NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public

31 August 2022

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Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 31 August 2022
Time	09:00 – 11:00
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 – **Verbal**	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 Approach to Integrated Care Across Wirral and Cheshire and Merseyside	Matthew Swanborough
	9.2 Quality and Performance Dashboard	Executive Directors
	9.3 Board Assurance Framework	David McGovern
	9.4 Month 4 Finance Report	Mark Chidgey
	9.5 Monthly Maternity Report, including Oversight of Monthly Parental Surveillance Tool	Tracy Fennell
	9.6 Digital Healthcare Update	Chris Mason
10.	Chief Nurse 6 Month Safe Staffing Report	Tracy Fennell
11.	Infection, Prevention and Control Annual Report	Tracy Fennell
Items for Decision		
12.	2021-2022 Annual Submission to NHS England North West: Appraisal and Revalidation	Dr Nikki Stevenson

13.	Governance and Committee Membership Update	Cate Herbert

Wallet Items for Information

14.	Communications and Engagement	Sally Sykes
15.	Committee Chairs Reports	Committee Chairs

15.1) Workforce Assurance Committee
15.2) Charitable Funds Committee
15.3) Council of Governors – **Verbal**
15.4) Quality Committee
15.5) Finance Business Performance and Assurance Committee – **Verbal**

Closing Business

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

Date and Time of Next Meeting

Wednesday 5 October 2022, 9.00 – 11.00

Meeting	Board of Directors in Public
Date	Wednesday 6th July 2022
Location	Boardroom, Education Centre, Arrowe Park Hospital

Members present:

SI	Steve Igoe	Non-Executive Director, Meeting Chair
SR	Steve Ryan	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
RM	Rajan Madhok	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Nicola Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
HK	Hayley Kendall	Chief Operating Officer
DS	Debs Smith	Chief People Officer
MC	Mark Chidgey	Chief Finance Officer
MS	Matthew Swanborough	Director of Strategy & Partnerships

In attendance:

SS	Sally Sykes	Director of Communications and Engagement
CM	Chris Mason	Chief Information Officer
DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
TC	Tony Cragg	Public Governor
AT	Andrew Tallents	Public Governor
RT	Robert Thompson	Public Governor
JL	Jo Lavery	Director of Nursing and Midwifery (for item 9.3)
RMe	Ranjeev Mehra	Deputy Medical Director (for item 9.4)
SL	Sharon Landrum	Workforce Diversity and Inclusion Lead and Freedom to Speak Up Guardian (for item 9.5)
PM	Paul Mason	Director of Estates, Facilities & Capital Planning (for item 9.7)

Apologies:

DH	Sir David Henshaw	Chair
AM	Alan Morris	Public Governor
SH	Sheila Hillhouse	Public Governor

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** The Chair welcomed everyone to the Board of Directors in Public Meeting. Apologies were received as noted above.	
2	**Declarations of Interest** No new interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting were approved as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** TF introduced the video which had been presented at the leadership conference and which was an overview of the positive work achieved by the Trust and its staff. NS commented that while the Board hears from patient and families who have a less positive experience this montage did represent what the Trust delivers in the majority of cases. It is useful to view this as a benchmark for what is going on across the Trust. Members agreed, noting the positive impact and work being undertaken by staff. TF added that the patient promise groups have been key in driving positive improvements. SI noted that there is a lot of good going on in the Trust, and that we are a learning organisation who respond when something goes wrong. SI noted that this is encouraging particularly considering the challenges and constant pressure faced by the Trust. The Board **NOTED** the Patient Story.	
6	**Chair's Business and Strategic Issues** No business or strategic items were raised.	
7	**Chief Executive Officer's Report**	

	JH gave an overview of the report, highlighting the IPC changes within the Trust as relate to COVID, the National Chief Nursing and Midwifery Silver Award for outstanding contributions to maternity care was given to Debbie Edwards and the positive visit by the Chief Midwife for England, the completion of the UECUP Gateway 3 review, and the June Leadership Conference for staff. JH also drew attention to the serious incidents and RIDDORs reported since the last meeting. The Board **NOTED** the report.	
8	**Chief Operating Officer's Report** HK reported that the Trust did not meet the P2 month end trajectories for May the month end final position over reporting 93 P2 breaches against a month end plan of 60, due to the prioritisation that had to take place due to limited operating theatres. There have been no 104 week waits. In the cancer backlog, the 2 week wait standard will be slightly behind target for Q1 due to April's performance when the Breast Service were recovering from a backlog position, and 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. HK noted the excellent performance of radiology diagnostics, and noted that the main area of challenge is endoscopy which is monitored weekly by executives. In terms of unscheduled care, 28 patients breached the 12 hour DTA target in May, which is not unexpected with the level of occupancy that the Trust is running, the restart of the elective programme, and ED attendance numbers compounded with ED space issues. HK also highlighted the mental health unit pressures and noted that we are working with partners to improve this. SL enquired about the loss of 300 procedures and what the plan for recovery is. HK noted that the LLP will help, and that it is primarily in surgery and gynaecology. Both areas have recovery plans, and Board will continue to be sighted on this. SI commented that the challenges are significant and that a response is not just for WUTH but for the system as a whole to consider.	

	The Board **NOTED** the report.	
9	**Board Assurance Reports** **9.1 Quality and Performance Dashboard** NS noted the dip in acknowledgement of complaints and she is looking into the rationale for this. NS also noted that there was one breach of the duty of candour. Duty of candour had been performed but it was out of the timescale, and work to reiterate the importance of this has been picked up with the divisions. SR enquired about research changes. NS replied that promoting research is key and that a new R&I manager is being recruited. The R&I Committee will also be constituted to monitor this. DS highlighted the workforce KPIs and commented that positions on mandatory training and appraisals are improving. DS also highlighted an improvement in sickness absences and the management of sickness absence, although noted that there is likely to be an increase next month due to the increase in COVID. CC enquired if the team undertake audits of appraisal quality. DS replied that a piece of work was on-going to improve the quality of appraisals, and this includes understanding the current quality. DS agreed to share a summary. TF highlighted that C. Difficile has been extremely challenging and that while mitigations are in place, we are engaging with the system to draft a system wide action plan that includes management of the use of antibiotics. TF also noted the CHPPD figure and noted that the wards were safe despite these figures due to supernumerary international nurses and newly qualified nurses on preceptorship. The Board **NOTED** the report. **9.2 Month 2 Finance Report** MC presented the report, noting that the figures were presented to FBPAC. MC noted that the Board had approved a deficit plan at the last meeting but that this was not accepted by NHSE, and that further work was undertaken to reach a break even position. This included an increased stretch target of £1.1m to be delivered by	DS

WUTH, and there is a mechanism to deliver this. The ICS will also provide £2.7m to cover inflation, and we have committed another £2.4m of non-recurrent CIP in year.

MC requested that the Board approve this new break even plan.

MC then highlighted the financial position for Month 2, noting the four main factors are continuing escalation capacity, increased bank and agency spend, significant recurrent CIP that has not been delivered, and the elective recovery plan. MC added that the elective recovery plan is not in the forecast figures.

MC highlighted the mitigations, which include working with partnership on domiciliary care to mitigate capacity, reviewing bank and agency controls, and working with divisions to fully identify wider, strategic, and high value CIP plans.

MC noted the cash position has improved.

SL observed that there are real risks to the plan and that we have to keep control of what we can to achieve it.

MC agreed, noting that we will need non recurrent CIP measures to offset this but that we must identify recurrent measures to rebase our costs.

SI enquired about the extent of inflation exposure.

MS replied that it is substantially already built into the plan as the amount that the ICS has provided does not fully cover the amount expected.

MC added that we are tracking our underlying performance as well and Board will continue to see this.

SL noted that FBPAC reviewed the establishment review which may help to mitigate some of the bank and agency spend.

The Board

- **APPROVED** the revised balanced plan for 2022/23; and
- **NOTED** the report.

9.3 Maternity Quarterly Report, including Ockenden Final Report Update

TF reported that we are on track to achieve the Ockenden recommendations, and we have submitted current status to LMNS. Those that depend on regional guidance are ready to be implemented on receipt of that guidance.

TF indicated serious incident performance, and noted the risk assessment that has taken place on continuity of carer which the Trust will continue to implement safely.

SR stated that he reviewed the risk assessment on continuity of carer, and he felt assured that WUTH have a good approach and plan which maps across to areas of deprivation.

The Board **NOTED** the report, and particularly:

- The content of the Perinatal Clinical Surveillance Quality Assurance Report
- The compliance report detailing progress with the 15 IEAs from the Ockenden final report
- The Continuity of Carer Assurance plan

9.4 Learning from Deaths Quarterly Report

NS reported that the Summary Hospital Level Mortality Indicator (SHMI) remains stable at 107.04, within the acceptable range. The Dr Foster benchmark data has highlighted one area that requires more work to understand a raised SHIMI (Stroke). This work will be coordinated through the Mortality Review Group.

NS added that the Hospital Standardised Mortality Ratio (HSMR) has fallen this quarter to 93.5, having previously been 95, below the expected level of 100.

NS noted that we are still reporting nosocomial COVID deaths and added that it has been a challenge to find isolation beds due to capacity issues.

Board were also informed of the learning identified through mortality reviews, and that the process for assurance on mortality through the Mortality Review Group is working.

SR noted that he attends the Mortality Review Group, and commented that they had noted at the last meeting that SHMI does not take into account socioeconomic factors which can have an impact on mortality.

The Board **NOTED** the mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group.

9.5 Freedom to Speak Up Annual Report

SL presented the report, noting that the number of people speaking up has fallen in the last quarter which is in line with national trends.

Board were informed of the breakdown of speaking up data, including those by occupational group and noted that we want to improve this in areas that are not speaking up.

Work is ongoing to ensure that staff know about the service and feel able to use it, and SL noted that there have been no anonymous concerns reported in year.

NS noted that SL had attended Medical Board to raise awareness of the FTSU service.

DS added that this report is key to triangulate the culture, which is part of why the Freedom to Speak Up post will be combined with the Just and Learning Culture work.

DS noted that more detail is provided to the Workforce Assurance Committee and Steering Board.

The Board **NOTED** the report.

9.6 Guardian of Safe Working Quarterly Report

NS gave an overview of the report, stating that there are 298 doctors in training and that exception reports have been raised mainly at F1 level. There is a process to review each of these and determine if there have been any breaches. NS noted that fines are levied if there are consistent breaches and there have been no fines this quarter.

SL enquired if there would be a breach if a junior doctor took a locum and had worked their 48 hours.

NS replied that it would not as fines relate to contracted hours and not voluntary work. NS noted though that there would be a question to that doctor as to whether they were safe to work that time.

SL enquired about rota setting.

NS replied that it is the divisional triumvirate who work with medical staffing.

The Board **NOTED** the report.

9.7 Estates, Facilities and Capital Update

PM reported that the team are developing a dashboard to provide further granularity on the service's performance to Board, and indicated the metrics proposed.

PM noted that the approach can change and evolve as required.

	Members agreed that this information was useful and it was noted that the capital management compliance could be considered for inclusion once that system was in place. The Board **NOTED** the update. **9.8 Digital Healthcare Update** CM noted the progress update for the projects taking place in digital healthcare, and indicated the proposals for a dashboard with key metrics. CM gave an overview of these metrics, and noted that the approach can evolve. CM added that metrics on cyber security will be added. SL enquired if the team link with CIP in terms of the service improvement work being undertaken. CM replied that they do, and that the operational plan is delivered jointly with the divisions. SL enquired if there is a way to track how systems create improvement and efficiency. CM replied that this is managed through the service improvement team and that the DH team provide the capability for efficiency but that the system users are key to delivering that efficiency. SI commented that it would be useful to see a metric on skills availability/succession planning given the challenges in ICT recruitment. JH added that there is a service review process being undertaken which will pick up elements such as this which sit on the risk register for the Digital Healthcare team. The Board **NOTED** the update.	
13	**Communications and Engagement** SS highlighted the restart of the Staff Awards which will take place in November, the Leadership Conference, and the work of the Charity. The Board **NOTED** the report.	
14	**Committee Chairs Reports** **14.1 Capital Committee**	

	SI highlighted the G4S security review which was commissioned by the Trust and which highlighted a number of recommendations for implementation. These will be monitored by the Committee and will deliver several improvements in security. The Board **NOTED** the report. **14.2 Finance Business Performance Assurance Committee** SI commented that the Committee reviewed a report on service line reporting, which is restarting and will be a useful tool for the organisation. The Board **NOTED** the report.	
15	**Questions from the Public** No questions from the public were raised.	
16	**Any other Business** DM noted that future Board meetings will move public and private Boards to the morning, and afternoons will then be used for development, training, and walkabout opportunities.	

(The meeting closed at 10.50am)

Action Log
Board of Directors – Public Meeting
31 August 2022

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	2 March 2022	8	To provide further details in respect of the review of Governance structures and Committee Terms of Reference.	David McGovern	Complete. Discussed at Board Development Day.	July 2022
2.	2 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 are completed.	Cate Herbert	In progress. An outline of the process undertaken to monitor RIDDORs within the Trust will be brought to the September Audit Committee.	September 2022
4.	6 July 2022	9.1	To provide feedback on the work on-going to improve the quality of appraisals, including understanding the current quality.	Debs Smith	Complete. A summary was circulated by email on 25 July.	July 2022

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 7**
31 August 2022

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

Report Purpose and Recommendations
This is an overview of work undertaken and important recent announcements in July and August. It is recommended that the Board: • 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	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
This is standing report to the Board of Directors			

1	**Narrative**
1.1	**COVID-19 Update** The Trust has seen a small decrease in the number of patients with COVID (approx. 30 patients in hospital). These are predominantly patients where respiratory COVID was not the primary cause of admission and thus an incidental finding. The Trust continues

	with Infection, Prevention and Control (IPC) measures in line with the "living with COVID". The IPC team continues to monitor the organisational position and relevant guidance is actioned weekly via the Clinical Advisory Group. Staff FITT testing continues, and IPC policies and procedures remain in place should another COVID wave occur in the forthcoming months. As a precautionary measure Fluid repellent surgical face masks continue to be worn in all clinical areas in a bid to reduce nosocomial infection risk and transmission of COVID within the hospital. Visiting in all areas remains open. This winter it is expected respiratory infections including COVID will be circulating at high levels increasing pressure on hospitals. The Clatterbridge Vaccination Centre is preparing to support the Covid Autumn Booster programme. The booster programme will target people aged 50 and over, those in care homes, and those aged 5 years and over in clinical risk groups as well as health and social care staff. The Clatterbridge Vaccination Centre will therefore support the autumn booster programme and the Flu programme for Trust staff, running pop up clinics at the Arrowe Park site as well as the roaming service for Flu vaccines to enable maximum compliance with vaccine uptake for staff.
1.2	**Monkeypox Update** The Trust has seen a small number of monkeypox cases. These cases have been managed following strict IPC control procedures and treatment protocols to maintain patient and staff safety.
1.3	**Serious Incidents** The Trust declared 4 serious incidents (SI) in the month of July 2022; this is a decrease of 1 on the previous month. The Serious Incident panel report and investigate under the "Serious Incident Framework" so that learning can be identified. Three of the SI's declared were related to falls and one a missed diagnosis. The Trust reported 0 Never Events in the month of July. Duty of Candour has been commenced in line with legislation and national guidance. **RIDDOR** There have been two incidents that were reported to the Health & Safety Executive (HSE) in accordance with RIDDOR in July 2022. The first was reported as a Slip/Trip/Fall. The second was a manual handling injury. All RIDDOR reported events are subject to a local review investigation to ensure appropriate learning is identified to prevent a similar reoccurrence.
1.4	**WUTH Charity Update** The WUTH Charity was recently presented with a cheque for £12,000 from the Mayor of Wirral resulting from his year's fundraising activities. WUTH Charity along with RNLI were his charities of the year. The Charity is also expecting to receive £6,200 in a location fee donation from ITV for the filming of season two of their series 'The Tower' on site at Arrowe Park Hospital.
1.5	**Local Maternity & Neonatal System (LMNS) Visit**

	A designated Insight team visit was undertaken by NHSE/I Regional Maternity team and the Local Maternity & Neonatal System (LMNS) visited Wirral Women and Children's Hospital on 16 August 2022. The purpose of the visit was to assess the implementation of the 7 Immediate and Essential Actions (IEA's) from Ockenden Part 1 and the opportunity to visit the Maternity & Neonatal Unit to speak to staff and the wider multidisciplinary team including Maternity Voices Partnership (MVP) Chair and the Trust Executive and Non-Executive Safety Champions. The feedback was overwhelmingly positive with good examples noted of improvement and innovation – some of which are going to be shared nationally to promote the development of services in line with Ockenden requirements. The workforce was described as open, transparent, dedicated, and committed with recognition of the innovation utilised specialist roles that further support the delivery of maternity services. Many areas of good practice were identified including Live streams by the Consultant Midwife and strong coproduction with service users and MVP, and succession planning of senior roles. The Trust was described as having a strong safety culture at all levels with good Board oversight, and the visiting team noted they had witnessed safety huddles being embedded and recorded well, and good use of care improvement forms and feedback meetings supported by a strong MDT approach to all aspects of care. The team noted strong compliance with the Saving Babies Lives Care Bundle and commended the Trust on their approach to the roll out of Continuity of Carer and maintenance of a less than 1% midwifery vacancy rate. Detailed feedback will be provided in the form of a slide deck in approximately 2 weeks' time, and this will be presented as part of the next Board of Directors quarterly maternity update.
1.6	**Cheshire and Merseyside (C&M) Surgical Centre – Clatterbridge** Phase one of the surgical centre development is nearing completion with the first patients being operated on confirmed as the 3rd October 2022. Out of the TIF funded schemes within the region the Clatterbridge development is the only theatre hub that has access to ring fenced elective beds on the same site (cold site) and is able to perform all surgeries (excluding Ophthalmology which is on the APH site). Phase two is due to commence in October pending national approval on the 2nd September, taking the total new theatres to four and a dedicated redesign of the recovery area into a three phase recovery model. The additional theatre capacity was offered to all organisations within C&M with the Countess of Chester Hospital (COCH) being allocated 40% of the new theatre timetable. There has been significant clinical engagement in developing COCH capacity at the surgical centre and this will be built upon as phase two is developed. With the significant development of the cold site there are future opportunities to provide additional capacity and resilience to elective programmes across the region.

2	**Implications**
2.1	N/A

3	**Conclusion**

3.1	The Board are asked to note and receive this report.

Report Author	Janelle Holmes, Chief Executive
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Board of Directors in Public **Item No 8**
31 August 2022

Title	Chief Operating Officer's Report
Area Lead	Hayley Kendall, Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Bailey, Deputy Chief Operating Officer Nicola Cundle-Carr, Head of Business Improvement
Report for	Information

Report Purpose and Recommendations

This paper provides an overview of the Trust's current performance against the elective 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 and the key performance metrics for the Emergency Department (ED).

It is recommended that the Board:

- Note the report 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:	
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 report to Board of Directors			

1	Introduction / Background
	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the National Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to clear the backlog of patients awaiting their elective care pathway. Patients are prioritised in line with the nationally mandated clinical prioritisation of patients, with a focus on those prioritised as clinically urgent and very long waiters irrespective of their priority status. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. Through the pandemic unscheduled care performance was extremely challenged and this continues with the high bed occupancy levels within the Trust.

2	Planned Care
2.1	**Elective Activity** For FY 2022/23 the elective activity has been profiled against the corresponding periods in FY2019/20. In July 2022, the Trust attained 92.82% against a plan of 100.60%. For elective admissions 80.68% of activity was delivered against a target of 106.60%. **Outpatient activity by POD** **Elective activity by POD** There have been significant challenges with restoring elective services to pre-pandemic levels across Endoscopy and Theatres. To ensure the monthly activity plans are delivered two focussed workstreams have commenced across these areas with weekly monitoring of delivery led by the Chief Operating Officer.
2.2	**Priority 2 Performance (P2)** The Trust did not meet the P2 month end trajectories for July the month end final position over reporting 105 P2 breaches against a month end plan of 48.

	Target	Actual
New	98.00%	88.92%
F/UP	101.70%	94.35%
Combined	100.60%	92.82%

	Target	Actual
Day Case	108.20%	80.68%
Inpatients	97.80%	80.67%
Combined	106.60%	80.68%

2.3	**Referral to Treatment** The National Standard is to have no patients waiting over 104 weeks by July 2022 and to eliminate routine elective waits of over 78 weeks by April 2023 and 52 week waits by March 2025. • 104+ Week Wait Performance - as at the end of July the Trust continued to have no patients waiting longer than 104 weeks. • 78+ Week Wait Performance - 91 patients • 52+ Week Wait Performance- 1119 patients Waiting List Size • In July 2022 there were 34,933 patients on an active RTT pathway which is higher that the Trust's trajectory of 31,200 (local C&M target). The loss of the theatres during April and May has significantly impacted on the 52 week and waiting list size positions as approximately 300 cases each month the theatres were unavailable were lost. The Divisions are focussed on recovering the lost activity and performance, but this is challenging given the volume of activity that was lost.
2.4	**Cancer Performance** Full details of cancer performance is covered within the Trust dashboard, but exceptions are covered within this section for Quarter 2 to date: • 2 Week Waits - sustained increase of 2WW referrals meaning increased demand on the system which shows no sign of reduction (currently 20% increase across the Trust). Positive Jul 22 performance with achievement of the standard. • Faster Diagnosis Standard - continued achievement of the 28-day target (patients being informed they do or do not have cancer within 28 days of referral). • All Other Targets - all targets for the quarter are predicted to be red apart from 31-day subsequent drug in line with the recovery trajectory. • Recovery plans are in place to recover Trust aggregate performance back to pre-COVID and green from February 2023. Challenged tumour sites include Urology and Colorectal and was a theme pre-Covid.
2.5	**DM01 Performance – 95% Standard** In July 87.50% (pre-submission) of patients waited 6 weeks or less for their diagnostic procedure for those modalities included within the DM01 cohort. This is against the new national standard of 95%. All modalities achieved the 95% compliance target with the exceptions of Endoscopy and Urology Services. Endoscopy performance is achieving against the internal recovery trajectory, and work is ongoing with Urology to secure additional capacity to treat the significant backlog of patients awaiting a cystoscopy.
2.6	**Risks to recovery and mitigations** The Trust has robust systems in place to monitor and review elective performance which continues to be monitored weekly at executive level. The clinical divisions are progressing through their plans outlined in the previous updates including insourcing, outsourcing and the exciting progress made with the Cheshire and

	Merseyside Surgical Centre (Clatterbridge) providing much needed additional theatre capacity, due to go live from the 3rd October 2022. There is a very recent risk associated with the national position from the British Medical Association (BMA) on recommended rates of pay for additional work over job plan, with a risk of reduced levels of uptake for additional elective work. This will directly impact the Trust recovery plans and patient waiting times if it is enacted locally. 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. Task and finish groups have also been established in August for those areas remaining most challenged.

3 Unscheduled Care

3.1 Performance

Type 1 performance: Performance against the **four-hour standard** for type 1 attendances has decreased from 51.67% in June to 48.53% in July.

Type 1 ED attendances:

- 7,891 in June
- 8,195 in July
- 0.5% increase

Type 3 ED attendances:

- 3,063 in June
- 3,176 in July
- 0.3% increase

Attendances to the department has marginally increased in July compared to the previous month and remains above the 2019/20 level.

In July 69 patients (42 outstanding validation) exceeded the 12 hour DTA target. In month the Trust has seen a significantly higher levels of bed occupancy, with occupancy running at 99% and over. This level of occupancy has a significant impact on flow out of the department for those patients requiring a bed and this has resulted in the increase in DTAs. The challenge continues to be the number of patients in the acute bed base who do not have a criteria to reside with current performance at 220, 150 patients more than the Trust accommodated pre-Covid. This equates to 30% of the Trust bed base and is the biggest risk to improving flow across the Trust and improving waiting time and performance within ED. In response the Trust has every physical G&A bed open and staffed (54 above the normal run rate for this time of year). The Trust's concerns have been escalated to system partners for a response as the Trust is at high risk in this area in relation to patient experience and performance.

Arrowe Park Site ED Type 1 Attendances vs 2019

Month	2022/23	2019/20	YoY Variance	% Var	% of 19/20
April	7,707	7,585	122	1.6%	101.6%
May	8,407	7,696	711	9.2%	109.2%
June	7,891	7,455	436	5.8%	105.8%
July	8,185	7,813	372	4.8%	104.8%

3.2	**Risks to improving performance** • Physical environment in ED is challenging during peaks in demand impacting on ability to delivered the timed pathways and there is regular overcrowding • Continued increase in walk in attendances to ED • Delivery of the LLOS recovery trajectory is at risk due to community capacity constraints for complex discharge pathways 1,2,3 • Boarding time in department increased due to bed pressures and the risk of increasing 12 hour DTAs • Increasing mental health activity and significant increases of attendances under S136 leading to the Mental Health Unit being regularly over 100% and patients being cared for in the ED Initial Assessment Area • 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 Social Care System impacting bed occupancy and the ability to deliver the full elective programme. The number of patients on the 3 pathways combined increased in month running at an average of 220 per day • Availability of mental health inpatient beds resulting in 12 hour breaches for mental health patients and excessive LOS in the ED.

4	**Conclusion**
	The Trust had a significantly challenged month in relation to non-elective performance that has also impacted on the ability to deliver the full elective recovery programme, mainly related to bed occupancy and availability. The Board of Directors should note that with 30% of the total bed base occupied by patients that require another care setting there is a significant risk of not improving performance across the UEC pathways and the elective programme. Given that this risk is so high in the summer months there is a real risk approaching and planning for Winter if the system position remains the same. The Chief Operating Officer along with the Clinical Divisions is leading the planning process for winter with this in mind and exploring all opportunities to deliver services differently.

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Board of Directors in Public **Item No 9.1**
31 August 2022

Title	Approach to Integrated Care Across Wirral and Cheshire and Merseyside
Area Lead	Janelle Holmes, Chief Executive
Author	Matthew Swanborough, Chief Strategy Officer David McGovern, Director of Corporate Affairs
Report for	Information

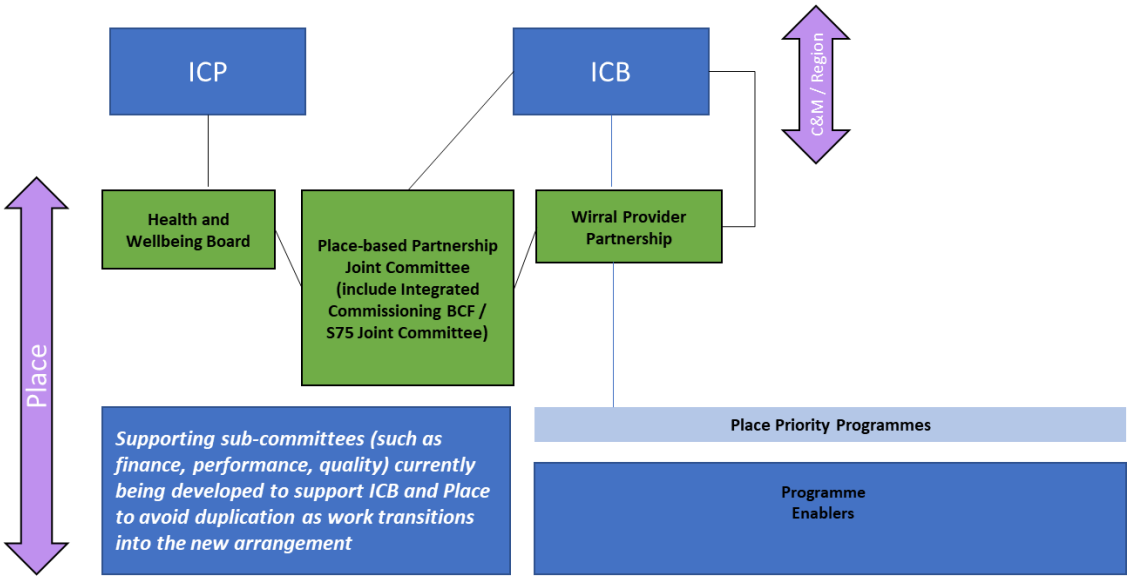
Report Purpose and Recommendations
This is an overview of work undertaken across the Trust and wider NHS footprint to implement an integrated care system. It is recommended that the Board: • Note the report

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	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
All Board Meetings in Public	Board in Public	Approach Integrated Care across Wirral and Cheshire and Merseyside	For Information

1	**Narrative**
1.1	**Cheshire and Merseyside Integrated Care Board** The Cheshire and Merseyside Integrated Care Board (C&M ICB) was established as a statutory organisation on the 1 July 2022, following changes in legislation, which led to

	the formal establishment of 42 Integrated Care Boards (ICBs) across England and the disestablishment of Clinical Care Commissioning Groups (CCGs), with the transfer of CCG functions into ICBs. The establishment of the C&M ICB included the appointment of executive and non-executive positions and formation of the Board function, including a constitution. The C&M ICB has outlined four initial priories, which include: • Improve population health and healthcare • Tackle health inequality, improving outcomes and access to services • Enhancing quality, productivity, and value for money • Helping the NHS to support broader social and economic development. The second ICB Board meeting took place in St Helens on Thursday (August 4), more than 40 members of the public attended the meeting – with 112 people accessing a live stream of the meeting via YouTube. This was the first of a 'roadshow' of monthly meetings in public across each of Cheshire and Merseyside's nine Places and was immediately followed by a lively and well-attended marketplace featuring a wide range of local health and care exhibitors.
1.2	**Wirral Place** To support the delivery of the C&M ICB priorities, 9 Places have been established, aligning to the 9 local authority areas across Cheshire and Merseyside, including Wirral. A ICB Place Director has been appointed at each Place, to support and work with local health providers and the relevant local authority to deliver and improve health and care provision and the priorities. As part of the formation of the Wirral Place, a target operating model was developed, which set out the role and function of Place as well as the key governance arrangements. This operating model is now being implemented, with the Wirral Partnership Committee expected to have its first meeting in September 2022. The diagram below provides an overview of the governance structure for the Wirral Place. 

	As part of Wirral Place, the NHS providers are also developing the Wirral Integrated Provider Partnership, which will lead the delivery of Wirral priority programmes. This is expected to be in place by late September 2022.
1.3	**CMAST** To support the ICB, the Cheshire and Merseyside Acute and Specialist Trust (CMAST) provider collaborative has been established, bring together the 14 NHS acute and specialist providers across Cheshire and Merseyside, with a focus on collaboration at scale, support, and integration. A number of engagement events have taken place to socialise the emerging CMAST governance arrangements including the principles of the Joint Working Agreement and a Committees in Common approach. These documents have been socialised with Boards and teams to provide feedback and to support adoption. The ambition is to secure Board approvals by the end of September. A provider engagement event took place on 2nd August for Non-Executive Directors of Boards across both Cheshire and Merseyside provider collaboratives and the ICB. The event provided a space for shared system discussions and workshops which provided for focused discussions on system working, shared challenges, and governance changes to the way in which trust Boards are expected to work and be accountable going forward. Outputs following this workshop will be shared over the coming weeks. A future engagement programme will be developed with Chairs. This will be shaped around feedback and designed to respond to the wants and needs of NED Board members. The ICB welcomed their invite to the first session and are keen to explore a shared agenda going forward.
1.4	**Board Reporting and Governance** Whilst work is currently being carried out to finalise governance structures, it is now proposed that the Board will receive an update report at each meeting outlining the work of the ICB and associated bodies and fora. The implementation of the ICB includes, along with the refreshed NHS Code of Governance, requirements for Boards to have due consideration to the activity of the ICB in its own planning and Governance arrangements. Work will continue to evolve the content and format of this report. Board is also asked to note that a seminar is currently being planned to further update the Board on progress. The seminar will be arranged for mid-September.

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

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Board of Directors in Public
31 August 2022

Item No 9.2

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 July 2022.

It is recommended that the Board:

- Note performance to the end of July 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
This is a standing report to the Board.			

1	Narrative
1.1	Of the 49 indicators that are currently reported against thresholds (excluding Use of Resources): - 35 are off-target or failing to meet performance thresholds - 14 are on-target

	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. 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. 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 and the Chief Operating Officers report to the full Board of Directors meeting.

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

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Quality Performance Dashboard

August 2022
Upated 16-08-22

	Indicator	Objective	Director	Threshold	Set by	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	2022/23	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	0.05	0.10	0.10	0.05	0.19	0.18	0.18	0.22	0.04	0.22	0.09	0.09	0.33	0.18	
	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	96.2%	97.6%	96.9%	96.9%	97.2%	96.9%	96.7%	96.2%	96.4%	96.8%	96.9%	96.6%	96.5%	96.7%	
	Never Events	Safe, high quality care	CN	0	SOF	2	0	0	0	0	1	0	1	0	0	0	0	0	0	
	Clostridioides difficile (healthcare associated)	Safe, high quality care	CN	Maximum 72 for 2022-23. Max 6 cases per month	WUTH	1	6	13	6	5	3	18	12	13	7	8	16	17	48	
	Gram negative bacteraemia : e-coli	Safe, high quality care	CN	Maximum 56 for 2022-23. Max 4 cases per month	National	-	-	-	-	-	-	-	-	-	8	4	9	12	33	
	Gram negative bacteraemia : klebsiella	Safe, high quality care	CN	Maximum 19 for 2022-23. Max 1 case per month	National	-	-	-	-	-	-	-	-	-	0	4	1	3	8	
	Gram negative bacteraemia : pseudomonas	Safe, high quality care	CN	Maximum 9 for 2022-23. Max 0 cases per month	National	-	-	-	-	-	-	-	-	-	0	0	0	0	0	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	0	0	0	0	1	0	0	0	0	0	0	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	1	0	0	0	0	0	1	1	1	4	0	0	1	5	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	96%	96%	96%	95%	96%	96%	94%	95%	92%	89%	91%	96%	97%	93%	
	Safeguarding Audits	Safe, high quality care	CN	≥90%	WUTH	-	-	-	-	-	-	-	-	82.6%	71.6%	93.5%	89.6%	94.7%	87%	
	Mandatory Training compliance	Safe, high quality care	CPO	≥90%	WUTH	90.1%	90.9%	91.3%	90.8%	90.5%	90.4%	89.0%	87.2%	87.2%	87.17%	89.21%	90.39%	89.73%	89.7%	
	Sickness Absence % (12-month rolling average)	Safe, high quality care	CPO	≤5%	SOF	6.12%	6.17%	6.21%	6.22%	6.24%	6.40%	6.48%	6.53%	6.70%	6.79%	6.83%	6.89%	6.94%	6.9%	
	Sickness Absence % (in-month rate)	Safe, high quality care	CPO	≤5%	SOF	6.48%	6.53%	6.62%	6.67%	6.37%	7.86%	8.72%	7.05%	7.73%	6.84%	6.23%	6.50%	7.08%	6.66%	
	Staff turnover % (rolling 12 month rate)	Safe, high quality care	CPO	≤10%	WUTH	13.0%	12.6%	12.9%	13.3%	13.2%	13.4%	13.7%	13.9%	14.1%	14.1%	14.4%	14.4%	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	4	4	4	3.3	

	Indicator	Objective	Director	Threshold	Set by	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	2022/23	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	95.9%	96.7%	96.4%	96.2%	93.8%	92.6%	91.7%	96.7%	96.9%	94.6%	97.1%	98.3%	95.9%	96.5%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	98.0%	97.0%	96.0%	96.4%	95.5%	94.6%	95.2%	97.3%	96.3%	97.7%	98.3%	99.0%	98.9%	98.5%	
	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	95	126	132	126	141	157	206	195	187	220	194	211	214	214	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	79.8%	82.0%	83.4%	83.7%	82.0%	77.9%	77.2%	77.9%	83.7%	79.3%	83.1%	80.9%	82.0%	81.5%	

	Indicator	Objective	Director	Threshold	Set by	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	2022/23	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	4	1	2	2	3	8	3	2	3	1	1	1	5	8	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	76.0%	76.0%	71.1%	72.8%	72.4%	77.7%	75.9%	77.3%	67.2%	74.0%	74.7%	77.4%	73.6%	74.9%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	95.0%	96.0%	94.0%	94.3%	95.1%	94.4%	95.4%	94.5%	92.3%	94.8%	94.1%	93.1%	95.6%	94.4%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	93.0%	94.0%	93.2%	94.1%	93.7%	94.3%	94.3%	94.1%	93.6%	93.5%	94.3%	93.5%	94.6%	94.0%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	97.0%	98.0%	94.1%	98.8%	94.7%	94.6%	96.6%	93.5%	97.7%	93.1%	98.0%	100.0%	96.9%	97.0%	

Quality Performance Dashboard

August 2022
Upated 16-08-22

	Indicator	Objective	Director	Threshold	Set by	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	2022/23	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	≥95%	National	67.8%	66.2%	63.4%	62.6%	59.5%	60.6%	59.1%	63.1%	61.5%	63.1%	63.4%	64.5%	62.3%	63.3%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	1	7	11	8	6	6	13	7	17	39	24	17	69	149	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	100%	National	57.7%	66.7%	48.1%	58.1%	49.8%	57.2%	57.3%	61.7%	54.0%	52.5%	53.5%	58.6%	53.6%	54.5%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	0%	National	8.0%	5.0%	9.2%	8.2%	9.4%	8.8%	11.0%	8.1%	11.6%	13.7%	10.7%	10.5%	14.6%	12.4%	
	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	78.9%	74.6%	73.9%	82.4%	86.9%	91.2%	85.1%	86.1%	90.6%	88.3%	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	14.5%	14.3%	23.5%	21.9%	22.8%	19.2%	18.0%	15.5%	25.2%	23.9%	21.9%	18.5%	16.0%	20.1%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	≥92%	SOF	75.13%	74.14%	72.88%	70.84%	70.14%	67.84%	67.57%	65.89%	65.38%	64.08%	66.72%	65.46%	64.80%	64.80%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	26979	27306	27424	26935	27046	27406	28665	29445	30430	31504	32373	33306	34933	34933	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	507	560	606	575	510	557	475	525	582	730	811	1028	1119	1119	
	Referral to Treatment - cases waiting 78+ wks	Outstanding Patient Experience	COO	NHSEI Plan Trajectory 2022-23	National	117	177	163	116	70	72	59	65	60	70	73	82	91	91	
	Referral to Treatment - cases exceeding 104 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	3	3	7	10	5	5	4	5	1	0	0	0	8	8	
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥99%	SOF	87.5%	86.0%	91.3%	94.3%	93.0%	89.8%	87.3%	86.4%	85.2%	82.8%	86.0%	87.2%	87.5%	85.9%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	95.4%	93.7%	95.7%	96.1%	87.9%	91.4%	76.2%	78.0%	76.2%	85.8%	96.6%	94.6%	94.4%	92.8%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	-	-	94.95%	-	-	91.63%	-	-	76.7%	-	-	92.5%	-	92.5%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	96.3%	96.4%	96.5%	95.4%	94.3%	94.8%	94.6%	95.1%	92.6%	91.2%	96.5%	96.4%	96.0%	95.0%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	-	-	96.41%	-	-	94.85%	-	-	94.1%	-	-	94.9%	-	94.9%	
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	84.7%	85.9%	84.4%	79.2%	79.7%	79.3%	79.6%	79.3%	75.9%	79.2%	79.6%	75.7%	85.1%	79.9%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	-	-	85.05%	-	-	79.38	-	-	78.1%	-	-	78.2%	-	78.2%	
	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	81	97	118	152	167	167	
	Cancer - Faster Diagnosis Standard	Outstanding Patient Experience	COO	≥75% within 28 days	National	80.4%	78.2%	77.9%	79.8%	79.2%	80.5%	70.5%	78.9%	79.5%	76.7%	75.4%	78.3%	79.6%	77.5%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	209	213	218	216	177	149	180	187	211	170	185	174	207	184	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	4.20	3.31	3.29	2.56	3.27	3.26	2.34	4.87	3.05	4.50	3.96	2.88	4.13	3.87	
	Formal Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	94%	94%	100%	61%	100%	100%	100%	100%	100%	86%	100%	91%	94%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	2	5	2	3	4	3	2	0	0	2	2	1	3	2	
	NEWS2 Compliance	Outstanding Patient Experience	MD/CN	≥90%	WUTH	-	-	-	-	-	-	-	-	85%	85.2%	88.3%	89.7%	89.1%	88%	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

August 2022
Upated 16-08-22

	Indicator	Objective	Director	Threshold	Set by	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	2022/23	Trend
Well-led	Duty of Candour compliance - breaches of the DoC standard for Serious Incidents	Outstanding Patient Experience	CN	0	WUTH	-	-	-	-	-	-	-	-	-	0	1	0	0	1	
	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	279	457	613	774	958	1121	1445	1575	1666	20	56	81	105	105	
	% Appraisal compliance	Safe, high quality care	CPO	≥88%	WUTH	82.7%	82.2%	81.2%	82.2%	82.7%	82.3%	82.0%	78.0%	77.9%	77.2%	83.2%	85.2%	86.2%	86.2%	

	Indicator	Objective	Director	Threshold	Set by	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	2022/23	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.2	-0.2		-0.7	-0.6	2.3	-0.1	0.1	-1.0	-0.4	-0.2	-0.4	-0.4	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.2	-0.1	0.0	1.0	-0.9	1.9	-0.5	-0.3	-0.9	0.3	-1.2	-0.6	-0.6	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	Not reported	Not reported	Not reported	Not reported	Not reported	
	CIP Performance (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	6.03%	9.05%	14.50%	Not reported	77.21%	48.24%	78.70%	78.61%	91.33%	7.26%	45.26%	47.60%	57.50%	57.50%	
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	-40.5%	-11.7%	-5.2%	-50.0%	-25.1%	-6.7%	-4.3%	-8.0%	-15.0%	-43.9%	-316.0%	-88.0%	-218.8%	-218.8%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-15.7	-15.4	-15.2	-16.2	-15.9	-18.0	-16.2	-18.6	-20.0	-21.4	-12.0	-16.6	-16.4	-16.4	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	18.0%	22.6%	24.4%	30.7%	36.3%	48.0%	59.0%	76.2%	100.0%	0.7%	1.4%	4.0%	8.7%	8.7%	

Metrics Added

Metrics Amended

WUTH Quality Dashboard Exception Report August 2022

Wirral University Teaching Hospital NHS Foundation Trust

Safe Domain

Falls resulting in moderate/severe harm per 1000 occupied beddays reported on Ulysses

Executive Lead: Chief Nurse

Performance Issue:

The Trust monitors the number of moderate/severe harms as reported on the Ulysses system and expresses this as a rate per 1000 occupied beddays. The maximum threshold is set at < 0.24 per 1000 bed days.

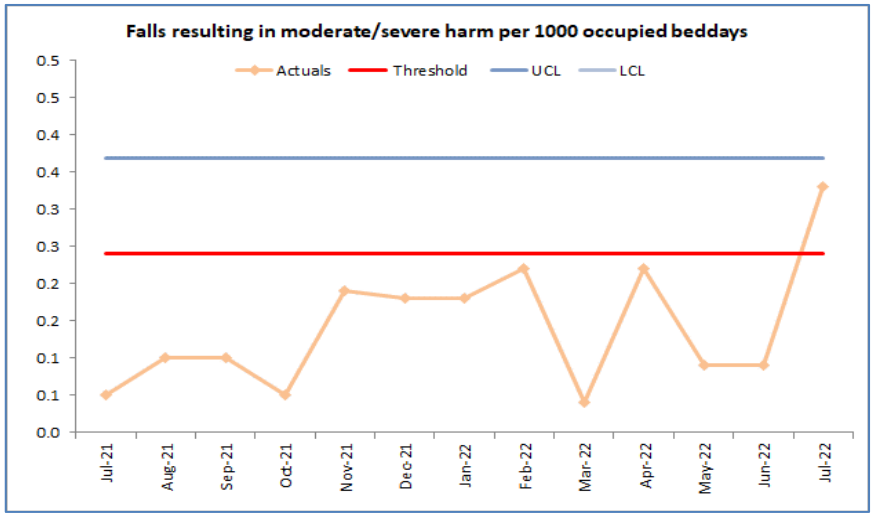
The rate for July 2022 was above threshold at 0.33. The statistical process chart shows that the upper control threshold has not been breached and that the special cause for concern has not been reached.

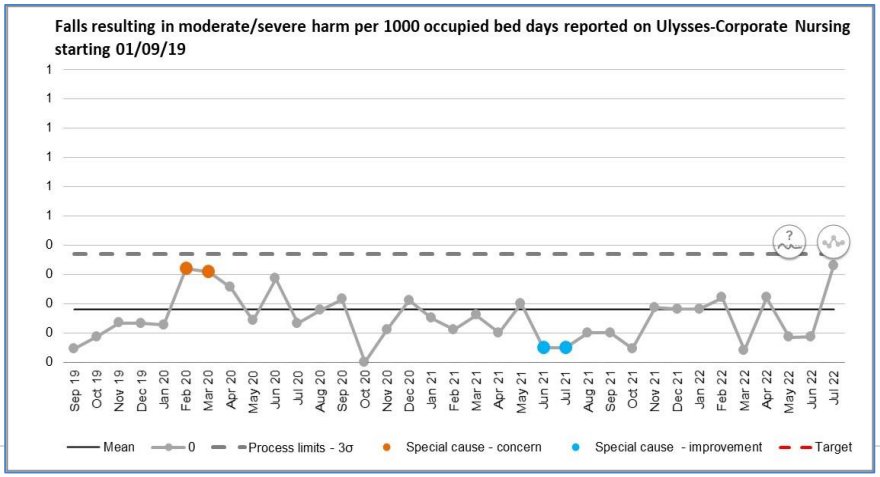
Action:

The Corporate Nursing Team, in conjunction with divisions, has led a full review of the Patient Safety Learning Assurance Framework, associated processes, and lines of accountability.

The revised processes will:

- Increased the opportunities for shared learning by strengthening the divisional processes and oversight.
- Provide a higher level of ward and divisional assurance regarding progress of local improvements.
- Revise the purpose of the Falls Steering Group to enable Trust wide multidisciplinary improvements to be driven forwards.
- Strengthen the governance for patient safety learning inclusive of falls.





A falls strategy is currently in development and will have a programme of work that is progressed by the Falls Steering Group.
Expected Impact: The number of patients in our care falling resulting in moderate / severe harm to be consistently below the maximum threshold.

Clostridioides difficile (Healthcare Associated)

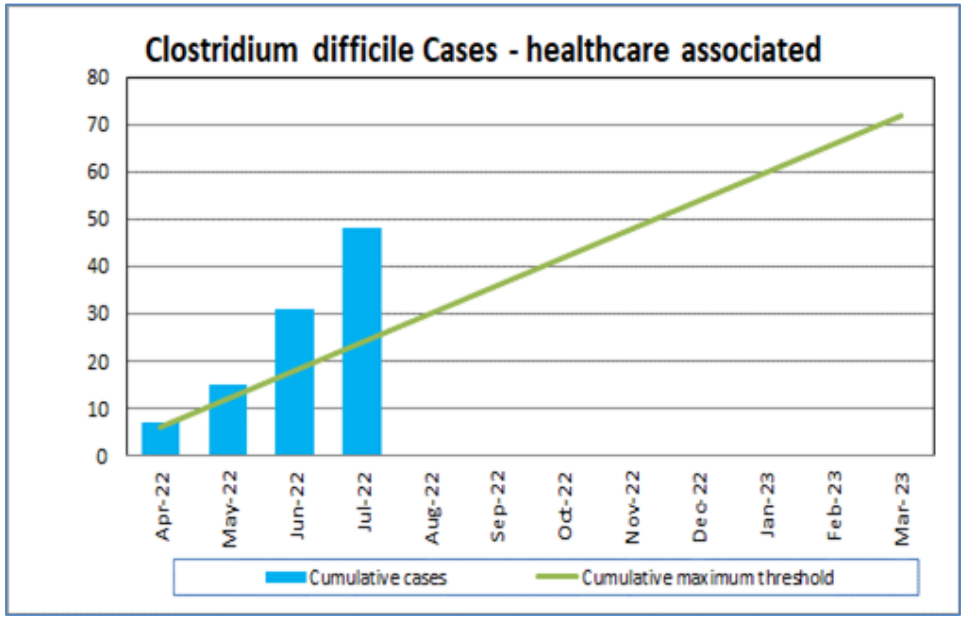
Executive Lead: Chief Nurse

Performance Issue:

The threshold target set for healthcare associated *Clostridioides difficile* infections (CDI) for 2022-23 is 72. This is derived from a baseline of the 12 months ending November 2021, as this was the data available to NHSE/I at time of calculating the figures.

The monthly trajectory has been calculated by dividing the threshold target of 72 by 12, equaling a maximum of 6 cases per month.

The monthly threshold has been exceeded: 17 cases have been reported in July. A total of 48 cases since April 2022. This is 50% (24 cases) above the cumulative year to date threshold of 24.



Action:

Scrutiny of individual cases continue with executive and senior oversight of the multidisciplinary team RCA reviews. Causative factors and learning opportunities are identified and plans to address shortfalls are developed. Divisional responsibility for progressing local improvements plans enables ward and department changes to occur. In addition to the reactive plans common themes and key challenges inform quality improvement initiatives and have enabled the development of a trust wide improvement plan that is monitored through the IPC group.

The trust wide improvement plan will be shared with partners to inform the development of system wide improvements that will be overseen by the Health Protection Board for Wirral.

Key initiatives in July include a focus on prompt sampling, isolation of patients, and a review of environmental audits resulting in an increase of cleaning frequencies in assessment areas. A new daily digital sit rep has been created to improve overview of single rooms to provide a risk-based

approach to patients who require isolation that incorporates IPC and care priorities.
Expected Impact: Reduction in patients diagnosed with healthcare associated *Clostridioides difficile*

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

Executive Lead: Chief Nurse

Performance Issue:

For 2022-23 the Gram-negative blood stream infection objective has been separated into individual targets for *E-coli, klebsiella* and *pseudomonas*. All thresholds are derived from a baseline of the 12 months ending November 2021, this was the most recent available data at the time of calculating the figures.

The threshold for Gram-negative *E-coli* is set at a maximum 56 cases, with a monthly threshold of 4 per month. In July 12 patients were diagnosed with an *E-coli* bacteraemia.

Action:

Senior IPC nurse attends the Patient Safety Learning Group to apply specialist knowledge to the scrutiny of cases and extract learning to enable the development of plans for sustainable improvement. Divisions are responsible for progressing the improvement plans, monitored at Divisional Quality Board meetings.

Urinary management has been identified as a learning theme in July. A review of catheter management has commenced, and a quality improvement project is planned to proactively enable healthcare professionals to make changes to their practice.

Expected Impact:

The number of patients diagnosed with an *E-coli* blood stream infection is reduced to below the monthly threshold and the annual objective for 2021 – 2022 is achieved.

Gram-Negative bloodstream infections - klebsiella

Executive Lead: Chief Nurse
Performance Issue: For 2022-23 the Gram-negative blood stream infection objective has been separated into individual targets for *E-coli, klebsiella* and *pseudomonas*. All thresholds are derived from a baseline of the 12 months ending November 2021, this was the most recent available data at the time of calculating the figures. The threshold for Gram-negative *Klebsiella* is set at a maximum 19 cases, with an alternating threshold of 1 and 2 per month for monitoring purposes. There were 3 cases reported in July 2022, against a threshold of 1. Since April 2022 8 cases have been reported; this is 2 over a trajectory of 6.
Action: Investigations are taking place to determine causative factors and learning outcomes. Senior IPC nurse attends the Patient Safety Learning Group to apply specialist knowledge to the scrutiny of cases and extract learning to enable the development of plans for sustainable improvement. Divisions are responsible for progressing the improvement plans, monitored at Divisional Quality Board meetings.
Expected Impact: The number of patients diagnosed with a *Klebsiella* blood stream infection is reduced to below the monthly threshold and the annual objective for 2022 – 2023 is to be achieved.

Pressure Ulcers – hospital acquired category 3 and above

Executive Lead: Chief Nurse

Performance Issue:

An internal standard of 0 hospital acquired pressure ulcers because of lapses in care at category 3 or above has been set for 2022 / 2023.

1 hospital acquired category 3 pressure ulcer has been reported in July 2022.

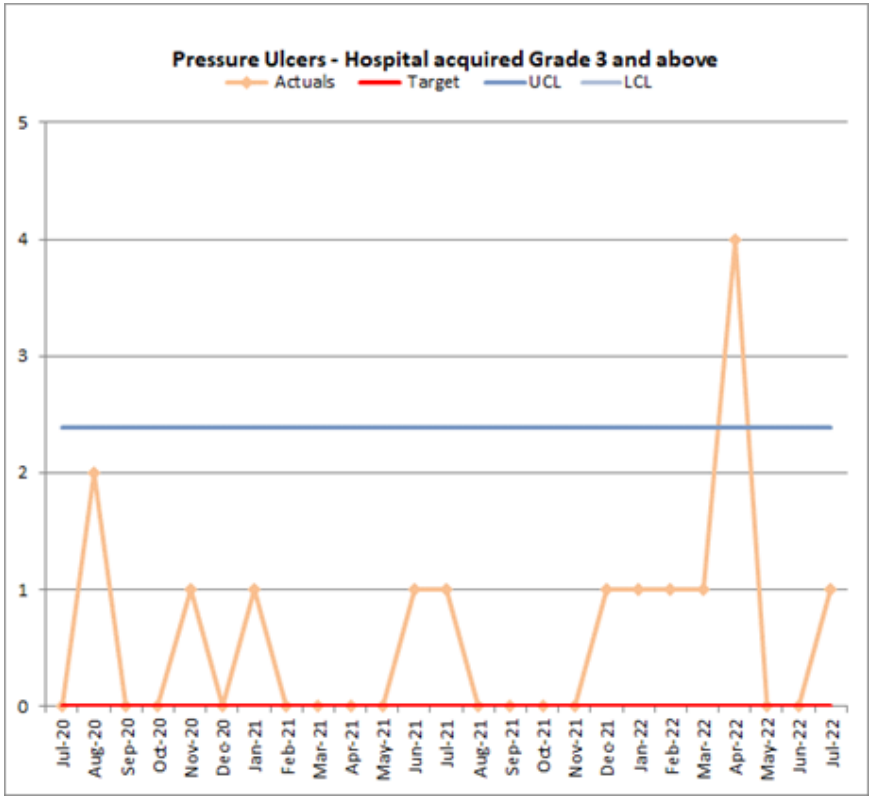
Action:

Following scrutiny at the Patient Safety Learning Panel lapses in care that contributed to the development of the patient's pressure damage have been identified. On review there were identified lack of knowledge. Tissue viability e learning modules are available for all staff on ESR, and nursing staff will be accessing the face-to-face pressure ulcer validation sessions. Tissue Viability Team are working directly with the wards to address the specific care standards. Pressure Ulcer Steering group has the oversight of a trust wide continuous improvement plan.

Areas of learning have been identified to be associated with moisture associated skin damage (MASD). MASD training materials and patient information leaflets have been drafted, in line with the regional network guidance. Ratification is being for the training materials and implementation plan are being presented to Pressure Ulcer Steering group in September 2022.

Expected Impact:

No hospital acquired category 3, 4, and unstageable pressure ulcers due to lapses in care.



Mandatory Training %

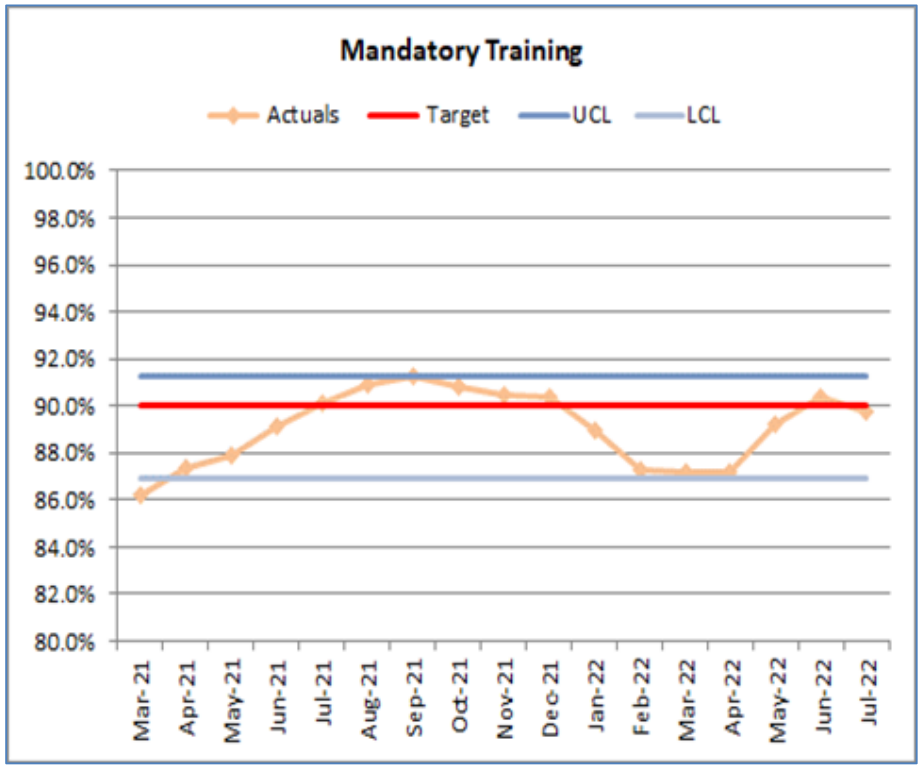
Executive Lead: Chief People Officer

Performance Issue:

The Trust has an internal target for 90% of staff to be compliant with applicable Mandatory Training. The rate for July 2022 was 89.73%

From a Divisional perspective, Clinical Support Services, Corporate Division, Surgery Division and Women's and Children's have achieved the Trust target. The division with the lowest compliance is Acute at 84.32%.

There is a wide variance in compliance by staff group, with Add Prof, Scientific and Technical with the highest compliance rate at 98.03%, and Medical and Dental with the lowest compliance rate at 74.31%.



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. All Divisions have produced improvement trajectories and have confirmed expected date of compliance to Trust Management Board.

Steps have been taken by the Learning and Development Team to improve access to mandatory training. During August the team will be targeting staff that are out of compliance with PVP Levels 3 and 4 and IPC levels 1 and 2 to support the Trust in boosting compliance in these subject areas.

The SME network for mandatory training has now been re-established. The network's first priority is to ensure all mandatory training subjects map to the updated National Core Skills and Training Framework. Once mapped, this

will enable greater ‘portability’ of mandatory training records between Trusts.

Plans for a phased re-introduction of face-to-face Induction has commenced. This includes a one-day WUTH Welcome for all staff and an additional two days for clinical staff for them to complete mandatory training. To support existing staff the L&D Team have re-introduced face-to-face e-Learning drop-in sessions which will provide hands on support to people accessing online mandatory training modules.

There is an on-going issue relating to access to e-learning. This has been escalated via Trust risk process and to the National ESR e-learning team. Whilst these are resolved, a work around has been introduced.

Expected Impact:

The impact of covid on training provision has been significant and there are a number of challenges in sustaining compliance. It is anticipated that continued focus on targeting completion will continue a trajectory of improvement that enables the Trust to achieve its KPI. However, it must be recognised that a strategic and long-term approach is required, particularly in relation to the provision of face-to-face provision, to achieve sustained increases in compliance.

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 July 2022 was 7.08% Of this 1.85% is related to COVID-19.

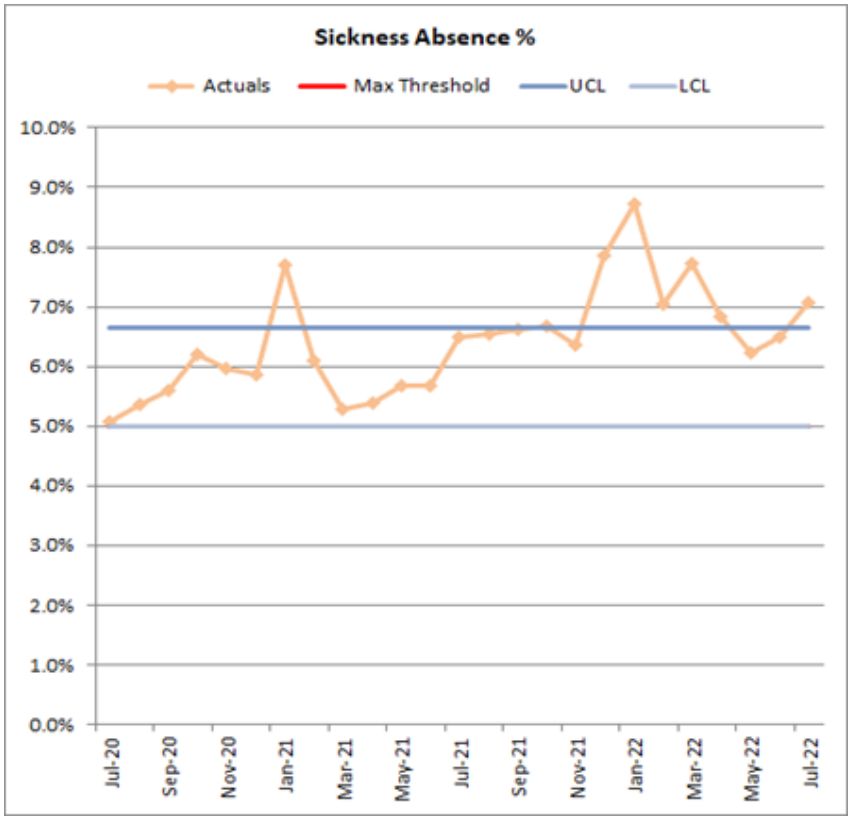
All Divisions in July 2022 have exceeded the 5% KPI and showed no improvement, except for Medicine.

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). All Divisions have reintroduced Sickness Auditing to ensure the Attendance Management Policy is being consistently applied at departmental level.

Managers, supported by the HR Team, continue to apply a greater level of oversight and focus on short term sickness and targeting hot spot areas with high episodes of sickness absence and rolling sickness absence. The HR Team are providing additional support to management including further coaching, training and development in how to manage attendance.
The next Cohort of Effective Manager training starts in Sept and Attendance Management is a key element within the Programme. New approaches, based on evidence and best practice, are continuously reviewed, such as the trial of a new absence proforma in Surgery Division and the trial of a return-to-work app in Facilities.



The re-write of the Attendance Policy with significant changes based on the NHSE/I feedback has been extensively negotiated with Staff Side and will be presented at Policy, Pay Terms in September.

Workforce Wellbeing
We continue to focus on the implementation of support provisions and improvements in the areas of Physical Health, Mental Health, Morale boosters and Enabling Resilience. Wellbeing Surgeries take place every three months with each focusing on a particular theme chosen by staff. As part of the wellbeing offer to our staff, refurbishment work has been completed to enhance two staff wellbeing areas at Arrowe Park and Clatterbridge. There will be continued support for staff around wellbeing and this will be offered to staff in a more flexible way. The Wellbeing Hub located near the main lifts at Arrowe Park will continue to be used for staff wellbeing by Occupational Health to offer one-to-one support to staff.

Flu Vaccination Programme
The Trust is in preparation for the 2022/23 programme in anticipation of the winter season as outlined in the Tripartite Annual Flu Letter. The Trust has appropriate governance and reporting mechanisms in place to maintain oversight of the programme. Flu vaccines will be offered at both sites, Arrowe Park Hospital and Clatterbridge Hospital.

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 as we look beyond the pandemic to recovery of both staff and services, in the context of ongoing Covid-19 pressures. We continue to appropriately prioritise workforce wellbeing and our commitment to mental health support.

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 July 2022. Rolling 12-month turnover to July 2022, calculated on permanent assignments only, is 11.89%.

The Trust in-month performance is 1% - 0.17% over target. Within the Divisions all except Clinical Support and Women & Children's are above the Trust Turnover KPI of 0.83%.

All Divisions are over the 10% KPI for the rolling 12 months, highest division - Acute is at 17.35% to the closest to target at 12.3% in Estates, Facilities and Capital.

Actions:

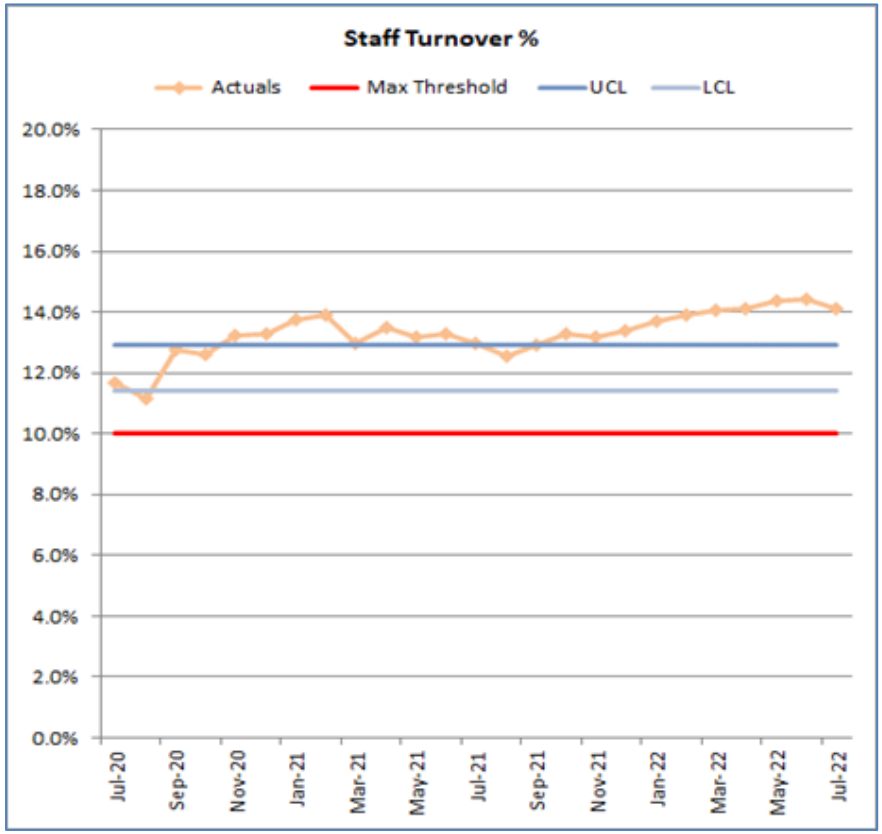
Monitoring of the Turnover KPI is on-going via Divisional Management, Divisional governance infrastructure, and via Divisional Performance Reviews (DPRs), with specific actions in place according to the local feedback.

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

A Retention workstream has been included as part of the People Strategy 2022-2026 Delivery Plan and an HRBP project lead identified with key quarterly deliverables to aid the improvement of retention across all staffing groups.

Q1 deliverables and Q2 ongoing activities include:

- Utilisation of NHS England and NHS National Retentions programme resource to review and implement evidence based best practice.



- Identification and set up of task and finish groups for the following Staff Groups - Medical and Dental, AHP's and Corporate. The current Nurse and CSW Recruitment & Retention Group is also being reviewed to have an enhanced focus on retention, work continues in this group.
- The review of retention plans from across the Cheshire Mersey network and understand success to date to highlight best practise for WUTH.
- Completion of a gap analysis based on 75 Trust wide responses to identify key deliverables to aid in the improvement of retention within WUTH and help inform the delivery plan.
- Links have been made with NHS England and NHS Improvement's National Retention Programme Team.
- Identification and review in progress of workforce data sources: ESR reporting, Exit Surveys and Staff Survey to determine priorities and inform the delivery action plan.
- Terms of reference and membership of a Trust Retention Group has been considered and will be aligned to the task and finish groups.

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.

Care Hours Per Patient Day – number of wards below 6.1

Executive Lead: Chief Nurse

Performance Issue:

The Trust monitors the number of wards that are below a care hours per patient day (CHPPD) threshold of 6.1. The metric for the Trust overall is set at a maximum of three wards to be below this threshold.

The number of wards for July 2022 was four: Ward 36 = CHPPD 6; Ward 22 = CHPPD 5.9; Ward 38 = CHPPD 5.5; M1 Rehab = CHPPD 5.5

Action:

The Trust has a series of robust safer staffing review measures in place. One of these measures is a CHPPD tracker, introduced in May 2022 to monitor if any areas are consistently recording a CHPPD <6.1.

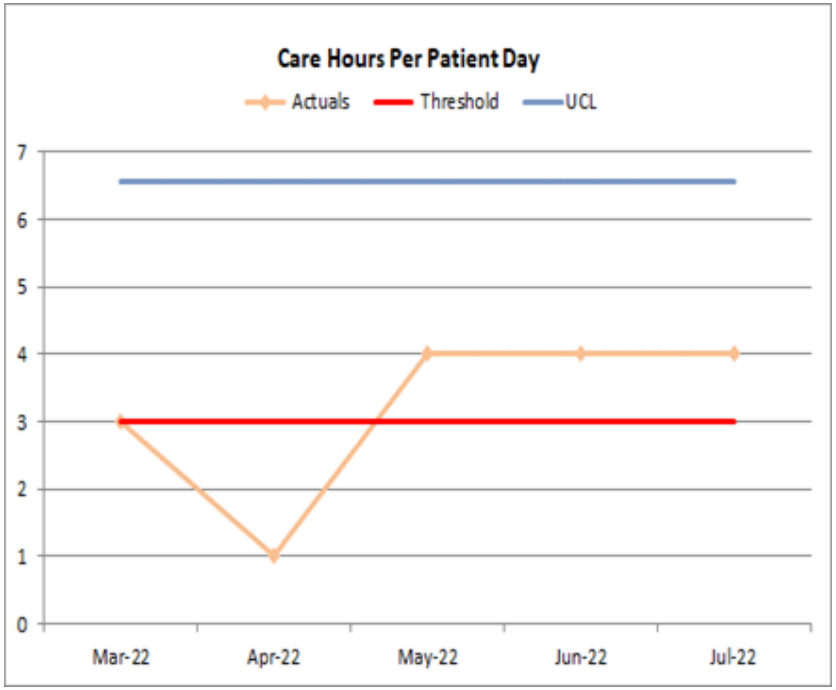
1 of the wards who had a CHPPD of <6.1 had a variance of 0.1 this is equivalent to 6 minutes of care.

Ward 38 staffing levels is being undertaken as the ward has had a CHPPD consistently below 6.1 since November 2021.This has been due to CSW shortfalls due to staff moves to support higher risk staffing challenges across the Trust.

Impacts on care are being monitored and have remained minimal in this area. The Trust has targeted CSW recruitment campaigns ongoing and continues to run the CSW apprenticeship programme to enable the Trust to maintain low CSW vacancies.

Expected Impact:

A reduction in the number of wards with a consistent CHPPD of <6.1 by Q4.



Effective Domain

Theatre in session utilisation %

Executive Lead: Chief Operating Officer

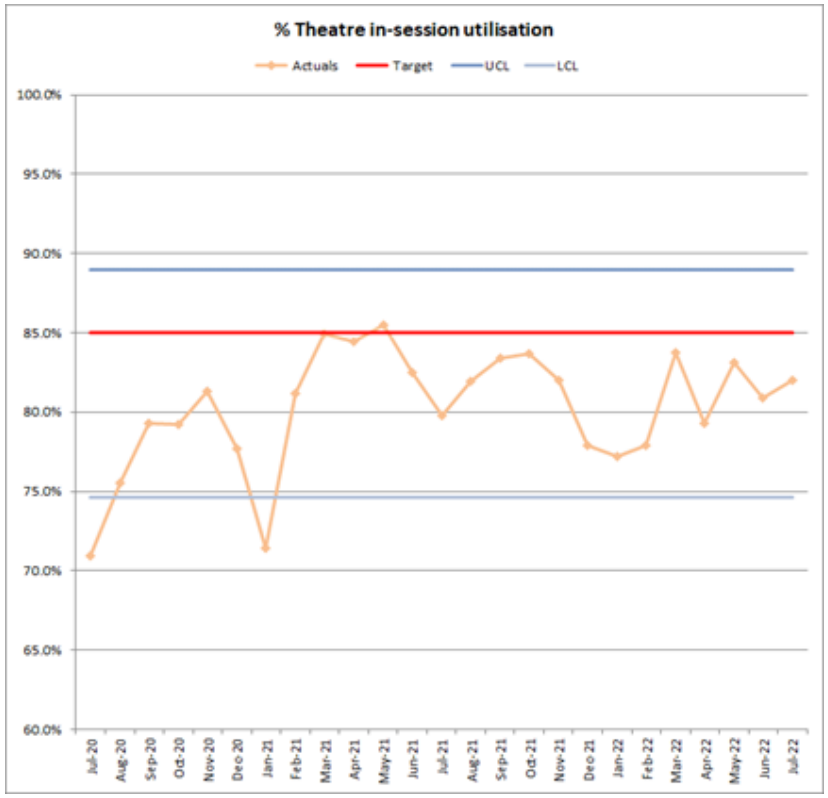
Performance Issue:
The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. Overall July's performance was 82.0%, up from June's 80.9%.

Focus remains on improving utilisation of core sessions as part of reset and recovery. This has been critical given following the loss of 6 theatres due ventilation failures in quarter 1. Works have been completed in M3-5 and the second fix remedial work of M1 & M2 are holding. G1 remains out of action. Average of Core Session utilisation for July 2022 was 80%, when adjusted for closed estate.

July saw increase in on the day cancellations from 3.7% in June to 5.5%. 67 on the day cancellations were recorded in July with 55% of the cancellations reflecting non clinical cancellations. Predominant reasons include list overrunning and bed availability postoperatively.

Theatre scheduling meeting remains locked down to 3 weeks (barriers to 4 weeks includes anaesthetic cover and theatre staffing (vacancies in ODPs, Ortho Staffing, and increased sickness. Aiming for 4-week lockdown during August/September which enables patients to be booked 4 weeks ahead.

Backfilling process being reviewed as part of the new theatre floor plans to support increase in backfill requests for core capacity over 50-weeks (above establishment) to support increase in session delivery. There is a risk of late cancellations which will need careful management.



Action:

- Maintain the daily TCI meeting to prevent cancellations on the day for inpatients and risk further reduction in in-session utilisation
- Continue to attempt to deliver above core capacity through backfills and additional requests for sessions
- Identify change process for backfills to support above
- Continue with revamped TRG meetings to support increase in planned session utilization
- Explore a ring-fenced Elective Ward
- Reestablish Perioperative Improvement Programme as one of the Trust 4 key improvement pillars

Expected Impact:

Increase in in session utilisation and increase in case throughput.

Caring Domain

Same sex accommodation breaches

Executive Lead: Chief Nurse

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

Same sex accommodation breaches are most often due to patients waiting more than 24 hours for transfer from critical care areas to general wards – there were 5 such breaches in July 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.

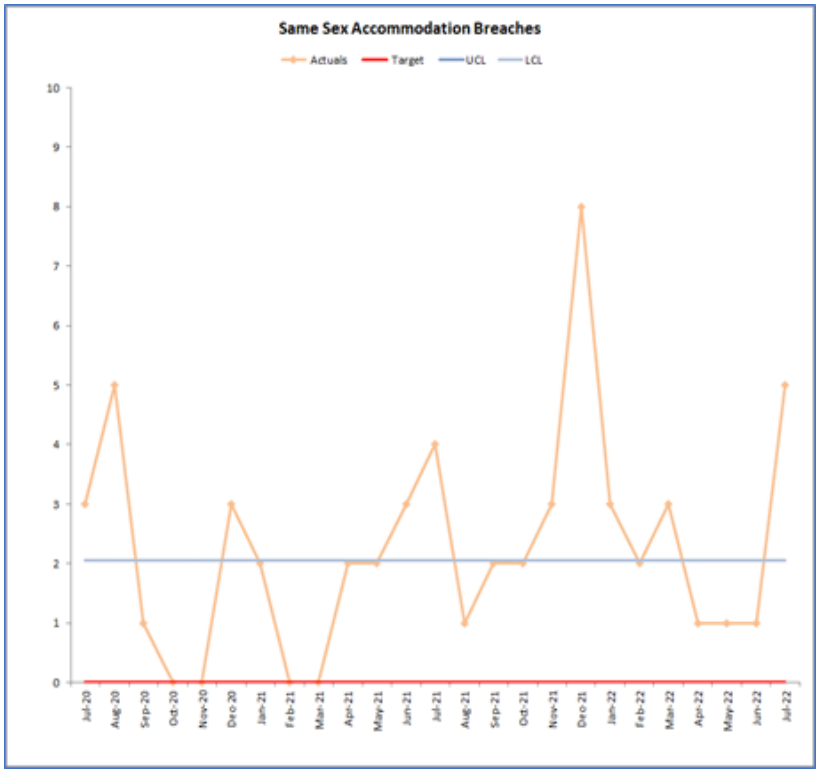
Action:
Increased pressure due to system challenges resulting in high levels of activity throughout the hospital and an increased proportion of patients with no criteria to reside continued in July 2022.

Joint working processes are in place, between critical care, Patient Flow Team and the Divisional Directors to expedite critical care stepdown. This includes daily oversight of individual patients requiring a stepdown indicating and the length of time waiting.

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 Trust standard of 95% 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 July 2022 was:

- Emergency Department (ED) – 73.6% (below threshold)
- Outpatients – 94.6% (below threshold)
- Inpatients – 95.6% (better than threshold)

Maternity 96.9% (better than threshold)

Action:

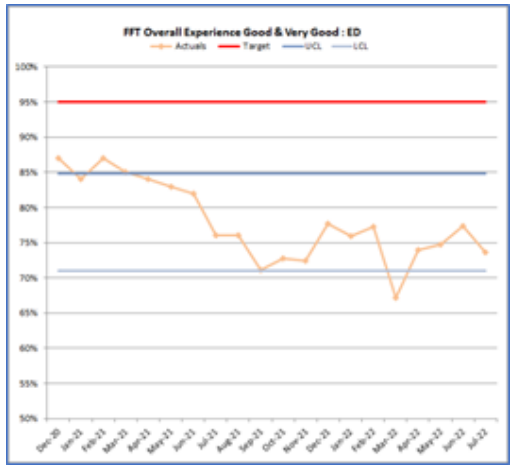
Operational pressures continue within ED, which is reflected nationally. FFT scores are lower than the standards set but we are consistent with peer organisations regionally. The negative feedback focuses on waiting times.

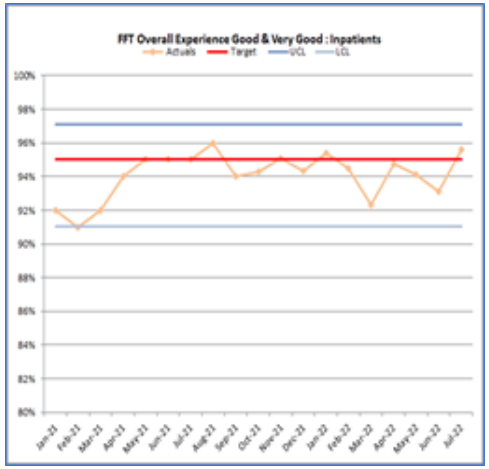
Enhancing effective communication to patients is a key area for improvement and a priority focus for the divisional triumvirate. Digital methods of informing patients of the current length of wait and key messages are being developed.

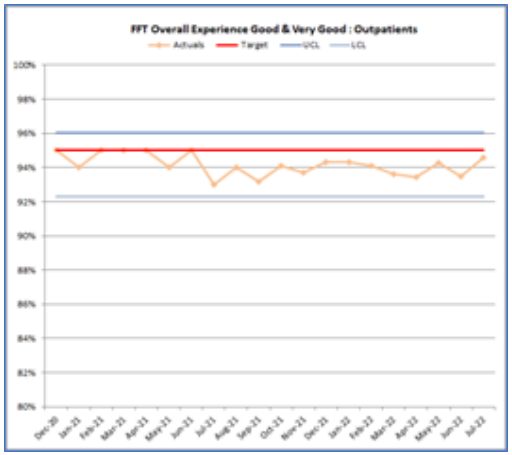
The Trust formally launched its Patient Experience Strategy on the 4 April 2022 with five strategy promises; Welcome, Safe, Inclusive, Care, and Supported. Promise action groups will focus on identifying improvement opportunities to improve the patients' experience.

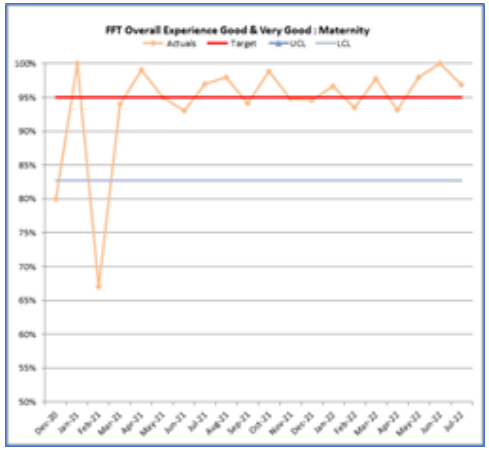
Expected Impact:

Improved FFT scores within the Emergency Department and an expectation to reach the Trust target for Outpatients in Q4.





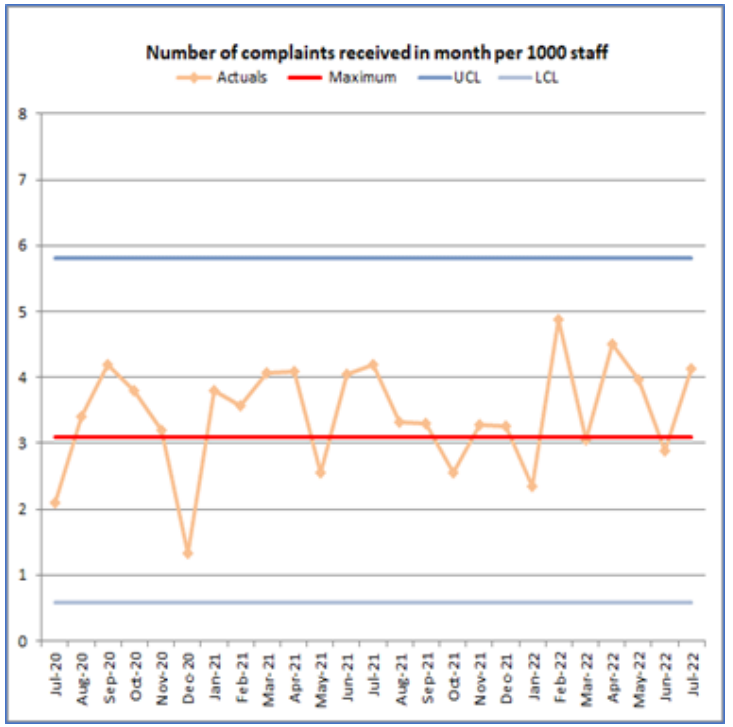




Responsive

Number of complaints received in month per 1000 staff

Executive Lead: Medical Director
Performance Issue: WUTH has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per 1000 staff. The rate for July 2022 was 4.13
Action: Although there has been a rise in July (more so in Medicine), 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. 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. During July 2022 the Trust registered 23 new formal complaints and closed 22 complaints. The Deputy Director for Quality Governance has introduced a weekly complaints management meeting attended by all divisions. The purpose of the meeting is to support management of complaint responses and to identify and address barriers to completion as early as possible.
Expected Impact: Not applicable.



NEWS2 Compliance

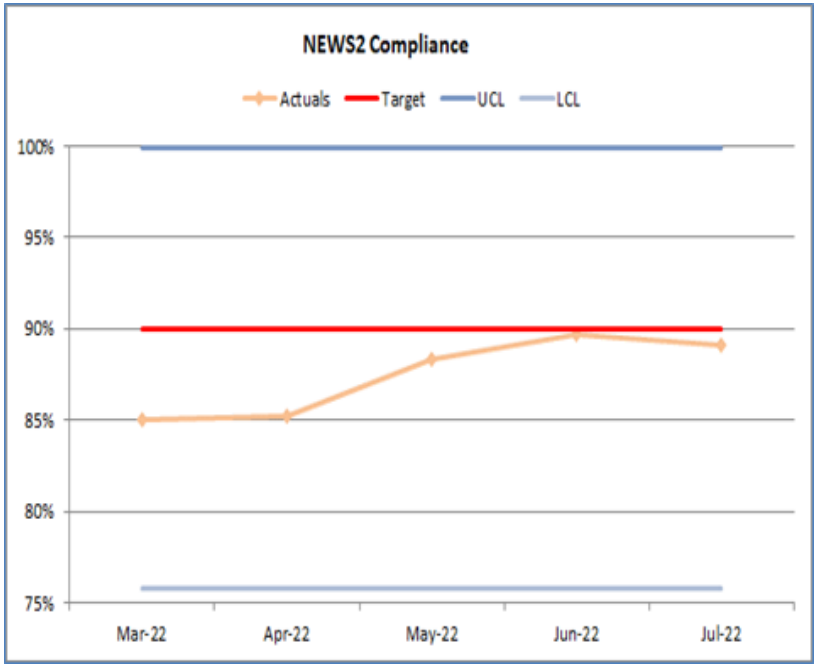
Executive Lead: Chief Nurse

Performance Issue:
A threshold of greater than 90% compliance with NEWS2 patient observations conducted within national guidelines and Trust NEWS2 policy has been set. Compliance is measured by a rolling programme of monthly ward audits: sustained improvement has been achieved since April 2022; July 2022 compliance was below target by 0.9% at 89.1%.

Action:
The Trust has progressed two workstreams to support an increase in compliance with the recording NEWS2 observations. NEWS2 compliance is reported to the Executive Management Team fortnightly as part of a series of nursing quality metrics.

A fast-track improvement programme has been developed to provide enhanced 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 planned introduction of integrated systems to enable observations to be recorded on modified observations machines to instantly migrate into patient medical records, increasing compliance is in progress. From August 2022 a new process has been introduced whereby the Clinical Practice Facilitator reviews patients that are scoring NEWS2 observation of either 5 – 6* or 7* and above to enable learning to be fed back directly to ward staff where improvements can be made.

A Deteriorating Patient Faculty, led by the Chief Nurse, has overseen quality improvement projects across a number of wards. An initiative has proved to be successful from the outset, resulting in trust wide change. The observational live report (available on the Bi Portal) identifies patients whose NEWS2 observation have ran over the recording time. Using this information as a supplement to the nursing worklist identifies has enabled patient needs to be responded to and saved nursing time.



Expected Impact:
The expectation is for all areas to achieve greater than 90% for completing NEWS2 observations by Q4.

Well-led Domain

Appraisal compliance %

Executive Lead: Chief People Officer

Performance Issue:

The target for annual appraisal compliance is 88%. Compliance has continued to improve over the last 3 months. At the end of July 2022 86.2% of the workforce had received an appraisal in the last 12 months.

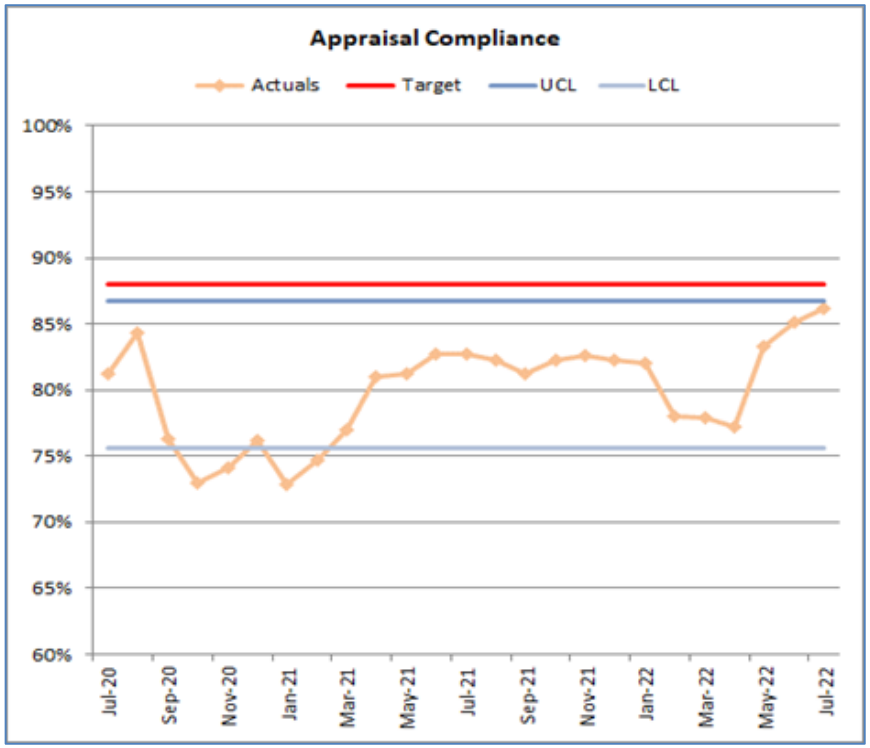
From a Divisional perspective, both Clinical Support and Women & Children's have achieved the Trust target. Acute division are the lowest with 74.04% compliance. All Divisions, with the exception of Estates and Facilities and Medicine, have seen an increase in compliance this month.

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. All Divisions have produced improvement trajectories and have confirmed expected date of compliance to Trust Management Board. This is closely managed via Divisional Performance Reviews.

Over the course of the past three months all areas that are out of compliance have received targeted support.



The review of appraisal has concluded and a proposal with recommendations to develop will be presented at Workforce Steering Board on 25th August 2022. If approved, the project will transform appraisal and management supervision at the Trust with a view to making the process more person centered, focused upon individual contribution (including performance), development and wellbeing. It will also seek to measure the quality of appraisal and supervision discussions alongside compliance figures. The newly developed Manager Essentials programme has launched. This includes training for managers on 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 any increase in clinical pressures may create continuing challenges in maintaining appraisal completion rates over forthcoming months.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework
September 2022/23

Item 9.3

Board Assurance Framework
David McGovern Director of Corporate Affairs

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

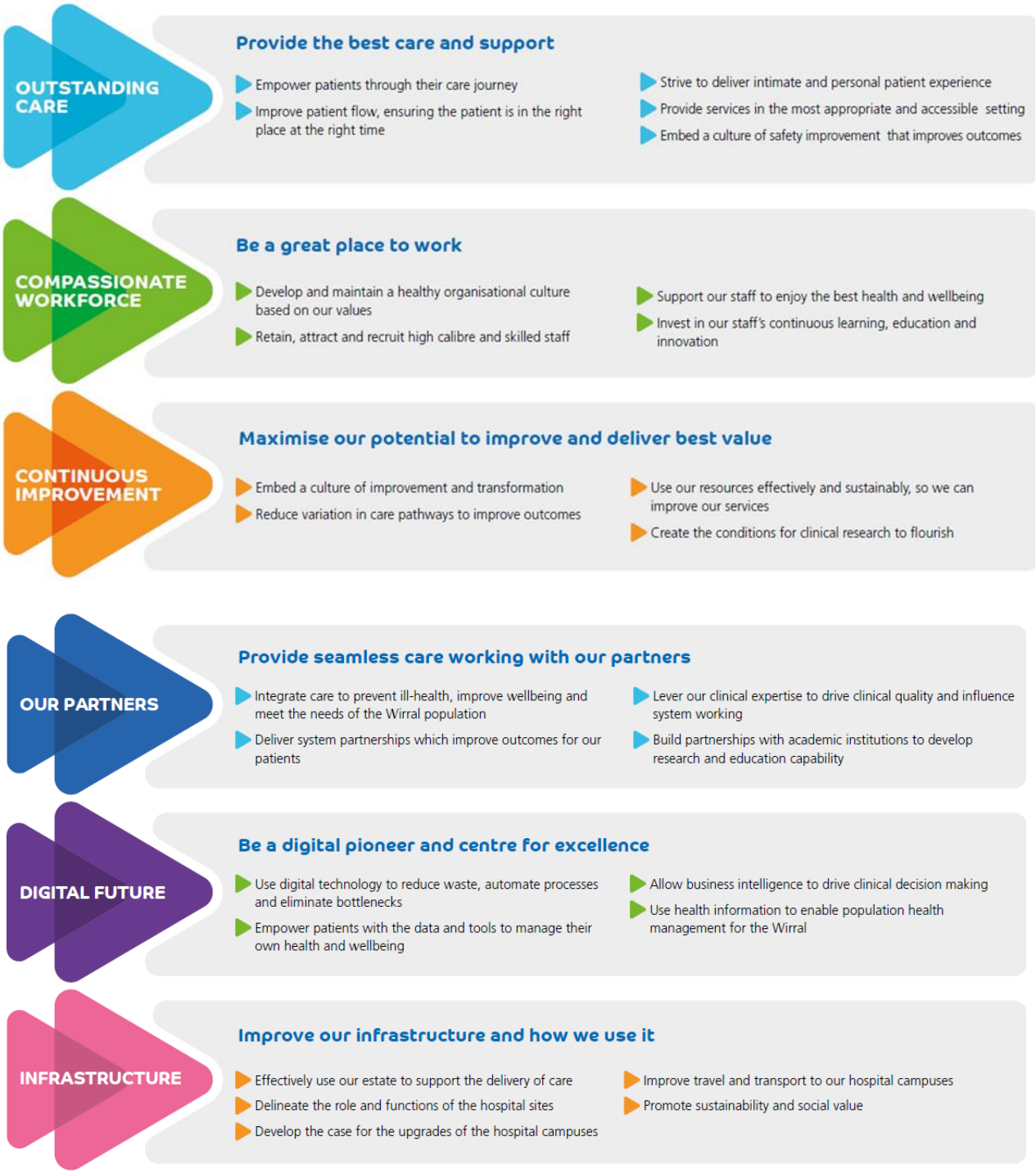
2. Vison, Strategy and Objectives

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. Our Risk Appetite

3.1 Risk Appetite Statement

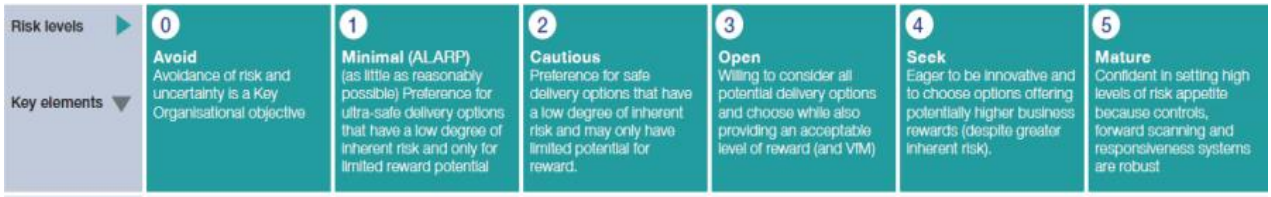
The Trust endeavours to establish a positive risk culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

The Trust Board is committed to ensuring a robust infrastructure to manage risks from ward to board level, and where risks crystallise, to evidencing improvements are put in place.

The Trust's intention is to **minimise** the risk to the delivery of quality services in the Trust's accountability and compliance frameworks and maximise performance.

To deliver **safe, quality** services, the Trust will encourage staff to work in collaborative partnership with each other and service users and carers to minimise risk to the greatest extent possible and promote patient well-being. Additionally, the Trust seeks to minimise the harm to service users arising from their own actions and harm to others arising from the actions of service users.

The Trust wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures consistent with the strategic direction set out in the Trust Strategy, whilst respecting and abiding by its statutory obligations.



Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Outstanding Care – Provide the best care and support.	Various	The Trust has an OPEN risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation. The Trust has MINIMAL risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed. We have a SEEK appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.
SO2: Compassionate Workforce – Be a great place to work	OPEN	The Trust Board has an open risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Trust is an employer of choice.
SO3: Continuous improvement – Maximise our potential to improve and deliver best value	OPEN	The Trust Board is prepared to accept risk in relation to innovation and ideas which may affect the reputation of the

		organisation but are taken in the interest of enhanced patient care and ensuring we deliver our goals and targets.
SO4: Our partners – Provide seamless care working with our partners	SEEK	The Trust Board recognises there may be an increased inherent risk faced with collaboration and partnerships, but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.
SO5: Digital Future – Be a digital pioneer and centre for excellence	SEEK	The Trust Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: Infrastructure - Improve our infrastructure and how we use it	OPEN	The Trust Board has an open risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.

4. Operational Risk Management

4.1 Operational Risk Management

The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities and threats. Uncertainty of outcome is how risk is defined. The Trust's approach to Risk management includes identifying and assessing risks and responding to them. The Trust will take all reasonably practicable steps to protect patients, staff, visitors and contractors from the risk of harm.

The Trust's governance framework is supported by an effective risk management system that delivers continuous improvements in safety and quality and maximises opportunity for growth and development. Risk management provides a solid foundation upon which to build a culture of high reliability wherein clinical and organisational excellence can flourish.

The overall purpose of risk management at the Trust is to:

- Reduce the level of exposure to harm for patients, colleagues or visitors by proactively identifying and managing personal risk to a level as low as reasonably practicable.
- Promote success and protect everything of value to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income.
- Ensure the Trust complies with all relevant statutory provisions.
- Continuously improve performance by proactively adapting and remaining resilient to changing circumstances or events.

The Trust has established an effective risk management system which ensures that:

- All risks are identified that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust.
- Priorities are determined, continuously reviewed and expressed through objectives that are owned and understood by all staff.
- Risks to the achievement of objectives are anticipated and proactively identified.
- Controls are put in place, effective in their design and application to mitigate the risk and understood by those expected to use them.

- The operation of controls is monitored by management.
- Gaps in control are rectified by management.
- Management is held to account for the effective operation of controls.
- Assurances are reviewed and acted on.
- Staff continuously learn and adapt to improve safety, quality and performance.
- Risk management systems and processes are embedded locally across divisions, directorates and within corporate services including business planning, service development, financial planning, project and programme management and education.

The Trust shall achieve this by:

- Anticipation of opportunities or threats and responsive adaptation through an explicit risk management process.
- Regular, effective and sufficient assessments of risk are carried out in all areas of the Trust's operations.
- Providing training to keep risk under prudent control.
- Investigating thoroughly, learning and acting on defects in care.
- Liaising with enforcing authorities, regulators and assessors.
- Effective oversight of risk management through team and committee structures.
- Formulation and implementation of policies and procedures for all significant hazards arising from the Trust's undertakings.
- Effective reporting and arrangements to hold staff to account.

5. Creating and Monitoring the BAF

5.1 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.

5.2 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 and Risk Committee with oversight of the Risk Management Framework.
- Reporting to every other meeting of Board Committees.
- Bi-Monthly Reporting to the Trust Management Board; and
- Bi-Monthly Reporting to the Risk Management Committee.

6. Monthly Update Report

6.1 September 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.

6.2 Changes to the previous version

Following refreshment, changes have been incorporated into the BAF where scorings have changed, or actions been completed/added.

All changes are highlighted in the report and register.

6.3 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 is 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 planned to take in the next month to align current strategic risks with the refreshment to Trust annual objectives.
- The Full Board will be asked to consider proposals for the future development of the BAF in a session to be jointly facilitated by the Good Governance Institute (GGI) in line with the Board Development Programme timetable.

6.4. Recommendations

Board is asked to:

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

BOARD ASSURANCE FRAMEWORK 2022-23										
BAF DASHBOARD 2022-23										
Strategic Priority	**Risk No**	**Risk Description**	**Lead**	**Committee**	**Initial Score**	**October/ December 2021**	**January/ March 2022**	**April/ June 2022**	**July/ September Current**	**Target**
Outstanding Care	1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	Chief Operating Officer	Quality and Board	20 (4 x 5)	N/A	16 (4 x 4)	16 (4 x 4)	20 (4 x 5)	12 (4 x 3)
Outstanding Care	2	Failure to meet constitutional targets, resulting in an adverse impact on patient experience and quality of care.	Chief Operating Officer	Quality and Board	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	20 (4 x 5)	12 (4 x 3)
Outstanding Care	3	Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints.	Medical Director and Chief Nurse	Quality	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)
Compassionate Workforce	4	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.	Chief People Officer	People	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)
Compassionate Workforce	5	Failure to retain enough staff, adversely impacting on the Trust's ability to provide high quality patient care.	Chief People Officer	People	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)
Compassionate Workforce	6	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.	Chief People Officer	People	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)
Compassionate Workforce	7	Constraints in Board capacity and capability due to turnover, lack of succession planning and talent management.	Chief Executive Officer	Board	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	8 (4 x 2)	8 (4 x 2)
Continuous Improvement	8	Failure to deliver sustainable cost improvements.	Chief Finance Officer	FBP	16 (4 x 4)	N/A	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)
Continuous Improvement	9	Failure to deliver the financial plan due to uncertainty around the future financial regime.	Chief Finance Officer	FBP	16 (4 x 4)	N/A	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	8 (4 x 2)
Continuous Improvement	10	Delays/restrictions in accessing capital resources to support the delivery of the Trust's strategies, e.g., digital and estates.	Chief Strategy Officer	Capital and Board	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Continuous Improvement	11	Failure to deliver sustainable productivity gains due to an inability to embed service transformation.	Chief Strategy Officer	Board	16 (4 x 4)	N/A	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)
Our Partners	12	Risk that ongoing uncertainty regarding the infrastructure of the Cheshire and Merseyside ICS causes material variability in strategic resourcing and planning, resulting in a change in strategic direction and uncertainty regarding Trust role in PLACE governance arrangements.	Chief Strategy Officer	Board	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Digital Future	13	Failure to sustainably and successfully implement EPR transformation and progress towards full electronic records.	Chief Finance Officer	FBP and Board	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Digital Future	14	Loss of clinical systems due to a cyber-attack, resulting in an adverse impact on the delivery of services.	Chief Finance Officer	FBP and Board	20 (5 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Digital Future	15	Failure to successfully implement the digital strategy, resulting in an adverse impact on patient care.	Chief Finance Officer	FBP and Board	12 (4 x 3)	N/A	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)
Infrastructure	16	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	Chief Strategy Officer	Capital and Board	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Infrastructure	17	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	Chief Strategy Officer	Capital and Board	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)

BAF RISK 1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.

Strategic Priority	Outstanding Care	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Operating Officer	20 (4 x 5)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Committee	Quality and Board						

Controls	Assurance
• Annual preparation and presentation of a system wide Winter plan in line with the National UEC Recovery Action. • 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. • Onsite support from Wirral Community Trust with the Chief Operating Officer focusing on admission avoidance and supporting early and timely discharge. • Monitoring of ED improvement plan and Wirral system urgent care plan by system Chief Operating Officers including Director of Adult Social care. • Health Economy CEO oversight of Discharge Cell. • Additional spot purchase care home beds in place but use very limited due to the number of Covid outbreaks, and then no admissions. • Participation in C&M winter room including mutual aid arrangements. • NWAS Divert Deflection policy in place and followed. • Rapid reset programme launched with a focus on hospital flow and discharge. • Continued communications out to primary care and to Wirral residents around only use A+E for urgent care requirements. • Regular meetings with the divisional leadership teams to ensure actions for improvement are delivered.	• Trust Management Board (TMB) Assurance • Divisional Performance Review (DPR) • Executive Committee • Health Wirral Urgent Care Improvement Program • Weekly Wirral COO and CEO Group and A+E Delivery Board

Gaps in Control or Assurance	Actions
• The Trust continues to be challenged delivering the national 4 hour standard for ED performance. • The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criteria to reside. • Due to the above system position the Trust has not got access to any further escalation beds in preparation for the normal winter surge and thus occupancy is already at 100% prior to winter surge.	• 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 several 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. **Due September 2022** • Delivery of a WUTH and Wirral system Winter Plan – focus on out of hospital care.

Progress
Key Changes to Note • Further gaps in controls identified. • Additional action added.

BAF RISK 2	Failure to meet constitutional targets, resulting in an adverse impact on patient experience and quality of care.

Strategic Priority	Outstanding Care	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Operating Officer	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	20 (4 x 5)	12 (4 x 3)
Committee	Quality and Board						

Controls	Assurance
• 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. • 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. • Weekly review via the performance meeting, chaired by the COO, on key targets and indicators with agreed actions and mitigations.	• Performance Oversight Group (Weekly) • Divisional Access & performance Meetings (weekly) • Theatre Resource Group & Theatre scheduling (weekly) • Monthly Divisional Quality Board Divisional Performance Reviews • Trust Management Board (TMB) • 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.

Gaps in Control or Assurance	Actions
• 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. • National challenge relating to medical staff rates of pay creating uncertainty with regards to additional capacity.	• Continue with delivery of mitigation plans for scheduled care, managing the risk with the utilisation of the national policy on clinical prioritisation. **Due September 2022.** • Explore alternative avenues of providing additional core surgical capacity to reduce the backlog of long waiting patients. • Assess the requirement to request mutual aid across Cheshire and Merseyside.

Progress

Key Changes to Note

- Further gaps in controls identified.
- Additional action added.
- Current Risk Score increased.

BAF RISK 3	Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints.

Strategic Priority	Outstanding Care	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Medical Director and Chief Nurse	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)
Committee	Quality						

Controls	Assurance
• CQC compliance focus on ensuring standards of care are met. • Embedding of safety and just culture. • Implementation of learning from incidents. • Development and implementation of patient safety, quality, and research strategies. • Initiative-taking monitoring and review of quality and safety indicators at monthly divisional performance reviews. • WISE Accreditation Programme.	• Patient Safety and Quality Board oversight and monitoring of quality and clinical governance themes and trends through the Quality and Patient Safety Intelligence Report at Quality Assurance Committee • Review of modified harm review Trust process Mortality Review Group Oversight Regular board review of Quality Performance Report, highlighting exceptions and mitigations • GIRFT • Quality audits • IPCG and PFEG • CQC focussed reviews of maternity, infection prevention and control services, diagnostics, and surgery • Cheshire and Merseyside ICB oversight of Trust clinical governance, including Sis, never events action plans • Internal Audit – MIAA. • PSIRF introduced – 14 month project plan • Maternity self-assessment

Gaps in Control or Assurance	Actions
• Fully complete and embedded patient safety and quality strategies.	• Develop, finalise, and complete the patient safety and quality strategies. **Due Q3.** • Implementation of PSIRF. • Implementation of Mental Health key priorities. • QI collaboratives roll out • Complete delivery of Ockenden action plan

Progress
Key Changes to Note • Additional actions added.

BAF RISK 4	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.

Strategic Priority	Compassionate Workforce	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief People Officer	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)
Committee	People						

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives. • CSW apprenticeship recruitment. • Targeted recruitment initiatives such as recruitment campaigns and international recruitment. • Vacancy management and recruitment systems and processes. • TRAC system for recruitment. • E-Rostering systems and procedures used to plan staff utilisation. • E-rostering and job planning to support staff deployment.	• Workforce Steering board and People Committee oversight.

Gaps in Control or Assurance	Actions
• National shortages in certain roles and full rollout of clinical job planning are pending workforce planning processes	• Monitor impact of retention and recruitment initiatives. **Ongoing.**

Progress
Key Changes to Note • N/A

BAF RISK 5	Failure to retain enough staff, adversely impacting on the Trust's ability to provide high quality patient care.

Strategic Priority	Compassionate Workforce	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief People Officer	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)
Committee	People						

Controls	Assurance
• Retention Working Group has been established. • Facilitation in Practice programme. • Implementation of staff survey action plans. • Training and development activity. • Exit interview process. • Utilisation of NHS England and NHS National Retentions programme resource to review and implement evidence based best practice. • Identification and set up of task and finish groups for the following Staff Groups - Medical and Dental, AHP's and Corporate. The current Nurse and CSW Recruitment & Retention Group is also being reviewed to have an enhanced focus on retention, work continues in this group. • Links have been made with NHS England and NHS Improvement's National Retention Programme Team. • Identification and review in progress of workforce data sources: ESR reporting, Exit Surveys and Staff Survey to determine priorities and inform the delivery action plan.	• Workforce Steering board and People Committee oversight.

Gaps in Control or Assurance	Actions
• 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.	• Sign-off of associated action plan within the workforce strategy. **Due September 2022.**

Progress
Key Changes to Note • Addition of controls. • N/A

BAF RISK 6	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.

Strategic Priority	Compassionate Workforce	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief People Officer	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)
Committee	People						

Controls	Assurance
• COVID-19 Absence Support Team established. • New Supporting People to Manage Attendance Programme. • Attendance Management Policy review commenced. • Health and safety and attendance management policies. • Workforce Wellbeing plan. • Staff Survey Action Plans which are heavily focused on Health, Wellbeing and Attendance. • Wellbeing Conversations. • Wellbeing Surgeries. • Flu vaccination programme.	• Workforce Steering board and People Committee oversight

Gaps in Control or Assurance	Actions
• Current barriers to accessing the wellbeing support offers. • Residual impact of COVID experience on staff wellbeing. • Staff Attendance Rates.	• Implementation of People Plan elements pertaining to health and wellbeing. • Sign-off of associated action plan within Staff wellbeing plan. **Due September 2022.**

Progress
Key Changes to Note • Addition of controls.

BAF RISK 7	Constraints in Board capacity and capability due to turnover, lack of succession planning and talent management.

Strategic Priority	Compassionate Workforce	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Executive Officer and Director of Corporate Affairs	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	8 (4 x 2)	8 (4 x 2)
Committee							

Controls	Assurance
• Implementation of Executive Director recruitment plan. • Executive Director and Board development plan. • Board succession planning. • Initial assessment of Board maturity.	• Board approval of Board development plan. • 2021/22 Deloitte Well led review report and action plan. • Initial assessment of Board maturity. • Current recruitment complete.

Gaps in Control or Assurance	Actions
• The Trust has licence condition undertakings pertaining to Board capability and capacity. • The Deloitte well led review action plan is in place and being actioned. • Succession and Talent Development Plans.	• Implementation of Deloitte well led review and Board development plan. • Complete assessment against NHS Code of Governance. • Complete progress against Board Maturity matrix. • Finalise leadership succession planning and talent management plans. **All actions due end of 2023 Financial Year.**

Progress
Key Changes to Note • Further controls added. • Further assurance added. • Additional gaps in control identified. • Additional actions identified. • Current score reduced.

BAF RISK 8	Failure to deliver sustainable cost improvements.

Strategic Priority	Continuous Improvement	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Finance Officer	16 (4 x 4)	N/A	16 (4 x 4)	12 (4 x 3)	16 (4 x 4)	12 (4 x 3)
Committee	FBP						

Controls	Assurance
• 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.

Gaps in Control or Assurance	Actions
• 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. • Lack of fully identified and costed CIP Plan for 2022/23.	• Continue delivery of CIP programme and maintain oversight of divisional progress. **Ongoing.** • Complete benchmarking and productivity opportunities review pack – **September 2022.** • Develop CIP opportunities to include all trust wide strategic and transformational plans – **September 2022.** • Review and develop CIP Governance and Accountability – **September 2022.**

Progress
Key Changes to Note • Additional gaps in control identified. • Additional actions identified. • Current score increased.

BAF RISK 9	Failure to deliver the financial plan due to uncertainty around the future financial regime. **Change to Failure to Deliver the Annual Financial Plan.**

Strategic Priority	**Continuous Improvement**	**Risk Score 2022/23**					
Review Date	31/08/22	**Initial**	**October/ December**	**January/ March**	**April/ June**	**July/ September Current**	**Target**
Lead	Chief Finance Officer	16 (4 x 4)	N/A	16 (4 x 4)	12 (4 x 3)	16 (4 x 4)	8 (4 x 2)
Committee	FBP						

Controls	**Assurance**
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime.	• Monthly reports to Divisional Boards, TMB, FBP 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.

Gaps in Control or Assurance	**Actions**
• Forecasting has proven inaccurate, historically, and further work needed to strengthen arrangements.	• Finalise estates strategy and agree priority programmes - **September 2022.** • **CFO to present a full review of Forecasting to the FBPAC - September 2022.**

Progress
Key Changes to Note • Wording of the Risk altered. • Additional actions identified. • Current score increased.

BAF RISK 10	Delays/restrictions in accessing capital resources to support the delivery of the Trust's strategies, e.g., digital and estates.

Strategic Priority	Continuous Improvement	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Committee	FBP						

Controls	Assurance
• Expression's interest submitted where appropriate for any additional national funding available. • Implementation of capital programme. • Ongoing programme of external reviews of the estate. • Appointment of authorised engineers' development and implementation of masterplans for Hospital plans. • Operational plan for the Digital Strategy. • Capital Management Group meets on monthly basis with representation from Operational teams, Estates and Finance. • Received NHSE funding for two additional modular theatres, for construction in March - May 2022.	• 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

Gaps in Control or Assurance	Actions
• 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.	• Drafted Estates strategy. • Master Plan for Clatterbridge Hospital completed. • Risk assessment of the Capital backlog. **Ongoing.**

Progress
Key Changes to Note • Additional control added.

BAF RISK 11	Failure to deliver sustainable productivity gains due to an inability to embed service transformation.

Strategic Priority	Continuous Improvement	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	N/A	16 (4 x 4)	12 (4 x 3)	16 (4 x 4)	12 (4 x 3)
Committee	FBP						

Controls	Assurance
• Programme Board oversight. • Service improvement team and Quality Improvement team resource and oversight. • QIA guidance document implemented as part of transformation process. • Implementation of a programme management process and software to track delivery. • 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.

Gaps in Control or Assurance	Actions
• 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.	• Implementation and delivery of Cost improvement and Transformation Programmes for 22/23 and delivery of 22/23 Improvement Programme to plan. • Implementation of revised Cost Improvement approach.

Progress
Key Changes to Note • Additional gaps in control identified. • Additional actions identified. • Current score increased.

BAF RISK 12	Risk that ongoing uncertainty regarding the infrastructure of the Cheshire and Merseyside ICS causes material variability in strategic resourcing and planning, resulting in a change in strategic direction and uncertainty regarding Trust role in PLACE governance arrangements.

Strategic Priority	Our Partners	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)
Committee	Board						

Controls	Assurance
• WUTH senior leadership engagement in ICS through Director of Strategy and CEO. • 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. • National guidance on PLACE based partnerships Legislation framework. • ICS design framework. • ICS Body governance. • Input of Trust CEO and Director of Strategy into Outline of the ICP Structure.	• CEO and Director of Strategy updates to Board and Executive Director meetings. • Chair, CEO and Chief Strategy Officer attendance at Healthy Wirral Partners Board. • Secondment of Head of Strategic Planning to develop ICP/Place operating model. • ICS Chair updates, ICS meetings, ICS Self-assessment submission. • CMAST CEO and Directors of Strategy meetings. • Healthy Wirral Partners Board.

Gaps in Control or Assurance	Actions
• Time to establish C&M ICS accountability and governance infrastructure, Delays in the consolidation of CCGs to ICS. • Place lead appointment for Wirral. • Function and role of C&M ICS working with the Trust and Formal.	• Development of PLACE governance arrangements with Wirral partners. • Completion of ICS and PLACE governance self-assessment. • Development of PLACE operating model. **Due September 2022.**

Progress
Key Changes to Note • Additional actions identified. • Current score decreased.

BAF RISK 13	Failure to sustainably and successfully implement EPR transformation and progress towards full electronic records.

Strategic Priority	Digital Future	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Finance Officer	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Committee	FBP						

Controls	Assurance
• 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. • HIMSS level 5 assessment criteria undertaken

Gaps in Control or Assurance	Actions
• Team infrastructure for EPR rollout is not in line with national benchmarking. • Baseline review start date is yet to be confirmed.	• Identify and address EPR team infrastructure gaps. **Due September 2022.**

Progress
Key Changes to Note • N/A

BAF RISK 14	Loss of clinical systems due to a cyber-attack, resulting in an adverse impact on the delivery of services.

Strategic Priority	Digital Future	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Finance Officer	20 (5 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Committee	FBP						

Controls	Assurance
• Implementation of disaster recovery plan. • Implementation of digital strategy operational plan. • Cyber essentials accreditation. • Implementation of cyber security action plan. 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. • MIIA internal audit review of cyber security, undertaken in 2020/21, which highlighted an audit opinion of moderate assurance.

Gaps in Control or Assurance	Actions
• 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. • Partnerships – input into Community Trust preventative measures is a threat to our resource capacity. • Integration – information governance. • Perception of IT functions impacting resourcing. • Implementation of cyber security action plan is yet to be completed.	• Continue rollout of cyber-security plan and explore option of cyber security insurance. **Due September 2022.**

Progress
Key Changes to Note • N/A

BAF RISK 15	Failure to successfully implement the digital strategy, resulting in an adverse impact on patient care.

Strategic Priority	Digital Future	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Finance Officer	12 (4 x 3)	N/A	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)
Committee	FBP						

Controls	Assurance
• Agreed operational plan with divisions over the next 12 months. • Implementation of digital strategy through the operational plan. • Agreement of priorities at Digital Programme and Services Oversight Committee, where oversight takes place. • 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. • Chief Information Officer regional meetings.

Gaps in Control or Assurance	Actions
• Currently a number of unknown variables which will potentially impact on the agreed schedule.	• Submit digital strategy implementation plan to Board. **Due TBD.**

Progress
Key Changes to Note • N/A

BAF RISK 16	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

Strategic Priority	Infrastructure	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Committee	Quality and FBP						

Controls	Assurance
• Implementation of capital programme, which includes remedial works at Clatterbridge and Arrowe Park Hospital. • Implementation of social distancing in waiting rooms and screens, use of security controls across site to manage access. • Allocation of ward status. • Senior Clinician input in key decisions around key areas such as critical care. • Ward refurbishment programme.	• Capital Committee oversight. • FBP oversight of capital programme implementation.

Gaps in Control or Assurance	Actions
• Review to be extended to cover Arrowe Park. • Estates Strategy is currently under development. • Delays in backlog maintenance.	• Finalise Arrowe Park master plan and Prioritisation of estates improvements. **September 2022.** • Receive confirmation of support for the Masterplan from NHSE **– TBC.**

Progress
Key Changes to Note • Additional action identified.

BAF RISK 17	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.

Strategic Priority	Infrastructure	Risk Score 2022/23					
Review Date	31/08/22	Initial	October/ December	January/ March	April/ June	July/ September Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Committee	Capital and FBP						

Controls	Assurance
• Implementation of capital programme, which includes remedial works at Clatterbridge. • Implementation of social distancing in waiting rooms. • Allocation of ward status. • Senior Clinician input in key decisions around key areas such as critical care. • Estates Strategy.	• Capital Committee oversight. • FBP oversight of capital programme implementation.

Gaps in Control or Assurance	Actions
• Review to be extended to cover Arrowe Park. • Estates Strategy is currently under development. • Delays in backlog maintenance.	• Finalise Arrowe Park master plan and Prioritisation of estates improvements. **September 2022.** • Asset audit. **September 2022** • Implementation of the new Capital Assets and Facilities system. **April 2022.**

Progress
Key Changes to Note • Additional actions identified.

Appendix – Risk Scoring Matrix

Risk Scoring and Grading:

Use table 1 to determine the consequence score(s) (C)
Use table 2 to determine the likelihood score(s) (L)
Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score)
Assign grade of risk according to risk score.

	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

Appendix – Risk Appetite Scoring Matrix

Board of Directors in Public
31 August 2022

Item No 9.4

Title	M4 Finance Report
Area Lead	Mark Chidgey, CFO
Author	Robbie Chapman, Deputy CFO
Report for	Information

Report Purpose and Recommendations

At Month 4 (M4) the Trust is reporting a deficit of £1.980m which is an adverse variance against budget of £2.395m. Whilst the Trust continues to forecast a break-even position, achievement of this should be considered as at risk by the Board.

The year to date variance is largely attributed to overspends on employee costs, driven by underperformance in respect of recurrent CIP and the continued use of escalation wards staffed at premium rates. The Trust has been able to partially, but not fully, mitigate these overspends by non-recurrent mitigations such as the release of deferred income and underspends in non-pay resulting from reduced elective activity.

As agreed across the ICS, the financial position assumes that the Trust will retain 100% of the Elective Recovery Fund (ERF) income. This is a risk to the forecast because national policy on this my change and performance against the agreed elective plan is significantly below the target level of 104% of 19/20 levels.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to the following key risk:

- 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 of Directors meeting.

Month 4 Finance Report 2022/23

Contents

1. Executive Summary

1.1 **Table 1: Financial position – M4**

Month 4 Financial Position	In Month (£'000)			Year to Date (£'000)		
TRUST	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Income from Patient Care Activities	£33,200	£33,238	£38	£132,800	£132,853	£53
Other Income	£3,447	£3,855	£409	£13,719	£15,399	£1,680
Total Income	**£36,647**	**£37,094**	**£447**	**£146,519**	**£148,252**	**£1,732**
Employee Expenses	-£25,262	-£25,634	-£372	-£101,215	-£104,086	-£2,871
Operating Expenses	-£11,197	-£10,346	£851	-£45,186	-£42,374	£2,812
Total Operating Expenditure	**-£36,459**	**-£35,980**	**£478**	**-£146,401**	**-£146,460**	**-£59**
CIP	£1,420	£296	-£1,124	£6,071	£2,328	-£3,743
Total CIP	**£1,420**	**£296**	**-£1,124**	**£6,071**	**£2,328**	**-£3,743**
Non Operating Expenses	-£1,443	-£1,840	-£396	-£5,774	-£6,099	-£325
Surplus/(Deficit)	**£165**	**-£430**	**-£595**	**£416**	**-£1,980**	**-£2,395**

1.2 The Trust is reporting a deficit of £1.980m at M4, an adverse variance against plan of £2.395m.

1.3 Total income was £148.252m at M4, a positive variance of £1.732m. This relates to the release of deferred income in respect of international nurse recruitment and teledermatology and the recharge of energy costs to Clatterbridge Cancer Centre. All of these costs are offset by increases in expenditure. Income is discussed in more detail in 3.1.

1.4 The Trust is at risk of financial penalties for any underperformance in respect of the elective programme at 75% of the value. We estimate the potential risk at M4 to be penalties of £3.615m. This is not reflected within the position. This is discussed in more detail from 3.1.3.

1.5 Total employee expenses were £104.086m at M4, this represents an overspend against our budget of £2.871m. The overspend against plan is discussed in more detail at 3.2.1 and from 3.6.1 onwards but is primarily driven by the continued reliance on bank and agency staff as a result of staff sickness and use of escalation wards, together with the under-delivery of pay CIP.

Table 2: Pay cost analysis

Pay Analysis	IN MONTH			YEAR TO DATE		
	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Consultants	-£4,125	-£3,840	£285	-£16,581	-£16,719	-£139
Other medical	-£2,705	-£2,828	-£123	-£10,811	-£11,524	-£713
Nursing and midwifery	-£7,176	-£7,772	-£596	-£28,859	-£31,142	-£2,284
Allied health professionals	-£1,395	-£1,442	-£47	-£5,574	-£5,722	-£148
Other scientific, therapeutic and technical	-£587	-£559	£28	-£2,349	-£2,250	£100
Health care scientists	-£1,149	-£1,114	£35	-£4,587	-£4,393	£194
Support to clinical staff	-£4,682	-£4,811	-£129	-£18,617	-£19,213	-£596
Non medical, non clinical staff	-£3,349	-£3,172	£177	-£13,462	-£12,743	£719
Apprenticeship Levy	-£94	-£96	-£2	-£375	-£380	-£5
Total	**-£25,262**	**-£25,634**	**-£372**	**-£101,215**	**-£104,086**	**-£2,871**

1.6 Operating expenses were £42.374m at M4, an underspend of £2.812m. This is reflective of reduced elective activity, most notably within the Surgery division. This is discussed in more detail from 3.3.1.

1. Executive Summary

1.7 The Trust has delivered £2.328m of CIP at M4, an adverse variance of £3.743m. However, of the figure achieved only £0.872m of this has been delivered recurrently. This is discussed in more detail from 3.5.

1.8 Cash balances at the end of M4 reduced to £25.835m.

1.9 The Trust has recorded a capital spend of £3.908m at M4 compared to an expected spend of £9.677m.

2. Risk

2.1 The revised Oversight Framework does not require us to report our Use of Resources rating. We do, however, believe that there are two previously reported indicators (cash liquidity and agency spend) that warrant inclusion in this report.

2.2 Cash liquidity at 31 July 2022 was -16.4 days which is a deterioration from M2 (-12 days) but work is progressing well on a review of the historical accruals on the balance sheet so a further improved position moving forward is expected.

2.3 The agency spend cap is now monitored at ICS level with all Trusts expected to reduce expenditure on Agency by 10% from the prior period. Agency spend at M4 is £3.399m which is £2.333m above budget and a 0.5% increase against 21/22. This is explained in more detail at 2.5.4.

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

2.4.1 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 M4, the limited progress against the CIP plan (see below) and potential clawback against ERF all indicate that this risk has increased.

2.4.2 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. We are forecasting £5.051m in respect of recurrent CIP, a shortfall against plan of £8.798m. At M4 only £0.872m CIP has been transacted recurrently and £2.330m has been transacted non-recurrently.

2.4.3 Risk 3 – Failure to complete capital programme

- Our capital expenditure envelope for 22/23 totals £44.851m which will be the largest capital programme the Trust has delivered in one financial year. The internally generated capital plan for 22/23 totals £9.765m and is described in more detail at 4.2.

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

2.5.1 CIP

- Failure to deliver CIP remains our most significant risk and achievement so far this year indicates this risk has increased. Please see 3.4 for more detail.

2.5.2 Shortfall in funding

- With all funding confirmed, the most significant risk in respect of funding is any potential clawback in respect of ERF. This is discussed in more detail from 3.1.3.

2.5.3 Activity below plan

- As at M4, the Trust has delivered £4.820m less elective activity than plan, resulting in potential clawback of £3.615m. Despite the fact that all but one of the theatres are now back in use, the delay in opening the new modular theatres until October means that the opportunity to recover activity in line with the annual plan has reduced. The risks and opportunities associated with potential clawback are discussed from 3.1.3.

2.5.4 Reliance on agency staff

- Workforce information indicates that the reliance upon high cost agency staff has reduced from the peak in M1 and M2 but remains higher than plan, principally due to the continued use of escalation wards.

2.5.5 Inflation

- Whilst inflation continues to run significantly higher than forecast we have received funding equivalent of 0.7% increase in tariff to adjust for higher than expected inflation. This amounts to additional, recurrent funding of £2.682m.

2.5.6 COVID-19

- The Trust has spent in line with planned COVID-19 expenditure at M4. Please see from 3.3.4 for more detail.

3.1 **Income**

3.1.1 The Trust has received £149.234m at M4, a positive variance of £2.714m.

Table 4: Income analysis for M4

	IN MONTH			YEAR TO DATE		
Point of Delivery	**Budget (£'000)**	**Actual (£'000)**	**Variance (£'000)**	**Budget (£'000)**	**Actual (£'000)**	**Variance (£'000)**
Elective & Daycase	£5,508	£4,257	-£1,250	£20,548	£16,120	-£4,428
Elective excess bed days	£122	£70	-£52	£412	£329	-£84
Non-elective	£9,083	£8,885	-£198	£36,022	£36,284	£261
Non-elective Non Emergency	£1,177	£1,054	-£123	£4,672	£4,343	-£329
Non-elective excess bed days	£558	£517	-£41	£2,216	£1,877	-£339
A&E	£1,505	£1,500	-£5	£5,884	£5,773	-£111
Outpatients	£4,017	£3,961	-£56	£14,888	£14,966	£79
Diagnostic imaging	£325	£218	-£107	£1,205	£907	-£297
Maternity	£421	£423	£2	£1,629	£1,717	£87
Non PbR	£7,013	£5,558	-£1,455	£27,708	£22,724	-£4,985
HCD	£1,601	£1,613	£12	£6,094	£6,102	£7
National Top up	£2,328	£2,328	£0	£9,313	£9,313	£0
Other	-£1,357	£1,409	£2,766	-£1,386	£7,823	£9,209
Sub-Total Clinical Income	**£32,301**	**£31,794**	**-£508**	**£129,206**	**£128,277**	**-£929**
Other patient care income	£251	£444	£193	£976	£2,192	£1,216
Elective Recovery Fund	£899	£899	£0	£3,594	£3,594	£0
COVID-19 Income	£362	£865	£503	£1,446	£1,672	£226
Non-NHS: private patient & overseas	£24	£13	-£11	£98	£61	-£36
Injury cost recovery scheme	£43	£87	£44	£173	£261	£89
Total Patient Care Income	**£1,578**	**£2,308**	**£729**	**£6,286**	**£7,781**	**£1,495**
Other operating income	£2,767	£2,992	£225	£11,027	£12,193	£1,167
Other non operating income	£0	£0	£0	£0	£0	£0
Total Other income	**£2,767**	**£2,992**	**£225**	**£11,027**	**£12,193**	**£1,167**
Total income	**£36,647**	**£37,094**	**£447**	**£146,519**	**£148,252**	**£1,732**

3.1.2 Clinical income at M4 was £128.277m, a negative variance against budget of £0.929m. However, as shown in the table, income is lower than budget across a larger number of activity categories and this is offset by back to block, system top up monies (under "National Top Up") and other, which includes release of non-recurrent deferred income. Whilst this does not represent the same risk that would be the case under full Payment by Results, the introduction of AIP does mean that underperformance against activity will again have an impact on the Trust's financial position.

3.1.3 Income includes 4/12ths of the Trust's allocation of Elective Recovery Funding (ERF) which is to support delivery of 104% of 2019/20 elective activity thereby reducing the length of time patients are waiting for treatment. The baseline is calculated using 104% of 19-20 trust activity valued at 22-23 tariffs as per the national guidance. As per the guidance, the Trust's funding should be adjusted up or down by 75% of tariff if actual activity delivered is above or below the 104% baseline value.

3.1.4 At M4 the elective baseline is £36.543m and the actual M4 activity valued at national and local tariffs is £31.723m, this includes capping the outpatient follow ups at 85% of the baseline as per the published guidance. Therefore, at M4 the Trust is £4.820m below the baseline with 75% of this is at risk of being recouped by the ICB (as a commissioner), which equates to £3.615m. Table 5 below demonstrates the position at M4.

Table 5 Comparison of actual performance against 19/20 baseline

	Cumulative Position at M4			
	Plan	Actual (inc FUPs @ 85% of 19/20 levels)	Variance	75% up or down
Day cases	£10,695,229	£9,517,564	(£1,177,665)	(£883,249)
Elective	£8,554,887	£6,817,214	(£1,737,673)	(£1,303,255)
OP Procedures	£1,840,197	£1,263,703	(£576,494)	(£432,371)
OP First Attendances	£7,651,425	£7,748,128	£96,704	£72,528
OP Follow Up Attendances	£7,801,851	£6,376,513	(£1,425,338)	(£1,069,004)
	£36,543,589	**£31,723,121**	**(£4,820,467)**	**(£3,615,350)**

3.1.5 However, as of M4 we have been directed by NHSE not to include provision for any adjustment for under-performance against this target.

3.1.6 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 be reintroduced). The Trust will be reintroducing charges as of the 1st September. The current suspension of charging creates an adverse variance of £0.176m.

3.2 Expenditure: Pay

3.2.1 The Trust has spent £104.086m on pay costs at M4, an overspend of £2.871m. Table 6 details pay costs by staff group, Table 7 details WTE by staff group and Table 8 details pay costs by pay category type.

Table 6: Pay costs by staff type

Pay Analysis	IN MONTH			YEAR TO DATE		
	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Consultants	-£4,125	-£3,840	£285	-£16,581	-£16,719	-£139
Other medical	-£2,705	-£2,828	-£123	-£10,811	-£11,524	-£713
Nursing and midwifery	-£7,176	-£7,772	-£596	-£28,859	-£31,142	-£2,284
Allied health professionals	-£1,395	-£1,442	-£47	-£5,574	-£5,722	-£148
Other scientific, therapeutic and technical	-£587	-£559	£28	-£2,349	-£2,250	£100
Health care scientists	-£1,149	-£1,114	£35	-£4,587	-£4,393	£194
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Non medical, non clinical staff	-£3,349	-£3,172	£177	-£13,462	-£12,743	£719
Apprenticeship Levy	-£94	-£96	-£2	-£375	-£380	-£5
Total	**-£25,262**	**-£25,634**	**-£372**	**-£101,215**	**-£104,086**	**-£2,871**

Table 7: WTE by staff type

Pay Analysis	WTE		
	Budget	Contracted	Actual
Consultants	289.45	274.33	289.98
Other medical	371.37	368.03	402.59
Nursing and midwifery	1,688.32	1,611.98	1,723.22
Allied health professionals	333.99	317.46	335.07
Other scientific, therapeutic and technical	113.82	109.79	109.89
Health care scientists	283.85	274.59	275.15
Support to clinical staff	1,814.91	1,754.47	1,927.89
Non medical, non clinical staff	1,134.51	1,057.44	1,120.58
Apprenticeship Levy	-	-	-
Total	**6,030.22**	**5,768.09**	**6,184.37**

Table 8: Pay costs by pay category (excluding COVID)

Month 4 Financial Position	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Substantive	-£24,212	-£22,625	£1,587	-£97,016	-£91,819	£5,197
Bank	-£81	-£1,275	-£1,194	-£322	-£5,152	-£4,829
Medical Bank	-£312	-£685	-£373	-£1,247	-£2,568	-£1,320
Agency	-£267	-£796	-£530	-£1,066	-£3,399	-£2,333
Other Employee	-£94	-£96	-£2	-£375	-£380	-£5
Total Employee Expenses	**-£24,965**	**-£25,477**	**-£512**	**-£100,027**	**-£103,318**	**-£3,291**

3.2.2 The biggest overspends in month related to Medicine (£0.424m in month, £1.470m YTD), Acute (£0.219m in month, £0.943m YTD) and Surgery (£0.185m in month, £1.331m YTD).

3.3 Expenditure: Non-Pay

3.3.1 The Trust has spent £40.904m on non-pay operating expenditure excluding COVID at M4, a positive variance of £3.161m.

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

Trust	IN MONTH			YEAR TO DATE		
Month 4 Financial Position	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Supplies and services - clinical	-£3,255	-£3,189	£66	-£13,006	-£11,461	£1,544
Supplies and services - general	-£410	-£463	-£53	-£1,643	-£1,770	-£127
Drugs	-£2,342	-£2,441	-£99	-£9,510	-£9,379	£132
Purchase of HealthCare - Non NHS Bodies	-£979	-£910	£70	-£3,954	-£3,352	£603
CNST	-£1,072	-£1,070	£2	-£4,286	-£4,280	£6
Consultancy	-£28	-£8	£20	-£112	-£7	£105
Other Operating	-£2,831	-£1,722	£1,109	-£11,554	-£10,655	£899
Total Operating Exenses excl Covid 19	**-£10,917**	**-£9,802**	**£1,115**	**-£44,066**	**-£40,904**	**£3,161**

3.3.2 Elective activity at M4 represented 87.6% of the plan submitted to NHSEI. This has resulted in significant underspends in respect of clinical supplies and services and drugs, most notably in surgery.

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

3.3.4 The Trust has spent £2.238m on COVID-19 costs at M4, with £0.768m on pay and £1.470m on non-pay.

Table 10: COVID-19 costs

Month 4 Financial Position	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Staff costs	-£297	-£158	£140	-£1,188	-£768	£420
Operating expenses	-£280	-£544	-£264	-£1,120	-£1,470	-£350
Total Covid 19 costs	**-£577**	**-£701**	**-£124**	**-£2,308**	**-£2,238**	**£70**

3.3.5 The vaccination costs were £0.355m at M4 which was in line with plan and is funded centrally so offset in income. We have been informed by NHSE that from September we will no longer be reimbursed retrospectively for our vaccination costs and will instead receive a fixed budget based on average costs and number of planned vaccinations but the budget has yet to be confirmed. The Trust is in the process of completing an exercise to review our operating model for vaccination with the intention of reducing costs in anticipation of the reduction in funding.

3.3.6 The testing costs were £1.331m at M4 and are funded centrally so offset in income.

3.4 **CIP Performance**

3.4.1 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.

3.4.2 As at the 10th August, 248 opportunities had been submitted by divisional teams with a recurrent value of £5.015m against a target of £13.849m. This represents a reduction of £1.621m compared with the figure reported at M2.

3.4.3 QIA panels are established on a fortnightly basis to prioritise CIP schemes and are chaired by the Deputy Medical Director and Deputy Director of Nursing. 52% of schemes identified have been approved at QIA to date.

Table 11 Identified savings by Division

Division	Annual Target	Forecast	FYE Variance	% Variance
DCS	£2,400,897	£712,909	-£1,687,988	-70%
Corporate	£1,260,526	£635,927	-£624,599	-50%
Medicine	£2,698,861	£1,267,181	-£1,431,680	-53%
Acute	£879,014	£102,398	-£776,616	-88%
Surgery	£2,617,788	£868,019	-£1,749,769	-67%
Estates	£1,131,379	£269,386	-£861,993	-76%
W&C	£1,136,000	£62,379	-£1,073,621	-95%
Trust Central	£1,724,535	£1,133,244	-£591,291	-34%
Total	**£13,849,000**	**£5,051,443**	**-£8,797,557**	**-64%**

3.4.4 £0.872m has been delivered in M4 against targets assigned of £4.545m and validated plans of £1.772m.

Table 12 YTD performance by Division

Division	YTD Target	YTD Plan	YTD Actual	YTD Variance to plan	YTD Variance to target
DCS	£800,300	£181,211	£166,161	-£15,050	-£634,139
Corporate	£420,226	£131,504	£149,461	£17,957	-£270,765
Medicine	£899,620	£611,599	£341,120	-£270,479	-£558,500
Acute	£293,005	£15,162	£21,206	£6,044	-£271,799
Surgery	£872,596	£131,731	£59,632	-£72,099	-£812,964
Estates	£377,127	£167,445	£110,241	-£57,204	-£266,886
W&C	£378,666	£29,949	£24,697	-£5,252	-£353,969
Trust Central	£503,664	£503,664	£0	-£503,664	-£503,664
Total	**£4,545,203**	**£1,772,265**	**£872,518**	**-£899,747**	**-£3,672,685**

3.4.5 26 projects have currently been identified as areas of opportunity and are awaiting sign off from the divisional directors to progress to gateway 2.

3.4.6 84 projects with a value of £0.982m have progressed to design & plan (gateway 2), meaning documentation is now being completed on Smartsheets with the support of the PMO. All schemes in gateway 2 are awaiting QIA completion by project leads.

3.4.7 9 projects with a value of £0.083m are in the governance and assurance (gateway 3), awaiting QIA panel 24th August.

3.4.8 44 projects with a value of £1.795m have been approved at QIA panel and are now in the implementation gateway.

4. Financial Position

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

4.1.1 The movement in total assets employed from M3 was £0.431m.

Statement of Financial Position 31 July 2022					
Actual 31.03.22 £'000		Actual 30.6.22 £'000	Actual 31.07.22 £'000	Variance £'000	Movement
	Non-current assets				
187,353	Property, plant and equipment	185,663	187,268	1,605	↑
14,871	Intangibles	14,577	14,185	(392)	↓
968	Trade and other non-current receivables	444	444	0	→
203,192		**200,684**	**201,897**	**1,213**	↑
	Current assets				
4,924	Inventories	4,068	4,894	826	↑
21,286	Trade and other receivables	26,391	24,653	(1,738)	↓
0	Assets held for sale	0	0	0	→
36,435	Cash and cash equivalents	29,336	25,835	(3,501)	↓
62,645		**59,795**	**55,382**	**(7,039)**	↓
265,837	**Total assets**	**260,479**	**257,279**	**(3,200)**	↓
	Current liabilities				
(56,598)	Trade and other payables	(55,390)	(54,916)	474	↓
(10,702)	Other liabilities	(13,134)	(11,245)	1,889	↓
(1,023)	Borrowings	(1,068)	(1,083)	(15)	↑
(13,206)	Provisions	(8,460)	(8,151)	309	↓
(81,529)		**(78,052)**	**(75,395)**	**2,657**	↓
(18,884)	**Net current assets/(liabilities)**	**(18,257)**	**(20,013)**	**(4,382)**	↑
184,308	**Total assets less current liabilities**	**182,427**	**181,884**	**(543)**	↓
	Non-current liabilities				
(2,371)	Other liabilities	(2,371)	(2,372)	0	→
(4,177)	Borrowings	(4,177)	(4,175)	0	→
(6,348)	Provisions	(6,016)	(5,905)	111	↓
(12,896)		**(12,564)**	**(12,452)**	**111**	↓
171,412	**Total assets employed**	**169,863**	**169,432**	**(431)**	↓
	Financed by				
	Taxpayers' equity				
186,445	Public dividend capital	186,445	186,445	0	→
(64,185)	Income and expenditure reserve	(65,047)	(65,478)	(431)	↑
49,152	Revaluation reserve	48,464	48,464	0	→
171,412	**Total taxpayers' equity**	**169,862**	**169,432**	**(431)**	↓

4. Financial Position

4.2 **Capital Expenditure – M4**

4.2.1 The Trust's programme for 22/23 has increased to £44.851m 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
Initial CDEL allocation	**9,765**
Heating and chilled water pipework replacement	2,132
Total CDEL	**11,897**
Modular theatre - phase 2	14,954
UECUP	18,000
Total PDC	**32,954**
TOTAL CAPITAL PLAN 22/23	**44,851**

4.2.2 At M4 spend was £3.908m against a plan of £9.677m. The key areas of underspend were UECUP (£2.569m), clinical equipment (£0.374m), IT (£1.003m) and backlog maintenance (£1.275m). UECUP is delayed as formal approval has yet to be received for the business case. Delays in equipment and IT spend is due to issues with supply chain but should be fully recovered before year end. Backlog maintenance has been delayed as a result of the issues encountered in respect of theatre ventilation and pipework.

4.2.3 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 14.594m for the second phase of the South Mersey Elective Hub theatre development.

4. Financial Position

4.3 **Statement of Cash Flows – M4**

Statement of Cash Flow 31 July 2022	
Opening cash	**36,436**
Surplus/(deficit)	(488)
Non-cash income and expense	
Depreciation and amortisation	4,604
Impairments / (impairment reversals)	0
Donated asset income (cash and non-cash)	0
Changes in working capital	(4,296)
Other movements in operating cash flows	(1)
Net cash generated from / (used in) operations	**(181)**
Cash flows from investing activities	
Interest received	92
Purchase of non-current (capital) assets	(10,512)
Sales of non-current (capital) assets	0
Receipt of cash donations to purchase capital assets	0
Net cash generated from/(used in) investing activities	**(10,420)**
Closing cash	**25,835**

4.3.1 Cash balances have reduced by £10.420m, adjusting for our variance from budget documented within plan this is in line with our expectations.

Board of Directors in Public **Item 9.5**

31 August 2022

Title	Monthly Maternity Update – Perinatal Clinical Surveillance Quality Assurance Report
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) via the Maternity Dashboard which are 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 the latest (July 2022) key quality and safety metrics.

The last Quarterly Maternity Update to Trust Board of Directors was presented in July 2022 with the next Quarterly Maternity Update paper being presented to the Board of Directors in October 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 July 2022 reports that WUTH is not an outlier for neonatal deaths and stillbirths. These outcomes are reported monthly to the LMNS via the monthly regional dashboard and are compared to other maternity providers in both the Cheshire and Merseyside region and the Northwest Coast. There is one serious incident ongoing since the last report which is the second SI reported to date in 2022. The last HSIB quarterly report confirmed that the Trust continues to report all cases meeting the HSIB criteria for review, and that Duty of Candour was reported as 100% for these cases. The vacancy rate has increased since last month and currently stands at 4.2% in the midwifery workforce and work continues with recruitment of newly qualified staff to address this shortfall. This requirement is working towards the Trusts ambition to achieve 100% Continuity of Carer by August 2023. To deliver the current mixed model the Trust hold a less than 1% vacancy rate for midwives. Midwifery vacancy rates across Cheshire and Merseyside has impacted on the need for escalation and divert of services with some providers. WUTH has not diverted its maternity service in July 2022 but has provided support and mutual aid on several occasions to neighbouring Trusts. Work continues to meet compliance with all safety actions outlined in Year 4 of the Maternity Incentive Scheme and whilst the declaration reporting date for the Maternity Incentive Scheme is 5 January 2023 a further update will be presented to the Board of Directors in October 2022. An Insight visit by the NHSE/I Regional Maternity team and the C&M LMNS has taken place 16 August 2022. The feedback was overwhelmingly positive with good examples noted of improvement and innovation – some of which are going to shared nationally to promote development of services in line with Ockenden requirements. The workforce was described as open, transparent, dedicated, and committed with recognition of the Innovation utilised specialist roles that further support the delivery of maternity services. Many areas of good practice were identified including Live streams by the Consultant Midwife and strong coproduction with service users and MVP, succession planning of senior roles, The Trust was described as having a strong safety culture at all levels with good Board oversight, the visiting team noted they had witnessed safety Huddles being embedded and recorded well, and good use of care improvement forms and feedback meetings supported by a strong MDT approach to all aspects of care. The team noted strong compliance with the Saving Babies Lives Care Bundle and commended the Trust on their approach to roll out of Continuity of Carer and maintenance of a less than 1% midwifery vacancy rate. Detailed feedback will be provided in the form of a slide deck in approximately 2 weeks' time this will be presented as part of the next Board of Directors Quarterly Maternity Update.

3	Conclusion
3.1	On review of the Perinatal Clinical Surveillance Quality Assurance Report there are no reported areas for escalation. Further update will be included in the Quarterly Maternity Update to the Board of Directors in October 2022.

Author	Debbie Edwards – Strategic Advisor for Ockenden - Women and Children's Services
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Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	No escalation from SCN / LMNS on outlier report
	Outlier for rates of neonatal deaths as a proportion of birth	no	No escalation from SCN / LMNS on outlier report
	Rates of HIE where improvements in care may have made a difference to the outcome	no	Very low rates of HIE, sitting way below the lower control limit for the region.
	Number of SI's	no	There is currently one SI in progress
	Progress on SBL care bundle V2	no	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP.
	Outlier for rates of term admissions to the NNU	no	The rate of avoidable term admissions remains low. Regular multi-disciplinary reviews of care take place
Service user and staff	MVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints. Improvement continues with the number of complaint responses outstanding and with the division significant reduced.
	Trainee survey	no	Consistently high scoring year on year. No update this month
	Staff survey	no	Nil to report this month.
	CQC National survey	no	Nil to report this month.
	Feedback via Deanery, GMC, NMC	no	There are 5 midwives who have been referred to the NMC by a patient and that we have responded to the NMC to state there are no practice concerns - NMC investigation continues.
	Poor staffing levels	no	Current vacancy rate of 4.2% for midwives.
	Delivery Suite Coordinator not supernummary	no	Supernummary status is maintained for all shifts.
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	New Director of Midwifery in post. Head of Midwifery has been appointed with an anticipated start date in October 2022.
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates.
	False declaration of CNST MIS	no	Externally audited by MIAA. Year 4 preparation ongoing. Next update to Board of Directors in October 2022.
	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 to report this month
Safety and learning culture	Lack of engagement in HSIB or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged
	Lack of transparancy	no	Being open conversations are regularly had and 100% compliance with duty of candour evident.
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all SI's, local reviews, rapid reviews, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations.
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. Gap analysis against the final Ockenden report completed with update to the Board of Directors in October 2022
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture.
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework.
	Never Events which are not reported	no	No maternity or neonatal never events in July 2022. All Locssipps currently in review as part of a Trust-wide review
	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 - Maternity specific Risk Management Strategy in draft for comments prior to ratification. Within division there is maternity and neonatal review of governance processes: 3 separate meetngs. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated.
	Business continuity plans not in place	no	Business continuity plans in place.
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	The service was able to continue to provide an acute service from the start of the pandemic due to the robust contingency plans in place. Business as usual was operated following changes necessary to safegaurd staff and service user well being. Continued involvement of MVP throughout the pandemic.
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Last CQC core service review was undertaken in May 2021 which did not highlight any concerns. Insight meeting planned for 16/08/2022.
	An overall CQC rationg of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third	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-	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 9.6**
31 August 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. The associated assurance dashboard in the appendices covers 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 report

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
19.08.2022	Digital Healthcare Team Senior Management Forum	Departmental Performance Management Review	To ratify figures reported in the dashboard and raise

			any points for specific focus.

1	Narrative
1.1	**Delivering our strategy:** 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. ***The operational plan:*** 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: • Extensive digital provision for the South Mersey Elective Hub • Replacement of the wired network infrastructure across the estate • Robotic Process Automation for streamlining of back office processes • Substantial roll out of Patient Portal offering including patient self-booking • Development of an in-house data warehouse to initially deliver clinical reporting • Completion of migration to the regional PACS solution • Introduction of a Learning Management System to baseline staff educational needs. • Digital consent – continuing our journey to one patient record. ***Monitoring delivery:*** Appendix A shows the RAG status for each of our Digital Programmes. Of the 42 projects within those programmes – 31 are currently green, 10 Amber and 1 red. The project currently showing as red is the implementation of storage and backup replacements which although late due to availability of kit, is nearing completion. One particular element of the operational plan which has been delivered in the last month is the upgrade of the Wirral Millennium which stabilizes the system significantly and also paves the way for future developments and configuration going forward. Overall the process went extremely well. There are a small number of outstanding issues – one in particular affecting radiology reporting, which is being progressed with our system supplier to implement a permanent fix. ***Changes to plan:*** There have been no requested changes to plan in the last period although there are a number of pieces of work in their initial stages which have the potential to impact current resourcing plans should they come to fruition. The DHT are currently working with colleagues from corporate departments to assess the priority of this work. ***Financials:*** 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.

There are a small number of exceptions to this:

1. Digital Dictation/Voice Recognition: Business case being developed
2. Oral Scanners: Business Case being developed
3. Foetal Monitoring: Alternative funding being sought from W&C
4. South Mersey Elective Hub: To be funded from elective recovery monies.

There are also projects where capital funds have been allocated and discussions are ongoing around the revenue implications.

High Level Risks

- 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.
- 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.

Business Continuity & Service Delivery

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. Appendix B shows our BAU dashboard.

Monitoring Delivery

Outstanding Care

Availability of both the network and our EPR continued at 100% throughout July. Access to this critical Patient Healthcare Information is integral to the running of the hospital in all settings. It is recommended that the dashboard is amended in future months to show availability of all of the Trust's Level 4 information assets, rather than just the EPR.

Compassionate Workforce

DHT continues to exceed targets in relation to both Appraisals and Mandatory Training. Sickness absence however has increased during July to 7.35% The senior management team are continuing to manage these issues which are discussed monthly at DHT Senior Management Group. We have a small number of individuals on long-term sickness who are being actively supported through the process with the help of our HR colleagues.

Continuous Improvement

	Helpdesk calls opened continued at levels seen in previous months at around the 3,500 mark, although July saw around 250 more calls being closed than opened which has led to approximately 1900 active open calls at month end. This is the first time in over six months that active calls have been below 2,000 and the team have been congratulated for their efforts. In essence, the lower the backlog of calls the more responsive the team can be to calls coming in, which of course bodes well for service users. From a risk perspective, DHT has one significant risk which relates to Information Governance. This is being actively progressed with both our EPR supplier and another Cerner organization. Mitigations have been put in place but we await the implementation of a technical fix. ***Our Partners.*** Interfaces to systems outside of WUTH were at 100% for July ensuring that healthcare professionals both inside and outside of the organization have all the information available to deliver quality care. ***Digital Future*** In terms of national data submissions the team continually delivers a high level of compliance and this month is no exception. Over 98% of submissions were made on time with just 4 reports being delayed due to technical issues with data being loaded into the data warehouse. **Future Developments** In future months the strategic delivery section of the dashboard will be re-categorised to give a clearer indication of what impact a project has on the organization – for example improving productivity and efficiency, working with partners etc. In addition, we are also developing some simple KPI's in relation to cyber security to give assurances on the measures we have in place to combat cyber threat.

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: - Using technology to reduce waste, automate processes and eliminate bottlenecks. - Empowering patients with the data and tools to manage their own health and wellbeing. - Allow business Intelligence to drive clinical decision making - Use health information to enable population health management for Wirral. Continued availability of our infrastructure and key applications ensures that all information is available for the delivery of safe patient care.

3	Conclusion
3.1	This period has seen the introduction of the Wirral Millennium EPR upgrade which has been the main focus of the DHT, in conjunction with divisional colleagues, for the past

	12 weeks. The next period will see a number of critical projects re-started following the upgrade. A strong governance model supports the prioritization of key pieces of work and ensures alignment to strategic goals. In specific situations the response must be instantaneous. It is important that our governance can flex to address immediate issues – whilst giving transparency describing how focus has been re-directed.

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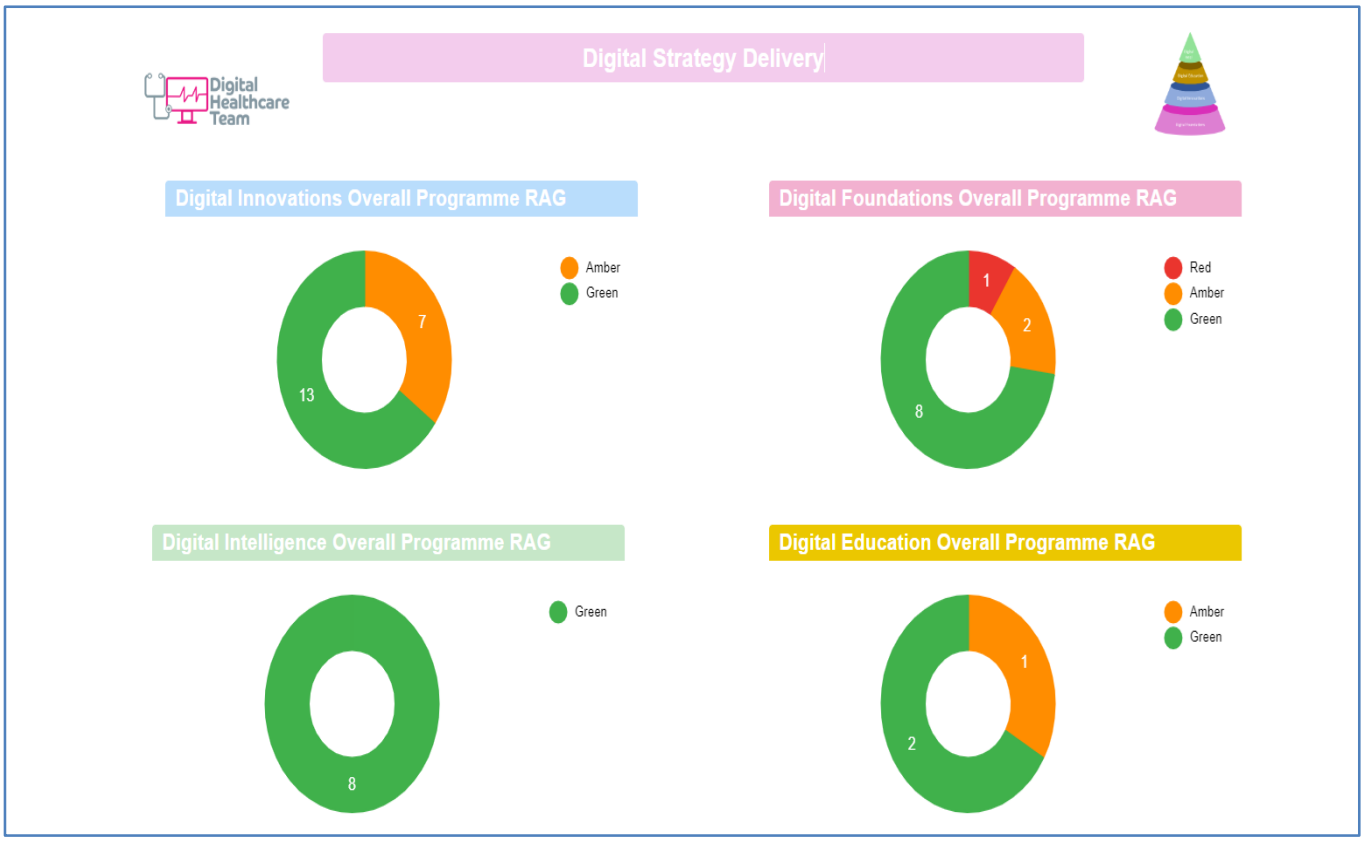
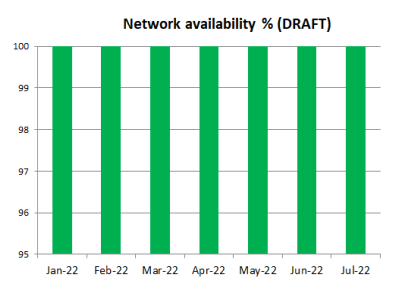
Appendix A: Digital Healthcare Team – Delivering Our Strategy

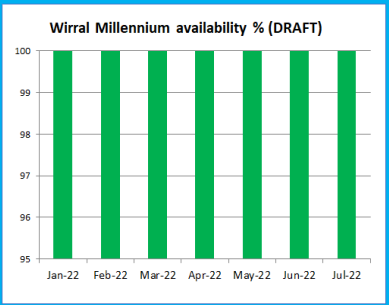


Appendix B: Service Delivery Dashboard

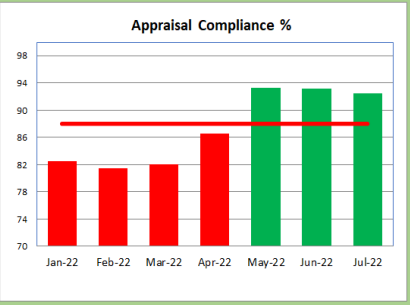
DHT - Business Continuity and Service Delivery | **August 2022**

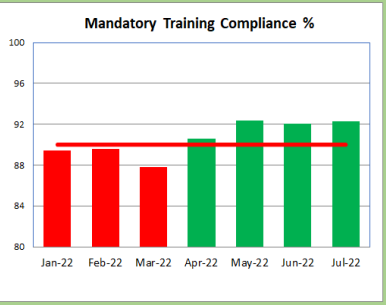
Outstanding Care

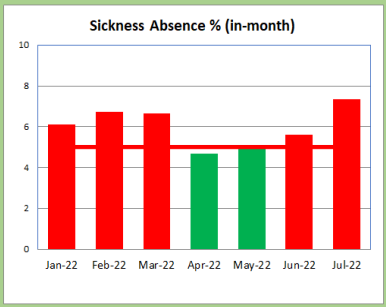




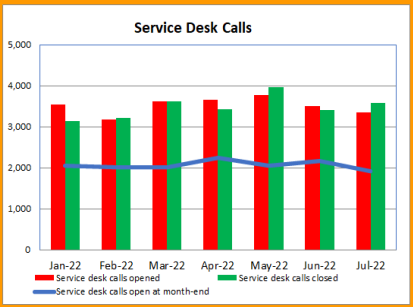
Compassionate Workforce

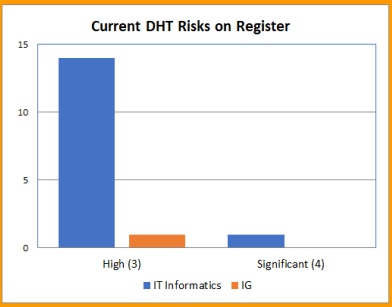




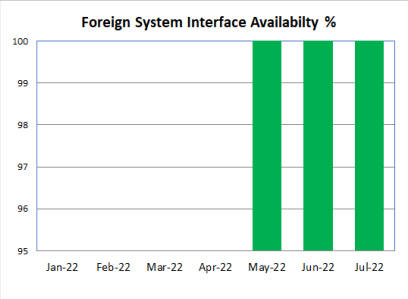


Continuous Improvement

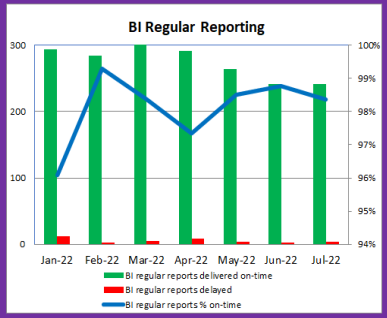




Our Partners



Digital Future



Board of Directors in Public **Item 10**

31 August 2022

Title	Chief Nurse 6 Monthly Safe Staffing Report
Area Lead	Tracy Fennell, Chief Nurse
Author	Vic Peach, Deputy Chief Nurse Johanna Ashworth-Jones, Programme Developer
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board of Directors with assurance that the Trust has met its regulatory requirements in accordance with national guidance 'Developing Workforce Safeguards' (NHSI 2018). National guidance sets out expectations for nurse staffing to ensure the right staff, with the right skills are deployed in the right place at the right time.

The report provides assurance that the Trust has met effective governance requirements that workforce decisions promote patient safety and comply with the Care Quality Commission (CQC) fundamental standards. Information presented within this report incorporates adult inpatient services and Women's & Children's division inpatient areas.

It is recommended that the Board:

- Note the report

Key Risks

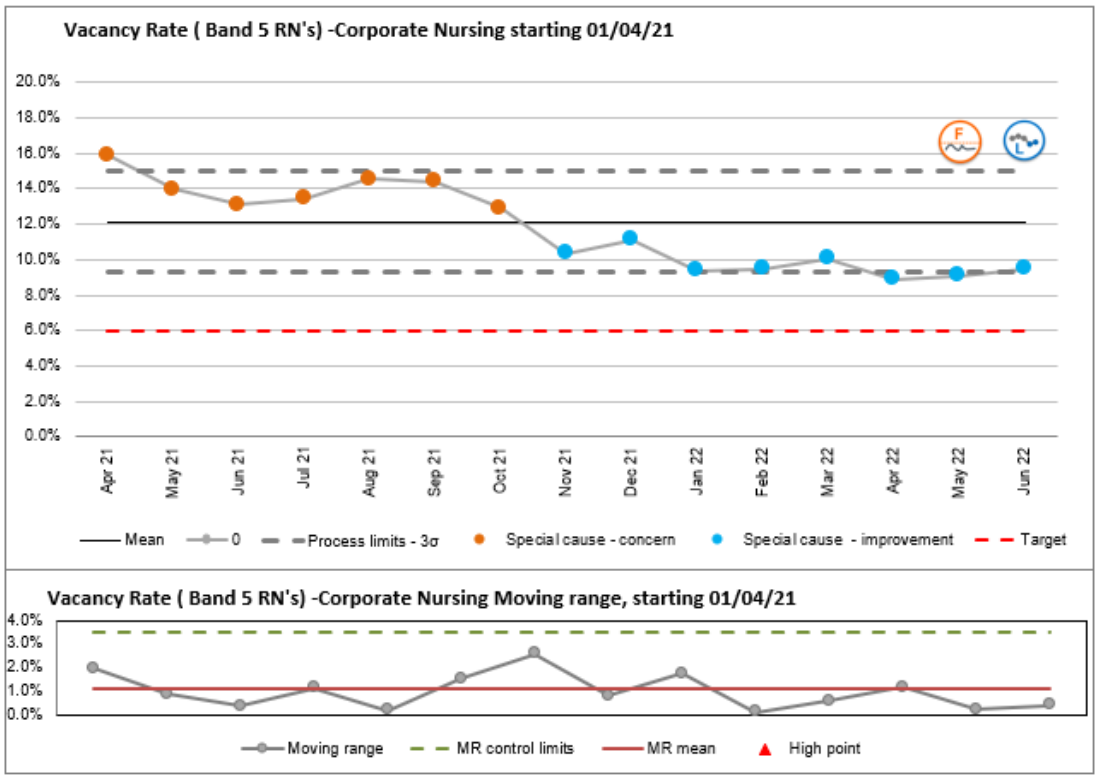
This report relates to the key risk:

- Risk No 175 - Nursing staffing levels are inadequate due to high levels of vacancies and sickness; having potential detrimental impact on patient safety, the delivery of fundamental care not being delivered to the desired standard, and staff / patient satisfaction.

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

1	Narrative
1.1	**Background** Trusts are required to comply with the National Quality Board (NQB 2016) guidance which states that providers: • Must deploy sufficient suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively. • Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service to always keep them safe. • Must use an approach that reflects current legislation and guidance where it is available. These expectations form part of 'Developing Workforce Safeguards' (NHSI 2018), along with other recommendations for consideration to provide a triangulated approach the review of staffing requirements. Trusts must demonstrate that they have used the following three components as part of their safe staffing reviews: • Evidence-based tools (where they exist). • Professional judgement. • Outcomes
1.2	**Governance** Alongside the regulatory requirement to undertake a formal 6 monthly review of nurse staffing establishments, a bi-monthly safe staffing report is presented to the Workforce Assurance Committee. The bi-monthly report provides an oversight regarding the visibility of safe staffing assurances including any known consequence on patient care, safety, or experience. Included is a comprehensive dashboard providing a month-by-month review of a range of patient outcome measures, workforce data, Care Hours Per Patient Day (CHPPD) data, shifts that are 'red flags', and patient experience metrics. Any known risk is highlighted along with mitigations and plans to enhance staffing assurances moving forward. The bi-monthly report provides narrative and statistical process control (SPC) charts based on the data within a staffing assurance dashboard, included as appendix 1 of this report.
1.3	**Vacancy date** The Trust has made a sustained improvement to the registered nurse (RN) vacancy position over the last 6 months as displayed in chart 1. This sustained improvement is predicted to continue with the proactive local recruitment campaign and the international recruitment of nurses (IR) campaign. The IR campaign has been a significant success for the Trust, with a total of 180 nurses recruited in 2021 and a recruitment ambition of 100 nurses in 2022. A programme of work has also commenced to support retention of the nursing and AHP workforce.

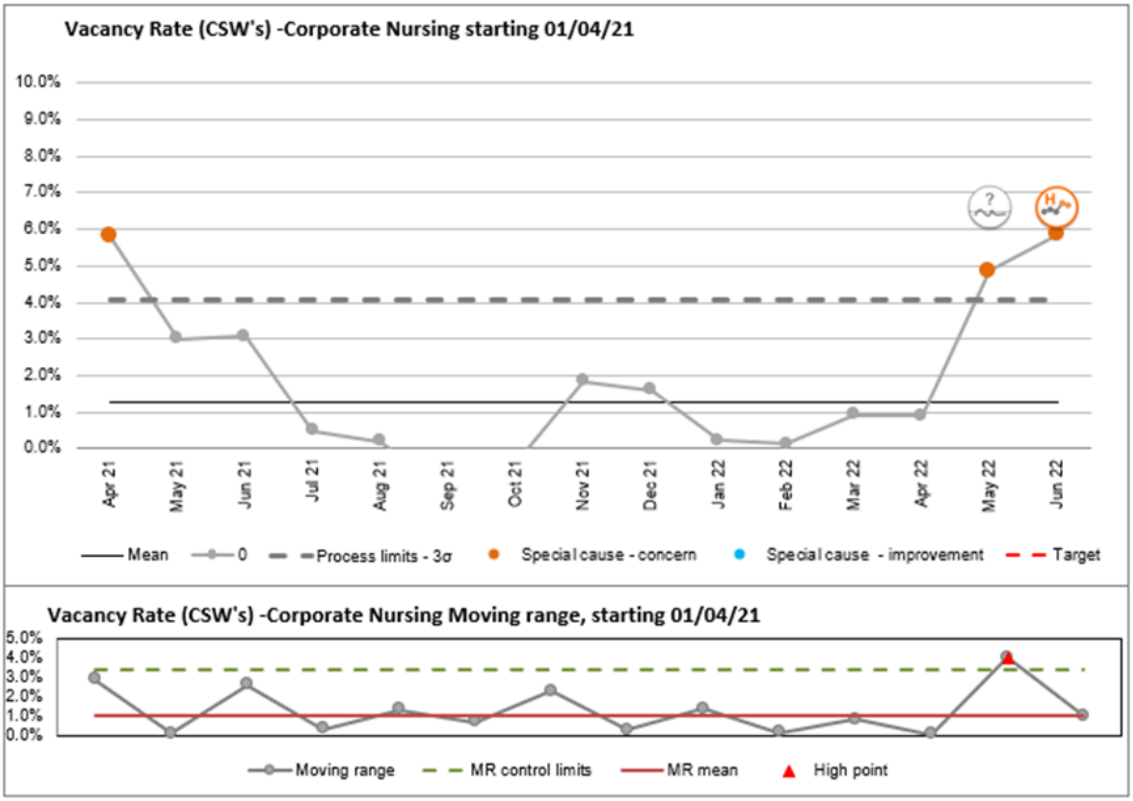
Chart 1.



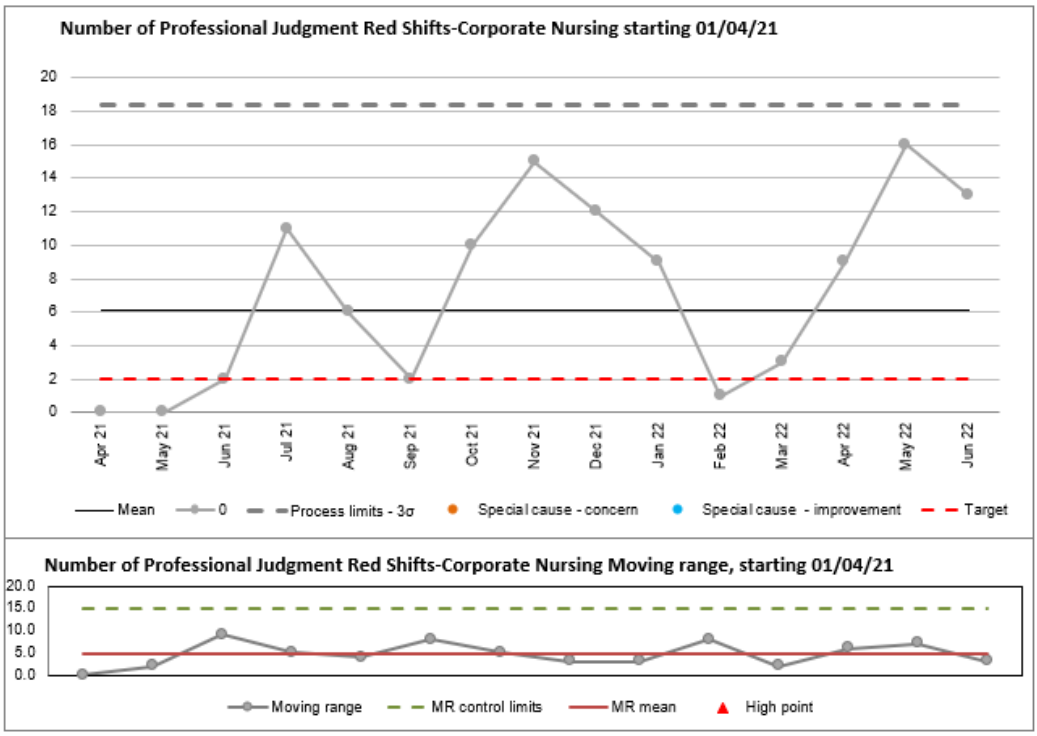
During May 2022, a special cause concern was noted within the clinical support worker (CSW) vacancy rate as displayed in chart 2. In May 2022, the vacancy percentage rate increased significantly from 0.9% to 4.9%.This prompted a review that determined two key factors: the Trust had significantly increased its baseline establishment requirement for CSW's in response to the staffing requirements for the Cheshire and Merseyside Surgical Centre, and there were increased CSW leavers. The following actions have been put in place to support the reduction of CSW vacancies:

- Weekly local CSW advert
- Trust "open day "recruitment campaigns for CSW
- CSW apprentice programme
- CSW Development programme (supported by NHSP)
- Exit interviews
- Scrutiny of areas where exit interviews are not undertaken
- All NHSP CSW's who undertake the care certificate programme are guaranteed an interview for a substantive post.

Chart 2:



1.4	**Trust Bed Occupancy** The national recommended safe bed occupancy is 85%. The Trust has had an occupancy rate consistently above this since September 2021: Q1 2022/23 bed occupancy figures remained consistently above 90% providing additional challenges to the Trust. The increase in bed occupancy is reflective of the national bed occupancy data seen across the NHS with averages reported at 95%, 10% above the safe bed recommendation. This increased bed occupancy provides further staffing challenges for the organisation. In quarter 1 the Trust has continually provided additional staffing requirements to support circa 100 escalation beds/areas. In addition, the Trust has been required to frequently enhance staffing in the Emergency Department to maintain safety due to the increase in the number of attendances and the need to enable early release of ambulance crews from the department.
1.5	**Quality Impact Data** The Safer Staffing Oversight Tool (SSOT) has the facility for shifts to be RAG rated applying professional judgement allowing senior nurse oversight of staffing risks, mitigations, and impacts on care. A red rated shift is where there is a high risk of care standards falling below expected levels. The historical number of shifts being professionally judged and rated as red is extremely variable and highlights the challenges in maintaining safe staffing, demonstrated in chart 3. **Chart 3:**



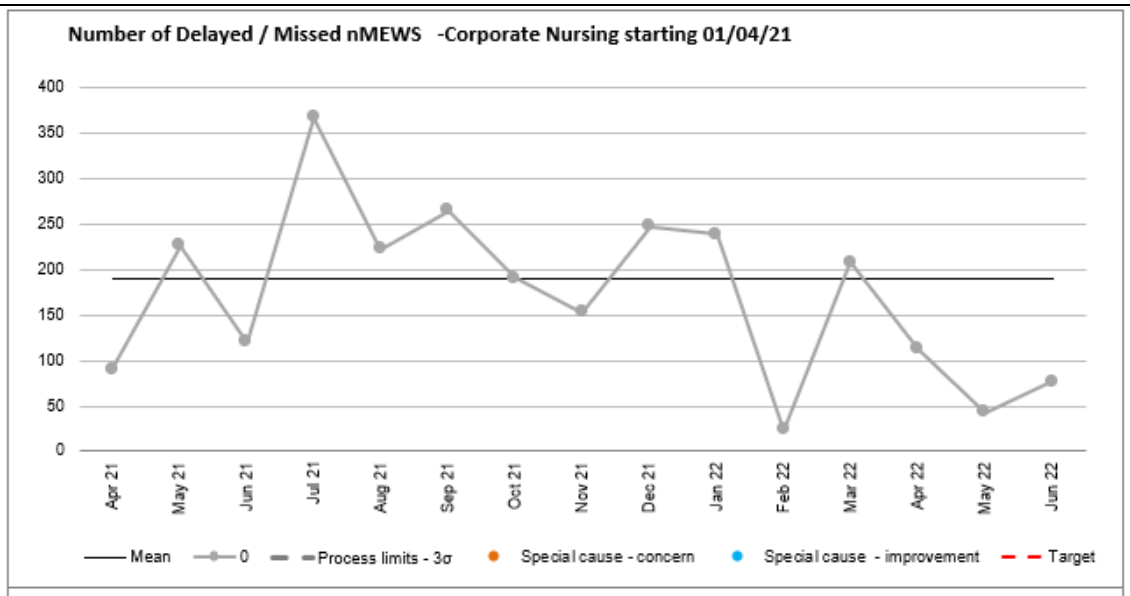
Where shifts have been deemed not to meet the agreed funded establishment for RN shifts, areas are required to complete a red flag events reflection section within the SSOT to highlight the quality and safety impact of reduced staffing on that shift. The monitoring of red flag events in relation to staffing levels is part of the National Institute for Health and Care Excellence (NICE) guidance 2014. A full list of these can be reviewed in the safe staffing assurance dashboard (appendix 1), which are reported to Workforce Assurance Committee bi-monthly.

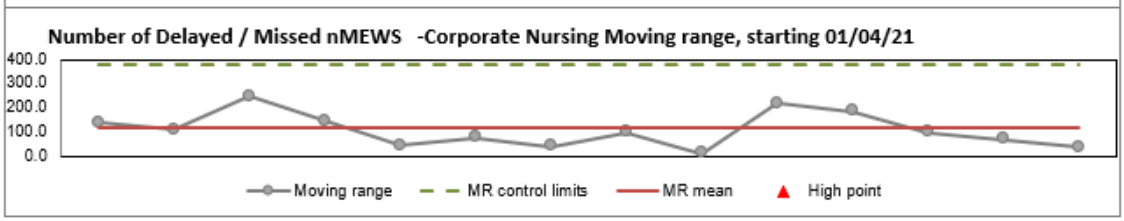
There have been no serious incidents (SIs) that have identified staffing levels as a primary cause. Since January 2022 within 9 SIs staffing levels were noted not be at optimum. Scrutiny to determine the impact of staffing in relation to every reported SI will continue to be standard practice via the SI Group reporting to Patient Safety Quality Board.

The high demand for therapeutic supervision of individual patients has been highlighted within the SSOT as an area requiring further review. The review will be included within the trust wide focus on falls reduction. The work will seek improve the ability to identify specific risks for individual patients more clearly, thus enabling senior staff to risk assess patient risks more easily when mitigating staffing gaps.

It has been reported previously to Workforce Assurance Committee short staffing has previously impacted on the ability for staff to undertake observations timely. A quality improvement project has been undertaken in relation to the deteriorating patient, concentrating on the increasing the compliance of NEWS2 observations being recorded. Since July 2021 there has been reduced number of delayed or missed recording of observations (chart 4), demonstrating that staff do not default to missed or delayed NEWS2 when staffing levels are reduced.

Chart 4:





Staff absences are closely monitored within the organisation. During Q4 and Q1 staff sickness continued to be heavily impacted by COVID – 19; absences reflected the high community prevalence levels. Staff fatigue and resilience has been a cause for concern due to the unprecedented pressures experienced by the nursing workforce from working through the pandemic. Staff health and wellbeing is a key area of focus for the Trust and a wealth of resources are accessible and promoted. Professional Nurse Advocates and a Pastoral Support Nurse have been introduced to deliver restorative supervision and additional support to staff.

RN sickness has seen a reduction over the last 6 months however this is not yet considered a sustained improvement due to slight fluctuation in the percentage levels which can be seen in the staffing assurance dashboard (appendix 1). CSW sickness has remained high >10% for the last 6 months this is being managed closely in line with HR policies. A programme of practice education has been implemented to support CSWs in practice and aid retention.

1.6 **Establishment Review Process**

The establishment reviews comprise of a systematic approach that allows for enhanced triangulation and scrutiny reviewing 78 multifactorial indictors including, nurse sensitive indicators, workforce sensitive indicators, financial and budgetary indicators, professional judgement and the outcome results of acuity and dependency audits.

1.7 **Evidence Based Tools**

The Shelford Safer Nursing Care Tool (SNCT) is the model used to review acuity and dependency within the adult inpatient settings: one of the recommend tools listed in the NICE guidance www.nice.org.uk/guidance/sg1/resources. The audit consists of reviewing every patient's clinical presentation at the same time each day for a period of 21 days denoting a level from the acuity and dependency matrix.

	Maternity services have used a national tool Birth Rate plus tool since 2021 working towards delivery of the 100% Continuity of Carer model, which is the NHSE recommended model of care to be in place for all providers by Q3 2024. Following the publication of the Ockenden Final Report a further review of the midwifery workforce has been undertaken. The Trust presented this risk assessment to the Board of Directors in quarter 2 with full support to continue to a Full Continuity of Carer Model by March 24. Midwifery staffing levels are reviewed every four hours as a minimum in conjunction with the acuity on the Delivery Suite and staff are moved accordingly in line with patient requirements. Processes are in place to support the effective deployment of staff across all areas including the community staff. In times of short staffing a regional Divert policy is enacted. The Trust is not noted to be flagging for high numbers of diverts. WUTH has been commended by the LMNS and NHSE/I for supporting other Trusts across the region who are experiencing high vacancy rates and increased sickness to ensure ladies can access safe care by accepting diverts from other providers. Staffing requirements of the Neonatal Unit vary depending on the acuity, number and level of care required for cots available. Neonatal capacity is managed through a process of mutual aid from providers across Cheshire and Merseyside. This enables the unit to close to admissions when capacity limits, which incorporate staffing requirements, are reached. Neonatal staffing is complaint with the British Association of Perinatal Medicine (BAPM) standards and as such is reviewed daily. The Children's ward has used the RCN guidance as a methodology to provide assurance that safe staffing levels are in place. It has been noted through the review although the ward remains safely staffed however occupancy of the ward is not always at full capacity. The staffing model currently is flexible to cover Children's Day Case, Children's High Dependency Unit and Paediatric Assessment Unit. In response a full-service review has been requested from the division to be completed during Quarter 3. The outputs of this will be reported in the next 6-month Safe Staffing Report to the Board of Directors. Critical care staffing model has been reviewed to support critical care nurse retention, provide increased leadership to a junior workforce. The current applied uplift considers the training and educational needs of staff, absence rates, annual leave, and staff support and wellbeing. The uplift also supports the requirement to apply the Professional Nurse Advocate and restorative supervision sessions. The unit is part of the Cheshire and Merseyside Critical Care Network, which ensures critical care capacity is maintained across the region. Within Q4 and Q1 the Trust has not needed to transfer patients with critical care needs to any other organisation. An Emergency Department SNCT to review acuity and dependency has been released in 2022 and is currently being rolled out nationally. A programme of cascade training is in place to enable the required audits to be undertaken. The recommendation is to undertake 2 sets of 12 consecutive days auditing to form part of the establishment setting process with a 14-day gap in between. To meet the licensing requirements of the new acuity & dependency tool timeframes and undertake the internal training outcomes of the ED acuity studies will not be available until end of Quarter 3 2022 with a view to present a full ED Nursing establishment paper to Board in Q4.

1.8	**Professional Judgement** The establishment profile of 78 indicators is shared with Divisional Nursing Teams in advance of a confirm and challenge meeting with the Chief Nurse and Corporate Nursing Team. Each template is reviewed with the Ward / Unit Manager, Matron and Associate Nurse Director along with finance and operational partners. The multidisciplinary frontline teams triangulate the data, apply their professional judgement and present recommendations for changes required to establishments to the Divisional Nurse Director for scrutiny. These recommendations are then taken forward or declined by the Divisional Nurse Director. Final recommendations in collaboration with finance business partners are taken forward to confirm and challenge meeting with the Chief Nurse and Chief Finance Officer for final approval.

2	**Establishment Review Outcomes**
2.1	Outcome details of the establishment reviews for each inpatient ward is provided in Table 1. This has been reviewed by the Chief Nurse and Chief Finance officer for overall approval. Table 1:

Wirral University Teaching Hospital: Establishment review July 2022							
Division	Number of beds	Ward	Establishment review proposal June / July 2022	Acuity Audit Results (Recommended WTE)	Funded establishment (WTE)	Proposed Establishment (WTE)	Outcome (Financial approval)
Surgical Division	21	10	No Change	29.58	28.31	28.31	NA
	25	11	Reduce	26.38	38.97	37.76	Approved
	20	12	No Change	26.38	23.43	23.43	NA
	8	WAFFU	No Change	13.25	17.01	17.01	NA
	29	14	No Change	45.6	43.45	43.45	NA
	20	17	No Change	44.04	50.01	50.01	NA
	30	18	Uplift	44.63	40.08	41.29	Approved
	29	20	Uplift	45.94	39.37	39.37	Approved
Medical Division	30	21	No Change	42.48	41.88	41.88	NA
	31	22	No Change	41.13	41.66	41.66	NA
	26	23	No Change	38.47	43.66	43.66	NA
	10	24	Reduce	26.38	33.5	32.06	Approved
	22	25	Uplift	27.43	47.75	48.96	Approved
	29	26	No Change	41.69	40.45	40.45	NA
	29	27	Uplift	43.96	40.29	41.5	Approved
	23	30	No Change	35.94	37.85	37.85	NA
	17	32	No Change	50	68.75*	68.75*	NA
	26	33	No Change	40.9	37.58	37.58	NA
	36	36	No Change	47.72	51.76	51.76	NA
	45	37&38	No Change	63.48	68.13	68.13	NA
	40	M1	Uplift	56.16	43.24	49.96	Approved
	30	CRC	No Change	37.52	40.7	40.7	NA
Acute	27	AMU	No Change	35.31	* Combined AMU, MSSW, UMAC	35.31	NA
	16	MSSW	Reduce	19.8		17.16	Approved
	24	OPAU	Uplift	33.66	32.45	33.7	Approved
Women's & Children's	8	Ward 54	No Change	15.65	* Combined with EPU & GDU	35.77	NA
	21	Children's Ward	No Change	NA	50.97	50.97	NA
	Maternity Service		*See full detail in report (Continuity of care model, Ockendon report recommendations and Birth rate plus)*				
Diagnostic	18	Critical Care	Uplift	NA	99.34	100.05	*Approved in principle*
* denotes a combined establishment							

The Cheshire and Merseyside surgical centre ward establishment (previously M2 and 3) establishment review will be included with Q2 and Q3 safe staffing report following the developments within this area.

Maternity services have been identified as requiring an uplift in line with the change to Continuity of Care and Ockendon recommendations. These details have been presented to Board in April 2022 Ockendon Gap Analysis report and as part of the Quarterly Maternity Services update July 2022.

The workforce review has been undertaken that considered skill mix, inclusive of the role of Maternity Support Worker, and uplift in the establishment needed; calculated at 24%. This uplift considered sick leave, maternity leave, training inclusive of additional training each midwife needs to complete, and annual leave; and was calculated over a 3-year period as outlined in the Ockenden recommendations. Plans are in place to meet the Continuity of Carer requirements, outlining the additional staffing requirements as detailed in the table below:

	BIRTHRATE PLUS WTE Bands 3 to 8	CURRENT FUNDED WTE Bands 3 to 8	VARIANCE with current WTE
Core Services and with Continuity Teams at 100%	158.79 required.	152.69	- 6.10

3	Conclusion
3.1	The Trust has applied effective governance processes to ensure visibility and scrutiny of nurse safe staffing from ward to board. Through these processes it is concluded that daily staffing monitoring processes continue, with a good system of internal control being applied constantly to ensure gaps are filled and managed effectively in line with the Safe Staffing Escalation Policy. The Trust has met the requirements in line with the Developing Workforce safeguards requirements to undertake the mandatory acuity, dependency and establishment review for adult wards and has identified 6 wards requiring staffing uplifts and a reconfiguration of two wards to reutilise staffing resources. Children's Services will be required to undertake a full-service review. Outcomes will be presented in the next six-month safe staffing report. The Emergency Department and Urgent Medical Assessment Centre will conclude its establishment review in Q4 following the roll out of the new Safer Nursing Care Tool for Emergency Departments this will be reported to the Board of Directors in Q4.

3	Recommendation
3.1	The Trust was required to modify its safe staffing reporting schedule due to COVID requirements affecting the previously agreed reporting schedule. Professional Judgement establishment reviews were continued throughout the pandemic to ensure staffing remained safe in line with ever changing demands. It is proposed acuity and dependency schedules return to pre pandemic arrangements. This will propose the next ward-based establishment review will commence in Q4 Reporting to Workforce Assurance Group in May and Board of Directors in June 2023. The Board of Directors is requested to support this recommendation.

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Appendix 1:

	Safe Staffing Board Assurance Dashboard 2021/2022												
Data Source	Indicator	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Spark line
Corporate Nursing	Care Hours Per Patient Day - Total	8.5	8.4	8.2	8.2	7.6	8.1	8	8.4	8.3	8.4	8.6	8.4	
Corporate Nursing	Care Hours Per Patient Day - Registered Nurses	4.1	4.2	4	4.1	3.8	4.1	4.1	4.2	4.3	4.3	4.7	4.4	
Corporate Nursing	Care Hours Per Patient Day - CSW's	3.6	3.6	3.4	3.5	3	3.3	3.3	3.5	3.4	3.4	3.3	3.4	
Corporate Nursing	Number of ward below 6.1 CHPPD	3	2	3	1	11	3	3	2	3	1	4	4	
Corporate Nursing	National Fill rates RN Day	82%	83%	82%	81%	85%	83%	84%	84%	84%	86%	86%	90%	
Corporate Nursing	National Fill rates CSW Day	97%	98%	95%	102%	97%	89%	88%	95%	93%	94%	90%	96%	
Corporate Nursing	National Fill rates RN Nights	78%	81%	81%	79%	82%	83%	82%	90%	87%	90%	90%	94%	
Corporate Nursing	National Fill rates CSW Nights	96%	103%	103%	99%	97%	98%	100%	107%	97%	98%	95%	99%	
Corporate Nursing	Nurse Ratio Day : Number of Shifts above 1:8			104	131	113	112	52	80	124	117	98	78	
Corporate Nursing	Nurse Ratio Night : Number of Shifts above 1:10			196	225	198	223	238	145	209	180	126	126	
Informatics	Trust Occupancy Rate	81.50%	84.10%	85.50%	88.10%	88.80%	88.40%	88.94%	88.80%	89.70%	90.70%	92.10%	93.30%	
Informatics	Occupancy Rate - APH	84.80%	87.30%	88.90%	90.30%	91.10%	89.71%	90.07%	91.57%	91.33%	92.70%	92.60%	94.60%	
Informatics	Occupancy Rate - CBH	50.50%	54.20%	55.90%	65.20%	65.70%	71.19%	69.02%	62.73%	70.07%	74.10%	80.20%	79.80%	
Workforce	Vacancy Rate (Band 5 RN's)	13.44%	14.56%	14.41%	12.90%	10.35%	11.14%	9.40%	9.50%	10.05%	8.91%	9.10%	9.49%	
Workforce	Vacancy rate (Band 5 inpatient wards)	12.31%	13.94%	13.16%	11.08%	7.93%	9.17%	6.88%	6.94%	6.94%	6.48%	5.82%	6.86%	
Workforce	Vacancy Rate - All RN (All grades)	6.97%	7.69%	7.44%	6.41%	4.85%	5.28%	4.81%	5.00%	4.80%	4.27%	4.23%	4.49%	
Workforce	Vacancy Rate (CSW's)	0.49%	0.21%	-1.09%	-0.41%	1.83%	1.59%	0.23%	0.13%	0.92%	0.90%	4.86%	5.85%	
Workforce	Sickness Rate - RN	6.79%	6.01%	6.43%	6.63%	6.05%	8.22%	9.77%	7.13%	7.34%	6.03%	5.48%	5.61%	
Workforce	Sickness Rate - CSW	9.16%	9.68%	9.63%	9.64%	10.30%	12.31%	13.58%	10.17%	11.50%	11.41%	10.32%	10.55%	
Workforce	Absences Rate - RN	1.12%	0.40%	0.35%	0.42%	0.45%	1.68%	1.03%	0.42%	0.55%	0.35%	0.11%	0.09%	
Workforce	Absences Rate- CSW	1.88%	0.67%	0.44%	0.60%	0.48%	1.81%	1.90%	0.59%	0.57%	0.32%	0.24%	0.13%	
Corporate Nursing	Number of Professional Judgment Red Shifts	11	6	2	10	15	12	9	1	3	9	16	13	
Corporate Nursing	Number of RN Red Shifts *	614	545	495	434	332	468	403	280	404	323	249	235	
Corporate Nursing	RN Red Shift Impact : Number of Falls	29	17	22	9	14	13	18	8	9	19	7	6	
Corporate Nursing	RN Red Shift Impact : Number of Falls with Harm	1	1	4	0	4	1	0	0	2	1	0	0	
Corporate Nursing	RN Red Impact : Meds Errors / Misses	2	2	3	2	0	2	6	0	0	0	0	1	
Corporate Nursing	RN Red Impact : Patient relative complaints	2	0	5	3	1	1	1	1	0	1	0	2	
Corporate Nursing	RN Red Impact : Staffing incident submitted	7	15	13	10	6	14	10	2	7	4	1	8	
Corporate Nursing	RN Red Impact : Special 1:1 (uncovered)	12	4	11	3	1	12	10	0	5	9	2	7	
Corporate Nursing	RN Red Impact: Missed Breaks	100	50	89	73	55	93	56	5	65	26	11	11	
Corporate Nursing	RN Red Impact: Delayed / Missed Obs	198	129	223	168	107	328	247	0	159	97	44	61	
Corporate Nursing	RN Red Impact: Delayed / Missed nMEWS	367	222	265	191	153	248	239	23	208	112	43	77	
Corporate Nursing	RN Red Impact: Delayed / Missed Pressure Care	82	64	96	176	31	228	375	6	116	68	33	29	
Corporate Nursing	RN Red Impact : Delayed Meds	263	248	217	192	90	128	93	0	77	69	35	29	
Governance support	Number of SI's where staffing has been a contributing factor	0	0	0	0	0	0	1	2	2	2	1	1	
Corporate Nursing	Total Number of staffing incidents	105	92	134	82	54	78	97	48	71	62	49	44	
Complaints team	Formal complaints in relation to staffing issues	0	0	0	1	1	0	0	1	1	0	0	0	
Complaints team	Informal Concerns raising staffing levels as an issue	0	0	0	1	0	0	2	0	0	0	0	0	
Corporate Nursing	Patient Experience feedback raising staffing levels as a concern	1	0	2	5	5	4	1	6	5	3	2	1	
Corporate Nursing	Staff Moves	407	301	299	281	259	178	256	158	226	236	235	222	
NHS Professionals	Number of RN hours requested	27501	28042	24544	28055	27507	26713	32318	33382	39643	32877	29141	27333	
NHS Professionals	Number of CSW hours requested	25435	25286	25635	30971	34417	34719	38400	35541	39454	35620	32429	32201	
NHS Professionals	% of requested filled RN's	59.00%	61.30%	67.40%	68.80%	68.80%	58.99%	65.37%	61.31%	61.48%	59.97%	67.89%	72.60%	
NHS Professionals	% of requested CSW filled	84.00%	85.60%	84.10%	84.00%	77.00%	72.36%	75.52%	79.24%	72.90%	76.36%	80.34%	84.30%	
NHS Professionals	% of Agency staff used RN	6.00%	7.00%	3.20%	3.40%	5.00%	4.50%	8.28%	14.34%	15.33%	15.74%	15.06%	8.99%	
NHS Professionals	% of Agency staff used CSW	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 11**

31 August 2022

Title	Infection Prevention & Control Annual Report
Area Lead	Tracy Fennell, Chief Nurse
Author	Jay Turner-Gardner, Associate Director of Nursing - Infection Prevention & Control
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide assurance to the Board of Directors on compliance with the Health & Social Care Act 2006, (updated 2008, 2012 and 2015): Code of Practice on the prevention and control of infections and related guidance (commonly known as the hygiene code).

It is recommended that the Board of Directors:

- Note the report

Key Risks

BAF references 1,2,4.

- Risk 609
- Patients who have their first positive specimen 8-14 days after admission are categorised as Hospital-Onset Probable Healthcare-Associated (HO-pHA). Patients who have their first positive specimen 15 or more days after admission are classified as Hospital-Onset Definite Healthcare-Associated (HO-dHA). SCORE 15
- Risk 799
- The demand on the Trust for beds is resulting in decisions having to be made that compromise our own Outbreak guidelines which is putting our staff and patients at an increased risk of acquiring COVID whilst in our care. SCORE 15

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
13.07.22	Infection Prevention & Control Group	As above	For information
28.07.22	Quality Committee	As above	For information

1	Executive Summary
1.1	Since March 2020 in response to the spread of the COVID-19 virus across the world the NHS declared a Level 4 incident, this remained throughout much of 2021/22 as we saw different waves of the virus sweep through the country. Regional and Trust level incident command structures continued to co-ordinate the response to the pandemic and oversee all daily functions and whilst the government released several documents regarding living with COVID and the way back to recovery COVID has remained a challenge to the trust whilst re-introducing elective surgery and outpatient services. During this time, the Infection Prevention and Control (IPC) Team along with the wards and departments continued to work tirelessly to promote the health, safety, and well-being of not only patients and visitors but also themselves in order to deliver clean, safe and effective care. This report is testimony to the hard work of all the teams in WUTH and acknowledges the incredible results that can be achieved when an organisation shares the same vision and values and how when we get the basics right, we become better and then can progress through to best. Despite the continued challenges of COVID the Trust remained under the national objective for CDT of 115 having reported 94 incidences, however this is over the local objective we set ourselves of 79. There has once again been a reduction in gram negative bacteraemia, with all reportable organisms being under our annual objectives set by NHSE/I. Whilst promoting a 'zero tolerance' approach to MRSA bacteraemia the Trust reported 2 MRSA bacteraemia in 2021/22 which is the same as the previous year. The Trust continues to report its quarterly mandatory laboratory data and the surgical division continue to report mandatory surgical site infection surveillance on a quarterly basis. The Infection Prevention and Control Team continue to support the quality improvement project regarding *Clostridiodes difficile* infection to take proactive action to sustain and maintain the improvements in 2020/21 particularly as COVID rates reduce. This requires a review of the successful work undertaken during COVID to embed this good practice across the Trust to promote continuous improvement and reduction in our infection rates. In conclusion, I would like to acknowledge the hard work of the IPC Team and the divisions; together they have shown commitment in the delivery of excellent infection prevention practices by managing our infection risks together in a caring and competent manner. Over the next 12 months we will continue to work hard and keep a focus on

	prevention of infections and compliance with good working practice collaborating with partners across the whole health economy.

3	Conclusion
3.1	The attached report details annual infection prevention and control activities in 2020/21 as reported to the monthly IPCG and the forward Infection Prevention & Control Plan for 2022/23. The infection control programme aims to continuously review and build on existing activity, driven by local needs, while incorporating and complying with the latest NHSE/I and UKHSA guidance and other relevant strategies and regulations pertaining to IPC.

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Wirral University Teaching Hospital
NHS Foundation Trust

INFECTION PREVENTION & CONTROL ANNUAL REPORT

2021/2022

Contents

1.0 Executive Summary

The purpose of this report is to provide assurance to the Board of Directors on compliance with the Health & Social Care Act 2006, (updated 2008, 2012 and 2015): Code of Practice on the prevention and control of infections and related guidance (commonly known as the hygiene code).

Since March 2020 in response to the spread of the COVID-19 virus across the world the NHS declared a Level 4 incident, this remained throughout much of 2021/22 as we saw different waves of the virus sweep through the country. Regional and Trust level incident command structures continued to co-ordinate the response to the pandemic and oversee all daily functions and whilst the government released several documents regarding living with COVID and the way back to recovery COVID has remained a challenge to the trust whilst re-introducing elective surgery and outpatient services.

During this time, the Infection Prevention and Control (IPC) Team along with the wards and departments continued to work tirelessly to promote the health, safety, and well-being of not only patients and visitors but also themselves in order to deliver clean, safe and effective care.

This report is testimony to the hard work of all the teams in WUTH and acknowledges the incredible results that can be achieved when an organisation shares the same vision and values and how when we get the basics right, we become better and then can progress through to best.

Despite the continued challenges of COVID the Trust remained under the national objective for CDT of 115 having reported 94 incidences, however this is over the local objective we set ourselves of 79.

There has once again been a reduction in gram negative bacteraemia, with all reportable organisms being under our annual objectives set by NHSE/I.

Whilst promoting a 'zero tolerance' approach to MRSA bacteraemia the Trust reported 2 MRSA bacteraemia in 2021/22 which is the same as the previous year.

The Trust continues to report its quarterly mandatory laboratory data and the surgical division continue to report mandatory surgical site infection surveillance on a quarterly basis.

The Infection Prevention and Control Team continue to support the quality improvement project regarding *Clostridiodes difficile* infection to take proactive action to sustain and maintain the improvements in 2020/21 particularly as COVID rates reduce. This requires a review of the successful work undertaken during COVID to embed this good practice across the Trust to promote continuous improvement and reduction in our infection rates.

In conclusion, I would like to acknowledge the hard work of the IPC Team and the divisions; together they have shown commitment in the delivery of excellent infection prevention practices by managing our infection risks together in a caring and competent manner. Over the next 12 months we will continue to work hard and keep a focus on prevention of infections and compliance with good working practice collaborating with partners across the whole health economy.

Tracy Fennell
Chief Nurse/Director of Infection and Prevention and Control (DIPC)

2.0 Description of Infection Prevention

2.1 Nursing Team

The Chief Nurse / DIPC has overall responsibility for the IPC Team, which is in the Corporate Nursing Directorate, this role was previously filled by Hazel Richards who retired in August 2021, Tracy Fennell, Hazel's deputy was successfully appointed as her replacement in March 2022.

Jay Turner-Gardner, Associate Director of Nursing / Deputy DIPC, is managed by and professionally accountable to the DIPC and deputises in her absence for matters relating to Infection Prevention.

The Band 8a Infection Prevention Matron has managerial responsibility for the Infection Prevention Team.

The Infection Prevention Nursing Team establishment consists of:

- 3 x band 7 (3.0 WTE) Senior Infection Prevention Specialist Nurses.
- 3 x band 6 (3.0 WTE) Infection Prevention Specialist Nurses
- 1 x band 5 (1.0 WTE) Analyst
- 1 x band 3 (1.0 WTE) Infection Prevention assistant
- 1 x band 3 (1.0 WTE) Secretary.

During 2021/2022 there remained several vacancies within the nursing team, as a result two band 6 nurses were seconded to the Team at the beginning of 2021 for 6 months to support during the ongoing recruitment process, these were then successful when interviewed for the substantive posts and commenced in Oct/Nov 2021, a new band 7 commenced in post in June 21.

The team for the first time in many years was fully established in Nov 21, however long-term sickness of one of the senior members of the team began in Dec 21.

The IPC analyst role moved under direct responsibility of the Programme Developer for Patient Experience & Nurse Quality Indicators in the Corporate Nursing Team for further development of the role.

The 'Environmental Safety Matron' transferred into the Estates, Facilities and Capital team at the beginning of 2022 to further support the extensive capitals programme building on the existing relationship between the IPC Team , the Clinical Teams and Estates and Facilities.

2.2 Medical Staff

The IPC team is supported by the consultant microbiology team of which there are 1.9 WTE consultant microbiologists. This includes the infection control doctor (3 PAs). There is one 1 WTE consultant vacancy, partially filled by this vacancy is currently filled by 0.4 WTE locum. The post has now been converted to 1 x fixed time speciality doctor post for 12 months and has now filled.
There are 2 WTE clinical scientists in the department, one of whom is leading on the Water and Ventilation safety aspects of IPC.

Out of hours consultant microbiologist support is available on call from 5pm – 9am, including weekends and bank Holidays for Microbiology and IPC advice.

2.3 Microbiology Laboratory Services

Chester and Wirral Microbiology Service (CWMS) is the Medical Microbiology laboratory providing high quality diagnostic bacteriology and virology services to Wirral and West Cheshire and it is in Bromborough, Wirral. It provides the majority of the lab diagnostics for WUTH including routine cultures, Infection screening tests (MRSA, VRE screens) and molecular testing for organisms such as Influenza, C. difficile, Norovirus , CPE and SARS-CoV -2. This is a 24/7 service, and an out of hours service restricted to urgent samples including blood cultures, CSF and COVID tests

A combination of on-site and off-site testing capabilities for SARS-CoV -2 testing has been implemented over the last 12 months. On-site testing capacity includes POCT for COVID +/- FLU A /B. Off-site services included tests done in CWMS and some referrals to Liverpool clinical laboratories

2.4 Infection Prevention on-call

The Infection Prevention Nursing Service is available Monday to Friday from 8am - 5pm and there is an on – call service from 5pm - 9am, including weekends and bank holidays. The on call is covered by the band 6 and 7 nurses and the IPC Matron.

2.5 Reporting Line to the Board of Directors

A schematic of the reporting arrangements for the Infection Prevention Control group within the Trust can be found in **Appendix 1**

2.6 The Infection Prevention and Control Group

This group continues to meet monthly, and each directorate provides representation. The group is chaired by the DIPC; the deputy chair is the ADN – IPC. Its purpose is to provide a two-way communication channel between the Trust Board via the Patient Safety and Quality Board (PSQB). The IPCG has an assurance/ management role and is authorised to approve Infection Prevention policies and to formulate recommendations for Infection Prevention and Control conveying these to the PSQB via a chairs report.

The Trust Infection Prevention & Control Terms of Reference can be found in **Appendix 2**. These are reviewed bi-annually.

2.7 Departmental/Divisional Infection Prevention and Control groups

The following groups meet monthly supported by the IPCT, discussing IPC related issues and incidents whilst developing assurance reports for the Infection Prevention and Control Group (IPCG).

- Medicine
- Acute Specialties

- Orthopaedics
- Specialist Surgery
- Surgery
- Theatres
- Women's and Children's
- Diagnostics

2.8 The Infection Prevention and Control Team

The Team meets weekly with the IP Doctor and together they provide the Infection Prevention service to the Trust. The ADN - Infection Prevention & Control is responsible for producing the 3 year IP strategy and delivering the Infection Prevention annual plan and annual audit plan on behalf of the DIPC, who reports to the Trust Board on behalf of the Infection Prevention & Control group.

2.9 The weekly 'HCAI oversight' meeting'

This meeting is chaired by the Associate Director of Nursing – IPC / Deputy DIPC and is accountability based reviewing all incidences of CDI and nosocomial COVID from the previous 10 days, concentrating on lessons learnt during the review of the patient pathway and how these were documented, and their implementation progressed. During periods of high CDT cases the Chief Nurse Chairs an Executive Led CDT Panel reviewing all CDT cases ensuring actions are enacted on any learning from RCAs.

2.10 The weekly 'Patient Safety Learning Review Panel'

This meeting is chaired by the Interim Associate Director of Nursing-Corporate Nursing and is accountability based, reviewing all 'patient harms' including Falls, Pressure damage and incidences of Bacteraemia, concentrating on lessons learnt during the review of the patient pathway, how these are captured. This meeting also determines avoidability status.

3.0 Reports to the Trust - Summary

Reports written and/or coordinated by the ADN- IPC include

- Daily IPC update including outbreak and surveillance summary for the senior management and nursing teams detailing any areas under increased surveillance due to an increase in prevalence of any specific organism.
- Daily Outbreaks in the community which could have an impact on our service by the WCT.
- Monthly Infection prevention data summary of activities for the IP divisional meetings and the IPCG.
- Monthly IPC chairs reports and updates for the PSQB/ Clinical Advisory Group
- Monthly PPE chairs report for H&S
- Annual Infection Prevention Report once per year which includes the Annual Infection Prevention plan and Annual Infection Prevention audit plan.
- Add hoc updates in relation to the Infection prevention board assurance framework

- Weekly Executive Team update for DIPC
- IPC BI portal
- Monthly IDA's - if required

4.0 Budget Allocation to Infection Prevention

4.1 Microbiology and Laboratory Services

The medical microbiologists are funded from the Pathology Directorate, which is within the Division of Clinical Support. Funding for microbiology laboratory services (including outbreaks of infection) is covered by the service level agreement between the Trust and United Kingdom Health Security Agency (UKHSA), formerly known as Public Health England (PHE).

4.2 Funding for Outbreaks of Infection

Funding for outbreaks of infection (excluding laboratory costs as detailed above), are funded locally by the Divisions.

4.3 The Infection Prevention and Control Nursing Team (IPT)

The IPC Team are funded from Corporate Nursing and the ADN – Infection prevention is the budget holder for the Infection prevention service, the budget funds the nursing team and any Infection prevention initiatives identified during the year. This includes Infection Prevention signage, posters, study days and campaigns.

4.4 Investments in Infection Prevention at WUTH

In the year 2021/22 the Trust continued in its investment of

- MRSA screening for all admissions
- CPE and VRE screening for all Orthopedic patients
- Hydrogen Peroxide Vapor (HPV) 'fogging' following incidences of CDI, COVID, VRE, CPE when capacity/patient flow allows
- Ongoing HPV programme when bed capacity allows
- EvaluClean - This simple system uses a UV marker which is invisible to the human eye, to mark objects, following environmental cleaning a UV torch is then used to see if the mark has been removed during the cleaning process
- Adenosine triphosphate (ATP) – ATP is the energy carrying molecule used in cells and we use it to detect the presence of organic matter (contamination) to measure the effectiveness of cleaning
- Increased cleaning in addition to the base line clean to meet COVID requirements
- Placement of PVC curtains and track in all in-patient bed areas.
- Disposable curtains

5.0 Health Care Associated Infection (HCAI)

Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections. The most well-known include those caused by Meticillin-resistant *Staphylococcus aureus* (MRSA), *Clostridium difficile* (C. difficile) and more recently COVID – 19.

HCAIs pose a serious risk to patients, staff, and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention is a key priority for the NHS. The 3-year IP strategy and annual plan for 2022/2023 focuses on revising and updating present arrangements, strengthening, and building on the work that has already been achieved in the previous year and planning for the new and continuing challenges ahead.

6.0 Surveillance/ Mandatory reporting

The Health and Social Care Act 2008, updated 2015 (Code of practice on the prevention and control of infections) clearly identifies criteria to ensure that patients are cared for in a clean environment, which minimises the risk of acquiring a HCAI. Public Health England's Data Capture System provides an integrated data reporting and analysis system for the mandatory surveillance of:

- Meticillin resistant *Staphylococcus aureus* bacteraemia (MRSA)
- Meticillin sensitive *Staphylococcus aureus* bacteraemia (MSSA)
- *Clostridioides difficile* infections
- *Escherichia coli (E-coli)* bacteraemia
- *Klebsiella* spp bacteraemia
- *Pseudomonas aeruginosa* bacteraemia

The monthly quality check of the mandatory data continues between the IPC analyst and AND-IPC prior to it being 'signed off' by the DIPC on behalf of the Chief Executive continues

Carbapenemase Producing *Enterobacteriaceae* (CPE) bacteraemia are reported locally as are VRE bacteraemia.

COVID-19 data is captured daily and published monthly, weekly, and daily using specified admission indicators via NHSE/I.

6.1 Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia

The NHS have made it clear that they consider it unacceptable for a patient to acquire an MRSA bloodstream infection (MRSA BSI) while receiving care in a healthcare setting .The Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) published their last guidance, 'Implementation of modified admission MRSA screening guidance for NHS (2014)', these guidelines outlined a more focused, cost-effective approach to MRSA screening whilst concentrating on reducing infections and improving patient health. The WUTH

guidelines were last reviewed in 2019 and the decision made at that time to continue to complete screening for MRSA as per existing local policy, however this policy now requires further review to reflect the 2014 guidelines to ensure the best cost-effective approach whilst continuing to promote patient safety. The proposed review will be in the 2022/2023 annual plan.

6.2 Reporting and monitoring arrangements for MRSA bacteraemia

It is mandatory for the Trust to report all incidents of MRSA bacteraemia onto the data capture system (DCS) and to subsequently complete a Post Infection Review. There is no longer a mandatory requirement to enter these investigations reports via the DCS reporting system unless requested so by UKHSA as a high outlier. Completed PIR reports are shared with the local clinical commissioning group (CCG) and cases are discussed at their quality meetings.

Following a laboratory confirmed result of MRSA bacteraemia a Multi-disciplinary Team, incorporating the patient's clinician, Microbiologist, ADN-IPC, Matron and Pharmacist meet to complete the investigation to determine the attribution of the MRSA bacteraemia and a local action plan is developed which is the responsibility of the directorate to achieve. Causation is determined once the information is gathered.
MRSA Bacteraemia are apportioned according to the DOH guidelines, example

- Day 0 = Day of admission community attributed (pre day 2)
- Day 1 = community attributed (pre day 2)
- Day 2 = Trust attributed (on or post day 2)

This year there was 2 MRSA bacteraemia reported on or after day 2 of admission (post) and 3 reported pre day 2.

6.3 The incidence of MRSA bacteraemia since 2014/15.

*Table 1 below provides a breakdown of **MRSA bacteraemia** by year since 2014/15*

Table 1

The incidence of MRSA Bacteraemia since 2014/15								
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Pre day 2 for WCT	4	5	3	0	3	2	0	3
Post day 2 for WUTH	3	1	1	2	3	1	2	2
Total for Wirral CCG	7	6	4	2	6	3	2	5

There has been no increase in the incidence of MRSA bacteraemia with the Trust reporting 2 hospital onset, hospital associated cases.

6.4 Themes from Post Infection review

The first MRSA bacteraemia was detected in a Person Who Injects Drugs (PWID) admitted with bilateral groin abscesses, these were found to be colonised with MRSA on admission. Initial blood cultures collected on admission grew MSSA and repeat blood cultures collected 3 days later grew MRSA. The patient was non-compliant with treatment and management of their condition. Although

some learning was identified it was not deemed to have contributed to the bacteraemia and was classified as unavoidable.

The second MRSA bacteraemia was detected in a patient who was known to be previously colonised with MRSA, screening swabs collected on admission were negative for MRSA. The patient developed thrombophlebitis from a cannula that had been inserted in ED. The cannula site was deemed to be the source of the bacetraemia therefore this was identified as avoidable.

6.5 Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia

All Acute NHS trusts report information on MSSA bacteraemia on the Data Capture System (DCS) in a similar fashion to the present collection of data on MRSA bacteraemia. *Staphylococcus aureus* that are sensitive to meticillin are termed meticillin sensitive *Staphylococcus aureus* (MSSA). There are no national or local objectives set against these at present and many are related to skin and soft tissue infections.

*Table 2 below provides a breakdown of **MSSA bacteraemia** by year and month.*

Table 2

The incidence of MSSA Bacteraemia since 2016/17													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016/17	4	2	4	1	1	1	1	3	0	1	4	1	23
2017/18	1	1	1	1	1	2	4	1	3	2	3	2	22
2018/19	2	1	5	1	1	2	0	4	1	3	0	3	23
2019/20	3	5	1	0	2	1	1	2	1	3	3	2	24
2020/21	4	1	1	0	0	2	2	3	0	1	4	0	18
2021/22	1	2	2	0	0	0	4	0	3	5	4	4	25

The Trust has increased its incidence of MSSA bacteraemia by 39% from the previous year. Proposed review will be in the 2022/2023 annual plan.

6.6 *Clostridioides difficile* Infection (CDI)

Clostridioidies difficile, formerly *Clostridium difficile* (C. difficile) was reclassified in 2016 when it became necessary to assign C difficile to a new genus following the restriction of the genus to Clostridium butyricum and related species in 2015. It is a bacterium that is found in people's *intestines.* It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of babies). C. difficile causes disease when the normal bacteria in the gut are disadvantaged, usually by someone taking antibiotics. This allows C. difficile to grow to unusually high levels. It also allows the toxin that some strains of C. difficile produce to reach levels where it attacks the intestines and causes mild to severe diarrhoea. C. difficile can lead to more serious infections of the intestines with severe inflammation of the bowel (pseudomembranous colitis). C. difficile is the biggest cause of infectious diarrhoea in hospitalised patients. You can become infected with C. difficile if you ingest the bacterium (through contact with a contaminated environment or person). People who become infected with C. difficile are usually those who have taken antibiotics, particularly the elderly and people whose immune systems are compromised.

6.7 Reporting and Surveillance of *Clostridioides difficile*

In respect of the COVID pandemic the national objective set for WUTH for healthcare associated *Clostridioides difficile* infections (CDI) this year was 115. This is an increase in the previous year and is not reflective of the achievements made in reducing CDI for the last 2 years. To promote continuous improvement an internal threshold had been agreed: a target of 79 healthcare associated CDI cases or less for 2021-2022. This a 10% reduction of last year's objective of 88.

Following a marked rise in the detection of CDI in September 2021 a targeted review took place which included typing of some of the samples, the 027-strain was found, and increased cleaning and targeted interventions led to a reduction in Oct 21. The Trust experienced a further increase in patients identified with CDT in January following which a Trust wide improvement plan was developed by the ADN-IPC and shared with the leadership teams. A weekly RCA oversight meeting was chaired by the Chief Nurse to review each patient pathway, identify causative factors, and develop action plans focusing on improvements. 027 was not found to be the dominant strain at this time.

Challenges with cleaning standards were addressed and assurances sought from the facilities Division regarding anticipated improvements.

A rapid QI initiative was commenced with a focus on CDI which was championed by 4 wards. Whilst Feb/March saw a resulting reduction this was not enough to remain below our local target

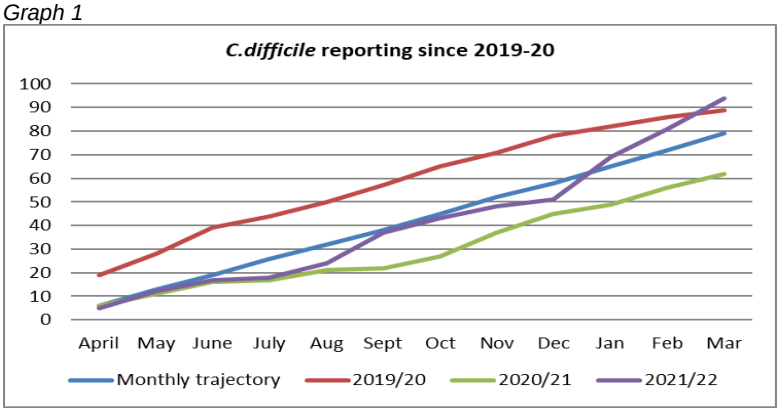
*Table 3 below provides a breakdown of **Clostridiodes difficile** by year and month.*

Table 3

Clostridium difficile													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	19	9	11	5	6	7	8	6	7	4	4	3	89
2020/21	6	5	5	1	4	1	5	10	8	4	7	6	62
2021/22	5	7	5	1	6	13	6	5	3	18	12	13	94

*Graph 1 below provides **Clostridium difficile** reported infections since 2019/20 and annual trajectory.*

Graph 1



In 2021/22 we have reported 94 *Clostridium difficile* infections. This is an increase of 32 cases when compared to 2020/21. We are 15 cases over our local trajectory for 2021/22 and 21 under our national objective.

6.8 Local reporting for CDI in 2022/23

Trusts are required under the NHS standard contract 2022/23 to minimise *C.difficile* infections so that they are no higher than the threshold levels set by NHS England and Improvement.

Objectives for this year are derived from a base line of the 12 months ending November 2021, as this is the most recent available data at the time that NHSE/I was calculating the figures.

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 that count. Our threshold for this year is 72.

NHS acute providers use the case assignment definitions:

- **Hospital onset healthcare associated**: (HOHA) cases that are detected in the hospital two or more days after admission.
- **Community onset healthcare associated**: (COHA) cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

6.9 Themes from CDI RCA investigation

Although it is not always possible to ascertain the cause, some of the common themes and learning outcomes from the RCAs are listed below:

- Staff not identifying the need for isolating a patient with diarrhoea until a positive sample result was known
- Environmental cleaning, although this has improved with additional cleaning during the COVID-19 pandemic
- Not taking a sample in a timely manner
- Poor documentation
- Delay in the start of treatment due to multiple reasons:
    - Delay in prescribing treatment following report of positive result
    - Stat doses not prescribed
    - Medication not dispensed from pharmacy in a timely manner
    - Staff unaware of escalation process for critical medication
- Antimicrobial prescribing not in line with Trust Formulary
- Clinicians not attending or supporting the RCA process

6.10 Gram-negative bloodstream infections (BSIs)

Gram-negative bacteria - *Escherichia coli (E. coli)*, *Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella* spp.) are the leading causes of healthcare associated bloodstream infections. The national ambition was to deliver a 25% reduction of healthcare associated Gram-negative blood stream infections by 2021-2022 with 50% by 2023-2024, (Jan 16 - Dec 16 data values). In 2021/2022 Trusts were given individual objectives for each organism..

E.coli

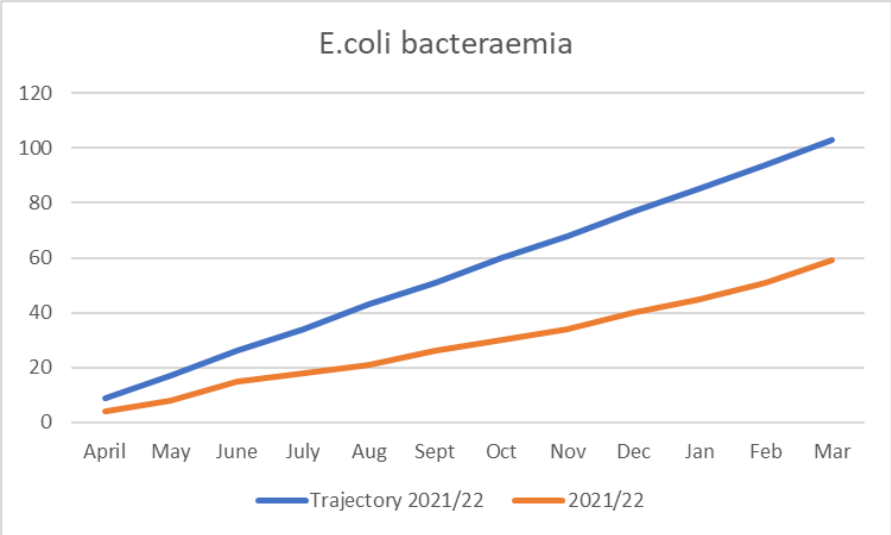
*Table 3 below provides a breakdown of Hospital attributed **E.coli bacteraemia** by month against the trajectory.*

Table 3

E.coli bacteraemia												
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*
Trajectory 2021/22	9	17	26	34	43	51	60	68	77	85	94	103
2021/22	4	8	15	18	21	26	30	34	40	45	51	59

We were **44** cases **under our trajectory** for 2021/22.
*Graph 2 below provides **E.coli bacteraemia** reported infections by month against the trajectory.*

Graph 2



Klebsiella

*Table 4 below provides a breakdown of Hospital Attributed **Klebsiella bacteraemia** by month against the trajectory.*

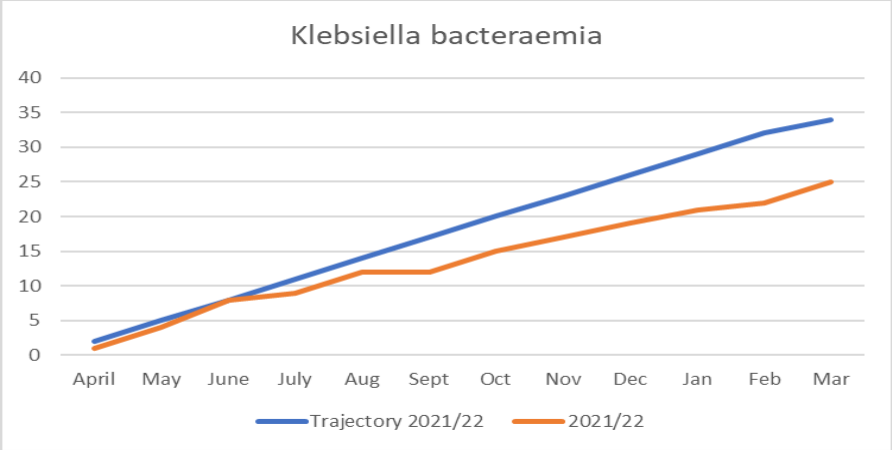
Table 4

Klebsiella bacteraemia												
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*
Trajectory 2021/22	2	5	8	11	14	17	20	23	26	29	32	34
2021/22	1	4	8	9	12	12	15	17	19	21	22	25

We were **9 cases under our trajectory** for 2021-2022

*Graph 3 below provides **Klebsiella bacteraemia** reported infections by month against the trajectory.*

Graph 3



Pseudomonas

*Table 5 below provides a breakdown of Hospital Attributed **Pseudomonas bacteraemia** by month against the trajectory.*

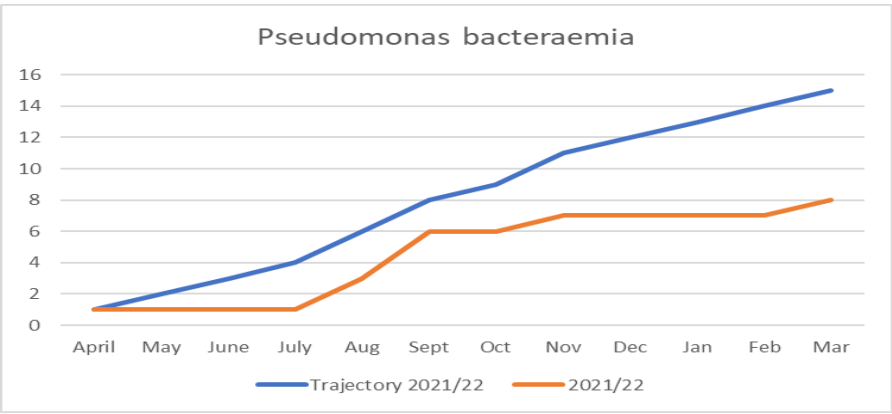
Table 5

Pseudomonas bacteraemia												
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*
Trajectory 2021/22	1	2	3	4	6	8	9	11	12	13	14	15
2021/22	1	1	1	1	3	6	6	7	7	7	7	8

We were **7 cases under our trajectory** for 2021-2022

Graph 4 below provides Pseudomonas bacteraemia reported infections by month against the trajectory.

Graph 4



6.11 Themes from gram negative RCA investigation

Email notifications are sent to the divisions to request for the RCA investigation to be undertaken for all hospital onset gram negative BSIs. These are then required to be presented at the weekly patient safety review panel with any resulting actions developed from lessons learnt monitored at the monthly divisional IPC meetings and presented at the monthly IPCG. Below are the themes that have been identified from the completed investigations.

- Poor documentation related to invasive devices, particularly urinary catheters and peripheral cannulas and wounds
- Delay removing invasive devices when no longer required, especially urinary catheters
- Delayed blood culture and urine collection resulting in failure to diagnose and treat in a timely manner
- Not always clear if staff who undertook blood collection had received training and been assessed as competent with ANTT

6.12 Carbapenemase-producing Enterobacteriaceae (CPE)

The spread of antibiotic resistance in gram-negative organisms continues to be an increasingly significant public health threat and a matter of national and international concern. They are an emerging cause of healthcare-associated infections, which represent a major challenge to healthcare systems.

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. These organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Environmental and surface contamination plays a significant role in transmission. Bacteria can survive on dry surfaces for extended periods, increasing the risk of cross contamination between patients.

*Table 7 below provides a breakdown of **all** CPE **bacteremia** by year and month.*

Table 7

The incidence of CPE Bacteraemia since 2019/20													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	0	0	0	1	0	0	0	0	0	0	0	0	1
2020/21	0	0	0	1	0	0	0	0	0	0	0	0	1
2021/22	0	0	0	0	0	0	0	1	0	0	0	0	1

As a result of the COVID pandemic the review of the current arrangements and introduction of a CPE policy, reflecting the national guidance was put on hold for 2 years, this will now be part of the annual plan for 2022.23.

6.13 Mandatory Glycopeptide resistant Enterococci (VRE) bacteraemia

There have been 4 incidences of VRE bacteraemia reported at WUTH during the period April 2021 - March 2022. This is an increase in 3 from the previous year. Unlike other organisms under mandatory surveillance, Public Health England (PHE) employs a reporting year which runs from October – September to publish national G/VRE data. There is no requirement to apportion cases, only report incidences.

*Table 8 below provides a breakdown of VRE **bacteremia** by month.*

Table 8

The incidence of *VRE bacteraemia since 2019/20*													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
2019/20	*0*	*0*	*1*	*0*	*1*	*0*	*1*	*1*	*0*	*0*	*1*	*0*	*5*
2020/21	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*
2021/22	*0*	*2*	*0*	*0*	*0*	*1*	*0*	*1*	*0*	*0*	*0*	*0*	*4*

6.14 Quarterly Mandatory Laboratory Reporting (QMRL)

The Quarterly Mandatory Laboratory Reporting data continues to be submitted via the laboratory to the UKHSA Health Care Associated Infection (HCAI) Data Capture System.

This data includes:

- Total number of blood culture sets examined
- Total number of glycopeptide resistant enterococci (GRE) positive blood culture episodes
- Total number of positive blood culture sets
- Total number of S. aureus positive blood culture sets
- Total number of *Clostridioides difficile* toxin positive reports in people aged 2 - 64 years
- Total number of *Clostridioides difficile* toxin positive reports results in people aged >=65 years
- Total number of stool specimens tested for diagnosis of C. difficile infection.
- Total number of stool specimens examined
- Total number of faecal specimens and rectal swabs taken for carbapenemase-producing Enterobacteriaceae (CPE) screening

6.15 Coronavirus (COVID-19)

Coronavirus (COVID-19) was first encountered in November 2019 in Wuhan, China. Following this there was rapid spread across the world resulting in a global pandemic that lasted 2 years and is not yet over. The Government's Scientific Advisory Group for Emergencies (SAGE) is clear there is considerable uncertainty about the path that the pandemic will now take in the UK.

Throughout the COVID-19 pandemic the government's aim has been to protect the lives and livelihoods of citizens across the United Kingdom (UK) and the ongoing new guidance published throughout 2021-22 has been aimed at protecting and supporting citizens by enabling society and the economy to open more quickly than many comparable countries by using vaccines and supporting the National Health Service (NHS) and social care sector.

SAGE recently considered four scenarios describing plausible outcomes, these are not predictions. All scenarios assume that a more stable position will eventually be reached over several years. In the 'reasonable best case' there may be a comparatively small resurgence in infections during autumn/winter 2022-23, and in the 'reasonable worst case' a very large wave of infections with increased levels of severe disease.

The emergence of new variants will be a significant factor in determining the future path of the virus. New variants of COVID-19 will continue to emerge This could include variants that render vaccines less effective, are resistant to antivirals, or cause more severe disease. The pathway to greater stability will also be affected using vaccination and other available treatments.

The term 'endemic' is sometimes used to denote when a more steady or more predictable state has been reached but it does not mean that a virus will necessarily circulate at low levels or that outbreaks cannot or will not occur. Once COVID-19 becomes endemic it should be possible to respond to the virus in a similar way to other existing respiratory illnesses, through sustainable public health measures. The transition to an endemic state will be highly dynamic and affected by the international situation. It will occur at different times globally due to differences in the spread of the disease and access to vaccines.

Effective monitoring and surveillance are central to understanding COVID-19 transmission within our hospital, providing transparency on performance, and supporting a focus on continuous improvement.
There are three categories for determining Hospital Onset COVID-19 infections:

- Hospital-Onset Indeterminate Healthcare-Associated (**HO-HA**) – First positive specimen date 3-7 days after admission to trust
- Hospital-Onset Probable Healthcare-Associated **(HO-HA)** – First positive specimen date 8-14 days after admission to trust
- Hospital-Onset Definite Healthcare-Associated **(HO-HA)** – First positive specimen date 15 or more days after admission to trust.

All **HO-HA** and **HO-HA** continue to undergo a Root Cause Analysis (RCA) to establish how the transmission occurred and whether there were any other linked cases that might indicate ongoing transmission within an area.

The table 13 below provides a breakdown of COVID-19 by month

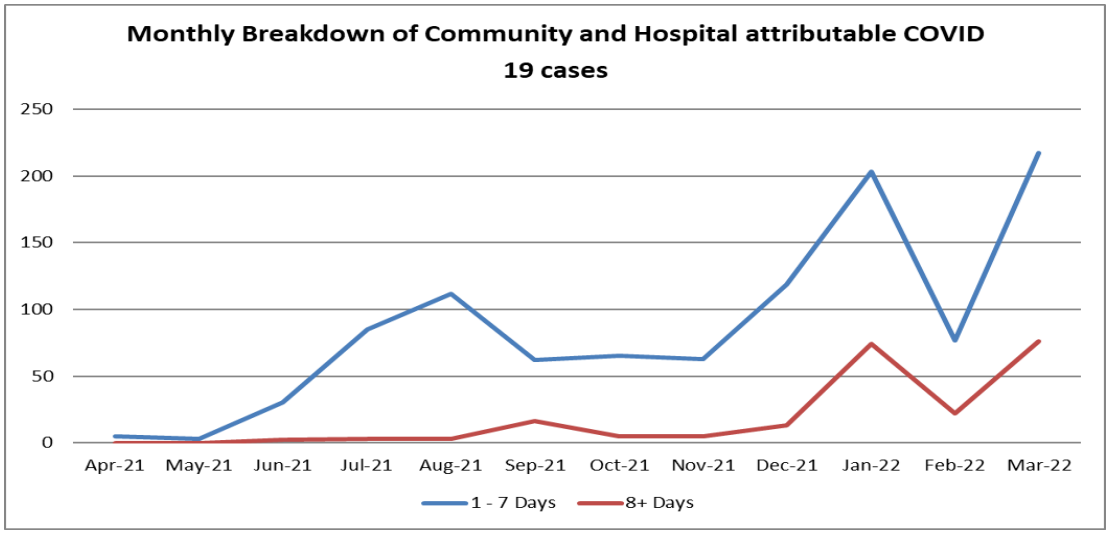
Table 13

	No. of COVID-19 cases				Total No. of cases per month
	Community Onset		Hospital Onset		
Month	1-2 days	3-7 days	8-14 days	15+ days	
Apr-21	4	1	0	0	5
May-21	2	1	0	0	3

Jun-21	25	5	2	0	32
Jul-21	83	2	3	0	88
Aug-21	106	6	2	1	115
Sep-21	59	3	5	11	78
Oct-21	58	7	2	3	70
Nov-21	57	6	2	3	68
Dec-21	110	9	4	9	132
Jan-22	182	21	22	52	277
Feb-22	70	7	14	8	99
Mar-22	184	33	27	49	293
Total	940	101	83	136	1260

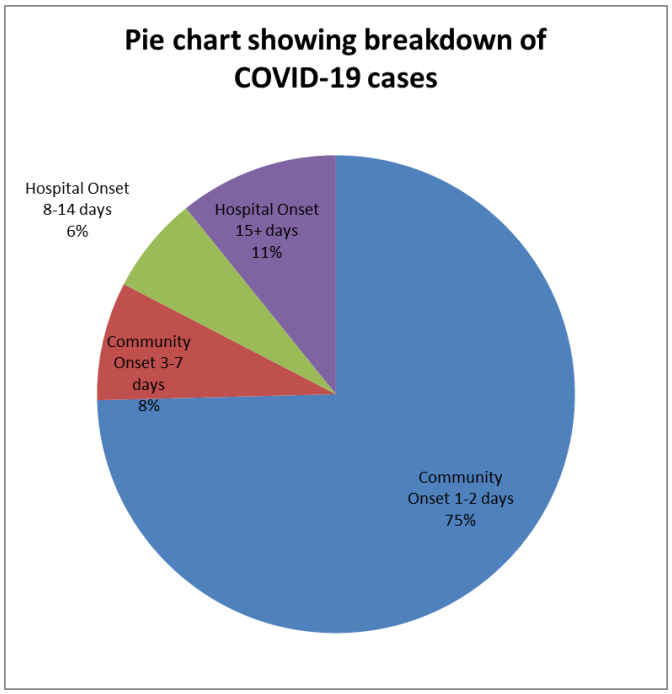
During 2021-2022 daily updates since England declared its first lockdown in March 2020 continued via United Kingdom Health Security Agency (UKHSA) formerly known as the PHE and other government web sites. The updates included numbers tested, numbers positive and vaccine uptake.
Staff testing and incidences of COVID positive results in staff and patients continued to be reported back at weekly meetings and papers and local SOPs developed following UKHSA guidance are readily available on the Trust intranet for staff to use

Graph 5 below shows the incidence of patient COVID-19 results in 2020/21.
Graph 5



The Pie chart 1 below provides a breakdown of COVID-19 in 2021-2022

Pie chart 1



Effective infection prevention and control has remained fundamental in the way in which WUTH for the second year running rapidly adapted to the response to the COVID pandemic and the ongoing waves of the disease. Improvements and initiatives continued throughout 2021/22 to strengthen IPC practices across the trust; this activity has continued to be captured in the Infection Prevention & Control Board Assurance Framework (IPC BAF) which was introduced at the beginning of the pandemic and is now on version 8. This assurance document is updated to reflect current Trust

guidelines and is reviewed by the Quality Committee as delegated by the Board of Directors on a quarterly basis. Local improvements throughout 2021/22 have included:

- Ongoing fit testing for staff of FFP3 masks.
- Add hoc training session for donning and doffing of PPE.
- COVID Screening for all patients on the day of admission and thereafter at day 3, 6 and then every 7 days of admission.
- Creation of a Vaccination Hub which opened in December 2020 to enable the roll out of the newly introduced COVID vaccine for all staff and the wider Wirral community at the Clatterbridge site.
- Introduction of twice weekly LFD testing for staff which then became weekly LAMP testing
- Bespoke leadership meetings to enable clinicians to discuss the control and management of COVID in the hospital based on PHE guidelines i.e., Bronze/Silver/Gold and the clinical advisory group (CAG) and the enhanced operational group.
- Frequent updates via the communications team in all manners of media including e-mails, team briefs, messages of the day and posters.

6.16 Seasonal Influenza

WUTH participates in the Unify2 influenza surveillance scheme for reporting cases occurring in level two and level three care settings (ICU and HDU).

The table 11 below shows the summary of Influenza Cases Reported through Unify2 Surveillance Scheme since 2019/2020

Table 11

	Influenza A, H1N1pdm09	Influenza A (H3N2)	Influenza A, unknown subtype	Influenza B	Influenza other/unknown subtype
April 2019 - March 2020	3	4	3	0	0
April 2020 - March 2021	0	0	0	0	0
April 2021 - March 2022	0	0	0	0	0

Although there were no influenza patients who required Critical Care we have seen a slight increase in flu cases from the previous year but not at levels experienced pre-COVID-19 pandemic.

Between September 2021 and March 2022 there were 77 positive flu results with most patients testing positive in ED, however not all patients required admission. There were 67 Flu A positives, 4 Flu B positives and 6 Flu A and Flu B positive. Some cases were an incidental finding due to the type of test that was performed for COVID-19; 7 patients tested positive a week after admission although many remained asymptomatic.

Three patients died during their inpatient stay however all patients had been admitted with flu.

Ward 27 bridge had been identified as a flu cohort area however due to the low numbers reported at any one time and the fact the Ward 27 was affected with outbreaks of COVID, any positive flu patient was able to be accommodated in side rooms across the Trust.

6.17 Surgical Site Infection (SSI)

There is a mandated requirement for all NHS Trusts in England to submit data with regards to Surgical Site Infections (SSI) to Public Health England (PHE) comprising of at least 1 quarter per year for one orthopaedic category as a minimum. The Trust historically submitted this minimum dataset, except for 2019 as PHE reported quarters as a calendar year whereby the Trust reported per financial year.

In response to the CQC 2019 report an action plan was developed and the Surgical Division produced an SSI strategy and recruited an SSI Surveillance Nurse. This has allowed ongoing surveillance to be undertaken for more than one surgical category as listed below:

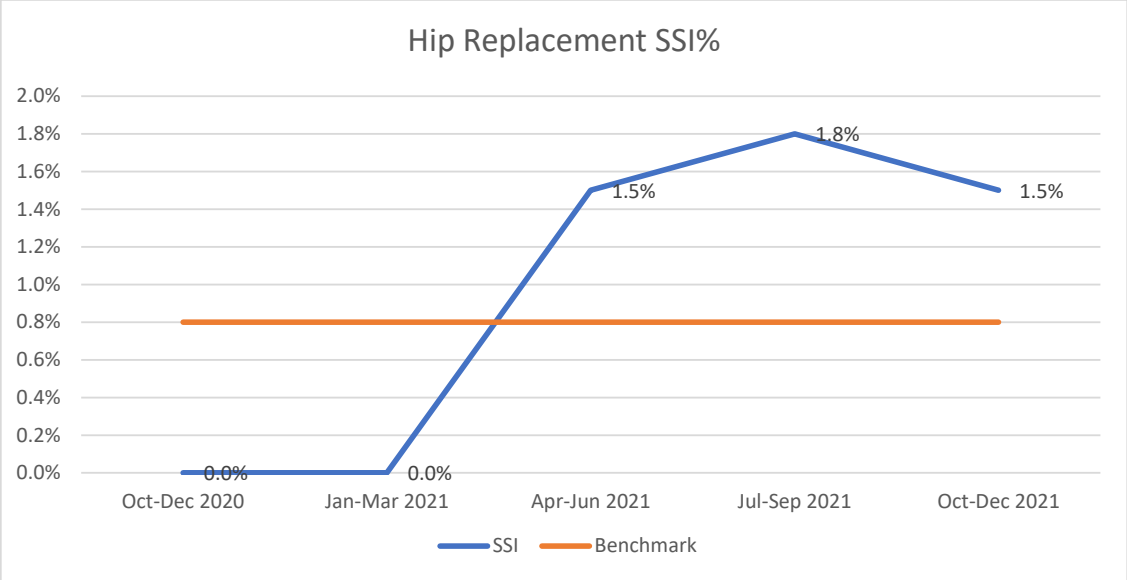
- Hip replacement
- Repair of neck of femur
- Small bowel surgery

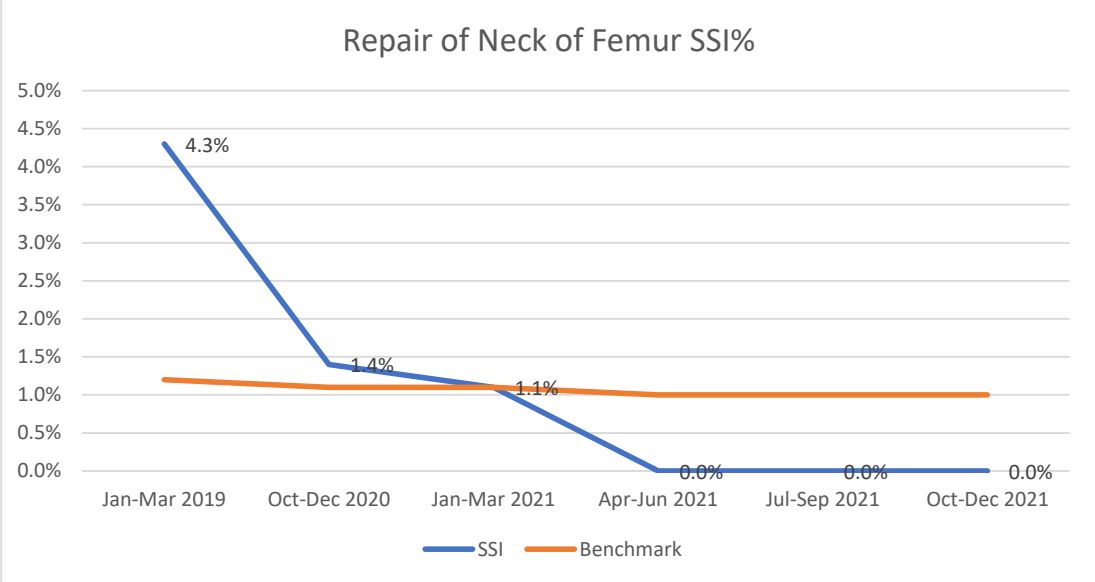
The data submission for January to March 2022 is not due until the end of June 2022 and is therefore not included within this report.

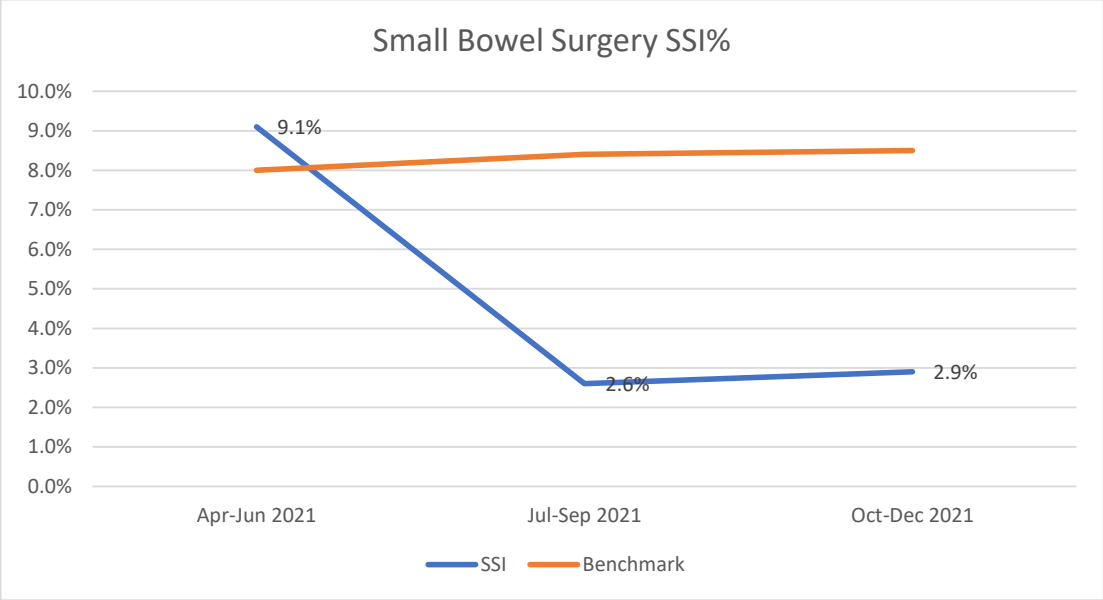
Category	**Jan-Mar 2021**		**Apr-Jun 2021**		**Jul-Sept 2021**		**Oct-Dec 2021**	
	Total No	SSI	Total No	SSI	Total No	SSI	Total No	SSI
Hip replacement	41	0	132	2 (1.5%)	109	2 (1.8%)	133	2 (1.5%)
Repair neck of femur	94	1 (1.1%)	75	0	65	0	75	0
Small bowel surgery	NA	NA	33	3 (9.1%)	38	1 (2.6%)	35	1 (2.9%)

All suspected SSIs are reviewed by the multidisciplinary team to agree if it is a confirmed SSI and identify learning.

Below are graphs for each surgical category comparing percentage of SSIs compared with the benchmark of all hospitals data over 5 years.


Hip Replacement SSI%
2.0%
1.8%
1.6%
1.4%
1.2%
1.0%
0.8%
0.6%
0.4%
0.2%
0.0%
0.0%
0.0%
1.5%
1.8%
1.5%
Oct-Dec 2020
Jan-Mar 2021
Apr-Jun 2021
Jul-Sep 2021
Oct-Dec 2021
SSI
Benchmark


Repair of Neck of Femur SSI%
5.0%
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
4.3%
1.4%
1.1%
0.0%
0.0%
0.0%
Jan-Mar 2019
Oct-Dec 2020
Jan-Mar 2021
Apr-Jun 2021
Jul-Sep 2021
Oct-Dec 2021
SSI
Benchmark



A monthly SSI MDT review meeting has been introduced to review incidents of SSI and identify learning, an SSI RCA process has also been developed and implemented to be completed by clinical area of identified SSI, this is then fed into divisional IPC for assurance.

Learning identified from the RCAs include:

- Lack of consistency of post operative wound education to patients
- Gaps in documentation with regards to wound care post-operatively and on discharge
- Inconsistencies in completion of the wound assessment tool on Cerner
- Wounds not always visualised, cleaned, and re-dressed prior to discharge
- Inappropriate prescribing of antibiotics by GPs

Actions that have been identified from the RCAs include:

- Standardise wound care practice and dressing availability
- Refresh ANNT practice across surgical division
- Link with tissue viability for expert support and guidance
- Standardise pre-operative patient preparation
- All patients to be given SSI information leaflet to advise of process and follow up
- Encourage patients to use the post-operative care clinic (SOS clinic) rather than accessing GPs for wound concerns

7.0 Outbreaks /Increased Incidences/Clusters of Infection

Infection surveillance supports the early detection of possible outbreaks which enables control measures to be instigated early to avoid escalation. The senior IPC Team arrange outbreak meetings with the divisional teams for all outbreaks detected and continue this ongoing collaboration to give support and advice until the outbreak is determined to be closed.

7.1 Norovirus

There was only on one norovirus outbreak reported between April 2021 and March 2022. 5 patients tested positive for norovirus although there were 8 patients and 1 staff who were symptomatic.

7.2 *Clostridiodes difficile*

There were three *C.difficile* outbreaks during 2021-2022,:

- Five CDIs linked to Ward 26 between August and October 2021; all patients were identified as having distinctive strains of CDI.
- Seven CDIs linked to Ward 36 between January and February 2022; three patients were identified as having the virulent 027 stain, one was unable to be typed due to insufficient sample size and the others were distinct strains.
- Four CDIs linked to Ward 11 / WAFFU between February and March 2022; one patient was identified as having the virulent 027 strain and the other were distinct strains.

All wards implemented an improvement plan and an enhanced clean, attention to outstanding Estates issues and HPV of the wards was undertaken.

7.3 COVID-19

The IPC Team reported 33 COVID outbreaks to the NHSE/I online reporting system between April 2021 and March 2022. 11 outbreaks were patient only, 2 outbreaks staff only and 21 outbreaks involved staff and patients. In total 219 patients and 111 staff were identified with COVID within these outbreaks.

7.4 CPE

Three CPE OXA-48, including one bacteraemia, were linked to an outbreak on Ward 30 during November and December 2021. An improvement plan was implemented and a deep clean and HPV of the ward was undertaken. No further cases were identified.

8 Incidents of communicable disease

Communicable diseases, also known as infectious diseases or transmissible diseases, are illnesses that result from the presence and growth of pathogenic (capable of causing disease) biologic agents in an individual human or other animal host. There may be occasions when patients or staff have been exposed to a specific infection e.g., scabies, Group A Streptococcus, identified by either the IP&CT or PHE which results in the need for either staff and Pt screening / treatment or both. When these situations have been identified the IP&C team support the ward teams to complete contact tracing and screening, if exposed patients / staff are identified immunisation records are checked by pts clinician and occupational health for verification of immunity and vaccination offered as required.

8.1 Group A *streptococcus*

1 patient was diagnosed with group A strep.

9. Antimicrobial Stewardship

Antimicrobial resistance resulting from infections with multidrug resistant organisms (MDROs) is a major public health concern. If MDROs continue to increase at the current rate, coupled with a limited pharmaceutical company pipeline of novel agents, even simple infections will become untreatable soon and most elective surgical procedures, such as joint replacements will become prohibitively dangerous. Common lifesaving operations and treatment regimens such as Caesarian sections and chemotherapy will carry a high risk of mortality.

One of the ways the rate of potentiation of MDROs is accelerating is through inappropriate use of broad-spectrum antimicrobials. Good antimicrobial stewardship practices limit their use to as short a duration as is clinically appropriate and promote use of narrower spectrum agents where possible.

NHS England and regulatory bodies such as the Care Quality Commission (CQC) expect secondary care organisations to be able to demonstrate adherence to guidance such as Start Smart Then Focus, a toolkit for antimicrobial stewardship in secondary care. Additionally, they must be able to demonstrate good performance against other measures of effective antimicrobial stewardship such as consumption as well as the relevant indicators of the Commissioning for Quality and Innovation (CQUIN) framework.

9.1 Antibiotic Safe Prescribing Indicators Report (ASPIRE) and Point Prevalence Survey (PPS)

As part of the audit and feedback program, providers should monitor adherence to SSTF principles regularly in all clinical areas to show:

- Evidence of documenting indication and duration (or review date) on the prescription
- Evidence of antimicrobial stewardship review of antibiotics at 48-72 hours after initiation and documentation of the antimicrobial prescribing decision (stop, change, switch, continue, OPAT) on the prescription or in the notes
- Adherence with local guidance on the choice of antibiotic therapy (or documented reason for non-compliance)

At WUTH these parameters are audited monthly as part of the Antibiotic Safe Prescribing Indicators Report (ASPIRE) audit which analyses antibiotic prescribing for five patients selected at random on each ward. The results are displayed as a dashboard demonstrating performance Trust wide as well as at a Divisional and Directorate level.

Results from 21/22 demonstrate that average trustwide performance across the year was as follows:

- Documentation of indication for antibiotics on prescription 97%
- Stop / review date on antibiotic prescription 99%
- Compliance with antibiotic formulary 98%
- Antibiotic clinical review undertaken within 72 hours of initiation 97%

These parameters are reported monthly trust-wide (via IPCG Antimicrobial Stewardship Assurance Report) and divisionally via Lead Divisional Pharmacist Reports.

Additionally, an antibiotic point prevalence survey reviews every antibiotic prescription for inpatients on the day of the audit. Data was collected in February 2022 and will be reported to MSOP later.

Although antibiotic prescriptions consistently have a documented review within 72 hours as required in the national standards, the outcome of these reviews is most frequently "continue" so the following objectives were added to monitor the quality of clinical reviews, see table below:

New objectives to monitor quality of 72 hour review	Baseline	Target	YTD
Reduce percentage of antibiotic courses "continued" at clinical review by 5% from current average measure by monthly ASPIRE audit.	56.4%	≤51.4%	63.1%
Reduce average total course length of all antibiotics by 1 day by year end measured by monthly ASPIRE audit.	9	8 or fewer	8
Reduce course length of parenteral antibiotics by 1 day by year end measured by monthly ASPIRE audit.	5	4 or fewer	5

It is anticipated that two of the service improvement strategies planned by the AMS Team discussed later in section 4 of this paper will improve the quality of these reviews and lead to reduced course lengths (total and parenteral):
-IV antibiotic prescriptions will be changed include a 3-day duration by default
-Fixing the AMS mPage tool designed to improve the quality of antibiotic reviews

9.2 Restricted Antibiotic Use

Certain antibiotics (listed within the Trust wide antimicrobial formulary) are restricted in use and should only be prescribed when recommended by the formulary for the specific indication being treated, or on the advice of a Consultant Medical Microbiologist (CMM). Out of hours these agents may be used but must be discussed with a CMM at the earliest opportunity. The Pharmacy Department receives a daily automated electronic report to allow follow up of these prescriptions to ensure this is the case.

During 2021/22, 3,783 restricted antibiotics were prescribed (incomplete data collection one month due to staff sickness), 99% of which were prescribed as per formulary or recommended by Microbiology. The 52 prescriptions which were not prescribed as per formulary or recommended by Microbiology were referred to the ward pharmacist to follow-up with the prescriber and reported via monthly Infection Prevention and Control Group AMS assurance reports.

9.3 Antimicrobial Stewardship Team (AST)

The Terms of Reference for the AST Committee state membership should consist of Consultant Medical Microbiologist (CMM) (Chair – Dr. Harvey), Consultant colleagues from each Division, Antimicrobial Pharmacists, Advanced Nurse Practitioners and primary care representation. The membership and terms of reference of the group are as mandated in Start Smart then Focus guidance with the aim of ensuring a multidisciplinary approach and improving dissemination of good practice and engagement across the organisation. Quarterly committee meetings restarted during 2021/22 and quoracy has improved, although the June 2021 meeting was not quorate, the meetings held in

September, December and March 2022 were quorate. Meetings have been well attended, co-opting relevant clinicians when specific issues require discussion.

9.4 Ward – focused Antimicrobial Stewardship Team

The Ward-Focused Antimicrobial Stewardship Team consists of a CMM and a specialist antimicrobial pharmacist. Together they undertake antimicrobial stewardship ward rounds with aim of providing patient specific clinical plans but also provision of case-based teaching to the MDT. The wards rounds occur in the following areas.

- Gastroenterology ward (weekly)
- Elderly Care wards x 2 (weekly)
- Respiratory Unit (weekly)
- Orthogeriatric wards/T&O x 3 (weekly)
- Older Persons Assessment Unit (weekly)
- Acute Care (three times weekly)
- Critical Care (daily)

AMS ward rounds had been reduced during 2020/21 and first quarter of 2021/22 due to social distancing and reduced staff resources but have since resumed normal service. Several additional areas have requested commencement of AMS ward rounds but there is insufficient CMM or pharmacist capacity to undertake these. Clinical scientists along with the antimicrobial pharmacist undertake a bacteraemia ward round on Thursdays depending on availability and continue to backfill for the shortage of microbiologists

9.5 Antibiotic Consumption

SSTF requires Trusts to understand their antibiotic consumption patterns. Antibiotic consumption is measured as defined daily doses (DDDs) which is the standard dose of that agent for an adult in a single day. Antibiotic consumption data is skewed by hospital occupied bed days and to introduce consistency is often measured by DDDs per 1000 admissions. National data analysis is also available on the RXInfo DEFINE and PHE Fingertips websites.

Performance against locally agreed AMS objectives:	**Baseline**	**Target**	**YTD**
Reduce total antimicrobial prescribing by 2% DDDs per 1000 admissions compared to calendar year 2018.	3811	<3743.8	3557 (6.7% reduction)
Maintain carbapenem prescribing below national average for England teaching hospitals measured as DDDs per 1000 admissions.	84.34	<84.34	80.95

9.6 Total Antibiotic Consumption

The target in the NHS Standard Contract (SC21.4) is to reduce total antibiotic consumption by 2% by the end of March 2022 against the baseline figure of consumption for calendar year 2018.

There is a time-lag in reporting accurate data on Fingertips which is currently showing only Q2 data. Data from DEFINE indicates this target has been achieved with a total antibiotic consumption of 3557 DDDs/1000 admissions in 2021/22, which represents a 6.7% reduction in usage compared to the calendar year 2018 when total antibiotic consumption was 3811 DDDs/1000 admissions. This reduction in total antibiotic consumption is encouraging but it should be noted that the nature of hospital admissions in 2021/22 will differ significantly from the baseline year in 2018 making a direct comparison problematic. The usage figures for the baseline year vary from previous local AMS reports because the data presets in DEFINE have been recently reconfigured to match new PHE criteria.

9.7 Consumption of Carbapenems.

There is no longer a national standard to achieve a reduction in carbapenem consumption, but it was agreed locally to aim to maintain carbapenem prescribing below the national average for English teaching hospitals.

PHE Fingertips website has not been updated since Q2 2021/22 but data from DEFINE indicates that WUTH usage of carbapenems is below the national average for similar type of hospitals. The data from DEFINE (see Trust 238 in chart 1) indicates carbapenem usage at WUTH is 80.95 DDDs per 1000 admissions. The average usage of similar type hospitals is 84.34 DDDs per 1000 admissions. The target to remain below the national average has been achieved but WUTH usage of carbapenems has increased year on year since 2019/20, this could be explained by the different nature of hospital admission during the pandemic, but specific audits are underway to determine appropriateness of antibiotics in neutropenic sepsis patients (high users of meropenem) and OPAT patients (where ertapenem use has seen recent significant growth).

9.8 Ongoing improvement strategies

The AMS mPage tool designed to improve the quality of antibiotic reviews requires fixes before its use can be further encouraged. Work has begun with informatics to improve it, but a complete rewrite of the tool is required. Informatics have advised that this work can begin in summer 2022 after a major software upgrade has taken place.

To improve rapid treatment of sepsis and timely review of IV antibiotics, stat doses and a 72 hour 'default' stop is being built into all IV antibiotic prescriptions. Currently a stop date on IV antibiotics is prompted but is random depending on what the prescriber chooses. The new 'default' duration will encourage a review of antibiotic prescriptions by 72hrs as mandated by NICE. These changes were scheduled to be implemented during World Antimicrobial Awareness Week in November (18th-24th) but this has been delayed allowing wider discussion amongst senior clinicians regarding safe implementation. A robust communications plan is in progress and implementation is planned for 3rd May 2022.

The use of procalcitonin was shown by local audit to reduce antibiotic course lengths by one day in COVID-19 patients. The AMS team will support any business case to broaden the use of this biomarker in other patient cohorts.

10.0 Decontamination

10.1 Decontamination Arrangements

The Care Quality Commission and the Health and Social Care Act 2008 requires healthcare organisations to keep patients and visitors safe by having procedures and systems in place to ensure that all reusable medical devices are properly decontaminated prior to use, and that all single use devices are not re-used. (Criterion 9).

Effective decontamination of reusable medical devices and equipment (including surgical instruments) is essential in minimising the risk of transmission of infectious agents to patients and staff.

Decontamination may involve a combination of processes (including cleaning, disinfection, and sterilisation) to render an item safe for further use on patients and for handling by staff. Any company supplying medical devices or equipment must offer clear instructions on suitable decontamination methods and it is essential that decontamination processes comply with manufacturers' guidelines and are available within the Trust. Failure to follow manufacturer's guidance may result in damage to items, invalidate warranties and transfer liability to the user, or the person authorising the decontamination process.'

WUTH has a standard Trust wide approach for decontamination and any queries regarding decontamination of any medical equipment is directed to Infection Control or the Decontamination Lead and if escalation is required this is by means of discussion at Decontamination Group Meetings. where possible actions/resolutions are agreed with the support of the Trust Microbiology representative, AE(D) and other group members. If actions remain unresolved it may be necessary to escalate to IPCG in the chairs report.

The Decontamination Group were unable to have all their scheduled meetings in 2021/22 due to competing priorities however it did report on progress of Trust wide decontamination issues and recommendations in relation to high risk medical devices i.e. for example those which come in to contact with mucous membranes. I.e., Scopes; the group minutes/ chairs report are tabled on the agenda of the IPCG and reports by exception.

10.2 Sterile Services

Sterile Services sits within the directorate of perioperative medicine and is situated at the APH site. The unit provides decontamination services to both Wirral University Teaching Hospital NHS Foundation Trust and to other NHS trusts and private facilities. The services include washing, decontamination, assembly packing and sterilisation of surgical instruments, theatre trays, soft packs, procedure packs and supplementary items. The service also provides an endoscopy decontamination unit at the CGH site providing sterilisation and decontamination of flexible endoscopes used at the site through wet sterilisation and dry holding.

The unit is committed to developing a comprehensive policy that gives assurance regarding the quality of the services provided to its customers, both internal and external to the organisation.

The unit conforms to the requirements of the Quality System Standard BS/EN/ISO 13485: 2016 and relevant requirements of European Directive 93/42/EEC through effective implementation of the department procedures.

The unit updates and reviews their protocols on a regular basis to ensure improvements in quality and customer service and their effectiveness is monitored through internal audits, complaints, and non-conformities. Assurance is provided to trust decontamination groups and also the directorate of perioperative medicine Infection Control Group and Safety & Quality Boards.

11.0 Cleaning Services

Wirral University Teaching Hospital NHS Foundation Trust have adopted a Domestic Service Cleanliness model that fully conforms to the Department of Health guidelines on the specification for the planning, application, measurement, and review of cleanliness services in hospitals and our cleanliness standards are governed by the following legislation:

- National Standards of Healthcare Cleanliness 2021 has replaced the National Specification for Cleanliness in the NHS 2007

In April 2021, NHS England and NHS Improvement launched the new National standards of healthcare 2021 that set out several key changes to how we perform and audit cleanliness to provide assurance of safe cleanliness standards across all our functional areas.

11.1 Management arrangements

The new standards set out to achieve the following ethos:

- Collaboration: A collaborative approach is essential to continuously improve cleanliness. The standards state that organisations should involve a board nominee, clinical colleagues, partner organisations and patients in setting and monitoring cleaning standards for consistently high levels of service

- Transparency and Assurance: The standards emphasise transparency to assure patients, the public and staff that safe standards of cleanliness have been met. The transparency of audit and reporting methods, display of audit results and the commitment to cleanliness charter provides assurance that an organisation is serious about cleaning

- Infection Prevention and Control: Cleaning is a vital part of the overall infection prevention and control process which aims to provide a clinically clean and safe environment for delivering safe patient care. Safe standards of cleanliness minimises risk to patient safety from inadequate

cleaning. The new standards will be the measure by which we deliver cleaning services into the future

- Continuous Improvement: To encourage continuous improvement the standards combine mandates, guidance, recommendations, and good practice. The new standards will allow organisations to measure performance in a uniform way and to benchmark it against similar organisations. They seek to drive improvements while being flexible enough to meet the different and complex requirements of all healthcare organisations

The Facilities Department provides a once daily baseline clean and an additional rapid response infection control cleaning service, which fully conforms and complies to all current legislation and recommendations. This service is audited using a recognised auditing tool to provide assurance of safe cleanliness standards.

11.2 Cleaning Programme

Domestic Services Team continues to provide a comprehensive range of cleanliness services to support the Trusts IPC agenda. These services include:

- Rapid Response
- Enhanced Cleans
- Hydrogen Peroxide Vaporisation (HPV) programme

Over the past 12 months there has been a significant impact on the continuity and standard of cleanliness achieved due to a more focused scrutiny on the outcomes. Improvements in the overall condition, appearance and maintenance of the environment and improved responsibility and collaboration across the multi-disciplinary groups has resulted in progress that has now started to show results across the hospitals.

During the unprecedented challenges of the COVID-19 pandemic the cleanliness service remained adaptable and high quality. We recognised the requirement for further development of systems and processes to manage the impact of COVID-19 and to maintain safe cleanliness standards throughout the pandemic and winter period. Therefore, we put in measures to support the organisation with the significant challenges ahead and provided assurance of cleanliness outcomes during 2021/22 which was as follows:

- Maximise staffing capacity to provide flexibility to meet the demand and needs of operational service delivery.
- Allocation of domestic hours to support additional COVID-19 enhanced cleaning throughout the Trust.
- Increased cleaning frequency twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.
- Cleaning frequencies of the Care environment in COVID-19 care areas were enhanced and single rooms, cohort areas and clinical rooms cleaned twice daily.

- Patient Flow now allocated the IPC cleans to assist with patient flow.

11.3 Performance Monitoring

To support the assurance of our cleanliness standards the Facilities Department use an industry approved Micad auditing software. It provides our quality control in the form of a visual inspection audit that monitors the quality of cleanliness of all our functional areas across all the responsibility groups of Domestics, Nursing and Estates. These technical audits involve the scoring of 50 elements within each area assessed and generate a score reflecting the standard of cleanliness achieved.

External monitoring

11.4 Patient-Led Inspection Programme (PLACE)

The Patient-led assessment of the care environment (PLACE) is an annual national inspection self-assessment programme, which is managed by NHS Digital on NHS England and NHS Improvement's behalf. The assessments mainly apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors, but other providers are encouraged and helped to participate in the programme. PLACE replaced the longstanding PEAT (patient environment action team) programme in 2013.

Under PLACE, organisations make an in-depth assessment of the non-clinical, patient-related aspects of the care environment for all qualifying inpatient settings. Responses contribute to scores across six domains, including one specifically for 'cleanliness'.

Questions within some of the other domains also relate to cleaning and associated services.

PLACE scores are released as an official statistic, and the results are published to help drive improvements in the care environment. The results show how healthcare organisations are performing both nationally and in relation to similar service providers.

We operate Place Lite within 2021-22 which was a reduced review with no external/patient assessment. The result was 98.49% for Arrowe Park we have been unable to provide a score for Clatterbridge as still awaiting validation.

It is intended to take part in the full place review in 2022-23.

11.5 New cleaning standards

The new National Standards of Healthcare Cleanliness 2021 were worked on within 201-22 and they primarily will encompass all cleaning tasks throughout the NHS regardless of which department is responsible for it. They are based around: being easy to use; freedom within a framework; fit for the future; efficacy of the cleaning process; cleanliness which provides assurance; and transparency of results.

The new standards are an update on the previously available guidance and provide a new framework within which healthcare establishments set out details for providing cleaning services and assessing

'technical' cleanliness. This will ensure that Wirral University Teaching Hospital has a sustainable, effective healthcare cleaning service that will:

- be patient focused
- be achieved through collaboration of all responsibility groups
- provide clarity for all cleanliness responsibility groups to ensure our healthcare environment is clean and safe
- be consistent with infection prevention and control standards and requirements
- have clear objectives that will provide a good foundation for service improvements
- provide a culture of continuous improvement
- provide an agreed and recognisable auditing and monitoring framework

Compliance with these standards will enhance quality assurance systems, meet the requirements of CQC outcome standard Regulation 15, provide benchmarks and output indicators and offer a recognisable auditing and monitoring system and more importantly will be future proof. As an Acute Trust we started implementation from April 22 and it is anticipated that we will have the new standards fully in place by March 2023.

11.6 The Decontamination Unit (Central Equipment Library)

The Decontamination Unit at Wirral University Teaching Hospital Foundation is under the Facilities Management Department covering Arrowe Park and Clatterbridge Hospital Sites.
The service is responsible for the cleaning, decontamination, and processing of non-invasive medical devices alternating mattress cells, covers and cushions.
Recent Capital Investment involving a structural upgrade and new equipment has increased IPC assurance reducing the risk of cross infection and improved environmental hygiene.

The investment has improved redesign in collaboration with Deputy Director of IPC based on HBN 001 Infection Control in the built Environment, areas of improvement are:

- Flow Design- Separate Entry/ Exit
- Delineated work areas for Decontamination and Clean Processing
- Stainless steel decontamination tables and bespoke shelving for devices
- Improved standard operating procedures for staff to follow within defined work areas
- Improved cleaning guidance of medical devices in line with Medical Devices Policy
- Labelling, processing, and storage of medical devices
- Re-introduction of ATP swabbing following mattress decontamination

11.7 New Initiatives

Installation of Otex Decontamination Laundry System planned for April 2022.This system is HTM 01-04 compliant and provides a validated chemical disinfection process by injecting a continuous flow of ozone into every wash cycle. Ozone disinfection system is effective against micro-organisms such as

MRSA E-Coli and C.difficile spores. The Otex system shows a reduction in water and energy costs by 35% in line with NHS Plan for Carbon Reduction and provides validated assurance of Ozone with each wash cycle

11.8 Service Improvements

- Education and Training of the Central Equipment Library Team to support the inspection, cleaning of foam mattresses in line with BHTA 2012.
- Identification of criteria for condemning of foam mattress supporting assurance for audit and working collaboratively with all ward staff.
- Purchase of new Trolleys for the safe transportation of foam mattress

11.9 Water Safety Group (WSG)

A multidisciplinary Water Safety Group (WSG) including Estates & Facilities in conjunction with Microbiology and Infection Prevention continue to meet monthly. The Water safety plan (WSP) is a risk-management approach to water safety and provides assurance that systems are in place to control/minimise the risk of morbidity and mortality due to infections related to water systems. This is achieved through control, monitoring, maintenance and testing of water outlets and water systems as required.

The WSP encompasses all areas of potential risk (*Pseudomonas aeruginosa* and Legionella) about water safety; this includes potable water, hot and cold-water systems, endoscopy waters (AER final rinse waters), hydrotherapy pool, birthing pool waters and renal waters. By employing innovative engineering and risk prevention strategies, leading to local reconfiguration of water system design, the WSG is working to reduce the risks and hazards at the point of provision of the water supply.

The WSG continue to give advice on remedial action when required where water systems or outlets are found to be contaminated and the risk to susceptible patients is increased. This includes an escalation procedure and convening extra ordinary meetings to trouble shoot and instigate remedial actions to reduce risks to patients and staff. This group reports into the Health and Safety Management committee and the Infection Prevention and Control Group.

11.10 Ventilation Safety Group (VSG)

The multidisciplinary Ventilation Safety Group (VSG) comprising of Estates & Facilities in conjunction with Microbiology and Infection Prevention meet monthly to look at the legal and mandatory requirements of ventilation systems in healthcare premises, this includes the design, maintenance, and the operation of ventilation systems. This group reports into the Health and Safety Management committee and the Infection Prevention and Control Group

11.11 Ventilation

Ventilation systems provide thermal comfort to patients and staff, enable the removal of pollutants and odours, provide protection from infection for vulnerable patients and reduce the risk of spread of

infection. Patients and staff have a right to expect that it will be designed, installed, operated, and maintained to standards that will enable it to fulfil its desired functions reliably and safely.

Specialist ventilation systems are used extensively in healthcare premises in many areas to closely control the environment and air movement of the space that it serves to contain, control, and reduce hazards to patients and staff from airborne contaminants. This includes operating departments, intensive care units, isolation suites, pharmacy and sterile supply departments and laboratories.

The sophistication of ventilation systems in healthcare premises is increasing and their importance has been further highlighted since the beginning of the COVID-19 pandemic.
Good indoor ventilation can reduce the risk airborne transmission of SARS-CoV-2 beyond 2 meters. CO2 air monitoring can be used as a proxy to indicate areas of poor ventilation. It can give an of effectiveness of ventilation in a multi-occupancy setting by monitoring levels of CO2 that can build up through exhaled air. It does not provide a direct measure of infection risk, or a direct measurement of ventilation rates.

In 2021, in response to guidance published on how to assess and improve indoor ventilation and after approval by the Ventilation Safety Group, the IPC team conducted a trust wide Co2 monitoring audit of open ward bays. Open bays were prioritised for assessment as these areas are a potentially higher transmission risk as they are multi-occupancy areas, and it is known that most ward bays are naturally ventilated. Doors have been added to the bays since the original building design, which may have an impact on air flow across the bays and wards. Current measures to improve ventilation in these areas is to open windows, which is variable according to time of day and outside temperature.

Six Non-Dispersive Infra-Red (NIDR) CO2 monitoring devices by AirVisual, were purchased to monitor the CO2 levels across 135 areas of the APH Site.

- A low reading of <800units was recorded in 93 of 135 (69%) areas. These areas were adequately ventilated at the time of monitoring
- A medium reading of 800-1499 was recorded in 30 of 135 (22%) of areas. These areas would require improvement in general ventilation.
- A high reading of >1500 units was recorded in 12 of 135 (9%) of areas. This is considered as a high-level requiring intervention.

A longer-term ventilation improvement plan is progress and includes assessment of mechanically ventilated areas. For more immediate mitigation of risk a total of 30 air purifiers have been purchased. The air purifiers purchased use HEPA filters which can reduce the number of potentially infectious particles in the air, thereby reducing the risk of transmission of infection. It must be noted that this intervention does not reduce transmission via close range aerosols and droplets or via fomites.

The audit has enabled identification of potentially poorly ventilated areas and prioritisation of placement of the air purification devices. These devices are also being used to reduce the risk of transmission in bays identified as a SARS-CoV-2 contact risk.

The Water & Ventilation safety groups promote Trust compliance to Criterion 1 and 2 of the Health and Social care Act 2008 which includes 1) Systems to manage and monitor the prevention and control of infection and 2) To provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

12.0 Training Activities

12.1 Infection Prevention Link Practitioners

The IPC Link Practitioner programme was not able to be re-instated due to challenges faced with the ongoing COVID-19 pandemic, this was due to a combination of workload, the limited ability to meet face to face and staff availability due to staff shortages due to sickness. The programme is planned to re-start again in 2022-2023.

12.2 Matrons Developmental Programme

The Matrons Development programme was not able to be continued during 2021-22 for the same reasons listed above. There is a plan to hold monthly collaborative meetings with Matrons and the IPC ADN and Matron in 2022-23 to support their development, share good practice and discuss new initiatives.

12.3 Student Nurse Training

There were no spoke placements arranged for student nurses during 2021-2022 due to the COVID pandemic, however a small handful of students have spent time shadowing the team for several hours over one day. Ad hoc training continued to be provided on the wards when requested or indicated.

12.4 Mandatory Training for Trust Staff

Infection prevention training is mandatory every 18 months for all WUTH staff based in the hospital and the community. Training is accessed online via the E-learning hub, which includes an e-learning Infection Prevention package for all clinical and non-clinical staff. The e-Learning package covers general principles of infection prevention, hand hygiene, the use of PPE and decontamination. The clinical package identifies more detailed information regarding alert organisms and standard precautions.

Evidence of completion of Infection Prevention and Control mandatory training is confirmed at appraisal and monitored at the Monthly IP performance meetings and reported to the Trust Board

The IPC team has continued to provide ad hoc training when visiting wards and departments as required ensuring that the hands-face-space concept was met.

The IP annual training programme comprises of:

Care support worker training

This has continued throughout the year and takes place once per month with reduced numbers in the clinical skills lab maintaining the hands-face-space concept. This is a 2-day programme of Clinical Support Workers Core Skills Course, which is part of the National Care Certificate. The session is an hour which covers general IPC update, hand hygiene, swab and specimen collection, diarrhoea management and mattress check.

The F1 induction programme
One F1 induction session was facilitated over Microsoft teams during 2021 – 2022 and two sessions were delivered face to face in the Undergraduate centre.

Developmental programme for all newly qualified RGNs
This was reduced to once per month with reduced numbers in the clinical skills lab maintaining the hands-face-space concept.

Clinical champion training
As a result of the COVID pandemic in collaboration with clinical skills this has been reduced to quarterly.

International Recruitment
The IPCT have worked in collaboration with the International Recruitment (IR) Pastoral Lead and delivered several IPC sessions to the new IR nurses. This has included face to face teaching, off site venues and via Microsoft teams

Donning and doffing of PPE
Ad-hoc bespoke training targeted at WUTH's COVID response for this has been provided for all wards and departments on a weekly basis and more frequently as and when requested. Videos are also available on the intranet for donning and doffing that staff can access.

12.5 Specific Training

The IPCT have supported bespoke training to departments including the housekeepers, domestic staff, catering teams, pharmacy technicians, IT departments and portering staff.

The team have also supported several campaigns such as 'Sharps Awareness' during Health and Safety week and led on the 'Clean Between' campaign to ensure equipment is being cleaned regularly and in between patients / use.

12.5.1 Hand Hygiene and Aseptic Protocols

Hand hygiene is fundamental to prevent HCAI's and the Trust is committed to striving for and maintaining high standards of hand hygiene from all WUTH employees. All staff receive hand hygiene refresher/update in the mandatory infection prevention training.

The Trust continues to be committed to the:

- Implementation of the 'Bare below the Elbows' initiative.

- Emphasis on the '5 moments for hand hygiene at the point of care' model from the World Health Organisation.
- Daily/weekly/Monthly monitoring of hand hygiene compliance via local departmental audits comprising hand hygiene technique with alcohol gel and liquid soap and water as well as monitoring compliance to hand hygiene opportunities, as per WHO 5 Moments.
- Targeted hand hygiene audits and teaching by members of the IP team, where an increased risk of infection has been identified: a hand hygiene compliance audit is completed by the Infection Prevention Team following the report of a *C.difficile* infection.
- Bespoke hand hygiene training which includes hands on practical training using the light box for specific staff groups such as volunteer groups and non-clinical staff.

Hand hygiene compliance remains a monthly KPI.

12.5.2 Aseptic Non-Touch Technique (ANTT)

The ANTT framework provides a clinical guideline for aseptic technique and is based on a theoretical evidence-based framework (Rowley 2001). Its purpose is to standardise practice and raise clinical standards. It can be applied to any aseptic procedure, such as intravenous therapy, wound care and urinary catheterisation.

ANTT is recognised as the 'gold standard' for aseptic practice and is followed throughout WUTH by members of staff who are required to undertake invasive clinical procedures, including those members of staff who work in the community.

Compliance to mandatory training of ANTT is monitored by Directorates at their monthly IPC meetings and reported monthly at the IPCG.

The table 13 below shows the results of the ANTT training in 2021/22 compared to the previous year.

Table 13

Training	Number of staff trained		Method of delivery
	2021/22	2020/21	
ANTT Train The Trainer	**40**	40	Face to Face training- 3 hour session
ANTT theory	**250**	817	e. Learning video
ANTT practical	**77**	742	Practical training either in Clinical Skills or on wards via Train the Trainers- e.g. 50 mins for theory & practical and demonstration on DP programme
Blood cultures	**7**	18	Face to face training 2 hrs
Catheterisation	**247**	90	Face to face training 3 hrs

12.6 Monthly IPC Newsletter

During 2021-22 the IPC team published 5 newsletters to promote various topics related to IPC

- Hand Hygiene
- Personal Protective Equipment
- Sharps Awareness

- Cleaning
- HCAIs Objectives

Regular newsletters will continue to published during 2022-23 to promote topical issues and aid learning and awareness for all staff.

13.0 Audit

13.1 Audit programme for 2021/22

The audit programme continued to focus on key policies which aim to prevent Health Care Associated Infection (HCAI), based on the Health and Social Care Act (2015).

13.2 IPC Environmental audit

April 2021 - March 2022 was the first year that all inpatient and outpatient departments had an IPC Environmental Audit undertaken, with some wards receiving more than one audit. In total 88 audits were undertaken; 12 areas scored Red, 59 areas scored Amber and 17 areas scored green. Results ranged from 44.4% to 97.8%. Exceptions to the standards are captured in action plans which are managed locally by the Divisions and reported via their monthly IPC directorate meeting.

Table 14- Breakdown of the ward category scores by Division for 2021-22

Table 14

Division	Green	Amber	Red
Medicine	4	14	0
Acute	1	4	1
Surgery	4	13	1
Women's & Children	0	8	2
Clinical Support	2	8	6
Total	**11**	**47**	**10**

13.3 Commode audit

Owing to the COVID pandemic a Trust wide commode audit has not been undertaken during 2021-2022, however audits are completed on a regular basis via the Tendable app by the ward staff. Ad hoc audits are completed by the IPC team following a patient being diagnosed with *C.difficile* toxin or a CD

equivocal result. Audit results are fed back real time for immediate improvement and reported by the Divisions in their exception report at the monthly IPC meetings.

13.4 Sharps audit

This was undertaken by WUTH sharps bin supplier 'Daniels' in March 2022. In total 83 wards/departments were visited, and 379 sharps containers were audited, all bins were found to be properly assembled, and none were more than three quarters full. Some of the learning was regarding

- 1 sharps container had protruding sharps,
- 2 containers had the wrong lid on the wrong base
- 3 sharps containers were found on the floor or at an unsuitable height
- 12 containers were not signed or dated after being assembled
- 13 containers had inappropriate contents
- 5 containers did not have the temporary closure in place when left unattended

The audit findings were reported to the IPCG meeting and the health & safety committee.

13.5 Audits via Tendable app

The following audits are done by the staff on the wards and departments:

- Hand Hygiene audits – undertaken weekly and increased to daily as required
- CPE Checklist – as required
- Personal Protective equipment – at least monthly
- Quick COVID-19 Assessment – as required

13.6 'Saving Lives' High Impact Interventions (HII's)

High Impact intervention care bundles are improvement tools used for monitoring the management of invasive devices and procedures that are associated with a risk of infection, for example peripheral vascular cannulation, urinary catheterisation. These are audited at least monthly in all applicable clinical areas involved. The IPT also undertake spot checks in clinical areas where specific concerns are raised. Compliance to each bundle is monitored by Directorates at local IPC meetings and reported by exception at the monthly IPCG.

The High Impact Interventions on Tendable will be reviewed in 2022-2023 to ensure all key elements are included to maintain standards.

14.0 External Assurance Assessments

There have been none related to Infection Prevention & Control during 2021-2022.

15.0 Policy Development

Progress with reviewing the IPC policies was impacted by the challenges of the senior IPC team and the increased workload with the ongoing COVID-19 pandemic, however three policies were ratified by IPCG in 2021-2022:

- Decontamination of Medical Devices Policy
- *Clostridiidiodes difficile*: prevention and management of infections Policy
- Isolation Policy

A risk assessment was undertaken in November 2021 of the out-of-date policies which did not identify any of the policies to be a significant risk. There are currently 6 policies which are out of date and will be prioritised for review in early 2022-23.

Specific policies relating to Micro-organisms are the responsibility of the Infection Prevention Dr/ Microbiologists to review whilst the Infection prevention 'procedures' policies are the responsibility of the nursing team.

16.0 Infection Prevention & Control Board Assurance Framework

NHSE/I published the first version of the Infection Prevention and Control Board Assurance Framework in 2020. Since this time there have been several published that are updated and refined to reflect the increased learning around COVID-19. The framework, structured around the existing 10 criteria set out in the Infection Prevention Control Code of Practice (2008)and link directly to Regulation 12 of the Health and Social Care Act (2008). The Trust added one additional criteria of 'leadership' in recognition of the important part that this plays in hospital management arrangements.

	IPC BAF Standard
1	Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and risks posed by their environment and other service users.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	The use of antimicrobials to optimise patient outcomes and manage adverse effect.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infection.
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

	IPC BAF local Standard
11	The Trust can demonstrate effective and knowledgeable leadership in relation to IPC at all levels, relevant to roles.

The reporting arrangements for each version have been via the Infection Prevention & Control Group, into PSQB and the Quality Committee, and onto the Board of Directors.
The current version is 1.8 and was published in December 2021

17.0 Quality Improvement.

At the beginning of 2021 IPC joined the quality improvement programme with a project entitled 'Create a health and care system where no person's health and wellbeing is harmed by a preventable infection'. The project lead was the Deputy DIPC and the executive sponsor the Chief Nurse/DIPC. The project Charter was created in April 2021 with support of the Quality Improvement Lead; however this covered all aspects of IPC and was deemed to be too broad. In November 2021 the Project Charter was refined to focus on *C.difficile* only. Three wards were identified to support the IPC QI Project; AMU, Ward 18 and Ward 21, and regular meetings were held to identify a specific project and follow the Plan, Do, Study, Act (PDSA) methodology with support of the new QI Lead.

The QI programme will continue in 2022-23 with a plan to recruit other wards to do similar projects to support a reduction in hospital associated *C.difficile* cases.

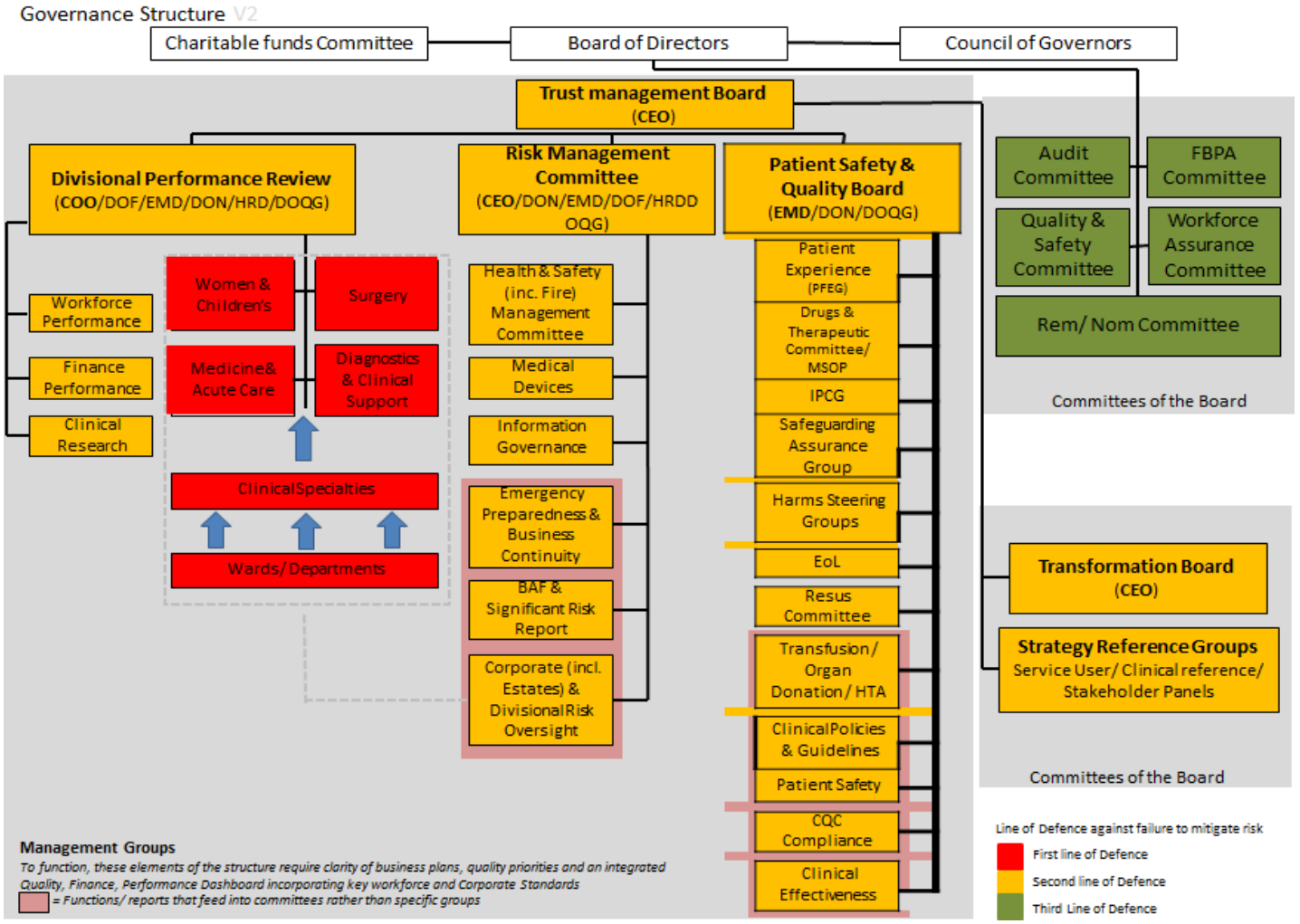
18.0 Conclusion

The above report details annual infection prevention & control activities in 2020/21 as reported to the monthly IPCG and the forward Infection Prevention & Control plan for 2022/23. The infection control programme aims to continuously review and build on existing activity, driven by local needs, while incorporating and complying with the latest NHSE/I and UKHSA guidance and other relevant strategies and regulations pertaining to IPC.

Jay Turner-Gardner
Associate Director of Nursing - Infection Prevention & Control
Deputy Director of Infection and Prevention and Control

APPENDIX 1

Governance Structure



APPENDIX 2

Infection Prevention and Control Group
Terms of Reference

1. CONSTITUTION

The Infection Prevention & Control group is authorised to formulate recommendations for Infection Prevention and Control within the Trust and reports to Trust board via PSQB to the Quality Assurance Committee. The Infection Prevention & Control Group is chaired by the Director of Infection Prevention and Control (DIPC), who is the Chief Nurse. The deputy chair is the Associate director of Nursing –Infection Prevention and Control who is also the deputy DIPC.

2. CORE MEMBERSHIP

- Chief Nurse / Director of Infection Prevention and Control (Chair)
- Associate Director of Nursing – Infection Prevention & Control/Deputy DIPC
- Consultant Microbiologist/Infection Control Doctor
- Clinical Scientist – Environmental microbiology
- Infection Prevention and Control data analyst
- Divisional Directors of Nursing
- Occupational health representative
- Antimicrobial Pharmacist
- Associate Director of Governance
- Director of Estates and Facilities
- Trust Decontamination lead
- Consultant in Public Health (PHE)
- Wirral Community Health and Care NHS Foundation Trust representative (WCHC)

CLINICAL LEADS FROM DIVISIONS

- Surgery Representative
- Women & Children representative
- Medicine and Acute representative
- Diagnostics and Clinical support representative

3. QUORUM

In order for decisions taken by the committee to be valid, the meeting must be quorate. This will consist of a minimum of 6 members from the core including the Director of Infection Prevention and control (or nominated deputy) and the Infection Prevention and control Doctor and the Associate Director of Nursing Infection Prevention and Control, including 1 representative from each division.

4. ATTENDANCE AT MEETINGS

The Infection Control Group may require from time to time, the attendance of

any Trust employee (or agent of the Trust) to attend the committee at the request of the Chair.

5. FREQUENCY OF MEETING

The Infection Prevention and Control Group will meet every month. (12 times Per year)

6. OVERVIEW

The Infection Control Group is a sub –Committee of the Patient Safety and Quality Board (PSQB) and develops and monitors the core Infection Prevention and Control strategic objectives. The core objectives are agreed by the Trust Board and are based on WUTH organisational priorities. The Trust IPCG will oversee and monitor the operational IPC programme.

7. SCOPE AND DUTIES

Oversee and directs all Infection Prevention and Control activity within the Trust and provide the Chief Executive with relevant information and advice.

Interpret and advise on national Infection Prevention and Control policy, relating it to the local situation.

Ensure NHS core standards and Department of Health recommendations on infection prevention and control are implemented

Review infection surveillance data, monitor performance and make recommendations for further action

Introduce, maintain and approve infection prevention and control policies and guidelines that promote a safe quality patient experience

Advise the Trust on its statutory requirements in relation to Infection Prevention and Control and the decontamination of medical and surgical equipment, e.g. Health Act 2008.

Ensure that training and supervision systems regarding Infection Prevention and Control are in place for all staff and contractors working within the Trust and that those systems are regularly monitored by their management Teams

Recommend an annual infection prevention and control programme; monitor and review the progress of the programme and produce an annual report Members of the IPCG are expected to actively participate in discussions pertaining to IPCC ensuring that solutions and action plans have Multidisciplinary perspectives and have considered the impact across all of the Directorates and

departments.

Members have a responsibility to disseminate the minutes from this meeting within the relevant departments and organisations and inform them of issues discussed.

Members have a responsibility to share the learning gained from IPCG within their divisions and departments to ensure that organisational learning occurs.

Members have a responsibility to Communicate to the IPCG risk issues and solutions discussed in the departments/organisational meetings to support the organisational learning.

Members have a responsibility to Present to the IPCG divisional/departmental progress with reducing directorate/ departmental risks.

8. ORGANISATION

The IPCG is serviced by the Associate Director of Nursing – Infection Prevention and Control's Secretary /Admin support who organises the meetings.

The Associate Director of Nursing – Infection Prevention and Control / Deputy DIPC will on behalf of the DIPC be responsible for the compilation of an agenda prior to each meeting.

A quarterly chairs report will be submitted to the PSQB prepared by the deputy DIPC and an assurance report submitted monthly.

The Minutes of the Decontamination group, Antimicrobial Stewardship group, Ventilation safety group and Monthly Divisional IP&C meetings will be considered at each meeting.

Estates & Facilities will provide Quarterly summaries regarding activities as Stated in criterion 1 and 2 of the Health and Social Care Act 2008

The ToR for the group will be review annually.

10. VERSION CONTROL

Version Control	Date	Comments
V1	August 2020	

11. DOCUMENT OWNER

Infection Prevention and Control Secretary / Team Administrator

APPENDIX 3

Annual Infection Prevention Audit Programme
2022/2023

Delivery of this audit plan is to support the Trust in meeting the NHS Commissioning Boards delivery of 'zero tolerance on MRSA bloodstream infection' and provider objectives for *Clostridium difficile* as set out in the *Clostridium difficile* infection objectives for NHS organisations in 2019/20 and guidance on sanction implementation. It also supports local compliance with the Health Act (2012), *'Saving Lives'* (2011) and Care Quality Commission standards.

	Audit topic	*Frequency*	*Where identified*	*Where reported*	*Responsibility*	*Lead*
1	Hand Hygiene (compliance & technique)	Weekly increasing to daily if required	IP Audit plan Directorate Action Plan Tendable app	Directorate Governance meetings Monthly Infection Prevention & Control Group meetings *Clostridium difficile*, Bacteraemia & COVID RCA proforma	Directorate	Ward/ Departmental Managers
2	Environmental audit	Annual by IPC As required by Directorate	IP Audit plan Directorate Action Plan Tendable app PLACE	Directorate Governance meetings Monthly Infection Prevention Control group meetings *Clostridium difficile* , Bacteraemia & COVID RCA proforma	IPC and Directorate	Ward/ Departmental Managers
3	Patient shared equipment	Monthly	IP Audit plan Directorate Action Plan Tendable app PLACE	Directorate Governance meetings Monthly Infection Prevention & Control Group meetings *Clostridium difficile*, Bacteraemia & COVID RCA proforma	Directorate	Ward/ Departmental Managers
4	Food safety	Monthly	IP Audit plan Tendable app PLACE	Monthly Infection Prevention performance meetings Directorate Governance meetings	Directorate	Ward/ Departmental Managers

5	*'Saving Lives'* High Impact Interventions Numbers 1-7	Monthly/as and when required	IP Audit plan Directorate Action Plan	Monthly Infection Prevention & Control group meeting Directorate Governance meetings *Clostridium difficile*, Bacteraemia & COVID RCA proforma as appropriate	Directorate	Ward/ Departmental Managers
6	Antimicrobial point prevalence audit	Monthly	IP Audit plan Directorate Action Plan Antimicrobial audit plan	Monthly Infection Prevention & Control group meeting Directorate Governance meetings	Pharmacy	Antimicrobial pharmacist
7	Commode audit	Annual	IP Audit plan Directorate Action Plan	Directorate Governance meetings Monthly Infection Prevention & Control group meeting *Clostridium difficile* RCA	Infection Prevention Team	Infection Prevention Team
8	Personal protective equipment	Monthly or more frequently	IP Audit plan Directorate Action Plan	IP Audit plan Directorate Action Plan	Directorate	Ward/ Departmental Managers
9	COVID screening compliance	Daily/ Monthly	IP Audit plan Directorate Action Plan	Infection Prevention & Control group meeting Directorate Governance meetings	Infection Prevention Team	IPC Analyst
10	Quick COVID assessment	As required	IP Audit plan Directorate Action Plan	IP Audit plan Directorate Action Plan	Directorate	Ward/ Departmental Managers
11	Mattress audit	Weekly /Following discharge of a patient	Tendable app	Infection Prevention & Control group meeting Directorate Governance meetings	Directorate	Ward/ Departmental Managers

APPENDIX 4

Infection Prevention Annual Plan 2022/2023

The 2022-2023 IPC annual plan describes the methods that will be used to accomplish the objectives as set out in the 3yr IPC strategy which reflects the

i) The Health and Social Care Act – Code of practice on the prevention and control of infections and related guidance, which sets out the 10 criteria against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements, which is set out in regulations

ii) National and local objectives.

Strategic objective	Action
Objective 1 Training and Education Regulation 12 & 7 (CQC) , Criterion 1 (The Hygiene Code)	• Re-introduce the link nurse programme • Continue to publish the Monthly newsletter on IPC related topics • Develop a monthly shared learning programme for the Matrons • Introduce further e-learing packages and training videos relating to IPC topics
Objective 2 Audit & Surveillance	• Complete mandatory surveillance of all alert organisms (Infections) • Provide timely information to divisions of alert organisms to monitor infections and detect potential outbreaks. • Support timely and effective RCAs • Work with the surgical division to strengthen the SSI strategy and establish an SSI group to develop a surveillance of SSI programme • Facilitate screening compliance reports to the divisions to promote improvements

Regulation 9, Criterion 4	• Work in partnership with commissioners/providers across Wirral to reduce the incidents of all alert organisms • Review IPC audit tools within Tendable to ensure they reflect national standards
Objective 3 Policies & Procedures Regulation 12, Criterion 1 & 9	• Develop a Carbapenemase producing *enterobacteriaceae* (CPE) policy based on national guidance v risk-based benefits to patients • Review the existing MRSA policy to ensure that it meets with the current national guidelines • Collaborative working with key stakeholders in Wirral to develop a Wirral wide IPC collaborative working group • Review the new National IPC manual against WUTH local policies
Objective 4 Care Environment Regulation 15, Criterion 2 & 7	• Regular meetings with Estates and Facilities • Attend water and Ventilation safety groups. • Ensure appropriate IPC representation at all schemes meetings • Ensure appropriate IPC representation at the Decontamination meeting
Objective 5 Communications & Information Regulation 17, Criterion 5	• Ongoing review of the IPC patient information leaflets • Work with the communications team to ensure IPC updates are communicated trust wide • IPC representation at IPC Divisional meetings • Work with information to develop the IPC BI portal
Objective 6 Research & Innovation	• To review and investigate any IPC innovations that can be introduced to support the teams with IPC improvements

Criterion 9	• Support the introduction of new technologies • Work in collaboration with procurement to promote cost effective care delivery. • Continue to support a quality improvement project based on Infection Prevention
Objective 7 Antimicrobial Stewardship Regulation 12, Criterion 3 & 9	• Support attendance at the antimicrobial sub – committee • Review antimicrobial practice as part of the CDI RCA programme • Weekly contribution to the CDI meeting

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 12**

31 August 2022

Title	2021-2022 Annual Submission to NHS England Northwest Appraisal and Revalidation
Area Lead	Dr Catherine Hayle, Medical Appraisal Lead
Authors	Dr Catherine Hayle, Medical Appraisal Lead & Cheryl Chaffe, Medical Professional Standards Lead.
Report for	Ratification

Report Purpose and Recommendations

The purpose of this report is to provide assurance to the Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for quality visits to Designated Bodies.

WUTH has a process in place for appraisal of senior medical staff which is quality assured and compliant with the Annual Organisational Audit (AOA) standards monitored by NHS England. This report refers to the appraisal year April 2021 - March 2022.

It is recommended the Board:

- Ratify the report

Key Risks

This report relates to these key Risks:

- None to note

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
29th July 2022	RO Meeting	2021-2022 Annual Submission to NHS England North West WUTH	All future actions agreed

1	Narrative
1.1	On an annual basis, Designated Bodies have been required to complete an Annual Organisational Audit (AOA) which is an element of the Framework of Quality Assurance for responsible officers. The AOA has been stood down again for the 2021/22 year. The Framework of Quality Assurance (FQA) for responsible officers and revalidation, Annex D: Board Report & Statement of Compliance is not being refreshed nationally therefore local amendments have been made to ensure effective reporting to our Board and provide the necessary assurance to the higher-level responsible officer. Each designated body is expected to submit a report to their own board or equivalent management team; where a Responsible Officer and supporting team have responsibility for more than one designated body, separate reporting is required to ensure each board is sighted on the information specific to their organisation. In essence, one separate report should be completed for each individual Designated Body as registered with the General Medical Council. Attached at Appendix 1 is the report due to be submitted on behalf of WUTH. The report has been designed to: • Help the designated body in its pursuit of quality improvement • Provide the necessary assurance to the higher-level responsible officer, and act as evidence for CQC inspections. • This template for an Annual Submission to NHS England Northwest is used as evidence for the Board of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to own board report where a local template exists, to give clear guidance on the structure, roles and process to deliver an appraisal system which is quality assured and fit for revalidation. Appraisal is underpinned by continuing professional development and if used properly can help to develop a reflective culture within service and training. Regular successful annual appraisal will provide the foundation stone upon which a positive affirmation of continued fitness to practice can be made every five years by the doctor's Responsible Officer to the General Medical Council. For the individual, appraisal is based on the domains in "Good Medical Practice" (General Medical Council) [1]. This describes the standards of competence, care and conduct expected of doctors in all aspects of their professional work. These seven domains are: • good clinical care • maintaining good medical practice • teaching and training • relationship with patients • working with colleagues • probity • health To be revalidated a doctor must collect a folder of supporting information, participate in annual appraisal in the workplace and collect independent feedback from colleagues and patients (where applicable). This multi-source feedback or 360 degree feedback

	must be completed at least once in a 5 year revalidation cycle. The doctor must declare all the roles they have and organisations they work in as the appraisal must cover all aspects of their work (Whole Practice Appraisal). Supporting information must be provided for all roles so that the appraiser can review this. This is the appraisal process which over a five year period will enable the Responsible Officer to make a positive recommendation of fitness to practise to the General Medical Council.
1.2	The statement of compliance should be signed off by the Chief Executive of the Designated Body's Board and submitted by 30 September 2022.

2	**Conclusion**
2.1	This completed document is required to be submitted to NHS England North West by the end of September 2022.

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2021-2022 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Name of organisation:	Wirral University Teaching Hospital, NHS Trust	
	Name	Contact information
Responsible Officer	Dr Nicola Stevenson	n.stevenson2@nhs.net
Medical Director	Dr Nicola Stevenson	n.stevenson2@nhs.net
Medical Appraisal Lead	Dr Catherine Hayle	catherine.hayle@nhs.net
Appraisal & Revalidation Manager	Mrs Cheryl Chaffe	cheryl.chaffe@nhs.net
Additional Useful Contacts	A&R Office	0151 604 7461

Contents

Introduction:

The Annual Organisational Audit has been stood down again for the 2021/22 year. A refreshed approach is planned for 2022/23. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for quality visits to Designated Bodies. These visits are now starting to be planned in again moving forwards.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted to NHS England North West by the end of September 2022 and should be sent to england.nw.hlro@nhs.net

Annual Submission to NHS England North West

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: Ongoing engagement with RO Network events.

Dr Stevenson remains in post. Dr Stevenson has accessed all necessary training and engages regularly with the Responsible Officers Network via NHSE/I North as well as the GMC RO Reference Group.

Action for next year: None

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes

Action from last year: Review of Appraisal & Revalidation Manager role

Following the planned retirement of the previous post holder, a review of the role was completed, and a revised JD developed. Mrs Cheryl Chaffe was appointed into the role, bringing with her nearly 20 years of relevant HR experience. The Appraisal & Revalidation Department establishment now consists of 1.0 WTE Band 7 Medical Professional Standards Lead, 0.7 WTE Band 3 Administrative Assistant, Medical Appraisal Lead (2PA) 3 Senior Appraisers (1PA each)

Appraisal & Revalidation support: WUTH has a system in place for appraisal of senior medical staff which is quality assured. In keeping with national guidance, an electronic appraisal system (L2P) was launched in June 2022 for appraisals from August 2022. This approach will minimise the administrative burden on doctors, as well as providing a comprehensive revalidation dashboard to support the RO and wider team in preparation of revalidation recommendations.

Action for next year: Embed online appraisal platform and amend Senior Medical Staff Appraisal Policy to take account of changes in process.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

2021/2022 update: The Trust Workforce Information Dept provides a monthly starter & leavers report to ensure accuracy. It has been agreed that doctors on nil hours arrangements will only remain connected if they have worked within the Trust during the preceding six weeks. Action for next year. Develop SOPs for managing connections and ensuring timely and robust 'Transfer of Information' (TOI) processes.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

List of relevant policies and date of last review: 2021/2022 update: Senior Medical Staff Appraisal Policy is currently under review with a completion date of 28th February 2023. This has been extended to ensure new processes associated with the implementation of L2P are incorporated, and to allow time for review at Joint Local Negotiating Committee (JLNC). Medical Staff Remediation Policy, currently under review with an anticipated completion date of September 2022. 'Procedure for handling concerns about conduct, performance, and health of Medical & Dental Staff' policy, updated June 2022, to be reviewed June 2025. Disciplinary Policy, updated November 2021, to be reviewed November 2024. Action for next year: Update Senior Medical Staff Appraisal Policy and Remediation Policy within agreed timescales. Both policies will be reviewed at the Responsible Officer Advisory Group (ROAG) and JLNC.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

2021/2022 update: Self-assessment was undertaken in 2018/19 against the Framework for Quality Assurance for Responsible Officers and Revalidation, and all associated actions are now complete.

Action for next year: Repeat this exercise in 2023 once implementation of L2P and review of Senior Medical Staff Appraisal Policy is complete.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

List of relevant policies and date of last review:

2021/2022 update: Agile and trust grade doctors sit within the ARCP system led by Professor Barrett (Director of Medical Education)

The Medical Professional Standards Lead has strong links with the Medical Education Team and attends the ARCP process to review evidence and inform revalidation recommendations.

Action for next year: This group of doctors will be included within the planned SOP for managing connections. Revalidation awareness sessions will be developed to ensure these doctors are aware of revalidation requirements and how the local ARCP process informs revalidation. The process for allocating educational supervisors is under review.

7. Where a Service Level Agreement for External Responsible Officer Services is in place

Describe arrangements for Responsible Officer to report to the Board: Dr Stevenson is also Responsible Officer for Wirral Hospice St John's. An RO Board Report is prepared each year, in collaboration with the Medical Director of Wirral Hospice St John's (Dr Emma Longford). Dr Stevenson visited Wirral Hospice St John's on 16th May 22 to meet with Dr Longford and review the Hospice's clinical governance processes.

Date of last RO report to the Board: 29th November 2021.

Action for next year: An annual report will continue to be developed together with the Hospice Medical Director and submitted to the Hospice Board each year.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

2021/2022 update: Our action from 2020/21 was to explore options and implement an online appraisal platform. This has been done, and appraisals from August 2022 will be conducted using the L2P platform. Medical appraisals have continued throughout the 2021/22 appraisal round, with excellent engagement across all specialties. Feedback on the Appraisal 2020 model has been broadly positive, with the caveat that it has sometimes increased the burden of work for appraisers. The latest 2022 guidance will be adopted within the L2P system in time for our launch in August 2022.

Action for next year: Embed new Appraisal 2022 model within L2P.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

2021/2022 update: Appraisal performance is monitored in real time, and this will be easier to achieve within the L2P platform. The reasons for any missed appraisals are recorded, and timely support is provided by the Medical Appraisal Lead or a Senior Appraiser for doctors who are struggling to engage in the appraisal process. The RO is involved when necessary.

Action for next year: None required

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

List of relevant policies and date of last review:

2021/2022 update: Trust Policy 215 Senior Medical Staff Appraisal Policy. This policy is currently under review to reflect the new electronic system implemented this year. Agreed Policy extension date, 28th February 2023.

Action for next year: Complete policy review and table for discussion and approval at ROAG and JLNC.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Number of available appraisers: 62

2021/2022 update: A further 8 completed training in April 2022.

The Trust holds two Appraiser Training Days per year for new appraisers.

Content for these sessions are regularly reviewed and considered by the senior appraiser team at the monthly departmental meetings.

Action for next year: Adapt content of Appraiser Training Days in keeping with launch of L2P.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

2021/2022 update:

There are several quality assurance and performance measures in place: appraisers receive annual feedback from the doctors they have appraised and are encouraged to attend the Appraiser Support Group meetings. All appraisals are quality assured by a member of the A&R Team during the 'sign-off' process. New appraisers undergo a face-to-face performance review with a senior appraiser after their first three appraisals and are observed once by the A&R Manager.

Within the L2P system there is an appraisal feedback questionnaire. The results of the questionnaires provide information to the Medical Appraisal Lead and Responsible Officer about the quality of the appraisal and provides feedback to help the appraiser reflect on their practice.

Appraiser Refresher Days are provided for appraisers (one full day per year, which we run twice to maximise opportunities for attendance).

Action for next year: Agree content for Appraiser Refresher Days during 2023.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

List of relevant policies and date of last review:

An annual report is presented at Trust Board in September each year, and progress is reviewed monthly at the monthly Responsible Officer's meeting.

Action for next year: Repeat self-assessment against FQA for Responsible Officers and Revalidation in 2023

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2022	390
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**369**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**21**
Total number of agreed exceptions	**3**

Doctors employed on trust-grade contracts (e.g. trust grade doctors / clinical fellows) are provided with an annual local ARCP, which is run by the Director of Medical Education. Of this group 17 out of 75 did not engage with the process.

Section 3 – Revalidation Recommendations to the GMC

7. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Recommendations to the GMC:	
Total number of positive recommendations submitted between 1 April 2021 and 31 March 2022	**54**
Total number of recommendations for deferral submitted between 1 April 2021 and 31 March 2022	**11**

Total number of recommendations for non-engagement submitted between 1 April 2021 and 31 March 2022	**0**
Total number of recommendations submitted after due date between 1 April 2021 and 31 March 2022	**0**

2021/2022 update:

The Medical Appraisal Lead or Senior Appraisers speak to doctors about reasons for deferral and all doctors receive confirmation of their GMC recommendation by email. If ongoing support is required for doctors who have been deferred, this is provided.

Action for next year: No new action required

8. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

2021/2022 update: There were 54 revalidation recommendations and 11 recommendations of deferral in the period April 2021 – March 2022. WUTH's deferral rate was 16.92%, against the national deferral rate of 21.96% reported by the GMC. All revalidation recommendations were completed on time.

One doctor connected to WUTH after their revalidation recommendation was due (the recommendation deadline was therefore missed), and was subsequently deferred. They were recommended within a year of their deferral.

We write to any doctor who is likely to be deferred, and offer to meet with them to discuss this and ensure they understand our local processes and GMC revalidation requirements. If we feel regular senior appraiser support would be of benefit, then this is offered.

Action for next year: No action required

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors. This includes reporting and collation of, for example, complaints, safeguarding concerns and incidents to identify necessity for appropriate intervention at the earliest opportunity.

List of relevant policies and date of last review:

All doctors are encouraged to report clinical incidents and near misses as they arise. A risk management report is produced for each doctor annually and uploaded to the appraisal document in advance. Doctors are required to reflect on any incidents, complaints, or legal claims either in writing, or during a documented discussion in their appraisal meeting.

The Trust has appropriate and established policies in place to deal with fitness to practise concerns. All serious concerns are raised with the RO as per the MHPS Policy who under the RO Regulations must manage concerns about a doctors practice. The RO determines how to proceed, and whether it is necessary to place temporary restrictions on their practice. As part of this process the RO consults with the Responsible Officer Advisory Group that has a Non-Executive Director, Deputy Medical Director and senior HR representation.

Numerous ways now exist in which concerns about a practitioner's performance can be identified; through which remedial and supportive action can be quickly taken before problems become serious or patients harmed; and which need not necessarily require formal investigation or the need to resort to disciplinary procedures.

Advice may also be accessed from the Practitioner Performance Advisory Service (PPA) and the Employment Liaison Advisor (ELA) via the GMC.

Action for next year: None required

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

2021/2022 update: The Trust has in place a Policy 'Procedure for handling concerns about the conduct, performance and health of medical and dental staff' (known as MHPS). This is an agreement between the Trust and the Local Negotiating Committee outlining the Trust's procedure for handling concerns about doctors' and dentists' conduct and capability.

When a concern arises the Trust respond in a way that is consistent with the application of 'just culture principles', which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology is applied that provided for full and careful consideration of context and prevailing factors when determining next steps.

The Appraisal and Revalidation Team are made aware of any concerns regarding an individual doctor during the monthly RO Meeting and they ensure that this is covered during their appraisal.

Furthermore, if required, a letter is sent from the RO requiring the individual to reflect on a specific incident or concern, this is uploaded on to their appraisal documentation.

Action for next year: No action required

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

List of relevant policies and date of last review:

2021/2022 update: List of relevant policies and date of last review:

Procedure for handling concerns about conduct, performance, and health of Medical and Dental staff – reviewed and up dated May 2022

Medical Staff Remediation Policy (Medical Staff) – published in April 2016 and is currently under review.

Action for next year: Complete review of Remediation Policy

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Outline arrangements and frequency for reporting to the Board:

2021/2022 update: The Procedure for Handling Concerns about the Conduct, Performance and Health of Medical and Dental Staff (known as MHPS) has been reviewed and updated. The revised MHPS Procedure was formally ratified at the Workforce Assurance Committee (WAC) in May 2022. The policy sets out the role of the RO and the Advisory Group. The policy is consistent with the application of 'just culture principles'.

The RO Advisory Group meets quarterly. There is currently only one MHPS investigation ongoing. With such low numbers meaningful analysis is not possible.

Action for next year: No action required

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

2021/2022 update: Procedure agreed and in place using the National Medical Practice Information Transfer Form (MPIT – Form)

Information is obtained from Workforce Information to support the National Medical Practice Information Transfer Form (MPIT – Form) to complete the Transfer of information (ToI) within the agreed timeframes.

Action for next year: Maintain current process and describe within an SOP

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

2021/2022 update:

All serious concerns are raised with the RO as per the MHPS Policy and discussed at the Responsible Officer Advisory Group (ROAG). The Trust MHPS Policy was recently updated in May 2022 and is consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology is applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

Formal meetings are supported by HR for example support management to ensure reasonable adjustment are in places as required and help identify and remove barriers which may impact on engagement. Policies and practices are also reviewed in line with current and emerging EDI challenges and risks.

Action for next year: No action required

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

List of relevant policies and date of last review:

WUTH adheres to NHS Employers recruitment guidelines and vetting check requirements (as detailed in the Safe Employment Policy); after interview all employment offers are made on a conditional basis so that all checks are completed and verified within the Trust prior to any new starters commencing in post.

Safe Employment Policy 192 sets out the minimum standards for due diligence in terms of safe employment.

All appointments to the organisation are subject to full and rigorous pre-appointment checks that include satisfactory references, occupational health clearance, qualification and professional registration checks, Disclosure & Barring Service (DBS) clearance and the legal right to work in the UK.

Agency workers are sourced through agencies on the HTE or CCS framework which gives us assurance that these workers have met satisfactory checks. Compliance is checked before booking a temporary external worker.

Action for next year: None required

Section 6 – Summary of comments, and overall conclusion

Engagement in medical appraisal has remained strong among consultants and SAS doctors during the 2021/22 appraisal round. Informal feedback has been positive in relation to the MAG (Medical Appraisal Guide) 2020 approach. Awareness of revalidation requirements and engagement in our local ARCP process was lower among trust grade doctors, and this will be key area of focus for the year ahead.

Funding and procurement of a web-based appraisal platform was a priority last year, and from August 2022 appraisals will be documented and stored online using the L2P platform. Another key priority was successful replacement of the Appraisal & Revalidation Manager following retirement of the previous postholder. Recruitment into this role is now complete, and we were delighted to welcome Mrs Cheryl Chaffe into the A&R Team.

In the year ahead, our focus will be on embedding L2P, updating our Senior Medical Staff Appraisal Policy and carrying out a self-assessment against the Framework for Quality Assurance for Responsible Officers and Revalidation. In addition, we will be working with the Director of Medical Education to support trust grade doctors in understanding medical revalidation and the importance of annual engagement in appraisal or ARCP. Bespoke education sessions will be developed for this staff group.

The full list of actions for 2022/23 is as follows:

- Embed online appraisal platform (L2P)
- Develop SOPs for managing connections and ensuring timely and robust 'Transfer of Information' (TOI) processes.
- Update Senior Medical Staff Appraisal Policy and Remediation Policy within agreed timescales. Both policies will be reviewed at the Responsible Officer Advisory Group (ROAG) and JLNC.
- Repeat self-assessment against the Framework for Quality Assurance for Responsible Officers and Revalidation during 2023, once implementation of L2P and review of Senior Medical Staff Appraisal Policy is complete.
- Agile and trust grade doctors: this staff group will be included within the planned SOP for managing connections. Revalidation awareness sessions will be developed to ensure these doctors are aware of revalidation requirements and how the local ARCP process informs revalidation. The process for allocating educational supervisors is under review.
- An annual report will continue to be developed together with the Hospice Medical Director and submitted to the Hospice Board each year.
- Adapt content of New Appraiser Training Days in keeping with launch of L2P.
- Agree content for Appraiser Refresher Days during 2023.
- Complete review of Remediation Policy

Overall conclusion: Despite the ongoing and unprecedented clinical pressures faced, medical appraisal processes remain strong within WUTH, with excellent rates of compliance and below average revalidation deferrals. We look forward to the year ahead with clear objectives and strong foundations on which to build ongoing progress.

Section 7 – Statement of Compliance:

The Board of Wirral University Teaching Hospitals NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Wirral University Teaching Hospital, NHS Foundation Trust.

Name: _ _ _ _ _ _ _ _ _ _ _ _

Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 13**

31 August 2022

Title	Governance and Committee Membership Update
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 a suite of governance documents to strengthen the governance arrangements in place, and to propose new membership for the Board Assurance Committees and new Board Champions, following the retirement of John Sullivan, and the appointment of Lesley Davies and Rajan Madhok.

It is recommended that the Board:

- Notes the Governor role profile and approves the remaining role profiles.
- Notes and provides feedback on the Terms of Reference; and
- Approves the revised membership of Committees and Board champions.

Key Risks

This report relates to these key Risks:

- The Trust should ensure that there is robust governance processes and documentation in place to support effective decision making and delivery of objectives.

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
1st December 2021	Board of Directors	Committee Membership and NED Portfolios	Approval of interim arrangements for Champion roles, and approval of Champion role profile.

1	Narrative
1.1	**Terms of Reference** As part of the wider governance review, a full refresh has been undertaken on all terms of reference for Board Assurance Committees. These have been reviewed with lead Executives, and with the Chair of each Committee, and are included in the report at Appendix 1. The documents should be viewed as a starting point, as Terms of Reference can and should be live documents that change as operations and challenges change. There may be new duties that will become clear over time, or the Board may ask a committee to take on another delegation. The implementation of the Accountability Framework and associated reporting structure may also highlight further areas that Board level Committees may need to review. These Terms of Reference will therefore remain under constant review and will be updated as time goes on. The Board are asked to feedback any comments on these documents to the Board Secretary, and to note that these will be taken through each of the Committees before being re-submitted to Board for approval at their next meeting.
1.2	**Role Profiles** A number of new role profiles have also been drafted, to support various roles across the corporate governance function. These are: • Chair • SID • Non-Executive Director • Committee Chair • Governor (included for feedback and noting) These are all included at Appendix 2 for comment. There is also a Board Champion role profile, which was presented in December this year, and which has been slightly refreshed to align the template and language. The Board are asked to provide feedback on these profiles and approve them. It should be noted that the Governor role profile will be submitted for approval to the October Council of Governors meeting.
1.3	**Committee Membership** Board will be aware that since Jayne Coulson's resignation and John Sullivan's retirement, there are a number of vacancies in Committee membership. The table below outlines the current roles along with vacancies and proposals for appointment to those roles, including membership of the newly established Research and Innovation Committee – all proposed changes have been highlighted:

Committee	NEDs Required by TORS	Current Membership	Proposed Membership
Audit and Risk Committee *NED only committee	3	Steve Igoe (Chair) NED Vacancy NED Vacancy	Steve Igoe (Chair) Rajan Madhok Chris Clarkson
Estates and Capital Committee	4	Sir David Henshaw (Chair) Chris Clarkson Sue Lorimer Steve Igoe Chief Executive Chief Finance Officer Chief Operating Officer Chief Strategy Officer	No change proposed
Charitable Funds Committee	3	Sue Lorimer (Chair) Steve Ryan NED Vacancy Chief Finance Officer Medical Director Chief Nurse	Sue Lorimer (Chair) Steve Ryan Lesley Davies Chief Finance Officer Chief People Officer ~~Medical Director~~ ~~Chief Nurse~~
Finance Business Performance Committee	3	Sue Lorimer (Chair) Steve Ryan Chris Clarkson Chief Finance Officer Chief Operating Officer Chief Nurse Medical Director	Sue Lorimer (Chair) Steve Ryan Chris Clarkson Chief Finance Officer Chief Operating Officer Chief Strategy Officer ~~Chief Nurse~~ ~~Medical Director~~
Research and Innovation Committee	TBC	N/A	Sir David Henshaw (Chair) Rajan Madhok Lesley Davies Steve Ryan Medical Director Chief Strategy Officer
Quality Committee	3	Steve Ryan (Chair) Chris Clarkson Steve Igoe	Steve Ryan (Chair) Chris Clarkson Steve Igoe Medical Director Chief Nurse Chief People Officer
People Committee	3	NED Vacancy (Chair) Chris Clarkson NED Vacancy	Lesley Davies (Chair) Chris Clarkson Rajan Madhok Chief People Officer Chief Nurse Chief Operating Officer

1.4 **Board Champions**

There are a number of NED champion roles in the trust, and these were last refreshed in December 2021. As part of that approval, it was noted that the Champion appointments would be reviewed following the completion of the NED recruitment exercise.

	The table below outlines the current Champion roles along with vacancies and proposals for appointment to those roles:

Board Champions and Roles	Current	Proposed
Wellbeing Guardian	Vacancy	Lesley Davies
Security Champion	Vacancy	Lesley Davies
Procurement Champions	~~Steve Igoe~~ Sue Lorimer	
CNST (Maternity) Champion	Steve Ryan	
Cyber Security Champion	Vacancy	Chris Clarkson
Emergency Preparedness EPPR Champion	Chris Clarkson	
Freedom to Speak Up Champion	Steve Igoe	

2	Implications
2.1	The Assurance Committees require sufficient membership to effectively discharge their duties and provide assurance to the Board, and the roles of individuals on those Committees and in key governance roles should be clearly defined and structured to support those undertaking them and to provide clarity around their scope. Clear terms of reference will support effective decision making and good governance.

3	Conclusion
3.1	It is recommended that the Board approve the suite of documents and the membership proposals as outlined in the paper.

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

Wirral University Teaching Hospital
NHS Foundation Trust

Audit and Risk Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: September 2023
Issue Date: October 2022
Version: 1.0
Authorisation Date: TBD

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to ensure effective governance in respect of annual reporting, strategic risk oversight, and the amendment of governance documents. The Committee will also seek assurance that the Trust has robust systems and controls in place via an internal and external audit programme.

The Committee is a Non-executive Committee of the Board and has no powers other than those specifically delegated in these Terms of Reference.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The role of the Committee will be to take a wide responsibility for the overarching scrutiny for the Trust's risk and assurance structures and processes which affect all aspects of the Trust's business.

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Governance, Risk Management and Internal Control:

3.1.1 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. This includes reviewing the effectiveness of the organisation's committee structure.

3.1.2 To review the adequacy of all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

3.1.3 To review the adequacy of underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

3.1.4 To review the adequacy of policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

3.1.5 To review the adequacy of policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect.

3.1.6 To review the integrity of the statutory financial statements of the Trust and any formal announcements relating to the Trust's financial performance, reviewing statutory financial reports and judgements contained therein.

3.1.7 To review the adequacy of annual plans / reports from the Local Counter Fraud Specialist and the Local Security Management Specialist.

3.1.8 To satisfy itself that the organisation has adequate arrangements in place for countering fraud and reviewing the outcomes of counter fraud work.

3.1.9 To review on behalf of the Board of Directors the operation of, and proposed changes to the Governance manual including standing financial instructions, scheme of delegation, the constitution, codes of conduct and standards of business conduct; including maintenance of registers.

3.1.10 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

3.2 Internal Audit:

3.2.1 The Committee shall ensure that there is an effective Internal Audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

3.2.2 This will be achieved by:

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- review and approval of the Internal Audit charter, strategy, audit operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- consideration of the major findings of internal audit work, management's response and progress on the implementation of recommendations;
- ensuring co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring adequate independent assurances are provided; and
- annual review of the effectiveness of internal audit.

3.2.3 The Committee will involve the Chief Finance Officer in the selection process of the Internal Auditor.

3.2.4 The internal auditors will have a right of access to the Chair of the Audit and Risk Committee.

3.3 External Audit:

3.3.1 To make a recommendation on behalf of the Committee to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor . To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

3.3.2 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

3.3.3 To assess the external auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

3.3.4 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor.

3.3.5 To review external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

3.3.6 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

3.3.7 To receive a statutory report and opinion on the annual report and accounts.

3.4 Other Assurance Functions

3.4.1 The Committee shall review the findings of other assurance functions, both internal and external to the organisation, and consider any governance implications.

3.4.2 These will include, but will not be limited to, any reviews by Department of Health arms length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.).

3.4.3 In addition, the Committee will work closely with the other Committees and be informed particularly on the work of risk through regular updates from the Risk Management Committee.

3.4.4 The Audit Committee will satisfy itself on the assurance that can be gained from the clinical audit function. This includes a review of the clinical audit plan and its effectiveness.

3.4.5 The Committee will review on an annual basis the the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

3.5 Annual Accounts Review

3.5.1 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. At this time the Committee will also receive the Annual Report which summarises the outcome of the external audit. This review will cover but is not limited to:

- The rigour with which the Auditor has undertaken the audit;
- the meaning and significance of the figures, notes and significant changes;
- areas where judgment has been exercised;
- changes in, and compliance with, accounting policies and practices;
- explanation of estimates or provisions having material effect;
- the schedule of losses and special payments;
- any unadjusted statements;
- any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved; and
- letter of representation.

3.5.2 To annually review the accounting policies of the Trust and make appropriate recommendations to the Board of Directors.

3.5.3 To review the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

3.5.4 The Committee will also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.6 Other

3.6.1 To examine any other matter referred to the Committee by the Board of Directors and to initiate investigation as determined by the Committee.

3.6.2 To ensure the effective use of the Board Assurance Framework to guide the Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions and reports and assurances sought from Directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference.

3.6.3 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

3.6.4 To support, if and when required, the collaborative work that the Board undertakes with the ICS

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Non-Executive Director (Chair)
- 2 other Non-Executive Directors

Members will be appointed by the Board from amongst the Non-Executive Directors of the Trust (excluding the Chairman) and at least one member shall have recent and relevant financial experience.

The composition of the Committee should be given in the Trust's Annual Report.

6. Attendance

Attendance (in a non-voting capacity) will also be expected from the following members of the Trust:

- Chief Finance Officer
- Director of Corporate Affairs

Other senior managers will attend when they have papers to present or when the Committee is discussing areas of risk or operation that are the responsibility of that Director/officer.

The Chief Executive will be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Attendance is also anticipated from Internal and External Auditors and the Local Counter Fraud Specialist.

The Director of Corporate Affairs will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chairman and committee members.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where non-voting members are unable to attend, they should send a designated nominated deputy.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

A quorum shall be two members.

Meetings shall be held as required but not less than four times per year. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

The Internal or External Auditors may request additional meetings if they consider such a meeting necessary.

Both the Internal and External auditors shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

The Trust's Annual Report shall include a section describing the work of the Audit Committee in discharging its responsibilities.

10. Conduct of Meetings

The agenda and supporting papers will be sent out four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Charitable Funds Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution** **Charities Act 2011** **Trustee Act 2000** **Charity Treasury Management Policy** **Charities Act 1992 "Controlling of Fund-Raising"**

Review Date: Sepember 2023
Issue Date: October 2017
Version: 2.0
Authorisation Date:

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors in order to ensure that the Trust's duty as Corporate Trustee of its Charitable Funds has been discharged. Its purpose is to oversee management, investment and use of charitable funds within regulations provided by the Charity Commission and ensures compliance with charity law, including responsibility for the charity's fundraising activities. It does not remove from the Board the overall responsibility and legal obligation for this area, but provides a forum for a more detailed consideration of charitable matters.

The Charitable Funds Committee has delegated responsibility, from the Corporate Trustee, within the limits set out in these Terms of Reference, the charitable funds sections of the Scheme of Reservation and Delegations and Standing Financial Instructions for the efficient governance and running of the Wirral University Teaching Hospital (WUTH) Charity.

2. Authority

The Charitable Funds Committee has delegated authority from the Corporate Trustee to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to cooperate with any request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources. The committee has delegated authority from the Board to:

i) Maintain the Charity's governing document and registration with the Charity Commission.

ii) Review and advise on those aspects of Standing Orders and Standing Financial Instructions that appertain to the charity and its operation.
iii) Apply all charitable funds in accordance with the NHS Acts, Charities Act 2011 and good practice (including but not limited to WUTH Charity Expenditure Policy) and ensure that decisions on the use of investments of such funds are restricted to the explicit conditions or purpose of each donation, bequest or grant.
iv) Make decisions involving the use of charitable funds for investments subject to the powers laid down in the "Declaration of Trust" and with regard to the "Trustee Act 2000" and any subsequent legislation.
v) Consider the appointment of investment advisors and monitor the performance of the charitable fund portfolio and consider changes when deemed necessary.
vi) To oversee the Investment Policy of the Charitable Funds as required by the Trustee Investment Act 1961 and the NHS Acts.
vii) Act as the control mechanism for any approved fundraising appeals which may be initiated and to be aligned to the Charity Income and Fundraising Guidance Policy. Appointment and control of fundraisers will be in line with regulations and guidance contained in part 2 of the Charities Act 1992 "Controlling of Fundraising" and subsequent legislation.
viii) Oversee and monitor the functions with regards to the investment, accounting and reporting on the use of charitable funds.
ix) Receive Annual Accounts and Annual Reports of the Trust's charitable funds for consideration and recommendation for final approval to the Board of Directors.
x) To develop the strategy, policies and objectives for the Charity for consideration and approval by the Corporate Trustee.

3. Objectives

Act as the Committee that discharges the Board's responsibilities (as sole Corporate Trustee) as they relate to Charitable Funds under the Trust's custodianship.

3.1 Risk

3.1.1 To ensure that unacceptable risks and inadequate levels of assurance related to financial performance of the Charitable Fund or associated investments are reported to the Board for consideration.

3.2 Statutory duties

3.2.1 Ensure the approval and submission of statutory returns, annual accounts and Trustee's Report in accordance with the Charity Commissions Statement of Recommended Practice.
3.2.2 Review and update annually these Terms of Reference, recommending any changes to the Board of Directors.
3.2.3 Invest and apply the income, funds and property of the Charity in accordance with the governing document and complies with all legal relevant requirements including the Charity Act 2016 and agreed expenditure policy.
3.2.4 Maintain the solvency and continuing effectiveness of the Charity.
3.2.5 Safeguard permanent endowments.
3.2.6 Evaluate its own membership and performance on an annual basis and report findings to the Board of Directors.

3.3 Other Duties

3.3.1 Invest and review the investment funds not needed for immediate applications, in accordance with the Charity's investment objectives and the principles outlined in the Trust's Investment Policy.
3.3.2 Monitor the performance of fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met.
3.3.3 Review and monitor the effectiveness derived from grants of money and property to the Trust.
3.3.4 Operate a visible and transparent decision making process for grants of money and property.

3.4 Governance

3.4.1 Ratify and review policies and procedures required for effective management of the Charity. This will incorporate oversight of associated compliance arrangements such as those required by the Charity Commission.
3.4.2 Ensure the Charity Treasury Management Policy is adhered to when considering related actions.
3.4.3 Give the Board assurance on an annual basis that the systems, policies and procedures they have put in place to deliver Charitable Funds plans are operating in compliance with appropriate standards, are effective, are focused on key risks and are driving the delivery of the Trust's objectives.
3.4.4 Consider, interpret and disseminate guidance from relevant bodies including the Charity Commission and other regulatory/advisory bodies relating to the Charitable Funds agenda.
3.4.5 Approve the establishment, work plans, duration and effectiveness of sub-committees and working groups.
3.4.6 Respond to action plans referred by the Audit Committee.
3.4.7 To support, if and when required, the collaborative work that the Board undertakes with the ICS

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Nominated Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Chief Finance Officer
- Chief People Officer

6. Attendance

Meetings of the Committee may be attended by:

Assistant Director of Finance (Financial Services)
Head of Fundraising
Director of Communication and Engagement
Director of Corporate Affairs

Either the Medical Director or Chief Nurse, or their deputy.

A nominated lay person, with appropriate experience, may attend upon invitation by the Chair.

Other officers of the Trust will be invited to attend on an ad-hoc basis to present papers or to advise the committee. Professional advisors regarding investments may be invited to attend, when deemed necessary.

The Trust Chair and all Non-Executive Directors have a right to attend the Committee.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Chair.

Where members are unable to attend they should consider sending a designated nominated deputy.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be three members, to include the Chair (or nominated deputy) and one Executive Lead/member of the Senior Management Team.

The Committee will meet at least four times a year. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

9. Reporting

The Committee will report to the Board following each meeting via a Chair's report and will present a comprehensive annual report to the Corporate Trustee.

The are no groups reporting to this Committee.

10. Conduct of Meetings

The agenda and supporting papers will be sent out four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Estates,Capital and Safety Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: September 2023
Issue Date: October 2020
Version: 2.0
Authorisation Date:

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to seek assurance with regards to the design, development and delivery of the Trust's capital programmes, and health and safety monitoring and compliance.

This includes the financial and operational delivery of capital programmes and development of future capital and estates plans, within the context of the requisite licence regulatory requirements and statutory obligations. This is a Non-Executive chaired committee.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to cooperate with any reasonable request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources within the delegated limits of the Committees members.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk and Assurance

3.1.1 To receive, monitor and seek assurance on risks relating to capital, estates, and estates related safety management, referred in accordance with the Risk Management Strategy
3.1.2 To review the policies and risks associated with estates and capital related to maintenance, health and safety, fire, security, and other related areas.
3.1.3 To receive audit reports and action plans as relate to capital and estates management areas
3.1.4 To agree a set of key performance indicators for the assessment of capital programmes, estates delivery, and health and safety compliance.
3.1.5 Review or undertake a "Deep dive" into areas of concern raised by the Board at the preceding meeting with a view to providing assurance to a subsequent Board meetings.

3.2 Estates Management

3.2.1 Ratify and review policies required for effective management the estates function andcompliance across the Trust, and where appropriate delegate responsibility for this to associated groups and respond to requests which come from those groups
3.2.2 Approval of the Campus Master Plans and strategies for estates and capital
3.2.3 To keep under review the land holdings of the Trust, advise the Board on acquisitions and disposals and monitor progress against schemes
3.2.4 To monitor capital delivery against plan

3.3 Health and Safety

3.3.1 Ratify and review policies required for effective management the health and safety across the Trust, and where appropriate delegate responsibility for this to associated groups and respond to requests which come from those groups
3.3.2 To approve the Trust's Health and Safety plan, recommending it to the Board for final approval
3.3.3 To monitor health and safety reviews to the annual health and safety plan
3.3.4 To consider any findings of major investigations of internal control over safety critical matters, as delegated by the Board or on the Committee's initiative and management's response
3.3.5 To review the effectiveness of the Trust's frameworks for and to provide scrutiny of occupational health and safety compliance, safety outcomes and achievement of KPI's, safety culture and staff experience/ satisfaction in relation to workplace safety, and any compliance disclosure made or to be made by the Board.

3.4 Capital Programme

3.4.1 Review proposed new developments and investments, undertake due diligence and make recommendations to the Board for approval in line with scheme of delegation.
3.4.2 Ratify and review policies and procedures required for effective management of capital programme
3.4.3 Receive assurance on all aspects of the delivery of capital programme and significant variances to planned levels of achievement.
3.4.4 To monitor the development of capital commercial opportunities across the Trust
3.4.5 To monitor and review business cases associated with major and minor capital developments, and to approve as necessary those business cases that fall within the capital budget;
3.4.6 To approve and recommend to the Board the strategy for capital works, and to monitor the implementation of the capital strategy and annual capital plan

3.5 Other

3.5.1 To support, if and when required, the collaborative work that the Board undertakes with the ICS

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Nominated Non-Executive Director (Chair)
- Three additional nominated Non-Executive Directors
- Chief Executive
- Chief Finance Officer
- Chief Operating Officer
- Chief Strategy Officer

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend they should send a designated nominated deputy.

6. Attendance

Meetings of the Committee may, at the request of the Chair, be attended by:

- Director of Capital Planning, Estates and Facilitites
- Associate Director of Estates (Chief Engineer)
- Director of Corporate Affairs
- Head of Health and Safety

Other officers of the Trust will be invited to attend as requested by the Committee.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be a minimum of four members, including two Non-Executive Directors.

The Committee shall meet as needed and at least 4 times per year.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

10. Conduct of Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Finance Business Performance Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Corporate Governance Manual (including Scheme of Reservation and Delegation and Standing Financial Instructions)**

Review Date: September 2023
Issue Date: October 2017
Version: 4.0
Authorisation Date:

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to seek assurance about the Trust's financial and operational performance, delivery of the in-year plans and the development of future plans within the context of the requisite licence regulatory requirements, statutory obligations and Trust strategy.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individual authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk and Assurance

3.1.1 To review any areas of specific risk or assurance highlighted within the Board Assurance Framework, and make recommendations for amendment if required.
3.1.2 Receive assurance on all aspects of the effective outturn delivery of financial, specified operational performance targets and significant variances to planned levels of achievement.
3.1.3 Review or undertake a "Deep dive" into areas of concern raised by the Board at the preceding meeting with a view to providing assurance to a subsequent Board meeting.

3.2 Financial Management and Assurance

3.2.1 To review the adequacy of the budget setting process and assumptions at Divisional and Corporate Services Level ahead of recommending the financial plan to the Board for approval.
3.2.2 To review the Trust's Financial Plan in accordance with agreed timescales and in line with the Trust's strategic objectives, making appropriate recommendations to the Board of Directors
3.2.3 Consider the robustness of the M12 and year-end out turn ahead of review of the Annual Accounts by the Audit Committee to provide assurance on the reliance of these
3.2.4 To review and recommend business, operational and financial plans to the Board of Directors
3.2.5 To seek assurance of effective due diligence in respect of business cases, approving those within the financial limits delegated and referring those in excess of delegated limits to the Board with recommendations
3.2.6 To consider future options for all non NHS income with specific reference to private patient income and ensure that income derived from activities related to the Trust's principal purpose of the NHS meets the limits as set by national governing bodies
3.2.7 To review, monitor and seek assurance on the achievement of value for money through use of benchmarking data, including reference costs and the work of the model hospital
3.2.8 To monitor and seek assurance on provider to provider and third party contractor SLA's that present a material risk to the organisation.
3.2.9 To review and seek assurance on the development, implementation and clinical engagement in the Service Line Management (SLM) process through Divisional representation.
3.2.10 To seek assurance on the Trust overall cash management position
3.2.11 Review proposed new investments, undertake due diligence and make recommendations to the Board for approval in line with scheme of delegation.

3.3 Performance and Improvement

3.3.1 To monitor the operational financial performance and agree, as necessary, corrective action
3.3.2 To instigate investigation into any aspect of performance that gives cause for concern, providing exception reports to the Board of Directors
3.3.3 To monitor and seek assurance on digitalisation agenda and associated action plans as pertains to its financial implications
3.3.4 To monitor and seek assurance on compliance against the procurement strategy
3.3.5 To monitor and seek assurance on compliance with the Agency Cap focussing particularly on recurrent risks and resource utilisation.

3.3.6 To review, monitor and seek assurance on the financial performance of the Trust including, income, expenditure, activity, oversight framework metrics and contract performance ensuring that actions are taken as necessary to remedy adverse variation
3.3.7 To monitor delivery and seek assurance of the CIP
3.3.8 To review and seek assurance on the capital programme and expenditure as required

3.4 Governance

3.4.1 To review and seek assurance on compliance against relevant legislation
3.4.2 To consider and seek assurance on the implementation and compliance of relevant national guidance, including directives from NHSI, CQC, DHSC, and national and local commissioning guidance where these have a new or significant financial impact on the Trust
3.5.3 To approve the establishment, work plans, duration and ensure the effectiveness of Groups reporting to the Committee
3.5.4 Ratify and review policies required for effective management of financial, performance and business development practice across the Trust
3.5.5 To support, if and when required, the collaborative work that the Board undertakes with the ICS

The Committee will promote a holistic approach to managing risk that will encourage all staff to integrate the management of finance into achieving their objectives in order to provide safe, effective, timely and efficient care to patients.

The Committee Chair and Chief Finance Officer will work with the Executive Management Team and Board to integrate clinical, financial and organisational governance and risk management processes and systems.

The Committee will work with other Committees including the Audit Committee to provide assurances required to support the Annual Governance statement.

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Nominated Non-Executive Director (Chair)
- Two additional nominated Non-Executive Directors
- Chief Finance Officer (Nominated Deputy – Deputy Chief Finance Officer)
- Chief Operating Officer
- Chief Strategy Officer

6. Attendance

The following officers will attend the Committee:

- Board Secretary
- Director of Quality & Governance

- Deputy Chief Finance Officer
- Either the Medical Director or Chief Nurse, or their deputy.

Other officers of the trust will be invited to attend as requested by the Committee.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend they should send a designated nominated deputy.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance they will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be four members, to include two Non Executive Directors, and the Chief Finance Officer (or Nominated Deputy).

The Committee shall meet as needed and at least 4 times annually.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

10. Conduct of Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

People Committee
Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: Sepember 2023
Issue Date:
Version: 1.0
Authorisation Date:

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors in order to ensure effective governance in respect of the delivery of the People Strategy and other workforce-related initiatives, and the strategic monitoring of people-related issues. The Committee will also seek assurance that the Trust has robust systems and processes to deliver a positive working environment to in turn deliver safe and high quality patient care.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk and Assurance

3.1.1 To monitor internal workforce performance indicators on behalf of the Board of Directors and report to the Board via the integrated performance report and on an exception basis;

3.1.2 To monitor and review the risks associated with the people agenda, workforce issues, and strategy as set out in the BAF, and recommend any new risks to the Board for inclusion;

3.1.3 To monitor progress on the Internal Audit Report actions that are relevant to workforce – related risks and provide progress updates to Audit Committee.

3.2 Strategy and Policy

3.2.1 To inform the direction and priorities for the development of workforce strategies, including approval of the Trust's People Strategy and monitoring its effectiveness on an ongoing basis.

3.2.2 To review the annual staff survey report against the Trust's People Strategy, monitor progress and outcomes, and advise the Board.

3.2.3 To influence and drive improvements across the integrated workforce agenda, working with our partners across health and social care.

3.3 Regulation

3.3.1 To receive and monitor the implementation of Equality and Delivery statutory delegations under the single Equality Duty (2011). These include annual review of the Equality Delivery system, Equality Duty Assurance Report, Workforce Race Equality Standard (WRES) and other relevant reports. The Committee is to act as the Trust's champion for all workforce-related Equality and Diversity issues.

3.3.2 To receive the annual report from the Freedom to Speak-Up Guardian.

3.3.3 To receive the quarterly reports from the Guardian of Safe Working.

3.4 Workforce

3.4.1 To oversee and monitor the evolution of a positive, forward thinking, people-focused culture in the Trust, including the embedding of just and learning culture principles. This will include consideration of the experiences of our staff and how we engage with them, and will be underpinned by a focus on Trust values.

3.5 Other

3.5.1 To support, if and when required, the collaborative work that the Board undertakes with the ICS

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Non-Executive Director (Chair)
- 2 other Non- Executive Directors

- Chief People Officer
- Chief Nurse
- Chief Operating Officer

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend they should send a designated nominated deputy.

6. Attendance

Meetings of the Committee may be attended by:

- Deputy Chief People Officer
- Equality and Diversity Lead
- Assistant Director of OD
- Director of Communications
- Head of HR
- Head of Occupational Health and Wellbeing
- Head of Employment Services
- Medical Director or a deputy representing Medical Education
- Governor Representative

The Committee may invite other persons to attend a meeting as required, and the Chair will be informed of these additions where possible prior to the meeting.

7. Conflicts of Interest

Not withstanding the definition of material interests applicable to Directors as set out in the constitution, Executive Directors may not take part in any discussions or decisions which pertain to their own employment or performance.

It will be for the Chair of the Committee to determine whether or not it is appropriate for Directors to be in attendance to advise on these matters. In such circumstances where that person is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be a minimum of four members, including two Non-Executive Directors, and two Executive Directors (or their nominated deputy).

Meetings shall be held as necessary and at least 4 times annually. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

10. Conduct of Committee Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Quality Committee
Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: September 2023
Issue Date: TBC
Version: 1.0
Authorisation Date:

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to provide assurance in relation to clinical quality and effectiveness, patient safety and patient experience (including complaints); the effectiveness of the quality governance framework; and learning and quality improvement. The Committee shall also provide assurance concerning clinical Health and Safety arrangements which ensure a safe environment for patients.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 To review the policies and practices that relate to patient safety and experience, clinical health and safety, and quality governance.

3.2 To review and approve the Trust's Quality Strategy, recommending them to the Board for final approval

3.3 To provide scrutiny of the Trust's patient safety record, clinical outcomes, patient experience ratings, compliance with fundamental standards of care, and learning effectiveness

3.4 To provide review and recommend the Quality Account/Report to the Board for approval on an annual basis

3.5 To provide to the Board such assurances as it may reasonably require regarding compliance by the Trust with all CQC and other quality regulations or legal obligations to which they are subject. This will include assurance on the outcomes of CQC and other quality related inspections;

3.6 To review the effectiveness of the Trust's frameworks for patient safety, quality governance, and clinical Health and Safety management, including providing scrutiny of risks, operational challenges, resourcing, etc.

3.7 To consider reports following relevant investigations or failures in clinical Health and Safety arrangements and to discuss and agree subsequent ation required to keep residual risk under prudent control

3.8 To monitor and review the BAF, in particular the risks associated with patient safety, quality governance

3.9 To consider any findings of major investigations of internal control over safety critical matters, clinical effectiveness, patient concerns, or clinical health and safety matters

3.10 To consider and review the Trust's compliance with the statutory duty of candour, and to be satisfied that the Trust is being open, honest and effectively engaging and supporting with patient's and relatives who have been victims of moderate or serious harm.

3.11 To be informed of the outcomes of clinical audits and to progress and monitor improvements highlighted by those audits, while acknowledging the role of the Audit Committee in tracking and monitoring the recommendations and risks associated with those recommendations. The Committee may also be informed and/or consulted on the clinical audit work plan for the internal auditors.

3.12 To review the general approach, nature and scope of the clinical audit programme and reporting obligations before the programme commences including, in particular:

- the nature of any significant unresolved findings or reservations arising from interim reviews,
- major judgemental areas (including all safety critical policies and procedures used by the Trust, the Trust's Quality Governance Framework, and changes thereto)
- all alternative treatments to compliance that have been discussed with management together with the potential ramifications of using those alternatives,
- the nature of any significant adjustments to the Quality Account, compliance with CQC fundamental standards and legal requirements,
- reclassifications or additional disclosures proposed which are significant or which may in the future become a material concern.

3.13 To support, if and when required, the collaborative work that the Board undertakes with the ICS

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Three Non Executive Directors, one of whom shall be appointed the Chair
- Medical Director
- Chief Nurse
- Chief People Officer

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend they should send a designated nominated deputy.

6. Attendance

Meetings of the Committee will generally be attended by:

- Director of Quality & Governance
- Director of Corporate Affairs

The Committee may invite other persons to attend a meeting as required, and the Chair will be informed of these additions where possible prior to the meeting.

No officer shall be present for discussions about his/her own remuneration.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

A quorum shall be at least 2 Non Executive Directors and either the Medical Director or Chief Nurse (or their deputy).

Meetings shall be held as necessary and at least 4 times annually. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

There will be a scheduled meeting each year to approve the Quality Account.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

The Committee will report annually on its work in support of the Annual Governance Statement and Quality Account/Report, as laid out in the reporting guidance for the creation of those documents.

10. Conduct of Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital NHS Foundation Trust

Research and Innovation Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Research and Innovation Strategy 2021-2026** **Research Policies and SoPs** **UK Policy Framework for Health and Social Care**

Review Date: 1st April 2022
Issue Date: TBD
Version: 1.0
Authorisation Date: TBD

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to ensure effective governance in respect of Research and Innovation activity across the Trust.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives and Duties

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 The primary purpose of the Committee is to drive, promote and support both the research and innovation cultures across the Trust and to ensure strong governance in line with relevant frameworks, policies, procedures and guidelines

3.2 The Committee is responsible for developing and fostering a close and meaningful relationship between research activity and clinical practice. To this end, the core purpose of the committee is to create an environment across all parts to the Trust to support excellent clinical delivery, and promote a culture of service innovation and evidence-based practice.

3.3 The Committee will lead decision-making regarding overall responsibility for research including sponsorship, study prioritisation and resolution of barriers to delivery.

The Committee will undertake the following duties:

3.4 **To develop, review and update the strategic direction and business planning for research and innovation by:**

3.4.1 Leading, contributing and supporting the delivery of the Trusts strategic objectives, priorities and ambitions;
3.4.2 Developing and delivering the research and innovation strategy, promoting and establishing collaborative relationships with universities, NHS partners, research and innovation networks and other key stakeholders such as social care and service user and carer groups;
3.4.3 identifying and reviewing changes in legislation and policy or guidance that impacts on the local delivery and management of Research and/or Innovation;
3.4.4 ensuring that service users/carers are involved with research and innovation activities;
3.4.5 monitoring outcomes arising from research and innovation carried out within the Trust and support the integration of findings, outcomes, R&I intelligence into business planning for clinical and corporate divisions;
3.4.6 overseeing, reviewing, and steering research and innovation finance and funding including management of any Research and Innovation fund;
3.4.7 embedding research and innovation at every level of the organisation.

3.5 **To develop and promote NIHR portfolio research by:**

3.5.1 monitoring the Trust's performance against DHSC high level objectives and regional metrics the NIHR high level objectives, including recruitment to portfolio studies;
3.5.2 providing infrastructure to support grant applications primarily for (but not exclusively) NIHR grant applications;
3.5.3 ensuring the communication of key messages regarding the importance of research and innovation as a routine part of clinical practice;
3.5.4 ensuring that a research advice and support service is provided to all Trust staff as required, and contributes to new and innovative ways to support research and research related activity.

3.6 **To oversee and direct the activities which support the development of a research into action culture, bringing research and clinical application closer. Activities include:**

3.6.1 ensuring information is widely available regarding all research undertaken within the Trust;
3.6.2 ensuring that headlines from research, evaluation, and research related activity are regularly publicised, to include early findings, progress and final outcomes;

3.6.3 profiling good practice regarding service improvements based on research findings;
3.6.4 ensuring that the library service resource is fully utilised to enable research application in clinical practice.

3.7 **To oversee and coordinate the activities relating to the development and promotion of innovation within WUTH. These activities will include:**

3.7.1 distributing and maintaining a Trust innovations framework and associated guidance;
3.7.2 developing regular communications to WUTH staff members to ensure they are aware of how to submit ideas and how to apply for innovation funding;
3.7.3 linking with individual staff, teams and/or service areas to generate and prioritise innovative ideas which align to the Trust objectives or which are designed to solve problems which have been identified in our clinical settings;
3.7.4 establishing WUTH as a leading organisation for innovation through a variety of methods e.g. networking, relevant event attendance, hosting of conferences;
3.7.5 identification of potential collaborative partners through external networks.

3.8 **To assure high robust management and governance of research and innovation:**

3.8.1 develop, monitor and regularly review the Trust's Research and Innovation policies and procedures;
3.8.2 ensure that other research-related policies, guidelines and standard operating procedures are developed and ratified as and when necessary;

3.9 **Other**

3.9.1 To support, if and when required, the collaborative work that the Board undertakes with the ICS

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- A Non Executive Director (Chair)
- 3 other Non Executive Directors
- Medical Director
- Chief Strategy Officer

6. Attendance

Attendance (in a non-voting capacity) will also be expected from the following members of the Trust:

- Deputy Medical Director

- Research Leads (TBC)

Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members or attendees are unable to attend, they should send a designated nominated deputy.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

A quorum shall be at least two Non-Executive Directors (including the Chair or Deputy Chair) and one Executive Director.

Meetings shall be held as required but not less than four times per year. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

10. Conduct of Committee Meetings

The agenda and supporting papers will be sent out four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Remuneration Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: Sepember 2023
Issue Date:
Version: 1.0
Authorisation Date:

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors in order to ensure effective governance in respect of Executive Director and other Executive Team Member appointments, succession planning and the remuneration of the same.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractors working on behalf of the Trust) are directed to co-operate with any request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Appointments – Executive Directors and other Executive Team Members:

3.1.1 To be responsible for identifying and appointing candidates to fill all Executive Director positions on the Board and for determining their remuneration and other conditions of service. When appointing the Chief

Executive, the committee shall be the committee described in all relevant legislation.

3.1.2 To monitor and review the composition of Executive Directors and other Executive Team members in terms of size and balance of experience, skills and qualifications.

3.1.3 Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

3.1.4 To ensure compliance with the terms of the Trust's constitution and best governance practice with regard to the processes for making Executive Director and other Executive Team Member appointments to the Board of Directors.

3.1.5 To authorise release dates following resignation/removal of an Executive Director or other Executive Team Member from office, where these are earlier than completion of the contractual notice period, having regard to a full risk assessment of the cicumstances, including consideration of potential 'Acting Up' arrangements.

3.1.6 To keep under review Executive Team Member development and succession planning.

3.1.7 To review and approve any interim Executive Director appointments in accordance with relevant guidance.

3.1.8 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

3.1.9 Ensure that all relevant appointees are subject to a full Fit and Proper Persons test prior to commencement.

3.1.10 Consider any matter relating to the continuation in office of any Executive Director including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.

3.2 Remuneration

The Committee has delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments. The Committee should also recommend and monitor the level and structure of remuneration for senior management (normally the first layer of management below board level) however decisions regarding the remuneration for individual senior managers should be made by the Executive Directors (subject to the proviso outlined in section 3.2.3 below).

3.2.1 To decide and review the terms and conditions of service of the Trust's Executive Directors and other Executive Team Members in accordance with all relevant Trust policies, including:

- All aspects of salary (including and performance-related elements/ bonuses).
- Provisions for other benefits, including pensions and cars.
- Allowances.

3.2.2 To monitor and evaluate the performance of individual Executive Team Members.

3.2.3 To review and decide on proposals relating to the remuneration of the other Executive Directors and senior managers on locally determined pay e.g. VSM.

3.2.4 To adhere to all relevant laws, regulations and NHS policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors / other Executive Team Members whilst remaining cost effective.

3.2.5 To approve contractual arrangements for Executive Directors and other Executive Team Members, including but not limited to termination payments.

3.2.6 To consider these items in respect of all staff where the Trust has discretion in respect of Terms of Service and/or benefits (e.g. discretionary bonuses).

3.2.7 To formulate and review any relevant policies.

3.3 Other duties

3.3.1 To support, if and when required, the collaborative work that the Board undertakes with the ICS

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- The Trust Chair (who will Chair the Committee) – nominated deputy is the Deputy Chair;
- All Non-Executive Directors; and
- The Chief Executive (in the appointment of Executive Directors other than the Chief Executive).

6. Attendance

Meetings of the Committee may, at the request of the Chair, be attended by:

- Director of Workforce;
- Director of Corporate Affairs (to advise on constitutional matters);
- Any other person who has been invited to attend the Committee so as to assist in deliberations.

No officer shall be present for discussions about his/her own remuneration.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend they should consider sending a designated nominated deputy. In the case of this Committee, no member or attendee may send a deputy without permission of the Chair.

7. Conflicts of Interest

Not withstanding the definition of material interests applicable to Directors as set out in the constitution, the Chief Executive will through the nature of his/her role, be deemed to have an interest in the following matters:

i) The appointment and removal of the Chief Executive.
ii) The remuneration of the Chief Executive.

It will be for the Chair of the Committee to determine whether or not it is appropriate for the Chief Executive to be in attendance to advise on these matters. In such circumstances where the Chief Executive is in attendance he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

A quorum shall be at least three Non-Executive Directors (including the Chair or Deputy Chair).

Meetings shall be held as necessary. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

There will be a scheduled meeting each year to receive the outcome of Executive Team appraisals, any recommendations on remuneration and to review the Executive Team succession plan.

9. Reporting

The minutes of all meetings shall be formally recorded.

The Committee shall ensure that Board of Directors' emoluments are accurately reported in the required format in the Foundation Trust's annual report.

The are no groups reporting to this Committee.

10. Conduct of Committee Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the board's annual performance review process, the committee shall review its collective performance each year.

12. Review

The terms of reference of the committee shall be reviewed as required and at least annually.

Role Profile

Wirral University Teaching Hospital NHS Foundation Trust

Job Title	Board Champion
Department	Board of Directors

Role

In addition to their responsibilities as a Board Member, the Board Champion will take a lead in an area of business defined by the Board and work with the Executive Team and other staff to assist in the development of strategy and policy.

Key Responsibilities

- To take a lead responsibility in a defined cross cutting area of the business.
- To be consulted on the development of strategy and policy prior to the consideration by the Board or Committee.
- Undertake visits to the Trust sites to observe activity in relation to the chosen area of business and meet with lead staff.
- To offer a Board member perspective to staff in relation to the cross cutting issue; and
- To contribute to learning events.
- To support the lead officer in the defined area of the business in the preparation of strategy and policy papers.
- To offer an advanced level of scrutiny on proposals prior to their consideration by the Board or Committee.
- To support joint working between Board members and staff.
- To ensure that Board members roles and responsibilities do not cross into the operational duties of staff.
- To uphold the Trust values and the highest standards of integrity and probity, including adherence to the Nolan Principles.
- To ensure the Trust promotes equality, diversity, and inclusion in all aspects of its operations.

Extra Factual Information

All Champions can do the following things

- Be clear about their role.
- Advice on best and comparative practice.
- Review and influence.
- Review policies and procedures.
- Create awareness.
- Scrutinise/critique e.g., Board reports.
- Help to embed.
- Raise the profile of the business area.
- Point of contact and ‘sounding board’ for advice; and
- Network with other organisations.

Role Profile

Wirral University Teaching Hospital NHS Foundation Trust

Job Title	Chair of the Board
Department	Board of Directors

Role

The role of the Chair of the Board is to provide clear leadership of both the Board and the Council of Governors. The Chair should demonstrate the highest standards of probity and governance and foster a collaborative culture of robust scrutiny and collective responsibility.

This role profile details those areas which the Chair of the Board specifically has a duty or responsibility for, outside of the duties and responsibilities that come with being a member of the Board.

Key Responsibilities

- To provide leadership of the board of directors and the council of governors.
- To encourage a learning culture at Board level, by ensuring that the NEDs are appraised regularly, identifying development opportunities and ensuring that the skills mix remains appropriate.
- To foster a collaborative working culture at Board level, ensuring that all members of the Board are given the opportunity to participate and scrutinise reports while encouraging that scrutiny to be provided in a constructive and respectful way.
- To ensure and facilitate the induction of new Board members and Governors.
- To ensure effective communication with members and other stakeholders
- To uphold the Trust values and the highest standards of integrity and probity, including adherence to the Nolan Principles.
- To ensure the Trust promotes equality, diversity, and inclusion in all aspects of its operations.

Duties and Key Tasks

- To develop constructive working relationship with the Executive Team, while maintaining sufficient independence of decision making to ensure scrutiny and decision making processes are robust.
- To establish constructive working relationships with the Board members, both Executive and Non-Executive, and the Council of Governors, making sure that directors are fully informed about issues which they make take decisions on, or which may have an effect on those decisions.
- To work at a regional and national level to continue to work towards improvement the effective delivery of services.
- To establish a constructive relationship with the CQC, NHSI, and other regulators/inspectorates.
- To set the agendas and facilitate effective, focused, and well managed Board and Council of Governor meetings.

Extra Factual Information

- A Deputy Chair may be appointed. The requirements of the Chair as outlined in this role profile shall apply to the Deputy Chair either on a case by case basis as requested or required by the Chair, or in the case that the Chair is conflicted and/or unable to carry out one or more of the requirements.

Role Profile

Wirral University Teaching Hospital NHS Foundation Trust

Job Title	Committee Chair
Department	Board of Directors

Role

The role of a Committee Chair is to provide leadership and a link to the Board to provide assurance that the Committee has discharged its responsibilities. The Chair should demonstrate the highest standards of probity and governance and foster a collaborative culture of robust scrutiny and collective responsibility.

This role profile details those areas which a Committee Chair specifically has a duty or responsibility for, outside of the duties and responsibilities that come with being a member of the Board.

Key Responsibilities

- To foster a collaborative working culture at Committee level, ensuring that all members of the Committee are given the opportunity to participate and scrutinise reports while encouraging that scrutiny to be provided in a constructive and respectful way.
- To liaise with the lead directors and trust secretary in establishing the agendas and work plan for the Committee, thereby facilitating the Committee in carrying out its delegated duties.
- To ensure effective communication with members and other stakeholders, including reporting back to the Board of Directors and Council of Governors
- To uphold the Trust values and the highest standards of integrity and probity, including adherence to the Nolan Principles.
- To ensure the Trust promotes equality, diversity, and inclusion in all aspects of its operations.

Duties and Key Tasks

- To develop constructive working relationship with the Executive Team, particularly those who lead the Committee, while maintaining sufficient independence of decision making to ensure scrutiny and decision making processes are robust.
- To establish constructive working relationships with the Committee members, both Executive and Non-Executive, and the Council of Governors, making sure that the Committee are fully informed about issues which they make take decisions on, or which may influence those decisions.

Extra Factual Information

- A Deputy Chair is not required but may be appointed. The requirements of the Chair as outlined in this role profile shall apply to the Deputy Chair either on a case by case basis as requested or required by the Chair, or in the case that the Chair is conflicted and/or unable to carry out one or more of the requirements.

Extra Factual Information

- Should the Chair be unavailable, and no deputy is appointed, the Committee shall elect a chair to lead the meetings, as per the terms of the Constitution.

Role Profile

Wirral University Teaching Hospital NHS Foundation Trust

Job Title	Trust Governor
Department	Council of Governors

Role

The Governor is a statutory role required for all Foundation Trusts, with statutory powers set out in the NHS Act 2006 and amended by the Health and Social Care Act 2012.

Governors represent the interests of members of the trust, the interests of the public and local partner organisations. They contribute to the future direction of the trust and hold the non-executive directors (collectively and individually) to account for the way the Board of Directors perform.

Key Responsibilities

- To spend time preparing for meetings and to attend and contribute by asking questions and providing scrutiny on the performance of the organisation. Governors should aim to attend all meetings of the Council of Governors and observe as many Board meetings as possible.
- To fulfil, to the best of their ability, the statutory duties as set out in the Duties and Key Tasks section.
- To attend and participate in training and development opportunities
- To engage with members, both of their constituency and more widely, to ensure their views are heard, and to support recruitment of new members.

Duties and Key Tasks

- To carry out the two core statutory duties of the Council of Governors:
  1. To hold the non-executive Directors individually and collectively to account for the performance of the Board of Directors; and
  2. To represent the interests of the members of the Foundation Trust as a whole and the interest of the public.
- To carry out the other statutory duties of the Council of Governors:
  - Appoint and, if appropriate, remove the chair.
  - Appoint and, if appropriate, remove the other non-executive directors.
  - Decide the remuneration and allowances and other terms and conditions of office of the chair and the other non-executive directors.
  - Approve (or not) any new appointment of a chief executive.
  - Appoint and, if appropriate, remove the NHS foundation trust's auditor.
  - Receive the NHS foundation trust's annual accounts, any report of the auditor on them, and the annual report at a general meeting of the council of governors.
  - Approve "significant transactions".
  - Approve an application by the trust to enter into a merger, acquisition, separation or dissolution.

Duties and Key Tasks

- Decide whether the trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions and
- Approve amendments to the trust's constitution.

Extra Factual Information

- Governors are not required to have any prior knowledge, skills or experience to stand for and be elected or appointed to the Council of Governors.
- Governors are not involved in the day-to-day running of the Trust e.g., setting budgets, staff pay, undertaking contractual arrangements or other operational matters. These responsibilities lie with the Board of Directors and individual directors who will manage the Trust day-to-day and exercise the powers granted to it
- The Council of Governors has no role in considering matters such as the appointment or dismissal, appraisal, pay levels, performance or conditions of service of executive directors or any other member of staff or officer of the Trust.
- Governors should not raise complaints on behalf of themselves or individuals and may not act as advocates or staff representatives. Any areas of concern should be communicated to the Board Secretary or to the Chair, who will, if appropriate, escalate through the relevant formal process.
- Governors may not make representations on behalf of individuals or groups.

Role Profile

Wirral University Teaching Hospital
NHS Foundation Trust

Job Title	Non-Executive Director
Department	Board of Directors

Role

The role of a Non-Executive Director is to provide oversight, scrutiny, and effective governance, supporting the Trust's delivery of strategy and the provision of safe, effective healthcare services. The Board should scrutinise the Trust's performance operationally and financially, its internal controls, and compliance with key regulation and legislation.

Non-Executive Directors are also responsible for appointing and determining the remuneration levels of the Executive Directors.

All Board Directors should demonstrate the highest standards of probity and governance and foster a collaborative culture of robust scrutiny and collective responsibility.

Key Responsibilities

- To establish the strategic direction and objectives of the Trust and hold the Executive Directors to account for its delivery.
- To seek assurance that internal controls and processes are robust and embedded within day to day activity.
- To liaise with the Council of Governors, having due regard for their opinions.
- To uphold the Trust values and the highest standards of integrity and probity, including adherence to the Nolan Principles.
- To ensure the Trust promotes equality, diversity, and inclusion in all aspects of its operations.

Duties and Key Tasks

- To ensure that the Trust complies with its licence, constitution, and other application legislation and regulation.
- To ensure the long term sustainability of the Trust by providing scrutiny of finances, risks, and other operational performance.
- To develop constructive working relationship with the Executive Team, while maintaining sufficient independence of decision making to ensure scrutiny and decision making processes are robust.
- To participate and contribute to Board and Committee meetings in a meaningful, prepared, constructive manner.
- To engage with the induction process, the annual appraisal process and development needs that may be identified;

Role Profile

Wirral University Teaching Hospital
NHS Foundation Trust

Job Title	Senior Independent Director
Department	Board of Directors

Role

The role of the Senior Independent Director (SID) is to function as an independent resource for the Chair, Board, and governors, providing a “sounding board” or serving to mediate any disputes that may arise. The SID should demonstrate the highest standards of probity and governance and foster a collaborative culture of robust scrutiny and collective responsibility.

This role profile details those areas which a SID specifically has a duty or responsibility for, outside of the duties and responsibilities that come with being a member of the Board.

Key Responsibilities

- To be available to the Board of Directors, both Executive and Non-Executive, where they have concerns which contact through normal channels has failed to resolve or for which such contact would be inappropriate.
- To be available to the Governors and members, where they have concerns which contact through normal channels has failed to resolve or for which such contact would be inappropriate.
- To resolve any disagreements that may arise between the Council of Governors and the Board of Directors in line with the terms set out in the constitution.
- To support the Chair of the Board, acting as a sounding board and source of advice.

Duties and Key Tasks

- To carry out the annual appraisal of the Chair of the Trust and report to the Nominations Committee of the Council of Governors on the outcome.
- To ensure that they remain independent throughout their appointment.

Extra Factual Information

- The Chair may not be the SID.

Board of Directors in Public **Item No 14**
31 August 2022

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

Report Purpose and Recommendations

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

It is recommended that the Board:

- Note the report

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, plus 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**
This is a 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. **Campaigns, media, social media, internal communications, staff engagement communications and stakeholder relations** **Campaigns** On 1st August 2022 the Trust supported the first Ectopic Awareness Day, raising awareness of ectopic pregnancy, which is a pregnancy that develops outside of the womb and, for some women, it can be a life-threatening condition. Approximately 1 in 80 pregnancies are ectopic. We continued to promote national and regional campaigns on lung cancer awareness, vaccinations and boosters and to support patient and staff wellbeing through the recent run of very hot weather. **Recruitment campaigns** strongly featured this month with our continuing partnership with 'Civvy Street'. WUTH has been working with Civvy Street Magazine and website to help attract military veterans to roles at the Trust. Civvy Street is a military resettlement magazine and web resource designed to help those leaving our armed forces transition and find work in civilian life. The July issue featured WUTH's senior medical photographer, James Elmer, who swopped army life for a career in the NHS, retraining and using his skills as an army photographer. You can read James' story **HERE** The Trust also held a very successful recruitment day for staff seeking to join the new South Mersey Elective Surgery Hub at Clatterbridge when its theatres open later this year. Over 5500 people engaged with our Facebook content and the recruitment day was really popular with potential new recruits. WUTH's Rainbow Network and other colleagues celebrated the national 50 years of **PRIDE**, joining the first live events since the start of the pandemic. The first Pride march took place in London on July 1st, 1972, when around 2000 people marched together to unite against discrimination and fight for the rights of all LGBTQ+ people. WUTH staff have attended parades in Liverpool, Chester and will be at New Brighton on 27th August. **Media** In July we highlighted that patients reported positive experiences at Wirral University Teaching Hospital Trust (WUTH), according to **the National Cancer Patient**

Experience Survey. The patients who took part in the survey gave an average rating of 9 out of 10 for the care they received at WUTH.

The survey, commissioned by NHS England and carried out by patient experience insight survey experts Picker, included people aged 16 years and over, with a confirmed primary diagnosis of cancer, who had been treated in hospital between April and June 2021. The survey is an important part of the national NHS Cancer Programme, which places patient experience on a par with clinical effectiveness and safety as a key strategic priority. A total of 59,352 people responded to the survey nationally- Positive experiences reported by WUTH patients in Cancer Patient Survey

New restaurant and wellbeing facility opens
In July we celebrated a milestone in staff experience and wellbeing as Arrowe Park Hospital officially opened its new restaurant and staff wellbeing area, named 'The Retreat'. The decision to revamp the restaurant came after Trust staff were asked for feedback on how they would like to see the funds spent.
The updated interior was partly funded by the £150,000 that was raised through the WUTH Charity COVID-19 Support Fund, which was a joint appeal by Wirral University Teaching Hospital (WUTH) and The Wirral Globe. Funding from NHS Charities Together national COVID-19 appeal has also contributed towards the cost of the refurbishment. The project was only made possible thanks to the generosity and fundraising efforts of the public and staff. It will be a legacy for the Trust for many years and will benefit thousands of people. In future, it will be opened up for visitors to also use the facility.

Clatterbridge Diagnostics Centre Milestone
WUTH and Clatterbridge Cancer Centre have collaborated to be one of the first new community diagnostics hubs in the NHS in England. The service is a partnership between The Clatterbridge Cancer Centre and Wirral University Teaching Hospital and is part of the NHS England Community Diagnostic Centre programme that aims to improve outcomes for patients, including those with suspected cancer and other serious health conditions, through earlier diagnosis.

More than 25,000 people have now benefited from faster access to vital diagnostic tests and scans with Paul Cotgrave, from Birkenhead, being the 25,000th person to be seen at Clatterbridge Diagnostics.

Clatterbridge Diagnostic Centre welcomes its 25,000th patient

NHS Performance
There continues to be media interest in NHS performance and national media coverage of the reset and recovery work post pandemic. As previously reported to the Board, national media are increasingly using data journalism to compare trusts' performance. One such is the Daily Telegraph's use of a range of NHS waiting list data, produced monthly and searchable (behind subscriber paywall) by trust. In the latest figures, WUTH's overall performance was a ranking of 46 out of 120 for its 'duties of care' to patients.

Awards

There were five new awards or nominations for WUTH staff in the month.

Congratulations go to the Volunteer and Vocational Development Team who have been awarded the '**Nurturing Talent Award'** from Wirral Metropolitan College. The award

goes to the team for the work they do in enabling young people of Wirral to access work experience and pre-employment programmes. Often these programmes lead to apprenticeships and paid employment at the Trust.

Congratulations also to the Clatterbridge Vaccination Centre team who have been awarded the **League of Friends Leverhulme Merit Award** at their recent Annual General Meeting. The award is handed to a person, team or department every two years and has been handed to the centre after their outstanding work over the last 20 months.

The Lung Clinical Nurse Specialist Team have been nominated for **Macmillan's Professionals' Excellence Award** by Dawn Miller, WUTH's Macmillan Lead Cancer Nurse. The award recognises and celebrates the work of truly exceptional Macmillan professionals and teams who have gone above and beyond expectations to do whatever it takes to support people living with cancer. The Lung Clinical Nurse Specialists and the cancer support team have worked exceptionally hard to support people with lung cancer when they need it most. It is a significant achievement to be selected, as the nominations were of a very high standard. The award ceremony will take place at the Macmillan Conference in London in November.

The Estates, Facilities, and Capital Team at Wirral University Teaching Hospital (WUTH) have been shortlisted for two awards at the October 2022 **Healthcare Estates IHEEM Awards event.** WUTH is being recognised for its investment in its infrastructure to support staff health and wellbeing, coupled with the recognition of the work and improvements made across Estates and Facilities. The two awards categories WUTH have been nominated for are Staff Wellbeing Initiative of the Year and Estates and Facilities Team of the Year.

Employee Communications
This month we supported the further communications and roll out of the Health and Wellbeing Day initiative for staff who can take an additional day's leave to support their wellbeing.

We also continued to highlight the changes necessary to facilitate the Urgent and Emergency Care Upgrade project enabling works, including changes to car parking.

Returning to in-person events with our leadership conference – '**Leadership for all' in June** was swiftly followed by communicating our new leadership for all offer with a programme of leadership support at all levels and settings. A new comprehensive leadership offer is also one of our Staff Survey actions, delivering immediate line manager training and development opportunities, as well as opening up leadership resources to all staff. Plans are also in hand for the 2022 Staff Survey campaign starting in September.

We are preparing for our staff awards as an in-person event on 25th November 2022 at Thornton Hall Hotel with nominations, including an award voted for by the public, opening week commencing 22/8/22.

Stakeholders

We continue to share resources from our partners and stakeholders like Wired, Maternity Voices, Carers' groups and Healthwatch.

	Our maternity team hosted a visit from TV sports presenter and BBC Question of Sport Team Captain, Samantha Quek, who is a great supporter of the unit. In the new integrated care landscape, we are now members of the Wirral Communications Collaborative with partners in health and social care and Wirral Council in the region. **WUTH Charity** The Charity team's main focus is now our events calendar. Our inaugural 'It's a Knock Out' took place on July 2nd at Arrowe Country Park. Teams of 12 and over 100 people took part in this classic 'funday'. It is expected to have raised £5000. Red Fox Thornton Hough has nominated WUTH Charity to benefit from Brunning and Price's Charity Giving for 2022. This resulted in a further £6000 on top of the spring lunch proceeds of £6000 and a promise to host another spring lunch in 2023. Sales are going well for Dave J Critchley, Executive Head Chef at Lu Ban's lunch to support the Tiny Stars appeal. The BBC's Great British Menu Chef will be hosting a three-course cooking demonstration followed by banquet lunch for guests at Thornton Hall Hotel on the 7th of September. The Arrowe Park Abseil is planned for 23rd September and Santander Bank will be supporting the event. Virtual London Marathon 2nd October. WUTH Charity has 25 places available for this year's virtual event. The Team are also preparing a range of seasonal fundraising activities for the autumn and Christmas.

2	Implications
2.1	The Board is asked to note the progress in communications, media, campaigns, employee communications (supporting staff engagement), patient communications and the WUTH Charity.

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

Report Author	Sally Sykes, Director of Communications and Engagement
Contact Number	0151 604 7640
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Board of Directors in Public
31 August 2022

Item 15.1

Report Title	Workforce Assurance Committee Chair's Report
Author	Lesley Davies

Overview of Assurances Received

To note that:

- The People Strategy continues to make progress across a range of areas identified as a priority in year 1.
- The NHS Staff Survey data has been disseminated and a number of divisions have already taken action and improvement plans are being developed to address any issues raised in the feedback. Work would also be undertaken to improve the uptake of the internal pulse surveys and the results used to provide assurance to WAC
- The committee welcomed the staff story from a long-serving international nurse who outlined the importance of being able to connect to a community when new to the UK and also described her development journey and how she has grown in confidence and now leads a staff team; given the successful growth in international nurses at the Trust, a good reminder on the wider implications and needs of staff joining from overseas
- Assurance was given that Sir Gordon Messenger's report on the future of NHS HR and OD has been reviewed and, where appropriate, recommendations mapped against our People and enabling strategies
- Covid 19 Terms and Conditions have now been withdrawn and this was successfully communicated to staff with no concerns raised
- Although staff sickness absence slightly decreased in May 22 to 6.23%, it is unlikely that the target of 5% will be met this year; the 20% disability self-declaration rate is also unlikely to be met. All areas continue to be monitored closely
- Staff turnover is also currently above target at 12.8% for May, against a target of 10%
- Appraisal's compliance still has some way to go before meeting the target of 89%, currently completion is at 83%
- Assurance was given that all divisions have trajectories in place for improving key areas of performance
- The committee was provided with a report on the number and type of employment tribunal cases open and was also given benchmarking data detailing the number of cases compared with neighbouring Trusts. It was difficult to draw conclusions from the data, but it was useful for the committee to seeing comparative data. Assurance was given on the level of risk faced by the Trust resulting from the tribunals.
- Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) – the data will be agreed before the 31st August 2022; the committee noted the Trust's performance against WRES and WDES
- In May the registered nurse vacancy rate continued to reduce to 4.23% and will be continued to be monitored to ensure safe staffing

New/Emerging Risks

- The Trust continued to make good progress in using its levy spend on apprenticeship provision. However, the Trust currently losses £21K per month in unspent levy and

therefore action is being taken to mitigate this loss with plans to increase apprenticeship programmes

Items for Escalation/Action

- Based on the data provided, WAC discussed the issue regarding ensuring reduced likelihood of any discrimination in recruitment practice and reviewing the reasons for not appointing. A review would be undertaken, and any necessary actions would form part of an action plan.
- Given the growth in the apprenticeship programmes, WAC requested further assurance on apprenticeship performance

Other comments from the Chair

- The membership and terms of reference of the Workforce Assurance Committee are currently under review

Board of Directors in Public
31 August 2022

Item No 15.2

Report Title	Report of Charitable Funds Committee 21 July 2022
Author	Sue Lorimer, Non-Executive Director

Overview of Assurances Received

- The committee received the Head of Fundraising's report setting out feedback on fundraising events completed since the last meeting of the committee. The committee was pleased to note the schedule of events and the active participation of different staff groups. The report also included a full schedule of planned events for the remainder of the year.

- The chair fed back on the recent meeting with two trustees of the Incubabies charity which she had attended with David McGovern. She reported that the trustees were very enthusiastic about supporting the Tiny Stars appeal and were keen to see some progress on refurbishing the Neonatal Unit. They had circa £250k to contribute to this development. The chair reported that David McGovern had spoken to Matthew Swanborough who would commission some plans for the development prior to inviting the trustees in to give their comments.

- The committee considered a report from the Head of Fundraising providing information from 8 other NHS hospital charities regarding the existence of specific funds for the benefit of staff and the nature of those funds. It was agreed that any such fund within the trust's charity would have to be for staff wellbeing projects rather than direct gifts to staff and the committee would need to see a detailed proposal regarding amending the objectives of the charity to allow this.

- The committee considered a report on the charity's finances and noted that there was outstanding income yet to be recorded. The Finance team raised the issue of continuing difficulties in changing the bank mandate with Barclays due to the fact that the bank had never updated the signatories list and that the signatories no longer worked for the trust. The chair proposed that some legal advice be commissioned due to the length of time this issue had been outstanding.

- The committee approved the charity's annual report and accounts for recommendation to the board of directors for approval.

New/Emerging Risks

- There were no significant risks noted by the committee.

Items for Escalation/Action

- The issue of the bank mandate requires resolution as soon as possible and this has been escalated to the Chief Executive

Board of Directors in Public
31 August 2022

Item No 15.4

Report Title	Committee Chairs Reports - Quality Committee
Author	Steve Ryan, Non-Executive Director

Overview of Assurances Received

This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 29 July 2022.

Board Assurance Framework

The relevant principle risk to the delivery of outstanding care was reviewed. The controls in place were felt to be appropriate and the levels of both impact and likelihood were judged to be correctly calibrated. The risks related to patient flow in unscheduled care are amplified by factors external to the organisation and as such cannot be directly mitigated by the Trust (e.g., delayed discharge due to restricted access to domiciliary care). On-going work at "Place" will be critical to reducing the risks.

Mental Health Key priorities

As part of a report by the Chair of the Mental Health Transformation Group, the committee was pleased to see the action plan developed to address key priorities. This including actions to ensure we meet our obligations to patients under the Mental Health Act, when their length of stay under Section 136 arrangements could exceed 24 hours. Other priority areas include staff education, strengthening of the policies and procedural frameworks, environmental risk assessment and improved communication with patients and their families.

Serious incidents

The report of the Serious Incident Panel Chair provided evidence of detailed and thorough investigations with clear actions and action tracking, which had been submitted to the Wirral Commissioning Group. The Committee gained understanding of the causes, consequence and arising actions including their timelines, in each of the cases reported. Known themes were highlighted in the report and are associated with on-going quality improvement actions and oversight. No further never events have been reported. We received a verbal report that backlog of overdue serious incident investigations had decreased from 9 to 3, which is a significant achievement.

The investigation reports will be presented to the Trust Board during its next private meeting, rather than the public one as they contain detailed information that could allow individual patients to be identified.

Infection Prevention and Control

The Committee received the Infection Prevention and Control Annual Report. The Committee noted this comprehensive report and gained assurance that the Trust was meeting its obligations in relation to the Health and Social Care Act hygiene code. The Trust also received positive verbal feedback from NHS England (NHSE) following their review of our ICP arrangements and our

response to the pandemic. NHSE particularly noted our positive infection control culture. They also felt that we had built on our experience in receiving the first cohort of patients from Wuhan, which gave us an early advantage in developing and implementing relevant processes and procedures, which we have since built on and maintained.

The committee however acknowledged that the lack of isolation facilities, high level of bed occupancy and large numbers of frail elderly patients with extended lengths of stay, represented a continuing increased risk of nosocomial infection, requiring constant vigilance and action.

Risk Management Review

Mersey Internal Audit Agency undertook a review of our risk management arrangements and in their opinion identified a 'Substantial level of assurance", there being "substantial controls in place which in the main operated effectively". Two medium and two low levels of action were recommended for which an action plan has been put in place. This report will also be reviewed at the Audit Committee.

Other comments from the Chair

- The Committee received appropriate and detailed documentation in relation to the items it considered on 29th July 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.