NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

6th April 2022

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Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Meeting of the Board of Directors in Public
Date	Wednesday 6th April 2022
Time	10.00am-12.00 midday
Location	Board Room, Arrowe Park Hospital

	Agenda Item	**Lead**
1	Apologies for Absence	Chair
2	Declarations of Interest	Chair
3	Patient Story	Chief Nurse
4	Minutes of Previous Meeting	Chair
5	Action Log	Chair
	Operational Oversight and Assurance	
6	Chair's Business and Strategic Issues	Chair
7	Chief Executive's Report	CEO
8	Chief Operating Officers Report	COO
9	Board Assurance Reporting	
	9.1 Quality and Performance Dashboard	Execs
	9.2 M11 Finance Report	CFO
	9.3 Learning from Deaths Quarterly Report	MD
	9.4 Maternity Quarterly Report	Director of Midwifery
	Items for Decision and/or Discussion	
10	Children and Young People Patient Survey	Chief Nurse
11	Maternity Inpatient Survey	Chief Nurse
	Wallet Items for Information (Not Presented)	
12	Communications and Engagement	CPO
13	Committee Chairs Reports	Chairs

- Finance, Business and Performance
- Quality Assurance
- Workforce Assurance

Closing Business

14	Questions from the Public	Chair
15	Any other business	Chair

Date and Time of Next Meeting

	Wednesday 4th May 2022	Chair

Meeting	Board of Directors in Public
Date	2nd March 2022
Location	Teams

Members present:

DH	Sir David Henshaw	Chair
JS	John Sullivan	Non-Executive Director & Vice Chair
CC	Chris Clarkson	Non-Executive Director
SI	Steve Igoe	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
SR	Steve Ryan	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Nicola Stevenson	Medical Director & Deputy Chief Executive
TF	Tracey Fennell	Interim Chief Nurse
HK	Hayley Kendal	Chief Operating Officer
DS	Debs Smith	Chief People Officer
MS	Matthew Swanborough	Director of Strategy and Partnerships
CW	Claire Wilson	Chief Finance Officer

In attendance

TC	Tony Cragg	Public Governor
AM	Alan Morris	Public Governor
AT	Andrew Tallents	Public Governor
RT	Robert Thompson	Public Governor
JL	Jonathan Lund	Associate Medical Director
CM	Chris Mason	Chief Information Officer
DMcG	David McGovern	Director of Corporate Affairs
SS	Sally Sykes	Director of Communications and Engagement

The meeting opened at 10:00am

Agenda Item	Minutes	Action
1	**Apologies for Absence** Apologies for absence were submitted on behalf of Sheila Hillhouse and Eileen Hume.	
2	**Declarations of Interest** No new interests were declared and no interests in relation to the agenda items were declared.	

3	**Patients Story** The Chief Nurse (TF) gave an update from the previous patient story and stated that visors were being distributed to staff to aid communications with deaf patients. The Board received a video story of the experiences of a patient and their carer. The story highlighted the importance of understanding and responding to the needs of individuals in a holistic way and not just focussing on physical health especially with regards to visiting and contact during a patient's stay. The Board welcomed the feedback and supported the executive directors in sharing the learning across the staff both in terms of care and in answering telephones on wards and noted that regional funding had been received to help in this endeavour. The Board **NOTED** the patient story	
4	**Minutes of the Previous Meeting** The minutes of the meeting held on 26 January 2022 were approved as an accurate record of the proceedings.	
5	**Action Log** The Board noted that all actions had been closed or completed.	
6	**Chair's Business** The Chair updated the Board on recent matters. The key points were: • he had recently been appointed as co-chair of Healthy Wirral Partners and • the start date for new integrated NHS governance arrangements had been moved back to May 2022 and good progress was being made developing the arrangements which were hoped to enable resolution of system-wide challenges such as delayed discharges. **The Board NOTED the Chair's business**.	
7	**Strategic Issues** The chair identified that there were no additional strategic issues to report. **The Board NOTED the update.**	
8	**Chief Executive's Report** The Chief Executive (JH) introduced her report on recent activities	

	at the Trust. The report covered updates on: • Covid-19 • Vaccination as a condition of employment consultation • Preparations for the national Covid public enquiry • Serious Incidents in January and one Reportable incident • the emergency care upgrade project and • modular theatre construction at Clatterbridge Hospital. In discussion, the following points were raised: • The Chief People Officer stated that it was had been announced that the requirement for staff to be vaccinated against Covid as a condition of deployment would be revoked as a result of the recent national consultation. • the Director of Corporate Affairs stated that a board workshop was being planned in the next couple of months to consider new streamlined governance proposals. It was also hoped that in-person meetings could re-commence subject to appropriate risk assessments. • There was a discussion on serious incidents and the Medical Director noted that these were across various divisions and that learning from each was shared. • the new system-wide governance arrangements were hoped to deliver financial and operational benefits. **The Board NOTED the report.**	**DMcG**
9	**<u>Chief Operating Officer's Report</u>** The Chief Operating Officer (HK) presented her update outlining the current organisational performance data for planned care (elective) and unplanned care (non-elective). Performance against the re-set recovery programme for planned care remained encouraging; however, performance against the target of 95% of patients attending the emergency department being seen and treated within 4 hours remained significantly challenged. There were also significant challenges noted with regards to patients waiting longer than 12 hours for access to Mental Health beds in Wirral but this had been escalated to system partners. Improvements in Trust performance was heavily reliant on working across the local health and care system as part of the Wirral Urgent Care Improvement Programme. Attending to the backlog of patients together with winter pressures and a surge in Covid-19 cases had let to challenges in achieving the Winter Improvement Plan.	

	Managing emergency and urgent care across the system was a priority including making best use of Walk-in centres and ensuring patients are given the right level of care. The Board thanked staff across the Trust for their continued efforts in delivering high quality care in challenging circumstances. **The Board NOTED the Chief Operating Officer's Report.**	
10	**<u>Assurance reports</u>** **<u>10.1 Board Assurance Report</u>** The Director of Corporate Affairs (DMcG) introduced the Board Assurance Framework (BAF) which set out the key risks to achieving the Trust's objectives. The BAF included a covering report highlighting changes. The Board welcomed the report and agreed to merge risks 4.1 and 4.2 into a consolidated risk relating to the emerging new governance arrangements of the Integrated System and Place based governance. The Board also agreed to merge risks 6.2 and 6.1 which both related to potential negative impacts on quality of care if estates, facilities, and supply chains are disrupted. The Board also agreed to amending some risks scores as set out in section three of the report, the most significant of which were raising scores from 16 to 20 (out of a maximum of 25) of risk relating to: - failure to manage unscheduled care - failure to meet constitutional standards, and - failure to meet scheduled care demand. The Medical Director added that, in light of recent global events, the cyber security risk had been reviewed and the score was likely to increase with a corresponding review of the controls in place. It was noted that the role of the Audit Committee in reviewing the BAF would be considered as part of the internal governance review. **The Board NOTED the assurance update and APPROVED merging the risks set out in section 2 and APPROVED amendments to risk scores set out in section 3.** **10.2 Quality and Performance** The Executive Directors briefed the Board on metrics in the dashboard and highlighted that some metrics had been suspended	

	during the pandemic response. It was noted that 27 were off-target or failing to meet performance thresholds and 20 were on-target. The Chief Nurse drew attention to recent cases of C-Difficile identified in patients. The Trust had exceeded its tolerance of cases and root cause analyses would help to put measures in place to manage the cases. Staff sickness had increased in December and January, primarily due to Covid-19. Work was ongoing to develop a well-being culture at the Trust and managing attendance levels in a supportive way. The COO noted concerns about the way the report was presented and stated that a review of the report format was underway with executive colleagues as part of the overall governance and assurance review, with a plan to move to Statistical Process Control (SPC) reporting to highlight variation of concern. The Board **NOTED** the dashboard. **10.3 Finance report** The Deputy Chief Finance Officer introduced the month 10 finance report. There had been a significant improvement from month 9 and the Trust was now forecasting a break-even position for the year. The key change, as well as budgetary controls had been the receipt of £2.5m non-recurrent funding from Cheshire and Merseyside Health and Care Partnership. In discussion it was noted that capital spend was high at present as the Trust responded to a need to update the facilities. There was an internal governance structure in place to ensure value for money and this had ensured that, even though the capital spend had increased in-year, capital was being invested wisely. The Board **NOTED** the report. **10.4 Maternity report** The Interim Chief Nurse (TF) briefed the board on progress in improving maternity services, a project that had been initiated following the publication of the Ockenden report in December 2020 and subsequent reports from across the country. TF assured the board that the Perinatal Clinical Surveillance Quality Assurance report was rated as green for January 2022 and that there were no issues for escalation. The Board **NOTED** the report.	**HK**

11	**<u>Estates Strategy</u>** The Director of Strategy and Partnerships (MS) presented the estates strategy which set out four campaigns of developments that would support delivery of the Trust's overall strategy. The Board was asked to approve the strategy. In discussion the following points were raised: • the strategy set out the approach at a high-level; detail would be added with each project in five phases • the strategy responded to identified risks • a board seminar of the developing plans was requested. The Board **APPROVED** the estates strategy.	**MS**
12	**<u>Green Plan</u>** The Director of Strategy and Partnerships (MS) introduced the Trust's Green Plan which had been developed as part of the overall approach being adopted by the Integrated Care System. The plan was in response to the guidance issued by NHS England and NHS Improvement in June 2021. It was noted that the executives had submitted a draft version by the deadline of 14 January. It had since been updated and was presented to the Board for approval prior to the deadline of 22 March 2022. A sustainability lead had been identified in the estates team and the board looked forward to progress in delivering the strategy. The Board **APPROVED** the Green Plan	
13	**<u>EPPR – Annual Report</u>** The Chief Operating Officer (HK) introduced the Emergency Preparedness, Resilience & Response annual report. Production of the report was a requirement under the Civil Contingencies Act 2004. It was reported that that Trust had met all three of the areas in which it was required to demonstrate robust plans in the event of serious disruption as reviewed by NHS England's assurance process. The Board was asked to note the report. The Board **NOTED** the report.	
14	**<u>Guardian of Safe Working Quarterly Report</u>** The Medical Director (NS) introduced the Guardian of Safe Working report which provided an update on compliance with the terms and conditions of service for NHS doctors and dentists in	

	training. NS stated that there were a number of gaps in the trainee medical workforce, and this had been making it difficult to ensure a safe working environment with all required self-development opportunities for trainee medics as well as meeting the working hours directive. In discussion it was noted that the Trust was being very supportive and had since resolved the issue by incorporating self-development time into foundation doctors' rotas. A reduction in exception reports was envisaged. The Board was reassured by the intervention and looked forward to an improved report for the next quarter. The Board **NOTED** the report.	
15	**<u>Chair's Report FBPAC</u>** The Chair of the Finance and Business Performance Committee provided a verbal report to the Board on recent proceedings of the committee. It was noted that finances continued to be scrutinised and the committee had been assured that a breakeven position would be achieved at year end. Regarding operational performance, the Trust was working hard to deal with the backlog of patients with a particular focus on cancer patients. An establishment review was underway to ensure appropriate levels of medical staffing across the Trust as part of reducing locum and agency costs. It was suggested that the Committee might look at high-cost drugs and see if financial efficiencies could be found. The Board **NOTED** the report	
16	**<u>Communications and Engagement report</u>** The Director of Communications and Engagement (SS) introduced the Communications and Engagement report which covered internal and external communications activities in January and February 2022. The importance of a two-way dialogue with staff was mentioned and listening events were welcomed. The Board **NOTED** the report.	
17	**<u>Questions from the Public</u>** Those members of the public in attendance were invited to ask	

	questions relating to items on the agenda. There was a question about upgrades of domestic staff areas and MS would discuss further with the team to ensure concerns were understood.	
18	**<u>Any Other Business</u>** There was no other business to discuss.	
19	**<u>Date of Next Meeting</u>** The date and time of the next meeting will be confirmed in due course as part of agreeing the calendar of business for the 2022/23 year.	

(The meeting closed at 11.51am)

Action Log
Board of Directors
6th April 2022

No.	Minute Ref	Action	By Whom	Action status	Due Date
1.	2nd March 2022 - 8	To provide further details in respect of the review of Governance structures and Committee Terms of Reference.	DMcG	Included in Board workshop to discuss the action planning for the Well Led Review.	End of April 2022
2.	2nd March 2022 - 10	To constitute a Board workshop to consider the future content and format for the Quality and Performance dashboard.	HK	Included on the Board Seminar agenda	April 2022
3.	2nd March 2022 - 10	To constitute a Board workshop to consider the current and future approach to the Cost Improvement Programme (CIP)	CFO	Included on the Board Seminar agenda	April 2022
4.	2nd March 2022 - 11	To constitute a Board workshop to consider the future Estates Strategy and in particular the approach to the Arrowe Park Masterplan	MS	To be included in May 2022	May 2022

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors **Item No 7**
6th April 2022

Title	Chief Executive's Report
Area Lead	Janelle Holmes, Chief Executive
Author	Janelle Holmes, Chief Executive
Report for	Information

Report Purpose and Recommendations
This is an overview of work undertaken and important recent announcements in March. It is recommended that the Board notes and receives the Chief Executive's report.

Key Risks
N/A

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
All Board Meetings in Public	Board in Public	Chief Executive's Report	For Information

1	Narrative
1.1	**COVID Update** The prevalence of Covid in the community continues to rise. There are currently >1000 cases per 100 000 population. This is likely to be an under-representation as people may not formally report positive lateral flow tests (LFD). As expected, this has resulted in a marked increase of the numbers of inpatients who are Covid positive (occupying 8.6% of available beds). 80% of these patients do not have Covid as a primary diagnosis but have been identified on screening. The high bed occupancy and high transmissibility of Omicron BA.2 has resulted in a number of outbreaks (defined as two or more confirmed cases of COVID-19 among individuals with onset within 14 days, due to direct exposure with at least 2 other confirmed cases in that setting.) within the hospital. In addition, there is a significant impact on staff attendance due to Covid positivity which adds to the challenging operational pressures. NHSE provided an update on testing – 'Living with Covid'- on 30th March which does not fundamentally change the testing regime within healthcare settings. However, there is a change in testing technology for planned elective patients. From 1st April, NHS staff are advised to continue testing twice weekly when asymptomatic. LAMP testing will no longer be available so they will be encouraged to undertake LFD tests which will be available through the gov.uk portal for staff with a patient- facing role. Symptomatic NHS staff should test themselves using LFDs and, if they test positive, will continue to follow the current return to work guidance. Staff who are household contacts of a positive COVID-19 case will now be able to continue to work as normal if they remain asymptomatic and continue to test twice weekly. They will no longer be required to have a PCR test in order to return to work.
1.2	**COVID – Public Inquiry** In May 2021 the Prime Minister announced the setting up of a widespread Public Inquiry into the Covid-19 pandemic. The Inquiry, set to begin its work in spring 2022, will be established under the Inquiries Act 2005, with full powers, including the power to compel the production of documents and to summon witnesses to give evidence on oath. The terms of reference of the inquiry are as follows: 1. Examine the COVID-19 response and the impact of the pandemic in England, Wales, Scotland and Northern Ireland, and produce a factual narrative account. Including: • In relation to central, devolved and local public health decision-making and its consequences: - preparedness and resilience; - how decisions were made, communicated and implemented; - intergovernmental decision-making; - the availability and use of data and evidence; - legislative and regulatory control; - shielding and the protection of the clinically vulnerable; - the use of lockdowns and other 'non-pharmaceutical' interventions such as social distancing and the use of face coverings; - testing and contact tracing, and isolation; - restrictions on attendance at places of education; - the closure and reopening of the hospitality, retail, sport and leisure

sectors, and cultural institutions;
- housing and homelessness;
- prisons and other places of detention;
- the justice system;
- immigration and asylum;
- travel and borders; and
- the safeguarding of public funds and management of financial risk.

- The response of the health and care sector across the UK, including:

  - preparedness, initial capacity and the ability to increase capacity, and resilience;
  - the management of the pandemic in hospitals, including infection prevention and control, triage, critical care capacity, the discharge of patients, the use of 'Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions, the approach to palliative care, workforce testing, changes to inspections, and the impact on staff and staffing levels;
  - the management of the pandemic in care homes and other care settings, including infection prevention and control, the transfer of residents to or from homes, treatment and care of residents, restrictions on visiting, and changes to inspections;
  - the procurement and distribution of key equipment and supplies, including PPE and ventilators;
  - the development and delivery of therapeutics and vaccines;
  - the consequences of the pandemic on provision for non-COVID related conditions and needs; and
  - provision for those experiencing long-COVID.

- The economic response to the pandemic and its impact, including government interventions by way of:

  - support for businesses and jobs, including the Coronavirus Job Retention Scheme, the Self-Employment Income Support Scheme, loans schemes, business rates relief and grants;
  - additional funding for relevant public services; and
  - benefits and sick pay, and support for vulnerable people.

2. Identify the lessons to be learned from the above, thereby to inform the UK's preparations for future pandemics:

   - In meeting these aims, the inquiry will:

     - listen to the experiences of bereaved families and others who have suffered hardship or loss as a result of the pandemic. Although the inquiry will not investigate individual cases of harm or death in detail, listening to these accounts will inform its understanding of the impact of the pandemic and the response, and of the lessons to be learned;
     - highlight where lessons identified from preparedness and the response to the pandemic may be applicable to other civil emergencies;
     - consider the experiences of and impact on health and care sector workers, and other key workers, during the pandemic;
     - consider any disparities evident in the impact of the pandemic and the state's response, including those relating to protected characteristics under the Equality Act 2010 and equality categories under the Northern

	Ireland Act 1998, as applicable; - have reasonable regard to relevant international comparisons; and - produce its reports (including interim reports) and any recommendations in a timely manner. We continue to work with our external advisers to scope and prepare for the inquiry. It is not expected that any public hearings will formally take place until spring 2023.
1.3	**Serious Incidents** The Trust declared 4 serious incidents in the month of February 2022; this is a decrease on the previous month. The Serious Incident panel report and investigate under the Serious Incident Framework so that learning can be identified. There were no common themes or areas identified from the 4 reported incidents, which spanned areas of the trust, including Diagnostics and Clinical Support (1) Medicine (1) and Acute (2). The Trust reported one Never Event in the month of February relating to a misplaced NG tube in ITU. Duty of Candour has been commenced in line with legislation and national guidance. **RIDDOR** Since the last report one incident was reported to the Health & Safety Executive in accordance with RIDDOR. This event was reported as a specified injury (a fracture) following a slip on a wet wipe which had been dropped on the floor. The event was subject to a RIDDOR local review investigation.
1.4	**Confirmation of Integrated Care Board Place Director for Wirral** Through a recruitment process led by Cheshire and Merseyside Integrated Care Board (ICB), in conjunction with Wirral Council and Partner Provider Organisations, the ICB have appointed Mr Simon Banks as the Wirral Place Director. Simon is currently the Accountable Officer for Wirral CCG and will formally commence in post on 1 July 2022, when NHS Cheshire and Merseyside Integrated Care Board (ICB) is established. It is expected that Simon will become involved from early April 2022 so he can contribute to the further design of the integration agenda at Place. Working closely with local partners, the Place Director will play a central role in the future integration of health and care across Wirral, working in conjunction with WUTH, taking a lead on tackling the health inequalities within our local communities.

2	**Implications**
2.1	N/A

3	**Conclusion**
3.1	The Board are asked to Note and receive this report

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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors **Item No 8**
6th April 2022

Title	Chief Operating Officer's Report
Area Lead	Chief Operating Officer
Author	Hayley Kendall, Chief Operating Officer Nicola Cundle-Carr, Head of BI Planned Care Jane Tombleson, Winter Resilience Director
Report for	For information

Report Purpose and Recommendations

This paper provides an overview of the Trust's current performance against the re-set and recovery programme for planned care and standard reporting for unscheduled care.

For planned care activity volumes, it highlights the Trust's 4-week average for weeks concluding 06/03/22 and the current February performance (snapshot at 16/03/22) as well as providing the latest comparative data nationally, across Cheshire & Merseyside (C&M) and the Northwest.

For unscheduled care, the report details performance and highlights the ongoing challenges with long length of stay patients and the impact this has on Urgent and Emergency Care (UEC) performance. The report also highlights the number of patients who remain in the department for longer than 12 hours since arrival. This is in preparation for the proposed new clinical standards from 1st April 2022.

The report also provides current risks in the Trust's ability to return to pre-pandemic activity levels and general Emergency Department (ED) performance overall on a sustainable level together with associated mitigations underway to manage these.

The Board of Directors is asked to note the performance and mitigations outlined within the paper.

Key Risks

This report relates to these key risks:

- Delivering timely and safe care for patients awaiting elective treatment
- Performance against the core UEC standards

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey
This is an annual report to the Board.

1	Introduction / Background
	March 2020 saw the first large scale cancellation of all, but the most urgent elective activities aligned to the National Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic. Over the last 23 months elective activity has been re-started and suspended during the 2nd and 3rd COVID19 waves alongside general disruption due to ongoing COVID19 pressures during this period. This has impacted negatively on both waiting list numbers and waiting times for treatment, in line with all hospitals within the region. The delivery of reset and recovery elective activity commenced in 2021 with the focus areas being on treating the most clinically urgent patients first followed by the long waiters. The Trust has operated in line with the national categorisation of elective patients awaiting treatment and there is clear sight of the volumes of patients waiting across the clinical categories. This is reviewed on a weekly basis by the clinical division and reported via the weekly Performance Oversight Group.

2	Planned Care
2.1	**Elective Activity** The national standard was to achieve 95% of 2019 comparable month's activity across all Points of Delivery (PODs). There are three things to note: 1. The actual is based on the value of the activity with activity numbers used as a proxy. 2. The threshold was revised for H2 2021/22 planning in that Trusts are required to close 89% of RTT pathways compared to the comparable month in 2019 to access to the Elective Recovery Fund (ERF). 3. To clear the backlog, systems need to be undertaking more than 100% of activity delivered in the comparable month of 2019. The table below summarises the 4-week average activity delivered for weeks concluding 06/03/2022:

POD	National	North West	Cheshire & Mersey	WUTH
OP New	92%	97%	95%	104%
OP FU	95%	100%	103%	116%
Day Case	84%	77%	72%	98%
Elective IP	81%	89%	91%	77%

The number of closed RTT pathways as a percentage of those closed within the comparable month of 2019 is shown in the below table.

	Admitted	Non-Admitted
Cheshire & Merseyside	92%	95%
WUTH	245%	84%

2.2	**Priority 2 Performance (P2)** The Trust continues to overachieve against the P2 month end trajectories with March's position better than plan at 66 open pathways against a month end plan of 72 open pathways.

2.3	**Referral to Treatment** • 52 Week Wait Performance Currently there are 578 patients waiting longer than 52 weeks which is below the Trust's submitted trajectory to C&M. Across C&M there are currently 16,010 patients waiting longer than 52 weeks for treatment. • 104 Week Wait Performance As at the end of February the Trust had a total of 11 patients waiting longer than 104 weeks for treatment against the January trajectory of 14, the current position as at 17th March is 6. Across C&M there are currently 1,170 patients waiting over 104 weeks. The National standard is to have zero 104-week waiters by July 2022. WUTH are aiming to have zero by end March 2022 with plans to hold this position thereafter. • Waiting List Size There are 29,807 patients on an active RTT pathway under WUTH services which is higher than the Trust's submitted trajectory to C&M of 27,431. This position has deteriorated since December 2020 mainly due to the significant decrease in elective activity due to Covid and non-elective pressures and the volume of patients that are currently inpatients that do not meet the criteria to reside. It is acknowledged nationally that the expectation is for all Trust's waiting list sizes continue to increase into 2024.
2.4	**Cancer Backlog Performance** Full detail of the cancer performance is covered within the Trust Dashboard, but exceptions are covered within this section. • 2 week waits There continues to be a particular challenge with performance within Breast Surgery due to the significant increase in referrals from early in 2021. At present recovering performance against the 2-week waits will be challenging for this financial year and trajectories are being developed as part of operational planning. • 31 and 62 day treatment There are continued pressures in the achievement of both standards within Colorectal and Urology. The Surgical Division have developed a recovery plan which is monitored through the weekly Performance Oversight Group. The current position is 75 62-day long waiters against a plan of 57. Cancer performance for Q3 performance was not achieved due to the number of Breast, Urology and Colorectal breaches and this will continue into Q4 which is driven by increases in referrals and prolonged capacity constraints. All activity plans for 2022/23 will incorporate mitigating actions to ensure performance returns to previous levels.
2.5	**DM01 Performance** The Trust did not achieve the required 99% in February 2022. Divisional Teams are currently working through recovery trajectories for the modalities not achieving 99% with a particular focus on Endoscopy recovery specifically increasing the number of points per list and continued use of Insourcing during 22/23. These will be monitored via the Performance Oversight Group.
2.6	**Risks to recovery and mitigations** There are robust systems in place to monitor and review elective performance, but there remain significant risks in performance and activity delivery as the rise in COVID admissions continues to hinder elective operational activities coupled with the loss of several theatres due to breakdowns over the last few weeks. In addition, workforce availability is a key challenge,

	balancing the requirement to deliver elective recovery, capacity for non-elective demand and continue to support the health and wellbeing of our people.
	
	The clinical divisions are well sighted on the risks to recovery and do have mitigations in place briefly summarised below:
	
	• Full participation in the C&M elective recovery programme which is supporting the coordination of:
	  ○ Use of the Independent Sector and Insourcing
	  ○ Regional/national capital, revenue, and technology bids to increase capacity and throughput.
	  ○ Regional review and agreement around staffing requirements to maximise qualified staff utilisation, particularly in critical care
	  ○ Introduction of HVLC (High Volume Low Complexity) surgical pathways including theatre lite alongside organisational bench marking.
	  ○ Green site working with the development on the Clatterbridge site
	• Divisional Director led cancer remedial action plans.
	• Appraisal of robot usage by non-cancer specialities/patients along with full service and staffing review.
	• Patient level tracking and active management in place monitored by the Divisional Directors via their weekly Access and Performance meetings and COO Performance Oversight Group.
	• Full participation in regional performance governance arrangements
	
	The Trust has also submitted ambitious but deliverable activity plans for the 2022/23 financial year to C&M that will further aid recovery and reduce waiting times across all points of delivery and modalities.

3.0	**Unscheduled Care**
3.1	**Performance** Performance for the APH site type 1: • February was 52.29% and YTD 56.88% • Including UTC 63.05% and YTD 66.17% The all-type Wirral Performance for February was 75.14% and 76.38% YTD. A total of 3,411 type 1 four-hour breaches were recorded in February. The key quality ED metrics which impact four-hour performance are the wait to be seen by an ED doctor after arriving in the Department and the 15 minute time to triage, In February, 31.99% of ED patients were seen by a doctor within 60 minutes of arriving in the Department, 61.74% of patients were triaged within 15 minutes of arrival. The Trust saw average daily attendances of 255 in February, an increase in the average of 230 for the same period in 2019/20. Total attendances for February were 7,150 against 6,694 for same period in 2019/20, an increase of 6.8%. Increasing delays in accessing Mental Health beds resulted in a number of reportable 12 hour breaches – 17 reported in January and 16 reported in February. The department has seen an average length of stay of 33 hours in the department awaiting MH inpatient bed capacity. The Trust saw a slight increase in conversion rate, an average of 28% compared to 27% in January.

	In February 79.2% were recorded as ED Delays, there were 3441 breaches in February of which 2,704 were ED delays. Total ambulance turnaround time was not achieved in February 2022 with a mean time of 36 mins against the 30 minute standard. Mean arrival to handover time was 25 minutes against the 15-minute standard. There were a total of 1592 ambulance conveyances in February, 37.75% within 15-30 minutes, 9.40% within 30-60 minutes and 6.09% above 60 minutes. The average number of super stranded patients (>21days LOS) increased in February to 197. Work is ongoing both internally and externally with system partners to improve the current position. The G&A Bed occupancy excluding silver capacity was 97.97% in February impacting on flow and contributing to overcrowding/ambulance handover delays in ED and assessment areas. In conclusion performance was significantly challenged in February due to increasing demands and high bed occupancy across the organisation.
3.2	**UEC and Winter Improvement** The Trust has embarked on a significant improvement plan focussed on urgent care and actions to mitigate operational pressures experienced during winter months in partnership with wider healthcare providers across the Wirral system. Progress against these plans are summarised as follows and the Programmes of work (UEC/Discharge) will now be managed through Programme Board and Performance Oversight Group. • "Frailty at the Front Door" pilot on-going with significant success. 190+ patients have now been turned around / discharge supported since the trial began on 17/01/22 – an average of 22 per week saving a significant bed days • Ambulance Handover Times improved significantly within January and February as a result of improvement work with NWAS and enhanced operational oversight • All paper-based trials of the Patient Safety Checklist now complete. Live trials due to start in April and NWAS are happy with the progress the Trust is making • 1200+ patients streamed to UTC following implementation of revised streaming model at the front door. This has improved patient experience and responds to a CQC recommendation • Clinical Review Standards developed and reportable pending next steps nationally • New GP / senior clinician streaming fast track model mobilised within ED to support an improvement in the minors performance • Governance and reporting structure now in place and meetings held throughout February and March within the Acute & Emergency Division • Work has commenced on the delivery of a Discharge Hub led by the System Discharge Director to support improved discharge performance • Existing discharge pathways mapped, the focus is now on pathway redesign • Discharge Delivery Project has changed a Cerner workflow to improve accuracy of CTR recording, agreed a plan for Model Board Round rollout and commenced Daily Discharge Checks on medical wards • Trajectory to deliver a reduction in the number of patients on Pathway 1, 2 and 3 is monitored through daily COO and CEO meetings.
3.3	**Risks to improving performance** • Physical environment in ED is challenging during peaks in demand impacting on ability to deliver the timed pathways • Delivery of the LLOS recovery trajectory is at risk due to community capacity constraints for Pathway 1,2,3 patients

	• Risk to delivery of additional step down capacity due to staff shortages and IPC guidance in both nursing homes and domiciliary care providers • Boarding time in department increased due to bed pressures • Increasing mental health activity and significant increases of attendances under S136 • Significant increase in the number of patients who do not meet the Criteria to reside on Pathway 1,2 and 3 due to capacity constraints within the Wirral system Availability of mental health inpatient beds resulting in 12 hour breaches for mental health patients.

4.0	Conclusion
	The Trust had a significantly challenged month in relation to non-elective demands and rising rates of patients admitted with Covid. Despite these challenges the improvement programme has continued and demonstrated the benefit of some of the clinical pathway changes. Recovery of the elective programme has continued, and performance is achieving the trajectories set, but pressure from non-elective demand is increasingly challenging.

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Board of Directors
6th April 2022

Item 9.1

Title	Quality and Performance Dashboard
Area Lead	Executive Team
Author	John Halliday - Assistant Director of Information
Report for	Information

Report Purpose and Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of February 2022.

It is recommended that the Board:

- notes performance to the end of February 2022

Key Risks

This report relates to the key Risks of:

- Quality and safety of care
- Patient flow management during periods of high demand

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey

Date	Forum	Report Title	Purpose/Decision
15th March 2022	Executive Management Team	WUTH Quality Dashboard Metrics Review March 2022	Discussion on results of review and agreement on next steps

1	Narrative
1.1	Of the 47 indicators that are reported (excluding Use of Resources): - 28 are off-target or failing to meet performance thresholds - 19 are on-target The metrics included are under review with the Executive Directors to consider the appropriateness and value of inclusion and the performance thresholds being applied. Amendments to previous metrics and/or thresholds are detailed below the dashboard.

2	Implications
2.1	The issues and actions undertaken for those metrics that are not meeting the required standards are included in the additional exception reports or covered within the Chief Operating Officers Report.

3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Quality and Performance Dashboard, and weekly at the operational meetings with the Clinical Divisions.

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Quality Performance Dashboard

March 2022
Upated 14-03-22

	Indicator	Objective	Director	Threshold	Set by	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	2021/22	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	CN	≤0.24 per 1000 Bed Days	WUTH	0.11	0.16	0.10	0.20	0.05	0.05	0.10	0.10	0.05	0.19	0.18	0.18	0.20	0.13	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	94.9%	94.0%	94.4%	94.5%	94.7%	93.3%	95.2%	94.5%	94.5%	95.2%	94.4%	94.6%	94.0%	94.48%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	96.6%	96.2%	96.4%	96.6%	96.6%	96.2%	97.6%	96.9%	96.9%	97.2%	96.9%	96.7%	96.2%	96.7%	
	Serious Incidents declared	Safe, high quality care	CN	≤48 per annum (max 4 per month)	WUTH	5	4	5	4	8	7	4	5	7	3	4	9	4	60	
	Never Events	Safe, high quality care	CN	0	SOF	1	0	0	1	0	2	0	0	0	0	0	0	1	4	
	CAS Alerts not completed by deadline	Safe, high quality care	CN	0	SOF	0	0	0	1	0	0	0	0	0	0	0	0	0	1	
	Clostridium difficile (healthcare associated)	Safe, high quality care	CN	Maximum 79 cases for 2021-22, with a varying trajectory of a max 6 to 8 cases per month	WUTH	7	6	5	7	5	1	6	13	6	5	3	18	12	81	
	Gram negative bacteraemia	Safe, high quality care	CN	Maximum 63 for financial year 2021-22, with a varying trajectory of a maximum 5 or 6 cases per month	National	6	6	3	5	7	3	3	2	7	6	8	4	2	50	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	0	1	0	0	0	0	0	0	0	1	2	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	98.9%	100.0%	99.2%	99.2%	99.0%	99.3%	99.0%	99.2%	99.2%	99.2%	99.4%	99.1%	99.8%	99.2%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	0	0	0	1	1	0	0	0	0	0	1	1	4	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	Not avail	96%	96%	96%	95%	96%	96%	96%	95%	96%	96%	94%	95%	96%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	79.1%	79.9%	84.3%	85.9%	87.5%	89.1%	91.0%	91.1%	90.0%	89.3%	88.9%	86.9%	86.6%	88.2%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	84.1%	82.3%	83.0%	83.6%	83.9%	86.1%	85.9%	87.2%	86.9%	86.0%	85.1%	84.5%	84.1%	85.1%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	80.1%	67.0%	69.5%	70.8%	72.3%	74.3%	75.5%	75.0%	73.6%	74.5%	72.5%	71.5%	73.3%	73.0%	
	Attendance % (12-month rolling average)	Safe, high quality care	CPO	≥95%	SOF	93.42%	93.48%	93.79%	93.90%	93.95%	93.88%	93.83%	93.79%	93.78%	93.76%	93.60%	93.52%	93.47%	93.47%	
	Attendance % (in-month rate)	Safe, high quality care	CPO	≥95%	SOF	93.91%	94.71%	94.62%	94.32%	94.32%	93.52%	93.47%	93.38%	93.33%	93.63%	92.14%	91.28%	92.95%	93.36%	
	Staff turnover % (in-month rate)	Safe, high quality care	CPO	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	0.67%	0.77%	0.95%	0.72%	0.79%	1.22%	1.86%	1.09%	1.01%	0.79%	1.10%	1.23%	0.95%	1.06%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	CPO	≤10%	WUTH	13.9%	13.0%	13.5%	13.2%	13.3%	13.0%	12.6%	12.9%	13.3%	13.2%	13.4%	13.7%	13.9%	13.9%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	8.9	9.0	8.7	8.3	8.8	8.5	8.4	8.2	8.2	7.6	8.1	8.0	8.4	8.3	

Quality Performance Dashboard

March 2022
Upated 14-03-22

	Indicator	Objective	Director	Threshold	Set by	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	2021/22	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	95.3%	98.0%	98.4%	98.3%	98.3%	95.9%	96.7%	96.4%	96.2%	93.8%	92.6%	91.7%	96.7%	95.9%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	97%	97%	99.0%	98.0%	98.0%	98.0%	97.0%	96.0%	96.4%	95.5%	94.6%	95.2%	97.3%	96.8%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	18.2%	16.8%	17.3%	17.2%	18.3%	19.9%	19.0%	16.9%	17.6%	17.3%	17.7%	18.8%	17.9%	18.0%	
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	MD / COO	≤156 (WUTH Total)	WUTH	354	341	323	329	318	319	368	393	416	432	441	469	456	456	
	Long length of stay - number of patients in hospital for 21 or more days	Safe, high quality care	MD / COO	Maintain at a maximum 52 (revised Sept 2020)	WUTH	106	88	96	85	99	95	126	132	126	141	157	206	195	195	
	Length of stay - elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤5.3 days average	WUTH	3.2	3.1	3.6	3.3	3.5	3.8	3.8	3.6	3.6	3.5	3.3	2.8	3.9	3.5	
	Length of stay - non elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤7.3 days average	WUTH	4.4	4.2	3.8	4.0	4.0	4.1	4.2	4.4	4.7	4.4	4.7	4.6	5.3	4.4	
	Emergency readmissions within 28 days	Safe, high quality care	COO	≤1,110 per month	WUTH	938	1097	1149	1131	1084	1115	1018	1010	1070	1039	1062	1012	925	1056	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	81.3%	84.9%	84.5%	85.5%	82.5%	79.8%	82.0%	83.4%	83.7%	82.0%	77.9%	77.2%	77.9%	81.5%	

	Indicator	Objective	Director	Threshold	Set by	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	2021/22	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	0	0	2	2	3	4	1	2	2	3	8	3	2	32	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	87.0%	85.0%	84.0%	83.0%	82.0%	76.0%	76.0%	71.1%	72.8%	72.4%	77.7%	75.9%	77.3%	77.1%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	91.0%	92.0%	94.0%	95.0%	95.0%	95.0%	96.0%	94.0%	94.3%	95.1%	94.4%	95.4%	94.5%	94.8%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	95.0%	95.0%	95.0%	94.0%	95.0%	93.0%	94.0%	93.2%	94.1%	93.7%	94.3%	94.3%	94.1%	94.1%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	67.0%	94.0%	99.0%	95.0%	93.0%	97.0%	98.0%	94.1%	98.8%	94.7%	94.6%	96.6%	93.5%	95.8%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	2021/22	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	NHSI Trajectory 2020-21, and Q2 21-22	SOF	76.8%	77.8%	76.1%	73.5%	78.0%	67.8%	66.2%	63.4%	62.6%	59.5%	60.6%	59.1%	63.1%	66.4%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	0	0	0	1	7	11	8	6	6	13	7	59	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	TBD	National	77.8%	78.8%	73.4%	68.1%	73.4%	57.7%	66.7%	48.1%	58.1%	49.8%	57.2%	57.3%	61.7%	61.1%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	TBD	National	2.3%	1.6%	1.7%	2.6%	2.3%	7.9%	4.9%	9.2%	8.0%	9.4%	8.8%	10.7%	8.0%	6.7%	
	Proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed	Safe, high quality care	COO	TBD	National	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	78.9%	74.6%	73.9%	82.4%	77.5%	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	6.6%	6.8%	8.2%	10.4%	7.6%	14.5%	14.3%	23.5%	21.9%	22.8%	19.2%	18.0%	15.5%	16.0%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	67.89%	69.26%	69.61%	72.57%	75.64%	75.13%	74.14%	72.88%	70.84%	70.14%	67.84%	67.57%	65.89%	65.89%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSEI H2 Plans Trajectory : Oct 21 to March 22	National	21955	23444	24774	25873	26671	26979	27306	27424	26935	27046	27406	28665	29445	29445	
	Referral to Treatment - cases waiting 0-18 wks	Safe, high quality care	COO	n/a	WUTH	14906	16238	17246	18775	20174	20270	20244	19986	19080	18969	18593	19370	19452	19452	
	Referral to Treatment - cases waiting 19-26 wks	Safe, high quality care	COO	n/a	WUTH	2903	2793	3054	2763	2552	3103	3302	3508	3807	3858	3827	3751	4160	4160	
	Referral to Treatment - cases waiting 27-40 wks	Safe, high quality care	COO	n/a	WUTH	2328	2802	2985	2843	2555	2222	2297	2445	2703	2997	3551	3969	4056	4056	
	Referral to Treatment - cases waiting 41-52 wks	Safe, high quality care	COO	n/a	WUTH	710	443	615	859	864	877	903	879	770	712	878	1100	1338	1338	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSEI H2 Plans Trajectory : Oct 21 to March 22	National	1108	1168	874	633	526	507	560	606	575	510	557	475	525	525	
	Referral to Treatment - cases exceeding 104 weeks	Safe, high quality care	COO	NHSEI H2 Plans Trajectory : Oct 21 to March 22	National	0	0	1	1	1	3	3	7	10	5	5	4	5	5	
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥99%	SOF	94.3%	97.4%	97.7%	98.5%	96.8%	87.5%	86.0%	91.3%	94.3%	93.0%	89.8%	87.3%	86.4%	91.7%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	97.6%	98.8%	96.9%	97.6%	97.2%	95.4%	93.7%	95.7%	96.1%	87.9%	91.4%	76.2%	78.0%	91.5%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	-	97.64%	-	-	97.21%	-	-	94.95%	-	-	91.63%	-	-	96.1%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	93.0%	93.5%	94.7%	95.2%	99.2%	96.3%	96.4%	96.5%	95.4%	94.3%	94.8%	94.6%	85.7%	94.8%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	-	94.73%	-	-	96.26%	-	-	96.41%	-	-	94.85%	-	-	96.3%	
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	82.1%	84.1%	84.5%	84.1%	85.3%	84.7%	85.9%	84.4%	79.2%	79.7%	79.3%	79.6%	75.0%	82.0%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	-	82.56%	-	-	84.66%	-	-	85.05%	-	-	79.38	-	-	84.9%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	165	170	157	156	145	209	213	218	216	177	149	180	187	182	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	3.56	4.07	4.09	2.56	4.04	4.20	3.31	3.29	2.56	3.27	3.26	2.34	4.87	3.44	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	95%	100%	93%	95%	100%	94%	94%	100%	61%	100%	100%	100%	94%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	4	4	0	2	1	2	5	2	3	4	3	2	0	2	

Quality Performance Dashboard

March 2022
Upated 14-03-22

	Indicator	Objective	Director	Threshold	Set by	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	2021/22	Trend
Well-led	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	CN	100%	National	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	700 for FY 21/22 (cumulative 59 per month until year total achieved)	National	206	87	22	38	107	279	457	611	790	1022	1209	1545	1697	1697	
	% Appraisal compliance	Safe, high quality care	CPO	≥88%	WUTH	74.7%	77.0%	81.0%	81.3%	82.7%	82.7%	82.2%	81.2%	82.2%	82.7%	82.3%	82.0%	78.0%	78.0%	

	Indicator	Objective	Director	Threshold	Set by	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	2021/22	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	-5.4	3.5	0.8	-0.5	-0.2	0.0	0.2	-0.2		-0.7	-0.6	2.3	-0.1	0.0	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	-5.4	3.9	0.8	-0.4	-0.4	0.0	0.2	-0.1	0.0	1.0	-0.9	1.9	-0.5	0.6	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2	
	CIP Performance (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.0	0.0	3.02%	6.03%	9.05%	14.50%	Not reported	77.21%	48.24%	78.70%	78.61%	78.6%	
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	-22.5%	-21.9%	-50.5%	-27.7%	-32.4%	-40.5%	-11.7%	-5.2%	-50.0%	-25.1%	-6.7%	-4.3%	-8.0%	-23.8%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-17.8	-16.9	-15.0	-15.5	-10.4	-15.7	-15.4	-15.2	-16.2	-15.9	-18.0	-16.2	-18.6	-18.6	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	-74.8%	100.0%	2.0%	5.6%	12.5%	18.0%	22.6%	24.4%	30.7%	36.3%	48.0%	59.0%	76.2%	76.2%	

(*) Updated Metrics

Metric Change

(**) Updated Thresholds

Threshold Change

WUTH Quality Dashboard Exception Report April 2022

Wirral University Teaching Hospital NHS Foundation Trust

Safe Domain

Eligible patients having VTE risk assessment within 12 hours of decision to admit

Executive Lead: Medical Director

Performance Issue:

A WUTH target has been set that at a minimum 95% of eligible patients will have a VTE risk assessment performed within 12 hours of the decision to admit. February performance was slightly below at 94.0%.

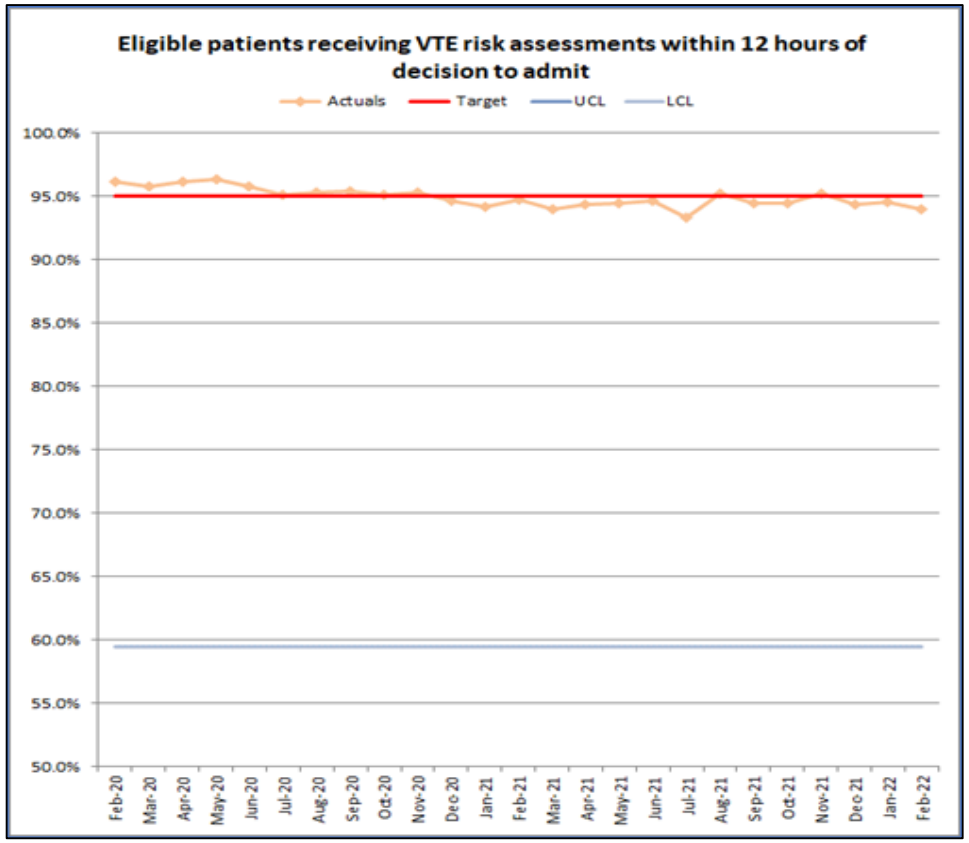
The nationally reported standard of all patients receiving a VTE risk assessment on admission to hospital is consistently met.

Action:

VTE compliance in each division is tracked through divisional governance reports to PSQB and through DPRs. A monthly report of all patients who did not receive as 12-hour assessment is shared with all AMDs to feedback to clinical teams. VTE compliance can also be tracked through the live BI portal.
Issues with data quality are being addressed to ensure all patients who do not clinically require a 12-hour assessment are not being inappropriately counted in the performance data.
Performance will continue to be closely monitored to ensure that there is not a significant deterioration in assessment and that there are no patient safety issues.

Expected Impact:

Improvement of performance to achieve minimum target value.



Clostridium difficile (Healthcare Associated)

Executive Lead: Chief Nurse

Performance Issue:

In respect of the COVID pandemic the National objective set for WUTH for healthcare associated *Clostridium difficile* infections (CDI) this year is 115. This is an increase in the previous year and is not reflective of the achievements made in reducing CDI for the last 2 years. To promote continuous improvement an internal threshold has been agreed: a target of 79 healthcare associated CDI cases or less for 2021-2022. This a 10% reduction of last year's objective of 88.
The cumulative position for 2021-2022 at the end of February is reported at 81 cases, and this is now higher than the cumulative threshold. The number of cases in the month of February 2022 was 12.

Action:

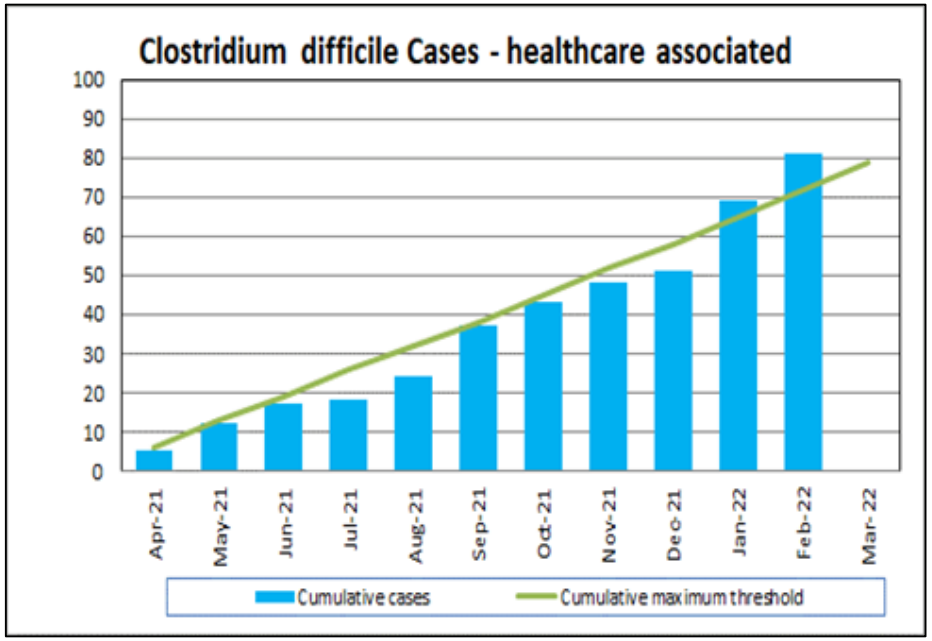
Several enhanced controls, actions and rapid QI initiative focusing on CDT across four wards and the completed that have resulted in the numbers of patients diagnosed with CDT reducing this month, despite this the IPC team have continued its increased support to the wards to ensure that improvements continue.

The weekly Chief Nurse led CDT meeting continues which reviews each patient pathway, identifying causative factors and developing local action plans to focus on improvements.

Trust currently remains significantly below the PHE target of 115 cases

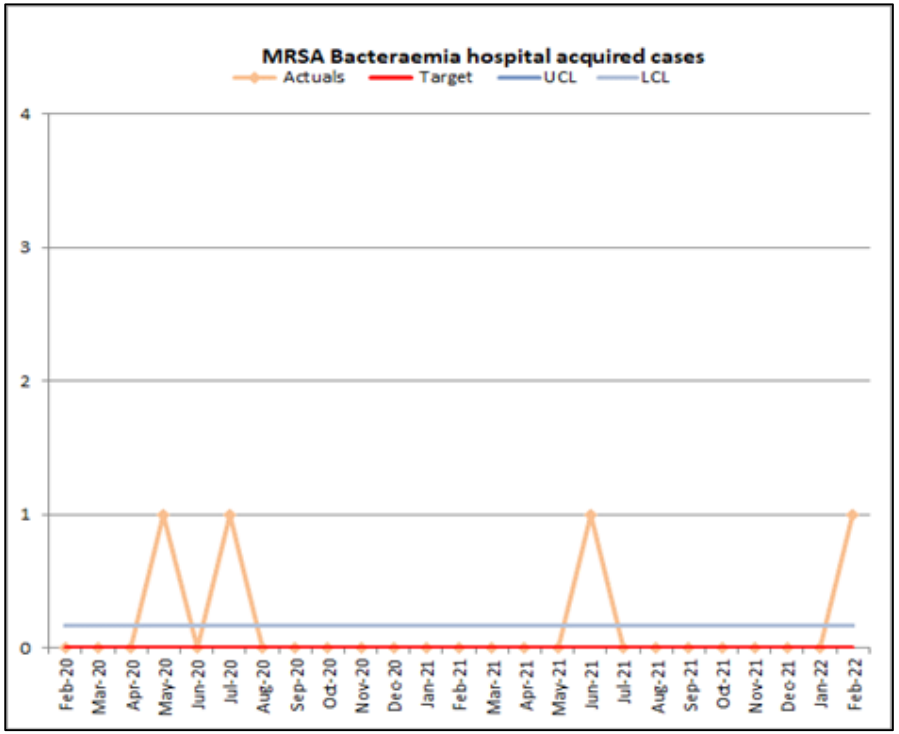
Expected Impact:

Healthcare associated *Clostridium difficile* cases to reduce



MRSA Bacteraemia – hospital acquired

Executive Lead: Chief Nurse
Performance Issue: Healthcare providers have been set the challenge of demonstrating '*zero tolerance'* of MRSA Bloodstream Infections. All MRSA blood stream infections are subject to a Post Infection Review (PIR). WUTH reported 1 MRSA bacteraemia in February 2022, with the most recent case before that being in June 2021.
Action: A Post Infection Review (PIR) has taken place and whilst it cannot be confirmed of the definite cause of the bacteraemia it was noted that on a previous admission the patient was colonised with MRSA although this was not detected on this admission screening. The patient had cannulas inserted which were identified as a potential risk factor. Lessons learnt were presented at the Divisional IPC meeting along with the resulting action plan**.** Lessons learnt are also shared at local safety huddles and Trust wide at the monthly IPCG.
Expected Impact: Targeted interventions will help to reduce the risk of MRSA bacteraemia.



Pressure Ulcers – hospital acquired category 3 and above

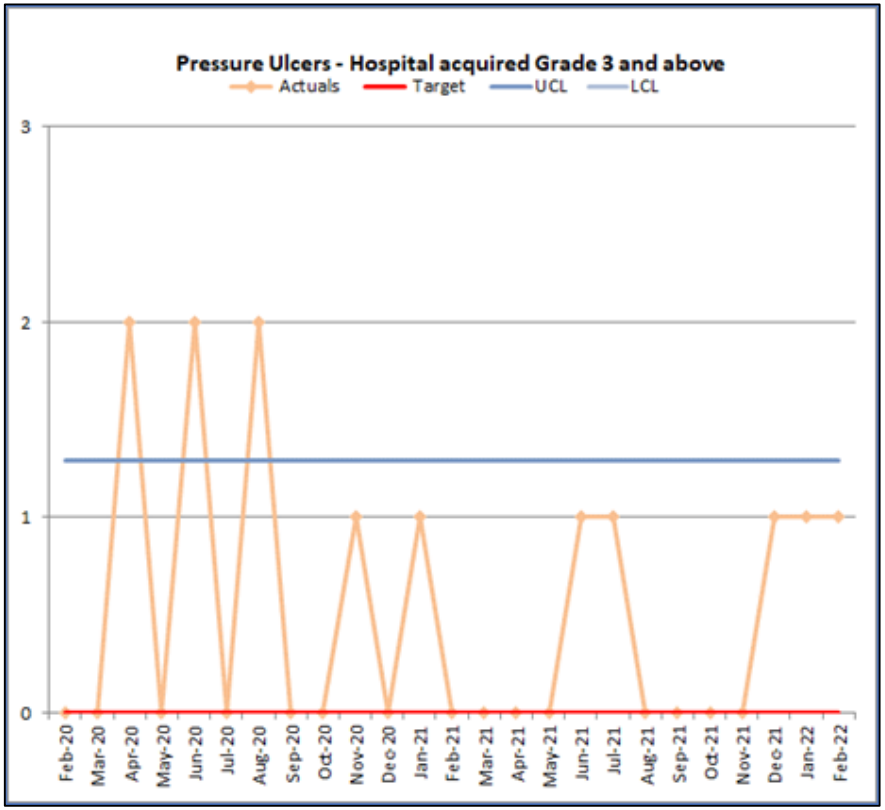
Executive Lead: Chief Nurse

Performance Issue:

WUTH has in an internal standard of zero hospital acquired pressure ulcers at category 3 or above.

Action:
There were two recorded Cat 3 pressure ulcers and one recorded Cat 4 in February 2022.
Scrutiny of both Category 3 incidents has been undertaken and learning shared. The findings suggest that there were no lapses in care directly resulting in deterioration. One patient was approaching last days of life and the second patient had a sudden deterioration in condition. Scrutiny of the HA Cat 4 which had deteriorated from a Cat 3 also suggested no lapses in care.
Tissue viability standards continue to be promoted across the Trust. An emphasis on supporting ED with skin assessments is ongoing alongside targeted education with individual clinicians. Introduction of the ASSKING bundle poster in all clinical areas as aide memoirs has raised awareness across the Trust. Tissue viability education e-learning and in person training is available. The Pressure Ulcer Prevention and Management Policy replicative of the Cheshire and Merseyside Pressure Ulcer Steering Group standards has been submitted for consultation.
There will now be focus on Moisture Associated Skin Damage (MASD) with the introduction of a leaflet and added E-Learning education to support a reduction of further skin deterioration. This will be supported by targeted improvement work led by the Corporate Nursing Team.

Expected Impact:
There will be a reduction in the number of patients with hospital acquired pressure damage. A reduction in MASD through increased awareness.



Protecting Vulnerable People Training - % Compliant Level 1

Executive Lead: Chief Nurse

Performance Issue:

WUTH has a target set at a minimum 90% of relevant staff being compliant with training. This standard has not been achieved in recent months, with February 2022 at 86.6%.

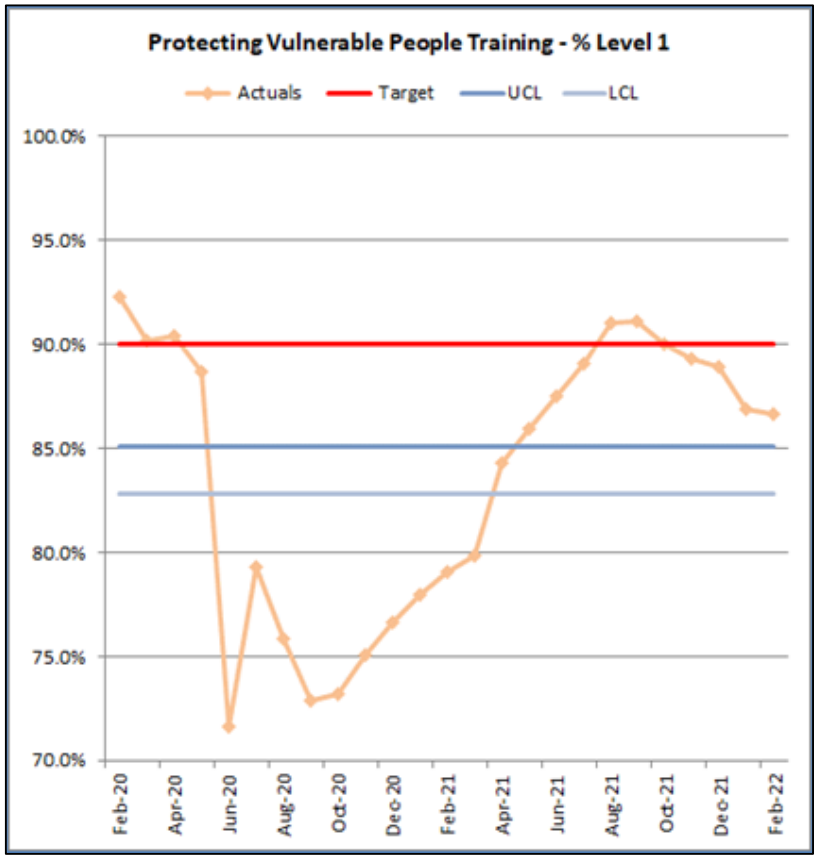
Improvements have been noted in Clinical Support (87.8%) and W&C who remain within the expected compliance over 90% (90.37%).
All Divisions remain over 87% compliance with corporate teams sitting at 77.81%.

Action:
Divisional triumvirates are aware of the declining position. Monthly reports continue to inform the leadership team of underperforming areas to enable a targeted approach to address low compliance during quarter 4. A list of non-compliant staff has been shared across the Triumvirates by the ADN for Safeguarding to address directly areas requiring improvements.

Training is available as eLearning that staff are able to access at any time; there are no capacity challenges for delivery of the training.

Expected Impact:

Level 1 PVP training compliance is expected to return to required compliance during Q4.



Protecting Vulnerable People Training - % Compliant Level 2

Executive Lead: Chief Nurse

Performance Issue:

Compliance target for level 2 training is set at a minimum of 90%. Performance has gradually declined since September 2021. February 2022 continued the recent deterioration to 84.1% compliance.

Action:

The recent suspension of mandatory training due to operational pressures during the pandemic have resulted in a declining position. Overall Divisions remain over 82% compliance except for Acute who are currently 77.88% compliant. Improvements have been noted in Medicine, Estates and Facilities and Surgery. Surgery is the only Division to have achieved compliance for level 2 PVP within February 2022.

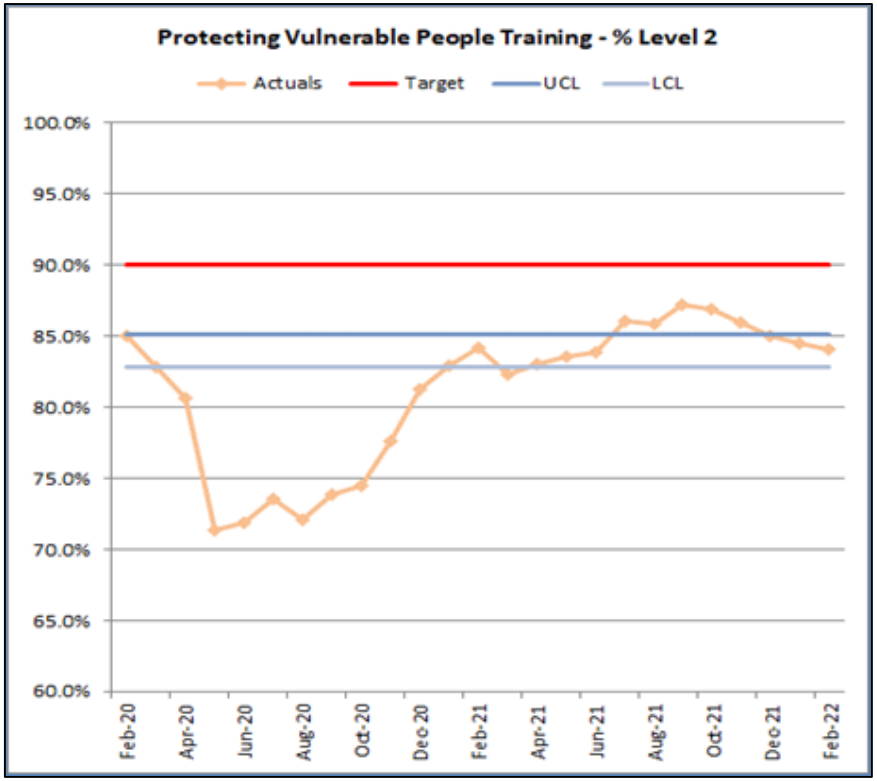
Divisional triumvirates are aware of the declining position. Monthly reports continue to inform the leadership team of underperforming areas to enable a targeted approach to address low compliance during quarter 4.

A list of non-compliant staff has been shared across the Triumvirates by the ADN for Safeguarding to address directly areas requiring improvements.

Training is available as eLearning that staff are able to access at any time; there are no capacity challenges for delivery of the training.

Expected Impact:

Level 2 PVP training is expected to increase towards the mandatory 90% compliance and above by the end of Q4.



Protecting Vulnerable People Training - % Compliant Level 3

Executive Lead: Chief Nurse

Performance Issue:

Compliance target is set at a minimum of 90% of relevant staff to have undertaken training every 3 years (available via eLearning). Performance improved in February 2022, up to 73.3%.

To comply with the intercollegiate training requirements for adults (2018) and children (2020) identified staff are required to have additional hours of interactive learning: this is set at a minimum of 90%.

Action:

All Divisions saw an improvement in Level 3 PVP compliance in February. Compliance across the divisions is over 70% with corporate as an outlier - compliance is currently 44.74%. Corporate requirements are currently being validated.

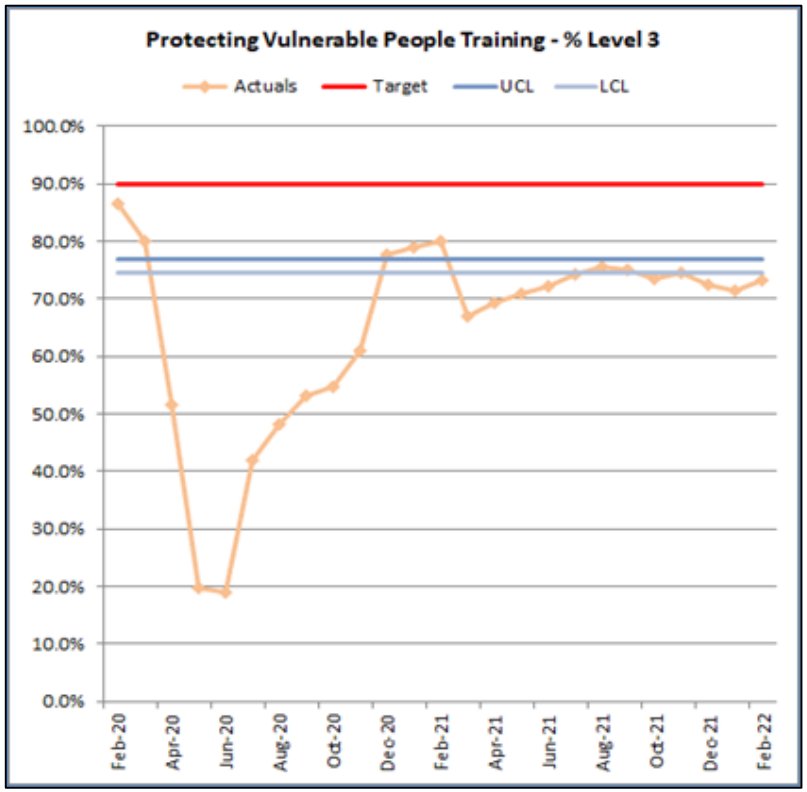
Divisional triumvirates are aware of the current position and further action required to achieve compliance to 90% and over by end of March (Q4).

Monthly reports continue to inform the leadership team of underperforming areas to enable a targeted approach to address low compliance during quarter 4.

Training is available as eLearning that staff are able to access at any time; there are no capacity challenges for delivery of the training. Bespoke training sessions are provided for interactive learning as required.

Expected Impact:

Level 3 PVP training is expected to increase towards the compliance requirement of 90% and aiming to be achieve by the end of Q4.



Staff attendance % (in-month rate)

Executive Lead: Chief People Officer

Performance Issue:

The Trust compliance threshold for sickness absence is 5%, both for in-month sickness and over a rolling 12-month period. Sickness absence was improved in February 2022, to 7.05%. Of this, 1.15% related to COVID-19.

All Divisions in February 2022 have exceeded the 5% KPI, although all Divisions showed an improvement in February 2022. It is noted that Estates and Hotel Services have continued to steadily improve since September 21.

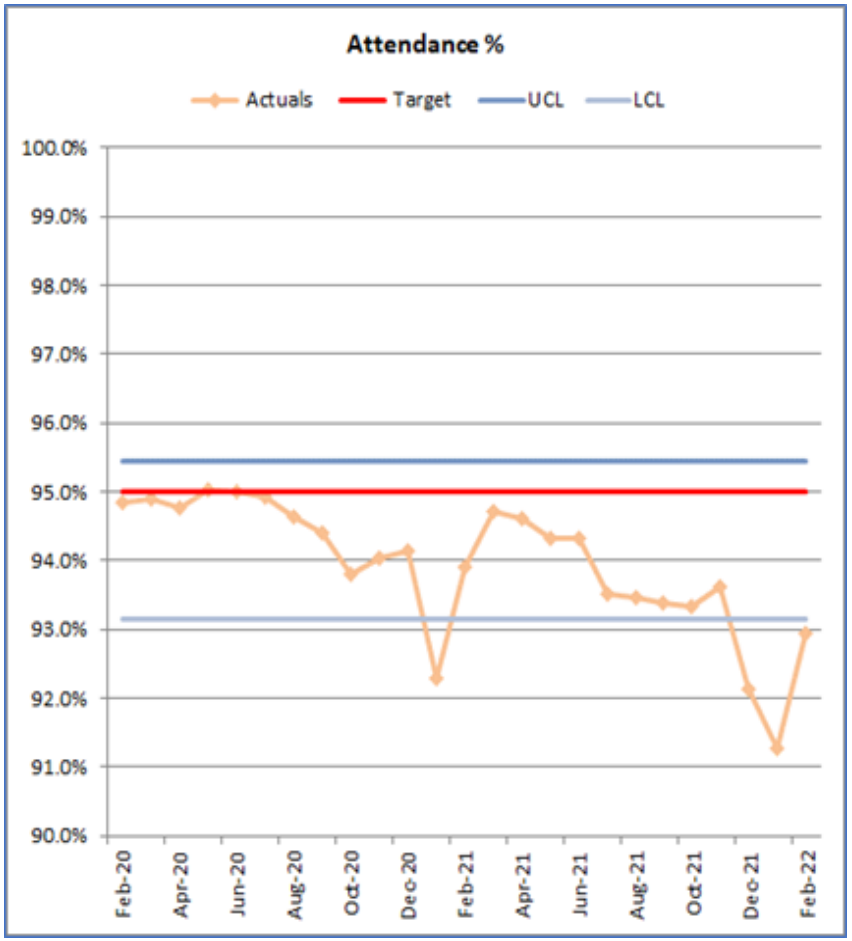
In February 2022, there was a further increase in long-term sickness absence as compared to January 2022. Proportionately, short term sickness absence continues to account for the majority (76%) of sickness absence.

Anxiety, Stress and Depression remains the highest reason (38%) for long term sickness absence. The 'Infectious Diseases' category was the highest reported reason for short-term sickness, followed by 'Gastrointestinal problems'.

Action:

Monitoring of the Sickness Attendance KPI and RTWs is on-going via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews (DPRs).

Work on the NHSE/I agreed HR Business Partner action plan continues against the Deep Dive Themes, in particular actions associated with the 'gold standard' recommendations regarding our Managing Attendance Policy and newly proposed Managers Toolkit.



All preparatory work for the full roll out of Health and Wellbeing Conversations has been complete, ahead of the 1 April 2022 launch date. The Workforce Wellbeing Winter Plan continues to be implemented. OH have recruited an additional Psychotherapist to support and strengthen our mental health response for counselling and cognitive behavioural therapy. OH are finalising the recruitment of an OH specialist Physiotherapist to manage MSK related injuries with a focus on returns and fitness to work as well as provide MSK resilience training to promote early identification and management of MSK injuries.
Expected Impact: The impact of high sickness is increased pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance and safety. Risks to Trust financial management, quality, patient safety and operational performance due to cost of sickness absence, expense of bank and agency cover will reduce as the sickness absence is gradually improved over time and as we emerge from the latest wave of the pandemic.

Staff turnover % (in month rate)

Executive Lead: Chief People Officer

Performance Issue:

The Trust target is set as a maximum rolling 12-month turnover threshold of 10%. Turnover in February 2022 was 0.95%, which is above the in-month KPI threshold of 0.83%.

If turnover is calculated based on permanent assignments only, excluding fixed term employees, the In-Month figure for February 2022 is 0.75% which is a reduction of 0.35% from January 2022.

The In-Month performance in Acute Care, Corporate Support and Women & Children's are all below the Trust Turnover KPI. All other Divisions are over the 10% KPI for the rolling 12 months.

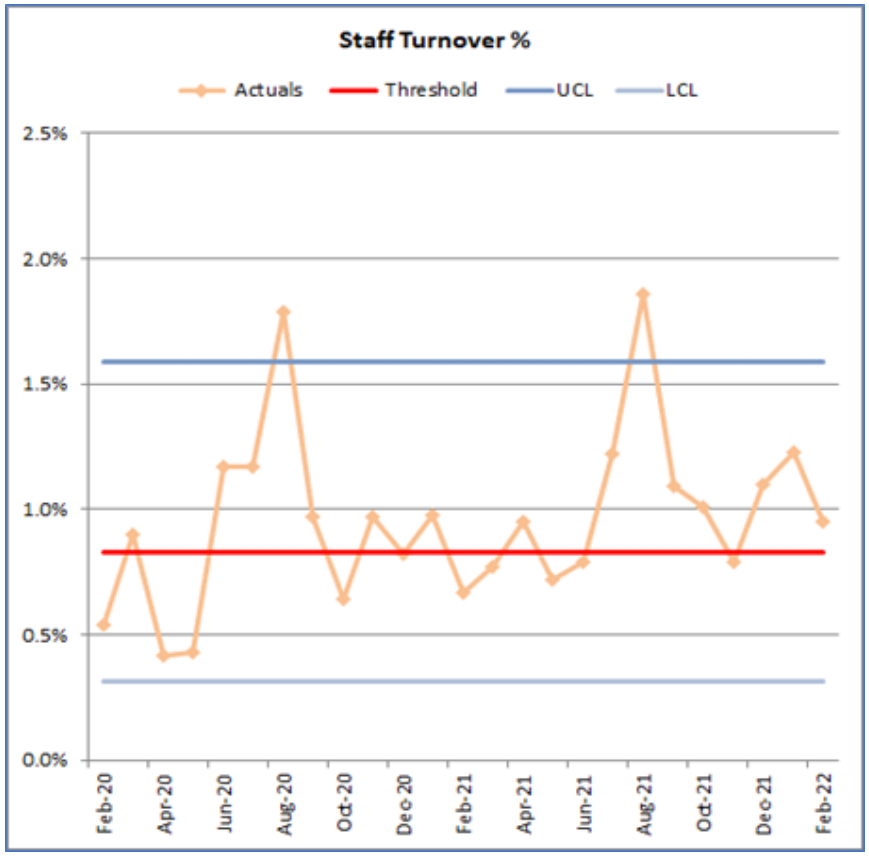
Actions:

Monitoring of the Turnover KPI is on-going via Divisional Management, Divisional governance infrastructure, and via Divisional Performance Reviews (DPRs), with specific actions in place according the local feedback.

<u>Current Interventions to support retention.</u>

Action is being taken to review and improve some core recruitment processes to ensure Nursing and CSW recruitment is managed through a centralised corporate recruitment pathway, rather than each Division undertaking separate campaigns. The next recruitment event is being held in May 2022, where recruitment leads will be invited to showcase their areas and attract new candidates.

The Trust are on target to deliver the 100 International Nurse Recruits. The intention is to complete delivery in time for the winter so the Trust can expect the last cohorts to be arriving in Sept/Oct.

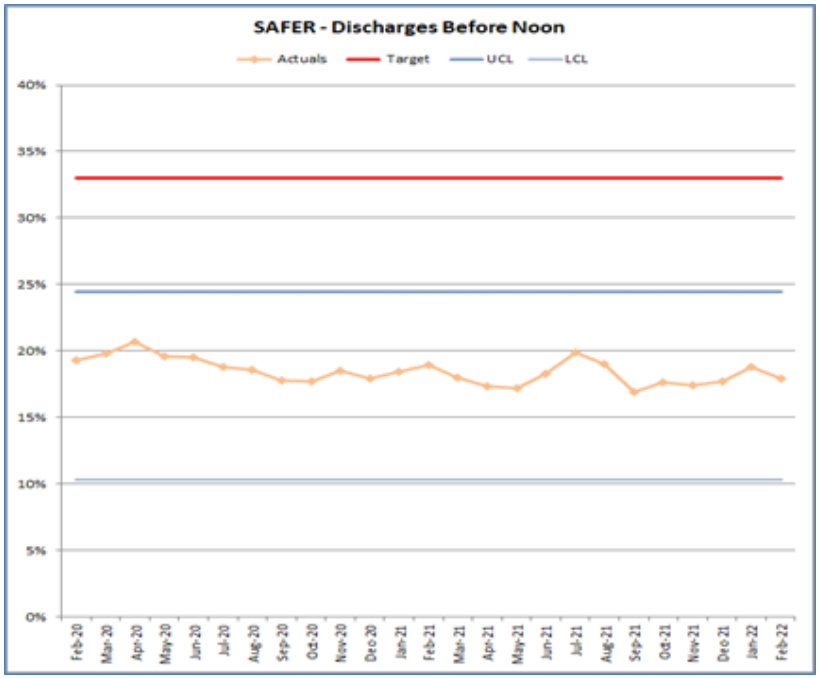


The Facilitation in Practice programme is scheduled for May 2022. Communications will be disseminated, and application forms will be available for staff to complete to obtain a place on the programme. Training dates for PARE and WEPP have been shared with preceptors. Details of new registrants will be also shared with Corporate Nursing to support WEPP. The “Golden Ticket” initiative is now being promoted with 3rd year students who are about to commence placement at WUTH.
Expected Impact: The impact of high Turnover increases pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance, and safety. Risks to Trust financial management, quality, patient safety and operational performance due to the cost of high Turnover and the expense of bank and agency cover should reduce as Turnover improves over time with the interventions outlined above.

Effective Domain

SAFER bundle: % of discharges taking place before noon

Executive Lead: Medical Director / Chief Operating Officer
Performance Issue: A WUTH target has been set that at a minimum 33% of inpatients are to be discharged before noon. The pattern of delivery has improved over the long term but is short of the optimum figure of 33%.
Action: The Trust is in the process of embedding the outputs of the ECIST intensive support from January that is focused on early discharge, structured board rounds to maximise flow through the organisation. There is daily visibility of the performance across all ward areas and discharges before noon are driven across all divisions.
Expected Impact: February data shows we were at 17.9% for patients discharged before midday. As per the above actions there is an expectation that this performance will improve with the roll out of the expected inpatient standards for all ward areas.



Theatre in session utilisation %

Executive Lead: Chief Operating Officer

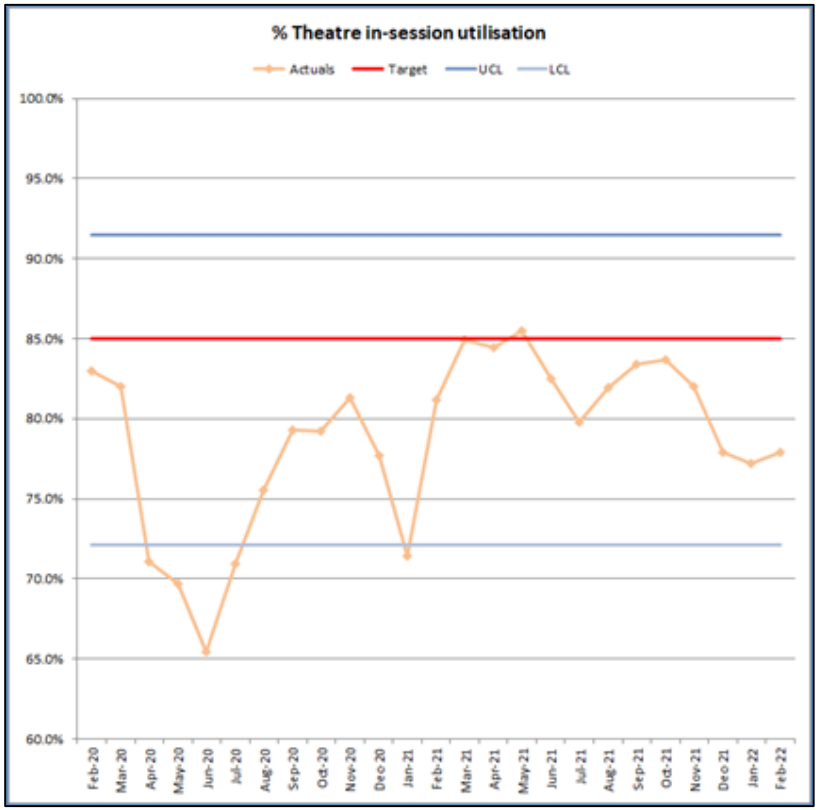
Performance Issue:
The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised.

Since September the Division had a real focus on improving utilisation of sessions as part of reset and recovery. This initially had the desired result, however, there have been further theatre ventilation failures resulting in theatres M1 – M5 and G1 being closed to maintain patient safety. Repairs are in place with M1 & M2 back in use in early March and a schedule of works for the remaining theatres being developed with all theatres expected to be in use from mid- May.

As COVID prevalence continues it has a direct impact on in-session utilisation due to patients being cancelled if their pre-op or pre-admission COVID swab is positive. Theatre lists are unable to be backfilled at such short notice due to clinical requirements and pathways. Proposals to change the process under "living with COVID" is to be presented at CAG this month.

COVID measures regarding PPE remain in place.

Following the reduction in January triggered by successional losses of elective wards across both sites, due to the number of patients not meeting the criteria to reside in hospital beds and COVID numbers increasing, IPC measures have been revised in view of national guidance enabling access to closed beds and the restoration of the elective wards.



Action:

- Maintain the Theatre scheduling meeting to minimise the loss of activity through theatre ventilation failures

• Maintain the daily TCI meeting to prevent cancellations on the day for inpatients and risk further reduction in in-session utilisation • Paper to CAG on the admission swab process and isolation periods • Theatre ventilation repair works schedule
Expected Impact: Increase in in session utilisation and increase in case throughput.

Caring Domain

Same sex accommodation breaches

Executive Lead: Chief Nurse

Performance Issue:

The national standard is set that providers should deliver same sex accommodation, except where it is considered in the overall best interests of the patient or reflects personal choice.

Same sex accommodation breaches are most often due to patients waiting more than 24 hours for transfer from critical care areas to general wards – there were 2 such breaches in February 2022. These reported breaches did not cause any delays or refused admissions to the Critical Care Unit as sufficient critical care bed capacity was available at this time. Patient's privacy and dignity needs are met whilst in critical care and the team ensures their specialty care is not compromised due to a lengthened critical care stay.

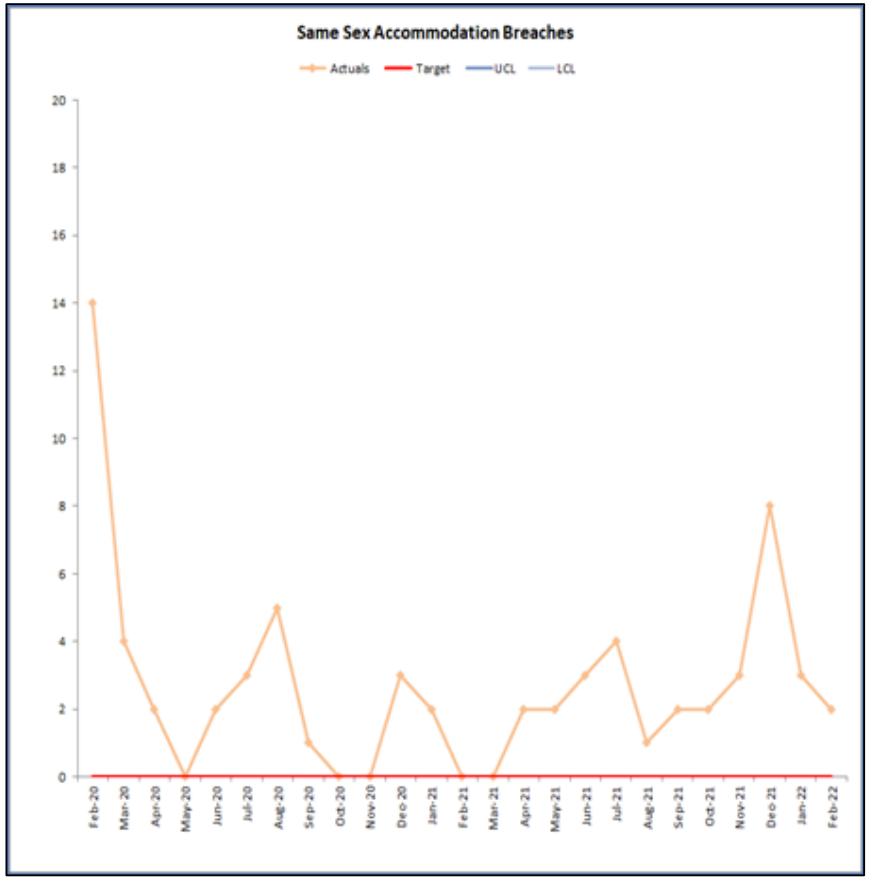
Action:

Increased pressure due to system challenges resulting in high levels of activity throughout the hospital and an increased proportion of patients with no criteria to reside continued in January 2022. Improvement noted in February

Joint working processes are in place, between critical care and the Patient Flow Team, to expedite discharges in response to an increase in acuity of patients.

Robust processes remain in place to ensure that delivering same sex accommodation continues to be a high priority and that breaches are managed promptly via bed capacity and operational meetings.

Expected Impact:
All patients are transferred to their specialty bed within 24 hours of discharge.



Responsive Domain

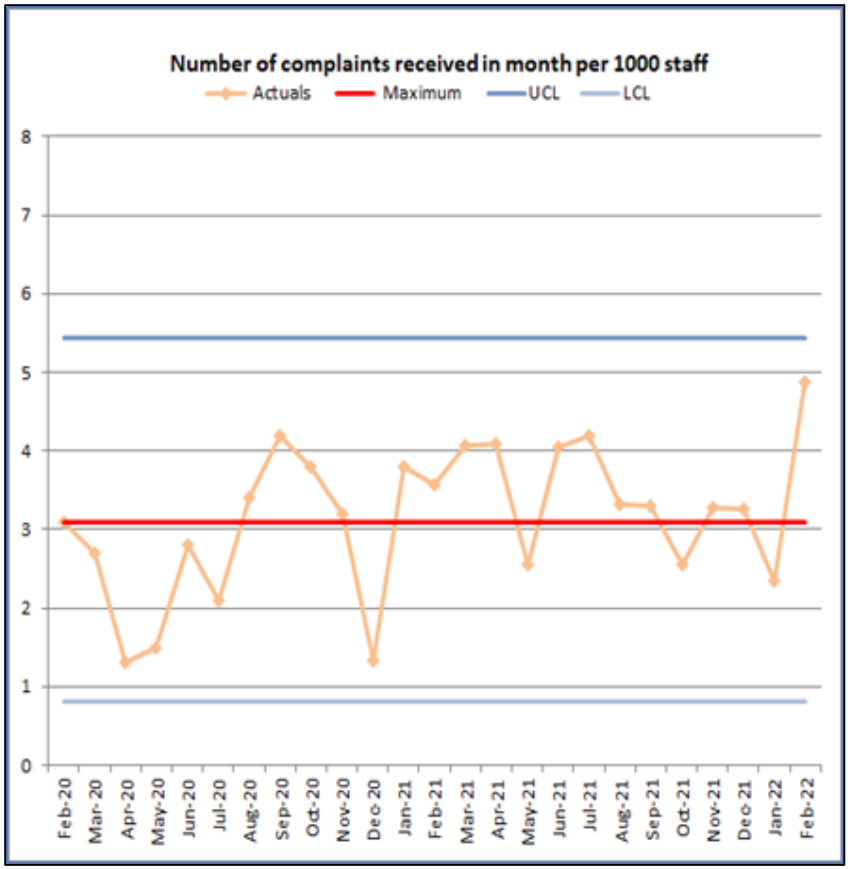
Number of complaints received in month per 1000 staff

Executive Lead: Chief Nurse

Performance Issue:
WUTH has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per 1000 staff. The rate for February 2022 was 4.87

Action:
The complaints number, timeliness and learning themes are reported regularly to Patient Safety Quality Board (PSQB). Training to support staff to respond to patient feedback, promote positive complaints management, local resolution and learning is being developed for introduction this year (2022).
The ongoing COVID-19 pandemic meant clinical staff needed to prioritise direct patient care, At the start of 2022 it was agreed that while complaints would continue to be acknowledged and investigated, the complainant would be informed that timescales for completion would not be indicated until the surge and subsequent clinical pressures reduced. The Trust continued to record internal deadlines for response, with the Patient Experience Team working with the Divisions to reduce the number of breached complaints. The Patient Safety Quality Board (PSQB) reintroduced the requirement to confirm timeframes in March. Complainants are now advised of specific deadlines for response, signaling a move back to business as usual.
Complaints accrued during the "stepdown" period are subject to a recovery plan. Required improvement in response times is supported by increased operational oversight of the Corporate Complaints Team, with weekly meetings between Divisional and Corporate Complaints Teams.
The key reported complaint themes in February have been Treatment/Procedure – Delay/Failure. In the main these have been due to the impact of COVID on elective surgery and delays in the Emergency Department. Assurance of learning and actions continues to require focus. To support this, actions identified within divisional reports and responses are now set out as a list in a new closing section of each response letter.

Expected Impact:
Actions being taken will strengthen the approach to complaint management within the Trust.



Well-led Domain

Appraisal compliance %

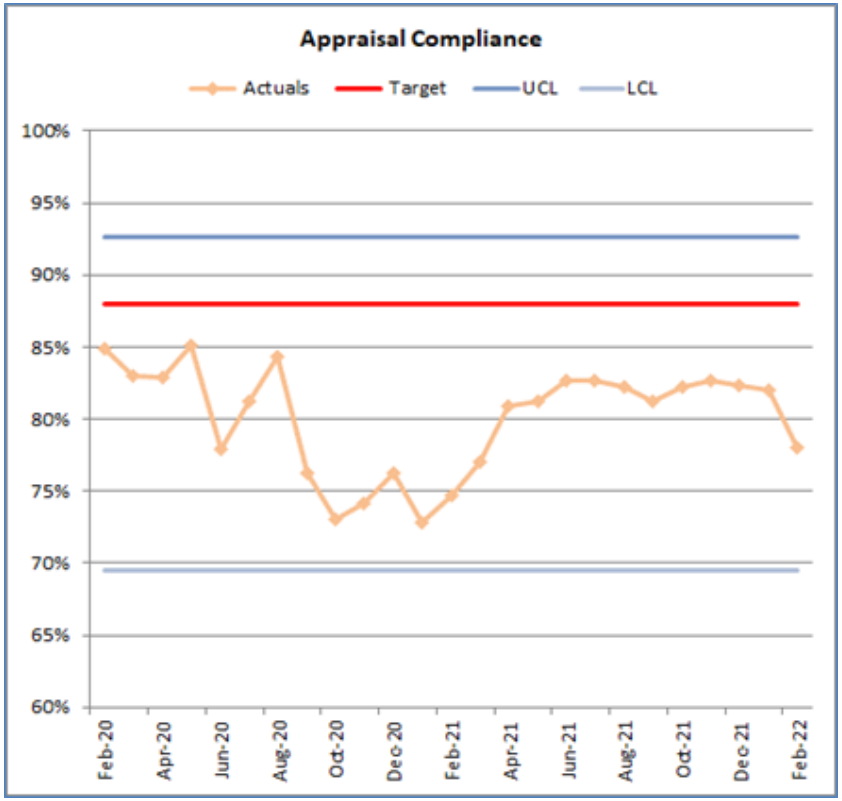
Executive Lead: Chief People Officer

Performance Issue:

The target for annual appraisal compliance is 88%. At the end of February 2022 78% of the workforce had received an appraisal in the last 12 months. This is a reduction from 82% in January 2022.

From a divisional perspective, appraisal compliance has reduced compared to the previous month across all divisions, except for Women and Children's who have remained static. No divisions this month have achieved the Trust KPI of 88%. The division with the highest compliance rate is Women and Children's at 82.21%, and the divisions with the lowest compliance rates are Acute (69.9%) and Medicine (74.6%).

Please note that Medical appraisal is currently excluded from the above figures.



Action:

Workforce compliance data is available to Divisions and the HR Services team to enable them to manage non-compliance for their areas and alerts of appraisals due are generated via the ESR system. HR Business Partners continue to support Divisional Management teams to identify and deliver actions to address low levels of compliance in specific areas. Check and challenge discussions take place at a divisional triumvirate levels and recommencement of divisional performance review meetings will see this challenged further.

As highlighted in last month's report a review of appraisal has now commenced. The scope of the review has broadened to also incorporate wellbeing

conversations into appraisal process. The rationale for this is to enable a more person-centered approach to appraisal conversation. Questions pertaining to quality of appraisals have been incorporated into a trust-wide wellbeing survey run this month, the results of which will inform findings of the review and subsequent development plans.
Expected Impact: Improvement in performance as the Trust returns to business as usual although it is acknowledged that winter pressures and pressures driven by the impact of covid-19 may create some challenges in maintaining appraisal completion rates across clinical areas over forthcoming months.

Board of Directors **Item 9.2**
6th April 2022

Title	M11 Finance Report
Area Lead	Robbie Chapman, Interim CFO
Author	Robbie Chapman, Interim CFO
Report for	Information

Report Purpose and Recommendations

The Trust is reporting a deficit of £0.163m at M11, a positive variance against budget of £0.039m.

We have received £4.706m of ERF in H2, giving a total for the year of £12.119m. We have not yet received confirmation of the amounts due in respect of M10 or M11 but our elective performance was strong during the period so it is possible we will receive further income but this is dependent on C&M performance as a whole.

The Trust is now forecasting a break-even position for the year.

It is recommended that the Board:

- Notes the report.

Key Risks

This report relates to these key Risks:

- PR3: failure to achieve and/or maintain financial sustainability.

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	No
Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	Yes

Governance journey

This is a regular update provided to each Board meeting.

Month 11 Finance Report 2021/22

Contents

1. Executive summary

1.1 **Table 1: Financial position – M11**

Month 11 Financial Position	Budget (Mth 11) £'000	Actual (Mth 11) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
NHS income - patient care	30,102	27,088	(3,014)	315,067	305,890	(9,177)
Income Guarantee	0	3,462	3,462	0	15,788	15,788
National Top-up	1,743	1,743	(0)	21,499	21,499	(0)
Elective Recovery Fund (ERF)	0	4,706	4,706	5,524	12,119	6,595
Covid 19 income	1,806	1,655	(150)	20,477	19,946	(531)
Non NHS income - patient care	392	424	32	4,331	4,325	(6)
Other income	3,008	3,282	274	27,966	29,926	1,960
Total Income	**37,050**	**42,360**	**5,310**	**394,864**	**409,494**	**14,629**
Employee expenses	(24,724)	(30,866)	(6,142)	(266,095)	(276,856)	(10,761)
Operating expenses	(11,586)	(11,246)	340	(124,987)	(128,264)	(3,276)
Total Expenditure	**(36,310)**	**(42,112)**	**(5,802)**	**(391,082)**	**(405,120)**	**(14,037)**
Non Operating Expenses	(389)	(425)	(36)	(4,304)	(4,673)	(368)
Actual Surplus / (deficit)	**351**	**(177)**	**(528)**	**(522)**	**(299)**	**224**
Control Total adjustment	29	41	12	321	136	(185)
Surplus/(deficit) - Control Total	**380**	**(135)**	**(516)**	**(202)**	**(163)**	**39**

1.2 The Trust is reporting a deficit of £0.163m at M11, a positive variance against plan of £0.039m.

1.3 Total income was £409.494m at M11, a positive variance of £14.629m. This reflects the 'block' contract arrangements with CCGs, income from specialist and direct commissioning and Elective Recovery Fund (ERF) income of £12.119m.

1.4 As indicated last month, we have now received £4.705m of ERF for M7-9 but as a result of this lost of the £2.522m of non-recurrent funding from C&M. Our elective performance in respect of M10 and M11 has been strong in comparison to 19/20 but income has yet to be confirmed as it is dependent on system side performance.

1.5 We have received £29.926m in other income, a positive variance of £1.960m. This is attributable to additional funding we received in respect of our telederm initiative, increased education and training funding and income in respect of Clatterbridge Diagnostic Centre. All of this is offset by increased expenditure.

1.6 Total employee expenses including COVID-19 were £276.856m at M11, this represents an overspend against our budget of £10.761m. The overspend against plan is discussed at in more detail at 4.2.3 but is primarily driven by a £8.066m overspend in respect of M&A and one off costs in respect of the Clinical Excellence Awards and a provision for the rebanding of Community Safety Workers. Employee expenses excluding COVID, which were £273.423m, can be broken down as follows:

Table 2: Pay cost analysis excluding COVID

1. Executive summary

Wirral University Teaching Hospital NHS Foundation Trust

Pay analysis (exc Covid)	Budget (Mth 11) £'000	Actual (Mth 11) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Consultants	(4,034)	(5,243)	(1,209)	(40,260)	(44,448)	(4,188)
Other medical	(2,746)	(2,829)	(84)	(29,910)	(29,695)	215
Nursing and midwifery	(6,497)	(7,094)	(597)	(70,740)	(73,385)	(2,646)
Allied health professionals	(1,403)	(1,426)	(23)	(15,067)	(15,516)	(449)
Other scientific, therapeutic and technical	(582)	(553)	29	(6,377)	(5,909)	468
Health care scientists	(1,090)	(1,112)	(23)	(11,980)	(12,166)	(186)
Support to clinical staff	(4,905)	(8,804)	(3,899)	(51,679)	(54,303)	(2,624)
Non medical, non clinical staff	(3,005)	(3,427)	(422)	(34,895)	(36,987)	(2,091)
Apprenticeship Levy	(75)	(96)	(21)	(926)	(1,015)	(89)
Total	(24,336)	(30,585)	(6,249)	(261,834)	(273,423)	(11,589)

1.7 Operating expenses including COVID were £125.101m at M11, an overspend of £2.631m. This reflects lower spend against purchase of healthcare from non-NHS bodies than budget offset by increased expenditure on drugs, premises and non-recurrent support in respect of reset and recovery.

1.8 Cash balances at the end of M11 were £32.7m.

1.9 The Trust has recorded a capital spend of £12.55m at M11, incorporating all spend including newly approved and PDC funded schemes, £3.066m behind plan.

2. Background

2.1 The Trust has a break-even plan for the period.

2.2 The draft guidance for 22/23 describes the new Aligned Payment and Incentive (API) rules, with providers and commissioners agreeing a block contract calculated on the basis of the agreed plan of activity. Where providers deliver activity above the agreed plan, they will earn an additional 75% of tariff. Where providers do not deliver against their agreed activity plan then funding worth 75% (previously 50%) of tariff will not be earned.

2.3 It has been agreed with C&M partners that we will not be in a position to implement full API contracts by the 1st April and that contracts will be rolled forward from H2. However, work will continue to develop API contracts and these will be run “in shadow” to current arrangements ahead of full implementation in 23/24.

2.4 The baseline requirement for CIP increased for Trusts nationally but the requirement within Cheshire and Merseyside rose to 2.6% for H2, amounting to £5.588m for the Trust. Nationally mandated CIP for 22/23 is 1.1% but organisations in the North West have been notified that we will be required to deliver an additional 0.9% of CIP as part of “convergence efficiency” to reflect our larger spend per weighted head of population compared to other systems. It has now been agreed with C&M partners that an additional CIP of 2.5% will be required of each orgaisation. Internally it has been agreed that we will seek to deliver 3% recurrently and 1.5% non-recurrently.

3. Dashboard and risks

3.1 **Table 3: M11 Performance Dashboard**

	Indicator	Objective	Director	Threshold	Set by	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	2021/22
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	0.8	-0.5	-0.2	0.0	0.2	-0.2		-0.7	-0.6	2.3	-0.1	0.0
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	0.8	-0.4	-0.4	0.0	0.2	-0.1	0.0	1.0	-0.9	1.9	-0.5	0.6
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2
	CIP Performance (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	3.02%	6.03%	9.05%	14.50%	Not reported	77.21%	48.24%	76.70%	78.61%	78.6%
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	-50.5%	-27.7%	-32.4%	-40.5%	-11.7%	-5.2%	-50.0%	-25.1%	-6.7%	-4.3%	-8.0%	-23.8%
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-15.0	-15.5	-10.4	-15.7	-15.4	-15.2	-16.2	-15.9	-18.0	-16.2	-18.6	-18.6
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	2.0%	5.6%	12.5%	18.0%	22.6%	24.4%	30.7%	36.3%	48.0%	59.0%	76.2%	76.2%

3.1.1 Agency spend is above threshold. This is discussed in more detail at 4.2.3.

3.1.2 Despite significant improvement over the last year, the Trust's liquidity days measure is below threshold. This is based on net current liabilities compared against operating expenses. Despite continued progress with removing historic accruals this position is unlikely to improve given the likely deferral of income in respect of the elective recovery programme.

3.2 **Risk summary (as per risks identified in risk register)**

3.2.1 Risk 1 – Failure to manage financial position

- Our ability to operate within the financial envelope is dependent on effective cost management alongside the delivery of activity trajectories, the management of COVID activity and the centrally funded vaccination and testing programmes. With the additional income received from C&M, ERF payments due and the potential for additional ERF in the final few months of the year we are now forecasting a break-even position for 22/23.

3.2.2 Risk 2 – Failure to deliver CIP

- The confirmed H2 CIP target is £5.588m and this has been incorporated into our plans submitted to NHSE/I. As at M11 we have underachieved against this plan by £1.421m. Our forecast outturn in terms of CIP performance is £4.139m but this will be offset by non-recurrent reductions in spend. This is discussed in more detail at section 4.5.

3.2.3 Risk 3 – Failure to complete capital programme

- Our capital expenditure envelope for 21/22 has now increased to £28.7m as a result of five additional PDC awards in December and January relating to the theatre modular build, WUTH recovery schemes, IT schemes and the C&M command centre for which we are the host. The risk profile has increased given the scale of the programme the Trust now needs to deliver.This is discussed in more detail at 5.2.

4. Financial Performance

4.1 **Income**

4.1.1 The Trust has received £409.464m at M11, a positive variance of £14.629m.

Table 4: Income analysis for M11

	Budget (Mth 11) £'000	Actual (Mth 11) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Elective & Daycase	3,915	3,048	(867)	44,995	40,093	(4,902)
Elective excess bed days	65	42	(23)	929	530	(399)
Non-elective	7,368	7,368	0	88,930	88,494	(437)
Non-elective Non Emergency	986	880	(107)	11,907	11,518	(389)
Non-elective excess bed days	334	23	(311)	4,008	2,482	(1,526)
A&E	1,154	1,247	93	14,278	14,989	711
Outpatients	2,982	3,288	305	34,765	36,425	1,660
Diagnostic imaging	243	177	(66)	2,995	2,308	(687)
Maternity	397	450	53	5,128	4,620	(508)
Non PbR	5,695	5,987	292	65,772	62,954	(2,818)
HCD	1,319	1,416	97	14,487	16,600	2,113
CQUINs	0	0	0	1,140	1,140	(0)
National Top up	1,743	1,743	(0)	21,499	21,499	(0)
Income Guarentee	0	3,462	3,462	0	15,788	15,788
Other	3,912	3,072	(841)	20,382	13,526	(6,856)
Sub-Total Board Clinical Income	30,114	32,202	2,088	331,214	332,965	1,751
Other patient care income	2,104	466	(1,638)	9,047	13,807	4,760
Elective Recovery Fund (ERF)	0	4,706	4,706	5,524	12,119	6,595
COVID-19 Income	1,806	1,655	(150)	20,477	19,946	(531)
Non-NHS: private patient & overseas	19	(9)	(28)	251	195	(56)
Injury cost recovery scheme	0	58	58	385	536	151
Total Patient Care Income	34,042	39,078	5,036	366,899	379,568	12,669
Other operating income	3,008	3,282	274	27,966	29,919	1,953
Other non operating income		0	0		7	7
Total income	37,050	42,360	5,310	394,864	409,494	14,629

4.1.2 Clinical income at M11 was £332.965m, a positive variance against budget of £1.751m. This includes reduced income across a large number of activity categories offset by the income guarantee with stronger performance in respect of Outpatients and HCD.

4.1.3 In H2, ERF has been calculated on the basis of RTT "clock stops" and the threshold for additional payment has been set at 89% of equivalent performance in 19/20. The Trust's combined clock stops in respect of admitted and non admitted patients in M7-9 of 19/20 was 24,563. For M7-9 of 21/22 the equivalent figure was 23,849. This represented 97% of the baseline and had a notional value of over £15m for the period but translated into a payment of £4.706m.

4.1.4 In M10 we had combined clockstops of 6,671 compared with the 19/20 equivalent of 8,289, representing 80% of the threshold. However, once the number of working days in the comparable months are taken into account our adjusted performance is 89%.

4.1.5 In M11 we had combined clockstops of 7,087 compared with the 1920 equivalent of 7,193, representing 99% of the threshold. There were no working day adjustments in

respect of M11. If C&M performance exceeds 89% as a whole then we would expect to receive a significant share of any ERF available.

4.1.6 Patient care income exceeded budget by £12.669m. This includes a positive variance of £6.595m in respect of ERF and £4.760m in respect of other patient care income. Other patient care income includes all funding we have received in respect of Elective+ and Targeted Investment Fund, for which there are corresponding increases in expenditure.

4.1.7 Other Operating income was £29.919m at M11, a positive variance of £1.953m. This is attributable to additional funding we received in respect of our telederm initiative, increased education and training funding and income in respect of Clatterbridge Diagnostic Centre. All of this is offset by increased expenditure.

4. Financial Performance

4.2 Expenditure: Pay

4.2.1 The Trust has spent £276.856m on pay costs at M11. Table 5 details pay costs by staff group excluding COVID-19, Table 6 details pay costs by pay category type and Table 7 details COVID pay costs.

Table 5 Pay costs by staff type (excluding COVID-19)

Pay analysis (exc Covid)	Budget (Mth 11) £'000	Actual (Mth 11) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Consultants	(4,034)	(5,243)	(1,209)	(40,260)	(44,448)	(4,188)
Other medical	(2,746)	(2,829)	(84)	(29,910)	(29,695)	215
Nursing and midwifery	(6,497)	(7,094)	(597)	(70,740)	(73,385)	(2,646)
Allied health professionals	(1,403)	(1,426)	(23)	(15,067)	(15,516)	(449)
Other scientific, therapeutic and technical	(582)	(553)	29	(6,377)	(5,909)	468
Health care scientists	(1,090)	(1,112)	(23)	(11,980)	(12,166)	(186)
Support to clinical staff	(4,905)	(8,804)	(3,899)	(51,679)	(54,303)	(2,624)
Non medical, non clinical staff	(3,005)	(3,427)	(422)	(34,895)	(36,987)	(2,091)
Apprenticeship Levy	(75)	(96)	(21)	(926)	(1,015)	(89)
Total	(24,336)	(30,585)	(6,249)	(261,834)	(273,423)	(11,589)

Table 6: Pay analysis by pay type

Pay analysis (exc Covid)	Budget (Mth 11) £'000	Actual (Mth 11) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Substantive	(21,923)	(27,642)	(5,719)	(238,192)	(245,592)	(7,400)
Bank	(1,103)	(1,352)	(249)	(9,953)	(12,468)	(2,515)
Medical Bank	(498)	(314)	183	(5,191)	(5,677)	(485)
Agency	(738)	(1,180)	(443)	(7,572)	(8,672)	(1,100)
Apprenticeship Levy	(75)	(96)	(21)	(926)	(1,015)	(89)
Total	(24,336)	(30,585)	(6,249)	(261,834)	(273,423)	(11,589)

Table 7: COVID Pay costs

COVID-19 COSTS	Apr (M1) £'000	May (M2) £'000	Jun (M3) £'000	Jul (M4) £'000	Aug (M5) £'000	Sep (M6) £'000	Oct (M7) £'000	Nov (M8) £'000	Dec (M9) £'000	Jan (M10) £'000	Feb (M11) £'000	Year to Date £'000
Medical Staff	(35)	(14)	(24)	(9)	(51)	(6)	(38)	(10)	(12)	(23)	(9)	(231)
Other Clinical Staff	(343)	(172)	(183)	(229)	(282)	(253)	(241)	(233)	(246)	(394)	(235)	(2,812)
Non Clinical Staff	(72)	(49)	(22)	(23)	(28)	(27)	(23)	(27)	(26)	(55)	(36)	(390)
Total Pay	(450)	(236)	(229)	(261)	(362)	(286)	(301)	(270)	(284)	(472)	(281)	(3,433)

4.2.2 Total pay costs at M11 were £276.856m, an overspend of £10.761m.

4.2.3 The main driver of this is the Medical & Acute Division, which has a £0.765m over-spend in month and £8.066m YTD. The pressure is being driven by the premium cost of using agency across all medical grades and increased demand for junior & middle grade doctors in ED to deal with increased demand.

4.2.4 At M11 M&A are still carrying vacancies across the Division despite the previously reported appointments in long-standing vacancies. The Division continues to employ additional consultants at premium cost to cover these vacancies and to assist with

reset and recovery across specialities with the largest backlog, specifically Rheumatology and Gastroenterology.

4.2.5 Whilst activity levels in ED fell in M9 and M10 they plateaued in M11 and are still 8.5% above 19/20 and the measures in place to address this are still place, specifically 2 junior doctors per shift, which amount to 10 Whole Time Equivalents(WTE), and 1 additional nurse and Clinical Support Worker per shift (10 WTE). In addition, sickness has been high in the nursing workforce at around 10% average throughout the year compared to approximately 6% in 19/20.

4.2.6 This additional demand for nurses and high rates of sickness and absence has driven the use of bank. Within M&A the premium element of the Nurse Incentive Scheme, i.e. the cash bonus that nurses receive for completing a certain number of shifts in month, has cost £0.481m in H2 and £0.681m across the Trust overall.

4.2.7 Employers are required to equally distribute this year's Local Clinical Excellence Award (LCEA) funds (and any remaining from previous years) among all eligible consultants. This will be a one-off, non-consolidated payment in place of a normal LCEA round. The investment ratio for LCEAs in 2021-2022 is set at 0.218 (0.218 points per eligible consultant, cumulative total 1.242 points per eligible consultant). This resulted in a one off payment due from 2019/20 to 2021/22 of £1.061m.

4.2.8 There are two national Agenda for Change profiles for Nursing – Clinical Support Workers at both band 2 and band 3. Staff Side have raised concerns that in a number of Trusts in the region, Health Care Assistants / Health Care Support Workers are working at a higher level than their current band. At WUTH this is being managed through pro-active partnership working. Currently we have a strong push from Staff Side to reflect clinical care in our CSW AfC Bandings which would potentially see some roles / many roles moving from AfC 2 to an AfC 3 banding. They have recently achieved this for the Outpatients CSW role and are now looking at the Trust wide implications – across all wards and departments – as per the new national profiles and match outcome. The financial risk of this move would be significant, not just for WUTH but for the entire NHS. Under a worse case scenario this would result in the rebanding of 738 staff. In addition to the current budgetary pressure this may result in backpay effective from when evidence confirms band 3 duties commenced. As a result we have made provision for approximately 2 years backpay for the individuals at risk of £3.993m.

4. Financial Performance

4.3 **Expenditure: Non-Pay**

4.3.1 The Trust has spent £125.101m on non-pay operating expenditure excluding COVID at M11, a variance of £2.631m YTD.

Table 8: Non-pay analysis (excluding COVID-19 costs)

Non Pay Analysis (exc Covid)	Budget (Mth 11)	Actual (Mth 11)	Variance	Year To Date Budget	Year To Date Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Supplies and services - clinical	(2,797)	(2,922)	(125)	(32,331)	(32,586)	(255)
Supplies and services - general	(298)	(224)	74	(3,978)	(3,933)	45
Drugs	(2,256)	(2,401)	(145)	(23,130)	(25,260)	(2,130)
Purchase of HealthCare - Non NHS Bodies	(842)	(699)	143	(10,052)	(8,699)	1,353
CNST	(1,152)	(751)	401	(12,669)	(12,266)	403
Consultancy	(1)	(104)	(103)	(137)	(589)	(452)
Other	(3,067)	(2,939)	128	(29,716)	(31,467)	(1,751)
Sub-Total	(10,414)	(10,040)	373	(112,013)	(114,801)	(2,788)
Depreciation	(948)	(940)	8	(10,457)	(10,300)	157
Impairment	0	0	0		0	0
Total	(11,362)	(10,981)	381	(122,470)	(125,101)	(2,631)

4.3.2 The overspend in respect of non-pay is being driven by pressure in respect of costs for high cost drugs, non-capital estates works and increased, non-recurrent costs associated with the elective recovery programme offset by much lower than anticipated spend with the independent sector.

4.3.3 Increased expenditure on high cost drugs is an issue across all clinical divisions but particularly prevalent within M&A and Surgery. Our analysis shows that the increase primarily relates to changes in prescribing practices, some of which are due to COVID. We have agreed with FBPAC that this will be looked at in much more detail in partnership with divisions and Pharmacy and will report back our findings in the new financial year.

4.3.4 Non-Pay spend in EHS continues to represent a significant pressure, with a pressure of £0.334m in month as a result pressures on minor works (£0.177m), building materials and engineering spend (£0.042m) and energy costs (0.176m) in month. Similarly, the YTD position is £0.903m overspent against budget with a £0.814m pressure on minor works and £0.357m pressure on energy. These pressures have been partially offset by reduced spend on mattress hire and lower catering supplies purchased which is offset by the reduced income levels within the divisional income position.

4.3.5 Expenditure on healthcare from non-NHS bodies reduced in M11 and is significantly below plan YTD. This cost, associated with the patient choice element of support, is anticipated to increase given longer wait times across a number of areas.

4.4 Expenditure: COVID–19

4.4.1 The Trust spent £6.596m on COVID-19 costs at M11, with £3.433m on pay and £3.163m on non-pay.

Table 9: YTD COVID-19 revenue costs

COVID-19 I&E	Apr (M1) £'000	May (M2) £'000	Jun (M3) £'000	Jul (M4) £'000	Aug (M5) £'000	Sep (M6) £'000	Oct (M7) £'000	Nov (M8) £'000	Dec (M9) £'000	Jan (M10) £'000	Feb (M11) £'000	Year to Date £'000
Total Income	2,313	2,129	1,118	1,796	1,641	2,118	1,486	2,177	1,745	1,768	1,655	19,946
Medical Staff	(35)	(14)	(24)	(9)	(51)	(6)	(38)	(10)	(12)	(23)	(9)	(231)
Other Clinical Staff	(343)	(172)	(183)	(229)	(282)	(253)	(241)	(233)	(246)	(394)	(235)	(2,812)
Non Clinical Staff	(72)	(49)	(22)	(23)	(28)	(27)	(23)	(27)	(26)	(55)	(36)	(390)
Total Pay	(450)	(236)	(229)	(261)	(362)	(286)	(301)	(270)	(284)	(472)	(281)	(3,433)
Clinical Supplies	(101)	(207)	(230)	(162)	(151)	(475)	47	(568)	(155)	(154)	(159)	(2,316)
Other Non-Pay	(106)	(129)	(39)	(24)	(15)	(54)	(22)	(5)	(300)	(47)	(106)	(847)
Total Non-Pay	(208)	(337)	(269)	(187)	(166)	(529)	25	(573)	(455)	(201)	(265)	(3,163)
Total Covid Expenditure	**1,655**	**1,557**	**620**	**1,349**	**1,113**	**1,303**	**1,209**	**1,334**	**1,006**	**1,095**	**1,109**	**13,351**

4.4.2 The vaccination costs were £1.378m at M11 which was in line with plan and is funded centrally so offset in income.

4.4.3 The testing costs were £2.341m at M11 and is funded centrally so offset in income.

4. Financial Performance

4.5 CIP Performance

4.5.1 The target for H2 was set at 2.6% or £5.560m. We have managed to recover some of the slippage reported last month and we are now forecasting a total CIP of £4.139m across 307 schemes, a shortfall against budget of £1.420m.

Table 10: IYE and FYE breakdown by Division

	Target	H2 Actual YTD IYE	H2 FOT	Variance
M&A	1,398,140	722,066	818,000	(580,140)
Surg	1,065,751	319,633	425,393	(640,358)
DCS	1,015,509	797,639	954,650	(60,859)
W&C	559,089	216,527	243,374	(315,715)
Corp	524,937	470,625	479,649	(45,288)
EHS	416,984	421,516	526,436	109,452
Procurement	579,588	-	691,526	111,938
Total	**5,559,998**	**2,948,005**	**4,139,028**	**(1,420,970)**

4.5.2 £0.518m has been delivered in month 11 against a plan of £0.806m. This is slippage is attributable to delays in transacting schemes in Pharmacy that we expect to complete by year end.

Table 11: IYE and FYE breakdown by Division

	H2 Plan YTD	H2 Actual YTD IYE	Variance	H2 Actual YTD FYE
M&A	899,335	722,066	177,269	1,362,000
Surg	746,904	319,633	427,271	640,235
DCS	1,089,254	797,639	291,616	1,043,272
W&C	213,558	216,527	- 2,969	338,223
Corp	499,362	470,625	28,737	660,649
EHS	222,283	421,516	- 199,233	524,703
Other	583,000	-	583,000	-
Total	**4,253,696**	**2,948,005**	**1,305,691**	**4,569,082**

4.5.3 The explanations behind the current forecast are set out in the table below.

Table 12: CIP Slippage

Medicine & Acute				
Scheme Name	**Scheme Description**	**Planned Savings**	**Forecasted saving**	**Reason**
Maintain closure of M1 beds	The Division's bed modelling work suggests that based on 100% 2019 NEL activity and working to a 90% bed occupancy rate, the Division in 21/22 could	**£658,000**	**£540,000**	The savings forecasted for the closure of the beds has been lower

	cope with demand with an additional 25 beds over and above current bed base. The Division are working with Surgery to develop a proposal to consolidate all medical outliers on ward 20; this additional bed base would be sufficient to cover Medical MEL demands.			than anticipated monthly.
Renal tender	Award of MSC for dialysis units at APH and CBH. Release of savings against historic contract for CBH site and potential additional savings to be achieved by implementation of MSC at APH.	**£250,000**	**£0**	
Agency Consultants - GIM	Recruitment of a substantive GIM consultant	**£100,000**	**£0**	Agency still in place, FOT reduced to £0. No substantive recruitment made.
Surgery				
Scheme Name	**Scheme Description**	**Planned Savings**	**Forecasted saving**	**Reason**
Colorectal	Use of a new device by the insides company resulting in reduce LOS and reduce PN	**£500,000**	**£0**	The number of patients classed as clinically appropriate for the use of the device, was lower than anticipated.
Post Op Seal Clinic	There are around 500 patients per annum that present to ED within 10 days of surgery with issues relating to post-operative concerns or issues. Although less than 60 patients require admission and significant intervention, the patient experience is poor and requires improvement. The project is to establish a clinic for patients with post-operative issues to attend SEAL and be managed through nursing and streamlined interventions to	**£75,000**	**£0**	Unable to quantify cash releasing savings. FOT £0.

	support improved patient access, experience, and outcomes.			
Women's and Children's				
Scheme Name	**Scheme Description**	**Planned Savings**	**Forecasted saving**	**Reason**
O&G Medical Staffing Review	Anticipated savings released from Consultant retirement	**£50,000**	**£0**	Savings used to fund additional staffing resource
DCS				
Pharmacy	Individual pharmacy schemes	**£160,000**	**tbc**	Further detail required to transact. Expected to recover in month 12.

4.5.4 The forecast of £4.139m is unlikely to be improved. Work is ongoing with the divisions to identify new CIPs to mitigate the under delivery in month and we anticipate that all slippage will be offset by non-recurrent reductions in expenditure.

4.5.5 11 projects with a value of £0.049m have currently been identified as areas of opportunity and are awaiting sign off from the divisional directors to progress to gateway 2.

4.5.6 10 projects have progressed to design & plan (gateway 2), meaning documentation is now being completed on PM3 and awaiting validation from finance. No value has been assigned to these projects as yet.

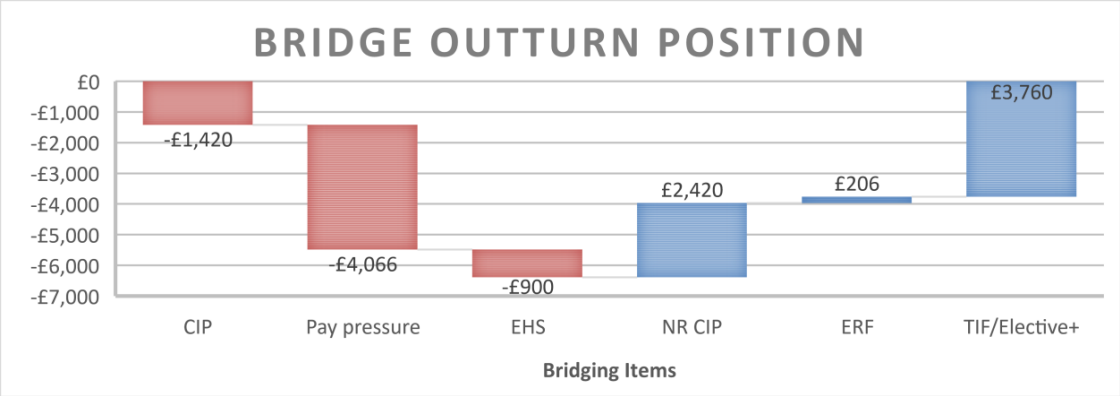
4.5.7 154 projects with a value of £1.142m have been approved at QIA panel and are now in the implementation gateway.

4.5.8 132 projects with a value of £2.948m have been transacted H2 YTD.

4.6 **Forecast**

4.6.1 We are forecasting a break-even position for 2022/23.

Table 14 2021/22 Forecast Outturn



4.6.2 This forecast is based on M1-11 run rates forecast for the remaining month of the year.

4.6.3 The biggest change from the previous forecast relates to the pay pressures referred to at 4.2.7 and 4.2.8. These are offset by increases in non-recurrent reductions in expenditure and non-recurrent income in respect of the Targeted Investment Fund and Elective+ monies.

4.6.4 Given our strong elective performance in M11 we believe there is a strong chance of increased ERF income but we are not in a position to include that within our forecast until the performance of the whole system has been confirmed.

4.6.5 The budget pressures in respect of EHS described at 4.3.4 are expected to continue for the remainder of the year and are forecast to result in a total pressure of £0.9m by the end of the year.

4. Financial Performance

5.1 **Statement of Financial Position (SOFP)**

5.1.1 The movement in total assets employed from M10 was £0.176m.

Statement of Financial Position (SoFP)

Actual as at 31.03.21 £'000		Actual as at 31.01.22 £'000	Actual as at 28.02.22 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
163,560	Property, plant and equipment	163,166	166,175	3,009	↑
12,864	Intangibles	12,327	12,223	(104)	↓
869	Trade and other non-current receivables	342	967	625	↑
177,293		**175,835**	**179,365**	**3,530**	↑
	Current assets				
4,788	Inventories	4,585	3,940	(645)	↓
16,848	Trade and other receivables	17,448	14,680	(2,768)	↓
0	Assets held for sale	0	0	0	→
21,294	Cash and cash equivalents	22,833	32,717	9,884	↑
42,930		**44,866**	**51,337**	**6,471**	↑
220,223	**Total assets**	**220,701**	**230,702**	**10,001**	↑
	Current liabilities				
(44,124)	Trade and other payables	(43,707)	(50,082)	(6,375)	↑
(4,622)	Other liabilities	(6,976)	(6,886)	90	↓
(1,090)	Borrowings	(1,099)	(1,108)	(9)	↑
(7,256)	Provisions	(7,273)	(11,267)	(3,994)	↑
(57,092)		**(59,055)**	**(69,343)**	**(10,288)**	↑
(14,162)	**Net current assets/(liabilities)**	**(14,189)**	**(18,006)**	**(3,817)**	↑
163,131	**Total assets less current liabilities**	**161,646**	**161,359**	**(287)**	↓
	Non-current liabilities				
(2,479)	Other liabilities	(2,389)	(2,380)	9	↓
(5,193)	Borrowings	(4,685)	(4,685)	0	→
(7,318)	Provisions	(6,553)	(6,451)	102	↓
(14,990)		**(13,627)**	**(13,516)**	**111**	↓
148,141	**Total assets employed**	**148,019**	**147,843**	**(176)**	↓
	Financed by				
	Taxpayers' equity				
171,121	Public dividend capital	171,121	171,121	0	→
(64,220)	Income and expenditure reserve	(64,518)	(64,518)	0	→
41,240	Revaluation reserve	41,240	41,240	0	→
148,141	**Total taxpayers' equity**	**147,843**	**147,843**	**0**	→

5.2 **Capital Expenditure – M11**

5.2.1 At M11 capital spend is behind original plan by £3.066m:

Capital programme 2021/22 - Spend	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	TOTAL
Pre-commitments	297	375	396	437	409	97	454	105	146	628	1,387	**4,731**
Estates	0	0	0	112	94	34	226	59	32	305	222	**1,084**
Informatics	0	0	69	0	14	0	10	36	(9)	150	0	**270**
Equipment - Medicine and Acute	0	93	310	0	17	0	18	15	(13)	38	9	**487**
Equipment - Clinical Support and Diagnostics	0	0	0	118	8	62	20	207	670	1	361	**1,447**
Equipment - Surgery	0	0	101	102	10	58	153	15	182	12	86	**719**
Equipment - Women and Children's	0	0	99	0	0	0	0	0	7	47	22	**175**
Donated assets	0	7	0	8	95	(1)	0	0	0	84	0	**193**
UEC (PDC)	9	0	0	0	1	0	0	116	190	165	279	**760**
Other PDC funded schemes	0	0	0	0	0	0	0	14	0	1,143	1,533	**2,690**
TOTAL	**306**	**475**	**975**	**777**	**648**	**250**	**881**	**567**	**1,205**	**2,573**	**3,899**	**12,556**
NHSE/I PLAN	**562**	**678**	**511**	**889**	**983**	**2,295**	**953**	**875**	**3,363**	**2,115**	**2,398**	**15,622**
VARIANCE FROM PLAN	**(256)**	**(203)**	**464**	**(112)**	**(335)**	**(2,045)**	**(72)**	**(308)**	**(2,158)**	**458**	**1,501**	**(3,066)**

5.2.2 The capital plan has grown over the last two months as we have been awarded PDC for:

- CGH Modular Theatres (£10.166m)
- Command Centre (C&M) (£1.355m)
- IT Schemes (£0.900m)
- IT Cyber (£0.250m)
- IT Maternity (£0.230m)
- Frontline Digitisation (£0.867m)
- RPA (£0.184m)
- Scopee (£0.046m)
- MRI Acceleration (£0.090m)
- Digital Diagnostics (£1.282m)

This takes our total capital programme to £28.5mm (excluding donated assets).

5.2.3 Robust governance arrangements have been strengthened further to monitor delivery. However, with limited availability in the supplier market and the significant lead in times for materials and equipment the the risk to delivery has greatly increased. We are seeking ways in which to maximise spend and weekly monitoring calls are taking place for all projects.

5.2.4 Forecast spend for the year is as follows:

4. Financial Performance

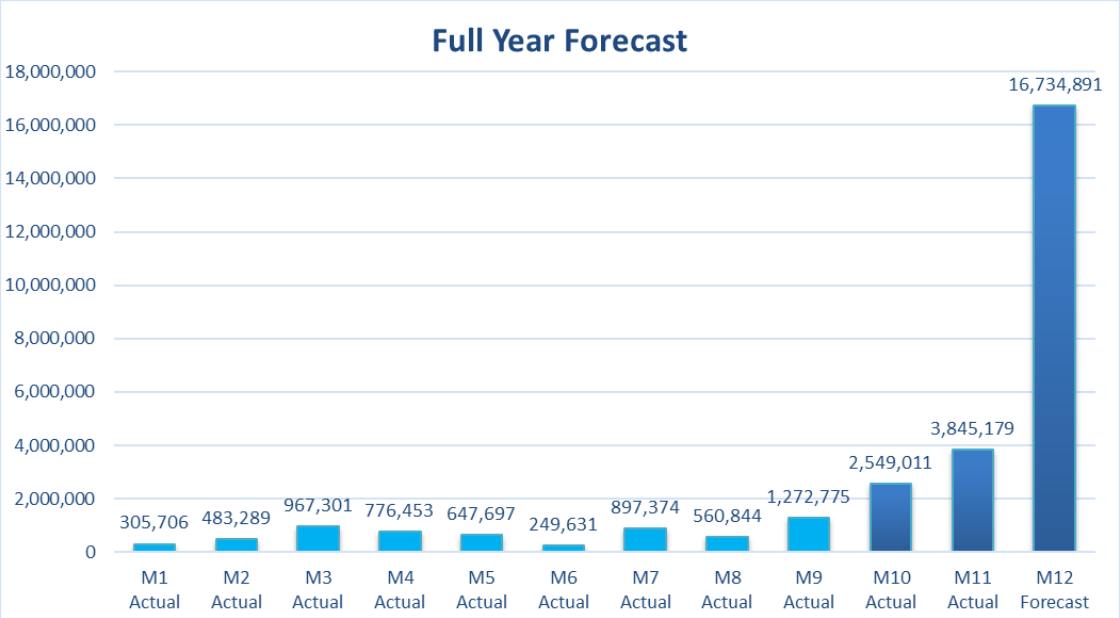
Capital Programme - 28 February 2022

	Full Year Budget			Full Year Forecast		Comments
	NHSI plan	Mvmnts	Trust Budget[1]	Forecast	Variance	
	£'000	£'000	£'000	£'000	£'000	
Funding						
Total Internally Generated Funding	12,738	432	13,170	13,170	0	
PDC (Public Dividend Capital) - Various	1,300	14,070	15,370	15,370	0	
External Funding - donations/grants	450	(257)	193	193	0	
Total funding	**14,488**	**14,245**	**28,733**	**28,733**	**0**	
Expenditure						
Pre-commitments 21/22	5,007	348	5,355	5,719	(364)	The largest overspend is in relation to Staff Changing Rooms (£338k).
Estates	2,671	116	2,787	3,536	(749)	Additional spend has also been incurred in year on schemes which were not part of the original plan but are operationally critical.
Informatics	784	(135)	649	649	0	
Medicine and Acute	715	66	781	770	11	Kitchen refurbishment costs are less than anticipated.
Clinical Support and Diagnostics	1,914	345	2,259	2,279	(20)	This overspend relates to the installation of the mammography equipment funded by PDC in 20/21. Costs were higher than originally anticipated.
Surgery	688	88	776	776	0	
Women and Children's	236	2	238	254	(16)	It is anticipated that the planned office conversion will cost more than anticipated.
Other	90	0	90	0	90	
Contingency[2]	633	(398)	235	0	235	
Donated assets	450	(257)	193	193	0	
PDC	1,300	14,070	15,370	15,370	0	
Total expenditure (accruals basis)	**14,488**	**14,245**	**28,733**	**29,546**	**(813)**	
Capital programme funding less expenditure	**0**	**0**	**0**	**(813)**	**813**	Although there is currently a forecast overspend, it is anticipated that works on a small number of projects will come in under budget based on recent estimates. However, valuations are still to take place therefore the overspend is still shown.
Capital expenditure	14,038	14,502	28,540	29,353		
NBV asset disposals	0	0	0	0		
Donated assets	450	(257)	193	193		
CDEL impact	**14,488**	**14,245**	**28,733**	**29,546**		

[1] This is the NHSI plan, adjusted for approved business cases including additional donated, leased and PDC funded spend.
[2] Funding is transferred as business cases are approved.

5.2.5 This graph shows actual spend to M11 and forecast spend for M12. This highlights the scale of works to be undertaken for the Trust to achieve spend against its capital envelope:

4. Financial Performance



5.3 **Statement of Cash Flows – M11**

Statement of Cash Flows (SoCF) - February 2022

	Month Actual £'000	Year to date Actual £'000
Opening cash	**22,833**	**21,294**
Operating activities		
Surplus / (deficit)	(177)	299
Net interest accrued	12	162
PDC dividend expense	416	3,598
Unwinding of discount	(3)	(28)
(Gain) / loss on disposal	0	38
Operating surplus / (deficit)	249	4,070
Depreciation and amortisation	940	9,365
Impairments / (impairment reversals)	0	0
Donated asset income (cash and non-cash)	0	(193)
Changes in working capital	10,127	15,479
Investing activities		
Interest received	3	7
Purchase of non-current (capital) assets [1]	(1,430)	(11,432)
Sales of non-current (capital) assets	0	16
Receipt of cash donations to purchase capital assets	0	180
Financing activities		
Public dividend capital received	0	0
Net loan funding	0	(375)
Interest paid	0	(105)
PDC dividend paid	0	(1,830)
Finance lease rental payments	(5)	(51)
Total net cash inflow / (outflow)	**9,884**	**15,130**
Closing cash	**32,717**	**36,424**

[1] Outflows due to the purchase of non-current assets are not the same as capital expenditure due to movements in capital creditors.

5.3.1 Cash balances have increased by £9.884m but there is a corresponding increase in current liabilities.

5.4 Treasury

Borrowings summary M11

Borrowings summary

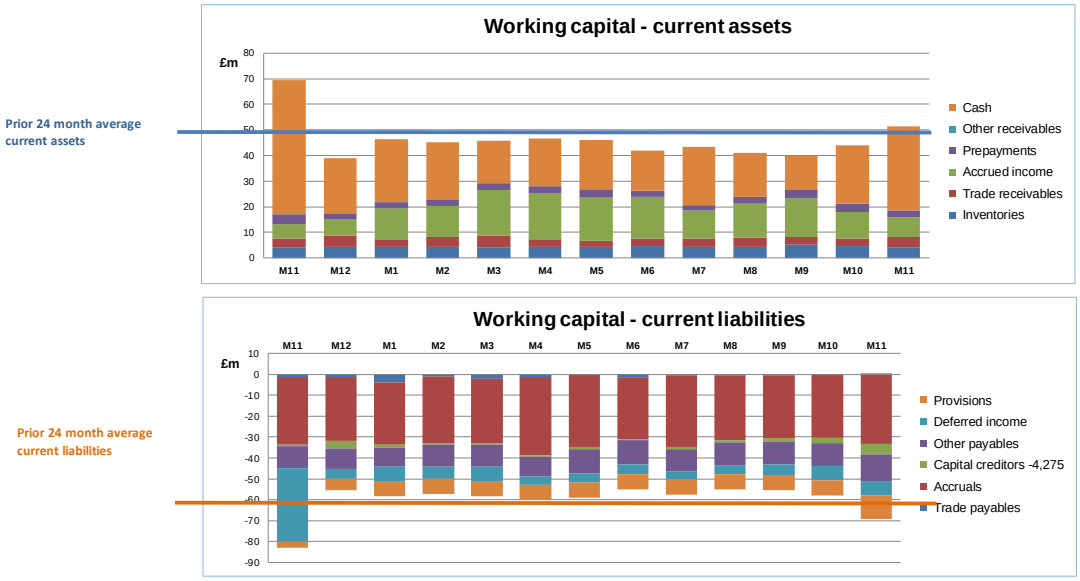
	Initial Loan Value	Loan Term	Interest rate (fixed)	Loan Balances Mar 21	Loan Repayment Sept 20	Loan Balances Dec 21	Loan Repayment Mar 22	Forecast Closing Balances Mar22
	£'000	Years	%	£'000	£'000	£'000	£'000	£'000
1. ITFF capital loan	7,500	10	1.96	2,625	(375)	2,250	(375)	1,875
2. ITFF capital loan	6,500	25	4.32	3,583	(133)	3,450	(133)	3,318
	14,000			6,208	(508)	5,700	(508)	5,193

This table does not include finance lease balances, which are included in Borrowings balances in the SoFP.
All listed borrowings are with the Department of Health and Social Care (DHSC).

5.4.1 The Trust's borrowings, comprising capital loans, will be repaid at a level of £1m per year.

5.5 Working capital profiles by month

5.5.1 2021/22 working capital profiles below show M11 working capital balances in the context of the previous 12 months, compared with an average of the previous 2 financial years. The credit risk associated with aged debt is monitored quarterly by the Audit Committee.



4. Financial Performance

5.6 Single oversight framework: Use of Resources (UoR) rating (financial) summary table

Use of Resources (UoR) Rating

Summary table

	Metric	Descriptor	Weight %	Year to Date Actual	
				Metric	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-18.6	4
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	2.9	1
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	0.0%	2
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.3%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	21.9%	2
	Overall NHSI UoR rating				**2**

5.6.1 The liquidity rating of 4 remains the same as M10 and is largely due to a high number of accruals made. The improvement in the I&E margin reflects the reported surplus. Agency spend is £2m above the cap in M11. The overall UoR rating of 2 is expected to continue for the remainder of the year.

Board of Directors **Item No 9.3**
6th April 2022

Title	Learning from Deaths Report (Q3 2021-22)
Area Lead	Dr Nikki Stevenson, Executive Medical Director
Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board of Directors with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q3 2021-2022.

Key points:

- The medical examiners continue to provide 100% scrutiny of adult deaths
- The Trust SHMI remains stable at 107.42
- HSMR has increased from 91 in the last quarter to 95 in this quarter, but remains lower than expected
- Dr Foster benchmark data has highlight two areas that require further assurance around post discharge mortality (Chronic obstructive pulmonary disease and Stroke). This work will be coordinated through the Mortality Review Group
- The Mortality review group meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner.
- In Q3 one case was escalated from MRG to the Trust Serious Incident Review panel and subsequently declared as a serious incident
- Learning form mortality reviews is fed back to clinical areas by the Divisional Morality leads.

It is recommended that the Board:

- Note the mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group.

Key Risks

BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No

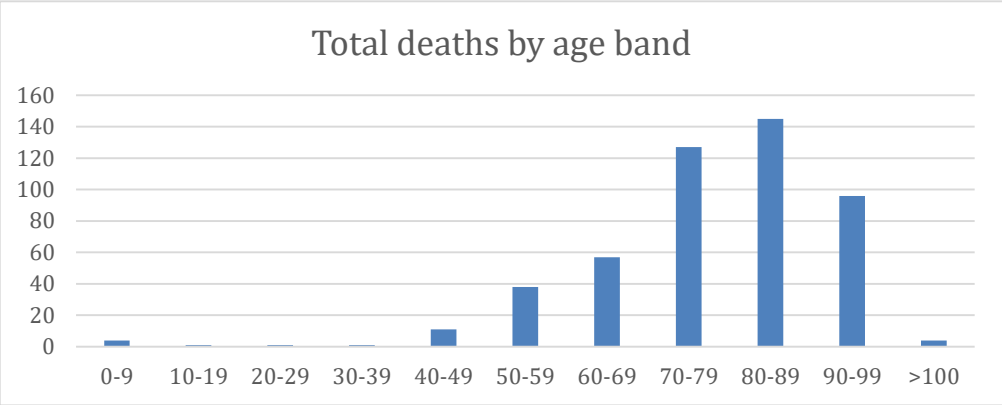
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey
This is a standing report.

1	**Narrative**
1.1	To provide a summary of the mortality review process, care issues, learning and current mortality comparator statistics. This paper is for Adult and perinatal mortality. Wirral University Teaching Hospital is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework: • Preventing people from dying prematurely. • Treating and caring for people in a safe environment and protecting them from avoidable harm. Wirral University Teaching Hospital uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a 'warning' of potential problems and help identify areas for investigation. The Medical Examiner service provides independent scrutiny for all deaths that occur within WUTH, and escalates any concerns for a mortality review, coordinated through the Trust Mortality Group. Additionally, a random 5% of non-escalated deaths are selected for a "quality assurance" mortality review. Lessons learnt from mortality reviews are fed back to each clinical Division via the Divisional Mortality leads who attend the Mortality Review Group. **Patient demographics** There was a total of 485 deaths in Q3 (Oct- Dec 2021). 50 of these deaths are in patients who died within 28 days of a positive COVID-19 swab. Six deaths were determined to have been nosomial COVID-19. All nosocomial deaths have been reviewed or are currently being reviewed via a mortality review and then scrutiny at the Serious Incident Review panel.

Category	Female	Male	Total
COVID	21	29	50
Not COVID	198	237	435
Total			**485**

As per previous trends most recorded deaths are in the over 60 age group and the vast majority fall into the “White British” Ethnic band.



Ethnicity	Number of deaths
White - British	448
White - Irish	4
White - Any other White background	0
Mixed - Any other mixed background	0
Asian or Asian British - Indian	1
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	1
Other Ethnic Groups - Chinese	3
Not stated	25
Total	485

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The SHIMI has remained stable when compared to the previous quarter. The latest available data (up to August 2021) shows the SHIMI to be 107.42.
Although the SHMI is higher than the expected 100, it is still within acceptable range.

SHIMI can be broken down into specific disease groups, and for Q3 there were two disease groups with a significantly raised SHIMI, Chronic Obstructive Airway Disease

and Acute Cerebrovascular Disease. These will be picked in more detail under the Dr Foster section of the paper.

Hospital Standardised Mortality Ratio (HSMR)

The HSMR has risen this quarter from 91 prviously to 95. This is still below the expected level of 100, and within the acceptable range.

As discussed in the previous Learning from deaths papepr the difference in HSMR and SHMI can be explained by the fact that SHMI does not exclude deaths with a palliative care code, whereas HSMR does. Palliative care coding for WUTH is higher than peers, reflecting the proactive nature of our palliative care team. Additionally SHIMI countts deaths occuring 30 days post discharge, whereas HSMR focuses on hospital deaths only.

MRG has been given assurance that processes around palliatve care coding are robust, and that this doees not represent a potential patient safety risk, but is a reflecton of good palliatve care.

COVID-19

National Mortality comparators are not calibrated to predict mortality due to COVID-19, so it is difficult to compare different organisations in terms of COVID-19 mortality if using SHIMI or HSMR.

In terms of raw mortality (total number of deaths as a percentage of admissions) WUTH has a mortality rate of 16.5%. This is lower than the national average of 17.78%

Mortality Dashboard

The medical examiners (MEs) continue to maintain 100% scrutiny of all WUTH adult deaths and escalate cases where potential concerns are identified.

27 cases escalated by the ME to the mortality review group have undergone a review during Q3. These cases have been reviewed using a revised PMR template (18 cases) or via the Royal College of Physicians Structured Judgement review tool (9 cases). One case was escalated to the Serious Incident Review panel and has been subsequently declared a serious incident as per the National Patient Safety Framework.

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 24 deaths were reviewed in Q3 (5%) using the PMR template. 3 of these deaths were further reviewed for potential learning identified. One of these cases was referred to the Trust Serious Incident Review panel for consideration of a serious incident, but it was not felt to have reached the threshold to be declared as a SI.

Summary of all Adult in patient deaths and case reviews							
	Total Adult In-patients Deaths	Total Reviewed by Med Examiner	Total No of cases escalated from Medical Examiner	Total No of SJR's opened from cases escalated	Serious Incidents opened following MRG review	Quality assurance PMR's undertaken	Total number of case reviews by MRG
Q4 (20-21)	588	588	57	5			62
Q1 (21-22)	390	394	21	5			26
Q2 (21-22)	415	415	26	9	3	20	49
Q3 (21-22)	485	485	27	9	1	24	60

Grading of Adult Care and avoidability (Following SJR review)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
Q3	6	2	0	1

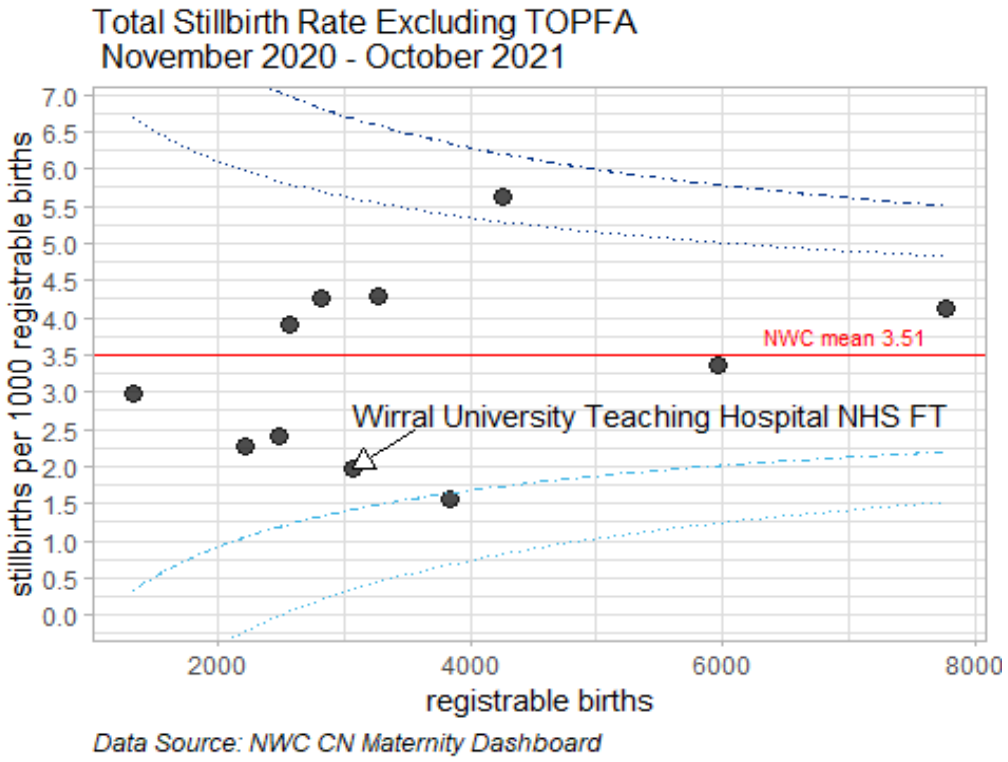
During Q3, 6 deaths were reported in patients identified as having a Learning disability. All 6 of these deaths have been reviewed using the SJR template and have also been referred for external review through the national LeDeR programme. Completed SJR reviews for this group of patients identified 3 cases where there were care issues, but none of these was felt to have been contributory factors in the patient's death.

Learning Disability Mortality Reviews				
	Total No. of LD Deaths	No. reviewed using SJR	Problems in Health care Identified in this Quarter	Referred to National LeDeR Programme
Q4 (20-21)	0	0	0	0
Q1 (21-22)	3	3	0	3
Q2 (21-22)	4	4	0	4
Q3 (21-22)	6	6	3	6

Perinatal and Neonatal deaths
In 2021, WUTH had 10 stillbirths ranging from 24+0 to 40+5 weeks gestation. Half (n=5) of our stillbirths were term (i.e. >37 weeks) however there were no intrapartum stillbirths which are testament to the ongoing improvement work around fetal physiology and CTG interpretation

Of the 10 stillbirths, 1 was determined to have been avoidable and was subsequently reported to StEIS – following a RCA, the learning was disseminated locally and regionally as part of the North West Coast Reducing Stillbirth Special Interest Group. Three others are awaiting review at the next Perinatal Mortality Review Tool (PMRT) review group.

Perinatal mortality Grading using PMRT (year to date 2021)				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
	3	3	0	1



Data Source: NWC CN Maternity Dashboard

All Neonatal deaths are discussed in a monthly neonatal mortality review meeting attended by Consultants, Nurse Managers, Advanced Neonatal Nurse Practitioners, trainee doctors and senior neonatal nurses. A standardised review template is used to collate information relating to the inpatient care. The deaths are then further reviewed using the PMRT which is a review that supports external attendance from Obstetricians, Neonatologists and Midwives.

There were 8 neonatal deaths in 2021, 5 of which were expected and 3 were unexpected deaths. Of those deaths, the cases were given the following grading (one death currently awaiting review)

Neonatal mortality Grading using PMRT (year to date 2021)				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
	2	5	0	0

Learning identified through review of mortality reviews during Q3

Learning for mortality is derived from 3 main sources

1. Mortality reviews (collated into a learning log)
2. Themes and trends escalated from the Medical Examiner
3. Learning identified through the SI process

Specific learning and themes identified during Q3 as well as actions taken are listed in the table below.

Learning theme	Source	Action taken
Medication errors	Mortality reviews	Fed back to Medicines Safety Optimisation Group by the Medications Safety Pharmacist
Poor end of life care	Mortality reviews	Fed back to End-of-Life lead, particularly issues around fast track discharge
Poor documentation	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads
Weight loss	Theme escalated by Medical Examiner	Issues identified around accurate weighing of patients, especially bed bound patients. New weighing scales bought. Ongoing work around nutrition and hydration coordinated by corporate nursing team.
ECG guidance in need of updating	SI report	Chest pain pathway reviewed by relevant clinical leads an updated to include recent guidance.

Additionally, several reviews have identified areas of good practice, and these have been feedback to the teams looking after patients.

Dr Foster Data

The Dr Foster dashboard informs the Trust of any new CUSUM alerts and any diagnosis/ procedures with significantly high mortality. During Q3 two areas were identified by Dr Foster as areas requiring further assurance.

These are:

- COPD

Deaths in this group of patients are above expected resulting in a higher-than-expected SHIMI for this group. However, this seems to be because of deaths occurring after discharge from hospital. MRG has asked the Clinical Lead for Respiratory Medicine to review the post discharge service and feedback to MRG

- Cerebral Vascular Disease

Deaths in this group were higher than expected in the post discharge group of patients, resulting in a higher-than-expected SHIMI. MRG has asked the Clinical lead to review the data and provide feedback.

The table below summarises ongoing as well as recently closed work resulting from Dr Foster data.

Diagnostic Group	Quarter Highlighted	Alert type	Work undertaken	Outcome/ Learning
Non-Specific Gastroenteritis	Q2 21-22	CUSM alert	Case note review	Closed. High alert triggered by inaccurate coding from clinical teams
Malignancy of unspecified site	Q2 21-22	CUSM alert	Case note review	Ongoing
COPD	Q3 21-22	High SHIMI	Review by Clinical Lead	Ongoing
Cerebral vascular Disease	Q3 21-22	High SHIMI	Review By Clinical Lead	Ongoing

2	Conclusion
2.1	Mortality indicators do not show cause for concern and remain relatively stable. The difference between SHIMI and HSMR can be explained by the relatively high palliative care coding at WUTH. Deaths attributable to COVID-19 are comparable to Q2. Nosocomial deaths are investigated through the SI process.

	The medical examiner continues to provide 100% scrutiny for all adult deaths and escalates concerns to the Mortality Review Group for further review. Learning from these reviews is disseminated through the Trust Divisional structures as well as relevant service leads. Perinatal and Neonatal mortality does not show any cause for concern, with all deaths subject to investigation through the Perinatal Mortality Review Tool (PMRT). Dr Foster data has highlight 2 additional areas requiring assurance (COPD and CVD). This work will be coordinated though MRG.

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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors **Item 9.4**
6th April 2022

Title	Quarterly Maternity Services Update Report Including an update on compliance with the recommendations from Part 1 of the Ockendon Report; 2021, Perinatal Mortality Review and Serious Incident Review Reports and an update to the Trust Equality and Equity Plan.
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and Director of Infection Prevention and Control (DIPC). Executive Director of Midwifery and Allied Health Professionals
Author	Debbie Edwards, Director of Nursing & Midwifery - Women's & Children's Division
Report for	Information

Report Purpose and Recommendations

The last quarterly update to Trust Board of Directors was presented in January 2022, with the following paper providing further update and oversight regarding the quality and safety of Maternity Services at Wirral University Teaching Hospitals (WUTH).

The Perinatal Clinical Surveillance Quality Assurance Report provides an overview of performance within Neonatal/Maternity Services, and this is further supported with the detail of 2021 Serious Incidents within both the Maternity and Neonatal Service/s and the 2021 Perinatal Mortality Review Tool Report.

This paper provides further update regarding compliance with the Ockenden (Part 1) recommendations and also includes recommendations from the Kirkup report in 2015. The compliance against all 7 Immediate and Essential Actions (EIAs) is further detailed within the Assurance and Assessment Tool.

The Board are asked to note the content of the paper but to discuss the Trust compliance with the Ockendon recommendations and the submission of compliance to NHSE/I.

Key Risks

Regionally the LMS continue to remain non complaint with some of the Ockenden EIAs – these are progressing however currently remain non-compliant.

Regionally there remains an large number of midwifery vacancies across the system.

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes

Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it	No

Governance journey
This report is provided on a quarterly basis.

1	Purpose
1.1	This paper provides a quarterly update to the Board of Directors with further oversight of the quality and safety of Maternity Services at Wirral University Teaching Hospital (WUTH). The paper provides a specific update regarding the evidence submitted to NHSE/I to support compliance with Ockenden recommendations (Part 1). Board of Directors are requested via letter dated 25 January 2022 (NHSE/I) to discuss any non-compliance with the 7 Immediate and essential actions (IEAs). Following the last quarterly update, the Maternity Equality and Equity plan is included in the paper for reference with a progress update of actions and improvements to date. The paper includes a 2021 review of serious incidents (SI's) within the Maternity and Neonatal Service as identified in the Ockenden recommendations – each SI report is also included for reference providing further detail.

2	Ockenden Review of Maternity Services – One Year On:
2.1	In response to the findings and recommendations from the independent review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust in December 2020 (Part 1 Ockenden Report) significant work has been undertaken nationally to improve the quality and safety within Maternity Services. NHSE has invested £95.6m to support improvement work which has included: • 1200 additional midwifery roles • 100wte Consultant Obstetricians • Support for Mandatory training and backfill • International recruitment of Midwives • Recruitment and retention of Maternity Support Workers with improvement to the training and mentorship provided. WUTH has been successful in its bid/s to secure part of this funding to support its workforce and service improvement work to meet compliance with Ockenden recommendations. An initial report outlining compliance against these recommendations was initially reported to the Board of Directors in January 2021. Since then, ongoing quality improvement work has been undertaken in the Maternity Service within the Trust to now support full compliance against all the recommendations.

In a letter dated 25 January 2022 NHSE requested that One Year on from Ockenden that all maternity providers should revisit the submission of the initial Assurance and Assessment Tool which outlined Trust compliance status with the Ockenden recommendations. In addition, given that it was evident to the national team that not all recommendations had been implemented across all Trusts from the 2015 Kirkup Report (Morecombe Bay Independent Investigation into Maternity Services) that all of these recommendations should be revisited, and a gap analysis undertaken to identify any further improvement work.

A gap analysis was undertaken by the Trust in 2015 following publication of the Kirkup report and work was undertaken to meet full compliance with all recommendations which are included in Appendix 1.

NHSE have requested that the Assurance and Assessment tool (Appendix 2) be used to support discussion at Trust Public Board meetings to ensure the Board of Directors have clear oversight of the Trust compliance against the Ockenden recommendations. Discussion did take place regarding progress against each of the 7 Immediate and Essential Actions (IEAs) outlined in Ockenden at the January 2022 with a full report of all recommendations and evidence submitted.

Progress with all recommendations is shared with the Local Maternity and Neonatal System (LMNS) on a weekly basis and the Regional Maternity Team have been further assured on Trust progress and have supported a submission nationally reporting Trust being fully compliant with all recommendations. From a Cheshire & Merseyside perspective the LMNS were outstanding with the implementation of some recommendations, but these have been progressed and ratified at their QSSG meeting on the 15 March 2022.

In summary WUTH compliance with the 7 IEA's is:

Northwest Region		IEA - 1		IEA - 2		IEA - 3			IEA - 4		IEA - 5	IEA - 6	IEA - 7
		Enhance safety		Listening to Women and Families		MDT Training			Complex Pregnancy		Risk Assessment	Fetal Well being	Informed Consent
		Clinical Priority	Clinical Priority	Clinical Priority	Clinical Priority	Clinical Priority	Clinical Priority	Clinical Priority	Clinical Priority	Clinical Priority	Clinical Priority	Clinical Priority	Clinical Priority
LMS	C&M	1A	1B	2A	2B	3A	3B	3C	4A	4B	5	6	7
	WUTH												

As the national focus on Maternity Services continues Part 2 of the Ockenden report was due to be published on the 22 March 2022, however this has been deferred due to parliamentary process with its publication anticipated on 30 March 2022.

The Independent Investigation into East Kent Maternity Services is due to be published on 29 June 2022. Both reports will be presented at future Board of Director meetings with the 2nd part of Ockenden to be presented in the July Public Board meeting.

3	**Maternity Incentive Scheme (MIS) – Year 3 and Year 4 update**
3.1	Since the last Board of Director Meeting the outcome of the Maternity Incentive Scheme - MIS (Year 3) has been communicated to all Trusts. The Trust's response was reviewed by NHS Resolution's Collaborative Advisory Group and Approval Committee with the Trust successfully achieving a rebate in its Maternity CNST premiums of £559,093. NHS Resolution in conjunction with NHSE/I confirmed in December 2021 that that Year 4 of the MIS be paused and there has been no indication as to it formally

	recommencing. The W&C Division has continued with its work to action the ten safety actions and is currently on track to meet the requirements of each action, with an update confirming this having been submitted to the LMNS. A detailed MIS update will be included in the next quarterly maternity update in July 2022 which will further inform the Trust declaration process for the Year 4 submission.

4	The Perinatal Clinical Surveillance Quality (PCSQ) Assurance Report:
4.1	A Clinical Surveillance Quality Tool has recently been developed by the LMNS in the form of a dashboard on a page, however this tool does not provide the same level of assurance as the WUTH developed tool does. Therefore, reporting using the WUTH Perinatal Clinical Surveillance Quality Assurance report will continue pending the publication nationally of a PCSQ tool. An updated PCSQ report is included in Appendix 3 with no areas of concern for escalation. This report provides Board of Directors with an oversight of key themes relating to the quality and safety of the Maternity Service.

5	The C&M Clinical Outcome / Outlier Report
5.1	The Strategic Clinical network have been unable to produce the outlier funnel charts prior to the maternity update paper being submitted this month. However for the purpose of assurance to the Board the regional clinical outcome /outlier report was presented to the LMNS QSSG meeting on 15 March 2022 and WUTH was not identified as an outlier against any of the dashboard metrics nor has it any actions currently outstanding. It is proposed that this report be included in the monthly maternity Board of Directors update in May 2022 once validated by the Executive and Non-Executive Safety Champions.

6	Serious Incidents (SI's) & Health Care Safety Investigation Branch (HSIB):
6.1	Serious incidents (SI's) are reported on the regional dashboard and to the LMNS by all maternity providers. A summary of these having previously been presented to the Board of Directors with a recommendation that the full detail of all 2021 SI's would be included in this maternity update. An overview and the detail of all SI's from 2021 are included in Appendix 4. When compared to other maternity providers across C&M WUTH is below the regional average in serious incidents and HSIB cases. In addition the Perinatal Mortality Review report for 2021 was presented to PSQB in February 2022 and is also included in Appendix 5. 100% of cases within the report have had external review with WUTH being the only provider in C&M achieving this with its PMRT cases.

7	Continuity of Carer
7.1	The Maternity Service is currently operating two models of maternity care – one that is traditional in its approach and some women are being cared for within a Continuity of Carer Model of care. Women being cared for by a team of midwives under the Continuity of Carer model appreciate the benefits of improved outcomes and experience compared to those cared for under traditional models. Following the Birthrate+ review the staffing model within the Midwifery Service has been expanded to enable the service to further increase the number of women cared

	for within a Continuity of Carer Team. To enable further improvement and further roll out of additional teams there has been a requirement to manage the change through HR process – Management of change. This has involved consultation with staff and 1:1 meetings with midwives with the support from HR, staff side and the Professional Midwifery Advocates (PMA's). The consultation is due to conclude at the end of the month when staff will be updated as to their preference of where to work. Whilst the process has increased the volume of work for the Senior Midwifery Team the feedback has generally been positive with staff appreciating the opportunity for discussion and 1:1 support. The roll out of a Continuity of Carer Model of care within the Trust is planned for June 2022, and the improvement plan for Continuity of Carer details the milestones to date. It is important that the Board of Directors have oversight of the workforce model supporting the delivery of this model of care and are sighted on the implementation plan. It is therefore proposed that the plan be presented at the Board of Directors in May 2022 when there will be further update to timescales and the consultation.

8	**Quality Health Maternity Survey – 2021**
8.1	The Women's Experience of Maternity Care Survey was undertaken by Quality Health (QH) in between April and August 2021. The survey sample was drawn from women aged 16 or over who had a live birth between the 1st and 28th of February 2021. The survey was undertaken during the third national lockdown for the COVID-19 pandemic and respondents will have gone through their antenatal, labour and birth, and postnatal stages under pandemic conditions. The results therefore reflect experiences of care throughout the COVID-19 pandemic The 2021 Maternity Survey was a mixed-mode maternity survey in the NHS Survey Programme, where women were encouraged to respond online (but were also given the option of postal completion). The response rate for WUTH was noted to have increased significantly from 36% in 2019 to 52% in 2021, with 89% of all women completing the survey online which is extremely positive. The survey findings were positive and, in some domains, showed improvement and demonstrated that WUTH was better than most other Trusts in 20% of the domains. The LMNS are collating results from each provider within C&M and will be sharing the findings inclusive of any learning and good practice. A separate paper further detailing the survey findings has been submitted to the Board of Directors and will also be discussed at the next Patient Family Experience Group Meeting.

9	**Equality & Equity Plan**
9.1	During the last Board of Directors Meeting, it was agreed that the Trust Equality and Equity plan specific to Maternity Services be shared (see Appendix 6). The LMNS are collating updates from all providers to inform a regional Equality and Equity plan with response to the national team. Whilst Wirral does not have a high population of women and families from a black and ethnic minority the MVP Chair supported by the Midwifery Team have been engaging with the Wirral Multicultural Society to further improve the experiences of women from

	these backgrounds which has been particularly important to those who are not fluent in English language. Work is ongoing to further support women from areas of high deprivation and to improve access to care and social prescribing through the Midwifery Teams. The Trust was successful in its bid to support social prescribing using a Maternity Support Worker and this work will be replicated moving forwards with the roll out of the Continuity of Carer Teams. Finally, there are opportunities to further develop the midwifery workforce that is being supported regionally with the introduction of an 18-month Midwifery Training Programme which is in addition to plans to roll out the Midwifery Apprenticeship. For the future workforce who live and reside on the Wirral the development of a career pathway that supports working and learning through apprenticeship/s is being developed and enhanced. The importance of growing local talent cannot be underestimated and is key to building a local workforce that is sustainable in the longer term. WUTH has been chosen to pilot an enhanced service for Maternal Mental Health which includes neonatal support as well as support during pregnancy and the postnatal period. The Trust are one of 3 sites who are supporting the project led by the LMNS and involves joint working with Mersey Care. Maternity visits to the Trust by both the regional NHSE Maternity team and national team are currently being finalised. This is to promote cultural improvement work that is being rolled out nationally to Trusts in addition to ensuring that each organisation has oversight of Maternity services. Dates are yet to be finalised however visit to WUTH is anticipated to take place in May 2022.

10	**Conclusion**
10.1	As the quality improvement work continues to incorporate the Neonatal Service as well as Maternity Service at WUTH the next quarterly update to the Board of Directors will be in July 2022. This update will include a detailed update on the MIS and will provide focus on the publication of the recommendations from Part 2 of the Ockenden report with an associated gap analysis. The detailed Continuity of Carer Implementation Plan including an update on workforce following the management of change consultation will also be included in the next quarterly update.

11	**Recommendations to the Board of Directors**
11.1	The Board of Directors are requested to note the contents of the report specifically: • The content of the Perinatal Clinical Surveillance Quality Assurance Report. • The compliance with all 7 IEA's from the Ockenden recommendations as detailed in the Assurance and Assessment report

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Appendix 1 – Updated Kirkup Gap Analysis

	Issues	Evidence	Gaps in assurance	RAG
1	The University Hospitals of Morecambe Bay NHS Foundation Trust should formally admit the extent and nature of the problems that have previously occurred, and should apologise to those patients and relatives affected, not only for the avoidable damage caused but also for the length of time it has taken to bring them to light and the previous failures to act. This should begin immediately with the response to this Report.	WUTH have a policy for being open and honest. There is also clear guidance within Women's and Children's regarding the process for RCA and Duty of Candour Preparation for CQC visit will also reiterate compliance with this Trust have identified Staff Guardians as a point of contact for staff raising concerns	**Nil**	**G**
2	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the skills, knowledge, competencies and professional duties of care of all obstetric, paediatric, midwifery and neonatal nursing staff, and other staff caring for critically ill patients in anaesthetics and intensive and high dependency care, against all relevant guidance from professional and regulatory bodies. This review will be completed by June 2015, and identify requirements for additional training, development and, where necessary, a period of experience elsewhere if applicable	There is a process for staff appraisal and the coordination and management of staff training – mandatory and non-mandatory of which compliance is updated monthly Supervision in midwifery also supports any identified practice issues. Review of role of MAP in maternity Review of the provision of Maternity Training undertaken to improve compliance within the Trust. Review feasibility of secondments for staff to other areas.	**May 2015: Initially partial compliance except midwives working in the Recovery area of theatre – Concern and issue escalated and is now on the Divisional Risk Register.** **No further action as Surgical Division responsible for this with the recruitment of theatre staff awaited** **March 2022 - Full compliance**	**G**
3	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up plans to deliver the training and development of staff identified as a result of the review of maternity, neonatal and other staff, and should identify opportunities to broaden staff experience in other units, including by secondment and by supernumerary practice. These should be in place in time for June 2015.	Training delivered in house – PROMPT Annually for all midwives See point 2	**Nil**	**G**

4	Following completion of additional training or experience where necessary, the University Hospitals of Morecambe Bay NHS Foundation Trust should identify requirements for continuing professional development of staff and link this explicitly with professional requirements including revalidation. This should be completed by September 2015.	Process for revalidation being introduced and clear guidance for professional staff development. Appropriate management of appraisals and a process of auditing appraisals is to be introduced within the Trust. All staff are being encouraged to complete PDP as part of revalidation	**Nil**	G
5	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and develop measures that will promote effective multidisciplinary team-working, in particular between paediatricians, obstetricians, midwives and neonatal staff. These measures should include, but not be limited to, joint training sessions, clinical, policy and management meetings and staff development activities. Attendance at designated events must be compulsory within terms of employment. These measures should be identified by April 2015 and begun by June 2015.	Positive working relationships within Women's & Children's – LWSG, Multidisciplinary FMU/Neonatal meetings, CG Steering group meetings Joint meetings with the Directorate management team and consultants ANNB Screening Board Meetings introduced	**Nil**	G
6	The University Hospitals of Morecambe Bay NHS Foundation Trust should draw up a protocol for risk assessment in maternity services, setting out clearly: who should be offered the option of delivery at Furness General Hospital and who should not; who will carry out this assessment against which criteria; and how this will be discussed with pregnant women and families. The protocol should involve all relevant staff groups, including midwives, paediatricians, obstetricians and those in the receiving units within the region. The Trust should ensure that individual decisions on delivery are clearly recorded as part of the plan of care, including what risk factors may trigger escalation of care, and that all Trust staff are aware that they should not vary decisions without a documented risk assessment. This should be completed by June 2015.	Clear guidance regarding risk assessment from the outset of pregnancy, during the antenatal, intrapartum and postnatal period. All policies are evidence based and NICE guidance fully implemented unless gaps evident which are reported via the governance team. Joint policies are also in place when neonatal / paediatric input is required e.g. readmission policy, jaundice policy, low birth weight policy.	**Nil**	G
7	The University Hospitals of Morecambe Bay NHS Foundation Trust should audit the operation of maternity and paediatric services, to ensure that they follow risk assessment protocols on place of delivery, transfers and management of care, and that effective multidisciplinary care operates without inflexible demarcations between professional groups. This should be in place by September 2015.	Clear policies for this in place – including risk assessments, IUT policy	**Nil**	G

8	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify a recruitment and retention strategy aimed at achieving a balanced and sustainable workforce with the requisite skills and experience. This should include, but not be limited to, seeking links with one or more other centre(s) to encourage development of specialist and/or academic practice whilst offering opportunities in generalist practice in the Trust; in addition, opportunities for flexible working to maximise the advantages of close proximity to South Lakeland should be sought. Development of the strategy should be completed by January 2016.	Strategy for the recruitment and retention of staff in place – staffing paper submitted to Trust board for approval and plan in place to address staffing shortfall BR+ undertaken and accepted in principal CPD process in place Risk Assessment / reporting if staffing is reduced. Audit of staffing – exception reports weekly Review of FFT and Patient Questionnaires	**Nil - Full establishment review with assurance re BR+ compliance.** **6 monthly workforce update to Board and monthly ratio re midwifery staffing evident on dashboard.**	G
9	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify an approach to developing better joint working between its main hospital sites, including the development and operation of common policies, systems and standards. Whilst we do not believe that the introduction of extensive split-site responsibilities for clinical staff will do much other than lead to time wasted in travelling, we do consider that, as part of this approach, flexibility should be built into working responsibilities to provide temporary solutions to short-term staffing problems. This approach should be begun by September 2015.	N/A	**N/A**	G
10	The University Hospitals of Morecambe Bay NHS Foundation Trust should seek to forge links with a partner Trust, so that both can benefit from opportunities for learning, mentoring, secondment, staff development and sharing approaches to problems. This arrangement is promoted and sometimes facilitated by Monitor as 'buddying' and we endorse the approach under these circumstances. This could involve the same centre identified as part of the recruitment and retention strategy. If a suitable partner is forthcoming, this arrangement should be begun by September 2015.	N/A as good regional networking – ANNB Meetings regionally, SCN, HOMs meetings.	**N/A**	G
11	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify and implement a programme to raise awareness of incident reporting, including requirements, benefits and processes. The Trust should also review its policy of openness and honesty CHAPTER EIGHT: Conclusions and recommendations 187 in line with the duty of candour of professional staff, and incorporate into the programme compliance with the refreshed policy.	Trust actively encouraging openness and honesty within the organisation. Team briefs introduced, CEO Forum opened up to all staff, Raising concerns promoted – Guardians identified for staff to link with W&C Website Governance page – RCA learning / Governance Structure with clear roles and responsibilities. Link with neonates – MDT. Attendance of the HOM at consultants meeting. Staff Guardians introduced within the Trust. Designated walkabouts by HOM and CSL to increase awareness. Trust team brief highlighted importance of same.	**Nil**	G

12	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in investigating incidents, carrying out root cause analyses, reporting results and disseminating learning from incidents, identifying any residual conflicts of interest and requirements for additional training. The Trust should ensure that robust documentation is used, based on a recognised system, and that Board reports include details of how services have been improved in response. The review should include the provision of appropriate arrangements for staff debriefing and support following a serious incident. This should be begun with maternity units by April 2015 and rolled out across the Trust by April 2016.	Policy and guidance relating to incident reporting and undertaking RCA's embedded in practice. Clear process for reporting incidents and follow up of incidents including the role of the SOM – reminder for the need for support also included in notification letter to SOMs Supervisor of Midwives team proactive in addressing practice issues/need for investigation. SOM Action plan in place and the monitoring of SOM activity achieved.	**Nil**	G
13	The University Hospitals of Morecambe Bay NHS Foundation Trust should review the structures, processes and staff involved in responding to complaints, and introduce measures to promote the use of complaints as a source of improvement and reduce defensive 'closed' responses to complainants. The Trust should increase public and patient involvement in resolving complaints, in the case of maternity services through the Maternity Services Liaison Committee. This should be completed, and the improvements demonstrated at an open Board meeting, by December 2015.	Complaints process in place and works well if formally logged with clear management re response times. However PALS can be disjointed and don't always go to the correct person for review. Same reviewed and process working well	**Nil**	G
14	The University Hospitals of Morecambe Bay NHS Foundation Trust should review arrangements for clinical leadership in obstetrics, paediatrics and midwifery, to ensure that the right people are in place with appropriate skills and support. The Trust has implemented change at executive level, but this needs to be carried through to the levels below. All staff with defined responsibilities for clinical leadership should show evidence of attendance at appropriate training and development events. This review should be commenced by April 2015.	Clear leadership arrangements and appraisals to reflect performance of same Review of Midwifery Management structure with the introduction of a Maternity Matron post as no designated matron for the Inpatient area. Deputy post out to advert with the additional remit of the Named Midwife for Safeguarding Same reviewed – for consultant midwife post. Out to advert w/c 14/09/15 – consultant midwife appointed	Nil	G
15	The University Hospitals of Morecambe Bay NHS Foundation Trust should continue to prioritise the work commenced in response to the review of governance systems already carried out, including clinical governance, so that the Board has adequate assurance of the quality of care provided by the Trust's services. This work is already underway with the facilitation of Monitor, and we would not seek to vary or add to it, which would serve only to detract from implementation. We do, however, recommend that a full audit of implementation be undertaken before this is signed off as completed.	Review of the Clinical Governance Structure within Surgery, Womens and Childrens. Designated team for W&C with clear process for escalation and review within the Division. Provision and circulation of a Maternity Dashboard – same reviewed and circulated to all consultants and Midwifery Leads. Maternity Performance Report to Board monthly.	**Nil**	G

16	As part of the governance systems work, we consider that the University Hospitals of Morecambe Bay NHS Foundation Trust should ensure that middle managers, senior managers and non-executives have the requisite clarity over roles and responsibilities in relation to quality, and it should provide appropriate guidance and where necessary training. This should be completed by December 2015.	Clear job descriptions, annual objectives, Trust values and appraisals regarding performance	**Nil**	G
17 & 18	The University Hospitals of Morecambe Bay NHS Foundation Trust should identify options, with a view to implementation as soon as practicable, to improve the physical environment of the delivery suite at Furness General Hospital, including particularly access to operating theatres, an improved ability to observe and respond to all women in labour and en suite facilities; arrangements for post-operative care of women also need to be reviewed. Plans should be in place by December 2015 and completed by December 2017. 18. All of the previous recommendations should be implemented with the involvement of Clinical Commissioning Groups, and where necessary, the Care Quality Commission and Monitor. In the particular circumstances surrounding the University Hospitals of Morecambe Bay NHS Foundation Trust, NHS England should oversee the process, provide the necessary support, and ensure that all parties remain committed to the outcome, through an agreed plan with the Care Quality Commission, Monitor and the Clinical Commissioning Groups.**188** All of the previous recommendations should be implemented with the involvement of the CCG	N/A	**Nil**	G
19	**Recommendations for the wider NHS** In light of the evidence we have heard during the Investigation, we consider that the professional regulatory bodies should review the findings of this Report in detail with a view to investigating further the conduct of registrants involved in the care of patients during the time period of this Investigation. Action: the General Medical Council, the Nursing and Midwifery Council.	The introduction of revalidation is being planned and developed within the Trust Kings Fund review of Supervision is looking at changing statutory supervision provision. Introduction of the revised Code for Midwives	**Nil**	G

20	There should be a national review of the provision of maternity care and paediatrics in challenging circumstances, including areas that are rural, difficult to recruit to, or isolated. This should identify the requirements to sustain safe services under these conditions. In conjunction, a national protocol should be drawn up that defines the types of unit required in different settings and the levels of care that it is appropriate to offer in them. Action: NHS England, the Care Quality Commission, the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the National Institute for Health and Care Excellence.	Await Baroness Cumberledge National review of Maternity services in December 2015 however WUTH is not isolated in the same way as a more rural inaccessible unit. 5 Year NHS Plan will influence the provision of Maternity Services. Clinical Summit 5/7/15 looking at service provision in the North West. Bid to CCG as an alternative provider to be resubmitted in December 2015	**Nil**	**G**
21	The challenge of providing healthcare in areas that are rural, difficult to recruit to or isolated is not restricted to maternity care and paediatrics. We recommend that NHS England consider the wisdom of extending the review of requirements to sustain safe provision to other services. This is an area lacking in good-quality research yet it affects many regions of England, Wales and Scotland. This should be seen as providing an opportunity to develop and promote a positive way of working in remote and rural environments. Action: NHS England.	N/A	**Nil**	**G**
22	We believe that the educational opportunities afforded by smaller units, particularly in delivering a broad range of care with a high personal level of responsibility, have been insufficiently recognised and exploited. We recommend that a review be carried out of the opportunities and challenges to assist such units in promoting services and the benefits to larger units of linking with them. Action: Health Education England, the Royal College of Obstetricians and Gynaecologists, the Royal College of Paediatrics and Child Health, the Royal College of Midwives.	N/A	**Nil**	**G**

23	Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would work. Action: the Care Quality Commission, NHS England, the Department of Health.	Clear Governance arrangements in place within WUTH including the maternity unit. Regular CIF meetings, LWSG, perinatal mortality, audit, clinical governance meetings take place RCA process clear with MDT involvement, involvement also from SOMs Review of Maternity Dashboard and circulation to the CGG meeting on a monthly basis for discussion and exception reporting	**Nil**	G
24	We commend the introduction of the duty of candour for all NHS professionals. This should be extended to include the involvement of patients and relatives in the investigation of serious incidents, both to provide evidence that may otherwise be lacking and to receive personal feedback on the results. Action: the Care Quality Commission, NHS England.	Included in policy and is adhered to with clear review of timescales	**Nil**	G
25	We recommend that a duty should be placed on all NHS Boards to report openly the findings of any external investigation into clinical services, governance or other aspects of the operation of the Trust, including prompt notification of relevant external bodies such as the Care Quality Commission and Monitor. The Care Quality Commission should develop a system to disseminate learning from investigations to other Trusts. Action: the Department of Health, the Care Quality Commission. CHAPTER EIGHT: Conclusions and recommendations **189**	Process in place within WUTH and Peer reviews/External bodies review services offered. Refer to CQC Plan and EQA plan NHS Protect report, May 2015. SOM Annual Report, Oct 2014 Maternity Service Review – completion of action plan addressing issues identified in 2013-14	**Nil**	G
26	We commend the introduction of a clear national policy on whistleblowing. As well as protecting the interests of whistleblowers, we recommend that this is implemented in a way that ensures that a systematic and proportionate response is made by Trusts to concerns identified. Action: the Department of Health.	NMC guidance clarifies this professionally for nursing and midwifery staff Raising concerns encouraged internally if issues need to be addressed Work ongoing to promote this clinically Staff Guardians introduced to promote a culture of openness and transparency.	**Nil**	G

27	Professional regulatory bodies should clarify and reinforce the duty of professional staff to report concerns about clinical services, particularly where these relate to patient safety, and the mechanism to do so. Failure to report concerns should be regarded as a lapse from professional standards. Action: the General Medical Council, the Nursing and Midwifery Council, the Professional Standards Authority for Health and Social Care.	NMC Guidance reflects the Trust policy and supports the process	**Nil**	**G**
28	Clear national standards should be drawn up setting out the professional duties and expectations of clinical leads at all levels, including, but not limited to, clinical directors, clinical leads, heads of service, medical directors, nurse directors. Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, the General Medical Council, the Nursing and Midwifery Council, all Trusts.	Await national standards	**N/A**	**G**
29	Clear national standards should be drawn up setting out the responsibilities for clinical quality of other managers, including executive directors, middle managers and non-executives. All Trusts should provide evidence to the Care Quality Commission, as part of their processes, of appropriate policies and training to ensure that standards are met. Action: NHS England, the Care Quality Commission, all Trusts.	Await national standards	**N/A**	**G**
30	A national protocol should be drawn up setting out the duties of all Trusts and their staff in relation to inquests. This should include, but not be limited to, the avoidance of attempts to 'fend off' inquests, a mandatory requirement not to coach staff or provide 'model answers', the need to avoid collusion between staff on lines to take, and the inappropriateness of relying on coronial processes or expert opinions provided to coroners to substitute for incident investigation. Action: NHS England, the Care Quality Commission.	Await National Protocol although revised guidance sent out April 2015 EQA visit for the ANNB Screening Programmes on the 9th and 10th June 2015 – report awaited from NHS England	**Nil**	**G**

31	The NHS complaints system in the University Hospitals of Morecambe Bay NHS Foundation Trust failed relatives at almost every turn. Although it was not within our remit to examine the operation of the NHS complaints system nationally, both the nature of the failures and persistent comment from elsewhere lead us to suppose that this is not unique to this Trust. We believe that a fundamental review of the NHS complaints system is required, with particular reference to strengthening local resolution and improving its timeliness, introducing external scrutiny of local resolution and reducing reliance on the Parliamentary and Health Service Ombudsman to intervene in unresolved complaints. Action: the Department of Health, NHS England, the Care Quality Commission, the Parliamentary and Health Service Ombudsman.	Clear process for addressing complaints refer to point 13 Local resolution encouraged whenever possible Learning from complaints is important – action plans to be developed to monitor progress and to evidence improvements	.	G
32	The Local Supervising Authority system for midwives was ineffectual at detecting manifest problems at the University Hospitals of Morecambe Bay NHS Foundation Trust, not only in individual failures of care but also with the systems to investigate them. As with complaints, our remit was not to examine the operation of the system nationally; however, the nature of the failures and the recent King's Fund review (*Midwifery regulation in the United Kingdom*) lead us to suppose that this is not unique to this Trust, although there were specific problems there that exacerbated the more systematic concern. We believe that an urgent response is required to the King's Fund findings, with effective reform of the system. Action: the Department of Health, NHS England, the Nursing and Midwifery Council.	LSA work closely with WUTH and action plan following LSA Annual Report developed and completed by the SOM Team. Further review and visit in October 2015 WUTH visit by NMC very positive with student feedback.	**Nil**	G
33	We considered carefully the effectiveness of separating organisationally the regulation of quality by the Care Quality Commission from the regulation of finance and performance by Monitor, given the close inter-relationship between Trust decisions in each area. However, we were persuaded that there is more to be gained than lost by keeping regulation separated in this way, not least that decisions on safety are not perceived to be biased by their financial **190** The Report of the Morecambe Bay Investigation implications. The close links, however, require a carefully coordinated approach, and we recommend that the organisations draw up a memorandum of understanding specifying roles, relationships and communication. Action: Monitor, the Care Quality Commission, the Department of Health.	Involvement by Monitor and relevant monitoring taking place within the organisation. CQC visit planned to Maternity in September 2015 however unannounced visits to the Trust have taken place. Mock inspections for CQC undertaken – see CQC action plan – visit 15/09/15 CQC Action plan to include any recommendations following visit	**Nil**	G

34	The relationship between the investigation of individual complaints and the investigation of the systemic problems that they exemplify gave us cause for concern, in particular the breakdown in communication between the Care Quality Commission and the Parliamentary and Health Service Ombudsman over necessary action and follow-up. We recommend that a memorandum of understanding be drawn up clearly specifying roles, responsibilities, communication and follow-up, including explicitly agreed actions where issues overlap. Action: the Care Quality Commission, the Parliamentary and Health Service Ombudsman.	N/A?	**Nil**	G
35	The division of responsibilities between the Care Quality Commission and other parts of the NHS for oversight of service quality and the implementation of measures to correct patient safety failures was not clear, and we are concerned that potential ambiguity persists. We recommend that NHS England draw up a protocol that clearly sets out the responsibilities for all parts of the oversight system, including itself, in conjunction with the other relevant bodies; the starting point should be that one body, the Care Quality Commission, takes prime responsibility. Action: the Care Quality Commission, NHS England, Monitor, the Department of Health.	N/A?	**Nil**	G
36	The cumulative impact of new policies and processes, particularly the perceived pressure to achieve Foundation Trust status, together with organisational reconfiguration, placed significant pressure on the management capacity of the University Hospitals of Morecambe Bay NHS Foundation Trust to deliver against changing requirements whilst maintaining day-to-day needs, including safeguarding patient safety. Whilst we do not absolve Trusts from responsibility for prioritising limited capability safely and effectively, we recommend that the Department of Health should review how it carries out impact assessments of new policies to identify the risks as well as the resources and time required. Action: the Department of Health.	Standard Framework - await any further guidance	**Nil**	G

37	Organisational change that alters or transfers responsibilities and accountability carries significant risk, which can be mitigated only if well managed. We recommend that an explicit protocol be drawn up setting out how such processes will be managed in future. This must include systems to secure retention of both electronic and paper documents against future need, as well as ensuring a clearly defined transition of responsibilities and accountability. Action: the Department of Health.	Await Department of Health Guidance Cerner Millennium Action plan developed to look at any issues. Daily report of documentation errors available Involvement by SOM re: record keeping Potential risk – losing records	**Nil**	G
38	Mortality recording of perinatal deaths is not sufficiently systematic, with failures to record properly at individual unit level and to account routinely for neonatal deaths of transferred babies by place of birth. This is of added significance when maternity units rely inappropriately on headline mortality figures to reassure others that all is well. We recommend that recording systems are reviewed and plans brought forward to improve systematic recording and tracking of perinatal deaths. This should build on the work of national audits such as MBRRACE-UK, and include the provision of comparative information to Trusts. Action: NHS England.	MBRACE reporting effective locally in addition to MDT review – Perinatal Meetings Review nationally commenced by RCOG – Every Baby Counts SCN are also reviewing this work as are Sabine	**Nil**	G
39	There is no mechanism to scrutinise perinatal deaths or maternal deaths independently, to identify patient safety concerns and to provide early warning of adverse trends. This shortcoming has been clearly identified in relation to adult deaths by Dame Janet Smith in her review of the Shipman deaths, but is in our view no less applicable to maternal and perinatal deaths, and should have raised concerns in the University Hospitals of Morecambe Bay NHS Foundation Trust before they eventually became evident. Legislative preparations have already been made to implement a system based on medical examiners, as effectively used in other countries, and pilot schemes have apparently proved effective. We cannot CHAPTER EIGHT: Conclusions and recommendations **191** understand why this has not already been implemented in full, and recommend that steps are taken to do so without delay. Action: the Department of Health.	See 38	**Nil**	G
40	Given that the systematic review of deaths by medical examiners should be in place, as above, we recommend that this system be extended to stillbirths as well as neonatal deaths, thereby ensuring that appropriate recommendations are made to coroners concerning the occasional need for inquests in individual cases, including deaths following neonatal transfer. Action: the Department of Health	Await National guidance	**Nil**	G

41	We were concerned by the ad hoc nature and variable quality of the numerous external reviews of services that were carried out at the University Hospitals of Morecambe Bay NHS Foundation Trust. We recommend that systematic guidance be drawn up setting out an appropriate framework for external reviews and professional responsibilities in undertaking them. Action: the Academy of Medical Royal Colleges, the Royal College of Nursing, the Royal College of Midwives.	Await National guidance	**Nil**	**G**
42	We further recommend that all external reviews of suspected service failures be registered with the Care Quality Commission and Monitor, and that the Care Quality Commission develops a system to collate learning from reviews and disseminate it to other Trusts. Action: the Care Quality Commission, Monitor.	Await National guidance	**Nil**	**G**
43	We strongly endorse the emphasis placed on the quality of NHS services that began with the Darzi review, *High Quality Care for All*, and gathered importance with the response to the events at the Mid Staffordshire NHS Foundation Trust. Our findings confirm that this was necessary and must not be lost. We are concerned that the scale of recent NHS reconfiguration could result in new organisations and post-holders losing the focus on this priority. We recommend that the importance of putting quality first is re-emphasised and local arrangements reviewed to identify any need for personal or organisational development, including amongst clinical leadership in commissioning organisations. Action: NHS England, the Department of Health.	Await National guidance	**Nil**	**G**

44	This Investigation was hampered at the outset by the lack of an established framework covering such matters as access to documents, the duty of staff and former staff to cooperate, and the legal basis for handling evidence. These obstacles were overcome, but the need to do this from scratch each time an investigation of this format is set up is unnecessarily time-consuming. We believe that this is an effective investigation format that is capable of getting to the bottom of significant service and organisational problems without the need for a much more expensive, time-consuming and disruptive public inquiry. This being so, we believe that there is considerable merit in establishing a proper framework, if necessary statutory, on which future investigations could be promptly established. This would include setting out the arrangements necessary to maintain independence and work effectively and efficiently, as well as clarifying responsibilities of current	Await national guidance but to address the staff survey and encourage staff to engage and create a culture of learning	**Nil**	**G**

Finally, review any previous reviews of Maternity Services at WUTH and ensure all issues addressed. Look at review of the Action plan through CGG meeting monthly with exceptions to Trust CGG meeting and DMT.
To provide feedback to the Quality & Safety Group as required.

Initial plan in May 2015 was produced with a review and update in March 2022
Debbie Edwards, Director of N&M, Women & Children's Division
Wirral University Teaching Hospital NHS Trust.
March 2022.

APPENDIX 2: Ockenden – Compliance update

7 Ockenden IEAs (including 12 Clinical Priorities): Wirral University Teaching Hospital NHSF Trust	Compliant	Partially Compliant	Non-Compliant
1) Enhanced Safety			
A plan to implement the Perinatal Clinical Quality Surveillance Model	**Compliant as Trust model implemented pending national tool. LMNS also finalising a document to implement based on WUTH tool and further tool being implemented across the NWC Region. Evidence also in return to NHSE/I and although WUTH deems itself as compliant it is acknowledged that compliance overall may depend on regional tool being implemented. ***		**N/A**
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	**Evidence submitted to portal (Q3 & Q8 : IEA 1)**		
2) Listening to Women and their Families			
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	**Question 13 & 15 : IEA 2 – Evidence submitted via portal.**		
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	**Question 11; 14 & 16: IEA 2 – Evidence submitted via portal.**		
3) Staff Training and working together			
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week	**Question 18 : IEA 3 – Evidence submitted via portal to support that ward rounds are taking place twice daily.**		
The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.	**Question 17 : IEA 3 – Evidence submitted via portal. TNA shared with LMNS and reporting template developed to further support reporting of compliance.**		
Confirmation that funding allocated for maternity staff training is ringfenced	**Question 19 : IEA 3 – Evidence submitted via portal and declaration of same by DoF.**		

APPENDIX 3: Perinatal Clinical Surveillance Quality Assurance Report

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	No funnel plot chart however no escalation from SCN / LMNS on outlier report
	Outlier for rates of neonatal deaths as a proportion of birth	no	No funnel plot chart however no escalation from SCN / LMNS on outlier report
	Rates of HIE where improvements in care may have made a difference to the outcome	no	Very low rates of HIE, sitting way below the lower control limit for the region.
	Number of SI's	no	2021 Report submitted to BoD - WUTH were not an outlier for SI's in 2021.
	Progress on SBL care bundle V2	no	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP.
	Outlier for rates of term admissions to the NNU	no	The rate of avoidable term admissions remains low. Atain action plan in place
Service user and staff feedback	MVP or Service User concerns/complaints not resolved at trust level	no	Current delays in responding to complaints but not an outlier regarding the number of complaints which are below most other providers each month
	Trainee survey	no	Consistently high scoring year on year.
	Staff survey	no	As a Division, we have maintained or improved in all domains, scoring higher than the Trust average for the majority of domains. Action plan in place to address areas for improvement.
	CQC National survey	no	Survey published Feb 2022 and submitted to BoD for oversight
	Feedback via Deanery, GMC, NMC	no	Nil to report
	Poor staffing levels	no	Vacancy rate below 1% a- will increase due to staff promotion/retiring
	Delivery Suite Coordinator not supernummary	no	Supernumerary status is maintained for all shifts.
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	HoM recruited into post and AND for Childrens Services commenced in post in Jan 2022.
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams.

	False declaration of CNST MIS	no	Externally audited by MIAA. Year 4 preparation ongoing
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil of note, bi-monthly listening events in place.
Safety and learning culture	Lack of engagement in HSIB or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead.
	Lack of transparancy	no	Being open conversations are regularly had and 100% DOC evident.
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all SI's, local reviews, rapid reviews, complaints and compliments.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations.
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations.
Incident reporting	Low patient safety or serious incdient reporting rates	no	Consistent rates of reporting across the speciality groups.
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework.
	Never Events which are not reported	no	No, no maternity or neonatal never events.
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales.
Governance processes	Unclear governance processes - SAT		Clear governance processes in place that follow the SI framework - Maternity specific Risk Management Strategy in draft for comments prior to ratification.
	Business continuity plans not in place	no	Business continuity plans in place.
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	The service was able to continue to provide an acute service from the start of the pandemic due to the robust contingency plans in place. Business as usual was operated following changes necessary to safeguard staff and service user well being.

CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Last CQC core service review was undertaken in May 2021 which did not highlight any concerns.
	An overall CQC rationg of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	N/a
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Board of Directors **Item 10**
6th April 2022

Title	Update following the publication of the 2020 Children's and Young People's patient experience survey
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and Director of Infection Prevention & Control (DIPC)
Author	Debbie Edwards, Director of Nursing & Midwifery, Women and Children's Division
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide assurance to Board of Directors that the findings of the 2020 Survey of Children and Young People have been acknowledged and are being acted upon with clear actions in place to support quality improvement work within the designated area.

In 2020 CQC commissioned a Children's and Young Persons CYP survey in line with the scheduled patient experience survey programme, the results support preliminary intelligence as part of the CQC inspection process and provides hospital trusts with comparative benchmarking data to identify areas of celebration and areas for continuous improvement.

The 2020 survey was undertaken during November 2020 and January 2021. Response rates were low at 16% compared with the national average of 24%, unfortunately there were insufficient responses from 8-11 years which meant meaningful analysis in this age bracket was unavailable.

WUTH's overall results were positive with seven indicators being banded as "Better" when compared with other hospital trusts and no indicators being banded as "Worse", it should be acknowledged that the survey was undertaken during the Covid pandemic, and this is reflective of the two indicators where the Trust saw a significant statistical decline in scores.

In line with the Trusts vision to be an outstanding organisation an improvement plan has been developed to ensure that where possible CYP and their families have the best experience of care and services delivered by WUTH. This improvement plan will be monitored at the Children's Clinical Governance meeting and via the Patient Experience and Family Group reporting to Patient Safety Quality Board.

It is recommended that the Board:

- Note and acknowledge the findings of the 2020 Children's and Young People's patient experience survey and to identify quality improvements and increase the overall response rate in the next national survey.

Key Risks
This report relates to these key Risks: • Board Assurance Framework references 1,2 and 4.

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
N/A			

1	Narrative
1.1	The 2020 survey of Children and Young People CYP involved 125 acute and specialist NHS Trusts providing Children's services across England. Patients (Children and Young people) were eligible to participate in the survey if they were admitted to hospital and aged between 15 days and 15 years old when discharged between the 1 November 2020 and 31 January 2021. The CYP 2020 survey featured three different questionnaires, each one appropriate for a different age group: • The 0-7 questionnaire, sent to patients aged between 15 days and 7 years old at the time of discharge. • The 8-11 questionnaire, sent to patients aged between 8 and 11 years old at time of discharge – WUTH did not have sufficient responses in this category to provide meaningful feedback. • The 12-15 questionnaire sent to patients aged between 12 and 15 yrs. Old at the time of discharge. Questionnaires sent to children aged 8-15 years had a short section for the child or young person to complete, followed by a separate section for the parent or carer to complete. For those children aged 0-7 years – a questionnaire was completed by the parent/carer only. CQC uses an analysis technique called the 'expected range' to determine if organisations are performing 'about the same', 'better' or 'worse' compared with most other Trusts. This expected range banding is the primary marker for inclusion of results details within this report. **Findings**

A total of 842 CYP / families were invited to complete a survey with 130 responding providing a response rate of 16% compared with the national average response rate of 24%. There were insufficient number of responses for the 8-11year old bracket to provide any meaningful analysis for WUTH.

WUTH were banded as “about the same” for 54 indicators, none of the results were banded as “Worse”, seven however were banded as “Better” as displayed in the table below.

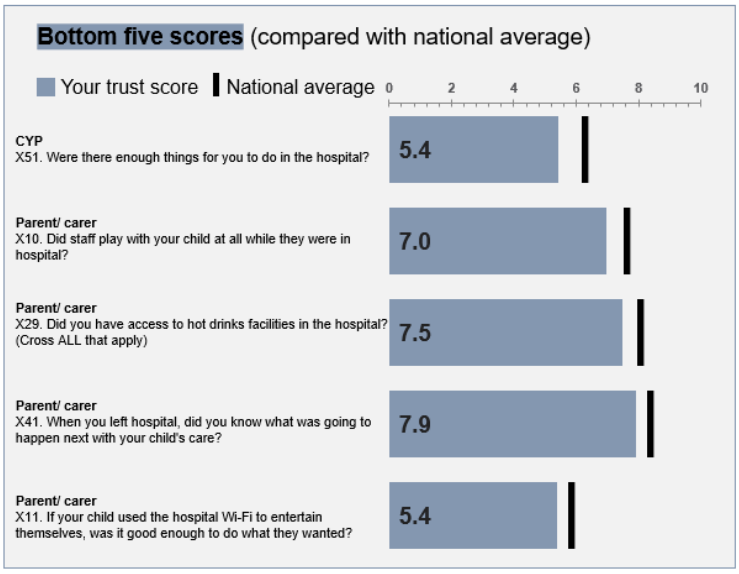
WUTH’s Results for indictors banded as “Better”
How clean do you think the hospital room or ward was that your child was in?
Did hospital staff keep you informed about what was happening whilst your child was in hospital?
Were you able to ask staff any questions you had about your child’s care?
Were members of staff available when your child needed attention?
How would you rate the facilities for parents or carers staying overnight?
Before your child had any operations or procedures did a member of staff explain to you what would be done?
Afterwards did staff explain to you how the operation or procedure had gone?

A direct comparison with the last survey in 2018 indicates that there was no statistical difference in results for 54 of the indicators, WUTH performed statically better for four indicators and significantly worse for 2 indicators. The two areas that had a statistically significant decline were as follows:

- Were there enough things for your child to do in the hospital?
- Were you able to prepare food in the hospital if you wanted to?

Whilst an improvement plan is looking at how best to address these shortcomings it should be acknowledged that these findings were heavily influenced by the restrictions and circumstances aligned to the Covid19 pandemic.

CQC highlight each Trust’s top five scoring indictors and the bottom 5 scoring indicators compared with the national averages as part of the benchmarking data. This enables organisations to identify areas of celebration and areas for continuous improvement as displayed in the tables below.



Assessment

This paper provides an update to the Board of Directors of the findings from the survey and improvements identified are being progressed through an improvement plan detailing all actions taken. The improvement plan has been produced in collaboration with all areas for improvement identified and appropriate actions with time scales agreed.

The survey report has been disseminated throughout the Children's Directorate within the Women and Children's Division with the findings from the report being discussed at various Divisional meetings including: the Monthly Senior Children's Meeting, the Children's Clinical Governance Meeting and the Divisional Management Team Meeting.

The Children's Clinical Governance meeting will oversee progress of quality improvement work detailed within the Improvement Plan with escalation of any issues or concerns to Divisional DMB and Patient Experience and Family Group reporting to PSQB.

3	Conclusion
3.1	The survey results for WUTH were pleasing with improvements noted in some key areas, such as facilities provision for families and communication, these findings have been acknowledged and celebrated by the team. The results demonstrate sustainability of the delivery of good standards of care, associated with a high level of positive feedback from service users for Children's services at the Trust. A key area of the improvement plan should address assurances around gaining feedback directly from CYP and engagement opportunities with them and their families/carers.

Report Author	Debbie Edwards – Divisional Director of Women and Children's Directorate

	Johanna Ashworth-Jones, Programme Developer, Patient Experience and Nurse Quality Indicators
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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors **Item 11**
6th April 2022

Title	Quality Health CQC Maternity Survey 2021
Area Lead	Debbie Edwards, Divisional Director of Nursing and Midwifery for Women's and Children's Division
Author	Jo Lavery, Head of Midwifery Johanna Ashworth-Jones, Programme Developer, Patient Experience and Nurse Quality Indicators
Report for	Noting

Report Purpose and Recommendations

The CQC Maternity Survey is an annual requirement and for which the results are used to support preliminary intelligence as part of the CQC inspection process. The survey provides information on Women's experiences during all aspects of their maternity care, including antenatal care, postnatal care, and the care received during labour and birth.

Due to the COVID pandemic there was no survey undertaken in 2020, therefore comparative data is made with 2019. The 2021 Maternity survey was also the first mixed-mode maternity survey in the NHS Survey Programme, where women were encouraged to respond online but were also given the option of postal completion.

The purpose of this report is to inform the Board of Directors of the results outlining the benchmarking data including areas of excellence and continuous improvement.

The results of the survey are predominately positive with 4 indicators banded by CQC as "Better", these and other areas where WUTH scored well in, centered on excellent communication and caring staff. WUTH did not have any indicators banded as "Worse" however there were areas of suggested improvement identified which will form part of an improvement plan monitored via the Divisional Clinical Governance Meeting.

Key Risks

This report relates to the following key risk:

- Recommendations to implement a different model of care to women as outlined in the publication of Better Births in 2016 is in response to feedback from women and the care that they receive. The Trust currently have two different models of care and is moving towards the full implementation of a Continuity of Carer model of care. The implementation of this model is planned for June 2022 and this will further support quality improvement identified following review of the survey results. This revised model is subject to a successful management of change process which is currently taking place with full engagement from all stakeholders.

Which strategic objectives this report provides information about:

Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
To be tabled on the agenda April 2022	Clinical Governance (W&C Division)	QH CQC Maternity Survey 2021	For information and sharing the results of the CQC survey

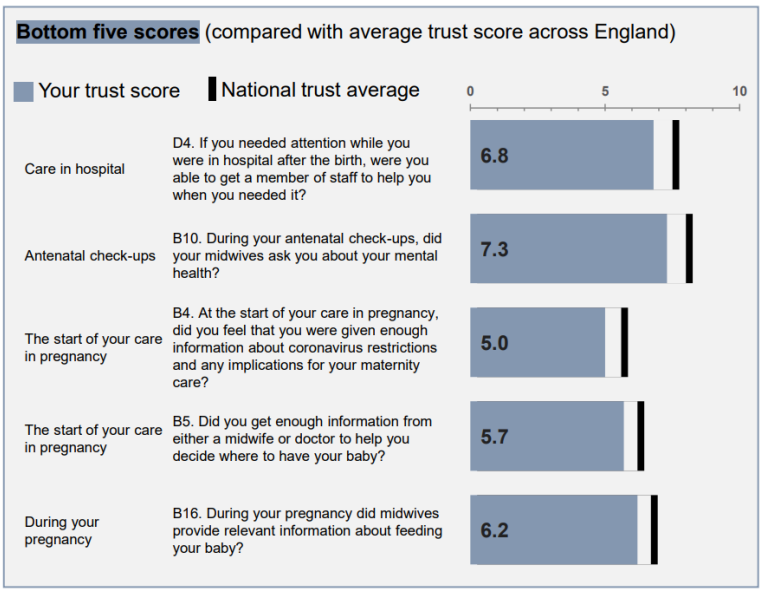
1	**Narrative**
1.1	The CQC National Maternity Patient Experience Survey results 2021 relates to Women who gave birth between 1 and 28 February 2021. This was during the third national lockdown for the COVID-19 pandemic and therefore it should be acknowledged that the respondents will have gone through their antenatal, labour and birth, and postnatal stages under pandemic conditions. The 2021 maternity survey was also the first mixed-mode maternity survey in the NHS Survey Programme, where women were encouraged to respond online but were also given the option of postal completion. The maternity survey is split into three sections that ask questions about: 1: Antenatal care 2: Labour and birth and 3: Postnatal care. Results are statistically standardised in order to provide a fair and direct comparison with other organisations and allows CQC to use an analysis technique called the 'expected range' to determine if organisations are performing 'about the same', 'better' or 'worse' compared with most other Trusts. 300 women were invited to take part in the survey with 138 responses providing a response rate of 46%. 47% of these indicated that this was their first baby. WUTH scored "about the same" for 46 indicators out of the 50, they were not scored as "Worse" for any indicators however they were scored as "Much better than expected" for 2 indicators and "Better than expected" for an additional 2 indictors. These were as follows: • **Much better than expected:** ○ Thinking about your care during labour and birth, were you spoken to in a way you could understand? ○ 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? • **Better than expected:** ○ Did you feel that the midwife or Midwifery Team that you saw or spoke to always listened to you? ○ Did you have confidence and trust in the Midwifery Team you saw or spoke to after going home?

A direct comparison of WUTH's results with the 2019 results is possible for 43 of the 50 indicators in the 2021 Survey. This comparison shows that there was no statistical difference for 28 indicators but there was a statistically significant decrease in 15 indicators.

Results are split into 8 headings across the 3 main sections, the table below demonstrates the overall scores for these 8 headings, the expected range outcome and a regional comparison. Performance range charts and regional comparison details are included as appendix 1 of this report.

Section Heading	Score	Expected Range	Regional Position
The start of your care during your pregnancy	4.8	About the same	Lowest scores
Antenatal check ups	7.7	About the same	N/A
During your pregnancy	8.2	About the same	N/A
Your Labour & Birth	8.1	About the same	Lowest scores
Staff Caring for you	8.6	About the same	Highest scores
Care in hospital after birth	7.8	Somewhat better	Highest scores
Feeding your baby	8.3	About the same	N/A
Care at home after birth	7.7	About the same	Highest scores

As part of the benchmarking analysis CQC highlights each Trust's top five scoring indicators and their bottom five scoring indictors compared with the National Trust average as displayed below.



2	Implications
2.1	The survey report has been disseminated throughout the Maternity Directorate within the Women and Children's Division with the findings from the report being discussed at the monthly Senior Maternity Meeting, the Divisional Management Team Meeting and is on the agenda for the Clinical Governance Meeting to be held in April 2022. Results from the survey will be used to formulate an improvement plan based on the bottom five scoring indicators, the 15 significantly decreased scores and regional comparatives where WUTH has scored lowest. As part of this improvement plan process cross referencing of all existing improvement framework actions will be undertaken to minimise the risk of duplication. The Maternity/Neonatal Clinical Governance meeting and Patient Experience and Family Group will oversee progress of quality improvement work detailed within the Improvement Plan with escalation of any issues to Divisional Management Board/Patient Safety Quality Board.

3	Conclusion
3.1	The Care Quality Commission (CQC) survey was carried out in February 2021, when COVID-19 precautions and restrictions meant a change to the way the Maternity Team cared for their patients and families. Despite this WUTH scored "Better" than other organisations for 4 indicators and were banded in the highest section of scores regionally for 3 of the 8 headings. The report supports WUTH in identifying areas for continuous improvement which will be addressed as part of an improvement plan. It is recommended that the areas highlighted should be compared with local patient experience feedback and local intel used as part of monitoring the implementation of any improvement actions. In conclusion the survey results are positive which reinforces the ongoing improvements of the Maternity Service at a time when the service has been under immense pressure due to the impact of the pandemic.

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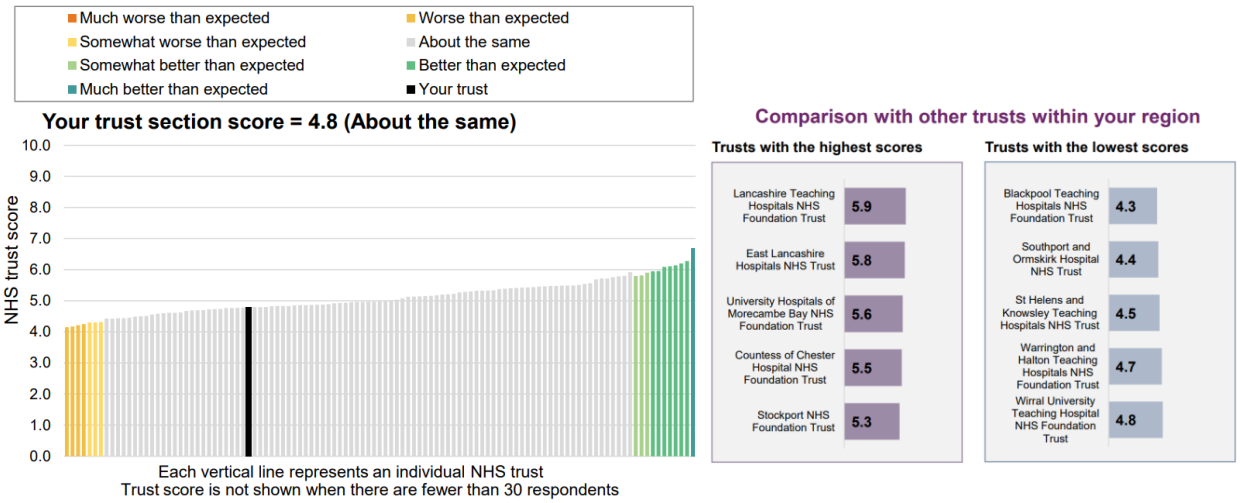
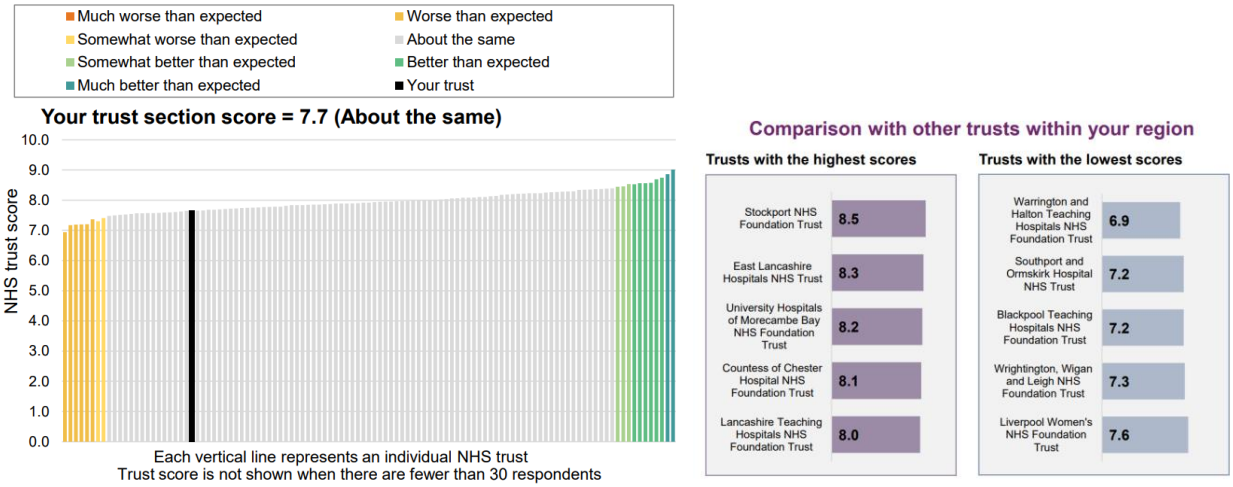
Appendix 1: Section score details:

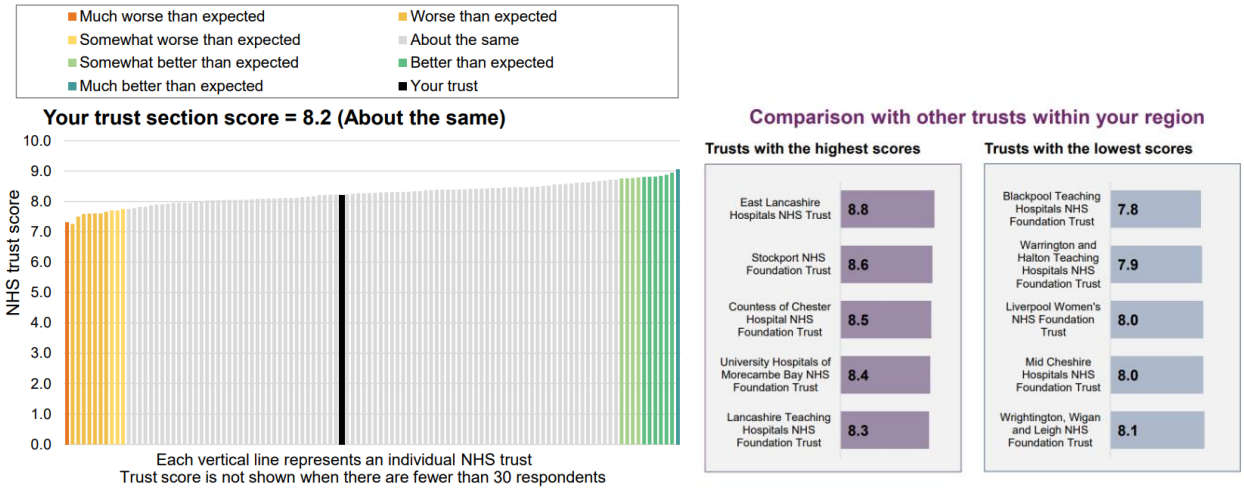
The start of your care during your pregnancy



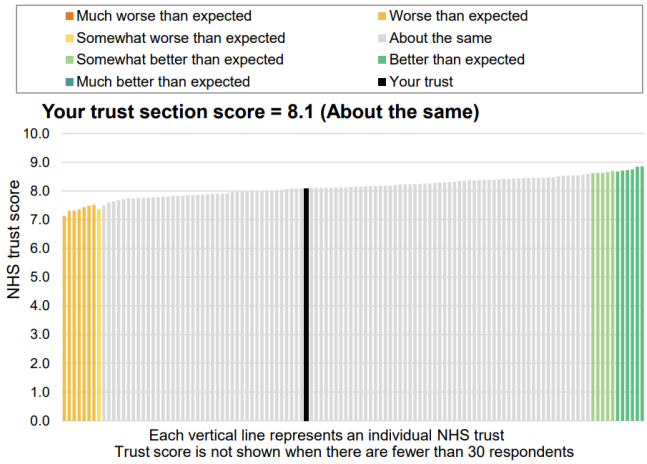
Antennal Check Ups

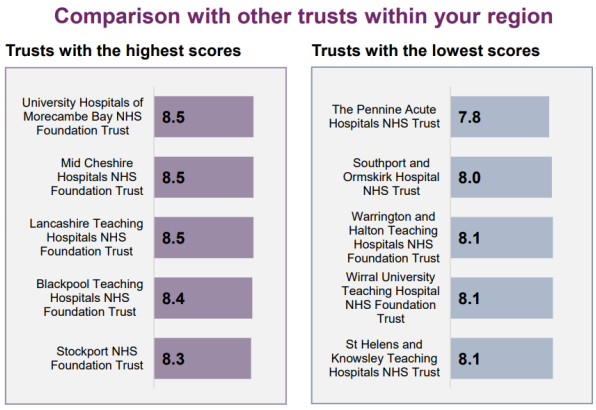


During Your Pregnancy

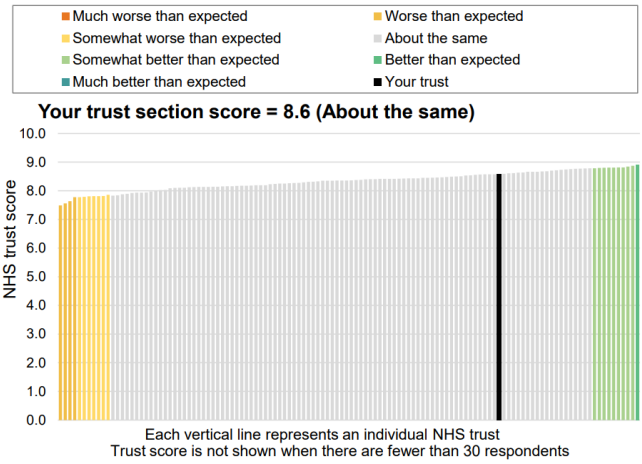


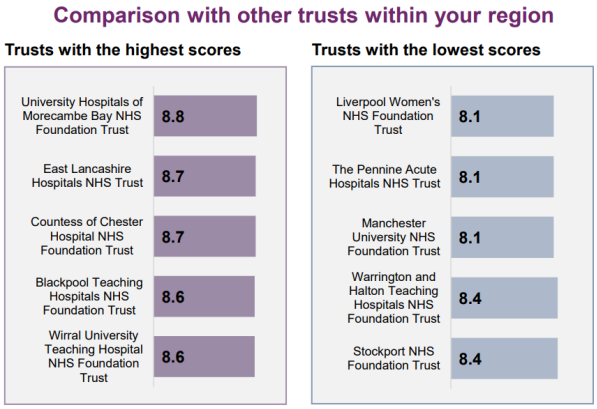
Your Labour and Birth



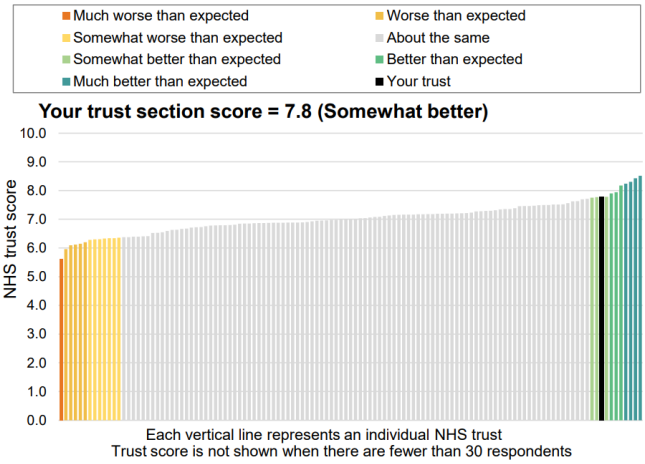


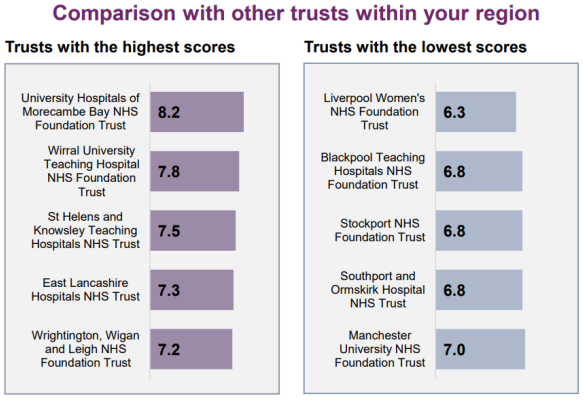
Staff Caring for You



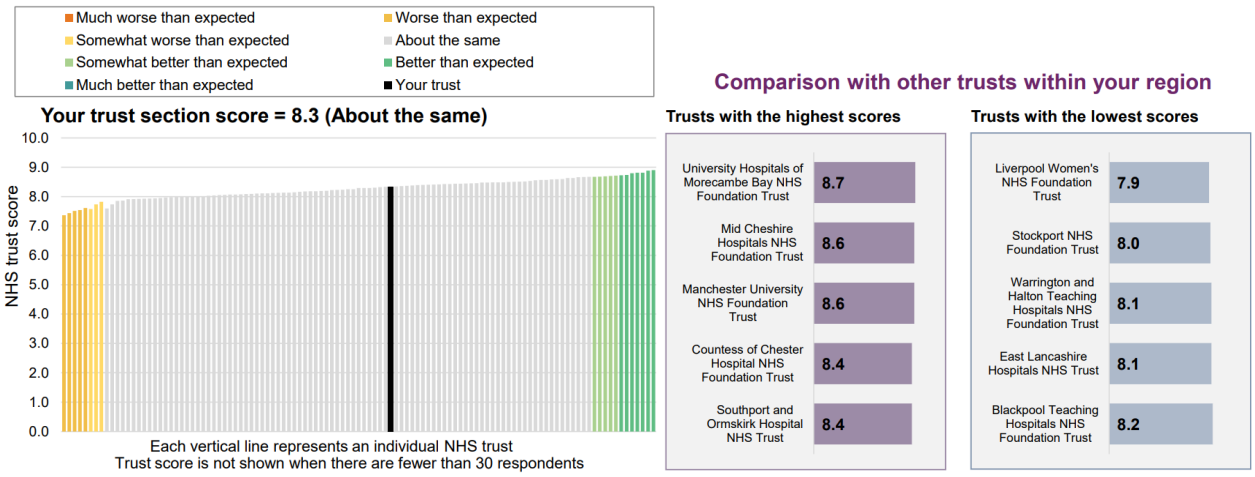


Care in Hospital After Birth

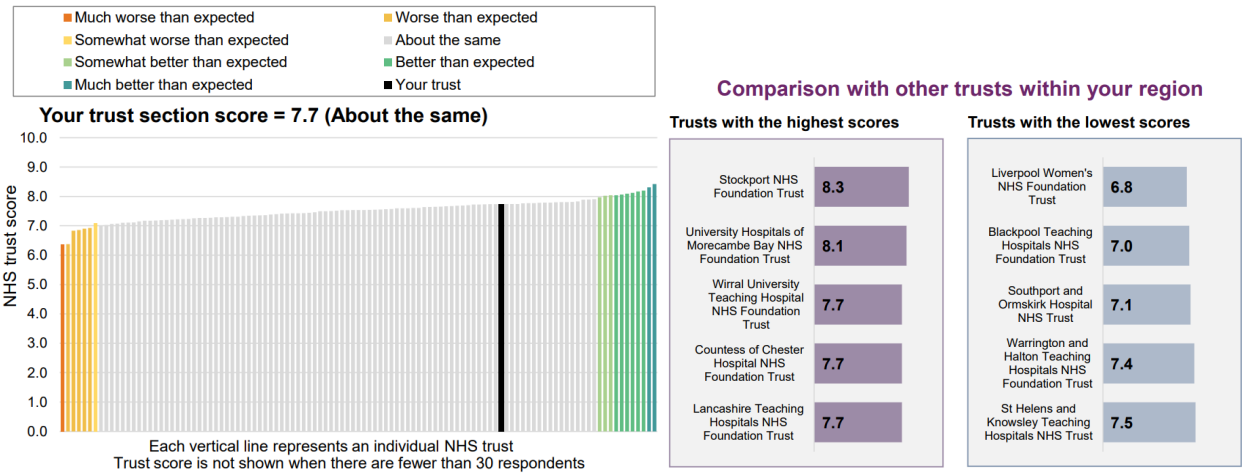




Feeding Your Baby



Care at Home After Birth



Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors **Item 12**
6th April 2022

Title	Communications and Engagement Report
Area Lead	Debs Smith, Chief People Officer Sally Sykes, Director of Communications and Engagement
Author	Sally Sykes, Director of Communications and Engagement
Report for	Information

Report Purpose and Recommendations

The purpose of the report is to update the Board on the Trust's communications and engagement activities in March 2022, including media relations, campaigns, marketing, social media, employee communications and stakeholder engagement, WUTH Charity and staff engagement.

Key Risks

This report relates to these key Risks:

Board Assurance Risk Framework

Risk 1.1 – Unscheduled care demand (communications interventions to support addressing this risk and Trust initiatives like addressing winter pressures and patient flow)
Risk 2.1 – Failure to fill vacancies (communications support on recruitment, retention and reputation)
Risk 3.4 – Failure of Transformation programmes (communications and engagement, including stakeholders and patients for WUTH Improvement activities for service transformation, patient flow and Winter Plan)
Risk 6.1 – Estates related risks (Communications, stakeholder and staff engagement to support delivery of Estates Strategy, Masterplans and capital programme developments. Including in month communications for the Urgent and Emergency Care Centre Upgrade plans)

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
None to date			

1	Narrative
	This is the report of the Director of Communications and Engagement, providing an update on the team's work to generate proactive media and social media coverage of WUTH, to keep staff informed of critical matters to help them work safely and to keep patients safe. **Campaigns, media, social media, internal communications, staff engagement and stakeholder relations** **Campaigns** **Celebrating 40 years of Arrowe Park Hospital** – on May 4th 2022, it will be 40 years since Her Majesty the Queen opened Arrowe Park Hospital and we have a number of commemorative events planned or underway to mark the occasion with staff, stakeholders and the local community. **The Vaccination Hubs** continued to require campaign and communications support – especially stepping up of the booster programme to combat the Omicron variant of COVID-19, the changes to cohort eligibility and the roll out of the fourth booster dose to over 75s. Internally, listening events have been taking place with staff to seek feedback on lessons learned from the Vaccination as a Condition of Deployment (VCOD) process and we also communicated the outcome of the Government consultation which showed a strong majority in favour of revoking the legislation. **In month campaigns**, including our usual strong support for International Women's Day, also covered Lymphoedema Awareness Week, Ovarian Cancer Month, World Kidney Day, World TB Day, Endometriosis awareness and World Delirium Awareness Day. Focussing on our people we supported National Cancer Nurse Specialist Awareness Day with case studies of our cancer nurses and NHS Careers Week with similar staff testimonials such as this example - National Careers Week, Irvine Mubaiwa. **To support our recruitment offer to veterans** and reservists we are partnering with Civvy Street Magazine, a unique platform for ex-military personnel to gain access to various support avenues such as job vacancies and relocation advice. Founded in 2004, the magazine is one of the UK's leaders in military resettlement. Civvy Street is owned and operated by former service personnel, who understand the issues faced by those who are looking to readjust to life after the service and who understand the various transferable skills of our Armed Forces. Our first collaboration features WUTH's commitment to the Military Covenant and in future issues we'll be highlighting former service personnel who have transitioned to the NHS at WUTH. Civvy Street Magazine - Monthly Military Resettlement Publication

Media

In March we highlighted new investment in our £10.6 million funding for operating theatre– new South Mersey Elective Hub The funding from NHS England and Improvement which has been allocated by Cheshire and Merseyside's Integrated Care System (ICS) and will enable the Trust to build two new 'modular theatres' at its Clatterbridge Hospital site, to treat around 3,000 patients a year.

There was further media coverage of our Clatterbridge site when the 10,000 patient 10,000 patients on Wirral have benefited from earlier access to diagnostics visited our diagnostics hub which is jointly operated with Clatterbridge Cancer Centre.

Also in CQC developments, we released news about the national survey of maternity services, which produced positive results for maternity services at Wirral Women and Children's Hospital. The Trust performance was reported as better than the majority of the 122 hospitals surveyed, in response to several questions. Positive results in CQC survey of maternity services | Wirral University Hospital NHS Foundation Trust (wuth.nhs.uk)

Employee Engagement Communications

We are preparing for the release and internal communications for **the NHS Staff Survey** results, due to be published on 30/3/22 and which will be then the subject of further planning, leadership support and action planning as advised to the Board.

We have promoted the latest round of the **NHS Parliamentary Awards** for staff who have demonstrated extraordinary commitment.

The Arrowe Park 40th Anniversary provides a great opportunity for staff involvement and we are building staff engagement into all the activities, including a special themed issue of our Trust magazine and a Wirral Globe supplement.

We were also pleased to facilitate filming of a **hip operation for The Royal College of Surgeons** in London, which has undergone a major redevelopment, including the Hunterian Museum of Surgery, which is due to reopen in 2023. They will use our film of an orthopaedic operation as part of an immersive experience for the public as they move through the history of surgery into modern day surgery.

The film will also be a positive Equality and Diversity initiative as the operation was performed by WUTH surgeon Gillian Jackson. Orthopaedics remains one of the specialties most underrepresented by women and the representation of a female surgeon will send a positive modern message and hopefully inspire girls at an early age who visit the museum.

By ensuring that the whole theatre team was represented, Miss Jackson and the team hope to show that surgery only happens with amazing team work. It will hopefully inspire visitors to consider all types of roles in theatre including anaesthetists, radiographers, nurses, HCAs and ODPs. The College and Museum are also keen to represent units outside of London and as the North West had a key role in the development of orthopaedics, we were a great fit; and we are looking forward to seeing the finished film.

The international situation in **Ukraine** also saw us responding through staff generosity and within the healthcare family. We signposted local initiatives in the Polish community, provided surplus medical stocks to a local convoy from Upton and promoted

	the DEC appeal. We also provided a prize for Health Service Journal's Ukraine fundraising. - Bid now for great rewards in HSJ's Ukraine e-auction | News | Health Service Journal **WUTH Charity** WUTH Charity highlights this month include: Plans to relocate the Charity Office to an even more prominent location at the junction of the entrance corridor and the main corridor, switching locations with the Patient and Family Support/PALS hub. Final preparations for the Tri4Life climb to the summit of Everest planned for May. Planning for the last event in the Wirral Mayoral charity year with a golf day on 12th May. Finalising plans for a family, staff and community fun event 'It's a Knock out' on 2 July and the Wirral Winter Ball for 11th November at Thornton Hall Hotel. Developing new branding to refresh the Tiny Stars Neonatal appeal.

2	Implications
	The Board is asked to note that patients and the public have been made aware of capital investment plans to improve capacity and services. The Board will note that the implications of the Staff Survey will involve action planning at corporate and divisional level to drive improvements in staff experience.

3	Conclusion
	The Board is asked to note the developments and progress outlined in the report, including plans to celebrate the 40th anniversary of Arrowe Park Hospital and the forthcoming staff survey.

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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors
6 April 2022

Item No 13.1

Title	Chair's Report – Finance and Business Performance Committee 14th March 2022
Area Lead	Robbie Chapman, Interim Chief Finance Officer
Author	Sue Lorimer, NED
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide assurance on the detailed work and assumptions made in preparing the activity and finance elements of the annual operational plan for 2022/23

It is recommended that the Board:

- Note that the Committee was content that the financial plan reflects the activity plan, that sufficient executive challenge has been made about cost pressures and CIP plans and that assumptions are reasonable at this stage.
- Note that the Committee gained assurance on the risk-based nature of the capital plan, engagement with the divisions and the investments support the Trust strategy.

Key Risks

This report relates to these key Risks:

- Failure to deliver the financial plan due to uncertainty around the future financial regime

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	Yes

Governance journey

This is a standing report to the Board.

1	Narrative
1.1	This report provides assurance to the Board of Directors on the robust nature of activity and financial planning for 2022/23. It is a report of an extraordinary meeting of FBPAC convened to scrutinize the compilation of the plan. Normally the plan would have Board approval prior to submission but due to uncertainties resulting from delays in central planning guidance and the formative nature of Cheshire and Merseyside ICB which is charged with approving Trust plans, the timescale has been extended. FBPAC considered an earlier draft of the plan at its previous meeting. Elective activity is planned to be 104% of 2019/20 levels to deliver treatment to as many patients as possible and to meet national targets enabling the Trust to receive elective recovery funding. The plan has been to Trust Management Board and the Executive Team for approval.

2	Implications
2.1	Income and Expenditure: - The I&E planned net deficit is £17.4m after assuming ERF funding of £15m and a CIP of £20.8m of which £13.8m to be recurrent. - Divisional cost pressures have been subject to check and challenge by the executive team resulting in a reduction of £4m and further scrutiny is planned. - The biggest areas of cost pressure are ED staffing, ward cover and high cost drugs. Risks: - The biggest risks are as follows: Achievement of CIP Achievement of activity levels to secure ERF funding Growth in high cost drugs Community Diagnostic Centre funding Pressure on maintenance budgets Growth in energy prices beyond assumptions Covid Capital Programme: - The capital programme is £9.8m - Major commitments of £7.9m are modular theatres, Ward 1 and essential IT - Bids against the balance hugely oversubscribed and allocations granted on a risk basis. Risks: - The biggest risks are as follows: Increasing cost of materials Demand for contractors exceeds supply Allocation is limited so risks remain relating to backlog maintenance and ageing equipment Risks will be monitored and managed through the performance management dashboard, systems of financial control and Executive oversight, Trust Management Board and FBPAC meetings.

3	Conclusion
3.1	The finance and activity plan 4th cut results in a deficit budget for the Trust but is sufficient to provide safe care and deliver the required elective activity. There are a number of significant risks but the executive team consider these to be manageable on balance. The Cheshire and Merseyside picture continues to develop and further refinement of the plan might be necessary. The capital budget does not meet all of the Trust's needs but there are likely to be further allocations released during the financial year and the Trust is in a good position to bid against these.

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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors
6 April 2022

Item No 13.2

Title	Report of the Quality Assurance Committee
Area Lead	Steve Ryan, Non-Executive Director
Author	Dr Nikki Stevenson, Executive Medical Director/Deputy CEO
Report for	Information

Report Purpose and Recommendations

This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 30th March 2022.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

- Principle BAF Risk 4: Catastrophic Failure in Standards of Care

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

1	Narrative
1.1	**Temporary modification of infection control procedures to balance risks to patient safety** Pending further national advice on Covid-19 surveillance due today, over the last 2 weeks, the impact of pandemic infection prevention and control measures has been subject to exceptional review. Existing procedures meant a reduction in capacity of around 65 beds, even after curtailment of elective care. Restricting the flow of patients into wards substantially increased the risk to patient safety in the emergency department, which became extremely high. Increased numbers of patients were being subjected to corridor care. In addition, increasing numbers of ambulances were

delayed in transferring patients into the department increasing the response time to attend time-critical callouts to stroke and other patients.

As a result, in consultation with regional officers, it was determined that modification of infection control procedures could be adjusted to free up beds to reduce these extreme risks to patient safety. Comprehensive oversight, monitoring, executive level sign off and further technical enhancements aim to minimise the risk of cross infection.

The changes were reviewed and supported by the Clinical Advisory Group. On receipt of the new national guidance, the plan will be reviewed and adapted as necessary.

The committee was assured that the measures introduced had been carefully considered and were appropriately balanced and had a high-level of on-going scrutiny.

Maternity

The committee received a high degree of assurance in relation to the quality of maternity and neonatal services, with the benefit of externally validated internal assessments and regional datasets. Progress with staff consultation on the Continuity-of-carer model was also noted. Importantly an update on the equity and equality action plan was provided.

Concerns over deconditioning of frail patients

Noted in the Quality and Patient Safety Intelligence Report was the concern about the large number of frail patients who are not able to be discharged back into the community when they no longer require hospital care. Such patients are known to be at risk of "deconditioning" where they become frailer and more dependent, which is a clear detriment to their life and a risk to their health. There are around 150 such patients in the Trust.

Never event – misplaced nasogastric tube

This was reported in February. Fortunately, due to the vigilance of staff the misplacement was detected early, and the patient came to no harm. The error resulted from the insertion of an additional nasogastric tube; the initial tube being mistaken for it on X-ray checking. Initial measures were taken with the clinical team and the incident is subject to a detailed investigation. We have reported the issue externally to appropriate regulators.

Safe standards for invasive procedures

The committee received and update on the action plan from a report from internal auditors, originally received by the Audit Committee, which gave limited assurance. There were 1 high, 5 medium and 1 low-level recommendations. Sixteen specific actions were identified of which 13 are green and three are amber. In addition, clinical leaders are promoting a just and empowered culture to ensure these standards are truly embedded.

Emerging quality issues

Emerging themes noted in Quality and Patient Safety Intelligence report were falls, nutrition and hydration issues as well as improved signposting to the end-of-life care

	team. Immediate actions to address these concerns were noted and progress will be tracked at the Committee through monthly metrics and the quarterly intelligence report. **Actions to support emergency patient pathways and staff providing them** Through a number of agenda items, the Committee noted the range of engagement and actions particularly targeted at extreme pressure felt at the "front end' of our emergency pathways, through the emergency department. National and trust data is demonstrating the negative impact this is having on patient experience and this was echoed on behalf of residents at a recent Health Overview and Scrutiny Committee attended by the Medical Director. As well as the modification of infection control procedures noted in the first item, a number of areas of mitigation are being developed and proposed to system partners. Examples include: • Minor injuries – high numbers of attendees who could be better directed to community resources • Patients medically fit for discharge who need access to domiciliary care where this is not being provided.

2	**Conclusion**
2.1	The Committee received appropriate and detailed documentation in relation to the items it considered on 30th March and was able to scrutinise this and note areas of progress, areas for development and areas of risk, receiving relevant assurance on actions to meet the objective of providing outstanding care.

Report Author	Steve Ryan, Non-Executive Director
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Email	n/a

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors
6 April 2022

Item No 13.3

Title	Workforce Assurance Committee Chair's Report
Area Lead	Debs Smith, Chief People Officer
Author	John Sullivan, Non-Executive Director
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board with a report of the Workforce Assurance Committee, which met on 29 March 2022. The meeting was not quorate and therefore the required procedure approvals will be completed outside the committee's meeting cycle.

The Committee received assurance that the strategic people agenda has evidenced momentum and is on a positive trajectory. Positive progress was reported in a number of workforce related areas. However, higher than target sickness absence and turnover levels remain the most significant Trust workforce risks.

It is recommended that the Board:

- To note the progress made in a number of Workforce Assurance areas.
- To note that staff issues with attitudes and behaviours form two thirds of recent Freedom to Speak Up reporting.
- To note the Monthly Nurse Safe Staffing Reports provided assurance regarding patient safety but that there is evidence the patient experience at WUTH is deteriorating due to increased Covid infections, demand pressures and high levels of staff absence.
- To note the continued progress made on the Trust's diversity and inclusion agenda.
- To note the embargoed 2021 Staff Survey results, demonstrating that WUTH is at or close to the average of 126 comparator acute Trusts across all of the survey themes.

Key Risks

This report relates to these key Risks:

- Risks 2.1, 2.2, and 2.3 the Board Assurance Framework

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No

Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

1	Narrative
1.1	To provide the Trust Board with assurance on Workforce matters including: • Freedom to Speak Up • Annual Gender Pay Gap report • Equality Delivery System 2 (EDS2) progress • Staff Flu vaccination programme progress • People strategy formulation progress • 2018-2022 Diversity and Inclusion Strategy update on implementation • 2021 Staff Survey results, preview and next steps • Workforce key performance metrics at February 2022 • Employee Relations cases -- metrics and trends • Workforce Policies for approval • Monthly Safe Nurse Staffing reports (November 2021 and January 2022) • International Nurse Recruitment – experience evaluation report • Acuity and Dependency – Establishment Review proposal and decision • Workforce Steering Board reports • Board Assurance Framework -- Workforce review • Cycle of Business 2022 / 2023

3	Conclusion
3.1	• The committee received a staff story which reinforced the value of Workforce staff assignments that are at the patient's side (in this case Ward 38) and contribute to timely and safe patient discharge. • The Freedom to Speak Up processes are working well at WUTH and our numbers are in line with comparator organisations. Issues with attitudes and behaviours (of WUTH staff) are two thirds of all reported FTSU issues. • The annual Gender Pay Gap report again highlighted the reluctance of some female applicants for Clinical Excellence Awards. • The Trust's People Strategy was presented and endorsed and supported. Final Trust Board ratification will be at the May 2022 Board meeting. • The 2021 / 22 Flu vaccination campaign was reviewed. 72.1 % of eligible staff are now vaccinated. Focus will now shift to the 2022 / 23 influenza vaccination campaign. • The 2021 Staff Survey results were presented. There were no outlier results when compared to 126 other acute trusts. • The Workforce KPIs are characterised by continuing high staff absence levels particularly in Acute and Estates & Facilities. Overall vacancy rates have improved to 5.39% as a result of considerable successes in recruitment. Return to Work process compliance and appraisal rates remain areas for management attention and improvement. • The Employee Relations Report provided assurance that the visibility and management of employee relations cases have significantly improved. • Monthly Nurse Safe Staffing reports gave assurance regarding patient safety but it was observed that patient satisfaction and quality of some care are adversely impacted by increases in Covid cases, demand pressures and high levels of staff absence.

	• The Board Assurance Workforce risks were reviewed and no changes to risk ratings were recommended. **Recommendations to the Board** • To note the progress made in a number of Workforce Assurance areas. • To note that staff issues with attitudes and behaviours form two thirds of recent Freedom to Speak Up reporting. • To note the Monthly Nurse Safe Staffing Reports provided assurance regarding patient safety but that there is evidence the patient experience at WUTH is deteriorating due to increased Covid infections, demand pressures and high levels of staff absence. • To note the continued progress made on the Trusts' diversity and inclusion agenda. • To note the embargoed 2021 Staff Survey results, demonstrating that WUTH is at or close to the average of 126 comparator acute Trusts across all of the survey themes.

Report Author	John Sullivan, Non-Executive Director
Contact Number	n/a
Email	n/a