Wirral University Teaching Hospital NHS Foundation Trust

# Public Board of Directors

# 1 June 2022

together we will

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Wirral University Teaching Hospital NHS Foundation Trust

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| **Meeting** | Board of Directors in Public |
| **Date** | Wednesday 1 June 2022 |
| **Time** | 10:00 – 12:00 |
| **Location** | Boardroom, Education Centre, Arrowe Park Hospital |

| Agenda Item | | Lead |
|---|---|---|
| 1. | Welcome and Apologies for Absence | Sir David Henshaw |
| 2. | Declarations of Interest | Sir David Henshaw |
| 3. | Minutes of Previous Meeting | Sir David Henshaw |
| 4. | Action Log | Sir David Henshaw |
| 5. | Patient Story | Tracy Fennell |
| **Operational Oversight and Assurance** | | |
| 6. | Chair's Business and Strategic Issues | Sir David Henshaw |
| 7. | Chief Executive Officer's Report | Janelle Holmes |
| 8. | Chief Operating Officer's Report | Hayley Kendall |
| 9. | Board Assurance Reports | |
| | 9.1 Quality and Performance Dashboard | Executive Directors |
| | 9.2 Board Assurance Framework | David McGovern |
| | 9.3 Month 1 Finance Report | Robbie Chapman |
| | 9.4 Monthly Maternity Update (including Ockenden 2 Progress) | Tracy Fennell |
| | 9.5 Digital Healthcare Update | Chris Mason |
| | 9.6 Estates and Facilities Update | Paul Mason |
| 10. | Operational Plan for 2022/23 | Hayley Kendall |
| 11. | NHS Staff Survey 2021 | Debs Smith |
| **Items for Decision and/or Discussion** | | |
| 12. | Modern Slavery Statement | Cate Herbert |
| **Wallet Items for Information** | | |
| 13. | Communications and Engagement | Sally Ann Sykes |

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| 14. | Committee Chairs Reports<br>14.1) Audit Committee (Annual Report) – **verbal update**<br>14.2) Quality Committee | Committee Chairs |

## Closing Business

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| 15. | Questions from the Public | Sir David Henshaw |
| 16. | Any other Business | Sir David Henshaw |

## Date and Time of Next Meeting

Wednesday 6 July 2022 @ 10am
Board Room, Arrowe Park Hospital

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| **Meeting** | Board of Directors in Public |
| **Date** | 4 May 2022 |
| **Location** | Boardroom, Education Centre, Arrowe Park Hospital |

**Members present:**

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| DH | Sir David Henshaw | Non-Executive Director & Chair |
| JS | John Sullivan | Non-Executive Director & Vice Chair |
| SL | Sue Lorimer | Non-Executive Director |
| SR | Steve Ryan | Non-Executive Director |
| CC | Chris Clarkson | Non-Executive Director |
| JH | Janelle Holmes | Chief Executive |
| NS | Nikki Stevenson | Medical Director & Deputy Chief Executive |
| TF | Tracy Fennell | Chief Nurse |
| HK | Hayley Kendall | Chief Operating Officer |
| DS | Debs Smith | Chief People Officer |
| RC | Robbie Chapman | Interim Chief Finance Officer |
| MS | Matthew Swanborough | Director of Strategy and Partnerships |

**In attendance:**

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| SH | Sheila Hillhouse | Public Governor |
| TC | Tony Cragg | Public Governor |
| PI | Paul Ivan | Public Governor |
| PB | Philippa Boston | Public Governor |
| DMcG | David McGovern | Director of Corporate Affairs |
| CM | Chris Mason | Chief Information Officer |
| SS | Sally Sykes | Director of Communications and Engagement |
| JN | Jonathan Lund | Associate Medical Director |
| CH | Cate Herbert | Board Secretary |
| JJE | James Jackson-Ellis | Corporate Governance Officer (Minutes) |
| DE | Debbie Edwards | Divisional Director of Nursing and Midwifery for Women's and Children's Division |
| JL | Jo Lavery | Delivery Suite Sister |
| NP | Natalie Park | Divisional Director of Women & Children's (Item 11) |
| LS | Libby Shaw | Consultant (Item 11) |
| CC | Catherine Cumberlidge | Patient Safety Manager (Item 11) |
| AK | Angela Kerrigan | Consultant (Item 11) |

**Apologies:**

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| SI | Steve Igoe | Non-Executive Director |

| Agenda Item | Minutes | Action |
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| 1 | **Welcome and Apologies for Absence**<br><br>The Chair welcomed everyone to the Public Board Meeting. Apologies were received from Steve Igoe. | |
| 2 | **Declarations of Interest**<br><br>No new interests were declared and no interests in relation to the agenda items were declared. | |
| 3 | **Minutes of Previous Meeting**<br><br>The minutes of the previous meeting held on 6 April were approved as an accurate record. | |
| 4 | **Action Log**<br><br>The Board noted that all actions had been closed or completed. | |
| 5 | **Patient Story**<br><br>The Board received a video story of the experience of a patient who had experienced a range of services provided by the Trust. The patient described the multiple procedures she received across the Trust and commented on the quality of care and professionalism of staff.<br><br>The Board acknowledged the patient had had several experiences and each one had been positive and was pleased the patient felt she had been treated as a person rather than a number.<br><br>DH enquired whether there was a forum for patients to share their experiences for the purposes of learning.<br><br>TF commented that an approach was already being taken by the Trust's Promise Groups whereby families, carers and patients on the Group provide intelligence for the Trust to improve and enhance the future patient experience.<br><br>The Board **NOTED** the patient story. | |
| 6 | **Chair's Business and Strategic Issues**<br><br>The Chair updated the Board on recent matters. The key points were:<br><br>• The Trust continues to be in a strong position with system partners and build and maintain positive relationships<br>• There will be an adjustment period for the Trust as change comes to the system | |

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| | • Good opportunity to review the existing contracts to ensure cost and efficiency effectiveness<br>• The Trust was being highlighted positively nationally for several reasons, for example the recruitment of international nurses<br><br>The Board **NOTED** the update. | |
| **7** | **Chief Executive Officer's Report**<br><br>JH reported the number of patients in hospital with COVID was beginning to decrease. At the beginning of April there were over 100 inpatients in hospital with COVID and this had decreased to circa 65 patients by the end of month. There had been no patients requiring critical care for several weeks. The prevalence in the community remained uncertain due to the ending of community testing. However, hospital inpatients continue to be routinely screened on admission, and on day 3 and 6 of their admission.<br><br>JH highlighted infection prevention and control measures had been updated following recent national guidance. However, due to high bed occupancy and the transmissibility of the current variant, there have been several COVID outbreaks within the Trust and these had been managed with close supervision from the infection prevention and control team.<br><br>DH queried if the Office for National Statistics (ONS) infection survey provided a figure for the prevalence of COVID in the community for Wirral.<br><br>NS confirmed Wirral had 113 cases per 100,000 and was the third lowest in Cheshire and Merseyside. Cheshire East and Warrington had the highest number of cases per 100,000 at 152. NS added the Trust's Clinical Advisory Group was forming decisions based on daily inpatient figures with COVID.<br><br>JH noted the Trust declared 6 serious incidents (SI) in March 2022 and 3 RIDDOR events were reported to the HSE.<br><br>JS queried if RIDDORs were being shared with the Audit Committee for the purposes of ensuring actions are completed.<br><br>NS commented RIDDORs were being brought to Trust's Patient Safety and Quality Board and then to Quality Committee for oversight and assurance. CH would ensure the Audit Committee were provided with assurance that actions following a RIDDOR were completed.<br><br>DMc highlighted that a new dashboard was being created in terms of a health and safety perspective as part of the new assurance reporting process for the Board. | Cate Herbert |

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| | The Board **NOTED** the report. | |
| **8** | **Chief Operating Officer's Report**<br><br>HK highlighted March and April had been challenging for both elective and non-elective patients and this was due to the unavailability of 5 theatres because of improvements being made to ventilation.<br><br>52 weeks wait performance had declined and there were now 637 patients waiting longer than 52 weeks, which was above the Trust's submitted trajectory of 550. The temporary loss of theatres had contributed to this position. Across Cheshire and Merseyside there are currently 16,695 patients waiting longer than 52 weeks for treatment.<br><br>Cancer backlog performance against 31- and 62-day treatment continue to face pressures within colorectal and urology with the position unlikely to be achieved until quarter 4 2022/23.<br><br>There were 17 patients that breached the 12 hours in emergency department (ED) target in month, the highest figure year to date. The Trust experienced significant bed occupancy levels as well as one of the highest months of ED attendances; this was also at the same time of the most recent surge of COVID-19 affecting the Trust.<br><br>SR commented it was positive see a dynamic response from both clinical and medical specialities teams and queried how the approach taken could become business as usual to deliver sustainable elective and non-elective care for patients.<br><br>HK confirmed there was a meeting with Clinical Leads w/c 9 May to review the systems and processes put in place to determine if any were sustainable to maintain for the medium/long term. Regular engagement with Clinical Leads also takes place fortnightly to consider resource implications and if the necessary impact is being made.<br><br>DH queried when the 52 week wait performance target would be back on track.<br><br>HK stated she was optimistic that the 52 week wait performance would be back on track for the beginning of quarter 3. This was due to volume of patients waiting and the challenges due to the theatre of ventilation issues.<br><br>JS queried if a presentation could be provided on the lessons learned from the theatre ventilation issues as this had affected the Trust's ambition to catch up on the backlog. | |

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| | MS confirmed the team would be able to provide a presentation to the Capital Committee once the work had been completed on the theatres.<br><br>The Board **NOTED** the report. | Matthew Swanborough |
| **9** | **Board Assurance Reporting**<br><br>**9.1 Quality and Performance Dashboard**<br><br>The Executive Directors briefed the Board on metrics in the dashboard. It was noted that of the 35 indicators that were reported 23 were off off-target or failing to meet performance thresholds and 12 are on-target.<br><br>DS drew attention to the 4 workforce indicators. Mandatory training and appraisal remained challenging to achieve the desired compliance target. Divisions have set an improved trajectories over the next 3 months and this was being managed in the Divisional Performance Reviews. Work was ongoing to review the appraisal approach around quality to ensure individuals have constructive conversations.<br><br>Sickness absence increased in March after a reduction in February and this was due to COVID-19. The Trust was broadly in line with other Cheshire and Merseyside Trusts with a 6% – 7% sickness absence rate.<br><br>Staff turnover over the 12-month period continues to increase. An internal working group had been set up to focus on both recruitment and retention, and there has also been an increased focus on retention due to the increasing rate of staff turnover. The working group would report to the Workforce Steering Group and onto Workforce Assurance Committee.<br><br>JS welcomed the increased focus on retention and observed that despite the high numbers of staff joining the same number or higher were leaving at the same rate. JS queried if there was a patient safety risk because staff joining had generally less experience and knowledge of NHS processes.<br><br>DS confirmed there was no indication about patient safety due to new staff joining the NHS but agreed to review the matter further to understand if there was correlation<br><br>CC queried if any trends were known about the reasons for leaving the Trust.<br><br>DS confirmed exit interviews are encouraged and one of the questions asked was the reason for leaving and no new trends had been identified. | Debs Smith |

DH noted the lead time from appointment to start date was long for new staff joining the Trust. Discussion also took place around the aging workforce and risk of many retirements at one time.

NS highlighted the number of formal complaints received in the year had increased and this was mainly due to patient visitor restrictions at the hospital. NS confirmed the hospital was open to visitors from today (4 May) therefore the number of complaints may reduce.

Complaints were acknowledged in a timely manner, but challenges remain when responding fully to some complaints. Several complaints had been regarding access and over-crowding in the ED, and they had been the most pressured team in terms of workload.

JH highlighted the Trust was continuing to work towards the delivery of the WISE accreditation programme and objectives were being set for each Division through the Diversional Performance Reviews.

The Board **NOTED** the report.

**9.2 M12 Finance Report**

RC introduced the Month 12 Finance Report. The Trust was reporting a surplus of £0.028m, a negative variance against budget of £0.162m.

The Trust would receive £5.401m in respect of Elective Recovery Fund (ERF) for quarter 4 2021/22. However, these figures were based on estimates for month 12 and the figure is subject to change. This gives total ERF for 21/22 of £17.688m

The improved income position was offset by significant increase in expenditure in month 12, with variances of £0.390m in respect of pay (including COVID) and £3.784m in respect of non-pay.

The Board **NOTED** the report.

**9.3 IPC Assurance Framework**

TF presented to the Board the IPC Assurance Framework. In April the Trust made decisions outside of national guidance to ensure operational effectiveness and this resulted in the effectiveness of archiving full assurance.

TF reported to the internal Patient Safety and Quality Board in April that 4 areas had limited assurance and those main areas where the ability to identify infectious patients, isolating patients and preventing the risk of spread of infections.

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| | Since April national guidance had been updated and the Trust was now reporting only 3 areas of limited assurance.<br><br>SR acknowledged the limited assurance related primarily to the structure of the building and queried if there was an opportunity for dynamic risk assessments and to use digital tools.<br><br>TF confirmed there were opportunities to be explored and these would be led by the internal Clinical Advisory Group. Other Trusts had asked for advice regarding swapping patients and how the Trust uses existing clinical systems.<br><br>The Board **NOTED** the report and **ACKNOWLEDGED** the controls in place to minimise the levels of risk associated with COVID-19 and the hard work during challenging times to sustain safe standards of care.<br><br>**9.4 Monthly Maternity Services Update Report**<br><br>TF presented the report and highlighted NHSEI recommended the Perinatal Clinical Surveillance Quality Assurance Report be presented monthly to the Board of Directors to ensure ongoing oversight of the quality of care in Maternity and Neonatal Services.<br><br>TF confirmed there was nothing to escalate to the Board this month and the Trust was fully compliant.<br><br>The Board **NOTED** the report. | |
| **10** | **People Strategy**<br><br>DS presented to the Board the People Strategy and provided an overview of how the strategy was developed and the key priorities for the period 2022-26.<br><br>JS commented the strategy had been well developed and it was positive that the relevant staff groups had been consulted throughout the process. JS queried the impact of artificial intelligence in the NHS on workforce, and if the Trust were relying on NHS providing guidance on how this would work or if the Trust would lead this.<br><br>DS confirmed the Trust would have a role to play in artificial intelligence and the Trust's Digital Strategy would support us further with this.<br><br>DH commented the People Strategy would provide a new narrative for the Trust to reconnect with staff directly now that Trust and the NHS was emerging from the pandemic. DH queried the metrics in determining successful delivery of any outputs. | |

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| | DS confirmed the metrics would be set each year through a delivery plan and would be overseen by the Workforce Steering Group and Workforce Assurance Committee.<br><br>SR queried about the connection between the yearly NHS staff survey and the Trust's own strategy to ensure both are not treated separately.<br><br>DS confirmed the Trust would continue to encourage staff to take part in the yearly NHS staff survey as well as quarterly pulse surveys. Both would act as a continuous check and be used to inform delivery of the yearly strategic plan with any outputs used as key metrics.<br><br>The Board **APPROVED** the People Strategy. | |
| **11** | **Ockenden 2 Gap Analysis**<br><br>TF highlighted the final report of the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, led by Donna Ockenden, was published on 30 March, and identified 15 immediate and essential actions essential actions for acute Trusts to undertake.<br><br>DE presented to the Board the gap analysis of Ockenden 2 and the risk assessment of continuity of carer.<br><br>HK queried what the Division's plans were regarding the escalation and accountability section of the gap analysis and what the plans were regarding the Trust aiming to increase resident consultant obstetrician presence where this is achievable.<br><br>DE confirmed that from a medical workforce perspective, NHS England are working on a toolkit that specifically looks at obstetrics and gynaecology medical staffing. However, from a Local Maternity and Neonatal System (LMNS) perspective and NHS England the report focusses on transformation of services and staffing required.<br><br>SL queried the escalation and accountability section of the gap analysis and enquired in regard to the details of the assurance mechanism to ensure staff were competent.<br><br>DE provided detail on the assurance mechanisms and noted that the Trust was not able to provide an onsite consultant 24/7 and the Trust needed further advice to improve compliance with this recommendation. The Trust does meet the recommendation from Ockenden 1 regarding the two ward rounds and the number of hours that consultants spend on the ward.<br><br>DE also confirmed the Trust had been critical on the gap analysis. This was due to the amount of evidence required for Ockenden 1, | |

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| | and the team wishing to err on the side of caution when measuring compliance at this stage.<br><br>NS confirmed no evidence had been found in the patient safety intelligence reports regarding any harm to patients due to inexperienced doctors, trainees, or locum doctors.<br><br>JH confirmed an updated report should be brought back to Board for June to determine a more accurate gap analysis and an agreed timescale for those rated partially complaint.<br><br>The Board **NOTED** the report, specifically the current compliance status with all 15 immediate and essential actions essential actions from part 2 of the Ockenden report recommendations. | Tracy Fennell/Debbie Edwards |
| **12** | **Communications and Engagement**<br><br>SS introduced the Communications and Engagement Report, and the key points were:<br><br>• Celebrating 40 years of Arrowe Park Hospital from 4 May, 40 years since Her Majesty, The Queen opened Arrowe Park Hospital. Several commemorative events were planned or underway to mark the occasion with staff, stakeholders, and the local community<br>• The Vaccination Hubs continued to require campaign and communications support – especially stepping up of the booster programme, the changes to cohort eligibility and the roll out of the fourth booster dose to over 75s and the further roll out to children aged 5-11 years.<br>• In month campaigns, included World Health Day 2022 where the climate change theme enabled us to highlight our Green Plan and we also took part in Bowel Cancer Awareness Month<br>• In month media relations were reduced owing to being in the 6-week pre-election period ahead of the local elections on 5 May<br><br>The Board **NOTED** the report. | |
| **13** | **Committee Chairs Reports**<br><br>**13.1 Audit Committee**<br><br>The Board **NOTED** the report.<br><br>**13.2 Council of Governors**<br><br>The Chair of the Council of Governors provided a verbal report to the Board on recent proceedings of the meeting held on 25 April. | |

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| | The Council of Governors heard about the NHS Staff Survey and received a COVID-19 update. The Council of Governors also approved the recommendation to appoint two new Non-Executive Directors and a date for a future get together was being arranged for the Governors to meet in person with the Chair and JH.<br><br>The Board **NOTED** the report.<br><br>**13.3 Finance Business and Performance Assurance**<br><br>The Chair of the Finance Business and Performance Assurance Committee provided a verbal report to the Board on recent proceedings of the meeting held on 28 April.<br><br>The Committee were pleased to hear the Trust met its breakeven plan for the financial year. The Committee noted a 22% underperformance in gynaecology and the Committee sought more information.<br><br>The Committee expressed concern about the backlog patient of equipment and the cost and were assured that this didn't pose a danger to patient and understood it was rather a risk to productivity. The Committee also considered and recommended several business cases for approval by the Board.<br><br>The Board **NOTED** the report. | |
| **14** | **Cycle of Business**<br><br>The Board **NOTED** the Cycle of Business. | |
| **15** | **Questions from the Public**<br><br>No questions from the public were raised. | |
| **16** | **Any other Business**<br><br>No other business was raised. | |

*(The meeting closed at 12:00)*

**Action Log**
**Board of Directors – Public Meeting**
**1 June 2022**

| No. | Date of Meeting | 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. | David McGovern | In progress. Included in Board workshop to discuss the action planning for the Well Led Review. | July 2022 |
| 2. | 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 | Matthew Swanborough | In progress. Deferred to October 2022. | October 2022 |
| 3. | 4 May 2022 | 7 | To ensure the Audit Committee are provided with assurance that actions following a RIDDOR were completed. | Cate Herbert | In progress. This will be completed through the piece of work ongoing on Board and Committee assurance reporting, in time for the next Audit Committee in September. | September 2022 |
| 4. | 4 May 2022 | 8 | To provide a presentation to the Capital Committee on theatre ventilation once work is completed. | Matthew Swanborough | In progress. Scheduled for the October Capital Committee. | October 2022 |
| 5. | 4 May 2022 | 9 | To confirm if there was a patient safety risk because of new staff joining the Trust, due to generally less experience and knowledge of NHS processes. | Debs Smith | Complete. Patient safety risks are monitored via Patient Safety Quality Board. No specific risks relating to new starters have been identified. Regarding nursing staff, pastoral and education support is in place for new starters, along with a sign off process. Until then they are in a shadowing capacity. In completing this action from Trust Board, an addition action has been | June 2022 |

| No. | Date of Meeting | Minute Ref | Action | By Whom | Action status | Due Date |
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| | | | | | identified relating to the measures place to support our new starters in other staff groups. This will be actioned by Education Governance Committee, with update to Workforce Steering Board. | |
| 6. | 4 May 2022 | 11 | To provide an updated report to Board with the Ockenden 2 Gap Analysis, and to include a timescale for any items that are not fully compliant. | Tracy Fennell/Debbie Edwards | In progress. Verbal update on progress to be provided to the June Board and the gap analysis will be brought back to July. | July 2022 |

**Board of Directors in Public** **Item No 7**
**1 June 2022**

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

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

| **Key Risks** |
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| N/A |

| **Which strategic objectives this report provides information about:** | |
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| **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** | | | |
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| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| All Board Meetings in Public | Board in Public | Chief Executive's Report | For Information |

| **1** | **Narrative** |
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| 1.1 | **COVID Update**<br><br>The prevalence of Covid in the community is reducing and this is reflected in the number of Covid inpatients within our hospitals- currently 10. We remain vigilant to new variants and expect to see increased numbers of Covid inpatients in Autumn and Winter. The Clinical Advisory Group will continue to monitor the situation, especially the interplay between any new variants and other non-Covid respiratory illnesses. |

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| 1.2 | **COVID Public Enquiry Update**<br><br>Following the consultation period into the COVID-19 Inquiry Terms of Reference, the Chair Baroness Hallett has completed an analysis of the responses received. On 12 May 2022 Baroness Hallett wrote to the Prime Minister and recommended that the scope of the Inquiry be reframed to put potential inequalities at its forefront; so that the investigation into any unequal impacts of the pandemic runs as a thread throughout the whole Inquiry. There are further proposed amendments which include a focus on the impact on the health, well-being and education of children and young people, and the wider mental health impact across the population.<br><br>The final decision on the Terms of Reference rests with the Prime Minister, but the recommendations of Baroness Hallett are likely to be accepted.<br><br>In a letter to the Prime Minister, Baroness Hallett said: "I believe these changes will ensure the Inquiry can best fulfil its purpose to examine the UK's preparedness and response to the COVID-19 pandemic and learn lessons for the future. |
| 1.3 | **Serious Incidents**<br><br>The Trust declared 8 serious incidents (SI) in the month of April 2022; this is an increase of 3 on the previous month. The Serious Incident panel report and investigate under the "Serious Incident Framework" so that learning can be identified.<br><br>There were no common themes or areas identified from the 8 reported incidents, which spanned areas of the trust, including the Surgical Services (2) Medicine (5) and Acute (1). Two SI declared in Medicine relate to Nosocomial Covid 19 Infection.<br><br>Duty of Candour has been commenced in line with legislation and national guidance.<br><br>**RIDDOR**<br><br>Since the last report there have been two incidents that were reported to the Health & Safety Executive (HSE) in accordance with RIDDOR in April 2022. Both events are subject to a local Review investigation to ensure appropriate action is taken to prevent a similar reoccurrence. |
| 1.4 | **Joint Advisory Group (JAG) on GI Endoscopy Accreditation Awarded**<br><br>I am pleased to announce that WUTH's Endoscopy Service has achieved its Joint Advisory Group (JAG) accreditation certificate from the Royal College of Physicians. The Endoscopy team have demonstrated they meet the best practice quality standards. |
| 1.5 | **Urgent and Emergency Upgrade Programme (UECUP) at Arrowe Park Hospital**<br><br>On the 6 May 2022, the Trust, in conjunction with Wirral Community Health and Care NHS FT, submitted the full business case (FBC) to NHS England for the redevelopment of the urgent and emergency care precinct at Arrowe Park Hospital. The full business case sets out the clinical model, design, construction approach, funding models and timeline for the redevelopment. The redevelopment will increase emergency department and urgent treatment centre capacity as well as improve patient access and flow within the department.<br><br>The FBC is expected to be presented to the Joint Investment Committee of the Department of Health and Social Care for approval in August 2022. |

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| | In addition, the Trust submitted the planning application to Wirral Council for the redevelopment, with formal construction aiming to commence from September 2022 and completing in March 2024. |
| 1.6 | **Modular Theatres at Clatterbridge Hospital**<br><br>In November 2021, the Trust was awarded funding for the construction of two modular theatres and internal refurbishments of the existing theatres complex at Clatterbridge Hospital, from the NHS England Targeted Investment Fund (TIF).<br><br>In April 2022, the new modular theatres were delivered to the Clatterbridge Hospital campus. These theatres are currently fitted out and equipped by the construction firm, with commissioning and handover to the Trust in August 2022. Once operational, these theatres will provide additional capacity for the Trust, along with other NHS providers across Cheshire and Merseyside Integrated Care System (ICS).<br><br>In addition, the Trust has submitted a further bid to the NHS England TIF for two additional modular theatres and further internal refurbishments of the theatre complex at Clatterbridge Hospital. If approved, this £14.5m bid would further support elective recovery across the Trust and wider Cheshire and Merseyside ICS footprint. |
| 1.7 | **Next steps on transitioning from COVID-19 response to recovery**<br><br>On 13 December 2021, the NHS declared a Level 4 (National) Incident to help prepare the NHS for the predicted surge in Omicron cases and to deliver the COVID-19 vaccine booster national mission. Since that point, the NHS has surpassed 730,000 patients with COVID-19 treated in hospitals and 123 million vaccine doses delivered, as well as delivering over 140,000 treatments through our new COVID medicine delivery units.<br><br>With community cases and hospital inpatient numbers now seeing a sustained decline – thanks in part to the success of winter and now spring booster vaccines – and following advice from the National Incident Director the NHS England and NHS Improvement Board have reclassified the incident from a Level 4 (National) to a Level 3 (Regional) Incident. |
| 1.8 | **Senior leadership appointments**<br><br>James Sumner officially started in post as Chief Executive and Accountable Officer at Liverpool University Hospitals NHS Foundation Trust.<br><br>Dr Amanda Doyle OBE currently Regional Director North West has been appointed to the role of National Director for Primary Care and Community Services for NHS England and NHS Improvement, responsible for the Primary Care, Community Services and Discharge and Personalised Care groups. Richard Barker, Regional Director for North East, and Yorkshire will take lead responsibility for the North West region**.** |

| **2** | **Implications** |
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| 2.1 | N/A |

| **3** | **Conclusion** |
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| 3.1 | The Board are asked to note and receive this report. |

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| **Report Author** | Janelle Holmes, Chief Executive |
| **Contact Number** | N/A |
| **Email** | Janelle.holmes@nhs.net |

**Board of Directors in Public** **Item 8**

**01 June 2022**

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| **Title** | Chief Operating Officer's Report |
| **Area Lead** | Hayley Kendall, Chief Operating Officer |
| **Author** | Hayley Kendall, Chief Operating Officer<br>Melanie Aldcroft, Senior Manager Planned Care |
| **Report for** | Information |

## Report Purpose and Recommendations

The purpose of this report is to provide 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 performance against the Targets set for this financial year.

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.

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.

It is recommended that the Board

- Note the performance and mitigations outlined

## 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: | |
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| **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 |

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| **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** |
| This is a monthly standing report to the Board. | | | |

| 1 | Planned Care |
|---|---|
| 1.1 | **Elective Activity**<br>For FY 2022/23 the elective activity has been profiled against the corresponding periods in FY2019/20. In April 2022, 101.9% of outpatient activity was delivered against a performance target of 104.3%. For elective admissions 86.2% of activity was delivered against a target of 109.5%.<br><br>**Outpatient activity by POD**<br><br>**Elective activity by POD**<br><br>Due to unplanned ventilation works, 6 theatres on the APH site were unavailable throughout April, resulting in a reduction of elective admissions. The programme of work is under continual review and a recovery plan will be available following confirmation of the works being completed and theatres being safe to use. They are planned for re-introduction 1st June 2022. |
| 1.2 | **Priority 2 Performance (P2)**<br>The Trust did not meet the P2 month end trajectories for April the month end final position over reporting 81 P2 breaches against a month end plan of 66, due to the prioritisation that had to take place due to the lack of operating theatres. |
| 1.3 | **Referral to Treatment**<br>• 52 Week Wait Performance<br>In April 2022, 730 patients waited longer than 52 weeks, which is higher than the Trust's trajectory of 550. The loss of 6 theatres has led to this position with an indicative 300 procedures lost as a direct result.<br><br>• 104 Week Wait Performance<br>As at the end of April the Trust had no patients waiting longer than 104 weeks. This is ahead of the national plan to have zero 104-week waiters by end July 22. |
| 1.4 | **Waiting List Size**<br>In April 2022 there were 31,504 patients on an active RTT pathway which is higher that the Trust's trajectory of 31,050. Again, the loss of the theatres has significantly impacted on the position losing approximately 300 cases in April. |

| | Target | Actual |
|---|---|---|
| New | 102.6% | 94.0% |
| F/UP | 104.9% | 105.0% |
| Combined | 104.3% | 101.9% |

| | Target | Actual |
|---|---|---|
| Day Case | 111.9% | 89.9% |
| Inpatient | 97.4% | 68.3% |
| Combined | 109.5% | 86.2% |

| | |
|---|---|
| 1.5 | **Cancer Backlog Performance**<br>Full detail of the cancer performance is covered within the Trust dashboard, but exceptions are covered within this section, however the narrative remains as per the April update.<br>• 2 week waits<br>The breast Surgery 2ww is expected to recover by June 2022 with no patient waiting more than 7 days for an appointment.<br>• 31- and 62-day treatment<br>Both standards for Urology and Colorectal are not expected to be achieved until the end of Q4 2022/23. Recovery plans have received executive oversight and are being monitored via the Performance Oversight Group. |
| 1.6 | **DM01 Performance – 95% Standard**<br>In April 82.76% waiting 6 weeks or less for their diagnostic procedure for those modalities included within the DM01 submission. This is against the new national standard of 95%. Excellent recovery performance should be noted across Radiology with CT and MR modalities achieving the 95% compliance target. Divisional action plans and recovery trajectories are being monitored via Performance Oversight Group. |
| 1.7 | **Risks to recovery and mitigations**<br>The Trust does does have robust systems in place to monitor and review elective performance, with performance for April significantly impacted because of the loss of the 6 theatres on the APH site, with workforce availability continuing to be a challenge with the effects of covid still felt within the operational teams. The Trust's activity plans are being monitored at executive level weekly and this will support the ongoing delivery of the national standards, reducing waiting times across all points of delivery and ultimately providing treatment for our patients.<br><br>The clinical divisions are progressing through their plans outlined in the previous update including insourcing, outsourcing and the exciting progress made with the C&M Hub providing much needed additional theatre capacity.<br><br>Governance structures are in place across all divisional teams, feeding into the executive led Performance Oversight Group weekly with full participation in regional recovery initiatives. |

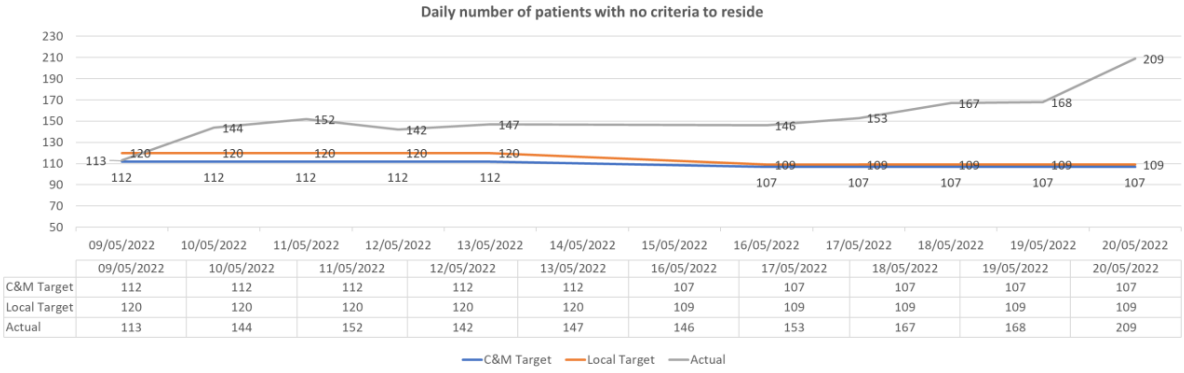
| **2** | **Unscheduled Care** |
|---|---|
| 2.1 | **Performance**<br>Performance for the APH site type 1 performance in April was 63.1% compared to 61.5% in March.<br><br>The key quality ED metrics which impact four-hour performance are the wait to be seen by an ED doctor after arriving in the Department and the 15-minute time to triage which in April was 52.5% a slight decrease from 54% in March. Ambulance handover delays were challenged within April with 23.9% of ambulances experiencing a 30-minute delay or more.<br><br>Daily ED attendances averages at 257 in month, 1% higher than in the same period of the previous financial year as detailed below ED and UTC combined: |

| Arrowe Park Site Combined ED & WiC Attendances | | | | | |
|---|---|---|---|---|---|
| **Month** | **2021/22** | **2020/21** | **YoY Variance** | **% Var** | **% of 20/21** |
| April | 10,457 | 10,347 | 110 | 1.1% | 101.1% |

There were 39 patients that breached the 12 hours in ED target in month, the highest figure year to date. The Trust experienced significant bed occupancy levels this was also at the same time of the most recent surge of Covid-19 affecting the Trust.

The average number of super stranded patients (>21days LOS) increased in month to 220 patients from 187 in March. Work is ongoing both internally and externally with system partners to improve the current position, but it remains a significant challenge to the delivery of our UEC indicators.

The Wirral system has an agreed trajectory to reduce the number of patients in an acute bed that do not have a criteria to reside which is to have no more than 70 patients without a criteria to reside occupying a bed. This is a significant challenge and recent performance has demonstrated a decline in performance; one of the challenges is that there is a real focus on making sure all patients admitted have a recorded criteria to reside status so has the potential now to be accurately reflecting the patient status within the acute bed base. The graph below details performance against the local Wirral target and the C&M target:




| | 09/05/2022 | 10/05/2022 | 11/05/2022 | 12/05/2022 | 13/05/2022 | 16/05/2022 | 17/05/2022 | 18/05/2022 | 19/05/2022 | 20/05/2022 |
|---|---|---|---|---|---|---|---|---|---|---|
| C&M Target | 112 | 112 | 112 | 112 | 112 | 107 | 107 | 107 | 107 | 107 |
| Local Target | 120 | 120 | 120 | 120 | 120 | 109 | 109 | 109 | 109 | 109 |
| Actual | 113 | 144 | 152 | 142 | 147 | 146 | 153 | 167 | 168 | 209 |

2.2 **Discharge improvement programme**

There is a significant focus on discharge improvement across the Trust and is being led by the Medicine Division. Model board rounds are one of the areas that has been focussed on and copied below is early feedback from one of the wards that has been the area of focus:

| | |
|---|---|
| |  <br>This demonstrates good performance across a number of indicators which is to be rolled out across the Medicine bed case and then onto other divisions. |
| 2.3 | **Risks to improving performance**<br>• Physical environment in ED is challenging during peaks in demand impacting on ability to delivered the timed pathways and there is regular overcrowding<br>• An increase in minor injury walk ins increasing<br>• Delivery of the LLOS recovery trajectory is at risk due to community capacity constraints for Pathway 1,2,3 patients<br>• Boarding time in department increased due to bed pressures<br>• Increasing mental health activity and significant increases of attendances under S136<br>• 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<br>• Availability of mental health inpatient beds resulting in 12-hour breaches for mental health patients and excessive LOS in the ED. |

| **3** | **Conclusion** |
|---|---|
| 3.1 | The Trust had a significantly challenged month in relation to non-elective demand and ED performance. Recovery of the elective programme continues with some areas of performance over-achieving the trajectories set, but pressure from non-elective demand is increasingly challenging |

| | |
|---|---|
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**Board of Directors in Public** **Item No 9.1**
**1st June 2022**

| | |
|---|---|
| **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 May 2022.

It is recommended that the Board:

- notes performance to the end of May 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 |
|---|---|---|---|
| 6th April 2022 | Board Seminar | Proposed 2022/23 Quality and Performance Dashboard | Discussion on results of review and agreement on next steps |

| 1 | Narrative |
|---|---|
| 1.1 | Of the 46 indicators that are currently reported against thresholds (excluding Use of Resources):<br><br>- 33 are off-target or failing to meet performance thresholds<br>- 13 are on-target<br><br>Following the recent discussions with the Executive Team and the Board as part of the Performance Management Framework Review, the metrics included in the Quality & Performance dashboard have been assessed for continued inclusion, alongside the relevant thresholds.<br><br>The approved changes to metrics have been adopted for this version of the dashboard. Some thresholds only apply from April 2022 onwards as they are components from the 2022/23 operational plans. Further development work is also continuing to clarify the precise definitions and thresholds on a small number of metrics.<br><br>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. |


| | |
|---|---|
| **Report Author** | John Halliday - Assistant Director of Information |
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# Quality Performance Dashboard

**May 2022**
Upated 25-05-22

| | 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 | Mar-22 | Apr-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 | 0.10 | 0.20 | 0.05 | 0.05 | 0.10 | 0.10 | 0.05 | 0.19 | 0.18 | 0.18 | 0.22 | 0.04 | 0.22 | 0.13 | |
| | 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 | 96.4% | 96.6% | 96.6% | 96.2% | 97.6% | 96.9% | 96.9% | 97.2% | 96.9% | 96.7% | 96.2% | 96.4% | 96.8% | 96.7% | |
| | Never Events | Safe, high quality care | CN | 0 | SOF | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 4 | |
| | Clostridioides difficile (healthcare associated) | Safe, high quality care | CN | Maximum 72 for 2022-23. Max 6 cases per month | WUTH | 5 | 7 | 5 | 1 | 6 | 13 | 6 | 5 | 3 | 18 | 12 | 13 | 7 | 101 | |
| | Gram negative bacteraemia : e-coli | Safe, high quality care | CN | Maximum 56 for 2022-23. Max 4 cases per month | National | - | - | - | - | - | - | - | - | - | - | - | - | 8 | | |
| | Gram negative bacteraemia : klebsiella | Safe, high quality care | CN | Maximum 19 for 2022-23. Max 1 case per month | National | - | - | - | - | - | - | - | - | - | - | - | - | 0 | | |
| | Gram negative bacteraemia : pseudomonas | Safe, high quality care | CN | Maximum 9 for 2022-23. Max 0 cases per month | National | - | - | - | - | - | - | - | - | - | - | - | - | 0 | | |
| | MRSA bacteraemia - hospital acquired | Safe, high quality care | CN | 0 | National | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 2 | |
| | Pressure Ulcers - Hospital Acquired Category 3 and above | Safe, high quality care | CN | 0 | WUTH | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 4 | 5 | |
| | Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide | Safe, high quality care | CN | ≥90% | WUTH | 96% | 96% | 95% | 96% | 96% | 96% | 95% | 96% | 96% | 94% | 95% | 92% | 89% | 95% | |
| | Safeguarding Audits | Safe, high quality care | CN | ≥90% | WUTH | - | - | - | - | - | - | - | - | - | - | - | 82.6% | 71.6% | - | |
| | Mandatory Training compliance | Safe, high quality care | CPO | ≥90% | WUTH | 87.3% | 87.9% | 89.1% | 90.1% | 90.9% | 91.3% | 90.8% | 90.5% | 90.4% | 89.0% | 87.2% | 87.2% | 87.17% | 87.2% | |
| | Sickness Absence % (12-month rolling average) | Safe, high quality care | CPO | ≤5% | SOF | 6.21% | 6.10% | 6.05% | 6.12% | 6.17% | 6.21% | 6.22% | 6.24% | 6.40% | 6.48% | 6.53% | 6.70% | 6.79% | 6.8% | |
| | Sickness Absence % (in-month rate) | Safe, high quality care | CPO | ≤5% | SOF | 5.38% | 5.68% | 5.68% | 6.48% | 6.53% | 6.62% | 6.67% | 6.37% | 7.86% | 8.72% | 7.05% | 7.73% | 6.84% | 6.74% | |
| | Staff turnover % (rolling 12 month rate) | Safe, high quality care | CPO | ≤10% | WUTH | 13.5% | 13.2% | 13.3% | 13.0% | 12.6% | 12.9% | 13.3% | 13.2% | 13.4% | 13.7% | 13.9% | 14.1% | 14.1% | 14.1% | |
| | Care hours per patient day (CHPPD) - number of wards below 6.1 | Safe, high quality care | CN | No of wards ≤3 | WUTH | - | - | - | - | - | - | - | - | - | - | - | 3 | 1 | | |

| | 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 | Mar-22 | Apr-22 | 2021/22 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Effective | Nutrition and Hydration - MUST completed at 7 days | Safe, high quality care | CN | ≥95% | WUTH | 98.4% | 98.3% | 98.3% | 95.9% | 96.7% | 96.4% | 96.2% | 93.8% | 92.6% | 91.7% | 96.7% | 96.9% | 94.6% | 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 | 99.0% | 98.0% | 98.0% | 98.0% | 97.0% | 96.0% | 96.4% | 95.5% | 94.6% | 95.2% | 97.3% | 96.3% | 97.7% | 96.8% | |
| | Long length of stay - number of patients in hospital for 21 or more days | Safe, high quality care | MD / COO | Maintain at a maximum 79 (Revised April 2022) | WUTH | 96 | 85 | 99 | 95 | 126 | 132 | 126 | 141 | 157 | 206 | 195 | 187 | 220 | 220 | |
| | % Theatre in session utilisation | Safe, high quality care | COO | ≥85% | WUTH | 84.5% | 85.5% | 82.5% | 79.8% | 82.0% | 83.4% | 83.7% | 82.0% | 77.9% | 77.2% | 77.9% | 83.7% | 79.3% | 81.7% | |

| | 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 | Mar-22 | Apr-22 | 2021/22 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Caring | Same sex accommodation breaches | Outstanding Patient Experience | CN | 0 | SOF | 2 | 2 | 3 | 4 | 1 | 2 | 2 | 3 | 8 | 3 | 2 | 3 | 1 | 36 | |
| | FFT Overall experience of very good & good: ED | Outstanding Patient Experience | CN | ≥95% | SOF | 84.0% | 83.0% | 82.0% | 76.0% | 76.0% | 71.1% | 72.8% | 72.4% | 77.7% | 75.9% | 77.3% | 67.2% | 74.0% | 76.1% | |
| | FFT Overall experience of very good & good: Inpatients | Outstanding Patient Experience | CN | ≥95% | SOF | 94.0% | 95.0% | 95.0% | 95.0% | 96.0% | 94.0% | 94.3% | 95.1% | 94.4% | 95.4% | 94.5% | 92.3% | 94.8% | 94.6% | |
| | FFT Overall experience of very good & good: Outpatients | Outstanding Patient Experience | CN | ≥95% | SOF | 95.0% | 94.0% | 95.0% | 93.0% | 94.0% | 93.2% | 94.1% | 93.7% | 94.3% | 94.3% | 94.1% | 93.6% | 93.5% | 94.0% | |
| | FFT Overall experience of very good & good: Maternity | Outstanding Patient Experience | CN | ≥95% | SOF | 99.0% | 95.0% | 93.0% | 97.0% | 98.0% | 94.1% | 98.8% | 94.7% | 94.6% | 96.6% | 93.5% | 97.7% | 93.1% | 95.8% | |

# Quality Performance Dashboard

**May 2022**
Upated 25-05-22

| | 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 | Mar-22 | Apr-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 | 76.1% | 73.5% | 78.0% | 67.8% | 66.2% | 63.4% | 62.6% | 59.5% | 60.6% | 59.1% | 63.1% | 61.5% | 63.1% | 65.7% | |
| | Patients waiting longer than 12 hours in ED from a decision to admit. | Outstanding Patient Experience | COO | 0 | National | 0 | 0 | 0 | 1 | 7 | 11 | 8 | 6 | 6 | 13 | 7 | 17 | 39 | 115 | |
| | Time to initial assessment for all patients presenting to A&E - % within 15 minutes | Safe, high quality care | COO | TBD | National | 73.4% | 68.1% | 73.4% | 57.7% | 66.7% | 48.1% | 58.1% | 49.8% | 57.2% | 57.3% | 61.7% | 54.0% | 52.5% | 59.9% | |
| | Proportion of patients spending more than 12 hours in A&E from time of arrival | Safe, high quality care | COO | TBD | National | 1.7% | 2.6% | 2.3% | 7.9% | 4.9% | 9.2% | 8.0% | 9.4% | 8.8% | 10.7% | 8.0% | 11.7% | 13.6% | 7.6% | |
| | 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 | 78.9% | 74.6% | 73.9% | 82.4% | 86.9% | 91.2% | 81.3% | |
| | Ambulance Handovers: > 30 minute delays | Safe, high quality care | COO | <5% | WUTH | 8.2% | 10.4% | 7.6% | 14.5% | 14.3% | 23.5% | 21.9% | 22.8% | 19.2% | 18.0% | 15.5% | 25.2% | 23.9% | 17.3% | |
| | 18 week Referral to Treatment - Incomplete pathways < 18 Weeks | Safe, high quality care | COO | NHSI Trajectory 20-21: minimum 80% for WUTH | SOF | 69.61% | 72.57% | 75.64% | 75.13% | 74.14% | 72.88% | 70.84% | 70.14% | 67.84% | 67.57% | 65.89% | 65.38% | 64.08% | 64.08% | |
| | Referral to Treatment - total open pathway waiting list | Safe, high quality care | COO | NHSEI Plan Trajectory 2022-23 | National | 24774 | 25873 | 26671 | 26979 | 27306 | 27424 | 26935 | 27046 | 27406 | 28665 | 29445 | 30430 | 31504 | 31504 | |
| | Referral to Treatment - cases exceeding 52 weeks | Safe, high quality care | COO | NHSEI Plan Trajectory 2022-23 | National | 874 | 633 | 526 | 507 | 560 | 606 | 575 | 510 | 557 | 475 | 525 | 582 | 730 | 730 | |
| | Referral to Treatment - cases waiting 78+ wks | Outstanding Patient Experience | COO | NHSEI Plan Trajectory 2022-23 | National | 83 | 90 | 90 | 117 | 177 | 163 | 116 | 70 | 72 | 59 | 65 | 60 | 70 | 70 | |
| | Referral to Treatment - cases exceeding 104 weeks | Safe, high quality care | COO | NHSEI Plan Trajectory 2022-23 | National | 1 | 1 | 1 | 3 | 3 | 7 | 10 | 5 | 5 | 4 | 5 | 1 | 0 | 0 | |
| | Diagnostic Waiters, 6 weeks and over - DM01 | Safe, high quality care | COO | ≥99% | SOF | 97.7% | 98.5% | 96.8% | 87.5% | 86.0% | 91.3% | 94.3% | 93.0% | 89.8% | 87.3% | 86.4% | 85.2% | 82.8% | 90.5% | |
| | Cancer Waiting Times - 2 week referrals (monthly provisional) | Safe, high quality care | COO | ≥93% | National | 96.9% | 97.6% | 97.2% | 95.4% | 93.7% | 95.7% | 96.1% | 87.9% | 91.4% | 76.2% | 78.0% | 76.2% | 85.7% | 89.8% | |
| | Cancer Waiting Times - 2 week referrals (final quarterly position) | Safe, high quality care | COO | ≥93% | National | - | - | 97.21% | - | - | 94.95% | - | - | 91.63% | - | - | 76.7% | - | 89.6% | |
| | Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional) | Safe, high quality care | COO | ≥96% | National | 94.7% | 95.2% | 99.2% | 96.3% | 96.4% | 96.5% | 95.4% | 94.3% | 94.8% | 94.6% | 95.1% | 92.6% | 91.3% | 95.1% | |
| | Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position) | Safe, high quality care | COO | ≥96% | National | - | - | 96.26% | - | - | 96.41% | - | - | 94.85% | - | - | 94.1% | - | 95.6% | |
| | Cancer Waiting Times - 62 days to treatment (monthly provisional) | Safe, high quality care | COO | ≥85% | SOF | 84.5% | 84.1% | 85.3% | 84.7% | 85.9% | 84.4% | 79.2% | 79.7% | 79.3% | 79.6% | 79.3% | 75.9% | 79.6% | 81.7% | |
| | Cancer Waiting Times - 62 days to treatment (final quarterly position) | Safe, high quality care | COO | ≥85% | SOF | - | - | 84.66% | - | - | 85.05% | - | - | 79.38 | - | - | 78.1% | - | 82.6% | |
| | Cancer Waits - reduce number waiting 62 days + | Outstanding Patient Experience | COO | NHSEI 2022/23 plans trajectory - max 68 | National | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 81 | 97 | 97 | |
| | Cancer - Faster Diagnosis Standard | Outstanding Patient Experience | COO | NHSEI 2022/23 plans trajectory - min 78% | National | 80.7% | 81.0% | 81.2% | 80.4% | 78.2% | 77.9% | 79.8% | 79.2% | 80.5% | 70.5% | 78.9% | 79.5% | 76.1% | 78.8% | |
| | Patient Experience: Number of concerns received in month - Level 1 (informal) | Outstanding Patient Experience | CN | ≤173 per month | WUTH | 157 | 156 | 145 | 209 | 213 | 218 | 216 | 177 | 149 | 180 | 187 | 211 | 170 | 184 | |
| | Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal) | Outstanding Patient Experience | CN | ≤3.1 | WUTH | 4.09 | 2.56 | 4.04 | 4.20 | 3.31 | 3.29 | 2.56 | 3.27 | 3.26 | 2.34 | 4.87 | 3.05 | 4.50 | 3.49 | |
| | Formal Complaint acknowledged within 3 working days | Outstanding Patient Experience | CN | ≥90% | National | 100% | 93% | 95% | 100% | 94% | 94% | 100% | 61% | 100% | 100% | 100% | 100% | 100% | 95% | |
| | Number of re-opened complaints | Outstanding Patient Experience | CN | ≤5 pcm | WUTH | 0 | 2 | 1 | 2 | 5 | 2 | 3 | 4 | 3 | 2 | 0 | 0 | 2 | 2 | |
| | NEWS2 Compliance | Outstanding Patient Experience | MD/CN | ≥90% | WUTH | - | - | - | - | - | - | - | - | - | - | - | 85.06 | 85.22 | | |

# Quality Performance Dashboard

**May 2022**
Upated 25-05-22

| | 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 | Mar-22 | Apr-22 | 2021/22 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Well-led | Duty of Candour compliance - breaches of the DoC standard for Serious Incidents | Outstanding Patient Experience | CN | 0 | WUTH | - | - | - | - | - | - | - | - | - | - | - | - | 0 | | |
| | Number of patients recruited to NIHR studies | Outstanding Patient Experience | MD | 700 for FY 22/23 (cumulative 59 per month until year total achieved) | National | 22 | 38 | 107 | 279 | 457 | 613 | 774 | 958 | 1121 | 1445 | 1575 | 1666 | 20 | 1666 | |
| | % Appraisal compliance | Safe, high quality care | CPO | ≥88% | WUTH | 81.0% | 81.3% | 82.7% | 82.7% | 82.2% | 81.2% | 82.2% | 82.7% | 82.3% | 82.0% | 78.0% | 77.9% | 77.16% | 77.2% | |

| | 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 | Mar-22 | Apr-22 | 2022/23 | Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | 0.1 | -2.7 | -2.7 | |
| | 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 | -0.3 | -2.7 | -2.7 | |
| | 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 | 3.0 | 3.0 | |
| | 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% | 78.70% | 78.61% | 91.33% | 7.26% | 7.26% | |
| | 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% | -15.0% | -43.9% | -43.9% | |
| | 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 | -20.0 | -21.4 | -21.4 | |
| | 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% | 100.0% | 0.7% | 0.7% | |

**Metrics Added**

| | |
|---|---|
| Safe | Gram negative bacteraemia : e-coli |
| | Gram negative bacteraemia : klebsiella |
| | Gram negative bacteraemia : pseudomonas |

**Metrics Amended**

| | |
|---|---|
| Well-led | Duty of Candour compliance - breaches of the DoC standard for Serious Incidents |

# Safe Domain

## *Clostridioides difficile* (Healthcare Associated)

**Executive Lead:** Chief Nurse

**Performance Issue:**

The National objective set for WUTH for healthcare associated *Clostridium difficile* infections (CDI) for this year 2022-23 is 72, this is derived from a base line of the 12 months ending November 2021, as this was the data available to NHSE/I at time of calculating the figures. The figures were calculated as below

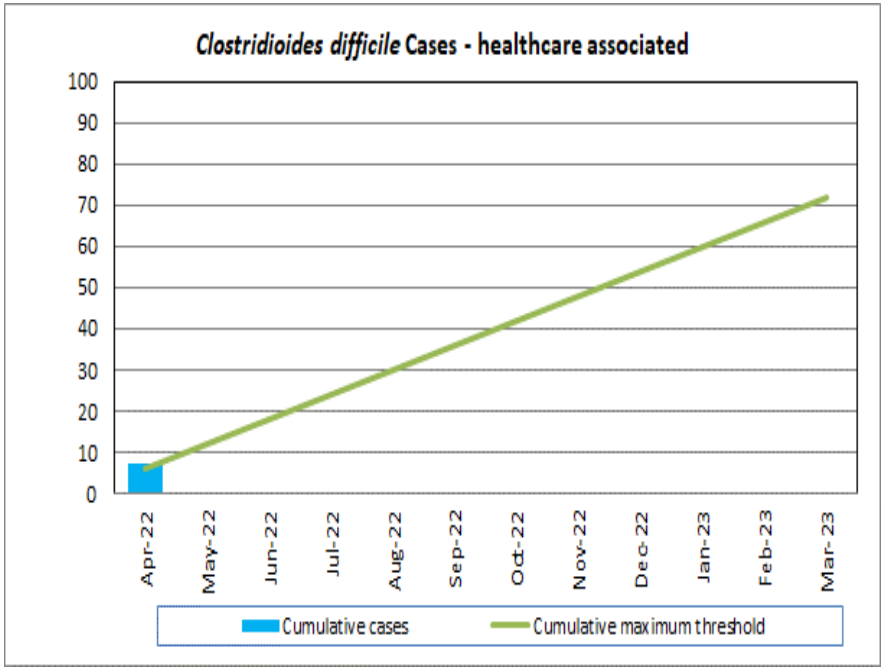
- If a trust had fewer than or equal to 10 cases during the 12 months ending November 2021, the threshold will be equal to that count. If a trust had more than 10 cases, the threshold will be one less than the count.
- All thresholds were rounded down to the nearest whole number and pertain to healthcare-associated cases i.e., Hospital onset, hospital associated (HOHA) and Community onset, Hospital associated (COHA)cases.

The monthly trajectory has been calculated by dividing the objective by 12,

The position for the end of April was 7 cases, therefore one case higher than the monthly threshold.

**Action:**

The weekly Chief Nurse led CDT meeting continues which reviews each patient pathway, identifies the causative factors which inform the local



| |
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| action plans to focus on improvements. The common themes are being addressed by the QI initiative. Monthly collaborative meetings with Wirral CCG to monitor improvements continue and the ADN-IPC represents WUTH. |
| **Expected Impact:**<br>Reduction in patients diagnosed with healthcare associated *Clostridioides difficile* |

## Gram-Negative bloodstream infections - *E-coli* bacteraemia

| |
|---|
| **Executive Lead:** Chief Nurse |
| **Performance Issue:**<br>For 2022-23 the maximum threshold for Gram-negative blood stream infections has been separated into the component elements of *E-coli, klebsiella* and *pseudomonas*. All thresholds are derived from a baseline of the 12 months ending November 2021, as this is the most recent available data at the time of calculating the figures.<br><br>For each of the three Gram-negative bloodstream infection types specified, if a trust had fewer than or equal to 10 cases during the 12 months ending November 2021, the threshold will be equal to that count. If a trust had more than 10 cases, the threshold will be 5% less than the count. All thresholds were rounded down to the nearest whole number and pertain to healthcare-associated cases i.e., Hospital onset, Healthcare associated (HOHA) Community Onset, Hospital associated (COHA)<br><br>The threshold for Gram-negative *E-coli* is set at a maximum 56 cases, equating to approximately 4 per month. There was 5 HOHA reported and 3 COHA reported in April 2022, |
| **Action:**<br><br>Senior representation continues at the weekly Patient Safety Learning Panel to enable in-depth scrutiny of the RCA investigations to ensure all learning areas are captured and action plans can be developed to promote improvements. |
| **Expected Impact:**<br><br>The number of patients diagnosed with a Gram-negative blood stream infection is reduced to below the monthly threshold and the annual objective for 2021 – 2022 is achieved. |

## Pressure Ulcers – hospital acquired category 3 and above

**Executive Lead:** Chief Nurse

**Performance Issue:**

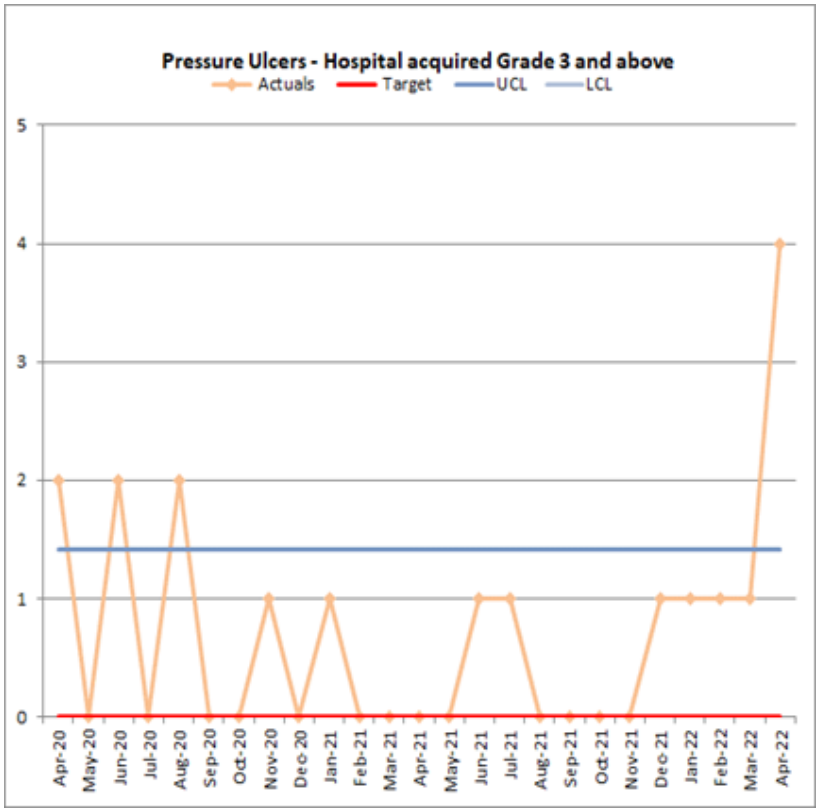
WUTH has in an internal standard of zero hospital acquired pressure ulcers at category 3 or above.

**Action:**
There were four Hospital Acquired (HA) Cat 3 reported in April. Incidents received a full review in the Patient Safety Learning Panel and full root cause analysis undertaken that identified some lessons to be learnt around effective documentation, appropriate action has been taken as a result.

The Trust continues to have a sustained low prevalence of HA Pressure ulcers with a rate of ≤1Per thousand bed days. This low prevalence is supported by continuous improvement work streams, launch of the SSKIN bundle focusing on prevention and launch of the Tissue Viability Education E-learning Training.

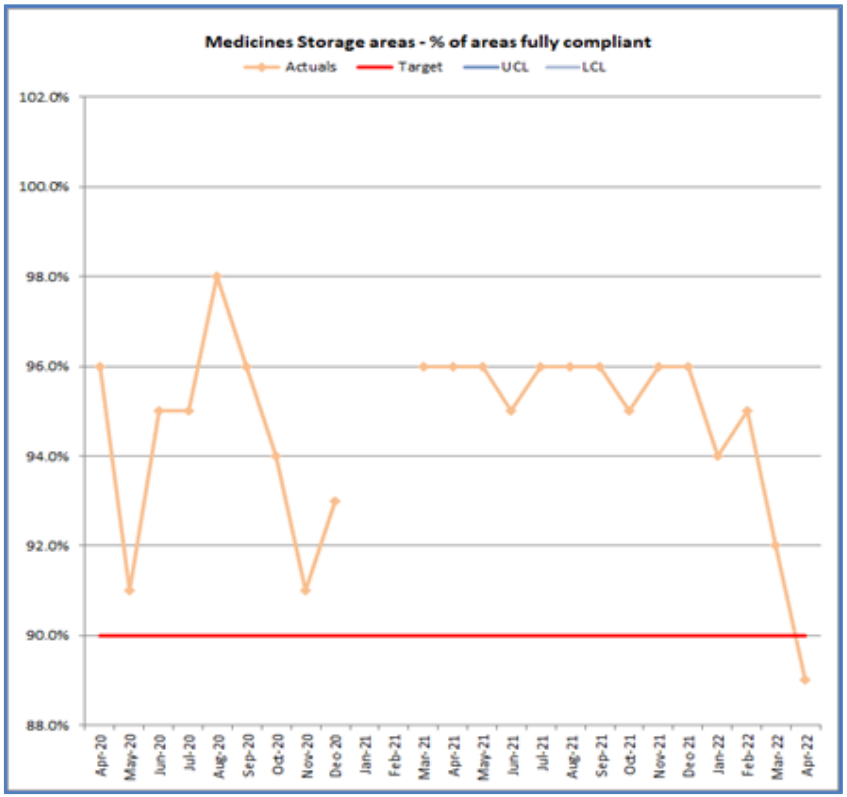
The Pressure Ulcer Prevention and Management Policy replicative of the Cheshire and Merseyside Pressure Ulcer Steering Group standards has been submitted for consultation.

**Expected Impact:**
There will be a reduction in the number of patients with hospital acquired pressure damage.



## Medicines Storage Areas - % of areas fully compliant

| |
|---|
| **Executive Lead:** Chief Nurse |
| **Performance Issue:**<br><br>WUTH has an internal regular audit on the storage of medicines across the Trust, to check % compliance against the expected standards.<br><br>The threshold of a minimum 90% compliance has been consistently achieved on a regular basis, however performance for April 2022 was 89%. |
| **Action:**<br><br>The reduced performance within April can in part be attributed to a reduction in the total volume of inspections submitted.<br><br>Deviations from the inspection schedule are directed to the Divisional Nurse Directors with expected trajectories for improvement. |
| **Expected Impact:**<br><br>The expectation is that each area completes their inspection in line with agreed schedules and demonstrate sustained improvements. |



## Safeguarding Audit

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| **Executive Lead:** Chief Nurse |
| **Performance Issue:**<br><br>WUTH has a regular rolling audit program to provide assurance that Safeguarding practice is in line with national and local standards. The audit is undertaken by the Trust Safeguarding Team and can be viewed as a stand-alone audit or part of the Trust's WISE Ward Accreditation Programme. The threshold of minimum 90% compliance was not achieved for April, with compliance recorded as 71.6%. |
| **Action:**<br><br>A rolling program for inspections is identified by the Corporate Nursing Team as part of the WISE Ward Accreditation programme. Each week the Safeguarding Team reviews an area, utilising the Tendable Inspection Tool. Detailed inspection results including comments from the inspector are available on the day of inspection. Each area is reviewed against a set criterion considering the care delivered to individual patients, staff knowledge and application of knowledge in the care setting. Detailed improvement plans are returned to the Corporate Nursing Team.<br>The Safeguarding Team are available to all areas for educational sessions and updates and there is an on-line Safeguarding educational package available to all staff and is a mandated session. The Safeguarding inspection is now available on Tendable for Ward teams to use as part of self-assessment improvement plans, although their self-assessment scores are not used for reporting. |
| **Expected Impact:**<br><br>The expectation is that all areas achieve greater than 90% within their Safeguarding Audits. |

## Mandatory Training %

**Executive Lead:** Chief People Officer

**Performance Issue:**

The Trust has an internal standard for 90% of staff to be compliant with applicable Mandatory Training. The rate for April 2022 was 87.17%

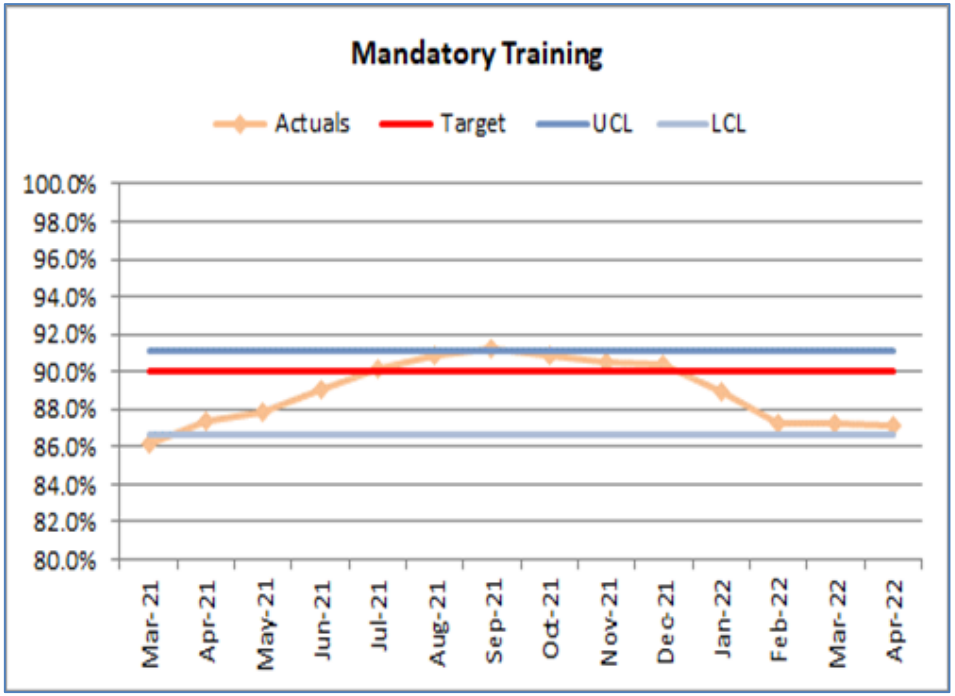
There were no Divisions in April 2022 that met the KPI. The highest compliance is Clinical Support at 89.32%, the lowest is Acute at 80.91%. Improvements this month were seen in Clinical Support, Corporate Support and Surgery.

There is a wide variance in compliance by staff group, with Add Prof, Scientific and Technical with the highest compliance rate at 96.44%, and Medical and Dental with the lowest compliance rate at 71.05%.

Of the 15 requirements for mandatory training, there are 5 subjects that are meeting the KPI of 90% compliance which are Conflict Resolution, Equality and Diversity (Level 1), Fire Safety (Level 1), Infection Control (Level 1) and Moving & Handling – People Handling. All other subjects are below 90%, with the lowest compliance levels seen in PVP Levels 3 and 4 which stand at 75.48% and 76.40% respectively, and CPR which currently stands at 80.04%.

**Action:**

Workforce compliance data is available to Divisions and the HR Services team to enable them to manage non-compliance for their areas. HR Business Partners continue to support Divisional Management teams to identify and deliver actions to address low levels of compliance in specific areas.



An Education Review is currently underway which includes within its scope an objective review of mandatory training as one of the indicators of safe care provision in line with CQC requirements.

In the meantime, there has been increased engagement and collaboration with Subject Matter Experts (SME's) through the establishment of an SME network, which will feed into the Trust's Education Governance Group. This is anticipated to commence from June 2022 and will support subject leads as all mandatory subjects receive an updated review against the national Core Skills Training Framework.

The L&D Team are working with SME's for PVP and CPR to understand subject specific risks pertaining to continued compliance below the Trust's target. This will enable greater focused work between the L&D team and subject matter expert to address the gap in compliance and reduce any associated risks.

Following a change in Trust covid restrictions enabling the provision of face-to-face training, work is ongoing to return some mandatory subjects to face-to-face delivery from June 2022. A return to face-to-face Corporate Induction is planned from July 2022, which will help improve new starter compliance for some key aspects of mandatory training.

In the meantime, there is a targeted approach to increasing compliance. This will place particular emphasis on a specific mandatory training subject to drive compliance. Alongside this, all Divisions have produced improvement trajectories and progress against these is reviewed via Divisional Performance Review.

**Expected Impact:**

The impact of covid on training provision has been significant and there are a number of challenges in sustaining compliance from venue suitability to ongoing clinical pressures. The above actions recognise that a strategic and long-term approach is required to achieve sustained increases in compliance, alongside ongoing actions to mitigate against immediate risk.

## Sickness absence % (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 in April 2022 decreased to 6.84%, from 7.73% in March. Of this 1.59% is related to COVID-19.

All Divisions in April 2022 have exceeded the 5% KPI, although all Divisions, except Estates & Hotel Services, showed an improvement in April 2022.

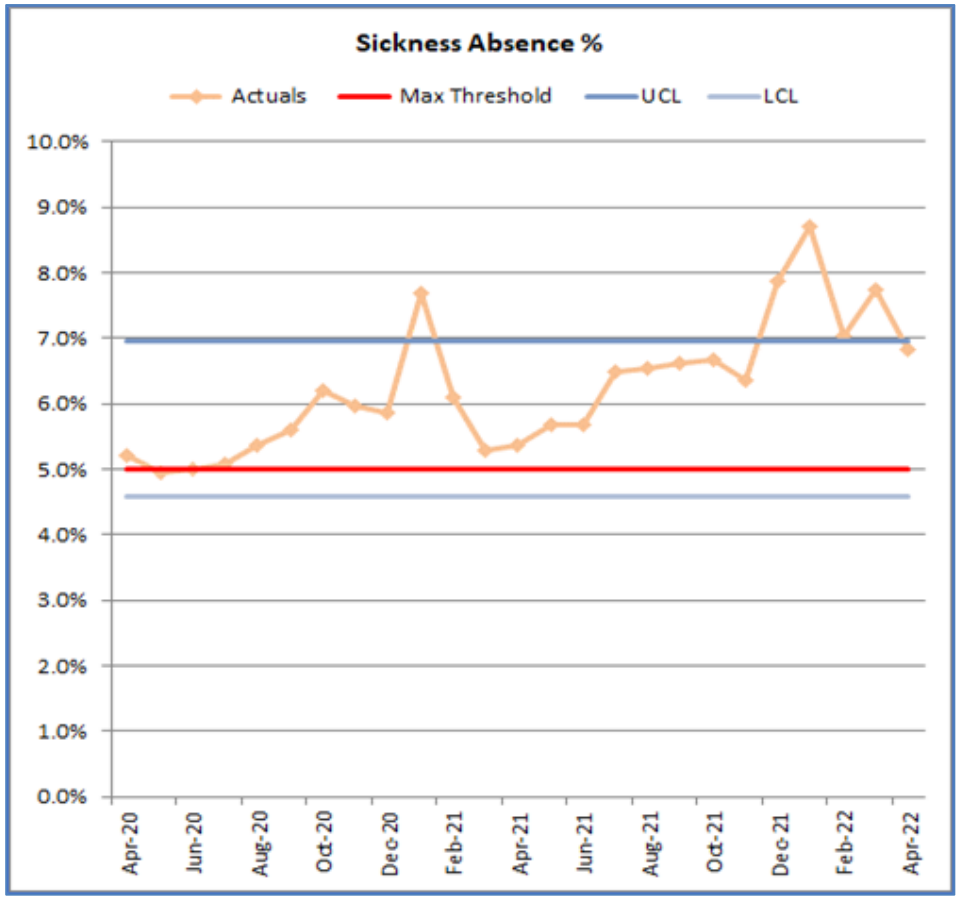
In April 2022, there was an increase in long-term sickness absence as compared to March 2022. Proportionately, short term sickness absence continues to account for the majority (82%) of sickness absence.

Anxiety, Stress and Depression remains the highest reason for long term sickness absence. The 'Infectious Diseases' category was the highest reported reason for short-term sickness, followed by 'Gastro Problems'.

**Action:**

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

Work on the NHSE/I agreed plan continues against the Deep Dive Themes, in particular actions associated with the revised Managing Attendance Policy and newly proposed Managers Toolkit. The aim of which is to ensure the Policy is fit for purpose, robust and encourages consistency in its application. Any subsequent policy changes will be supported with an implementation plan and appropriate communication campaign.



The Health and Wellbeing Day initiative is being promoted across the Trust in conjunction with the launch of Health and Wellbeing Conversations

The Workforce Wellbeing Winter Plan implementation has come to an end and the evaluation and review of the programme is underway. The aim of the analysis is to determine the provisions that staff found to have had the biggest impact on their wellbeing, with a view to embedding good practice into 'business as usual' as part of the work programme to deliver the commitments in the 'Looking After Our People' principle of the People Strategy.

From a development perspective, a Training Needs Analysis exercise is currently underway with divisional representatives. One of the themes arising relates to the need to support and develop leaders and managers. Arrangements are in progress to recommence face-to-face Management Development sessions, which includes Attendance Management as a core topic.

The HR team continues to deliver and support less formal training opportunities with operational managers across the Divisions. There have been recent appointments to the team with additional HR Advisors which is an integral role to enhancing grip on sickness levels as well as providing case management advice and support.

**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 pandemic and transition into Living with Covid-19 response.

## Staff turnover % (12-month rolling average)

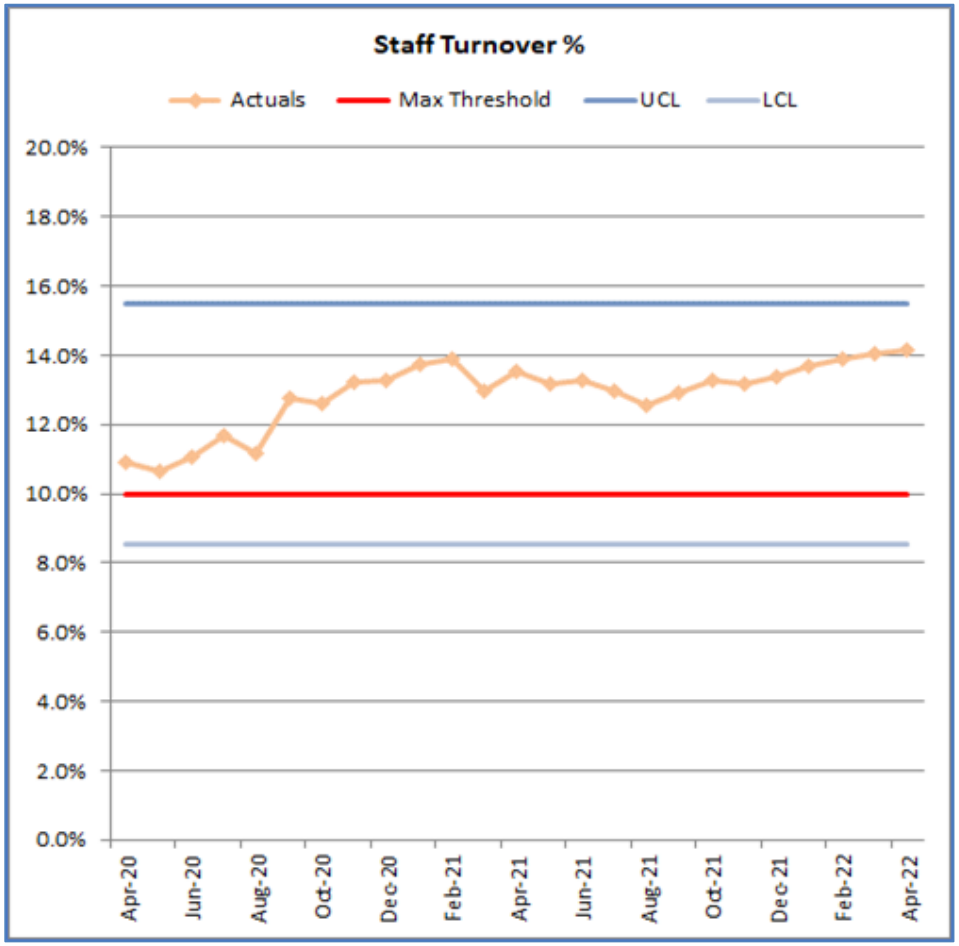
**Executive Lead:** Chief People Officer

**Performance Issue:**

The Trust target is set as a maximum rolling 12-month turnover threshold of 10%. Turnover was 14.13% for the rolling 12 months to April 2022, which is a similar position to that reported in March 2022 (14.1%). Rolling 12-month turnover to April 2022, calculated on permanent assignments only, is 11.92%.

The in-month performance in Acute Care, Surgery and Women & Children's are all below the Trust Turnover KPI. Medicine Division and Clinical Support and Diagnostics are above.

All 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 to the local feedback. A specific focus on Registered Nurse and CSW turnover is also discussed at the Recruitment and Retention Working Group which meets monthly.

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

A Nurse and CSW recruitment event was held in May 2022 with recruitment leads invited to showcase their areas and attract new candidates. A further event is planned for June focussing on CSW recruitment.

Work to understand predicted number of students taking up permanent posts on qualification is underway with 4 local universities enabling the Trust to set recruitment targets for future cohorts. The Recruitment and Retention Working Group is also looking at the reasons for student attrition and how to enhance student learners experience. Skill mix on wards is also being

considered to ensure learners are fully supported whilst wards maintain quality patient care.

International nurse recruitment continues and progress is on target. However, it should be noted that there is a national shortage of availability for OSCE courses. This has been raised regionally and will also be raised with the NMC in terms of seeking options available to ensure IR enables the Trust to maximise its workforce in preparation for the winter period.

Training dates for PARE and WEPP have been shared with preceptors. Recruitment have implemented a process for weekly reporting of new registrants to the Senior Nurse Lead for WEPP.

Specifically for April 2022, Medicine Division, Clinical Support and Diagnostics Division and the Corporate Division were above the in-month target.. Detailed review is being undertaken within the Divisions and appropriate actions implemented.

R&R Working Group have identified the following areas for action to further support retention:

- Poor compliance with Exit policy, specifically poor uptake and monitoring of the exit interview process. Options for improvement to be developed by the HR team and reviewed at the next meeting.

Student nurses' feedback: specific feedback that highlights issues which may be deterring student nurses from seeking permanent employment with the Trust is being acted upon.

**Expected Impact:**

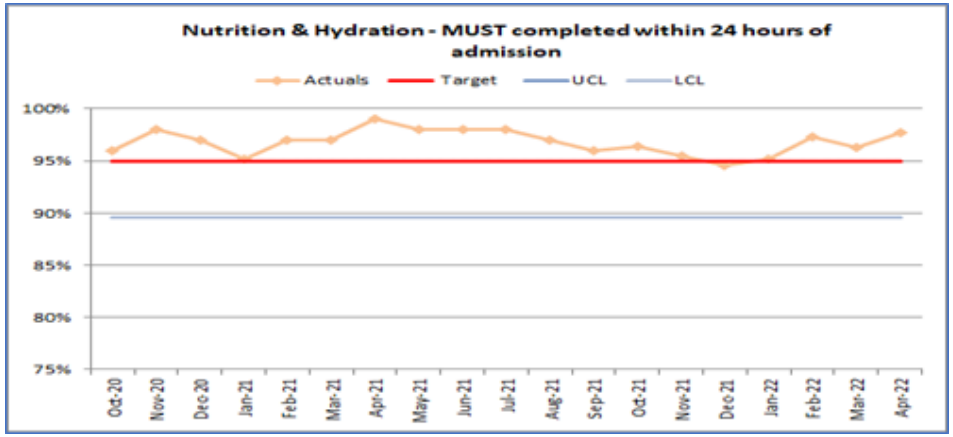
The impact of high Turnover increases pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance, and safety.

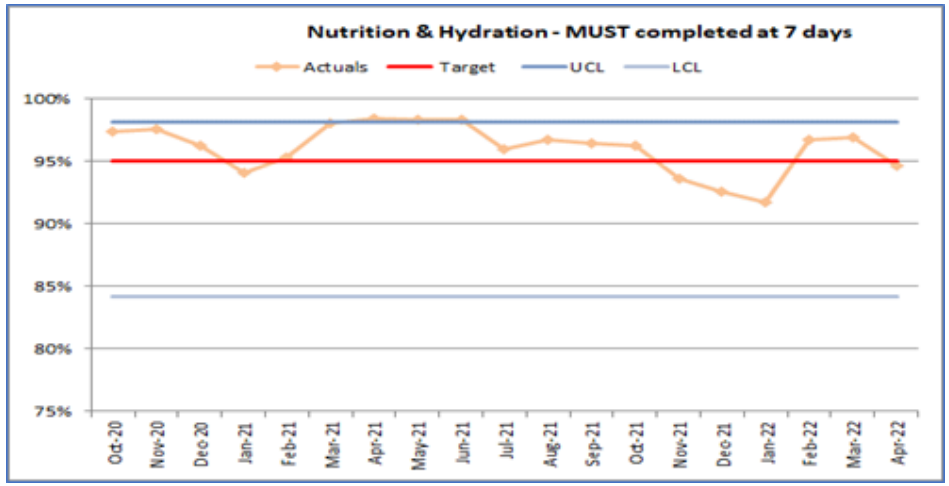
Risks to Trust financial management, quality, patient safety and operational performance due to the cost of high Turnover and the expense of bank and agency cover should reduce as Turnover improves over time with the interventions outlined above.

# Effective Domain

## Nutrition and hydration – MUST completed at 7 days

| |
|---|
| **Executive Lead:** Chief Nurse |
| **Performance Issue:**<br><br>An internal WUTH target is set at a minimum 95% compliance with MUST recording within 24 hours of admission, and every 7 days. Performance for April 2022 was above the 95% threshold at 97.7% for completed within 24 hours, however 7-day MUST was 0.4% below the target with a compliance of 94.6%. |
| **Action:**<br>The Corporate Nursing Team have implemented two daily reports that focus on Nutrition and Hydration and are elements that form part of the MUST assessment, which is supporting a focus on MUST completion.<br>Areas that do not achieve MUST compliance are invited to the Patient Safety Learning Panel to identify supportive metrics and learning outcomes.<br>Areas where additional operational capacity was opened are the main areas where compliance fell below the 95% target. |
| **Expected Impact:**<br><br>It is expected that 95% will be achieved for all MUST score from June 2022. |



## 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.

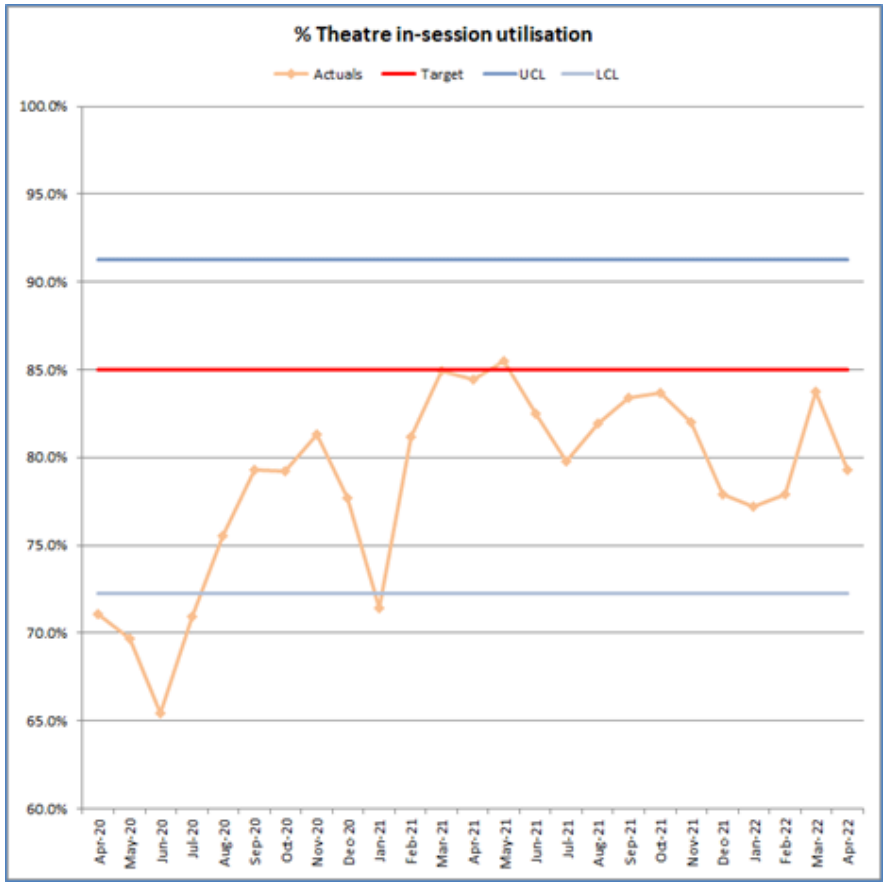
Focus remains on improving utilisation of core sessions as part of reset and recovery. This has been critical given the loss of 6 theatres due to ventilation failures resulting in theatres M1 – M5 and G1 being closed to maintain patient safety. The second fix remedial work of M1 & M2 were completed successfully at the start of May ahead of the full ventilation system replacement later this year.

As COVID prevalence continued to increase it had a direct impact on in-session utilisation due to patients being cancelled if their preop or pre-admission COVID swab was positive, and lists are unable to be backfilled at such short notice due to clinical requirements/pathways. Proposals to change the process under "living with COVID" was approved at CAG with in-session performance showing an improvement. This is expected to have greater impact as day cases are not required to isolate or have an admission swab unless clinically indicated.

Casemix selection was in issue in May with cases cancelled on the day due to a lack of operating time as a result of the number and complexity of cases listed per session.

COVID measures regarding PPE remain in place.

The number of patients not meeting the criteria to reside in hospital beds and COVID numbers remain high, though the loss in theatre estate has meant there have been minimal EL bed pressures. IPC measures have been revised in view of national guidance enabling access to closed beds and the restoration of the Elective wards.



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| **Action:**<br><br>• Maintain the Theatre scheduling meeting to minimise the loss of activity through theatre ventilation failures<br>• Maintain the daily TCI meeting to prevent cancellations on the day for inpatients and risk further reduction in in-session utilisation<br>• Theatre ventilation repair works schedule remains on track<br>• Heavier focus on CGH theatre to ensure >85% in-session delivery<br>• Through TRG focus on the case mix to ensure theatre time maximised |
| **Expected Impact:**<br><br>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 was 1 such breach in April 2022. This 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.

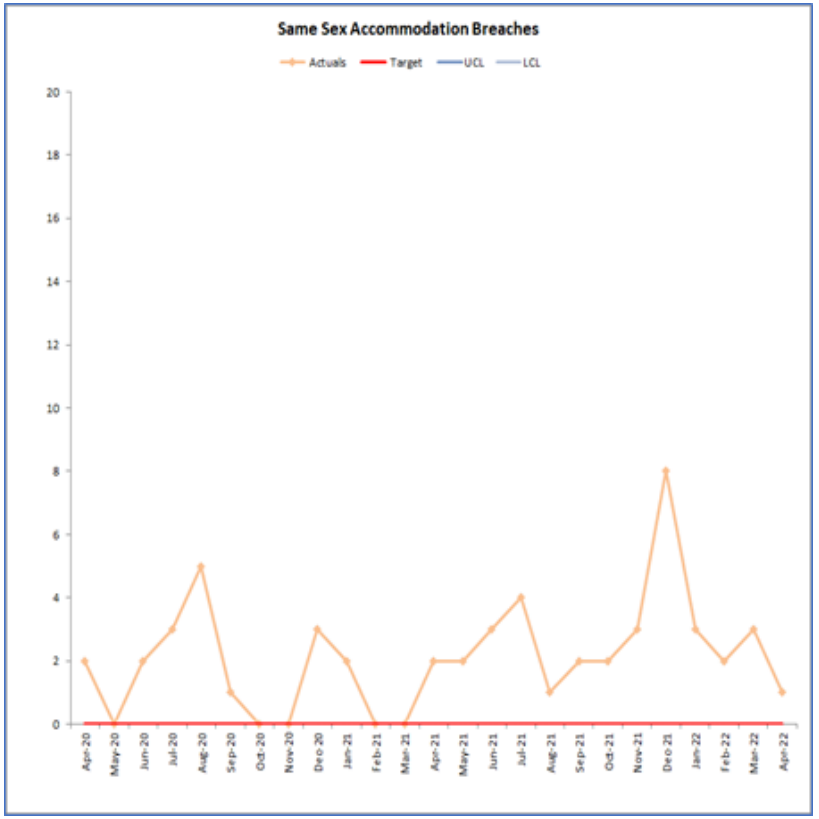
**Action:**
Increased pressure due to system challenges resulting in high levels of activity throughout the hospital and an increased proportion of patients with no criteria to reside continued in April 2022.

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.



## Friends & Family Test – Overall Experience

**Executive Lead:** Chief Nurse

**Performance Issue:**

A WUTH standard is set for achieving an overall experience rating of very good or good for each of the main care settings.
Performance against the 95% threshold for April 2022 was:

- ED - 74.0%
- Inpatients – 94.8%
- Outpatients – 93.5%
- Maternity 93.1%

**Action:**

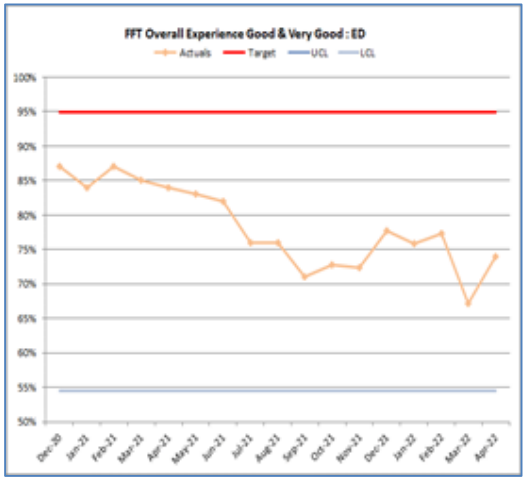
The Trust formally launched its Patient Experience Strategy on the 4th April with 5 main strategy promises: Welcome, Safe, Inclusive, Care and Supported. Promise action groups will focus on identifying improvement opportunities to improve the patients' experience.

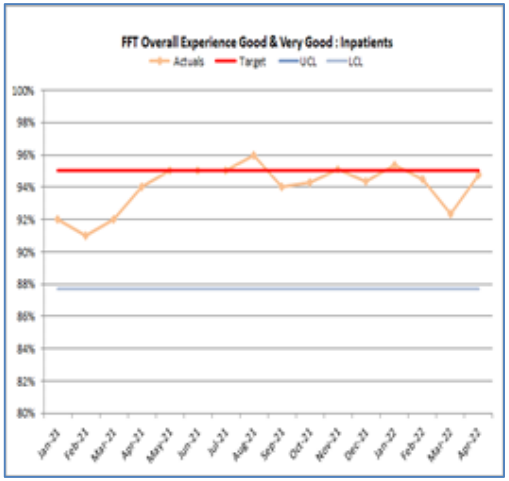
Operational pressures continue within the Emergency Department as they do nationally, whilst FFT scores are low they are in line with other regional organisations and negative feedback focuses on waiting times.

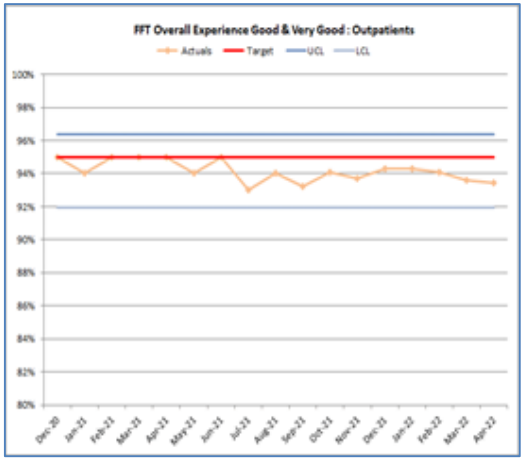
There are four wards that have not met the 95% target for 3 consecutive months and who will have a responding to feedback action plan developed to support improvements in scores. All areas receive regular patient experience feedback and areas are monitored for themes and trends.

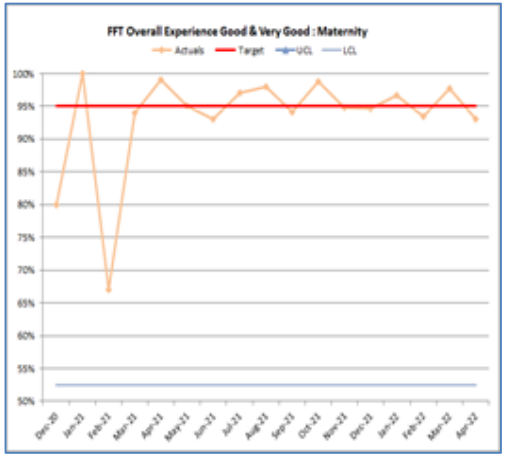
**Expected Impact:**

Improved FFT scores with an expectation to reach the Trust target for Inpatients, Maternity services and Outpatients.



## Responsive

### Number of complaints received in month per 1000 staff

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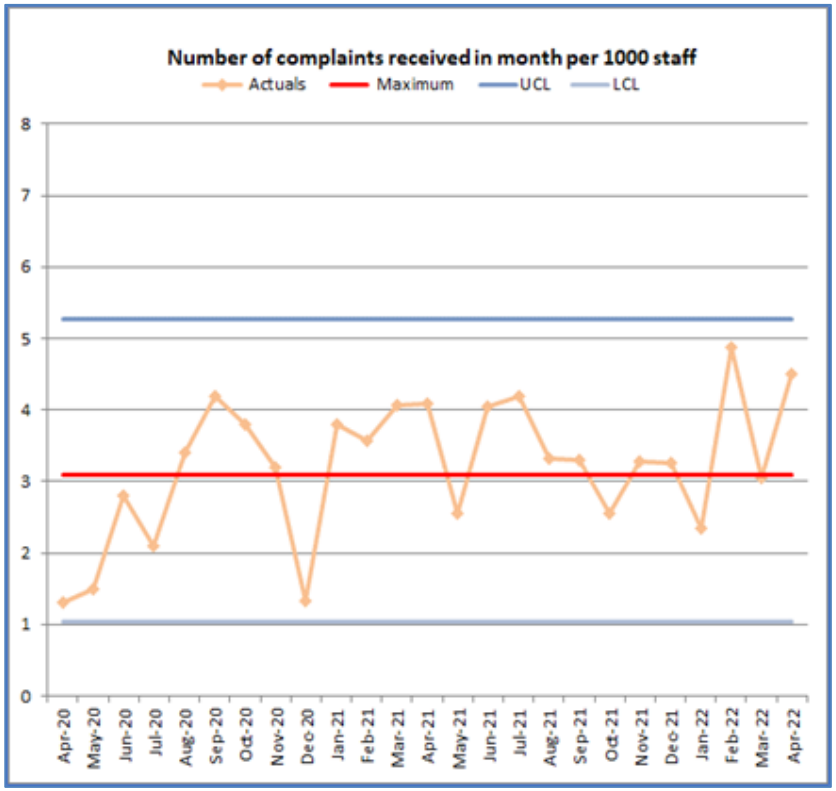
| **Executive Lead:** Chief Nurse |
| **Performance Issue:**<br><br>WUTH has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per 1000 staff. The rate for April 2022 was 4.50 |
| **Action:**<br><br>Although there has been a rise in April (particularly in Acute Care), complaint numbers remain broadly in line with historical performance. Over time, the numbers of complaints received each month have consistently increased in line with the trend seen nationally.<br><br>Divisions have localised plans to address the main continuing causes of complaint (communication / staff attitude and capacity pressures) and the ways in which these might be addressed, as well as any seasonal surges in numbers. |
| **Expected Impact:**<br><br>Actions being taken will strengthen the approach to complaint management within the Trust. |



## NEWS2 Compliance

**Executive Lead:** Chief Nurse

**Performance Issue:**

WUTH has set a threshold of greater than 90% compliance with NEWS2 patient observations carried out within timeframes agreed within national guidelines and Trust NEWS2 policy. Compliance is measured by a rolling programme of monthly ward audits - for April compliance was at 85.22%.

**Action:**

The Trust has progressed two workstreams to support an increase in compliance with the timeliness of recording NEWS2 observations.

Fast-Track Improvement Work

A fast-track improvement plan led by the Trust Medical Director has developed advanced communications in the form of a 'Deteriorating Patient Take 5' poster and a created a live report from the Trust's electronic patient record that identifies each ward / department NEWS2 compliance status. The 'Deteriorating Patient Take 5' communication poster has been presented at Chief Nurse Check-in and has been provided to all areas via Ward Managers as part of their Safety Huddles. To support staff accessing the new live NEWS2 compliance report a "Knowing How You are Doing" presentation has been delivered to all Ward and Department Managers. NEWS2 compliance is reported fortnightly as part of a series of Nursing Fundamentals.
The fast-track improvement plan also includes the planned introduction of integrated systems. This will allow observations recorded on modified observations machines to instantly migrate into patient medical records, increasing compliance with the timeliness of observations.

Quality Improvement Focused Work

| |
|---|
| The Trust has also established a Deteriorating Patient Faculty to oversee Deteriorating Patient Quality Improvement (QI) work on eight wards across the Trust.<br>Wards have participated in workshops to identify issues and potential solutions by using QI tools such as Fishbone and Driver Diagrams. Solutions are then assessed on wards using 'Plan, Do, Study, Act' cycles. The solutions are refined on the wards and presented at the executive-led Deteriorating Patient Faculty. Solutions considered successful and sustainable are to be compiled into a Deteriorating Patient Bundle for Trust-wide use |
| **Expected Impact:**<br><br>The expectation is for all areas to achieve greater than 90% for completing NEWS2 observations within national and locally agreed timeframes. |

# Well-led Domain

## Appraisal compliance %

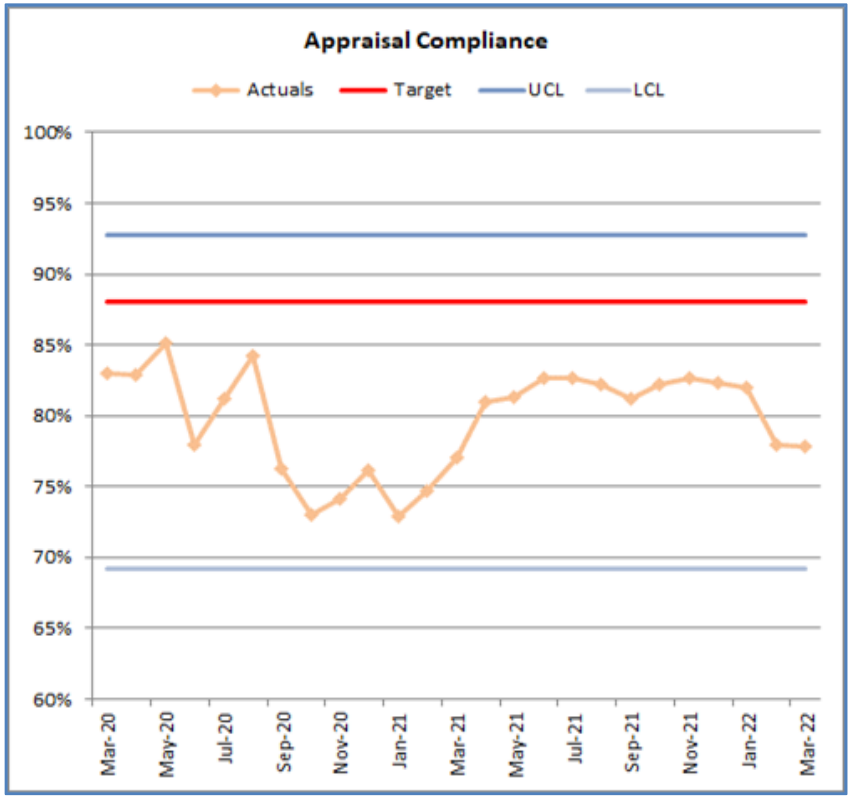
**Executive Lead:** Chief People Officer

**Performance Issue:**

The target for annual appraisal compliance is 88%. At the end of April 2022 77.16% of the workforce had received an appraisal in the last 12 months. This is a slight deterioration from the 77.85% at the end of March 2022.

From a Divisional perspective, no Divisions this month have achieved the Trust KPI of 88% appraisal and compliance is currently under 80% in all Divisional areas. There have been small increases in compliance in comparison to the previous month in Corporate Support, Estates & Hotel Services and Womens & Children's Divisions, with all other Divisions seeing a decrease in compliance. The Division with the highest compliance rate is Corporate Support at 85.25%, and the Division with the lowest compliance rate is Acute at 62.41% and Medical at 73.01%.

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 with alerts of appraisals due 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. Increased focus upon appraisal compliance is being placed at Divisional performance review (DPR) meetings and all Divisions have been tasked with producing improvement trajectories.

In addition, the L&OD Team have reviewed outstanding appraisals and are directly targeting areas of low compliance in each Division to provide staff with

support. This includes prompts of an over-due appraisal with supportive guidance that includes advice on how to record their appraisal onto ESR, as it is suspected a number of appraisals have been completed but not recorded on the system.

As highlighted in previous reports, a review of appraisal has now commenced. This has been accelerated from a 6 month to a 4-month piece of work due to the continued decline in compliance. To date, a quality audit and focus groups have been conducted to gain greater insight into the issues relating to appraisal, and further feedback has been gathered through specific questions in the trust-wide wellbeing survey. Early indications are that there are a range of opportunities to strengthen the quality of the appraisal experience, enhancing its value across the Trust and subsequently driving improvements in both quality and compliance. The diagnostics are informing a proposal and subsequent project plan that will encompass:

- Refreshed policy, guidance and appraisal and supervision documentation that focuses upon quality conversations between individual and their line manager.
- Refocus of appraisal and supervision that focusses discussion on an individual's contribution (including their performance), development and wellbeing as a continuous conversation throughout the year; ensuring appraisal and supervisions are not seen as separate but as one continuous cycle of support
- Development of a new process for reviewing appraisal and supervision quality with a proposal as to how this is also reported along-side compliance figures
- Review as to how appraisal is recorded, monitored, and reported ensuring divisions and board have adequate assurance that supervision and appraisal is taking place and that staff are having a quality experience
- A training plan to ensure all staff and manager know what is expected of them in the process and to ensure they have they have the skills to get the best out of their supervision and appraisal

**Expected Impact:**

Whilst actions will continue to increase compliance within the existing appraisal framework, the longer-term solution for maintaining compliance is to place a longer-term focus on quality improvement. It is acknowledged that ongoing clinical pressures may create some continuing challenges in maintaining appraisal completion rates across clinical areas over forthcoming months.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust



# Board Assurance Framework
## June 2022/23

**Item 9.2**

# Contents

# 1. Introduction

The Board Assurance Framework (BAF) provides a structure and process which enables the Board to focus on the key strategic risks which might compromise the achievement of our Strategic Objectives. We have adopted a '3 lines of defence' approach which highlights the levels of control in place and assurance obtained, both internally and externally, along with clear identification of those accountable for further actions to be taken in order to reduce risk.

***The successful and sustained achievement of your organisation's mission and objectives are reliant on robust governance, risk management and assurance processes. This means the board needs to be clear about what it wants to achieve, knows what the measures of success will look like, is open and honest in its dealings and alive to the key risks being faced within and outside of its operating environment, both at strategic and operational level.***

***Baker Tilly 2021***

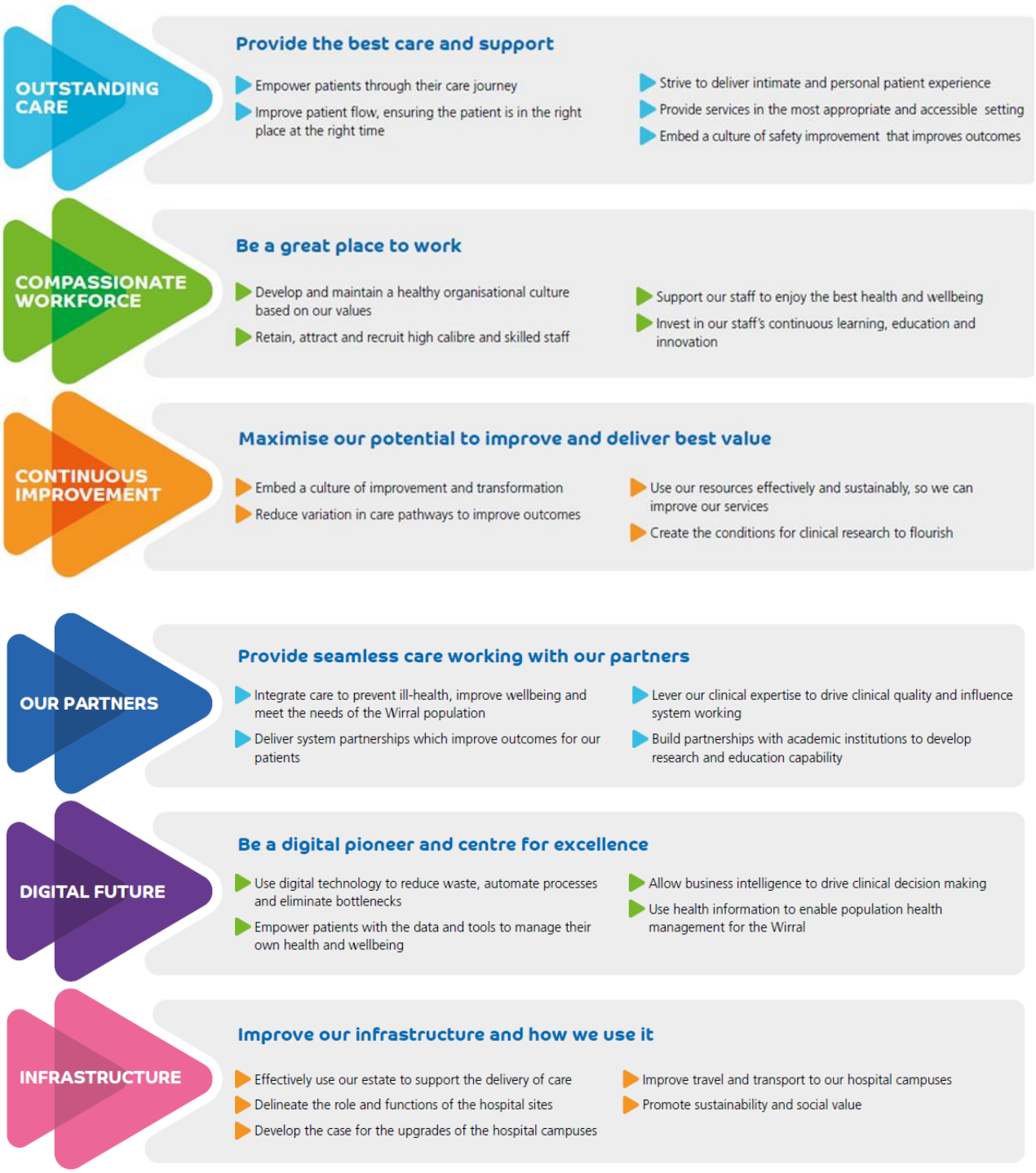
# 2. Vison, Strategy and Objectives

## 2.1 Our Vision

For us to realise our ambition it is essential that all business and work programmes are clearly aligned to our Vision, Values, Strategic and Corporate Objectives. Clear lines of sight from these down to individual objectives will support all staff in identifying how to contribute to overall achievement. Our Vision is:

## 2.2 Our Strategic Objectives

The BAF is derived from our overarching six strategic objectives and priorities which demonstrate our intension to provide outstanding care across the Wirral through our hospital sites and units, as a lead provider within the Wirral system. We will be a Hospital Trust that patients, families, and carers recommend, and staff are proud to be part of.



# 3. Creating and Monitoring the BAF

## 3.1 Creation of the BAF

The refreshed version of the BAF was created and approved in September 2021 following discussions and workshops with all Board members.

## 3.2 Monitoring the BAF

It was agreed that the BAF would be subject to ongoing refreshment and that it would be monitored as follows:

- Bi-Monthly Reports to the Board;
- Bi-Monthly Reports to the Audit Committee;
- Reporting to every other meeting of Assurance Committees;
- Bi-Monthly Reporting to the Trust Management Board; and
- Bi-Monthly Reporting to the Risk Management Committee.

# 4. Monthly Update Report

## 4.1 June 2022

The purpose of this report is to provide the Board with information and assurance as it relates to the Board Assurance Framework (BAF) and the current high level and strategic risks within the Trust.

The controls, assurance, and actions for each of the current strategic risks have been reviewed with Executive Team members and these changes are reflected in the attached appendix.

## 4.2 Changes to the previous version

Following refreshment, the following changes have been made to the BAF since its last reporting to the Board:

- Changes to controls in place, Internal and External Assurance and key actions are highlighted in RED;
- The current risk score in risk 1.1 has been reduced to 16 (4 x 4) to reflect the increased controls and activity taking place to monitor this risk; and
- Risk 1.2 and 1.3 have been merged to reflect the current position in relation to scheduled care.

## 4.3 Annual Refresh 2022

The purpose of this report is to provide the Board with information and assurance as it relates to the Board Assurance Framework (BAF) and the current high level and strategic risks within the Trust. In order to ensure that the BAF is always up to date the document is subject to regular review and annual refreshment. Board are asked to note the following actions:

- Regular review is ongoing with Executive Directors review of the BAF at Bi-Monthly intervals;
- The annual review of the BAF is currently taking place to align current strategic risks with the refreshment to Trust annual objectives;
- The Full Board will be asked to consider proposals for the refreshed BAF in a session to be jointly facilitated by the Good Governance Institute in line with the emergent Board Development Programme; and
- A fully refreshed BAF will be presented to the Board at its meeting in September 2022.

## 4.4. Recommendations

Board is asked to:

- Note the current BAF;
- Approve the proposed amendments to the BAF; and
- Note the proposals for the annual refreshment and updating of the BAF.

# Wirral University Teaching Hospital
# Board Assurance Framework - June 2022

| Risk Number | Responsible Director | Risk Description | Risk Controls in Place | Internal and External Assurance | Gaps in Control and Assurance | Initial Risk Score | Current Risk Score | Target Risk Score | Actions | Actions Due |
|---|---|---|---|---|---|---|---|---|---|---|
| **OUTSTANDING CARE** | | | | | | | | | | |
| 1.1 | Chief Operating Officer | Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience. | • Annual preparation and presentation of a system wide Winter plan in line with the National UEC Recovery Action.<br>• Full participation in the Unscheduled Care transformation programme which includes working with Wirral Community Trust to reduce the numbers of patients attending the ED department who can have their care needs met away from ED.<br>• Onsite support from Wirral Community Trust with the Chief Operating Officer focusing on admission avoidance and supporting early and timely discharge.<br>• Monitoring of ED improvement plan and Wirral system urgent care plan by system Chief Operating Officers including Director of Adult Social care.<br>• Health Economy CEO oversight of Discharge Cell.<br>• Additional spot purchase care home beds in place but use very limited due to the number of Covid outbreaks, and then no admissions.<br>• Participation in C&M winter room including mutual aid arrangements.<br>• NWAS Divert Deflection policy in place and followed.<br>• Rapid reset programme launched with a focus on hospital flow and discharge.<br>• Continued communications out to primary care and to Wirral residents around only use A+E for urgent care requirements.<br>• Regular meetings with the divisional leadership teams to ensure actions for improvement are delivered. | • Trust Management Board (TMB) Assurance<br>• Divisional Performance Review (DPR)<br>• Executive Committee<br>• Health Wirral Urgent Care Improvement Program<br>• Weekly Wirral COO and CEO Group and A+E Delivery Board | The Trust continues to be challenged delivering the national 4 hour standard for ED performance. | 20 (4 x 5) | 16 (4 x 4) | 12 (4 x 3) | There is one overall Emergency Department Improvement Plan in place which focusses on ambulance turnaround times, time patients spend in the department and all other national indicators. Following the completion of a number of service improvements the operational plan for ED will be revised to include new areas of focus as the new leadership team for that area commence in post. | Sept - 22 |
| 1.2 | Chief Operating Officer | Failure to meet constitutional targets, resulting in an adverse impact on patient experience and quality of care. | • Clinical harm reviews in place for long waiting patients, full divisional and trust oversight of the overdue follow-up appointments by specialty, the specialities utilise the national clinical prioritisation process which is monitored weekly in divisions. Referrals of P2 Status patients to regional hubs and weekly Clinical review every 7 days post P2 Breach.<br>• Use of the Independent Sector for Outsourcing and Insourcing for pressured specialties where availability exists. Access/choice policy in place. Detailed operational plans agreed annually.<br>• Weekly review via the performance meeting, chaired by the COO, on key targets and indicators with agreed actions and mitigations. | • Performance Oversight Group (Weekly)<br>• Divisional Access & performance Meetings (weekly)<br>• Theatre Resource Group & Theatre scheduling (weekly)<br>• Monthly Divisional Quality Board Divisional Performance Reviews<br>• Trust Management Board (TMB)<br>• NHSI/E oversight of Trust improvement plan | There are several specialities whereby recovery plans do not achieve reasonable waiting times in year. These are subject to a full service review with the COO and action plans as required. | 16 (4 x 4) | 20 (4 x 5) | 12 (4 x 3) | Continue with delivery of mitigation plans for scheduled care, managing the risk with the utilisation of the national policy on clinical prioritisation. | Sept - 22 |
| 1.3 | Chief Operating Officer | Failure to effectively manage volume of scheduled care demand, adversely impacting on quality of care and patient experience including, RTT 52 and 104 weeks and WL size, DM01, CA 62 and 31 day, Patient harm, H2 planning trajectories not met, financial risk – ERF | Note that this risk has been merged with risk 1.2 above and updated to reflect the current position in relation to scheduled care. | - | - | - | - | - | - | - |
| 1.4 | Medical Director and Chief Nurse | Failure to ensure adequate quality of care resulting in adverse patient | • CQC compliance focus on ensuring standards of care are met.<br>• Embedding of safety and just culture. | • Patient Safety and Quality Board oversight and monitoring of quality | Development of patient safety is being completed. | 16 (4 x 4) | 16 (4 x 4) | 16 (4 x 4) | Develop, finalise, and complete the patient safety and quality strategies. | July - 22 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | outcomes and an increase in patient complaints. | • Implementation of learning from incidents.<br>• Development and implementation of patient safety, quality, and research strategies.<br>• Initiative-taking monitoring and review of quality and safety indicators at monthly divisional performance reviews | and clinical governance themes and trends through the Quality and Patient Safety Intelligence Report at Quality Assurance Committee<br>• Review of modified harm review Trust process Mortality Review Group Oversight Regular board review of Quality Performance Report, highlighting exceptions and mitigations<br>• GIRFT<br>• Quality audits<br>• IPCG and PFEG<br>• CQC focussed reviews of maternity, infection prevention and control services, diagnostics, and surgery<br>• Cheshire and Merseyside CCG oversight of Trust clinical governance, including Sis, never events action plans<br>• Internal Audit - MIAA | | | | | | |
| **COMPASSIONATE WORKFORCE** | | | | | | | | | | |
| 2.1 | Chief People Officer | Failure to fill vacancies, resulting in an adverse impact on quality of care and a failure to meet regulatory standards, and a detrimental impact on staff wellbeing. | • International nurse recruitment.<br>• CSW recruitment initiatives.<br>• CSW apprenticeship recruitment.<br>• Targeted recruitment initiatives such as recruitment campaigns and international recruitment.<br>• Vacancy management and recruitment systems and processes.<br>• TRAC system for recruitment.<br>• E-Rostering systems and procedures used to plan staff utilisation.<br>• E-rostering and job planning to support staff deployment. | Workforce Steering board and Workforce Assurance Committee oversight | National shortages in certain roles and full rollout of clinical job planning are pending workforce planning processes | 20 (4 x 5) | 16 (4 x 4) | 16 (4 x 4) | Monitor impact of retention and recruitment initiatives | April - 23 |
| 2.2 | Chief People Officer | Failure to retain enough staff, adversely impacting on the Trust's ability to provide high quality patient care. | • Retention Working Group has been established.<br>• Facilitation in Practice programme.<br>• Implementation of staff survey action plans.<br>• Training and development activity.<br>• Exit interview process. | Workforce Steering board and Workforce Assurance Committee oversight | Availability of required capabilities and national shortage of staff in key Trust roles. Talent management and succession planning framework is yet to be implemented. Staff turnover rates. | 16 (4 x 4) | 16 (4 x 4) | 16 (4 x 4) | Sign-off of associated action plan within the workforce strategy. | July - 23 |
| 2.3 | Chief People Officer | High level of sickness absence (and long term detrimental impact on staff well-being), adversely impacting on the Trust's ability to provide high quality patient care. | • COVID-19 Absence Support Team established.<br>• New Supporting People to Manage Attendance Programme.<br>• Attendance Management Policy review commenced.<br>• Health and safety and attendance management policies.<br>• Workforce Wellbeing plan.<br>• Staff Survey Action Plans which are heavily focused on Health, Wellbeing and Attendance.<br>• Delivery against the plans is monitored via the Divisional Performance Reviews. | Workforce Steering board and Workforce Assurance Committee oversight | Current barriers to accessing the wellbeing support offers. Residual impact of COVID experience on staff wellbeing. Staff Attendance Rates. | 16 (4 x 4) | 16 (4 x 4) | 16 (4 x 4) | Implementation of People Plan elements pertaining to health and wellbeing. Sign-off of associated action plan within Staff wellbeing plan. | July - 22 |
| 2.4 | Chief Executive Officer | Constraints in Board capacity and capability due to turnover, lack of succession planning and talent management. | • Implementation of Executive Director recruitment plan.<br>• Executive Director and Board development plan.<br>• Implementation of Board succession planning. | Board approval of Board development plan.<br>2021/22 Deloitte Well led review report and action plan. | The Trust has licence condition undertakings pertaining to Board capability and capacity. The Deloitte well led review | 16 (4 x 4) | 16 (4 x 4) | 16 (4 x 4) | Implementation of Deloitte well led review and Board development plan. | September - 22 |

| | | | | | | | | | | |
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| | | | | | action plan is in place and being actioned. | | | | | |
| **CONTINUOUS IMPROVEMENT** | | | | | | | | | | |
| 3.1 | Chief Finance Officer | Failure to deliver sustainable cost improvements. | Implementation of Cost Improvement Programme and QIA guidance document | FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. Board receive update on CIP as part of monthly finance reports. CIP arrangements subject to periodic review by Internal Audit. Monthly CIP return subject to significant scrutiny by NHSEI | Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. Limited assurance on delivery as plans are in early stages and timelines for delivery still subject to change | 16 (4 x 4) | 12 (4 x 3) | 12 (4 x 3) | Continue delivery of CIP programme and maintain oversight of divisional progress | April - 23 |
| 3.2 | Chief Finance Officer | Failure to deliver the financial plan due to uncertainty around the future financial regime. | • Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance.<br>• Forecast of performance against financial plan updated regularly, with outputs included within monthly reports.<br>• CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. | Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. External auditors undertake annual review of controls as part of audit of financial statements Annual internal audit plan includes regular review of budget monitoring arrangements. | Forecasting has proven inaccurate, historically, and further work needed to strengthen arrangements. | 16 (4 x 4) | 12 (4 x 3) | 8 (4 x 2) | Finalise estates strategy and agree priority programmes | April - 23 |
| 3.3 | Director of Strategy and Partnerships | Delays/restrictions in accessing capital resources to support the delivery of the Trust's strategies, e.g., digital and estates. | • Expression's interest submitted where appropriate for any additional national funding available.<br>• Implementation of capital programme.<br>• Ongoing programme of external reviews of the estate.<br>• Appointment of authorised engineers' development and implementation of masterplans for Hospital plans.<br>• Operational plan for the Digital Strategy.<br>• Capital Management Group meets on monthly basis with representation from Operational teams, Estates and Finance. | Capital Committee oversight Authorised Engineers annual report. Annual Capital Bid Panel Condition Surveys and audits. NHS England Premises assurance Model, ERIC database and benchmarking model for trend analysis and authorised Engineer reports | Funding restrictions, 20% increase in material and labour costs for capital on capital schemes, restricted availability of materials. Ongoing development of Trust Asset survey and register. Lack of CAFM estates system. | 16 (4 x 4) | 16 (4 x 4) | 12 (4 x 3) | Drafted Estates strategy. Master Plan for Clatterbridge Hospital completed. Received NHSE funding for two additional modular theatres, for construction in March - May 2022. Risk assessment of the Capital backlog | April - 23 |
| 3.4 | Director of Strategy and Partnerships | Failure to deliver sustainable productivity gains due to an inability to embed service transformation | • Programme Board oversight.<br>• Service improvement team and Quality Improvement team resource and oversight.<br>• QIA guidance document implemented as part of transformation process.<br>• Implementation of a programme management process and software to track delivery.<br>• Quality impact assessment undertaken prior to projects being undertaken. | Quarterly Board assurance reports, Monthly Programme Board chaired by CEO to track progress, COO monthly tracking of individual projects with scrutiny at programme board meetings. Rotational presentations by divisions to FBPAC meetings with effect from October 2021. Monthly CIP report to FBPAC. MIIA internal audit review of Cost Improvement Programmes, which highlighted an audit opinion of moderate assurance. External audit report | Lack of protected time due to conflicting priorities in service delivery, particularly in relation to clinical staff. Lack of clarity on H2 arrangements and financial arrangements for 2022/23 period. Historic estate infrastructure system working. Lack of clarity on financial arrangements for 2022/23 period. Historic estate infrastructure Ability to deliver system wide change across Wirral NHS organisations. Lack of clarity on H2 arrangements and financial arrangements for 2022/23 period, limits level of assurance in board and committee reports | 16 (4 x 4) | 12 (4 x 3) | 12 (4 x 3) | Implementation and delivery of Cost improvement and Transformation Programmes for 22/23 and delivery of 22/23 Improvement Programme to plan. | April - 23 |
| OUR PARTNERS | | | | | | | | | | |
| 4.1 | Director of Strategy and Partnerships | Risk that ongoing uncertainty regarding the infrastructure of the Cheshire and Merseyside ICS | • WUTH senior leadership engagement in ICS through Director of Strategy and CEO. | CEO and Director of Strategy updates to Board | Time to establish C&M ICS accountability and governance infrastructure, | 16 (4 x 4) | 16 (4 x 4) | 12 (4 x 3) | Development of PLACE governance arrangements with Wirral partners. Completion of ICS and PLACE governance self-assessment. Development of PLACE operating model. | April - 23 |

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| | | causes material variability in strategic resourcing and planning, resulting in a change in strategic direction and uncertainty regarding Trust role in PLACE governance arrangements. | • Wuth Strategic intentions are aligned with the ICS, for example ensure master plans and decisions are taken as a system to optimise the way we use public estate across Wirral to deliver organisation and ICS objectives.<br>• National guidance on PLACE based partnerships Legislation framework.<br>• ICS design framework.<br>• ICS Body governance.<br>• Input of Trust CEO and Director of Strategy into Outline of the ICP Structure. | and Executive Director meetings<br>Chair, CEO and Director of Strategy attendance at Healthy Wirral Partners Board Secondment of Head of Strategic Planning to develop ICP/Place operating model.<br>ICS Chair updates, ICS meetings, ICS Self-assessment submission CMAST CEO and Directors of Strategy meetings, Healthy Wirral Partners Board. | Delays in the consolidation of CCGs to ICS Place lead appointment for Wirral.<br>Function and role of C&M ICS working with the Trust and Formal. Accountability infrastructure not in place till April 2022. | | | | | |
| DIGITAL FUTURE | | | | | | | | | | |
| 5.1 | Chief Finance Officer | Failure to sustainably and successfully implement EPR transformation and progress towards full electronic records. | Rollout of comprehensive EPR training programme implementation of baseline review action plan. | Exception reporting in place via Trust Management Board, with effect from July 2021 Initial discussions have taken place in relation to the implementation of an LMS to enable baseline and ongoing monitoring of digital knowledge.<br>HIMSS level 5 assessment criteria undertaken | Team infrastructure for EPR rollout is not in line with national benchmarking.<br>Baseline review start date is yet to be confirmed. | 16 (4 x 4) | 16 (4 x 4) | 12 (4 x 3) | Identify and address EPR team infrastructure gaps | July - 22 |
| 5.2 | Chief Finance Officer | Loss of clinical systems due to a cyber-attack, resulting in an adverse impact on the delivery of services. | • Implementation of disaster recovery plan.<br>• Implementation of digital strategy operational plan.<br>• Cyber essentials accreditation.<br>• Implementation of cyber security action plan.<br>• Trust assessment against cyber maturity model. | Digital Services Operational Committee oversight and approval of delivery plan, with assurances feeding into Board as appropriate Progress monitoring of MIIA Cyber action plan implementation Results from Trust's assessment against cyber maturity model.<br>MIIA internal audit review of cyber security, undertaken in 2020/21, which highlighted an audit opinion of moderate assurance. | • Legacy systems and technologies are present on site Environment – location of APH data centre poses risk of damages through leaks from surrounding wards and clinical areas.<br>• Partnerships – input into Community Trust preventative measures is a threat to our resource capacity.<br>• Integration – information governance.<br>• Perception of IT functions impacting resourcing.<br>• Implementation of cyber security action plan is yet to be completed. | 20 (5 x 4) | 20 (5 x 4) | 12 (4 x 3) | Continue rollout of cyber-security plan, and explore option of cyber security insurance | Ongoing |
| 5.3 | Chief Finance Officer | Failure to successfully implement the digital strategy, resulting in an adverse impact on patient care. | • Agreed operational plan with divisions over the next 12 months.<br>• Implementation of digital strategy through the operational plan.<br>• Agreement of priorities at Digital Programme and Services Oversight Committee, where oversight takes place.<br>• Change control process overseen by Trust Management Board, where assurance is received. | Digital Programme and Services Oversight Committee approval and monitoring of delivery plan, with assurances feeding into Board as appropriate Escalations from a delivery perspective agreed at Trust Management Board.<br>Chief Information Officer regional meetings | Currently a number of unknown variables which will potentially impact on the agreed schedule. | 12 (4 x 3) | 12 (4 x 3) | 12 (4 x 3) | Submit digital strategy implementation plan to Board. | TBC |
| INFRASTRUCTURE | | | | | | | | | | |
| 6.1 | Director of Strategy and Partnerships | Adverse impact on delivery of clinical care and application of infection control measures due to the quality of the Trust's estate, and substantial maintenance backlog | • Implementation of capital programme, which includes remedial works at Clatterbridge and Arrowe Park Hospital.<br>• Implementation of social distancing in waiting rooms and screens, use of security controls across site to manage access.<br>• Allocation of ward status. | Capital Committee oversight<br>FBPAC oversight of capital programme implementation. | Review to be extended to cover Arrowe Park<br>Estates Strategy is currently under development.<br>Delays in backlog maintenance. | 16 (4 x 4) | 16 (4 x 4) | 12 (4 x 3) | Finalise Arrowe Park master plan and Prioritisation of estates improvements. | Sept - 22 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | • Senior Clinician input in key decisions around key areas such as critical care.<br>• Ward refurbishment programme. | | | | | | | |
| 6.2 | Director of Strategy and Partnerships | Risk of business continuity and the provision of clinical services due to a critical infrastructure supply chain failure therefore impacting on the quality of patient care | • Implementation of capital programme, which includes remedial works at Clatterbridge.<br>• Implementation of social distancing in waiting rooms.<br>• Allocation of ward status.<br>• Senior Clinician input in key decisions around key areas such as critical care. | Capital Committee oversight<br>FBPAC oversight of capital programme implementation. | Review to be extended to cover Arrowe Park<br>Estates Strategy is currently under development.<br>Delays in backlog maintenance. | 16<br>(4 x 4) | 16<br>(4 x 4) | 12<br>(4 x 3) | Finalise Arrowe Park master plan and Prioritisation of estates improvements. | Sept -22 |

## Appendix – Risk Scoring Matrix

| | Likelihood | | | | |
|---|---|---|---|---|---|
| **Consequence** | **1** | **2** | **3** | **4** | **5** |
| | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost Certain** |
| **5 Catastrophic** | **5** | **10** | **15** | **20** | **25** |
| **4 Major** | **4** | **8** | **12** | **16** | **20** |
| **3 Moderate** | **3** | **6** | **9** | **12** | **15** |
| **2 Minor** | **2** | **4** | **6** | **8** | **10** |
| **1 Negligible** | **1** | **2** | **3** | **4** | **5** |

| Risk Grading | Risk Score |
|---|---|
| Low risk | 1 to 3 |
| Moderate risk | 4 to 6 |
| High risk | 8 to 12 |
| Significant risk | 15 to 25 |

**Board of Directors**
**1st June 2022**

**Item No 9.3**

| | |
|---|---|
| **Title** | M1 Finance Report |
| **Area Lead** | Robbie Chapman, Interim CFO |
| **Author** | Robbie Chapman, Interim CFO |
| **Report for** | Information |

## Report Purpose and Recommendations

The Board approved a deficit budget of £6.197m for the year but this has not yet been approved by NHSE/I.

The Trust is reporting a deficit of £0.956m at M1, an adverse variance against budget of £0.886m. This variance is attributed to our overspend on employee costs, driven largely by the continued use of escalation wards staffed at premium rates and underperformance in respect of CIP. This is offset by reductions in non-pay spend, specifically clinical supplies, as a result of the unavailability of theatres due to ventilation issues.

We can now confirm that the full balance of ERF income included within the plan will be received and will not be dependent upon activity. However, the introduction of the Aligned Incentive Payment (AIP) scheme does represent a risk of financial penalties in respect of underperformance associated with the elective programme.

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 1 Finance Report 2022/23

## Contents

# 1. Executive Summary

Wirral University Teaching Hospital NHS Foundation Trust

1.1 **Table 1: Financial position – M1**

| M1 Financial Position | In Month (£'000) | | | Year to Date (£'000) | | |
|---|---|---|---|---|---|---|
| **TRUST** | Bud | Act | Var | Bud | Act | Var |
| Income from Patient Care Activities | £32,770 | £32,683 | -£88 | £32,770 | £32,683 | -£88 |
| Other Income | £3,409 | £3,372 | -£37 | £3,409 | £3,372 | -£37 |
| **Total Income** | **£36,179** | **£36,054** | **-£125** | **£36,179** | **£36,054** | **-£125** |
| Employee Expenses | -£23,578 | -£25,591 | -£2,014 | -£23,578 | -£25,591 | -£2,014 |
| Operating Expenses | -£11,228 | -£10,145 | £1,083 | -£11,228 | -£10,145 | £1,083 |
| **Total Operating Expenditure** | **-£34,806** | **-£35,736** | **-£930** | **-£34,806** | **-£35,736** | **-£930** |
| Non Operating Expenses | -£1,443 | -£1,274 | £169 | -£1,443 | -£1,274 | £169 |
| **Surplus/(Deficit)** | **-£70** | **-£956** | **-£886** | **-£70** | **-£956** | **-£886** |

1.2 The Trust is reporting a deficit of £0.956 at M1, an adverse variance against plan of £0.886m.

1.3 Total income was £36.054m at M1, an adverse variance of £0.125m. Total patient care income is £0.088m behind plan and other income £0.037m behind plan. This is discussed in more detail in 4.1.1.

1.4 It has now been confirmed that the full allocation of £10.069m of Elective Recovery Fund (ERF) income will be received irrespective of the level of elective activity. However, with the introduction of the Aligned Incentive Payment (AIP) scheme, the Trust is now at risk of financial penalties for any underperformance in respect of the elective programme. Details of the scheme are described from 2.3 but we estimate the potential risk in respect of M1 performance to be penalties of £1.003m. This potential penalty is not reflected within the position.

1.5 Total employee expenses including COVID-19 were £25.591m at M1, this represents an overspend against our budget of £2.014m. The overspend against plan is discussed in more detail at 3.2.3 but is primarily driven by the continued reliance on bank and agency staff as a result of staff sickness and escalation, £0.912m adverse variance, together with the non-delivery of pay CIP in month of £1.147mm.

**Table 2: Pay cost analysis excluding COVID**

| Pay analysis (exc Covid) | Budget (Mth 1) £'000 | Actual (Mth 1) £'000 | Variance £'000 | Year To Date Budget £'000 | Year To Date Actual £'000 | Variance £'000 |
|---|---|---|---|---|---|---|
| Consultants | -£4,238 | -£3,838 | £400 | -£4,238 | -£3,838 | £400 |
| Other medical | -£2,720 | -£2,810 | -£90 | -£2,720 | -£2,810 | -£90 |
| Nursing and midwifery | -£7,196 | -£7,130 | £65 | -£7,196 | -£7,130 | £65 |
| Allied health professionals | -£1,388 | -£1,417 | -£28 | -£1,388 | -£1,417 | -£28 |
| Other scientific, therapeutic and technical | -£586 | -£568 | £18 | -£586 | -£568 | £18 |
| Health care scientists | -£1,136 | -£1,078 | £58 | -£1,136 | -£1,078 | £58 |
| Support to clinical staff | -£3,698 | -£4,723 | -£1,025 | -£3,698 | -£4,723 | -£1,025 |
| Non medical, non clinical staff | -£2,226 | -£3,682 | -£1,456 | -£2,226 | -£3,682 | -£1,456 |
| Apprenticeship Levy | -£94 | -£102 | -£8 | -£94 | -£102 | -£8 |
| **Total** | **-£23,281** | **-£25,348** | **-£2,067** | **-£23,281** | **-£25,348** | **-£2,067** |

## 1. Executive Summary

1.6 Operating expenses including COVID were £9.906m at M1, an underspend of £1.042m. Of this underspend, £1.562m is reflective of reduced activity levels but is offset by the non-delivery of non-pay CIP of £0.519m.

1.7 Cash balances at the end of M1 were £39.9m.

1.8 The Trust has recorded a capital spend of £0.3m at M1.

2.1 The Trust submitted a deficit plan of £6.197m to NHSE on the 28/04 and this was approved by the Board on 04/05. However, given the scale of the deficit at national and regional level, we have been informed that a revised plan will be required during the w/c 20th June. Cheshire and Merseyside currently have a deficit of £184m and whilst it is possible that the system will receive a further £66m from NHSE, it is our understanding that it is expected that the system will submit a break even plan in June.

2.2 Prior to the resubmission it has been agreed within the Cheshire and Merseyside system that Trusts in deficit will be subject to peer review to understand the causes of the deficit and idenitfy any mitigations. The review, which will take place in early June, will be chaired by Andy Davies, the Accountable Officer of Warrington CCG and will also include:

- Executive CFO of ICB
- Place Director
- CCG CFO
- Peer CEO (TBC)
- Peer DoF (TBC)
- Local Authority CEO or nominated representative
- ICB HR Director
- ICB Director of Performance
- ICB Chief Nursing Officer

Both the CFO and CEO will be required to attend the meeting. The information requested ahead of the review, which focuses on increases in run rate, growth of workforce since 2019/20 and financial recovery controls in place has already been shared with Cheshire and Merseyside.

2.3 Cheshire and Merseyside are now proposing the introduction of the AIP scheme within 2022/23. The aligned payment and incentive approach is a blended payment with a block and variable element. It is intended to support organisations achieve a stable transition away from the block payment arrangements used during COVID-19. This represents a change from the previous intention to continue with “block” contracts whilst developing AIP arrangements ahead of 23/24.

2.4 The two key components of the scheme are:

- a fixed element based on funding an agreed level of activity (104% of 19/20 elective activity).
- a variable element to increase or reduce payment based on the actual elective activity levels.

2.5 This means that if the Trust delivers over 104% of the value of 19/20 activity we will receive 75% of tariff and, conversely, if the Trust does not deliver 104% of 19/20 we will be penalised at 75% of tariff. Performance will be assessed on a cumulative basis and per the guidance will be reviewed quarterly. However, given the information is based on SUS data it is highly likely that we will not have confirmation from NHSE until 2-3 months after the end of each quarter.

2.6 This represents both a significant risk and an opportunity for the Trust. If we experience problems that result in reductions or stoppages to our elective programme then it will result in significant penalties. Discussions have been held about a potential cap equivalent to each Trust’s ERF allocation but this has yet to be agreed.

### 3 Table 3: M1 Performance Dashboard

| | Indicator | Objective | Director | Threshold | Set by | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 | Apr-22 | 2022/23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Use of Resources | I&E Performance (monthly actual) | Effective use of Resources | CFO | On Plan | WUTH | -0.5 | -0.2 | 0.0 | 0.2 | -0.2 | | -0.7 | -0.6 | 2.3 | -0.1 | 0.1 | -2.7 | -2.7 |
| | I&E Performance Variance (monthly variance) | Effective use of Resources | CFO | On Plan | WUTH | -0.4 | -0.4 | 0.0 | 0.2 | -0.1 | 0.0 | 1.0 | -0.9 | 1.9 | -0.5 | -0.3 | -2.7 | -2.7 |
| | 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 | 3.0 | 3 |
| | CIP Performance (YTD Plan vs Actual) | Effective use of Resources | CFO | On Plan | WUTH | 0.0 | 3.02% | 6.03% | 9.05% | 14.50% | Not reported | 77.21% | 48.24% | 78.70% | 78.61% | 91.33% | 7.26% | 7.3% |
| | NHSI Agency Performance (YTD % variance) | Effective use of Resources | CFO | On Plan | NHSI | -27.7% | -32.4% | -40.5% | -11.7% | -5.2% | -50.0% | -25.1% | -6.7% | -4.3% | -8.0% | -15.0% | -43.9% | -44% |
| | Cash - liquidity days | Effective use of Resources | CFO | NHSI metric | WUTH | -15.5 | -10.4 | -15.7 | -15.4 | -15.2 | -16.2 | -15.9 | -18.0 | -16.2 | -18.6 | -20.0 | -21.4 | -21.4 |
| | Capital Programme (cumulative) | Effective use of Resources | CFO | On Plan | WUTH | 5.6% | 12.5% | 18.0% | 22.6% | 24.4% | 30.7% | 36.3% | 48.0% | 59.0% | 76.2% | 100.0% | 0.7% | 0.7% |

3.1 Based on M1 performance, the Trust's overall UOR scoring is 3. The results from the in-month deficit combined with agency spend and CIP performance. Agency spend is discussed in more detail at 4.2.3.

3.2 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. Work is underway to review the historical issues contributing to this position.

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

3.3.1 Risk 1 – Failure to manage financial position

- Our ability to deliver the planned deficit is dependent on effective cost management, CIP delivery and the delivery of activity trajectories. Our financial performance in M1, our failure to deliver CIP to plan (see below) and potential penalties in respect of AIP indicates that this risk has increased.

3.3.2 Risk 2 – Failure to deliver CIP

- The 22/23 plan includes an assumed 2022/23 CIP target of 4.5% (£20.838m). Of this target, 3% (£13.849m) was planned to be delivered recurrently and 1.5% (£6.989m) was to be delivered non-recurrently. So far we have identified plans of £6.697m in respect of recurrent CIP, a shortfall against plan of £7.152m. In M1 only £0.126m CIP has been transacted recurrently and no CIP has been transacted non-recurrently. Whilst underperformance was expected given the planning and year end process, this does indicate that the risk has increased. This is discussed in more detail at 4.5.

3.3.3 Risk 3 – Failure to complete capital programme

- Our capital expenditure envelope for 22/23 totals £44.628m which is the largest capital programme the Trust has ever delivered in one financial year. The internally generated capital plan for 22/23 totals £9.765m and is described in more detail at 5.2.

3.4 **Risk summary (as per risks identified in budget report)**

3.4.1 CIP

- Please see 3.3.2 and 4.5.

3.4.2 Shortfall in funding

- All funding included within our planned deficit has now been confirmed. This includes ERF of £10.069m which will be received irrespective of activity levels.

3.4.3 Activity below plan

- As explained at 2.3-2.6, C&M will be introducing AIP in 22/23. The risks associated with this scheme as at M1 is discussed from 4.1.4.

3.4.4 Reliance on agency staff

- Workforce information indicates that the reliance upon high cost agency staff has actually increased in M1, principally due to the continued use of escalation wards. Please see 4.2 for more detail.

3.4.5 Inflation

- Whilst inflation continues to run significantly higher than forecast we have received confirmation from NHSE that they will fund equivalent of 0.7% increase in tariff to adjust for higher than expected inflation. This amounts to additional, recurrent funding of £2.241m. This additional income was confirmed after the finalisation of this report.

3.4.6 COVID-19

3.4.7 The Trust has spent £0.160m more than it received in respect of COVID-19 in M1, the first time that costs have exceeded income since 20/21. Despite reducing prevalence this remains a financial risk. Please see 4.4 for more detail.

## 4.1 Income

4.1.1 The Trust has received £36.054m at M1, an adverse variance of £0.125m.

**Table 4: Income analysis for M1**

| Point of Delivery | Budget (Mth 1) £'000 | Actual (Mth 1) £'000 | Variance £'000 | Year To Date Budget £'000 | Year To Date Actual £'000 | Variance £'000 |
|---|---|---|---|---|---|---|
| Elective & Daycase | £4,764 | £3,372 | -£1,392 | £4,764 | £3,372 | -£1,392 |
| Elective excess bed days | £96 | £54 | -£43 | £96 | £54 | -£43 |
| Non-elective | £8,074 | £8,244 | £171 | £8,074 | £8,244 | £171 |
| Non-elective Non Emergency | £1,145 | £972 | -£173 | £1,145 | £972 | -£173 |
| Non-elective excess bed days | £546 | £461 | -£85 | £546 | £461 | -£85 |
| A&E | £1,451 | £1,310 | -£140 | £1,451 | £1,310 | -£140 |
| Outpatients | £3,594 | £3,154 | -£440 | £3,594 | £3,154 | -£440 |
| Diagnostic imaging | £276 | £158 | -£118 | £276 | £158 | -£118 |
| Maternity | £382 | £385 | £3 | £382 | £385 | £3 |
| Non PbR | £6,599 | £5,435 | -£1,164 | £6,599 | £5,435 | -£1,164 |
| HCD | £1,582 | £1,203 | -£379 | £1,582 | £1,203 | -£379 |
| National Top up | £2,328 | £2,328 | £0 | £2,328 | £2,328 | £0 |
| Other | £1,933 | £5,606 | £3,673 | £1,933 | £5,606 | £3,673 |
| **Sub-Total Clinical Income** | **£32,770** | **£32,683** | **-£88** | **£32,770** | **£32,683** | **-£88** |
| Other patient care income | £201 | £203 | £3 | £201 | £203 | £3 |
| Elective Recovery Fund (ERF) | £42 | £0 | -£42 | £42 | £0 | -£42 |
| COVID-19 Income | £362 | £322 | -£39 | £362 | £322 | -£39 |
| Non-NHS: private patient & overseas | £24 | £9 | -£14 | £24 | £9 | -£14 |
| Injury cost recovery scheme | £43 | £57 | £13 | £43 | £57 | £13 |
| **Total Patient Care Income** | **£33,441** | **£33,274** | **-£167** | **£33,441** | **£33,274** | **-£167** |
| Other operating income | £2,738 | £2,780 | £42 | £2,738 | £2,780 | £42 |
| Other non operating income | | £0 | £0 | | £0 | £0 |
| **Total income** | **£36,179** | **£36,054** | **-£125** | **£36,179** | **£36,054** | **-£125** |

4.1.2 Clinical income at M1 was £32.683m, an adverse variance against budget of £0.088m. Income is reduced across a large number of activity categories but this is offset by back to block system top up monies which are now held centrally to reflect actual performance within the divisional positions.

4.1.3 Income includes 1/12 of the Trust's allocation of Elective Recovery Funding (ERF) to support delivery of 104% of 2019/20 elective activity in order to reduce the length of time patients are waiting for treatment. It has now been confirmed that providers in C&M will receive this income, irrespective of their level of activity and that the mechanism for recovery of income will be through AIP and not through ERF.

4.1.4 During 2022/23 the Trust will be monitoring its elective performance against an agreed NHSE/I baseline. Included in the scope of the baseline is elective, day case, outpatient attendances and procedures. For NHS England specialised commissioning, chemotherapy and radiotherapy delivery will also be included. The baseline is calculated using the 104% of 19-20 trust activity valued at 22-23 tariffs as per the national guidance. Actual activity will be monitored each month on a cumulative basis and the Trust's funding will be adjusted up or down by 75% of tariff if actual activity delivered is above or below the 104% baseline value.

4.1.5 For M1 the elective baseline is £8.481m and the actual month 1 activity valued at national and local tariffs is £7.143m, this includes capping the outpatient follow ups at 85% of the baseline as per the published guidance. Therefore, at month 1 the Trust is (£1.34m) below the baseline, however only 75% of this is at risk of being recouped by the commissioners which equates to (£1m). Table 5 below demonstrates the month 1 position.

**Table 5 Comparison of actual performance against 19/20 baseline**

| Month 1 - April | Plan £000s | Actual £000s | Variance £000s | 75% at risk of being recouped £000s |
|---|---|---|---|---|
| Day case | £2,356 | £2,021 | (£335) | (£252) |
| Elective | £2,091 | £1,589 | (£502) | (£377) |
| Outpatient Procedures | £377 | £267 | (£110) | (£83) |
| Outpatient FAs | £1,789 | £1,741 | (£48) | (£36) |
| Outpatient FUPs | £1,868 | £1,526 | (£341) | (£256) |
| | **£8,481** | **£7,143** | **(£1,338)** | **(£1,003)** |

4.1.6 The elective calculation is a cumulative calculation, so the Trust is able to increase activity in future months to cover any prior months under performance against the baseline. However, the baseline value for M1 was relatively low when compared to other months so this will be a challenge for the Trust especially given the issues with theatre ventilation and the continued use of escalation wards that have been experienced in May and are likely to continue into June.

4.1.7 Given the AIP scheme has not yet been finalised and performance is considered on a cumulative basis, the potential penalty has not been included within these accounts.

4.1.8 In line with national guidance, the financial plan assumes Car Parking income will revert back to pre COVID-19 level (i.e. patient and staff charges will come back into force). The Trust remains in discussions around the implications locally for its staff and as yet charges have not been reinstated. This creates an adverse variance of £0.042m.

4.2 **Expenditure: Pay**

4.2.1 The Trust has spent £25.591m on pay costs at M1 including COVID-19. Table 6 details pay costs by staff group excluding COVID-19, Table 7 details pay costs by pay category type and Table 8 details COVID pay costs.

**Table 6: Pay costs by staff type (excluding COVID-19)**

| Pay analysis (exc Covid) | Budget (Mth 1) £'000 | Actual (Mth 1) £'000 | Variance £'000 | Year To Date Budget £'000 | Year To Date Actual £'000 | Variance £'000 |
|---|---|---|---|---|---|---|
| Consultants | -£4,238 | -£3,838 | £400 | -£4,238 | -£3,838 | £400 |
| Other medical | -£2,720 | -£2,810 | -£90 | -£2,720 | -£2,810 | -£90 |
| Nursing and midwifery | -£7,196 | -£7,130 | £65 | -£7,196 | -£7,130 | £65 |
| Allied health professionals | -£1,388 | -£1,417 | -£28 | -£1,388 | -£1,417 | -£28 |
| Other scientific, therapeutic and technical | -£586 | -£568 | £18 | -£586 | -£568 | £18 |
| Health care scientists | -£1,136 | -£1,078 | £58 | -£1,136 | -£1,078 | £58 |
| Support to clinical staff | -£3,698 | -£4,723 | -£1,025 | -£3,698 | -£4,723 | -£1,025 |
| Non medical, non clinical staff | -£2,226 | -£3,682 | -£1,456 | -£2,226 | -£3,682 | -£1,456 |
| Apprenticeship Levy | -£94 | -£102 | -£8 | -£94 | -£102 | -£8 |
| **Total** | **-£23,281** | **-£25,348** | **-£2,067** | **-£23,281** | **-£25,348** | **-£2,067** |

**Table 7: Pay analysis by pay type**

| Pay analysis (exc Covid) | Budget (Mth 1) £'000 | Actual (Mth 1) £'000 | Variance £'000 | Year To Date Budget £'000 | Year To Date Actual £'000 | Variance £'000 |
|---|---|---|---|---|---|---|
| Substantive | -£22,529 | -£22,516 | £13 | -£22,529 | -£22,516 | £13 |
| Bank | -£81 | -£1,379 | -£1,298 | -£81 | -£1,379 | -£1,298 |
| Medical Bank | -£294 | -£552 | -£258 | -£294 | -£552 | -£258 |
| Agency | -£285 | -£801 | -£516 | -£285 | -£801 | -£516 |
| Apprenticeship Levy | -£94 | -£102 | -£8 | -£94 | -£102 | -£8 |
| **Total** | **-£23,281** | **-£25,348** | **-£2,067** | **-£23,281** | **-£25,348** | **-£2,067** |

**Table 8: COVID-19 pay costs**

| COVID-19 COSTS | Apr (M1) £'000 |
|---|---|
| Medical Staff | £3 |
| Other Clinical Staff | -£222 |
| Non Clinical Staff | -£24 |
| **Total Pay** | -£243 |

4.2.2 Total pay costs (excluding Covid) at M1 were £25.34m, an overspend of £2.067m. This overspend includes £1.147m of non-achieved pay CIP in month.

4.2.3 Medical & Acute Division has an adverse variance in month of £0.884m. The main drivers of this variance are the costs of escalation areas (approximately £0.335m per month for the Division) which remained open in April as well as high sickness levels in ED nursing (10% compared to the Trust taget of 5%) resulting in the use of premium cost bank and agency staff.

4.2.4 The 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, was £0.130m. This was not anticipated to continue in M1 but due to pressures was maintained but this has ceased in M2.

4.2.5 Surgery also has an adverse variance on pay costs of £0.482m. The main drivers of this overspend are agency spend associated with Agency consultants within Pain and ENT, agency junior doctors covering rotational gaps and bank and agency nursing covering the escalation beds that are still open. Within the Nursing Bank spend there is also spend covering vacancies, sickness and patient acuity.

4.3 **Expenditure: Non-Pay**

4.3.1 The Trust has spent £10.492m on non-pay operating expenditure excluding COVID at M1, a positive variance of £1.055m.

**Table 9: Non-pay analysis (excluding COVID-19 costs)**

| Non Pay Analysis (exc Covid) | Budget (Mth 1) | Actual (Mth 1) | Variance |
|---|---|---|---|
| | £'000 | £'000 | £'000 |
| Supplies and services - clinical | -£3,476 | -£2,938 | £537 |
| Supplies and services - general | -£420 | -£402 | £18 |
| Drugs | -£2,387 | -£2,037 | £350 |
| Purchase of HealthCare - Non NHS Bodies | -£1,117 | -£829 | £288 |
| CNST | -£1,073 | -£1,070 | £3 |
| Consultancy | -£28 | -£3 | £25 |
| Other | -£2,447 | -£2,630 | -£183 |
| **Sub-Total** | **-£10,948** | **-£9,909** | **£1,039** |
| Depreciation | -£1,049 | -£1,033 | £16 |
| Impairment | £0 | £0 | £0 |
| **Total** | **-£11,997** | **-£10,942** | **£1,055** |

4.3.2 Elective activity in M1 represented 77.7% of the plan submitted to NHSEI. This was attributable to issues around theatre ventilation and the continued use of escalation wards. This has resulted in significant underspends in respect of clinical supplies and services and drugs, most notably in surgery.

4.3.3 The underspend in respect of purchase of healthcare from non-NHS bodies relates to the Community Diagnostic Centre and our reduced reliance on insourcing and out-sourcing compared to plan, with more activity being delivered by our own staff. This is offset by reductions in income.

4.3.4 The underspend was offset by the non-achievement of non-pay CIP of £0.519m.

4.4 **Expenditure: COVID–19**

4.4.1 The Trust spent £0.482m on COVID-19 costs at M1, with £0.243m on pay and £0.239m on non-pay. This is set against income of only £0.322m, meaning that costs associated with COVID-19 have exceeded income for the first time since 20/21.

**Table 10: COVID-19 costs**

| COVID-19 I&E | Apr (M1) £'000 |
|---|---|
| **Total Income** | £322 |
| Medical Staff | £3 |
| Other Clinical Staff | -£222 |
| Non Clinical Staff | -£24 |
| **Total Pay** | -£243 |
| Clinical Supplies | -£204 |
| Other Non-Pay | -£35 |
| **Total Non-Pay** | -£239 |
| **Total Covid Expenditure** | **-£160** |

4.4.2 The vaccination costs were £0.125m at M1 which was in line with plan and is funded centrally so offset in income.

4.4.3 The testing costs were £0.236m at M11 and is funded centrally so offset in income.

4.5 **CIP Performance**

4.5.1 The 22/23 plan includes an assumed 2022/23 CIP target of 4.5% (£20.838m). Of this target, 3% (£13.849m) was planned to be delivered recurrently and 1.5% (£6.989m) was to be delivered non-recurrently.

4.5.2 Given the importance of recurrent CIP, non-recurrent CIP has not been assigned to divisions and will be managed centrally by Finance. This report will focus on delivery of recurrent CIP only.

4.5.3 As at the 23rd May, 205 opportunities have been submitted by divisional teams with a recurrent value of £6.697m against a target of £13.849m.

**Table 11 Identified savings by Division**

| | Target | Identified Savings |
|---|---|---|
| Medicine | 2,698,861 | 1,994,197 |
| Surgery | 2,617,788 | 1,128,840 |
| DCS | 2,400,897 | 613,682 |
| W&C | 1,136,000 | 65,697 |
| Acute | 879,014 | 82,684 |
| Corp | 1,260,526 | 505,919 |
| EHS | 1,131,379 | 794,627 |
| Other | 1,725,034 | 1,511,607 |
| **Total** | **13,849,499** | **6,697,253** |

4.5.4 £0.126m has been delivered in M1 against a plan of £1.153m.

**Table 12 In month CIP performance vs plan**

| | M1 Target | M1 Actual | Variance |
|---|---|---|---|
| Medicine | 224,905 | 38,890 | 186,015 |
| Surgery | 218,149 | 4,153 | 213,996 |
| DCS | 200,075 | 13,009 | 187,066 |
| W&C | 94,666 | 0 | 94,666 |
| Acute | 73251 | 3,557 | 69,694 |
| Corp | 105,044 | 24,976 | 80,068 |
| EHS | 94,282 | 41,548 | 52,734 |
| Other | 143,368 | 0 | 143,368 |
| **Total** | **1,153,740** | **126,133** | **1,027,607** |

4.5.5 The shortfall in delivery in respect of Medicine and Surgery can be largely attributable to planned bed closures that have not been possible due to the continued escalation of wards due to COVID and winter pressures. Whilst it is still the Trust's intention to close these beds, the in year effect of the closures will reduce due to their continued use into M2 and possibly M3.

4.5.6 The shortfall in delivery in respect of Other is attributable to continued expenditure in respect of the treatment, management and wider impact of COVID-19. Despite continued reductions in COVID-19 numbers, pressures on expenditure continue and the Trust has been unable to reduce costs as a result. If prevalence continues to reduce we hope that this expenditure will reduce but the in year effect of the reductions will decrease.

4.5.7 39 projects with no assigned value have currently been identified as areas of opportunity and are awaiting sign off from the divisional directors to progress to gateway 2.

4.5.8 72 projects with a value of £2.912m have progressed to design & plan (gateway 2), meaning documentation is now being completed on Smartsheets with the support of the PMO and awaiting validation from Finance.

4.5.9 2 projects with a value of £0.045m are in the governance and assurance (gateway 3), awaiting QIA panel 25th May.

4.5.10 61 projects with a value of £2.783m have been approved at QIA panel and are now in the implementation gateway.

# 5. Financial Position

## 5.1 Statement of Financial Position (SOFP)

5.1.1 The movement in total assets employed from M1 was £0.934m.

**Statement of Financial Position 30 April 2022**

| Actual 31.03.22 £'000 | | Actual 31.03.22 £'000 | Actual 30.04.22 £'000 | Variance £'000 | Movement |
|---|---|---|---|---|---|
| | **Non-current assets** | | | | |
| 187,353 | Property, plant and equipment | 187,353 | 187,472 | 119 | ↑ |
| 14,871 | Intangibles | 14,871 | 15,072 | 201 | ↑ |
| 968 | Trade and other non-current receivables | 968 | 397 | (571) | ↓ |
| **203,192** | | **203,192** | **202,941** | **(251)** | ↓ |
| | **Current assets** | | | | |
| 4,924 | Inventories | 4,924 | 4,679 | (245) | ↓ |
| 21,286 | Trade and other receivables | 21,286 | 18,531 | (2,755) | ↓ |
| 0 | Assets held for sale | 0 | 0 | 0 | → |
| 36,435 | Cash and cash equivalents | 36,435 | 39,917 | 3,482 | ↑ |
| **62,645** | | **62,645** | **63,127** | **482** | ↑ |
| **265,837** | **Total assets** | **265,837** | **266,068** | **231** | ↑ |
| | **Current liabilities** | | | | |
| (56,598) | Trade and other payables | (56,598) | (55,657) | 941 | ↓ |
| (10,702) | Other liabilities | (10,702) | (12,902) | (2,200) | ↑ |
| (1,023) | Borrowings | (1,023) | (1,038) | (15) | ↑ |
| (13,206) | Provisions | (13,206) | (13,208) | (2) | ↑ |
| **(81,529)** | | **(81,529)** | **(82,805)** | **(1,276)** | ↑ |
| **(18,884)** | **Net current assets/(liabilities)** | **(18,884)** | **(19,678)** | **(794)** | ↑ |
| **184,308** | **Total assets less current liabilities** | **184,308** | **183,263** | **(1,045)** | ↓ |
| | **Non-current liabilities** | | | | |
| (2,371) | Other liabilities | (2,371) | (2,371) | 0 | → |
| (4,177) | Borrowings | (4,177) | (4,177) | 0 | → |
| (6,348) | Provisions | (6,348) | (6,237) | 111 | ↓ |
| **(12,896)** | | **(12,896)** | **(12,785)** | **111** | ↓ |
| **171,412** | **Total assets employed** | **171,412** | **170,478** | **(934)** | ↓ |
| | **Financed by Taxpayers' equity** | | | | |
| 186,445 | Public dividend capital | 186,445 | 186,467 | 22 | ↑ |
| (64,185) | Income and expenditure reserve | (64,185) | (65,141) | (956) | ↓ |
| 49,152 | Revaluation reserve | 49,152 | 49,152 | 0 | → |
| **171,412** | **Total taxpayers' equity** | **171,412** | **170,478** | **(934)** | ↓ |

## 5. Financial Position

5.2 **Capital Expenditure – M1**

5.2.1 The Trust's core programme for 22/23 is £9.765m and is made up as follows:

| Capital plan 2022/23 | |
|---|---|
| IT - various schemes | 1,976 |
| Medical equipment | 737 |
| Facilities equipment | 93 |
| Bathroom refurbishment | 137 |
| Simulation suite refurbishment | 98 |
| Doctors mess refurbishment | 72 |
| Ventilation works | 400 |
| Flooring | 80 |
| Fire compartmentation | 400 |
| Ward 1 - Renal Unit refurbishment | 2,800 |
| Modular theatre build completion | 2,972 |
| **Total CDEL** | **9,765** |

5.2.2 At M1 spend against this plan was £0.320m which is made up primarily of IT purchases.

5.2.3 In addition to the internally generated capital spend, the Trust will be drawing down £18m of PDC funding for UECUP in 22/23. The Trust is also submitting a TIF funding bid of c£15m for the second phase of the South Mersey Elective Hub theatre development.

## 5. Financial Position

### 5.3 Statement of Cash Flows – M1

| Statement of Cash Flow 30 April 2022 | Month Actual £'000 |
|---|---|
| **Opening cash** | **36,435** |
| **Operating activities** | |
| Surplus / (deficit) | (956) |
| Net interest accrued | 15 |
| PDC dividend expense | 226 |
| Unwinding of discount | (3) |
| (Gain) / loss on disposal | 0 |
| Operating surplus / (deficit) | (718) |
| Depreciation and amortisation | 1,033 |
| Impairments / (impairment reversals) | 0 |
| Donated asset income (cash and non-cash) | 0 |
| Changes in working capital | 2,805 |
| **Investing activities** | |
| Interest received | 20 |
| Purchase of non-current (capital) assets [1] | 320 |
| Sales of non-current (capital) assets | 0 |
| Receipt of cash donations to purchase capital assets | 0 |
| **Financing activities** | |
| Public dividend capital received | 22 |
| Net loan funding | 0 |
| Interest paid | 0 |
| PDC dividend paid | 0 |
| Finance lease rental payments | 0 |
| Total net cash inflow / (outflow) | **3,482** |
| **Closing cash** | **39,917** |

5.3.1 Cash balances have increased by £3.5m but there is a corresponding increase in current liabilities.

## 5. Financial Position

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

**Use of Resources Rating**

| | Metric | Descriptor | Weight % | Actual | |
|---|---|---|---|---|---|
| | | | | *Metric* | *Rating* |
| Financial sustainability | **Liquidity (days)** | Days of operating costs held in cash-equivalent forms | 20% | -21.4 | 4 |
| | **Capital service capacity (times)** | Revenue available for capital service: the degree to which generated income covers financial obligations | 20% | 0.4 | 4 |
| Financial efficiency | **I&E margin (%)** | Underlying performance: I&E deficit / total revenue | 20% | -2.7% | 4 |
| Financial controls | **Distance from financial plan (%)** | Shows quality of planning and financial control : YTD deficit against plan | 20% | -2.5% | 1 |
| | **Agency spend (%)** | Distance of agency spend from agency cap | 20% | 43.9% | 3 |
| | **Overall NHSI UoR rating** | | | | **3** |

5.4.1 The liquidity rating of 4 remains the same as M12 and is largely due to a high number of accruals made. The I&E margin reflects the reported deficit. Agency spend is 43.9% above the cap and reflects the issues faced with sickness levels and the escalation areas remaining open. The overall UoR rating of 3 which is expected to improve.

**Board of Directors in Public** **Item 9.4**

**01 June 2022**

| | |
|---|---|
| **Title** | Monthly Maternity Update (including Ockenden 2 Progress) |
| **Area Lead** | Tracy Fennell, Chief Nurse |
| **Author** | Tracy Fennell, Chief Nurse |
| **Report for** | Information |

## Report Purpose and Recommendations

The purpose of this report is to provide a monthly update to the Board of Directors of key metrics reported to the Local Maternity and Neonatal System (LMNS) linked to the quality and safety of Maternity Services. Included in the paper is the Perinatal Clinical Surveillance Quality Assurance report (Appendix 1) providing an overview of these key quality and safety metrics. Wirral University Teaching Hospital NHSF Trust (WUTH) are not identified as an outlier in the metrics reported, with one serious incident reported since January 2022.

The last Quarterly Maternity Update to Trust Board of Directors was presented in April 2022. A further update was presented to the Trust Board of Directors in May 2022 following the publication of the final Ockenden Report, which reported an initial assessment with the 15 Immediate and Essential Actions. A further update will be included in the next Quarterly Maternity Update paper which will be presented to the Board of Directors in July 2022.

It is recommended that the Board:

- Note the report

## Key Risks

This report relates to these key Risks:

- Board Assurance Framework references 1,2,4

| 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** |
| This is a standing monthly report to Board | | | |

| 1 | Perinatal Clinical Surveillance Quality Assurance Report |
|---|---|
| 1.1 | The Perinatal Clinical Surveillance Quality Assurance report for June 2022 reports that WUTH is not an outlier for neonatal deaths and stillbirths. These outcomes are reported monthly to the LMNS and are compared to other maternity providers in both the Cheshire & Merseyside region and the Northwest Coast.<br><br>There have been no serious incidents (SI's) reported since the last report with one SI reported to date in 2022. A recent quarterly update from HSIB reported that the Trust is reporting all cases meeting the HSIB criteria for review and that Duty of Candour was reported as 100% for these cases.<br><br>The vacancy rate has increased to 3% in the midwifery workforce and work is ongoing through a recruitment campaign to address this shortfall. A further detailed update will be included in the Quarterly Maternity Update to the Board of Directors in July 2022.<br><br>Year 4 of the Maternity Incentive Scheme has been relaunched with work ongoing to meet all 10 safety action standards. The declaration reporting date for the Maternity Incentive Scheme is 5 January 2023. |

| 3 | Conclusion |
|---|---|
| 3.1 | On review of the Perinatal Clinical Surveillance Quality Assurance Report there are no reported areas of concern. Work continues within the W&C Division to further improve clinical outcomes and patient experience and an update will be included in the Quarterly Maternity Update to Board of Directors in July 2022. |

| | |
|---|---|
| **Author** | Debbie Edwards |
| **Contact Number** | 0151 678 5111 |
| **Email** | Debbie.edwards4@nhs.net |

**Maternity Update Appendix 1 - Perinatal Clinical Surveillance Quality Assurance Report June 22**

| Theme | Area requiring further enquiry or shared intelligence | Outlier | Evidence |
|---|---|---|---|
| Clinical Care | Outlier for rates of stillbirth as a proportion of births | no | Not identified as an outlier for stillbirths. |
| | Outlier for rates of neonatal deaths as a proportion of birth | no | Not identified as an outlier as per SCN / LMNS Dashboard |
| | 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 | Total of 3 Sis in 2021 - WUTH were not an outlier for SI's in 2021. One SI to date from January 2022 - May 2022 |
| | Progress on SBL care bundle V2 | no | Saving Babies Lives Care Bundle - SBLCBV2 is fully implemented with ongoing audits in place (registered on the FAAP). Work is ongoing to implement SBLCBV3 as outlined in Year 4 Maternity Incentive Scheme. |
| | 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 | Improvements made to response times with close monitoring by the Director of Midwifery and the Divisional Q&S Lead. Number of complaints received are low when |
| | Trainee survey | no | Positive feedback |
| | Staff survey | no | Response rate increased in 2021-22 survey. Trust action plan being developed inline with the People strategy implementation. |
| | CQC National survey | no | Survey published Feb 2022 with overall positive findings |
| | Feedback via Deanery, GMC, NMC | no | Nil to report |
| | Poor staffing levels | no | Vacancy rate currently 3% - recruitment campaign in progress |
| | 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 | Director of Midwifery is retiring June 2022 - Jo Lavery will replace vacating the Head of Midwifery post which will go out to advert externally. Current DoM to return part time to support. |
| | Concerns around the relationships between the Triumvirate and across perinatal services | no | Good effective working between the teams. |
| | False declaration of CNST MIS | no | Externally audited by MIAA. Year 4 was paused but has since been relaunched with a declaration date of 5th January 2023 |
| | 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 |
| | | | |
| fety and learning culture | Lack of engagement in HSIB or ENS investigation | no | Good engagement processes in place with monthly reports received of ongoing cases and updates accordingly |
| | Lack of transparancy | no | 100% DOC reported. |
| | Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact | no | Robust processes ensuring lessons learned from all SI's, local reviews and rapid reviews are shared both locally and regionally. |
| | Learning from Trust level MBRRACE reports not actioned | no | All reports receive a gap analysis to benchmark against the recommendations. |

| | | | |
|---|---|---|---|
| Sa | Recommendations from national reports not implemented | no | National 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 demonstrated through Divisional dashboard |
| | Delays in reporting a SI where criteria have been met | no | Robust SI process and SI framework in place. No delays experienced in reporting where applicable. |
| | Never Events which are not reported | 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 | | Clear governance processes in place that follow the SI framework |
| | Business continuity plans not in place | no | Business continuity plans are in place. |
| | Ability to respond to unforeseen events e.g. pandemic, local emergency | no | The service has an ability due to effective structures within the Trust to manage unforseen events including major incidents, local emergencies. Trust policies further support this. |
| | | | |
| CQC inspection and DHSC or NHSE/I request for support | DHSC or NHS England Improvement request for a Review of Services or Inquiry | no | CQC core service review was undertaken in May 2021 - positive feedback with no concerns reported. |
| | 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 |
| | | | |

Wirral University Teaching Hospital NHS Foundation Trust

**Board of Directors in Public** **Item No 9.5**
**1 June 2022**

| | |
|---|---|
| **Title** | Digital Healthcare Update |
| **Area Lead** | Chris Mason, Chief Information Officer |
| **Author** | Chris Mason, Chief Information Officer |
| **Report for** | Information |

## Report Purpose and Recommendations

The purpose of this report is to give a brief general update of progress on development and agreement of operational plans to deliver strategic priorities of the Trust over the next 12 months. In addition, it will outline the proposed assurance dashboard that will cover the delivery of strategic priorities and performance of "business as usual" activities that ensure the day-to-day provision of the robust digital infrastructure within the organization.

It is recommended that the Board:

- Note the current progress in relation to the annual planning cycle which will give context for further updates through the proposed assurance dashboard

## Key Risks

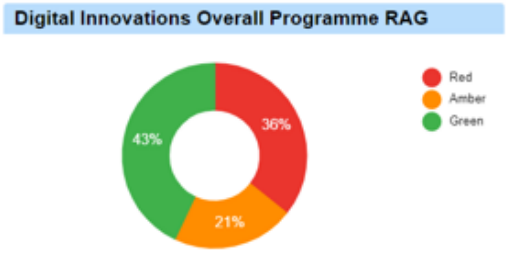
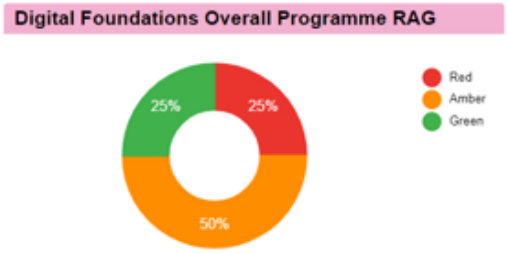
This report relates to these key Risks:

- BAF Risk 5.2 Loss of clinical systems due to a cyber-attack, resulting in an adverse impact on the delivery of care.
- BAF Risk 5.3 Failure to successfully implement the digital strategy, resulting in an adverse impact on patient 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 | No |
| **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. | No |

**Governance journey**

| Date | Forum | Report Title | Purpose/Decision |
|---|---|---|---|
| 20.05.2022 | Digital Healthcare Team Senior Management Forum | Departmental Performance Management Review | To clarify measures for reporting to Board in the immediate future and identify areas for further development |

| 1 | Narrative |
|---|---|
| 1.1 | **Delivering our strategy**<br>Following the publication of the Digital Strategy in August of 2021 the Digital Healthcare Team (DHT) have worked closely with Divisions to understand the clinical and operational priorities where enabling technologies are critical to achieving our strategic goals.<br><br>**The operational plan**<br>The schedule satisfies the required strategic deliverables of the Trust in financial year 22/23. Key projects due for implementation in the next financial year include:<br>• Extensive digital provision for the South Mersey Elective Hub<br>• Replacement of the wired network infrastructure across the estate<br>• Robotic Process Automation for streamlining of back office processes<br>• Substantial roll out of Patient Portal offering including patient self-booking<br>• Development of an in-house data warehouse to initially deliver clinical reporting<br>• Completion of migration to the regional PACS solution<br>• Introduction of a Learning Management System to baseline staff educational needs.<br>• Digital consent – continuing our journey to one patient record.<br><br>**Monitoring delivery**<br>Following sign-off at Digital Programme & Services Oversight Committee (DPSOC), delivery of the operational plan will be monitored through this governance channel. We are currently working on an initial draft of KPI's to ensure Board are sighted on progress against the plan and are made aware of any potential risks impacting delivery.<br><br>Each project within the plan will be rag rated on delivery status. This will then be rolled up into a high-level dashboard that gives a status summary for each of the sections within the Digital Healthcare Portfolio, those being – Digital Foundations, Digital Innovation, Digital Education and Digital Intelligence. The Illustration below gives an example.<br><br>  <br>  <br><br>**Changes to plan**<br>Any requested in-year amendments following the agreed change control process using the established digital governance model. |

| | |
|---|---|
| | Resource and financial Implications of any changes will be considered in line with any potential impacts on the existing schedule and associated delivery of Trust strategic objectives.<br><br>**Financials**<br>The majority of projects within the 22/23 schedule can be delivered within the allocated cost envelope. This has been funded from both Trust capital and central funding. From a central funding perspective, monies have been obtained from successful bids to the Unified Tech Fund and from Health Education England for our learning management system.<br><br>There are a small number of exceptions to this:<br>1. Digital Dictation/Voice Recognition: Business case being developed<br>2. Oral Scanners: Business Case being developed<br>3. Foetal Monitoring: Alternative funding being sought from W&C<br>4. South Mersey Elective Hub: To be funded from elective recovery monies.<br><br>**High Level Risks**<br>- Current lack of clarity around requirements for imminent large scale projects not in the schedule – This includes implications from projects such as the Regional Digital Diagnostic Care Programme and digital elements of the UECUP programme.<br>- Resource - Increased concern within the Informatics sector on staff retention and recruitment in a buoyant IT jobs market, reducing the service expertise and staffing levels. |
| 1.2 | **Business Continuity & Service Delivery**<br><br>In addition to delivery of strategic elements of the service, we also have a responsibility to ensure that our digital infrastructure, including networks, servers, desktop, and all of our applications continue to function on a daily basis to ensure effective, efficient and safe clinical care, whilst minimizing the threat from Cyber-attack. From a customer facing perspective our Service desk aims to deliver a highly responsive fault fixing service, supplemented by self-serve functionality.<br><br>**Monitoring Delivery**<br>In order to monitor delivery in this instance we will be proposing monthly KPI's in relation to network / application availability and Cyber security as well as giving indications as to the responsiveness of our service through information gathered from our service desk system. Some typical examples would be those illustrated below:<br><br>Network availability:<br>EPR availability:<br>Foreign System Interface availability:<br>Service Desk calls received:<br>Service Desk faults fixed:<br>Average fault fix time:<br>Number of active calls:<br>Cyber audit response:<br>Current Cyber risks recorded on the Trust Risk register rated "High" and above: |

| | |
|---|---|
| | For all of the above measures we would look to report on a monthly basis, showing trends over time. |

| 2 | Implications |
|---|---|
| 2.1 | Delivery of the proposed 22/23 Digital Healthcare operational plan will ensure achievement of the strategic priorities outlined in the Digital Strategy. Namely:<br>- Using technology to reduce waste, automate processes and eliminate bottlenecks.<br>- Empowering patients with the data and tools to manage their own health and wellbeing.<br>- Allow business Intelligence to drive clinical decision making<br>- Use health information to enable population health management for Wirral.<br><br>The proposed dashboard will increase visibility for the board around delivery and provide assurances in relation to both the project and technical infrastructure in place to deliver the objectives above. |

| 3 | Conclusion |
|---|---|
| 3.1 | We are positive about working with board members to further refine the measures within the dashboard and would encourage regular feedback to ensure continual improvement in this area. |

| | |
|---|---|
| **Report Author** | Chris Mason, Chief Information Officer |
| **Contact Number** | Ext 5475 |
| **Email** | chrismason@nhs.net |

**Board of Directors in Public** **Item 9.6**

**01 June 2022**

| | |
|---|---|
| **Title** | Estates, Facilities and Capital Update |
| **Area Lead** | Paul Mason, Director of Estates, Facilities and Capital planning |
| **Author** | Clare Jefferson, Head of Infrastructure Improvement |
| **Report for** | Information |

## Report Purpose and Recommendations

The purpose of this report is to provide an overview of the proposed Assurance dashboard that will be provided on an ongoing basis to the Board.

It is recommended that the Board:

- Considers the proposed content and advises on any additional areas for which assurance is to be provided and any metrics that should be removed

## Key Risks

This report relates to these key Risks:

- BAF Risk 3.3: Delays/restrictions in accessing capital resources to support the delivery of the Trust's Estates Strategy
- BAF Risk 6.1: Adverse impact on delivery of clinical care and application of infection control measures due to the quality of the Trust's estate, and substantial maintenance backlog

| 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. | Yes |

**Governance journey**

| Date | Forum | Report Title | Purpose/Decision |
|---|---|---|---|
| 16.05.2022 | Estates, Facilities and Capital Senior Leadership Review | Workshop to identify KPIs | To highlight what we can measure now and future goals |

| 1 | Narrative |
|---|---|
| 1.1 | **Background**<br>As we approach the 1-year anniversary of the integration of the Estates, Facilities and Capital departments the leadership team have moved into the second phase of improvement maturity: System Alignment. We have aligned behaviours, defined our strategy, and set our objectives for the year ahead.<br><br>This report outlines the measures aligned to our strategic priorities and defines our assurance reporting intent. |
| 1.2 | **Scope**<br>We have linked our assurance reporting to the CQC five questions as follows:<br>Safe – technical standards<br>Effective – performance of our services<br>Caring – patient experience<br>Responsive – response times<br>Well-led – people performance<br><br>The Capital Programme and the Infrastructure Improvement Programme have been excluded from the Assurance reporting as these have a direct reporting structure into the Board through the Capital Committee and Programme Board. |
| 1.3 | **Measure: Safe** (technical standards & audit)<br>For each Technical Standard we are in the process of developing an underlying set of criteria to demonstrate a self-assed level of compliance against standards in relation to People, Processes and Tools. These scores will be aggregated into a single performance metric reported to the Board.<br>Proposed compliance Targets as a percentage:<br>• Compliant **95% to 100%.**<br>• Controlled Compliancy **80% to 94%.** **Low Risk**<br>• Deficient Compliancy **70% to 79%.** **Moderate Risk**<br>• Fail Compliance **0% to 69%.** **High Risk**<br><br>22/23 Audit plans will be presented to the Board in July 2022. Monthly tracking against the Audit plan will be reported to the Board along with any escalations of 'Reportable findings to an external body' identified through the Audits.<br><br>An exception report will be provided for any audit which identifies areas of non-compliance with an associated Improvement Plan which will be tracked and monitored. |
| 1.4 | **Measure: Effective** (performance of our services)<br>The New National Standards of Healthcare Cleanliness 2021 are now being implemented across the Trust. The average cleanliness audit scores and the overall efficacy audit scores will be reported to the Board. |
| 1.5 | **Measure: Caring** (patient experience)<br>Patient and staff experience is incorporated into the weekly senior leadership meetings where Incidents, Complaints and RIDDORs are reviewed.<br>Formal complaints and RIDDORs will be reported to the Board. |

| | |
|---|---|
| 1.6 | **Measure: Responsive** (response times)<br>This KPI will provide an indication of our response time with regards to switchboard call handing, Portering requests, and reactive maintenance calls. |
| 1.7 | **Measure: Well-led** (people performance)<br>This KPI will provide an indication of how we are performing in relation to our Sickness levels, Mandatory Training and Appraisal compliance. |
| 1.8 | **Dashboard example**<br>Below is an illustration of KPI data which will be report to the Board. The metric will be RAG rated to highlight areas of achievement and those of concern. |

Key Performance indicators

| | | June | July | Aug | | Comments |
|---|---|---|---|---|---|---|
| KPI 1: Safe | % | | | | | |
| KPI 2: Effective | % | | | | | |
| KPI 3: Caring | No. Formal Complaints | | | | | |
| | No. RIDDOR | | | | | |
| KPI 4: Responsive | % | | | | | |
| KPI 5: Well-Led | % | | | | | |

Exception Commentary:

Audit findings (since last reported)

| | Rating | Commentary |
|---|---|---|
| Audit 1 | Moderate | |
| Audit 2 | Substantial | |
| Audit 3 | Limited | |

**Please note that this is an example and not a reflection of actual findings.*

| 2 | Implications |
|---|---|
| 2.1 | **Data instability**<br>The Technical Standards metrics are currently heavily weighted on subjective self-assessment reviews. As the recording and reporting matures over time, more quantitative metrics will be added which will increase the validity of the indicator. It is expected that over the next 12-months there will be artificial fluctuations in this indicator as more robust metrics are introduced. |
| 2.2 | **Discovery**<br>Whilst great advances have been made over the past 12-months, the aging infrastructure and lack of maintenance and investments in some areas of the Estate is resulting in critical audit findings requiring significant investment to resolve.<br><br>Areas of performance improvement or progression is highly likely to be subject to revenue or capital investment which if not made available may impeded developments and this will be reported on as matters arise. |

| 3 | Conclusion |
|---|---|
| 3.1 | The proposed approach is our baseline assurance reporting with the information that is currently captured across the departments, our aspiration is to produce a high-level PowerBI dashboard which will visualise the key Board assurance metrics to be accompanied by an exception report, as required. |


| | |
|---|---|
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Wirral University Teaching Hospital NHS Foundation Trust

**Board of Directors in Public** **Item No 10**
**1 June 2022**

| | |
|---|---|
| **Title** | Operational Plan for 2022/23 |
| **Area Lead** | Hayley Kendall, Chief Operating Officer |
| **Authors** | Executive Directors |
| **Report for** | Approval |

| **Report Purpose and Recommendations** |
|---|
| Each year NHS Trusts are required to develop and deliver an Annual Operational Plan that incorporates all elements of activity and operational performance, workforce plans to deliver the annual activity plans, quality plans that outline the key priorities and a financial plan that ensures the Trust remains financially sustainable.<br><br>The presentation attached outline the Trust's 2022/23 Annual Operational Plan and the Board of Directors is asked to note the content and approve it. |

| **Key Risks** |
|---|
| This report relates to all areas of the 2022/23 BAF as the Annual Operational Plan incorporates all areas of the Trust's activities. |

| **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** |
| 17/5/22 | Executive Committee | Operational Plan | Approved |

| | |
|---|---|
| **Report Author** | Hayley Kendall, Chief Operating Officer |
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Wirral University Teaching Hospital
NHS Foundation Trust

# Trust Annual Operational Plan 2022/23

# Table of Contents

# 1. Background and Context

# 1. Background and Context

### a. Overview of our Trust

- Wirral University Teaching Hospitals NHS Trust (WUTH) is one of the largest acute trusts in the North West of England, providing a range of community, secondary and tertiary services to the populations across the Wirral, Cheshire and North Wales. These clinical services are primarily provided from our two Hospital campuses, namely Arrowe Park Hospital and Clatterbridge Hospital.
- The Trust spends approximately £430m per annum providing the range of high quality clinical services and care to the local populations. In 2020/21, this included the delivery of over 400,000 outpatient appointments, 30,000 elective procedures and 80,000 accident and emergency attendances. These services are delivered and supported by our 6,200 staff.

### b. Our Vision and Values

- Our Vision and Values set out what our patients can expect from us and have been developed with the feedback of over 2,500 staff, patients and visitors who told us what matters most to them.
- Our vision is:

- Underpinning our Vision are our Values:

together we will
...deliver the best quality and safest care to the communities we serve

d across the Trust and form the eliver clinical services across the Wirral.

caring for everyone | committed to improvement | respect for all | embracing teamwork

### c. Our 2021-2026 Strategy

- In 2021/22, we successfully launched Our 2021-2026 Strategy, underpinned by our six strategic objectives:
  - Outstanding Care: Provide the best care and support
  - Compassionate workforce: Be a great place to work
  - Continuous improvement: Maximise our potential to improve and deliver best value
  - Partnerships: Providing seamless care working with our partners
  - Digital future: Be a digital pioneer and centre for digital excellence
  - Infrastructure: Improve our infrastructure and how we use it.
- Our six strategic objectives and priorities demonstrate our intention to provide outstanding care across the Wirral through our hospital sites and units, as a lead provider within the Wirral system. Our 2021-2026 Strategy was launched in October 2020.

### d. Enabling Strategies

- Our 2021-2026 Strategy will be delivered through our seven enabling strategies. In November 2021, we delivered our first Strategy Event, a bi-annual away day to facilitate working with our clinical and non-clinical divisions and corporate services to monitor and celebrate progress of the delivery of priorities against our strategic objectives and ensure enabling strategies are delivered across the organisation.

### Clinical Service Strategy

- Our 2021-2026 Strategy, will be delivered through our seven enabling strategies. The first to be developed was the Clinical Service Strategy, which also launched in 2021, working with our 32 individual clinical services to understand how they will support the Trust to deliver its strategic objectives over the next five years.
- Together, Our 2021-2026 Strategy, and our Clinical Service Strategy form the basis for our strategic priorities over the next five years, and is used as a framework for our Clinical Divisions to develop their annual priorities.
- In November 2021, we delivered our first Strategy Event, a bi-annual away day to facilitate working with our clinical and non-clinical divisions and corporate services to monitor and celebrate progress of the delivery of priorities against our strategic objectives and ensure enabling strategies are delivered across the organisation.

# 1. Background and Context (continued)



## Digital Strategy

- In May 2021, our Digital Strategy was finalised following engagement with patients, staff and wider stakeholders, detailing our IT and information priorities for the next five years aligned to our Digital Future strategic objective.
- The Digital Strategy outlines clear priorities for each of its four domains: Digital Intelligence, Digital Education, Digital Innovations, and Digital Foundations, and encapsulates our strategic focus through a new patient focused digital vision; Delivering digitally enabled Best Care for Everyone.

## Patient Experience Strategy

- This Patient Experience Strategy sets out our road map of improving patient experience, and has been separated out from Quality & Safety Strategy to ensure that we set out clear intentions, and that it is easy for us to follow, embed and measure our success.
- The Patient Experience strategy reveals our Patient Experience Vision:


- The patient experience vision statement was co-designed through extensive engagement with our partners by listening to feedback detailing what is most important in relation to the patient journey and breaking down the patient journey into promises. These promises will be utilised to measure our success in achieving our patient experience vision.

## Estates Strategy

- Our Estates Strategy showcases our Estates, facilities and capital areas of focus for the next five years to deliver our Infrastructure strategic objective, underpinned by our Estates vision: *"Health connects us, buildings enable us".*
- The Estates Strategy is broken down into four campaigns: Technical Management Review, People, Support Delivery of Clinical & Non-Clinical Service Strategies, and Portfolio Development and Future Planning. The strategy was developed following engagement with over 210 staff, patients and external stakeholders through six workshops and two questionnaires.

## Research and Innovation Strategy

- This Strategy has been developed following engagement with over 210 staff, 65 patients and 11 external partner organisations, and will be launched in Q1 22-23. The Research and Innovation Strategy vision: *"Tomorrow's Outstanding Care is Built on Today's Best Research"* represents our commitment to transform research and innovation activity across the trust and is aligned to our Continuous Improvement and Our Partners strategic objectives.
- The strategy outlines priorities for research and innovation over the next five years across four components: Culture, Partners and Place, Capacity and Capability, and Patient Experience.

## People Strategy

- Originally titled "Workforce and Education Strategy", our People Strategy is aligned to our Compassionate Workforce strategic objective, and is based around the four pillars of the NHS People Plan: Looking after our people and each other, Belonging in the NHS and at WUTH, New ways of working and delivering care, and Growing for the future.
- As well as building on the themes found in our staff survey, over 100 staff members across the organisation participated in the development of the strategy over a series of eight workshops. The 5-year People Strategy will be launched in Q1 22-23.

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# 1. Background and Context (continued)



### e. Our Partners

- In 2022-2023, particular focus will be given to working with our partners and to align services and decision making at place and system levels in the interest of local people.

### f. Healthy Wirral and Cheshire & Merseyside Integrated Care System

- The Trust operates as a member of the Healthy Wirral Partnership, an alliance of Wirral local health and care organisations, including WUTH, Wirral Community and Care NHS Foundation Trust (WCT), Cheshire and Wirral Partnership NHS Trust, the five Wirral PCNs, Wirral Council and Wirral CCG.
- Healthy Wirral, is one of 9 designated Places, with the wider Cheshire and Merseyside Integrated Care System, with responsibility for improving the delivery of health and care provision as well as improving the health outcomes for the Wirral population. The Healthy Wirral Partnership has developed a 5 year plan, which focuses on integration of services, improving population health, clinical sustainability and financial sustainability.
- The Trust's 2022/23 Operational Plan is consistent with the Healthy Wirral Plan, with the anticipated system benefits and impacts incorporated into our operational planning assumptions, including pathway redesign, patient flow and financial improvement

### a. NHS Planning Guidance 22-23

- In late December 2021, NHS England published the 2022/23 Priorities and Operational Planning Guidance, setting out the key priorities and expectation for the 22/23 financial year.
- This builds on the 21/22 H2 (Q3-4) Planning Guidance and highlights the current challenges across the NHS as well as the flexibility and resilience of services over the last two years. The document also indicates the operational environment and the Level 4 National Incident, indicating the need for flexibility over the coming financial year.
- The document details 10 key priorities for the coming year:
    a. Invest in workforce
    b. Respond to Covid 19 ever more effectively
    c. Deliver significantly more elective care
    d. Improve the responsiveness of urgent and emergency care
    e. Improve timely access to primary care
    f. Improve mental health services and services for people with learning difficulties
    g. Develop approach to population health management
    h. Exploit the potential of digital technologies
    i. Make effective use of our resources
    j. Establish ICBs and collaborative system working

### Trust Operational Priorities for 22/23

- Building on Our 2021-2026 Strategy, NHs Planning Guidance, and the Healthy Wirral and Cheshire and Merseyside Integrated Care System Strategic Plans, the Trust has identified a number of strategic priorities for the 2022/23 financial year. These are listed in Section 2 of this document.

# 2. Trust Strategic Priorities for 22-23

# 2. Trust Strategic Priorities for 2022-23

## a. Annual Strategic Priorities

- Utilising the 21-26 Trust Strategy, enabling strategies and NSH England national planning guidance for 2022/23, the Executive Team developed key strategic priorities for 22/23, as detailed on the following pages.

# 2. Trust Strategic Priorities for 22-23



| WUTH Strategic Objectives | WUTH Strategic Priorities | WUTH Annual Operational and Strategic Actions 2022/23 | Key deliverables | Action Ownership |
|---|---|---|---|---|
| **Outstanding Care**<br><br>Provide the best care and support | Empower patients through their care journey | 1. Develop and deliver Urgent and Emergency Improvement Plan including<br>a. ED Staffing<br>b. Acute take model<br>c. Staff and team development (OD) | 1.<br>- Improvement Plan approval<br>- Bi-monthly tracking of delivery through Programme Board | 1. COO |
| | Improve patient flow, ensuring the patient is in the right place at the right time | 2. Deliver Year 1 of Infection Prevention and Control Strategy, including implementation of NHS England IPC guidance | 2.<br>- Year 1 IPC Strategy action plan developed, approved and tracked<br>- Assessment and alignment of IPC to new NHSE guidance | 2. CNO |
| | Strive to deliver intimate and personal patient experience | 3. Deliver year 1 of 22-25 Patient Experience Strategy | 3.<br>- Develop and deliver year 1 Patient Experience Strategy annual priorities<br>- Provide 6 monthly update | 3. CNO |
| | | 4. Develop 22-25 Trust Quality and Safety Strategy | 4.<br>- Approval of Trust Quality and Safety Strategy by Board<br>- Development of Year 1 priorities | 4. Medical Director/CNO |
| | Provide services in the most appropriate and accessible setting | 5. Develop and deliver plan for quality improvement across Trust, including establishing methodologies and delivery vehicle | 5.<br>- Approved QI plan<br>- Embedded QI methodologies | 5. CNO |
| | | 6. Develop Clinical Outcomes Group to monitor the quality of service delivery across the Trust | 6.<br>- Establishment of Group<br>- Development of clinical outcomes methodology<br>- 22/23 Work plan development and delivery | 6. Medical Director |
| | Embed a culture of safety improvement that improves outcomes | 7. Deliver national maternity improvement requirements and revisions to national policy | 7.<br>- Conduct review against revised requirements and policy<br>- Develop and deliver action plan<br>- Track through Board updates | 7. CNO |
| | | 8. Understand the impact of covid and post covid recovery on health inequalities of patients across Wirral | 8.<br>- Undertake analysis and review | 8. Medical Director |

# 2. Trust Strategic Priorities for 22-23



| WUTH Strategic Objectives | WUTH Strategic Priorities | WUTH Annual Operational and Strategic Actions 2022/23 | Key Deliverables | Action Ownership |
|---|---|---|---|---|
| **Compassionate Workforce**<br><br>Be a great place to work | Develop and maintain a healthy organisational culture based on our values | 1. Implement Year 1 of the People Strategy across 4 pillars:<br>a. Looking after ourselves and each other<br>b. Belonging at WUTH<br>c. Transforming ways of working<br>d. Shaping our future | 1.<br>- Development and delivery of Year 1 People Strategy priorities | 1. CPO |
| | | 2. Development and delivery of People Inclusion Plan | 2.<br>- Development of People Inclusion Plan<br>- Year 1 Implementation of Plan | 2. CPO/ CNO |
| | Retain, attract and recruit high calibre and skilled staff | 3. Review, develop and implement revised human resource governance arrangements across the Trust, including for:<br>a. Staff systems and processes<br>b. Job planning<br>c. Workforce analysis and reporting | 3.<br>- Identify and map governance arrangements<br>- Develop and deliver action plan<br>- Align to Programme Board reporting | 3. CPO |
| | Support our staff to enjoy the best health and wellbeing | | | |
| | Invest in our staff's continuous learning, education and innovation | | | |

# 2. Trust Strategic Priorities for 22-23

| WUTH Strategic Objectives | WUTH Strategic Priorities | WUTH Annual Operational and Strategic Actions 2022/23 | Key deliverables | Action Ownership |
|---|---|---|---|---|
| **Continuous Improvement**<br><br>Maximise our potential to improve and deliver best value | Embed a culture of improvement and transformation | 1. Deliver Elective Recovery Programme to plan, including productivity reviews across:<br>a. Gynaecology<br>b. Urology<br>c. Colo-rectal surgery | 1.<br>- Reduction in waiting list size<br>- Reduction in 52+ week waiters<br>- Development and delivery of Improvement plans following service reviews | 1. COO |
| | Reduce variation in care pathways to improve outcomes | 2. Deliver financial sustainability across 22/23 | 2.<br>- Delivery to 22/23 financial plan<br>- Development and delivery of CIP<br>- Delivery of capital programme to budget | 2. CFO |
| | | 3. Develop 22-26 Financial Strategy | 3.<br>- Board approval of 22-26 Financial strategy | 3. CFO/DoS |
| | | 4. Develop and implement 22/23 Productivity and Efficiency plan, including transformation programme alignment | 4.<br>- Board approved Productivity and Efficiency Plan | 4. DoS/CFO |
| | Use our resources effectively and sustainably, so we can improve our services | 5. Review central corporate functions | 5.<br>- Completion of reviews and implementation of action plans | 5. CEO |
| | | 6. Review and implement revisions to NHS England access standards across the Trust | 6.<br>- Assess new access standards to current processes across Trust<br>- Implement, track and report new access standards | 6. COO |
| | Create the conditions for clinical research to flourish | 7. Review clinical model and functions across hospital sites, aligning to clinical service strategies | 7.<br>- Establishment of review group<br>- Approval of review report<br>- Action plan to transfer functions and/or activity between hospital campuses | 7. COO<br><br>8. Director of Corporate Services |
| | | 8. Development and delivery of Trust Accountability Framework | 8.<br>- Board approved Accountability Framework<br>- Roll out programme for Accountability Framework | 9. Medical Director |
| | | 9. Develop and deliver Year 1 of the Research and Innovation Strategy | 9.<br>- Development and tracking of Y1 priorities | 10. Medical Director |
| | | 10. Continue to deliver CQC Action Plan to agreed timelines | 10.<br>- Update of CQC action plan<br>- Monitoring of delivery of action plan | |

# 2. Trust Strategic Priorities for 22-23

| WUTH Strategic Objectives | WUTH Strategic Priorities | WUTH Annual Operational and Strategic Actions 2022/23 | Key deliverables | Action Ownership |
|---|---|---|---|---|
| **Our Partners**<br><br>Provide seamless care working with our partners | Integrate care to prevent ill-health, improve wellbeing and meet the needs of the Wirral population | 1. Develop approach for Trust at ICB/CMAST and Place level | 1.<br>-Develop and implement representation plan and priorities across ICB/CMAST and Place<br>- Support establishment of Place – Wirral Integrated Providers | 1. DoS |
| | Deliver system partnerships which improve outcomes for our patients | 2. Develop opportunities for clinical, clinical support and corporate service consolidation and integration with WCT and across C&M | 2.<br>- Map clinical services across two Trusts<br>- Identify models for integration<br>- Develop plan for integration | 2. DoS |
| | Lever our clinical expertise to drive clinical quality and influence system working | 3. Deliver South Mersey Hub at Clatterbridge Hospital, aligning to new theatre complex | 3.<br>- Design and deliver clinical model for partner Trusts<br>- Design and deliver financial and workforce model for partner Trusts | 3. COO |
| | Build partnerships with academic institutions to develop research and education capability | | | |

# 2. Trust Strategic Priorities for 22-23

| WUTH Strategic Objectives | WUTH Strategic Priorities | WUTH Annual Operational and Strategic Actions 2022/23 | Key deliverables | Action Ownership |
|---|---|---|---|---|
| **Digital Future**<br><br>Be a digital pioneer and centre for excellence | Use digital technology to reduce waste, automate processes and eliminate bottlenecks | 1. Deliver Year 2 of Digital Strategy | 1.<br>- Develop Y2 Annual priorities and delivery plan<br>- Track across financial year | 1. CFO/CIO |
| | Empower patients with the data and tools to manage their own health and wellbeing | 2. Optimise invested digital solutions, including Cerner | 2.<br>- Stocktake of digital solutions use and optimisation across Trust<br>- Develop and deliver digital transformation projects<br>- Track progress through Programme Board | 2. CFO/CIO |
| | Allow business intelligence to drive clinical decision making | 3. Complete review of analytical functions across Trust | 3.<br>- Complete review recommendations<br>- Implement recommendations | 3. CFO/CIO |
| | Use health information to enable population health management for the Wirral | | | |

# 2. Trust Strategic Priorities for 22-23

| WUTH Strategic Objectives | WUTH Strategic Priorities | WUTH Annual Operational and Strategic Actions 2022/23 | Key deliverables | Action Ownership |
|---|---|---|---|---|
| **Infrastructure**<br><br>Improve our infrastructure and how we use it | Effectively use our estate to support the delivery of care | 1. Design and deliver 22/23 Capital Programme | 1.<br>- Confirm Capital Programe projects<br>- Monitor project delivery to plan | 1. DoS |
| | Delineate the role and functions of the hospital sites | 2. Complete and close Capital Improvement Programme, aligning to Archus Review recommendations | 2.<br>- Monitor improvement project delivery<br>- Track delivery through Programme Board<br>- Complete projects and undertake improvement close out | 2. DoS |
| | Develop the case for the upgrades of the hospital campuses | 3. Deliver UECUP FBC and construction phases to Plan | 3.<br>- Deliver FBC and gain approval by DHSC/NHSE<br>- Gain planning approval from Council<br>- Revise governance for construction phase<br>- Monitor construction delivery to plan | 3. DoS |
| | Improve travel and transport to our hospital campuses | 4. Deliver Year 1 of Estates Strategy and Green Plan | 4.<br>- Development and delivery of Year 1 Estates Strategy priorities<br>- Development and delivery of Year 1 Green Plan priorities | 4. DoS |
| | Promote sustainability and social value | 5. Develop master plan for the Arrowe Park Hospital campus | 5.<br>- Seek approval from NHSE<br>- Appoint Architects<br>- Undertake internal and external engagement<br>- Design master plan | 5. DoS |

# 3. 2022/23 Activity and Performance Plan

# 3. Activity Plan

## a. Overview

- The Trust has developed its annual activity plan utilising capacity and demand plans from across the clinical divisions. The plans take into account the backlog of patients as a direct consequence of Covid-19 and specialities have developed ambitious plans to significantly reduce the waiting time for elective patients through the next financial year.
- 2019/20 has been used as the base year for reference.
- The Trust utilised regional and national planning assumptions relating to growth and any impact from the Healthy Wirral priorities.

## b. 2022/23 Activity Plans

- Activity plans set by each specialty to achieve at least 2019/20 outturn with an ambitious plan set to achieve 104% across the board.
- Clear NHS guidance on the requirement to deliver 104% of pre-Covid levels of activity to aid recovery of elective waiting times
- NHS guidance that clock stops should be at 110% compared to 2019/20, again aiding elective recovery.
- Outpatient transformation is a key feature of the activity plans for this year implementing nationally driven schemes such as Patient Initiated Follow-up (PIFU), Advice and Guidance and Attend Anywhere.
- There will be a review of speciality configuration across both the Arrowe Park and Clatterbridge maximising opportunities to have a clear demarcation between elective and non-elective clinical work.
- There is a focus on delivering a Winter Plan that encompassed:
    - Increasing alternatives to admission across the healthcare system
    - Healthcare system approach to reducing the number of patients who do not have a criteria to reside
    - Ensure clear workforce plans are developed to safely staff additional areas for escalation across the winter months
    - Improving patient flow, implementing new pathways to stream patients to the right place the first time

**Table: WUTH Activity profile 22/23**

| Activity Line | 2019/20 Outturn | 2022/23 Plan |
|---|---|---|
| First outpatient attendances (consultant-led, specialist acute) | 105,492 | 109,188 |
| First outpatient attendances with procedures (consultant-led, specialist acute) | 7,076 | 7,334 |
| Follow-up outpatient attendances (consultant-led, specialist acute) | 238,871 | 252,339 |
| Follow-up outpatient attendances with procedures (consultant-led, specialist acute) | 27,439 | 29,048 |
| Total outpatient attendances (all specialties, consultant & non-consultant-led) | 479,682 | 503,499 |
| | | |
| Elective admissions - total specific acute elective spells | 51,291 | 54,411 |
| Elective admissions - specific acute day case spells | 44,518 | 47,819 |
| Elective Admissions - specific acute elective ordinary spells | 6,773 | 6,592 |
| | | |
| Non-elective spells - total specific acute | 48,795 | 48,795 |
| Non-elective spells - length of stay zero days | 14,446 | 14,446 |
| Non-elective spells - length of stay 1 or more days | 34,349 | 34,349 |
| | | |
| ED attendances - total category 1&2 excluding planned follow-ups | 90,114 | 90,114 |

# 3. Operational Performance

**Table: WUTH performance profile 2022/23**

| | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 52 Weeks | 550 | 545 | 540 | 535 | 530 | 525 | 520 | 515 | 510 | 505 | 500 | 495 |

| | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 78 Weeks | 70 | 64 | 58 | 52 | 46 | 40 | 34 | 28 | 22 | 16 | 10 | 4 |

| | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 104 Weeks | 6 | 4 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

### a. Elective Priorities

- Deliver 10% more elective activity than pre-pandemic levels in 2022/23
- Ambition to deliver 30% more elective activity by 2024/25
- Eliminate waits of over 104 weeks and maintain through 2022/23
- Reduce waits of over 78 weeks with 3 monthly reviews for this cohort of patients
- By 1st July 2022 three monthly reviews for patients waiting over 52 weeks
- Plans to reduce overall 52 week waits
- Reducing hospital follow ups by 25% against 2019/20 activity levels by March 2023

### b. WUTH Response

- Deliver zero 104 week waits by end of Q1 (excluding patient choice and mutual aid)
- Eliminate 78 week waits by end of 2022/23
- Stretch target to reduce 52 week waits by the end of the financial year
- Implement all outpatient transformation avenues to maximise throughput and reduce waiting times for patients
- Engage in C&M Elective Recovery Programme and provide mutual aid to partners where capacity exists within WUTH services

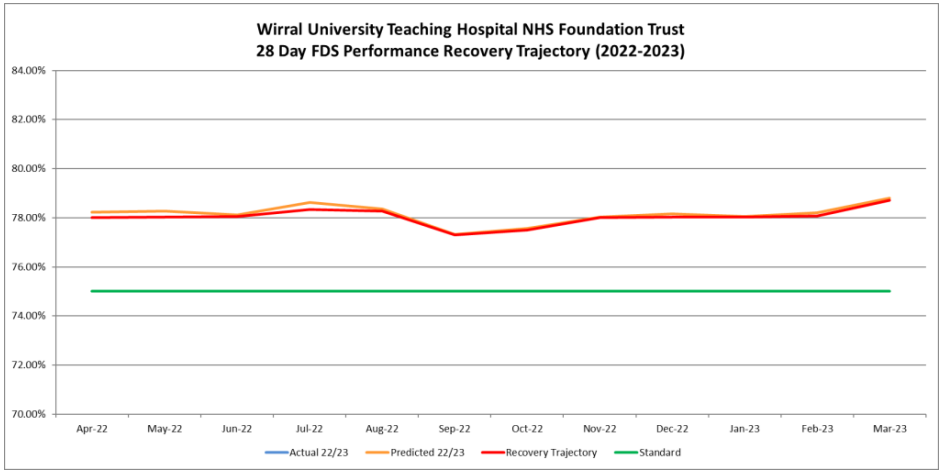
### c. Urgent Care

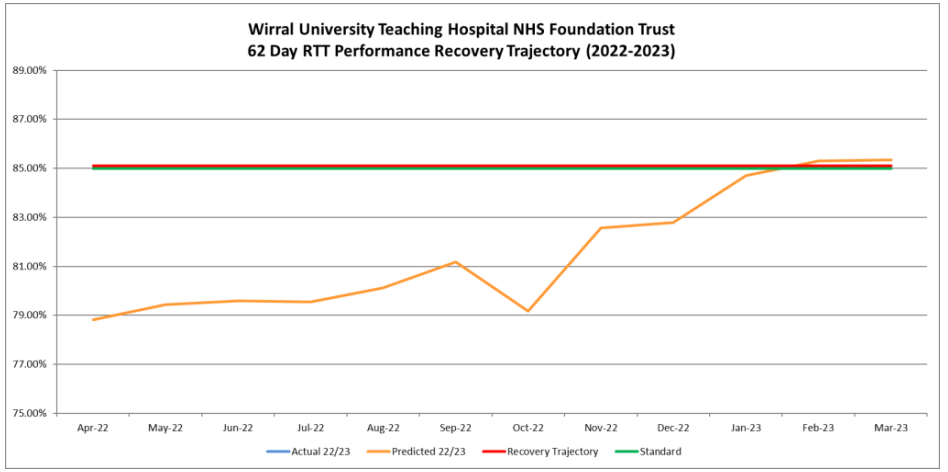
- A plan to achieve G&A bed occupancy of 92% is in development directly linked to the system wide trajectory for reducing the number of patients who don't have a criteria to reside and the implementation of virtual wards.
- A system plan has been developed to achieve reductions in the number of patients in hospital for longer than 14 and 21 days, utilising national benchmarks and regional stretch targets.
- Full UEC improvement programme in place focussing on improving ambulance turnaround times, waiting time in the department and an improvement trajectory for the 4 hour standard.

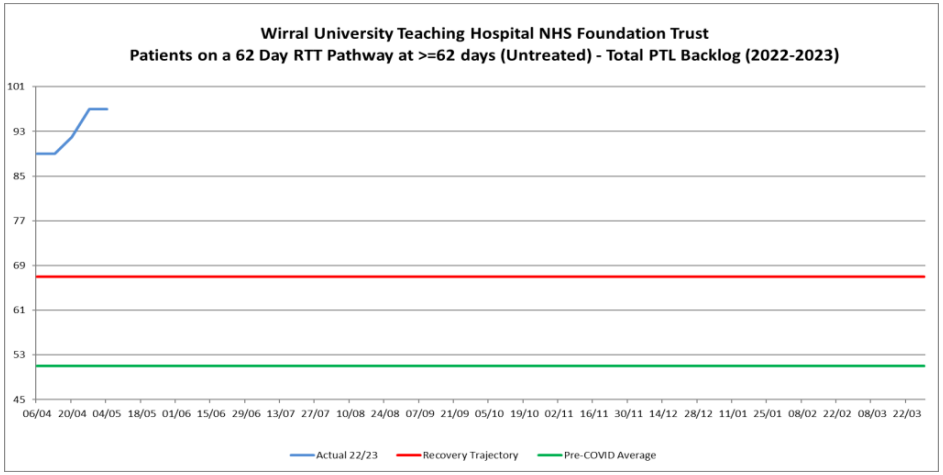
# 3. Operational Performance

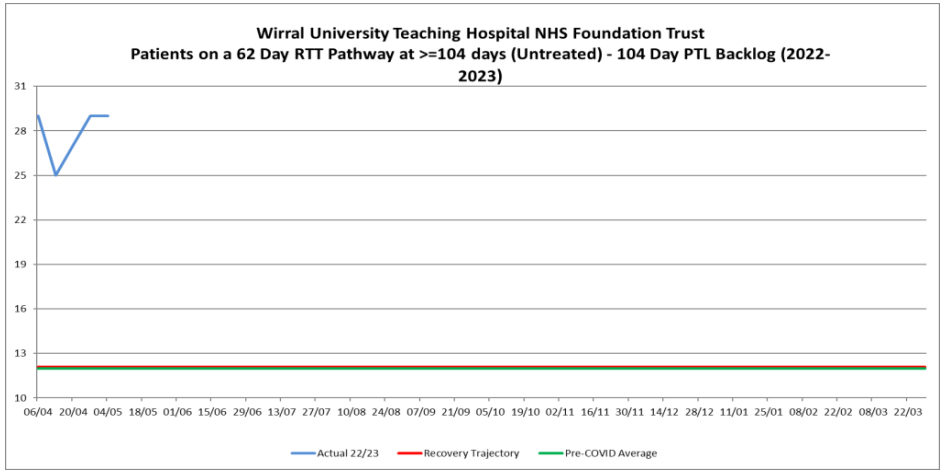
Wirral University Teaching Hospital NHS Foundation Trust

## Cancer Performance Trajectories 22/23




- No 14 day national standard, replaced within 28 day FDS
- Ambitious recovery targets submitted due to the size of the backlog of patients waiting longer than standard during the Covid-19 pandemic

# 4. Quality Plan and Priorities

# 4. Quality Plan



### a. Overview

- The Executive Medical Director and Chief Nurse lead on quality on behalf of the Board of Directors. They collectively share responsibility for patient safety, patient experience and clinical outcomes. They are supported by the Deputy Chief Nurse and Deputy Medical Director responsible for Quality and Safety. Specific responsibilities for quality are discharged operationally via divisional triumvirates, which are made up of an Associate Medical Director, Divisional Director of Operations and Divisional Nurse Director. The Governance Support Unit, lead by the Deputy Director for Quality Governance, oversees quality and safety.
- Improvement priorities are determined from:
  (i) assessment of strategic goals and progress;
  (ii) analysis of internal intelligence (such as event reporting, performance results, service user feedback, staff reporting arrangements);
  (iii) local intelligence (such as information received from stakeholders including GP's, CCG and other local providers of care); and
  (iv) findings following inspection or review of services (including but not limited to those received following a royal college review, or CQC, HSE, MHRA or Environmental Health inspection).

  (v) analysis of national data such as NICE, GIRFT, Dr Foster,

  SHIMI/HSMR
- Where a need to act has been identified outside the quality priorities previously determined, the Trust will initiate priority action proportional to the risk in concert with other relevant stakeholders and/or regulators where appropriate.

### a. Overview (cont.)

- Quality is primarily controlled at the patient interface (i.e. at ward and departmental level) using policies, procedures, staff and training resources. This is subject to divisional management oversight. Divisional triumvirates are held to account for control and compliance at the Divisional Performance Review meetings. At Trust level, quality is led and overseen by the Patient Safety & Quality Board which has strong clinical representation and is chaired by the Executive Medical Director. Assurance is provided to and reviewed on the Board's behalf by the Quality Committee, which is led by non-executive directors independent of operational management. The Board receive assurance directly from the Chair of Quality Committee, except for those matters which are reserved for the Board or where the Board has specifically requested assurance on an issue of concern.
- Non-Executive Directors lead on the acquisition and scrutiny of assurances and, with input from the Executive, determine assurance priorities for quality. An annual cycle of business for both the Quality Committee and Patient Safety & Quality Board is designed to ensure that over a 12-month cycle there is emphasis given to relevant CQC registration regulations. To support this clinical and other audit resources are deployed where appropriate to provide second or third line assurance, carry out testing and confirm the adequacy of assurances provided.
- A Service Improvement Team with specific and specialised skills in improvement science is in place to support front line teams to make improvements in their work. Our approach to quality improvement is largely based on a well-defined improvement method known as PDSA which has currency and is widely adopted across the NHS. In 2021/22 the Trust intends to embed Quality Improvement initiatives led by the Chief Nurse. The Quality and Safety Strategy will be updated and will link to the Patient Experience Strategy and Mental Health Key Priorities led by the Chief Nurse..

# 4. Quality Plan

## Quality Strategic Priorities for 2022/23

| Campaign | KPI | | YEAR 2 - BETTER By 31 March 2023 |
|---|---|---|---|
| **A positive patient experience** | Staff satisfaction: percentage of staff who believe 'care is the Trust's top priority' | | ≥90% |
| | Patient satisfaction: Response to Question – I have trust and confidence in staff who care for me | | ≥90% |
| | Patient satisfaction: Response to question Care was designed by me for me | | ≥90% |
| | Patient Recommendation Ratings (FFT) | | 97% |
| **Care is progressively safer** | Falls risk: assessment and implementation of care plans for people at risk | | ≥95% |
| | Reducing hospital acquired infections | Hospital Acquired Clostridium difficile | Achievement of trajectory |
| | | No Hospital Acquired MRSA Bacteraemia | ≥365 consecutive days (reset) |
| | Pressure sore risk: assessment and reliable implementation of care plans for people at risk | | ≥95% |
| | Compliance with LOCCSIPPs procedures across the Trust | | ≥90% |
| | Safer surgery: compliance with WHO checks | | 100% |
| | Deteriorating Patient fluid balance monitoring: completion and calculation of fluid balance daily | | ≥95% |
| | All wards will achieve a minimum of Level 3 WISE Accreditation | | 95% |
| | Safe staffing levels: fill rates (Care hours per patient day ) | | 6-10 |
| | Compliance with completion of MNEWS assessment in line with policy | | 90% |
| | Review by senior doctor every day (ST3 or above) | | ≥90% |
| | Achievement of 15 EIAs from Ockenden Final Report | | 100% |
| **Care is clinically effective and highly reliable** | Reduce exposure to harm for those who have a learning disability | | 5% Lower than 2021/22 |
| | Reducing emergency admissions in the last 90 days of life | | 5% Lower than 2021/22 |
| | Mortality Ratio: proximity to expected range | | Below 5% |
| | Delivery of the national audit programme | | 100% |
| | Patient satisfaction: Response to question Felt I am well supported with my after care | | ≥90% |
| | Patient satisfaction: complaints concerning discharge quality | | 5% Lower than 2021/22 |
| | Reduce the number of incidents awaiting managers review in the incident reporting system | | 20% below 22/22 |
| | Assessment of compliance with GIRFT recommendations: assessment at specialty level | | ≥90% |
| | Every patient is reviewed by a consultant within 14 hours of admission | | ≥98% |
| | Delivery of the CQC must do actions | | 100% |
| **We stand out** | Delivery of the patient experience work plan | | 100% |
| | Delivery of the Mental Health Key Priorities | | 100% |
| | Rapid review of potentially serious incidents: scoping within 72 hours | | ≥90% |
| | Achieve a reduction in harm per 1000 bed day of high-risk medicines, errors falls and pressure sores | | 5 % below 21/22 |

# 4. Quality Plan



## Risks and Risk Management

- We understand that success represents an ever-increasing challenge as we learn to balance rising demand for healthcare alongside intensifying financial, quality and workforce risks. There are many risks that will need to be effectively managed in order to remain resilient and promote success. At a high level the primary risks to quality that we expect to face, and are working to mitigate, are detailed in the table, below:

Table: Risk Management

| Potential Risk | *How the Risk might arise* | How the risk is being mitigated |
|---|---|---|
| **Catastrophic failures in standards of safety and care** | *This may arise if safety-critical controls are not complied with, there are shortfalls in staffing to meet patient need, demand exceeds capacity for a prolonged period, or there is a loss of organisational focus on safety and quality within the governance of Wirral University Teaching Hospitals* | Maintaining a strong emphasis and focus on safety, clinical outcomes and patient experience as part of the Trust's governance and performance management framework; striving for excellence and challenging unsatisfactory performance regarding organisational control; delivering training, complying with safety-critical organisation policies and procedures, and learning from adverse events and effective use of data and oversight systems are ways we are currently mitigating and monitoring this risk |
| **Demand for care overwhelms our capacity to deliver care safely and effectively** | *This risk may arise if growth in demand for care exceeds planning assumptions and capacity in secondary care; primary care is unable to provide the service required or there is a significant failure of a neighbouring acute provider. The risk may also arise if there are unexpected surges in demand, such as those created by pandemic disease* | Managing patient flow, developing and maintaining effective working relationships with primary and social care teams, working collaboratively across the wider health system to reduce avoidable admissions to hospital are some of the risk treatment strategies that will feature in how we mitigate this risk going forward. Development of South Mersey Hub will increase capacity and assist in preventing avoidable emergency admissions. UECUP will support effective streaming to appropriate services and provide an environment to enable efficient management of emergency patients. |
| **A critical shortage of workforce capacity and capability** | *Due to the number of clinical staff eligible for retirement, the availability of newly qualified practitioners, and increasing competition for the clinical workforce, we anticipate the staffing challenges to be significant* | The People Strategy is specifically designed to help mitigate this risk. By focussing on attracting and retaining high calibre practitioners, building and sustaining high-performing teams, by engaging and developing clinical teams, and adapting to meet the needs of a changing workforce - we aim to make Wirral University Teaching Hospitals the employer of choice. We will continue with the success of the International Recruitment Programme to reduce vacancies across our hospitals. |
| **A failure to achieve and maintain financial sustainability** | *The delivery of high quality care helps to mitigate financial risk by reducing avoidable expenditure, minimising harmful care that extends length of stay or requires additional treatment. This risk may arise if the trust is not able secure sufficient funds to meet planned expenditure, maintain or replace vital assets, and/or is not able to reduce expenditure in line with system-wide control totals* | A local and system-wide Financial Improvement Plan is specifically designed to address the financial challenge and deliver financial outturn in accordance with agreed control totals, gradually progressing towards break-even (no surplus or deficit at the year-end). To safeguard quality, proposals to reduce expenditure are subject to Quality Impact Assessment – overseen by the Executive Medical Director and Chief Nurse. |

# 5. Workforce Plan

# 5. Workforce



## a. Workforce Plan 2022 / 2023

The table below details the changes in establishment and staff in post within the workforce plan for 2022 / 2023

| Staff Group | Change in Current Establishments | Increase in Staffing on Current Staff in Post |
|---|---|---|
| **Nursing and Midwifery** | +25.02 | 112.18 |
| **Registered scientific, therapeutic and technical staff** | +37.10 | 14.45 |
| **Support to clinical staff** | -88.38 | 7.40 |
| **Total NHS infrastructure support** | -9.10 | 40.10 |
| **Medical and dental** | +34.24 | 12.53 |
| **Any other staff** | +1.00 | 0.00 |
| **Total** | -0.12 | 186.66 |

Establishments set out in the workforce plan reflect the activity plan for 2022 / 2023.

Establishments have been rebased and service pressures reviewed, and these have been incorporated into the plan.

The Theatre expansion on the Clatterbridge site is subject to separate funding and will be part of a collaborative approach with other providers across Cheshire and Merseyside. This has therefore not been included in the workforce plan.

The plan assumes the following:

- Bank and Agency staffing levels will remain consistent with previous years;
- Staff absence levels will improve, to levels prior to COVID;
- There are no service redesign assumptions within the plan; any activity of this nature will be completed within existing establishment.

# 5. Workforce

## b. Workforce Challenges

### Recruitment

Whilst significant progress has been made in the recruitment of both Care Support Workers and Registered Nurses, Trust wide vacancies remain over 5%. The effects of this are compounded by other absences and increasing demand. Vacancies across the workforce, impacted by labour-market challenges in specific staff groups, remain a significant risk and are currently scored at 16 on the Board Assurance Framework.

### Retention

Trust turnover is currently circa 13.9% and has been above threshold for over 12 months. The underlying causes of this are multifaceted, with different challenges in different staff groups. Retention is currently scored at 16 on the Board Assurance Framework.

### Health and Wellbeing

The health and wellbeing of our workforce is a particular challenge, particularly given the impact of staff experiences during the COVID-19 pandemic. Sickness absence is currently at 7% and has been above threshold for over 12 months. In the most recent staff survey, there was a significant (9.5%) increase is staff reporting that they come to work despite being unwell and only 50% of staff reported that the organisation takes positive action on health and wellbeing.

### Additional Staffing Processes

Systems and processes relating to the identification, deployment and control of additional staffing are not optimised, resulting in a lack of assurance around utilisation, value for money and planning.

## C. Operational Workforce Priorities 2022 / 2023

The operational priorities set out below are based on the challenges outlined above, the Trusts objectives and the NHS England Priorities 2023

- **Health and Wellbeing:** continue to support the holistic health and wellbeing of our people including through wellbeing surgeries, health and wellbeing conversations and line manager support.
- **Equality, Diversity and Inclusion:** accelerate the delivery of the inclusion plans in place including Model Employer, WRES and WDES
- **Workforce Planning:** implement a workforce planning approach, aligned to activity planning, accelerating the implementation of new roles.
- **Levels of Attainment:** advance the Trust levels of attainment for e-rostering and e-job planning.
- **International Recruitment:** continue to expand international nurse recruitment.
- **Additional Staffing Processes:** review systems and processes to ensure the most effective use of additional staffing.
- **Employee Engagement:** deliver a range of activity to advance employee engagement, including a refreshed recognition approach.
- **Leadership Development:** implement the refreshed approach to leadership development.

# 5. Workforce

## d. People Strategy 2022 – 2027

The Trust People Strategy 2022 – 2027 has been drafted through engagement with our workforce and is currently going through ratification processes. The strategy is comprised of four components and an ambitious vision has been set for each component, along with strategic priorities:

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| **Component** | **Looking after our selves and each other** | **Belonging at WUTH** | **Transforming ways of working** | **Shaping our future** |
| **Vision** | We will develop a wellbeing culture where supporting and enabling the holistic wellbeing of our people becomes the norm. | We will develop an inclusive culture were everyone's voice is represented. | We will embrace new ways of working and create opportunity to enable our people to achieve their potential. | We will improve outcomes across Wirral for health, employment and wellbeing by working with our partners to be the best place to work. |
| **Strategic Priorities** | 1.1 Deliver first class, innovative Occupational Health and Wellbeing Services.<br><br>1.2 Equip our line managers and leaders with the knowledge, skills and tools to develop a wellbeing culture within their teams.<br><br>1.3 Fully embrace flexible working across all roles.<br><br>1.4 Create the conditions for civility and respect amongst our workforce. | 2.1 Proactively increase and celebrate diversity at all levels of the workforce.<br><br>2.2 Enable a strong voice for our people throughout the Trust and recognise their contributions.<br><br>2.3 Create the environment for compassionate and inclusive leadership. | 3.1 Develop our people to equip them for both the current challenges and the future.<br><br>3.2 Work with partners across Wirral and beyond to maximise workforce opportunities.<br><br>3.3 Embrace technology to transform how we work. | 4.1 Ensure we have a thorough understanding of our workforce requirements and utilise new roles and opportunities to deliver those requirements.<br><br>4.2 Become an employer of choice which attracts and retains the best people.<br><br>4.3 Lead the way as an 'anchor institution' which is rooted in our community |

An annual delivery plan will be developed against the strategic priorities set out under each component. Delivery and monitoring of impact will be overseen by Workforce Steering Board, with assurance provided to Workforce Assurance Committee.

# 6. Finance Plan

# 6. Financial Plan

## a. 21/22 Financial Delivery

- The Trust is currently finalising its financial accounts and is expected to report a very small surplus for 2021/22.
- The Trust received £17.7m from the Elective Recovery Fund for the year. Whilst this funding will continue into 22/23, the underlying methodology and mechanism for payment will change. This will result in a large reduction compared to 21/22.
- This 21/22 position also includes financial support from Cheshire and Merseyside and in respect of COVID-19 that will reduce significantly in 22/23.
- The Trust had a target of £6.6m for CIP in 21/22 and delivered a programme of £6.3m, of which £5.2m was delivered recurrently and £1.1m non-recurrently. This leaves a shortfall of £0.3m in terms of the headline target and £1.3m in terms of recurrent CIP and these costs will be included in the 22/23 financial plan.

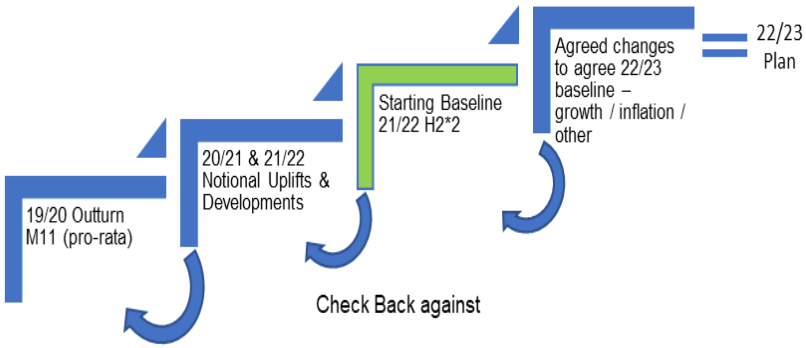
### Table 1: 2021/22 financial position

| 2021/22 Financial Position | Budget £'000 | Actual £'000 | Variance £'000 |
|---|---|---|---|
| NHS income - patient care | 345,122 | 330,408 | (14,714) |
| Income Guarantee | 0 | 15,590 | 15,590 |
| National Top-up | 23,242 | 24,242 | 1,000 |
| Elective Recovery Fund (ERF) | 5,524 | 17,668 | 12,144 |
| Covid 19 income | 22,283 | 21,847 | (436) |
| Non NHS income - patient care | 4,723 | 4,796 | 73 |
| Other income | 30,979 | 36,072 | 5,093 |
| **Total Income** | **431,873** | **450,623** | **18,749** |
| Employee expenses | (290,736) | (301,492) | (10,756) |
| Operating expenses | (136,602) | (144,058) | (7,456) |
| **Total Expenditure** | **(427,338)** | **(445,550)** | **(18,212)** |
| Non Operating Expenses | (4,695) | (5,038) | (343) |
| **Actual Surplus / (deficit)** | **(160)** | **35** | **195** |
| Control Total adjustment | 350 | (7) | (357) |
| **Surplus/(deficit) - Control Total** | **190** | **28** | **(162)** |

## b. Planning Assumptions for 2022/23

- In addition to mandated planning guidance, issued in December, the Trust has made the following assumptions in relation to the 22/23 draft financial plan:
  - Elective activity will be at least 104% of the weighted value of 19/20.
  - A CIP of £20.8m (4.5%) is delivered in full; 3% recurrently and 1.5% non-recurrently.
  - Contracts agreed with key commissioners on principles described in chart 1. These contracts will be novated to the Integrated Care Board on the 1st July.
  - COVID bed occupancy will average at 2% but additional costs will be incurred in respect of absence caused by COVID and additional IPC controls.

### Chart 1: Agreed mechanism for C&M contracts



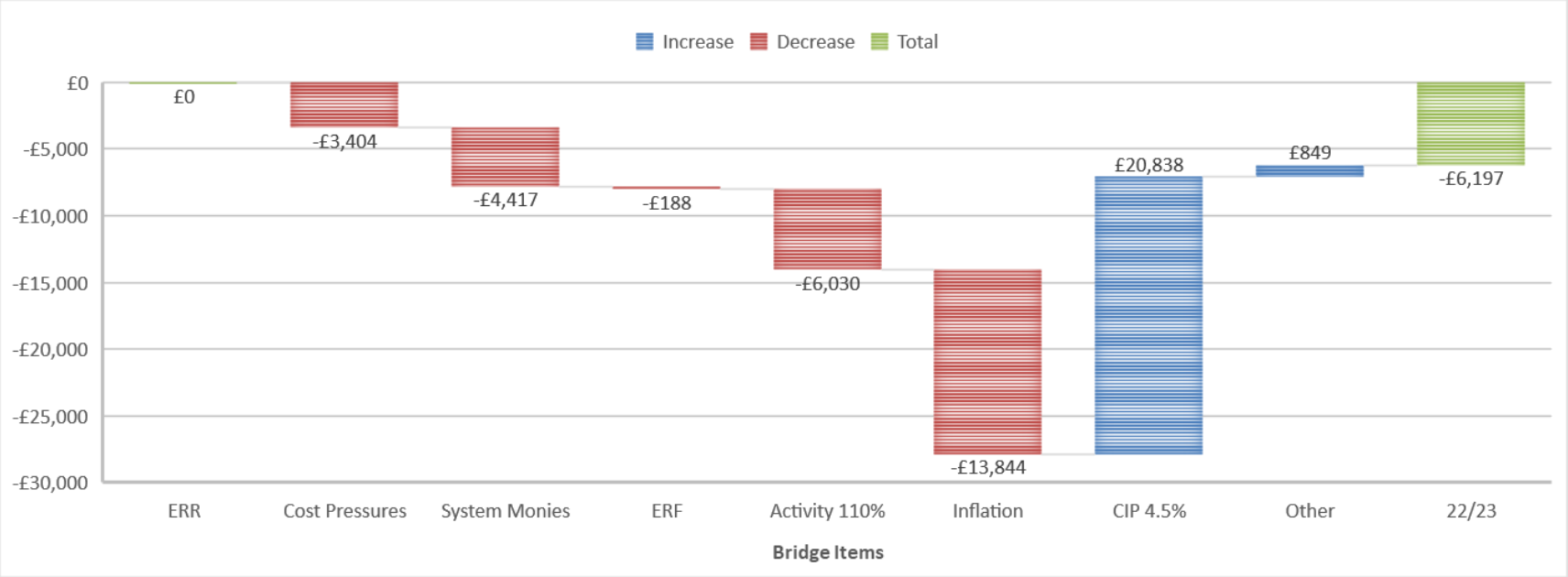
# 6. Financial Plan



### c. 22/23 Financial Plan

- System allocation confirmed with Cheshire & Merseyside.
- 1.1% CIP mandated nationally, additional 0.9% for NW convergence and further 2.5% agreed with C&M.
- All costs in line with activity levels specified within operational plan.
- Inflation provided for in line with guidance but specific uplifts included where known, most notably in respect of energy costs.
- C&M allocation of ERF included within position but receipt is dependent on delivering 104% of value of 19/20 activity.
- Potential for additional funding for activity beyond 104% of value of 19/20 activity but excluded given uncertainty of recovery.
- Series of check and challenge meetings held with all non-clinical budget holders and group meeting with clinical teams and COO.

**Chart 2 : Bridge from 21/22 run rate to 22/23 plan**



# 6. Financial Plan



### d. 22/23 Income

- Starting income position has been agreed with Wirral CCG and other key commissioners and confirmed with Cheshire and Merseyside.
- However, ICB looking to implement system of Aligned Payment Incentive (API) contracts in year to ensure that organisations that go beyond agreed activity plans are funded appropriately, with penalties for organisations that do not deliver plans. Key issue for WUTH given investment in elective capacity and management of the South Mersey Elective hub.
- System monies reduced by approximately 15%, no more support for non-operating income and 57% reduction in COVID funding.
- Non-recurrent support from Targeted Investment Fund, Hospital Discharge Programme and Elective+ all removed from 22/23 plan.
- Funding from Specialist Commissioning has been confirmed.

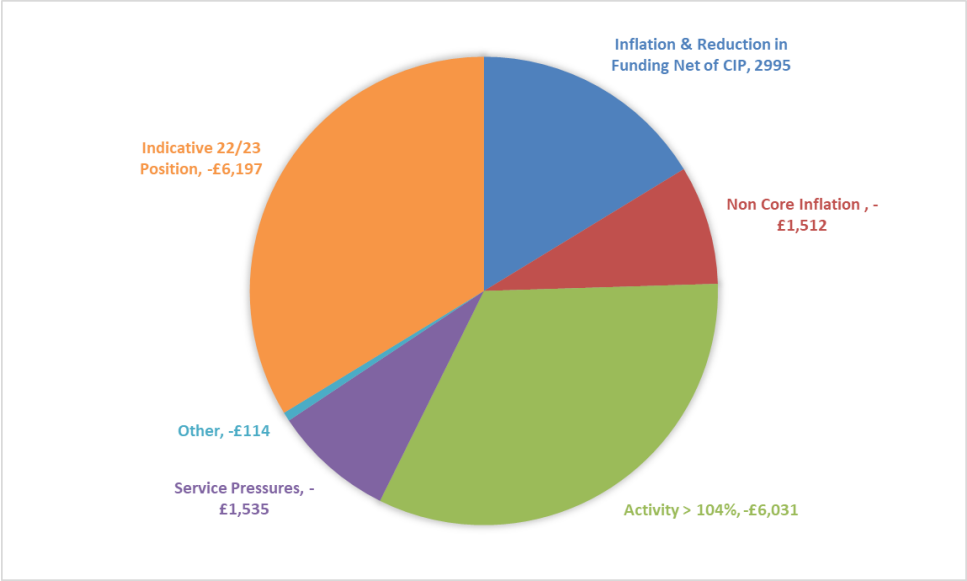
### e. 22/23 Expenditure

- New cost pressures of £1.5m wholly attributable to excess demand for services and patient safety issues.
- Activity beyond 104% of 19/20 value results in marginal costs of £6m; essential that introduction of API results in income flows to fund this.
- Plan assumes that all expenditure associated with Community Diagnostic Centre will be funded but so far only confirmed for H1.
- Provision for Winter costs based on 21/22 plan and not outturn costs.
- 21/22 included costs of recruitment and induction of 160 international nurses, no provision included for 22/23.
- Indicative deficit currently £6.5m. Contributing factors set out in chart 3.

### Table 2: 22/23 summary income and expenditure

| 22/23 Financial Plan | | | £000s |
|---|---|---|---|
| Operating income from patient care activities | | | 396,695 |
| Other operating income | | | 37,561 |
| Staff costs: | Substantive staff | 278,082 | |
| | Bank staff | 5,904 | |
| | Agency staff | 5,031 | |
| | Apprenticeship levy | 1,126 | |
| | | | 290,143 |
| Operating expenditure | | | 145,622 |
| **Operating deficit** | | | 1,509 |
| Interest expense | | | 118 |
| PDC divided payable | | | 4,906 |
| **Deficit for the year** | | | **6,533** |
| Adjustments to financial performance | | | 336 |
| **Adjusted financial deficit** | | | **6,197** |

### Chart 3: 22/23 deficit breakdown



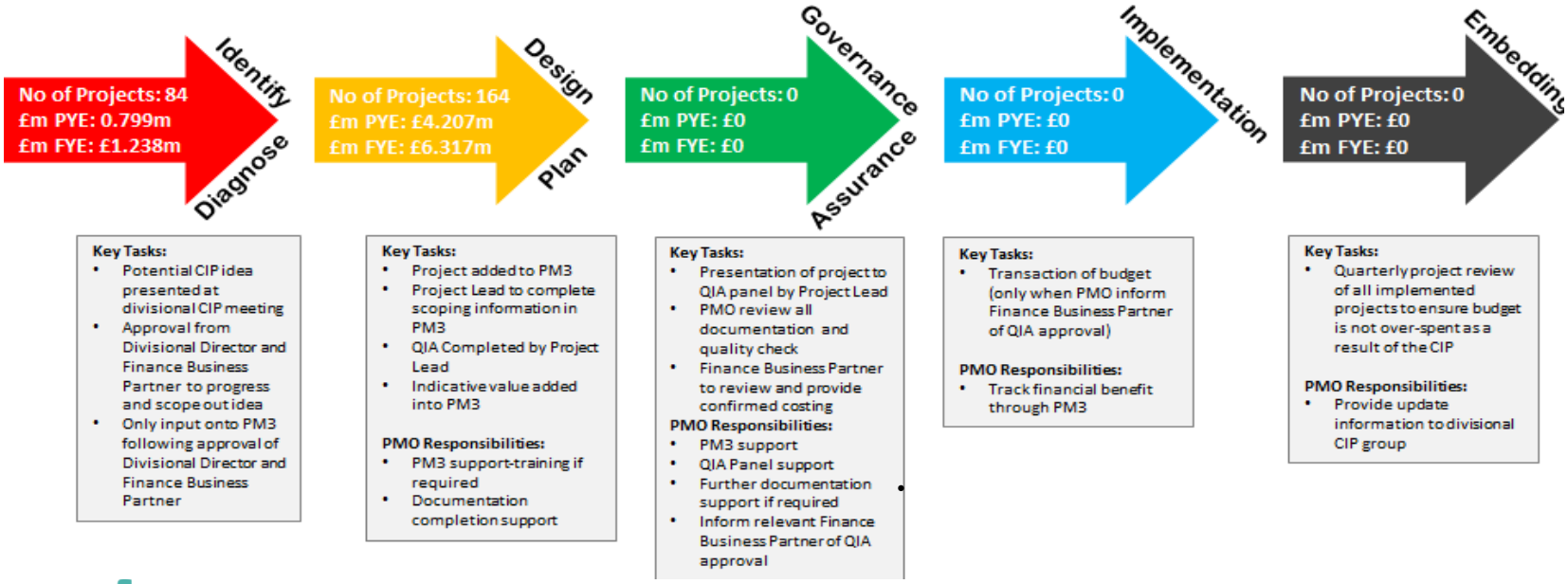
# 6. Financial Plan



### f. Efficiency savings and CIP governance

- The CIP governance framework remains in place and is described in chart 4 below.
- CIP is tracked and monitored through the project management system smart sheets. CIP project leads provide a fortnightly progress narrative and a RAG rating. The leads all use the progress narrative to escalate any areas of concerns that may impact delivery, and to ask for further support where needed.
- All CIP schemes will be subject to a robust Quality Impact Assessment for approval via the QIA panel. The panel consists of the Deputy Director of Nursing, Deputy Medical Director, Deputy Chief Peoples Officer and Equality and Diversity lead.
- A CIP ideas generation submission form has been developed and will be launched Trust wide imminently. This enables any staff member to submit a potential area of efficiency. The PMO will collate all submissions and scope out opportunities. Feedback will be provided to all submissions.
- Fortnightly divisions CIP meetings are in place, chaired by the Divisional Director. The appropriate finance business partner and PMO team attend all meetings to support with idea development and costings.
- The Trust wide CIP dashboard reports a detailed position statement of progress through the CIP gateways. The gateways also provide a drill down function to individual scheme level.

**Chart 3 : WUTH CIP Governance Framework**



# 6. Financial Plan



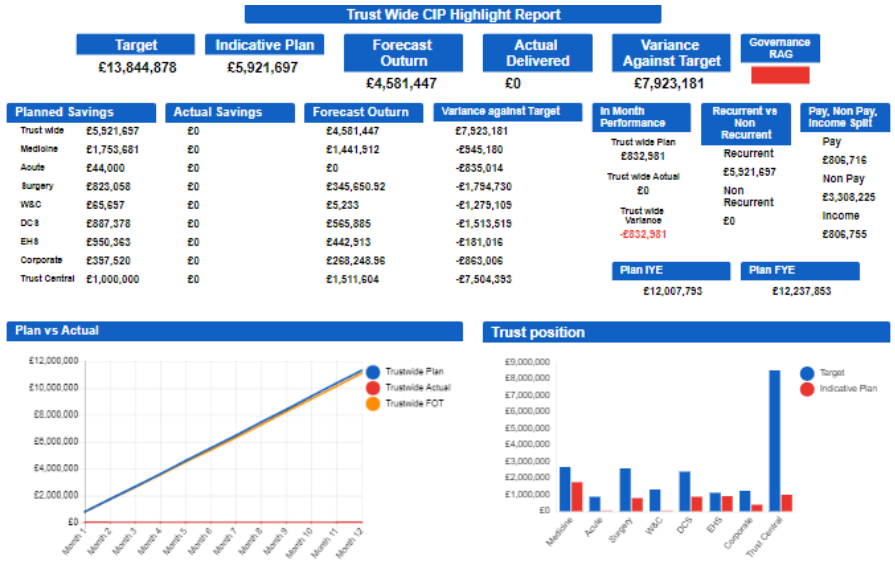
### g. 2022/23 efficiency savings and CIP

- The Trust has a 4.5% CIP target, with 3% to be delivered recurrently and 1.5% to be delivered non-recurrently. This represents a £20.8m combined target.
- Target of 1.5% for non-recurrent CIP is equal to £7m. Finance will monitor and record all non-recurrent reductions in spend. Some of target met by turnover of staff and reductions in activity. Any positive movements in balance sheet will contribute to position.
- The divisions have been set 3% recurrent targets which equates to £13.845m. Failing to achieve this plan represents the most significant risk within the 2022/23 financial plan. Plans identified to date are detailed in table 3 and whilst this is a positive start they remain significantly short of target.
- CIPs are tracked and monitored on an individual basis. CIP leads provide fortnightly position statements through smartsheets along with an updated RAG rating. CIP scheme performance is discussed and reviewed during fortnightly CIP meetings.
- The Trust wide CIP dashboard within smartsheets provides a live position statement. The finance business partners are in the process of updating the monthly profile of all schemes. The dashboard is automatically updated as soon as figures are inputted into the system by finance.
- Divisional highlight reports have been developed that provide an overview of individual performance.
- The productivity & efficiency team continue to liaise with other organisations through the National Efficiency Forum to share best practice and present opportunities to the divisions.
- A fortnightly Cheshire & Merseyside CIP meeting, chaired by WUTH, has been implemented to share areas of best practice. Following these meetings, WUTH are in the process of working with a number of system partners to understand their success.

**Table 3: 22/23 CIP plan against recurrent target**

| Division | Target £000 | Plan £000 | Current Variance £000 |
|---|---|---|---|
| Acute | 879 | 44 | 835 |
| Corporate | 1,261 | 410 | 850 |
| EHS | 1,131 | 1,035 | 96 |
| Surgery | 2,618 | 737 | 1,881 |
| Trust Central | 1,512 | 1,012 | 500 |
| DCS | 2,401 | 823 | 1,578 |
| W&C | 1,345 | 125 | 1,219 |
| Medicine | 2,699 | 1,735 | 964 |
| **Total** | **13,845** | **5,922** | **7,923** |

**Chart 4: Trust wide CIP highlight report**



# 6. Financial Plan



### h. Cash flow Plan

- The results of the Trusts cash flow modelling for 2022/23 are set out in the Statement of Cash Flows in Table 4. Cash balances fall to £33.9m at the end of the year from an opening balance of £12.9m.
- This table represents a summary of the in-depth analysis that the Trust undertakes in respect of cash flow on a daily basis, forecasting for the next 18 months to understand exactly when cash pressures will materialise and taking steps to mitigate.
- Despite the forecast deficit and the large reductions in cash holdings forecast in 22/23, we do not anticipate any issues in terms of cash flow and do not believe any additional working capital requirements for the year.

**Table 4: Statement of Cash Flows**

| 22/23 Cash Flow Statement | £000s |
|---|---|
| **Opening cash balance** | **33,903** |
| Operating deficit | -1,509 |
| Capital donation income | -12 |
| Purchase of fixed assets | -44,228 |
| Depreciation | 12,585 |
| PDC payable | -4,906 |
| PDC receivable | 34,863 |
| Loan repayments | -1,015 |
| Interest paid | -118 |
| Movement in assets/liabilities | -17,075 |
| **Closing cash balance** | **12,488** |

### h. 2022/23 Capital Plan

- The Trusts draft capital programme for 2022/23 totals £9.8m and is summarised in Table 5.
- The Trust has a significant level of backlog maintenance and essential infrastructure requirements and has therefore undertaken a detailed capital planning process to ensure that key risks are being addressed with the limited resources available.
- Included within the programme is a £18m PDC drawdown against the capital allocation for the Urgent & Emergency Care Upgrade Programme. This is to support key enabling works to be undertaken during the year.
- Schemes have been prioritised using ratings set out in the Trusts risk register which is regularly reviewed as part of the Trusts internal governance processes. Schemes with a risk rating of 15 or above are recommended for approval.

**Table 5: Summary of Capital Plan**

| | £000s |
|---|---|
| IT - various schemes | 1,976 |
| Medical equipment | 737 |
| Facilities equipment | 93 |
| Bathroom refurbishment | 137 |
| Simulation suite refurbishment | 98 |
| Doctors mess refurbishment | 72 |
| Ventilation works | 400 |
| Flooring | 80 |
| Fire compartmentation | 400 |
| Ward 1 - Renal Unit refurbishment | 2,800 |
| Modular theatre build completion | 2,992 |
| **Total CDEL** | **9,785** |

# 6. Financial Plan

## h. Risks and mitigations

### i. Risks

- High risk of non CIP achievement which will need to be managed through tight expenditure control. Ability to deliver £20.8m CIP (4.5%) is at least double what has been achieved in recent years.
- ERF income included wholly dependent on 104% 19/20 activity.
- National inflation currently running at 7%, almost 5% above inflation per planning guidance. Potential for further increases in budgeted cost, most notably in respect of energy costs, building materials and high cost drugs.
- War in Ukraine and potential for further sanctions on Russian linked companies, most notably Gazprom UK.
- Community Diagnostic Centre funding only confirmed for H1.
- No allowance for contingency due to affordability.
- Staffing pay awards are assumed to be as per national guidance but have not yet been agreed.
- Impact of additional demand associated with a rise in COVID-19 could be significant.

### ii Mitigations

- Monthly divisional CIP monitoring meetings and fortnightly QIA panel to ensure CIP opportunities transacted quickly.
- All costs associated with activity beyond 104% of 19/20 included within plan but no associated income.
- Continue legal process in respect of Frontis accommodation and seek to minimise costs associated with the lease.
- Tight expenditure and vacancy control.
- Regular review of balance sheet in line with best practice to ensure system inefficiencies do not impact on over estimated levels of expenditure.
- Careful monitoring of bed capacity requirements

# 7. Risks to delivery of the 2022/23 Operational Plan

# 7. Risks to delivery of the 2020/21 Operational Plan

NHS Wirral University Teaching Hospital NHS Foundation Trust

## a. Identification of risks to the delivery of the 2022/23 Operational Plan and mitigation

- Through the development of the 2020/21 Operational Plan, the Trust has identified a range of risks to delivery of the plan, aligning these to the Trust's risk register and Board Assurance Framework. As part of this process the Trust has developed a number of actions to mitigate and reduce these risks, as detailed in the table below:

| Risk | Risk Detail | Domain | Mitigating / managaing actions |
|---|---|---|---|
| Internal | Risk to delayed care for elective patients due to flow and capacity constraints and the backlog as a direct output of the Covid-19 pandemic | Operational | Full validation process in place with escalation to clinical teams, harm reviews in place and escalation as required, full P coding of patients on the waiting list. Recovery plans developed per specialty. Performance reviewed weekly |
| | The risk of reduced capacity and safety/quality of care due to the failure or breakdown of estate, facilities and or equipmrnt | Estates and Facilities | Prioritisation of capital funds, proactive planned maintenance of theatres, endoscopy areas etc |
| | The risk of non-elective demand remaining at winter seasonal levels and impacting elective capacity | Operational | Full site reconfiguration plan to protect elective services, development of a robust winter plan focussed on admission avoidance and different models of care for patients who don't have a C2R. Robust staffing plans for esclation areas |
| | The risk of not delivering against the 2022/23 financial plan | Finance | Robust internal plans to monitor divisional financial positions. Monthly deep dive sessions with divisions for adverse areas. |
| | | | |
| External | Uncertainty of the external financial environment and the changing arrangements | Fiance | Engagement in ICS financial governance, strong 22/23 position submitted. |
| | The risk that system partner work programmes do not deliver the required benefits for patients and Trust capacity | Operational | Engagment with system partners and governance structure. Ensure clear alignment of priorities and monitoring of expected outputs |
| | The risk of Covid-19 surges and the impact on service delivery as well as operational, financial and workforce performance across 2022/23 | Operational / Finance / Workforce | Establishment of EPRR aproach to Covid-19. Regular briefing sessions with leadership and staff. Management of Covid019 costs and reporting |

Wirral University Teaching Hospital
NHS Foundation Trust

**Board of Directors in Public** **Item No 11**
**1 June 2022**

| | |
|---|---|
| **Title** | NHS Staff Survey 2021 |
| **Area Lead** | Deborah Smith, Chief People Officer |
| **Author** | Hayley Curran, Associate Director of OD |
| **Report for** | Information |

| **Report Purpose and Recommendations** |
|---|
| The purpose of this report is to provide Board with an update as to how results of the 2021 NHS Staff Survey are progressing following a presentation of results and priority areas for action at May 2022 Workforce Assurance Committee meeting. It is recommended that the Board:<br>• Note the 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 | No |
| **Infrastructure:** improve our infrastructure and how we use it. | No |

| **Governance journey** | | | |
|---|---|---|---|
| **Date** | **Forum** | **Report Title** | **Purpose/Decision** |
| 26 May 2022 | Workforce Assurance Committee | Staff Survey Update | To provide Workforce Assurance Committee (WAC) with an update as to how results of the 2021 National NHS Staff Survey are progressing following a presentation of results and priority areas for action at March 2022 WAC meeting. |

| 1 | Narrative |
|---|---|
| 1.1 | **Context**<br>The 2021 staff survey was conducted between end Sept and end of November 2021. The Survey return rate was the largest sample size in the last five years with 46% of the workforce completing the survey. The survey results were delayed by approximately 4 weeks due to realigning the results to the national NHS People Promise, which not only enables Trusts to review the data by questions theme, but it also enables Trusts to benchmark their progress against the national people promise.<br><br>WUTH benchmarked 'on average' or slightly below average (not statistically significant) when compared to all 126 Acute and Acute & Community services in England. Whilst benchmarking against the National NHS People Promise has highlighted high-level areas for improvement, when the underlying data is analysed further, thematic areas of decline and improvement are identifiable. It is from these themed areas that priority areas of focus have been identified. Priority areas were identified based upon a decline or improvement of 5% or where scoring is identified as statistically significant by Quality Health whom WUTH commission to conduct survey on its behalf.<br><br>As highlighted previously, there were a number of thematic areas for priority focus, these were:<br>• **Staff Engagement**. In particular, scores surrounding staff **looking forward to coming to work** and staff **recommendation of the Trust as a place to work or receive treatment.**<br>• Development for **immediate managers** to help empower them to better support their direct reports.<br>• Ensure staff are **recognised and rewarded** for good performance<br>• Explore lower scores in '**autonomy and control**.' In particular, seek to **involve staff** in key decisions.<br>• Continued priority of **health and wellbeing and stress at work**<br>• Review **learning and development** opportunities for staff. Drill down into professional groups<br>• Explore lower scores within '**flexible working**' and '**team working**'<br><br>Areas in which we saw significant improvements were:<br>• Staff knowing how to and feeling confident to **raise concerns**<br>• **Equality, Diversity & Inclusion** – a number of indicators including WRES scores have significantly improved<br>• Staff have **strong personal connections to their team**<br>• **Reduction in staff experiencing MSK** problems in the last 12-months<br>• **Reduction in staff experienced work related stress** in last 12-months, and below sector average<br>• **Reduction in staff Experienced physical violence** by patients / services users<br>• **Reduction in experience of harassment / bullying** by patients / service users |

| 2 | Implications |
|---|---|
| 2.1 | **Mobilising the 2021 Staff Survey**<br>Following the embargo lift on 30th March 2021 results have been cascaded to divisions and professional workforce groups. A plan has been developed for the cascade of results and ongoing communications has been developed and reported to Workforce Assurance Committee.<br><br>Work is underway to address the priority areas set out in section 1. The 2021 survey results provide a significant evidence base for development of both the People Strategy 2022 – 2026 and the annual 2022 People Strategy delivery plan, which is currently being finalised. The delivery plan will be submitted to Workforce Steering Board in June 2022. Key work streams, informed by the staff survey results, have been commenced including the design and delivery of a new leadership development offer, the re-launch of Annual Staff Awards and the introduction of wellbeing surgeries.<br><br>Results are being shared with key leads across the Trust to inform annual plans such as quality and safety and workforce specific themes, for example results were cascaded to nursing colleagues via the 'Chief Nurse check in' this highlighted areas for improvement in '*morale*' '*we are safe & healthy*' and 'we *are recognised and rewarded'*, leading to discussions as to how these could be begin to be addressed (in part) through celebration of International Nurses day (12th May 22).<br><br>HR Business Partners are facilitating results across divisions and are engaging divisions in identify priority areas of action also. These will be monitored locally via Divisional Management Board meetings.<br><br>Appendix A gives an overview of planned activities and programmes of work that will address the priorities highlighted from the 2021 National Staff Survey. As the Staff Survey is just one of our Trust diagnostics for engaging staff and informing plans this work will form part of a continuous cycle of seeking feedback and making improvements as opposed to the 'traditional' process of an staff survey action plan that is refreshed annually. It is recognised that achieving sustainable will often take more than a series of annual activities to achieve. Therefore, rather than have an annual staff survey action plan, the activities identified in appendix A will form part of Trust plans to ensure they arere not perceived as 'additional' but central to improvements. |

| 3 | Conclusion |
|---|---|
| 3.1 | The 2021 National Staff Survey saw an increased response rate of 46%, the highest response rate in the last five years. Results are now aligned to the National People Promise and overall, WUTH was rated average or just below average (NOT statistically significant) when compared to other 126 Trust in its sector against the People Promise themes.<br><br>There are a number of areas for priority and whilst there has been / will be work undertaken to address, this is not an exhaustive list and work also continues to address areas for improvement through 'business as usual' delivery.<br><br>Unlike in previous years the staff survey will not be a stand-alone action plan but will instead form part of various annual delivery plans that deliver both Trust enabling |

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| | strategies and operational delivery plans. This ensures addressing staff feedback forms part of 'business as usual' and isn't perceived as 'an added extra'.<br><br>Furthermore, annual staff survey will form one of a series of Trust-wide diagnostics that monitor our people experience and inform plans for continuous improvement, as will be set out in the Trust new Engagement Framework. |

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| **Report Author** | Hayley Curran – Associate Director for Organisational Development |
| **Contact Number** | Ext 7379 |
| **Email** | Hayley.curran3@nhs.net |

Appendix A

| Theme | Key Activities to Address |
|---|---|
| Staff Engagement. In particular scores surrounding staff looking forward to coming to work and staff recommendation of the Trust as a place to work or receive treatment. | 1. Development of Engagement Framework<br>2. Improvement in use of Quarterly Pulse Survey diagnostic aligned to staff survey priorities; taking a regular 'temp-check' of workforce<br>3. Divisional activities to address services with low scores including OD support for services where scores are particular outliers |
| Development for immediate managers to help empower them to better support their direct reports. | 1. Development of a new Leadership Qualities Framework (LQF)<br>2. Design and delivery of a new leadership development offer aligned to the LQF<br>3. Manager toolkit developed and launched to support line manager development<br>4. On-going delivery of Effective Manager programme<br>5. Working in collaboration with divisional Triumvirates to more effectively target development for line managers who most require it<br>6. Annual calendar of Leadership Masterclasses available to all staff across the Trust to enable greater autonomy and empowerment |
| Ensure staff are recognised and rewarded for good performance | 1. WUTH E-Cards launched in April 2022 as another means for providing appreciation and positive feedback to staff<br>2. Re-launch of Annual Staff Awards<br>3. Re-launch of Annual 'Long-service' staff awards<br>4. Reward and Recognition is a key component of the staff engagement framework – which will include an annual calendar of recognition events<br>5. Divisional leadership teams to develop local plans for reward and recognition |
| Explore lower scores in 'autonomy and control.' In particular seek to involve staff in key decisions. | 1. Workforce Engagement Team to undertake further engagement to understand this score, which will include working with staff networks to generate ideas for how this score can be improved<br>2. Devolving of autonomy and empowering staff forms an essential component of staff the LQF and will be an element of learning with the leadership development offer<br>3. Series of engagement activities have taken place to enable staff to shape strategic plans such as workshops to inform enabling strategies and Just and Learning Culture visions and plan<br>4. Annual leadership conference to include a broad mix of staff and NOT just those in senior leadership roles |
| Continued priority of health and wellbeing and stress at work | 1. Delivery of Workforce Winter Wellbeing plan<br>2. Series of 'Leadership for All' masterclasses run with focus upon 'looking after self' |

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|---|---|
| | 3. Recurrent investment in mental health services for staff – increased sessions of in-house psychotherapy<br>4. Introduction of Wellbeing Surgeries<br>5. Development of holistic health and wellbeing checks<br>6. People Strategy priority 'Looking After Ourselves and Each-other' firmly places health and wellbeing as central to our strategy<br>7. Plans to build manager capability to support workforce wellbeing incorporated into the new Leadership Qualities Framework<br>8. Wellbeing conversations to form essential component of appraisal and supervision as part of the current review and re-launch of staff appraisal |
| Review learning and development opportunities for staff. Drill down into professional groups | 1. Review of Education and Training commissioned to highlight areas of good practice and areas for improvement<br>2. Training needs analysis developed to inform Up-skilling investment<br>3. Programme of ward-based learning for clinical skills development to return – '*learning at the point of care'*<br>4. New leadership development offer to be launched at Leadership Conference in June 22<br>5. Refreshed process for appraisal and supervision to increase focus upon development<br>6. Review of Education Governance group to be established with greater alignment for all professional groups<br>7. Work currently underway with Estates and Facilities division to develop profession specific skills pathways |
| Explore lower scores within 'flexible working' and 'team working' – NOTE: these will have been affected by Covid-19. | 1. Review of flexible working is currently underway to benchmark current practice<br>2. Review of the flexible working policy<br>3. Flexible working is a key objective within the new People Plan and it is anticipated a programme of work to improve flexible working at the Trust will commence following review |

**Board of Directors in Public**

**01 June 2022**

**Item 12**

| | |
|---|---|
| **Title** | Modern Slavery Statement |
| **Area Lead** | David McGovern, Director of Corporate Affairs |
| **Author** | Cate Herbert, Board Secretary |
| **Report for** | Approval |

## Report Purpose and Recommendations

The purpose of this report is to provide the Board with the annual update of the Modern Slavery Statement as required by the 2015 Act.

It is recommended that the Board:

- Approves the updated statement for 2022-23.

## Key Risks

This report relates to these key Risks:

- Compliance with legislative requirements to publish a regularly reviewed and updated statement.

| 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 | 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 |

## Governance journey

This is an annual report brought to the Board for approval.

| 1 | Narrative |
|---|---|
| 1.1 | The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency both in the organisation and within its supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act. |

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| | The requirement for an annual statement is set out in Section 54 of the Act, specifically addressing the requirement for transparency in the supply chain. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The Act requires that the statement is approved annually by the Board of Directors.<br><br>This year's statement has been updated in discussion with the Director of Corporate Affairs and the Head of Procurement. The Board are asked to review the statement at section 1.2 and provide approval. Following this, it will be signed by the Chair and the CEO and published on the Trust website. |
| 1.2 | **Modern Slavery and Human Trafficking Act 2015 Annual Statement – 2022**<br><br>Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.<br><br>The aim of this statement is to demonstrate that the Trust follows good practice, and all reasonable steps are being taken to prevent slavery and human trafficking.<br><br>Wirral University Teaching Hospital NHS Foundation Trust provides a comprehensive range of high quality acute care services, our more than 6,200-strong workforce serves a population of about 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider Northwest footprint. We operate across two main sites, these being Arrowe Park Hospital in Upton and Clatterbridge Hospital in Bebington. We also provide a range of outpatient services from community locations at St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey.<br><br>The Trust has well established and robust recruitment and vetting procedures and ensures that suppliers operate in accordance with the provisions of the Modern Slavery Act.<br><br>The Trust has a total non-pay spend of c.£130m on goods, equipment and services. The Trust aims to achieve value for money and to promote social values through its contracting and purchasing activity, and the effective utilisation of the Trust's spend contributes significantly to the quality of the patient environment and patient care<br><br>The Trust supports the eradication of Modern Slavery through its procurement procedures and processes and is clear that it expects all potential suppliers to be fully compliant with the provisions of the Modern Slavery Act. The Trust does this in a number of ways including the use of Public Sector Frameworks where there is strong awareness of and monitoring for Modern Slavery in the supply chain. The Trust's tendering documentation includes the provision for the mandatory exclusion of any bidder that has been convicted of a human trafficking offence, and the Trust's contracts include terms and conditions conferring a legal responsibility on Contractors to support that same objective to eradicate slavery and human trafficking.<br><br>Procurement professionals within the Trust are Members of the Chartered Institute of Procurement and Supply with a requirement to undertake training in Social Value as part of their Continuing Professional development. |

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| | The Trust will continue to follow good practice, ensuring all reasonable steps are taken to prevent slavery and human trafficking within its supply chain and will monitor and review its approach via the Trust's Procurement Strategy. |

| **2** | **Implications** |
|---|---|
| 2.1 | This statement has been prepared in line with the guidelines and requirements set out in the Modern Slavery and Human Trafficking Act 2015 and supports the Trust's compliance with legislative requirements. |

| **3** | **Conclusion** |
|---|---|
| 3.1 | Board is requested to approve the statement set out at 1.2 for publication on the website. |

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| **Author** | Cate Herbert, Board Secretary |
| **Email** | Catherine.herbert5@nhs.net |

**Board of Directors in Public** **Item No 13**
**1 June 2022**

| | |
|---|---|
| **Title** | Communications and Engagement Report |
| **Area Lead** | Debs Smith, Chief People Officer<br>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 April 2022, including media relations, campaigns, marketing, social media, employee communications and stakeholder engagement, WUTH Charity and staff communications to support engagement.

## Key Risks

This report relates to these key Risks:

- Risk 1.1 – Unscheduled care demand (communications interventions to support addressing this risk and Trust initiatives like addressing discharges 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 and elective recovery)
- 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 Upgrade Programme)

| 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** |
| Standing report to Board | | | |

| 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.<br><br>**Campaigns, media, social media, internal communications, staff engagement communications and stakeholder relations**<br><br>**Campaigns**<br><br>**Celebrating 40 years of Arrowe Park Hospital** – on 4th May, we celebrated the 40th Anniversary of the day Her Majesty the Queen, accompanied by the Duke of Edinburgh, officially opened Wirral's new hospital at Arrowe Park.<br><br>We received a special letter from the Palace, which said: "The Queen has asked me to thank you for your kind letter on behalf of Wirral University Teaching Hospital NHS Foundation Trust, sent on the occasion of the Hospital's Fortieth Anniversary which is being celebrated on 4th May."<br><br>"Her Majesty much appreciated your thoughtfulness in writing as you did and, in return sends her best wishes to you all for a most memorable and enjoyable year celebrating this notable milestone."<br><br>The hospital was decorated with a new flag flying with stands and display boards in the main entrance. To celebrate the day and to make it as inclusive as possible for all WUTH sites, Trust colleagues at Arrowe Park, Clatterbridge, St. Catherine's and Microbiology in Bromborough were treated to tea and celebration cake. All Trust staff will receive a 40th anniversary keepsake pin badge.<br><br>There were social media posts hashtag **#ArrowePark40** with photos of staff in the 40th Anniversary Frame and a fabulous video, featuring colleagues from around the Trust talking about what Arrowe Park means to them.<br><br>A special 40th anniversary supplement was produced in The Wirral Globe- online **here** with more inside the paper **here**. The story also featured on ITV News website **here** and on local radio. Staff and the public entered into the spirit of celebrations of this special day in the history of Arrowe Park Hospital with lots of social media engagement and goodwill towards the hospital.<br><br>Further celebrations and thanks to staff took place on 5th May (International Day of the Midwife), 11th May (National Staff Networks Day) and12th May (International Nurses' Day). We also launched a new staff network in May – our Menopause Staff Support Network. For our nurses, we distributed further small thank you gifts and donated goods including hand cream developed 'by nurses for nurses'.<br><br>There was a further day of celebrations on 20th May to recognise people professionals |

across our Workforce team on International HR Day with video from Chief People Officer Debs Smith International HR Day video and social media content from colleagues in the Directorate and from senior leaders highlighting the value of the work of our people professionals.

May 5th was also World Hand Hygiene Day and our colleagues from Infection Prevention and Control were about the hospitals promoting key messages about hand hygiene, not just to prevent COVID-19, but other infections too.

**Media**

Once the local elections were over, we resumed normal media activities with our press release on the formal submission of planning for the Urgent and Emergency Care Upgrade Programme (UECUP), which gained regional and national coverage. The Wirral Globe: Plans submitted for £28m care facility at Arrowe Park Hospital | Wirral Globe

Birkenhead News: Plans submitted for urgent and emergency care facility at Arrowe Park Hospital – Birkenhead News

BBC online: https://www.bbc.co.uk/news/uk-england-merseyside-61428708

Liverpool Echo: Arrowe Park Hospital set for £28m transformation - Liverpool Echo

We took part in a HSJ interview to discuss our capital plans. This also covered aspects of our improvement journey to create a just and learning culture, and a well-led organisation.

We launched our Patient Experience Strategy and our Research and Innovation Strategy completing the suite of enabling strategies for WUTH

**'Nursing Times' Award Shortlist**

Our Practice Education Facilitators have been shortlisted for a Student 'Nursing Times' Award 2022 as part of the Cheshire and Merseyside Annexe Collaborative, which includes 4 universities and 15 trusts across Cheshire and Merseyside, who are working in partnership to enhance practice learning and implement the Nursing and Midwifery Council Future Nurse skills (annexe A and B) across adult, child, mental health and learning disability fields of nursing. The Practice Education Facilitator team have implemented training to support the student nurses to achieve the Future Nurse skills.

The category they are shortlisted for is 'Partnership of the Year'. This award seeks to recognise the important collaboration between higher educational institutions and organisations providing healthcare to the public with a view to providing a conducive learning environment.

You can view the full criteria for the categories and shortlist on the Student Nursing Times awards website **here.**

**Employee Communications**

**Employee health and wellbeing** continued to be an important focus for communications, including the launch of staff and manager wellbeing conversations and sharing resources for seminars on financial wellbeing and the cost-of-living crisis.

We also launched our staff awards planned as an in-person event on 25th November 2022.

**Stakeholders**

The first meeting was held on 3 May for a new place-based network of senior communications leads across Wirral from the Council, third sector, The Integrated Care Board and other NHS providers to support integrated working and prepare for the transition to the Integrated Care System in July.

We publicised that the second Healthy Wirral Schwartz Round "Outside my Comfort Zone" will take place online on Wednesday 25th May from 12.30 to 1.30 pm. This is for all staff and volunteers from across Wirral Health, care, voluntary, community and faith sectors and aims to support them through listening to, and sharing, common experiences – more details **here** and to find out more about Schwartz Rounds, see **here**.

**WUTH Charity**

The Charity team focus this month has been the successful relaunch of the Tiny Stars Neonatal appeal.

**The Spring Lunch**, April 26th raised £6500 for the Tiny Stars Neonatal appeal. This reception and 3 course lunch for 80 guests was kindly donated by the Red Fox Thornton Hall. The event, which officially relaunched the appeal was organised in partnership with WUTH Charity supporter Mandy Molby who accepted the role of WUTH Charity ambassador at the event.

**Mayor of Wirral Charity Golf Day**. 13th May Caldy Golf Club. The last event of Mayor Councillor George Davies term raised £11,150, matching the total raised throughout the year. This means The RNLI and the Tiny Stars Neonatal appeal will both receive this amount. The Charity will be presented the funds at a reception in the Mayor parlour later this month. We would like to thank the Mayor and Mayoress for their continued support over the last 3 years during their term as both Deputy Mayor and Mayor of Wirral. Cllr George Davies has pledged to continue to support WUTH Charity and the appeal.

**Tri4life Everest Summit Challenge.** Three of the four team members successfully reached the summit of Everest on Thursday 12th May and are now safely back in Kathmandu. Unfortunately, Dr Martin Pritchard Howarth was unable to attempt the final summit challenge due to developing altitude related complications at Base Camp. Martin was airlifted to hospital in Kathmandu. He has since been discharged and reunited with his team on their successful return to Kathmandu. The team have raised £13,000 and the Tiny Stars Neonatal appeal is one of three charities to benefit. Tri4Life fundraising for Wirral University Teaching Hospital . They also took Tiny Stars branding to the summit of Everest and sent us this heart-warming video, which can be seen **here**.

**Wirral Coastal Walk** Sunday 22nd May. The Charity team will be supporting a team of 35 walkers completing the 12.5mile route in support of Tiny Stars, including a strong turn out from our midwives.

**It's a Knock Out** July 2nd Arrowe County Park 11am – 4pm. Up to 24 teams of 12 will take part in this classic 'fun day'. Owing interest in the event, a staff special offer of £20 per person for NHS staff is available until Friday 4th June. Head of Fundraising Victoria Burrows has approached Medicash to be headline sponsor for the event, initial feedback is positive.

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| | **Heswall Hall 70's, 80's & 90's Party Night**. July 9th 7pm – Midnight. Tickets cost £10 and are available from the Charity Office.<br><br>**Arrowe Park Abseil** 23rd September. This popular event will return for a third year. Booking for this event will open in June. Head of Fundraising Victoria Burrows and Community and Events Fundraiser Phil Crawford are currently working with Santander to try and secure them as headline sponsor for the event.<br><br>**Virtual London Marathon** 2nd October. WUTH Charity has 25 places available for this year's virtual event. The ballot for this event will open in June.<br><br>**Wirral Winter Ball** 12th November. Thornton Hall Hotel. Newly appointed WUTH Charity ambassador Mandy Molby has confirmed WUTH Charity will be the major beneficiary again this year. It is hoped that it will exceed last year's total of £40,000 raised. Sponsors Grosvenor Insurance, Harrogate Wealth Management and KMC Legal are confirmed repeat sponsors to date. |

| **2** | **Implications** |
|---|---|
| 2.1 | The Board is asked to note the progress and the 40th anniversary commemorations and publicity for capital plans. |

| **3** | **Conclusion** |
|---|---|
| 3.1 | The Board is asked to note the developments and progress outlined in the report. |

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| **Report Author** | Sally Sykes, Director of Communications and Engagement |
| **Contact Number** | 0151 604 7640 |
| **Email** | wih-tr.Communications@nhs.net |

**Board of Directors in Public** **Item No 14.2**
**1 June 2022**

| | |
|---|---|
| **Title** | Committee Chairs Reports - Quality 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 25 May 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 | **Learning from deaths report (Q4 2021-2022)**<br><br>In receiving this report and gained good assurance that there are robust processes in place for the review of all deaths that take place at the Trust, with the Medical Examiner role now well embedded. There is appropriate monitoring of mortality rates (presently within expected levels) and an early warning system in place for possible high rates within diagnostic groups. The Mortality Review group through its Chair were complimented on the significant progress made in the last year in developing the quality of their processes and their clearer interaction with other quality monitoring processes at the Trust. |
| 1.2 | **Approval of Quality Account 2021-2022** |

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| | Subsequent the Audit Committee, this Committee approved the Quality Account for forwarding to the Board for final approval. The account as set out is constrained in style and layout by national specifications, but the Committee felt that a more engaging format could be developed in addition which we could share with our wider stakeholders. |
| 1.3 | **Care Quality Commission Action Plan**<br><br>The Committee noted this updated action plan (following the inspection report received by the CQC in January 2022) which blended the few remaining in completed items from the existing action plan with the new ones. Actions ongoing and closed were noted and the Committee will receive regular updates on progress. |
| 1.4 | **Infection Prevention and Control Board Assurance Framework and Risk Assessment**<br><br>The Committee received a report that confirmed the arrangements currently in place to control the risk of Covid-19 infection and still allow good access to care for all patients. These are consistent national and regional guidance and have previously been reported the Trust Board. |
| 1.5 | **Mental Health Care in the Emergency Department**<br><br>The Committee received a report about improvement activity following a clinical audit that showed improvement in the metric for Trust staff reviewing patients in mental health crisis after their assessment by a mental health practitioner. It was felt however that despite this, further work was required to provide full assurance that improvement was consistently established. |
| 1.6 | **Internal Audit Report into Mortality and Sepsis Clinical Coding**<br><br>Already considered at the Audit Committee, this report provided substantial assurance about clinical coding and indicated high reliability of our clinical coding processes but also an opportunity to improve them even further. Actions are in place to make those improvements. |
| 1.7 | **Serious Incident Review Panel's Chair's report**<br><br>Following discussion of the Serious Incident (SI) Panel's Chair's report it was agreed to consider how better we could consolidate our understanding of the actions and improvements recommended in SI action plans. It was agreed that a retrospective review on a thematic basis, which tied in relevant areas of quality improvement, as well as assurance on actions being completed would be helpful and a proposal will be brought back to the Committee. |

| **2** | **Conclusion** |
|---|---|
| 2.1 | The Committee received appropriate and detailed documentation in relation to the items it considered on 25th May 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. |

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| **Report Author** | Steve Ryan, Non-Executive Director |
| **Contact Number** | n/a |
| **Email** | n/a |