governance structure.**
Medicines reconciliation was completed within 24 hours of admission for 48% of patients. 77% of patients had MR completed during inpatient stay. **There were 25 controlled drug incidents.** **There was 1 medication harm incident reported in month.**				

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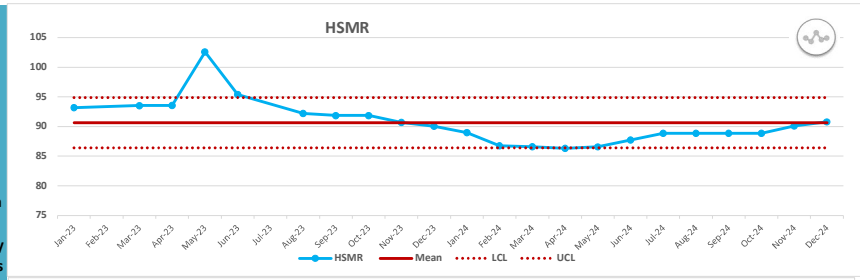
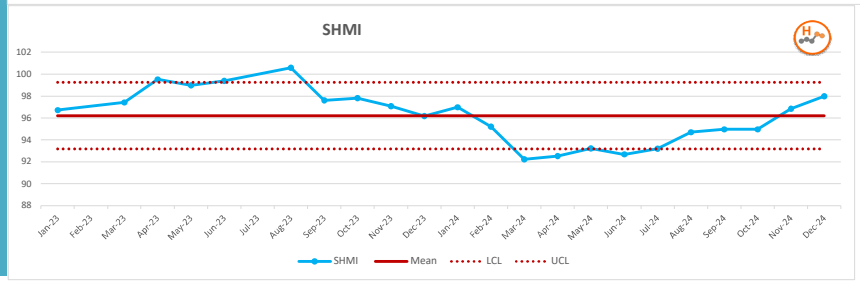
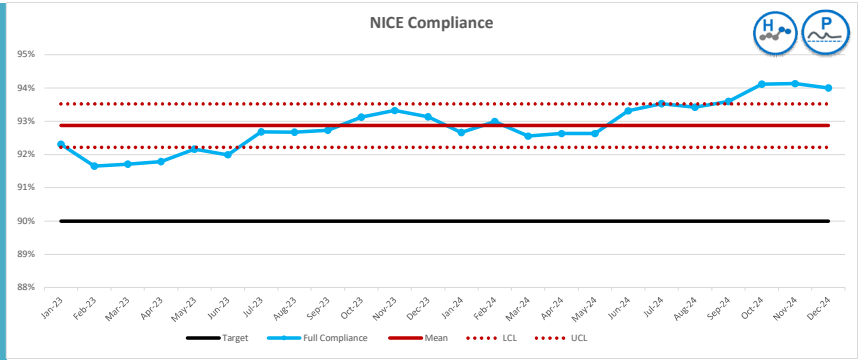
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
14. Staffing - Average Fill Rate **Target: 90%**	**In month, the average staffing fill rates were:** **Day (Nurses/Midwife) 92.29%** **Day (Care Staff) 90.83%** **Night (Nurses/Midwife) 95.28%** **Night (Care Staff) 105.85%** RR115 RR1108		**Assurance: N/A Grouped Indicator** **Variation: N/A Grouped Indicator**	**There has been a reduction in vacancies for both Heath Care Assistants and registered nurses, and a reduction in turnover. However, sickness has increased in December 2025, mainly due to respiratory illness.** **Additional beds were also in use across the Trust (highest n=28) due to increased number of patients attending the Emergency Department (ED).**	**Staffing is reviewed twice daily by the Senior Nursing Team and acuity and activity are monitored to ensure safe patient care at all times. All wards have senior nurse oversight by a Matron and Lead Nurse.** **The current percentage vacancy for December 2024 for registered staff is 9.65% against a Trust target of 9%. This is mainly due to ED increased establishment of 49.36 WTE. Specialist recruitment is taking place. A Health Care Assistant recruitment event took place in January, attendees are being signposted to current vacancies.** **The current percentage vacancy for December 2024 for unregistered staff is 13.85% against a Trust target of 9%. Monthly recruitment is taking place alongside specialist recruitment. Recent specialist recruitment has successfully appointed 12 unregistered staff who are now being supported through recruitment processes. Cohort 42 of NHSP CSWD staff x 12 have now commenced their ward placement, with 4 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: 4.1 hours** **Care Staff: 3.2 hours** **Overall: 7.4 hours**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common cause variation.**	**The CHPPD for December 2024 has decreased to 7.4 from 7.6 in November 2024 which is below the national target of 7.9. This is due to the increase in the number of beds due to extra capacity and increased sickness across unregistered and registered staff groups in December 2025.**	**Staffing is reviewed twice daily by the Senior Nursing Team to maintain safety and work is ongoing to reduce agency usage, recruit to posts and migrate regular agency workers to NHSP. There are clear processes for escalation to ensure staffing is based upon acuity to ensure patient safety. Sickness is being manged in line with policy. Escalation areas are expected to close by the end of March 2025.**

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16. Mortality ratio - HSMR Target: Plan 17. Mortality ratio - SHMI Target: Plan	SHMI and HSMR are within the expected range. The Hospital Standard Mortality Ratio (HSMR) in month was 90.79. The Summary Hospital Level Mortality Indictor (SHMI) ratio in month was 97.98.	 	(HSMR) Assurance: NA - no target Variation: Common Cause Variation. (SHMI) Assurance: NA - no target Variation: Special Cause Variation of a concerning nature.	Comparing the SHMI trends graphs, 2022-2024 with those from 2016-2018, significant improvements can be seen. This has been since there has been increased focus on both the governance and coding around mortality. WHH SHMI was consistently around 10 points higher than expected and was consistently higher than peers in the Northwest and all other acute Trusts in England, it is now consistently reporting lower than expected and lower than other Trusts following the improvement in coding. Prior to August 2023, both the SHMI and HSMR was reporting higher over the weekends when compared to weekdays. It is noted this has now significantly improved, and the figures demonstrate there is no longer a higher trend of WHH patients passing away at weekends compared with weekdays.	Our Clinical Coding Quality Improvement Manager has completed a coding review for the Acute Cerebral Vascular Disease Variable Life Adjusted Display alert. As a result, 9 stroke related deaths underwent a focussed review which was discussed with Mortality Review Group attendees in December 2024. Coding improvement work continues.
18. NICE Compliance Target: 90%	The Trust achieved 94% 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.	Of the 637 pieces of NICE Guidance WHH rates 545 at full compliance. 20 are for information only, with the remaining Nice Guidance under review. Based on this we are 94.00% compliant. The Clinical Business Units (CBUs) are asked to review the partial compliance elements and when relevant actions have been completed the guidance is re-reviewed to determine the updated compliance against the relevant guidance. WHH has consistently remained above the 90% compliance target.

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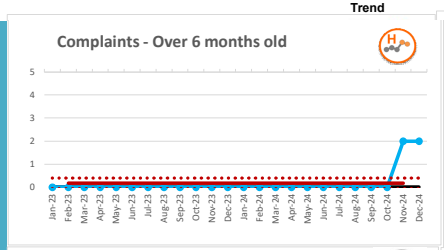
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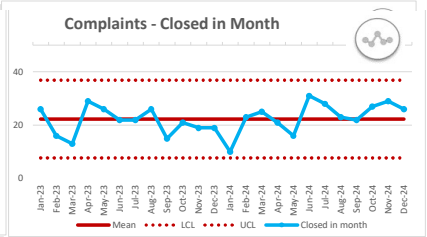
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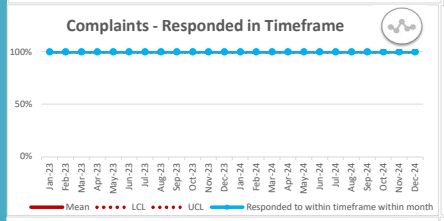
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
19. Complaints Target: Zero complaints open over 6 months old/in the backlog	Complaints - Over 6 months old Complaints - Closed in Month Complaints - Responded in Timeframe Complaints - Dissatisfied opened in month Complaints - New Complaints Complaints - PHSO open Complaints - PALS concerns received in month	Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of a concerning nature.	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. One has been on hold due to illness within the family and the other is on hold due to awaiting questions from the complainant, who would like the complaint to remain open.	There were 78 open complaints at the time of reporting. All complaints continue to be closely monitored to ensure that a timely quality response is completed. Where appropriate, complaints are directed to PALS for local resolution. All complainants are offered an initial meeting with the Clinical Teams, as well as follow up meetings upon receipt of the initial response letter. All CBUs have a designated complaints case handler to ensure consistency. All complaints are quality assured by the Deputy Chief Nurse/Director of Governance and the Chief Nurse. Themes are collated and reported in the Learning from Experience Report to Quality Assurance Committee quarterly.

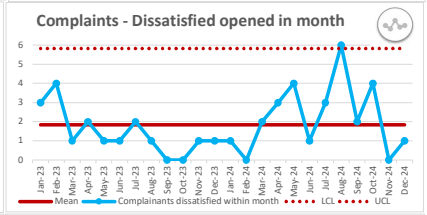
In month, 18 new complaints were received to the Trust which was a decrease of 4 from the previous month. There were 1 dissatisified complaints received in month, which is an increase from the previous month.

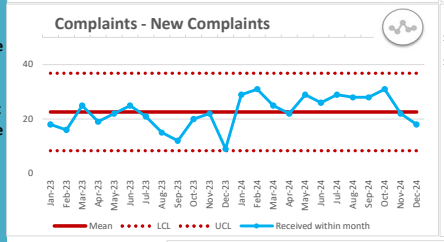
7 PHSO cases were open at the time of reporting, these were not linked to a specific area or theme.

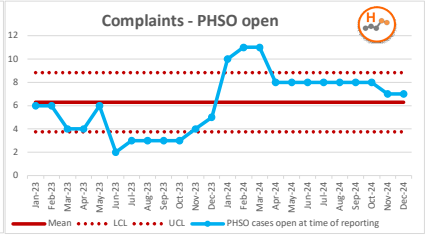


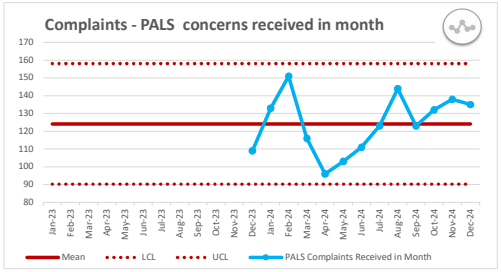










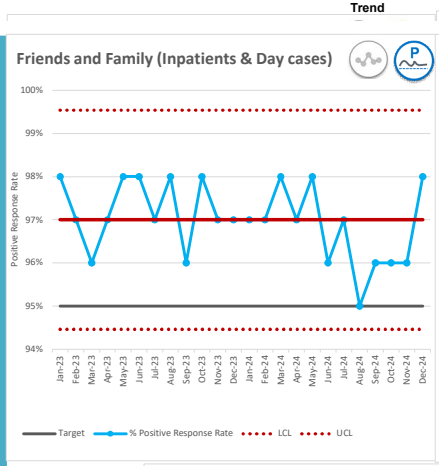
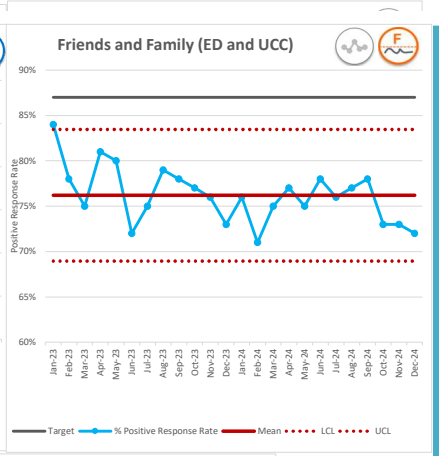
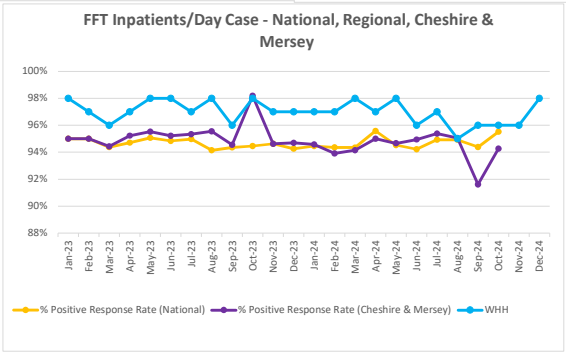
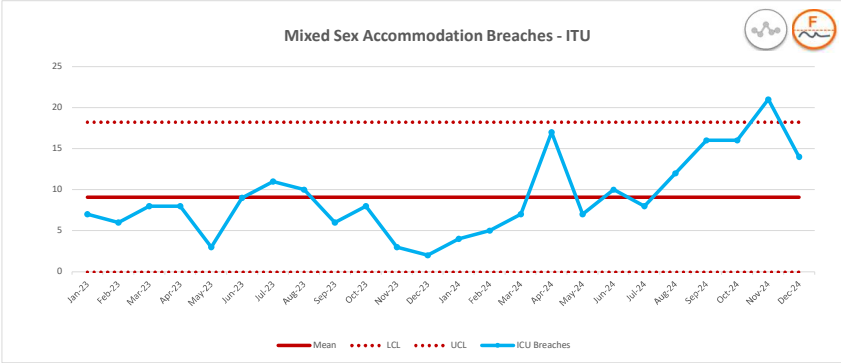


Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key: SOF System Oversight Framework; CQC Care Quality Commission; RR116; S

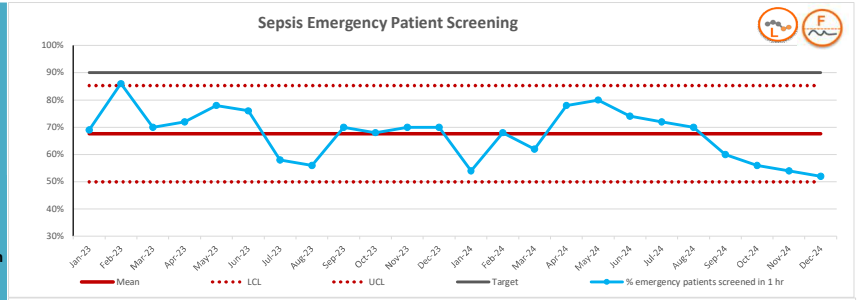
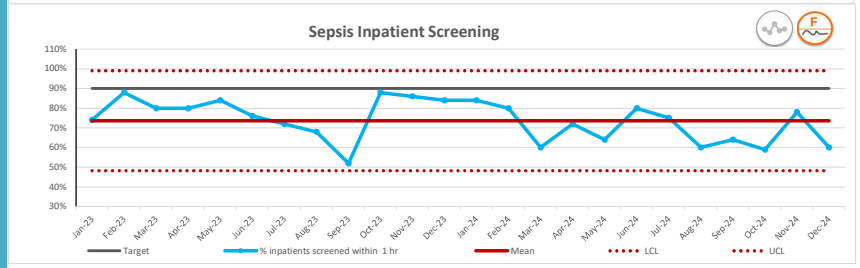
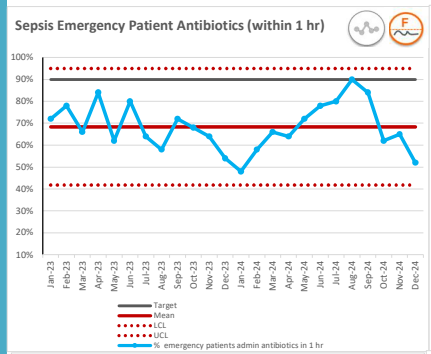
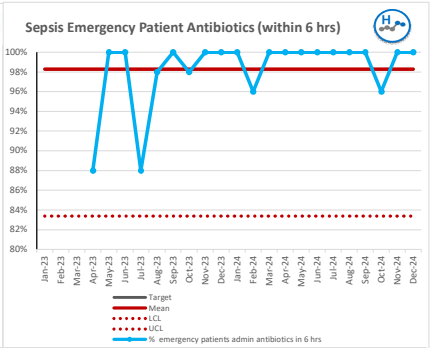
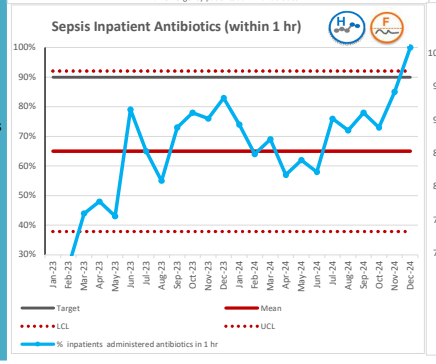
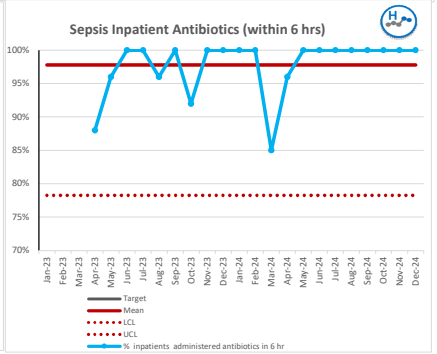
Quality Improvement - Trust Position

Appendix 2

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
20. Friends and Family (Inpatients & Day cases) **Target: 95%** **21. Friends and Family (ED and UCC)** **Target: 87%**	**The Trust achieved 98% in month for Inpatient & Day case FFT and 72% for ED/UCC FFT.**	  	**(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**	**ED/UCC – WHH saw a reduction in positive feedback in Friends and Family Test results in December 2024 (72%). The main theme is in relation to waiting times within the department. This aligns with the increasing number of patients attending the department during this period.** **Inpatients – WHH saw an increase in satisfaction rates to 98% in December 2025. WHH consistently achieves above the Cheshire and Merseyside average for FFT Inpatients.**	**Key themes reviewed to highlight improvement areas- Themes include communication, waiting times and the environment. A digital information TV screen is being procured to improve communication on waiting times.** **Streaming continues to try to release pressure on the Emergency Department. WHH has continuous flow and ward boarding procedures to alleviate pressure in the Emergency Department. A Health Care Assistant is based in the waiting room to enable patients to ask questions or flag concerns.** **Opportunities are being created to involve volunteers in supporting patients with FFT completion within the department.** **Volunteers are assisting with drinks rounds, care and comfort and nutrition and hydration support.** **The Urgent and Emergency Care Service Improvement Project has commenced for 2024-2025, this work will address overcrowding, length of stay and discharge challenges**
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 December 2024, this is a decrease of 7 compared to November 2024. These were all within the Intensive Care Unit due to the inability to step patients down to ward based care due to the unavailability of beds across WHH.** **There were 0 breaches within any other ward areas.**	**Work continues within the Unplanned Care Group and the 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 WHH, this is a contributory factor.** **The Mixed Sex accommodation Policy is currently being updated. This is expected to be ratified in February 2025.** **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 throughout the day.**

Quality Improvement - Trust Position

Appendix 2

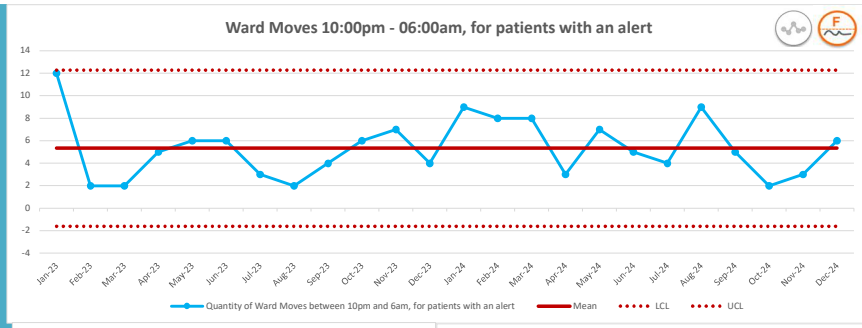
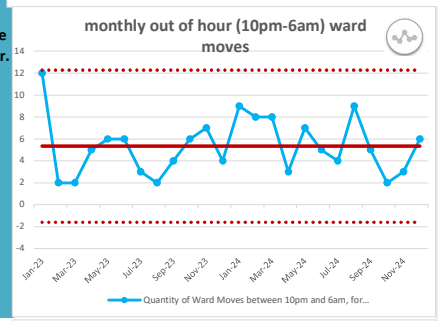
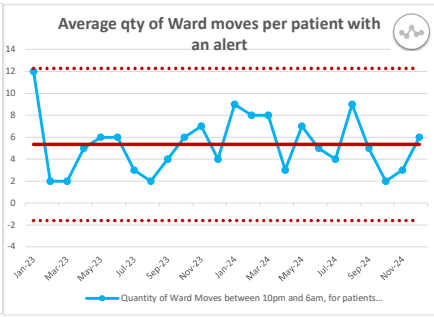
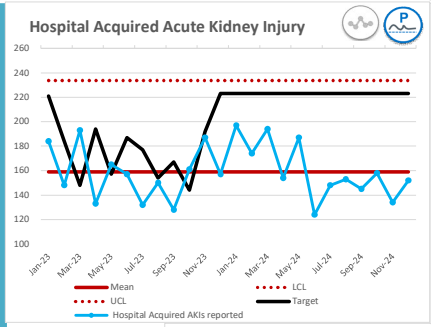
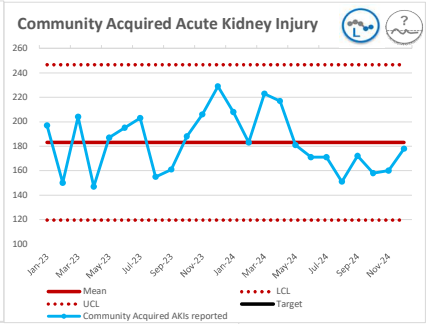
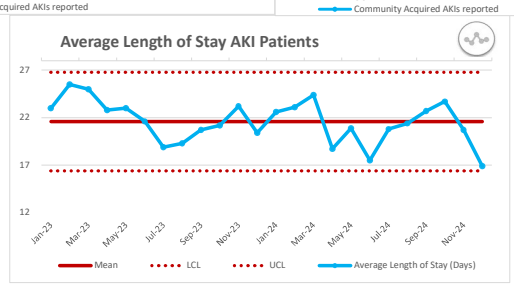
Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
23. Sepsis - % screening for all emergency patients. **Target: 90%** The Trust achieved: • 52% Sepsis screening for all emergency patients with suspected sepsis within 1 hour. • 60% screening for all inpatients with suspected sepsis within 1 hour.	 	(Emergency) Assurance: The Trust consistently fails the target. Variation: Variation: Special Cause variation of a concerning nature. (Inpatient) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	The reduction in compliance generally related to blood culture completion, as these are collected by a registered nurses whereas other elements of the screening process are undertaken by Health Care Assistants. The Emergency Department has a number of new staff who have not yet completed blood culture training.	This month's sepsis compliance was the third month using the new NG51 guidelines, which considers a patients NEWS2 score resulting in the identification of level of risk e.g. moderate or high risk as opposed to red and amber flags. In a bid to improve compliance additional blood culture training is now available, ED staff are accessing this training. Trust leads have been identified who will attend the Sepsis Group and lead on improvement work. ED Manager undertaking Quality Improvement Practitioner Training and leading QI work in the Emergency Department. 2 spaces have been identified in the Emergency Department for patients with potential sepsis to enable all screens to be taken in 1 dedicated equipped area.
24. Sepsis - % screening for all inpatients **Target: 90%**				
25. Sepsis - % of patients within an emergency setting, receive antibiotics administered within 1 hour of diagnosis to patients with red flag **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. • 100% of emergency patients with suspected sepsis were administered antibiotics 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.	There has been a deterioration in this metric in ED following a change in when the 1-hour time period starts for antibiotics administration. Previously the guidance stated this was from the time "query sepsis" was recorded in the notes. Now this is from the time the NEWS is recorded thus the time is now starting earlier. All patients included in both audits 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 has been circulated through Trust-wide Safety Brief. The new e-learning package is being promoted for completion. All junior doctors get training on induction. Not all staff are aware of the change of the change in when the 1-hour time period starts for antibiotics administration following the introduction of the new guidance. An education and communication campaign is ongoing to raise awareness.
26. Sepsis - % of patients within inpatient settings, receive antibiotics administered within 1 hour of diagnosis **Target: 90%** • 100% 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.	 			

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key: SOF System Oversight Framework; CQC Care Quality Commission; RR116

Quality Improvement - Trust Position

Appendix 2

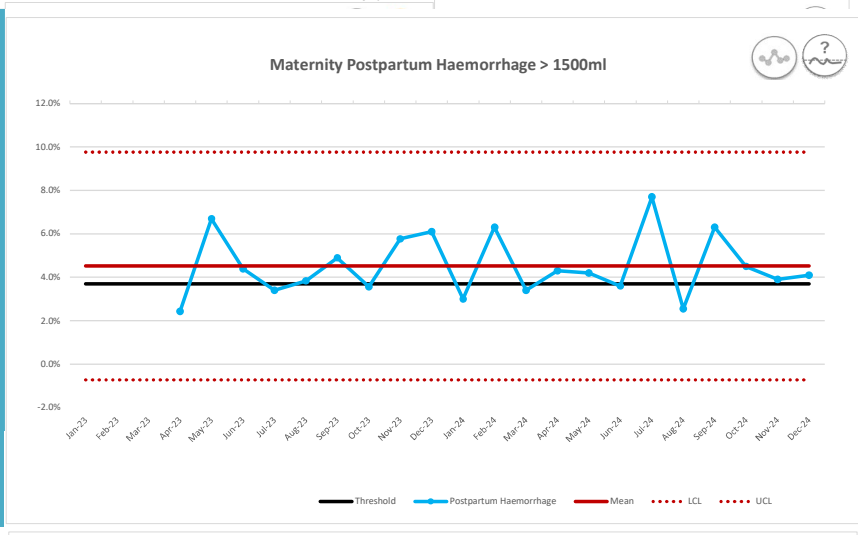
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
27. Ward Moves between 10:00pm and 06:00am with a dementia, LD and/or Mental Health alert **No Target**	There were a total of 6 ward moves in month between 10pm-6am for patients with an alert, compared to 4 in the same period in the previous year.	  	Assurance: The Trust consistently fails the target. Variation: Common cause (normal) variation.	The reason for the reduction on ward moves after 10pm for this reporting period compared to last year is as a result of the out of hours Patient Flow Team 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 152 acute kidney injuries reported in month compared to 134 last month.	  	Assurance: The Trust Consistently passes the target. Variation: Common Cause (Normal) variation.	No Variation with LOS and Hospital Acquired(HA)-AKI with both being below the mean and HA-AKI below target.	Focus on appropriate and accurate fluid balance completion Trust wide, this will not just impact AKI but support the recognition of the deteriorating patient. Trust wide Fluid Balance Audit actions have been agreed including amendments to the AKI E-learning package to strengthen Fluid Balance Guidance. The AKI Lead is providing ward-based AKI education AKI Clinics are held each week to reduce the 30-day readmission rate.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
COC Care Quality Commission
RR116

Quality Improvement - Trust Position

Appendix 2

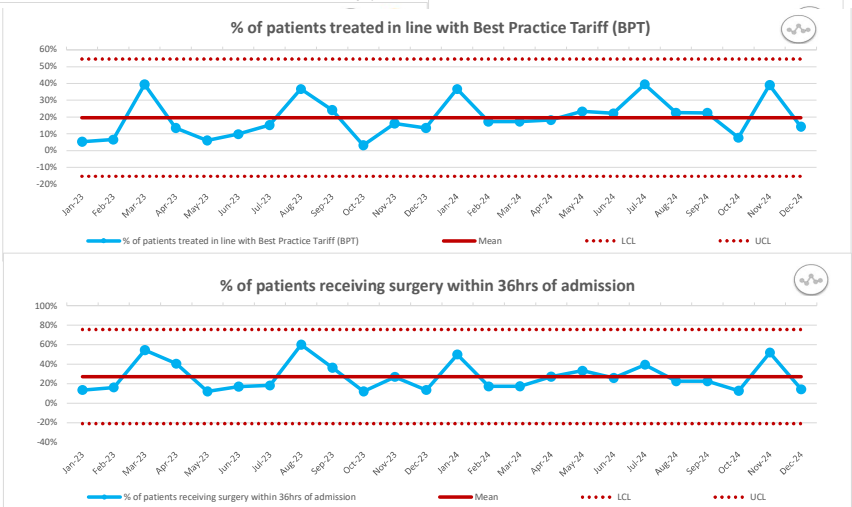
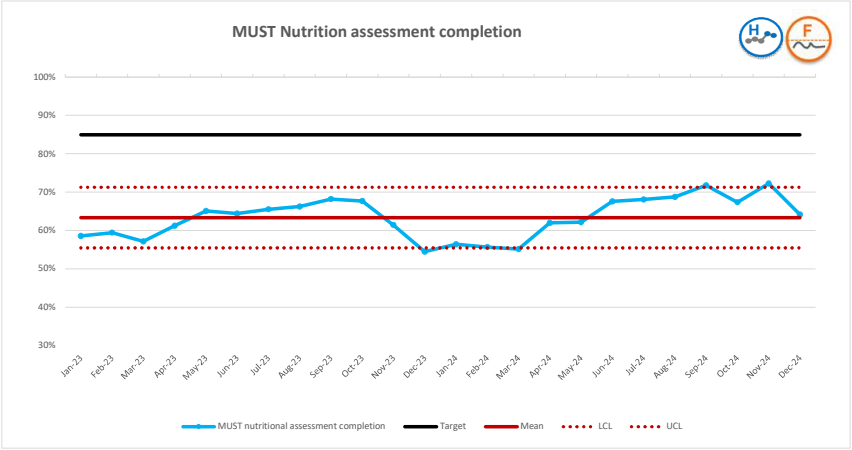
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
29. Maternity Postpartum Haemorrhage >1500ml **Threshold: < 3.7%**	**There were 4.1% Postpartum Haemorrhages >1500ml in month.**		**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 34.4/1000 births. The WHH rate is 45.8 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.** **Several 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.** **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 PPH QI Working Group has acknowledged there are limitations to the change ideas which can be trialled as a PDSA cycle whilst awaiting the guideline publication. Accordingly, it has been agreed to stand down the formal QI project.** **The working group will now focus to the implementation of new standards once released. The PPH Action Plan is reported monthly to Quality Assurance Committee alongside an SPC chart.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Key:
SOF System Oversight Framework
CQC Care Quality Commission

Quality Improvement - Trust Position

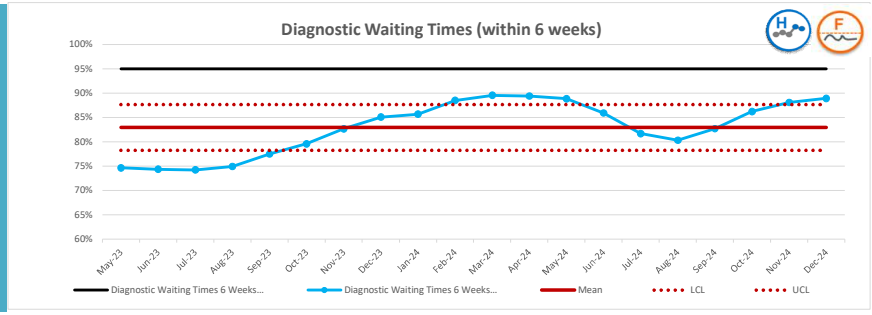
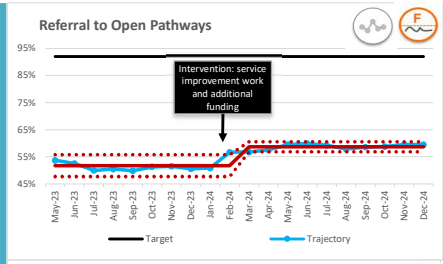
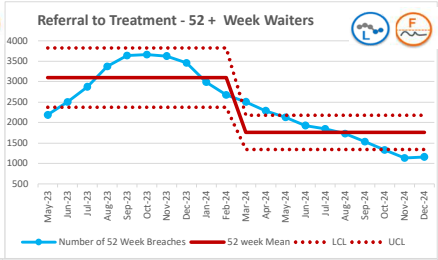
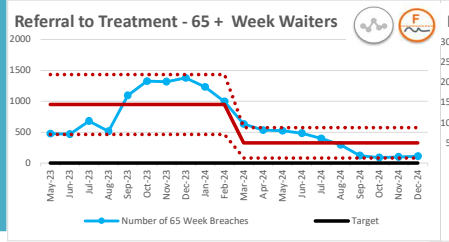
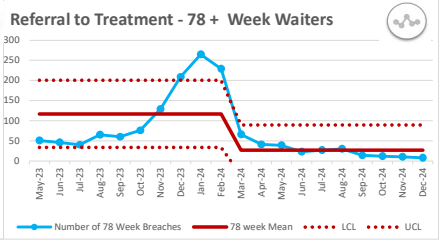
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
30. Fractured Neck of Femur **Target: Best Practice Tariff**	**14.28% of patients were treated in line with Best Practice Tariff (BPT) in Dec-24.**	 	**Variation: Common Cause (Normal) variation.**	**December data saw a higher number of patients eligible for Best Practice Tariff (BPT) but with this higher level of patients there is more demand on the ability of theatre infrastructure to support the increase.** **In December the majority of other BPT elements we are compliant.**	**Performance is measured against KPI's and BPT and presented along with an improvement action plan to the Fractured Neck of Femur Group and Patient safety and Clinical Effectiveness Sub Committee.** **Local improvement initiatives are ongoing to reduce the time it takes to transfer patients with a fractured neck of femur from the ED to a dedicated orthopaedic ward. Escalation procedures are in place to flag when patients are unable to access theatre slots. This is overseen by the Planned care Triumvirate.**
31. MUST nutritional assessment completion **Target: above 85%**	**MUST Nutrition assessment completion was 64.16% in month.**		**Assurance: The Trust consistently fails the target.** **Variation: Special cause variation of an improving nature.**	**MUST compliance continues to improve. There was a slight deterioration in December due to the increased pressures seen in the hospital in December.**	**Work is being completed towards improving the clinical indicators function on Lorenzo to enable teams to see that the compliance is about to turn red (amber status) giving teams the chance to complete and meet compliance.** **The ED Team identified a gap in training resulting in low compliance in EAU which then has affected wider compliance when the patient reaches the ward. Training for ED staff is ongoing. Nutrition status and MUST assessments are being included in other harm profile reviews such as Pressure Ulcers to raise awareness of links of nutrition with pressure ulcer prevention. Compliance Meetings are in place with the Deputy Chief Nurse/Director of Governance for areas struggling to achieve compliance.**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

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

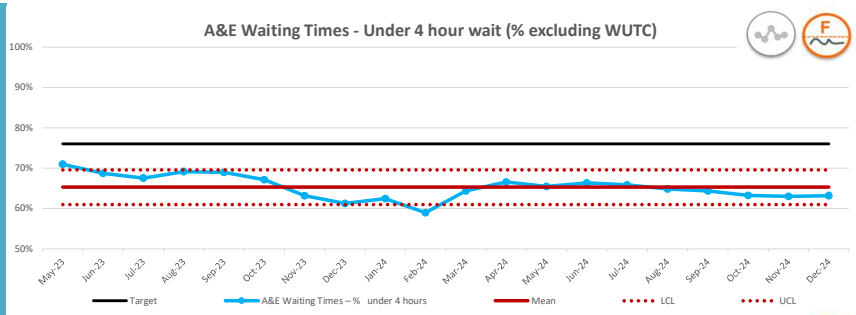
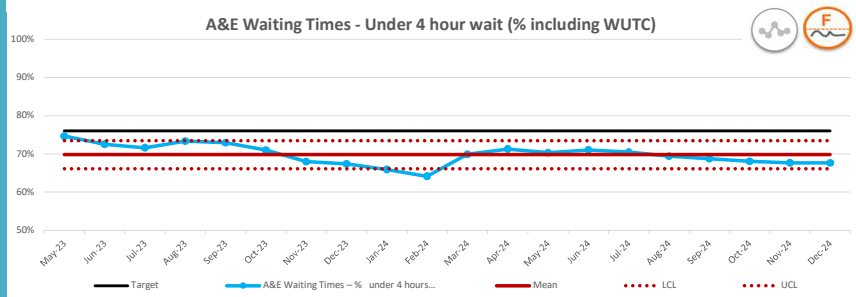
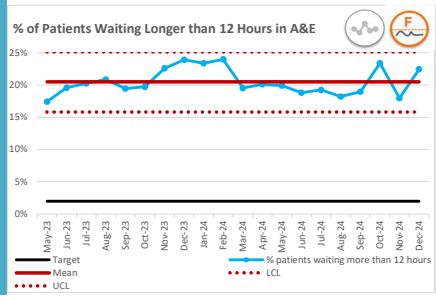
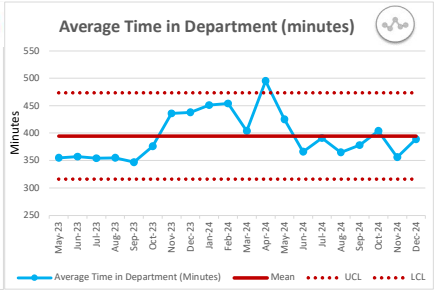
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
32. Diagnostic Waiting Times 6 Weeks Target: 95%	The Trust achieved 88.93% in month.		Assurance: The Trust consistently fails the target. Variation: There is special cause variation of an improving nature.	The diagnostic standard was not achieved. The position continues to be managed in line with the recovery trajectory.	A recovery plan has been agreed and patients are being clinically prioritised accordingly in line with national guidance. This links to the recovery plan for elective surgery and is monitored weekly at the Performance Review Group (PRG). Although radiological modalities remain fully recovered, challenges remain in Cardiorespiratory, mainly Echocardiography and Sleep Studies and Endoscopy, Endoscopy is improving with the opening of the hub.
33. Referral to treatment Open Pathways Target: 92% 34. RTT - Number of patients waiting 52+ weeks Target: 0	The Trust achieved 59.47% in month. There were 1163, 52 week breaches, 8, 78 week breaches and 110, 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 special cause variation of an improving nature.	RTT performance - 52 weeks is behind trajectory, mainly in planned care. 65 weeks has a small residual number of patients remaining with 110 submitted for December with 17 capacity breaches, the remainder of the patients were choice or complex	Recovery of the elective programme is taking place with: • Elective activity being prioritised along with all patients being clinically reviewed in conjunction with guidance released for the management of patients. • Restoration and recovery plans for 2024/25 have been drawn up in line with current Operational Planning Guidance. • Commencement of the TIF elective project has necessitated the closure of theatres 1 and 2 at Nightingale, Halton, sessions have been redistributed across both sites, once works have completed this will give an additional theatre at Halton Nightingale

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

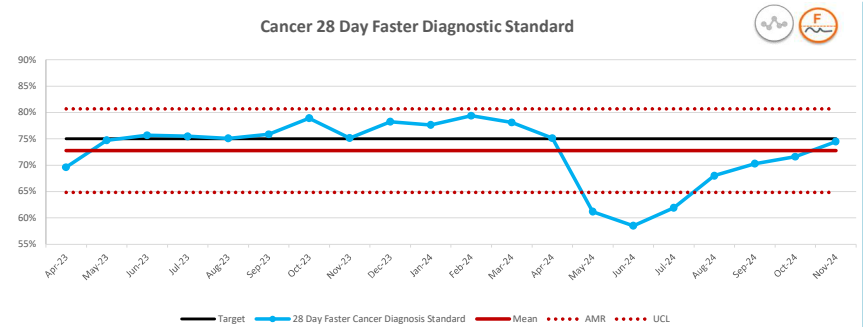
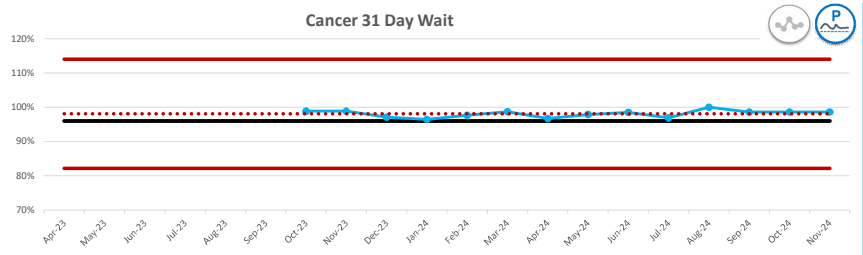
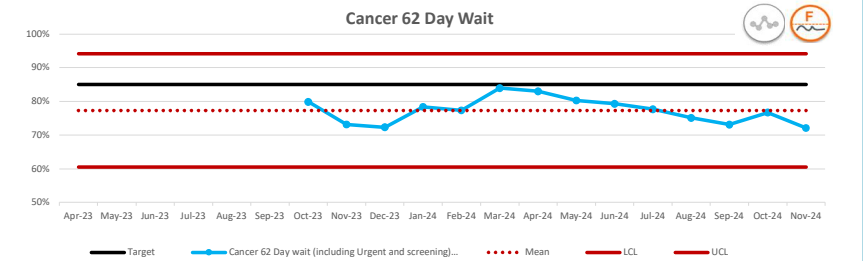
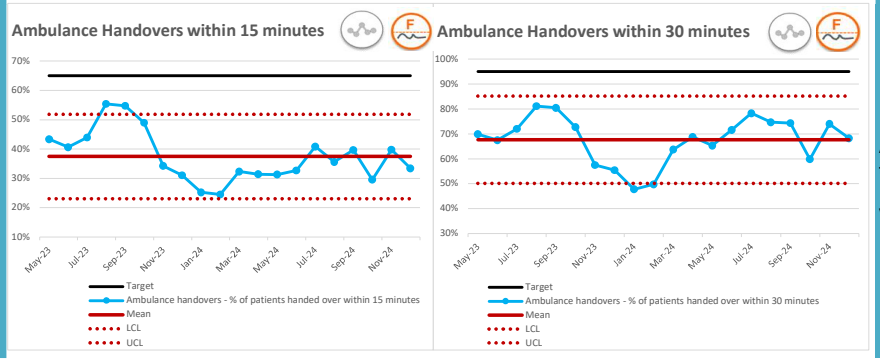
Key: Risk Register (RR116) | System Oversight Framework (SOF) | Care Quality Commission (CQC)

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
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 63.21% excluding Widnes UTC in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) Variation.	Performance continues to be negatively impacted by high attends, and long length of stay and a overall high bed occupancy.	• System partners have been engaged to support the reduction of Super Stranded Patients in the bed base to create capacity in order to support flow. • System resource investment in order to support Pathway 1 discharges. • A10 escalation beds closed on 7th June taking out 14 beds which negatively impacts on ED performance. It has opened as planned on 3rd Nov which will support Novembers position
76.A&E Waiting Times – % patients waiting under 4 hours from arrival to admission, transfer or discharge. (Including WUTC) Target: 75%					
36. Average time in department ED No Target	The Trust achieved 67.65% excluding Widnes UTC in month.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.		
37. A&E Waiting Times – % patients waiting longer than 12 hours from arrival to admission, transfer or discharge. Target: 2% or less	22.44% of patients in A&E were waiting longer than 12 hours from presentation to admission/discharge. The average time in department was 389 minutes.	 	Assurance: The Trust consistently fails the target. Variation: Common Cause 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 24/25 tiering of Urgent Care performance for ICBS. A service improvement for group for ED for 24/25 is set up to support improvement.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

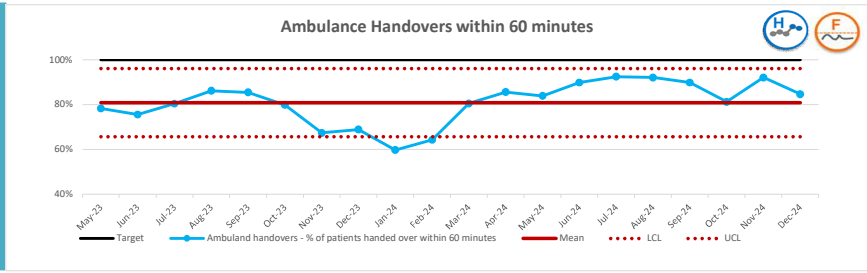
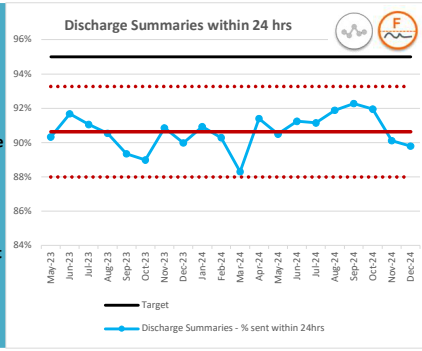
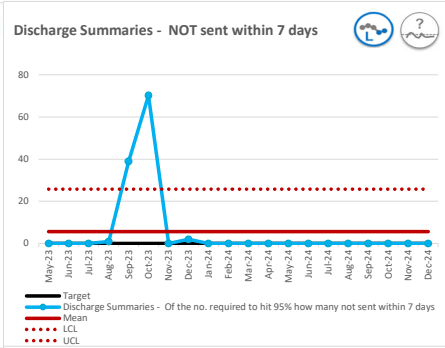
Key: Risk Register (RR116) | System Oversight Framework (SOF) | Care Quality Commission (CQC)

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
38. 28 Day Faster Cancer Diagnosis Standard Target: 75%	The Trust achieved 74.5% in month.		Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation.	The Trust is currently not meeting the 28 Day FDS. This remains challenging due to delays in some pathways including gynaecology and Breast that whilst now resolving may affect performance in forthcoming months. Under the changes to Cancer Waiting Times standards that come into force on 1st October 2023 the operational standard will remain at 75% with a view to delivering 80% by March 2026 and an interim target of 77% by March 25.	The Trust will continue to monitor and review performance of this standard via the Performance Review Group (PRG). A recovery trajectory has been developed to monitor recovery.
39. Cancer 31 Day wait Target: 96%	The Trust achieved 98.6% in month for Cancer 31 Day Wait.		Assurance: Target met consistently Variation: Common Cause Variation	The Trust achieved the 31 day target.	
40. Cancer 62 Day wait Target: 85%	The Trust achieved 72.1% in month for Cancer 62 Day Wait.		Assurance: The Trust consistently fails the target. Commitment to achieveing 70% by March 25 required nationally. This is currently being met Variation: Common Cause 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.	Septembers position has improved to 72.5% and the Trust is anticipating a continuation of that improvement
41. Ambulance Handovers within 15 minutes Target: 65%			Assurance: The Trust consistently fails the target. Variation: Common Cause variation		
42. Ambulance Handovers within 30 minutes Target: 95%					

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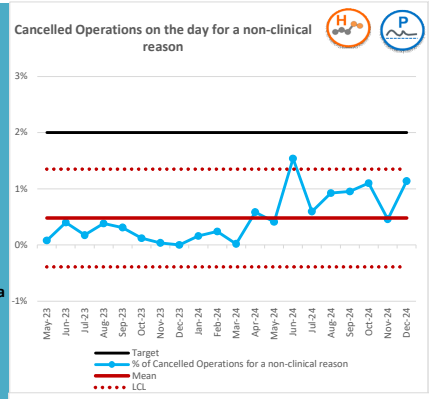
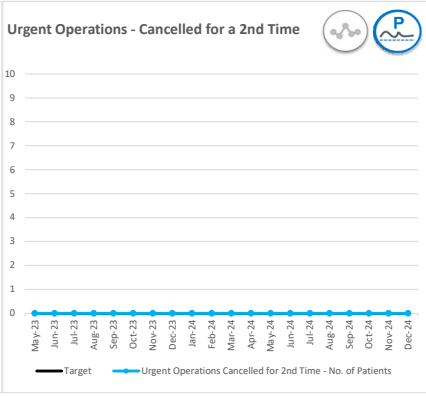
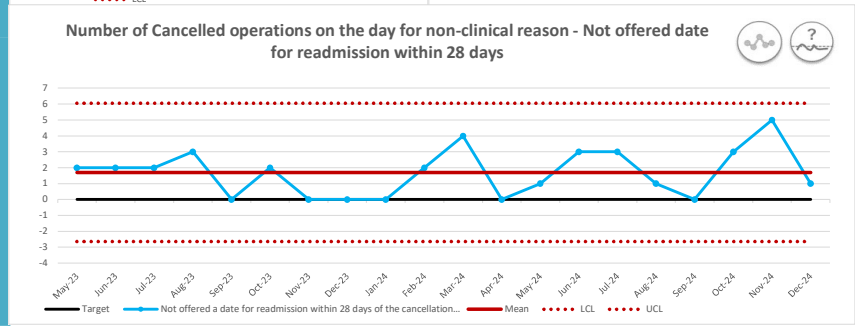
Key:
RR116 Risk Register
SOF System Oversight Framework
CQC Care Quality Commission

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
43. Ambulance Handovers within 60 minutes Target: 100%		(60) Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an Improving nature		
44. Discharge Summaries - % sent within 24hrs Target: 95% 45. Discharge Summaries - Number NOT sent within 7 days Target: ZERO	The Trust achieved 89.79% in month for discharge summaries sent within 23 days, against the target of 95%. There were 0 discharge summaries in month not sent within 7 days, against the target of 0.	 	(24 hrs) Assurance: The Trust consistently fails the target. Variation: Common Cause (Normal) variation. (7 Days) Assurance: The Trust inconsistently passes/fails the target. Variation: There is special cause variation of an improving nature.	Performance of discharge summaries within 24 hours has been maintained despite workforce challenges. The reporting logic for this metric has now been agreed.	The Performance Review Group (PRG) continues to monitor this standard to support improvements.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Access & Performance - Trust Position

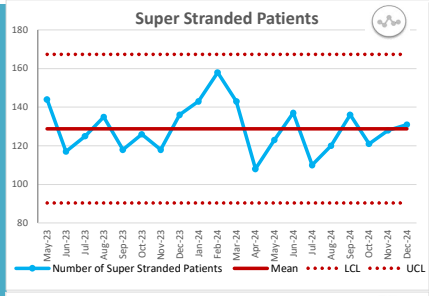
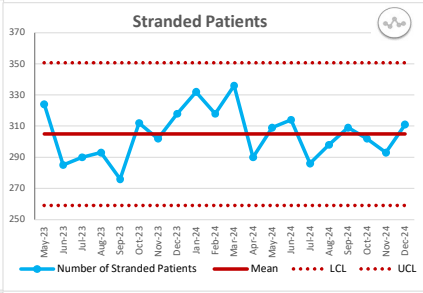
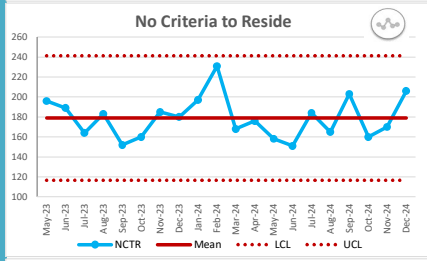
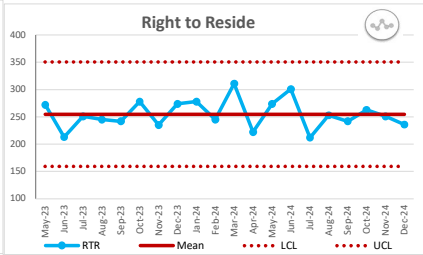
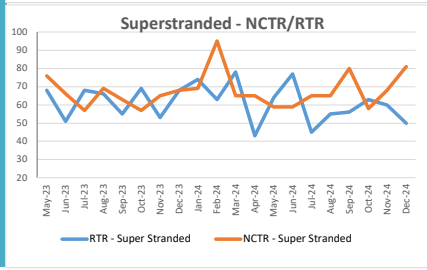
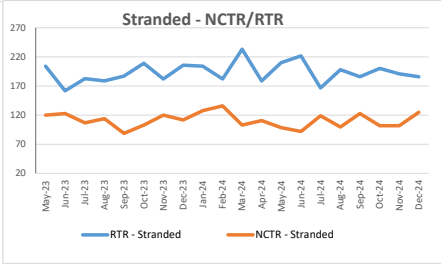
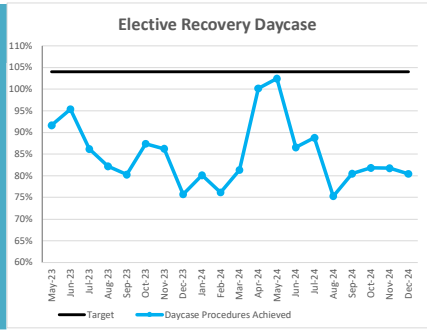
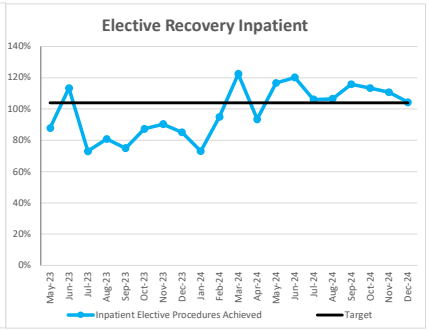
Key:
Risk Register
System Oversight Framework
Care Quality Commission

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
46. Cancelled Operations on the day for a non-clinical reason Target: Less than 2%		(Cancelled - non-clinical reason) Assurance: The Trust consistently passes the target. Variation: There is special cause variation of an declining nature.		
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.	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.
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

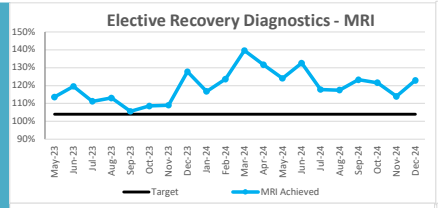
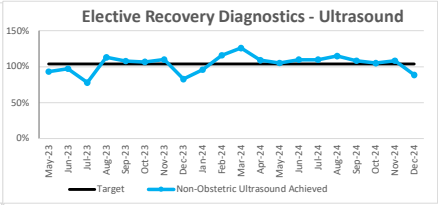
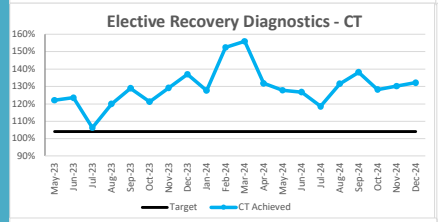
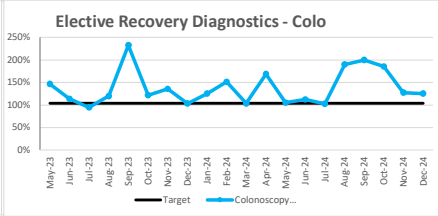
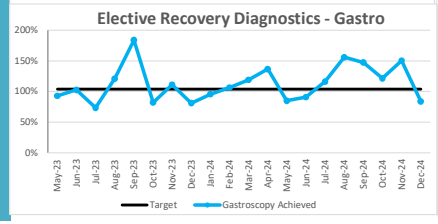
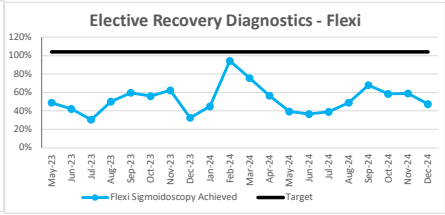
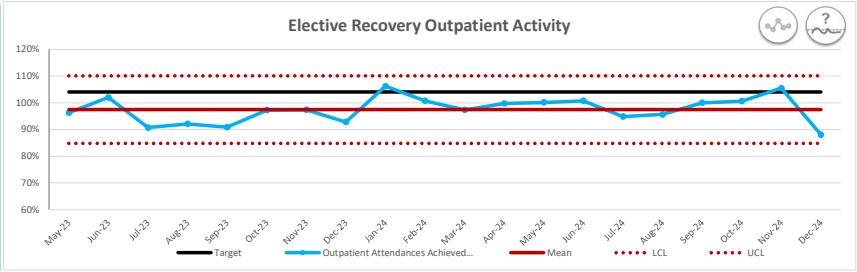
Key:
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Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
49. Super Stranded Patients Target: Trajectory 50. No Criteria to Reside (NCTR) There were 311 stranded and 131 super stranded patients at the end of month. A Superstranded Patient Trajectory has not yet been agreed for 2023/24.	     	(Super Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (Stranded) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (NCTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation. (RTR) Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (normal) variation.	The number of Super Stranded patients has increased in month showing a similar pattern to last year, this is being driven by NCTR patients, work is on-going with system partners to support a reduction	The Trust is working in collaboration with partners from local authorities and community providers to ensure community capacity is available.
SOF RR1125 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 104.27% of Inpatient Elective Procedures.	 	N/A - Grouped indicator.	Inpatient electives conitnues 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.

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Access & Performance - Trust Position

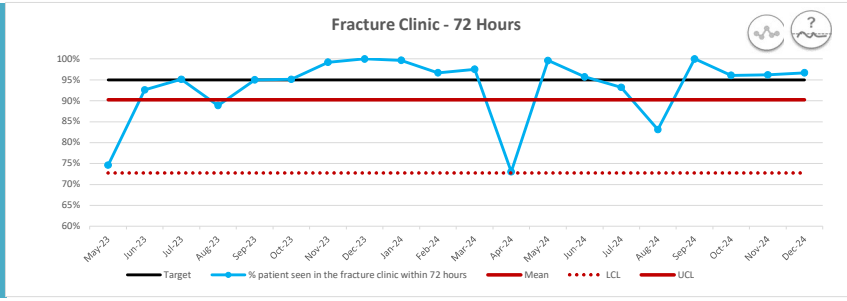
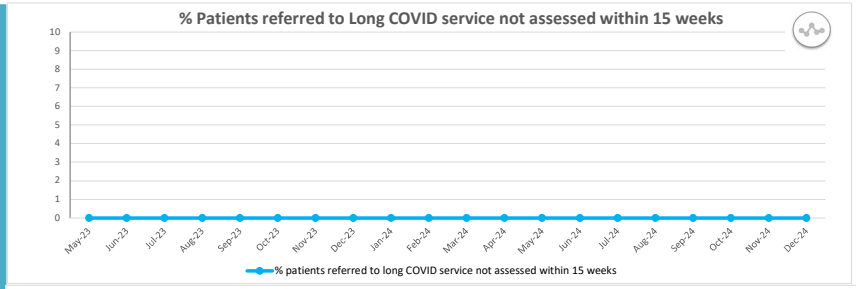
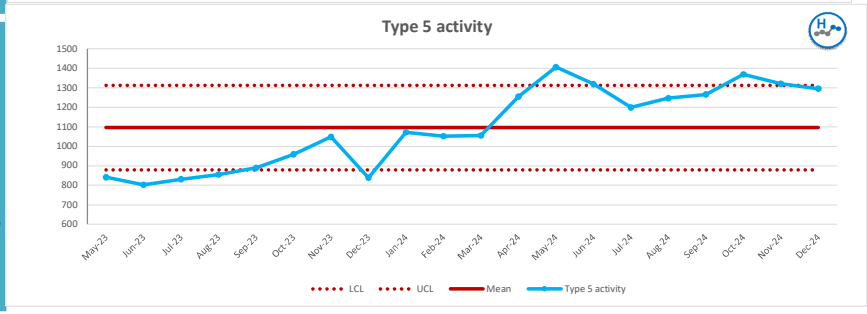
Key: Risk Register (RR116) | System Oversight Framework (SOF) | Care Quality Commission (CQC)

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
52. Elective Recovery Diagnostics Aggregate Target: 104% % activity is against activity in the same month in 2019/20				
SOF, RR1125 **In month, the Trust achieved the following % of activity against 2019.** **This included:** **122.91% of MRI** **132.16% of CT** **88.65% of Non-Obstetric Ultrasound** **47.41% of Flexi Sigmoidoscopy** **125.6% of Colonoscopy** **83.85% of Gastroscopy** RR1125	     	**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%				
SOF, RR1125 **In month, the Trust achieved 88.07% of Outpatient activity against 2019.**		**Assurance: The Trust inconsistently passes/fails the target.** **Variation: Common Cause (normal) variation**	**The Trust continues to deliver Outpatient activity inline with operational planning guidance**	**The Trust continues to restore clinical services in line with the national operating guidance.** **The position will improve following completion of coding of OPD procedures.**

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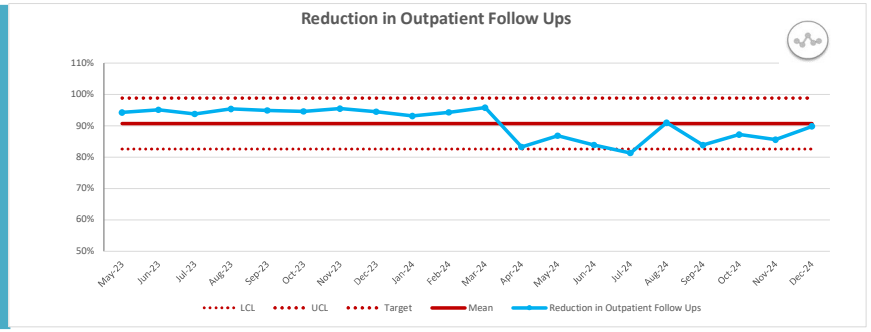
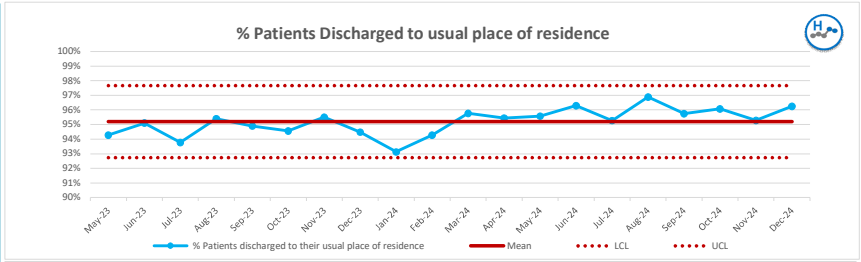
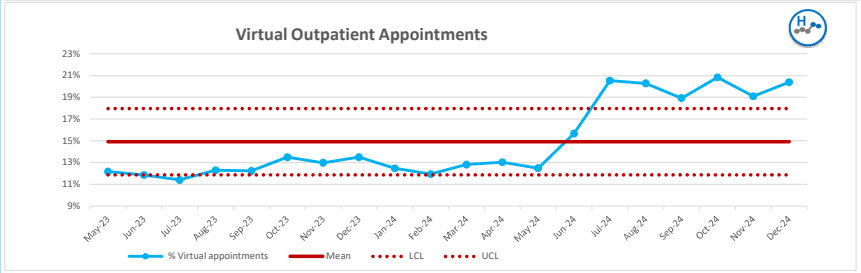
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
55. Patients seen in the Fracture Clinic within 72 hours Target: 95%	In monthy, the fracture clinic saw 96.7% of patients within 72 hours.		Assurance: The Trust inconsistently passes/fails the target. Variation: Common Cause (normal) variation	Good performance position is being sustained.	This improvement is being sustained by the introduction of the Virtual Fracture clinic (VFC) and will be further improved with the introduction of e-trauma software to support the VFC implementation.
56. % patients referred to long COVID service not assessed within 15 weeks	This month, the Trust had 0 patients referred to the Long COVID service who weren't assessed within 15 weeks.		Assurance: N/A Trajectory Not Agreed. Variation: Common Cause (Normal) variation.		
57.Type 5 (previously SDEC) activity No Target	Pre-November 2024 activity has been estimated as attendances that would be considered a 'Type 5' attendance. In month there were 1296 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.	

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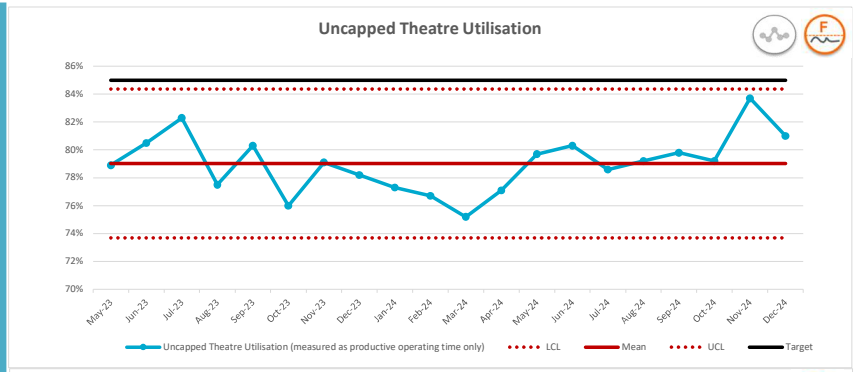
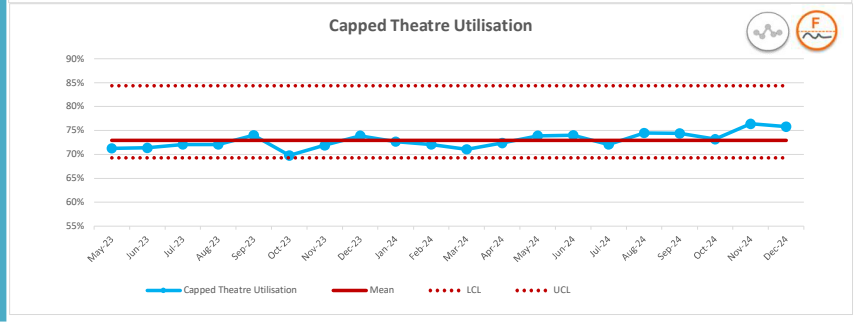
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	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
58. Reduction in Outpatient Follow Ups compared to 19/20 activity Target: 75% or less based on 2019/20 activity	**Outpatient follow ups have reduced to 89.84% 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	**96.25% 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)	**20.39% Virtual Outpatient appointments in month.**		**Assurance: N/A Trajectory Not Agreed.** **Variation: Special Cause Variation of an improving nature.**	**Use of the Virtual clinics for both Frailty and Respiratory is monitored via the bed meetings on a daily basis**	**Capacity in Frailty Virtual clinic has increased in line with the service maturing, case finders for both Respiratory and Frailty support utilisation**

Warrington and Halton Teaching Hospitals NHS Foundation Trust

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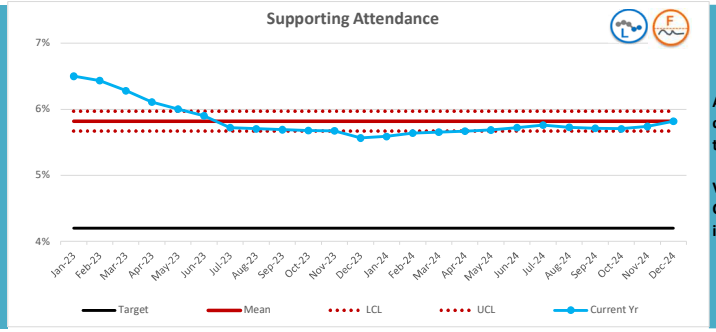
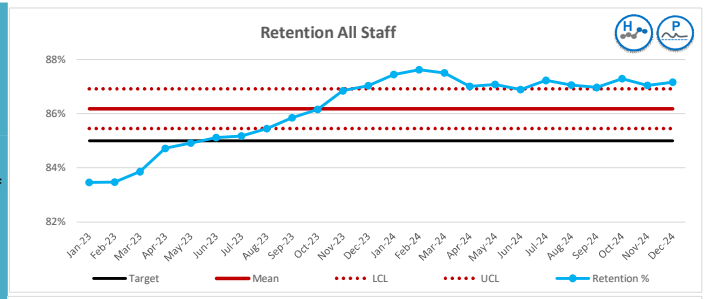
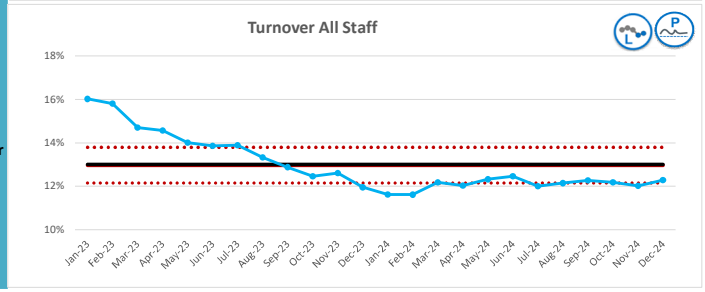
Access & Performance - Trust Position

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)?
61. Uncapped Theatre Utilisation (measured as productive operating time only) Target: 85%		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 24/25. *Please note, data in the IPR has been revised to reflect utilisation - previously a combined utilisation and productivity figure. As a result, figures are different from those previously reported in the IPR.	The Planned Care Transformation Group is focussed on increased utilisation, with a key area of priority of Late Starts in line with the Model Hospital data. Relaunch of late start program is 11th September, following agreement with Planned Care Clinical Directors.
81% Uncapped Theatre utilisation in month (measured as productive operating time only). 75.8% Capped Theatre utilisation in month (measured as productive operating time only).				
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

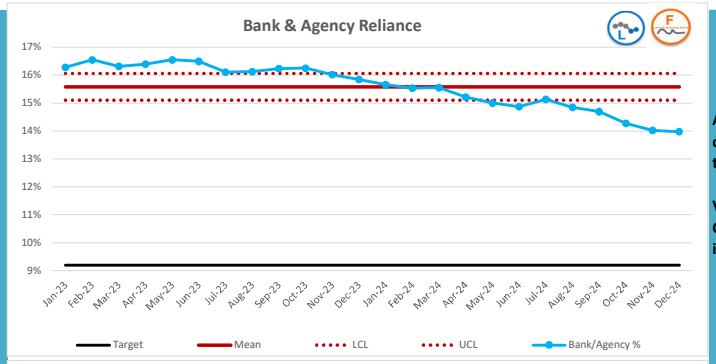
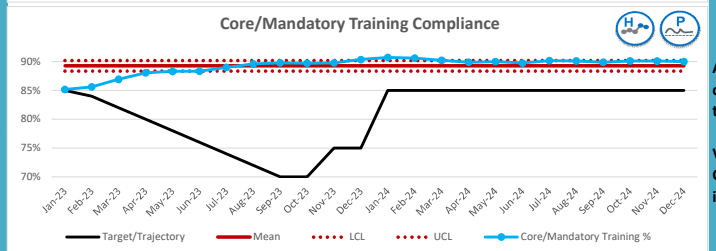
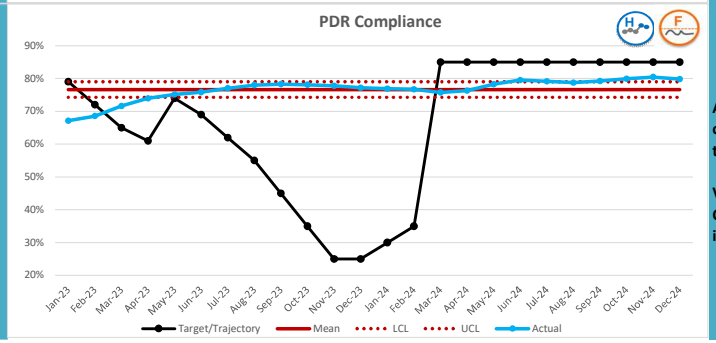
KEY:
SOF System Oversight Framework
UoR Use of Resources Assessment
CQC Care Quality Commission
Trust Strategy
RR208 Risk Register

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
63. Supporting Attendance Target: Below 4.2%	UoR SOF S The Trust's annualised sickness rate was 5.82%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Annualised sickness absence is showing an Improving Variation. The annualised sickness absence percentage in December 2024 was 5.82%, which is a slight increase to the previous 12 months. Reasons for the reduction in sickness absence from 2022 can be attributed to the reduction in long term sickness following implementation of the new Attendance Management policy and the People Health and Wellbeing Group being established which focuses on specific reasons for absence and interventions to reduce.	Sickness absence levels remain above target but are below 2022/23 absence rates. A regional review of sickness absence targets is currently being undertaken for review for April 2025 onwards. Stress, anxiety and depression and MSK continue to be the highest reason for sickness absence. Rugby League Cares (RLC) is currently supporting 2 areas with high levels of sickness due to stress and anxiety. OH Specialist Nurses are undertaking training sessions with managers in areas where there is high sickness and complex sickness cases to support the effective management of cases.
64. Retention Target: 85%	UoR RR1108 RR1134 The Trust's annualised retention of all staff was 87.17%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Annualised retention is showing an Improving Variation. Retention of all staff in December 2024 was above Trust target at 87.17%, a slight decrease from 87.3% in October 2024. Retention for permanent staff in December 2024 remains above Trust target at 89.57%.	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 methodolgy went live in November 2024 for shifts in January 2025. The percentage of staff who are working their preferred shifts has increased from 7.2% to 63.9% across both wards.
65. Turnover Target: Below 13%	S CQC SOF UoR The Trust's annualised turnover of all staff was 12.28%.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of an improving nature.	Turnover is showing an Improving Variation. Turnover in December 2024 was 12.28%, a slight increase from October 2024 at 12.19% Turnover of permanent staff in December 2024 remains below Trust target at 11.48%.	

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce - Trust Position

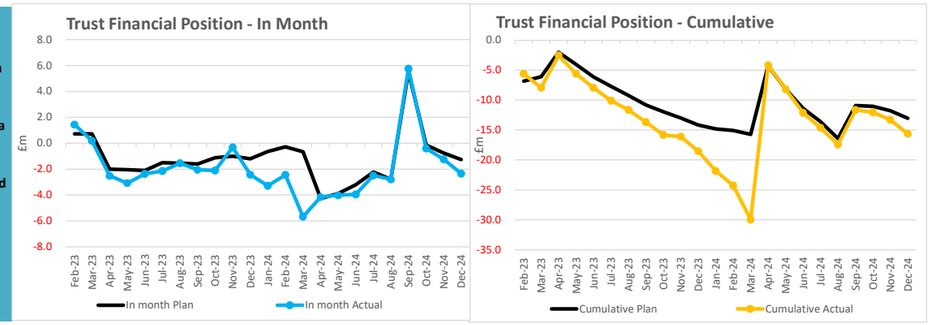
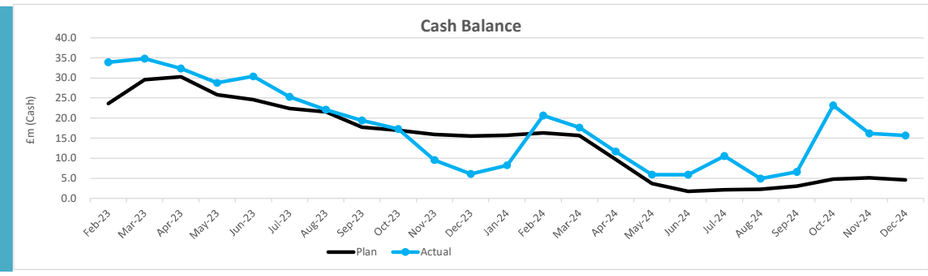
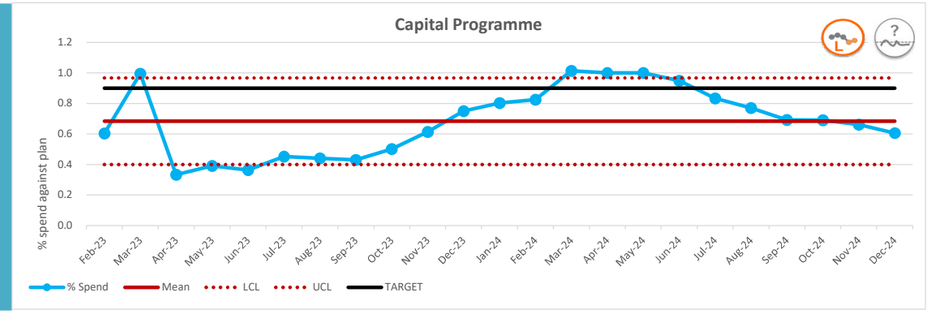
KEY:
- SOF System Oversight Framework
- UoR Use of Resources Assessment
- CQC Care Quality Commission
- Trust Strategy
- Risk Register

	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
66. Bank and Agency Reliance Target: 9% or Below	Annualised Bank and Agency Reliance was 13.78%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of an improving nature.	Bank and Agency reliance is showing an Improving Variation. Bank and Agency reliance in Decemeber 2024 was 13.78%, an improvement from October 2024 at 14.07%. Bank reliance in December 2024 is 12.67%, a slight decrease from 12.71% in October 2024. Agency reliance continues to decrease and was 1.64% in December 2024 against a target of 3.2%.	The Medical and Nursing Workforce Review Groups are using information regarding agency and bank usage to target areas of high usage / high cost, and 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. For temporary staffing, Trusts should use bank staff by default for patient care quality and managing spend, the higher the usage the better. The NW recommended KPI for bank shift use as a % of temporary staffing usage is 75%. As at November 2024, the Trust's bank usage was 90% of temporary staffing.
67. Core/ Mandatory Training Target: 85%	Core/Mandatory training compliance was 90% in month.		Assurance: The Trust consistently passes the target. Variation: Special Cause Variation of a improving nature.	CSTF Training is showing an Improving Variation. In December 2024, CSTF Mandatory Training compliance was 90%.	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 79.81%.		Assurance: The Trust consistently fails the target. Variation: Special Cause Variation of a improving nature.	Appraisals are showing an Improving Variation. In December 2024, appraisal compliance was 79.81%, a slight decrease from 79.92% in October 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

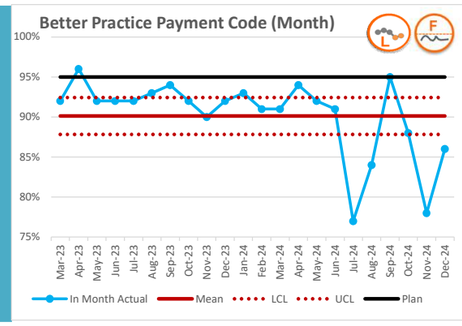
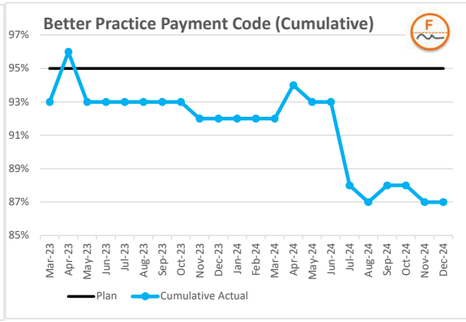
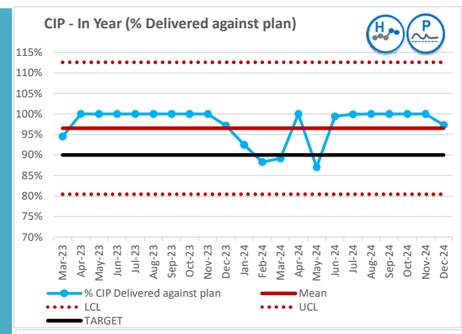
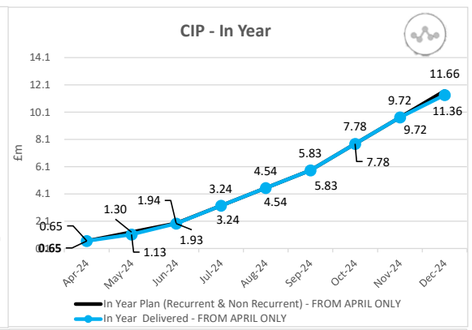
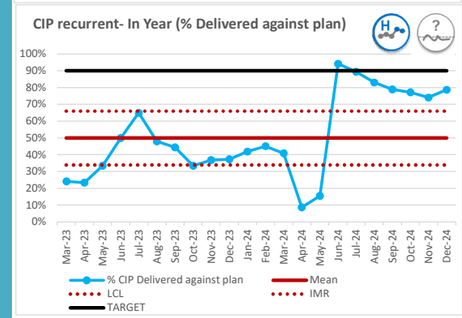
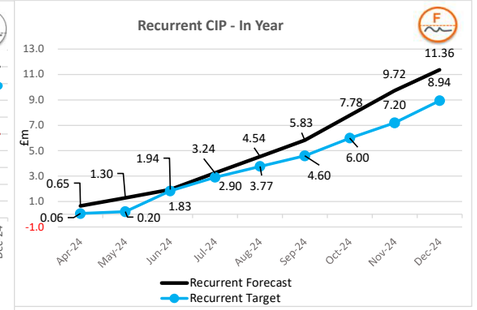
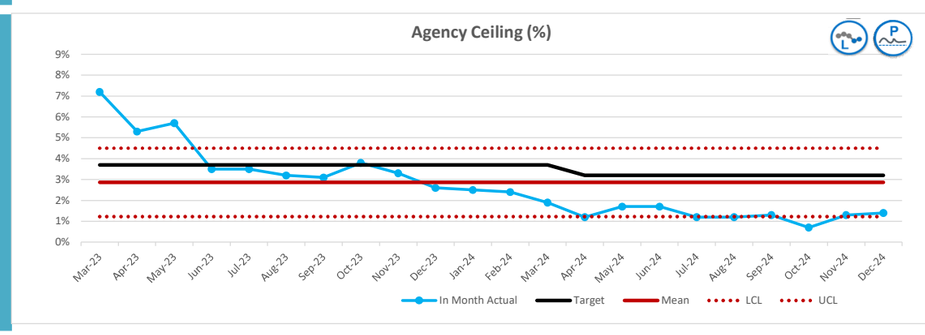
	Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
69. Trust Financial Position Target: Plan	The Trust has recorded a year to date deficit position of £15.6m at 31 December 2024 against a revised deficit plan of £13m. The Trust has submitted a risk adjusted forecast of £8.6m deficit and the year to date position is in line with this forecast.		The Trust has recorded a year to date deficit position of £15.6m at 31 December 2024 against a revised deficit plan of £13m. The Trust has submitted a risk adjusted forecast of £8.6m deficit and the year to date position is in line with this forecast.	The drivers for the deficit being worse than plan is the impact of Industrial Action, the cost of the pay award in excess of funding received CIP not being delivered, cost pressures that have not been offset as in previous months and PwC consultancy costs with benefits forecasted in March 2025.	Work is ongoing to identify additional CIP schemes, reduce cost pressures and increase activity to ensure delivery of the risk adjusted forecast. 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.
70. Cash Balance Target: On or better than plan	UoR The cash balance at 31 December 2024 is £15.7m. RR134		The cash balance at 31 December 2024 is £15.7m.	The current cash balance is £15.7m which is £11.1m higher than the cash plan. This is predominantly due to payment of £12.4m deficit support funding. Of the £15.7m cash, £1.8m 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 was not required in Q3 following the receipt of the deficit support and pay award funding, however a maximum of £5.166m cash support is required in March 2025.
71. Capital Programme Target: On plan 90%-100%	UoR 0		Assurance: The Trust inconsistently passes/fails the target. Variation: Special Cause Variation of a declining nature.	Capital expenditure at the end of month 9 is £7.5m against a plan of £12.4m. 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 9 is £2.3m behind the Trust internal plan of £9.8m at month 9. This is due to timing and is expected to catch up later in the year.	The reason for the year to date variance is due to timing and is expected to catch up later in the year. 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:
SOF System Oversight Framework
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Trust Strategy

Trust Performance	Trend	Statistical Narrative	What are the reasons for the variation and what is the impact?	How are we going to improve the position (Short & Long Term)?
72. Better Payment Practice Code **Target: Cumulative performance 95%** 0	 	**Assurance: The Trust consistently fails the target.** **Variation: Special Cause Variation of a declining nature.**	**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.**
73. Cost Improvement Programme (recurrent and non-recurrent) – In year performance to date **Target: >90% plan delivered YTD** 0	   	**Assurance: The Trust consistently passes the target.** **Variation: Special Cause Variation of an improving nature.** **Assurance: The Trust inconsistently passes/fails the target.** **Variation: Special Cause Variation of an improving nature.**	**At month 9 £11.4m has been delivered against a target of £11.7m.** **The £0.3m 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 £8.6m away from plan.** **£8.9m CIP has been delivered recurrently against the target of £11.4m.** **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.**	**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 October 2024 coding freeze, the Trust achieved 98.9% (101.1% in month) which is an improvement from September 2024 which was 98.5%. 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. Work continues to identify additional schemes in excess of the £19.4m to mitigate against this.**
74. Cost Improvement Programme (recurrent) – In year performance to date **Target: Recurrent Forecast is more than 90% of annual target** 0				
75. Agency Ceiling **Target: Agency spend should not exceed 3.2% of total pay (ICS target)** 0		**Assurance: The Trust consistently passes the target** **Variation: Special Cause Variation of an improving nature.**	**The Trust Agency spend in month is 1.4% 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 1.4%.**	**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 expendature 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?

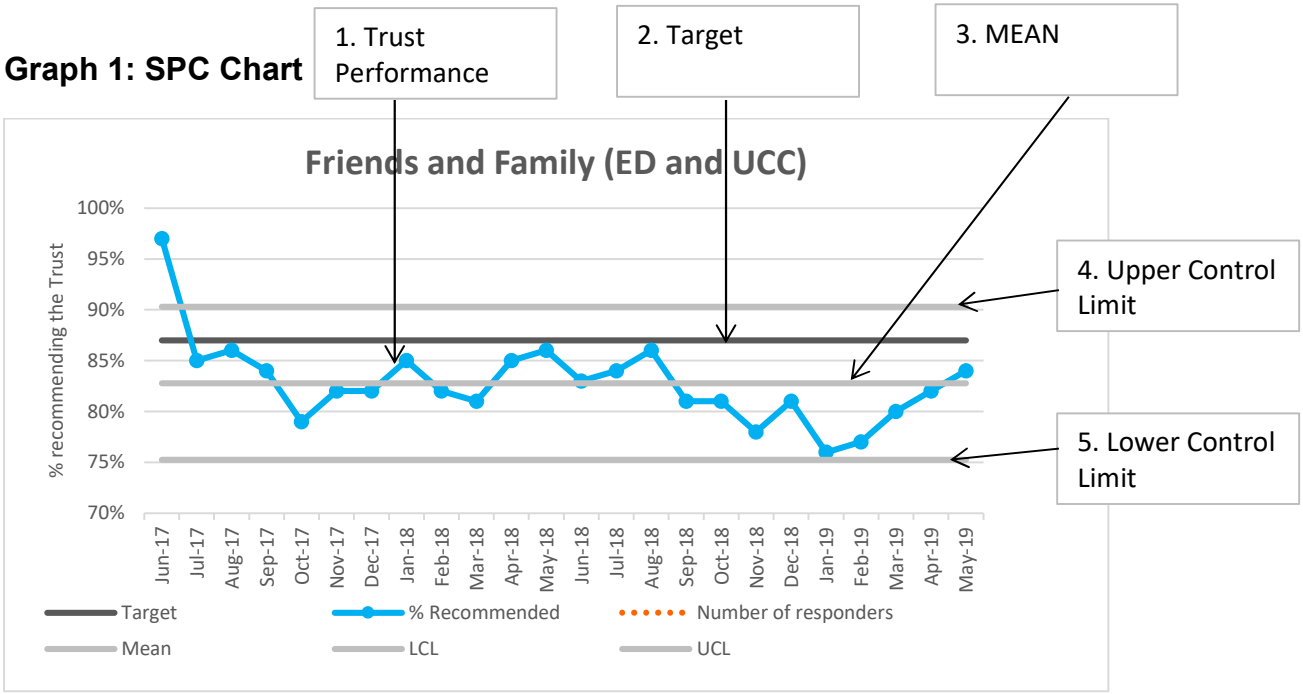
Statistical Process Control (SPC) is method used to measure changes in data/processes over time and is designed to move away from month-to-month data comparisons. SPC charts help to overcome the limitations of RAG ratings, through using statistics to identify patterns and anomalies, distinguishing changes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

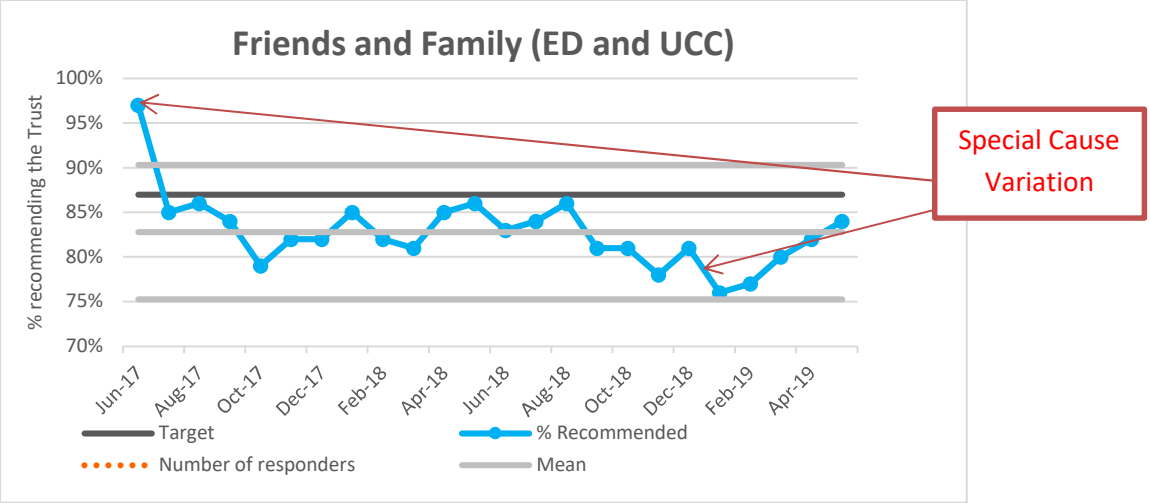


2.1 Interpreting a SPC Chart

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 31st December 2024

Income Statement	Annual	Month			Year to date		
	Budget £000	Budget £000	Actual £000	Variance £000	Budget £000	Actual £000	Variance £000
Operating Income							
NHS Clinical Income	**341,562**	**28,245**	**28,288**	**43**	**255,377**	**258,305**	**2,927**
Non NHS Clinical Income							
Private Patients	8	1	1	0	6	6	0
Non NHS Overseas Patients	71	5	9	4	56	51	-5
Other non protected	670	62	72	10	483	785	302
Sub total	**749**	**68**	**81**	**13**	**545**	**842**	**297**
Other Operating Income							
Training & Education	9,541	782	1,008	226	7,196	7,876	680
Donations and Grants	50	5	7	2	35	50	15
Miscellaneous Income	14,681	1,223	1,757	534	10,832	13,932	3,100
Sub total	**24,272**	**2,010**	**2,772**	**762**	**18,063**	**21,858**	**3,796**
Total Operating Income	**366,582**	**30,323**	**31,141**	**818**	**273,985**	**281,005**	**7,020**
Operating Expenses							
Employee Benefit Expenses	-265,264	-22,170	-23,412	-1,243	-202,590	-210,331	-7,741
Drugs	-21,934	-1,811	-1,736	75	-16,501	-16,827	-327
Clinical Supplies and Services	-23,849	-2,007	-2,465	-458	-17,999	-20,430	-2,431
Non Clinical Supplies	-46,875	-3,909	-4,223	-314	-34,961	-34,936	25
Depreciation and Amortisation	-15,843	-1,320	-1,378	-58	-11,883	-11,935	-53
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**	**-31,217**	**-33,214**	**-1,997**	**-283,933**	**-294,459**	**-10,526**
Operating Surplus / (Deficit)	**-7,183**	**-894**	**-2,073**	**-1,179**	**-9,948**	**-13,454**	**-3,506**
Non Operating Income and Expenses							
Profit / (Loss) on disposal of assets	0	0	0	0	0	30	30
Interest Income	393	19	104	85	333	1,100	767
Interest Expenses	-147	-12	-22	-10	-107	-103	4
PDC Dividends	-4,834	-398	-398	0	-3,642	-3,642	0
Total Non Operating Income and Expenses	**-4,588**	**-391**	**-316**	**75**	**-3,416**	**-2,616**	**800**
Surplus / (Deficit) - as per Accounts	**-11,771**	**-1,285**	**-2,389**	**-1,104**	**-13,364**	**-16,071**	**-2,706**
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	-2	-35	-50	-15
Add Depreciation on Donated & Granted Assets	487	41	55	14	365	495	131
Total Adjustments to Financial Performance	**437**	**36**	**48**	**12**	**330**	**445**	**115**
Adjusted Surplus / (Deficit) as per NHSI Return	**-11,334**	**-1,249**	**-2,341**	**-1,092**	**-13,034**	**-15,626**	**-2,591**

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

IPR - December 2024 Detail
5th February 2025

Introduction

Warrington and Halton Teaching Hospitals NHS Foundation Trust

There are **2 indicators that are both failing and have special cause variation of a concerning nature**, these are:

Quality:

- **23.** Sepsis - % screening for all emergency patients

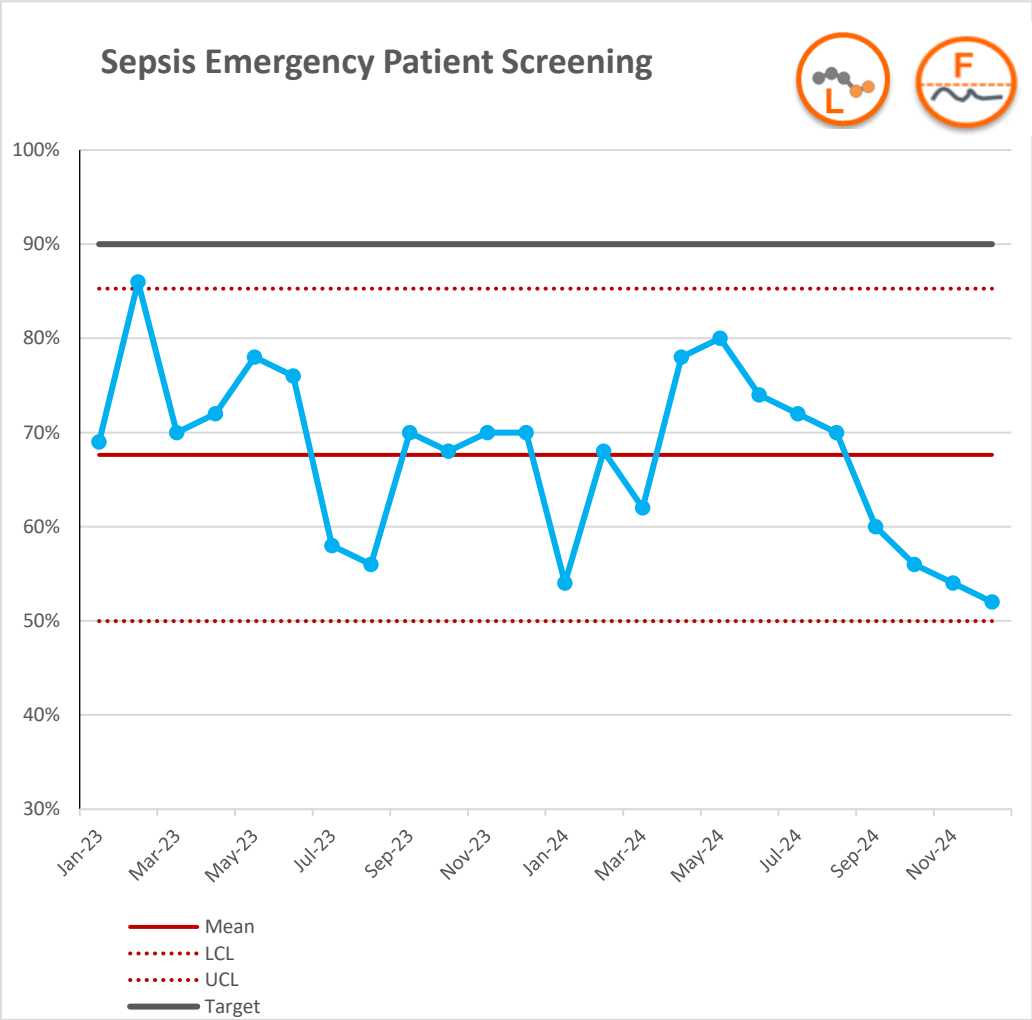
Finance and Sustainability:

- **72.** Better Payment Practice Code

A&E Performance is also included, due to the recent pressures on the service.

23. Sepsis - % screening for all emergency patients

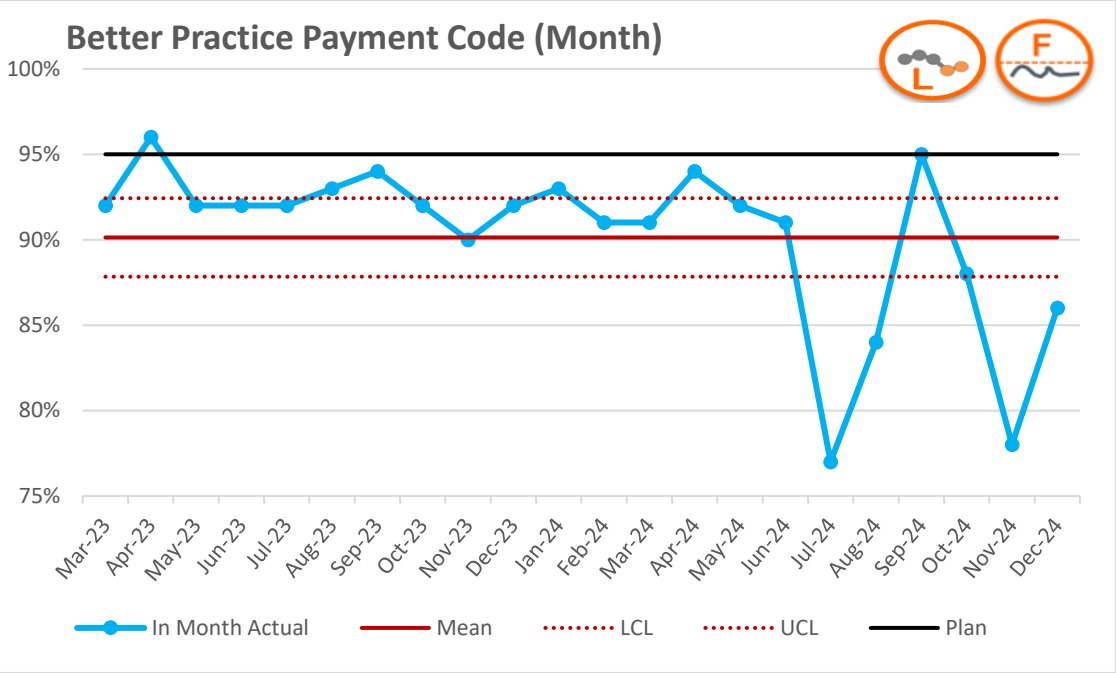
Warrington and Halton Teaching Hospitals NHS Foundation Trust



- The main issues driving the fall in sepsis screening performance are:
  - Patients not having blood cultures within an hour
  - Change in clock start time with new sepsis measures
  - Volumes of unwell patients in the department
- Of note the majority of patients who failed this measure did so solely as due to not having blood cultures within the hour (90% 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

72. Better Payment Practice Code

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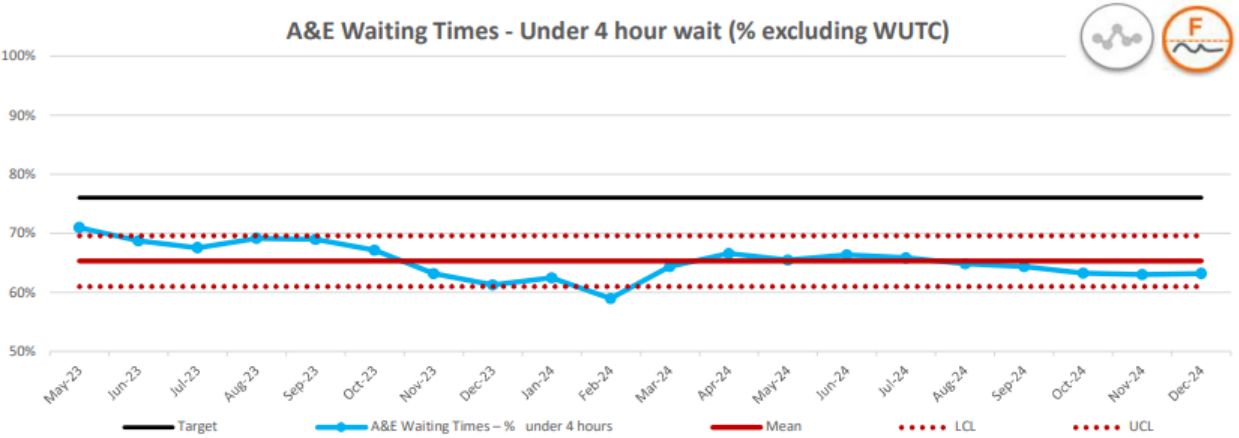


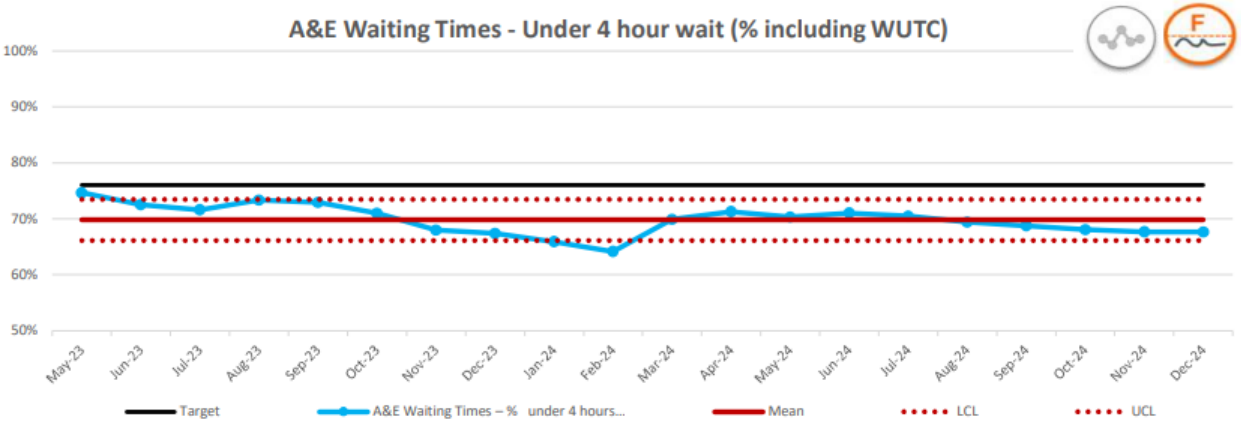
- BPPC has dipped again in November due to a lower number of invoices being approved in October which were paid in November after they had timed out. These invoices had not been placed on hold / in query or transferred to an alternative approver whilst the budget managers were on annual leave which meant that the clock had continued running.
- If an invoice is place on hold / in query this stops the clock with respect to BPPC.
- Guidance is routinely emailed to budget managers advising them of this.

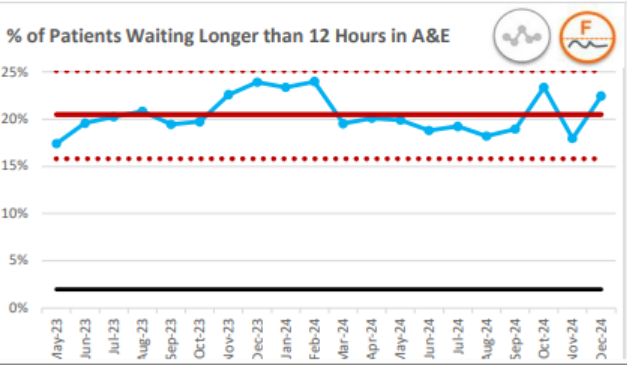
	BPPC Paid Period	Invoice Count	Invoice Count (Passed)	% Passed	BPPC Amount	Invoice Amount (Passed)	% Amount Passed
RWW	Apr-24	4,212	3,938	93.49%	15,556,883.31	13,767,479.00	88.50%
RWW	May-24	3,386	3,129	92.41%	10,926,139.58	10,261,733.77	93.92%
RWW	Jun-24	2,362	2,147	90.90%	8,231,309.05	7,577,539.25	92.06%
RWW	Jul-24	4,106	3,159	76.94%	10,207,767.22	8,297,908.22	81.29%
RWW	Aug-24	3,434	2,895	84.30%	8,687,704.51	8,128,969.07	93.57%
RWW	Sep-24	3,314	3,136	94.63%	7,612,385.93	7,180,799.64	94.33%
RWW	Oct-24	3,107	2,719	87.51%	8,965,554.90	8,673,532.12	96.74%
RWW	Nov-24	3,514	2,744	78.09%	8,921,335.23	8,535,023.12	95.67%
RWW	Dec-24	5,732	4,918	85.80%	11,855,176.18	11,296,835.20	95.29%

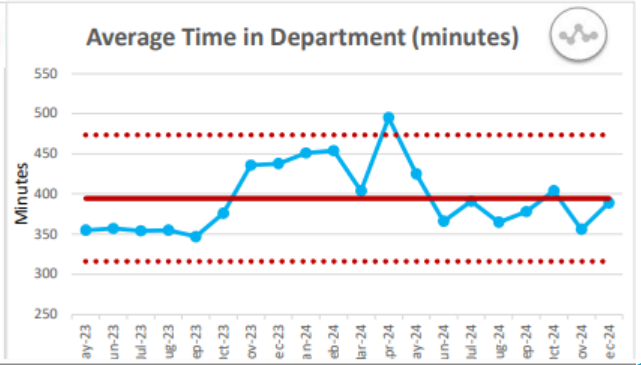
A&E Performance

Warrington and Halton Teaching Hospitals
NHS Foundation Trust









- Improvement seen in November's 12 hour performance with the opening of winter beds on A10 as part of the winter plan. This wasn't sustained during December 2024, but was still an improvement December 2023.
- Recent introduction of UEC rep of the day to focus on 4 hour and 12-hour performance.
- Continued focus on triage and streaming processes.
- On-going work with core 24 to reduce mental health waits and transfer time.
- Continued work via the UEC System Improvement Programme with system partners.

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Recommendation

The Trust Board is asked to note the actions being taken in relation to these 2 failing IPR indicators, and A&E performance.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/02/149a (i)	Meeting	Trust Board	Date Of Meeting	5 February 2025

Date of Meeting	10 December 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/24/12/192	**Deep Dive Sepsis performance**	The Committee received a presentation - Deep Dive in relation to Sepsis. The presentation included • Overview of new NICE 51 Guidance – implementation/next steps. • Incidents overview. • Oversight of Aqua 2023 Annual Report. • Overview of performance. Points to note include • WHH performs consistently in the top 7 Trusts in Cheshire and Merseyside. • WHH launched the new NG51 tool on 13 September 2024.	**Moderate** Strong governance and senior oversight. Need further improvements need to be seen in the screening of patients in ED/ administering antibiotics in 1 hour.	**Substantial:** Monthly reporting with Executive oversight through Patient Safety and Clinical Effectiveness Sub Committee. (PSCESC) Escalated to through reporting to Quality Assurance Committee (QAC) as necessary/IPR dashboard.	PSCEC January 2024 Escalated to quarterly reporting via QAC/ IPR dashboard.
QAC/25/01/212	**Patient Safety and clinical**		**Moderate**	**Substantial**	January 2025

	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 – No patient harm identified to date, reduction in spirometry waiting list. • Urology – decreasing numbers of high risk follow up patients being seen. • ENT – additional capacity via LLP is supporting reduction in patients. • Fractured Neck of femur – prompt surgery remains a challenge Escalations process and plan in place, solutions being explored. • Overview of out-of-date policies – plan to resolve by end Q4.	Assurance received – regarding fragile services – further improvements required.	Monthly oversight at QAC Executive oversight monthly of all fragile services via PSCESC	
QAC/24/12/194	**Delays to follow up – outpatient backlogs**	The committee received an update in relation to outpatient follow ups. This included ▪ Key risks. ▪ Mitigations. ▪ Plan to address backlog.	**Moderate** Strong governance and senior oversight. Need to see improvements in patient backlogs	**Substantive** Oversight by Executives Directors and Non-Executives at QAC.	QAC Quarterly

The Committee also received the following items.
QAC/24/12/195 Integrated Performance Report
QAC/24/12/196 Safeguarding Annual Report
QAC/24/12/197 PSIRF update and next steps
QAC/24/12/199 ED long waits and harm profile
QAC/24/12/200 Maternity update
QAC/24/12/201 Learning from deaths
QAC/24/12/202 Better Care Together Integration update

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes.*

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

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

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/01/149a (i)	Meeting	Trust Board	Date Of Meeting	5 February 2025

Date of Meeting	14 January 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/25/01/210	**Deep Dive – Pressure Ulcers**	The Committee received a presentation - Deep Dive in relation to Pressure Ulcers The presentation included • Overview of Incidents/themes and actions • Governance structure and oversight Points to note include • Increase in patient frailty/deconditioning • Benchmark 2nd in Cheshire and Mersey acute providers in relation to low pressure sore incidence • Reduction in harm profile over last 2 years following improvement work	**Moderate** Strong governance and senior oversight. Reduction in harm profile- need to see further reduction in Category 2 pressure ulcer incidents/training review concluded.	**Substantial:** Monthly reporting with Executive oversight through Patient Safety and Clinical Effectiveness Sub Committee. (PSCESC) Escalated to through reporting to Quality Assurance Committee (QAC) as necessary/IPR dashboard.	PSCEC February 2025 Escalated to quarterly reporting via QAC/ IPR dashboard.
QAC/25/01/212	**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	**Moderate** Assurance received – regarding fragile services – further	**Substantial** Monthly oversight at QAC	**February 2025**

		• Progress made with Cardiology – clear plans in place to resolve issues. • Urology - ongoing pressures in demand – plan for specialist nurses to support – training ongoing • ENT waiting list reduced significantly – 2 new consultants to commence in post • Fractured Neck of femur – Work ongoing to improve time to theatre – Escalations process and plan in place • Mortality backlog of Subject Judgement Reviews due to vacancy – plan in place to recover • HSE – reported incident relating to labelling of a sample – All actions taken, responses sent to HSE for assurance	improvements required.	Executive oversight monthly of all fragile services via PSCESC	
QAC/25/01/214	**Mortuary licence Activity Report**	The committee received an overview of • Biannual Update Mortuary Licenced Activity Report • WHH noted to be fully compliant with the 17 recommendations	**Moderate** Strong governance and senior oversight. Await external sign off for final accreditation	**Substantive** Oversight by Executives Directors and Non-Executives at QAC.	QAC Biannually

The Committee also received the following items.
QAC/25/01/211 Board Assurance framework
QAC/25/01/213 New approach to 7-day service
QAC/25/01/215 Infection Control BAF- Biannual update
QAC/25/01/216 Violence Reduction Strategy
QAC/25//01/217 Health and Safety Report – Biannual update
QAC/25/01/218 Clinical Audit Report
QAC/25/01/219 ED long waits and harm profile
QAC/25/01/220 Maternity update
QAC/25/01/223 IG and corporate records Q2 update

Assurance Key:

Delivery Assurance: *Assurance in achieving outcomes.*

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

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

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

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/02/149b (i)	Meeting	Trust Board	Date Of Meeting	5 February 2025

Date of Meeting	Wednesday 18th December 2024
Name of Meeting and Chair	Strategic People Committee, Chaired by Julie Jarman
Was the Meeting Quorate?	Yes

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

Agenda Ref	Agenda Item	Issue and Lead Officer	Delivery Assurance	Governance Assurance	Follow Up/ Review Date
SPC/24/12/150	**HOT TOPIC – PWC Actions Update**	**Carl Roberts, Associate Chief People Officer** Provided an update on the draft PWC report, specifically the people related actions. There are currently 8 grip and control people related actions, and 2 integration people related actions. The committee received an update on progress against the various actions. In addition, the People Directorate identified actions that were expected in the report, but they currently appear to be a gap. The group were reminded the report is still in draft and the Trust can engage with PWC about potentially adding actions.	The Committee received **substantial assurance** of delivery of the PwC actions.	The Committee received **substantial assurance** regarding the governance infrastructure to support implementation.	As required

Other reports received by the Committee:

- SPC/24/12/151 - Integration & Workforce Update
- SPC/24/12/152 - Chief People Officer Report
- SPC/24/12/153 - Workforce Brief on National, Regional, ICB or Local Workforce Issues
- SPC/24/12/154 - Workforce Policies & Procedures Overview Report Q1 & Q2
- SPC/24/12/155 - Improving People Practices Bi-Annual Update
- SPC/24/12/156 - Safer Staffing Report

Chairs Logs received by the Committee:

- SPC/24/11/157 - Workforce Equality, Diversity & Inclusion Sub-Committee
- SPC/24/11/158 - Workforce Review Group Chair's Log

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
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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/25/02/149b (ii)	Meeting	Trust Board	Date Of Meeting	5 February 2025

Date of Meeting	Wednesday 15th January 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/25/01/166	**Hot Topic: Agenda for Change, Nursing and Midwifery Evaluation**	**Laura Hilton: Associate Chief People Officer** An update was provided to the Committee on the WHH response to the NHS Employers agenda for change job evaluation work being undertaken nationally. The organisation has strengthened the job evaluation process, supported through Trust-wide communications and embedding grip and control within the process. This has been further strengthened by inclusion of a question relating to whether individuals are working to job description as part of the updated appraisal process which has been cited as best practice regionally. A number of actions have been drafted into a robust action plan, including identification of number of nursing and midwifery posts within the organisation and an overview of when these roles were last reviewed to understand whether they cover single or	The Committee received **moderate assurance** on delivery due to reliance upon external risk factors.	The Committee received **substantial assurance** regarding the governance considerations already undertaken and the proactive action plan in place.	As required

		multiple post holders. An audit will also be undertaken and a self-assessment has commenced in partnership with Staff Side colleagues to determine readiness for change.			
SPC/25/01/167	**Deep Dive: Culture**	**Rebecca Patel: Associate Chief People Officer** An update was provided to the committee on the progress of the culture plan for phase one of the programme "getting the basics right". The Committee were advised of the approach to deploying OD interventions to improve culture within departments and teams and to maintain performance demonstrating how evidence drives activity and effective deployment of specialist resources. The Committee were advised that categorisation of departments and teams happen on a quarterly basis to respond to a range of data insights as appropriate and on an annual basis as a result of the annual staff survey.	The Committee received **substantial assurance** on the delivery of the culture plan and the progress made to date.	The Committee received **substantial assurance** on the governance processes in place to support the ongoing approach to improving culture within the organisation.	March 2025
SPC/25/01/170	**Workforce Brief on National, Regional, ICB or Local Workforce Issues**	**Michelle Cloney: Chief People Officer** The Committee received an update on the national review of physicians and anaesthetics associates and will respond appropriately as an organisation whilst ensuring robust support is given to the organisation's PA workforce currently in light of unwelcome national attention.	The Committee received **moderate assurance** on delivery due to awaiting outcome of national review which may have a detrimental impact on the workforce.	The Committee received **substantial assurance** of the governance processes in place to support the PA workforce within the organisation.	As needed
SPC/25/01173	**Better Care Together Update**	**Lucy Gardner: Chief Strategy and Partnership Officer and Michelle Cloney: Chief People Officer**	The Committee received **substantial**	The Committee received **substantial**	February 2025

		The Committee were advised of the substantial work being undertaken in relation to options appraisal and associated resourcing plan to share with the ICB. An updated milestone plan is available for the whole programme. Highlight reports from communications, corporate and workforce continue to drive the agenda forward. Significant work has been undertaken from a workforce perspective in terms of developing an organisational change framework for both organisations. A joint vacancy approval process has been implemented and looking to develop and bring together quality assessment processes from each organisation.	**assurance** on the developments of the Better Care Together programme.	**assurance** on the governance processes to support the Better Care Together programme.	

Other reports received by the Committee:

- SPC/25/01/165 – Staff story on Supported Internships programme
- SPC/25/01/168 – Board Assurance Framework
- SPC/25/01/169 - Chief People Officer Report
- SPC/25/01/171 – Bank Reduction Q3 Update
- SPC/25/01/172 – Safer Staffing Report

Chairs Logs received by the Committee:

- SPC/25/01/174 – Operational People Committee's Chair's Log

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

Level of Assurance	Description
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NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/02/149c (i)	Meeting	Trust Board	Date Of Meeting	5 February 2024

Date of Meeting	16 December 2024
Name of Meeting & Chair	Finance and Sustainability Committee, Chaired by John Somers
Was the meeting quorate?	Yes

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

Agenda ref	Agenda item	Issue and lead officer	Delivery Assurance	Governance Assurance	Follow up / Review date
FSC/24/12/186	**Hot Topic – PwC Update & Report**	The Committee received the presentation noting:- • PwC were asked to review three areas (Grip and Control, Productivity (Theatre) and Integration) • Final savings expected to be circa £4.5m FYE with £0.6m in 2024/25, still to be finalised with PwC prior to final report being issued • PwC noted a number of grip and control schemes already in train, savings expected to support the £8.6m risk adjusted forecast deficit	The Committee received **moderate** assurance given this the report is still draft	The Committee **noted** and discussed the presentation receiving **substantial** assurance around grip and control and credibility	**FSC January 2025**
FSC/24/12/187	**Deep Dive – CIP Update, Governance & Review**	The Committee received the presentation noting:- • Month 8 CIP position is on plan, £9.7m achieved • Fully identified £19.4m schemes of which £2.5m is high risk, £1.3m is medium risk and £15.6m is either delivered or low risk • Delivery mainly from central schemes rather than operational delivery • Further £1m reduction in outsourcing recovery spend is deemed medium risk, if this is removed the Trust will have 65 and 52 week breaches at the end of the financial year – expectation circa £0.5m may be required and therefore worsen the CIP forecast	The Committee received **limited** assurance based on delivery of the CIP plan	The Committee **noted** and discussed the report receiving **moderate** assurance	**FSC January 2025**

		• Non-recurrent savings are identified at month end and this review will continue to the end of the financial year to mitigate the risky schemes • CIP allocation and methodology for 5% target discussed and approved to be based on budget size and NCC score acknowledging the risk around delivery based on current year achievement in clinical areas particularly around productivity			
FSC/24/12/188	**Corporate Performance Report**	The Committee received the report noting:- • 4 hour performance has seen a deterioration in month largely attributed to an increase in the wait to be seen in ED for Type 1 • Patients waiting over 12 hours in department saw a significant improvement following A10 being opened	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 January 2025**
FSC/24/12/189	**Recovery Update**	The Committee received the report noting:- • £2.1m spent year to date at month 8 • 52 week behind schedule mainly in Planned Care, if continue at same rate forecasting spend of £3.5m and will have circa 1,000 patients left • Middle of the pack in C&M in terms of 52 weeks, starting to slip on 65 week waiters, expected to have circa 100 patients remaining	The Committee received **moderate** assurance given the progress that has been made	The Committee received **substantial** assurance given the plans in place	**FSC January 2025**
FSC/24/12/191	**Monthly Productivity Improvement Update**	The Committee received the report noting:- Theatres • Improvement in capped theatre utilisation and reduction of on the day cancellations • Continues to be an issue around late starts and need to understand the drivers behind theatre capacity compared to job planned activity UEC • Demand and acuity increasing as we move into Winter, CIP not expected to deliver in year as previously reported Outpatients improvement • Significant work is being done to identify additional income • Outpatient clinic standardisation underway with the expectation that there will be some significant improvements and gains	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 January 2025**

FSC/24/12/192	**Cost Pressures M8**	The Committee received the report noting:- • Cost pressures continue, the majority relate to nursing and medical • Forecast overspend is currently £7.9m, with £5.7m year to date variance currently being offset non-recurrently in the current financial position therefore a £2.2m pressure remains in the forecast • Grip and control impacting and reducing the nursing cost pressures • Detail on the top ten cost pressures in the report to understand the drivers as well as actions being taken to reduce them where possible	The Committee received **limited** assurance based on the continued overspend on cost pressures	The Committee **noted** and discussed the report receiving **moderate** assurance of the ongoing review	**FSC January 2025**
FSC/24/12/193	**Pay Assurance**	The Committee received the report noting:- • Agency rates has been reduced which has come down below bank rates, therefore a review of bank rates was undertaken • Notice has been given and the bank rates will reduce from 13 January 2025, this is consistent with other trusts across the North West • To achieve the WTE plan a reduction of 68 WTE bank staff is required • Support to clinical staff and NHS infrastructure support vacancy approvals have reduced with approvals mainly being clinical staff	The Committee received **moderate** assurance given the review of bank rates	The Committee **noted** the paper receiving **substantial** assurance around level of detail reported	**FSC January 2025**
FSC/24/12/199	**Monthly Finance position – month 8**	The Committee received the report noting:- • At M8 the Trust is reporting a year to date £13.3m deficit (adverse variance of £1.5m due to Industrial Action, pay award and PwC costs) • Cost pressures are currently being mitigated year to date • No further cash support is required for Quarter 3 • ICB position has worsened and there is national pressure as a result • ERF variable activity has delivered 98.9% of plan at M8	The Committee received **moderate** assurance due to risks to the financial position.	The Committee **noted** the paper receiving **substantial** assurance	**FSC January 2025**
FSC/24/12/200	**Capital Position Month 8**	The Committee received the report noting:- • Confirmation received that EPCMS funding of £5.2m will be moved from 2024/25 to 2025/26	The Committee received **moderate** assurance due to	The Committee **noted** the presentation receiving **substantial** assurance, **approved**	**FSC January 2025**

		• Month 8 capital spend is £2.2m behind plan, mainly due to the EPCMS project for which the plan cannot be updated • Movement in capital contingency was approved • Supported the forecast position being in line with plan for Trust Board approval	spend being behind plan.	the contingency changes and **supported** the forecast for Trust Board approval	
FSC/24/12/200ii	**CDC 2025/26 plan**	The Committee received the report noting:- • Contribution of £1m from direct services which reduces to £0.4m following unfunded capital charges • Bid of £0.4m for central costs submitted and raised funding issue due to PDC not being funded as has been the case in previous years • Concerns raised that MRI and CT are making a significant loss • Risk in Dermatology AI Pathway if consultant costs are not covered by block income to be mitigated by turning off the AI pathway	The Committee received **moderate** assurance due to the loss making services	The Committee **noted** the paper receiving **substantial** assurance	

Items for noting

FSC/24/12/190 Monthly CIP Update M8
FSC/24/12/194 Warrington and Halton Integration Highlight Report
FSC/24/12/195 EPR update
FSC/24/12/196 Costing Update
FSC/24/12/197 Benefits Realisation Q2
FSC/24/12/198 Revenue Requests – If required - none
FSC/24/12/200 Schemes over £500k
FSC/24/12/201 Minutes and Terms of Reference of Event Planning Group Meeting
FSC/24/12/202 Digital Strategy Group Update

Assurance Key:

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/02/149c (ii)	Meeting	Trust Board	Date Of Meeting	5 February 2025

Date of Meeting	27 January 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/25/01/232	**Hot Topic – Non recurrent elective restoration monies**	The Committee received the presentation noting:- • Reduction in spend from £4.6m to £3.3m which will clear 65 week waiters and lead to a significant reduction in 52 week waiters • SDF bid for £60k successful to fund the cost, £450k bids outstanding which are being followed up for an outcome • RTT performance forecast to be 59%-60%, 5% improvement required as part of 2025/26 operational planning (65% by March 2026 requires estimated £3.3m cost to deliver). 92% required by March 2029 which wouldn't be achieved with an increase in 5% each year • Need to book patients 6 weeks in advance therefore need to agree 2025/26 budget in order to progress. This needs to be agreed in line with the overall operational plan, however the plan is to spend up to £500k in Q1 which will be approved via the Executive Team Meeting	The Committee received **moderate** assurance given the progress that has been made	The Committee received **substantial** assurance given the plans in place	**FSC February 2025**
FSC/25/01/233	**Deep Dive – Drivers of the deficit and operational plan**	The Committee received the presentation noting:- • Underlying deficit of £20m driven by the size of the Trust, NCTR and inappropriate admission per the Newton report • Significant top up received over recent years if this is withdrawn it will have a significant impact on the bottom line	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 based on	**Trust Board February 2025**

		• Focus on WTE from 2022/23 to 2024/25 (7% increase), expectation is a reduction of 4% as part of the 2025/26 operational plan • The 2025/26 ask from the ICS is a deficit of £19.5m (improvement of £16.9m from the 2024/25 forecast outturn) • 4% CIP has been included in the 2025/26 plan (£16m) of which £14.1m opportunities have been identified to date • Draft plan for 2025/26 currently stands at £40.3m deficit, early cut to be submitted on 28 January 2025 with the draft plan due on 5 February 2025 following Trust Board approval • The draft plan is likely to change due to some outstanding information expected when the guidance is received (income top up not yet confirmed (risk of £53m), inflation expected to increase, pay award and industrial action unlikely to be fully funded and a proportion of payback from historical borrowing expected) • Activity planning underway to meet operational targets as well as full year effect of activity relating to TIF funding received ensuring funding is available for ERF • Workforce plan is based on 2024/25 forecast outturn plus the FYE of strategic schemes and the 4% WTE reduction expectation		no guidance yet being received	
FSC/25/01/235	**Corporate Performance Report**	The Committee received the report noting:- • 4 hour performance has decreased slightly in month due to a decline in performance in Widnes UTC, however the Trust remains in the middle of the pack when compared to the rest of the System • Patients waiting over 12 hours in department remains a challenge with the improvement seen in November not continuing	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 February 2025**
FSC/25/01/237	**Monthly CIP Update**	The Committee received the report noting: • Month 9 CIP position is off plan by £0.3m • 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 February 2025**

FSC/25/01/238	**Monthly Productivity Improvement Update**	The Committee received the report noting:- **Theatres** - Downturn in December over a number of metrics however the overall capped utilisation position is improving over the long term. Late starts have plateaued rather than continuing to reduce, this along with scheduling will have an impact on improving productivity **UEC -** More detail to come to FSC next month to cover the impact to date and where the focus needs to be going forward **Outpatients improvement -** Significant work is being done to identify additional income. Potential additional charging of activity under discussion with Commissioners	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 February 2025**
FSC/25/01/239	**Cost Pressures M9**	The Committee received the report noting:- • Focus on two medical cost pressures in Paediatrics and Obstetrics & Gynae which are driven by consultant sickness and deanery gaps when allocations are received by the Trust • The Obstetrics & Gynae pressure has been addressed by recruiting to middle grades which will lead to cost avoidance • The focus in next month's paper is to be on changes in the cost pressures since the beginning of the year and what is the driver of this	The Committee received **limited** assurance based on the continued overspend on cost pressures	The Committee **noted** and discussed the report receiving **moderate** assurance of the ongoing review	**FSC February 2025**
FSC/25/01/240	**Cash Support**	The Committee received the report noting:- • A total of £19.4m cash support has been received in total, £12.1m in 2024/25 • Support for March 2025 request of maximum of £5.166m. • Risk around non approval discussed along with mitigations in place	The Committee received **substantial** assurance on the monitoring of cash requirements	The Committee **noted** the report receiving **substantial** assurance and **supported** the March cash request	**Trust Board February 2025**
FSC/25/01/244	**Monthly Finance position – month 9**	The Committee received the report noting:- • At M9 the Trust is reporting a year to date £15.6m deficit (adverse variance of £2.6m due to Industrial Action, pay award, under delivery of CIP, cost pressures not offset and PwC costs) • ERF variable activity has delivered 98.6% of plan at M9, M7 in month actual following freeze is 101.1% • Revenue requests 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 February 2025**

FSC/25/01/245	**Capital Position Month 9**	The Committee received the report noting:- • Movement in capital contingency was approved and clearance of oversubscription noted • Supported the forecast position being in line with plan 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 February 2025**
FSC/25/01/245	**CDC 2025/26 plan**	The Committee received the report noting:- • The Government ask is for a 7 day service for MRI and CT therefore the plan has been resubmitted to meet this requirement • Funding for PDC costs have been requested (£0.6m) • Risks raised around MRI and CT being loss making services	The Committee received **moderate** assurance due to the loss making services	The Committee **noted** the paper receiving **substantial** assurance	

Items for noting

FSC/25/01/234 Board Assurance Framework
FSC/25/01/236 Recovery Update
FSC/25/01/239 Cost Pressures M9
FSC/25/01/241 Pay Assurance
FSC/25/01/242 Integration Update
FSC/25/01/245 Schemes over £500k
FSC/25/01/245 CDC Update
FSC/25/01/246 Digital Strategy Group Update

Assurance Key:

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

Trust Board: Committee Assurance Report

Agenda Reference	BM/25/01/149d	Meeting	Trust Board	Date Of Meeting	5 February 2025

Date of Meeting	12 December 2024
Name of Meeting & Chair	Charitable Funds 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
CFC/24/12/21	**Charity Impact Story**	CFC has now introduced a Charity Impact Story at the start of every committee meeting. This was included for the first time at the December 2024 committee, with a presentation from Debbie Monfared from the Macmillan Delamere Cancer Information & Support Centre on the impact of WHH Charity funding. The presentation and discussion were welcomed and added real value to the meeting. This format will be continued going forward.	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	**March 2025**
CFC/24/12/22	**Fundraising Report and Quarterly Workplan**	CFC noted the quarterly fundraising report, including updates on campaigns, plans for payroll giving, and progress against the charity's three-year strategy. **Lead:** Kate Henry	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	**March 2025**

CFC/24/12/23	**Finance Report Q2 Update**	CFC noted the financial position for quarter 2 (1 July to 30 September 2024) and the period 1 April to 30 September 2024 as follows: • Income is £123k below plan in quarter 2 and £26k above plan YTD. • Expenditure (overheads) is £27k (breakeven against plan) in quarter 2 and £4k above plan YTD. • Expenditure (disbursements of funds) is £22k in quarter 2 and £60k YTD. • The net fund balance is £614k. • The balance after commitments for purchases, reserves and overheads is £181k. **Lead:** Jane Hurst	The Committee received **substantial assurance** as income is ahead of plan	The Committee received **high assurance** as sufficient processes and reporting are in place	**March 2025**
CFC/24/12/24	**Bid Applications**	Two bids were approved by CFC: • Children's ward sensory equipment and activities – funded by corporate partner charity golf day • Delamere Cancer Information Centre complementary therapies and courses – funded by CANsupport Charity 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	**March 2025**
CFC/24/12/26	**Charity Commission Checklist for Trustees**	CFC noted the update to the Charity Commission Checklist for Trustees to progress to Corporate Trustee. **Lead:** Kate Henry	The Committee received **substantial assurance**	The Committee received **high assurance**	**Trust Board February 2025**
CFC/24/12/27	**Annual Report & Accounts (FINAL)**	CFC supported the final version of the Annual Report and Accounts to progress on to Trust Board for approval prior to submission by 31 January 2025. **Lead:** Jane Hurst	The Committee received **substantial assurance**	The Committee received **high assurance** as the annual report and accounts and independently audited	**Trust Board January 2025**

The committee also received reports on:

- CFC/24/12/25 Review of Reserves Policy
- CFC/24/12/28 Committee Effectiveness Review 2024 Results

Assurance Key:

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Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/02/150**	
SUBJECT:	**Fragile Clinical Services**	
DATE OF MEETING:	5 February 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.	
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:
None</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 clear progress towards stabilising the ENT staffing position with plans to the reduce cost of mitigating actions through February and March
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>
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REPORT TO BOARD OF DIRECTORS

SUBJECT	Fragile Services Oversight	AGENDA REF:	BM/25/02/150

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. SER VICES ENTERING FRAGILE SERVICES OVERSIGHT SINCE LAST BOARD

None

4. SERVICES REMAINING UNDER FRAGILE SERVICES OVERSIGHT

Urology

Summary

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

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

- P2 – waiting list remains static
- P3 & P4 waiting lists show an overall positive reducing trend – P3 reducing after recent growth
- Transperineal prostate biopsy position shows sustained improvement (>75% sustained reduction in undated waiting list patients from 120>40)
- Surveillance cystoscopy position very significantly improved from peak, with waiting list falling to fewer than 75 patients in December
- Decreased numbers of undated high risk follow up patients
- Ongoing risk of harm remains given P2/Stone, surveillance cystoscopy and emergent cancer performance risk
- Service exceeding clinical activity targets (>104% of 19/20 activity)

- Completed Actions
    - Increased endoscopy cystoscopy capacity by 40/week
    - WLI and outsourced sessions approved and actioned
    - Additional middle grades recruited
    - Locum consultants commenced in post

    - Successful transfer of cystoscopy into UIU - UIU have increased cystoscopy case numbers per list.
    - Some weekend P3 outsourcing capacity diverted to deliver P2 activity in week

- Current mitigations
    - Stent register process in place – further failsafe refinements made, with process audited for assurance
    - Hot stone list implemented at Warrington site
    - PCNL Stone patients transferred to Chester as required
    - Ongoing harm review process
    - Specialist nurse delivered cystoscopy training underway with practitioners approaching completion of training

- Ongoing improvement plan actions:
    - 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 capacity.

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

Ear Nose and Throat Surgery

Summary

Waiting list position improved predominantly due to insourcing. Mitigations in place for medical staffing challenges, improving consultant staffing – 3 consultants now in post, further consultant joining 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 joining in March
- No harm reported to date
- Additional capacity via LLP is supporting the reduction of patients awaiting 1st OPD appointments
- New OP waiting list has reduced significantly from >3500 to <1500.
- FU OP waiting lists remain a challenge but have improved in month
- High risk FU patients continue to be prioritised

- Completed Actions
  - Task and finish group established
  - Enrolled in phase one of GIRFT Further Faster program
  - Additional ENT stacker and scope in 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
    - Consultant vacancy out to advert
    - 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
    - Consultant post to advert
    - 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:
    - Recruitment to Consultant post
    - Complete job planning exercise to reduce Cath Lab capacity and realign with OPD and inpatient work – complete end Jan – implement end Feb 2025
    - Complete scoping exercise to for ambulatory disposable patches
    - Monitor Spirometry Waiting Times following recruitment of ATOs
    - Pursue training support from Cheshire & Merseyside Physiologist Network for training support in Cardiorespiratory
    - Complete Cardiorespiratory Workforce Skill mix review

5. RECOMMENDATIONS

Trust Board is asked to:

- Note the current list of Fragile Services, associated clinical risk and high-level progress updates
- Note the 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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/02/151**
SUBJECT:	**Maternity & Neonatal Update**
DATE OF MEETING:	5 February 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. ✓ SO2 We will... Be the best place to work with a diverse and engaged workforce that is fit for now and the future SO3 We will ...Work in partnership with others to achieve social and economic wellbeing in our communities.
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (*Please DELETE as appropriate)*	**#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff

LINK TO PUBLIC SECTOR EQUALITY DUTIES

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

	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 improving safety and outcomes for this cohort.

	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 improving safety and outcomes for this cohort.

	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 improving safety and outcomes for this cohort.

EXECUTIVE SUMMARY ***(KEY ISSUES):***	This paper provides an overview of activity, performance and quality within the maternity and neonatal services. The paper provides Board with oversight of the WHH position in relation to key national safety and quality issues and in line with the requirements of Safety Action 9 within the Maternity Incentive Scheme Year 5 *(Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues)* alongside emerging local and regional matters. The paper provides a summary in relation to the following reports for oversight and discussion: • December Maternity Quality & Safety update – appendix 1a -1e • January Maternity Quality & Safety update – appendix 2 • Maternity Incentive Scheme Year 5 and 6 – appendix 3a and 3b • ATAIN Q2 2024/25 – appendix 4 • Transitional Care Q2 2024/25 – appendix 5a & 5b		
PURPOSE: ***(please select as appropriate)***	Approval	To note ✓	Decision
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	QAC/24/12/200 QAC/25/01/223	
	Date of meeting	10th December 2024 14th January 2025	
	Summary of Outcome	Noted and approved	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO BOARD OF DIRECTORS

SUBJECT	Maternity & Neonatal Update Summary Report	AGENDA REF:	BM/25/02/151

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:

- December Maternity Quality & Safety update – appendix 1a -1e
- January Maternity Quality & Safety update – appendix 2
- Maternity Incentive Scheme Year 5 and 6 – appendix 3a and 3b
- ATAIN Q2 2024/25 – appendix 4
- Transitional Care Q2 2024/25 – appendix 5a & 5b

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

2. QUALITY & SAFETY MEASURES & METRICS

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

2.1 Patient Safety Events

In October and November 2024 themes from patient safety events were as follows:

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

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

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).

2.1.2 Postnatal Readmissions

There were 8 postnatal readmissions in October 2024 and 7 in November 2024, a reduction from 11 readmissions in both August and September. Two key workstreams are underway with regard to readmissions as follows:

Postnatal Readmissions Due to Wound Infections

A wound surveillance working group has been established to address the number of women readmitted to the maternity unit due to wound infections. Actions underway include:

- Reviewing literature on QI projects to reduce c-section surgical site infections (SSI) at the next meeting in December 2024.
- Conducting ongoing audits by the maternity theatre lead to determine if readmissions were avoidable or unavoidable.
- Reviewing health surveillance questionnaire responses when available.
- Changing practice to include metronidazole alongside cefuroxime as prophylactic antibiotics before surgery.

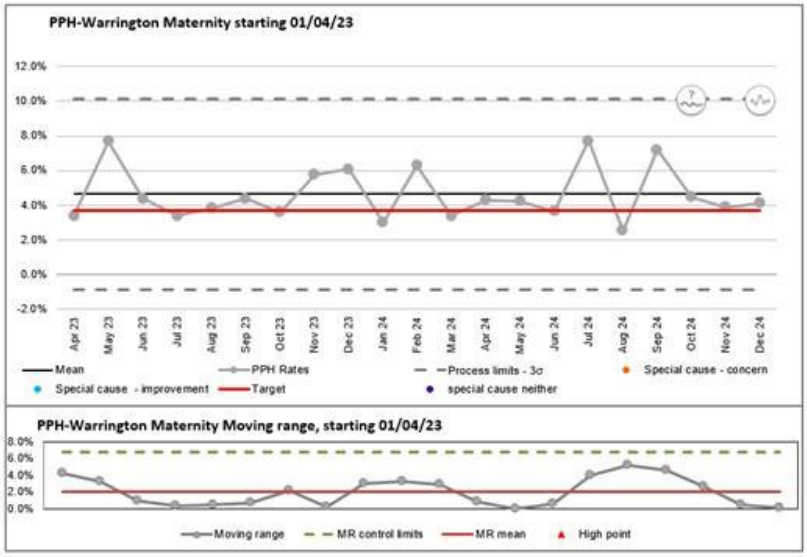
Postnatal Readmissions Due to Hypertension

The Q2 review identified avoidable readmissions related to suboptimal blood pressure management before discharge. Actions taken include:

- Escalating the increased incidence of postnatal readmissions to the labour ward lead.
- Developing a discharge checklist for women with known hypertension.
- Educating the maternity ward team on the importance of regular blood pressure monitoring.
- Reviewing the BadgerNet system and early warning score by the Digital Midwife and maternity ward manager.
- Sharing education on the 'red/yellow' score and appropriate escalation and monitoring.
- Awaiting the rollout of the national MEWS2 tool in March 2025.
- Progressing a regional guideline for pre-eclampsia and gestational hypertension.

2.1.3 Postpartum Haemorrhage (PPH)

The Statistical Process Control (SPC) chart for PPH ≥1500mls shows no current trend, indicating common cause variation with stability over the last three months.



However, metrics from across the LMNS have highlighted a higher rate of PPH ≥1500mls at WHH**:**

- **WHH rate**: 49 cases per 1000 births (rolling year to end of October 2024).
- **Cheshire & Mersey rate**: 34.4 cases per 1000 births.
- **England rate:** 30 cases per 1000 births.

Quality Improvement (QI) project progress
The PPH QI project has been ongoing throughout 2024, focusing on:

- **Good Practice Sharing:** Disseminating effective practices.
- **Bespoke Training:** Implementing specialised training for resident doctors on managing the 3rd stage of labour.

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.

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

2.2 Moderate Harm Events

15 moderate harm events 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.

2.2.1 Key findings and actions from the cluster review

OASI Incidence:

- 2% of normal vaginal deliveries resulted in OASI.
- 8% of forceps births resulted in OASI.
- A theme of OASI with forceps births in primigravida without episiotomy (3 cases) was identified.

Actions:

- Feedback to individual practitioners.
- Additional training for obstetric colleagues.
- Focused OASI training for midwives.
- Reminder resources in clinical areas.
- Pelvic Health now included in mandatory midwifery training.

The remaining moderate harm event occurred in November 2024 and related to a baby born in poor condition and transferred to Liverpool Women’s Hospital for cooling therapy. This was reviewed via an initial safety review (ISR). Initial learning was identified via the ISR in relation to categorisation of the cardiotocography (CTG). Immediate actions are in progress.

In addition, an MDT task and finish group has been established to lead a number of wider actions with regard to fetal surveillance and monitoring. This will include a review of current education provision. In line with national guidance, this case was also referred to the Maternity and Newborn Investigation (MNSI) team for review. The case has been accepted for investigation (MNSI ref MI-039124).

2.3 Operational Safety Review

A new operational review group (ORG) was introduced from 1st December 2024 to enhance the review process for safety events such as maternity service diverts, neonatal unit closures, and lack of transitional care provision. The first ORG considered the following:

- Neonatal Unit Closure 03/11/2024
- Maternity Divert 05/11/2024

A quarterly update regarding learning and actions from this group will be presented to QAC in April 2025.

2.4 Workforce metrics

Positive performance with regard to retention and vacancy rates are being sustained across the maternity and neonatal teams. Compliance with PDR completion has improved significantly from 77.33% in October (excluding those with a long term absence) to 86.01% at the end of November. Work will continue to ensure we continue to improve against this metric.

Compliance with maternity specific training standards is being sustained:

Current position – Training compliance - maternity specific

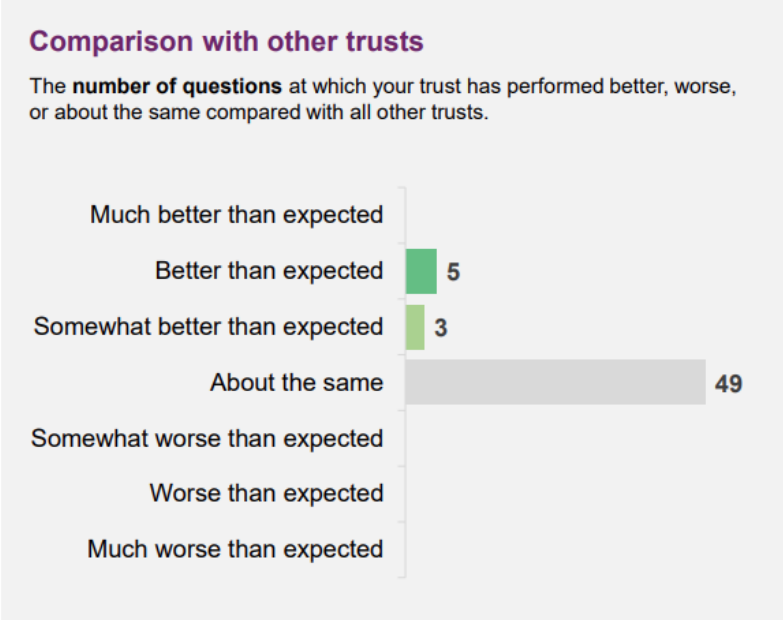
	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)#	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	98.4%	93.1%	95.1%	95.4%	85.8%
Obstetric Consultants	100%	100%	91.6%	n/a	n/a
Other Obstetric	100%	100%	100%	n/a	n/a
Obs Anaesthetic	96.2%	n/a		n/a	n/a
Maternity Support Workers	96.5%	n/a		n/a	74%
Neonatal medical and ANNP	n/a	n/a	n/a	94.4%	n/a

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

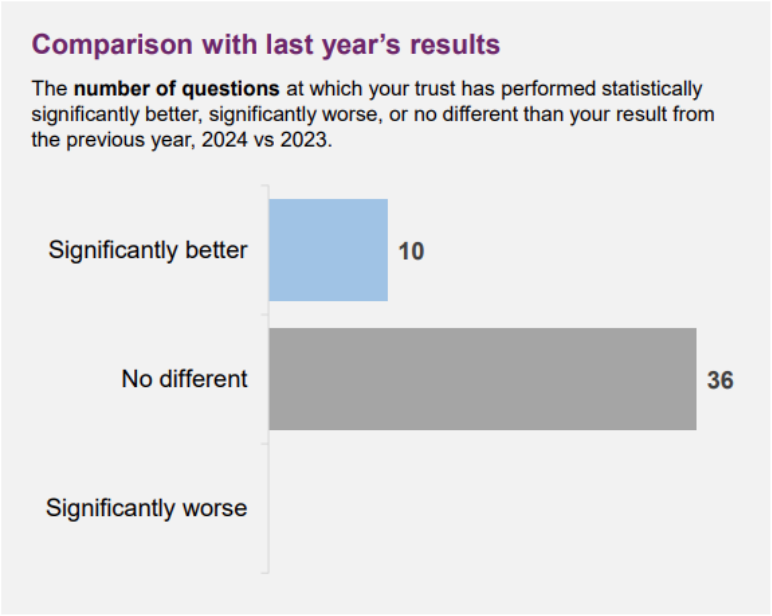
2.5 Service User Feedback

The service received its results of the 2024 CQC maternity survey on 28th November 2024. The results were positive with the WHH maternity service revealed to be one of eight Trusts across the country and one of only two in the north west region whose results were rated as 'better than expected' overall, meaning families experiences of using maternity services were substantially better than the national average.

The service scored better than other trusts in 8 of 49 questions and was rated in the top five across the north west region for seven out of ten overarching measures.



The survey results also showed an improvement in WHH's results compared to its 2023 performance:



A detailed analysis of the report is underway, the learning and next steps from this analysis will be shared to a future QAC and Trust Board.

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.
- 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 way.

Individual feedback from families is included the Quality and Safety report presented to Quality Assurance Committee in January 2025 (appendix 2).

2.6 Staff feedback

A maternity and neonatal safety champion walkaround of the maternity and neonatal unit took place on 12th November 2024.

Discussions took place with staff in all areas in relation to improvements to service provision and these matters will now be taken forward for further exploration. A series of ideas events with clinical teams are ongoing. These are due to be completed in early 2025 when the feedback will be collated and next steps shared.

2.7 Maternity Triage

In November 2024 539 triage attendances were recorded on the BadgerNet patient record system.

Triage attendances Dec 23 - Nov 24		
Month	Attendances	Ave per day
December	499	16.1
January	573	18.5
February	553	19.1
March	526	17.0
April	576	19.2
May	590	19.0
June	567	18.9
July	582	18.8
August	618	19.9
September	556	18.5
October	545	17.5
November	539	17.9

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

2.8 Induction of Labour (IOL)

November data from the LMNS (provided below) highlights WHH continues to perform less well with regard to timeliness of IOL activity when compared to other local providers:

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

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	38	110	55	35	93	95	73	499
Total Delayed	2	25	4	1	19	37	15	103
% of Total	5.26%	22.73%	7.27%	2.86%	20.43%	38.95%	20.55%	20.64%

A review of data quality is underway to confirm WHH is reporting in the same way as other providers. Improvement work to improve IOL pathways has also commenced. A task and finish group is in place and a lead midwife to support the workstream has been identified. 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.

2.9 Maternity and Newborn Safety Investigation (MNSI) position

2.9.1 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.

2.9.2 Cases year to date

In 2024, MNSI accepted six cases for investigation. Progress as at 31/12/2024 was 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 MNSI investigation report was received in November and December 2024 (MNSI reference MI-037421).

Following investigation by MNSI, there were six specific safety recommendations. Actions to meet these recommendations have been developed and are underway. A case on a page has also been developed and shared with all maternity staff (included in appendix 1). The full MNSI report is included in appendix 1c for information.

2.10 Progress against other workstreams

2.10.1 Continuity of Carer (CoC)

CoC data is extracted from BadgerNet monthly and shared with the LMNS. Key measures include:

- % of women at 29 weeks gestation on a CoC pathway
- % of Black, Asian, or Mixed Ethnicity (BME) women at 29 weeks gestation on a CoC pathway
- % of women in the bottom decile of deprivation at 29 weeks gestation on a CoC pathway

In Q3 2024-25, the percentage of women receiving continuity at 29 weeks gestation ranged from 48.7% to 52.2%. For BME women, 50-70% received CoC. For women in the bottom decile, the percentage increased to 54.4% in December 2024, up from 17-30% in previous months. This improvement followed a review of caseloads and team boundaries to ensure areas of deprivation are covered by a CoC team.

Measures are in place to support vulnerable groups, including high-quality antenatal and postnatal team case-holding, enhanced maternity support workers, and 'baby shower' events for infant feeding and smoking cessation support. Team River, an enhanced continuity team, casehold particularly vulnerable women, such as those experiencing teenage pregnancy, mental health issues, substance misuse, and asylum seekers.

Balancing intrapartum continuity with safe inpatient staffing remains challenging. Community staff can work in traditional, continuity, or birth availability models. However, community midwives in continuity teams are unwilling to adopt the birth availability model, which could lead to staff attrition and vacancies. Discussions continue on how to best utilise existing intrapartum shifts to support continuity.

2.10.2 Diabetes in Pregnancy

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. Care pathways for diabetic pregnant women are supported by an MDT team, and a diabetes in pregnancy working group meets monthly to improve services. Efforts include providing quicker access to blood sugar self-monitoring in the Antenatal Day Unit and exploring weekly reviews led by the Specialist Midwife - Diabetes. Women with abnormal results are referred to the diabetic nurse team. Referral pathways for diabetic pregnant women admitted to non-maternity settings are being streamlined.

The group has improved referrals of pre-existing diabetic women to the Diabetic Nurse Team. From 2025, the diabetic nurse team will support MDT PROMPT training for midwives and obstetricians, the session will include learning in relation to the management of DKA and diabetes complications.

A regional guideline for gestational diabetes management is expected in Q4 2024/25. In the interim, improved patient information leaflets are being developed. Plans are also underway to offer separate clinics for women with pre-existing diabetes and those diagnosed during pregnancy, as recommended by the Saving Babies Lives Care Bundle.

No further cases where maternal diabetes was a contributory factor have been identified since June 2024. An update on progress will be provided to QAC in April 2025.

2.11 Complaints

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

Specialty	Description	Complaint Opened
Maternity	Concerns regarding birth trauma experienced in 2022.	23/10/2024
Maternity	Unhappy with care and treatment during labour	18/11/2024
Maternity	Unhappy with treatment during birth	27/11/2024
Maternity	Communication and concerns with suturing	27/11/2024

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

2.12 Coroner Enquiries

No Regulation 28 enquiries have been received.

3 MATERNITY INCENTIVE SCHEME (MIS)

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. The Local Maternity and Neonatal System (LMNS) have completed their review of all MIS evidence to date. The service is awaiting the formal outcome of that review but feedback to date has been positive.

A timetable to ensure internal WHH assurance processes have been completed against all MIS year 6 safety actions prior to submitting the Board declaration form has been developed.

A completed Board declaration form must be submitted to NHSR by 12 noon on 3 March 2025.

The full reports are included in appendix 3a and 3b.

4 Q2 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 Q2 (1st July 2024 to 30th September 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 Q2 ATAIN Rate was 6.6%, higher than national and NWNODN targets but a 0.24% decrease from the last quarter. Other trusts exclude admissions of less than six hours from ATAIN data. In Q2, WHH identified seven babies admitted for less than six hours. Excluding these, the term admissions rate would be 5.6%, within targets. The Q3 report is expected to align WHH data with other trusts by differentiating between <6 hour and >6 hour admissions. All term admissions will continue to be reviewed for learning opportunities. Of the 45 term admissions, two were for social reasons and not included in the ATAIN process, reducing the Q2 ATAIN rate to 6.32%.

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%
Q3 Oct – Dec 2023	619	34	5.49%			
Q4 Jan – Mar 2024	586	41	6.99%			
Q1 Apr – Jun 2024	612	42	6.86%	5.8%		
Q2 Jul – Sept 2024	680	45	6.62%	5.6%		

4.3 Themes and Learning: Outcomes of ATAIN review

All term admissions in Q2 were reviewed and learning from these cases informs the ATAIN action plan. 58% (26) of term admissions were respiratory-related, i.e. required admission or additional observations due to signs of respiratory distress which includes grunting and low oxygen saturation (SATs or oxygen requirement). Only 9 of these cases were deemed avoidable if care had been optimal. Reasons for categorising term admissions as avoidable included:

- PEEP for 30 minutes may have avoided admission
- Care could have been provided on Transitional Care
- Baby's low temperature could have been avoided

4.3.1 Good Practice:

- 30 minutes of peep project is ongoing and proving to be effective
- Good recognition of potential sepsis in mother and baby

4.3.2 Learning Points/Themes/Actions:

- MDT CTG workshops to recommence twice weekly
- Update of thermoregulation guideline to be completed
- Cord gas syringes and FSE clips have been changed on birth suite to enable more accurate cord gas results and CTG monitoring
- Ongoing additional training underway in Lunar team and for midwives providing care in low-risk care setting
- Consideration being given to deteriorating baby simulation training

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 targeted support for staff as required from cases requiring individualised learning.
- Continue regular ATAIN meetings including the introduction of resident doctors to the ATAIN meeting to discuss cases and actions/progress with involvement from the wider team.
- Shared learning from ATAIN to continue to be disseminated to all midwifery, paediatric, neonatal and obstetric staff.
- Regular review of ATAIN actions to ensure timely completion.
- Senior midwifery review of all babies to be facilitated on Birth Suite and C23 in order to support early identification of deteriorating babies to allow actions to prevent admission.

The full report is included in appendix 4.

5. Q2 2024/25 TRANSITIONAL CARE REPORT

5.1 Overview

During Q2 2024/258, 24 babies met the criteria for TC. The audit identified the following:

- Babies admitted direct to TC: 0
- Babies who received NNU care and stepped down to TC: 5
- Babies allocated to PEEP for 30 pathway: 5
- Term baby requiring feeding support: 2
- Did not receive TC: 12

5.2 Key Findings

- **Initial Care:** One baby initially stayed with their mother but was admitted to NNU due to worsening respiratory acidosis. Two babies were suitable for TC from birth but were admitted to NNU due to staffing issues.
- **Feeding Support:** One term baby received TC for poor feeding but was later admitted to NNU as the mother wished to be discharged.
- **Enhanced Care:** One baby required NNU admission due to hypothermia but was later discharged to TC for feeding support and temperature control.
- **Missed TC Care:** One baby did not receive TC care due to not being identified as meeting the criteria, no harm caused.

5.3 Babies requiring respiratory support

- The other 21 babies who met the broad TC criteria in Q2 required some level of respiratory support and were initially provided with care via NNU. Of these:
- **Did Not Meet TC Criteria:** Eleven babies did not meet TC criteria once medically fit for discharge from NNU, though two could have stepped down sooner.
- **Stepped Down to TC:** Five babies were appropriately stepped down to TC when clinically indicated, showing improvement in timely step-down.
- **PEEP for 30 Pathway:** Five babies followed this pathway, part of a QI project to wean babies off respiratory support quickly.

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.
- NNU Matron continues to deliver training at MAMU (Maternity Mandatory Updates).
- Review of enhanced care criteria completed, disseminated to all staff and displayed in all areas.
- Revisited and redesigned the TC Audit. This is now lead by the NNU Matron.

5.5 Additional Audit

A specific review of preterm infants (34-36+6 weeks gestation) showed no eligible babies were admitted to NNU unnecessarily. All required neonatal admission and were stepped down to TC appropriately

5.6 Recommendations

- **Training:** Time for midwifery lead to complete TC training.
- **Respiratory Support:** Repeat audits to review the duration of respiratory support.
- **Step-Down Process:** Consider stepping babies down sooner to utilize TC.
- **Education:** Ensure staff understand the importance of thermoregulatory care.
- **Staffing:** Continue to allocate neonatal staff to TC babies and review long-term staffing plans.
- **Length of Stay:** Estate work to improve the area for families receiving TC.

5.7 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 appendices 5a and 5b.

6. 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.

7. ASSURANCE COMMITTEE

The contents of this report has previously been noted and discussed at Quality Assurance Committees on 10th December 2024 and 14th January 2025.

8. RECOMMENDATIONS

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

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/01/151 Appendix 1a**			
SUBJECT:	**Maternity & Neonatal Quality Review – October 2024**			
DATE OF MEETING:	5 February 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)***	**#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information: 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.			
	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 and provides oversight of matters related to maternity and neonatal care focussing attention on improving outcomes for this protected group.			

<table>
<tr><td rowspan="2"></td><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></td><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>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="4">This paper provides an update in relation to maternity and neonatal quality and Trust Board with oversight of key matters on maternity and neonatal safety and quality issues.

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 eight moderate harm events in October 2024. All related to 3rd degree tears. Whilst no issues with care were identified a cluster review of all 3rd and 4th degree tears (OASI) for the year to date has been completed to ensure all learning and areas for improvement are captured.

There were no severe or fatal harm events in October 2024.

Themes from maternity/neonatology patient safety events in October are as follows:

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

Work remains ongoing with regard to all of these themes.

At the end of October compliance for Trust mandatory training across maternity and child health colleagues is above the Trust target. Compliance with PDR completion is improving with a targeted piece of improvement work ongoing.</td></tr>
</table>

	The service received its results of the 2024 CQC maternity survey on 28th November 2024. The results were positive with WHH revealed to be one of eight Trusts across the country and one of only two in the north west whose results were rated as 'better than expected' overall, meaning families experiences of using maternity services were substantially better than the national average. A maternity and neonatal safety champion walkaround of the maternity and neonatal unit took place on 12th November 2024 and feedback from staff captured. In October 96% of attenders to maternity triage were seen within 15 minutes of arrival. 99.81% of attenders were seen within less than 30 minutes of arrival. For both metrics this is an improvement from the September performance. There has also been improvement in triage performance when compared to other providers across the LMNS. In October 2024 2.38% of WHH triage attendances breached. The average across Cheshire and Mersey providers was 4.5%. Work is ongoing with regard to improving the service position with regard to postnatal readmissions. October data from the Local Maternity and Neonatal System (LMNS) highlights WHH continues to perform less well with regard to timeliness of induction of labour (IOL) activity when compared to other local providers albeit with some improvement in the position. An overview of the sevice's position with regard to cases being investigated by MNSI is provided for oversight. Two complaints were received in the CBU in October 2024. One related to care within the maternity service. The second complaint related to care within the child health service. No Regulation 28 enquiries have been received.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the content of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/12/200iv**	
	Date of meeting	10 December 2024	

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

REPORT TO TRUST BOARD

SUBJECT	Maternity & Neonatal Quality Review – October 2024	AGENDA REF:	BM/25/01/151 Appendix 1a

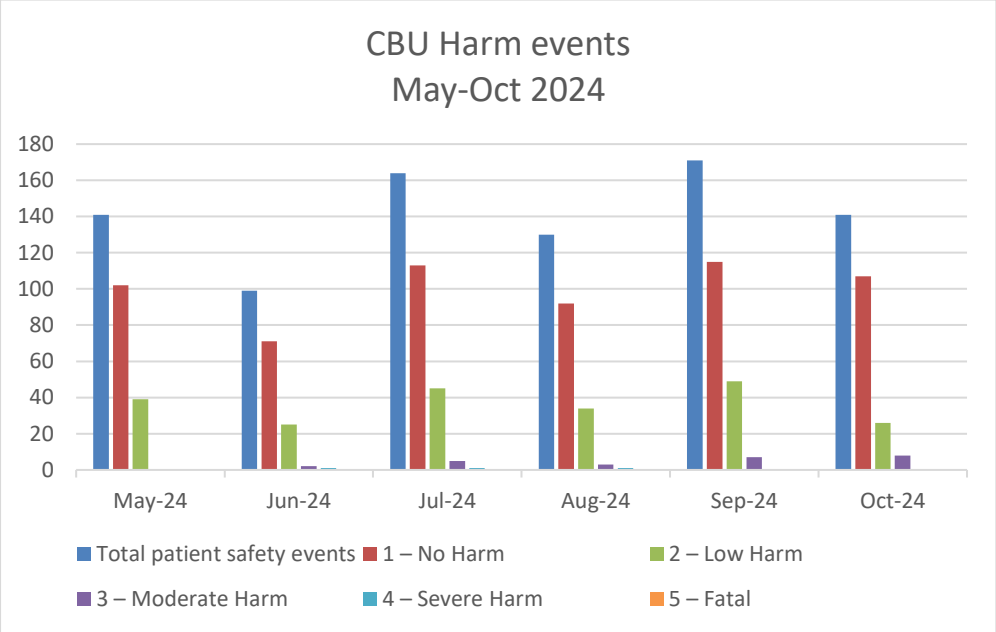
1. BACKGROUND/CONTEXT

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



There were 141 patient safety events reported across the CBU in October 2024. Of these there were no severe harm or fatal events.

There were no maternity or neonatal patient safety events with immediate concerns which met the criteria for an initial safety review. Cases were however reviewed via the multidisciplinary (MDT) Intrapartum Review Group (IRG). In total there were 19 moderate/low harm reviews undertaken in IRG in October.

There were eight moderate harm events. All eight occurred in the maternity service and related to 3rd degree tears. These were all reviewed in IRG, there was no concerns identified with care.

However, the service had identified an increase in incidence of 3rd and 4th degree tears (OASI) across the months of September and October. All cases had been reviewed in IRG, with no

theme noted to the learning from individual reviews. However, in light of the notable increase in cases it was agreed an MDT cluster review would be completed. This review considered all cases of OASI year to date (n=33).

From this review the following learning and actions were identified

- 2% of 'normal vaginal delivery' resulted in a case of OASI
- 8% of forceps birth resulted in a case of OASI
- A theme of OASI with forceps birth in primigravida without episiotomy (3 cases) – feedback to be provided to individual practitioner.
- Additional training update for obstetric colleagues to be provided
- Focussed approach to OASI for midwives to be included on the training train and facilitated by Specialist Midwife team and Consultant Midwife
- Reminder resources to be added to the clinical areas as support for colleagues
- Pelvic Health has already been included in mandatory MAMU-3 training, facilitated by the Specialist Midwife- Pelvic Health

One After-Action Review was declared in October for a maternity service divert.

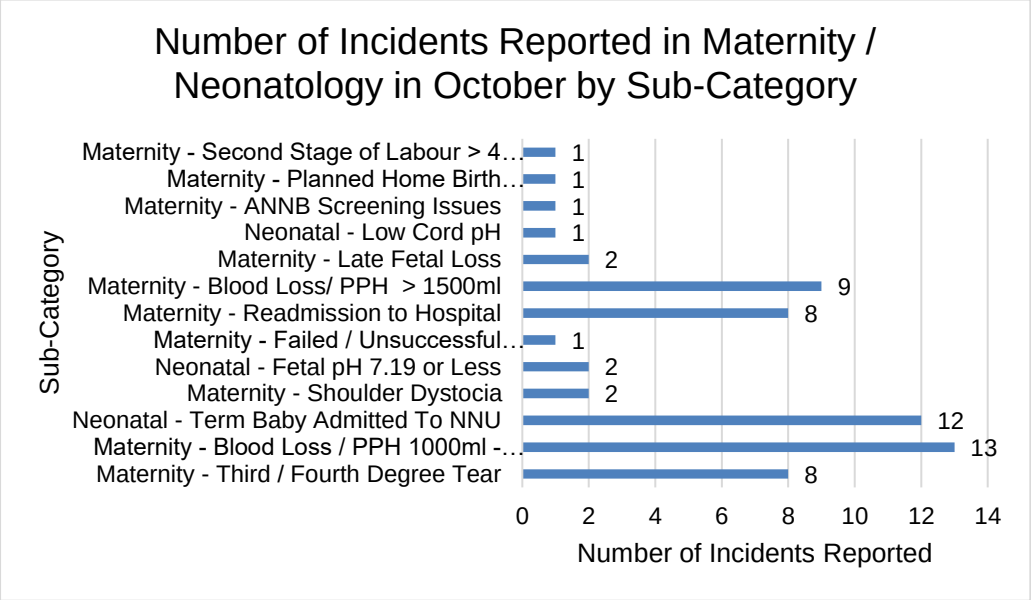
To further enhance the process of review of operational safety patient safety events such as maternity service diverts, a new operational review group is being introduced into the maternity and neonatal services with effect from 1st December 2024.

This will provide an opportunity for a senior MDT review utilising the PSIRF framework of safety events as follows:

- Maternity diverts and deflects
- Neonatal unit closures
- Lack of transitional care provision
- Service unable to provide choice of place of birth via Nest or home birth service
- Cancellation of planned caesarean sections
- Requests for mutual aid due to delayed induction of labour

A quarterly update regarding learning and actions from this group will be presented to QAC in April 2025.

Themes from maternity/neonatology in October 2024 are detailed in the table below:

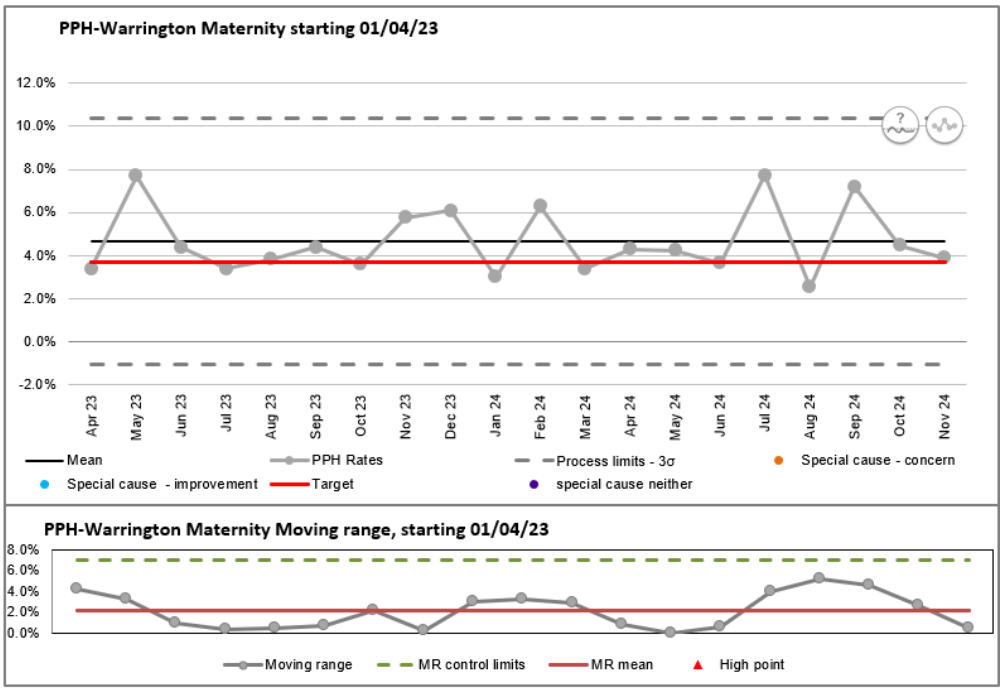


12 term babies were admitted to the neonatal unit (NNU). All cases of term admission are reviewed via ATAIN which reports quarterly to QAC.

8 postnatal readmissions were reported in October 2024. This is a reduction from both August and September when there were 11 readmissions in month.

There were 13 cases of PPH 1000ml-1500ml and 9 cases of PPH ≥1500mls in October 2024.

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



However, metrics from across the LMNS have highlighted a higher rate of PPH ≥1500mls at WHH, with a WHH rate of 49 cases per 1000 births (rolling year to end of October 2024). As a comparison, across Cheshire & Mersey most recent data notes a rate of 34.4 cases per 1000 births and across England 30 cases per 1000 births.

Trust Board will be aware the PPH QI project has been ongoing throughout 2024. 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 with regard to PPH is due to be published shortly. Colleagues form WHH have participated in the regional working group tasked with developing this guideline and many of the change ideas advocated by WHH will be included within the guideline.

The PPH QI working group have acknowledged there are limitations to the change ideas which can be trialled as a PDSA cycle whilst awaiting the guideline publication. Accordingly, it has been agreed to stand down the formal QI project. The working group will continue but change its focus to the implementation of the new standards. The team will continue to meet bi-weekly, sharing learning and supporting implementation of the latest guideline once published.

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 improve and sustain compliance with mandatory training and completion of staff appraisals.

At the end of October compliance for mandatory training across maternity and child health colleagues is 89.42% for Trust mandatory training (including safeguarding training), 88.39% 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 improving. Rates in October (excluding those with a long term absence) for maternity and child health services is 77.33%. This is an increase of 5.33% from the end of September. A targeted piece of work is underway, and all managers are aware outstanding PDRs need to be completed by 30th November 2024.

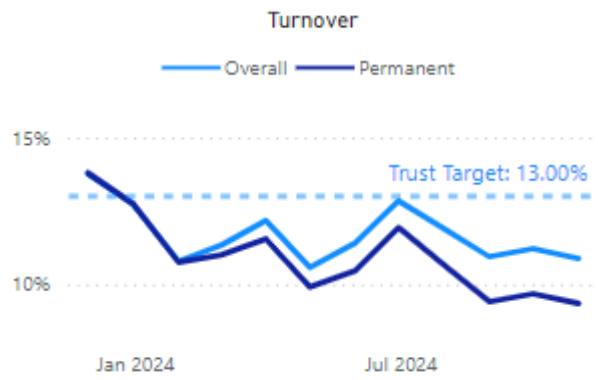
Compliance with maternity specific training standards is being sustained

Current position – Training compliance - maternity specific

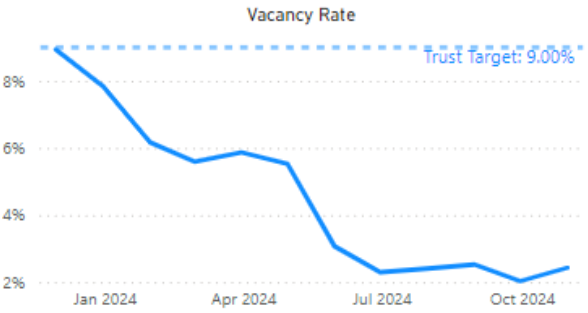
	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)#	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	94.7%	91.6%	98.4%	92.6%	78.1%
Obstetric Consultants	100%	90%	90.9%	n/a	n/a
Other Obstetric	100%	100%	100%	n/a	n/a
Obs Anaesthetic	100%	n/a		n/a	n/a
Maternity Support Workers	93.3%	n/a		n/a	53.5%
Neonatal medical and ANNP	n/a	n/a	n/a	94.1%	n/a

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

Turnover for maternity and child health staff (permanent staff) in September was 9.35% and is below the Trust target. Turnover has remained below the Trust target of 13% since December 2023. This is illustrated in the graph below:



The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 2.43% in October 2024, significantly below the Trust target. This is illustrated in the graph below:



At the end of October 2024, the vacancy rate for registered midwives was 1.8%.

4. SERVICE USER FEEDBACK

The service received its results of the 2024 CQC maternity survey on 28th November 2024. The results were positive with the WHH maternity service revealed to be one of eight Trusts across the country and one of only two in the north west whose results were rated as 'better than expected' overall, meaning families experiences of using maternity services were substantially better than the national average.

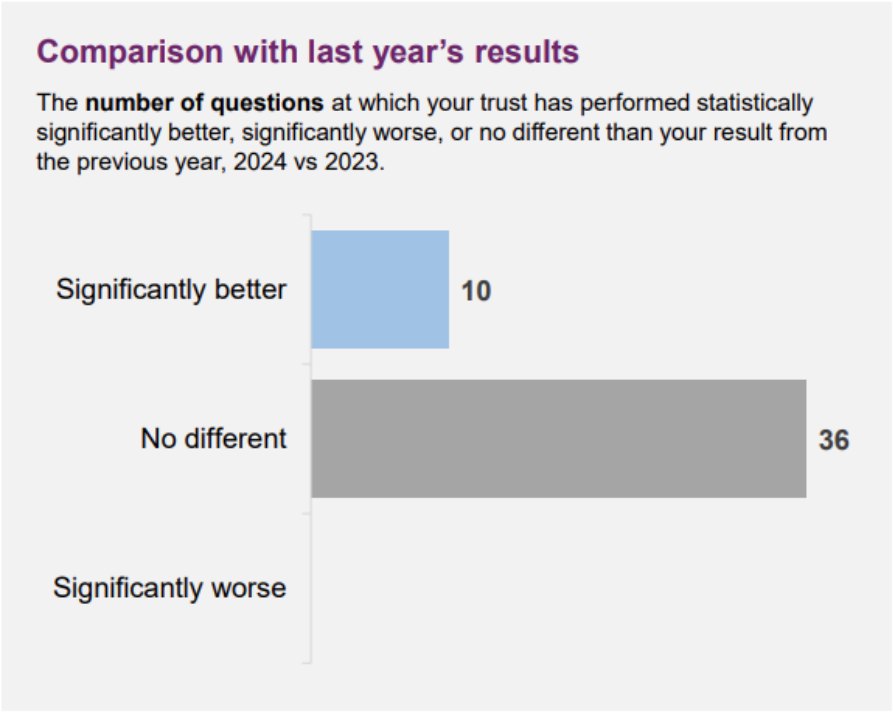
The service scored better than other trusts in 8 of 49 questions and was rated in the top five across the north west region for seven out of ten overarching measures specifically:

- The start of your care during pregnancy
- Antenatal check-ups
- Triage: Assessment and Evaluation

- Your labour and birth
- Staff caring for you
- Care in the ward after birth
- Complaints



The survey results also showed an improvement in WHH's results compared to its 2023 performance:



A detailed analysis of the report is underway, the learning and next steps from this analysis will be shared to a future QAC/Trust Board.

The full survey results are included in appendix 1.

5. STAFF FEEDBACK

A maternity and neonatal safety champion walkaround of the maternity and neonatal unit took place on 12th November 2024.

Discussions took place with staff in all areas in relation to improvements to service provision and these matters will now be taken forward for further exploration. In particular:

- Administrative processes in relation to paper records
- Availability of transcutaneous bilirubin (TcB) devices used to assess for jaundice in babies in the community setting
- NNU unit capacity
- Estates issues in particularly in relation to the area previously utilised for induction of labour

A series of ideas events with clinical teams are ongoing. These are due to be completed by the end of January 2025 when the feedback will be collated and next steps shared.

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 October 2024 545 triage attendances were recorded on the BadgerNet patient record system.

Triage attendances Dec 23 - Sept 24		
Month	Attendances	Ave per day
December	499	16.1
January	573	18.5
February	553	19.1
March	526	17.0
April	576	19.2
May	590	19.0
June	567	18.9
July	582	18.8
August	618	19.9
September	556	18.5
October	545	17.5

- 18% of attendees were seen immediately on arrival, a significant improvement from previous months
- The longest wait recorded for initial review was 35minutes.

- 96% of attenders were seen within 15 minutes of arrival (best practice guidance). This is improvement from September and beyond the KPI of 90% review within 15 minutes.
- 99.81% of attenders were seen within less than 30 minutes of arrival (NICE guidance). Again, this is an improvement from the September performance and is beyond the KPI of 95% review within 30 minutes.
- 0.9 of attendees were categorised as red on arrival. All were seen within ten minutes and appropriate ongoing care was provided in all cases.
- 22.75% of attendees were categorised orange on arrival, this is a further increase from previous months.
- There has also been improvement in triage performance when compared to other providers across the LMNS. In October 2024 2.38% of WHH triage attendances breached. The average across Cheshire and Mersey providers was 4.5%.

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

7. INDUCTION OF LABOUR (IOL)

October data from the LMNS (provided below) highlights WHH continues to perform less well with regard to timeliness of IOL activity when compared to other local providers:

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

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	59	95	61	40	91	63	82	491
Total Delayed	8		13	4	15	23	25	88
% of Total	13.56%	0.00%	21.31%	10.00%	16.48%	36.51%	30.49%	17.92%

Improvement work to improve IOL pathways has commenced. A task and finish group is in place and a lead midwife to support the workstream has been identified. 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.

8. MNSI POSITION AND REPORTS RECEIVED

1.1 Background

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

1.2 Current position

Year to date 2024, MNSI have accepted five cases for investigation. Progress as at 30/11/2024 is as follows:

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

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

8.3 Reports received

One new report has been received in November 2024 (MNSI reference MI-037421).

This case related to a woman in her first pregnancy. The mother was booked for low-risk care at another provider in her first pregnancy. Whilst under the care of the other provider there were some additonal scans due to concerns refgaridng the baby's growth.

The mother transferred her care to WHH at 36+5 weeks gestation and she was risk assessed for shared care. The mother had an additional scan at 36+6 weeks as it was thought the Baby may be in a breech 'bottom first' position. The Baby's growth was not assessed during this scan.

The Mother called the maternity triage unit at 38+5 weeks reporting a 'watery loss'. She was reassured and remained at home. Following this, she experienced stomach pains which increased in intensity, and she made telephone calls and attended the maternity triage unit once over several days.

During a routine pregnancy review at 39+2 weeks her blood pressure was found to be higher than the expected ranges and her stomach pain continued to worsen. The Mother attended the maternity triage unit. Her assessment was within normal parameters, and she was discharged with a follow up appointment.

The following day, the Mother called the maternity triage unit reporting reduced fetal movements and pain. She attended the maternity triage unit for assessment and the Baby was found to have sadly died. The Mother and Father consented to a post-mortem examination (PME) which found the Baby was small and cause of death was placental abruption. Following investigation by MNSI, there were six specific safety recommendations:

- Trusts A and B develop a structured information transfer process to ensure that when a mother transfers from one provider to another a robust process is in place to support staff to access and retrieve the required information such as (not limited to) medical records, USS reports/imaging, and test results to inform ongoing clinical decision making and management of care.
- The Trust review its guidance to meet national recommendations to develop a robust person, systems-centred process and environment to support the role of dedicated midwifery staff to be solely responsible for the telephone triage advice line service and provide a space to facilitate this.
- The Trust reviews and re-develops its guidance to be clear and consistent in its advice in line with national recommendations to support staff to assess and offer mothers to attend triage if there is any uncertainty about whether prelabour rupture of the membranes has occurred.
- The Trust review works with staff to promote the use of a structured communication pathway to support the sharing of information about the number and content of calls a mother makes to the triage telephone advice line when transferring to another area to inform clinical decision-making.
- The Trust review its guidance to ensure it reflects the system currently in use with a particular focus on the number of calls made by a mother and how this is communicated to relevant members of staff. MNSI recommends that the Trust supports maternity triage staff to undertake a full holistic assessment for every mother attending the triage assessment unit to provide a comprehensive review of maternal and fetal wellbeing.

Actions to meet these recommendations have been developed and are underway. A case on a page has also been developed and has been shared with all maternity staff (appendix 2).

The final MNSI report is included in full in appendix 3 for information.

9. UPDATE ON OTHER WORKSTREAMS

9.1 – Postnatal readmissions due to wound infections

Further to previous information shared regarding the number of women readmitted to the maternity unit due to wound infections, a wound surveillance working group has been established. Actions are underway as follows:

- Review literature search into 'QI projects to reduce c-section SSI' at next Wound Surveillance meeting (December 2024)
- 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

A slide deck containing more detail regarding the current position is included in appendix 4.

9.2 – Postnatal readmissions due to hypertension

The Q2 review of postnatal readmissions shared to November QAC identified a number of avoidable cases of readmission related to blood pressure management not being optimised prior to discharge home. A cluster review has been completed, the learning and actions from this are included in detail in appendix 5.

Summary actions are as follows:

- Theme of increased incidence of postnatal readmissions escalated to labour ward lead:
- Plan to develop discharge checklist with labour ward lead for women with known hypertension antenatally or in labour
- Education around the importance of regular BP monitoring shared with maternity ward team.
- Review of BadgerNet system and early warning score undertaken by Digital midwife and maternity ward manager.
- Education shared with maternity ward team about 'red/yellow' score and appropriate escalation and monitoring
- Awaiting roll out of national MEWS2 tool (planned March 2025)
- Regional guideline for pre-eclampsia and gestational hypertension in progress

10. COMPLAINTS

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

Specialty	Description	Complaint Opened
Maternity	Concerns regarding birth trauma experienced in 2022.	23/10/2024

The other complaint received related to care within the child health service.

11. RECOMMENDATIONS

No Regulation 28 enquiries have been received

12. RECOMMENDATIONS

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

Appendix two - Learning from investigations – case MI- 037421

MNSI
Maternity & Newborn
Safety Investigations

Learning from Investigations

NHS
Warrington and Halton
Teaching Hospitals
NHS Foundation Trust

The Case

The mother was booked for low-risk care at MFT in her first pregnancy. During a routine pregnancy appointment at 31+1 weeks, it was noticed that the growth was below what was expected, and she was referred for an ultrasound scan. This scan (31+6 weeks) and a further growth scan at 34+3 weeks showed that the Baby was growing as expected.
The mother transferred her care from MFT to WHH at 36+5 weeks gestation and she was risk assessed for shared care. The Mother had an additional scan at 36+6 weeks as it was thought the Baby may be in a breech 'bottom first' position. The Baby's growth was not assessed during this scan.
The Mother called the maternity triage unit at 38+5 weeks reporting a 'watery loss'. She was reassured and remained at home. Following this, she experienced stomach pains which increased in intensity, and she made telephone calls and attended the maternity triage unit once over several days.
During a routine pregnancy review at 39+2 weeks her blood pressure was found to be higher than the expected ranges and her stomach pain continued to worsen. The Mother attended the maternity triage unit. A CTG and BP profile were complete which were within normal parameters, and she was discharged with an appointment for her to have her BP checked again at 39+5 weeks.
The following day, the Mother called the maternity triage unit as the Baby was not as active as usual since the previous night and her pains were unbearable. She attended the maternity triage unit for assessment and the Baby was found to have sadly died. The Mother was transferred to the labour ward when her cervix was found to be 3cm to 4cm dilated and her waters were artificially broken. The Mother's labour continued into the following day (39+4 weeks), when the Baby was stillborn.
The Mother and Father consented to a post-mortem examination (PME) which found the Baby was small and cause of death was placental abruption.

MNSI Findings

- There was no robust system or guideline in place to share maternity records between Trusts. This meant that the previous concerns about the Baby's growth were not considered to inform the Mother's future care.
- Different growth charts were in use by each Trust which led to discrepancies between measurements of the Baby's growth.
- The BSOTs telephone triage advice did not support staff to invite a mother for assessment with suspected broken waters when the Mother called at 38+5 weeks. This meant that there was no assessment of whether the Mother's waters had broken.
- There is evidence that triage care is not prioritised due to there being no dedicated telephone triage midwife and redeployment of staff who may be initially allocated to telephone triage duties.
- When the Mother attended triage at 39+1 weeks all information about the previous calls to triage was not included. The Mother's BSOTs rating was incorrectly assessed as 'green', which meant when she attended with a stomach-ache, the required obstetric review did not take place. This meant that no further action was taken to further investigate, her unexplained pain in early labour, her multiple telephone calls to triage, and the latent phase of labour lasting days.
- When the Mother was referred to triage at 39+2 weeks with raised blood pressure in addition to her unexplained pain, the multiple telephone triage calls and the latent phase of labour lasting over several days; due to a focused approach on the presenting condition and not accessing the previous calls the required holistic obstetric review did not occur.
- There was postmortem evidence indicating the Mother may have had an unknown, prolonged rupture of membranes with the presence of an infection.

MNSI Safety Recommendation	Trust actions and learning
MNSI recommends that Trusts develop a structured information transfer process to ensure that staff can access and retrieve the required information to inform ongoing clinical decision making and management of care.	To liaise with the LMNS Maternity and Neonatal Safety Oversight Group to support the development of robust care pathways for women who are cared for across the C&M region.
MNSI recommends that the Trust review its guidance to meet national recommendations to develop a robust person, systems-centred process and environment to support the role of dedicated midwifery staff to be solely responsible for the telephone triage advice line service and provide a space to facilitate this.	To review the establishment for maternity triage establishment to ensure this reflects the requirement for dedicated midwifery staff for telephone triage.
MNSI recommends that the Trust reviews and re-develops its guidance to be clear and consistent in its advice in line with national recommendations to support staff to assess and offer mothers to attend triage if there is any uncertainty about whether prelabour rupture of the membranes has occurred.	Review the Trust Triage Operational Policy (BSOTs) for alignment with national guidance (NG235).
MNSI recommends that the Trust works with staff to promote the use of a structured communication pathway to support the sharing of information about the number and content of calls a mother makes to the triage telephone advice line when transferring to another area to inform clinical decision-making.	Explore the option of data triangulation between BadgerNet and telecommunications to directly link the calls to the triage department with the patient record to ensure the safe clinical assessment of mothers and babies.
MNSI recommends that the Trust's guidance reflects the system currently in use with a particular focus on the number of calls made by a mother and how this is communicated to relevant members of staff.	Introduce daily department safety huddles to include activity and acuity with clear pathways for escalation for telephone triage. Procurement of a digital whiteboard in the maternity triage department for visibility and oversight of the activity, acuity for patient safety.
MNSI recommends that the Trust supports maternity triage staff to undertake a full holistic assessment for every mother attending the triage assessment unit to provide a comprehensive review of maternal and fetal wellbeing.	Existing Maternity Triage Working group to review the assessment in BadgerNet to provide assurance that completion of this is evidence of a comprehensive review of maternal and fetal wellbeing. Audit the completion of the full holistic assessment within BadgerNet for women who attend the maternity triage department for assurance.

Lisa Davies Jan 2023

NHS Maternity Services Survey 2024 Benchmark Report

Warrington And Halton Teaching Hospitals NHS Foundation Trust



NHS

Care Quality Commission

Survey Coordination Centre

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5. Comparison to Other Trusts
- Comparison to other trusts

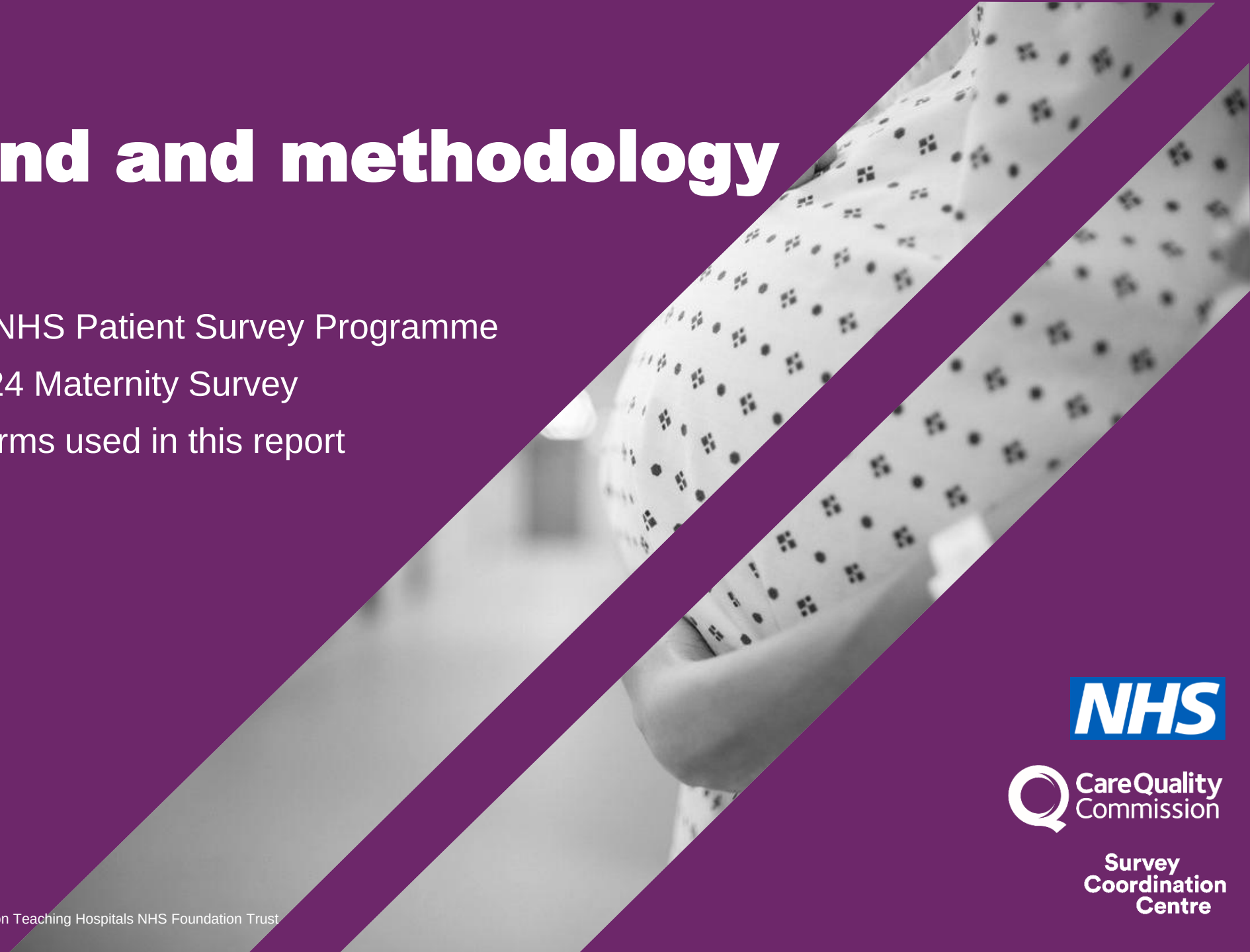
This work was carried out in accordance with the requirements of the international standard for organisations conducting social research (accreditation to ISO27001:2013; certificate number GB10/80275).

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Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the 2024 Maternity Survey
- a description of key terms used in this report
- navigating the report



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Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Maternity Survey was first carried out in 2007. The 2024 Maternity Survey will be the eleventh caried out to date. CQC use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The 2024 Maternity Survey

The survey was administered by the Survey Coordination Centre (SCC) at Picker.

A total of 46,687 maternity service users were invited to participate in the survey across 120 NHS trusts.

Completed responses were received from 18,951 maternity service users, an adjusted response rate of 41.2%.

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. Full sampling criteria can be found in the sampling instructions.

Fieldwork took place between May and August 2024.

Trend data

In 2021, the Maternity Survey transitioned from a solely paper-based methodology to both paper and online. This dual approach was continued in 2022, 2023 and 2024.

Analysis conducted prior to the 2021 survey, concluded that this change in methodology did not have a detrimental impact on trend data. Therefore, data from the 2013 survey and subsequent years are comparable with previous years, unless a question has changed or there are other reasons for lack of comparability such as changes in organisational structure of a trust.

Where results are comparable with previous years, a section on historical trends has been included. Where there are insufficient data points for historical trends, significance testing has been carried out against 2023 data.

Further information about the survey

- For published results and for more information on the Maternity Survey, please visit the Maternity Survey page on the NHS Surveys website.
- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Patient Surveys website.
- To learn more about CQC's survey programme, please visit the CQC website.

Background and Methodology (continued)

Antenatal and Postnatal data

The Maternity Survey is split into four sections that ask questions about:

- Antenatal care
- Labour and birth
- Postnatal care
- Complaints

It is possible that some maternity service users may have experienced the first three stages of care in different trusts. This may be for many reasons such as moving home, or having to travel for more specialist care, or due to variation in service provision across the country. For the purpose of benchmarking, it is important that we understand which trust the respondent is referring to when they are completing each section of the survey.

When answering survey questions about labour and birth we can be confident that in all cases respondents are referring to the trust from which they were sampled. It is therefore possible to compare results for labour and birth across all 120 NHS trusts that took part in the survey.

Trusts were asked to carry out an “attribution exercise”, where each trust identifies the individuals in their sample that are likely to have also received their antenatal and postnatal care from the trust. This is done using either electronic records or residential postcode information. This attribution exercise was first carried out in the 2013 survey. In 2024, all of the 120 trusts that took part in the survey completed this exercise.

The survey results contained in this report include only those respondents who were identified as receiving care at this trust.

Limitations of this approach

Data is provided voluntarily. In 2024, all trusts provided this data. The antenatal and postnatal care sections of this report are therefore benchmarked against all trusts that provided the required information.

Some trusts do not keep electronic records of antenatal and postnatal care. Where this is the case, location of antenatal and postnatal care is based on residential location of respondents. This is not a perfect measure of whether antenatal and postnatal care was received at the trust. For example, respondents requiring specialist antenatal or postnatal care may have received this from another trust. This may mean that some respondents are included in the data despite having received care from another trust.

Key terms used in this report

The ‘expected range’ technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the Comparison to Other Trusts section.

Standardisation

Demographic characteristics, such as age, can influence care experiences and how they are reported. Since trusts have differing profiles of maternity service users, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual service user responses to account for differences in demographic profile between trusts.

For each trust, results have been standardised by parity (whether or not a service user has given birth previously) and age of respondents to reflect the ‘national’ age distribution (based on all respondents to the survey). This helps ensure that no trust will appear better or worse than another because of its profile of maternity users and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For selected questions in the survey, the individual (standardised) responses are converted into scores, typically 0, 5, or 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example A2), and others are ‘routing questions’, which are designed to filter out respondents to whom subsequent questions do not apply (for example C23). These questions are not scored. Please refer to the scored questionnaire for further details. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied. More information can be found in the ‘An example of scoring’ slide.

National average

The ‘national average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document which is on the 'Analysis and Reporting' section of the 2024 Maternity Survey webpage on the NHS surveys website.

Using the survey results

Navigating this report

This report is split into five sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the maternity service users who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Only trusts that provide data on antenatal and/or postnatal care and have sufficient respondent numbers are also provided with survey results for antenatal and postnatal care within this report.
- **Change over time** – includes your trust's mean score for each evaluative question in the survey shown in a significance test table, comparing it to your 2023 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.
- **Comparison to Other Trusts** – includes additional data for your trust.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section 'Benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the 'How to interpret benchmarking in this report' slides.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; technical document: https://www.cqc.org.uk/publications/surveys/maternity-survey
- National and trust-level data for all trusts who took part in the 2024 Maternity Survey https://nhssurveys.org/surveys/survey/04-maternity/year/2024/. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how CQC monitors hospitals: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the best and worst scores for your trust



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Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of maternity service users who took part in the survey.

300 invited to take part

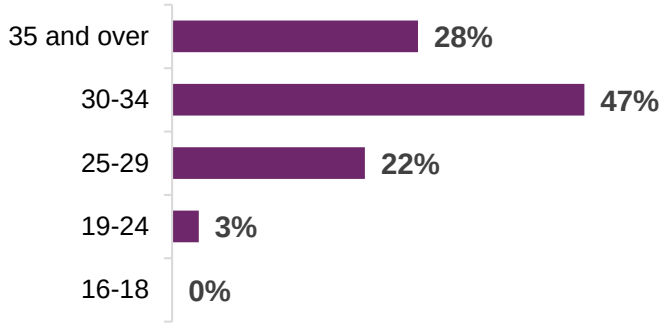
132 completed

44% response rate

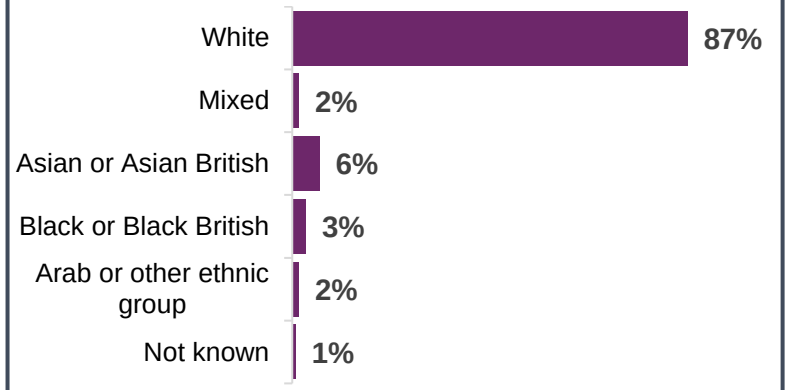
41% average response rate for all trusts

41% response rate for your trust in 2023

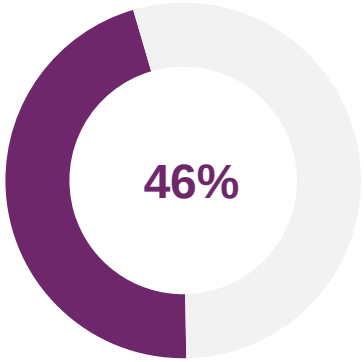
Age



Ethnicity



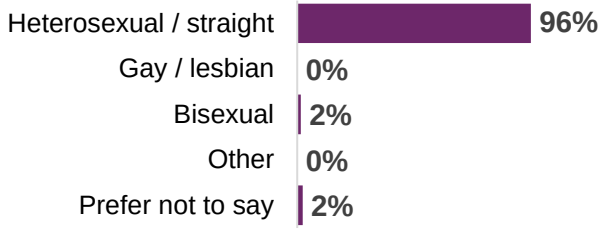
Parity



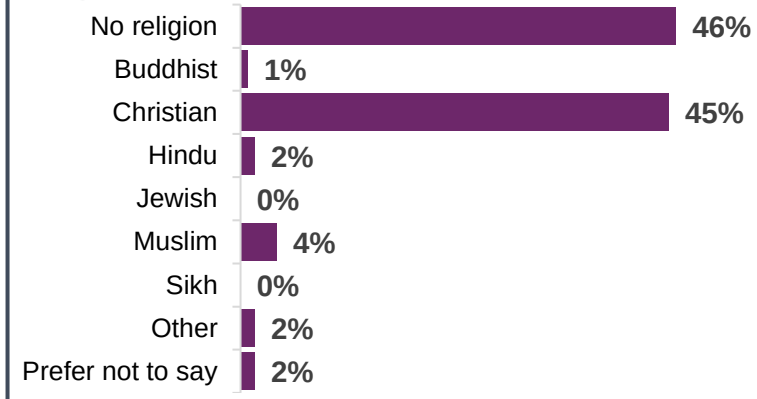
of respondents gave birth to **their first baby**.

Sexuality

Which of the following best describes your sexual orientation?



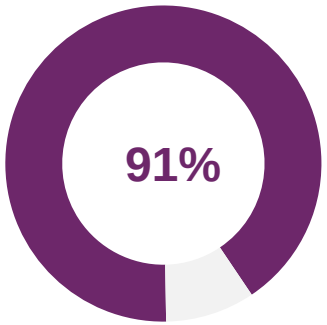
Religion



Who took part in the survey? (continued)

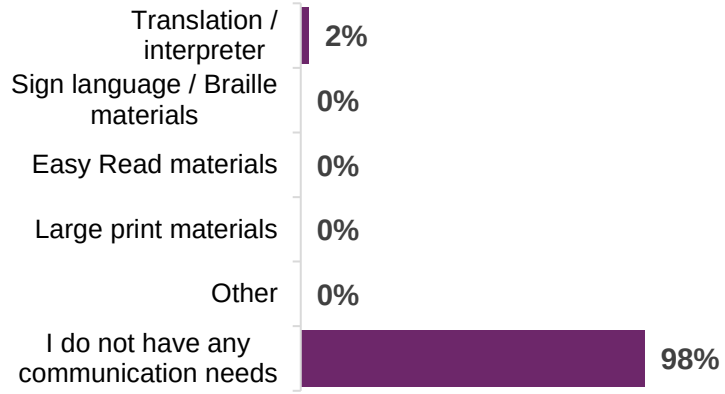
This slide is included to help you interpret responses and to provide information about the population of maternity service users who took part in the survey.

English as main language

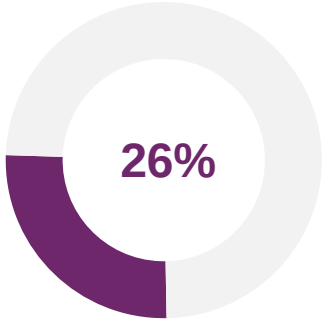


of maternity service users have **English as their main language.**

Types of communication needs

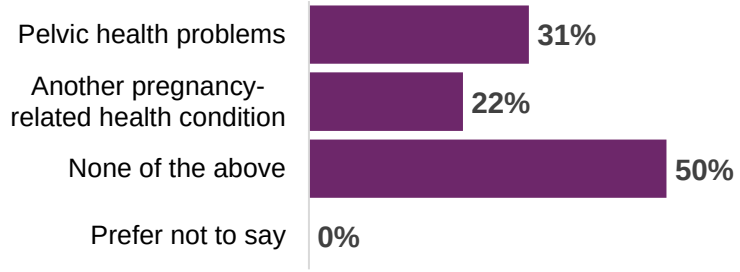


Long-term conditions

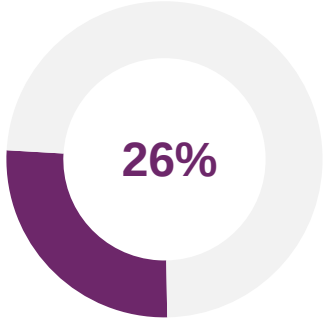


of maternity service users have a **physical or mental health condition or illness** that has lasted or is expected to last for 12 months or more.

Pregnancy-related health conditions



Baby received neonatal care

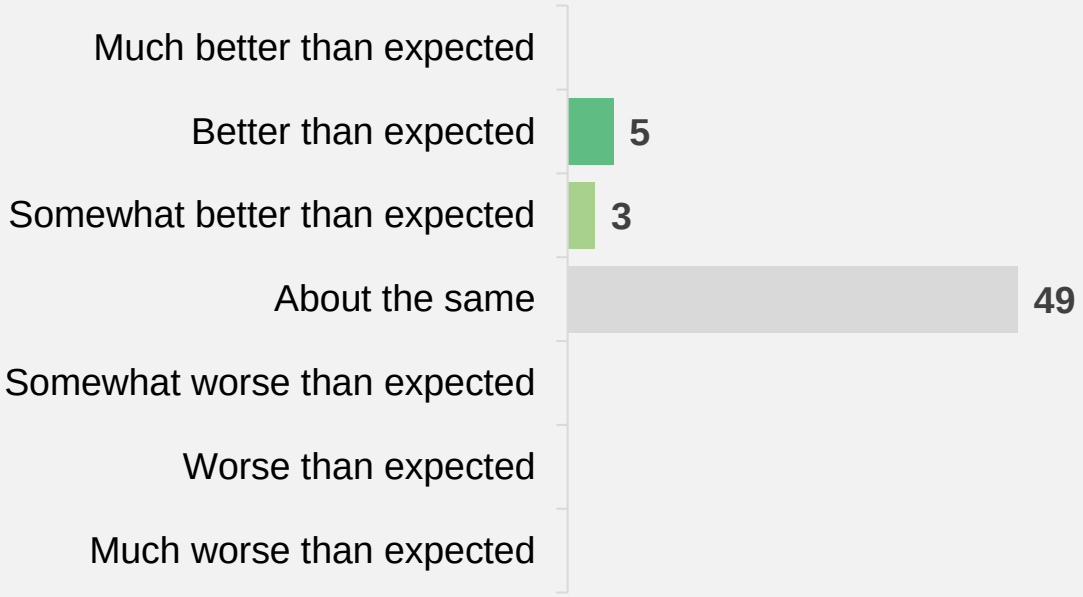


of respondents reported that their baby received **neonatal care**.

Summary of findings for your trust

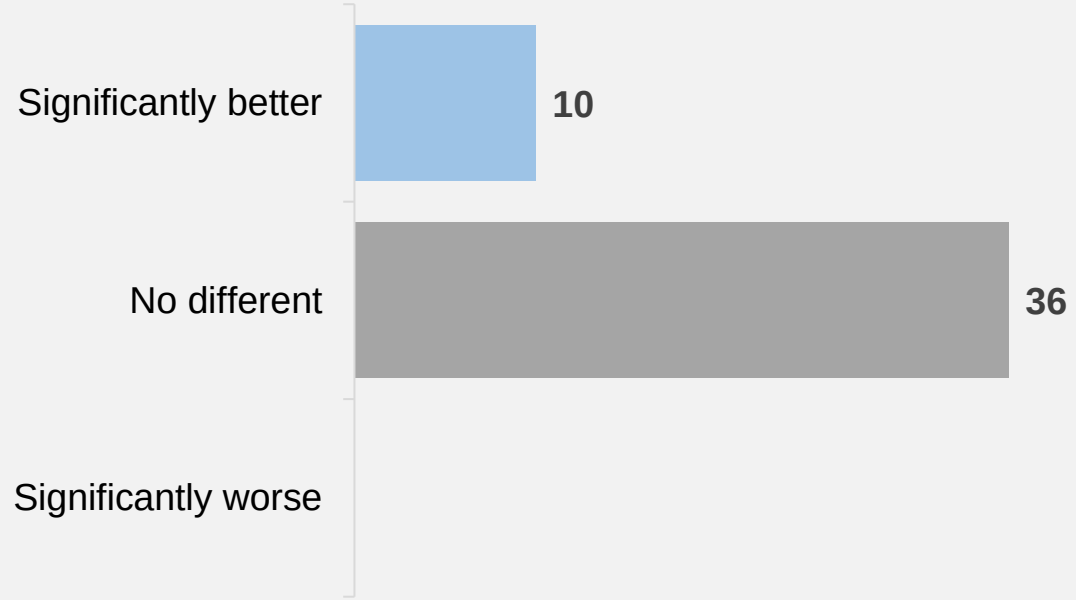
Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2024 vs 2023.



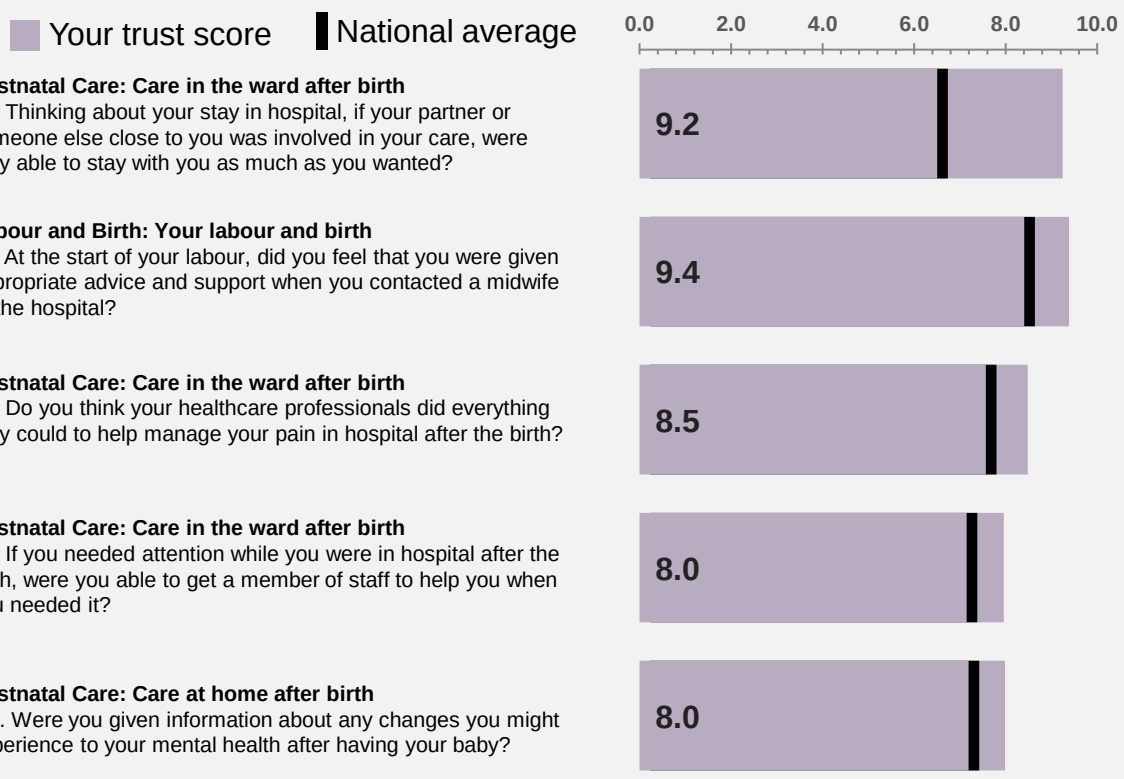
For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the section "Comparison to Other Trusts".

Best and worst performance relative to the national average

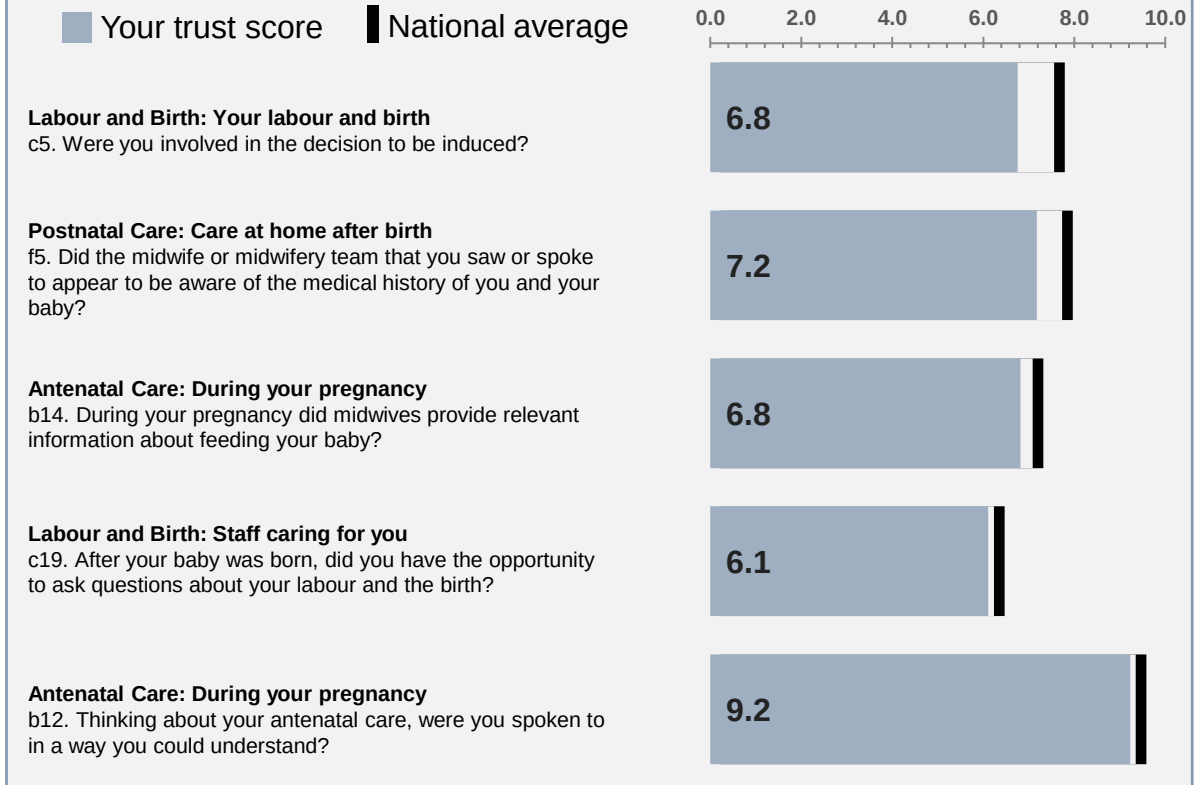
These five questions are calculated by comparing your trust's results to the the average trust score across England.

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.

Top five scores (compared with national average)



Bottom five scores (compared with national average)



2024 Maternity Survey

Results for Warrington And Halton Teaching Hospitals NHS Foundation Trust

Where service user experience is best

- ✓ **Postnatal Care: Care in the ward after birth:** Partner or someone else close to service user was able to stay as much as the service user wanted
- ✓ **Labour and Birth: Your labour and birth:** Feeling that they were given appropriate advice and support when they contacted a midwife or the hospital
- ✓ **Postnatal Care: Care in the ward after birth:** Healthcare professionals doing everything they could to manage service user's pain
- ✓ **Postnatal Care: Care in the ward after birth:** Being able to get help from staff when needed
- ✓ **Care after birth:** Being given information about possible changes to mental health

Where service user experience could improve

- ○ **Labour and Birth: Your labour and birth:** Being involved in the decision to be induced
- ○ **Care after birth:** Midwife/midwifery team being aware of service user and baby's medical history
- ○ **Antenatal care: During your pregnancy:** Relevant information provided from midwives to service users about feeding their baby
- ○ **Labour and Birth: The staff caring for you:** Being offered the opportunity to ask questions about the labour and birth
- ○ **Antenatal care: During your pregnancy:** Being spoken to in a way they could understand

These questions are calculated by comparing your trust's results to the national average. "Where service user experience is best": These are the five results for your trust that are highest compared with the national average. "Where service user experience could improve": These are the five results for your trust that are lowest compared with the national average.

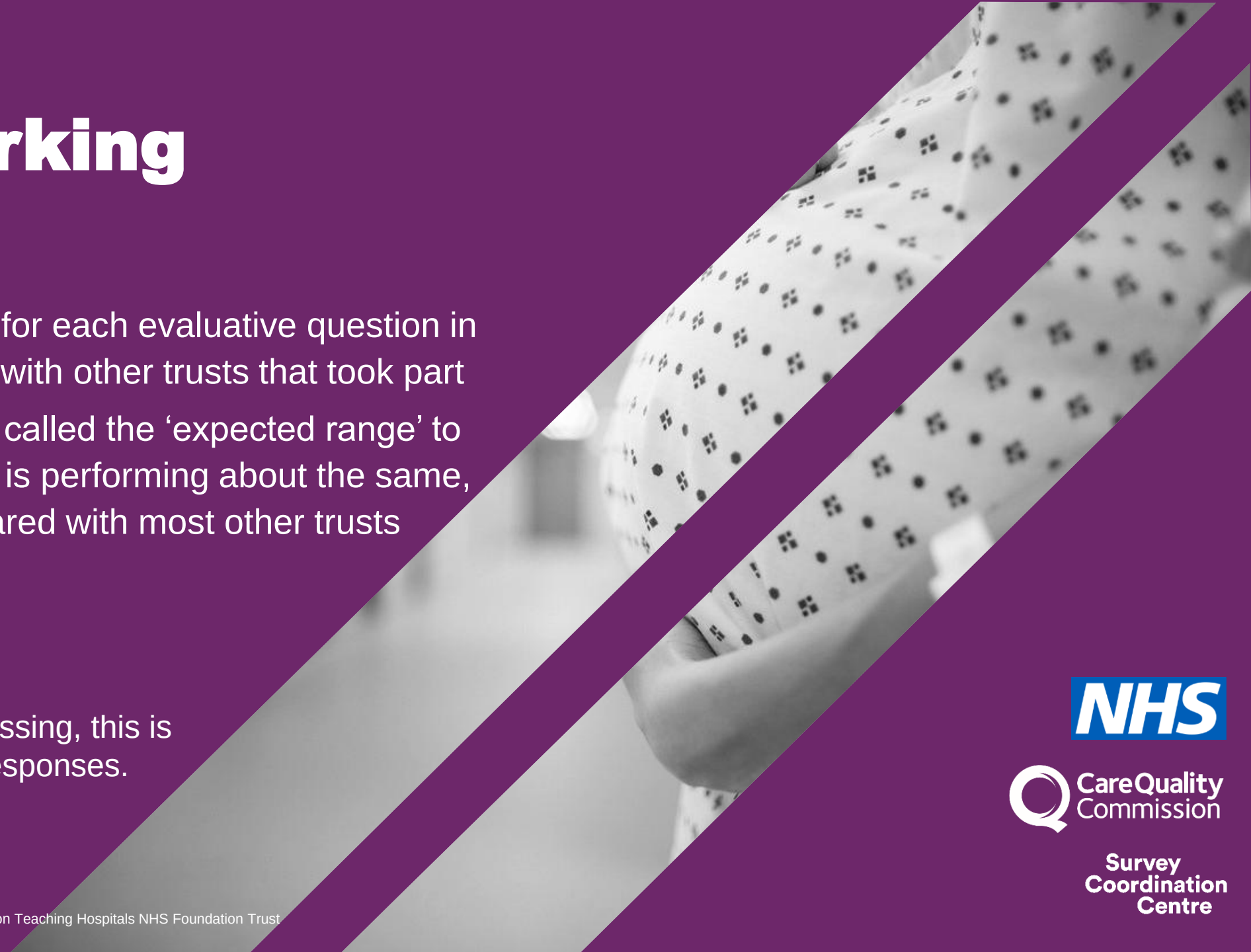


This survey looked at the experiences of service users who gave birth at the trust in January and/or February 2024. Between May and August 2024, a questionnaire was sent to 300 recent service users who gave birth at Warrington And Halton Teaching Hospitals NHS Foundation Trust. Responses were received from 132 service users at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

Benchmarking

This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts



Please note: If data is missing, this is due to a low number of responses.

NHS

Care Quality Commission

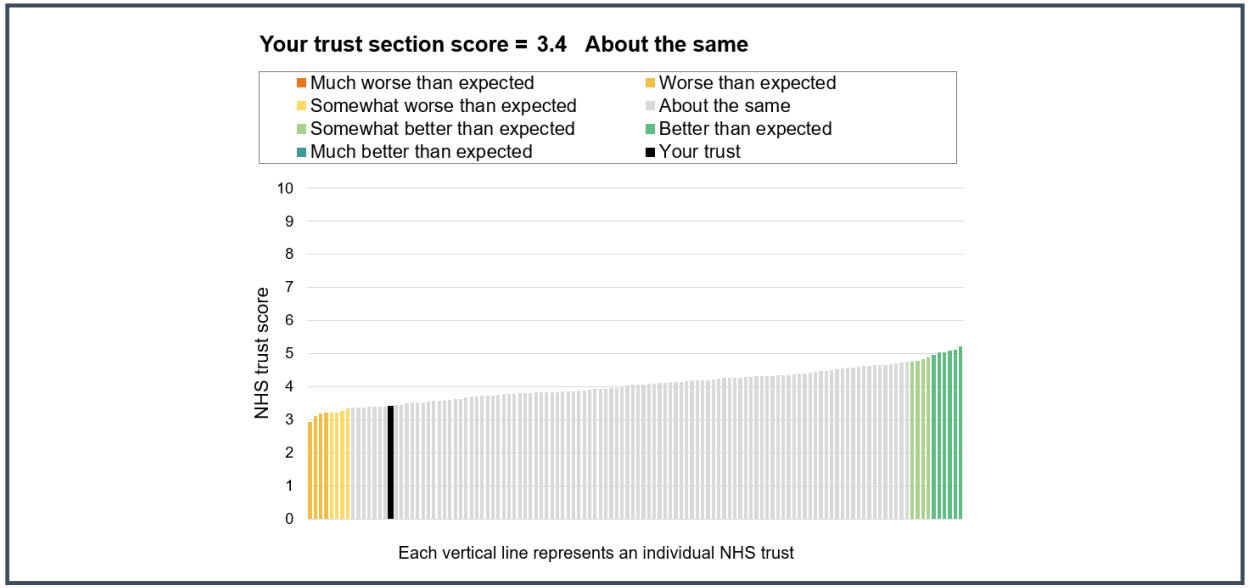
Survey Coordination Centre

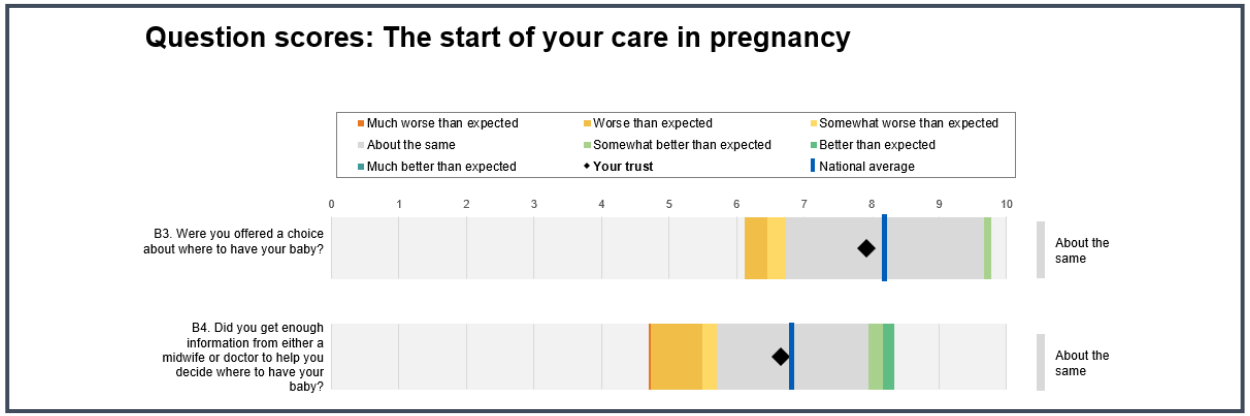
How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange section** of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

The ‘much better than expected’, ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’, and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases, this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the maternity service user's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive maternity service user experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of maternity service user experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question B11 "During your pregnancy, if you contacted a midwifery team, were you given the help you needed?":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive maternity service user experience possible.
- The answer code "Yes, sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer codes "No" and "No, as I was not able to contact a midwifery team" would be given a score of 0, as these responses reflect considerable scope for improvement.
- The answer code "I did not contact a midwifery team" would not be scored, as they do not have a clear bearing on the trust's performance in terms of maternity service user experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the survey technical document.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

Benchmarking

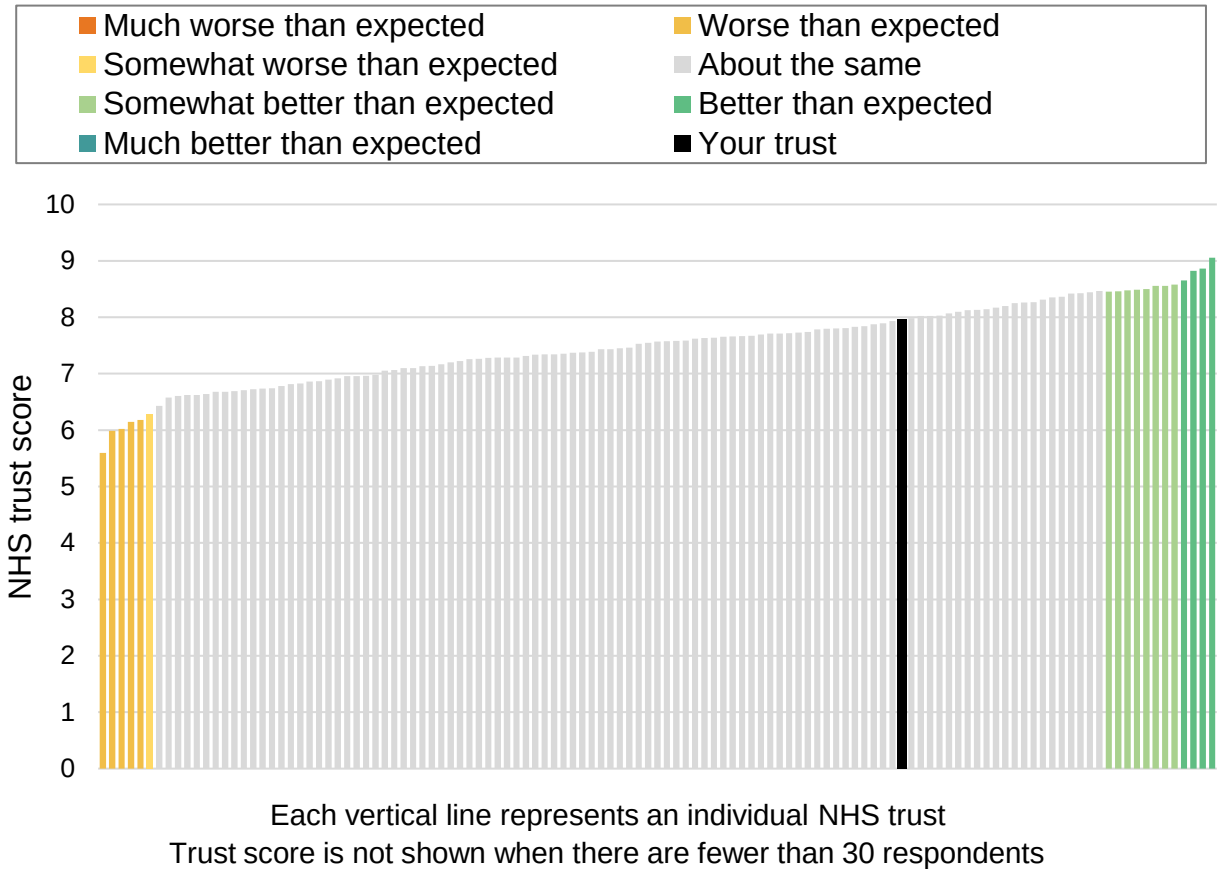
Section 1: Antenatal Care



The start of your care during pregnancy

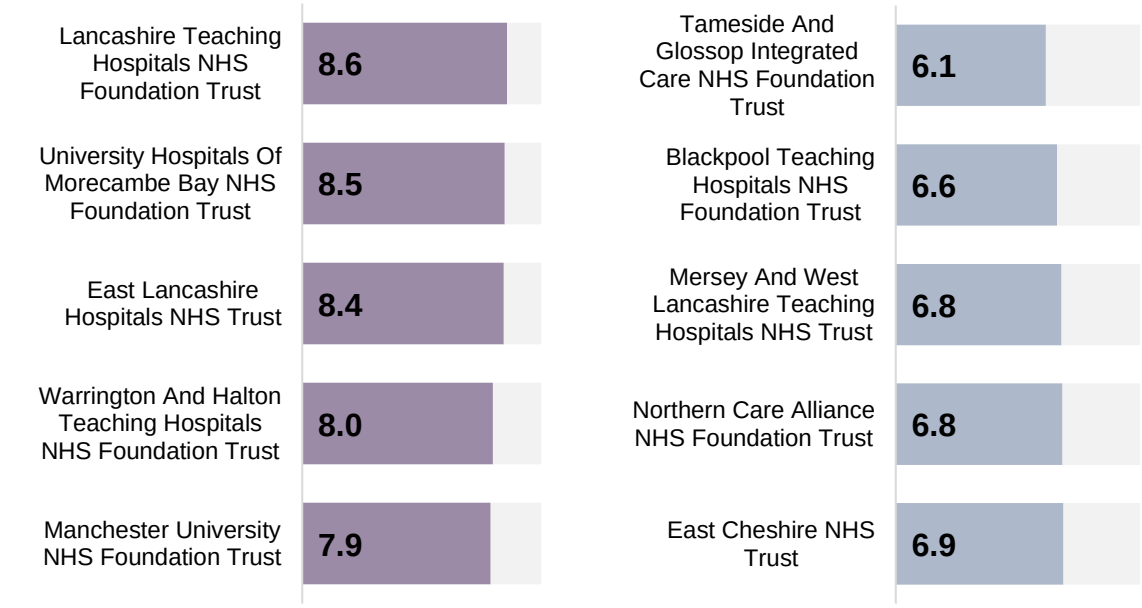
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'the start of your care during pregnancy' is calculated from questions B3 and B4. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.0 **About the same**



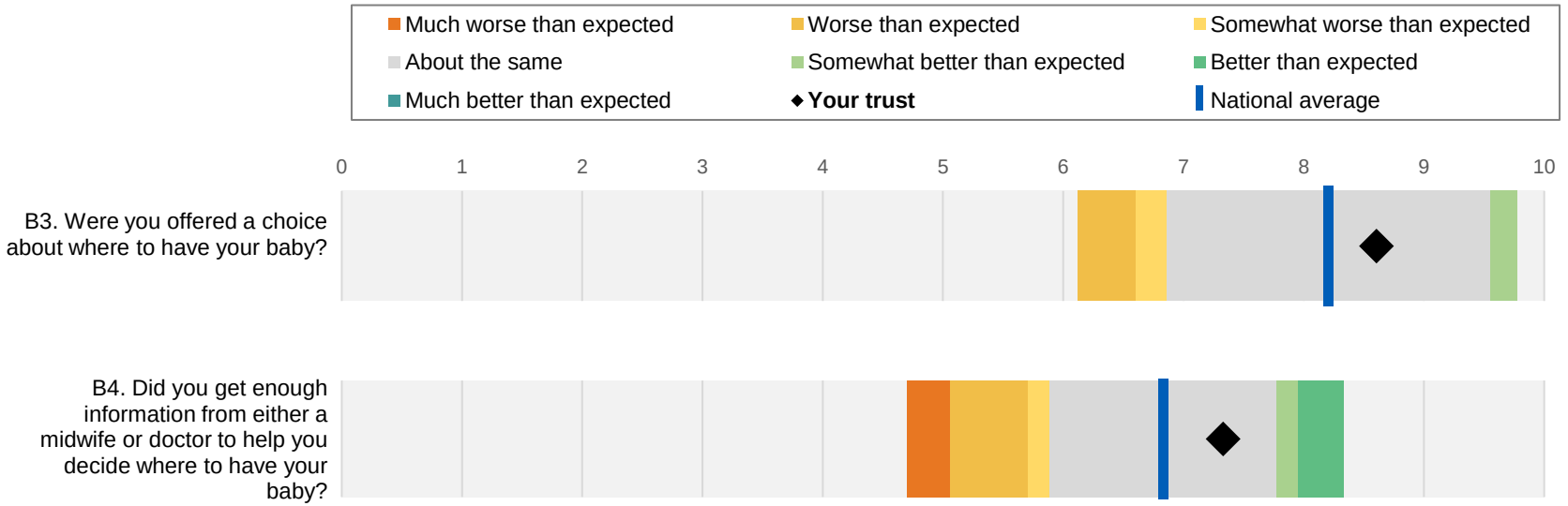
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 1. Antenatal Care

Question scores: The start of your care in pregnancy



			All trusts in England		
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
B3. Were you offered a choice about where to have your baby?	100	8.6	8.2	6.1	9.8
B4. Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	118	7.3	6.8	4.7	8.3

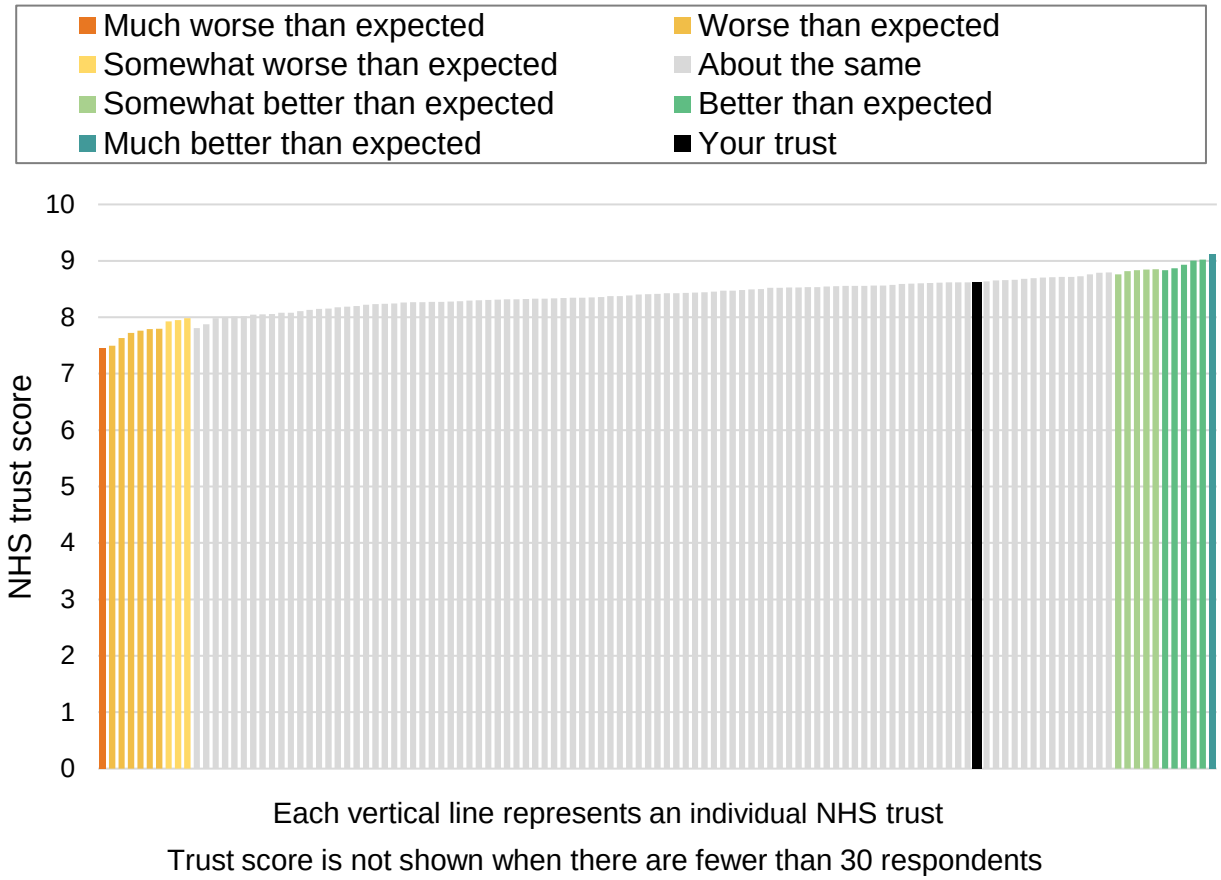
About the same

About the same

Antenatal check-ups

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'antenatal check-ups' is calculated from questions B6 to B9. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

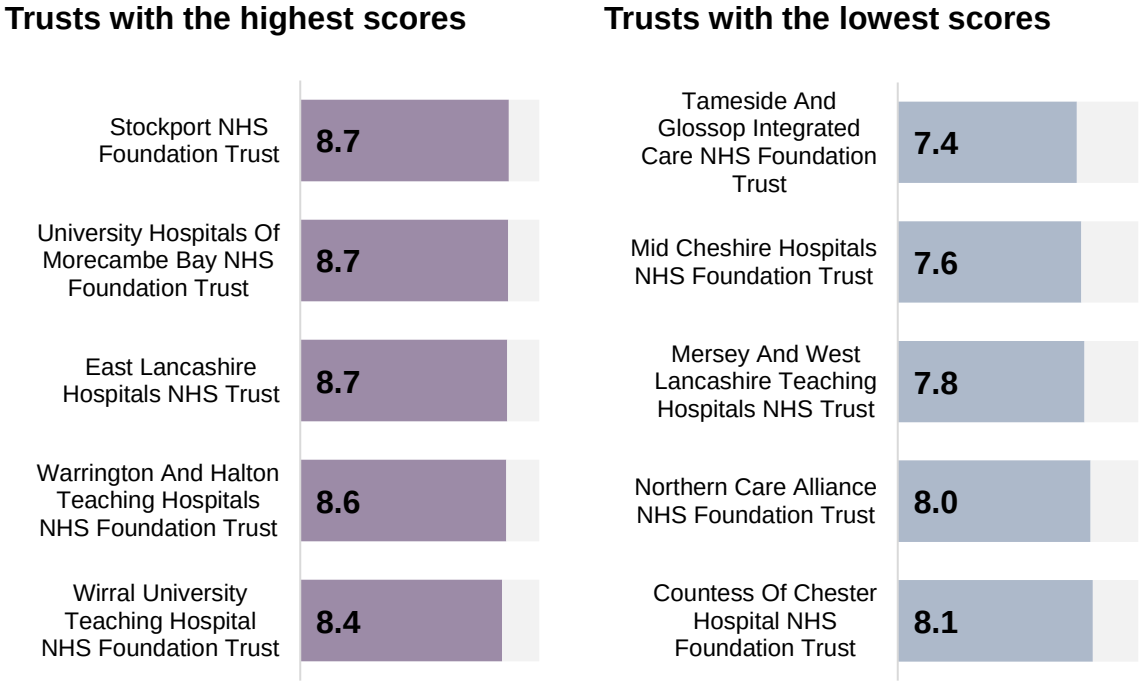
Your trust section score = 8.6 **About the same**



Each vertical line represents an individual NHS trust

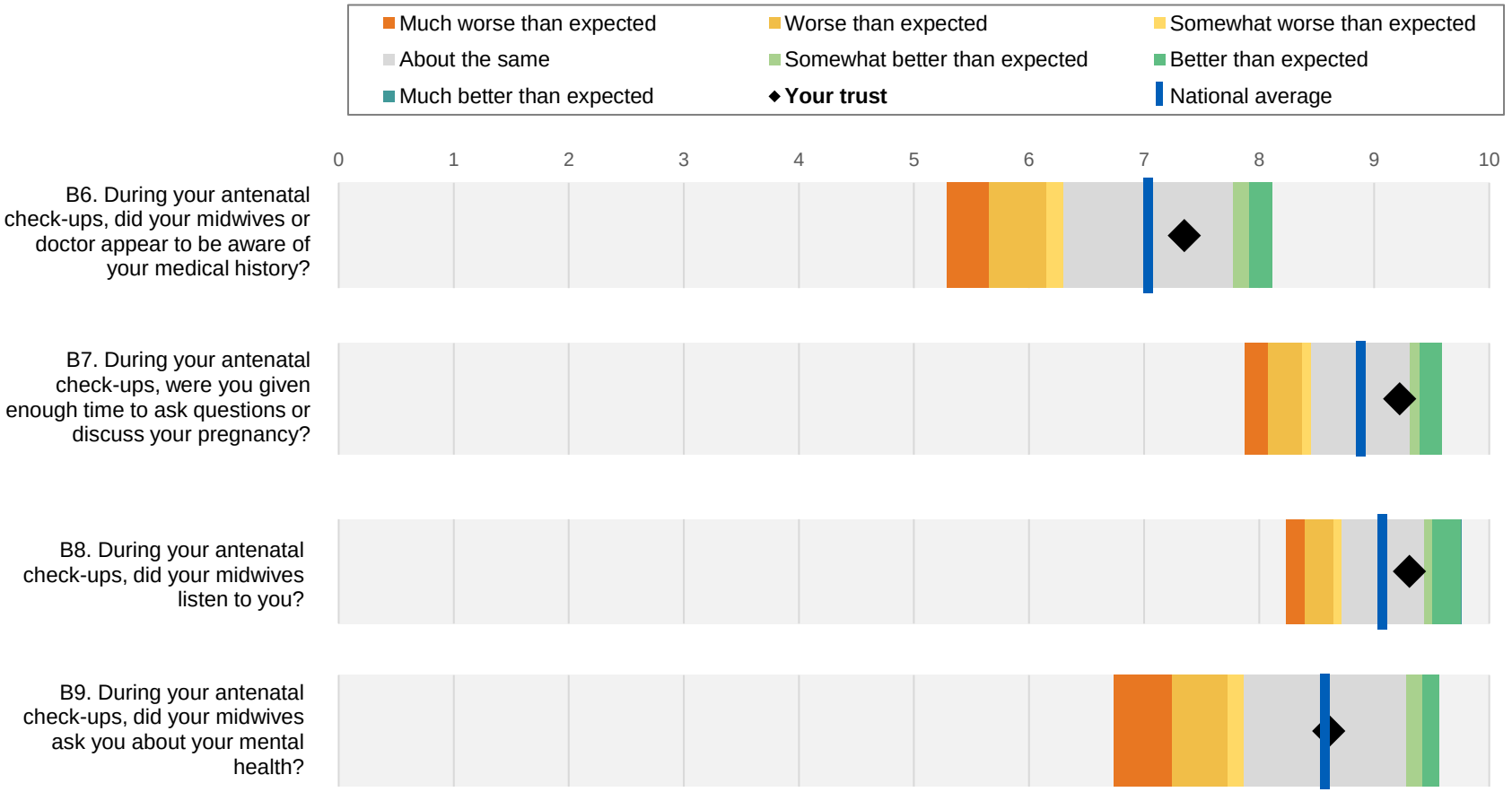
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 1. Antenatal Care

Question scores: Antenatal check-ups

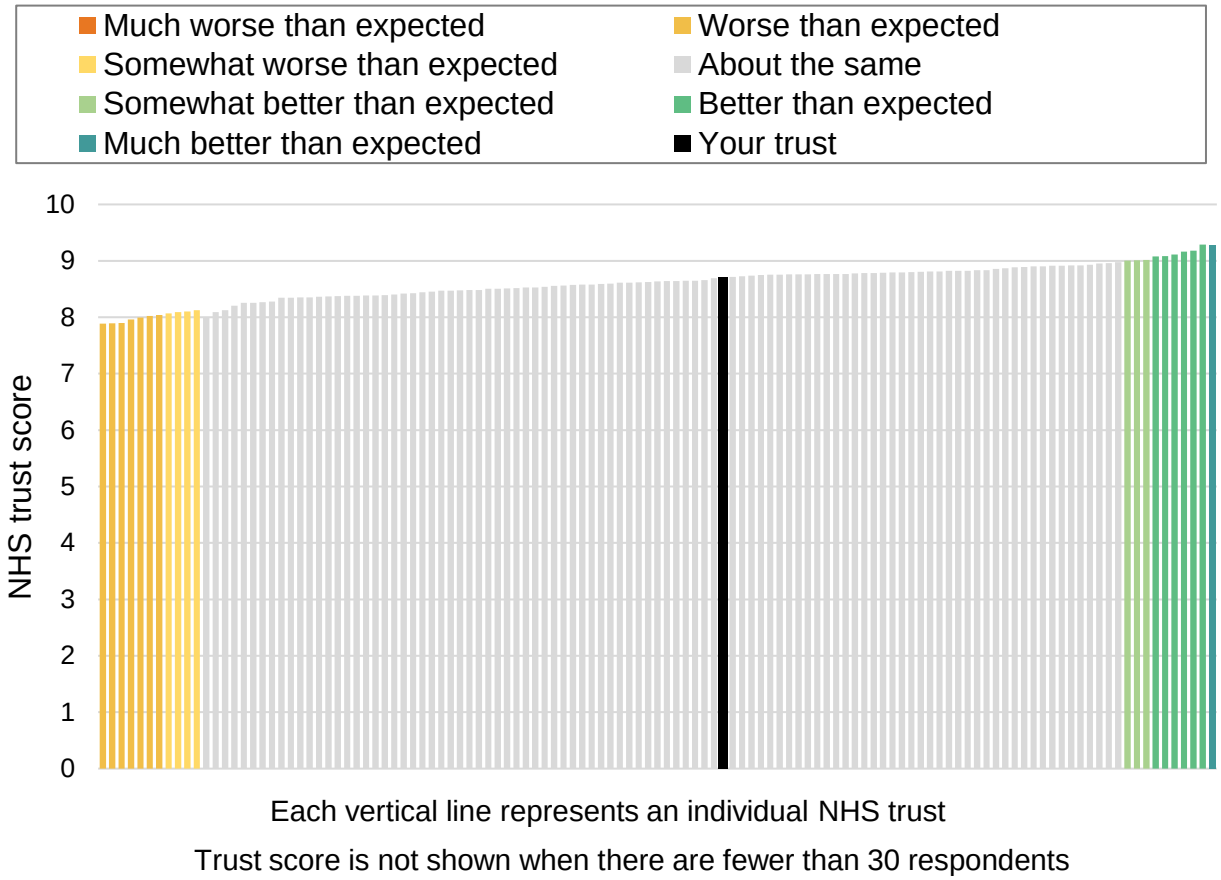


		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	123	7.3	7.0	5.3	8.1
About the same	120	9.2	8.9	7.9	9.6
About the same	122	9.3	9.1	8.2	9.8
About the same	121	8.6	8.6	6.7	9.6

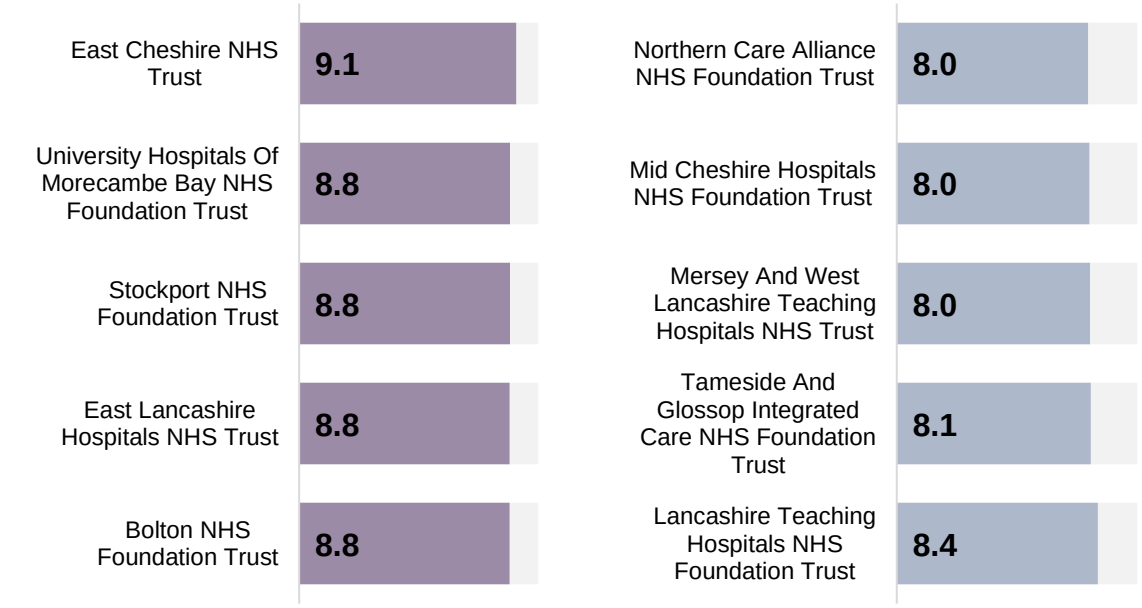
During your pregnancy

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'during your pregnancy' is calculated from questions B10 to B18. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.7 **About the same**



Comparison with other trusts within your region



Section 1. Antenatal Care

Question scores: During your pregnancy



		All trusts in England		
Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
75	8.9	8.9	7.2	9.8
111	8.6	8.3	6.9	9.3
123	9.2	9.4	8.7	9.7

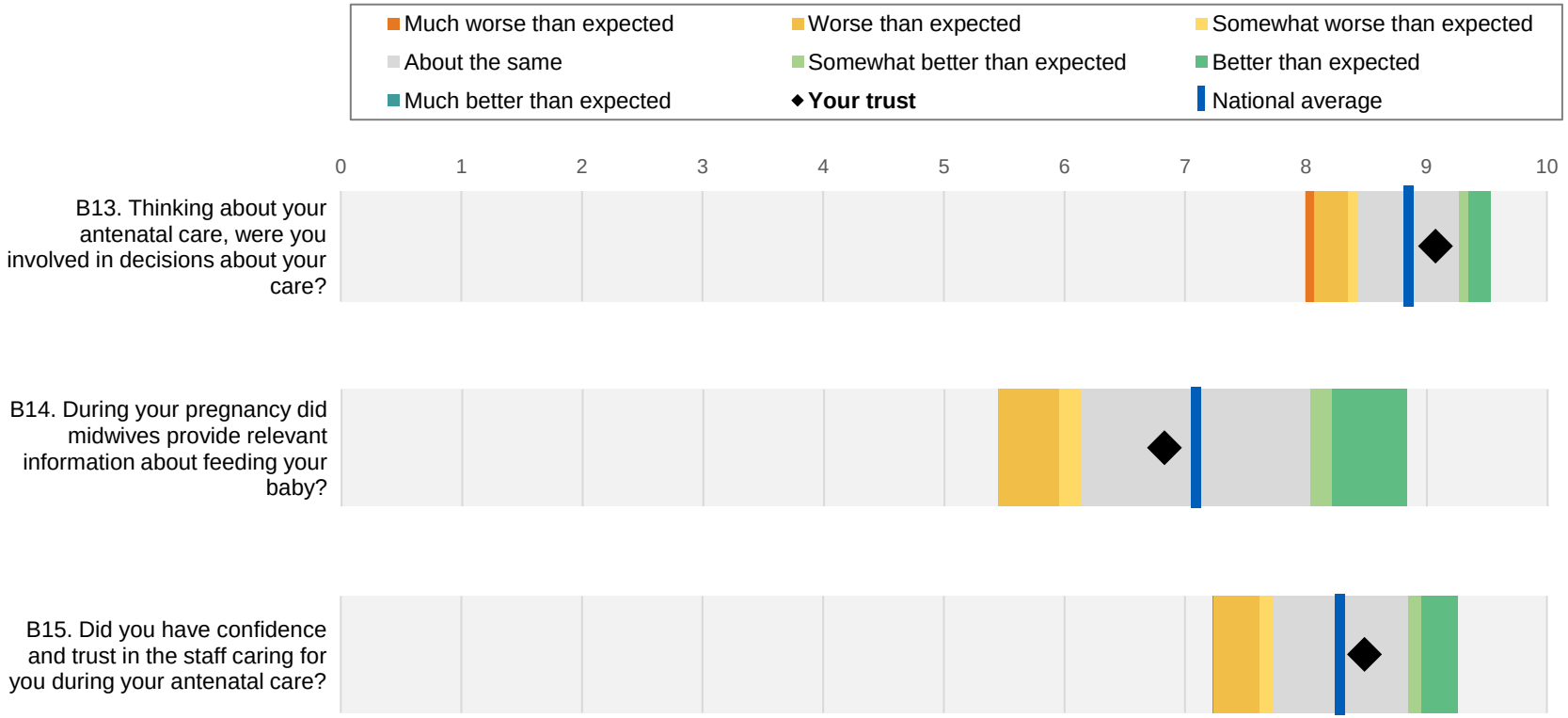
About the same

About the same

About the same

Section 1. Antenatal Care (continued)

Question scores: During your pregnancy



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	121	9.1	8.9	8.0	9.5
About the same	122	6.8	7.1	5.4	8.8
About the same	123	8.5	8.3	7.2	9.3

Section 1. Antenatal Care (continued)

Question scores: During your pregnancy



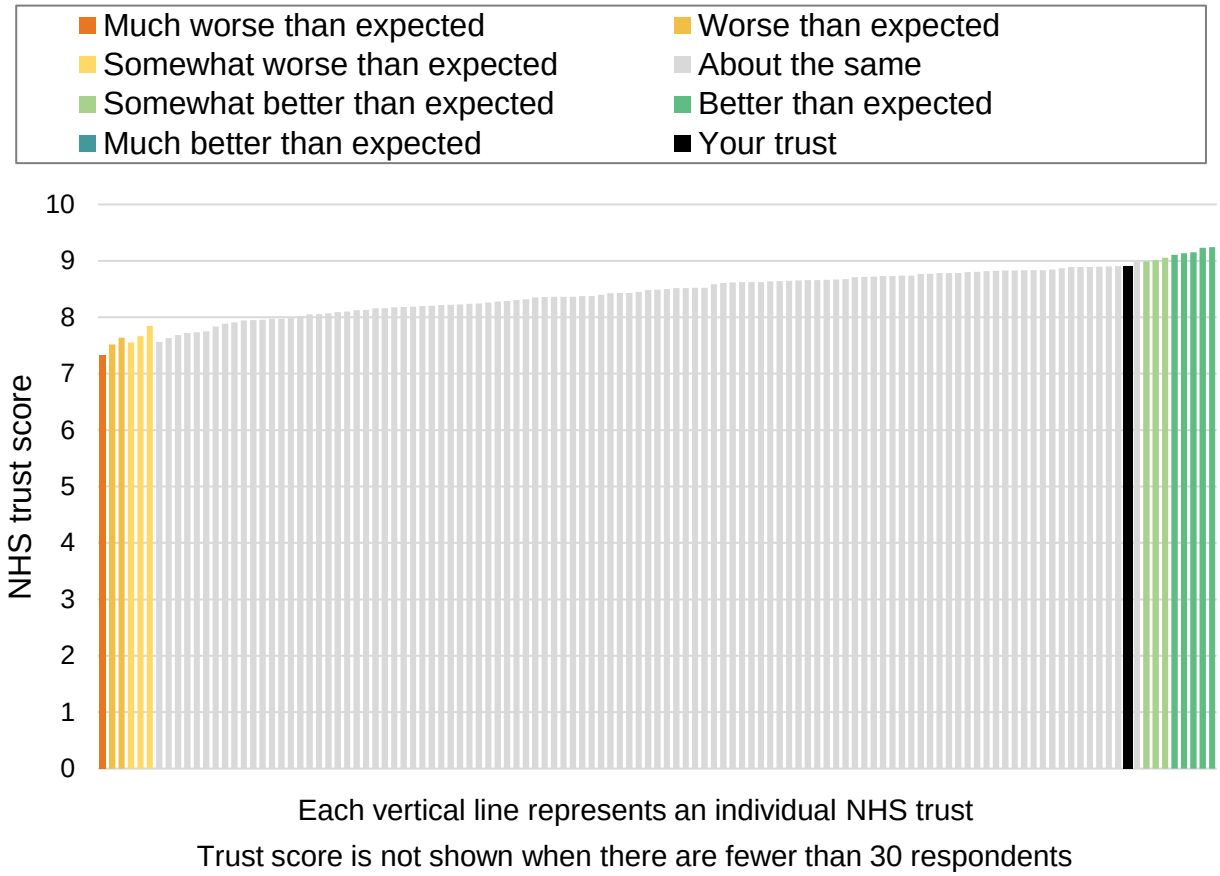
		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
B16. Thinking about your antenatal care, were you treated with respect and dignity?	122	9.5	9.3	8.6	9.8
B17. If you raised a concern during your antenatal care, did you feel that it was taken seriously?	90	8.9	8.8	7.4	9.8
B18. Thinking about your antenatal care, were you given information about any warning signs to look out for during your pregnancy?	122	9.0	8.6	7.5	9.4

About the same

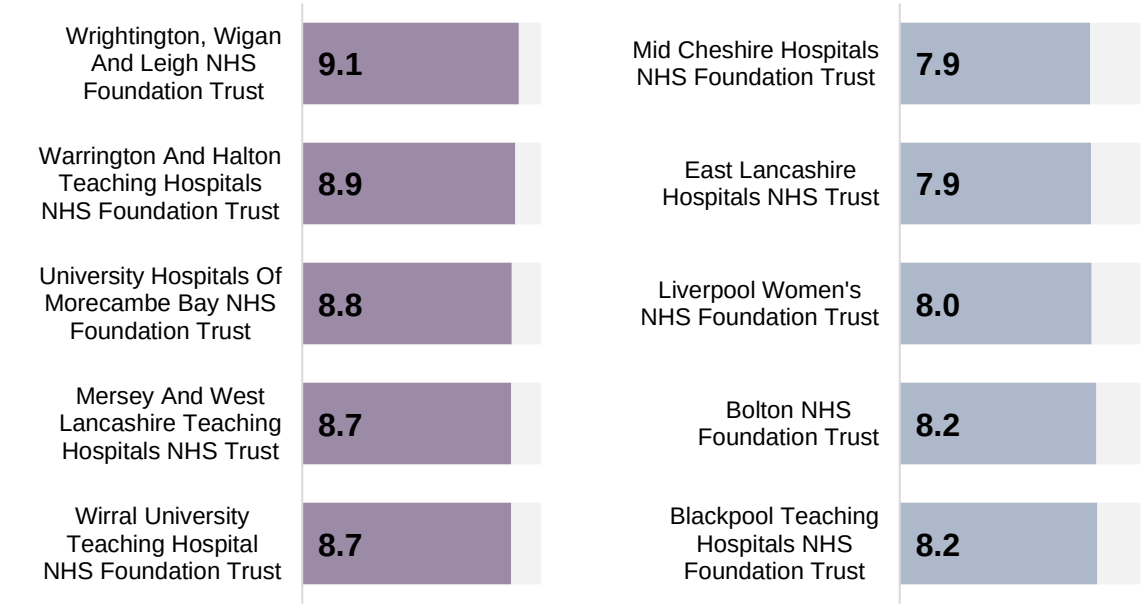
Triage: Assessment and Evaluation

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'triage: assessment and evaluation' is calculated from question B20. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.9 **About the same**

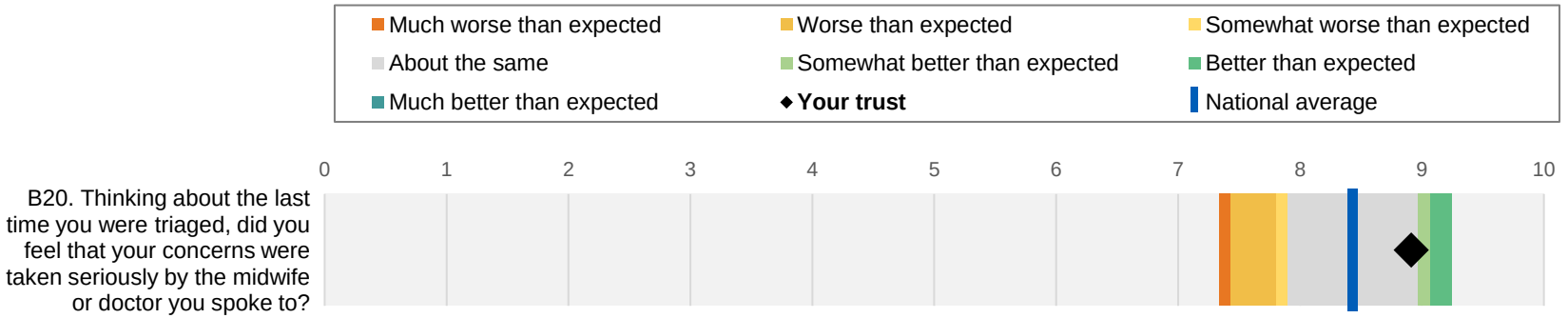


Comparison with other trusts within your region



Section 1. Antenatal Care

Question scores: Triage: Assessment and evaluation



	All trusts in England			
Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
106	8.9	8.4	7.3	9.2

Benchmarking

Section 2: Labour and Birth



NHS

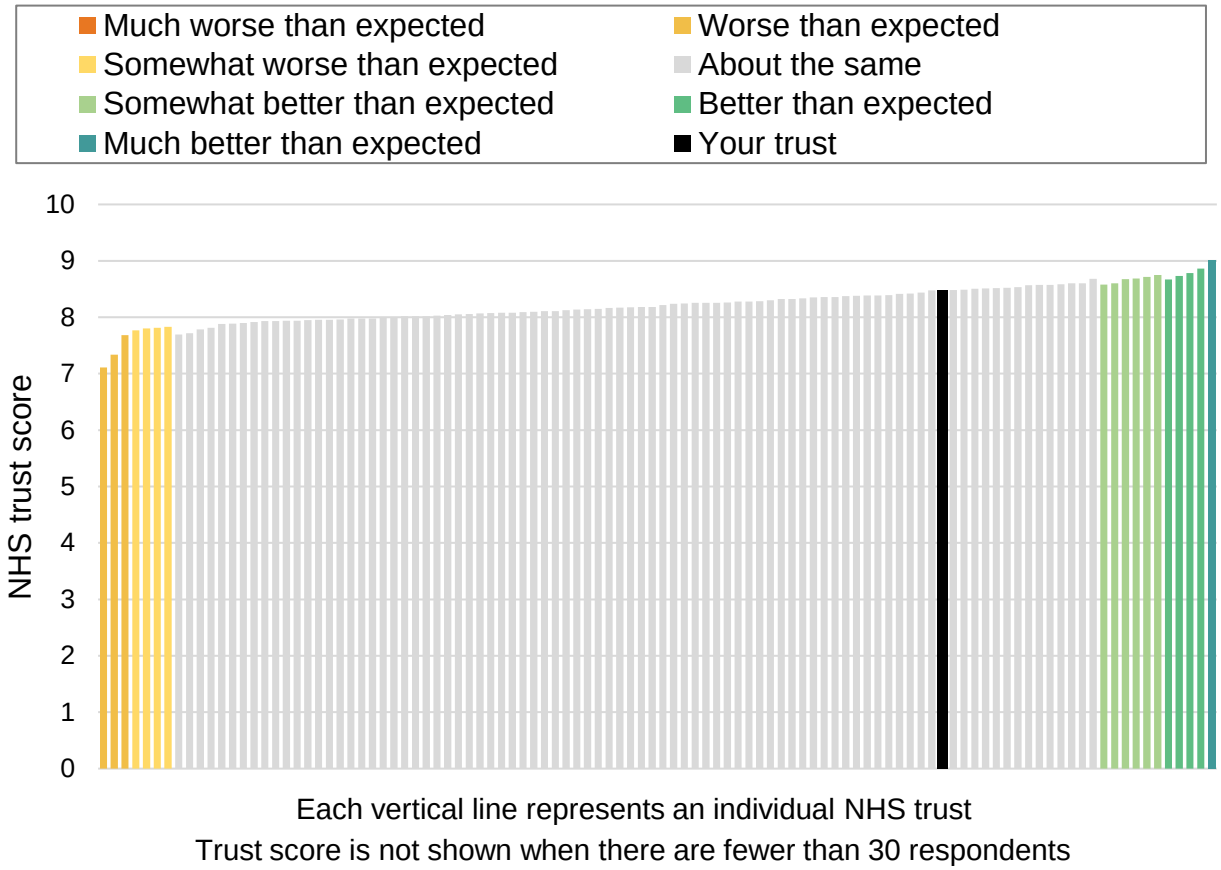
Care Quality Commission

Survey Coordination Centre

Your labour and birth

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'your labour and birth' is calculated from questions C4 to C9. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

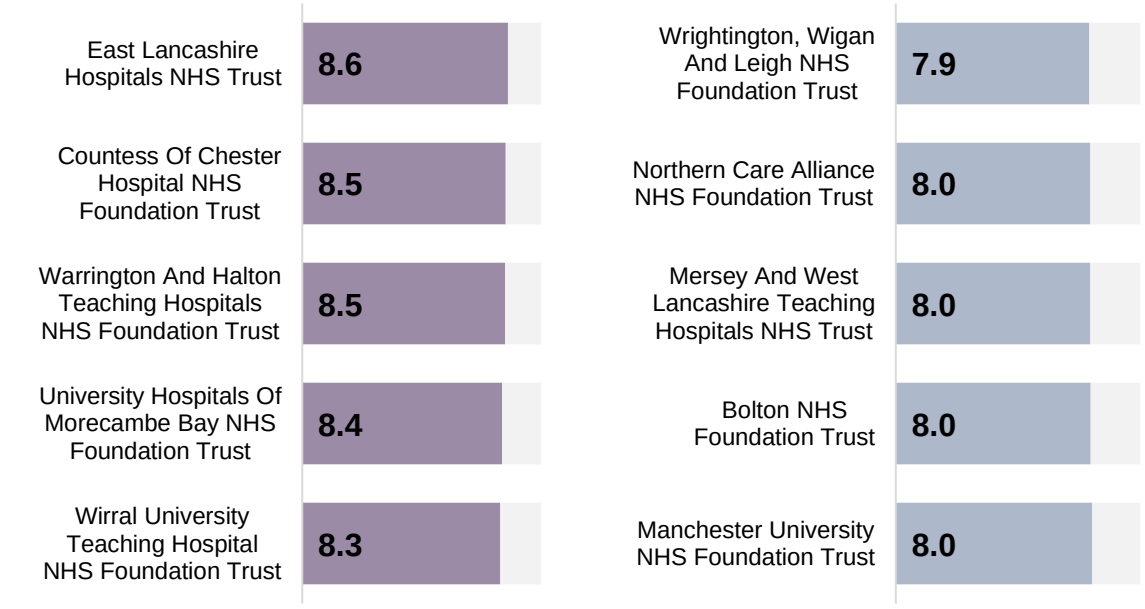
Your trust section score = 8.5 **About the same**



Each vertical line represents an individual NHS trust

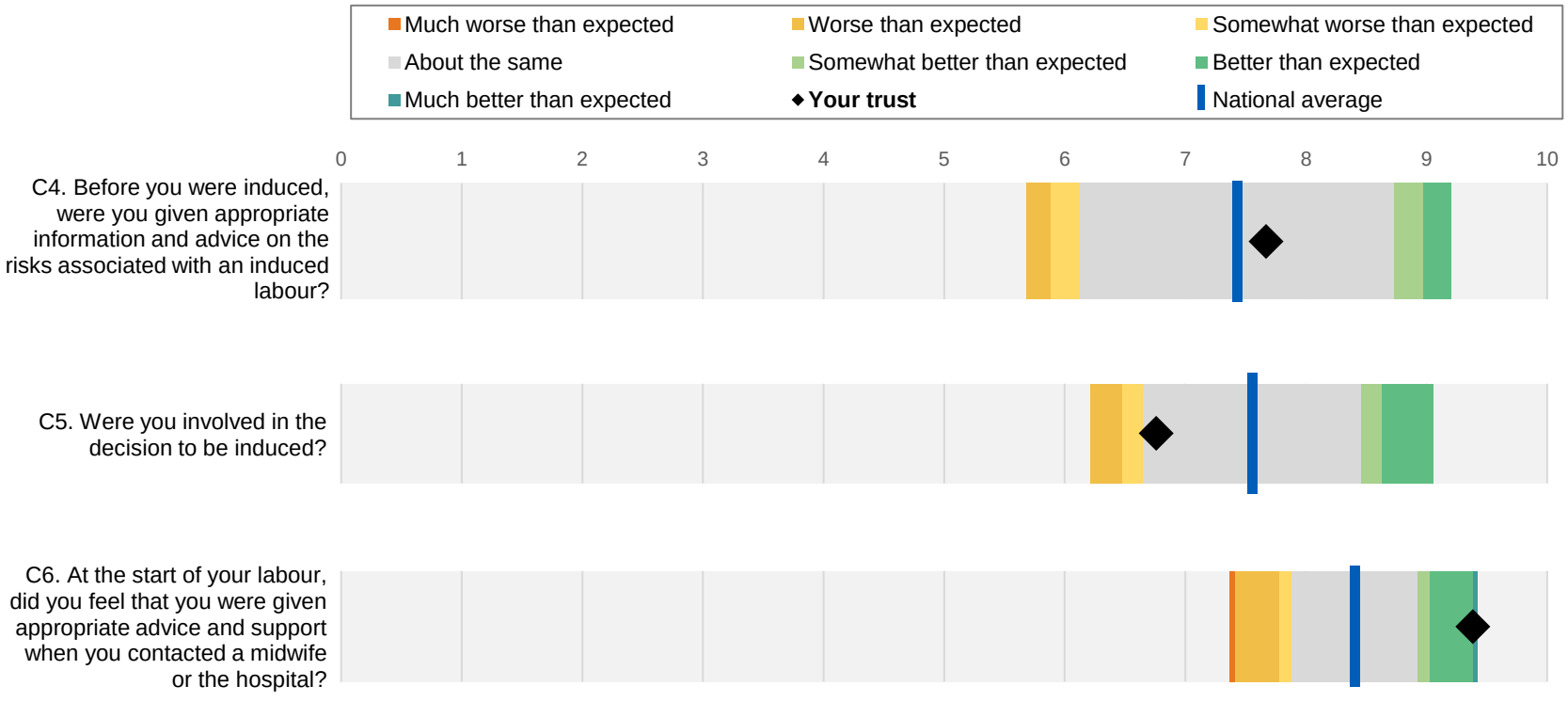
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 2. Labour and Birth

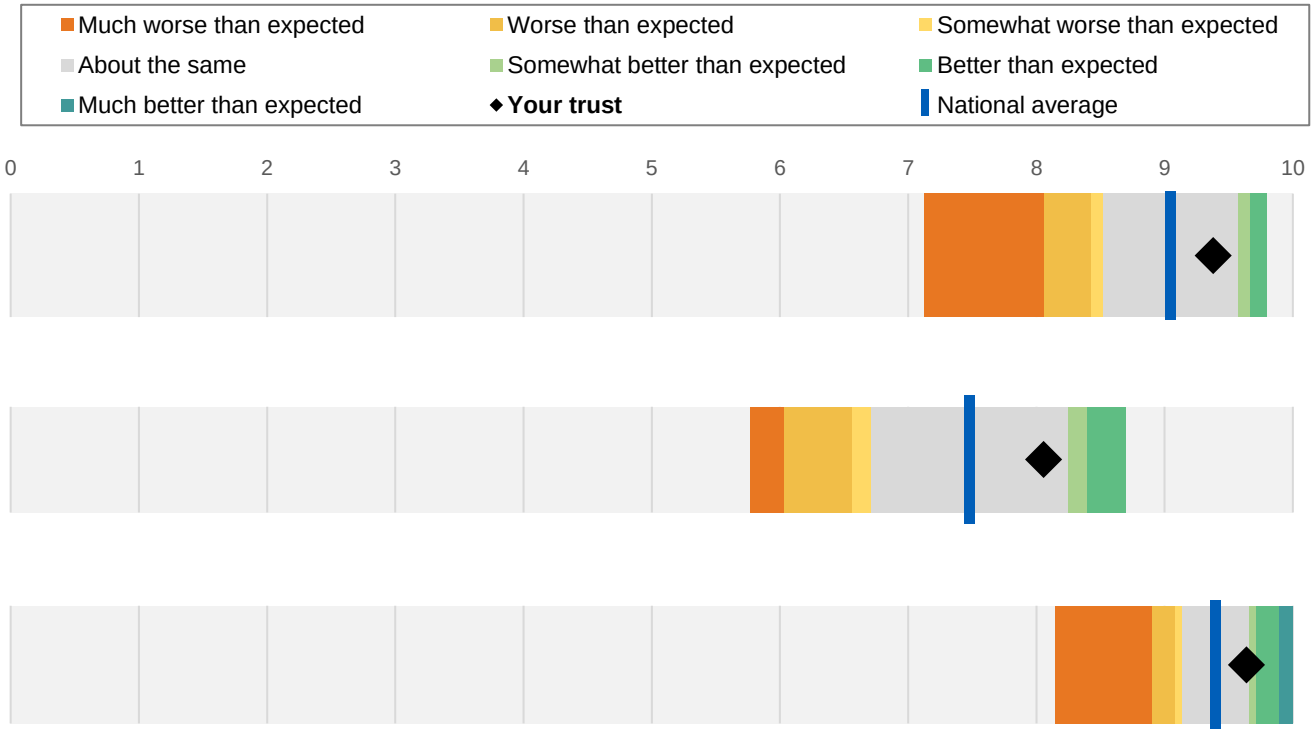
Question scores: Your labour and birth



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	35	7.7	7.4	5.7	9.2
About the same	40	6.8	7.6	6.2	9.1
Better than expected	72	9.4	8.4	7.4	9.4

Section 2. Labour and Birth (continued)

Question scores: Your labour and birth

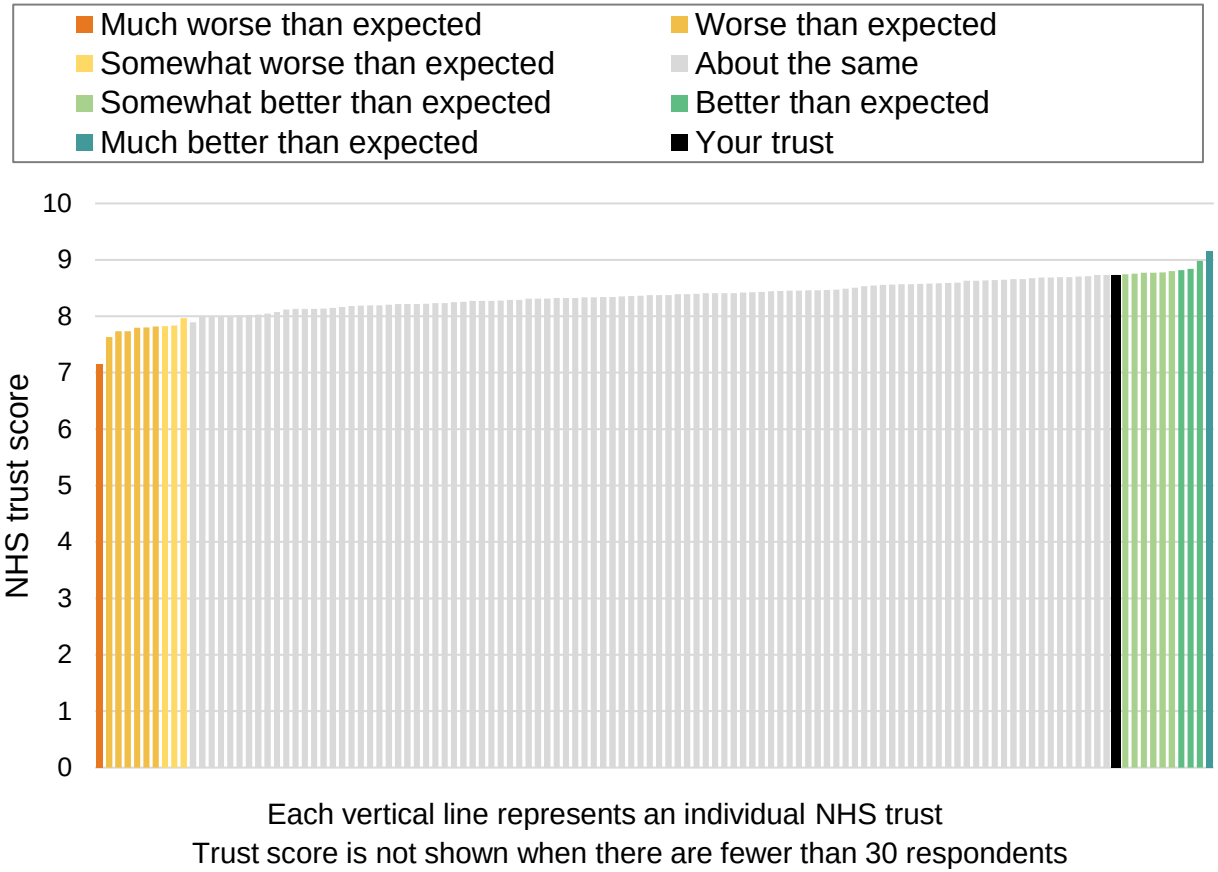


		All trusts in England				
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
C7. During your labour, were you ever sent home when you were worried about yourself or your baby?	About the same	93	9.4	9.0	7.1	9.8
C8. Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?	About the same	90	8.1	7.5	5.8	8.7
C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	About the same	128	9.6	9.4	8.1	10.0

Staff caring for you

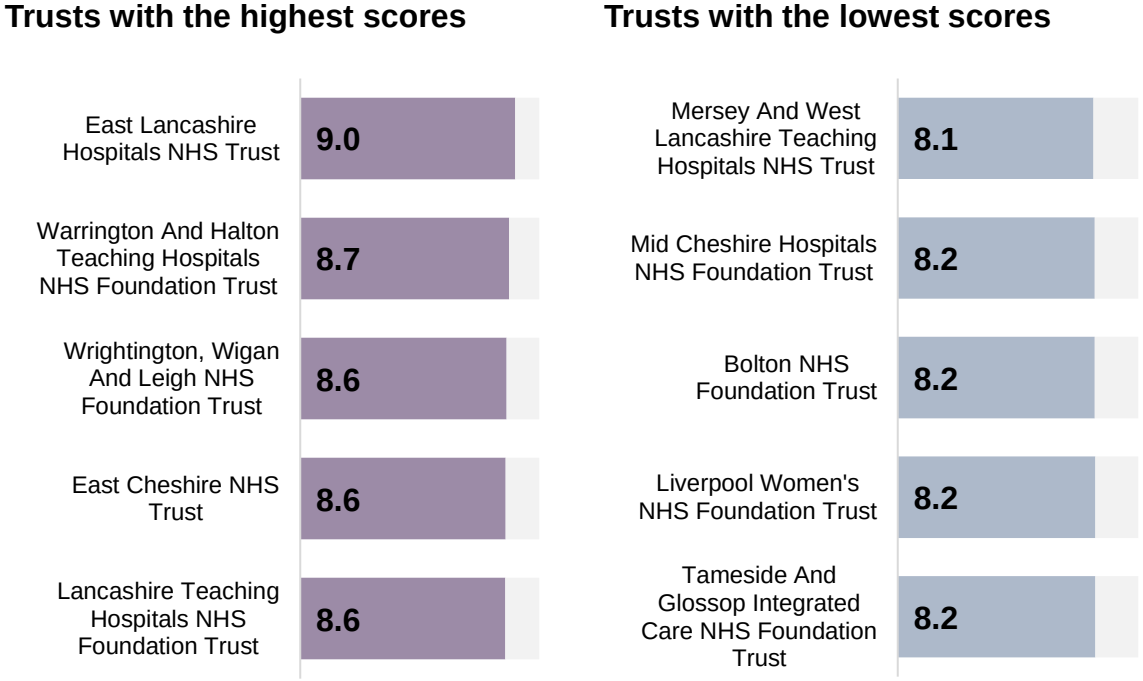
This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'staff caring for you' is calculated from questions C10 to C21. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.7 About the same



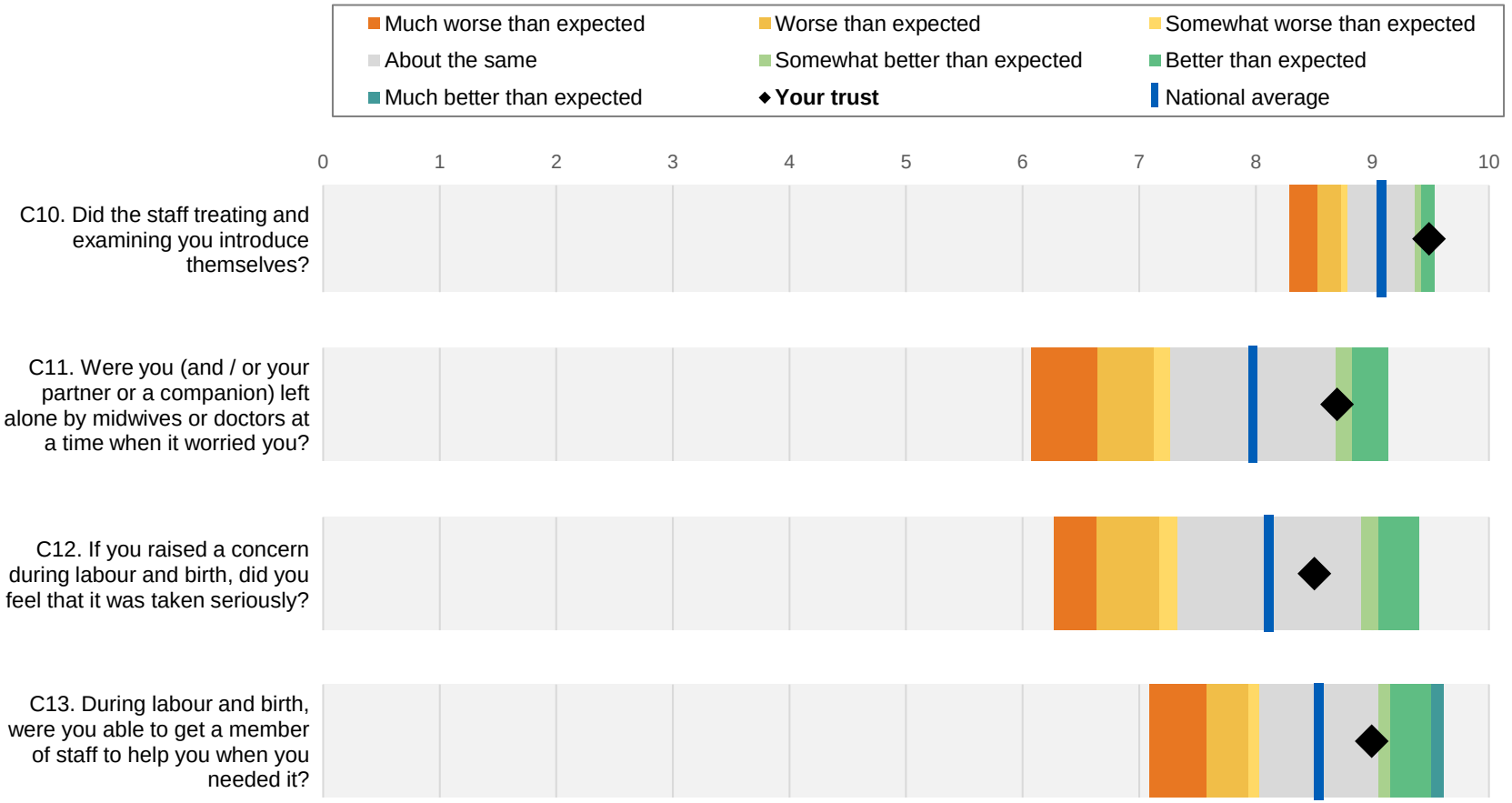
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 2. Labour and Birth

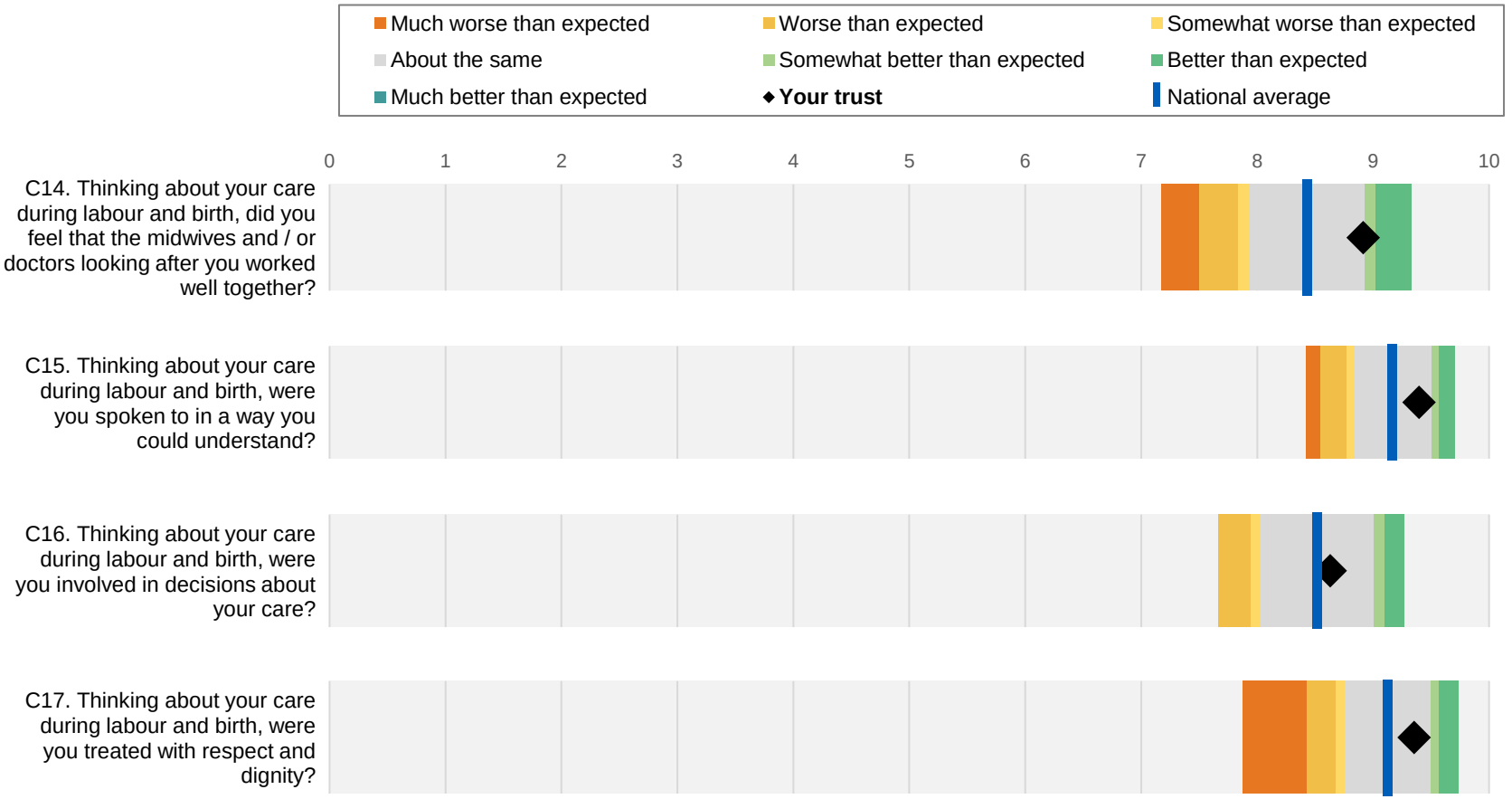
Question scores: Staff caring for you



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
Better than expected	127	9.5	9.1	8.3	9.5
Somewhat better than expected	125	8.7	8.0	6.1	9.1
About the same	78	8.5	8.1	6.3	9.4
About the same	127	9.0	8.5	7.1	9.6

Section 2. Labour and Birth (continued)

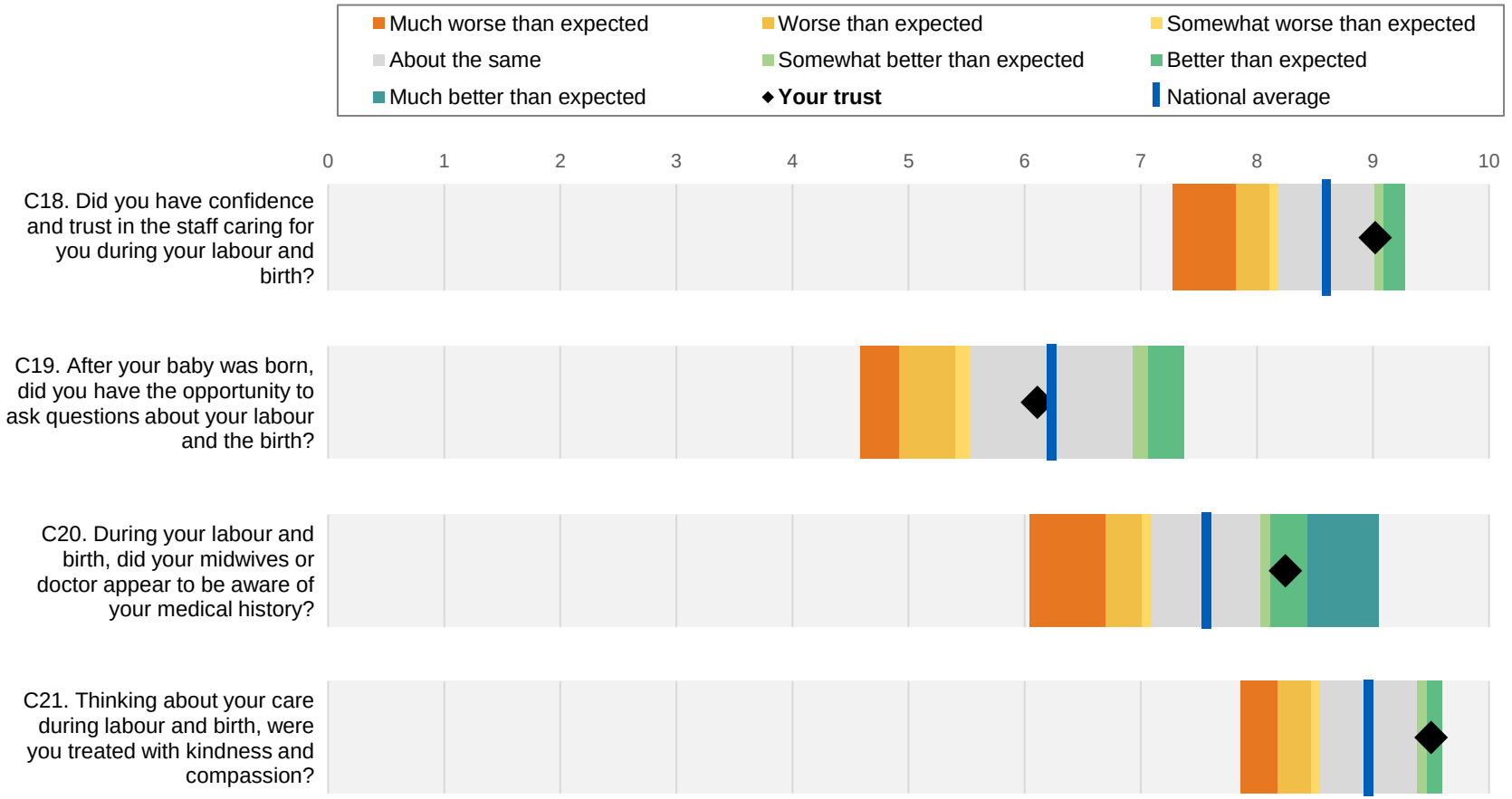
Question scores: Staff caring for you



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	128	8.9	8.4	7.2	9.3
About the same	126	9.4	9.2	8.4	9.7
About the same	126	8.6	8.5	7.7	9.3
About the same	129	9.4	9.1	7.9	9.7

Section 2. Labour and Birth (continued)

Question scores: Staff caring for you



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
Somewhat better than expected	128	9.0	8.6	7.3	9.3
About the same	115	6.1	6.2	4.6	7.4
Better than expected	112	8.2	7.6	6.0	9.0
Better than expected	128	9.5	9.0	7.9	9.6

Benchmarking

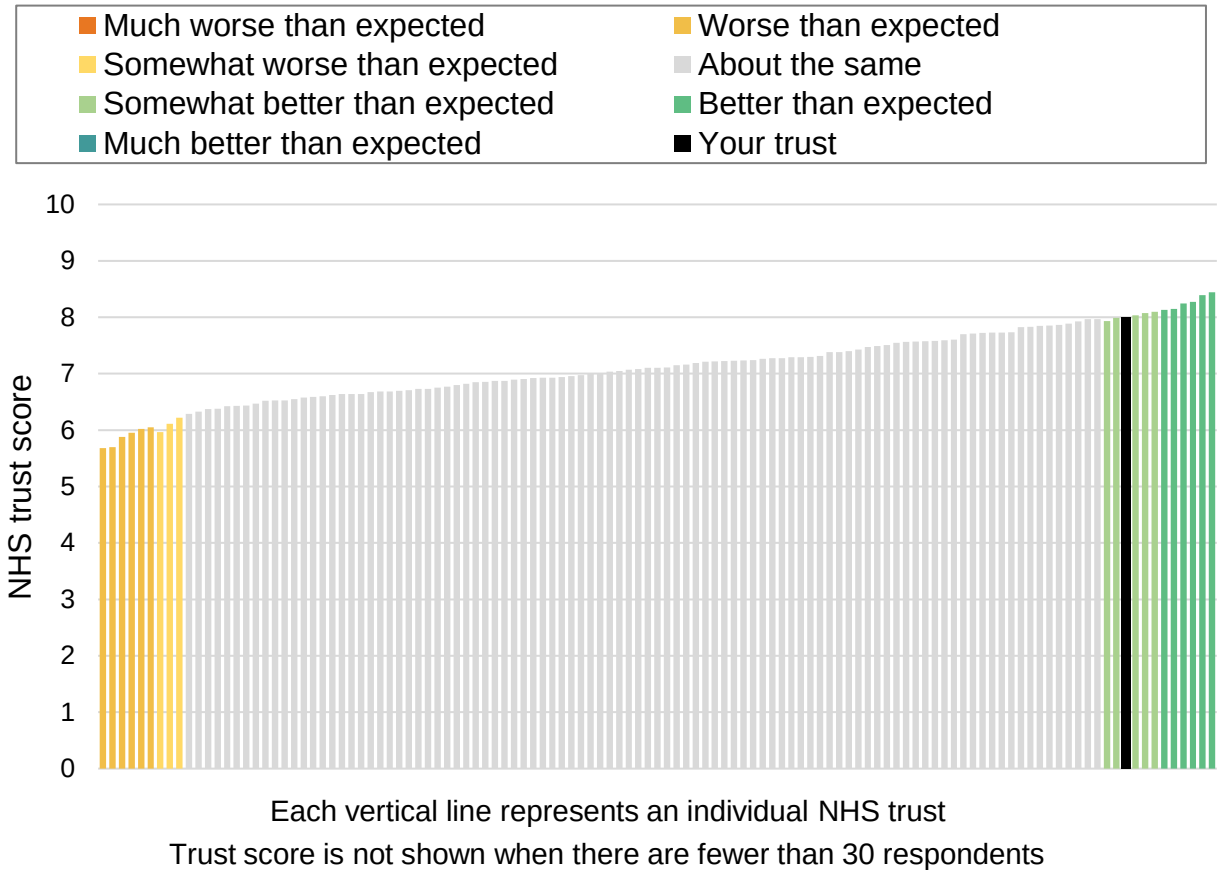
Section 3: Postnatal Care



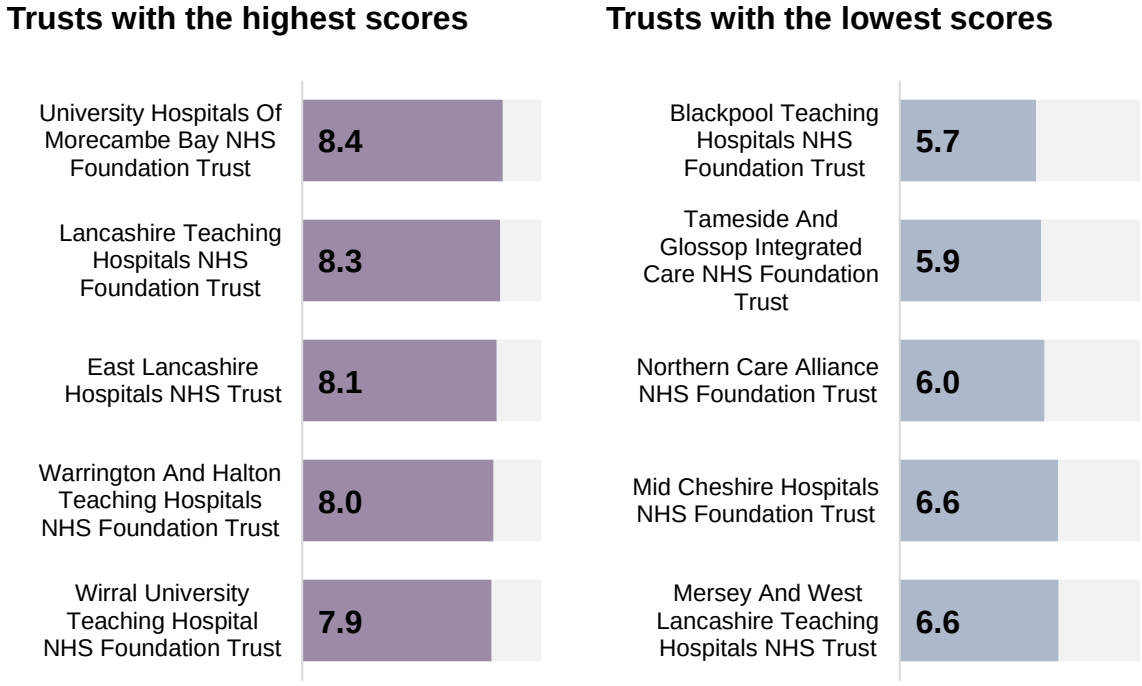
Care in the ward after birth

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care in the ward after birth' is calculated from questions D2 to D7. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.0 Somewhat better than expected



Comparison with other trusts within your region



Section 3. Postnatal Care

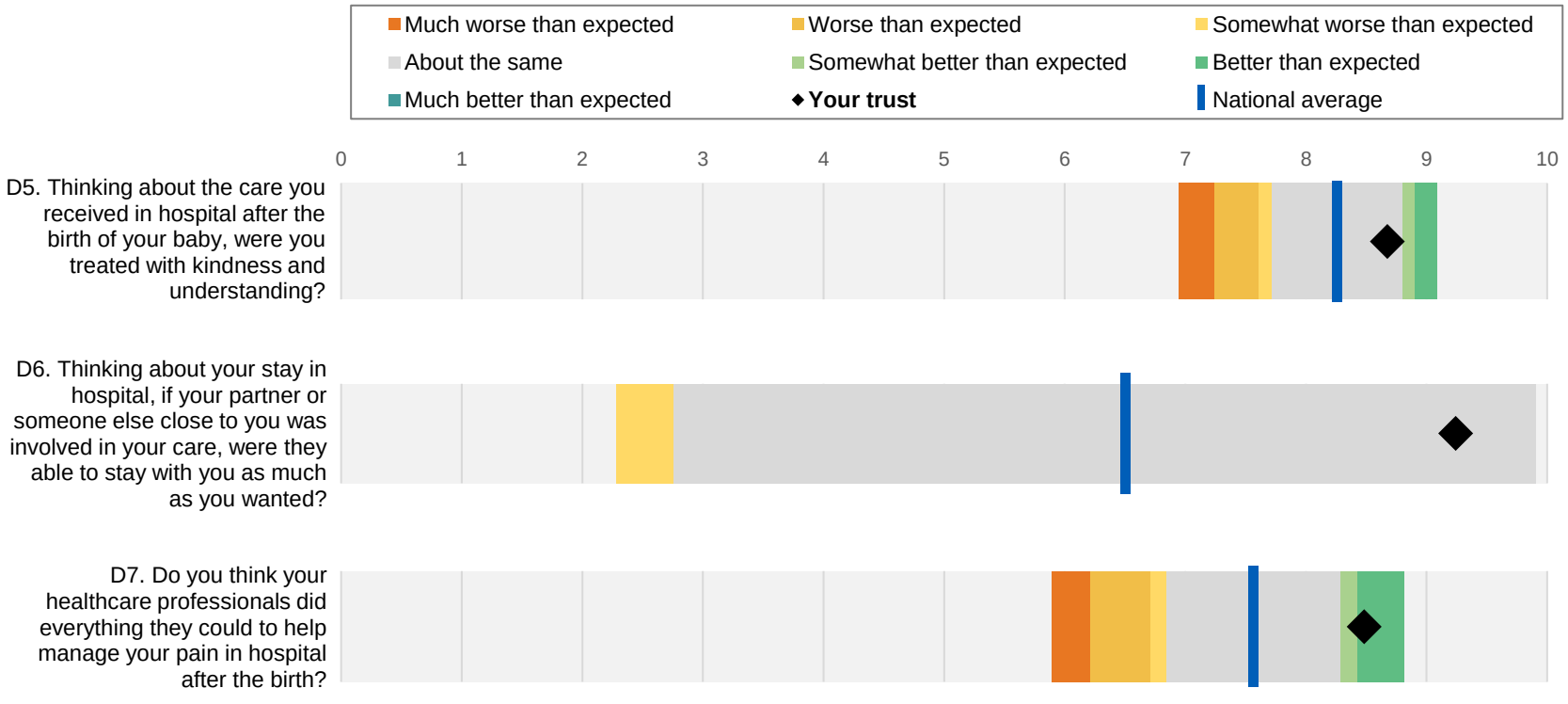
Question scores: Care in the ward after birth



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	120	6.2	6.0	4.4	8.0
About the same	112	8.0	7.1	5.0	8.7
About the same	119	7.4	7.3	5.7	8.2

Section 3. Postnatal Care (continued)

Question scores: Care in the ward after birth

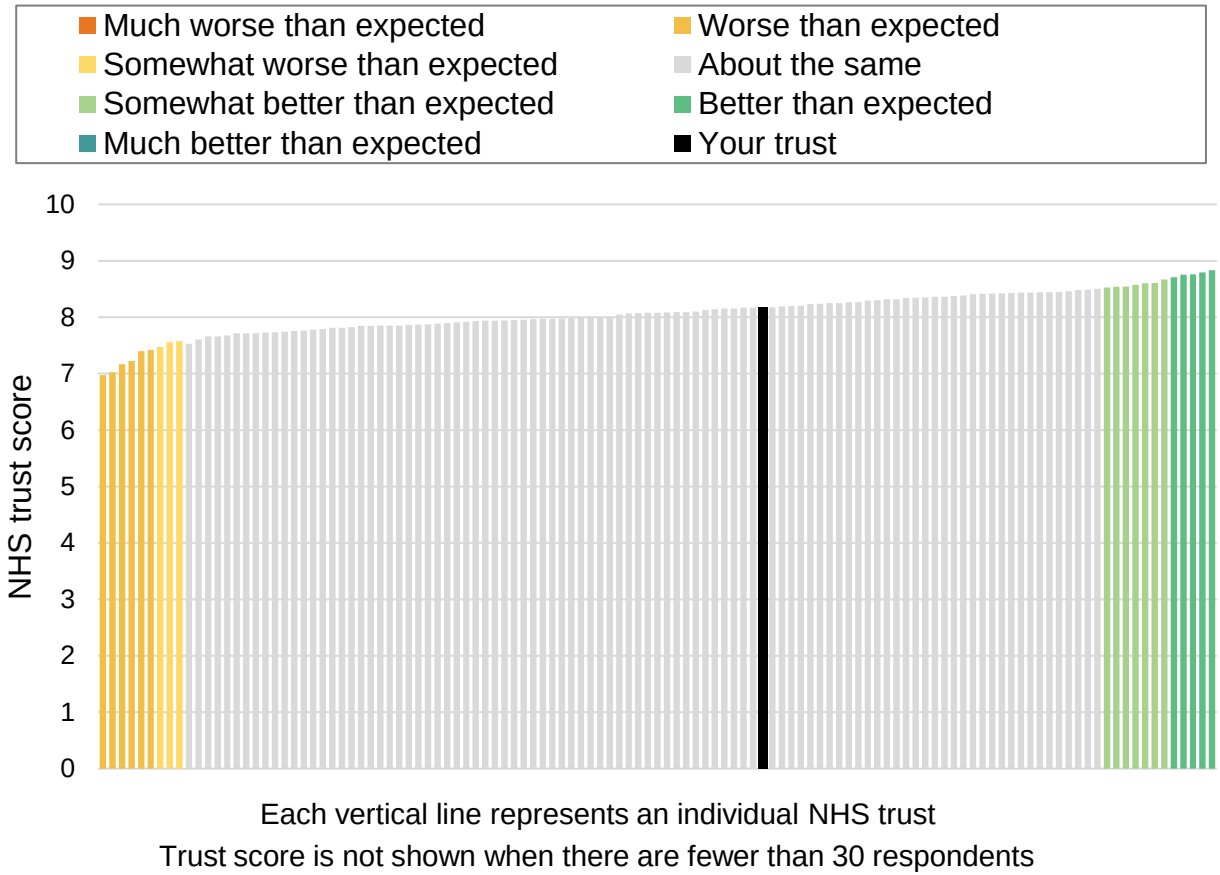


		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	121	8.7	8.3	6.9	9.1
About the same	118	9.2	6.5	2.3	9.9
Better than expected	115	8.5	7.6	5.9	8.8

Feeding your baby

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'feeding your baby' is calculated from questions E2 and E3. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.2 **About the same**

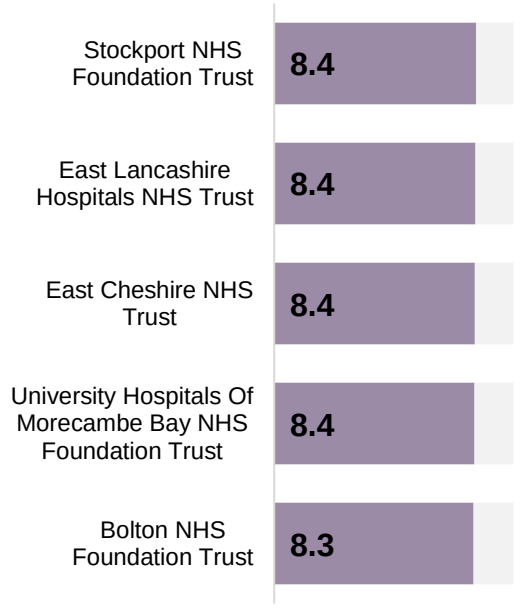


Each vertical line represents an individual NHS trust

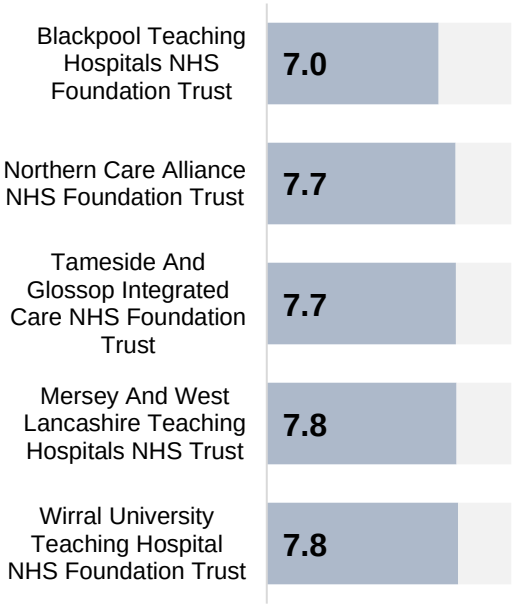
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores

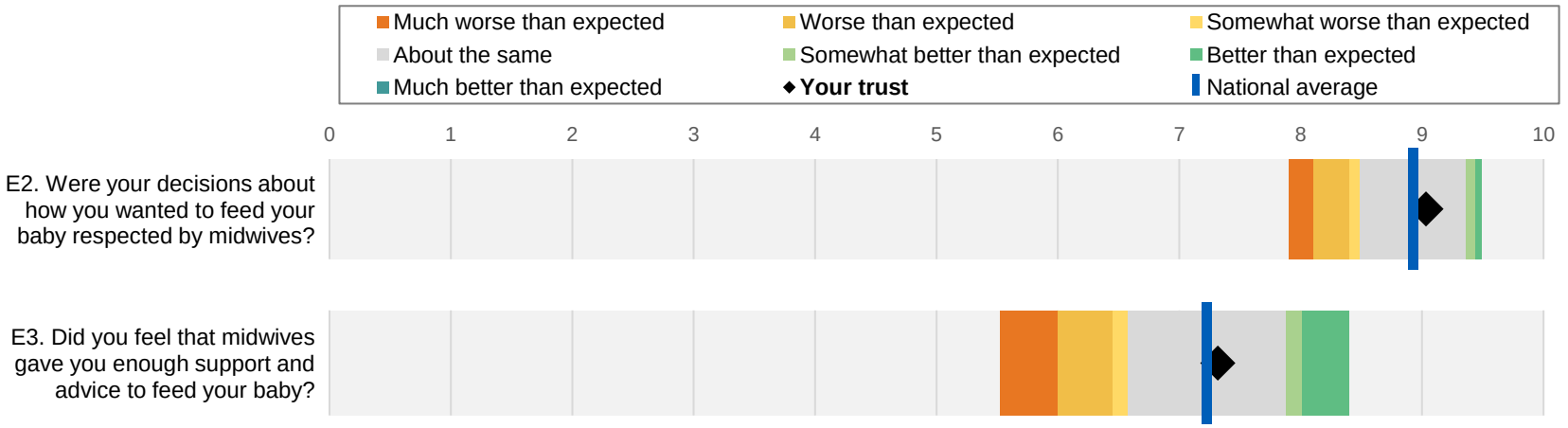


Trusts with the lowest scores



Section 3. Postnatal Care (continued)

Question scores: Feeding your baby

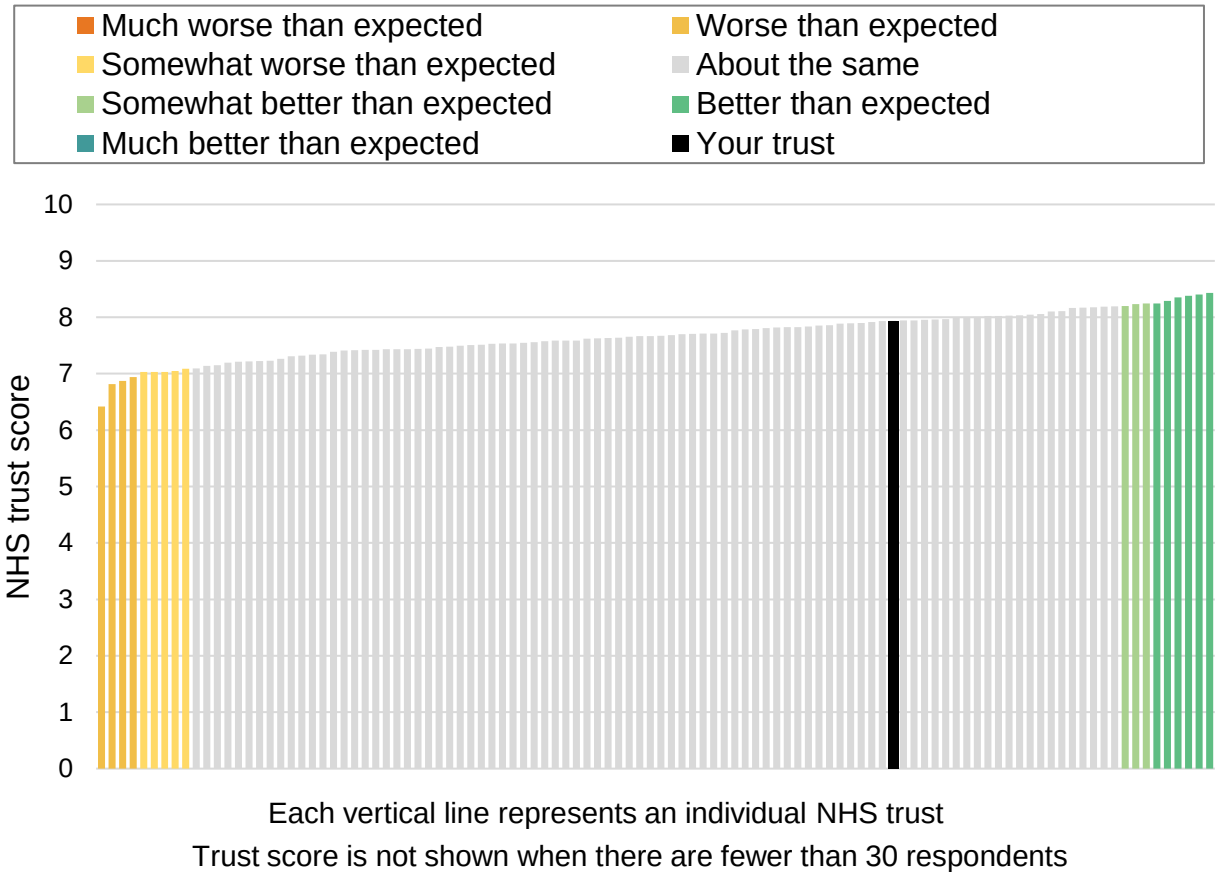


			All trusts in England		
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	125	9.0	8.9	7.9	9.5
About the same	114	7.3	7.2	5.5	8.4

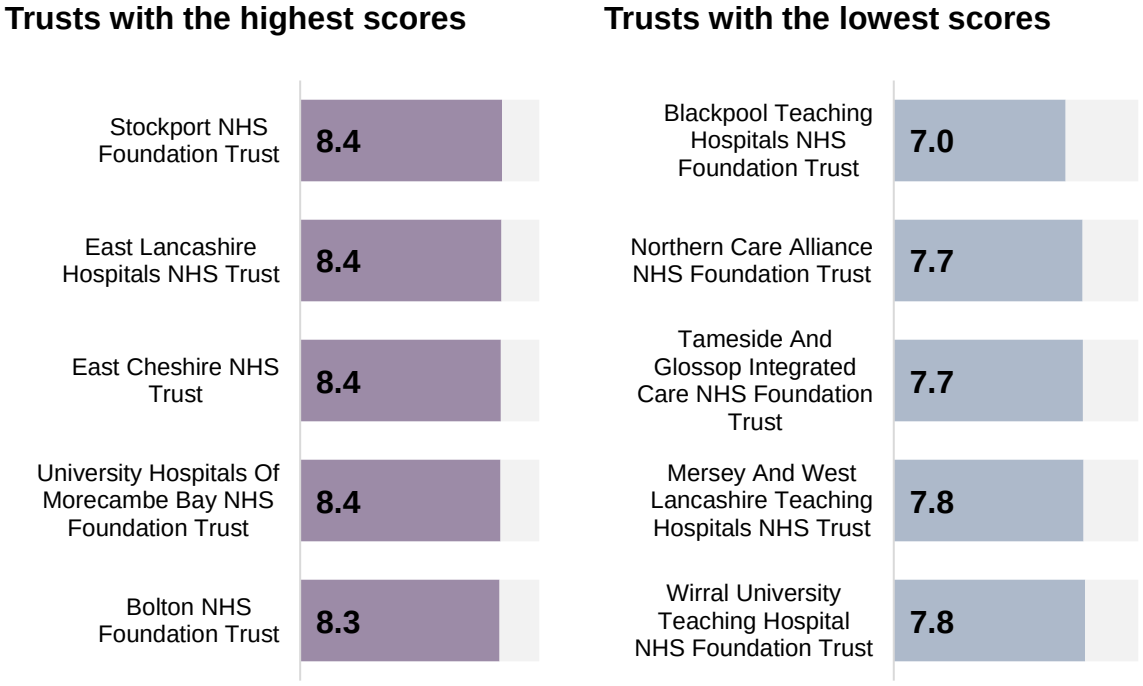
Care at home after birth

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care at home after birth' is calculated from questions F1 and F2, F4 to F8, and F10 to F16. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.9 **About the same**

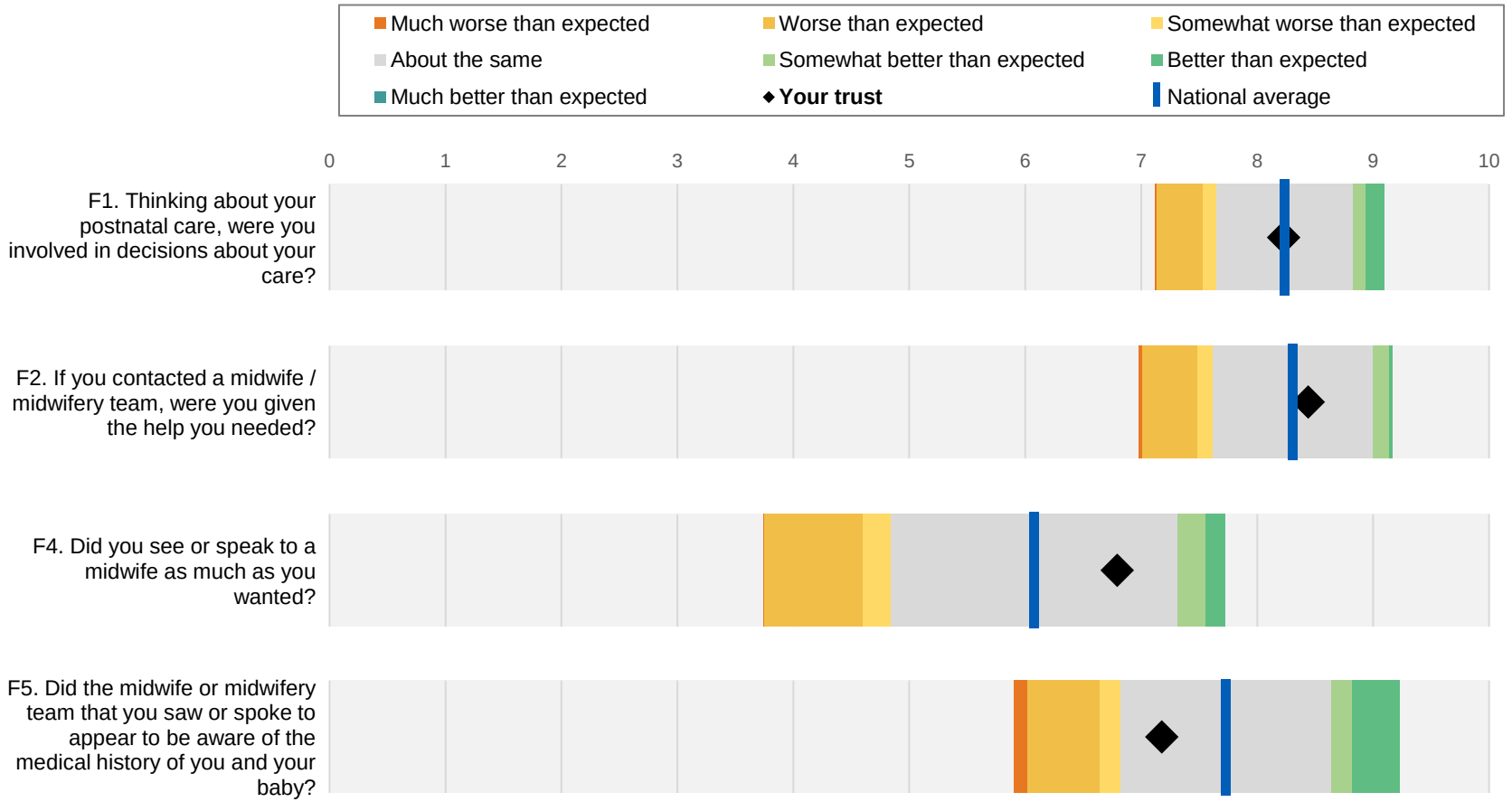


Comparison with other trusts within your region



Section 3. Postnatal Care

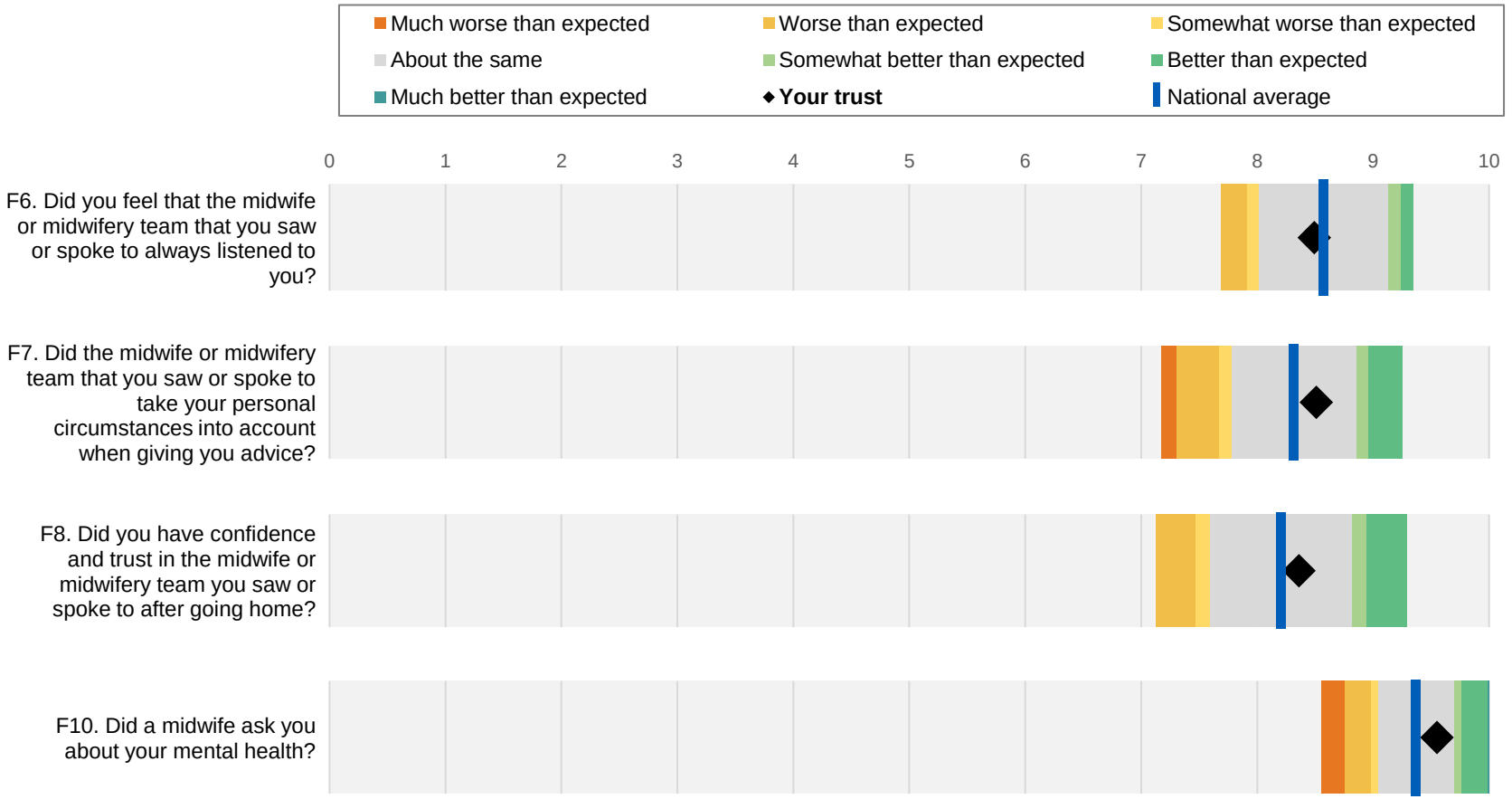
Question scores: Care at home after birth



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	122	8.2	8.2	7.1	9.1
About the same	102	8.4	8.3	7.0	9.2
About the same	125	6.8	6.1	3.7	7.7
About the same	114	7.2	7.7	5.9	9.2

Section 3. Postnatal Care (continued)

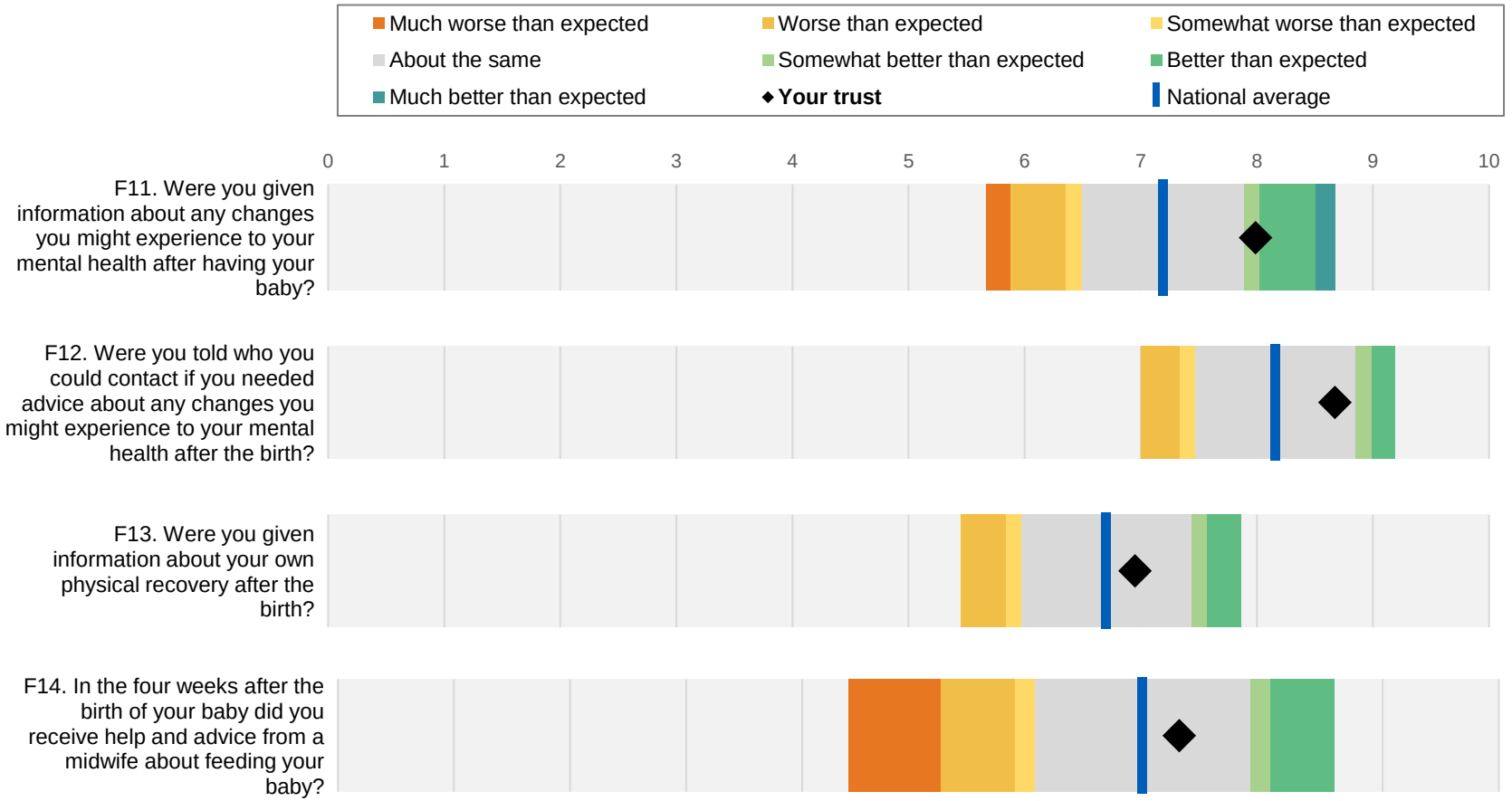
Question scores: Care at home after birth



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	124	8.5	8.6	7.7	9.3
About the same	122	8.5	8.3	7.2	9.3
About the same	121	8.4	8.2	7.1	9.3
About the same	124	9.6	9.4	8.6	10.0

Section 3. Postnatal Care (continued)

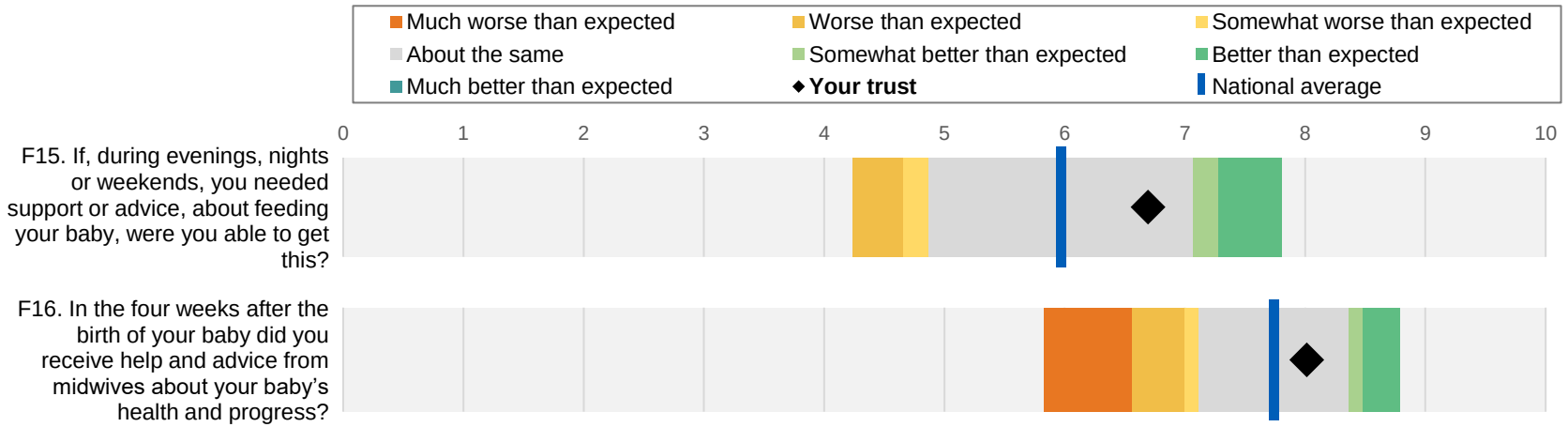
Question scores: Care at home after birth



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
Somewhat better than expected	121	8.0	7.2	5.7	8.7
About the same	107	8.7	8.2	7.0	9.2
About the same	120	6.9	6.7	5.5	7.9
About the same	99	7.2	6.9	4.4	8.6

Section 3. Postnatal Care (continued)

Question scores: Care at home after birth



		All trusts in England			
	Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
About the same	49	6.7	6.0	4.2	7.8
About the same	108	8.0	7.7	5.8	8.8

Benchmarking

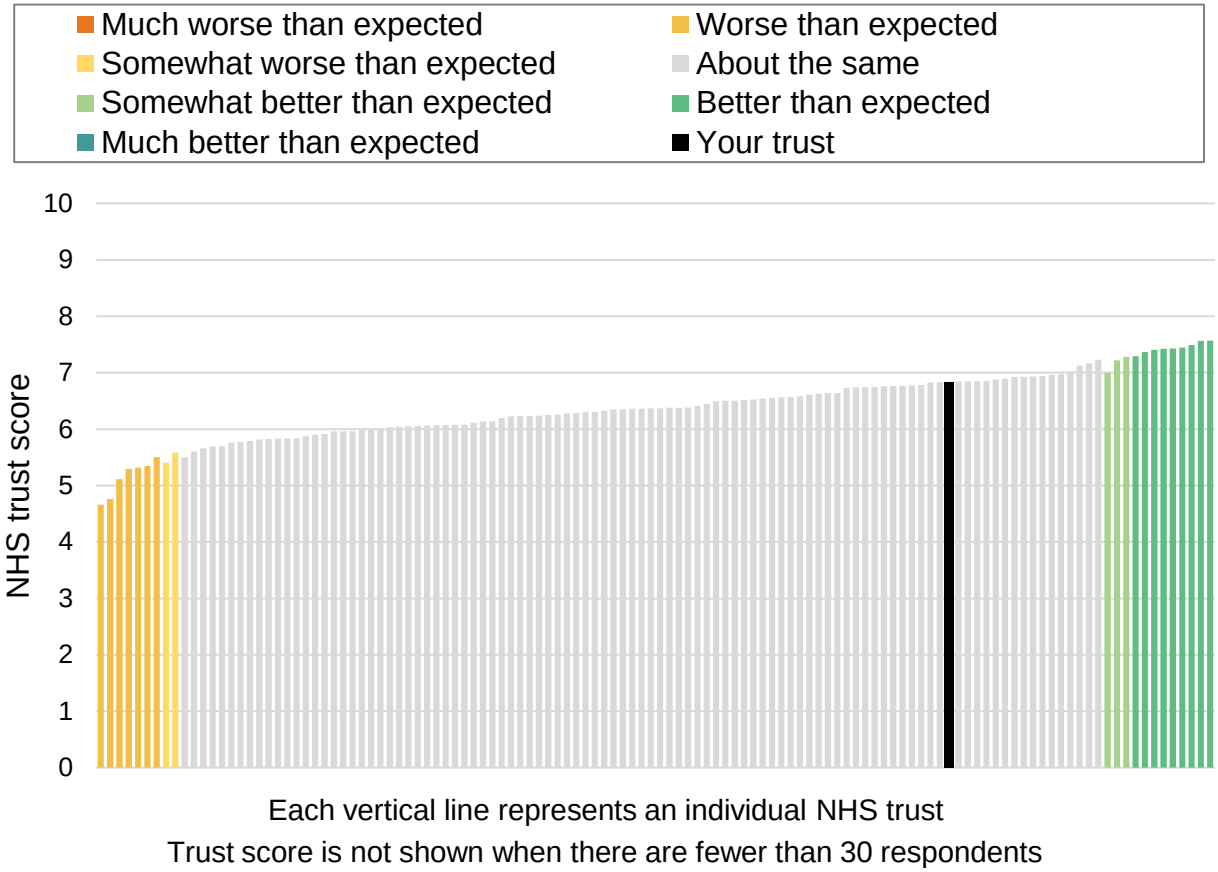
Section 4: Complaints



Complaints

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, ‘complaints’ is calculated from question F19. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the ‘expected range’ analysis technique used, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

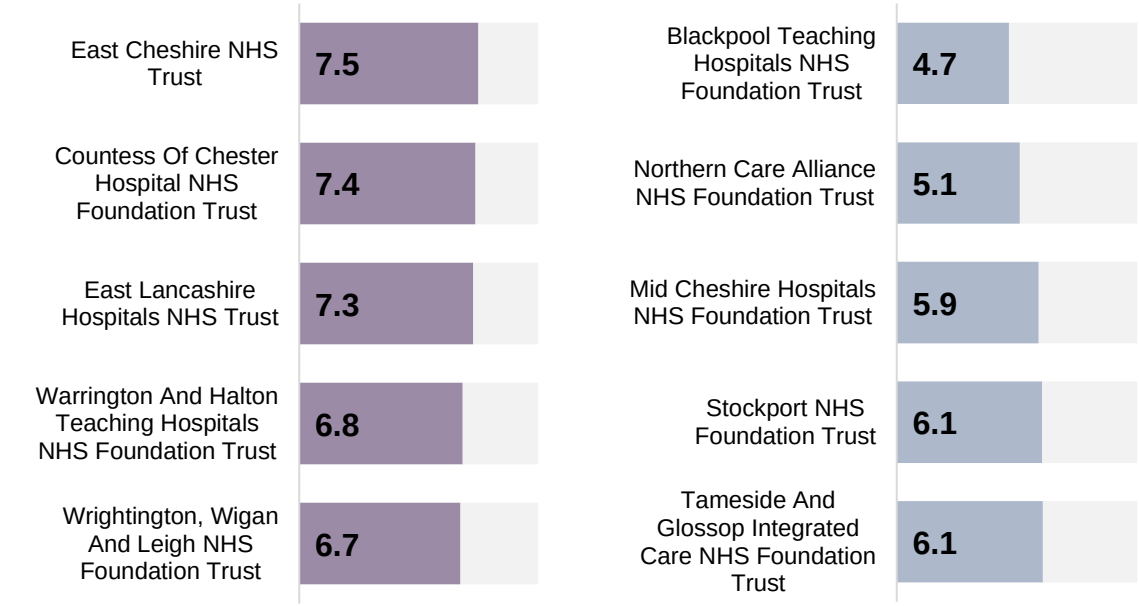
Your trust section score = 6.8 About the same



Each vertical line represents an individual NHS trust

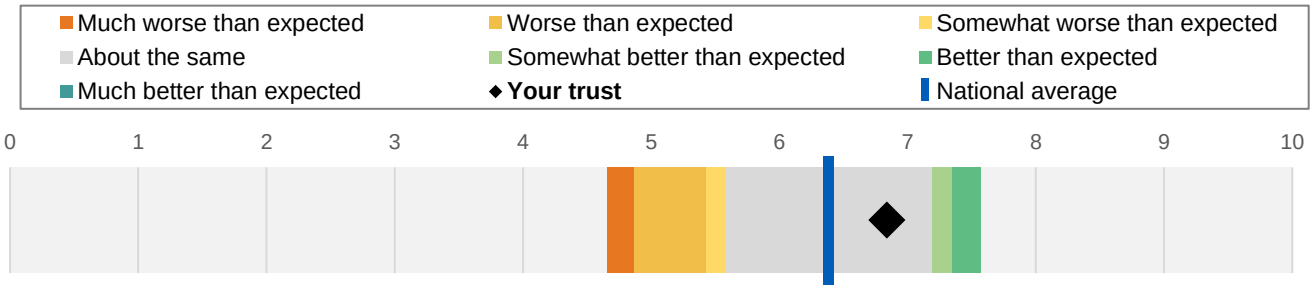
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region



Section 4. Complaints

Question scores



F19. At any point during your maternity care journey, did you consider making a complaint about the care you received?

About the same

	All trusts in England			
Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
129	6.8	6.4	4.7	7.6

Change over time



This section includes:

- your mean trust score for each evaluative question in the survey
- where comparable data is available, statistical significance testing using a two-sample t-test has been carried out against the 2023 and 2024 survey results for each relevant question. Where a change in results is shown as ‘significant’, this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust

Please note:

- If data is missing for a survey year, this is due to a low number of responses, or because the trust data was not included in the survey that year, due to sampling errors or ineligibility.
- The following questions were new or changed for 2024 and therefore are not included in this section: B3, B18, B20, C5, C7, C14, E3, F2, F10, F14, F16, G12.

NHS

Care Quality Commission

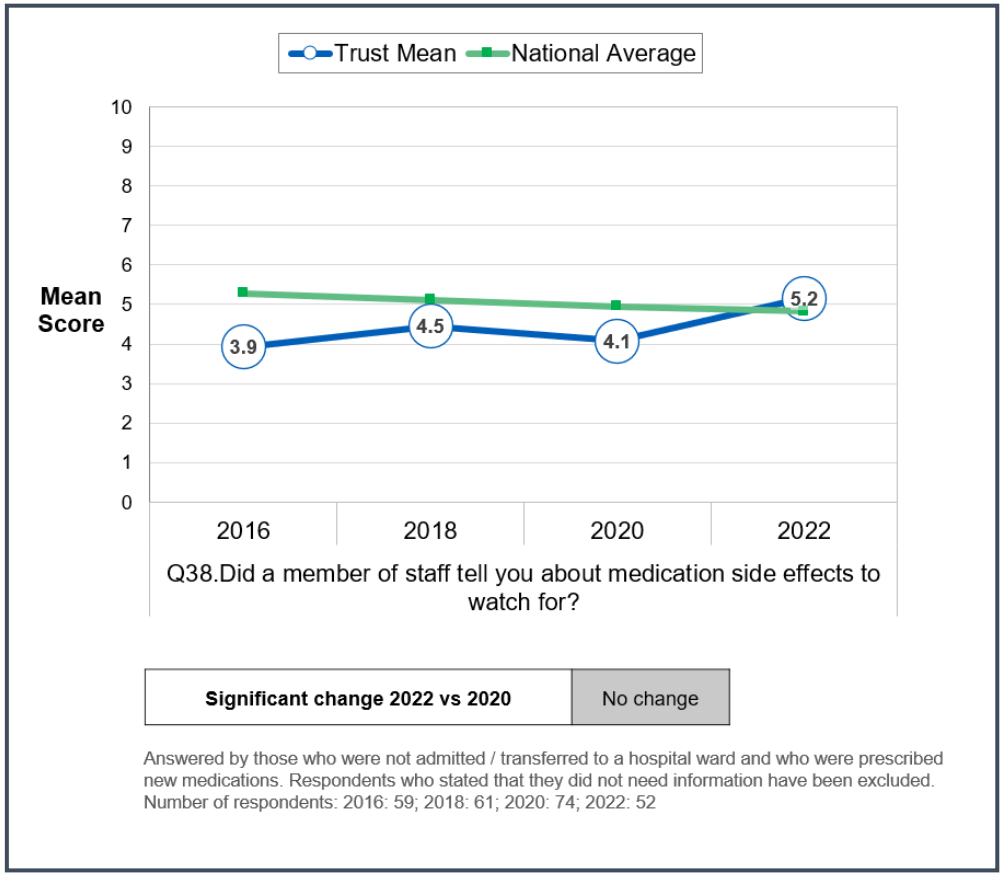
Survey Coordination Centre

How to interpret change over time in this report

The charts in the ‘change over time’ section show how your trust scored in each Maternity survey iteration. Where available, trend data from 2013 to 2024 is shown. If a question only has one data point, this question is not shown. Questions that are not historically comparable are also not shown.

Each question is displayed in a line chart. These charts show your trust mean score for each survey year (blue line). The national average is also shown across survey years, this is the average score for that question across all NHS trusts with a maternity department in England (green line). This enables you to see how your trust compares to the national average. If there is data missing for a survey year, this may be due to either a low number of responses, because the trust was not included in the survey that year, sampling errors or ineligibility.

Statistically significant changes are also displayed in tables underneath the charts, showing significant differences between this year (2024) and the previous year (2023). Z-tests set to 95% significance were used to compare data between the two years (2024 vs 2023). A statistically significant difference means it is unlikely we would have obtained this result if there was no real difference.



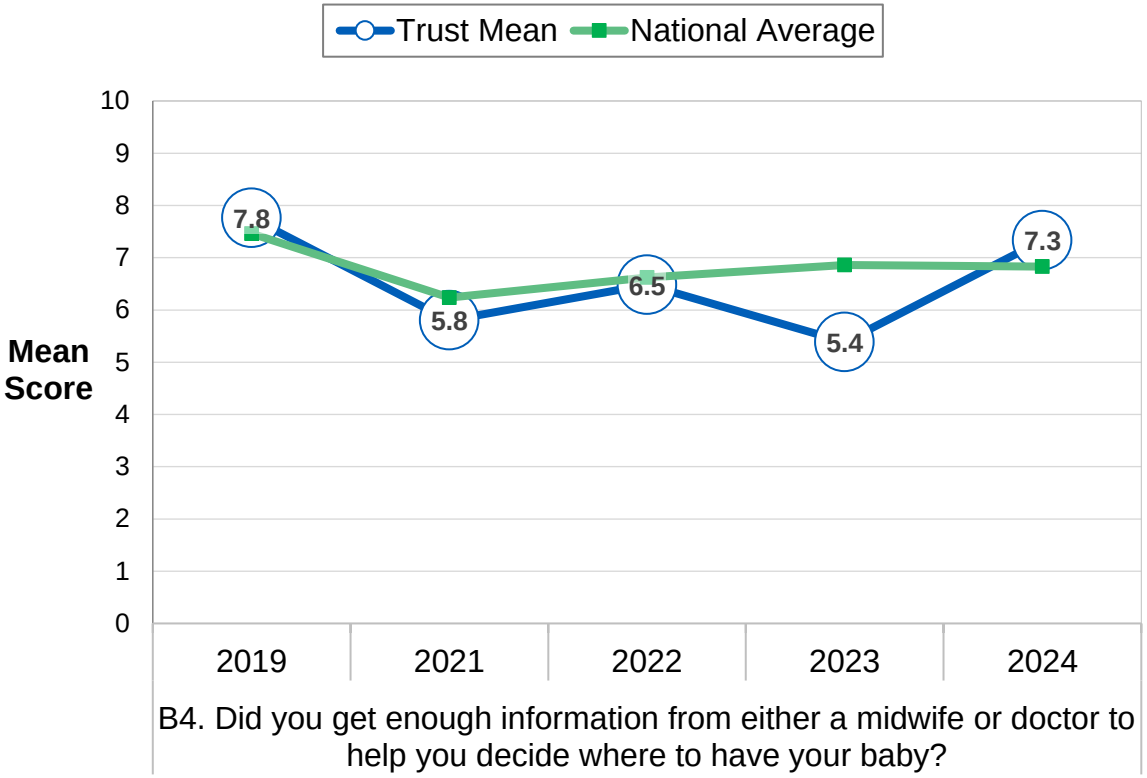
Change over time

Section 1: Antenatal Care



Section 1. Antenatal Care

The start of your care during pregnancy

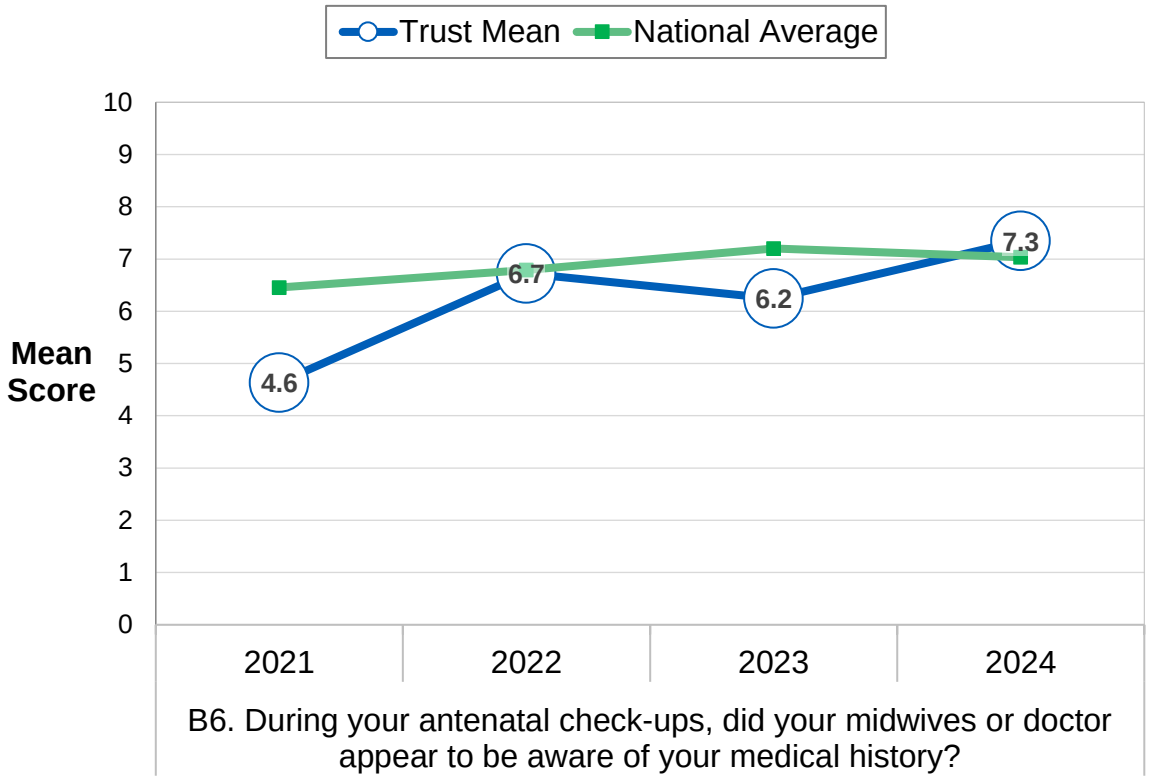


Significant change 2024 vs 2023	Increase

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2019: 63; 2021: 130; 2022: 113; 2023: 103; 2024: 118

Section 1. Antenatal Care

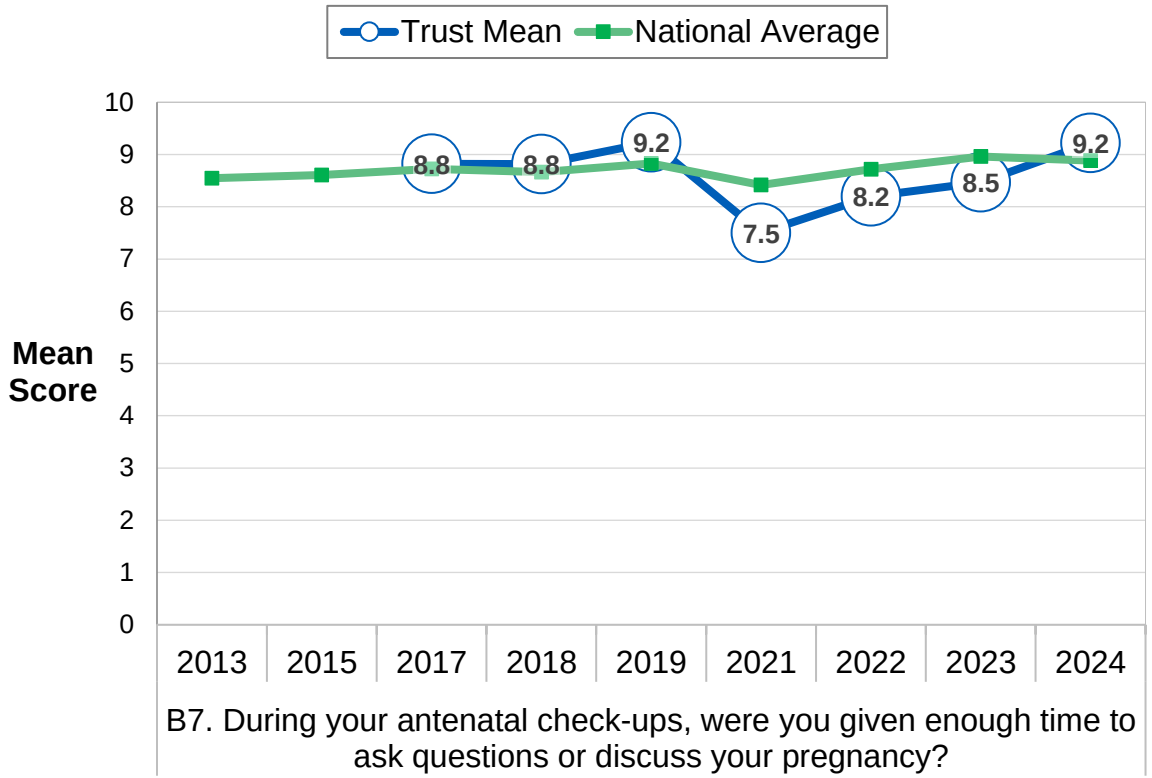
Antenatal check ups



B6. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?

Significant change 2024 vs 2023	Increase

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2021: 134; 2022: 122; 2023: 110; 2024: 123



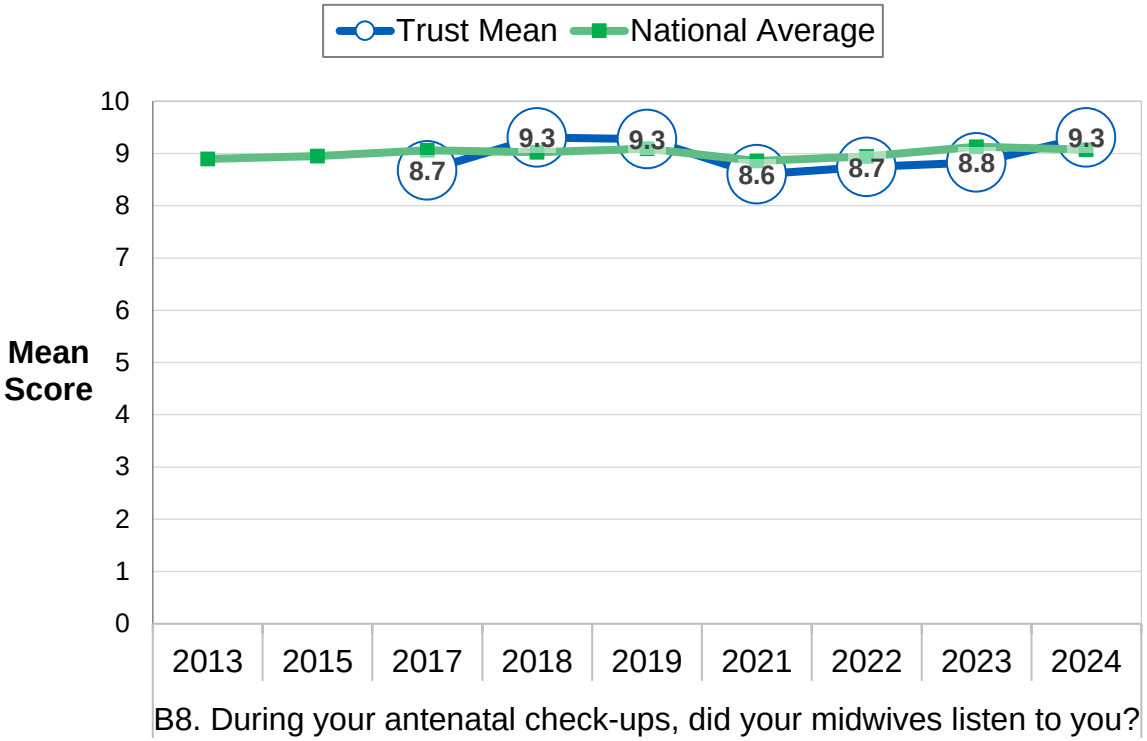
B7. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?

Significant change 2024 vs 2023	Increase

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 66; 2018: 71; 2019: 62; 2021: 137; 2022: 123; 2023: 112; 2024: 120

Section 1. Antenatal Care

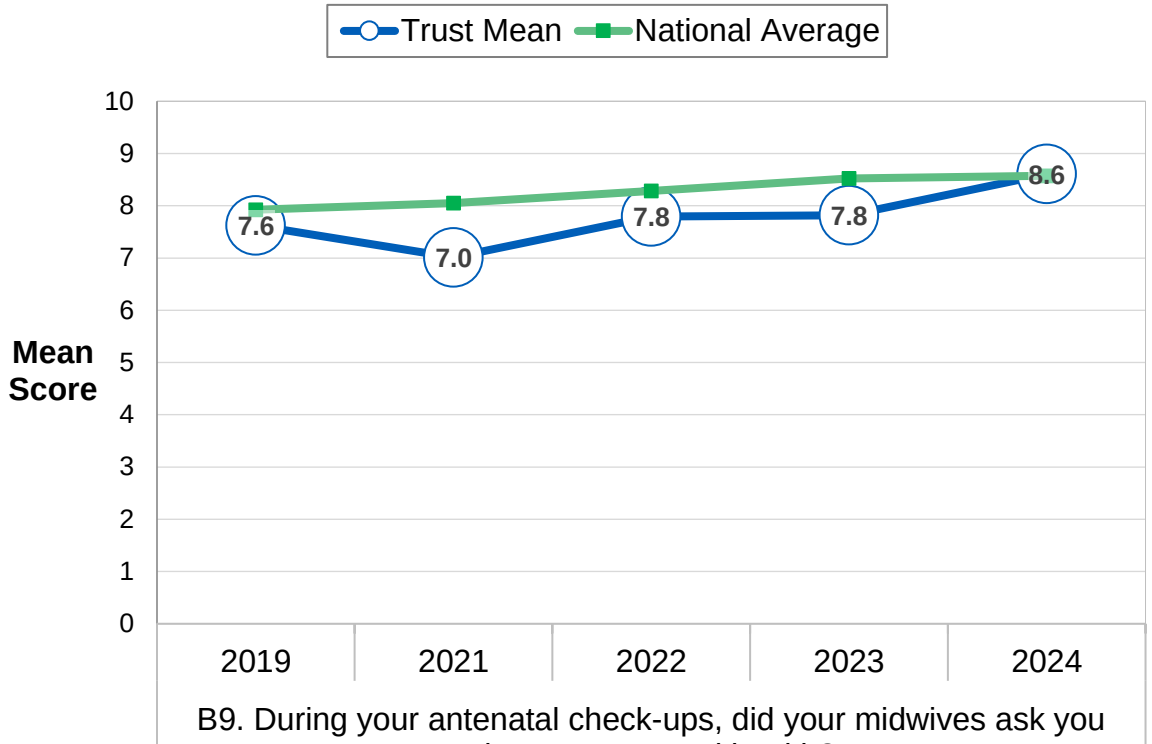
Antenatal check ups



B8. During your antenatal check-ups, did your midwives listen to you?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 66; 2018: 71; 2019: 62; 2021: 137; 2022: 123; 2023: 112; 2024: 122



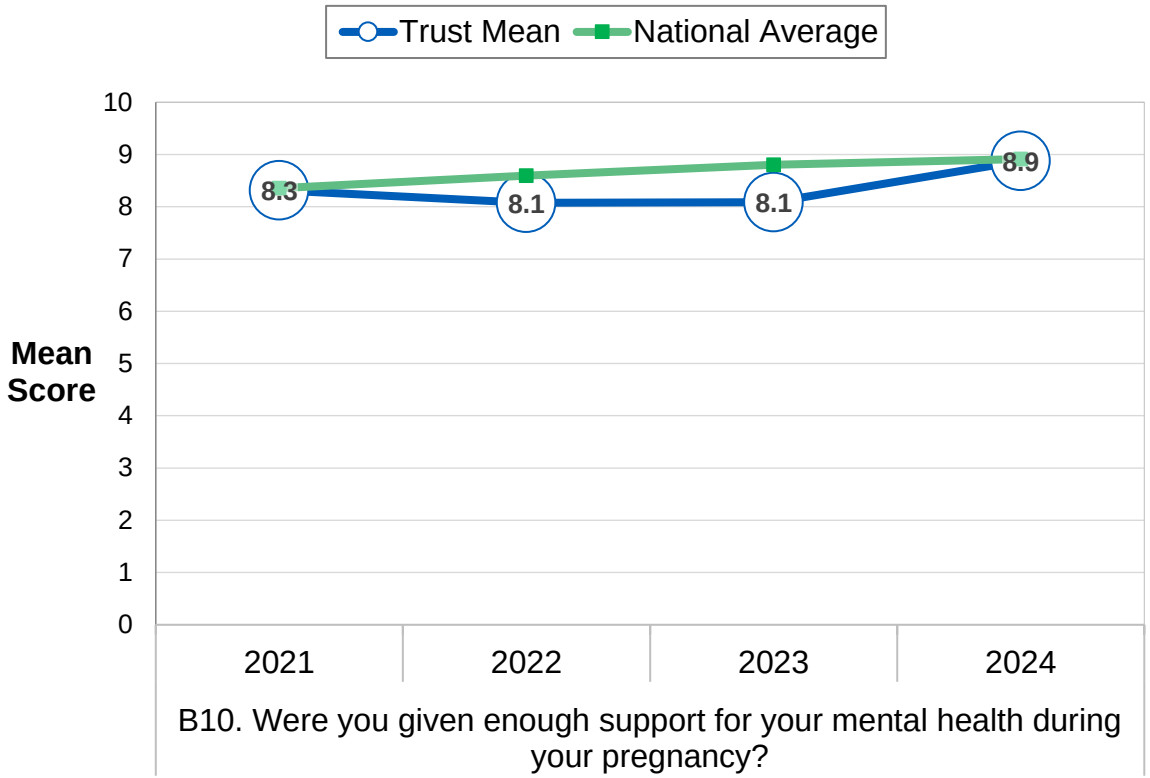
B9. During your antenatal check-ups, did your midwives ask you about your mental health?

Significant change 2024 vs 2023	Increase

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2019: 61; 2021: 132; 2022: 122; 2023: 110; 2024: 121

Section 1. Antenatal Care

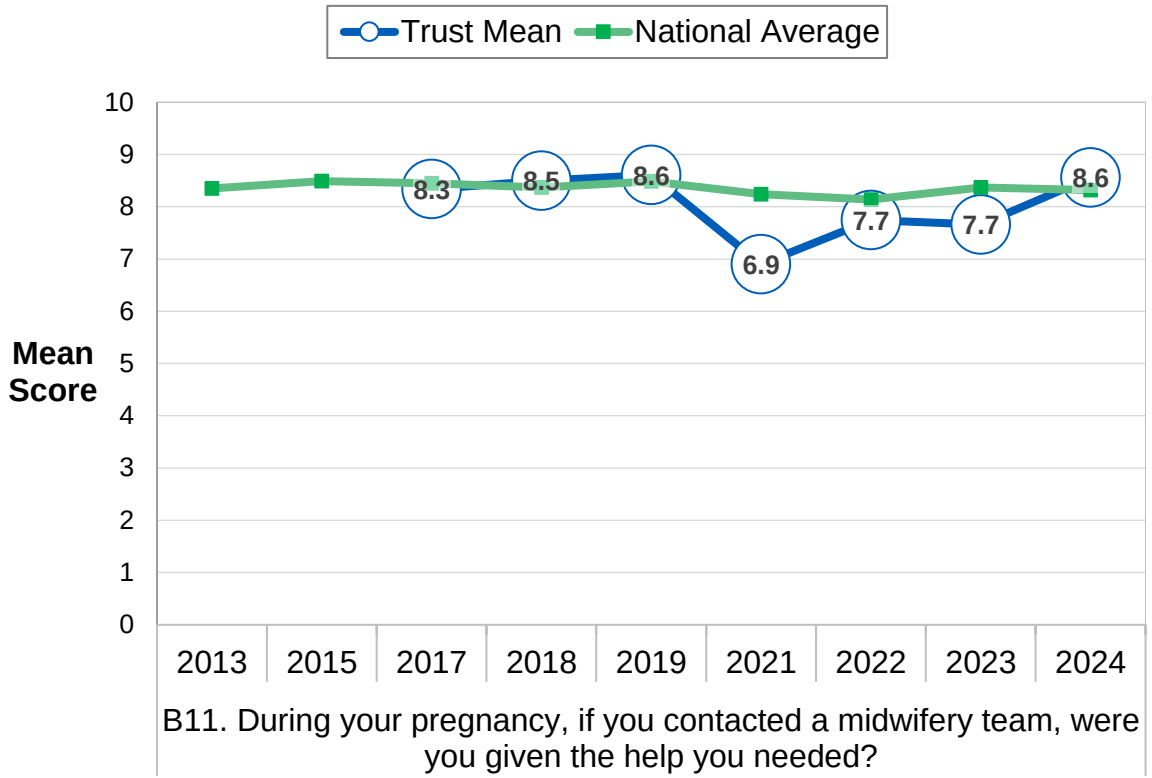
During your pregnancy



B10. Were you given enough support for your mental health during your pregnancy?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want / need support have been excluded.
Number of respondents: 2021: 67; 2022: 85; 2023: 53; 2024: 75



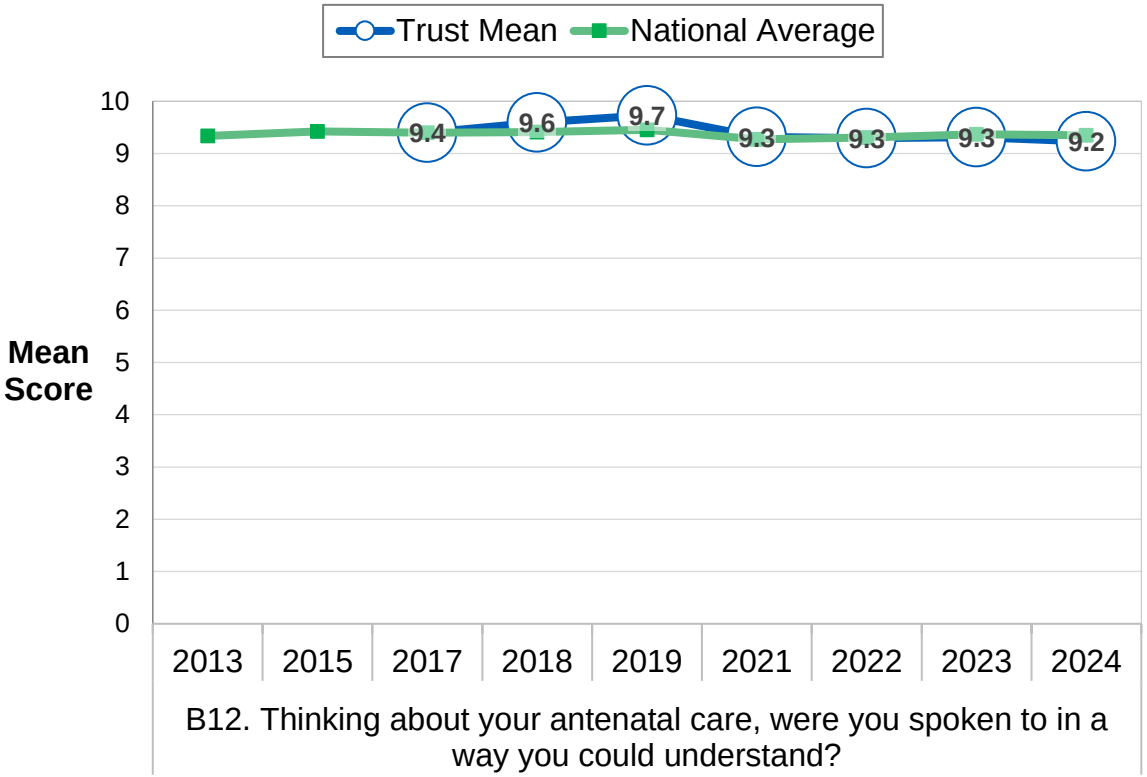
B11. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?

Significant change 2024 vs 2023	Increase

Answered by all. Respondents who stated that they did not contact a midwifery team have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 56; 2018: 56; 2019: 55; 2021: 124; 2022: 115; 2023: 107; 2024: 111

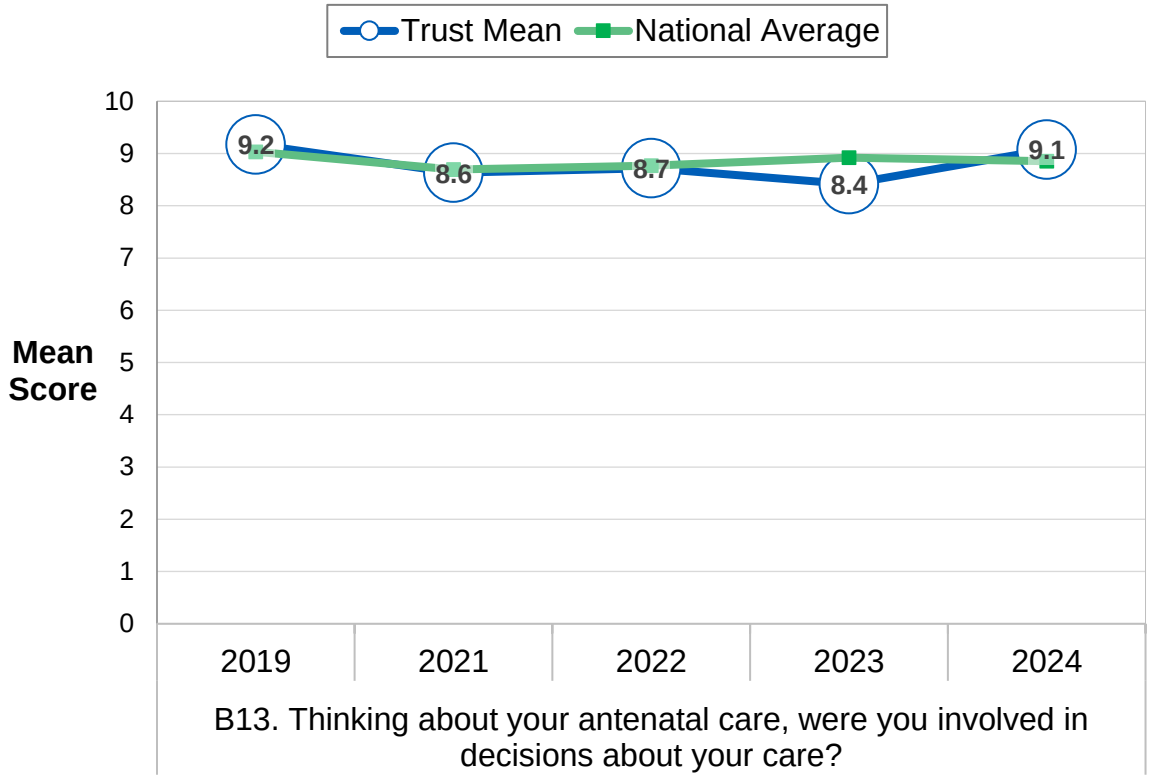
Section 1. Antenatal Care

During your pregnancy



Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 67; 2018: 71; 2019: 62; 2021: 136; 2022: 123; 2023: 112; 2024: 123

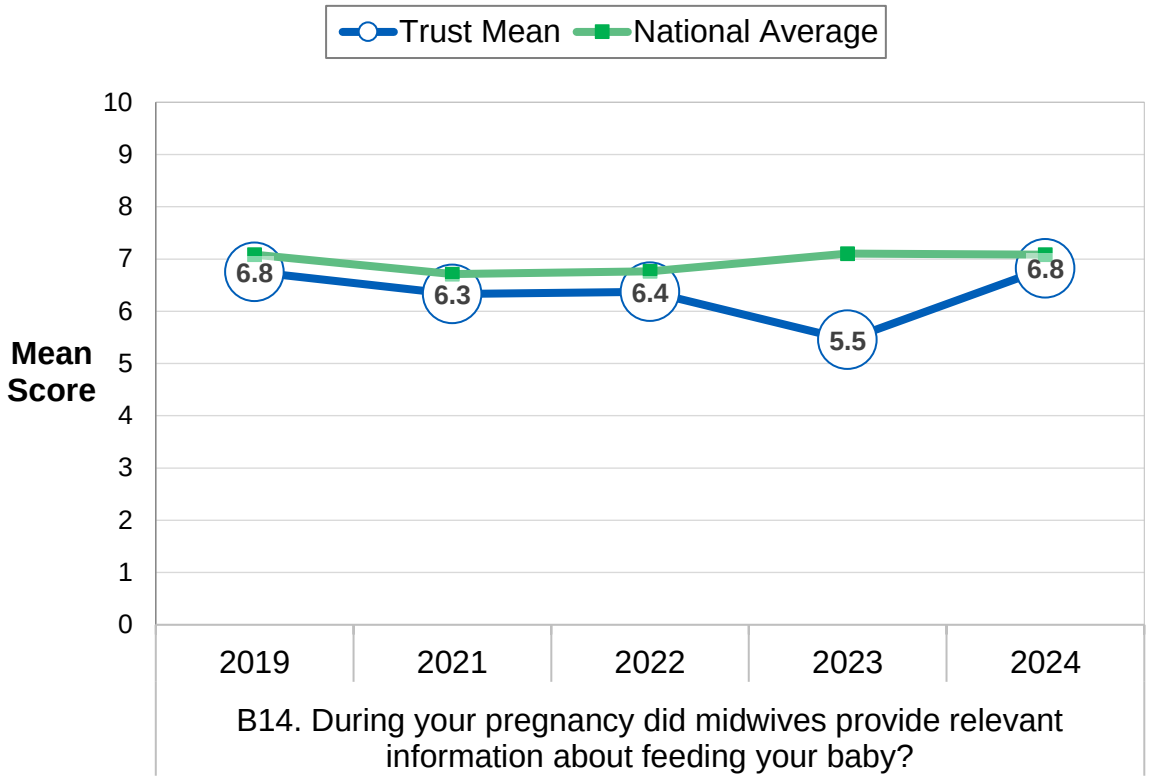


Significant change 2024 vs 2023	Increase

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not want / need to be involved have been excluded.
Number of respondents: 2019: 62; 2021: 133; 2022: 121; 2023: 109; 2024: 121

Section 1. Antenatal Care

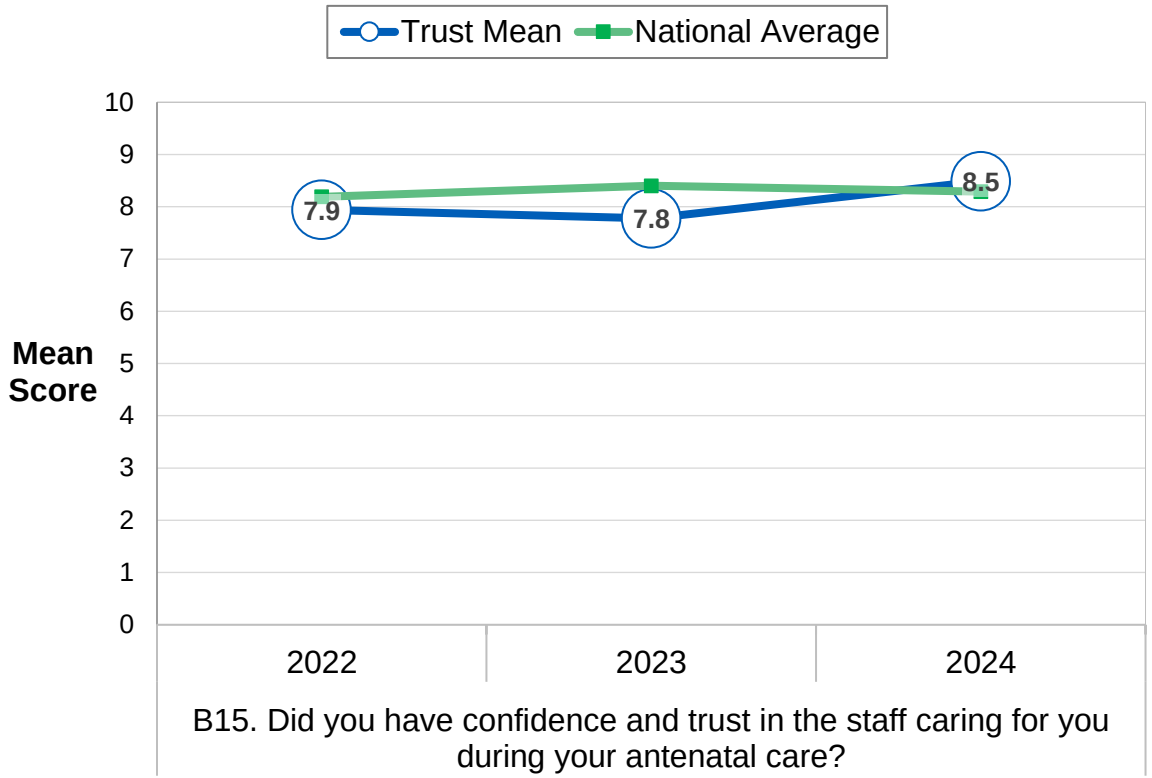
During your pregnancy



B14. During your pregnancy did midwives provide relevant information about feeding your baby?

Significant change 2024 vs 2023	Increase

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 62; 2021: 133; 2022: 121; 2023: 108; 2024: 122



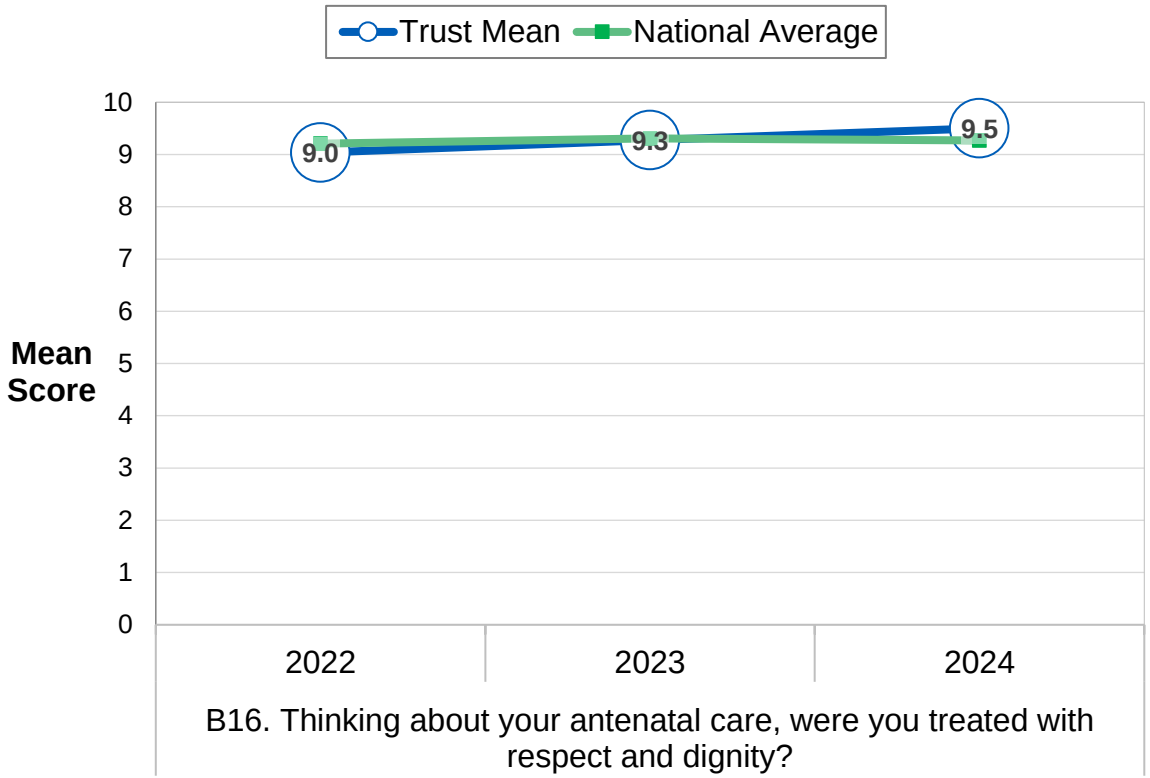
B15. Did you have confidence and trust in the staff caring for you during your antenatal care?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2022: 123; 2023: 112; 2024: 123

Section 1. Antenatal Care

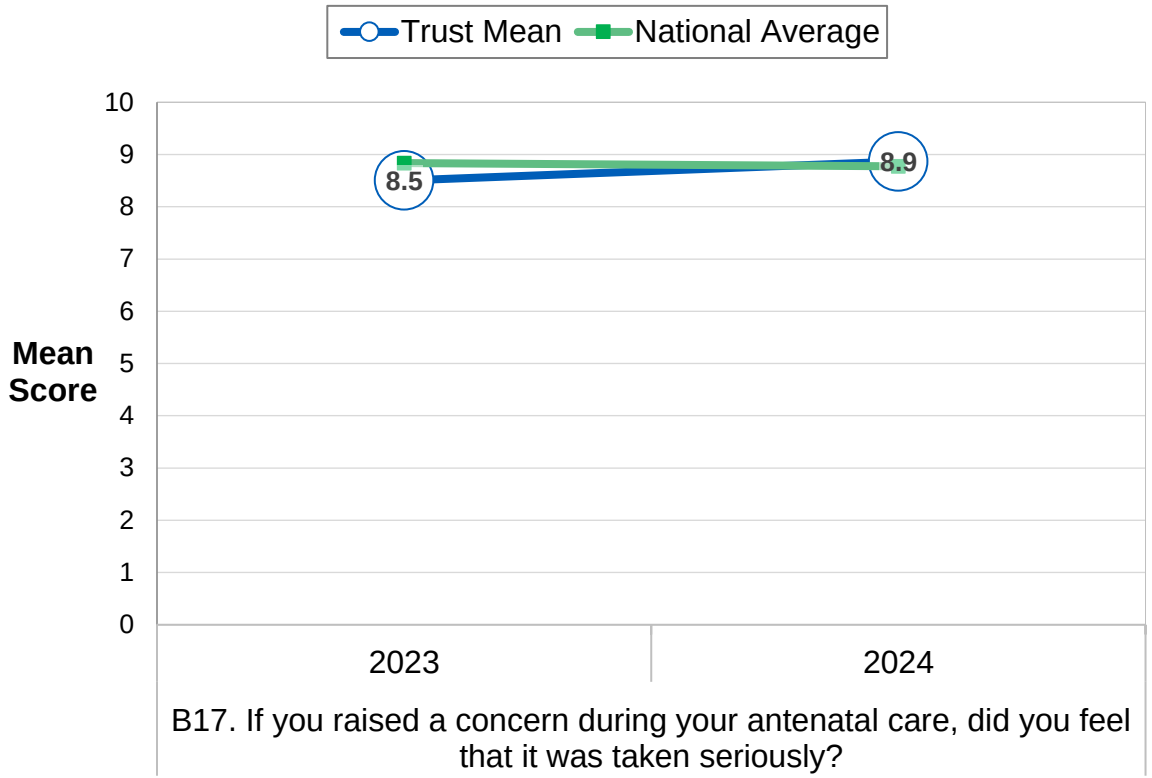
During your pregnancy



B16. Thinking about your antenatal care, were you treated with respect and dignity?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2022: 123; 2023: 112; 2024: 122



B17. If you raised a concern during your antenatal care, did you feel that it was taken seriously?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2023: 83; 2024: 90

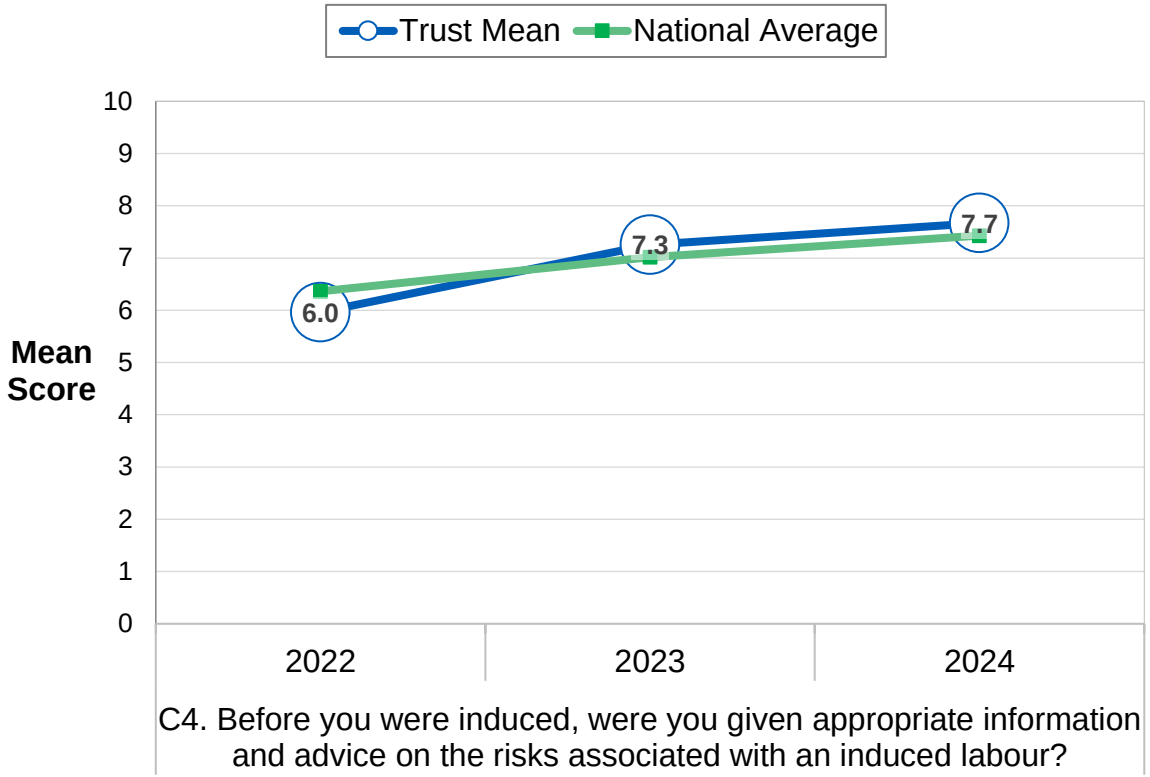
Change over time

Section 2: Labour and Birth



Section 2. Labour and Birth

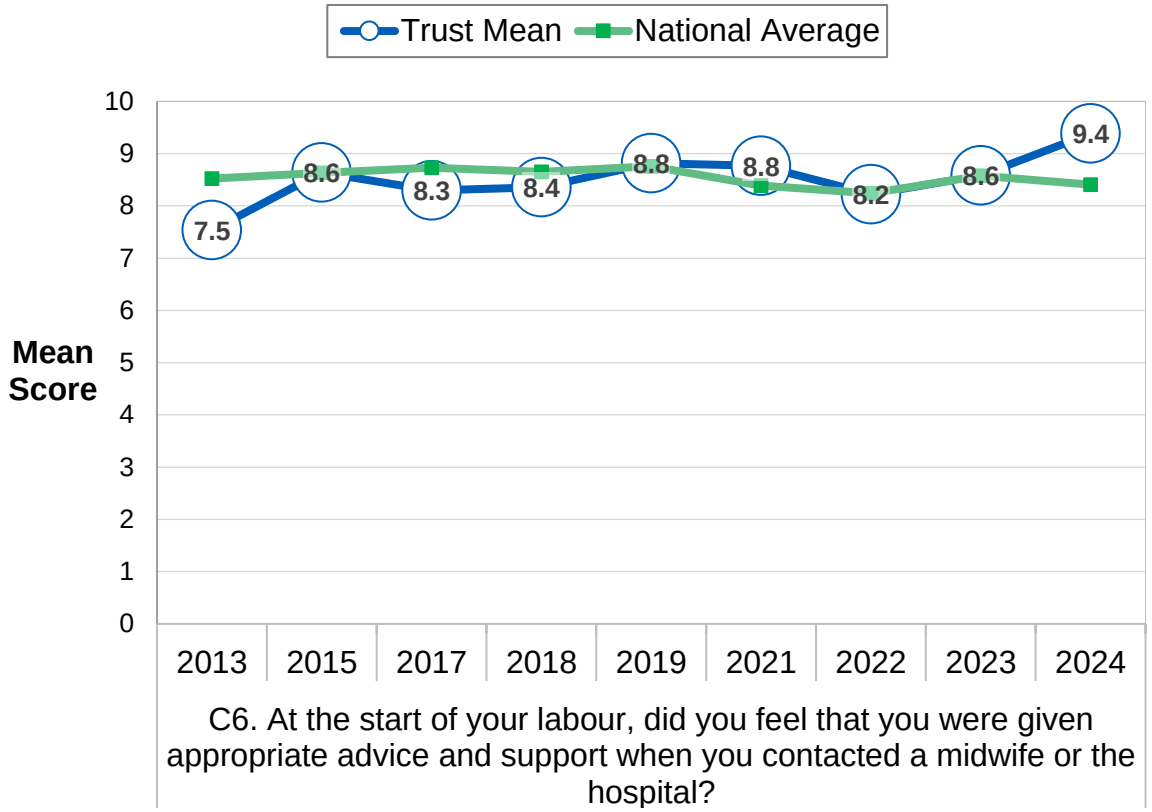
Your labour and birth



C4. Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?

Significant change 2024 vs 2023	No change

Answered by those who were induced. Respondents who stated that they didn't know or couldn't remember have been excluded. Note of caution when interpreting the trend data: The 2023 preceding question asking about information and advice on the benefits of an induced labour was removed.
Number of respondents: 2022: 43; 2023: 36; 2024: 35



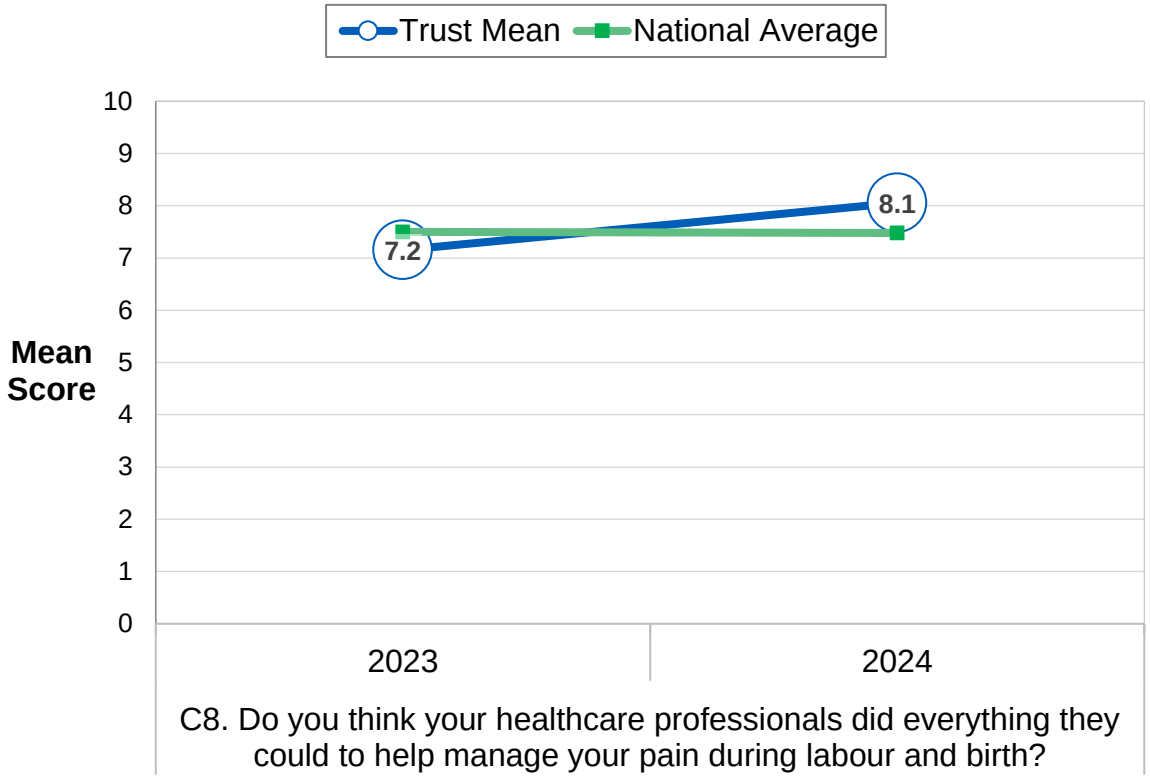
C6. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?

Significant change 2024 vs 2023	No change

Answered by those who went into labour. Respondents who stated that they did not contact a midwife / the hospital have been excluded.
Number of respondents: 2013: 83; 2015: 75; 2017: 65; 2018: 58; 2019: 52; 2021: 108; 2022: 85; 2023: 77; 2024: 72

Section 2. Labour and Birth

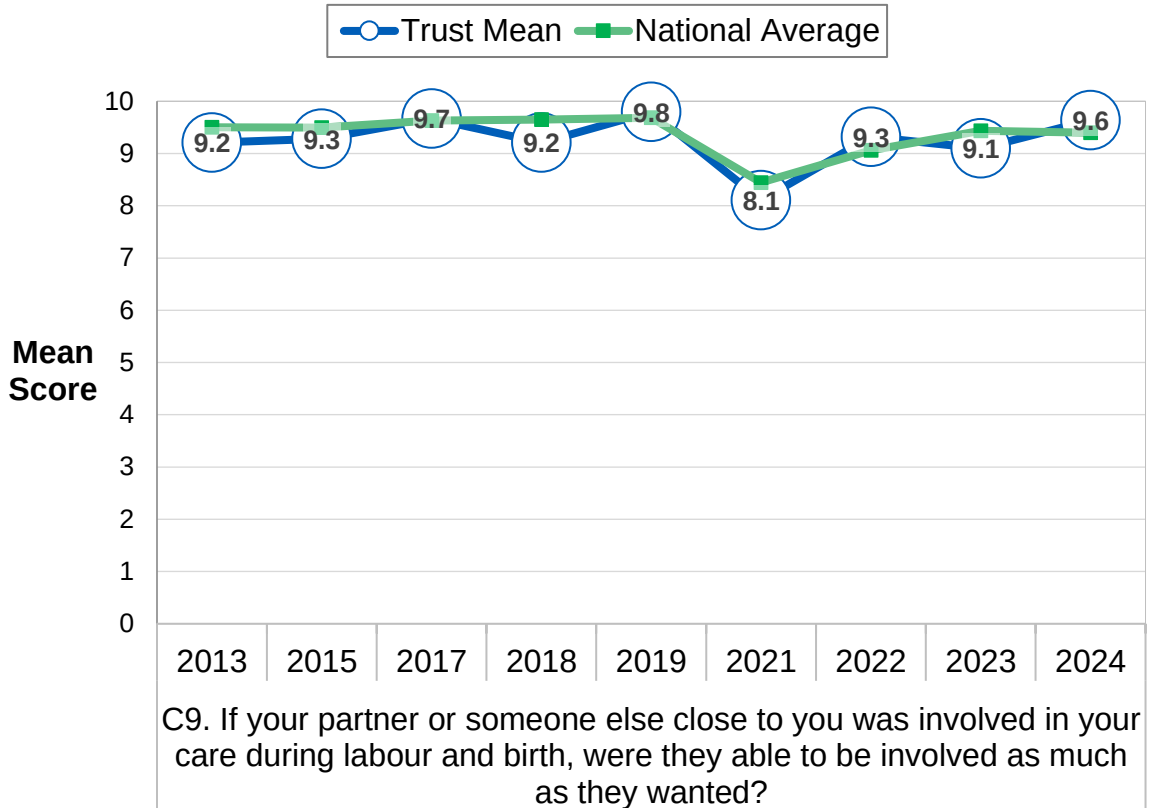
Your labour and birth



C8. Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?

Significant change 2024 vs 2023	No change

Answered by those who had a labour. Respondents who stated that they didn't know or couldn't remember or did not need any help with pain relief have been excluded.
Number of respondents: 2023: 91; 2024: 90



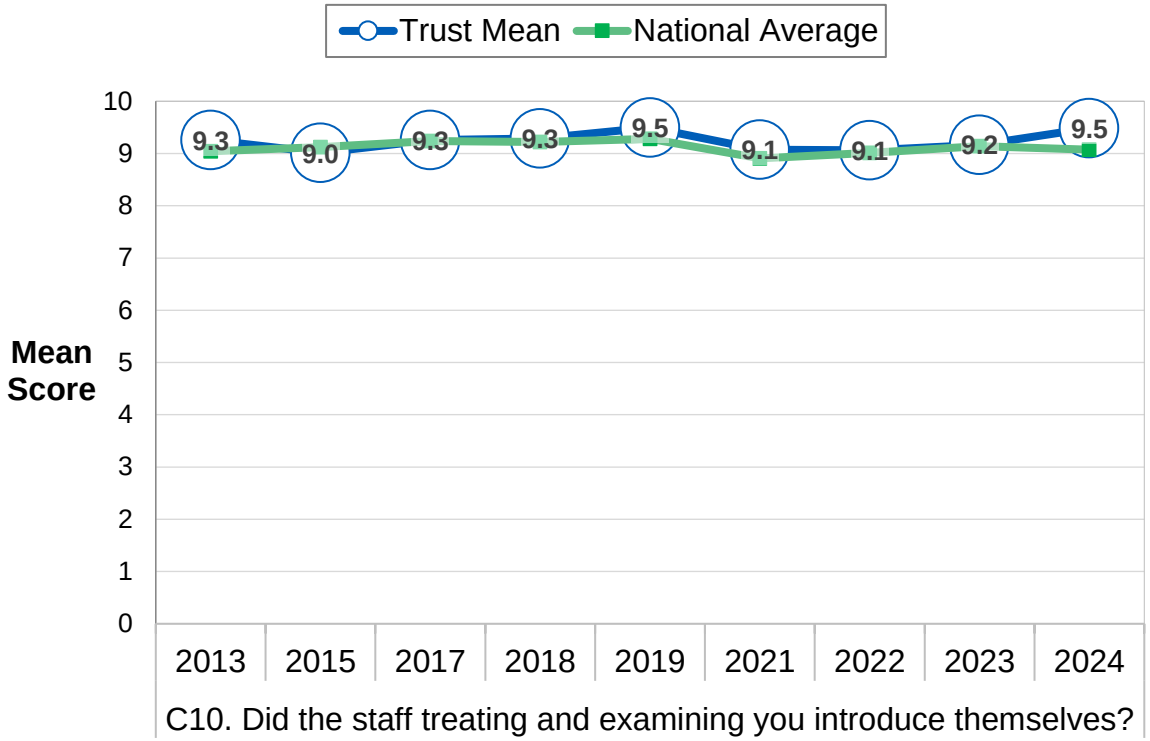
C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they did not have a partner / companion with them, did not want their partner / companion to be involved, or that their partner / companion did not want to / could not be involved have been excluded.
Number of respondents: 2013: 114; 2015: 112; 2017: 94; 2018: 86; 2019: 91; 2021: 162; 2022: 131; 2023: 117; 2024: 128

Section 2. Labour and Birth

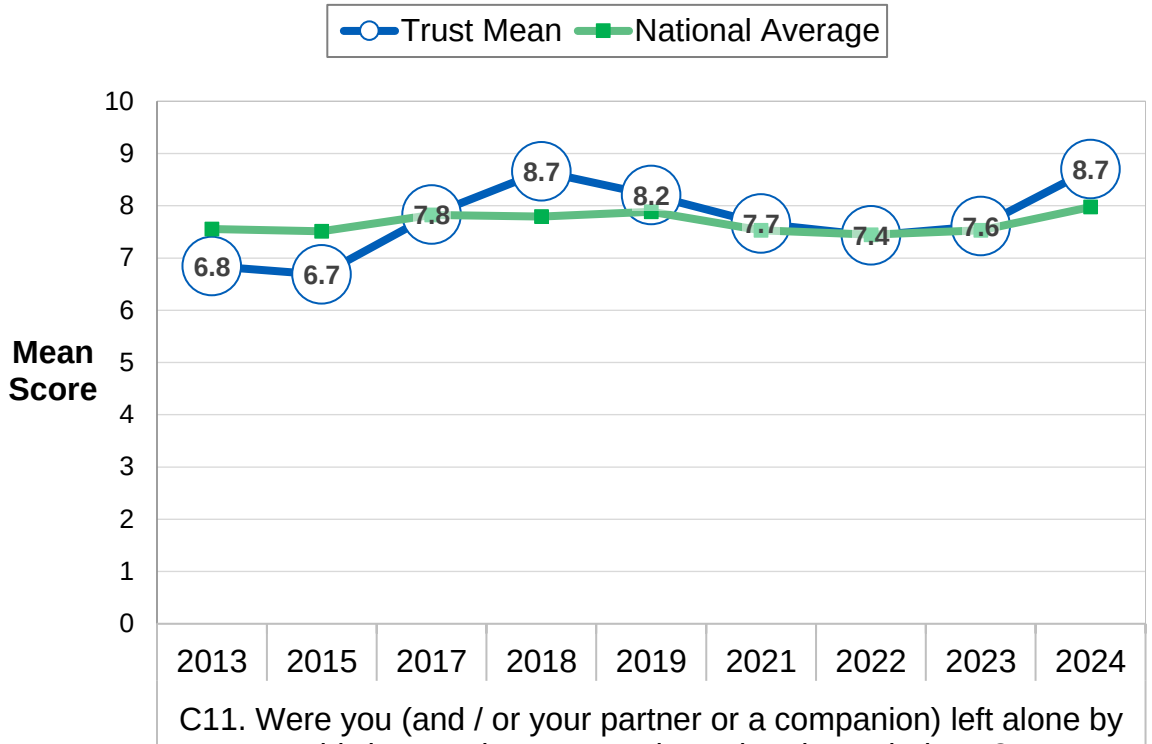
Staff caring for you



C10. Did the staff treating and examining you introduce themselves?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 114; 2015: 112; 2017: 93; 2018: 89; 2019: 90; 2021: 163; 2022: 130; 2023: 118; 2024: 127



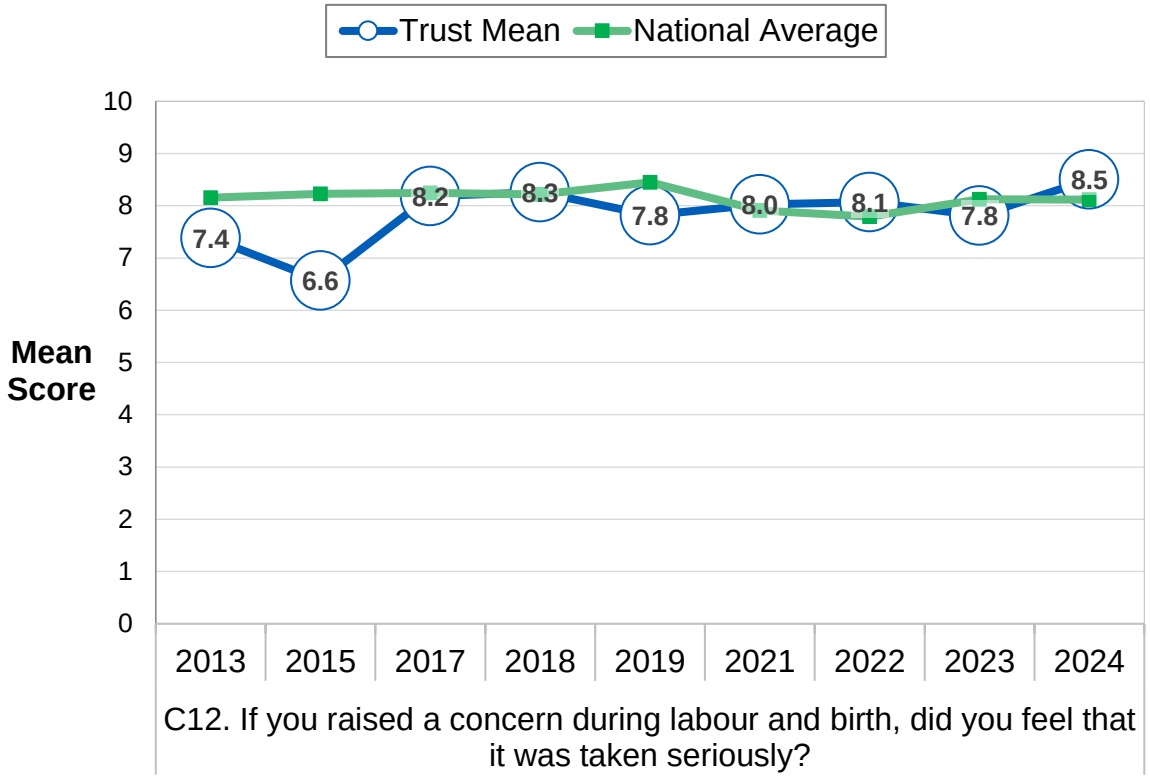
C11. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?

Significant change 2024 vs 2023	Increase

Answered by all. Multiple response question: percentages may sum to more than 100.
Number of respondents: 2013: 116; 2015: 112; 2017: 93; 2018: 88; 2019: 93; 2021: 163; 2022: 131; 2023: 119; 2024: 125

Section 2. Labour and Birth

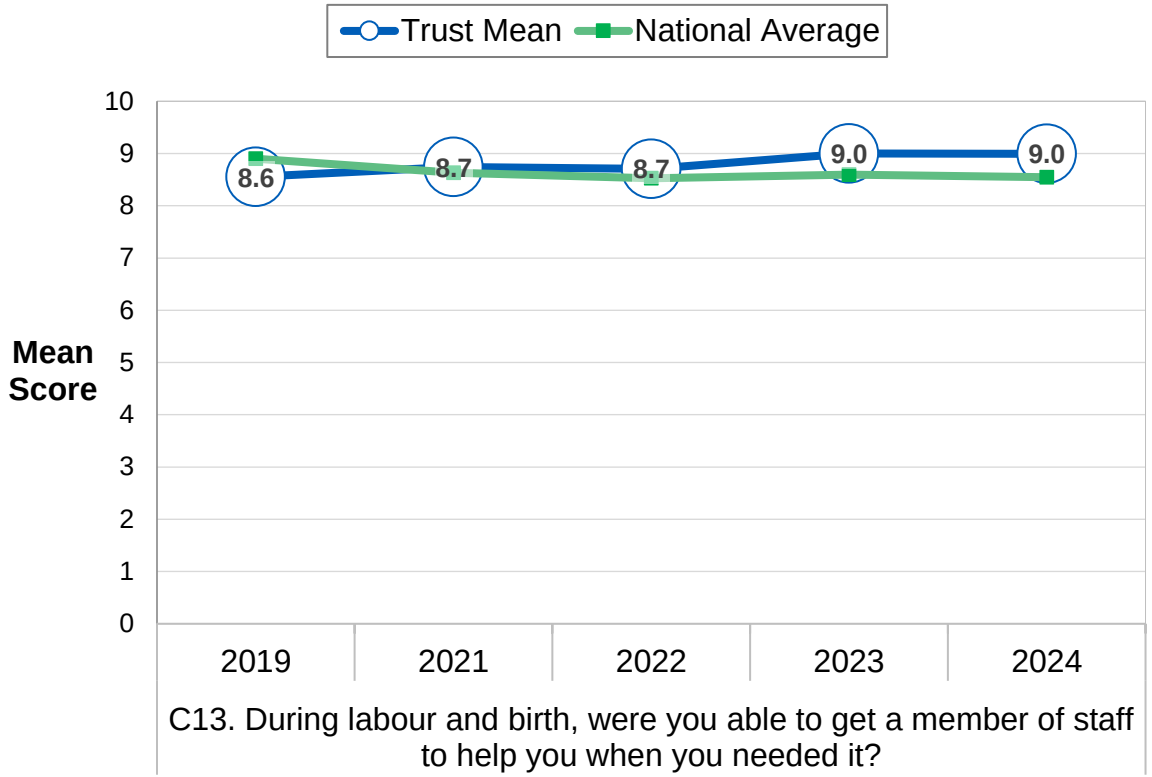
Staff caring for you



C12. If you raised a concern during labour and birth, did you feel that it was taken seriously?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they did not raise any concerns have been excluded.
Number of respondents: 2013: 66; 2015: 65; 2017: 50; 2018: 57; 2019: 67; 2021: 103; 2022: 86; 2023: 82; 2024: 78



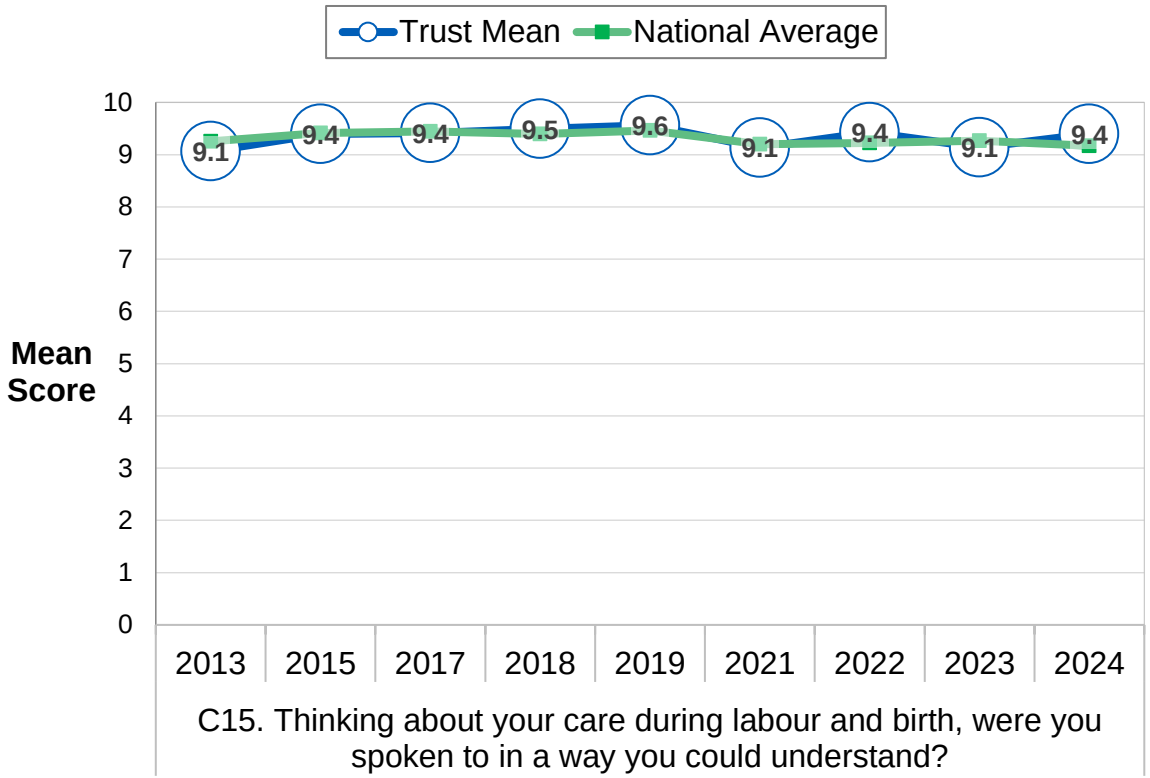
C13. During labour and birth, were you able to get a member of staff to help you when you needed it?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want / need this have been excluded.
Number of respondents: 2019: 91; 2021: 158; 2022: 130; 2023: 117; 2024: 127

Section 2. Labour and Birth

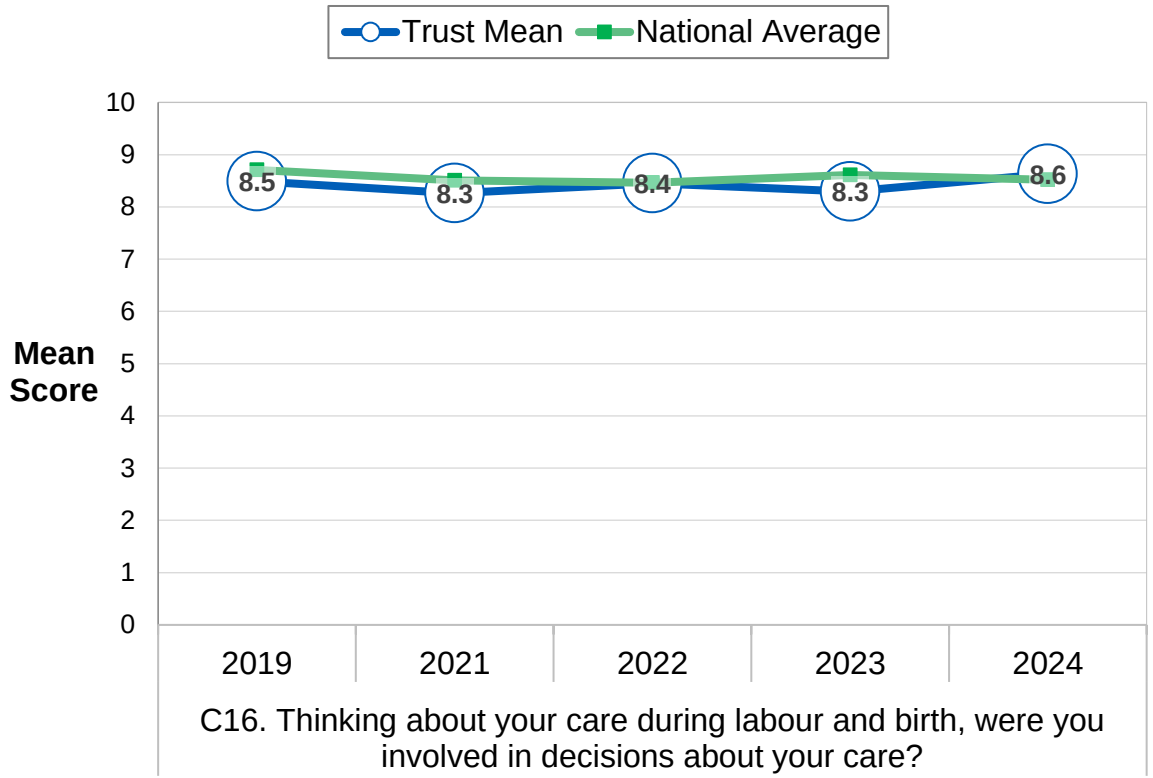
Staff caring for you



C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 117; 2015: 112; 2017: 93; 2018: 87; 2019: 92; 2021: 162; 2022: 130; 2023: 118; 2024: 126



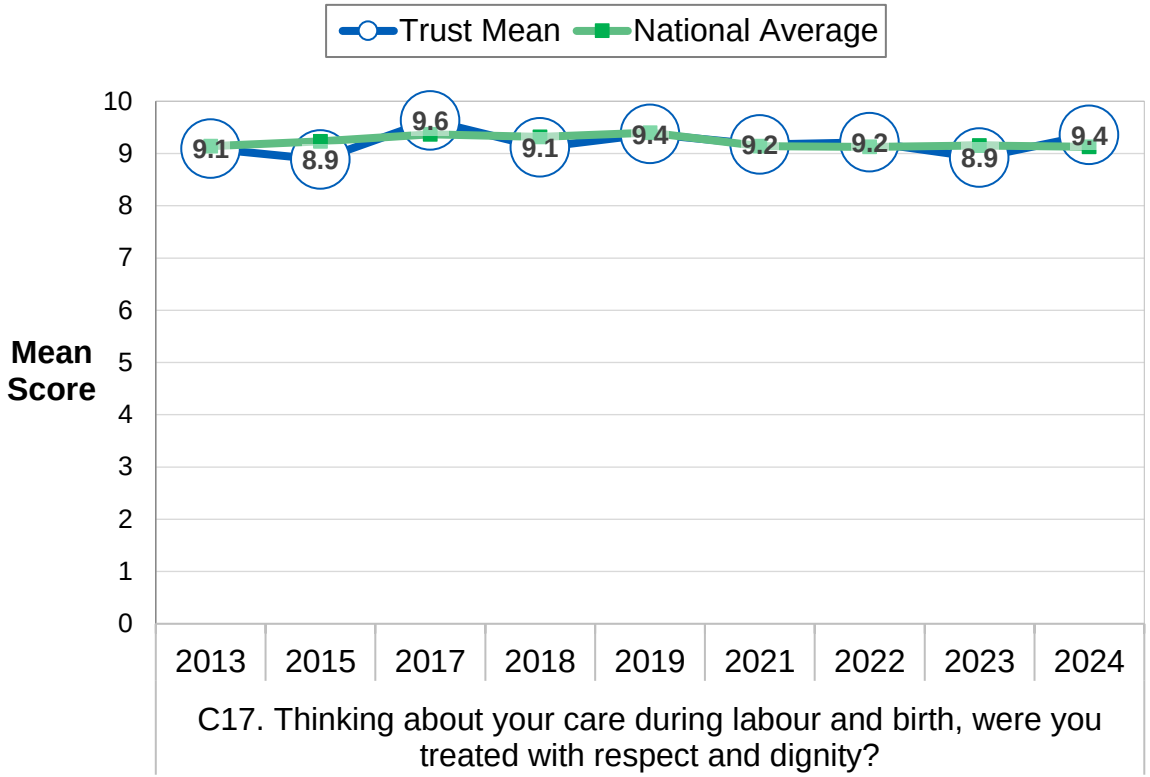
C16. Thinking about your care during labour and birth, were you involved in decisions about your care?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want / need to be involved have been excluded.
Number of respondents: 2019: 91; 2021: 159; 2022: 127; 2023: 118; 2024: 126

Section 2. Labour and Birth

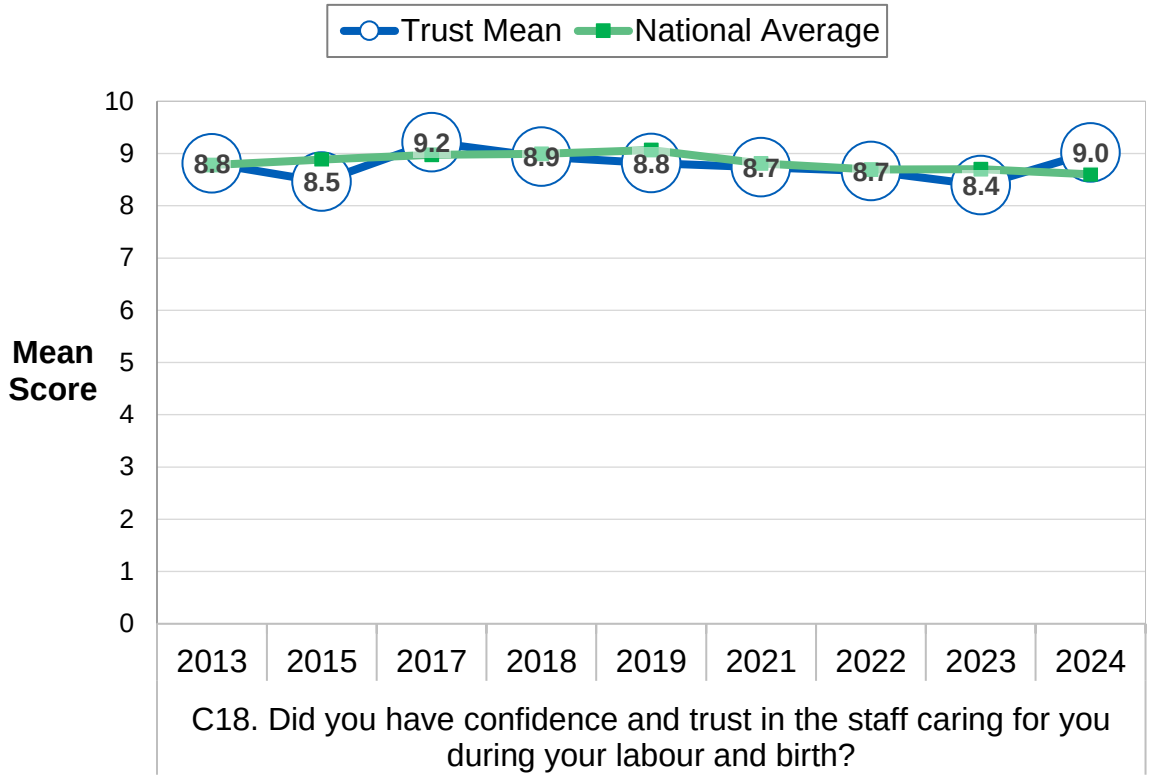
Staff caring for you



C17. Thinking about your care during labour and birth, were you treated with respect and dignity?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 117; 2015: 113; 2017: 93; 2018: 89; 2019: 93; 2021: 162; 2022: 130; 2023: 119; 2024: 129



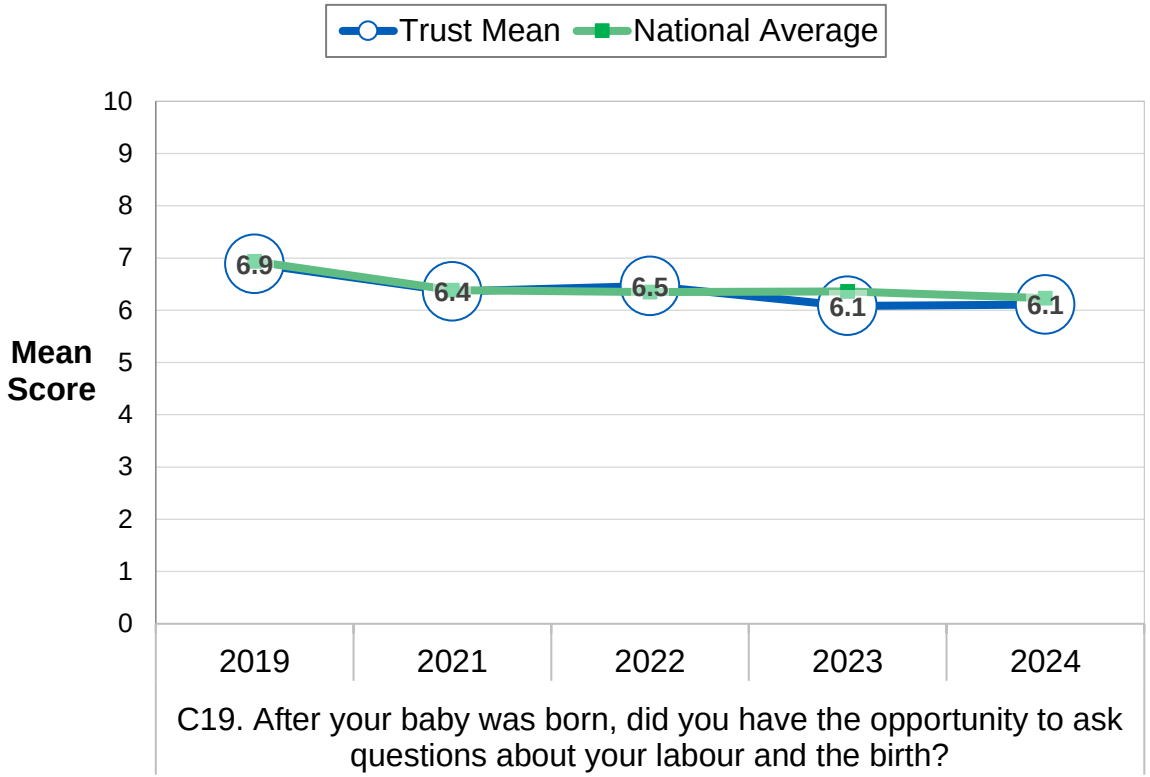
C18. Did you have confidence and trust in the staff caring for you during your labour and birth?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 116; 2015: 113; 2017: 92; 2018: 88; 2019: 93; 2021: 163; 2022: 130; 2023: 119; 2024: 128

Section 2. Labour and Birth

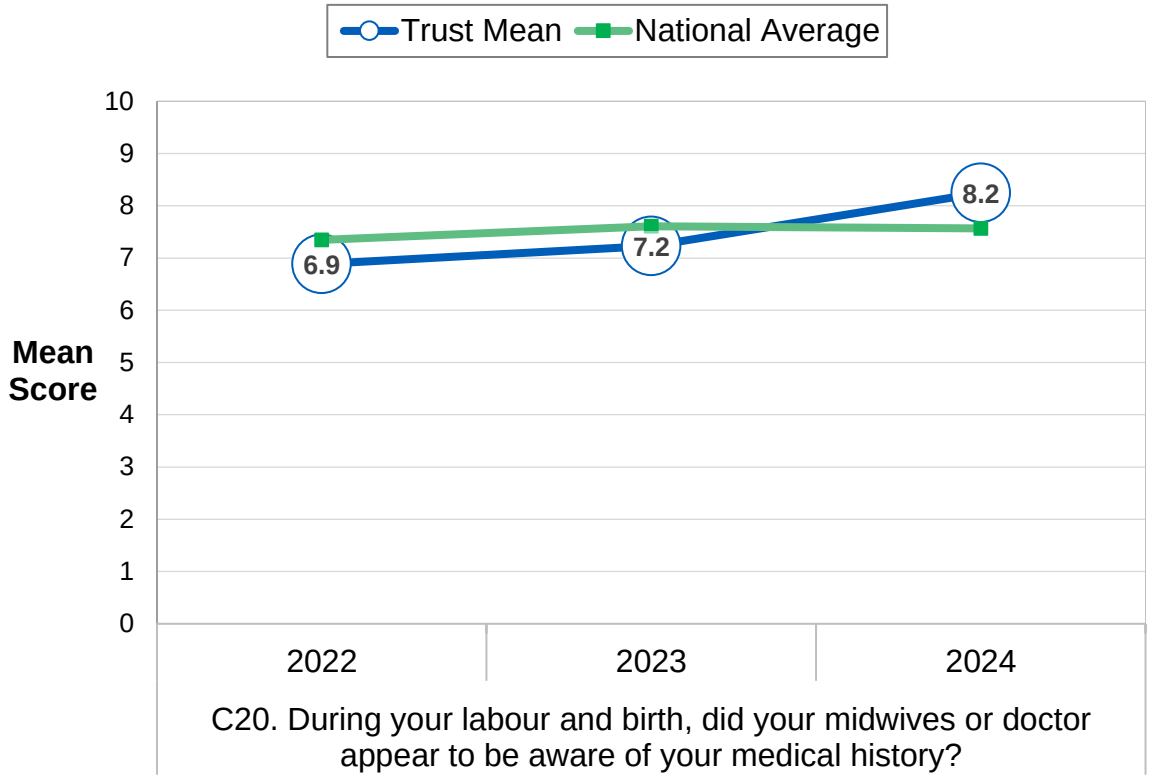
Staff caring for you



C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or that they did not want / need this have been excluded.
Number of respondents: 2019: 86; 2021: 140; 2022: 116; 2023: 103; 2024: 115



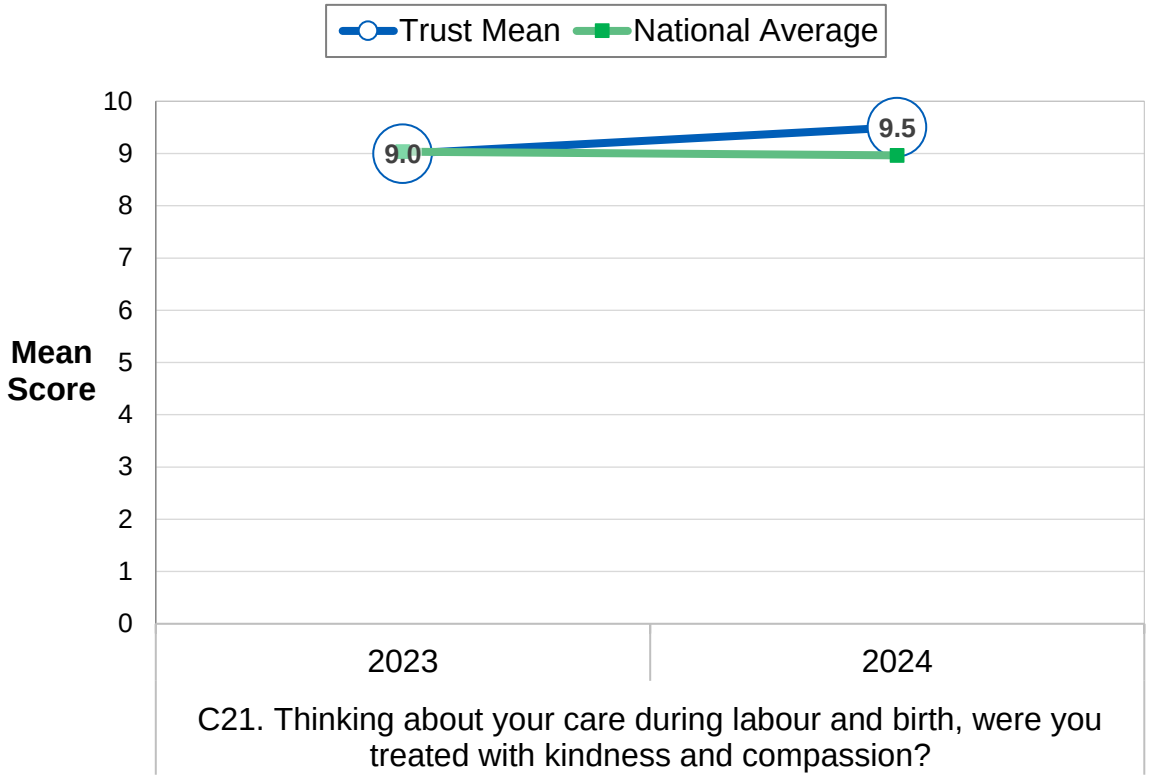
C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?

Significant change 2024 vs 2023	Increase

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2022: 121; 2023: 110; 2024: 112

Section 2. Labour and Birth

Staff caring for you



Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2023: 119; 2024: 128

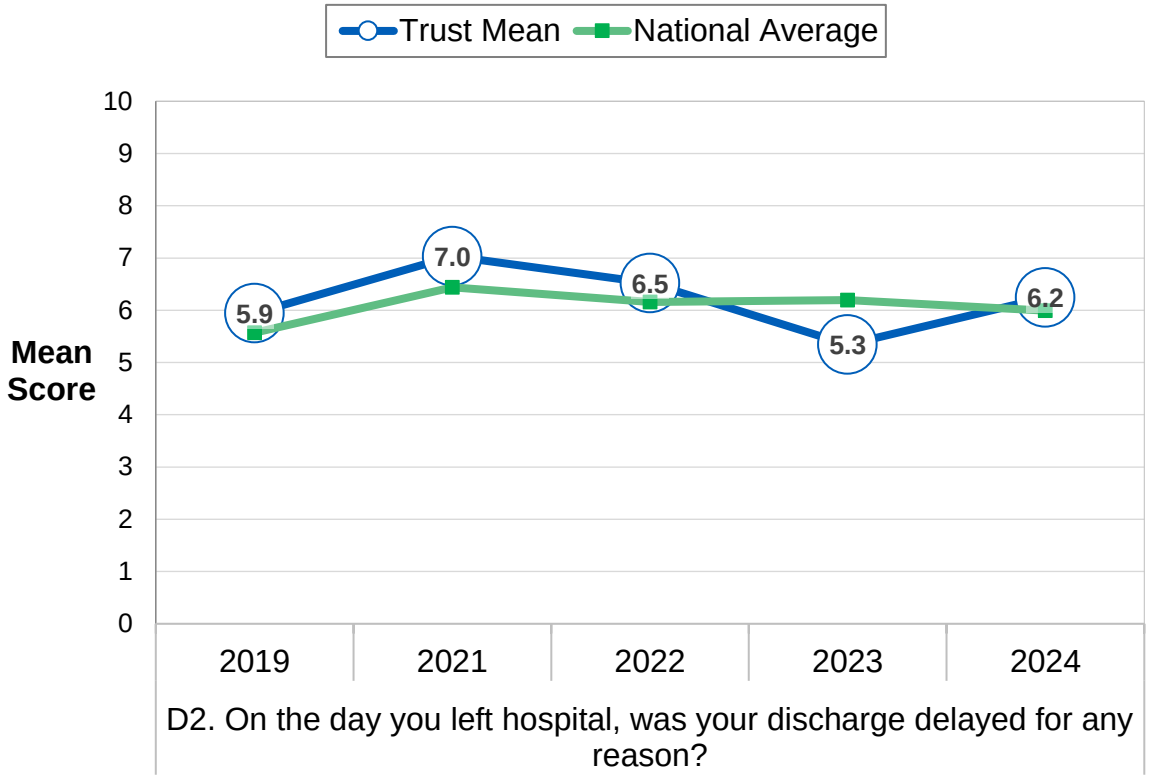
Change over time

Section 3: Postnatal Care



Section 3. Postnatal Care

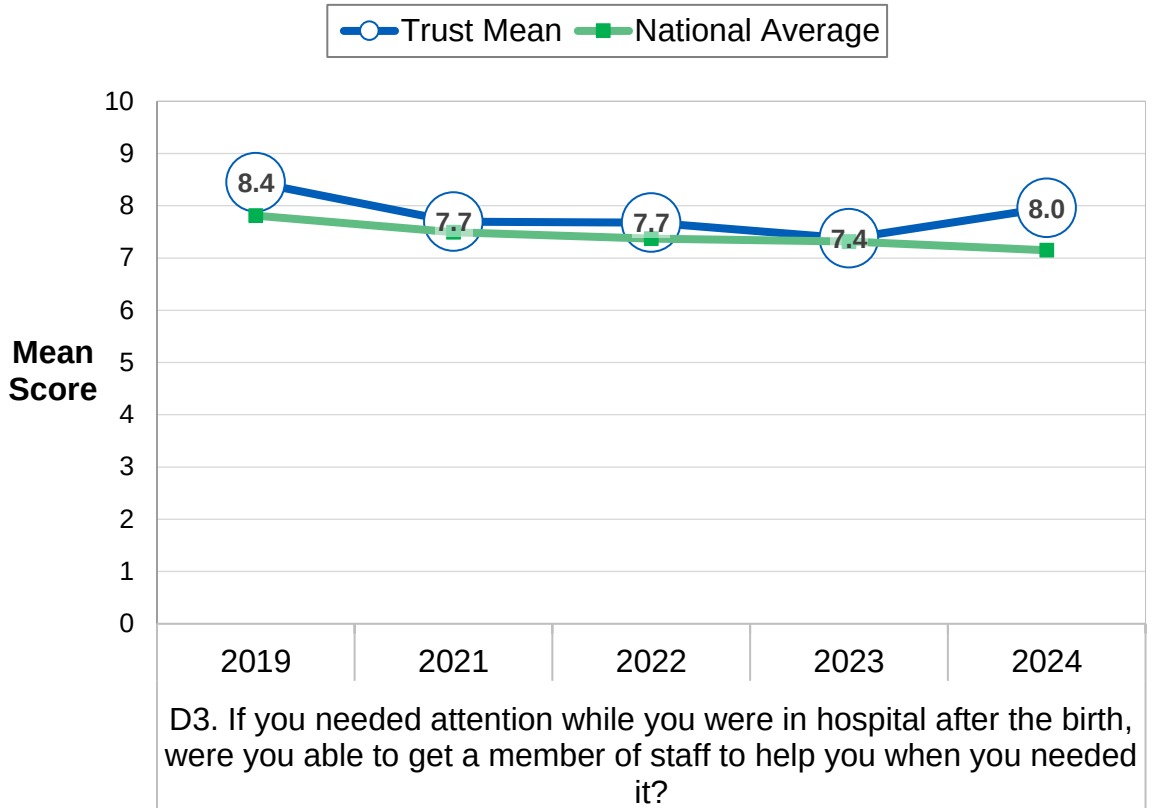
Care in the ward after birth



D2. On the day you left hospital, was your discharge delayed for any reason?

Significant change 2024 vs 2023	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth.
Number of respondents: 2019: 89; 2021: 158; 2022: 129; 2023: 120; 2024: 120



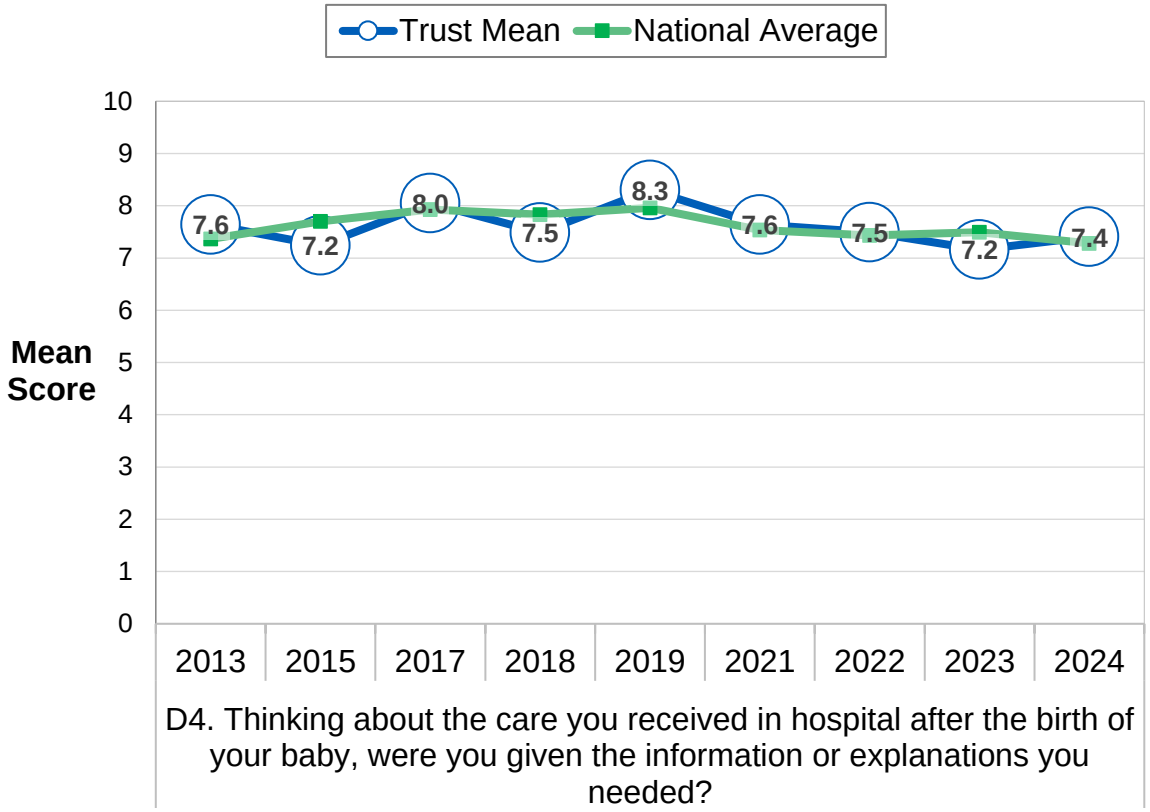
D3. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?

Significant change 2024 vs 2023	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth.
Respondents who stated that they didn't know / couldn't remember or did not want / need this have been excluded.
Number of respondents: 2019: 81; 2021: 146; 2022: 120; 2023: 115; 2024: 112

Section 3. Postnatal Care

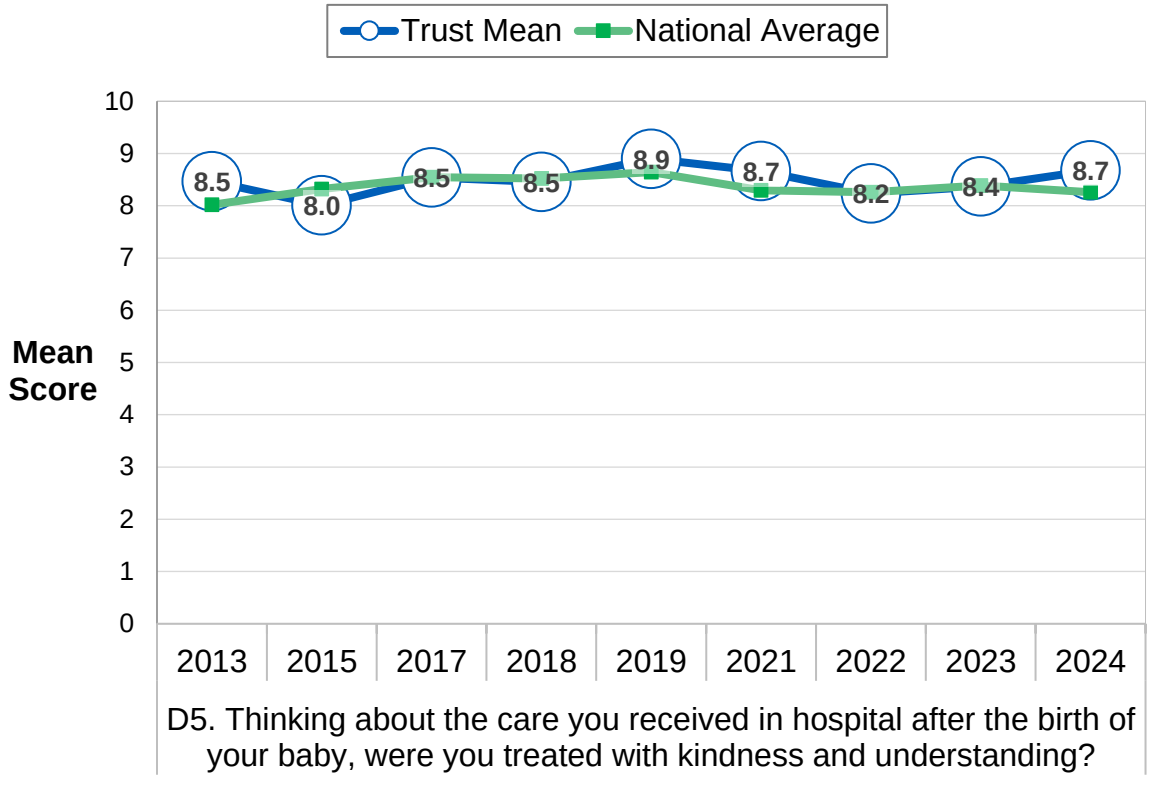
Care in the ward after birth



D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

Significant change 2024 vs 2023	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2013: 113; 2015: 112; 2017: 91; 2018: 89; 2019: 87; 2021: 157; 2022: 128; 2023: 120; 2024: 119



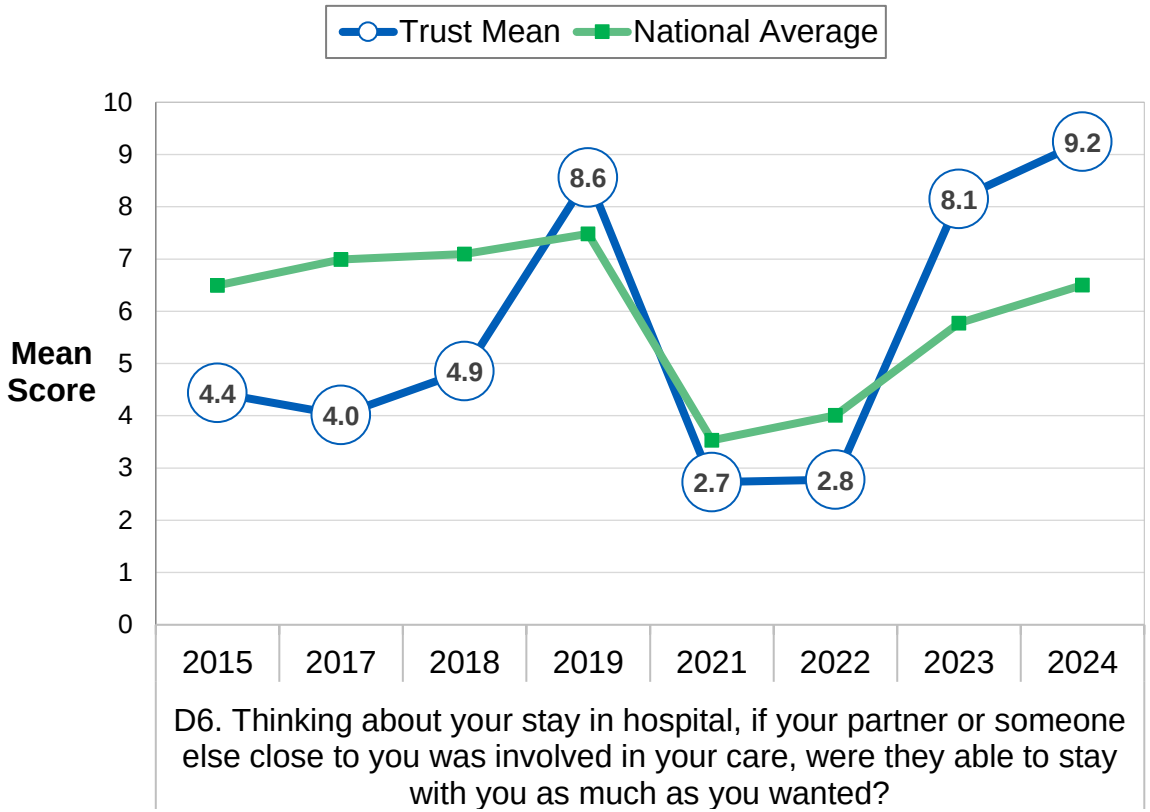
D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

Significant change 2024 vs 2023	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 114; 2015: 112; 2017: 91; 2018: 88; 2019: 89; 2021: 157; 2022: 129; 2023: 120; 2024: 121

Section 3. Postnatal Care

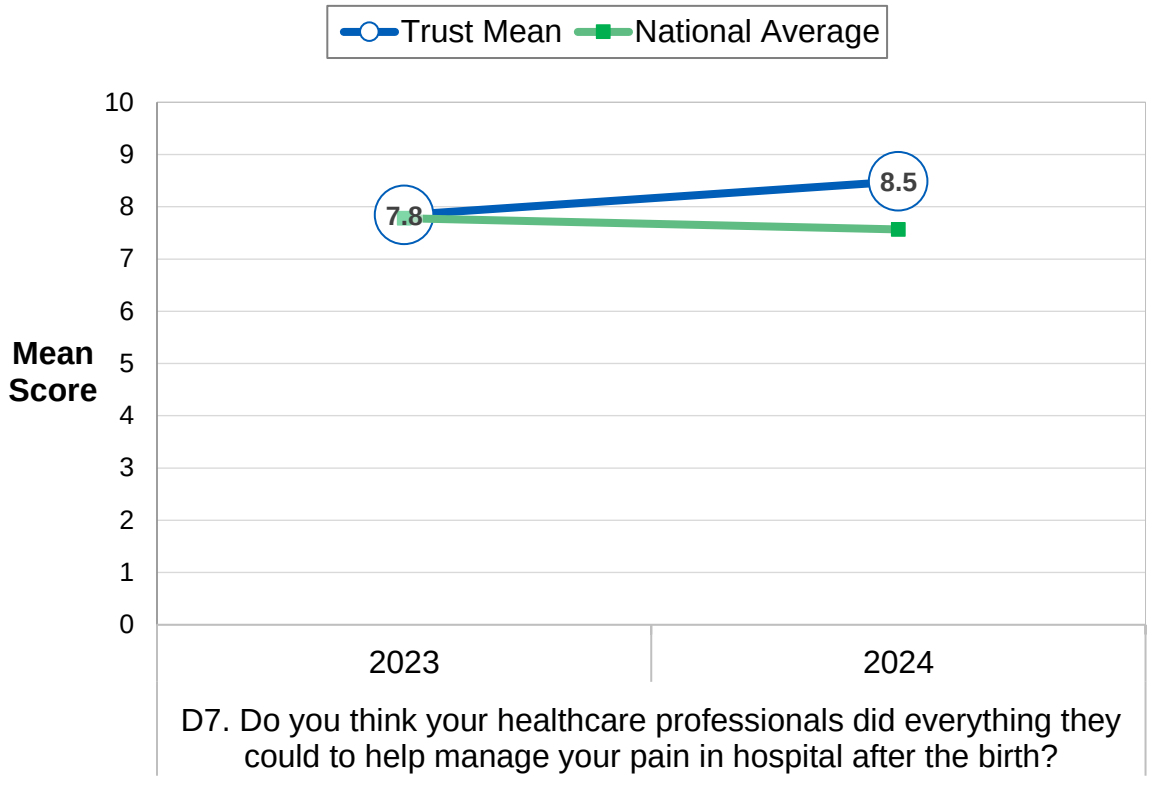
Care in the ward after birth



D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?

Significant change 2024 vs 2023	Increase

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that their partner / companion was not able to stay for another reason or that they did not have a partner / companion with them have been excluded.
Number of respondents: 2015: 109; 2017: 89; 2018: 84; 2019: 84; 2021: 134; 2022: 121; 2023: 115; 2024: 118



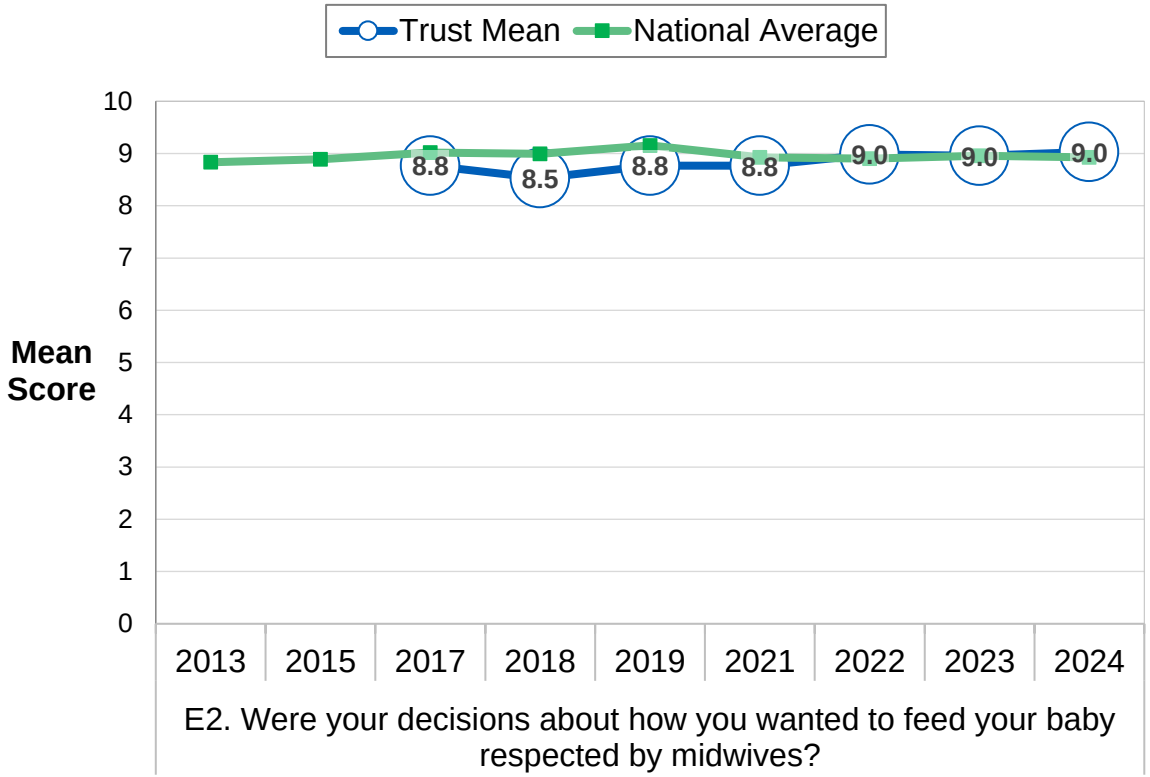
D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?

Significant change 2024 vs 2023	No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't need any help with pain relief or didn't know / couldn't remember have been excluded.
Number of respondents: 2023: 114; 2024: 115

Section 3. Postnatal Care

Feeding your baby

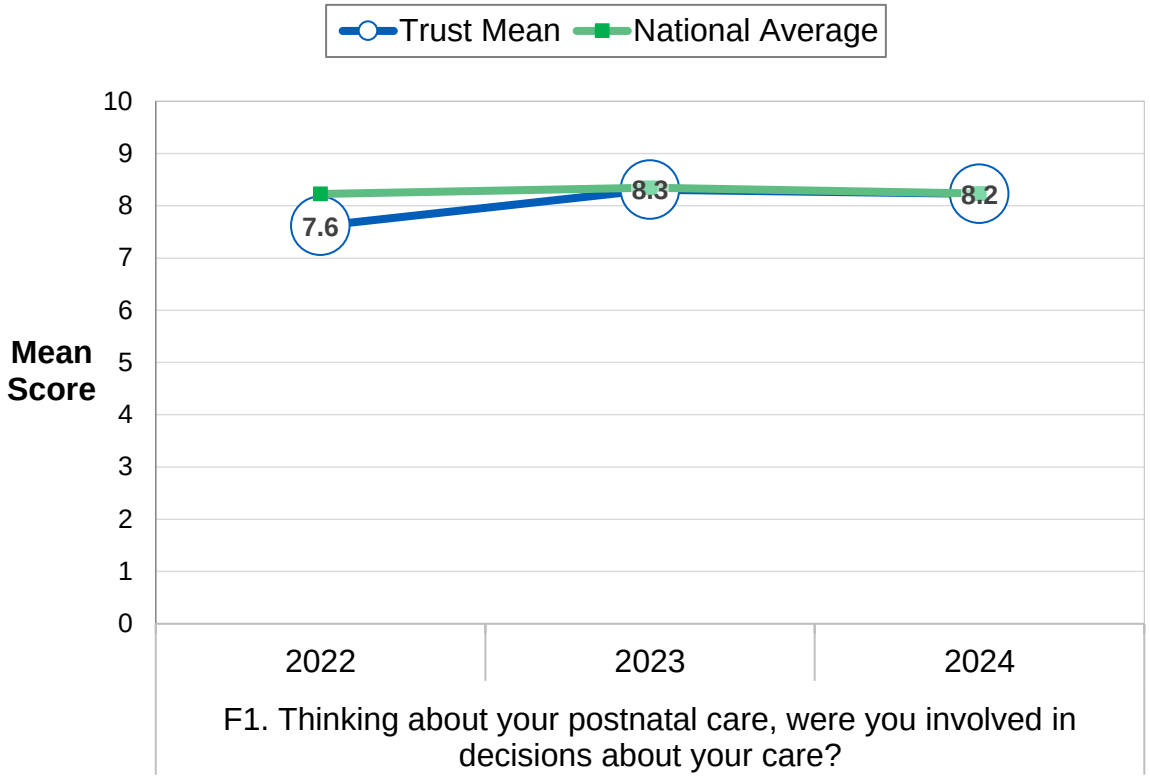


Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 67; 2018: 77; 2019: 64; 2021: 160; 2022: 115; 2023: 117; 2024: 125

Section 3. Postnatal Care

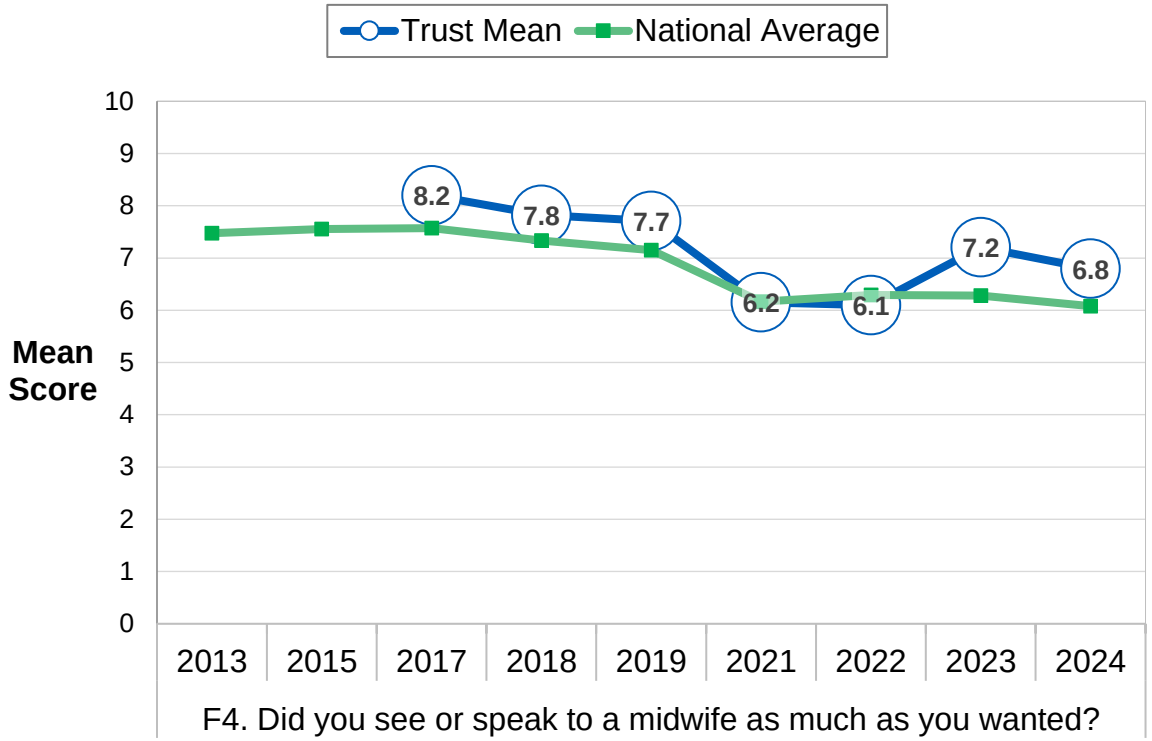
Care at home after birth



F1. Thinking about your postnatal care, were you involved in decisions about your care?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want/ need to be involved have been excluded..
Number of respondents: 2022: 110; 2023: 114; 2024: 122



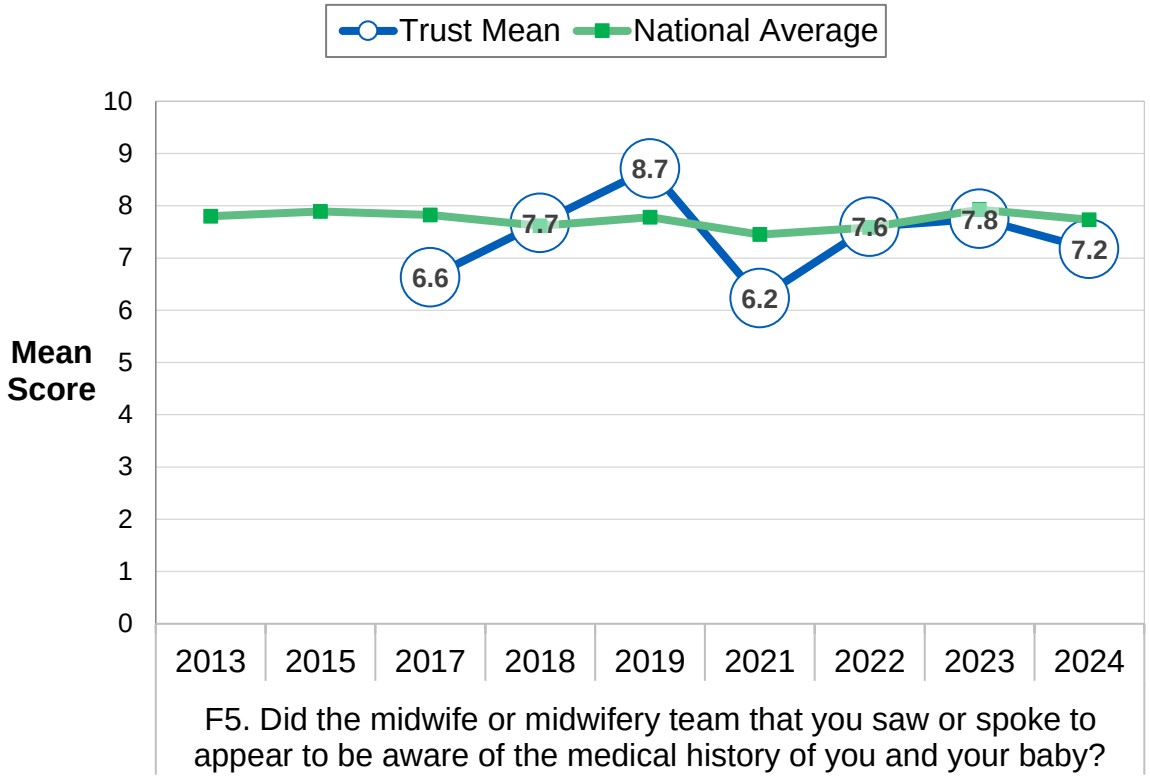
F4. Did you see or speak to a midwife as much as you wanted?

Significant change 2024 vs 2023	No change

Answered by all.
Number of respondents: 2013: -; 2015: -; 2017: 69; 2018: 77; 2019: 66; 2021: 158; 2022: 114; 2023: 114; 2024: 125

Section 3. Postnatal Care

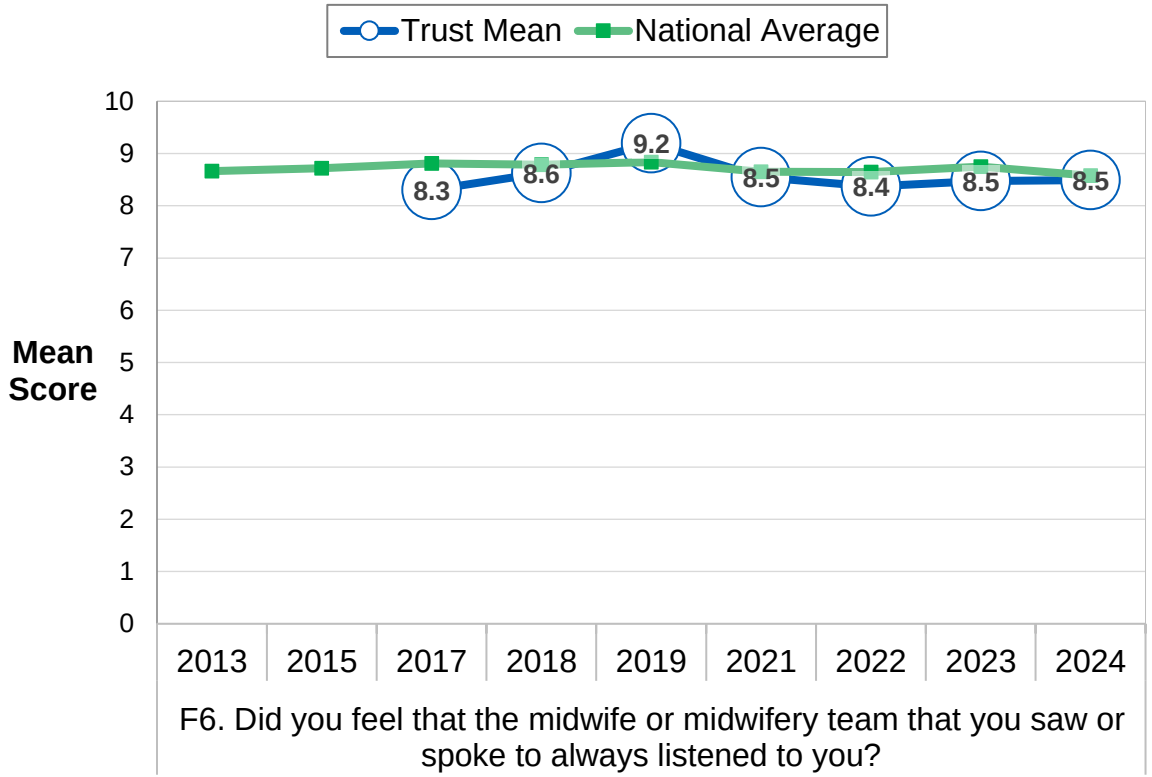
Care at home after birth



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?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 62; 2018: 75; 2019: 63; 2021: 143; 2022: 104; 2023: 103; 2024: 114



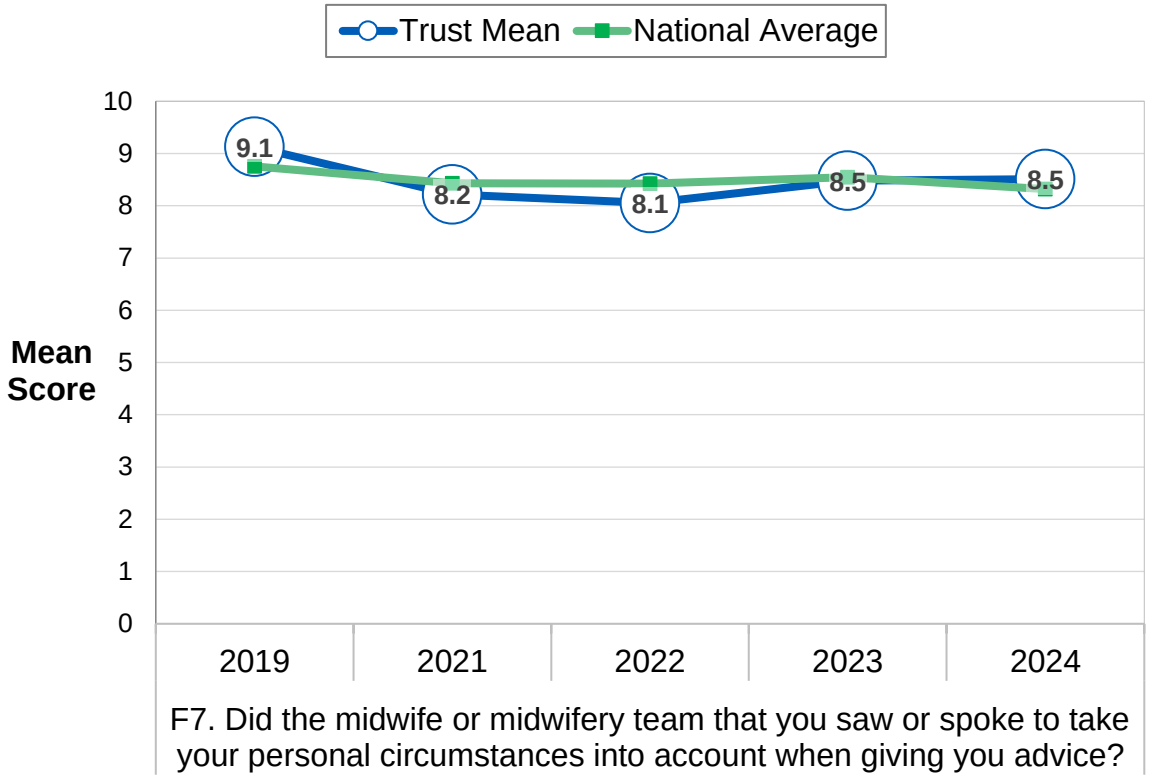
F6. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 69; 2018: 77; 2019: 66; 2021: 157; 2022: 114; 2023: 113; 2024: 124

Section 3. Postnatal Care

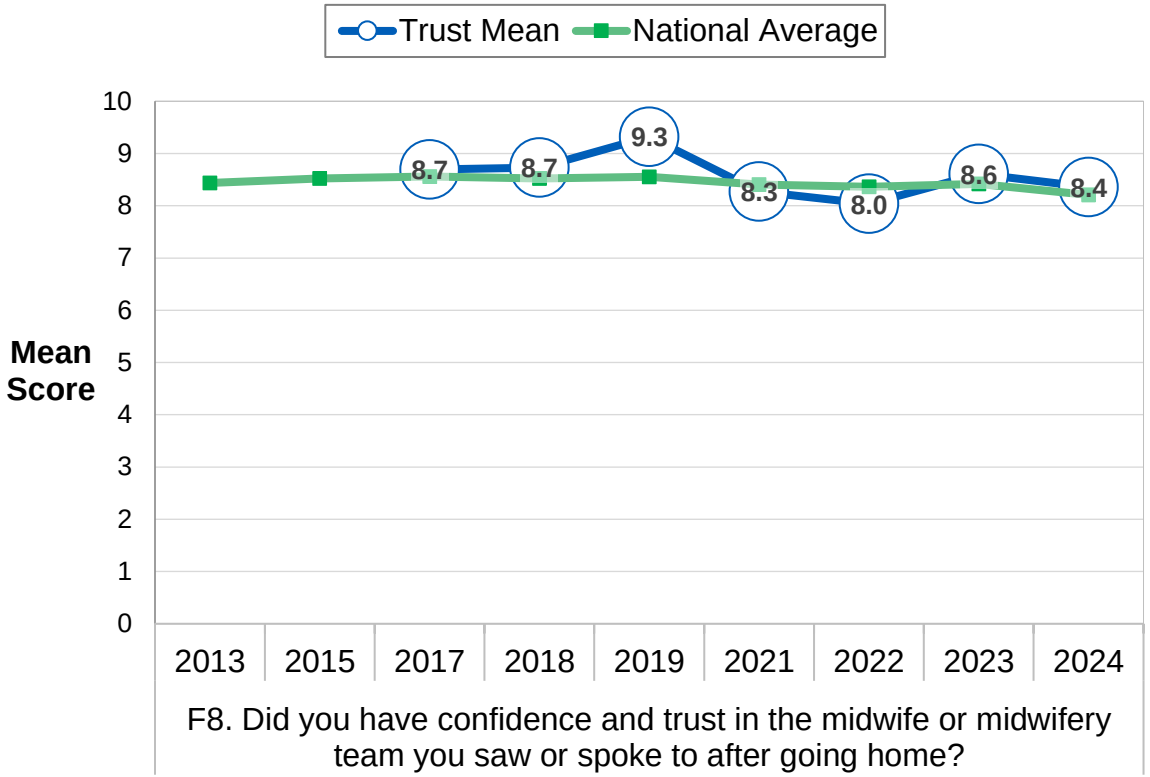
Care at home after birth



F7. Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 66; 2021: 146; 2022: 108; 2023: 110; 2024: 122



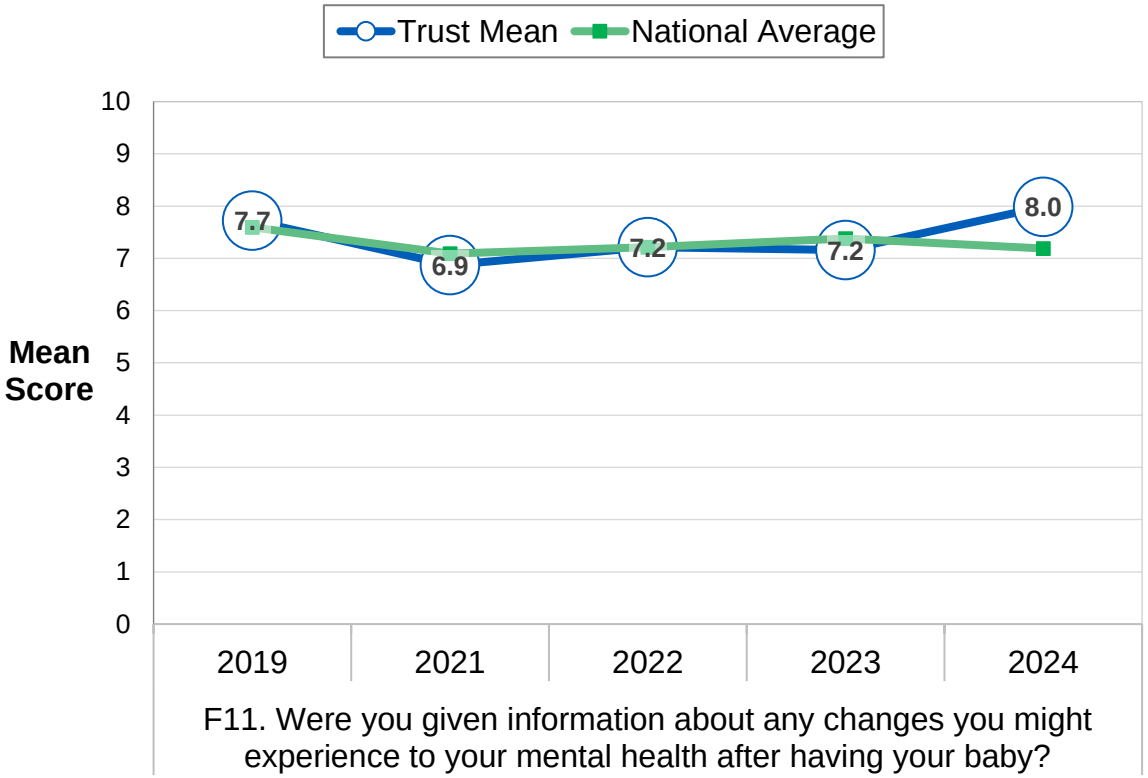
F8. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: -; 2017: 69; 2018: 76; 2019: 66; 2021: 155; 2022: 113; 2023: 113; 2024: 121

Section 3. Postnatal Care

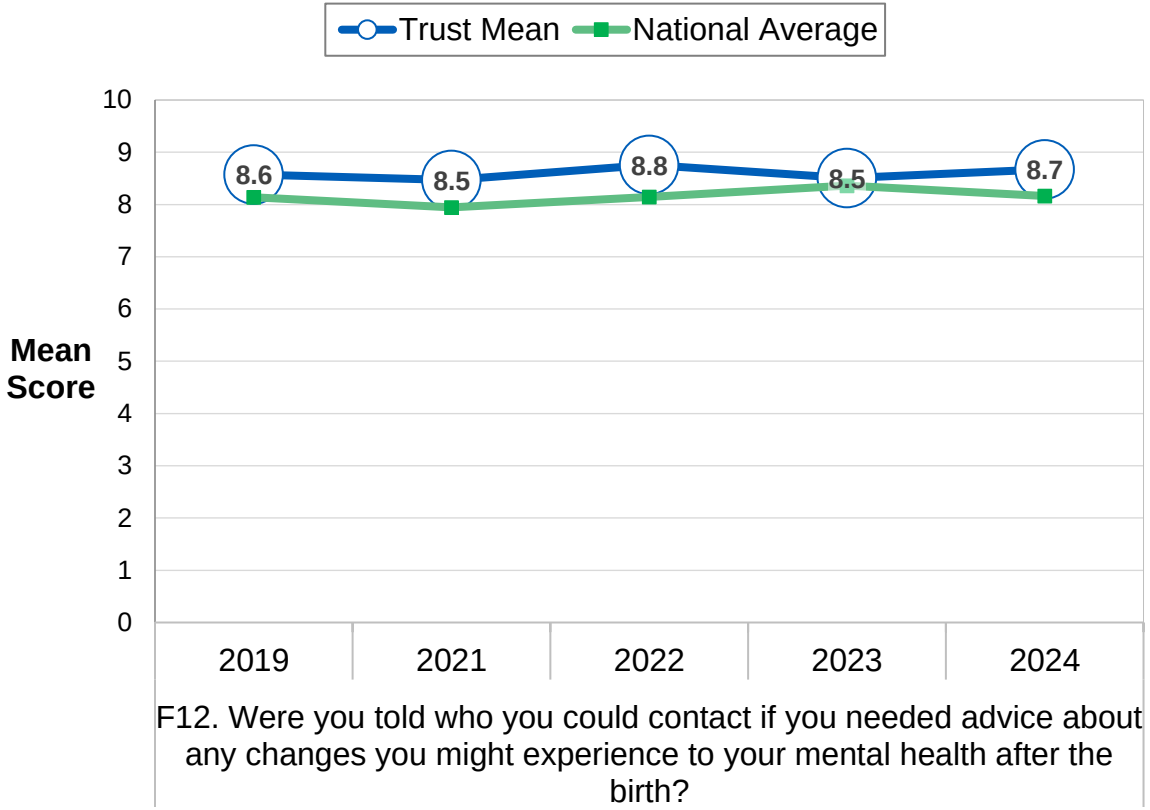
Care at home after birth



F11. Were you given information about any changes you might experience to your mental health after having your baby?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 65; 2021: 156; 2022: 115; 2023: 115; 2024: 121



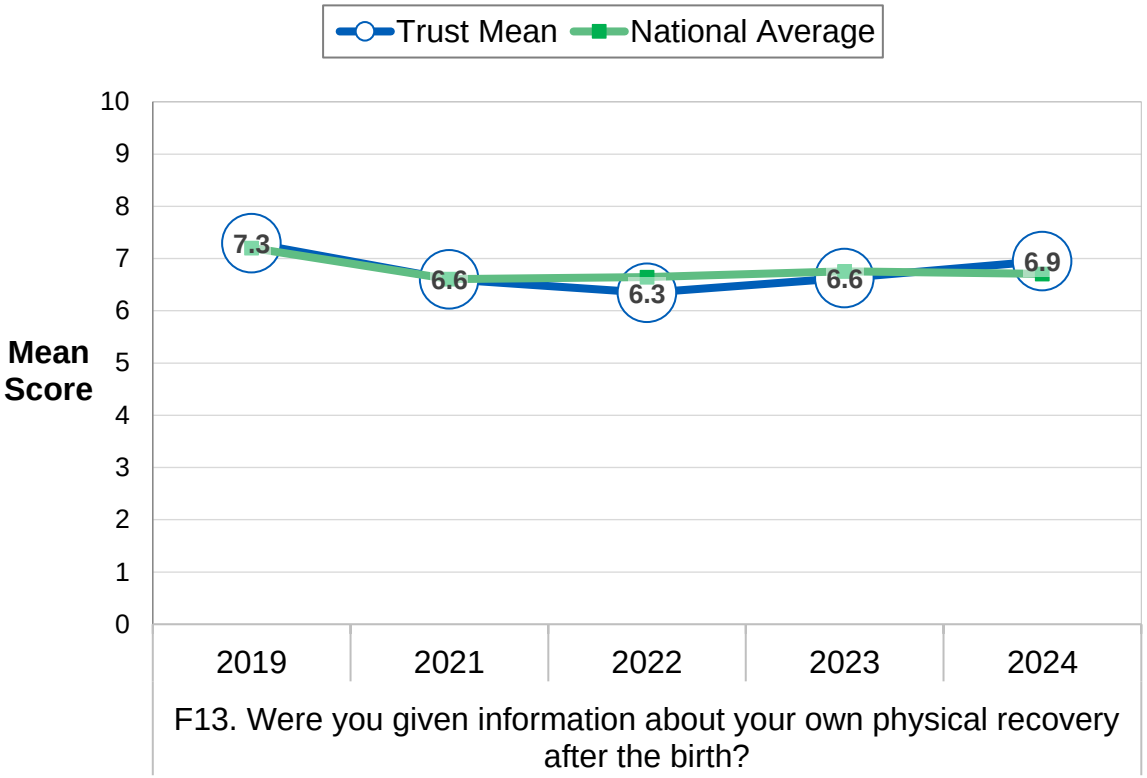
F12. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2019: 60; 2021: 136; 2022: 98; 2023: 103; 2024: 107

Section 3. Postnatal Care

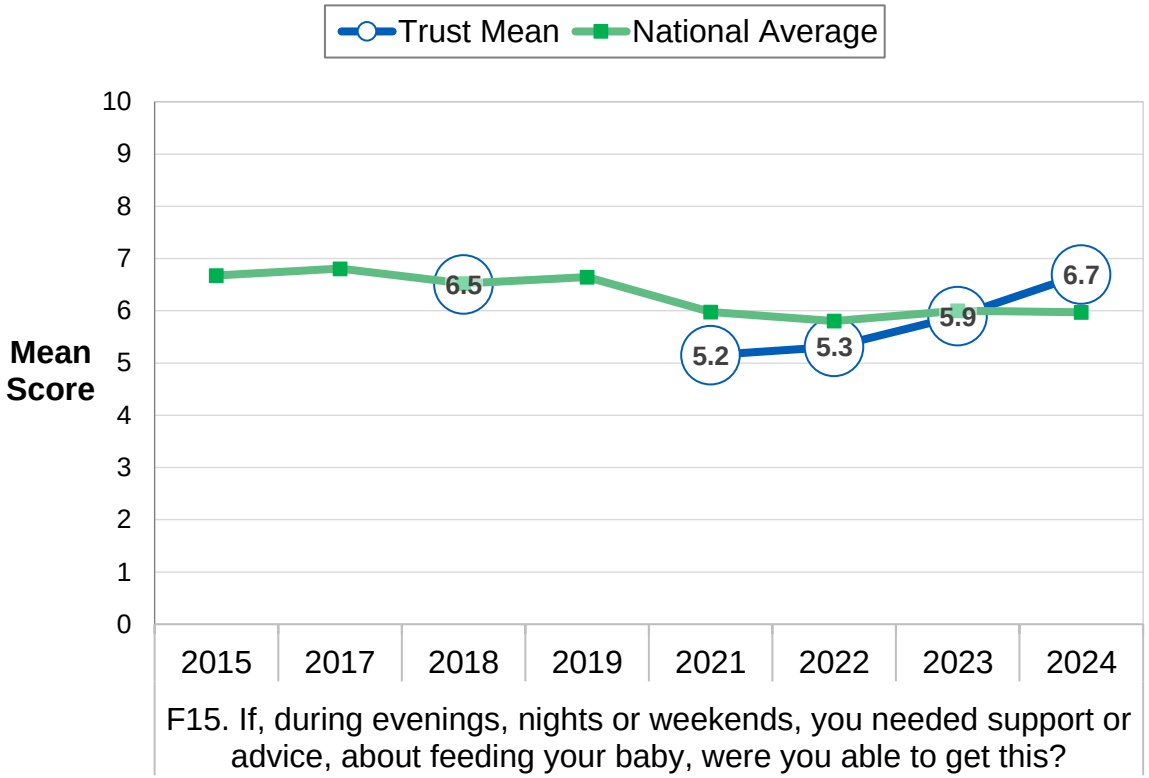
Care at home after birth



F13. Were you given information about your own physical recovery after the birth?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not need this information have been excluded.
Number of respondents: 2019: 65; 2021: 153; 2022: 114; 2023: 115; 2024: 120



F15. If, during evenings, nights or weekends, you needed support or advice, about feeding your baby, were you able to get this?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not need support or advice about feeding their baby have been excluded.
Number of respondents: 2015: -; 2017: -; 2018: 30; 2019: -; 2021: 67; 2022: 46; 2023: 45; 2024: 49

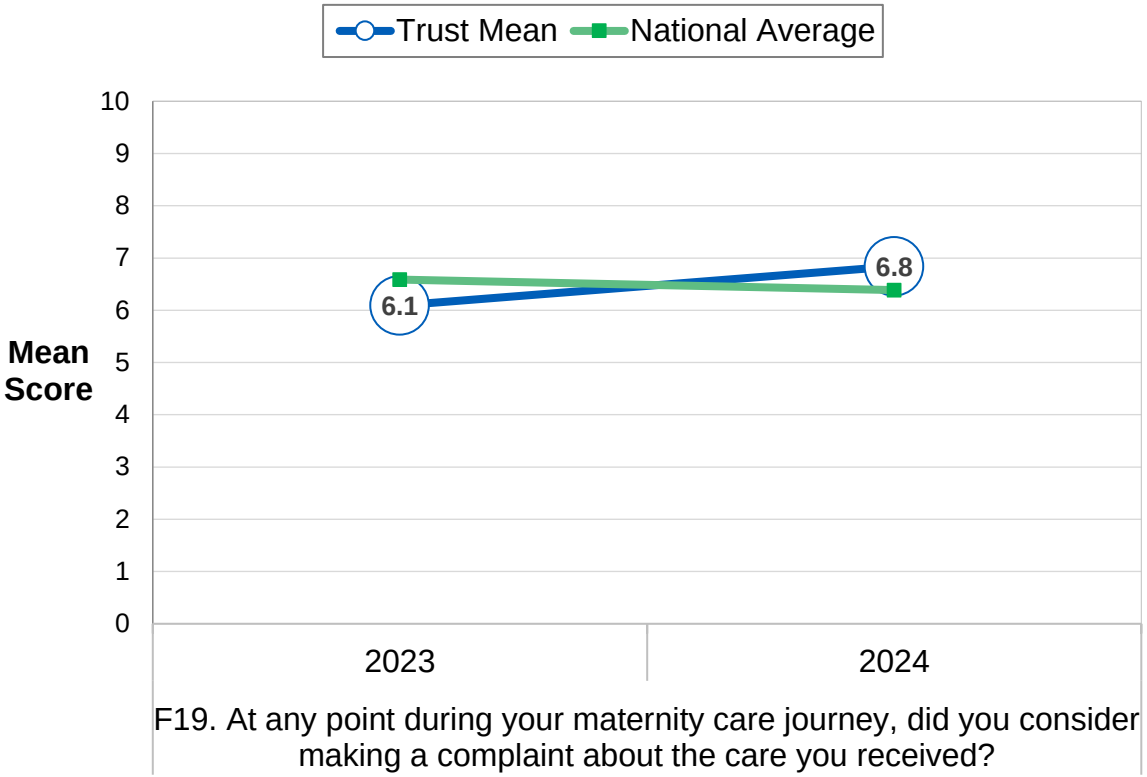
Change over time

Section 4: Complaints



Section 4. Complaints

Complaints



F19. At any point during your maternity care journey, did you consider making a complaint about the care you received?

Significant change 2024 vs 2023	No change

Answered by all. Respondents who stated that they didn't know / couldn't remember whether they considered making a complaint have been excluded.
Number of respondents: 2023: 120; 2024: 129

Comparison to Other Trusts



Comparison to other trusts

The questions where your trust has performed much better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much better than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions where your trust has performed better than compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected

- 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?

Comparison to other trusts

The questions where your trust has performed somewhat better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat better than expected

- 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?

Comparison to other trusts

The questions where your trust has performed somewhat worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions where your trust has performed worse compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions where your trust has performed much worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- No questions for your trust fall within this banding.

For further information

Please contact the Survey Coordination Centre:
maternity@surveycoordination.com



MNSI
Maternity & Newborn Safety Investigations

Maternity Investigation MI-037421

Independent report by the
Maternity and Newborn Safety Investigations (MNSI) programme.

Final investigation report November 2024



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Any enquiries regarding this publication should be sent to us at enquiries@mnsi.org.uk

About the MNSI programme

The Maternity and Newborn Safety Investigation programme (MNSI) is hosted within the Care Quality Commission (CQC). MNSI is responsible for patient safety investigations of NHS maternity care in England which meet the criteria outlined in the Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions (2023). Details of our criteria can be found in appendix 1, and on our website: What we investigate (mnsi.org.uk)

MNSI investigations replace the local investigation carried out by the healthcare organisation. We work closely with those who received care, their families and healthcare staff affected by patient safety incidents, and we do not attribute blame or liability.

We acknowledge the health inequalities that impact some mothers, pregnant persons and their babies. MNSI is committed to working with relevant organisations to understand the factors behind these health inequalities and to inform changes that support safer maternity care. The information we collect during our investigations will be used to support wider work regarding addressing the known disparities in maternal, fetal and neonatal outcomes for people from certain ethnic or socio-economic backgrounds.

MNSI's investigation approach

Most harm in healthcare results from problems within the systems and processes that influence how care is delivered. Our investigations seek to identify the contributory factors that have led to harm, or the potential for harm. Safety recommendations for healthcare organisations and safety prompts identified within our reports aim to improve healthcare systems and processes, reduce risk, and improve safety.

Findings, safety recommendations and safety prompts

This report contains **findings** from our analysis of the evidence gathered during our investigation. The report may also contain **safety recommendations** and **safety prompts.**

Safety recommendations are made to an NHS organisation when the evidence indicates a change is needed to make care safer.

Safety prompts describe an action that may help to improve safety at a local level and where there was insufficient evidence to support a safety recommendation. This could be because the issue fell outside the direct scope of the investigation.

Not all reports will contain **safety recommendations** or **safety prompts**. On these occasions, maternity services are encouraged to use the findings within the report to promote and support learning.

A note of acknowledgement

We would like to thank the parents whose experience is central to this investigation and detailed in this report. The family generously gave their time and shared their thoughts openly with the investigation. Information shared by them helped to inform the investigation and provided valuable insight into the impact of such events.

We would also like to thank the healthcare staff involved in the investigation. MNSI acknowledges staff involved in safety events may be adversely affected and require additional support. The investigation found the healthcare staff were open and willing to support improvements.

To preserve anonymity, the family is referred to as the Mother and the Father throughout. The Baby may be referred to as the Fetus, fetal or the Baby until the birth and is referred to as the Baby after birth.

Executive summary

When the Mother attended the maternity triage unit with pain and reduced fetal movements at 39 weeks and 3 days the Baby's heartbeat could not be heard and they were stillborn. The Babys death was referred to the MNSI programme under the intrapartum stillbirth criteria (when a baby was thought to be alive at the start of labour and was born with no signs of life).

The maternity and newborn safety investigation programme was informed about his birth 3 months later due to misinterpretation of the MNSI referral criteria at the time of his birth. An independent review of care by the Trust in the weeks after his birth determined that the case should be referred.

Incident Overview

The Mother of Asian ethnicity was initially assessed at her pregnancy booking appointment (Trust A) as being at low risk and was suitable for midwife-led care which meant her appointments would be with midwifery clinicians.

During her routine pregnancy appointment at 31+1 weeks, it was noticed that the growth measurements of the Mother's uterus were below what was expected, and she was referred for an ultrasound scan. This scan (31+6 weeks) and a further growth scan at 34+3 weeks showed that the Baby was growing as expected.

The Mother changed her maternity care to another hospital (Trust B) at 35+6 weeks. She went to a 'transfer of care' pregnancy booking appointment at 36+3 weeks and was risk assessed for shared care which meant her appointments would be with midwifery and obstetric clinicians.

The Mother had an additional scan at 36+6 weeks as it was thought the Baby may be in a breech 'bottom first' position. The Baby's growth was not assessed during this scan. The Mother called the maternity triage unit at 38+5 weeks reporting a 'watery loss'. She was reassured and remained at home. Following this, she experienced stomach pains which increased in intensity, and she made telephone calls and attended the maternity triage unit once over a number of days.

During a routine pregnancy review at 39+2 weeks her blood pressure was found to be higher than the expected ranges and her stomach pain continued to worsen. The Mother attended the maternity triage unit. Following an obstetric assessment the Mother was told to come back if

she had any symptoms of having a raised BP and for her to have her BP checked again at 39+5 weeks.

At 39+3 weeks the Mother called the maternity triage unit as the Baby was not as active as usual since the previous night, her stomach pains were unbearable and her tummy felt ‘hard’. She attended the maternity triage unit for assessment and the Baby’s heartbeat could not be heard; at 23:35 hours the Baby was confirmed to have died. The Mother was transferred to the labour ward when her cervix was found to be 3cm to 4cm dilated and her waters were artificially broken. The Mother’s labour continued into the following day (39+4 weeks), when the Baby was stillborn at 19:02 hours and weighed 2,900g which was on the 12.3 customised growth chart centile line.

The Mother and Father consented to a post-mortem examination (PME) which found the Baby was small and signs that the placenta had separated from the wall of the uterus. There were also signs of infection and poor placental function (which can be associated with pre-eclampsia, clotting disorders and diabetes).

Findings

1. When the Mother transferred her care from Trust A to Trust B, there was no single, robust system or guideline in place to share and provide a mother’s antenatal and medical records to inform staff of previous clinical management and future planning of their maternity care. This meant that the previous concerns about the Baby’s growth were not considered to inform the Mother’s future care.
2. Different growth monitoring charts were in use by Trust A and Trust B. Following the Mothers transfer of care and the discrepancies in the measurements of the Mother’s uterus (symphysis fundal height - SFH) consideration of a baseline growth USS may have been required. This may have offered a reference point of the Babys growth and supported a plan of care from that point onwards.
3. The telephone assessment area and tools used by Trust B (RCOG (2023); BSOTS (2024)) did not support staff to invite a mother for assessment with suspected broken waters when the Mother called at 38+5 weeks. This meant that there was no assessment of whether the Mother’s waters had broken.
4. There is evidence that Triage care is not prioritised due to there being no dedicated telephone triage midwife and redeployment of staff who may be initially allocated to telephone triage duties.

5. When the Mother attended the triage assessment unit at 39+1 weeks all information about the previous calls to triage was not included. The Mother's BSOTs rating was incorrectly assessed as 'green', which meant when she attended with a stomach ache, the required obstetric assessment did not take place.
6. This meant that no further action was taken to further investigate, her unexplained pain in early labour, her multiple telephone calls to the maternity triage unit, and the latent phase of labour lasting days.
7. When the Mother was referred to the triage assessment unit at 39+2 weeks with raised blood pressure in addition to her unexplained abdominal/pelvis pain, the multiple telephone triage calls and the latent phase of labour lasting over a number of days; due to a focused approach on the presenting condition and no access to previous records the required holistic obstetric review did not occur.
8. There was postmortem evidence indicating the Mother may have had an unknown, prolonged rupture of membranes (when the waters are broken for more than 24 hours before birth) with the presence of an infection.

Safety recommendations and safety prompts

Safety recommendations

1. MNSI recommends that Trusts A and B develop a structured information transfer process to ensure that when a mother transfers from one provider to another a robust process is in place to support staff to access and retrieve the required information such as (not limited to) medical records, USS reports/imaging, and test results to inform on-going clinical decision making and management of care.

2. MNSI recommends that the Trust review its guidance to meet national recommendations to develop a robust person, systems-centred process and environment to support the role of dedicated midwifery staff to be solely responsible for the telephone triage advice line service and provide a space to facilitate this.

3. MNSI recommends that the Trust reviews and re-develops its guidance to be clear and consistent in its advice in line with national recommendations to support staff to assess and offer mothers to attend triage if there is any uncertainty about whether prelabour rupture of the membranes has occurred.

4. MNSI recommends that the Trust works with staff to promote the use of a structured communication pathway to support the sharing of information about the number and content of calls a mother makes to the triage telephone advice line when transferring to another area to inform clinical decision-making.

5. MNSI recommends that the Trust's guidance reflects the system currently in use with a particular focus on the number of calls made by a mother and how this is communicated to relevant members of staff.

6. MNSI recommends that the Trust supports maternity triage staff to undertake a full holistic assessment for every mother attending the triage assessment unit to provide a comprehensive review of maternal and fetal wellbeing.

Safety prompts

The investigation found the completion of the USS request forms was delegated to another member of staff:

- Are there any barriers to ensuring this is completed by the referrer?
- Are there adequate resources such as time and equipment?
- Is there training or a tool in place to support staff?

The investigation found the completion of the ‘Exam coding’ section of the USS request did not reflect the examination required:

- Are there any barriers to ensuring this is completed correctly?
- Is there training or a tool in place to support staff to understand what is required on an USS request form?
- Is there any coding information/prompts available for staff to reference when completing the request form?

The investigation found that there were two different perceptions of the information shared and given during the telephone triage conversation between the clinician and the Mother.

- How does the system support staff to easily document whilst managing multiple tasks
- Are there any barriers to complete documentation?
- What processes are there to support the recording of telephone triage contacts accurately?
- What processes are in place to assure staff a mother understands the information and advice being given

The investigation found the use of a Dawes Redman analysis of the CTG was used whilst the Mother was having contractions. This is only recommended for use in the antenatal period when there is no uterine activity present (Nuffield Department of Women's and Reproductive Health, 2023):

- Are there any barriers to ensuring this is completed in line with guidance?
- Are there adequate resources such as time and equipment?
- Is there training in place to support staff?

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1. Investigation approach

1.1 Summary of investigation process

The Trust contacted MNSI to inform them of the Baby's stillbirth three months and four days after the event. The event met the criteria for MNSI to carry out an independent investigation (The Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions 2023).

During the investigation, advice was provided by experienced and senior clinicians in relevant specialities. Following evidence collection and analysis, the findings were written in a draft report. This was reviewed by senior members of the MNSI programme. The draft report was then shared with the trusts and the family for their review and comment before being finalised.

The healthcare organisations are responsible for acting on any safety recommendations and safety prompts directed to them.

1.2 Terms of reference

The terms of reference were shared with, and informed by, those affected by the event. For the purposes of the investigation the clinical record for the Mother was reviewed. Following this, the terms of reference (the key areas to be explored) for investigation were agreed. Ethnicity and other health inequalities will be explored as part of the following terms of reference.

The terms of reference for this investigation were:

- Investigate all aspects of maternity care from the pregnancy booking appointment to 39+3 weeks when the baby's heartbeat could no longer be heard and an intrapartum stillbirth was confirmed, paying particular focus on:
    - Assessment and management of the growth of the Baby.
    - Care and management of the Mother during the triage calls and attendances.
    - Holistic overview and management of the Mother's multiple triage attendances.
- Consider infrastructure and resources available within the organisation and the structure of maternity services within the trusts.
- Ensure that the perception of events is captured from the family, the trusts and staff directly involved in the care of the Mother and baby.

1.3 Information gathering

The investigation used different sources of evidence to help understand the circumstances surrounding the Mother's care, and any factors that may have contributed to the Baby's stillbirth. Consideration was given to ethnicity and other health inequalities, the environment, equipment, tasks, policies, and processes to understand how these may have influenced staff decisions and actions. This allowed the investigation to form an understanding of the healthcare systems involved and how they contributed to care and the outcome.

Information sources included:

- a meeting and telephone conversation(s) with the Mother and Father
- a review of relevant guidance
- a review of the Mother's clinical records
- a site visit to the maternity triage unit and telephone triage service
- reviews with advisors with a specialist knowledge in obstetrics, midwifery, and fetal medicine
- interviews with staff who provided clinical care to the Mother and Baby
- meetings with staff working at the trusts to understand the healthcare systems and processes which impacted on the care that the Mother received

The evidence gathered was analysed to identify learning. These informed the identification of themes and the development of safety recommendations and safety prompts.

Further details about the MNSI programme's criteria and approach to information gathering can be found in appendix 1.

2. Background and context

2.1 Incident criteria: Intrapartum stillbirth

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

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

2.2 Ethnicity and health inequalities

The Maternity and Newborn Safety Investigation programme (MNSI) acknowledges that maternity care requires system level changes to make the navigation of maternity services safer for Black and Asian mothers who are more likely to die than White mothers (MBRRACE-UK, 2022a).

In our reports, we refer to ethnicity and not race. Under the Equality Act 2010, ethnicity includes ‘colour, nationality and ethnic or national origins’ (NHS Digital, 2022).

Health inequalities are avoidable differences in health outcomes between groups or populations – such as differences in how long we live, or the age at which we get preventable diseases or health conditions (The Office for Health Improvement and Disparities, 2022). ‘Ethnic minorities’ refer to all ethnic groups except the White British group. The term ‘ethnic minorities’ includes White minorities, such as Gypsy, Roma and Irish Traveller groups (Race Disparity Unit, 2021).

MNSI aims to raise awareness of health inequalities and ethnicity in maternity care and supports changing the current system to reduce health inequalities leading to better outcomes for mothers, babies and families from Black, Asian or minority ethnic backgrounds.

MNSI will share findings and recommendations with all hospitals and organisations working with maternity care services across England.

The 2022 MBRRACE-UK perinatal surveillance report (MBRRACE-UK, 2022b) explains the effects ethnicity and deprivation have on perinatal and maternal mortality:

- Black mothers are 3.7x more likely to die than White mothers (MBRRACE-UK, 2022a).
- Asian mothers are 1.8x more likely to die than White mothers (MBRRACE-UK, 2022a).

Since the inception of MBRRACE-UK in 2013 perinatal surveillance reports have shown very high rates of stillbirth and neonatal death for the Asian population compared with the White population. When this enquiry was being planned, the MBRRACE-UK perinatal surveillance report for UK perinatal deaths for births from January to December 2019 showed that babies of Asian or Asian British ethnicity were at 57% increased risk of stillbirth and 59% increased risk of neonatal mortality compared with babies of White ethnicity.

2.3 Fetal growth

2.3.1 Symphysis fundal height (SFH) measurements

One method of monitoring a mother's symphysis-fundal height (SFH) growth trajectory is to use a SFH growth chart; this can be either customised for a particular mother or be population based.

Population based symphysis-fundal height growth charts

One method of monitoring a mother's symphysis fundal height (SFH) growth trajectory is to use a population based SFH growth chart. The chart is used to plot the measurements of a mother's uterus (the SFH).

Measurements plotted on the chart during the pregnancy may detect a change in the SFH growth trajectory suggesting a baby may be smaller or larger than expected. (MNSI)

Customised growth chart

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

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

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

Trust A uses the World Health Organisation (WHO) population-based growth chart and Trust B uses the Perinatal Institute's growth assessment protocol (GAP) guidance recommending that from 26 or 28 weeks, a SFH measurement is to be taken in low risk mothers every 2 to 3 weeks. Local guidance advises fundal height (FH) should be measured and plotted on the respective growth chart at every scheduled antenatal appointment from 26-28 weeks of pregnancy.

The chart is used to plot serial measurements of a mother's uterus (the SFH). These measurements may detect a change in the SFH growth trajectory, suggesting a baby may be smaller or larger than expected. A growth ultrasound scan may then be required.
The curved lines (centile lines) on a baby's growth chart represent the range of growth that is expected. Most babies will continue to grow along the same curve.

Centile line
Centile lines are the curved lines on a pregnancy growth chart. A baby's measurements are plotted on the chart throughout pregnancy and compared to the centile lines to monitor their growth. For example, for a baby whose growth is plotted on the 50th centile, 50 out of 100 babies' growth, at the same gestation, will be on that line. (MNSI)

2.3.2 Small for Gestational Age (SGA)

Babies who are small for gestational age (SGA) are known to be at increased risk of perinatal morbidity and stillbirth (Gardosi et al, 2018). Fetal growth restriction, FGR is a condition where a baby's growth slows or stops during the pregnancy. FGR babies are more likely to find the stress of labour difficult. FGR was found to be the largest category of SGA babies accounting for over half of all normally formed stillbirths (Williams et al, 2018). Occasionally, a baby that is suspected to be FGR, may not be small for gestational age (Robson et al, 2013). Antenatal detection of SGA or FGR babies enables a management plan to be implemented which reduces the risk of stillbirth and perinatal morbidity.

A number of antenatal packages have been developed with the aim of detecting small babies prior to labour and birth. Regardless of the package used approximately half of SGA babies are not detected prior to birth (Williams et al, 2018 and Vieira et al 2022).

Other national guidance recommends that the SFH is measured from 24 weeks, at each antenatal appointment (Robson, 2013), no more frequently than every 2 weeks (NICE, 2021). Defined thresholds below the 10th and above the 90th centile are commonly used to identify babies at risk.

National guidance on the management and timing of birth are specific to an individual baby and whether they have been identified as being SGA, FGR or have additional complications present (NHS England, 2019).

National intrapartum guidance recommends that when babies are suspected to be SGA (which would include FGR babies), a discussion with the mother is indicated. This discussion should include the chance that any serious problems for a baby can be increased, or there may be additional complications during labour and birth if the baby is growth restricted (NICE, 2019).

2.4 Latent phase of labour

National guidance (NICE, 2017) defines the latent phase of labour as:

- A period of time, not necessarily continuous, when there are painful contractions; and
- There is some cervical change, including cervical effacement and dilatation up to 4cm.

Local guidance on care in the latent phase of labour outlines the expectations of a contact. This should include an assessment of a mother's level of pain, including her wishes for coping with labour along with the range of pain relief options available.

In line with local guidelines, if a mother is unable, reluctant to go home or requires pain relief in the latent phase she should be admitted to the maternity unit.

There is no national guidance to inform the frequency of a mother's and baby's observations during the latent phase of labour.

2.5 Spontaneous rupture of membranes (SROM)

When the membranes rupture (waters break), this may be experienced by the woman as an obvious gush of fluid or a leak of fluid. This could be the water in front of a babys head (forewaters) or behind a babys head (hindwaters).

Methods to confirm whether the membranes have ruptured include examination with a speculum (instrument to visualise a mother's cervix) to check whether any liquor can be seen. Bedside testing is also available.

Bedside testing for rupture of membranes

There are a number of commercially available rapid bedside testing kits for identifying if the membranes (bag) of amniotic fluid (waters) that surround the baby in the womb have broken. A swab collects fluid from the top of the vagina which is then processed at the bedside using molecular techniques to identify specific proteins from the amniotic fluid. A positive test would indicate the membranes had broken. (MNSI)

Local (2020) and national (NICE, 2023) guidance recommend full assessment of maternal and fetal wellbeing with options for immediate induction of labour or for labour to begin by itself. These would be discussed as clinically indicated in a maternity unit when a woman reports that her membranes may have ruptured.

Induction of labour

Induction of labour (IOL) is the process of artificially starting labour using a variety of medications and techniques. Usually the first stage is to soften and prepare a mother's cervix by using prostaglandin tablets, pessaries or gels. Sometimes her cervix will be prepared using a mechanical method, such as a balloon. The next stage is to artificially break the waters (artificial rupture of membranes (ARM)). If contractions are still not strong or regular enough the drug oxytocin is given. This is one of the hormones produced naturally by mothers in labour and assists in increasing the frequency of contractions. Oxytocin is given through a drip, and the timing of the subsequent contractions are monitored closely. If the contractions are too sparse, or become too frequent, the amount of oxytocin given via the drip will be altered.

Further information from: NICE - induction of labour

2.6 Maternity triage

Maternity triage is for pregnant women or new mothers who need to be seen outside of their scheduled maternity appointments because of urgent pregnancy related concerns or unexpected complications. The service should be available at all times. Advice on when and how to contact maternity triage should be discussed at scheduled appointments and in information available from the woman's handheld patient records (RCOG, 2023).

National recommendations advise using a standardised assessment and clinical prioritisation process rather than seeing women in the order in which they arrive. This is to ensure those

who have urgent issues are seen ahead of those with less urgent concerns and helps guide treatment according to their clinical need (RCOG, 2023).

2.6.1 Birmingham symptoms specific obstetric triage system (BSOTS)

Trust B uses the Birmingham symptoms specific obstetric triage system (BSOTS) algorithm designed to enable telephone calls to be triaged in line with national guidance (RCOG, 2023). The member of staff is prompted to record the 'primary reason' a mother has called triage from eight options available. Once an option is selected, prescribed questions lead the staff member through the algorithm based on the mother's answers.

Trust B uses BSOTS in their face-to-face triage of mothers. It includes a standardised initial assessment of all women and their babies within 15 minutes of arrival and the use of symptom-specific algorithms to determine the clinical urgency. With this initial assessment the mother is allocated a 'traffic light' colour code which reflects the clinical need and urgency of when a full clinical assessment is needed:

- Red = Immediate
- Amber = 15 minutes
- Yellow = 1 hour
- Green = 4 hours

Local guidance for reduced fetal movements and the Birmingham symptoms specific obstetric triage system algorithm states that a woman with absent fetal movements has an 'amber' level of clinical urgency. This means an initial assessment within 15 minutes of arrival and a full assessment within 30 minutes of arrival which includes a cardiotocograph (CTG) if required.

National Guidance (RCOG (2023) Good Practice 17-maternity-triage, (BSOTS (2024)) recommends that 'calls are taken by a midwife who are specifically trained to assess pregnant and post-natal women both over the telephone and in person. Their duties at that time are solely for telephone triage', are taken outside the clinical area in a dedicated and protected quiet space – to ensure confidentiality; this is not consistently supported or reflected in local guidance.

2.6.2 Triage staffing

For a Trust with a similar birth rate to Trust B, RCOG (2023) recommends the minimal staffing levels for maternity triage with this birth rate is one midwife and one maternity support worker at all times and to consider one additional midwife for peak time workload which is typically

13:00 hours to 21:00 hours. In addition to this there should be an appropriately trained midwife familiar with maternity triage whose role is to solely answer a dedicated triage telephone line available 24 hours per day in a protected and quiet space located outside the clinical area. Calls should ideally be audio recorded with consent; this trust does not audio record.

2.7 Reduced fetal movements

Most mothers are first aware of their baby moving when they are 18-20 weeks. Feeling a baby move is a sign for a mother that their baby is well.

If the pattern of a baby's movements changes, reporting this to healthcare professionals is encouraged. This may be referred to as reduced fetal movements. RCOG - reduced fetal movements and Kicks Count - fetal movements. After 28 weeks, a CTG should be carried out. Sometimes, a growth scan may be performed.

National guidance on reduced fetal movements states that upon presenting with reduced fetal movements a history should be taken to assess a mother's risk factors for stillbirth and fetal growth restriction (FGR) (Whitworth et al, 2011).

The association between reduced fetal movements and a poor outcome for babies is well known, with the risks increased when mothers experience multiple episodes of reduced fetal movements in late pregnancy, after 28 weeks. (NHS England, 2019). National guidance recommends that induction of labour could be discussed for mothers who present with a single episode of reduced fetal movements after 38+6 weeks. In addition to this, it is important that mothers presenting with recurrent episodes of reduced fetal movements are informed of the associated increased chance of stillbirth and given the option of delivery for reduced fetal movements alone after 38+6 weeks (NHS England, 2019).

3. The safety event that affected the Mother and the Baby

This section summarises the Mother's pregnancy, labour and birth based on the recollections of family, staff and the medical records. Further information can be found in appendix 2.

3.1 Antenatal care

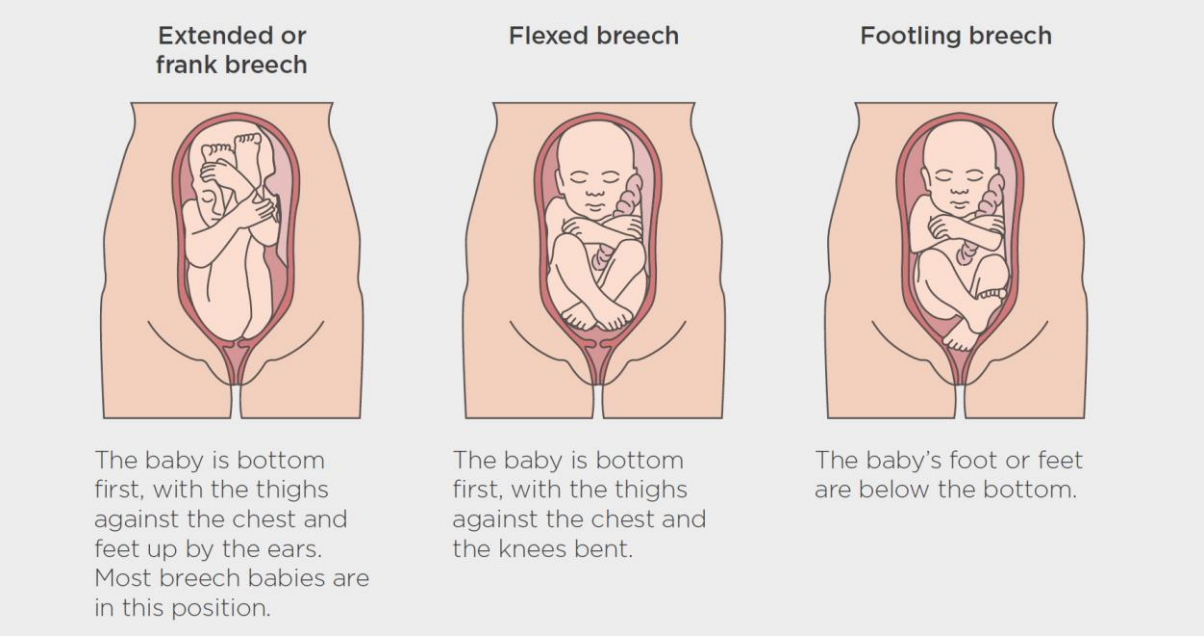
The Mother, whose ethnicity was Asian, found out she was pregnant when she was 34 years old. English was not her first language although speaking English was her preference and she was described as fluent. It was her first on-going pregnancy, and she had her first pregnancy appointment with the midwives (booking appointment) at Trust A when she was 7 weeks and 6 days pregnant (7+6 weeks). The Mother was assessed as being at low risk. It was recorded that the Mother was suitable for midwife-led care which meant her appointments would be with midwifery clinicians.

During her routine pregnancy appointment at 31+1 weeks, it was noticed that the Mother's uterus measured below that expected (29cm) and a growth ultrasound scan was requested which she attended at 31+6 weeks. This scan showed that the Baby was growing as expected with the estimated weight of the Baby being 1,666g which was just below the 19.5th centile line of a population-based growth chart (appendix 2a).

The Mother attended her next routine pregnancy appointment at 34+1 weeks when her SFH measurement was 31cm, below the expected range. The Mother was referred for a further growth ultrasound scan which she went to at 34+3 weeks when the Baby's estimated weight was measured at 2,278g which plotted on the 33rd centile on the population-based growth chart and was found to be in the expected range (see appendix 2a). This was the last growth ultrasound scan of the Baby. The Baby was also found to be in a bottom first (breech) position, and another ultrasound scan was booked for 36+0 weeks to check if the Baby had changed position. The Baby's position continued to be breech on ultrasound at 36+1 weeks, the Baby's growth was not measured at this scan as it was a presentation scan.

Breech presentation

When a baby is coming feet or bottom, (rather than head) first.



Further information from: RCOG - breech baby, RCOG - external cephalic version (ECV) guideline and RCOG - breech presentation guideline

3.2 Transfer of care

The Mother chose to change her maternity care to another hospital (Trust B) at 35+6 weeks. She went to a 'transfer of care' pregnancy booking appointment at 36+3 weeks. A wellbeing assessment of the Mother and the Baby was undertaken, all observations taken were within the expected ranges; it was noted that the Baby was still in a breech position. The height measurement of the Mother's uterus was not done, and it was noted that an ultrasound scan was 'last week' and the 'FGR (fetal growth restriction) risk is low'. It was recorded that the Mother was risk assessed for shared care which meant her appointments would be with midwifery and obstetric clinicians.

As part of this care the Mother went to a routine pregnancy review with a member of the obstetric team at 36+5 weeks when it was noted that she had recently transferred her care from another hospital 'having growth scan due to SFH discrepancies was breech on scan 36+1……growth normal'. A portable ultrasound scan showed the Baby to be in a 'head down' position; a referral was also made for a departmental ultrasound scan to confirm this. The Mother went for the scan at 36+6 weeks, the position was confirmed as 'head down'; the growth of the Baby was not measured.

The Mother went to a routine pregnancy assessment at 37+2 weeks, both the assessment of the Mother and the Baby were within the expected ranges. At 38+2 weeks the Mother went to another routine pregnancy review when the completed assessments of the Baby and the Mother were as expected.

3.3 Triage care

3.3.1 Triage telephone contact at 38+5 weeks

The Mother telephoned the maternity triage unit when she was 38+5 weeks, at 09:04 hours, when ‘some watery loss’ was recorded ‘with a pinkish tinge and was sticky’. The Mother recalled that she was told it could be a ‘mucous plug’ and to ‘put a pad on’ and call the triage unit back in 1 hour to see if anything else had leaked on the pad. The records indicated the advice was for the Mother to ‘attend’.

Show

A show describes when the plug of mucus at the neck of a mother’s womb (cervix) comes away. A show may contain some blood. (MNSI)

The Mother telephoned the maternity triage unit back at 09:57 hours and told the same member of the midwifery team that there had been no more blood. The Mother was ‘advised to take paracetamol if needed and stay at home’. The Mother felt reassured this event was a ‘show’ and was nothing to worry about.

3.3.2 Triage telephone contact at 38+6 weeks

The following day (38+6 weeks), she telephoned the maternity triage unit at 11:04 hours due to having stomach pains which were mainly at night, and she could not sleep. It was recorded that the Mother had contractions ‘2 to 5 minutes apart lasting 30 seconds but managing to sleep through’. It was recorded that that there was loss of the mucus plug but no other vaginal loss reported, and the Mother was in early labour (latent phase). The Mother was told to have a warm bath and to take mild pain relief tablets (paracetamol).

3.3.3 Triage telephone contact and attendance at 39+1 weeks

The Mother told the investigation the stomach-ache carried on, so she telephoned the maternity triage unit when she was 39+1 weeks pregnant at 07:08 hours. It was recorded the reason for the call was ‘suspected labour’. The Mother was assessed during the telephone call when it was recorded ‘there was uterine activity 2:10 (contractions occurring at a rate of 2 in a

10-minute period) but not coping', there were no other concerns noted such as vaginal loss. The Mother was advised to attend maternity triage unit.

The Mother attended the maternity triage unit at 07:54 hours and was assessed by a member of the midwifery team 4 minutes later. On admission maternal observations were performed, an assessment to confirm fetal wellbeing was also undertaken by listening into the Baby's heartbeat. The Mother's uterus was not measured and there was no reference made about the growth of the Baby. All maternal and fetal (baby) observations undertaken were within the expected range. A vaginal examination was performed at 08:11 hours, and the Mother's cervix was found to be '1-2cm dilated'. The Mother was colour coded as a 'green' categorisation using the Birmingham Symptom Specific Obstetric Triage System (BSOTS)©.

Vaginal examination

A mother may be offered a vaginal examination during her pregnancy or labour. During a vaginal examination, a clinician will insert two fingers into a mother's vagina to assess the vagina, cervix (neck of her womb) and, during labour, the position of the baby's head within the birth canal. A vaginal examination may be offered for several reasons including to break the waters around a baby, to insert medications for induction of labour and to assess the opening of a mother's cervix. (MNSI)

It was recorded that she was in the latent phase of labour and a plan was made for her to receive pain relief, to go home and to 'continue with scheduled community midwifery appointments' returning to triage if she had any of the 'important symptoms discussed'. The Mother was given stronger oral pain relief (codeine), and she was discharged home at 08:40 hours. Staff understood that the Mother was happy with the plan to go home.

The following day (39+2 weeks) the Mother went to the antenatal day unit at the hospital for her routine pregnancy appointment at 19:44 hours. The Mother told the investigation she was exhausted because she had not been able to sleep for five nights due to the continuous stomach-ache that extended into her pelvis, and that the pain was worsening. When she arrived, latent phase was explained again to the Mother. The midwifery clinician assessed the wellbeing of the Mother and the Baby and was made aware of the pain she was experiencing. All observations were within the expected ranges apart from her blood pressure (BP), which was higher than expected at 141/93 millimetres of mercury (mmHg) and was repeated a further

three times (133/87mmHg, 135/92mmHg and 144/95mmHg). A referral was made for the Mother to go to the maternity triage unit due to the rise in her BP.

Blood pressure in pregnancy

Blood pressure is recorded with two numbers. The systolic pressure (higher number) is the force at which the heart pumps blood around the body. The diastolic pressure (lower number) is the pressure in the arteries when the heart rests between beats. They are both measured in millimeters of mercury (mmHg). As a general guide: high blood pressure in pregnancy is considered to be 140/90 mmHg or higher. (MNSI)

3.3.4 Triage attendance at 39+2 weeks

When the Mother arrived at the maternity triage unit (20:50 hours) her observations were within the expected ranges (BP 132/86mmHg). A cardiotocograph (CTG) using the Dawes-Redman analysis tool was started at 20:44 hours and removed at 21:20 hours (36-minute duration) to assess the Baby's wellbeing and was recoded to meet the criteria.

Dawes-Redman CTG analysis

Cardiotocography (CTG) is an electronic means of recording an unborn baby's heart rate pattern, to assess their wellbeing. During the antenatal period, if a mother has no uterine activity, computer software, known as Dawes-Redman, may be used to analyse the baby's heart rate pattern. A CTG from a healthy baby would be expected to meet the Dawes-Redman criteria. The antenatal use of computerised CTG analysis is recommended in national guidance due to its potential to reduce the risks of human error (NHS England, 2019). (MNSI)

The Mother had further BP measurements at 20:54 hours (132/86mmHg) and 23:45 hours (138/88mmHg).

An obstetric review at 23:47 hours documented as 'face to face' found that the Mother was feeling the Baby move, she had no headaches, no limb swelling, she was having 'some irregular tightenings' and that she experienced a show last week. Her BP in community clinic was acknowledged and it was noted that all observations taken were within the expected range and the CTG recording of the Baby met the expected criteria. A plan was made for the Mother to go home and to come in if any symptoms of raised BP, occurred. There was an appointment made to go to the antenatal day unit at the hospital in 2 days' (at 39+5 weeks) for a BP profile

(a series of blood pressure measurements taken over a given time) and to discuss a cervical sweep.

Membrane sweep

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

3.4 Triage attendance at 39+3 weeks and care during labour

The Mother felt the Baby was not as active as usual at 39+3 weeks since the previous night and she told the investigation her stomach pains were unbearable and her tummy felt 'hard'. The Father telephoned the maternity triage unit at 22:20 hours and was told to bring the Mother into the maternity triage unit. It was recorded that the reason was due to the reduced movements of the Baby, and that she was having contractions every 5 minutes.

When the Mother and the Father arrived at 22:54 hours, her observations were taken and found to be in the expected ranges. It was noted that she had concerns about the Baby's movements. A midwife tried to listen for the Baby's heartbeat and could not hear it when she used a handheld Doppler machine (devices used to listen to a baby's heart rate). A member of the obstetric team was called at 23:00 hours and arrived to see the Mother at 23:20 hours. It was incorrectly noted the growth of the Baby was last measured by ultrasound at 36+1 weeks. They performed a bedside ultrasound scan and could not find a heartbeat. A consultant obstetrician was called and arrived around 23:30 hours. A second ultrasound scan was taken at 23:35 hours and confirmed the Baby had died.

The Mother was transferred to the labour ward her cervix was found to be 3cm to 4cm dilated. Her membranes could be felt and were artificially broken when brown-stained liquor was seen. The Mother's labour was induced using oxytocin and continued into the following day (39+4 weeks), when the Baby was stillborn at 19:02 hours and weighed 2,900g which was on the 12.3 customised growth chart centile line.

3.5 Post-mortem examination and placental histopathology

The Mother and Father consented to a post-mortem examination (PME) which found the Baby was small and signs that the placenta had separated from the wall of the uterus. There were also signs of infection and poor placental function (can be associated with pre-eclampsia, clotting disorders and diabetes).

4. Investigation analysis and findings

This section described the findings of the investigation into The Mother's and Baby's care. It focuses on the factors that affected and influenced decisions and actions of clinicians at that time. Due to the delay in referring the case to MNSI recollection of events was limited for some clinicians. The report gives attention to factors and themes which emerged from analysis of the evidence:

- Communication and information sharing systems between Trust A and Trust B
- Systems and processes for monitoring and management of the growth of the Baby
- The processes in place to support clinicians to care for the Mother received during her contact with the triage department
- Systems to support clinicians to undertake a holistic overview of the Mother's care

4.1 Communication and planning of the Mother's care between trusts

The investigation found that when a low-risk mother transfers her care from Trust A to Trust B, there was no single, robust system or guideline in place to share and provide a mother's antenatal and medical records to inform staff of previous clinical management and future planning of their maternity care. This meant that the previous concerns about the Baby's growth were not considered to inform the Mother's future care.

At 35+6 weeks the Mother transferred her maternity care from Trust A to Trust B for reasons not related to her pregnancy. Electronic patient record (EPR) systems are different between these trusts and do not 'talk' to each other which means the transfer of a mother's medical records cannot be automatically shared.

There is a patient application (app) used for smartphones at Trust A and Trust B; these are different apps for each trust and used independently of each other. These were uploaded separately and used by the Mother. The app from Trust A has the functionality to allow a mother to share her antenatal records including (not limited to) ultrasound scan reports, growth charts and blood results with another provider. This sharing function available in the app from Trust A was not in use for the Mother at the time of her transfer of care (35+6 weeks) which meant she was unable to electronically share her records.

When the Mother attended the antenatal transfer booking appointment (36+3 weeks) at Trust B she had printed onto paper all of her Trust A antenatal records (multiple pages) and took them with her to the transfer booking appointment. The Mother described how she shared

these with the clinician and a ‘quick review of notes’ was done and then handed back to her. The investigation learned the only way of retrieving information about previous antenatal care is by “picking up the phone and speaking to the midwife at the other trust”. This was not routinely undertaken and was not done for the Mother. The investigation was told there is a reliance on mothers to relay information verbally and by sharing their handheld notes to inform care decisions.

The investigation learned there is a function on the EPR system to scan and upload maternity handheld records. The investigation team were told there is no guidance in place to support staff regarding this aspect of care and scanning medical records from another trust is not a requirement. The investigation team learned that scanning documents onto the EPR system can be time-consuming. Staff are limited in time and availability of scanning equipment, with not all staff having the required scanning access code which may act as barriers ‘preventing’ busy staff from scanning in large records.

The investigation learned the transfer booking appointment is seen as a complete antenatal review and re-assessment for any low-risk mothers who transfer their care. Clinicians make a full assessment, a new management plan including risk assessments and any referrals required such as an obstetric referral or for an ultrasound are made. The investigation learned that staff understand that the antenatal transfer booking appointment at Trust B is the reference point for all staff to access to inform their clinical decision making and a mothers ongoing care.

MNSI safety recommendation.

1. MNSI recommends that Trusts A and B develop a structured information transfer process to ensure that when a mother transfers from one provider to another a robust process is in place to support staff to access and retrieve the required information such as (not limited to) medical records, USS reports/imaging, and test results to inform on-going clinical decision making and management of care.

4.2 Growth monitoring of the Baby

The investigation found when the Baby was born (at 39+4 weeks) their weight was on the 12th centile on the customised GROW charts used at Trust B using the recorded birth weight of

2,900g. Trust A uses the WHO population-based growth chart (appendix 2a) and Trust B uses the customised growth chart (appendix 2b). Due to the different growth monitoring charts, the transfer of care and the discrepancies in the measurements of the Mother's uterus (symphysis fundal height - SFH) consideration of a baseline growth USS may have been required. This may have offered a reference point of the Babys growth and supported a plan of care from that point onwards.

4.2.1 Growth charts and symphysis fundal height (SFH)

The investigation found there were three times when the Mother's SFH measurements were not taken (36+3 weeks, 38+2 weeks and 39+1 weeks). The investigation could not establish why this did not happen. Some staff told the investigation this could have been an oversight. The SFH measurement is required at every antenatal contact, at least 2 weeks apart, in line with local and national guidance. This was not undertaken for this Mother; it is unknown if this impacted on the overall outcome for the Baby.

MNSI has reviewed the growth assessments which were plotted onto the respective trust's growth charts and these showed consistent growth within the expected range (appendix 2c).

4.2.2 Ultrasound scanning (USS)

The investigation found the reference point to confirm the growth of the Baby was incorrectly taken as the 36+1 weeks US scan (Trust A). The last, documented growth USS was actually done at 34+3 weeks (Trust A) when the Baby's growth was found to be within the expected range. This meant the Babys growth was not measured, and a baseline growth recording did not take place following transfer of the Mother's care.

At the obstetric review (36+5 weeks) it was manually recorded in the EPR system (Trust B) as part of the review that the growth of the Baby was 'normal'. This was written underneath the details referring to the last USS at 36+1 weeks undertaken at Trust A; this scan was a presentation scan only to check the Baby's position. The investigation learned that this USS (36+1 weeks) was used as a reference point from that entry onwards by clinicians to be the last growth scan. This was further supported in the medical records stating the growth of the Baby was 'normal' (36+5 weeks) and at 39+3 weeks. The investigation was told that this gave assurance that the growth of the Baby was within the expected range.

Staff told the investigation there was no mechanism for the clinicians to check previous scan reports at Trust A due to the information sharing complexities described in section 4.1 and staff

are not able to access patient information to ‘double-check’. Due to the information recorded at 36+5 weeks it was noted that the Mother did not meet the criteria for re-measuring growth at the 36+6 weeks USS as it was believed that it had been less than a week since the Baby’s growth had been assessed.

The investigation also found that the clinical information electronically entered on the USS referral form (appendix 2d) was not completed by the referrer. A member of the midwifery team enters all of the USS requests on the electronic radiology referral system during the antenatal clinic and uses ‘Exam: ‘US Obstetric Foetal Growth’ as the code for all antenatal USS requests. This meant that the information available to the sonographer may not have been an accurate reflection of the original clinical request.

The investigation learned that the reference point for the sonography team to obtain further detail prior to undertaking a mother’s USS is on the ‘other details’ section of the referral form (appendix 2d); this had incorrect information included. The coding for the USS (Exam: ‘US Obstetric Foetal Growth’) was the incorrect code used to represent a presentation scan so is not a reliable ‘check’ point. The sonographers do not use this as a mechanism for a ‘reference check’ as this code is often incorrect and used to cover all requests in maternity which meant that a growth scan did not take place.

MNSI safety recommendation (as above section 4.1)

MNSI recommends that Trust A and B develop a structured information transfer process to ensure that when a mother transfers from one provider to another a robust process is in place to support staff to access and retrieve the required information such as (not limited to) medical records, USS reports/imaging, and test results to inform on-going clinical decision making and management of care.

MNSI safety prompt.

The investigation found the completion of the USS request forms was delegated to another member of staff:

- Are there any barriers to ensuring this is completed by the referrer?

- Are there adequate resources such as time and equipment?
- Is there training or a tool in place to support staff?

The investigation found the completion of the 'Exam coding' section of the USS request did not reflect the examination required:

- Are there any barriers to ensuring this is completed correctly?
- Is there training or a tool in place to support staff to understand what is required on an USS request form?
- Is there any coding information/prompts available for staff to reference when completing the request form?

4.3 Telephone triage assessment at 38+5 weeks

The investigation found that local (2020) and national guidance (RCOG, 2023) supports mothers to attend the hospital if there is any uncertainty whether the membranes have ruptured to confirm or discount if this has happened. The telephone assessment area and tools used did not support staff (RCOG (2023); BSOTS (2024)) to invite a mother in. The investigation found that during periods of high activity, staff can be working in a challenging and busy environment, caring for more than one mother. This can impact on the time and capacity for understanding provided to mothers in the early stages of labour, as well as to the wellbeing of staff. As a result, the Mother was not invited in to attend when she reported leaking fluid during the telephone contact and was reassured that all was well. This meant that there was no assessment of whether the Mother's waters had broken.

When the Mother telephoned the maternity triage unit reporting a 'watery loss' she told the investigation team she had reported stomach-ache at night and saw some blood and water dripping down her legs to the floor. A member of the midwifery team spent a total of 6 minutes on the call. The Mother told the investigation that her understanding was to call back to report back if there was "any more blood come out". Triage calls are not recorded at this trust, so the investigation team were unable to establish any further information.

During this call, the advice selected from a dropdown list on the EPR system was for the Mother to 'attend'; the investigation learned it was presumed that the pad would be wet when the Mother called back and this informed the option chosen when documenting the contact.

The investigation found at the time of the call, the midwife was multitasking which included answering the triage telephone lines and caring for other mothers in the triage unit.

The Mother telephoned the maternity triage unit back at 09:57 hours (47 minutes later, 4 minutes duration) and told the same member of the midwifery team that there had been no more blood. The Mother told us her understanding of the advice was to look for further blood on the pad which did not happen, and this is what was reported.

The explanation given to the Mother offered her reassurance at this point that this loss was a 'show' and required no further investigation. The watery loss was not noted at any subsequent contacts as this loss was recorded as a 'show' which was judged to be expected. The investigation learned decision making during telephone triage was based on the advice and questions being understood correctly based on what a mother is telling a clinician, available local guidance, experience and clinical judgement, with staff acknowledging the difficulty when assessing mothers and making these decisions over the telephone.

National guidance advocates the use of the BSOTs algorithm. The BSOTS algorithm does not reflect local and national guidance in relation to management of a mother with possible ruptured membranes. This meant that when there was a query about SROM the mother was not invited in for assessment.

The investigation learned there is a more updated version (3) which is not currently in use at the Trust. The advice on both versions contradicts local and national guidance when supporting staff to make a clinical decision if there is uncertainty whether prelabour rupture of a mother's membranes has occurred:

> Local BSOTS telephone triage guidance (2022) - spontaneous rupture of membranes guidance as advised in national telephone guidance (BSOTS, 2020 and 2024):
>
> - 'Advise not to attend if: Uncertain history of [spontaneous rupture of membranes]'.
>
> Local guidance for pre-labour spontaneous rupture of membranes at term (2020) advises: 'Women with an uncertain history of pre-labour [spontaneous rupture of membranes] should be offered a sterile speculum examination to determine whether their membranes have ruptured.'

National Guidance [NG235] (2023): ‘If it is uncertain whether prelabour rupture of the membranes has occurred, offer the woman a speculum examination to determine whether the membranes have ruptured.’

4.3.1 Maternity triage staffing

The investigation learned that staffing for the maternity triage unit does not include a dedicated telephone triage midwife. Efforts are made to provide a dedicated specialist midwife to carry out this role when staffing will allow during the times 09:00 hours to 17:00 hours, Monday to Friday. The investigation was told that this is not always possible, which leaves the triage midwife to answer calls, this is in addition to caring for and assessing mothers attending the unit. When clinicians are multi-tasking, it can impact on performance making clinicians vulnerable to errors (Dekker, 2011). The investigation also learned that calls can be taken by obstetric doctors, students or midwifery support workers who will take messages and refer to the midwife in the unit.

Observation of the maternity triage area during the investigation showed the telephone triage service is located on the triage unit in a small office, it has three computer points for general use and when taking telephone triage calls. The office is also the main area were staff complete records and documentation. This is a busy area making it difficult for staff to fully concentrate on calls due to these potential distractions. There is a dedicated quiet office, available when a specialist midwife answers calls into the triage unit. When calls are answered by the triage midwife, these are taken in the triage office area.

There is a portable, handheld telephone dedicated to receiving triage calls which has no facility to use a handsfree system (headset) which does not limit background noise, promote confidentiality and can impact on the efficiency of using a keyboard whilst taking a call at the same time. The investigation requested a copy of the telephone recording as calls should ideally be recorded with consent ((RCOG, 2023); the Trust confirmed triage calls are not currently audio recorded.

MNSI safety recommendation.

2. MNSI recommends that the Trust review its guidance to meet national recommendations to develop a robust person, systems-centred process and environment to support the role of dedicated midwifery staff to be solely

responsible for the telephone triage advice line service and provide a space to facilitate this.

MNSI safety recommendation.

3. MNSI recommends that the Trust reviews and re-develops its guidance to be clear and consistent in its advice in line with national recommendations to support staff to assess and offer mothers to attend triage if there is any uncertainty about whether prelabour rupture of the membranes has occurred

MNSI safety prompt.

The investigation found that there were two different perceptions of the information shared and given during the telephone triage conversation between the clinician and the Mother.

- How does the system support staff to easily document whilst managing multiple tasks
- Are there any barriers to complete documentation?
- What processes are there to support the recording of telephone triage contacts accurately?
- What processes are in place to assure staff a mother understands the information and advice being given

4.4 Triage attendance at 39+1 weeks

When the Mother attended the triage assessment unit at 39+1 weeks with stomach-ache all information about the previous calls to triage was not included. The Mother's BSOTs rating was incorrectly assessed as 'green', which meant her unexplained pain in early labour, her multiple telephone calls to the maternity triage unit, and the latent phase of labour lasting days required obstetric assessment which did not take place. Earlier holistic assessment may have led to a different pathway of care.

The investigation learned the Mother attended the unit following a shift change of maternity staff; the number of calls previously made to triage was not handed over. This meant there was

no knowledge of the Mother's previous calls (three over 2 days). The investigation was told that the reference point for the Mother's antenatal clinical history was the transfer booking appointment at 36+3 weeks. There is also usually a reliance on a mother offering a verbal history of their pregnancy or presenting their handheld maternity notes.

The investigation found that local guidance (2023) advises staff to complete paper-based triage cards (appendix 2e) at every call; staff told the investigation these are not used. All calls are currently entered onto the EPR system.

The investigation learned staff can access a mother's records on the EPR system to gain knowledge of previous antenatal contacts. The total number of calls made does not appear on the patient 'dashboard'; the dashboard is the first page seen by staff when accessing a patients details. Incoming triage calls of all contacts over time are visible if the staff member accesses these on a specific tab by 'clicking through' the system. The investigation could not establish why this was not accessed at the time.

The investigation team was told the additional information of the total number of calls made by the Mother would have been useful to have known to inform clinical decision-making and may have changed the Mother's BSOTS rating from 'green' to a higher rating (yellow or orange). A yellow or orange BSOTS rating supports a review by a member of the obstetric team as part of a mother's triage assessment.

MNSI safety recommendation.

4. MNSI recommends that the Trust works with staff to promote the use of a structured communication pathway to support the sharing of information about the number and content of calls a mother makes to the triage telephone advice line when transferring to another area to inform clinical decision-making.

MNSI safety recommendation.

5. MNSI recommends that the Trust updates their guidance to reflect the system currently in use, with a particular focus on the number of calls made by a mother and how this is communicated to relevant members of staff.

4.5 Holistic overview: Triage attendance at 39+2 weeks

The Mother went to her routine antenatal appointment (39+2 weeks) which prompted a referral to the triage assessment unit due to concerns about her raised blood pressure readings. The investigation found that when the Mother attended the triage assessment unit, a holistic assessment was required to inform her ongoing care. Due to not having the Mother's previous records (from Trust A) available on the EPR system and being focused on the presenting condition (raised blood pressure) meant no further action was taken to further investigate the unexplained pain she continued to experience, the multiple telephone triage calls at term and the latent phase of labour lasting over a number of days.

Some members of the team had limited recall of the events that took place during the Mother's attendance due to the length of time that had passed between her attendance and the investigation. The normal working practices were discussed, the investigation was told a member of the obstetric team reviews and focuses on the medical contacts only; details of these are found on a separate 'tab' to the triage contacts in the EPR system. The investigation was told all midwifery contacts are not usually accessed; the clinicians seek additional information verbally from the midwifery team to support a clinical review. It was documented that the obstetric review was undertaken 'face to face'; the Mother and the Father's recollection was that they were seen by midwives only and were told a consultant had undertaken a review. The investigation could not reconcile this part of the Mother's care.

The investigation was told the Mother attended triage due to high blood pressure; this was the focus and was managed in accordance with both local and national guidance (2021, 2023). The investigation was told there was no recollection of knowing about the 'watery loss' reported at 38+5 weeks, so this was not factored into the overall clinical assessment. The investigation learned there was the understanding a growth USS had been requested at Trust B; but did not know that the growth USS was not done. The investigation team was told that if the growth was 'tailing off' at this point then this would have changed the direction of care and consideration of an induction of labour would have been offered.

The investigation reviewed the use of the Dawes Redman CTG when the Mother was experiencing abdominal tightening's and raised blood pressure. This was used to support the assessment of the Baby's wellbeing when the Mother was found to be in early labour (latent phase). A Dawes Redman analysis of the CTG is only recommended for use in the antenatal period. It is not an appropriate tool for assessing fetal well-being in the presence of uterine

activity either in active labour or in the latent phase (Nuffield Department of Women's and Reproductive Health, 2023). The investigation could not establish why this was used.

MNSI safety recommendation.

6. MNSI recommends that the Trust supports maternity triage staff to undertake a full holistic assessment for every mother attending the triage assessment unit to provide a comprehensive review of maternal and fetal wellbeing.

MNSI safety prompt.

The investigation found the use of a Dawes Redman analysis of the CTG was used whilst the Mother was having contractions. This is only recommended for use in the antenatal period when there is no uterine activity present (Nuffield Department of Women's and Reproductive Health, 2023):

- Are there any barriers to ensuring this is completed in line with guidance?
- Are there adequate resources such as time and equipment?
- Is there training in place to support staff?

4.6 Postmortem examination and placental histology

The postmortem examination and placental histology reported findings of a probable placental abruption, inflammation of the placental membranes (chorioamnionitis) and poor placental function. Information gathered during the investigation indicates the Mother may have had an unknown, prolonged rupture of membranes (when the waters are broken for more than 24 hours before birth) contributing to the chorioamnionitis.

Placental abruption

Placental abruption is the separation of the placenta from the uterine wall before a baby is born. It usually presents with abdominal pain and bleeding, although sometimes it is concealed, and no blood loss is seen. Its effect on a mother and baby depend on the severity of the bleeding and the gestation of the pregnancy. If the abruption is large, it can cause collapse in a mother and/or distress in a baby and requires urgent birth. Although there are certain factors in a mother that make placental abruption more likely, it can happen in any pregnancy (MNSI).

4.7 The impact of ethnicity and/or health inequalities on the Mother and the Baby's wellbeing

There was no evidence that ethnicity or health inequalities directly impacted on the care or outcome during the Mother's and the Baby's care. The Mother and her family did not feel ethnicity or health inequalities impacted on their care. While this had no impact during this episode of care, MNSI is committed to working with other system partners to understand and further reduce the factors behind health inequalities faced by mothers, babies and families from Black, Asian or minority ethnic backgrounds.

Appendices

Appendix 1: Additional information about the MNSI programme

Appendix 2: Additional clinical information

Appendix 3: References

Appendix 1: Additional information about the Maternity and Newborn Safety Investigation programme (MNSI)

MNSI investigates in line with the criteria outlined in the Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions (2023). Eligible babies include all term babies (at least 37+0 weeks of gestation) born following labour, who have one of the following outcomes –

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

(b) **Early neonatal death:** when a baby died within the first week of life (i.e. days 0–6) of any cause.

(c) **Severe brain injury:** diagnosed as occurring in the first 7 days of life, when the baby—

(i) was therapeutically cooled (active cooling only), or

(ii) has been diagnosed with moderate to severe encephalopathy, consisting of altered state of consciousness (lethargy, stupor or coma) and at least one of the following:

- low tone (hypotonia);
- abnormal reflexes including oculomotor or pupillary abnormalities;
- absent or weak suck;
- clinical seizures.

The defined criteria for maternal death investigations are:

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

Direct: deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above. This excludes cases of suicide.

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

*Includes giving birth, treatment of an ectopic pregnancy, miscarriage or termination of pregnancy

Information about the MNSI programme's approach to gathering information

Review of information

After consent is obtained from the family to access the relevant clinical records, these are uploaded by the healthcare organisations and MNSI starts the investigation.

Records that can be used include, (and are not limited to), hospital records, GP records, ambulance service records and transcripts, and relevant trust guidelines and procedures. Information reviewed may also include an assessment of tools used to monitor staffing levels (acuity), and staff working patterns.

Investigators may undertake a walk-through of a mother's, pregnant person's or birthing parent's and baby's journey within the maternity service and observe the clinical environment.

Family interviews

Interviews and telephone conversations are held with the family to listen to their recollection of events and any concerns they may have. Families' involvement in the investigation process is central to an MNSI investigation.

Specialist review panels

Advisors with a specialist knowledge provided advice and guidance during the investigation process: signposting to evidence, including national guidance and expected practice. They assisted in formulating the investigation's terms of reference and key lines of enquiry.

Staff interviews

Face to face or video interviews are held with staff involved in a mother's, pregnant person's or birthing parent's or baby's care to understand what influenced their decision making and the

care provided. Interviews may also be held with other staff members who can provide further information to support the investigation.

Communication during investigations

Throughout the investigation process, the investigator provides regular updates with families and healthcare organisations. If a safety concern that needs immediate action is identified, this is escalated to the healthcare organisation during the investigation. This helps ensures that there is an opportunity for a healthcare organisation to address safety issues in a timely manner.

Post-mortem examination

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

His Majesty's Coroner information

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

Analysis

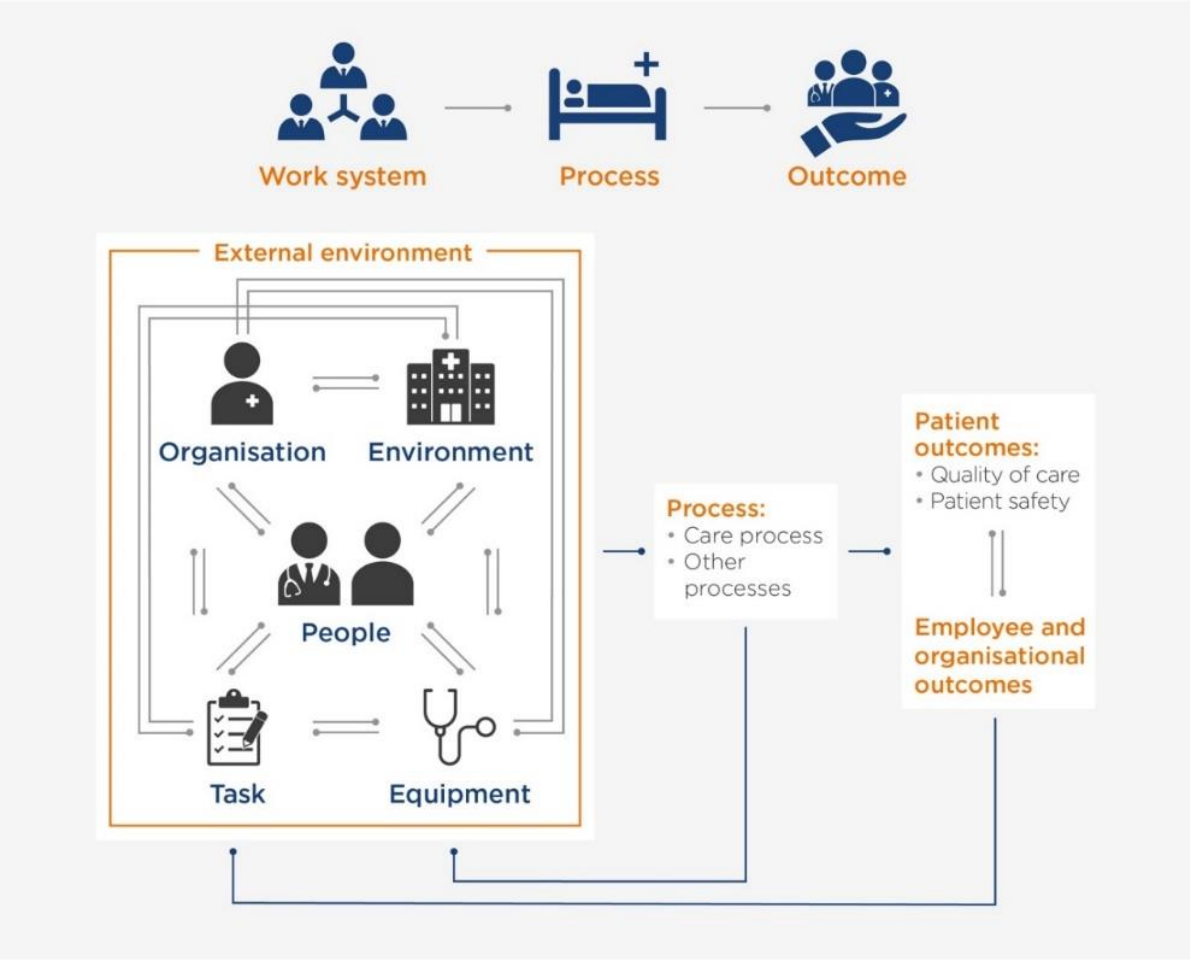
The investigator can access a range of resources to help understand what contributed to care.

MNSI promotes use of the Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon, 2006; Holden et al, 2013) as one way to help understand why incidents occur. The investigators consider the relationships and interactions between people, tasks, technology and tools, the environment, organisational factors, and national policies and professional guidance, that contribute to how incidents occur.

Once analysis is complete MNSI may develop safety recommendations, safety prompts and findings. This is aimed at supporting the immediate and sustainable improvement of care and service provision locally and across the wider NHS.

Learning from individual reports are analysed and are used nationally to share wider thematic learning.

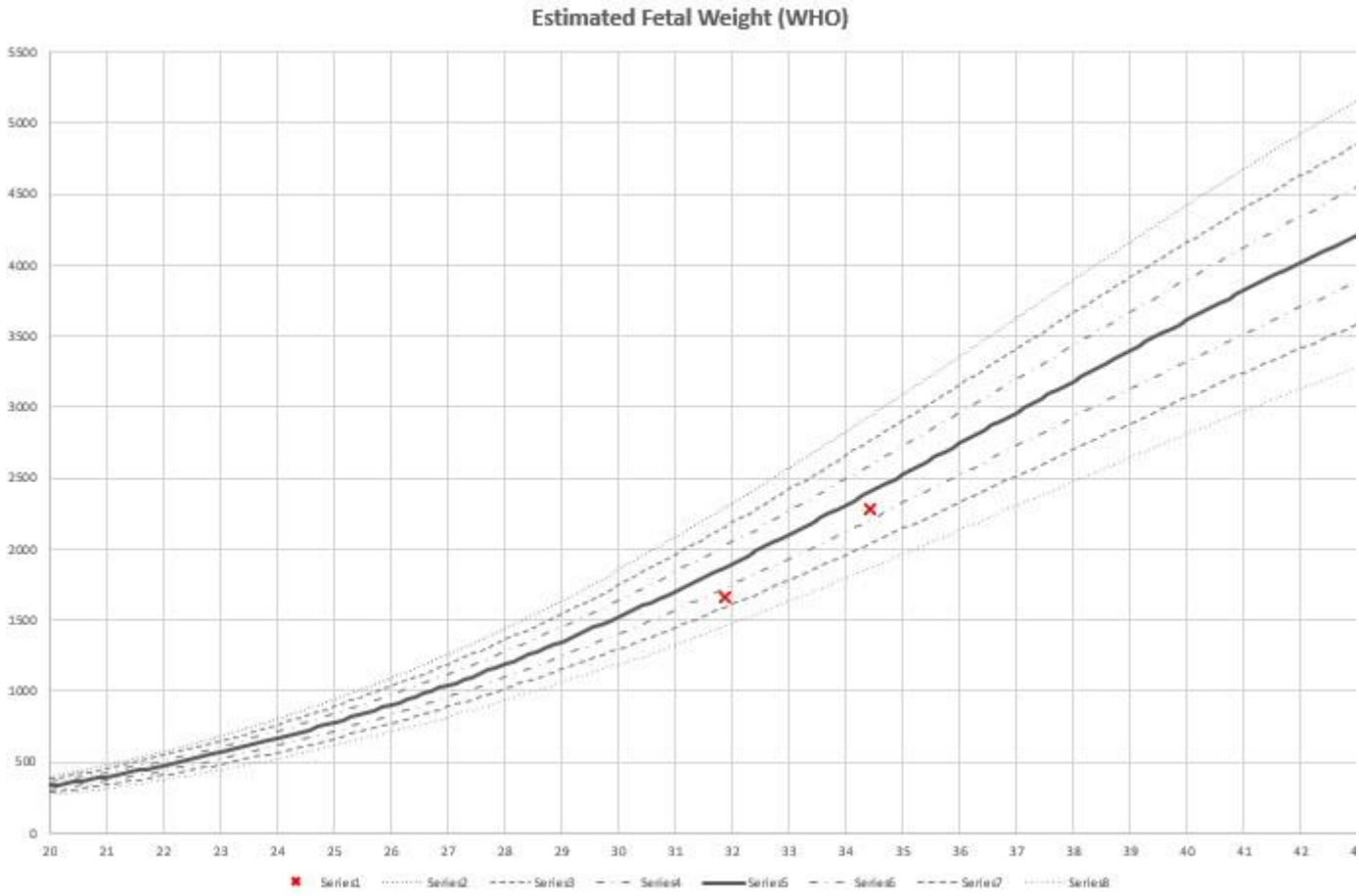
Image 1. Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon, 2006; Holden et al, 2013)



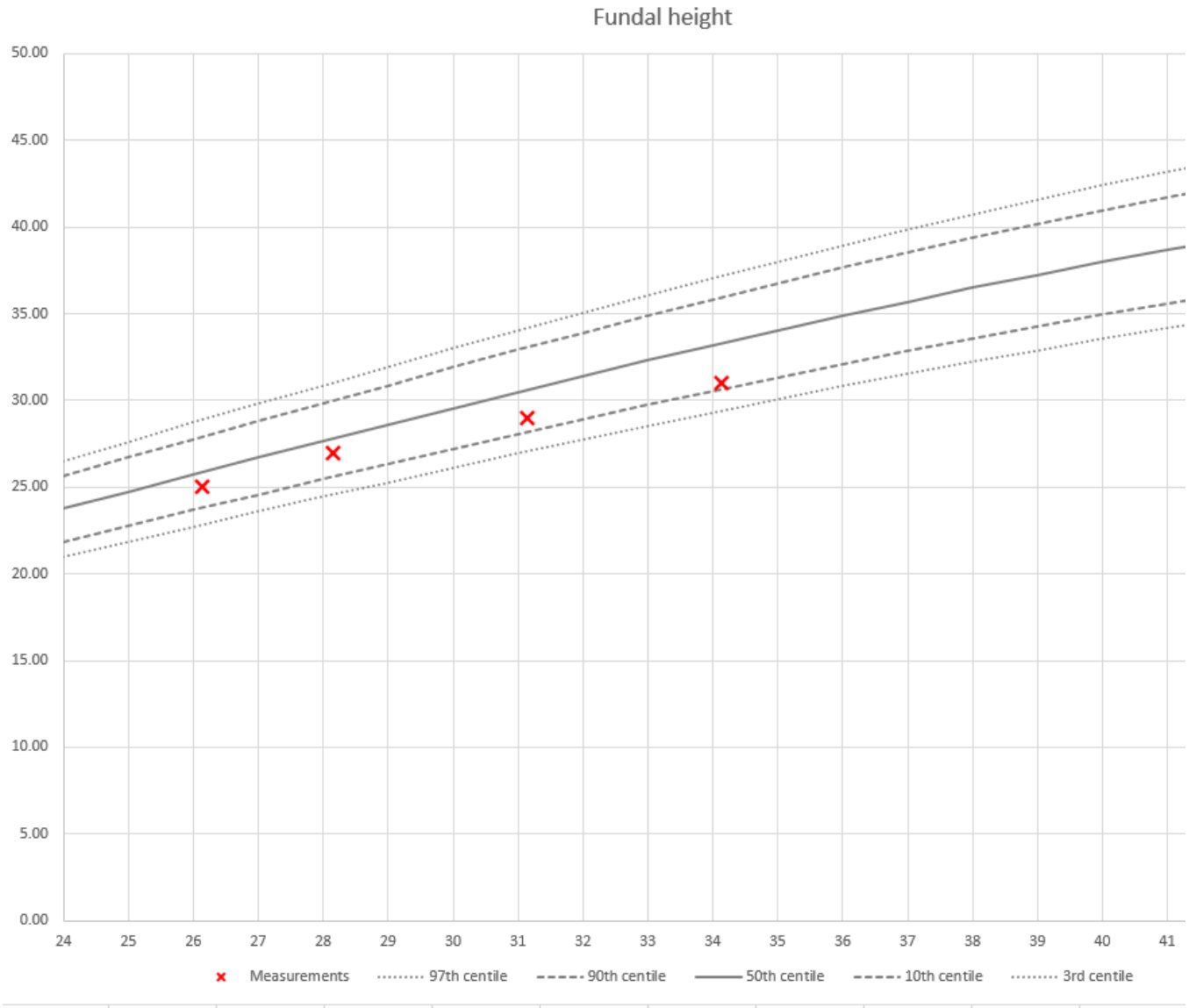
Appendix 2: Additional clinical information

a. Trust A WHO Population based growth charts

Fetal Weight (g)

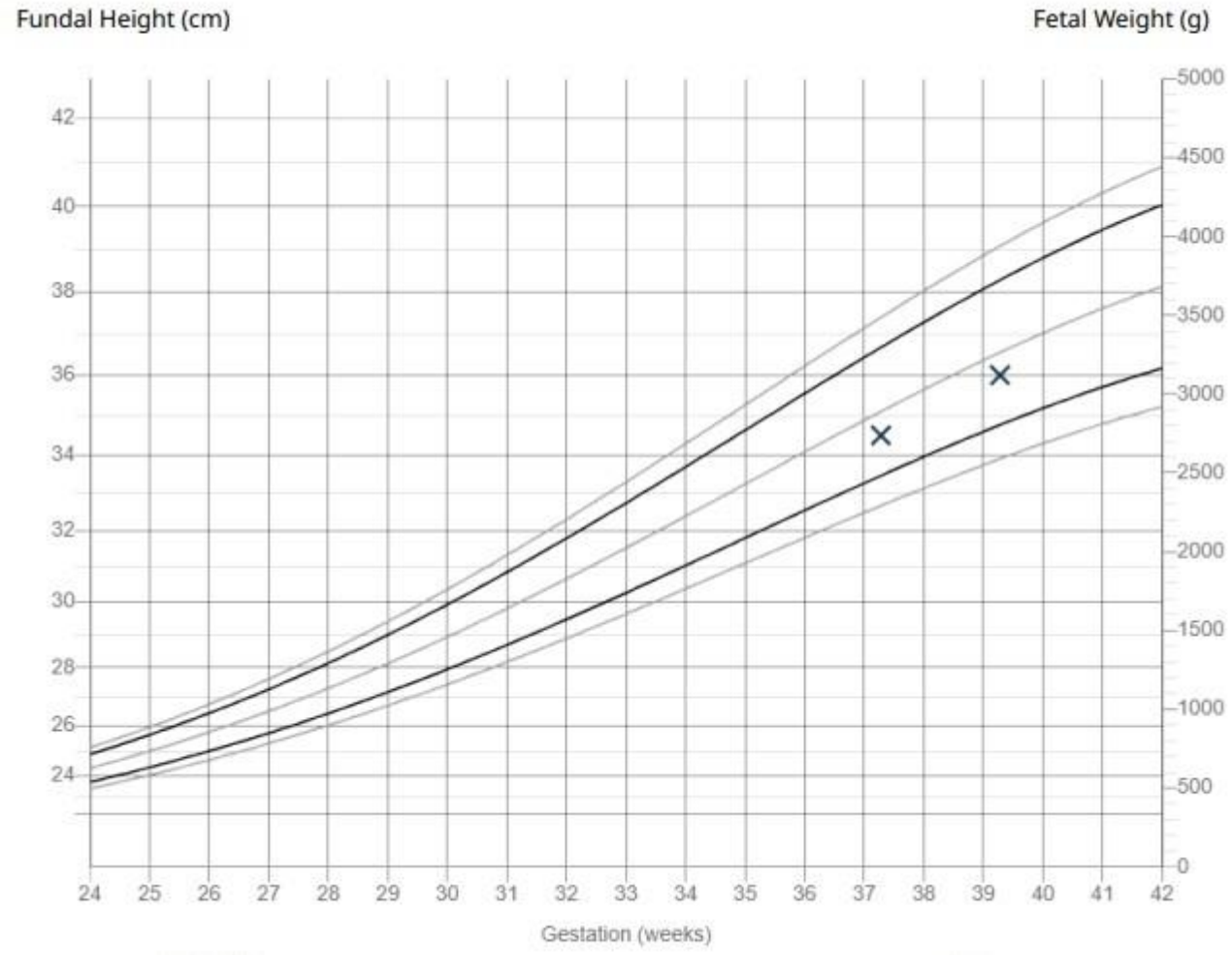


Weeks (gestation)



Gestation		FH (cm)	Centile
26	1	25	29.4%
28	1	27	32.1%
31	1	29	19.5%
34	1	31	13.1%

b. Trust B Customised growth chart

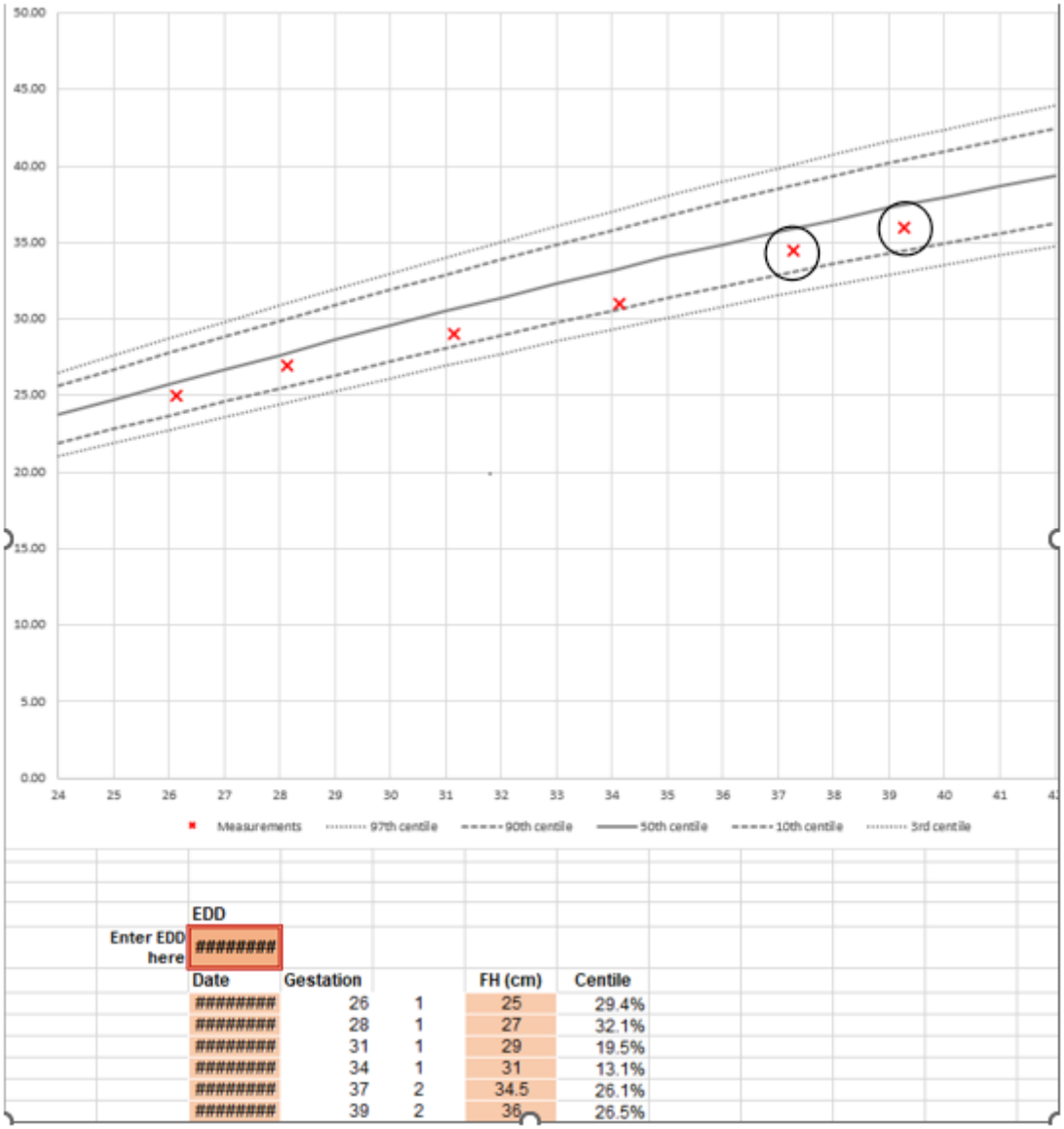


37+2 weeks the SFH was 34.5cm and 39+2 weeks the SFH was 36.0cm

c. Analysis of growth SFH measurements

Plotting of all the SFH measurements on the WHO population-based growth chart.

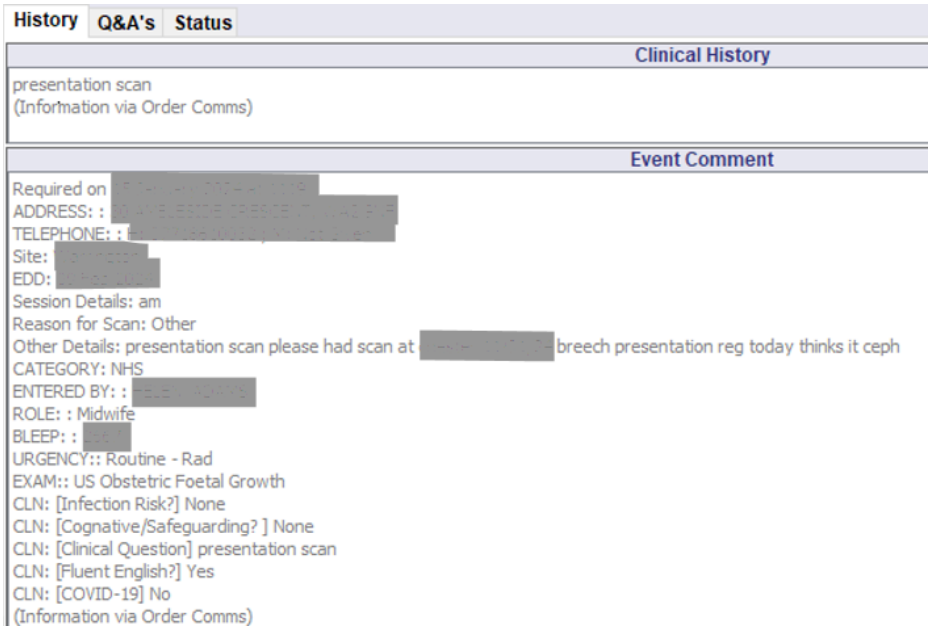
Fundal Height



	EDD				
Enter EDD here	########				
	Date	Gestation		FH (cm)	Centile
	########	26	1	25	29.4%
	########	28	1	27	32.1%
	########	31	1	29	19.5%
	########	34	1	31	13.1%
	########	37	2	34.5	26.1%
	########	39	2	36	26.5%

Please note, the 37+2 weeks and 39+2 weeks are plotted from the measurements taken at Trust B.

d. Trust B Ultrasound Request form



History | Q&A's | Status

Clinical History

presentation scan
(Information via Order Comms)

Event Comment

Required on [redacted]
ADDRESS: : [redacted]
TELEPHONE: : [redacted]
Site: [redacted]
EDD: [redacted]
Session Details: am
Reason for Scan: Other
Other Details: presentation scan please had scan at [redacted] breech presentation reg today thinks it ceph
CATEGORY: NHS
ENTERED BY: : [redacted]
ROLE: : Midwife
BLEEP: : [redacted]
URGENCY:: Routine - Rad
EXAM:: US Obstetric Foetal Growth
CLN: [Infection Risk?] None
CLN: [Cognative/Safeguarding?] None
CLN: [Clinical Question] presentation scan
CLN: [Fluent English?] Yes
CLN: [COVID-19] No
(Information via Order Comms)

e. Telephone Triage Assessment cards

TELEPHONE TRIAGE ASSESSMENT CARD	1st Call	[redacted]

Telephone call taken by	Print Name											PIN			
	Signature														
	Date					Time						Location			
Woman's name												Woman's Telephone number			
Registration no. or DOB								Lead Professional							
Gravida		Parity		EDD or Date of delivery	D	D	-	M	M	-	Y	Y	Gestation	Days PN	

Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension		
	Postnatal concern		Ruptured membranes		Suspected labour		
	Unwell/other		Reduced fetal movements				
Relevant medical & obstetric history							
Current pregnancy							
Additional information (including social & lifestyle history)							
Advice given including time-frame if you ask woman to attend triage							
Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action		
Actions if woman advised to attend	Timeframe for woman to attend	Inform LW and medics if urgent attendance	Request hospital notes (ward clerk)	Inform ward clerk of urgency & to alert you when notes are received			

Specific early labour advice	Mobilise		Paracetamol		To call back if:				
	Rest		Regular fluids		Any changes		PV Bleed		
					Change in FMs		SROM		
	Regular snacks		Warm bath		Increase in strength and/ or frequency of contractions		Worried about anything		

PLEASE ATTACH TO HOSPITAL NOTES AND FILE ON ADMISSION

TELEPHONE TRIAGE ASSESSMENT CARD			2nd Call		Consider Triage attendance	
Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension	
	Postnatal concern		Ruptured membranes		Suspected labour	
	Unwell/other		Reduced fetal movements			
Relevant medical & obstetric history						
Current pregnancy						
Changes since last call						
Advice given including time-frame if asked to attend triage						
Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action	
Actions if woman advised to attend	Timeframe for woman to attend	Inform LW and medics if urgent attendance	Request hospital notes (ward clerk)	Inform ward clerk of urgency & to alert you when notes are received		
Print Name & PIN		Signature		Date & time call completed		

TELEPHONE TRIAGE ASSESSMENT			3rd Call		Recommend Triage attendance	
Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension	
	Postnatal concern		Ruptured membranes		Suspected labour	
	Unwell/other		Reduced fetal movements			
Relevant medical & obstetric history						
Current pregnancy						
Changes since last call						
Advice given including time-frame if asked to attend triage						
Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action	
Actions if woman advised to attend	Timeframe for woman to attend	Inform LW and medics if urgent attendance	Request hospital notes (ward clerk)	Inform ward clerk of urgency & to alert you when notes are received		
Print Name & PIN		Signature		Date & time call completed		

Appendix 4: Reference list

Carayon, P., Schoofs Hundt, A., Karsh, B. T, Gurses, A. P., Alvarado, C. J., Smith, M., and Flatley Brennan, P. (2006) Work system design for patient safety: the SEIPS model. Quality & Safety in Health Care, 15 Suppl 1(Suppl 1), i50–i58.

Dekker, S. (2011) Patient Safety: A Human Factors Approach. CRC Press.

Draper, E. S., Gallimore, I. D., Smith, L. K., Matthews, R. J., Fenton, A. C., Kurinczuk, J. J., Smith, P. W and Manktelow, B. N. on behalf of the MBRRACE-UK Collaboration. (2022b) MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2020. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University
of Leicester [Online]. Available at layout (infantjournal.co.uk) (Accessed 20 June 2024)

Health Services Safety Investigations Body (HSSIB). (2024) Fatigue risk in healthcare and its impact on patient safety. Available at Launch report: Fatigue risk in healthcare and its impact on patient safety (hssib.org.uk) (Accessed September 2024)

Gallimore ID, Matthews RJ, Page GL, Smith LK, Fenton AC, Knight M, Smith PW, Redpath S, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths of Babies Born in 2022 - State of the Nation Report. Leicester: The Infant Mortality and Morbidity Studies, Department of Population Health Sciences, University of Leicester. 2024. Online, available at: MBRRACE-UK-perinatal-mortality surveillance-report-2022.pdf (le.ac.uk) (Accessed 13 September 2024)

Holden, R. J., Carayon, P., Gurses, A. P., Hoonakker, P., Hundt, A. S., Ozok, A. A. and Rivera-Rodriguez, A. J. (2013) SEIPS 2.0: A human factors framework for studying and improving the work of healthcare professionals and patients. Ergonomics 2013 November; 56 (11)

Kicks Count – fetal movements. Online, available at Your Baby's Movements | Kicks Count (Accessed 20 June 2024)

Knight, M., Bunch, K., Patel, R., Shakespeare, J., Kotnis, R., Kenyon, S. and Kurinczuk, J. J. (Eds.) on behalf of MBRRACE-UK. (2022a) Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. Oxford: National Perinatal Epidemiology Unit, University of Oxford [Online]. Available at

https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_UPDATE.pdf (Accessed 20 June 2024)

National Institute for Health and Care Excellence. (2021) Antenatal care for uncomplicated pregnancies. Clinical guideline [NG201] [Online]. Available at https://www.nice.org.uk/guidance/ng201 (Accessed 20 June 2024)

National Institute for Health and Care Excellence. (2019) Intrapartum care for women with existing medical conditions or obstetric complications and their babies. NICE guideline [NG121] [Online]. Available at https://www.nice.org.uk/guidance/ng121 (Accessed 20 June 2024)

NHS Digital (2022). Ethnicity [Online]. Available at https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/submit-data/data-quality-of-protected-characteristics-and-other-vulnerable-groups/ethnicity (Accessed 20 June 2024)

NHS England. (2019) Saving Babies' Lives Version 2. A care bundle for reducing perinatal mortality. [Online]. Available at https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/ (Accessed 20 June 2024)

Nuffield Department of Women's and Reproductive Health (2023). [Online]. Available at Dawes-Redman+and++Uterine+Activity.pdf (squarespace.com) (Accessed 20 June 2024)

Office for Health Improvement and Disparities (2022). Health disparities and health inequalities: applying All Our Health [Online]. Available at https://www.gov.uk/government/publications/health-disparities-and-health-inequalities-applying-all-our-health/health-disparities-and-health-inequalities-applying-all-our-health (Accessed 20 June 2024)

Race Disparity Unit on behalf of the Cabinet Office (2021). Writing about ethnicity [Online]. Available at https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity#ethnic-minorities-and-ethnic-groups (Accessed 20 June 2024)

Robson, S. C., Martin, W. L. and Morris, R. K. on behalf of the Royal College of Obstetricians and Gynaecologists. (2013) Small-for-gestational-age fetus, investigation and management. Green-top guideline no. 31 [Online]. Available at https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg31/ (Accessed 20 June 2024)

The Care Quality Commission. (2023). Maternity and Newborn Safety Investigation Programme Directions. [Online]. Available at: The Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions 2023 (publishing.service.gov.uk). (Accessed 20 June 2024)

The Royal College of Obstetricians and Gynaecologists. (2011) Reduced Fetal Movements. Green top guideline no. 57 [Online]. Green-top guideline no. 57 [Online]. Available at https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg57/ (Accessed 20 June 2024)

Vieira, M., Relph, S., Muruet-Gutierrez, W., Elstad, M., Coker, B., Moitt, N., Delaney, L., Winsloe, C., Healey, A., Coxon, K., Alagna, A., Briley, A., Johnson, M., Page, L., Peebles, D., Shennan, A., Thilaganathan, B., Marlow, N., McCowan., Lees, C., Lawlor D., Khalil, A., Sandall, J., Copas, A., Pasupathy, D., on behalf of the DESIGN Collaborative Group. (2022) Evaluation of the Growth Assessment Protocol (GAP) for antenatal detection of small for gestation age: The DESIGN cluster randomised trial [Online]. Available at

Evaluation of the Growth Assessment Protocol (GAP) for antenatal detection of small for gestational age: The DESiGN cluster randomised trial | PLOS Medicine. (Accessed 20 June 2024)

Whitworth, M. K., Fisher, M. and Heazell, A. on behalf of the Royal College of Obstetricians and Gynaecologists. (2011) Reduced fetal movements.

Williams, M., Turner, S., Butler, E. and Gardosi, J. (2018) Fetal growth surveillance – Current guidelines, practices and challenges. Ultrasound, 26 (2), 69-79 [Online]. Available at Fetal growth surveillance – Current guidelines, practices and challenges (perinatal.org.uk) (Accessed 20 June 2024)

Wound Infections

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

What we know so far

- Feeling amongst obstetricians and midwives that there has been an increased incidence of postoperative wound infections.
- Work was already ongoing by antenatal and postnatal matron to review postnatal readmissions quarterly. For quarter one, there were 30 women readmitted. Of these 30 readmissions, 26% (N=8) were due to wound infections requiring IV antibiotics. For quarter two, there were 24 women readmitted. Of these 24 women, 50% (N=12) were due to wound infections requiring IV antibiotics.
- Further in-depth audit of postnatal readmissions from a wound infection undertaken (see next slide)



Postnatal Readmissions: Quarters One and Two Findings

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Wound Infections requiring PN readmissions

- 89% of women readmitted had a BMI >25, 50% of women readmitted had a BMI >30.
- PICO dressing used for all women with BMI >35. Opsite dressing used for remainder of women.
- 72% of women readmitted had an emergency caesarean (CS) (category 1-3)
- There were no other co-morbidities identified.
- 2% chlorhexidine in 70% alcohol was used to prep the skin of women
- 85% of Opsite dressings were removed after 24 hours.
- Women were counselled appropriately about the risk of infection when consented for CS.

Wound Infections

Current position

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Opsite wound dressing to be removed on Day 2 post CS as per NICE (implemented September 2024). Hoping to see an improvement in Quarter 3 data
- Day 5 postnatal visit conducted by CMW not MSW to review wound for women following CS (implemented August 2024). Will allow for early escalation to GP for oral antibiotics to reduce the need for readmission and IV antibiotics.
- Health surveillance questionnaire circulated to all women post CS. Phone call at 6/52 from IPC team to capture women who have experienced a wound infection and have been treated as an outpatient, either via maternity triage or GP
- Wound surveillance working group meet monthly to discuss current data, issues arising and ongoing improvement ideas
- Leukomed Sorbact dressing explored, need further health surveillance data to support business case. R Ayra to encourage the use of PICO dressing for eligible women in the interim
- Advice and best practice circulated by R Ayra:
    - Ensure IV antibiotics pre knife to skin at sign in
    - Vaginal prep with antiseptic if SROM pre-CS
    - Checking subcut haemostasis
    - Drape is adherent and chlorhexidine has dried prior to draping

Wound Infections

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Future Improvement

- Review literature search into ‘QI projects to reduce c-section SSI’ at next Wound Surveillance meeting (December 2024)
- 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

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NHS Foundation Trust

Postnatal Readmissions- Hypertension

What we know so far

- Rise in number of women readmitted postnatally with hypertension from Quarter One (N=2) to Quarter Two (N=4)
- Review by ward manager highlighted that blood pressure monitoring not optimised on C23. Other themes included: lack of escalation to a senior clinician, antihypertensive medication discontinued postnatally and women discharged <24 hours following changes to medication.
- In most cases, 'antihypertensive medication discontinued postnatally and women discharged <24 hours following changes to medication' in line with current hospital guidance. Awaiting regional guideline in maternity services which improvements to postnatal management of hypertension.

Postnatal Readmissions: Cases

Warrington and Halton Teaching Hospitals NHS Foundation Trust

KH

Developed severe pre-eclampsia at 39/40. CMW referred (another provider) for raised BP and admitted for IOL. Commenced on TDS labetalol and received 20mg STAT MR nifedipine during IOL. Decision for CS made category 2 CS in light of severe preeclampsia. EBL 1300ml. Commenced on 24 hours MgSO4 and 5mg enalapril postnatally. Plan to omit medication if BP <130/80mmHg as per guideline. Remained normotensive and BP monitored 4 hourly whilst admitted to C23. Discharged with 5mg enalapril TTO and for BP monitoring by CMW. Attended Day 5 PN following CMW visit with BP 163/102mmHg. BP >160/100mmHg requires obstetric review. Unavoidable readmission.

SO

Attended 39/40 for ELCS for previous ELCS. BP on arrival 146/91mmHg. Urine not dipped. Normotensive following CS. Routine discharge on Day 1 PN. Attended 72 hours postnatal. Enalapril 5mg commenced. Declined admission and discharged home for CMW follow up. Admitted day 7 postnatally with raised BP. Commenced on Enalapril 10mg and Amlodipine 5mg and admitted. Attempts made to monitor BP conservatively in community and via triage unsuccessful. Unavoidable readmission.

ZH

Referred to triage at 39+6 with raised BP by CMW. Seen in triage. Nil proteinurea. Plan for BP monitoring in triage and await bloods. Admitted at T+1, commenced on labetalol 200mg TDS and for IOL. BP stable following birth, known sepsis. 48 hours postnatal, BP raised on ward. STAT labetalol and nifedipine given on verbal prescription due to raised BP. Commenced on TDS labetalol postnatally and discharged with labetalol TTO. Not prescribed enalapril/amlodipine postnatally as per guidance. Readmitted day 6 postnatally with raised BP. Avoidable readmission.

Postnatal Readmissions: Cases

Warrington and Halton Teaching Hospitals NHS Foundation Trust

SB

Developed raised BP in labour. STAT labetalol prescribed. Registrar review prior to transfer to C23 states raised BP due to pain. BP borderline prior to discharge home (141/83mmHg, 130/90mmHg). Not escalated to medical team. BP by community midwife 128/99mmHg and 138/90mmHg. Not medicated and not referred to maternity triage for review. BP at home on day 3 134/101mmHg, plan to repeat BP in 2 hours. BP 155/98mmHg. Advised to attend birth suite. Avoidable readmission.

JT

Known essential hypertensive. BP raised when attended for ELCS. Prescribed QDS labetalol antenatally. BP raised 37 hours post birth. 100mg STAT labetalol prescribed. Senior review prior to discharge. Switched to enalapril 5mg OD. Remained inpatient for 24 hours BP monitoring. BP stable upon discharge. No BP monitored on primary visit. Missed opportunity to monitor BP. BP raised at next CMW visit and transferred in to triage. Unavoidable readmission.

AC

Normotensive antenatally, during labour and prior to discharge from C23. Developed borderline BP in community, reviewed in triage. BP remained borderline. PET bloods taken and plan for CMW follow up. Transferred in 2 days later with elevated BP and raised bile acids. Admitted for medication and BP monitoring. Unavoidable readmission.

Postnatal Readmissions- Hypertension

Future Improvement

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Theme of increased incidence of postnatal readmissions escalated to Labour Ward Lead
- Aware awaiting regional guideline for pre-eclampsia and gestational hypertension
- Plan to develop discharge checklist with labour ward lead for women with known hypertension antenatally or in labour
- Education around the importance of regular BP monitoring shared with C23 team (minimum of 4 hourly monitoring)
- Review of BadgerNet system and early warning score undertaken by digital midwife and C23 manager. Education shared with C23 team about ‘red/yellow’ score and appropriate escalation and monitoring
- Awaiting roll out of National MEWS2 tool (planned March 2025)

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/01/151 Appendix 2**	
SUBJECT:	**Maternity & Neonatal Quality Review – November 2024**	
DATE OF MEETING:	5 February 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)***	**#1215** If the Trust does not have sufficient capacity (theatres, outpatients, diagnostics) then there may be delayed appointments and treatments, and the trust may not be able to deliver planned elective procedures causing possible clinical harm and failure to achieve constitutional standards and financial plans. **#115** If we cannot provide minimal staffing levels in some clinical areas due to vacancies, staff sickness, patient acuity and dependency then this may impact the delivery of basic patient care. **#1134** If we are not able to reduce the unplanned gaps in the workforce due to sickness absence, high turnover, low levels of attraction, and unplanned bed capacity, then we will risk delivery of patient services and increase the financial risk associated with temporary staffing and reliance on agency staff	
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***	

	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 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 Board with oversight of key matters to provide assurance on maternity and neonatal safety and quality issues. 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 seven moderate harm events in November 2024. The moderate harm case was that of a baby born in poor condition and transferred to Liverpool Women's Hospital for cooling therapy. The remaining cases relate to incidence of OASI (3rd degree tear). There were no severe or fatal harm events in November 2024. Themes from maternity/neonatology patient safety events in October 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 and Trust Board. At the end of November compliance for mandatory training across maternity and child health colleagues is above the Trust target. Compliance with PDR has improved significantly from 77.33% in October (excluding those with a long term absence) to 86.01% at the end of November. An MNVP led 15 Steps challenge took place in November 2024. Feedback from the challenge is included in the report for information. There were no urgent matters for escalation.

	The service continues to achieve its KPIs for Maternity Triage. Work is ongoing regarding improvement to the service position related to care of women with diabetes in pregnancy and implementation of continuity of carer. November data from the Local Maternity and Neonatal System (LMNS) highlights WHH continues to perform less well in relation to timeliness of induction of labour (IOL) activity when compared to other local providers albeit with some improvement in the position. An overview of the sevice's position with regard to cases being investigated by MNSI is provided for oversight. Six complaints were received in the CBU in November 2024. Three related to care within the maternity service. The remainder related to care within the gynaecology service. No Regulation 28 enquiries have been received.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/25/01/223ii**	
	Date of meeting	14 January 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 – November 2024	AGENDA REF:	BM/25/01/151 Appendix 2

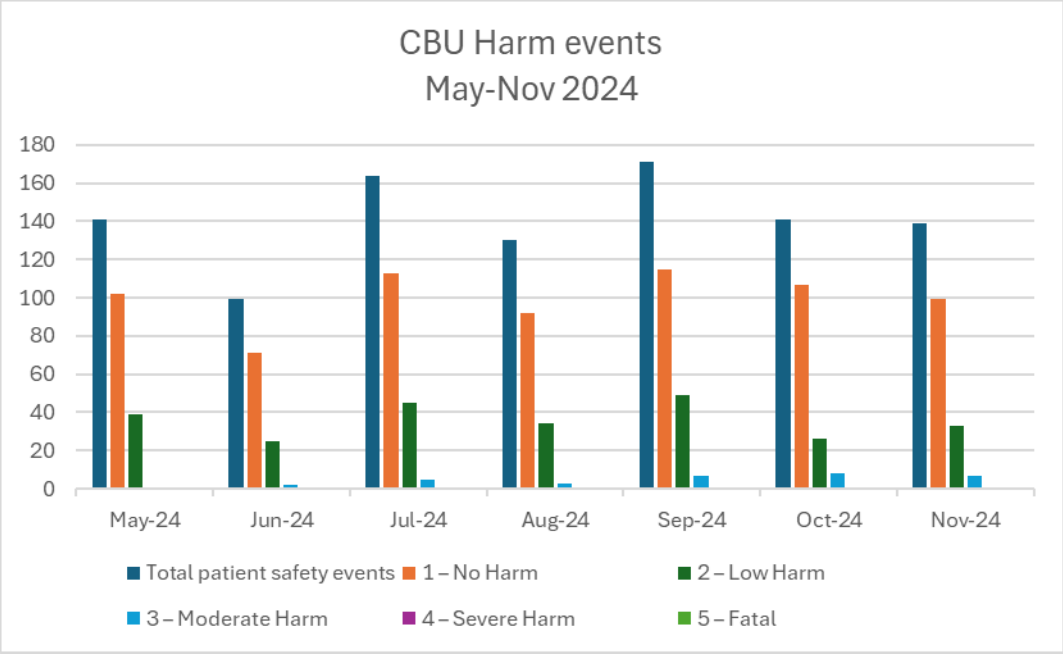
1. BACKGROUND/CONTEXT

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



There were 139 patient safety events reported across the CBU in November 2024. Of these there were no severe harm or fatal events. There were seven moderate harm events. All seven occurred in the maternity service. There was one moderate harm case of a baby born in poor condition and transferred to Liverpool Women's Hospital for cooling therapy. This was reviewed via an initial safety review (ISR). Initial learning was identified via the ISR in relation to categorisation of the cardiotocography (CTG). Immediate actions are in progress. In addition, an MDT task and finish group has been established to lead a number of wider actions with regard to fetal surveillance and

monitoring. This will include a review of current education provision. In line with national guidance, this case was also referred to the Maternity and Newborn Investigation (MNSI) team for review. The case has been accepted for investigation (MNSI ref MI-039124).

The remaining six moderate harm cases were all OASI (3rd degree tears) and were reviewed in Intrapartum Review Group (IRG), learning from the IRG reviews will feed into the existing workstream related to OASI.

In total there were 20 moderate/low harm reviews undertaken in IRG in November.

All incidents reported are reviewed by the Governance Team and escalated where required.

The first Operational Review Group (ORG) meeting has been held. As described to December QAC this meeting will provide an opportunity for a senior MDT review utilising the PSIRF framework of safety events as follows:

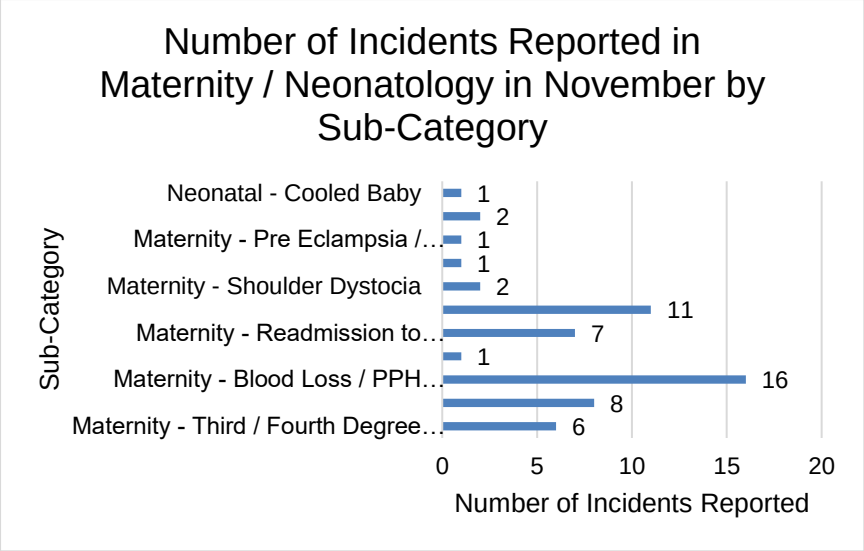
- Maternity diverts and deflects.
- Neonatal unit closures
- Lack of transitional care provision
- Service unable to provide choice of place of birth via Nest or home birth service.
- Cancellation of planned caesarean sections
- Requests for mutual aid due to delayed induction of labour

The first ORG considered the following:

- Neonatal Unit Closure 03/11/2024
- Maternity Divert 05/11/2024.

A quarterly update regarding learning and actions from this group will be presented to QAC in April 2025 and then to Board.

Themes from maternity/neonatology in November 2024 are detailed in the table below:

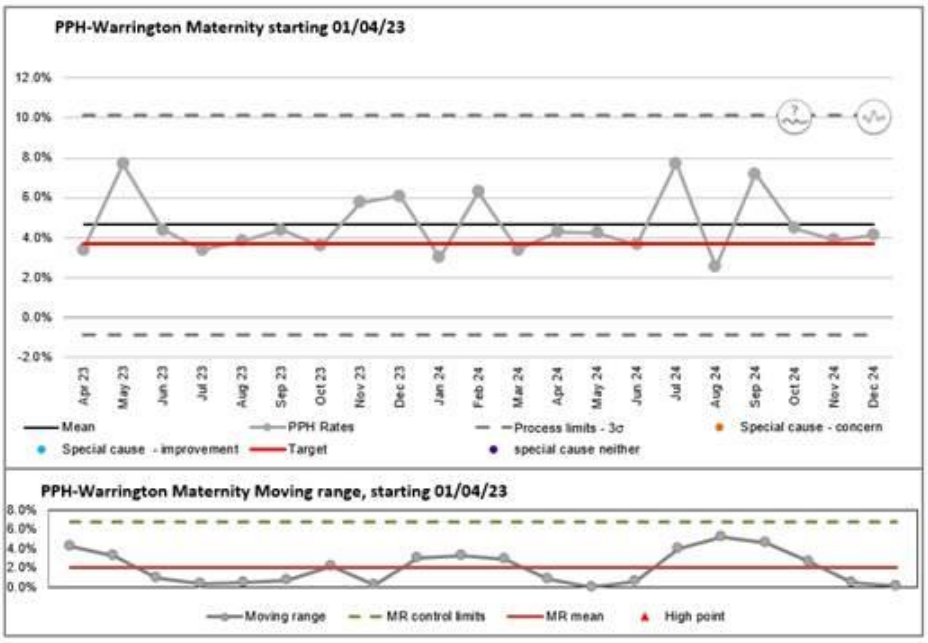


11 term babies were admitted to the neonatal unit (NNU). All cases of term admission are reviewed via ATAIN which reports quarterly to QAC.

7 postnatal readmissions were reported in November 2024. This is an ongoing reduction from both August and September when there were 11 readmissions and October when there were 8 in month.

There were 16 cases of PPH 1000ml-1500ml and 8 cases of PPH ≥1500mls in November 2024. The PPH audit is underway and will report to QAC in February 2024.

The SPC chart for PPH ≥1500mls continues to show common cause variation, but with stability over the last 3 months.



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 November compliance for mandatory training across maternity and child health colleagues is 89.01% for Trust mandatory training (including safeguarding training), 87.21% 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 has improved significantly from 77.33% in October (excluding those with a long term absence) to 86.01% at the end of November. Work will continue to ensure we continue to improve against this metric.

Compliance with maternity specific training standards is being sustained.

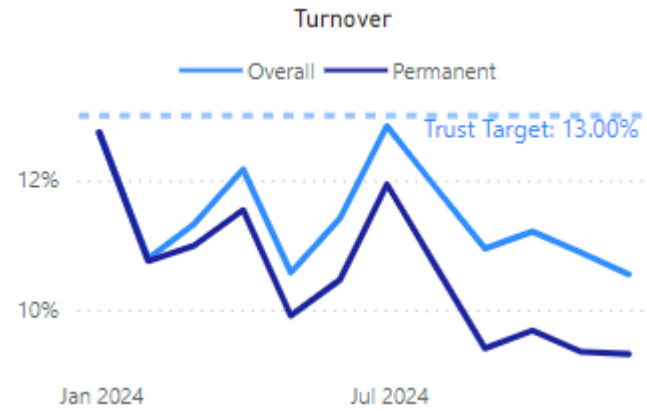
Current position – Training compliance - maternity specific

	PROMPT (MDT skills training)	MAMU 2 (Fetal surveillance)	K2 (fetal surveillance competencies)#	Newborn Life Support Level 2	MAMU 3* (new from January 2024)
Midwives	98.4%	93.1%	95.1%	95.4%	85.8%
Obstetric Consultants	100%	100%	91.6%	n/a	n/a
Other Obstetric	100%	100%	100%	n/a	n/a
Obs Anaesthetic	96.2%	n/a		n/a	n/a
Maternity Support Workers	96.5%	n/a		n/a	74%
Neonatal medical and ANNP	n/a	n/a	n/a	94.4%	n/a

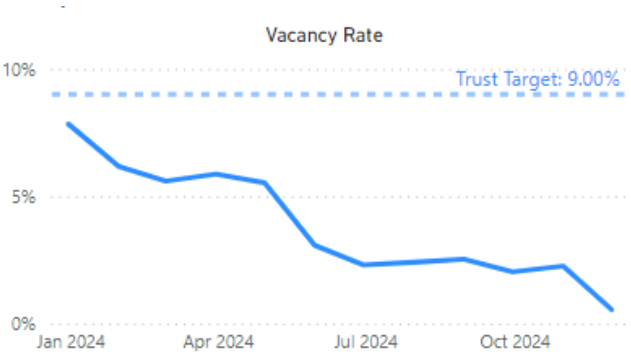
*New training implemented wef 1/2/2024 as part of reorganisation of wider training programme – trajectory on track

Turnover for maternity and child health staff (permanent staff) in November is 9.35% and is below the Trust target. Turnover has remained below the Trust target of 13% since December 2023.

This is illustrated in the graph below:



The vacancy rate for maternity and child health staff remains positive, from a peak of 17.23% in September 2022 to 0.55% in November 2024, significantly below the Trust target. This is illustrated in the graph below:



4. SERVICE USER FEEDBACK

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.
- 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 way.

Feedback from families received directly into the service is included in appendix one for information.

5. STAFF FEEDBACK

The series of ideas events with clinical teams is ongoing. These are due to be completed by mid-February 2025.

To date five sessions have been held, exploring the following areas which were identified in the SCORE survey and subsequent cultural conversations as part of the maternity and neonatal services involvement in the NHSE perinatal and cultural leadership programme (PCLP)

- Focus on kindness through building relationships, trust and understanding each other's roles, responsibilities and pressures which will also support shared decision making.
- Increase collaboration through improved teamwork across teams and specialisms.
- Increase communication to gather ideas, help staff rise to the challenge, deal with change and foster inter role relationships questions the feedback will be collated and next steps shared.

Staff who have attended the sessions have been positive and solution focussed albeit acknowledging the ongoing work the service needs to do to further improve workplace culture particularly in relation to improving relationships between clinical areas. Actions identified as part of the sessions are being incorporated into the PCLP action plan.

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 November 2024 539 triage attendances were recorded on the BadgerNet patient record system.

Triage attendances Dec 23 - Nov 24		
Month	Attendances	Ave per day
December	499	16.1
January	573	18.5
February	553	19.1
March	526	17.0
April	576	19.2
May	590	19.0
June	567	18.9
July	582	18.8
August	618	19.9
September	556	18.5
October	545	17.5
November	539	17.9

- 18.2% of attendees were seen immediately on arrival.
- The longest wait recorded for initial review was 39 minutes.
- 93% of attenders were seen within 15 minutes of arrival (best practice guidance). This is beyond the KPI of 90% review within 15 minutes.
- 99.3% 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.
- 1.8 of attendees were categorised as red on arrival. Nine were seen within ten minutes, one within 20 minutes. Appropriate ongoing care was provided in all cases.
- 18.5% of attendees were categorised orange on arrival.

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

7. INDUCTION OF LABOUR (IOL)

November data from the LMNS (provided below) highlights WHH continues to perform less well with regard to timeliness of IOL activity when compared to other local providers:

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

	COC	LWH	MCHT	MWL S&O	MWL Whiston	WHH	WUTH	Grand Total
Total number undergoing Induction of Labour	38	110	55	35	93	95	73	499
Total Delayed	2	25	4	1	19	37	15	103
% of Total	5.26%	22.73%	7.27%	2.86%	20.43%	38.95%	20.55%	20.64%

A review of data quality is underway to confirm WHH is reporting in the same way as other providers. Improvement work to improve IOL pathways has also commenced. A task and finish group is in place and a lead midwife to support the workstream has been identified. 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.

8. MNSI POSITION AND REPORTS RECEIVED

1.1 Background

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

Current position

Year to date 2024, MNSI have accepted six cases for investigation. Progress as at 31/12/2024 is as follows:

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

On receipt of the final report from MNSI, reports and associated actions are presented to the Trust Safety Oversight meeting (SOM). Once this has taken place, reports and

learning are cascaded within the maternity team. With effect from October 2024 reports are also shared with QAC and Trust Board as part of this paper to ensure discussions regarding safety intelligence are taking place in line with the Maternity Incentive Scheme Safety action 9.

8.3 Reports received

No reports were receved in December 2024.

9. UPDATE ON OTHER WORKSTREAMS

9.1 Continuity of Carer

Continuity of Carer (CoC) data is extrapolated from Badgernet monthly and shared with the LMNS.

Measures include:

- % of women at 29 weeks gestation on a CoC pathway
- %percentage of Black, Asian or Mixed Ethnicity (BME) women at 29 weeks gestation on a CoC pathway
- % of women in bottom decile of deprivation at 29 weeks gestation on a CoC pathway.

The percentage of women receiving continuity at 29 weeks gestation has ranged from 48.7%-52.2% in Q3 2024-25, this is consistent with data since April 2023 when community services were streamlined and the number of continuity teams reduced from seven to four to support safe staffing in inpatient areas.

The other outcome measures vary dependant on the population of women at 29 weeks gestation in each given month; for BME women 50-70% received CoC in Q3 2024-25. Work is underway to assess whether adjusting the catchment area for one of the existing CoC teams would improve this.

For women in the bottom decile, women allocated to a CoC team increased to 54.4% for December 2024. This is an increase from 17%-30% in previous months. This figure would be 66% if out of area women were not included in the dataset. This improvement has been achieved following a thorough review of caseloads and moving team boundaries, to ensure areas of deprivation are covered by a CoC team.

Measures are also in place to ensure vulnerable groups, who do not formally receive CoC, are fully supported along the pregnancy continuum. This includes high quality antenatal and postnatal team case-holding; the work of the three enhanced maternity support workers and capitalising on the ‘baby shower’ events held in Halton, which provide a drop-in for infant feeding and smoking cessation support alongside an opportunity to meet the WHH homebirth team and community midwives.

In addition, Team River is an enhanced continuity team which will casehold women who are considered to be particularly vulnerable. This includes women experiencing teenage pregnancy, women with mental health problems, women with level three safeguarding, bereaved women, women affected by substance misuse, women for whom English is not their first language and women who are seeking asylum.

It remains difficult to balance intrapartum continuity of carer with safe inpatient staffing, alongside retention of community staff. Currently, community staff can either work in a traditional model, continuity model or birth availability model. Community midwives in continuity teams remain unwilling to adopt a birth availability model of working. If imposed, the senior leadership team are concerned this will lead to attrition of staff and increased vacancy.

The maternity matron for antenatal and postantal care has explored the feasibility of Team Ocean, Team River and Team Clover providing a member of staff for every Birth Suite shift, however, this would result in more than 8 members of staff in each continuity team and is not in line with guidance from ‘Better Births’. Conversations continue to explore how to best utilise existing intrapartum shifts to support intrapartum continuity.

9.2 Diabetes in pregnancy – quarterly update

In June 2024 learning from a cluster review of all cases investigated via the PMRT process where maternal diabetes was identified as a contributory factor in the outcome. An improvement piece of work was instigated to respond to the themes identified.

Care pathways for those women with diabetes in pregnancy is currently supported via an MDT team of obstetric, medical, AHP, nursing and midwifery colleagues.

A diabetes in pregnancy working group also meets monthly and has developed an action plan to improve the service.

Work continues to offer in a group setting to provide quicker access to blood sugar self-monitoring in Antenatal Day Unit. The working group is exploring the possibility of the Specialist Midwife - Diabetes leading on a weekly review of all women who are managing their diabetes via diet and self-monitoring their blood sugars. This would be in liaison with the dietician. Women who have abnormal results and require medication would be referred to the diabetic nurse team. Work is also underway to continues to improve and streamline referral pathways for diabetic pregnant women admitted to a non-maternity setting.

The group has seen a great improvement in pre-existing diabetic women being referred to the Diabetic Nurse Team following the booking appointment. To further support this, from 2025, the diabetic nurse team will support the MDT PROMPT training for midwives and obstetricians. As part of this, the updated programme will include recognition and management of DKA/complications of diabetes.

It is anticipated the regional guideline for the management of gestational diabetes in pregnancy will be ratified in quarter four 2024/25. This will further inform pathways and processes at WHH. In the interim, work is ongoing via the Specialist Midwife - Diabetes to develop improved patient information leaflets for gestational and pre-existing diabetic women. This will include information in relation to their specific care pathways, i.e. members of the team, schedule of appointments, links to diabetes UK resources, when to contact maternity triage, dietary advice, etc.

Plans are also underway to offer a separate clinic for women with pre-existing diabetes from those who are diagnosed with diabetes during pregnancy. This is a recommendation within the Saving Babies Lives Care Bundle.

There have been no further cases identified via the PMRT/MNSI processes where maternal diabetes was identified as a contributory factor since those presented in June 2024. A further update of progress with this workstream will be provided to QAC in April 2025.

10. COMPLAINTS

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

Specialty	Description	Complaint Opened
Maternity	Unhappy with care and treatment during labour	18/11/2024
Maternity	Unhappy with treatment during birth	27/11/2024
Maternity	Communication and concerns with suturing	27/11/2024

The other complaints received related to care within the gynaecology service.

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 one – feedback from families

“I wanted to share some positive feedback from a few of my families….

These women all had different births but commonly expressed the same positive experience thanks to midwife CL, stating how kind, caring and attentive she was. How she listened to what they needed, she communicated her recommendations for their care, and they felt in control, informed, and involved in their own care and informed maternal choices. They expressed how funny and personal she was with them which relaxed them in such a stressful, emotional, and personal time of their lives. They all wanted to express how thankful they were for having CL as part of their birth/labour care.” – shared by continuity midwife.

“Just wanted to share with you some feedback I had from three women over the weekend when visiting them in the community postnatally. Each one of them and their partners were absolutely thrilled with the care they received last week in every department they had contact with - triage, birth suite and C23. (Midwives MSW's and students were all mentioned)

They each did not have a bad word to say about their time with us and were delighted with their care.

Two of them were on induction suite for a few days and although a frustrating wait. they said the team of midwives made the whole experience much better. One lady had a PPH and blood transfusion and although her experience was felt to be traumatic, she said everyone was so calm and reassuring.

There were too many names to mention between the three women but just wanted to share the positive feedback - we may feel that we are "just doing our job" but to lots of women we are making such a difference.” – shared by continuity midwife.

“I just wanted to share some positive feedback from a lady who I completed a birth reflection with last week – the woman had experienced a 4th degree tear and is now 11 months postnatal, but she couldn't praise you enough. Both the woman and her partner felt that they were listened to, they felt safe in your care, they remembered that pain relief was discussed in detail and they didn't feel pressured about their decision making, they witnessed handover of care to be of a very high standard between professionals when shifts ended and also really appreciated how all members of staff involved with their care addressed them using first names this made their care feel very personal.” shared by Specialist Midwife – Pelvic Health

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/01/151 Appendix 3b**			
SUBJECT:	**December Maternity Incentive Scheme Year 6 Update**			
DATE OF MEETING:	5 February 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:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
				✓
	Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles of CNST and the Maternity Incentive Scheme (MIS) is to ensure safer care for this cohort. Achieving the principles of MIS will have a positive impact on this group.			
EXECUTIVE SUMMARY *(KEY ISSUES):*	NHS Resolution's (NHSR) Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety			

	Actions which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025. NHSR is now operating Year six of the Clinical Negligence Scheme for Trusts (CNST) MIS following publication of guidance on 2 April 2024. Conditions of eligibility for payment under the Scheme are set out in the guidance. 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. At that time feedback from the LMNS confirmed 90% compliance overall for the 6 elements. Current data suggests three out of the six elements are 100% compliant. Following the review meeting further evidence will be uploaded which will improve overall compliance with SBLCBv3 further. The LMNS were positive re the Trust's position. The reporting period for MIS Year 6 is to 30th November 2024. The Local Maternity and Neonatal System (LMNS) are completing their review of all MIS evidence to date. Once this is complete, the LMNS will confirm their level of assurance. A timetable to ensure internal WHH assurance processes have been completed against all MIS year 6 safety actions prior to submitting the Board declaration form has been developed. A completed Board declaration form must be submitted to NHSR by 12 noon on 3 March 2025.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the content of this paper		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/24/12/200ii**	
	Date of meeting	10 December 2024	

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

REPORT TO TRUST BOARD

SUBJECT	December Maternity Incentive Scheme Year 6 Update	AGENDA REF:	BM/25/01/151 Appendix 3b

1. BACKGROUND/CONTEXT

NHS Resolution has now commenced year six of the Clinical Negligence Scheme for Trusts (CNST) MIS to continue to support the delivery of safer maternity care by implementing 10 safety standards. Specifications and timelines were released on 2 April 2024. Trusts are required to complete their Board declaration form and submit to NHS Resolution by 12 noon on 3 March 2025.

Trusts that can demonstrate all 10 safety standards will recover 10% of their CNST contribution and receive a share of unallocated funds.

2. CURRENT POSITION

2.1 Overall position

Successful achievement of all 10 Safety Actions for MIS Year 5 was published on 10 April 2024 and circulated to all providers of maternity services.

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

2.2 Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the SBLCBv.3.

Progress against SBLCBv.3 continues to be reviewed and monitored by LMNS on a quarterly basis. The latest review of SBLCBv3 took place on 4 December 2024. As part of that review, the LMNS confirmed 90% compliance overall for the 6 elements.

Following the review meeting further evidence will be uploaded which will improve overall compliance with SBLCBv3 further. The LMNS were positive regards the progress made and the Trust's overall compliance position.

There are three elements where full compliance has not been achieved:

- Element 1: Smoking in pregnancy (90% compliant)
- Element 2: Fetal growth restriction (80% compliant)
- Element 5: Preterm birth (93% compliant)

The latest position in relation to these three elements is as follows: -

Element 1: Smoking in pregnancy – 90% compliant (9/10 interventions fully implemented).

- Intervention 1.3 - Smoking status at 36/40 weeks
  - Required compliance 85%. Achieved 75% in October. BadgerNet system updated to include as a mandatory field. November audit findings note 96.6% compliance - will meet the standard.

Element 2: Fetal Growth restriction – 80% compliant (16/20 interventions fully implemented).

- Intervention 2.7: Uterine artery doppler scans
  - Required compliance 95%. Audit standard achieved, LMNS require confirmation of the gestation at which the scans were undertaken. This will be provided and uploaded following the next review on 4th December and will meet the standard.

- Intervention 2.17: Risk assessment and management of growth disorders in multiple pregnancy
  - LMNS require a more detailed audit demonstrating compliance with NICE guidelines. This has been undertaken and will be uploaded following the next review and will meet the standard.

- Intervention 2.18: Percentage of babies <3rd centile born >37+6
  - Required compliance <50%. GAP report demonstrates 56.5%. Local cases reviewed for October where high incidence was noted. Care was appropriate in all cases and there was not opportunity for identification or birth before. This is monitored on a monthly basis through local reporting and is also reported quarterly through GAP reports.

- Intervention 2.19: Percentage of babies <3rd centile born >37+6
  - Required compliance <10%. GAP report demonstrates 10.3%. Local data is monitored on a monthly basis through local reporting and is also reported quarterly through GAP reports.

Element 5: Preterm birth – 93% compliant (25/27 interventions full implemented)

- Intervention 5.6: Risk assessment and management of growth disorders in multiple pregnancy
  - LMNS require a more detailed audit demonstrating compliance with NICE guidelines. This is the same as intervention 2.17 and has been undertaken and will be uploaded following the next review. This will meet the standard.

- Intervention 5.9: Percentage of symptomatic women for preterm birth that are assessed using quantitative fetal fibronectin measurement (qfFN).
  - LMNS have noted qfFN no longer available and requesting further update to include actions relating to manual audits. Clarification required from LMNS in relation to audit standards for assessment. This will be discussed at the next quarterly review meeting.

Following the review meeting, the service has five days to upload further evidence at which point the LMNS will reassess the evidence and adjust compliance accordingly. This will be shared with the Trust by the end of December 2024. An updated position with regard to compliance with SBLCBv3 will be provided to January QAC.

3. MONITORING/REPORTING ROUTES

Progress with the remaining aspect of MIS Year 5 (SBLCBv3), and MIS Year 6 is shared and discussed at CBU Governance meetings. The content of this report was shared at Women's Health Governance in December 2024.

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. The LMNS are undertaking their review of the evidence to date. Once this is complete, the LMNS will confirm their level of assurance.

A timetable to ensure internal WHH assurance processes have been completed against all safety actions prior to submitting the Board declaration form has been developed. These key internal review dates are detailed in appendix one.

4. RECOMMENDATIONS

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

Appendix one - WHH MIS Year 6 assurance process

WHH internal assurance timetable

Date	Action	Name
8th January 2025 (latest)	Review with Chief Nurse / Deputy Chief Executive	Ali Kennah/Dan Moore
8th January 2025 (latest)	Review and sign off with Chief Executive	Nikhil Khashu
14 Jan 2025	Presentation to Quality Assurance Committee	Ailsa Gaskill-Jones
5th Feb 2025	Present MIS Evidence and presentation to Trust Board	Ailsa Gaskill-Jones
5th Feb 2025	Final sign off by Chief Executive (Board Notification Form)	Nikhil Khashu

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/01/151 Appendix 3b**	
SUBJECT:	**January 2025 Maternity Incentive Scheme Year 6 Update**	
DATE OF MEETING:	5 February 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. 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.

	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. 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.

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

Further Information: The paper relates to care of pregnant people/those on the pregnancy continuum. The principles 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. The Local Maternity and Neonatal System (LMNS) have completed their review of all MIS evidence to date. The service is awaiting the formal outcome of that review but verbal feedback to date has been positive. A timetable to ensure internal WHH assurance processes have been completed against all MIS year 6 safety actions prior to submitting the Board declaration form has been developed. A completed Board declaration form must be submitted to NHSR by 12 noon on 3 March 2025.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the content of this report.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee	
	Agenda Ref.	**QAC/25/01/223i**	
	Date of meeting	14 January 2025	
	Summary of Outcome		
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

REPORT TO TRUST BOARD

SUBJECT	January 2025 Maternity Incentive Scheme Year 6 Update	AGENDA REF:	BM/25/01/151 Appendix 3b

1. BACKGROUND/CONTEXT

NHS Resolution has now commenced year six of the Clinical Negligence Scheme for Trusts (CNST) MIS to continue to support the delivery of safer maternity care by implementing 10 safety standards. Specifications and timelines were released on 2 April 2024. Trusts are required to complete their Board declaration form and submit to NHS Resolution by 12 noon on 3 March 2025.

Trusts that can demonstrate all 10 safety standards will recover 10% of their CNST contribution and receive a share of unallocated funds.

2. CURRENT ELEMENTS

2.1 Overall position

Successful achievement of all 10 Safety Actions for MIS Year 5 was published on 10 April 2024 and circulated to all providers of maternity services.

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

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. To date formal written feedback has not been received from the LMNS however verbal confirmation has been received that the LMNS have relevant evidence to provide them with assurance regarding the WHH position in relation to MIS year 6

2.2 Safety Action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the SBLCBv.3.

Progress against SBLCBv.3 continues to be reviewed and monitored by LMNS on a quarterly basis. The latest review of SBLCBv3 took place on 4 December 2024. As part of that review, the LMNS has confirmed full compliance for the 6 elements.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	40%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	25%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Not implemented	0%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Not implemented	0%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Partially implemented	4%	Fully implemented	100%	CNST Met
Element 6	Diabetes	Not implemented	0%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	14%	Fully implemented	100%	CNST Met

This is excellent news and testament to the hard work across the Maternity and Neonatal team.

Work will remain ongoing to sustain and monitor progress across all SBLCBv3 workstreams. A further quarterly review with the LMNS will take place in March 2025.

3. NEXT STEPS

Following further guidance from the LMNS, the timetable to ensure internal WHH assurance processes have been completed against all safety actions prior to submitting the Board declaration form has been updated. These key internal review dates are detailed in appendix one.

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 January 2025.

5. RECOMMENDATIONS

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

Appendix one - WHH MIS Year 6 assurance process

WHH internal assurance timetable - amended

Date	Action	Name
31st January 2025 (latest)	Review with Chief Nurse / Deputy Chief Executive	Ali Kennah/Dan Moore
31st January 2025 (latest)	Review and sign off with Chief Executive	Nikhil Khashu
5th Feb 2025	Present MIS Evidence and presentation to Trust Board (LMNS rep present)	Ailsa Gaskill-Jones
5th Feb 2025	Final sign off by Chief Executive (Board Notification Form)	Nikhil Khashu
12 noon 3rd March 2025 (latest)	Board declaration form submitted to NHS Resolution	Ailsa Gaskill-Jones

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/01/151 Appendix 4**	
SUBJECT:	**2024-2025 Quarter 2 Avoiding Term Admission into Neonatal Unit (ATAIN) Report**	
DATE OF MEETING:	5 February 2025	
AUTHOR(S):	Ailsa 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:***	

	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 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	✓		
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			✓
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.			

<table>
<tr><td>EXECUTIVE SUMMARY
(KEY ISSUES):</td><td colspan="3">Q2 2024/25 ATAIN rate (Avoiding Term Admission into Neonatal Unit) is 6.6%, which is above both the national and NWNODN targets of 6% and 5.6% respectively and is a decrease of 0.24% on the last quarter.
WHH is the only Trust which reports babies that have been admitted to NNU for under six hours; in Q2 WHH had 7 babies who were admitted to NNU for less than six hours. If these babies were also excluded from the ATAIN admissions the total number of term admissions as a % of live births would be 5.6%.
From Q3, admissions <6 hours will be excluded from the WHH data submission, to align more evenly with other trusts in the region.
All term admissions in Q2 were reviewed and learning from these cases informs the ATAIN action plan.
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.</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 rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Quality Assurance Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">QAC/24/11/200i</td></tr>
<tr><td>Date of meeting</td><td colspan="2">10 December 2024</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">None</td></tr>
</table>

REPORT TO TRUST BOARD

SUBJECT	2024/2025 Quarter 2 Avoiding Term Admission into Neonatal Unit (ATAIN)	AGENDA REF:	BM/25/01/151 Appendix 4

1. BACKGROUND/CONTEXT

NHS Resolution is operating a sixth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) to continue to support the delivery of safer maternity care.

The ATAIN objective is to reduce the number of unexpected term admission of infants ≥37+0 weeks gestation to the neonatal unit (NNU). The national ambition is to ensure that term admission rates are below 6% of live births. North West Neonatal Operational Delivery Network (NWNODN) has set a separate target of 5.6% for term admissions to neonatal units. This initiative is to keep mothers and babies together as much as possible and avoids separating them at the crucial time after birth.

This paper describes the current position of Warrington and Halton Teaching Hospital (WHH) against Safety Action 3 of MIS Year 6 which relates to Avoiding Term Admissions into Neonatal Units (ATAIN) Programme. More specifically MIS Year 6 specify the ATAIN action plan should be shared with Trust Board, Local Maternity and Neonatal System (LMNS), and Integrated Care System (ICS) quality surveillance meetings.

2. KEY ELEMENTS

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 Q2 reporting period from 1st July 2024 to 30th September 2024.

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

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

2.2 Summary of unexpected term admissions to NNU

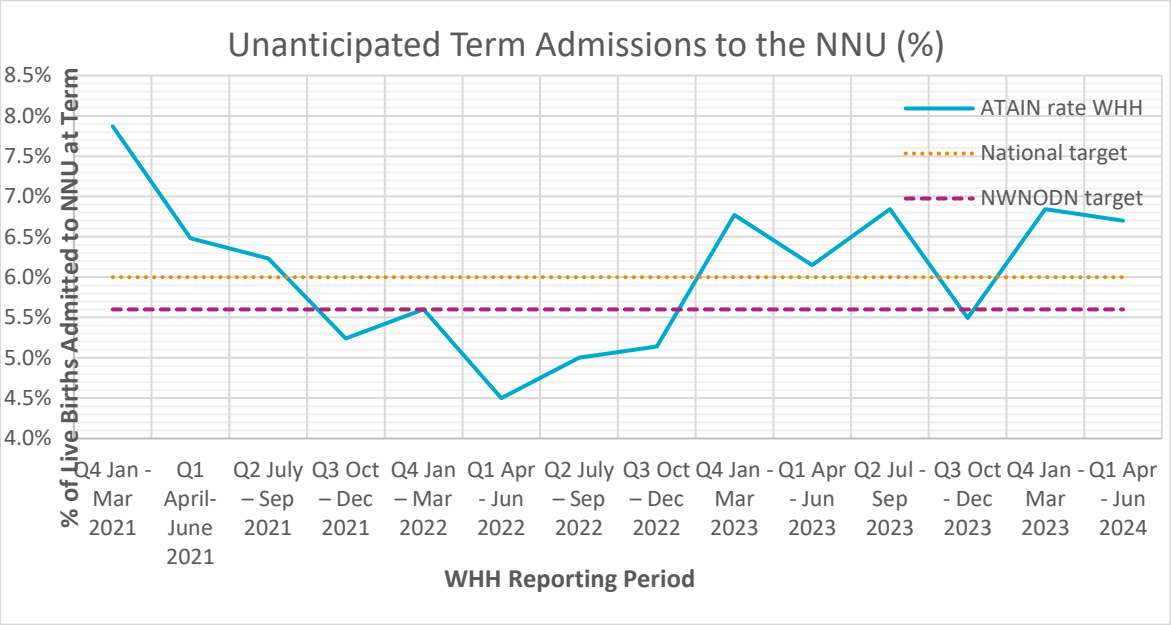
The Q2 ATAIN Rate was 6.6% which is higher than the national and NWNODN targets but with a decrease of 0.24% on the last quarter.

However, as per the previous report, other trusts are excluding neonatal unit admissions of less than six hours duration from ATAIN data. In Q2, WHH has identified seven babies who were admitted to NNU for less than six hours. If these babies were also excluded from the ATAIN admissions the total number of term admissions as a percentage of live births would **be 5.6%, which** is within national and NWNODN targets.

It is anticipated that the Q3 report will bring WHH data in line with other trusts' data as we will be differentiating between <6 hour and >6 hour admissions formally. However, we will continue to review all term admissions of any duration to identify any learning. Of the 45 term admissions, two did not require review as part of the ATAIN process as the babies were well and admitted for social reasons. If these two admissions were not included, this would reduce the ATAIN rate for Q2 to 6.32%.

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%
Q3 Oct – Dec 2023	619	34	5.49%			
Q4 Jan – Mar 2024	586	41	6.99%			
Q1 Apr – Jun 2024	612	42	6.86%	5.8%		
Q2 Jul – Sept 2024	680	45	6.62%	5.6%		

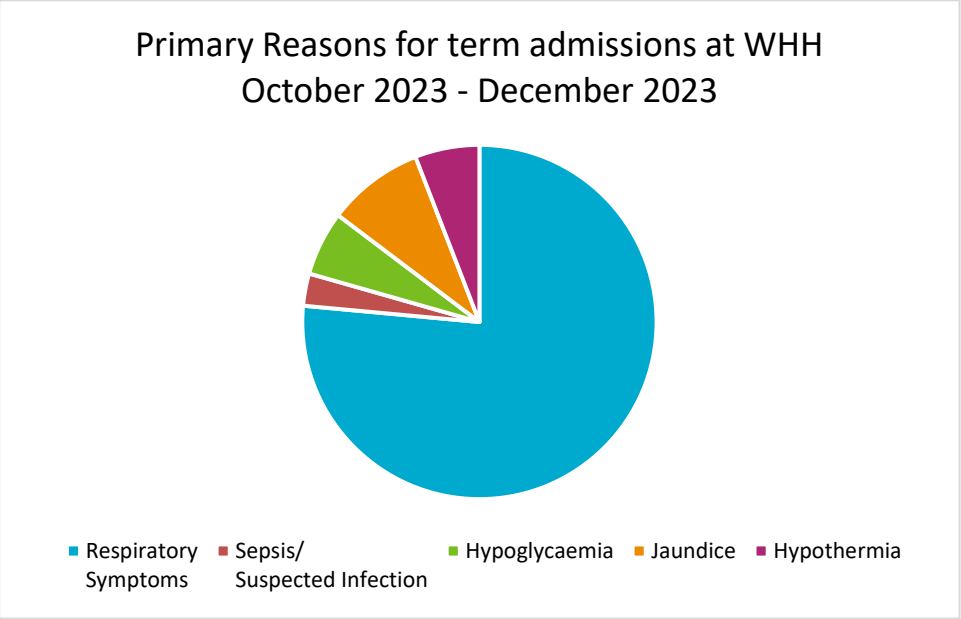
Below is a summary of unanticipated term admissions to Neonatal Unit from July 2022 – September 2024.



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

WHH Number Live Births 2022-2023		Term Admissions		Respiratory Symptoms		Sepsis/ Suspected Infection		Hypoglycaemia		Jaundice		Hypothermia	
		Number	% Live births	No of babies	% Term admissions	No of babies	% Term admission	No of babies	% Term admissions	No of babies	% Term admission	No of babies	% Term admissions
Q3 Oct-Dec 2023	619	34	5.49%	17	50%	0	0%	3	8.8%	2	5.9 %	2	5.9%
Q4 Jan-Mar 2024	586	41	6.99%	23	56%	1	2.4 %	3	7.3%	3	7.3	1	2.4%
Q1 Apr-June 2024	612	42	6.86%	29	69%	2	4.7 %	2	4.7%	1	2.4 %	0	0%
Q2 Jul-Sept 2024	680	45	6.62%	26	58%	1	2.2 %	2	4.4%	3	6.7 %	2	4.4%

The below table details primary reasons for term admissions to NNU at WHH:



58% (26) of term admissions were respiratory-related, i.e. required admission or additional observations due to signs of respiratory distress which includes grunting and low oxygen saturation (SATs or oxygen requirement). Only 9 of these cases were deemed avoidable if care had been optimal.

2.4 Themes and Learning: Outcomes of ATAIN review

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%

Reasons for categorising term admissions as avoidable included:

- PEEP for 30 minutes may have avoided admission.
- Care could have been provided on Transitional Care
- Baby's low temperature could have been avoided.

2.4.1 Good Practice:

- 30 minutes of peep project is ongoing and proving to be effective.
- Good recognition of potential sepsis in mother and baby

2.4.2 Learning Points/Themes/Actions:

- MDT CTG workshops to recommence twice weekly.
- Update of thermoregulation guideline to be completed
- Cord gas syringes and FSE clips have been changed on birth suite to enable more accurate cord gas results and CTG monitoring.
- Ongoing additional training underway in Lunar team and for midwives providing care in low-risk care setting.
- Consideration being given to deteriorating baby simulation training.

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

2.4.3 Recommendations:

- Continuation of targeted support for staff as required from cases requiring individualised learning.
- Continue regular ATAIN meetings including the introduction of resident doctors to the ATAIN meeting to discuss cases and actions/progress with involvement from the wider team.
- Shared learning from ATAIN to continue to be disseminated to all midwifery, paediatric, neonatal, and obstetric staff.
- Regular review of ATAIN actions to ensure timely completion.
- Senior midwifery review of all babies to be facilitated on Birth Suite and C23 in order to support early identification of deteriorating babies to allow actions to prevent admission.

3. MONITORING/REPORTING ROUTES

The ATAIN action plan is monitored at the Women's and Children's Clinical Business Unit Governance Meeting monthly, prior to reporting to the Quality Assurance Committee.

4. RECOMMENDATIONS

Members of the Trust Board are requested to receive and discuss the findings of this paper for information as per Safety Action 3 of MIS Year 6 recommendations.

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	QI project to give 30 min PEEP in theatre prior to admission to NNU to reduce admission rate	Neonatal CD, ANNPs	Complete	Completed	QI Project of 30 min of peep is now embedded into practice, and other units are asking for our guideline on this to emulate	
5	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	
6	Alternative cord gas syringes to be procured to support with the ongoing issues around obtaining cord gases. Cord gas QI project to be commenced.	Birth Suite Manager & Maternity Theatre Co-ordinator	Complete	Completed	New syringes obtained and in use – will continue to monitor whether paired samples are achieved successfully	

7	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	Ongoing	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	

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

<table>
<tr><td>AGENDA REFERENCE:</td><td colspan="3">BM/25/01/151 Appendix 5</td></tr>
<tr><td>SUBJECT:</td><td colspan="3">Quarter 2 2024/25 Transitional Care (TC) Report</td></tr>
<tr><td>DATE OF MEETING:</td><td colspan="3">5 February 2025</td></tr>
<tr><td>AUTHOR(S):</td><td colspan="3">Ailsa Gaskill-Jones – Director of Midwifery</td></tr>
<tr><td>EXECUTIVE DIRECTOR SPONSOR:</td><td colspan="3">Ali Kennah, Chief Nurse</td></tr>
<tr><td>LINK TO STRATEGIC OBJECTIVE:

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

(Please DELETE as appropriate)</td><td colspan="3"></td></tr>
<tr><td>LINK TO PUBLIC SECTOR EQUALITY DUTIES</td><td colspan="3">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: 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.</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>
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<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>
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<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 July - September 2024.
An audit of babies who received TC within Q2. 2024/25 has been undertaken and results of this will be described within this paper along with any identified learning.

Key points to note:

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 Q2 Transitional Care audit has identified the following:
24 babies who met the broad admission criteria for TC in Q2.
No babies were admitted direct to TC from birth.
Two babies were suitable to receive TC from birth, but 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, this baby was admitted to NNU as Mother wished to be discharged home at day 8.
The majority of babies who met the broad TC criteria in Q2 required some level of respiratory support and were initially provided with care via NNU.
The audit has identified significant learning, and a robust action plan has been developed.
The action plan is monitored via Women’s & Children’s Governance (WCH) and the Neonatal Oversight meeting.
A quality improvement project continues in order to further enhance our transitional care offering, which will reduce term admissions and separation of mothers and babies.

</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">Choose an item.</td></tr>
<tr><td></td><td>Agenda Ref.</td><td colspan="2">QAC/24/12/200iii</td></tr>
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	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 2 2024-25 Transitional Care (TC) Report	AGENDA REF:	BM/25/01/151 Appendix 5

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 Q2 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 Q2 reporting period from 1st July 2024 to 30th September 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 Q2, 24 babies met the criteria for TC. An audit of these cases has identified the following:

Admitted direct to TC	0
Appropriately received NNU care and stepped down to TC when well enough	5
Allocated to PEEP for 30 pathway	5
Term baby requiring feeding support	2
Did not received TC	12

Of the 24 babies who met the criteria in Q2, one baby initially stayed with their mother from birth however this baby had a worsening respiratory acidosis which required admission to NNU. Two babies were suitable to receive TC from birth however NNU were unable to staff TC due to high acuity and acute staff sickness.

One term baby who initially stayed with their mother received TC for poor feeding, this baby was admitted to NNU as Mother wished to be discharged home ON day 8.

One baby was receiving enhanced care however required admission to NNU due to hypothermia. Baby was discharge from NNU to TC for feeding support and temperature control.

One baby of 35+6 gestation did not receive TC care as was not identified as meeting the criteria and therefore received normal midwifery care. No harm was caused, and learning has been shared.

The other 21 babies who met the broad TC criteria in Q2 required some level of respiratory support and were initially provided with care via NNU. Of these:

- Five babies were appropriately stepped down to TC when clinically indicated. As part of the audit an improvement was seen in relation to the timely step down of these babies.
- Eleven babies did not meet TC criteria once medically fit for discharge from NNU. However, it is possible two of these babies could have stepped down sooner therefore remaining within TC criteria.
- Five followed the PEEP for 30 pathway. 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
2	Staffing	Review staffing
3	Length of stay	Estate work to improve area for families receiving TC

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.
- NNU Matron continues to deliver training at MAMU (Maternity Mandatory Updates).
- Review of Enhanced Care criteria completed, disseminated to all staff and displayed in all areas.
- Revisited and redesigned the TC Audit. This is now lead by the NNU Matron. Audit information is reported to QAC.

2.4 Recommendations:

- Time to be given to the midwifery lead for TC to complete the TC training programme.
- NNU team to consider stepping babies down sooner to utilise TC.
- 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.

2.6 Additional audit of babies ≥ 34 weeks gestation to 36+6 weeks gestation

In addition to the overarching TC audit, a specific review of preterm infants admitted to the neonatal unit has been completed by the Specialist Midwife - Preterm Birth to ascertain if their care could have been provided by TC.

This audit has shown, no eligible babies for TC were admitted to the NNU unnecessarily. All babies admitted required neonatal admission, i.e. respiratory support, bilirubin level above the transfusion line. The audit also noted neonates admitted to the neonatal unit were stepped down appropriately to TC in a timely manner.

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 5b 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 discuss the findings of this paper.

Warrington and Halton Teaching Hospitals
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Transitional Care

Background and November 2024 Update

Samantha Nichols- Maternity Matron

Background

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- 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.

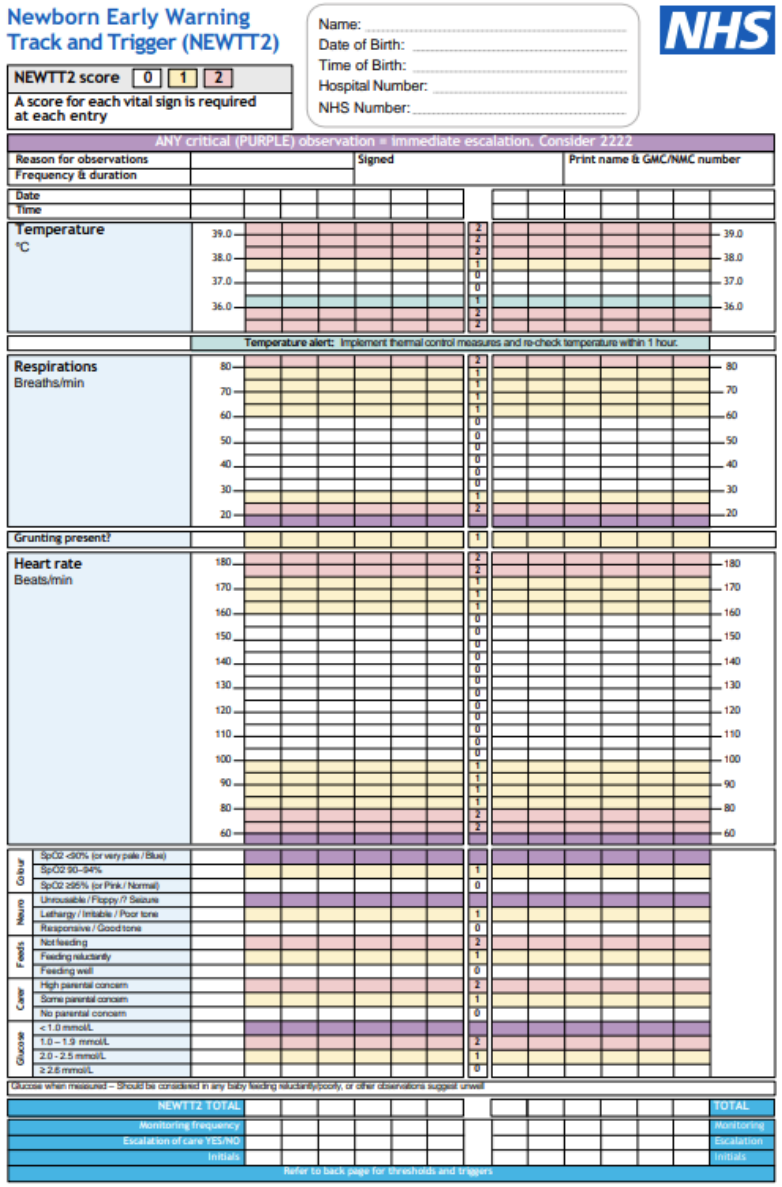
- Following the CQC inspection of Maternity Services at WHH in September 2023, a review of the current transitional care model has taken place, from this a working group was created and a robust action plan developed.

TC Position November 2024

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- ✓Working group continue to meet monthly with representatives from both Maternity and Neonatal Services
- ✓TC registered as a QI project
- ✓Action plan updated monthly to monitor progress
- ✓The Transitional Care Action Plan is monitored via WCH Governance and the Neonatal Oversight Group
- ✓Transitional Care of the Newborn Guideline is live on the Intranet- for review December 2025. Inclusion criteria is based on BAPM guidelines and includes:
    - ✓Babies ≥ 1.6kg (It is to be expected that all babies weighing < 1600 g will be admitted initially to a NNU for observation of feeding and temperature control)
    - ✓Gestation ≥ 34 weeks
    - ✓NG tube feeds
    - ✓Requires IV antibiotics with other risk factors identified
    - ✓Frequent SBR with other risk factors
    - ✓Babies on 4 hourly or more frequent scoring regime for withdrawal. Scores >6 or increasing trend in scores on withdrawal observation chart

November 2024 Update: NEWTT2



Newborn Early Warning Track and Trigger (NEWTT2)

Name:
Date of Birth:
Time of Birth:
Hospital Number:
NHS Number:

NEWTT2 score 0 1 2

A score for each vital sign is required at each entry

ANY critical (PURPLE) observation = immediate escalation. Consider 2222

Reason for observations
Frequency & duration
Signed
Print name & GMC/NMC number

Date
Time

Temperature °C
39.0
38.0
37.0
36.0

Temperature alert: Implement thermal control measures and re-check temperature within 1 hour.

Respirations Breaths/min
80
70
60
50
40
30
20

Grunting present?

Heart rate Beats/min
180
170
160
150
140
130
120
110
100
90
80
60

Colour
SpO2 <90% (or very pale / Blue)
SpO2 90–94%
SpO2 ≥95% (or Pink / Normal)

Neuro
Unrousable / Floppy / ? Seizure
Lethargy / Irritable / Poor tone
Responsive / Good tone

Feeds
Not feeding
Feeding reluctantly
Feeding well

Carer
High parental concern
Some parental concern
No parental concern

Glucose
< 1.0 mmol/L
1.0 – 1.9 mmol/L
2.0 - 2.5 mmol/L
≥ 2.6 mmol/L

Glucose when measured – Should be considered in any baby feeding reluctantly/poorly, or other observations suggest unwell

NEWTT2 TOTAL
TOTAL
Monitoring frequency
Monitoring
Escalation of care YES/NO
Escalation
Initials
Initials

Refer to back page for thresholds and triggers

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- ✓ NEWTT2 is a track and trigger system that aligns current recommendations for newborn care and has acknowledged feedback from healthcare professionals.
- ✓ The chart encompasses parental concern to acknowledge the importance of the opinion of the family in addition to the wider multi-disciplinary team. The inclusion of parental concern supports concerns highlighted and recommendations made in recent national maternity investigations.
- ✓ Includes oxygen saturations. Aims to identify deterioration early and to increase frequency of observation/ offer early interventions which may prevent admission to the NNU and supports the TC model
- ✓ Local Task and Finish group created for the launch of the National NEWTT2 tool.
- ✓ National breakthrough event attended in September 2024 and further event planned November 2024.
- ✓ Awaiting national guidance and direction of EPR systems to be able to launch tool. Currently, digital providers advised to await National Team. Digital providers advised not to revert to paper documentation to launch tool earlier.
- ✓ National roll out planned for March 2025
- ✓ Ongoing discussion with neonatal team to assess feasibility of all babies receiving saturation monitoring (pre and post ductal) within 1 hour of birth.

November 2024 Update: Workforce and Estate

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Workforce:

- ✓Staffing model reviewed. Neonatal staff are allocated to provide care for TC babies. If neonatal staff are unable to remain on Ward C23, hourly rounding is completed.

- ✓Initial staffing review completed to provide dedicated TC team. Would require significant financial investment.

- ✓Audit suggests current staffing model provides adequate staffing to match activity. Continually review. Datix system utilised to monitor occasions where TC care unavailable due to neonatal staffing.

Estate:

- ✓ TC Bay on Ward C23- completion planned as part of wider development plans for C23

November 2024 Update: Audit

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

TC Audit Results Q1

- 15 babies met the TC criteria in Q1, only one baby was admitted straight to TC from birth due to the other babies requiring respiratory support.
- The other 14 babies who met the broad TC criteria in Q1 required some level of respiratory support and were initially provided with care via NNU.

Of these:

- One baby was not suitable for TC due to safeguarding concerns and the baby requiring genetic investigations.
- Ten babies were appropriately stepped down to TC when clinically indicated. As part of the audit an improvement was seen in relation to the timely step down of these babies.
- Three followed the PEEP for 30 pathway (to be discussed)

TC Audit Quarter 2 findings to be presented to QAC December 2024

November 2024 Update: ATAIN and Transitional Care

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- Term admissions to the neonatal unit are monitored via ATAIN. Neonatal and obstetric leads meet bi-monthly with the theatre, birth suite, NEST and C23 managers to review the clinical care of the mother and neonate. Aim is to ascertain if admission was avoidable or unavoidable and identify any emerging safety actions.

- As part of the ATAIN review, consideration is given to if babies admitted to the neonatal unit could have been cared for in a TC setting.

- For Quarter Four (January 2024-March 2024), there were 41 babies admitted to the neonatal unit. Of these babies, 8 could have been cared for in a TC setting (20%). It was identified that babies were being admitted for observations, screening, thermoregulation and bloods that could have been facilitated by TC.

- In February 2024, a TC lead band 6 lead was appointed and education was provided to midwives on birth suite and C23.

- Following this, for Quarter One, there were 33 babies term babies admitted to the neonatal unit. Of these babies, 2 could have been cared for in a TC setting (6%).
    - One baby could have received NAS observations in TC
    - One baby admitted to NNU for a septic screen

November 2024 Update: Babies ≥ 34 weeks Gestation to 36+6 weeks Gestation

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

- ✓ Review of preterm infants admitted to the neonatal unit completed by the Specialist Preterm Birth Midwife to ascertain if care could have been provided by TC.
- ✓ No eligible babies for TC were admitted to the neonatal unnecessarily. All babies admitted required neonatal admission, i.e. respiratory support, bilirubin level above the transfusion line
- ✓ Identified neonates admitted to the neonatal unit were stepped down appropriately to transitional care in a timely manner
- ✓ Audit identified that documentation on maternal BadgerNet system often did not include reason for admission to neonatal unit. Information could be found in neonatal hospital record (paper record)
- ✓ Neonatal BadgerNet system is outdated. Neonatal documentation relies on paper records. Neonatal and maternal BadgerNet system not compatible. Risk added to the risk register

November 2024 Update: Transformation Project

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

PEEP for 30 minutes

- ✓For babies born showing signs of respiratory distress. Babies receive 30 minutes of PEEP to support with transition to extrauterine life. Aim to prevent admission to the neonatal unit and reduce separation of mothers and babies
- ✓Transformation Project
- ✓6 months data now collected and being analysed
- ✓50 babies have been enrolled in PEEP for 30 in Quarter 2. 25 have been successful- (50%) success rate. This is down previously from a 62% success rate- however, reporting is lower, which may explain the reduced success.
- ✓Most success with rapid commencement of 30 minutes of PEEP
- ✓Least successful following instrumental delivery and delays in recognition of respiratory distress
- ✓PEEP for 30 is the 'Topic of the Month' for November on NNU and the project lead will be focusing on the project with medical colleagues in December to fall in line with the next doctor rotation.

November 2024 Update: Good Practice

Warrington and Halton Teaching Hospitals NHS Foundation Trust

- Improvement seen in the early recognition of babies who can step down to TC
- Two Infant Feeding chairs for Transitional Care provided by Halton Local Authority
- 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.
- NNU Matron continues to deliver training at MAMU (Maternity Mandatory Updates).
- Band 6 TC Midwifery champion in place, attending TC training and attends working group (protected time each month).
- Review of Enhanced Care criteria completed, disseminated to all staff and displayed in all areas.
- Revisited and redesigned the TC Audit. This is now lead by the NNU Matron. Audit information is reported to QAC.
- “Think TC” Boards in each clinical area – to remind staff of TC admission criteria. Includes updates re progress with TC project.
- Infant Feeding Specialist Midwife now based on C23 to ensure optimum nutrition for babies receiving TC care. Collaborative working with Infant Feeding Champion on the NNU.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/02/152**			
SUBJECT:	**Communications and Engagement Update – Q3 2024-25**			
DATE OF MEETING:	5 February 2025			
AUTHOR(S):	Alison Aspinall, Head of Communications and Engagement			
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications & Engagement			
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (***Please DELETE as appropriate)***	All			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes** ✓	**No**	**N/A**
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes** ✓	**No**	***N/A***
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes** ✓	**No**	**N/A**
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	This report updates on communications and engagement activity during quarter 3 of 2024-25. It incorporates the quarterly reporting on the Working with People and Communities Strategy and elements of the previous Communications and Engagement Dashboard into one report. The report consists of: • Overview of Q3 communications and engagement activity from October 2024 to December 2024 • Updates on Experts by Experience activity and involvement • Key communications campaigns and highlights from Q3			

	• Working with People and Communities Strategy Q3 2024-25 update Details of the current plan of upcoming engagement events which the Trust is hosting or planning to attend during 2025		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the contents of this update on Communications and Engagement activity during the quarter.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Choose an item.	
	Agenda Ref.		
	Date of meeting		
	Summary of Outcome	To note	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	None		

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TRUST BOARD
5 February 2025

Communications and Engagement Update QUARTER 3 2024-25 (October to December 2024)

Kate Henry, Director of Communications and Engagement

Working Together | Excellence | Inclusive | Kind | Embracing Change

Our role within WHH

The Communications and Engagement Team remit covers:

- Communications and Engagement Strategy development
- Communications planning and evaluation to support strategic projects
- Internal communications including content production for The Week and Team Brief
- External communications including media relations and stakeholder updates
- Digital communications including content development for the Trust's corporate social media channels and updates to the website
- Identity, branding and design
- Engagement in our communities
- Experts by Experience programme
- Processing and review of clinical patient information

During the Q3 period (October to December 2024) the Communications and Engagement Team…

- processed and allocated **62** communications 'job requests' for design, film, photography and communications campaign support
- issued **10** media releases
- Prepared / issued **6** media statements
- handled **9** enquiries from local, regional and national print and broadcast media
- Issued **1** 'Charity editorial'
- Processed **10** new patient information leaflets, reviewed **7** and identified **51** leaflets due for review in the quarter (which are currently being followed up with authors)

Q3 activity and achievements overview

- Launched the redeveloped website for Warrington, Halton, St Helens and Knowsley Breast Screening Service in December 2024
- Supported Baby Loss Awareness Week communications and messaging, including the Butterfly Lantern Walk and Wave of Light Remembrance Service
- Supported development of a combined ‘Good morning message’ across BCH and WHH from joint Chief Executive Nikhil Khashu
- Delivered a refreshed Team Brief, now held monthly for staff across both BCH and WHH at 3pm and 9pm via MS Teams
- Provided communications support for the 2024 governor elections including a morning message, social media, website promotion and distributing a media release
- Supported public participation within the Trust’s annual Equality Delivery System (EDS) / equality review engagement events
- Supported the MaDE for Christmas campaign with internal and external communications to raise awareness of how families and carers can help WHH plan for their loved ones to be home for Christmas
- Launched screen savers on WHH PCs and laptops to provide an additional communications channel



Details of other communications and engagement activity is included in the highlights section of this update.

Media

The Trust issued 10 media releases during Q3 including:



WHH's Dementia Team awarded for outstanding care
Read the release



Announcement of joint chief executive arrangements
Read the release



WHH named in top 10 Trusts in national maternity survey
Read the release



Family raise money for Warrington Hospital's Neonatal Unit following safe delivery of premature triplets
Read the release

We also facilitated a Chief Executive interview, discussing the need for a new hospital, published as an extended front page report in the Warrington Guardian on 24 December 2024 read the article.

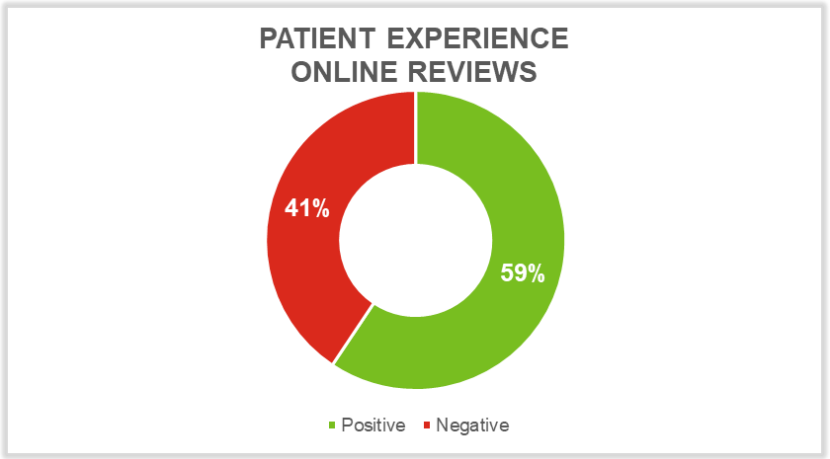
All media releases / news items can be viewed on our website.

Engagement, involvement and insight

During Q3 (October to December 2024) we recruited 4 Experts by Experience (EbyEs)

We received requests for engagement support for the following projects:

- Virtual Living Well Hub
- Scam / debt support to address health inequalities
- Health inequalities focus group
- Norovirus trial recruitment for over 60s
- Breast Screening Service website redevelopment (see slide 12)
- Care journey mapping from admission to discharge



A total of 64 online reviews from patients rating their WHH experience were published in Q3.

Sources of data:

- NHS Choices
- Google reviews
- I want great care

Experts by Experience (EbyE) projects

Project Name	Overview	No of EbyEs requested	Outcomes
Virtual Living Well Hub	Request for involvement in system design workshops and survey to develop a virtual hub (to replace My Life Warrington)	24	• 21 survey responses • 6 EbyEs recruited to join workshops and ongoing development work
Scam / debt support to address health inequalities	Request for involvement regarding experience of debt / scams, to support wider health inequalities approaches	4	• 4 EbyEs recruited to join workstream • Feedback shared with project lead (Director of Population Health and Inequalities)
Health inequalities focus group	Request for involvement in health inequalities Task and Finish Group	1	• 1 EbyE recruited to take part in questionnaire group and workstream
Norovirus trial recruitment for over 60s	Request for involvement in norovirus investigational vaccine trial with Halton Clinical Research Unit	Unspecified	• Unspecified

Experts by Experience projects (continued)

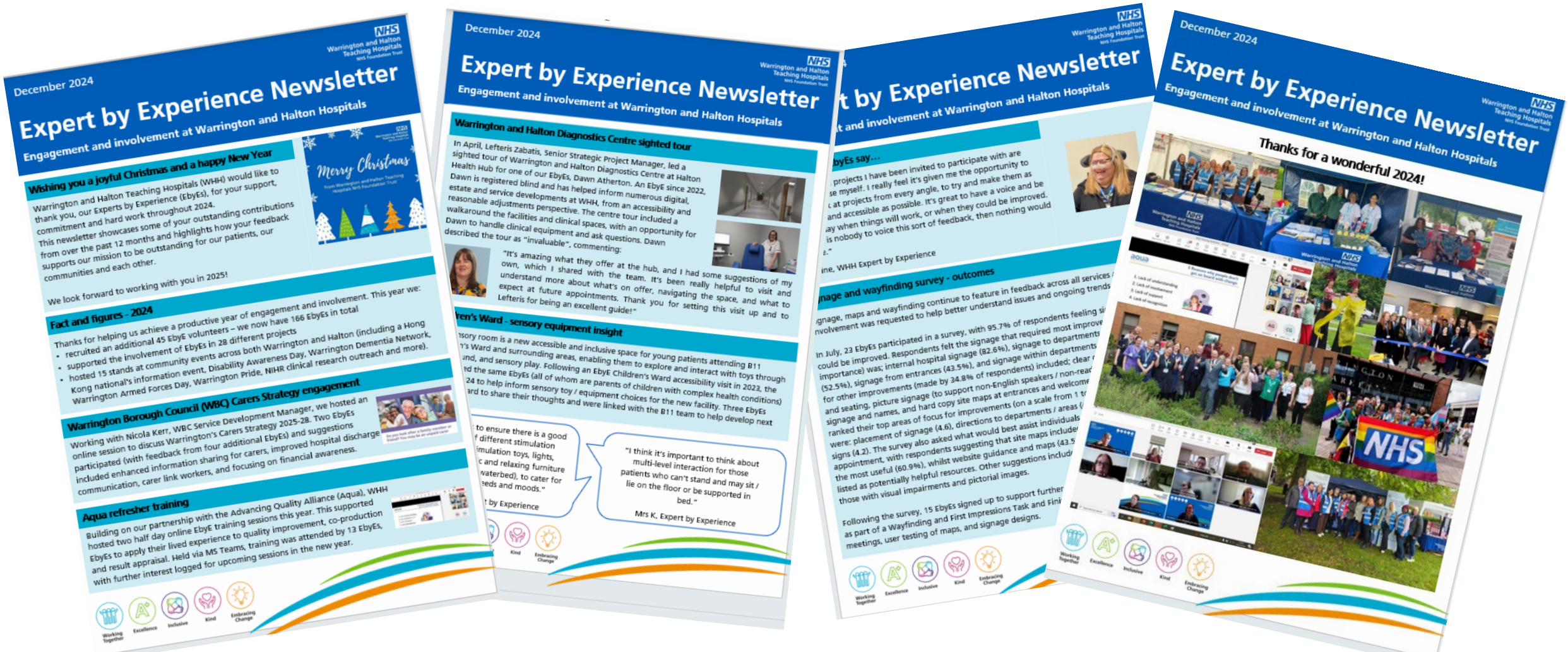
Project Name	Overview	No of EbyEs requested	Outcomes
Breast Screening Service website (see slide 9)	Request for involvement in website issues, design, formatting and testing	11	• 5 EbyEs participated in online showcase • 11 EbyEs participated in user testing tasks
Care journey mapping from admission to discharge	Request for interview participation, undertaken by Healthwatch Halton	6	• 6 EbyEs participated in care journey mapping experience interviews • Feedback shared with project leads (Clinical Lead for AHPs and Transformation Programme Lead, Bridgewater Community Healthcare)

Local / national campaigns shared with EbyEs: 3

- Children's oral health campaign and survey (Healthwatch Warrington)
- Improving hospital gynaecology and maternity services in Liverpool (NHS Cheshire and Merseyside)
- Digital drop-in sessions (Warrington Voluntary Action and Warrington Borough Council)

EbyE newsletter

Our annual EbyE newsletter, issued in December 2024, showcases the outstanding contributions throughout 2024 and highlights how EbyE feedback supports our mission to be outstanding for our patients, our communities and each other.



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Key campaigns / highlights from Q3

Better Care Together

We continue to work with our counterparts at Bridgewater Community Healthcare and have developed a number of joint channels to support the integration programme.

These include:

- Shared staff microsite – launched in October 2024 to WHH and BCH colleagues, with 2,338 visits to the landing page so far, providing access to:
  - background on the case for change
  - updates on programme workstreams
  - news stories – eight published in Q3
  - frequently asked questions
- Good morning message now distributed to WHH and BCH staff three times per week
- Joint Team Brief – broadcast to WHH and BCH staff at 3pm and 9pm each month
- Better Care Together information published on both Trust's websites with a feedback mechanism for patients and public



Better Care Together

Home · Community · Hospital

Financial recovery

Communications support provided throughout Q3 to update staff on ongoing financial pressures.

Key messages and principles shared across all internal channels (e.g. Good morning messages, Team Brief, The Week) including:

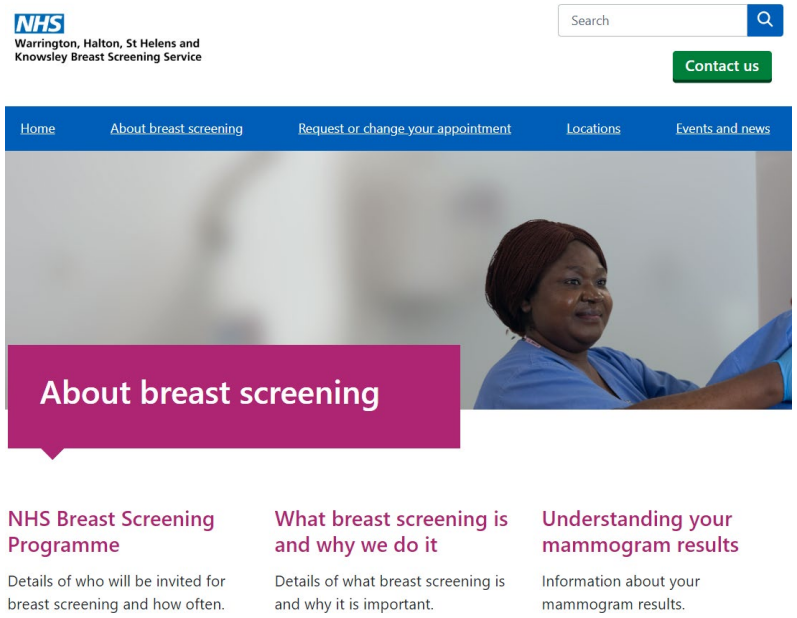
- highlighting our current financial position and expected end of year deficit – why it matters to all of us
- NHSE mandated support – what it is, what it means for the Trust, and what actions we need to take
- recruiting to vacant posts – additional scrutiny introduced on vacancies and reviewing use of bank, agency and overtime
- encouraging staff to suggest other ways to reduce costs and be more efficient, while ensuring the quality of our services for our patients remains our priority
- promoting staff drop-in sessions – held in person at both Warrington and Halton sites, and on MS Teams – with members of the Executive Team for staff to ask questions and discuss ways to work together to further improve our financial position

Breast Screening Service

Website redevelopment engagement

Involvement stages (with Experts by Experience unless otherwise stated):

- Website redevelopment survey (Jan 2024)
- Online website redevelopment session (Nov 2024)
- Website draft structure showcase sessions (Nov 2024)
- Equality and Health Inequalities Impact Assessment (EHIA) completed (Nov 2024)
- Accessible form testing (Dec 2024)
- User testing tasks with EbyEs, governors and external stakeholders (Dec 2024)
- Website updated with user testing feedback (Dec 2024)
- **Website launched 19 December 2024** with a feedback form to gather further feedback from users



Initial feedback on the website

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"Well done to all involved in the project – the website looks detailed and very comprehensive."

"I thought the tabs at the top were clear, and I could get to the desired page quickly."

"It was very easy to read / understand, and links went straight through."

"The site looks great and very helpful. Thank you for sharing this great info!"

"The links to specific areas were clear and made searching easy."

"The website is both accessible and useable."

Feedback on the new website can be provided at:
https://www.whsthkbss.nhs.uk/events-and-news/news/tell-us-what-you-think-of-our-new-website/

WHH Charity

Social media highlights:
Increased number of posts and paid ads boosted views and interactions, raising charity awareness.

- **Facebook:**
  - 325,000 views (26% organic, 74% ads), up 2,081% from Q2
  - 6,434 interactions, up 125% from Q2
- **Instagram:**
  - 23,000 views (69% organic, 31% ads), up 256% from Q2
  - 1,400 interactions, up 97% from Q2







Editorials:

1. WHH Charity crafters support patients and families.
2. Family fundraises for Neonatal Unit after triplets' safe delivery.
3. Free meals introduced for parents of children in care.

Newsletters:
Three newsletters published - view them here.

Sacred Heart Primary School Videos:
WHH Charity collaborated with Sacred Heart Primary in Warrington to create three videos. Sixteen students showcased the charity's mission, impact, and partnership with the school. Filming took place across multiple locations including the school and Warrington Hospital's Children's Ward.
Visit the YouTube channel to view videos

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Working with People and Communities Strategy
Q3 update

Pillar 1: Co-production in Service Change/ Development

Recruit, train, deploy, maintain, recognise and reward patients and public who are 'Experts by Experience' to specific estate and service change programmes

1. Grow Experts by Experience (EbyE) capacity to embed Co-production in service design within WHH	• 41 Experts by Experience recruited during 24/25 (4 in Q3). • 169 Experts by Experience total (cumulatively to date). • Continuing to work with WHH colleagues to identify opportunities to involve EbyEs from the outset of projects (#StartwithPeople).	• Ongoing
2. Support EbyE recruitment and retention	• 13 EbyE Projects delivered in 24/25 (plus 4 extended projects – Breast Screening Services website redevelopment, PEP, Trust website redevelopment and virtual Living Well Hub). • 46 EbyEs participating in Q3 projects.	• Ongoing
3. Enhance our programme for involvement	• Annual involvement timetable for awareness days and events informs engagement plan – dependent on team availability (see slide 21). • Ongoing discussions with Estates and Strategy teams to ensure substantial strategic, capital or service developments have EbyE involvement / representation.	• Ongoing
4. Undertake consultation and engagement to enable effective support for services	• Inclusion of EbyE engagement from beginning of significant projects e.g. Breast Screening Services website redevelopment, has continued. • Ongoing EbyE participation to be included in Q4 projects including Better Care Together workstreams for clinical and operational services integration	• Ongoing
5. Ensure representation to support Place-Based integrated care delivery	• Use our resources to support wider place-based initiatives and to access insight from our communities and advocacy / equality groups. • Better Care Together continues to be supported in partnership with Bridgewater colleagues, with a survey seeking views on options for a name to reflect our partnership (to be shared in Q4.)	• Ongoing

Pillar 2: Accessible Information Standard (AIS)

Launch WHH AIS policy to support those with sensory impairments, learning disabilities and non-English speakers to access our services and participate equally in their care

1. Patient Letters	• Working with Patient Experience team to ensure accessibility functionality in the PEP is maximised ahead of launching the 5 Rights campaign. • Work continues on tendering for a new Electronic Patient Record (EPR) system to succeed the current system, Lorenzo. Functionality to support accessible information and communication needs will be key to this development.	• 2025-26
2. Ensure website compliance with Web Content Accessibility Guidelines (WCAG) standards	• The new Trust website has improved significantly in accessibility by complying with WCAG 2.2. From initially being rated 'Good' at 64% compliant for accessibility and placed 210th place in the NHS (September 2024) to being rated 'Great' at 84% compliant for accessibility and in 85th place in the NHS (December 2024) Source: Silktide index. • Warrington, Halton, St Helens and Knowsley Breast Screening Service redeveloped website launched 9 December 2024, based on the Trust website accessibility approach.	• Ongoing
3. Accessible content creation	• Working with the Patient Experience Team to launch the 5 Rights campaign, to promote the AIS to support patient's rights, including refreshing an animation aimed at educating staff on their AIS responsibilities.	• Ongoing
5. Patient Information	• The updated Production of Patient Information Policy has been ratified and is now being utilised within the Trust. • Awaiting completion of digital system changes to launch Communications Passport – see update on EPR above.	• Ongoing
7. Signage/Wayfinding	• Delivered via Wayfinding and First Impressions Task and Finish Group.	• Ongoing

Pillar 3: Reducing Health Inequalities

Using WHH engagement and understanding health inequalities to geographical areas of Warrington North, Warrington South, Widnes and Runcorn

1. Strengthen WHH engagement programme	• Work ongoing with collective WHH teams (Patient Experience and Inclusion, Workforce EDI / Culture and Inclusion, Membership and Governance, Children / Young People, Dementia, Staff Health and Wellbeing team, charity, volunteers, chaplaincy, catering/estates, ward/service reps) to set/link events calendars and activities for 2025/26. • Planning an updated events plan and schedule in partnership with Bridgewater Community Healthcare for 2025/26.	• Ongoing
2. Provide opportunities for governors to engage in their communities	• Promotion and encouragement of governor event engagement opportunities i.e. speaking with visitors about the constituencies they represent, showcasing their roles, sharing info, collecting details of visitors interested in becoming a WHH Foundation Trust Member. Events undertaken in Q3 were: ✓ WHH Annual Members' Meeting ✓ EDS / Annual Equality Review engagement sessions x 3	• Ongoing
3. Support Place Based activity and other key local events	• Ongoing promotion of Warrington Living Well Hub via WHH social media.	• Ongoing

Pillar 4: Anchor Institution/Building Social Value

Use Trust estate and resources in partnership with others for the benefit of the wider community

1. Establish WHH's position as an anchor institution in our communities	• Use WHH communication channels to increase engagement with the voluntary and third sector and raise awareness of key campaigns, health improvement and economic wellbeing initiatives. • Ongoing sharing of '350 Careers, One NHS, Your Future' booklet and online link to information.	• Ongoing
2. Promote opportunities for work, training or volunteering	• Promote WHH as a great place to work, train or volunteer in order to enhance the aspirations and life chances of local people. • Level of engagement with social media and websites. • Promoted recruitment events including a Clinical careers day (Halton) in October 24, with a Healthcare Support worker event (Warrington) and Surgical nursing career day (Warrington) held in November 24.	• Ongoing
3. To utilise local suppliers and venues	• Use local suppliers and venues to support engagement and involvement programmes, where possible.	• Ongoing
4. Support the work of the WHH Charity	• Cherry Tree Courtyard hub – continued initial discussions with People Directorate to ensure this facility is accessible and available to support patient / community engagement where appropriate. • Continue work with the charity team to facilitate charity presence at public engagement and involvement events. WHH Charity activity and fundraising shared bi-monthly at the combined Patient Experience Sub Committee and Patient Equality, Diversity and Inclusion Sub-Committee (PE&ISC). • Charity stakeholder newsletters shared monthly.	• Ongoing

Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Upcoming engagement events

Upcoming engagement events: 2025

Date	Event	Time	Venue	Event purpose
20 May 2025	WHH International Clinical Trials Day	10am to 2pm	Main entrance, Warrington Hospital and George Lloyd Restaurant, Halton Hospital	Trust-led, annual event promoting the accomplishments of clinical research professionals in public health/medicine and their efforts in clinical trials.
14 June 2025	Warrington Pride	TBC	Warrington town centre / Golden Square	Annual partnership event celebrating the LGBTQIA+ community in the town.
28 June 2025	Warrington Armed Forces Day	10am to 6pm	Crosfields Rugby Club, 131 Hood Lane North, Great Sankey, Warrington, WA5 1XU	Annual partnership event comprised of Armed Forces Rugby League games, military vehicle displays, stands and activities.
13 July 2025	Disability Awareness Day	10pm to 4pm	Walton Hall and Gardens, Higher Walton, Warrington, WA4 6SN	Annual family fun day and pan-disability event led by Warrington Disability Partnership.
Sept 2025	Warrington Mela	TBC	Queen's Gardens, Palmyra Square, Warrington, WA1 1JN	Annual open event supporting cultural diversity and community inclusion within the town.
Oct 2025	Annual Members' Meeting	TBC	Post Grad Centre, Warrington	Annual Trust membership event, bringing together Foundation Trust Members, Governors, Directors and the Chair.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/02/153**			
SUBJECT:	Bi-monthly Strategy Highlight Report			
DATE OF MEETING:	5 February 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:***			
	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 Living Well Hub in Warrington has seen over 9,300 visitors attend since the doors opened in mid-March 2024. Around 50% of these attendances have been people "dropping in" to the hub to access a service, and the remainder have been for pre-booked appointments. The Hub now has its own social media account to help raise the profile and share information about new and existing services with the local population. • Over 68,000 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 new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) is now live and work has also commenced to implement a new gynaecology bleeding pathway utilising the new CDC spaces. • Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital Trust. An options appraisal for the legal mechanism of integration is ongoing with outcome expected to be presented to WHH and Bridgewater Boards in early February. All workstreams are progressing with previously agreed priorities and detailed delivery plans are in development. • The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly. Referrals to the Same Day Emergency Care (SDEC) unit have increased and are consistently above target (currently over 1,100 attendances per month). ED attendances are down by 3% compared to the same period last year. Although the Emergency department remains extremely busy, and patients are still being nursed on the corridor, the time spent there has reduced significantly.		
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
November-December 2024

NHS
Warrington and Halton Teaching Hospitals
NHS Foundation Trust

Section 1 - Key messages			
Slide 2	Summary of key developments this reporting period		
Section 2 - Stakeholder engagement			
Slide 3-4	Summary of key stakeholders engaged during the reporting period		
Section 3 - Key strategic projects			
Page	**Project**	**Strategy Lead**	**Status**
Slide 5-6	WHH/BCH Integration programme	Stephen Bennett	
Slide 7-8	Runcorn town deal	Carl Mackie/Viviane Risk	
Slide 9-10	Community diagnostic centre	Lefteris Zabatis/Stephen Bennett	
Slide 11-12	New hospitals programme and strategic estates	Carl Mackie/Viviane Risk	
Slide 13-14	Warrington Living Well Virtual Health & Wellbeing Hub	Rachel Moran/Stephen Bennett	
Slide 15	Completed projects	Strategy team	
Section 4 - Other trust strategic updates			
Slide 16-17	Summary of other Trust strategy related updates		
Section 5 - Place-based strategic updates			
Slide 18	Summary of strategic updates from local places (Warrington and Halton)		
Section 6 - Cheshire and Merseyside strategic updates			
Slide 19	Summary of strategic updates from Cheshire and Merseyside		

Key messages

- The Living Well Hub in Warrington has seen over 9,300 visitors attend since the doors opened in mid-March 2024. Around 50% of these attendances have been people “dropping in” to the hub to access a service, and the remainder have been for pre-booked appointments. The Hub now has its own social media account to help raise the profile and share information about new and existing services with the local population.

- Over 68,000 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 new pathway for paediatric respiratory diagnosis in CDC Phase 2 (Runcorn Shopping City) is now live and work has also commenced to implement a new gynaecology bleeding pathway utilising the new CDC spaces.

- Work continues with the integration programme between Bridgewater Community Healthcare Trust and Warrington and Halton Hospital Trust. An options appraisal for the legal mechanism of integration is ongoing with outcome expected to be presented to WHH and Bridgewater Boards in early February. All workstreams are progressing with previously agreed priorities and detailed delivery plans are in development.

- The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly. Referrals to the Same Day Emergency Care (SDEC) unit have increased and are consistently above target (currently over 1,100 attendances per month). ED attendances are down by 3% compared to the same period last year. Although the Emergency department remains extremely busy, and patients are still being nursed on the corridor, the time spent there has reduced significantly.

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Fiona Watson Ian Baddeley	Public Health, Halton	Potential to develop a virtual health and wellbeing hub for Halton
Naz Ghodrati	CEO, Warrington Voluntary Action	Warrington Virtual Hub, UEC Steering group
Ian Triplow	CDC Programme Director, Cheshire & Merseyside	Community Diagnostic Centre
Damian Nolan	Director Commissioning and Provision, Adult Social Care, Halton Borough Council	Urgent and Emergency Care System Improvement
Caroline Williams	Director of Adult Social Services, Warrington Borough Council	Living Well programme and Virtual Hub, Urgent and Emergency Care System Improvement
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 integration options appraisal
Rob Cooper	CEO, Mersey and West Lancashire Teaching Hospitals	Pathology Collaboration
Sally McGrail	Adult Social Care Lead, Warrington Borough Council	Supporting CQC assessment of WBC adult social care services as a key partner
Debbie Watson	Director of Public Health, Warrington Borough Council	Staying Well Programme Board and Living Well Hub site visit
Adam McClure	Senior Programme Manager, Cheshire and Merseyside Diagnostic Programme	Regional Pathology Collaboration
Kevin McLachlan and MWL colleagues	Pathology Manager	MWL and Regional Pathology Collaboration
Sangeetha Steevart And colleagues	Clinical director Warrington Place	Warrington Clinical Care Advisory Group

Stakeholder and engagement overview

Key stakeholder engagement in period	Job title, organisation	Topic/Nature of engagement
Tony Leo	Place Director, Halton	Place development
Carl Marsh	Place Director, Warrington	Place development
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
Asia Bibi Alfie Bass Dani Jones Adam Bateman	Alder Hey Children's Hospital	Paediatric surgical hub at Halton
Phillip Lawrence	Senior Respiratory Clinical Scientist, Alder Hey Children's NHS Foundation Trust	Paediatric respiratory diagnosis pathway
Paul Marsh	Regional Health Sector Lead, Kier Construction | North and Scotland	New Hospitals Programme and Strategic Estates
Chris Woodforde	GP- Halton	CYP CDC Respiratory diagnosis pathway
Paul Tyerman Lee Matthews Laurence Pullan Tom Kearney Rachel Cartwright	Warrington Borough Council	Living well virtual Hub
Sarah Hall MP Steven Broomhead Stephen Young	MP Warrington South CEO, Warrington Borough Council CEO, Halton Borough Counicl	New hospitals. Healthcare estate. Integration.
Linda Buckley	Managing Director, CMAST	CMAST. C&M strategy
Key partner stakeholders, including ICB, Local Authorities, elected members voluntary sector and GPs	GPs, WBC, HBC, Naz Ghodrati, ICB	Better care together integration programme.
Trust Board members and Councils of Governors BCH and WHH	Trust Board members and Councils of Governors BCH and WHH	Better care together integration 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.

What does this mean for WHH?

Over the coming months, we will be working to finalise governance arrangements, introduce a shared executive team, and make progress in delivering improved pathways for our patients. Together, we will develop new and improved ways of working, starting first with services identified as an urgent priority. Subject to all necessary approvals, we hope to become a single organisation as soon as possible.

Progress:

- Agreed Nikhil Khashu will be Chief Executive for both Trusts, commenced 1st November
- Drafted and approved high level summary case for change
- Established workstreams and SROs, with 6, 12 and 24 month priorities
- Programme governance arrangements in place
- Held joint board sessions
- Sought advice from partners and networks who have undertaken integration recently
- Obtained initial advice on options for legal mechanisms to bring organisations together
- Reviewed model health care data to inform potential financial benefits
- Issued joint media statement and internal communications
- Established joint vacancy review process
- Developed initial quality, performance and financial benefits
- Developed and agreed workforce principles and single EIA process
- Developed and approved initial milestone plan
- Signed data sharing agreement
- Approved risk/gain share agreement
- Held first clinical and operational services workshop to identify where services can align to deliver benefits
- Programme branding approved and in use
- Frequently asked questions agreed and added to internal microsite
- Workstreams developing delivery plans
- Communications and engagement plan finalised
- Options appraisal for the legal mechanism for integration in progress- recommended option to be presented to Boards for approval in Feb 25
- Overarching programme delivery plan developed

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
Options appraisal outcome	February 2024
Resourcing plan	March 2024
Detailed delivery plans developed	March 2024
Clinical summits commence	February 2024

Better Care Together

Home · Community · Hospital

Integrating community and hospital services provided by Bridgewater Community Healthcare NHS Foundation Trust and Warrington and Halton Teaching Hospitals NHS Foundation Trust

Contact details
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Stephen Bennett
Head of Strategy and Partnerships
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Runcorn town deal-part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

WHH is a key partner within Runcorn Old Town's submission to the Town Deal Investment Fund, with an overall opportunity to bring up to £25m to the town. The health and education hub project is led by WHH and is one of 7 projects within the Town Deal plan. The hub is planned to deliver services focussed on prevention, women and children and long-term conditions from a central location in Runcorn.

The project is being developed in partnership with a range of health and care providers across Runcorn, including Bridgewater and Halton Borough Council. The scheme includes a flexible education element designed in partnership with Riverside College.

What does this mean for WHH?

- Delivery of WHH services, including maternity, respiratory, and phlebotomy, from a convenient and accessible town centre location
- Opportunity to work with the local further education college to provide education and training tailored to jobs in health and care, helping to reduce our vacancies
- Opportunities to further integrate services with other providers across health, care and wellbeing

Progress since last report

- Tender programme complete and preferred contractor identified
- Heads of Terms agreed
- Further development of the Collaboration and Contribution Agreement

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
Approval of Collaboration Agreement	December 2024
Contractor Appointed	January 2025
Work on site to commence	March 2025







Contact details
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Carl Mackie
Halton Healthy New Town and Strategy Manager
carlmackie@nhs.net

Community diagnostic centre-part 1

Warrington and Halton Teaching Hospitals NHS Foundation Trust

Project Overview

- As part of the national strategic vision to create Community Diagnostics Centres (CDC) across England, the Trust is working alongside the regional team to develop a centre for outpatient diagnostics to serve the populations of Warrington and Halton. This will also be a regional resource.
- The final approved CDC Programme covers three phases:
  - Phase 1 (now complete) saw the development of a range of diagnostic services within the Nightingale Building at Halton
  - Phase 2 (now complete) saw a range of diagnostic services established within the Halton Health Hub at Runcorn Shopping City
  - Phase 3 will see the development of a new build extension to the CSTM building on the Halton site to accommodate additional CT and MRI services

What does this mean for WHH?

- Additional capacity to undertake diagnostic testing for patients of Halton and Warrington, and the wider Cheshire and Merseyside region
- New estate at Halton General Hospital and at the Halton Health Hub in Runcorn Shopping City, which supports new hospitals plans and the estates strategy

Progress since last report

- Over 68,000 additional diagnostic tests have been undertaken in the new CDC spaces (Phases 1+2) since Phase 1 went live in May 2023
- External structure for the final phase is now complete and break-through into existing CSTM building happened w/c 9th December
- Completion of the final phase of the programme has been delayed and is now 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 contribution to the Trust's financial position 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
Completion of new build CDC (phase 3)	May 2025
Commence clinical activity in phase 3 (MRI/CT)	June 2025







Contact details
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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 the Captain Sir Tom Moore building to incorporate all existing services and additional services, whilst releasing land to support the Hospital and Wellbeing Campus vision

What does this mean for WHH?

- Delivery of Trust services from modern, accessible and safe environments
- Opportunities to develop service provision in appropriate clinical settings and expand opportunities to work with local partners or in external locations

Progress since last report

- Assessment of latest draft of Cheshire and Merseyside NHS Infrastructure Plan
- Discussions ongoing with construction partners on development of master- planning for new hospitals programme
- Communications plan in development to engage with staff on the upcoming publication of the Trust's estate strategy
- Bids sent to NHSE / NHS Cheshire and Merseyside for potential capital programme spending in 2025/26

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	February 2025





Contact details
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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

- Contract with software developer Made Open commenced
- Wide stakeholder engagement and networking
- System design workshops held with partners across Warrington
- Cleanse of data and migration of MyLife content to new platform started
- Options appraisal/ scoping of investment in marketing, coms, engagement and in digital infrastructure as part of UKSPF allocated funds

Living Well Virtual Hub- 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
Living well online photo competition	February 2025
End user testing	February 2025
Soft launch	5th March 2025
Hard launch	w/c 24th March 2025

LIVING WELL IN WARRINGTON

Contact details
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Rachel Moran
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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
- At October 2024, more than 50,000 patient contacts have occurred at the hub

Warrington Living Well Hub

- The Living Well Hub has seen over 9,300 visitors attend since the doors opened in mid-March 2024. Around 50% of these attendances have been people “dropping in” to the hub to access a service, and the remainder have been for pre-booked appointments.
- The service model continues to evolve with the following new services commencing during the report period:
    - Female contraceptive fitting clinic (Primary Care)
    - South Asian dementia support group (Warrington Speak Up - VCFSE partner)
    - Complimentary Therapies Clinic (WHH maternity team)
    - Gambling Related Harms Drop in (VCFSE)
    - Evening ‘Safe and Well’ event
    - White Ribbon Campaign to raise awareness of domestic abuse (IDVA service - Independent Domestic Violence Advisors, WBC)

Other Trust strategic updates

Daycase Unit & Theatre 5 at CSTM, Halton

- Construction works complete
- All areas handed over to operational teams

C&M Endoscopy Hub at Nightingale Building, Halton

- First patient seen in Endoscopy Hub on Monday 9th September 2024
- Decontamination unit handed over as planned on Monday 23rd September 2024
- All areas handed over to operational teams

Theatre 3 at Nightingale Building, Halton

- Currently in full construction
- WHH Project Team working closely with contractors to manage early warning notices and compensation events

Upgrade to Ward B2 at Nightingale Building, Halton

- Currently in full construction
- WHH Project Team working closely with contractors to manage early warning notices and compensation events
- Handover planned date 31st January 2025

Other Trust strategic updates

Digital Projects

EPCMS Update

- Discussions are ongoing between WHH and MWL joint EPR procurement

PEP Update

- 52% of appointment letters have been read digitally reducing the need for printing and postage of letters
- 178k Messages have been sent to our patients, 74K of which were sent via the NHS App
- Phase 2 is underway, and various pilots are in planning
- The Trust is now live with appointment letters directly into the NHS App. In the first 5 weeks we have an average read rate of 24%
- 60% of patients have registered on the NHS app, 62% at Warrington and 56% at Halton

Place based strategic updates

Urgent and Emergency Care System Improvement

- The Urgent and Emergency Care System Improvement Programme continues. All five workstreams are working to agreed delivery plans and making progress which is reported to the ICB regularly. Referrals to Same Day Emergency Care (SDEC) have increased and are consistently above target (currently over 1,100 attendances per month). ED attendances are down by 3% compared to the same period last year. Although the Emergency department remains extremely busy, and patients are still being nursed on the corridor, the time spent there has reduced significantly. Virtual ward capacity has increased, and utilisation is good. There is sustained improvement in the length of stay for patients in hospital, although the number of admissions remains a challenge

Halton

- Wat Phra Singh UK, Buddhist Temple in Runcorn, have been successful in their application for £80,380 for the mechanical and electrical elements of the new Ubosot Hall via FCC Communities Foundation. Together with the Town Deal funding, a large contribution from the parent temple in Chiang Mai, Thailand and the temple's own reserves, there is now funding in place to commence construction in the new year – a real success based on partnership working!
- The Cardio-Renal-Metabolic Quality Improvement Programme: Delivering Change for Patients with Long-term Conditions in Widnes has been shortlisted for the HSJ awards in the category of Most effective contribution to improving care for those with Long -term conditions. The programme works with stakeholders across the care system, including WHH to look at creating an optimised pathway for those with heart failure and other long-term conditions.

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 last year and a formal programme to implement the new solution was launched in December 2024. The contract has been awarded to the preferred supplier and implementation is planned to begin in 2027.
- The current focus of the implementation programme is on harmonisation and clinical design to support development of the new system.
- The LIMS project team are linking closely with the pathology collaboration team working on the hub model to ensure alignment

Pathology collaboration

- The pathology hub delivery group (East) has been established and a potential Target Operating Model described. An outline Business Case has been approved by WHH Trust Board. Detailed work is ongoing to develop a full business case which will be presented to Trust Board in 2025. If the business case is approved, WHH will become an essential Services Laboratory working closely with the hub in MWL to form the East Pathology Hub

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 activity on the Halton site to create a paediatric surgical hub. Demand and capacity data is currently being considered and a detailed project plan will be developed.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/02/154**			
SUBJECT:	**Strategy Bi-Annual Delivery Report**			
DATE OF MEETING:	Wednesday 5 February 2025			
AUTHOR(S):	Carl Mackie, Halton Healthy New Town and Strategy Manager			
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.			
LINK TO PUBLIC SECTOR EQUALITY DUTIES	***Please indicate below the Equality considerations for Patients & Service Users and/or Workforce as appropriate:***			
	1. Eliminate unlawful discrimination, harassment and victimisation, and other prohibited conduct	**Yes**	**No**	**N/A**
				✓
	Further Information:			
	2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not	**Yes**	**No**	***N/A***
		✓		
	Further Information:			
	3. Foster good relations between people who share a protected characteristic and those who do not	**Yes**	**No**	**N/A**
		✓		
	Further Information:			
EXECUTIVE SUMMARY *(KEY ISSUES):*	In May 2023 Trust Board ratified governance and reporting arrangements for the updated Trust Strategy 2023-25. It was agreed that reporting against the delivery of the Strategy would be standardised, including a bi-annual update of progress against the priorities within each of the strategic aims (Q, P, S) to the appropriate Board committee.			

	There are a total of 62 strategic priorities within the refreshed 2023-25 Trust Strategy. These are broken down and monitored as below: There are 18 strategic priorities against the 4 objectives within the Quality aim of the Trust strategy. These are reported twice yearly through Quality Assurance Committee. H1 KPIs were reported to 10th December 2024 as per the Quality Priorities Quarter 2 (Q2) 2024 – 2025 with a number of metrics also reported via the Trust Integrated Performance Dashboard. There are 24 strategic priorities against the 4 objectives within the People aim of the Trust strategy. These are reported twice yearly through Strategic People Committee. H1 KPIs were reported to SPC on 16th October 2024 as per the WHH People Strategy Annual Report. There are 16 strategic priorities against the 4 objectives within the Sustainability aim of the Trust strategy. These are reported twice yearly through Finance and Sustainability Committee. H1 KPIs were reported to FSC on 25th November 2024 as per the Sustainability Strategic Priorities Bi-Annual Report. As of this report, the Trust is on target to meet 33 priorities, 22 are behind expectations with mitigations and programmes in place to bring back in line with expectations, and 3 are behind expectations with limited or no mitigations. Additionally, this report outlines 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.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	Trust Board is asked to: 1. Note progress against the delivery of the Trust Strategy 2023-25 through the Strategic Priorities across Quality, People and Sustainability aims 2. Note the process currently underway to refresh the Strategic Objectives and Priorities for the period 2025/26 3. Note the programme of work underway to rationalise the Trust's Enabling Strategies ahead of the completion of the integration programme between the Trust and Bridgewater Community Healthcare NHSFT.		
PREVIOUSLY CONSIDERED BY:	**Committee**	Quality Assurance Committee; Strategic People Committee; Finance and Sustainability Committee	

	Agenda Ref.	Various
	Date of meeting	Various as described
	Summary of Outcome	Noted
FREEDOM OF INFORMATION STATUS (FOIA):	Partial FOIA Exempt	
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Section 43 – prejudice to commercial interests	

REPORT TO TRUST BOARD

SUBJECT	Strategy Bi-Annual Delivery Report	AGENDA REF:	BM/25/02/154

1. BACKGROUND/CONTEXT

In March 2023, Trust Board approved a refresh of the Trust Strategy, which included a set of 12 strategic objectives underpinned by high level priorities. A summary of the refreshed Strategy is below.

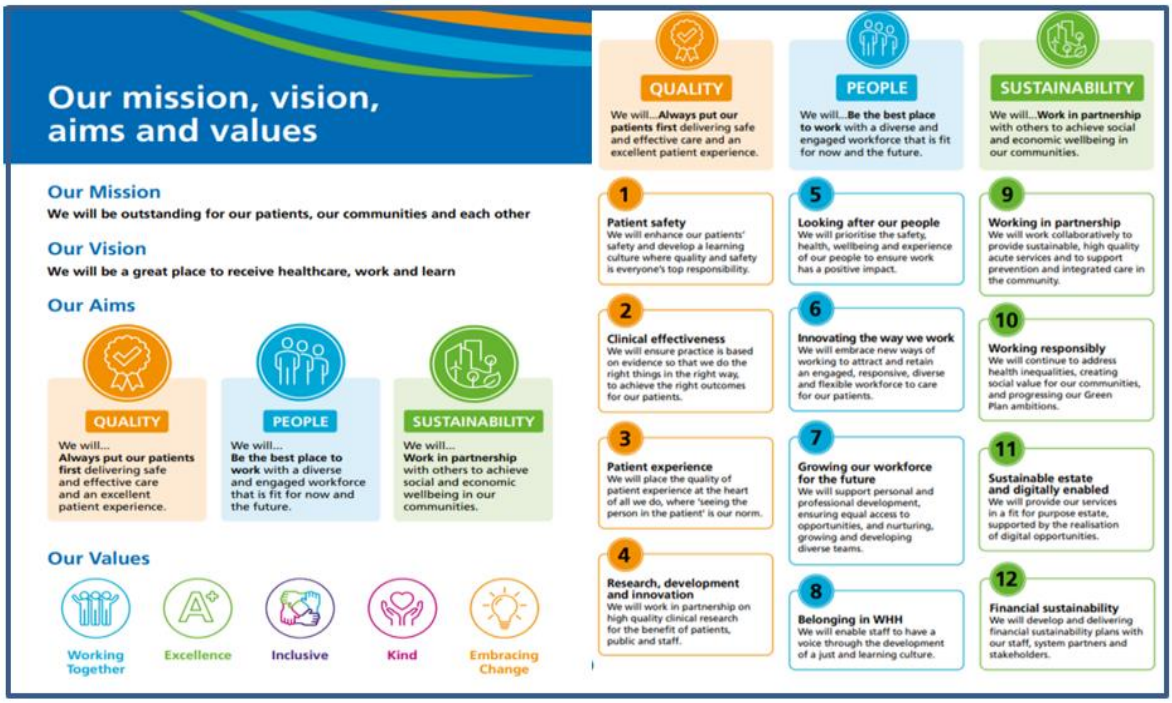


Figure 1: Summary of Trust Strategy 2023-25

In May 2023, Trust Board ratified the governance and reporting arrangements for the updated Trust strategy. This included the alignment of reporting across all aims of the strategy, and the approval of KPIs and / or Measures of Success aligned to each strategic priority.

As part of the alignment of reporting it was agreed that progress on the delivery of the strategy would be reported twice yearly, with the measures of success/KPIs relating specifically to Quality aims being monitored via Quality Assurance Committee, People aims being monitored via Strategic People Committee, and Sustainability aims being monitored via Finance and Sustainability Committee.

There are 10 changes to the Strategic Objectives as previously reported for 2023/24; 9 of these are a result of changes to the Trust's Quality Priorities. There is also one additional metric (11.5) relating to the delivery of the Trust's EPCMS system. These changes have been ratified by the appropriate Trust Committee.

The updated Strategic Objectives are described below, with the associated measures of success / KPIs reflected as appropriate within the overall position table later in this report.

Trust Aim	Trust Objective	2023/24 Strategic Priority	2024/25 Strategic Priority
Quality	**1. Patient Safety**	1.4 We will improve recognition and response to deteriorating patients.	1.4 Ensure that all patients within the Emergency Department receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes
		1.5 We will reduce the number of category 2 hospital acquired pressure ulcers by 20%, with zero tolerance of category 3 and 4 pressure ulcers (aligned to 23/24 CQUIN)	1.5 Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		1.6 We will continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework.	1.6 Reduce the number of Category 2 pressure ulcers by 20% with zero tolerance of Category 3 and Category 4 pressure ulcers.
	2. Clinical effectiveness	2.4 We will improve a culture of quality, safety and learning through the consistent application of LOCSIPs, achieving >90% compliance in documentation and observational audits.	2.4 Improve Theatre Safety with a focus on improving safety culture and compliance with Safe Surgery Safety Standards
		2.5 We will improve Clinical Pathway Optimisation through the 'Get it Right First Time' programme.	2.5 Delivery of the Trust wide improvement programmes across all Care Groups aligning to GIRFT recommendations to support timelier and more effective patient care
		2.6 We will improve and embed a culture of Quality Improvement across the organisation (aligned to the Patient Safety Incident Response Framework).	2.6 Continue to embed Patient Safety Incident Response Framework by developing and maintaining effective systems and responses for responding to patient safety incidents across the Trust
	3. Patient experience	3.4 We will improve patient experience for those with mental health attendance.	3.1 Ensure that there are robust frameworks in place to care for patients with mental health challenges, evidenced through the implementation of a training package for nursing and medical staff and 95% compliance with the completion of Mental Health Act assessment and detention documentation

Trust Aim	Trust Objective	2023/24 Strategic Priority	2024/25 Strategic Priority
		3.5 We will reduce health inequalities by ensuring that patients and carers have access to appropriate communication methods.	3.2 Reduce internal Hospital delays related to discharge planning to support safe and effective discharge, this will be evidenced through a reduction in failed discharges and a reduction in patients with 'no criteria to reside' averaged over 12 months
		3.6 We will improve patient experience by the pilot of a patient/family 'access line' primarily for out of hours.	3. 6 Improve the compliance with the Nutritional Assessment of Adult inpatients utilising the Malnutrition Universal Screening Tool (MUST). The overall target of the Trust is to achieve 95% compliance with assessment being completed within 24 hours of admission and then as a minimum every 7 days during their inpatient stay. With an aim to improve on current compliance in both metrics by 25% this year and to provide assurance that the appropriate level of intervention is provided to support patients in relation to their assessed needs and improve clinical outcomes.
Sustainability	**11. Sustainable Estate and digitally enabled service models**	N/A – additional metric developed for 2024/25 onwards	11.5 We will replace our Electronic Patient Records system to reduce paper use, minimising physical storage needs, and eliminate the dependency on paper records, reducing bother material and disposal costs. It will facilitate better patient flow management reducing waiting times and allowing more efficient use of clinical resources. It will contribute greener healthcare infrastructure. The improved EPR will provide proactive alerts to enhance decision making by providing clinicians with real-time, evidence-based insights that support accurate diagnoses, treatment choices, and resource utilisation.

Table 1: Updated Strategic Priorities for 2024/25

2. KEY ELEMENTS

The updated position for H1 2024/25 is reflected in the table below.

An update on progress of the Strategic Priorities for the Quality aims was reported to QAC on 10th December 2024 as per the Quality Priorities Quarter 2 (Q2) 2024 – 2025. Metrics are derived from this update and from the relevant Integrated Performance Report to Board (November 2024).

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
1. Patient Safety: We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.	1.1 We will reduce avoidable harm and patient deterioration with a focus on Covid-19 elective recovery.	Delivery of 110% of pre-pandemic activity by the end of 2022/23.	100% (2019/20 activity)	Oct 2024: 81% of Daycase Procedures and 115.78% of Inpatient Elective Procedures against 2019 activity Oct 2024: 97.27% of Outpatient activity against 2019.	104%		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.
		Potential Harm review panel will continue to undertake reviews where harm is suspected following a delay to treatment – feeding into wider governance processes					
	1.2 We will implement actions to deliver new standards required	Progress against action plans - Ockenden 1b:	94.91%	100.00%	100% compliant by Dec 23		A review of the Ockenden action plan has been completed the Quadrumvirate have

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
	as a result of national reviews in Maternity care/provision, ensuring learning is acted upon.						agreed to close the Ockenden action plan. 4 actions from Ockenden 2 action plan have been transferred to an Ockenden Issues Log. These actions require further monitoring and some analysis of audit, and it was agreed to close on the action plan and transfer to an Ockenden Issues Log so that they remain under scrutiny.
		- Ockenden 2:	68.53%	100.00%	100% compliant by Nov 23		
		Change in practice as a result of learning being acted upon, evidenced through monthly tracking of improvements and impact of actions with triumvirate.					
	1.3 We will enhance timely patient recovery through therapy led initiatives, including work around deconditioning and rehabilitation.	Reduction in the number of patients who develop pressure ulcers.	10	14 (Oct 2024)	0		Pressure Ulcers - Actions to improve the position include: 1. After Action Reviews are taking place and lessons are shared with ward teams and via Operational Patient Safety Group. 2. TED stocking provider has been changed- no further incidents have been reported relating to TED stockings since mid-October. 3. High focus on nutrition being raised at the After-Action Review Meetings with the Deputy Chief Nurse/Director of Governance.
		Patients participating in active movement and cognitive stimulation on the wards.					
		Annual reduction in the number of inpatient falls & harm levels. Based on 590 falls in 2021/22	418 (2023/24)	There have been 238 inpatient falls YTD in 2024/25. We are expecting a 2% increase in falls from last year.	Fewer than 418		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
							4. A new body map template has been launched. 5. The intentional Rounding Template is being revised following learning from After Action Reviews – this will be launched in December. 6. During November the Tissue Viability Team have been raising the importance of timely and appropriate use of Pressure relieving equipment in line with patient needs with Ward Teams across the Trust. Inpatient Falls: Use of an enhanced care presentation/video within healthcare assistant induction is proving effective. The video demonstrates good and poor practice examples of providing enhanced care (this has also been shared with all inpatient areas). Falls Policy update to be completed and ratified in Q3 following which the bedside eyesight vision check will be launched Trust wide.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
							There is a plan to increase awareness of environmental hazards relating to falls throughout Quarter 4, these events will be open to all staff and learners.
	1.4 We will improve recognition and response to deteriorating patients.	Reduce the number of Category 2 pressure ulcers by 20% with zero tolerance of Category 3 and Category 4 pressure ulcers.	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				• Compliance for Q2 is 51.79% against the target of the (minimum) 70%. This is based on the following: o Pressure Ulcer Risk Assessment (Waterlow) completed within 6 hours of admission. o Pressure Ulcer Prevention Care Plan completed within 24 hours of admission (if Waterlow over 10). o Pressure Ulcer Risk Assessment (Waterlow) updated every 30 days during admission. • The work of The Task and Finish Group has now concluded with outstanding actions being monitored through separate workstreams. Progress against these is reported through to the Operational Patient Safety Group to Patient Safety and Clinical Effectiveness.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
							• Weekly Pressure Ulcer Review Meetings chaired by the Deputy Chief Nurse/Director of Governance commenced during October 2024 to continue to identify themes and monitor progress against actions.
	1.5 We will reduce the number of category 2 hospital acquired pressure ulcers by 20%, with zero tolerance of category 3 and 4 pressure ulcers (aligned to 23/24 CQUIN)	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				• Diagnostic Monthly Waiting Times and Activity Reporting (DMO1) is currently reporting at 82.72% (September 2024) at an aggregated position. • Gaps remain in the speciality workforce which continues to impact some departments from receiving the agreed target. Actions to address each area are being progressed. • The Trust remains on target for the agreed trajectory to be met by March 2025 as per operational planning guidance. • There is a risk relating to delays in patient care. Each risk has been individually

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
							recorded on each relevant Clinical Business Unit Risk Register. Harm reviews continue and are reported to Patient Safety and Clinical Effectiveness Sub Committee. No moderate or serious harms were reported to the November PSCESC.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
	1.6 We will continue to evidence a culture of quality, safety and learning aligned to the National Patient Safety Framework.	Ensure that all patients within the Emergency Department receive timely assessment and treatment resulting in improved patient experience and improved clinical outcomes	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				• The Manchester Triage Score (MTS) has been rolled out within the Emergency Department, UTC (Urgent Treatment Centre) and SDEC (Same Day Emergency Care) areas. SDEC is not monitored nationally but is locally monitored, within the Trust. • At the end of Q2 (September 2024) 52.28% of type 1 and type 3 patients were assessed within the standard of 15 minutes. • Further collaboration between teams is ongoing to learn from SDEC to improve performance in other areas. There is a registered QI project with clear timeframes to support the project. Triage performance is reported to Quality assurance Committee monthly.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
2. Clinical effectiveness: We will ensure practice is based on evidence so that we do the right things in the right way, to achieve the right outcomes for our patients.	2.1 We will continue to utilise and evidence best clinical practice through the evidencing of compliance with guidance, such as the National Institute for Clinical Effectiveness.	NICE compliance	91.65%	94.11%	90%		

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
	2.2 We will continue to embed a positive risk management culture from ward to board.	Flexibility in risk appetite is recognised, this will be informed by the management of risk registers at service level, corporately and through the Board Assurance Framework.					The Risk Management Strategy provides a framework for managing risk across the Trust. The Strategy describes the process for managing risks and the roles and responsibilities of the Board of Directors, its Committees and that of all staff and provides a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the Trust. Local risk registers are monitored and maintained locally within the Clinical Business Units (CBU) which enables risk management decision-making to occur as near as practicable to the risk source. For those risks that cannot be managed locally these are escalated to the Corporate Risk Register and Strategic Risk Register where required. The Trust employs a

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
							number of systems to ensure that risk management is embedded within the organisation including business planning, performance management frameworks and clinical information systems. Regular reports are also available to the various committees responsible for aspects of risk management. There are corporate policies and procedures in place to support risk management, covering the management of incidents, risk assessment and consent and general risk management arrangements. Risk appetite levels will depend on circumstances; for example the Trust will have a low tolerance to taking risks which may impact on patient or staff safety, but a greater appetite for opportunity risks such as major service developments which present significant

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
							challenges, but will ultimately bring benefits to the organisation. Expressing risk appetite can therefore enable an organisation to take decisions based on an understanding of the risks involved. It can also be a useful method of communicating expectations for risk-taking to managers and improve oversight of risk by the Board. Risk appetites are determined by the Trust Board. The Trust encourages stakeholder and partner organisations' participation and has developed an active Patient Experience Committee. Partners and Governors are encouraged to raise issues, be involved in determining solutions and input to all aspects of risk management. The Trust has a Board Assurance Framework in place which is reviewed by

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
							the Board of Directors and includes: the identification of the key risks to the achievement of the Trust strategic objectives and the systems in place to manage/mitigate these risks; the control systems in place to manage the key risks; the identification of sources of internal and external assurances evidencing the management of risk; and evidence of compliance with equality, diversity and human rights legislation. The Board Assurance Framework is reviewed by the Board of Directors at each of their meetings and the Audit Committee, and bi-monthly by the Board Committees, which provides additional challenge and scrutiny of the risks identified.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
	2.3 We will recover core services and improve productivity in line with targets set in the NHS Long-term plan.	% of plans on track to deliver annual operational improvement trajectories	0%	67%	100%		The Trust continues to restore clinical services in line with the national operating guidance. 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. 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. The Trust continues to deliver Outpatient activity inline with operational planning guidance
	2.4 We will improve a culture of quality, safety and learning through the consistent application of	Improve Theatre Safety with a focus on improving safety culture and compliance with Safe Surgery Safety Standards	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				• Theatres continues to have had no 'Never Events' for 5 months (May-September 2024). • 9 out of the 11 recommendations have

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
	LOCSIPs, achieving >90% compliance in documentation and observational audits.						been completed following the Theatre Safety Day (8 December 2023). The 2 remaining actions are monitored through Procedural Safety Steering Group (PSSG) with expected completion 31 March 2025.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
	2.5 We will improve Clinical Pathway Optimisation through the 'Get it Right First Time' programme.	Delivery of the Trust wide improvement programmes across all Care Groups aligning to GIRFT recommendations to support timelier and more effective patient care	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				**Outpatient Improvement Programme** •The New Access Policy has been ratified. •The review of standardisation of clinic templates across specialities has begun initially starting with Diabetes and Rheumatology. •Gastroenterology has been identified as the first speciality for Knowledge and Evidence Team to support with DNA (Did Not Attend) reasons project. **Theatre Improvement Programme** •Short notice cancellations remain high and only a small improvement has been seen throughout September 2024. A short notice workshop took place on 14 and 18 October 2024. An action plan was developed, and all actions are now completed. •Quality Improvement (QI) motion study being undertaken from ward to Operating Room to identify key barriers to start on time

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
							shared with Operational Teams. Actions are currently being developed following this. •A Standard Operating Procedure (SOP) is in progress for minor operations to be delivered in Captain Sir Tom Moore Procedure Room. This is expected to be signed off by December 2024. **UEC Internal and System Improvement Programme** •The average triage time for Type 3 and 5 activity consistently meets the 15-minute target. •Frailty Assessment Unit (FAU) Virtual Ward and ARI Acute Respiratory Unit (ARI) are linking with UEC Team to develop effective communications to encourage teams to consider whether patients are suitable to be put on a Virtual Ward in the Emergency Department to avoid admission entirely. •Frailty Assessment Unit Hot Clinics have now commenced.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
	2.6 We will improve and embed a culture of Quality Improvement across the organisation (aligned to the Patient Safety Incident Response Framework).	Continue to embed Patient Safety Incident Response Framework by developing and maintaining effective systems and responses for responding to patient safety incidents across the Trust	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				•5 Patient Safety Specialists within the organisation are currently undertaking the level 3 and level 4 Patient Safety Training Syllabus with Loughborough University. Conclude January 2025, 4 more Patient Safety Specialists identified who commence training in January 2025. •A central record of the compliance for HSSIB Level 2 Training is held, to enable appropriate allocation of investigation leads. •Training figures will continue to be monitored, and support will be provided to Clinical Business Units with new investigation methodologies. •Data analysis has been undertaken to enable review of local priorities within Q 3. Stakeholder engagement planned for December to agree future local priorities.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
3. Patient experience: We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is our norm.	3.1 We will empower patients to be active participants in their care, giving consistent information, listening and discussing next steps in their care.	A reduction in both PALS and complaints in relation to communication as a key theme.	9.4% (Complaints with a primary theme of communication)		>9.4%		The Trust continues to sustain performance in the timely completion of complaints with 100% completed within time. There was an increase in the number dissatisfied complaints in month no key themes have been identified.
			22.75% (PALS with a primary theme of communication)		>22.75		
	3.2 We will ensure an inclusive communications method for each patient, taking into account their personal circumstances, using clear and easy to understand language.	Evidenced through improved use of interpreters for both people of whom English is not their first language and British sign language users					Language line call volumes have increased by 10%, with an average of 402 bookings made each month in 2024/25.

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
	3.3 We will create first and lasting impressions which contribute towards a positive experience of care.	Monitored by: - Ward accreditation - Leadership observations - Patient experience walk round - Governors walk rounds. - Feedback received at Patient experience sub committee					Actions ongoing include: Monitoring of themes, through dashboard and free text comments to identify areas for improvement, share best practice at Patient Experience and Inclusion Sub-Committee (PEISC). Trust Board, Governors, PLACE and Patient Experience Team observations directly fed back to wards/departments. Action plans are initiated and monitored through PEISC. Patient Experience Volunteers being recruited to increase the opportunities for patients to provide feedback.
	3.4 We will improve patient experience for those with mental health attendance.	Ensure that there are robust frameworks in place to care for patients with mental health challenges, evidenced through the implementation of a training package for nursing and medical staff and 95% compliance with the completion of Mental Health Act assessment	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				•During Q2, Two Training sessions were delivered by the Mental Health Law Admin Team. •Feedback has been received from the Mental Health Law Administration Team confirming that improvement in compliance has been observed since training commenced. Compliance has been noted as 97.04% (October

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
		and detention documentation					2024) •An increase in the completion of section 17 paperwork when patients leave the Trust has been seen. This compliance is monitored via the Mental Health Steering Group bimonthly and presented to Quality Assurance Committee quarterly.
	3.5 We will reduce internal Hospital delays related to discharge planning to support safe and effective discharge, this will be evidenced	Evidenced through a reduction in failed discharges and a reduction in patients with 'no criteria to reside' averaged over 12 months	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				• The Care Needs Assessment CDC Form has been updated and is being piloted across multiple wards. The results of this pilot will be available during Q3. • Data to review the effectiveness of the CDC Form changes will be available in Q3. • Transfer of Care Hub (TOCH) Nurses are now embedded across 5 wards as planned. This will be reviewed during Q3. This work will compliment and align with the work undertaken by the Discharge Improvement task and finish group

Strategic Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr-2)	Current Position (Sep-24)	Target	RAG	Comments
	3.6 We will improve the compliance with the Nutritional Assessment of Adult inpatients utilising the Malnutrition Universal Screening Tool (MUST).	The overall target of the Trust is to achieve 95% compliance with assessment being completed within 24 hours of admission and then as a minimum every 7 days during their inpatient stay. With an aim to improve on current compliance in both metrics by 25% this year and to provide assurance that the appropriate level of intervention is provided to support patients in relation to their assessed needs and improve clinical outcomes.	For detailed performance information against this metric please see latest Quality Priorities update, shared twice annually at QAC for assurance				• Continued improvements have been seen in all three-assessment metrics during Q2. • The MUST has now been added to the Clinical Indicators Tab on Lorenzo and a further amber indicator prior to red is being piloted as a warning to allow staff sufficient time to ensure the MUST is completed with an aim to increase all metrics. • The average overall Nutrition and Hydration on the Quality Metric Audit Tool score is 97.5%.

Table 2: Quality Strategic Priorities and Measures of Success September 2024

An update on progress of the Strategic Priorities for the People aims was reported to SPC on 16th October 2024 as per the WHH People Strategy Annual Report.

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 24)	Target	RAG	Comments
5. Looking after our people: We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.	5.1 We will ensure leaders have the skills, competencies, and behaviours to support staff health and wellbeing.	Reduction in sickness absence	5.60%	5.19%	4.2% supporting attendance		Development of WHH Leaders to Support Staff's Health and Wellbeing - 57% implemented
	5.2 We will support staff to remain in work and be present through the adoption of best practice, as evidenced through utilisation of the NHS Health and Wellbeing Cultural Framework.	Improved Retention	83.36%	86.97%	86% retention		Embed the NHS Health and Wellbeing Cultural Framework - 75% implemented
	5.3 We will provide bespoke health promotion programmes to our workforce to address population health inequalities impacting on their health and wellbeing.	Reduction in bank and agency reliance	17.00%	14.63%	9% reliance		Develop Bespoke Health Promotion Programmes to Address Population Health Inequalities - 40% Implemented
	5.4 We will equip line managers to use person centred engagement practices which improve employee experience.	Reduced turnover	15.98%	12.27%	13%		Empower Managers to Enhance Employee Experience - 40% Implemented
	5.5 We will implement employee recognition and appreciation schemes, which are accessible and valued by our staff.	Reduction in vacancy rate	11.53%	7.54%	9%		Promote Employee Recognition and Appreciation Schemes - 58% Implemented
	5.6 We will consistently apply onboarding process to the recruitment of our leaders, ensuring they have a personal priority to establish a great first impression for our patients and staff.						Onboarding - Create a Great First Impression - 47% Implemented

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 24)	Target	RAG	Comments
6. Innovating the way we work: We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.	6.1 We will develop strategic workforce plans which are reflective of current and future needs.	Reduction in Vacancy Rate	11.53%	7.54%	9%		Development of Workforce Plans - 69% Implemented
	6.2 We will participate in system wide workforce planning.	Reduced Staff Turnover	15.98%	12.27%	13%		System wide approach to Education that enables Fair and Equitable access - 75% Implemented
	6.3 We will embed new roles within multidisciplinary teams, which harness available skill sets of a diverse workforce and promote adaptable ways of working and create agile teams.	Improved Retention	83.36%	86.97%	86% retention		Embed Agile Working Principles - 50% Implemented
	6.4 We will attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.	Reduction in bank/agency reliance	17%	14.63%	9% reliance		Equip the Workforce to review Models of Care - 50%
	6.5 We will equip our workforce with the skills to shape and deliver effective and changing models of care.						Enhance the Digital Capability - 85% Implemented
	6.6 We will enhance digital capability, skills and leadership which embrace digitally enabled services.						Improve Attraction and Retention - 40% Implemented
7. Growing our workforce for the future: We will support personal and professional	7.1 We will recruit and develop managers and leaders using the WHH Line Management standards within the Line Management Training Framework.	Improved mandatory training compliance	86.11%	89.90%	85% compliance for mandatory		WHH Leadership Development Programme - 100%

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 24)	Target	RAG	Comments
development, ensuring equal access to opportunities, and nurture, grow and develop diverse teams.	7.2 We will develop a pipeline of career development opportunities aimed at nurturing and growing diverse teams from Kickstart Scheme recruits, work experience placements, apprenticeships, pre-registers multi professional students, inhouse training programmes and continuous professional development programmes (Further and Higher education) aligned to annual workforce plans.	Improved role-specific training compliance	84.21%	87.46%	85% compliance for role specific training		Widen Participation in Development Programmes - 100% Implemented
	7.3 We will maximise accessible development programmes including apprenticeship programmes, Continuous Professional Development programmes, role specific training and leadership development.	Reduction in Vacancy Rate	11.53%	7.54%	9%		Review Mandatory and Role Specific Training - 75% Implemented
	7.4 We will implement the NHS Talent Management and Succession Planning framework Scope for Growth to ensure line managers are clear about their responsibilities for their staff.	Reduced Staff Turnover	15.98%	12.27%	13%		Scope for Growth Appraisal Implementation - 100% Implemented
	7.5 We will provide a range of options for all staff seeking career progression, including professional education, training, shadowing, mentoring, coaching, and secondments.	Improved Retention	83.36%	86.97%	86%		WHH Career Development - 67% Implemented

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 24)	Target	RAG	Comments
	7.6 We will equip Team leaders to use structured tools and techniques to develop effective team working within their Care Groups, across Care Groups and with the wider health and social care system.	Reduction in bank/agency reliance	17.00%	14.63%	9%		Team Development - 80% Implemented
		Improved appraisal compliance	64.24%	79.22%	79%		
8. Belonging in WHH: We will enable staff to have a voice through the development of a just and learning culture.	8.1 We will ensure staff are able to speak up and feel heard, without fear of reprisal – including access to staff networks, Freedom to Speak Up channels and trade unions.	Reduction in Vacancy Rate	11.53%	7.54%	9%		Staff Able to Speak Up and Feel Heard - 67% Implemented
	8.2 We will ensure all leaders and line managers have the skills to create psychological safety and enable workforce recovery consistent with the principles of restorative and just cultures.	Reduced Staff Turnover	15.98%	12.27%	13%		Create a culture of Psychological Safety - 50% Implemented
	8.3 We will deliver compassionate interventions for individuals and teams who have experienced hurt due to people practices, incivility, bullying, harassment, or discrimination.	Improved Retention	83.36%	86.97%	86%		Compassionate Leadership - 50% Implemented
	8.4 We will ensure leaders and line managers have access to co-created resources designed to assist them to deliver compassionate and inclusive people practices.	Reduction in bank/agency reliance	17.00%	14.63%	9%		Access to Co-Created Resources to Assist in the Delivery of Compassionate and Inclusive People - 60% Implemented
	8.5 We will ensure principles of a restorative and just culture are evident in all workforce policies and procedures.	Reduction in sickness absence	5.60%	5.19%	4.20%		Adopt Principles of a Restorative and Just Culture - 25% Implemented

Trust Objectives	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position (Sep 24)	Target	RAG	Comments
	8.6 We will embed a behavioural framework in WHH appraisal process for each Trust value which promotes civility, kindness, and respect for all staff.						Behavioural Framework Embedded for Each Trust Value which Promotes Civility, Kindness and Respect for all Staff - 71% Implemented

Table 3: People Strategic Priorities and Measures of Success September 2024

An update on progress of the Strategic Priorities for the Sustainability aims was reported to FSC on 25th November 2025 as per the Sustainability Strategic Priorities Bi-Annual Report.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
9. Working in partnership: We will collaboratively work to provide sustainable, high quality acute services and to support prevention and integrated care in the community	9.1 We will collaborate with local secondary care providers to help tackle care backlogs, reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.	RTT – Number of patients patient waiting 65+ weeks will be 0 by March 2024	423	530	0		RTT performance - 52 week waits are improving in line with the trajectory, a small residual number of 78 weeks remain who are patient choice and complex patients, these are forecasted to clear to zero in December 24. 65 weeks have significantly reduced and are largely due to patient choice or complexity, mitigation plans through use of insourcing and mutual aid are continuing to support recovery. 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. • Transformation plans for Theatre and Outpatient productivity are established across the Trust We are working with others to provide services that increase activity, reduce health inequality and improve access to care- for example: • Living well hub • Health and education hub • CDC with new pathways
		Volume and Impact of collaborative projects being delivered with partners to reduce care backlogs to reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.					
	9.2 We will collaborate with primary care, community care, social care and all	Increased number of clinical appointments in off-site locations	82,636 (Total number of appointments, including	50,863 (21% increase against same time	5% increase		All projects on track or delivered as per individual plans. The Trust continues to be embedded within a number of projects at place and region, including Prevention Pledge (ICB)

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	community partners, including the voluntary sector to support the provision of integrated care in the community and prevention of ill health. It is proposed that this includes relocation of appropriate secondary care into the community, following the principle of right service, delivered in the right place to deliver excellent patient care and experience and to improve access and address health inequalities.		DNAs & cancellations)	period 2023/24)			and One Halton Wider Determinants of Health (Place) among others. The Strategy Team is also working with a number of partners in Widnes to develop and enhanced service model initially focussed on heart failure. *Phase 1 and 2 of CDC programme fully complete and operational. Phase 3 on track to complete in March 2025.*
		Deliver Living Well Hub in 2023/24.					
		Deliver Runcorn Town Deal Hub by end of 2025/26.					
		Deliver phase 1 and 2 of new Community Diagnostic Centre in 2023/24.					
		Deliver phase 3 of new Community Diagnostic Centre in 2024/25.					
		Deliver breast screening reconfiguration at Bath Street by 2023/24.					
		Actively contribute to delivery of projects at place and regional level which seek to improve access and					

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
		address health inequalities					
	9.3 We will review opportunities to provide services more locally for our residents who currently travel to specialist Trusts. This would be approached on a service by service basis to ensure the best outcomes for patients and our regional healthcare system.	Proactively review repatriation opportunities at service level.					Discussion of opportunities undertaken through strategic priority setting conversations. These will be continued with Care Group through developing their strategic priorities and business plans over H2 2024/25. Opportunities including Paediatric Hub in partnership with Alder Hey in progress.
10. Working responsibly: We will continue to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.	10.1 We will work in coordination with our system and place partners to prioritise the five strategic priorities for tackling health inequalities and improving population health, as outlined in the Core20PLUS5 approach.	Support both Warrington and Halton to develop place maturity. Deliver our Core20PLUS5 objectives. Deliver community spirometry services on behalf of Warrington and Halton.					Trust embedded within Place and ICB governance to support place maturity. This includes leading on a number of workstreams within both One Halton and Warrington Together. Following completion of the collaborative place project to develop the Living Well Hub in the town centre, WHH is now leading on a follow-on project to develop a virtual health and wellbeing hub for Warrington. This new resource is aimed to support improved visibility of health and wellbeing support on offer across the town and easier access to those services. The initial phase of the system is scheduled to go live to the public before the end of March 2025.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
							Community Spirometry services across both Warrington and Halton are now delivered by WHH respiratory team via the CDC programme and locations. Trust has identified Core20PLUS5 cohorts across catchment and is working within local and national improvement programmes, including the Women's and Children's Transformation Programme, ICB-led programmes on chronic respiratory disease (Long-Term Conditions workstream at One Halton), and with PCNs on other opportunities for pathway improvement (Heart Failure pathway with Widnes PCN and partners).
	10.2 We will identify opportunities to reduce the Trust's consumption of resources in order to reduce CO2 emissions.	Heat decarbonisation plan in place by end of 2023/24 for Halton and Warrington sites.					Requirements for production of HDCP identified but funding source for external expertise identified not yet secure. Discussions are underway with NHS C&M around how to maximise assets and resources to deliver across the system. The Trust does not have dedicated sustainability resource, putting delivery of this priority at risk. CO2 emissions are not collected routinely; this measure will be updated in the H2 report expected May 2024.
		Annual reduction in CO2 emissions	14,200tCO2e		5-10% reduction by 2025		
		Number of procedures/care pathways with carbon footprints calculated.	0	1	5		
	10.3 We will drive improved social value for our local population increasing the social and	Maintain the number of local people employed by the Trust	77.00% (staff with a Warrington or Halton postcode)		77.00%		4 local jobs supported through the creation of the Warrington Living Well Hub

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	economic wellbeing in the communities we serve.						The Living Well Hub has welcomed 6,000 visitors through the door between March and September 2024. 50% of attendances have been 'drop-in' rather than booked appointments and around 20% of visitors have accessed more than one service as part of their attendance. The Department for Work and Pensions have an established presence in the Living Well Hub and have seen over 200 attendees in the facility since it opened in March 2024. The Trust continues to support local people into health jobs, for example internship and apprenticeship programmes. The Warrington and Vale Royal College Health and Social Care Academy was developed in partnership with the Trust, and a similar project is ongoing with Riverside College as part of the Runcorn Health and Education Hub, expected September 2025. The Trust's proportion of local staff and proportion of local spend are not routinely reported. This information will be available at the H2 report due in May 2025.
		Prioritise spend with local suppliers In Cheshire and Merseyside.					
		Jobs created as a result of projects.					
		Increased Town centre footfall as a result of enhancing service provision within community locations, own Centre.		More than 10,000 contacts at Living Well Hub or Halton Health Hub since November 2023			
		Learning opportunities created and supported to support people into education and jobs					
	10.4 We will embed sustainability as part of our business-as-usual processes, making it a core consideration of the way the Trust	Staff-led initiatives / Quality Improvement projects incorporating sustainability.					Inclusion of social value and net zero questions within technical element of procurement exercises, including CDC and Living Well Hub. Methodology for capturing information needed to calculate carbon/environmental

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	operates, empowering staff to take action and delivering care in a way that supports NHS green ambitions of achieving a net zero National Health Service by 2045	Green ambitions included within corporate paperwork (job descriptions, Trust induction etc)					impacts developed to ensure robust calculations and like-for-like comparisons.
		Assessment criteria for environmental impact included in capital project proposals					
	10.5 We will deliver the commitments set out in the NHS Prevention Pledge and use data and digital technologies to inform care planning, to support the development and adoption of innovative, population-based models of care.	Delivery of prevention pledge action plan.					Prevention Pledge work ongoing. Director of Public Health and Strategy Programme Manager delivered joint presentation to peers at Prevention Pledge Conference in November 2024.
11. Sustainable Estate and digitally enabled service models: We will provide our services in an estate that is fit	11.1 We will continue to develop our plans for a new hospital in Warrington and a new hospital and wellbeing campus in Halton, seeking all investment opportunities to realise our new hospitals vision.	Submit bids at all available opportunities.					The Trust's New Hospitals programme continues to explore options to deliver against the vision for new estate. Local MPs have been briefed following recent election. Phased redevelopment plan to be developed, pending release of identified funding.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
for purpose, supported by the realisation of digital opportunities and aligned to the needs of our patients, staff and populations							Key elements of business cases documented for identified development opportunities, enabling us to bid for any funding opportunities at short notice.
		Delivery of case of need communications plan.					
		Explore alternative funding options to deliver new hospitals and estates enablers.					
	11.2 We will review how and where our services are delivered, investing wisely in existing estate to support long-term plans and make the most appropriate and effective use of clinical space, whilst we work towards our realisation of our new hospitals.	Deliver TIF					All projects on track or delivered as per individual plans. Content of Trust Estate Strategy ratified. A communications plan is in development to share with staff. Trust embedded within Place and ICB governance for strategic estate programmes. Director of Strategy and Partnerships is co-chair for the Warrington Strategic Estates Group. Work is underway with Bridgewater Community Healthcare through the Better Care Together programme to identify opportunities to improve estate utilisation and strategic planning of estate resource.
		Deliver CDC					
		Deliver Living Well Hub					
		Deliver Runcorn Health & Education Hub.					
		Deliver Trust Capital Programme					
		Refresh Trust Estates Strategy and develop opportunities.					
		Work with partners at place and in C&M to maximise public sector estate utilisation.					

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	11.3 We will enhance our digital infrastructure to ensure it is reliable, modern, secure, sustainable and resilient, developing high performing multi-disciplinary digital teams to deliver major digital investments in electronic patient records and cloud migration.	WGLL Digital Maturity Assessment (DMA) - Smart Foundations.	DMA Overall 2.9	Smart Foundations – 3.6	Smart Foundations 4.6		• The IT replacement programme is a trust funded capital scheme across 2 years. 2024/25 is the second year of the programme, which is on track to deliver a complete replacement of the trust's wired and wireless local area network by the end of 2024/25. • A new high speed Digital Diagnostics IT network has been installed and configured. This advanced infrastructure solution has been implemented in preparation for migration to PACS cloud (December 2024) and a regional LIMS (2026/27 at WHH) • Subject to confirmation of NHSE funding for the national eBCMS programme, a Trust Board approved business case includes funding for Real Time Location Services (RTLS). RTLS will enable the trust's Wi-Fi network to be used for tracking people and equipment around the hospital site.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	11.4 We will transform care pathways and reduce unwarranted variation, using digital solutions to enhance services for patients, ensuring they can access services when and where needed, including remote care that is optimised though Patient Held Records (PHRs) and smartphone Apps, enabling patients to take an active role in their healthcare.	Empowering Citizens		Empowering Citizens 1.10	Empowering Citizens 4.1		• The WHH Patient Engagement Platform (PEP) is due to go live on 10th June 2024. In conjunction with the NHS App, the PEP will allow all WHH patients to securely receive electronic correspondence from the hospital and to manage appointments easily online, reducing DNAs and telephone calls to Outpatients. • The initial scope at go live is for all appointment related correspondence and details to be available to all WHH patients who wish to register for using the App. Initially this will exclude Radiology Appointments, due to some technical integration challenges, but its anticipated this will be added to the live system within the first month after go live • Future phases of PEP include self-assessments, waiting list management, test results etc., to be planned and prioritised in line with wider trust requirements
	11.5 We will replace our Electronic Patient Records system to reduce paper use, minimising physical storage needs, and eliminate the dependency on paper records, reducing bother material and disposal costs. It will facilitate better patient flow management reducing waiting times	Delivery of EPCMS system					• Work is underway to prepare for the re-launch of the EPCMS procurement, updating the Outline Business Case (OBC) for TB approval in November 2024. Frontline Digitisation (FD) programme has been requested to contribute funding back to central government. WHH, funding modelled with revised allocations. The overall funding remains the same, implications for FY24/25 and FY25/26 which is proposed to be changed. Once central government approve, WHH receive confirmation of the revised allocations. The revised implementation

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
	and allowing more efficient use of clinical resources. It will contribute greener healthcare infrastructure. The improved EPR will provide proactive alerts to enhance decision making by providing clinicians with real-time, evidence-based insights that support accurate diagnoses, treatment choices, and resource utilisation.						plan for mobilisation December 2025 to March 2026, 18-month Deployment March 2026 to September 2027. The Trust is currently exploring options for a joint procurement with MWL, pending further review and subject to Trust Board approval.
12. Finance sustainability: We will act according to our duty to collaborate, by working with partners on	12.1 We will deliver the Trust's agreed financial plan.	Achievement of CIP programme	19.4m (Baseline as Apr 2024)	CIP performance at Month 7 is £7.8m against a £7.8m target (£6m recurrent)	£19.4m		Within the £19.4m target, there is high risk of £2.5m mainly relating to the added mitigation schemes following a recent review of schemes due to start.

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
shared financial objectives to achieve sustainability of the Trust and the wider Cheshire and Merseyside system.		Achievement of agreed financial plan	£27.8m deficit revised to £11.3m deficit following receipt of deficit support funding (£16.5m) (As April 2024)	£12m (October 2024)	£11.3m deficit		The Trust has recorded a deficit position of £12.05m at 31 October 2024 against a deficit plan of £11.03m. The drivers of the variance are the impact of industrial action with cost and loss of income totalling £1m with only £0.25m funded and £0.27m cost of the pay award in excess of funding received. There is significant risk to achieving the 2024/25 plan including collaboration, CIP delivery including the impact of underperformance of activity, impact of the pay awards, industrial action and ongoing cost pressures. The Trust submitted a revised risk adjusted forecast with a variance of £8.6m.
	12.2 We will participate, lead and contribute to system wide procurement to drive increased efficiencies and benefits.	Actively participate and contribute to the delivery of the ICS Procurement 34 Point Action Plan. Actively participate and contribute to the development of procurement within the ICS. Successful in leading on the introduction of a single Contract Management					The Trust is playing an active role in the development of the ICS procurement programme. Alison Parker is the Deputy Chief Procurement Officer. The Trust has now adopted Atamis, a centralised contract tender management system across the ICS to include trusts workplan's and contract registers. The C&M Procurement Community has developed a workplan to delivery increased savings and has appointed HealthTrust Europe to support Trusts in delivery of the workplan. There are also links with other ICS level networks to support collaboration (HR, IT, Estates etc.)

Trust	Strategic Priorities	Measures of Success / KPIs	Baseline (Apr 23)	Current Position	Target	RAG	Comments
		platform across the ICS.					A savings tracker has been developed to track savings a both Trust and ICS Level. Governance has been developed and introduced for the management of projects. A Procurement Strategy is in draft.
	12.3 We will deliver value for money by ensuring efficient use of resources	Amber or Green rating achieved in the Value for Money assessment undertaken by the Trust's external auditors and reported in the Auditor's Annual Report	Amber	Red – A risk of significant weakness with regard to the Trust's arrangements to secure financial sustainability was identified. The Trust recorded a deficit position worse than plan in 2023/24 and is in receipt of cash support from NHSE.	Amber or Green rating		Given the Trust is 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.

Table 4: Sustainability Strategic Priorities and Measures of Success September 2024

3. MONITORING/REPORTING ROUTES

The monitoring and reporting route for the Trust Strategy is described in the diagram below:

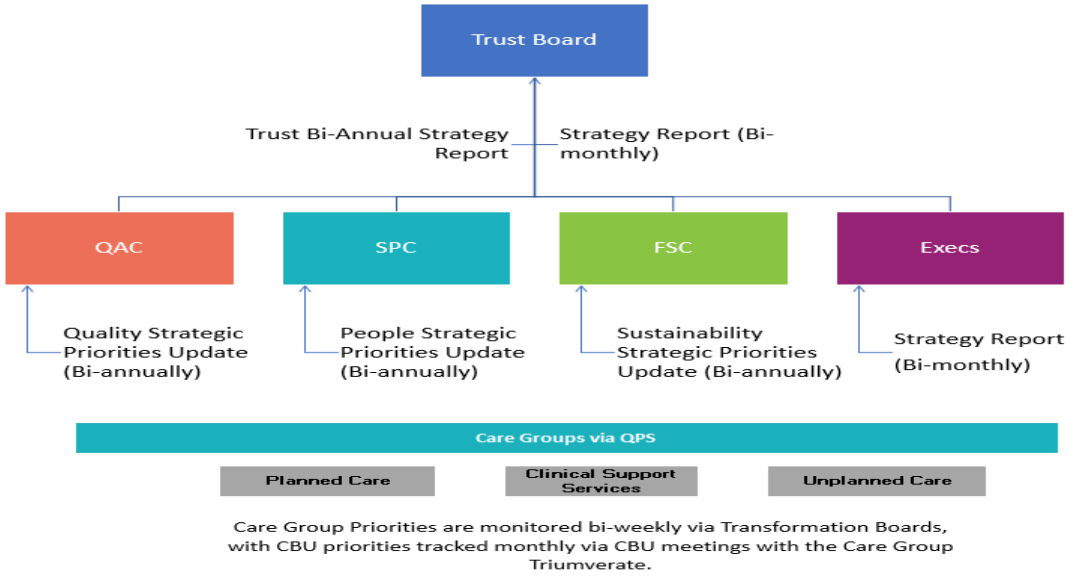


Figure 2: Monitoring and reporting arrangements for Trust Strategy 2023-25

4. TIMELINES

The strategy spans a two-year timeframe from 2023-25. The measures of success/KPIs will cover the duration of the strategy with bi-annual monitoring of delivery through each committee of the Board. The KPIs will be reviewed and refreshed as appropriate.

A further update on the H2 position 2024/25 will be presented to Board after April 2025.

Additionally, the Trust Strategy is due for refresh in 2025. As the Trust is undertaking a programme of integration with Bridgewater Community Healthcare NHS Foundation Trust, this full refresh of the strategy will take place as part of the integration programme.

Ahead of the development of an integrated strategy the intention is to perform a relatively light touch review and refresh of the Strategic Objectives and their measures of success / KPIs to ensure that the Trust continues to provide assurance on progress against a suitable strategic direction.

Updated Strategic Objectives have therefore been discussed with Trust Executives and relevant departments throughout the organisation. The proposed updated objectives for 2025/26, agreed by the executive team, are presented overleaf. Success measures will be developed across the next two months and reported back to Board for approval ahead of the H1 update on Strategy Delivery, expected after September 2025.

During the process to update these Strategic Objectives, steps will be undertaken to ensure that the resulting report aligns with any changes made to the Integrated Performance Report, and to ensure that the report enables a better understanding of triangulation and insight across both the three Trust Aims, and across the different clinical and corporate directorates across the Trust.

Aligned to the above approach, an update was taken to quality assurance committee in July 2024 to describe prosed changes to the Trust's Enabling Strategies, which support delivery of the organisation's overall strategy. This report outlined the status of strategies nearing expiry and outlined recommendations for the management of enabling strategies moving forward.

There are light-touch refreshes currently ongoing to several enabling strategies, including Advanced Clinical Practice; Knowledge and Evidence; Frailty; Quality; and Mental Health and Learning Disability. This process is being supported by the strategy team to ensure updated strategies are consistent in format and approach and align to the Trust strategy.

It was agreed by Quality Assurance Committee to implement a new structure with fewer Enabling Strategies in 2025. Currently the Trust has 25 Enabling Strategies, and these vary in strategic content. The updated and streamlined Enabling Strategies will be underpinned by key principles documents and workplans that align to strategic priorities. For example:



Figure 3: Potential Enabling Strategies – please note, this is an example from another NHS organisation for illustration purposes only.

This process will be supported by the review of all current enabling strategies and is proposed to involve the migration to key principles documents and workplans as appropriate.

Quality Assurance Committee will be kept appraised as to the progress of this piece of work as per the regular standing item on the agenda.

Strategic Objectives - Quality	Strategic Priorities - Quality	Source
1. Patient Safety: We will enhance our patients' safety and develop a learning culture where quality and safety is everyone's top responsibility.	1.1 We will keep our patients, service users and staff safe from harm through the delivery of harm free care.	Updated Quality Priority
	1.2 We will create a culture where the safety of patients, their relatives and our staff is our foremost priority	Updated Quality Priority
	1.3 Design and support safety programmes that deliver effective and sustainable change	Updated Quality Priority
2. Clinical effectiveness: We will ensure practice is based on evidence so that we do the right things in the right way, to achieve the right outcomes for our patients	2.1 We will make sure we 'get it right first time' by providing consistent care and supporting productivity improvement projects which deliver the best outcomes for our patients	Updated Quality Priority
	2.2 We will prioritise the application of QI training to empower staff and achieve measurable improvement work with identifiable learning and sustainable results.	Updated Quality Priority
	2.3 We will work with our partners to understand and address the causes of health inequality to help people stay in control of their own health.	Updated Quality Priority
3. Patient experience: We will place the quality of patient experience at the heart of all we do, where 'seeing the person in the patient' is our norm.	3.1 We will ensure a positive patient experience, enhancing the experience of our patients and service users.	Updated Quality Priority
	3.2 We will maintain our focus on patients and their families' equality, diversity and inclusion.	Updated Quality Priority
	3.3 The patients and the publics' voice is integral in the decision making process when making changes to services or care delivery.	Updated Quality Priority
4. Research, Development and innovation: We will work in partnership on high quality clinical research for the benefit of patients, public and staff.	4.1 We will continue to create opportunities for members of the public to gain access to clinical research trials contributing to the health of our population.	2023 - 25 Strategic Priority
	4.2 We will further develop and grow our research capability through the application and selection for clinical trials.	2023 - 25 Strategic Priority
	4.3 We will develop staff across a range of disciplines as Principle Investigators to grow research capability within our workforce.	2023 - 25 Strategic Priority
	4.4 We will grow the academic research portfolio supporting staff recruitment and retention.	2023 - 25 Strategic Priority
	4.5 We will seek to expand our research offer seeking opportunities for further collaboration through the Halton Clinical Research Unit.	2023 - 25 Strategic Priority

Table 5: Proposed updated Quality Strategic Priorities 2025/26

Strategic Objectives - People	Strategic Priorities - People	Source
5. Looking after our people: We will prioritise the safety, health, wellbeing and experience of our people to ensure work has a positive impact.	5.1 We will ensure leaders have the skills, competencies, and behaviours to support staff health and wellbeing.	2023 - 25 Strategic Priority
	5.2 We will support staff to remain in work and be present through the adoption of best practice, as evidenced through utilisation of the NHS Health and Wellbeing Cultural Framework.	2023 - 25 Strategic Priority
	5.3 We will provide bespoke health promotion programmes to our workforce to address population health inequalities impacting on their health and wellbeing.	2023 - 25 Strategic Priority
	5.4 We will equip line managers to use person centred engagement practices which improve employee experience.	2023 - 25 Strategic Priority
	5.5 We will implement employee recognition and appreciation schemes, which are accessible and valued by our staff.	2023 - 25 Strategic Priority
	5.6 We will consistently apply onboarding process to the recruitment of our leaders, ensuring they have a personal priority to establish a great first impression for our patients and staff.	2023 - 25 Strategic Priority
	5.7 We will understand where there are workplace inequalities and take action address them.	Proposed addition / amend to 2023 - 25 Strategic Priority
	5.8 We will ensure that all individuals and teams have measurable objectives on equality, diversity and inclusion.	Proposed addition / amend to 2023 - 25 Strategic Priority
6. Innovating the way we work: We will embrace new ways of working to attract and retain an engaged, responsive, diverse and flexible workforce to care for our patients.	6.1 We will develop strategic workforce plans which are reflective of current and future needs.	2023 - 25 Strategic Priority
	6.2 We will participate in system wide workforce planning.	2023 - 25 Strategic Priority
	6.3 We will embed new roles within multidisciplinary teams, which harness available skill sets of a diverse workforce and promote adaptable ways of working and create agile teams.	2023 - 25 Strategic Priority
	6.4 We will attract and retain a transformed and flexible workforce that can deliver care to patients in new and different ways.	2023 - 25 Strategic Priority
	6.5 We will equip our workforce with the skills to shape and deliver effective and changing models of care.	2023 - 25 Strategic Priority

Strategic Objectives - People	Strategic Priorities - People	Source
	6.6 We will enhance digital capability, skills and leadership which embrace digitally enabled services.	2023 - 25 Strategic Priority
	6.7 We will create continuous improvement processes, seeking feedback from staff networks and other groups.	Proposed addition / amend to 2023 - 25 Strategic Priority
	6.8 We will provide clear and inspiring pathways to address under-representation of our staff with protected characteristics.	Proposed addition / amend to 2023 - 25 Strategic Priority
7. Growing our workforce for the future: We will support personal and professional development, ensuring equal access to opportunities, and nurture, grow and develop diverse teams.	7.1 We will recruit and develop managers and leaders using the WHH Line Management standards within the Line Management Training Framework.	2023 - 25 Strategic Priority
	7.2 We will develop a pipeline of career development opportunities aimed at nurturing and growing diverse teams from Kickstart Scheme recruits, work experience placements, apprenticeships, pre-registers multi professional students, inhouse training programmes and continuous professional development programmes (Further and Higher education) aligned to annual workforce plans.	2023 - 25 Strategic Priority
	7.3 We will maximise accessible development programmes including apprenticeship programmes, Continuous Professional Development programmes, role specific training and leadership development.	2023 - 25 Strategic Priority
	7.4 We will implement the NHS Talent Management and Succession Planning framework Scope for Growth to ensure line managers are clear about their responsibilities for their staff.	2023 - 25 Strategic Priority
	7.5 We will provide a range of options for all staff seeking career progression, including professional education, training, shadowing, mentoring, coaching, and secondments.	2023 - 25 Strategic Priority
	7.6 We will equip Team leaders to use structured tools and techniques to develop effective team working within their Care Groups, across Care Groups and with the wider health and social care system.	2023 - 25 Strategic Priority
	7.7 We will recognise and sponsor high potential individuals from under-represented backgrounds to enable them to fulfil their potential with a clear development plan.	Proposed addition / amend to 2023 - 25 Strategic Priority
	7.8 We will use and monitor key equality, diversity and inclusion indicators to develop diverse teams.	Proposed addition / amend to 2023 - 25 Strategic Priority

Strategic Objectives - People	Strategic Priorities - People	Source
8. Belonging in WHH: We will enable staff to have a voice through the development of a just and learning culture.	8.1 We will ensure staff are able to speak up and feel heard, without fear of reprisal – including access to staff networks, Freedom to Speak Up channels and trade unions.	2023 - 25 Strategic Priority
	8.2 We will ensure all leaders and line managers have the skills to create psychological safety and enable workforce recovery consistent with the principles of restorative and just cultures.	2023 - 25 Strategic Priority
	8.3 We will deliver compassionate interventions for individuals and teams who have experienced hurt due to people practices, incivility, bullying, harassment, or discrimination.	2023 - 25 Strategic Priority
	8.4 We will ensure leaders and line managers have access to co-created resources designed to assist them to deliver compassionate and inclusive people practices.	2023 - 25 Strategic Priority
	8.5 We will ensure principles of a restorative and just culture are evident in all workforce policies and procedures.	2023 - 25 Strategic Priority
	8.6 We will embed a behavioural framework in WHH appraisal process for each Trust value which promotes civility, kindness, and respect for all staff.	2023 - 25 Strategic Priority
	8.7 We will understand, encourage and celebrate diversity ensuring that we equip staff with the equality, diversity and inclusion knowledge to be inclusive allies, recognising that although staff may not be a member of a marginalised group(s), they are able to support others.	Proposed addition / amend to 2023 - 25 Strategic Priority
	8.8 We will develop leaders and managers to build on existing interventions and develop new mechanisms to support all staff to speak up and feel heard, without fear of reprisal.	Proposed addition / amend to 2023 - 25 Strategic Priority

Table 6: Proposed updated People Strategic Priorities 2025/26

Strategic Objectives - Sustainability	Strategic Priorities - Sustainability	Source
9. Working in partnership: We will collaboratively work to provide sustainable, high	9.1 We will collaborate with local secondary care providers to help tackle care backlogs, reduce unwarranted variation in care access and service delivery, address health inequalities and deliver more efficient, sustainable services.	2023 - 25 Strategic Priority

Strategic Objectives - Sustainability	Strategic Priorities - Sustainability	Source
quality acute services and to support prevention and integrated care in the community	9.2 We will collaborate with primary care, community care, social care and all community partners, including the voluntary sector to support the provision of integrated care across Halton and Warrington	Proposed addition / amend to 2023 - 25 Strategic Priority
	9.3 We will review opportunities to provide services more locally for our residents who currently travel to specialist Trusts, in line with local and regional opportunities	Proposed addition / amend to 2023 - 25 Strategic Priority
	9.4 We will realise opportunities to deliver excellent patient care and experience and to improve access and address health inequalities aligned to the principle of right service, delivered in the right place	Proposed addition / amend to 2023 - 25 Strategic Priority
	9.5 We will work with partners across our places to enhance the resilience of our Urgent and Emergency Care system, improving patient experience	Proposed addition / amend to 2023 - 25 Strategic Priority
	9.6 We will develop a programme of integration with our local community Trust to improve patient outcomes and experience, improve operational delivery and improve financial sustainability	Proposed addition / amend to 2023 - 25 Strategic Priority
10. Working responsibly: We will continue to address health inequalities, creating social value for our communities, and progressing our Green Plan ambitions.	10.1 We will work in coordination with our system and place partners to prioritise the five strategic priorities for tackling health inequalities and improving population health, as outlined in the Core20PLUS5 approach.	2023 - 25 Strategic Priority
	10.2 We will identify opportunities to reduce the Trust's consumption of resources in order to reduce CO2 emissions.	2023 - 25 Strategic Priority
	10.3 We will drive improved social value for our local population increasing the social and economic wellbeing in the communities we serve.	2023 - 25 Strategic Priority
	10.4 We will embed sustainability as part of our business-as-usual processes, making it a core consideration of the way the Trust operates, empowering staff to take action and delivering care in a way that supports NHS green ambitions of achieving a net zero National Health Service by 2045	2023 - 25 Strategic Priority
	10.5 We will deliver the commitments set out in the NHS Prevention Pledge and use data and digital technologies to inform care planning, to support the development and adoption of innovative, population-based models of care.	2023 - 25 Strategic Priority
11. Sustainable Estate and digitally enabled service models: We will provide our	11.1 We will continue to develop our plans for a new hospital in Warrington and a new hospital and wellbeing campus in Halton, seeking all investment opportunities to realise our new hospitals vision.	2023 - 25 Strategic Priority

Strategic Objectives - Sustainability	Strategic Priorities - Sustainability	Source
services in an estate that is fit for purpose, supported by the realisation of digital opportunities and aligned to the needs of our patients, staff and populations	11.2 We will review how and where our services are delivered, investing wisely in existing estate to support long-term plans and make the most appropriate and effective use of clinical space, whilst we work towards our realisation of our new hospitals.	2023 - 25 Strategic Priority
	11.3 We will enhance our digital infrastructure to ensure it is reliable, modern, secure, sustainable and resilient, developing high performing multi-disciplinary digital teams to deliver major digital investments in electronic patient records and cloud migration.	2023 - 25 Strategic Priority
	11.4 We will transform care pathways and reduce unwarranted variation, using digital solutions to enhance services for patients, ensuring they can access services when and where needed, including remote care that is optimised though Patient Held Records (PHRs) and smartphone Apps, enabling patients to take an active role in their healthcare.	2023 - 25 Strategic Priority
12. Finance sustainability: We will act according to our duty to collaborate, by working with partners on shared financial objectives to achieve sustainability of the Trust and the wider Cheshire and Merseyside system.	12.1 We will deliver the Trust's agreed financial plan.	2023 - 25 Strategic Priority
	12.2 We will participate, lead and contribute to system wide procurement to drive increased efficiencies and benefits.	2023 - 25 Strategic Priority
	12.3 We will deliver value for money by ensuring efficient use of resources	2023 - 25 Strategic Priority
	12.4 We will pursue commercial and growth opportunities where in line with Trust strategy to improve the sustainability of the Trust and the services we provide	Proposed addition / amend to 2023 - 25 Strategic Priority
	12.5 We will deliver improvements to Trust productivity	Proposed addition / amend to 2023 - 25 Strategic Priority

Table 7: Proposed updated Sustainability Strategic Priorities 2025/26

5. ASSURANCE COMMITTEE

All as noted above.

6. RECOMMENDATIONS

Trust Board is asked to:

1. Note progress against the delivery of the Trust Strategy 2023-25 through the Strategic Priorities across Quality, People and Sustainability aims
2. Note the process currently underway to refresh the Strategic Objectives and Priorities for the period 2025/26
3. Note the programme of work underway to rationalise the Trust's Enabling Strategies ahead of the completion of the integration programme between the Trust and Bridgewater Community Health Care.

Warrington and Halton Teaching Hospitals NHS Foundation Trust

REPORT TO TRUST BOARD

AGENDA REFERENCE:	**BM/25/02/155**			
SUBJECT:	**Charity Commission Checklist**			
DATE OF MEETING:	5 February 2025			
AUTHOR(S):	Kate Henry, Director of Communications and Engagement			
EXECUTIVE DIRECTOR SPONSOR:	Kate Henry, Director of Communications and Engagement			
LINK TO STRATEGIC OBJECTIVE: (***Please select as appropriate)***	**SO1** We will.. Always put our patients first delivering safe and effective care and an excellent patient experience.	✓		
	SO2 We will.. Be the best place to work with a diverse and engaged workforce that is fit for now and the future	✓		
	SO3 We will ..Work in partnership with others to achieve social and economic wellbeing in our communities.	✓		
LINK TO RISKS ON THE BOARD ASSURANCE FRAMEWORK (BAF): (***Please DELETE as appropriate)***	N/A			
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 Charity Commission for England and Wales set out guidance on Charity fundraising: a guide to trustee duties (updated October 2022). It features six principles that trustees should follow to help meet their responsibility for their charity's fundraising. These principles are: 1. Planning effectively 2. Supervising your fundraisers			

	3. Protecting your charity's reputation, money, and other assets 4. Identifying and ensuring compliance with the laws or regulations that apply specifically to your charity's fundraising. 5. Identifying and following any recognised standards that apply to your charity's fundraising. 6. Being open and accountable. The guidance also includes a checklist designed to help charity trustees evaluate the charity's performance, at suitable intervals, against the legal requirements and good practice recommendations set out in the fundraising guidance. Each of the questions on the checklist links to a paragraph of the fundraising guidance. Not all of the issues listed in the checklist are appropriate for all charities. At WHH, this fundraising checklist is presented to the Charitable Funds Committee with delegated authority from the Trust Board, which is the Corporate Trustee. The checklist has been updated to reflect progress since the last report to the Committee in September 2023. It is presented to the Corporate Trustee on an annual basis.		
PURPOSE: ***(please select as appropriate)***	**Approval**	**To note** ✓	**Decision**
RECOMMENDATION:	The Trust Board is asked to note the annual Charity Commission Checklist for Trustees		
PREVIOUSLY CONSIDERED BY:	**Committee**	Charitable Funds Committee	
	Agenda Ref.	CFC/24/12/26	
	Date of meeting	12 December 2024	
	Summary of Outcome	The Committee noted the updated progress against the Checklist for Trustees and agreed to submit it to the Corporate Trustees for assurance.	
FREEDOM OF INFORMATION STATUS (FOIA):	Release Document in Full		
FOIA EXEMPTIONS APPLIED: ***(if relevant)***	Choose an item.		

Charity Commission Fundraising Checklist for Trustees

Updated December 2024

Principles and guidance	Current status	Mitigations/actions/notes
Planning effectively		
We have set out our fundraising plan		• 2022-25 Strategy approved March 2022 and KPIs are monitored at CFC, with agreement to extend for a further 12 months. • We continue to review our Strategy periodically in line with changing trends in charitable giving.
It reflects our charity's values		• WHH Charity's values are: Ethical, Transparent, Accountable, Compassionate, Creative. The Charity also adopts the values of the Corporate Trustee of Working Together, Excellent, Inclusive, Kind and Embracing Change. Strategy is in alignment with these values.
The resources we use and the costs we incur in our fundraising		• Our overheads are subject to scrutiny at CFC as part of the Finance Report. • Work has been undertaken over recent years to reduce overheads as much as possible and we benchmark similarly to similar charities in terms of our overheads to income ratio. • Income and expenditure (actual and forecast) are scrutinised and challenged at CFC. • A reserves policy and an overheads policy are in place.
The key financial and reputational risks we may face		The Charity's Risk Management Statement is approved and reviewed annually by the CFC. WHH Charity risks are managed through the Trust's Datix system and reported to CFC, at least annually.
We monitor progress		A fundraising activity and financial report are reviewed by the CFC at each meeting in line with the Governing Document and Cycle of Business.
We manage key risks		The key risks are reviewed at least annually by the CFC, and more frequently if required.
Supervising our fundraisers		
We have considered and decided which fundraising issues we will not delegate		Our Governing Document sets out our approach to delegations and is reviewed and approved by CFC on behalf of the Corporate Trustees. Our fundraising team is accountable to a member of the executive team.
Our fundraising staff have job descriptions.		Current and in place, and in line with Agenda for Change.
Our fundraising staff are doing the job successfully		PDRs are up to date and conducted annually. Fortnightly 1-1s between Head of Fundraising and Deputy Director take place, as well as monthly charity leadership meetings with the director of communications and engagement. The past year has seen an increase in fundraising activity and charity presence.

Our volunteers know who they report to and who to approach with problems or concerns		Charity volunteers are part of the Trust's volunteer service. They are assigned to the charity, reporting to and being supervised by the Head of Fundraising.
Our volunteers understand the boundaries within which they must work when representing the charity		They receive Trust induction from WHH Volunteers and local induction from the Head of Fundraising.
Our subsidiary trading company is monitored for effectiveness and only enters into commercial partners in the charity's best interest		
Our arrangements with commercial providers fully comply with relevant legal requirements		We undertake all procurement through the Corporate Trustee (WHH) and ensure through contracts and commercial development that all legal requirements are met and maintained
Our arrangements with commercial providers are in our charity's best interest because appropriate due diligence is undertaken		We procure using the Corporate Trustee's procurement team. Where possible we will endeavour to work with local businesses.
Our fundraising values and expectations are communicated		Our values feature on our website, our strategy, impact report, and other charity materials.
The costs are justifiable and can be explained		All expenditure is reviewed by the Budget Holder and reported through the Finance Report
Proper control is kept of the money raised		All monies are routed into the WHH Charity bank account, no other methodology is permitted. Staff training and awareness on the correct processing of charitable donations is continuous and written into the WHH Staff Handbook. Finance manage the funds and ensure that expenditure in fully in line with the approvals obtained as per our Governing Document / SoRD requirements.
Fundraising communications used are reviewed		All communications are approved by the Head of Fundraising and Deputy Director of Communications and Engagement.
Compliance with the agreement is monitored		Compliance is monitored following contract by the Head of Fundraising and/or Deputy Director of Communications and Engagement.
Any conflicts of interest are recognised and dealt with		The Corporate Trustee has a Managing Conflicts of Interest Policy which has been adopted by WHH Charity.
Protecting our charity's reputation, money and other assets		
The reputational risks our charity may face are identified, assessed, and managed		Reputational risks are addressed in our risk management statement, and any risks are recorded on our risk register
Likely donor, supporter and public perception is considered when income expectations and other goals are considered		This is considered as part of the bid application process and as part of the approval process for new campaigns.
The legal rules and recognised standards which apply to our fundraising are followed		We follow the Code of Fundraising Practice, the Chartered Institute of Fundraising and the Association of NHS Charities Together guidance. We are registered with and regulated by the Charity Commission.
Our values are communicated to the people who work on our fundraising.		All WHH staff adopt and practice the values of the Corporate Trustee, they and the public are further briefed on the aims and objectives of WHH Charity

		and are guided on how to proceed with fundraising initiatives on a personal/team/company level.
The costs of our fundraising are managed and explained.		We control our costs through a bid application process / overhead approval process. We review our costs at CFC meetings.
Our fundraising finance is planned and monitored		We have an annual plan in place, the KPIs of which are reviewed at CFC.
Effective financial controls are in place and followed		Charitable spend is incorporated within the Corporate Trustee's Scheme of Reservation and Delegation. The Corporate Trustee's Finance Team monitor and report on expenditure
Risks of financial crime and fraud are reduced		We make use of the Corporate Trustees training and arrangements in place in relation to counter fraud awareness. WHH Charity provides a letter of authorisation to every fundraiser who is requested to sign acceptance of the agreement between us.
Our charity is alerted to any suspicious donations		Our Finance Team review all bank statements and incoming direct funds. Provenance of all cheque and cash donations is tracked through the donor journey and recorded via Harlequin, with a receipt and thank you letter posted out to the donor.
Our charity can stop or authorise any unauthorised fundraising activity using its name		We use a letter of authorisation to authorise fundraisers to raise funds on our behalf. We would alert the relevant authorities to any suspicious activity undertaken in our name and cease or suspend the arrangements immediately.
Serious incidents are reported to the Commission, police, and other agencies		Reporting to the relevant authorities would take place if a serious incident arose. NHS Counter Fraud Authority may also be contacted where NHS Employees or their families are involved.
Our data, name, image, logo, and IP are protected		• We do not issue our logo independently for 3rd party use. • We use letters of authorisation for 3rd party fundraisers. • We provide our own branded materials for support.
Following the law and recognised standards		
We have effective systems in place so that the Code of Fundraising Practice and other resources are used to find out about the legal rules and recognised standards which apply to our fundraising		We follow the Code of Fundraising Practice, Institute of Fundraising, and the Association of NHS Charities guidance. We are registered with the Fundraising Regulator.
These rules and standards are followed		We follow the Code of Fundraising Practice, Institute of Fundraising, and the NHS Charities Together guidance
Be open and accountable		
Any legal rules and requirements that apply to how our charity reports and accounts for its fundraising are complied with.		We are audited periodically and produce an annual report and accounts.
Our open and accessible complaints procedures are followed if concerns are raised		In the first instance complaints should be raised to the Head of Fundraising. The Charity uses the resources of the Corporate Trustee ie PALS and Complaints procedure.
Our fundraising aims, and achievements are clearly		Our website is maintained and updated regularly.

communicated to the public and donors/supporters		Our social media platforms are updated regularly. Increased communications activity is underway and progressing well.