Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public

1 March 2023

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Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 1 March 2023
Time	09:00 – 11:00
Location	Board Room, Education Centre, Arrowe Park Hospital

Agenda Item		Lead	Presenter
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)	Quality and Performance Dashboard	Executive Directors	
9.2)	Month 10 Finance Report	Mark Chidgey	
9.3)	Monthly Maternity Report	Tracy Fennell	Jo Lavery
9.4)	Guardian of Safe Working Report	Dr Nikki Stevenson	Helen Kerss
9.5)	Estates, Facilities and Capital	Matthew Swanborough	Paul Mason
9.6)	Digital Healthcare	Mark Chidgey	Chris Mason
9.7)	Productivity and Efficiency Update	Matthew Swanborough	
Wallet Items for Information			
10.	Committee Chairs Reports	Committee Chairs	
10.1)	Quality Committee		
10.2)	People Committee		
10.3)	Charitable Funds Committee – **Verbal**		

10.4) Audit and Risk Committee
10.5) Council of Governors – **Verbal**
10.6) Finance Business
Performance Committee

Closing Business

11.	Questions from the Public	Sir David Henshaw
12.	Any other Business	Sir David Henshaw

Date and Time of Next Meeting

Wednesday 5 April 2023, 9:00 – 11:00

Meeting	Board of Directors in Public
Date	Wednesday 25 January 2023
Location	Board Room, Education Centre, Arrowe Park Hospital

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Deputy Chair
SR	Steve Ryan	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
SLO	Sue Lorimer	Non-Executive Director
RMA	Rajan Madhok	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
DS	Debs Smith	Chief People Officer
MC	Mark Chidgey	Chief Finance Officer
MSW	Matthew Swanborough	Chief Strategy Officer
HK	Hayley Kendall	Chief Operating Officer

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
SS	Sally Sykes	Director of Communications & Engagement
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (item 9.3)
MSA	Mustafa Sadiq	Consultant (item 9.3)
DG	Debby Gould	LMNS Quality and Safety Lead (item 9.3)
RME	Dr Ranj Mehra	Deputy Medical Director (item 9.4)
SLA	Sharon Landrum	Workforce Diversity & Inclusion Lead/ Freedom to Speak Up Guardian (item 9.5)
AP	Amy Park	Head of HR (observing)
TC	Tony Cragg	Public Governor
PI	Paul Ivan	Public Governor
RT	Robert Thompson	Public Governor
AT	Andrew Tallents	Public Governor
SH	Sheila Hillhouse	Public Governor

Apologies:

LD	Lesley Davies	Non-Executive Director
CM	Chris Mason	Chief Information Officer

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed all present to the meeting. Apologies are noted above.	
2	**Declarations of Interest** No 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 held on the 7 December were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story of a mother who had a mixed experience across maternity and neonatal care. TF stated this specific patient story and learning was shared with each Division through Divisional Performance Boards. TF added the welcome pack for new mothers had also been updated to address some of the concerns raised by the mother. SR commented about the importance of communication between staff and new mothers. The Board **NOTED** the patient story.	
6	**Chair's Business and Strategic Issues** DH updated the Board of Directors on recent matters and highlighted a meeting of Wirral system partner CEOs and Chairs would take place on 8 February to discuss how organisations work better together to support patient flow by understanding and reviewing the business processes. DH also highlighted the ICB had recently published the Report on Liverpool Hospital Services Review and local Chairs had already had a briefing on this. JH commented the report had already been discussed in the Executive Team and agreed to circulate the Report on Liverpool Hospital Services Review for further discussion at the next Board meeting.	Janelle Holmes

	The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH provided an industrial action update and explained the Royal College of Nursing (RCN) and the Chartered Society of Physiotherapy (CSP) returned a mandate for action. JH stated Unison, Unite and Royal College of Midwives returned no mandate for action. The Hospital Consultants and Specialists Association and the British Medical Association currently have open ballots. JH added the Trust had undertaken extensive planning led by the Trust's Emergency Preparedness, Resilience and Response (EPRR) lead as well as partnership working with Staff Side colleagues and the ICB. JH gave an infection, prevention, and control (IPC) update and reported there had been a number of challenges due to the increasing number of winter viruses circulating. The number of patients in hospital with COVID and flu had reduced from a peak in December. JH added there had also been an increase in the number of children attending the hospital with respiratory viruses. JH stated there had been national issues with portable oxygen cylinders, however the Trust had not been required to submit any mutual aid requests and there were no patient safety incidents reported at the Trust. JH highlighted in December a new Renal Dialysis Unit at Arrowe Park opened following a £2.8m capital investment. JH added the Urgent and Emergency Care Upgrade Programme (UECUP) continued, following phase 1 enabling works being completed in November 2022, phase 2 construction had started. Further phases are due to commence from the autumn of 2023. JH reported the Trust had been awarded the NHS Pastoral Care Quality Award, the Library and Knowledge Services Team had been awarded a Service Improvement Award and the Digital Healthcare Team achieved the Excellence in Informatics Level 1 accreditation. JH reported the Trust declared 3 serious incidents in November and 1 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS) incident. JH gave an update on the recent Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board meetings as well as the Hewitt Review. DH queried how the region had been affected by the industrial action and commented there was a risk to elective activity the longer industrial action continues.	

	JH stated Cheshire and Merseyside experienced the biggest impact and there was an expectation to continue elective activity during industrial action. NS commented all routine and cancer activity had been cancelled but urgent limb and life services at the Trust continued during industrial action. This will be reviewed during future waves of industrial action. DH queried the timeframe for the upcoming CQC inspection. NS stated the Trust continued to hold engagement meetings with the CQC on a monthly basis and there was a new Engagement Officer. NS added the CQC had been reviewing the format for inspections and it was unclear which format the Trust would be inspected against. JH commented there had been positive service inspections since the last full inspection and were keen to have the well-led indicator inspected. The Board **NOTED** the report.	
8	**Chief Operating Officer's Report** HK provided an overview of the Trust's current performance against the elective recovery programme for planned care as well unscheduled care. HK highlighted in December the Trust attained 101.1% against a plan of 109.8% for outpatients. For elective admissions 116.2% of activity was delivered against a target of 109.0%. HK provided an update on the number of patients waiting for referral to treatment. HK stated the Faster Diagnosis Standard was 75.16% in October against a target of 75% and explained performance was becoming challenging given the increase in 2 week wait referrals. HK reported unscheduled care type 1 performance was down 1.91% in December and rank 25th out of 41 Trusts in the Northwest, however the Trust continued to perform well in terms of overall 4-hour performance and is ranked 5th out of the 41 Trust's. HK stated 35% of the total bed base was occupied by patients that require another care setting. This continued to pose a significant risk of not improving performance across the Urgent Treatment Centre (UTC) pathways and the elective programme, and not being able to provide the optimal patient experience at times of high demand through the ED.	

	SI noted the high emergency department (ED) attendance and queried what the original capacity was. HK stated that it was built to accommodate 40,000 attendances, and is regularly operating 100% above the original capacity for when the ED was built. DH commented it was important to continue to model future attendance to consider future capacity implications for the new Urgent and Emergency Care building. CC noted the number of patients that had no criteria to reside at the hospital was circa 200 and queried the make up of this. HK stated the make-up was split evenly, with half requiring care at home and half requiring discharge to a care home. HK added the Trust's performance against pathway 1 was poor in comparison to neighbouring Trusts'. DH acknowledged corridor care continued to be provided was particularly high during November and industrial action. DH queried the patient safety risks. NS stated there was repeated patient safety risks due to corridor care and this was regularly escalated to Wirral system partners. NS added the Trust declared Operational Pressures Escalation Levels (OPEL) 4 during industrial action and reopened ward 41 due to the high number of patients on the corridor. NS stated the ward was closed promptly once OPEL 4 was stood down. JH commented the Trust was not an outlier in providing corridor care and neighbouring Trusts were in a similar position. JH added HK had been appointed by CMAST to lead the discharge response for Cheshire and Merseyside and the first meeting had recently taken place. SI queried if there was a correlation between a lack of face-to-face GP appointments and an increase in ED attendance. JH stated no analysis had been carried out, but it was reported in the press that a lack of face-to-face GP appointments was driving some ED attendance. JH added the Wirral position was mixed and some GPs were working hard to see patients face-to-face. DH suggested DM organise a Board away day to consider current and future strategic considerations. The Board **NOTED** the report.	David McGovern
9	**Board Assurance Reports** **9.1) Quality and Performance Dashboard**	

DS highlighted sickness absence remained above 6% and reiterated from December Board that this has been a challenge throughout winter with sickness absence expected to increase further in December and January. DS added short term sickness remained the main driver. The new Attendance Management Policy had been strengthened and would be launched in February.

DS explained staff turnover remained above target. The Trust's Strategic Retention Group were improving ESR and digitising a leavers form. DS stated current intelligence indicates that flexible working and work/life balance remained largest reasons for turnover.

DS stated despite the numerous pressures faced by staff both mandatory training and appraisal remained complaint and on Trust target.

SR queried the wellbeing offer available for staff.

DS stated the Trust had a range of wellbeing options available including a wellbeing day and access to resources. DS added the Trust had also utilised the Cheshire and Merseyside Resilience Hub for staff to access as well. DS commented the funding for Resilience Hub was unclear from April 2023 however options were being considered.

TF highlighted a reduction in the number of C. difficile and other gram-negative bacteraemia cases, and this was due to a strong infection prevention and control focus by all staff.

DH queried when the Trust would amend the indicators.

HK stated updated indicators would be in place for April.

The Board **NOTED** the report.

9.2) Month 8 Finance Report

MC highlighted the Trust was reporting a deficit of £4.670m, an adverse variance against budget of £5.368m. The variance was attributed to overspends on employee costs, driven largely by underperformance in respect of recurrent cost improvement programme (CIP), the unfunded element of the national pay award and the continued use of escalation wards staffed at premium rates, and by increases in energy prices.

MC stated this was offset by a reduction in non-pay spend in M1-6, specifically clinical supplies, as a result of reduced elective activity compared to plan as well as the release of deferred income.

MC explained the Trust had the potential to exceed the elective recovery target but consistent with national guidance, no additional income has been assumed from the Elective Recovery Fund (ERF).

MC provided an update on the key financial targets and the RAG rating for each, highlighting financial efficiency, financial stability and agency spend were red, capital was green, and cash was amber. MC explained the key drivers, mitigations, and corrective actions for each.

The Board:

- **NOTED** the report
- **NOTED** that without further mitigation the forecast position remains a £6m deficit

9.3) Quarterly Maternity Services Report

JL and MSA gave a presentation focussing on compliance with the Clinical Negligence Scheme for Trust's (CNST) Maternity Incentive Scheme (MIS) Year 4. The presentation outlined how the ten safety actions, which have all been assessed as compliant, had been met and provided details of the evidence.

The Board were also informed of the rigour of the review process, and assurance was provided from SR (both Chair of Quality Committee and NED Maternity Safety Champion), who had a separate and in depth review of the evidence.

It was also noted that this had been reviewed by the Chief Nurse as the Executive Maternity Safety Champion, and the LMNS who had observed both Quality Committee and were observing this section of the Board meeting.

JL provided an update regarding Part 2 of the Ockenden Report, along with an overview of the 'Reading the Signals' Maternity and Neonatal Services in East Kent – the Report of an independent investigation.

JL also highlighted the Maternity Continuity of Carer Implementation Plan as well as the workforce requirements in line with Birth Rate Plus recommendations.

RMA queried if there were any implications for the Trust following the Kirkup Report.

MSA stated an open and positive culture was important as well as robust clinical governance. MSA added the Maternity Services at the Trust was already in a strong position and had good teamwork and communication. It was noted the Trust had reviewed the

recommendations from the Kirkup reports across all Divisions in Divisional Performance reviews, and not just in maternity services.

DH queried the approach to managing oversight and assurance with wider system partners.

JL stated the Maternity Services had a positive relationship with wider system partners and the relationship between the LMNS and ICB was continuing to develop.

TF thanked JL for the report and for her leadership of the Maternity Team over the past year.

The Board:

- **NOTED** the report
- **NOTED** the Ockenden update
- **NOTED** the publication of the East Kent Services Report
- **NOTED** the workforce update with specific reference to the Continuity of Carer model of maternity care and the Trusts position to implement this model as a default model of care subject to approval to improving the midwifery establishment
- **APPROVED** the Trust compliance with year 4 of the Maternity Incentive Scheme and **NOTED** the supporting evidence prior to the Chief Executive sign off of the Trust declaration form and submission to NHSR by noon on 2 February 2023

9.4) Learning from Deaths Report Q2 2022/23

RME highlighted there were 446 deaths in Q2, with 46 deaths occurring within 28 days of a positive COVID-19 swab and 6 after acquiring COVID-19 in hospital. Most recorded deaths were in the over 60 age group and the vast majority fall into the “White British” ethnicity. RM add there was one neonatal death and no reported paediatric deaths or stillbirths.

RME summarised the Summary Hospital Level Mortality Indicator (SHIMI) and Hospital Standardised Mortality Ratio (HSMR) mortality comparators. RME added the comparators remained relatively stable and the difference between SHIMI and HSMR was attributed to the relatively high palliative care coding and higher than average deprivation on Wirral when compared to the average for England.

RME indicated Telstar Health data had highlighted deaths in the diagnostic group of pneumonia as an area of focus.

SLO queried how the Trust was confident palliative care coding was better in comparation to similar Trust’s.

SR stated this was due to palliative care being proactively engaged from the patient's time of arrival, while ensuring the correct code was entered promptly to sure specialist care and advice can be provided. SR added care records were also regularly audited.

The Board:

- **NOTED** the report and mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group

9.5) Freedom to Speak Up Report (FTSU) (Q1-Q2 2022/23)

SLA highlighted the number of people speaking up to FTSU Guardians had increased with 31 people speaking up in Q2 as opposed to 18 in Q1. Communications had taken place to promote the FTSU service during Q2 and the increase could be as a result of increased publicity of the FTSU team.

SLA reported the number of concerns raised by Division and by each theme and explained two new categories had been introduced: 1) other inappropriate behaviour and 2) worker safety or wellbeing. No concerns raised in Q2 highlighted areas of patient safety as opposed to 3 cases in Q1.

SLA stated 1 anonymous concern was received in Q1 as well as 1 in Q2. SLA added anonymous reporting remained low which was positive given the number of increased concerns in Q2.

DS provided an update on the FTSU approach at the Trust and explained following national guidance and policies being updated a gap analysis was carried out. DS summarised the action plan and objectives. DS added SLA would step down as Lead FTSU Guardian at the end of January and thanked her for her leadership and positive impact on staff.

RMA queried if the Trust wanted more or fewer staff speaking up.

DS stated the Trust wanted staff to speak up and raise concerns and the Freedom to Speak Up was one of a number of methods to do this. DS added staff had feedback that concerns were dealt with promptly and did not suffer from speaking up.

JH highlighted in the past the Trust had a high number of concerns raised anonymously. JH added it was positive the number of anonymous concerns had reduced as this demonstrated a cultural change within the organisation.

NS stated due to the success of the Freedom to Speak Up process staff were more confident of a resolution or explanation.

	NS added the number of staff concerns reported to the Care Quality Commission had also reduced. DH thanked SLA for her work as Lead FTSU Guardian, who was stepping down at the end of January. The Board **NOTED** the report.	
10	**Communications and Engagement Report** The Board **NOTED** the report.	
11	**Committee Chairs Reports** **11.1) Finance Business Performance Committee** The Board **NOTED** the report.	
12	**Questions from the Public** TC queried cancelled care packages and if it was possible to keep packages open for longer for patients as there was experience of some being cancelled. HK stated care packages were held for 2 weeks and if a patient stays longer the care package is cancelled. HK added there is some flexibility. NS stated care package responsibility lay with the Wirral Place Director and addressing discharge was key. RT noted the Government had announced £500m discharge fund and queried who would receive this. HK stated the Wirral Place Director was responsible for this fund as well as the money that required spending before March 2023. No other questions from the public were raised.	
13	**Any other Business** No other business was raised.	

(The meeting closed at 11:20)

Action Log
Board of Directors in Public
1 March 2023

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	31 August 2022	9.3	To include the due dates against the mitigating actions on the Board Assurance Framework	David McGovern	In progress. A refreshed version is due for presentation in a Board report in April.	April 2023
2.	2 November 2022	9.4 & 15	To provide further detail in the next update around meal wastage, and around statutory compliance	Paul Mason	Complete. Included in the quarterly update.	March 2023
3.	25 January 2023	6	To circulate the Report on Liverpool Hospital Services Review and to discuss at the next meeting	Janelle Holmes	In progress. To be discussed as part of the away day.	April 2023
4.	25 January 2023	8	To organise a strategic away day for the Board to consider current and future strategic considerations	David McGovern	In progress. To be held in place of the April Board Seminar.	April 2023

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 7**
1 March 2023

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 January and February. 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 a standing report to the Board of Directors			

1	**Narrative**
1.1	**Industrial Action Update** As has been previously reported, the announcement of the 2022/2023 pay award resulted in increased Trade Union activity and a number of Trade Unions have balloted for Industrial Action. In Wirral University Teaching Hospital ballots undertaken by the Royal College of Nursing (RCN), the Chartered Society of Physiotherapy (CSP),

	Hospital Consultants and Specialists Association (HCSA) and the British Medical Associate (BMA) did return a mandate for action. The RCN have taken strike action in the Trust on 18th and 19th January 2023, and on 6th and 7th February 2023. Planned strike action on 1st and 2nd March 2023 has been paused as the RCN enter into negotiation with the Government. The BMA, who have balloted Junior Doctors, have not yet issued formal notice of strike action although it is expected that 72 hours of continuous action will take place in March 2023. In addition to the Industrial Action involving Trust employees, the Trust has been impacted by North West Ambulance strike action across a number of periods in December, January and February. Further strike action is planned on 6th and 20th March. Extensive planning has taken place, and continues, led by the Trust EPRR Lead, and partnership working mechanisms are in place with Staff Side colleagues to ensure that patient safety and staff support are prioritised.
1.2	**Infection, Prevention and Control (IPC) Update** The Trust has seen less infection control challenges throughout January with COVID and flu incidences being at the lowest point since the start of the pandemic. Cases of norovirus and C. difficile continue to be seen during the winter period. However, the Trust has been able to prevent the spread of this using strict infection control practices. A steady continued reduction in the number of C difficile cases continues as a result of the improvement plan actions.
1.3	**Maternity Incentive Scheme (MIS) Update** Following the January Board of Directors receiving assurance and approving Trust compliance with year 4 of the MIS, the Trust has been notified this has been approved by the LMNS and ICB. As a result, the Trust will receive the full financial benefit of £0.559m.
1.4	**Serious Incidents** The Trust declared 1 serious incident in December, which occurred within the Medicine Division. The Serious Incident Panel report and investigate under the Serious Incident Framework to identify learning. Duty of Candour has been commenced in line with legislation and national guidance. **Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS)** There were no RIDDOR incidents reported to the Health & Safety Executive (HSE) in December.
1.5	**System and Place** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** CMAST Leadership Board met on 3 February for an extended meeting. Trust Chairs joined the meeting to jointly receive an update on CMAST delivery during 2022/3 and a look forward to anticipated deliverables and priorities in 2023/4. Review and endorsement of CMAST's vision and continuing priorities were invited. Anticipated priorities for each of the programmes were then discussed as follows:

Elective Recovery Programme:

- Waiting List Management; reducing long waits, waiting list validation and risk stratification and a focus on outpatients.
- System Resources: capitalising on accessible, system wide, elective hubs, mutual aid coordination and optimisation; system wide patient treatment lists and independent sector optimisation
- Reducing variation: targeting top decile performance for all trusts, implementing GIRFT and best practice pathways in tandem with workforce transformation initiatives

Clinical Pathways Programme:

- Implementing established improvement models and focus in dermatology and ENT
- Implement outcomes and priorities from the Orthopaedics Alliance

Diagnostics Programme:

- Reduce waiting times across all specialities
- Increase productivity and turnaround times
- Deploying digital investment in a system directed way to increase collaboration
- System wide transformation – whole system view and optimisation coupled with future Pathology needs assessment for the ICS
- AI deployment across diagnostics
- Deploy collaborative staff bank

Workforce Programme:

- Working towards a single staff contract to support movement of staff across the system, supporting mutual aid and resource placement with greatest need
- Developing an evidence base to support intelligence led action on - staff recruitment, retention and market development
- Developing consistent workforce approaches and responses for staffing, recruitment and employment issues and needs including linking with wider partners and agencies to optimise routes to employment

Finance Efficiency and Value Programme

- Supporting delivery of an ICS wide financial strategy
- Establishing sustainable and transparent funding flows underpinned by common governance and risk approaches
- Bridging ICB / ICS led initiatives with the required Trust Board assurance and regulatory impact
- Delivery of efficiency at scale work programme and expanded scope

Recognising C&M Cancer Alliance's (CMCA) accountability to NHSE the Leadership Board also received an update on 2022/3 deliverables and future plans, in line with CMAST programmes, recognising the absolute interconnectivity of this critical programme of work and the alignment of priorities across member organisations and with elective recovery, clinical pathways and diagnostics in particular.

The Leadership Board considered recent ICB discussions in response to the conclusion of the Liverpool Clinical Services Review. The Board recognised the need to make progress on the issues and evidence detailed within the report but also the importance of aligning these activities with existing work programmes across the ICS,

	including CMAST, and the need to ensure that health inequalities and access across C&M were actively considered. The Board also received an update on the ICB led Joint Forward Plan. A document which provides an NHS delivery framework to realise the ambition of the ICP strategy. The Board received a proposal for the C&M provider collaboratives to consider a draft of the plan by the end of March aligned to when NHSE will require an initial submission. Opportunity for system and partner engagement, including Trust Boards, would be possible from April through June. **Cheshire and Merseyside ICB** At its meeting on 23 February the ICB focussed on activity at Knowsley Place including a resident story within that area. Assurance reports were provided in relation to Director of Nursing update, current financial position, Quality and Performance reporting and update from ICB Committee Chairs. There were further proposals relating to E,D and I, future ICB Risk Management and prioritisation and initial work on delegated authorities. **Wirral Place Based Partnership Board** At its meeting on 9th February the PBPB for Wirral included items providing a cyclical update from Healthwatch, the Wirral Dementia Strategy, the Wirral sport and activity strategy, finance updates and detail regarding the NHS 2023-24 priorities and operational planning guidance. Detail can be found at (Public Pack)Agenda Document for Wirral Place Based Partnership Board, 09/02/2023 10:00)

2	Conclusion
2.1	The Board of Directors are asked to note the report.

Report Author	Janelle Holmes, Chief Executive
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Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 8**
1 March 2022

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

Report Purpose and Recommendations

This report 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 of Directors:

- Note the report

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			

1	Introduction / Background
1.1	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 and benchmarks well within Cheshire and Merseyside in terms of elective performance. 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 which in turn impacts on the elective recovery programme.

2	Planned Care
2.1	**Elective Activity** For FYE 2022/23 the elective activity has been profiled against the corresponding periods in 2019/20. In January 2023, the Trust attained 99.2% against a plan of 98.3% for Outpatients. For elective admissions 99.1% of activity was delivered against a target of 96.0%. **Outpatient activity by POD** **Elective activity by POD** In line with the Trust recovery plans elective activity for January was positive notwithstanding the significant pressure on hospital occupancy and the requirement to cancel all routine patients due to Industrial Action.
2.2	**Priority 2 Performance (P2)** The Trust did not meet the P2 month end trajectories for January with the final position reporting 98 P2 breaches against a month end plan of 12. All P2 patients are reviewed by the clinical team to ensure the most urgent patients are prioritised for treatment but due to the significant increases in demand it is challenging to accommodate P2 patients within the timeframes required. There are significant challenges within two specialities namely Urology and Colorectal and specialty level recovery plans have been developed and agreed.
2.3	**Referral to Treatment** The national standard is to have no patients waiting over 104 weeks in January 2023 and to eliminate routine elective waits of over 78 weeks by April 2023 and 52 week waits by March 2024. The Trust's performance at the end of January against these indicators (pre RTT freeze and final validation) was as follows: • 104+ Week Wait Performance – zero patients waiting • 80+ Week Wait performance – 59 patients with a plan of 0 (local C&M target) • 78+ Week Wait Performance - 77 patients with a plan to be compliant with zero patients waiting longer than 78 weeks by the end of the financial year (notwithstanding patient choice) • 52+ Week Wait Performance - 1304 patients • Waiting List Size - there were 38,949 patients on an active RTT pathway which is higher that the Trust's trajectory of 31,556 (local C&M target)

	Target	Actual
New	93.8%	90.1%
F/UP	100.1%	103.0%
Combined	98.3%	99.2%

	Target	Actual
Day Case	96.5%	100.0%
Inpatients	93.4%	94.1%
Combined	96.0%	99.1%

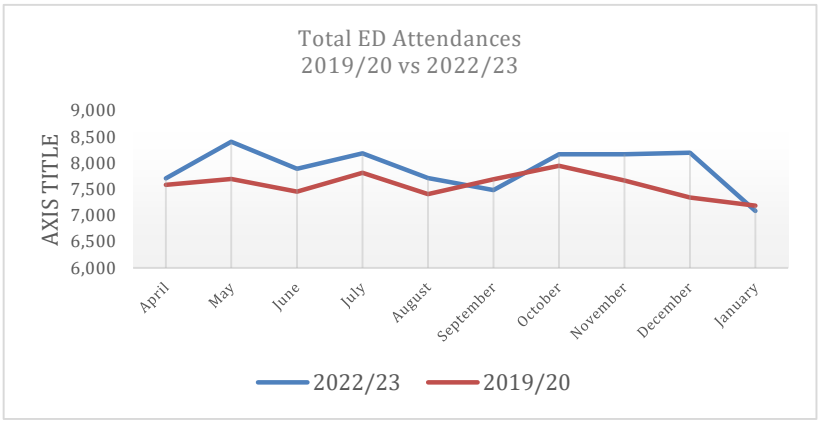
2.4	**Cancer Performance** Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 3 to date: • 2 Week Waits – 2WW performance declined in December due to another increase in referrals. Colorectal, Urology, Gynaecology and Breast services have seen significant increases in the number of patients referred on the 2 weeks wait pathway and accommodating all patients within the 14 days is a challenge. • Faster Diagnosis Standard – was 76.24% in December against a National target of 75%. • All other targets - all targets for the quarter are predicted to be non-compliant apart from 31-day subsequent drug in line with the recovery trajectory. As with all Trusts across C&M delivery against the 31- and 62-day indicators remains a priority but given the increases in demand the recovery of performance against the targets will be a longer term improvement plan over the next 12 months. • The Surgical Division has initiated a multi-disciplinary working group to review and action any patient currently waiting over 62 days. This is being led by the Divisional Director with a focus on reducing the patients waiting longer than 104 and 62 days.
2.5	**DM01 Performance – 95% Standard** In January (pre-submission) 87.65% of patients waited 6 weeks or less for their diagnostic procedure for those modalities included within the DM01. This is against the national standard of 95%. All modalities achieved the 95% compliance target with the exceptions of CT, Echo and urology. Endoscopy achieved 95.8%. Additional capacity has been secured for urology and improvements against the 6-week target will be evident from February. It should be noted that the cystoscopy backlog includes planned patients exceeding six weeks from their target scope date. This is a change in year as previously planned patients were not on an active waiting list (standard across the NHS) and they now are included to ensure the Trust is sighted on this patient group. Once the cystoscopy backlog is cleared, the Trust will achieve DM01 compliance.
2.6	**Risks to recovery and mitigations** The clinical divisions are continuously working through options to reduce the backlogs of patients awaiting elective treatment. These include the recruitment of new staff, with a focus on consultants, additional activity outside of core capacity and the utilisation of an LLP. The major risk to the delivery of the elective recovery programme is the continually high bed occupancy levels and the risk that this poses to maintaining the ringfenced and protected elective beds, particularly given the number of patients that do not have a criteria to reside still being in the region of 200 per day. The Chief Operating Officer has direct oversight of this challenge, and the use of the elective beds does not form part of the Trust's Winter Plan. Industrial action across a number of disciplines has had a significant impact on elective recovery and will do moving forward with disruption to patients. On RCN strike days all patients were cancelled for treatment or outpatients with only a small number of cancer patients receiving treatment.

3.0	**Unscheduled Care**
3.1	**Performance** January Type 1 performance was up by 4.23% on December, ranking the Trust 22nd out of 42 Trusts in the Northwest (includes Children's Hospitals), however the Trust continues to perform well in terms of overall 4-hour performance and is ranked 5th out of the 42 Trusts (including UTC). Type 1 ED attendances: • 8,195 in December (avg. 264/day) • 7,087 in January (avg.228 /day) • 13.4% decrease per previous month

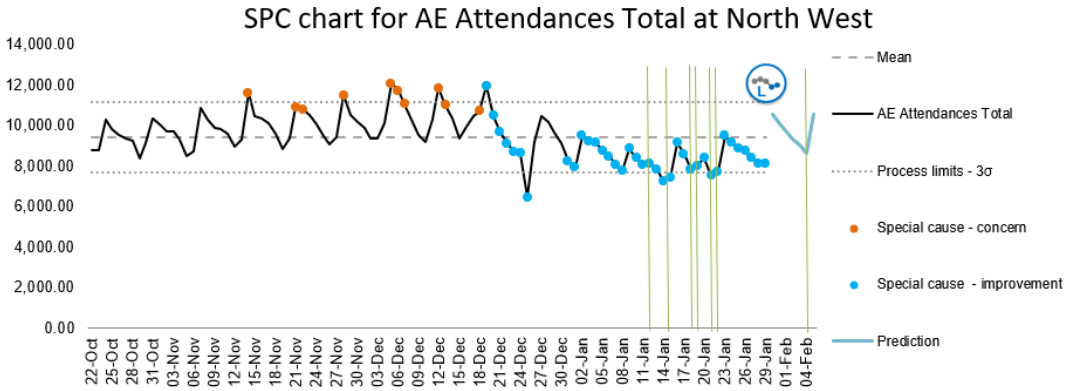
Type 3 ED attendances:

- 3,093 In November
- 2,507 in December
- 26% increase

Type 1 ED Attendances by month compared to 2019/20:

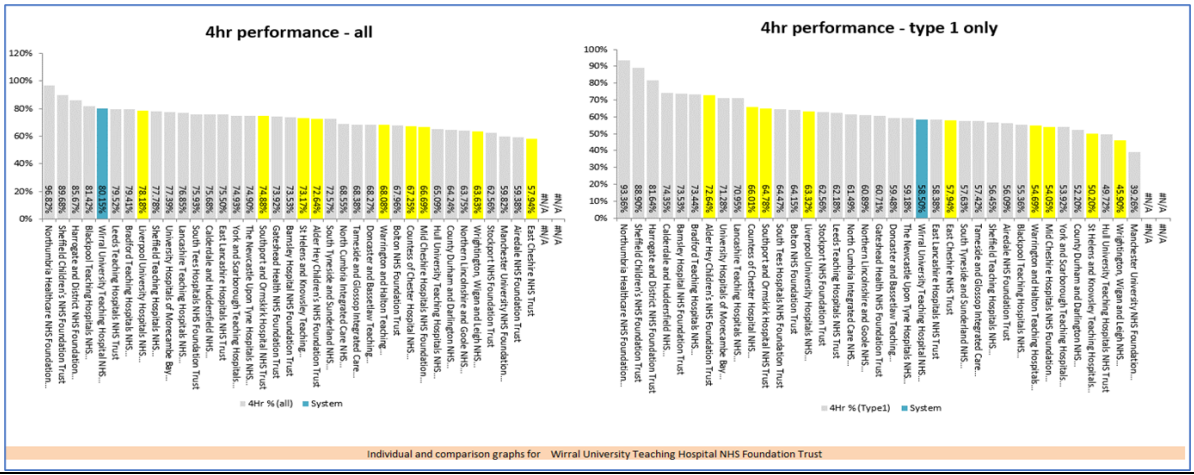


The decrease in Type 1 and Type 3 attendances has been seen across the North West for the month of January, with some of the decrease likely due to both the ambulance and nursing industrial action.



The green lines demonstrating days of industrial action.

The graphs below demonstrate Wirral's 4-hour performance (blue bar) on the left and just the type 1 performance on the right hand graph plotted against other acute providers in C&M (yellow bars):



	The creation of an Ambulance Arrival Zone (AAZ), opening in early March, will provide 12 spaces for patients admitted via ambulance to be cared, removing a significant proportion of corridor care. The Trust is working with NHS England on the national model for SDEC services and is participating in two pilots focusing on the PE pathway direct to UMAC and the Care of Experience in SDEC. The Trust is currently awaiting confirmation of whether funding will be approved by the system to proceed with a GP to support triage in SPA following the successful trial in December. The system continues to focus on reducing the number of patients who do not have criteria to reside. The measures following the 'flow week' are to be implemented before the end of March 23.
3.2	**Risks and mitigations to improving performance** The current building work taking place as part of UECUP has caused some disruption to patients experience in the ED, but remedial action has been taken. The Acute Divisional team is working closely with the UECUP team to ensure that disruption is kept to a minimum. In January, the department improved signage at ED and throughout the department. During periods of high demand in the waiting room, especially after days of industrial action, the front lobby area was also used reducing congestion in the department. We have started to plan the patient journey through the new ED and to consider how we will work with the local partners to improve the offer for Wirral patient. Patient flow through the hospital remains a challenge. The impact of poor egress from the ED continues to result in patients waiting a very long time for a bed (the number of 12 hour decisions for admission continues to remain high). The Trust continues to respond to the days of increased pressure with the enactment of the Full Capacity Protocol which speeds up the transfer of patients out of the department but there are days where a large proportion of patients wait longer than 12 hours. The new Ambulance Arrival Zone will reduce the number of patients receiving corridor care however the bed requests will remain at the current position until the Trust see increase an increase in discharges.

4.0	**Conclusion**
	The Board should note that when 35% of the total bed base is occupied by patients requiring alternative care, there is a significant risk that the performance of the UEC pathways and elective programme will not be improved and that an optimal patient experience cannot be provided during periods of high demand via the ED. The Chief Operating Officer continues to explore alternative ways of working with clinical departments and system partners to mitigate and reduce the risks posed by the ongoing demand. There are currently few system-wide solutions to address the current challenge with the criteria to reside patients in acute beds and this has been escalated through Place and the Integrated Care Board.

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Board of Directors in Public **Item 9.1**
1 March 2023

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 January 2023 It is recommended that the Board: • notes performance to the end of January 2023

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 Board			

1	**Narrative**
1.1	Of the 49 indicators that are currently reported against thresholds (excluding Use of Resources): - 31 are off-target or failing to meet performance thresholds - 18 are on-target

	Following the 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 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 or covered within the Chief Operating Officers Report.

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

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Appendix 2 Quality Performance Dashboard - SPC Version - February 2023

Approach

The metrics from the existing WUTH Quality Performance Dashboard have been adopted into SPC format.
The template from the NHS England 'Making Data Count' (MDC) Team is the starting point.
The metrics have retained their CQC domain category, and grouped into 'themes'.

Issues / limitations

SPC charts should only be used for 15 data points or more. Some of the WUTH metrics only apply from 2022, so will take time to build up.
The national template does not support including a target where it is variable over time, eg a reducing trajectory for RTT long waiters
Larger scale adoption across the Trust, eg down to sub-Divisional level, is being explored with support from the MDC Team.

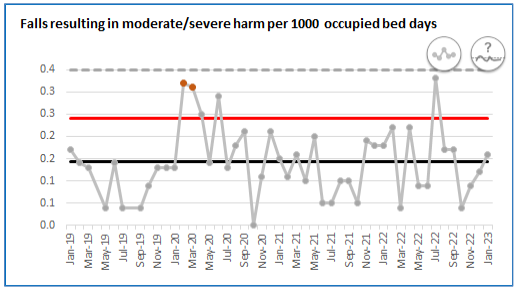
Notes:

This iteration of the dashboard now includes summary tables against each metric on performance and variation type.
Not all metrics have been adopted into SPC format, as it is not always appropriate. The best chart format for these metrics are to be confirmed.
Supporting narrative is now included for many of the metrics classed as 'Red', using the commentary provided in the parallel IDA (exception) reports.
For the metrics covered by the separate COO report, narrative text has not been duplicated.
Further discussion on establishing the most beneficial narrative format for all metrics would be helpful.
As agreed with the Board, the existing performance dashboard will continue to be maintained until the replacement SPC format is considered acceptable.

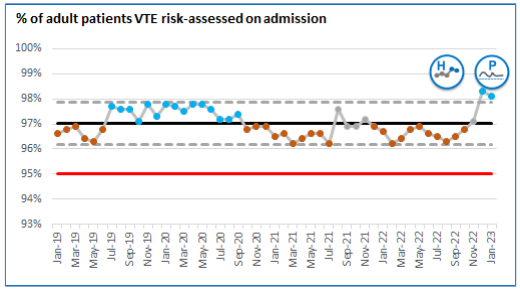
Metrics not included:

CQC Domain	Indicator
Well-led	Duty of Candour compliance - breaches of the DoC standard for Serious Incidents
Well-led	Number of patients recruited to NIHR studies
Use of Resources	I&E Performance (monthly actual)
Use of Resources	I&E Performance Variance (monthly variance)
Use of Resources	NHSI Risk Rating (not reported for 2022/23)
Use of Resources	CIP Performance (YTD Plan vs Actual)
Use of Resources	NHSI Agency Performance (YTD % variance)
Use of Resources	Cash - liquidity days
Use of Resources	Capital Programme (cumulative)

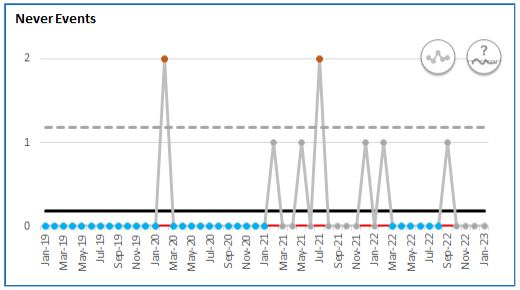
Safe - Avoiding Harm



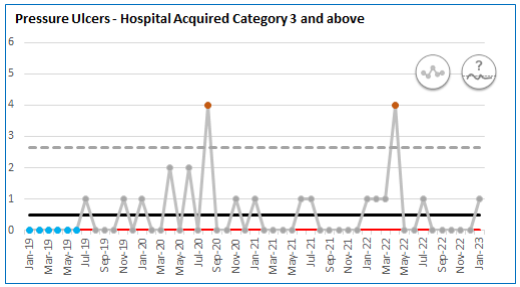
Jan-23
0.159
Variance Type
Common cause variation
Threshold
≤0.24
Assurance
Hit & miss target subject to random variation



Jan-23
98.10%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Performance consistently achieves the target



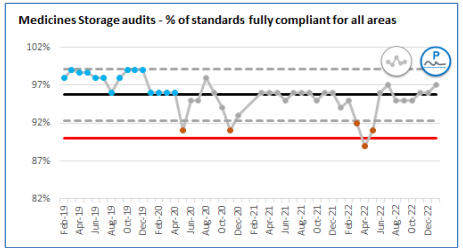
Jan-23
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation



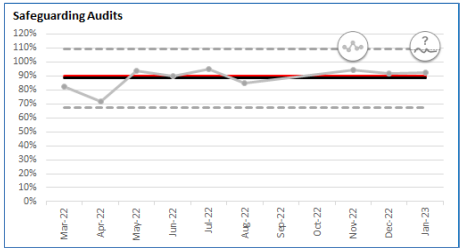
Jan-23
1
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Issues:	**Action & Expected Impact:**
Falls resulting in harm: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved
VTE risk-assessment on admission: Special cause variation - High improving. The target threshold is consistently achieved, including the most recent month.	No narrative on action as metric achieved
Never events: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved
Pressure ulcers HAI category 3: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	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 a pressure ulcer prevention plan was not put in place within the initial 24 hours of the patient's hospital stay which met the individual patient's needs. The Tissue Viability Team have worked directly with nursing staff within the Emergency Department (ED) to address the specific areas for improvement. In addition, staff have been requested to complete the tissue viability e-learning modules that are available on ESR. The increased length of stay within the ED (circa 24 hours) due to the associated flow challenges is considered a contributory factor to the development of the patient's pressure ulcer. Expected Impact: no hospital acquired category 3, 4, and unstageable pressure ulcers due to lapses in care.

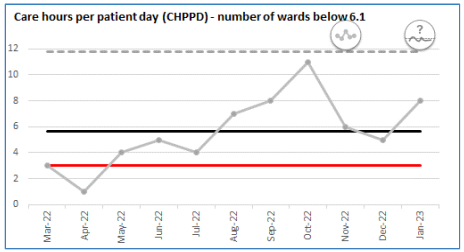
Safe - Assurance Audit



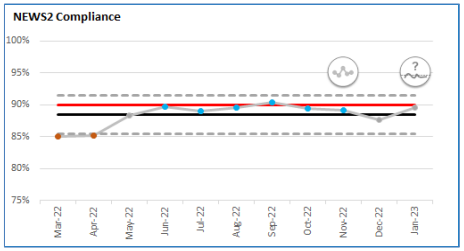
Jan-23
97%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target



Jan-23
92.4%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation



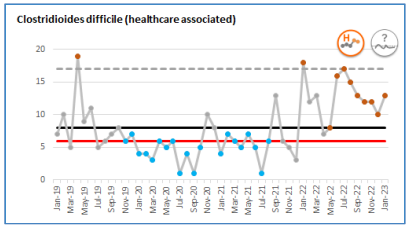
Jan-23
8
Variance Type
Common cause variation
Threshold
≤3
Assurance
Hit & miss target subject to random variation



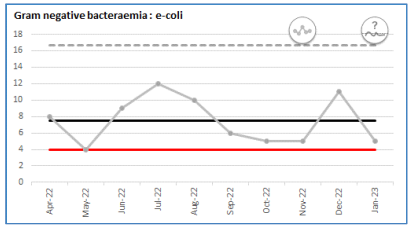
Jan-23
89.6%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Issues:	**Action & Expected Impact:**
Medicines storage audits: Common cause variation. The target threshold is consistently achieved, including the most recent month.	No narrative on action as metric achieved
Safeguarding audits: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved
Care hours per patient day: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	The CHPPD tracker is one of the safer staffing measures to monitor if any areas are consistently recording CHPPD <6.1. The CHPPD data is triangulated with further staffing metric data to monitor the impact on care. Impacts on care are being monitored and have remained minimal with the areas of lower than threshold CHPPD. January, with 8 wards below the required threshold is lower than the highest point, which occurred in October 2022 (11), and the same as September 2022. 6 of the wards had a CHPPD of 5.9, only 0.2 below the required threshold. Wards 20, 24 and 27 have not been below threshold since November 2022. Wards 22, 36, 38, and M1 have had consecutive months of a CHPPD of < 6.1. Ward M1 provides care to patients who do not have the criteria to reside. Healthcare professional input will not be required at the same level or frequency to that of an acute area. All wards with a CHPPD consistently < 6.1 are overseen by the Matron. Daily allocation of staff is considered on a trust wide perspective, risk managed, and professional judgement applied to maximise staffing resource to maintain patient safety. Expected Impact: a reduction in the number of wards with a consistent CHPPD of <6.1 by end of Q4.
NEWS2 Compliance: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	NEWS2 compliance with the recording NEWS2 observations is reported to the Executive Management Team fortnightly within nursing quality metrics. Sustained improvement in compliance of recording NEWS2 since April 2022 continues to be achieved. This has been achieved through the Deteriorating Patient Quality Improvement Faculty led by the Chief Nurse creating a trust wide change, in conjunction with focused workstreams. The model of care for patient with no criteria to reside has been amended in accordance with their clinical requirements. One change is the reduction in observations being recorded for those with a NEWS2 score of 0 – 4 from 12 hourly to once daily. Compliance in the recording of NEWS2 score 0-4 continues to be the area of challenge, this may be impacted upon the compliance requirements remaining twice daily not once daily for this population. Changes to the BI portal have been requested. Expected impact: the expectation is for all areas to achieve greater than 90% for completing NEWS2 observations by Q4.

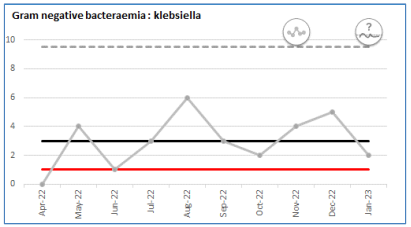
Safe - Infection Control



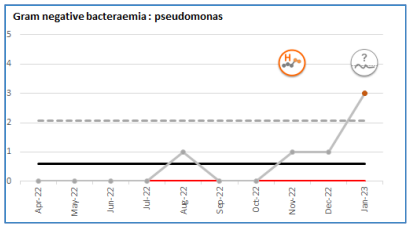
Jan-23
13
Variance Type
Special cause variation - concerning
Threshold
≤6
Assurance
Hit & miss target subject to random variation



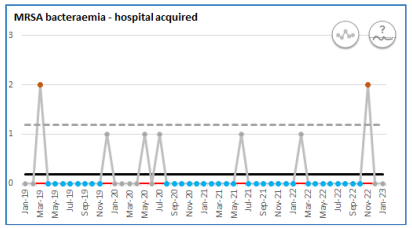
Jan-23
5
Variance Type
Common cause variation
Threshold
≤4
Assurance
Hit & miss target subject to random variation



Jan-23
2
Variance Type
Common cause variation
Threshold
≤1
Assurance
Hit & miss target subject to random variation



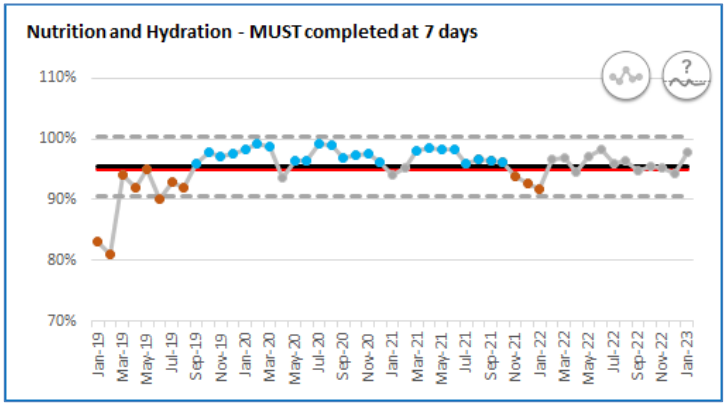
Jan-23
3
Variance Type
Special cause variation - concerning
Threshold
≤9 for 2022/23
Assurance
Hit & miss target subject to random variation



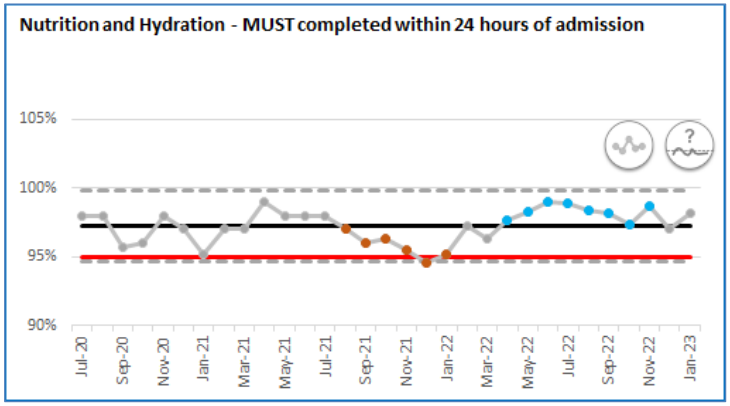
Jan-23
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Clostridioides difficile (healthcare associated): Special cause variation - High concerning. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Governance processes continue to be in place monitoring the CDI improvement plan, directly overseen by the Chief Nurse / DIPC. Collaboration with healthcare partners continues with system wide challenges being addressed through the multi-agency Health Protection Board for Wirral. Q3 evidenced positive outcomes with a sustained reduction in the number of CDI's. Continued reduction in the number of cases has not been further sustained in January 2023, returning to case numbers consistent with Sept to Nov 2022. An outbreak was identified on 1 ward in January with 3 cases of the same CDI strain. Immediate actions were taken and improvements made to address cleaning standards, patient isolation and IPC practices. Enhanced auditing of the cleaning standards continues to drive improvements across the Trust. Collaborative working with facilities teams supports a proactive approach to achieve required standards consistently. Delays in isolation remain a challenge. The IPC team is working closely with patient flow and wards to embed the revised isolation priorities and manage the flow as effectively as possible. The prevention of transmission of infection remains a priority during the bed capacity challenges currently evident throughout the Trust. Expected impact: sustained reduction in patients diagnosed with healthcare associated Clostridioides difficile by Q4.
Gram-negative bacteraemia e-coli: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Individual case scrutiny continues enabling learning opportunities to be identified and remedial actions to be put into place where required. Many blood stream infections are diagnosed in severely ill patients with no indication that there is a clinical omission in care. Process to determine if a bacteraemia can be avoided have been reviewed. This has resulted in the streamlining of cases, prioritising those where the source of the bacteraemia is unknown or / and the care of the patient is likely to have contributed to the infection. Future scrutiny will determine areas for focus. Key priority areas that may contribute to the reduction of E-coli bacteraemia are progressing within the Trust and as a Wirral wide system approach. This includes appropriate antibiotic prescribing, urinary catheter care and management, and aseptic non-touch technique. Expected impact: the number of patients diagnosed with an E-coli bacteraemia is reduced to below the monthly threshold.
Gram-negative bacteraemia klebsiella: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Klebsiella is a gut organism and common sources identified during the RCA process relate to the management of indwelling devices and intra-abdominal complexities. 1 case has been reviewed in January 2023 that was hospital onset healthcare-associated; the other was community onset healthcare associated. Learning from the hospital onset case has identified it to be associated with catheter care, recognizing the complexities of the patient condition. Opportunities for learning have been shared with the Continence Steering Group for trust wide communication. Key priority areas that may contribute to the reduction of Klebsiella bacteraemia are progressing within the Trust and as a Wirral wide system approach. This includes appropriate antibiotic prescribing, urinary catheter care and management, and aseptic non-touch technique. In addition, the 'Gloves off' campaign continues to be promoted. Expected impact: the number of patients diagnosed with a Klebsiella blood stream infection is reduced to below the monthly threshold.
Gram-negative bacteraemia pseudonomas: Special cause variation - High concerning. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Three cases in January 2023, making a cumulative six for the year-to-date. This is still within the trajectory of a maximum nine for the full year 2022-23.
MRSA bacteraemia: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved

Effective - Nutrition



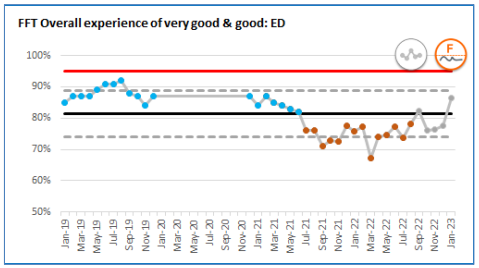
Jan-23
97.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



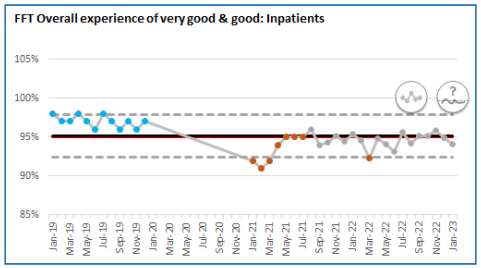
Jan-23
98.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Issues:	**Action & Expected Impact:**
MUST completed at 7 days: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved**.**	No narrative on action as metric achieved
MUST completed within 24 hours of admission: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved

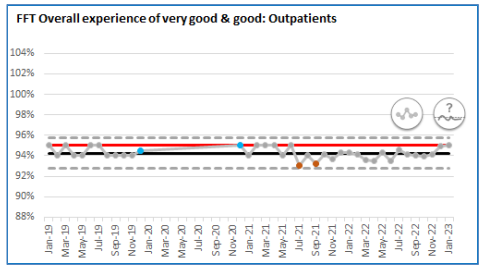
Caring - Patient Experience



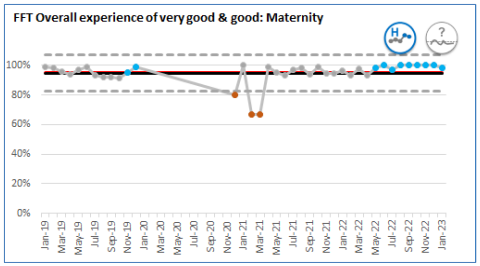
Jan-23
86.5%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target



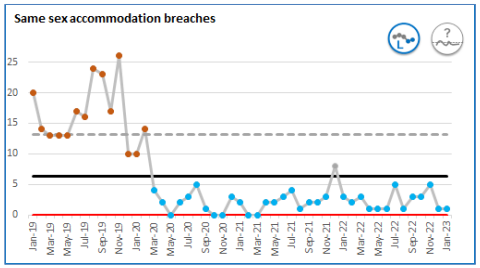
Jan-23
94.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Jan-23
95.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Jan-23
98.5%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Jan-23
1
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

Issues:

FFT Overall experience - ED: Common cause variation. Performance consistently fails to achieve the target, including the most recent month.

FFT Overall experience - Inpatients: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

FFT Overall experience - Outpatients: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.

FFT Overall experience - Maternity: Special cause variation - High improving. Achieving the threshold is hit & miss, with the most recent month being achieved.

Same sex accommodation breaches: Special cause variation - Low improving. Achieving the threshold is hit & miss, with the most recent month not being achieved.

Action & Expected Impact:

Each of the Patient Experience Strategy promise groups focuses on identifying patients' experience improvement opportunities.

Operational pressures within the Emergency Department, consistent with the national position, has impacted on the FFT score. FFT score for ED remains below the Trust threshold of 95% however a significant improvement has been noted this month to 86.5% from 77.7% December 2022. Waiting times continue to be reported as an area of challenge.

Outpatients have achieved the target of >95% for the first time since June 2021.

Inpatients FFT score of 94.0%, 1.0% below threshold, is consistent with previous months. Volunteers are visiting wards to conduct FFT surveys and laminated QR codes have been introduced to increase the opportunity for feedback in these areas.

Expected impact: improved FFT scores within the ED and an expectation to reach the Trust target for Outpatients in Q4.

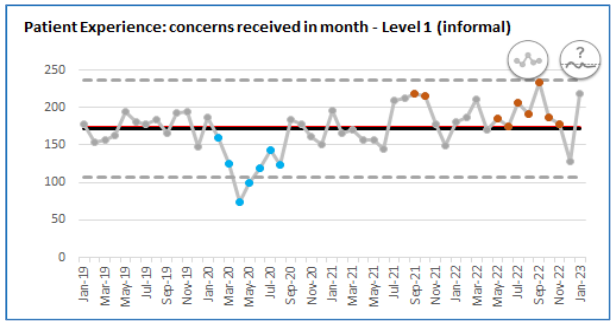
Breaches are often due to patients waiting more than 24 hours for transfer from critical care areas inclusive of Coronary Care Unit (CCU) to general wards; there was 1 such breach in CCU in January 2023. The breach did not cause any delays or refused admissions to CCU. The patient's privacy and dignity needs were met whilst the person waited for transfer to a base ward.

Delivering same sex accommodation is a high priority. It is recognised that system challenges resulting in high levels of activity and a high proportion of patients with no criteria to reside, which continued throughout January 2023, has an impact on the ability to deliver same sex accommodation.

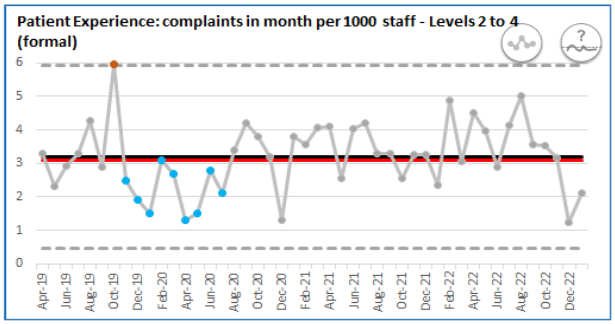
Processes are in place that enable joint working with ICU, CCU, Patient Flow Team, and Divisional Directors and each breach is risk assessed and concerns are managed promptly via bed capacity and operational meetings. This enables daily oversight of individual patients requiring a stepdown and the length of time waiting.

Expected impact: same sex accommodation breaches are minimised and all patients are transferred to their specialty bed within 24 hours of discharge.

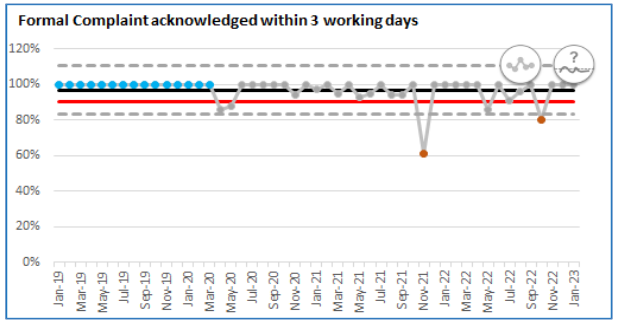
Responsive - Complaints



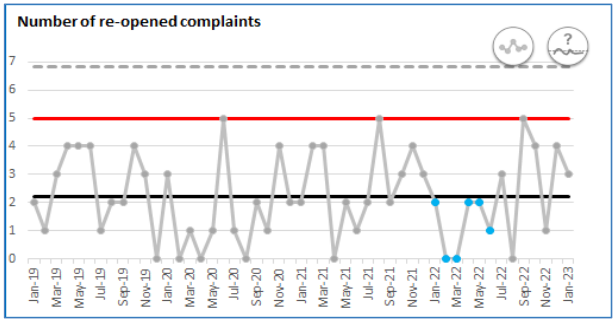
Jan-23
219
Variance Type
Common cause variation
Threshold
≤173
Assassurance
Hit & miss target subject to random variation



Jan-23
2.12
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation



Jan-23
100%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation



Jan-23
3
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

Issues:

Concerns received in month (level 1): Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

Complaints in-month per 1000 staff: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.

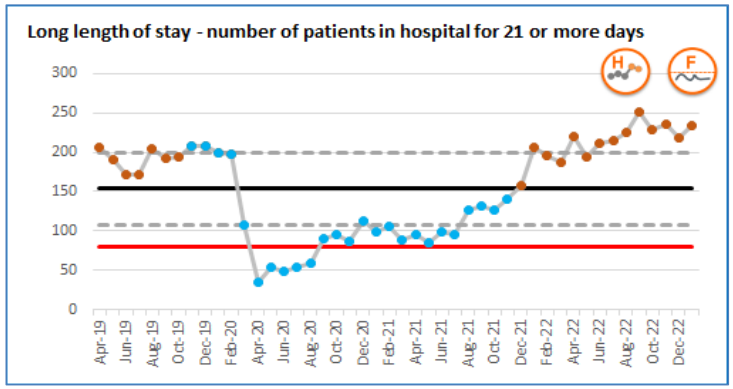
Formal complaint acknowledged < 3 working days: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.

Number of reopened complaints: Common cause. Achieving the threshold is hit & miss, with the most recent month achieved.

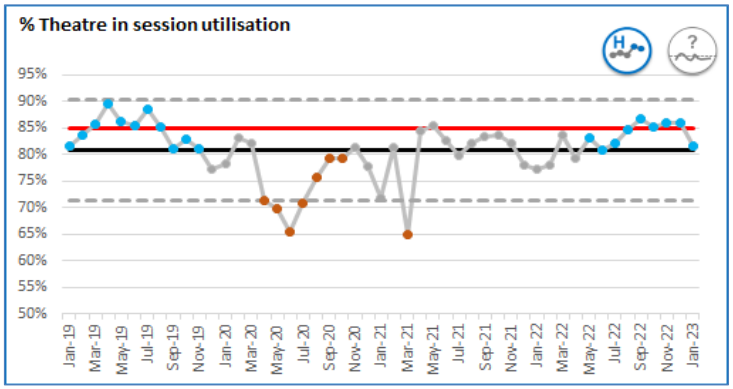
Action & Expected Impact:

The increase in concerns (Level 1) received in month considered common cause variation.
No narrative on actions for the other metrics as achieved.

Effective - Productivity



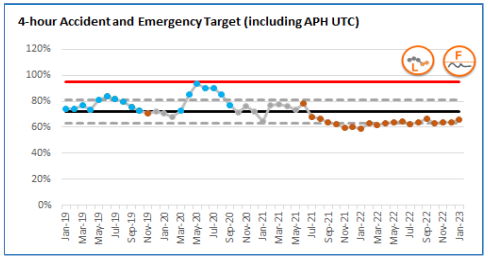
Jan-23
234
Variance Type
Special cause variation - concerning
Threshold
≤79
Assurance
Performance consistently fails to achieve the target



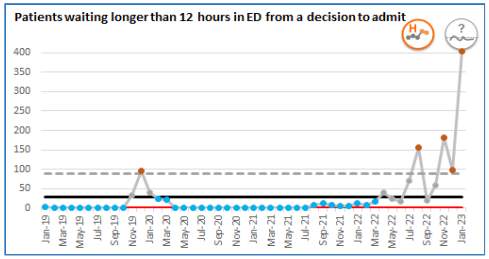
Jan-23
81.5%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Long Length of stay (21+): Special cause variation - High concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
% Theatre in-session utilisation: Special cause variation - High improving. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Focus remains on improving utilisation of core sessions as part of planning for 2023/24 and is one of the key priorities of the Surgery Division. There has been a decrease in on the day cancellations from 76 in December to 70 in January. Of the 70 in January, 51% of the cancellations reflected non-clinical cancellations. Predominant reasons include list over-running and bed availability post-operatively. The theatre scheduling meeting is now locking down to 4 weeks and moving forward further from 4 weeks in some areas. This enables patients to be booked 4 weeks ahead. The backfilling process is being reviewed as part of the new theatre floor plans to support increasing 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. Actions: •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 the above •Think Big Challenge in Surgery to focus on efficiency and productivity gains including supporting an increase in planned session utilisation •Ensure protected elective beds remain protected for elective activity Expected Impact: increase in in-session utilisation and an increase in case throughput.

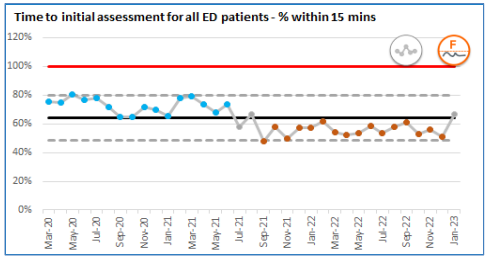
Responsive - Urgent Care



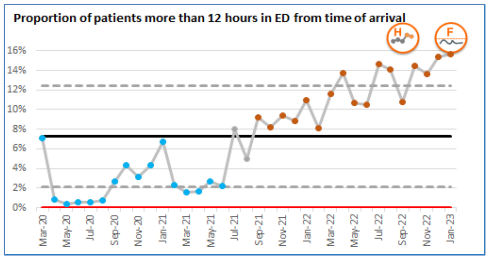
Jan-23
65.7%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target



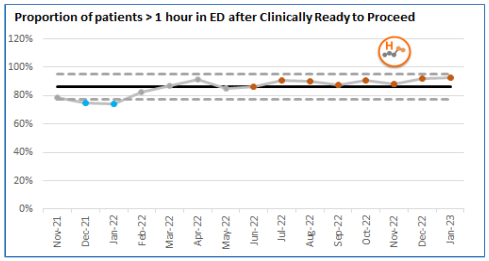
Jan-23
405
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation



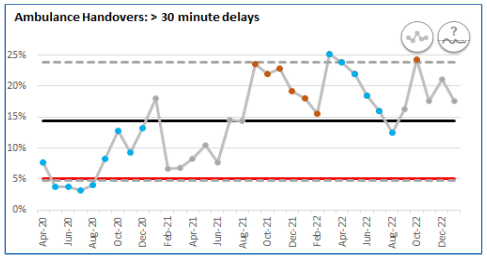
Jan-23
66.6%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target



Jan-23
15.6%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target



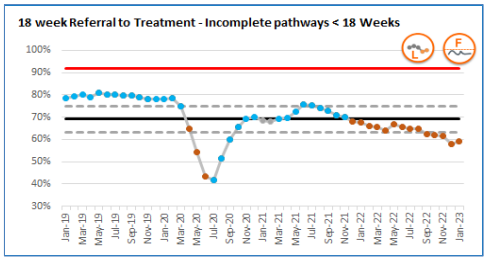
Jan-23
92.4%
Variance Type
Special cause variation - concerning
Threshold
TBC
Assurance



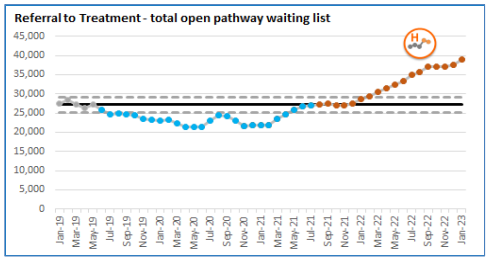
Jan-23
17.6%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
4-hour A&E Target : Special cause variation - Low concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
Patients waiting > 12 hours in ED: Special cause variation - High concerning. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board
Time to initial assessment - % < 15 mins: Common cause variation. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
Proportion of ED patients in > 12 hours: Special cause variation - High concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
Proportion of ED patients > 1 hour in ED after CRtP: Special cause variation - High concerning. Performance threshold TBD.	Narrative provided in separate COO Report to the Board
Ambulance handovers > 30 mins delays: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board

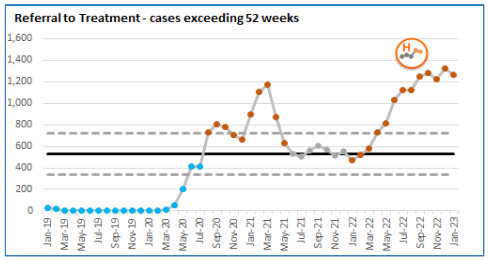
Responsive - Elective Care - RTT



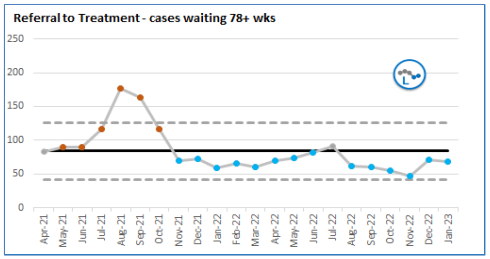
Jan-23
58.97%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target



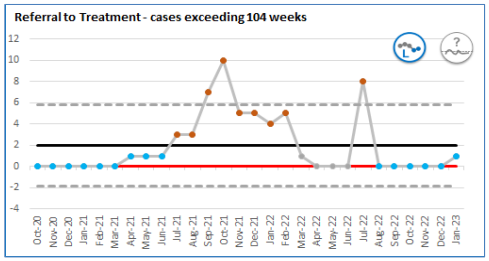
Jan-23
38911
Variance Type
Special cause variation - concerning
Threshold
≤31352
Assurance
Trajectory target not appropriate for SPC Assurance reporting



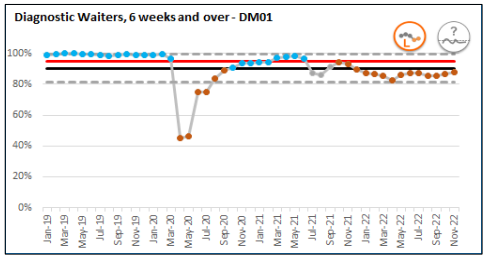
Jan-23
1219
Variance Type
Special cause variation - concerning
Threshold
520
Assurance
Trajectory target not appropriate for SPC Assurance reporting



Jan-23
68
Variance Type
Special cause variation - improving
Threshold
≤55
Assurance
Hit & miss target subject to random variation



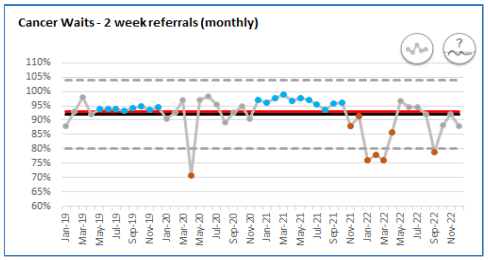
Jan-23
1
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation



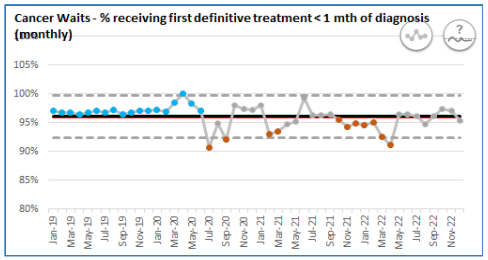
Jan-23
87.4%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
18 week RTT - % incomplete: Special cause variation - Low concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
RTT total open waiting list: Special cause variation - High concerning. Trajectory target not appropriate for SPC Assurance reporting. The target for the most recent month was not achieved.	Narrative provided in separate COO Report to the Board
RTT cases exceeding 52 weeks: Special cause variation - High concerning. Trajectory target not appropriate for SPC Assurance reporting. The target for the most recent month was not achieved.	Narrative provided in separate COO Report to the Board
RTT cases exceeding 78 weeks: Special cause variation - Low improving. Trajectory target not appropriate for SPC Assurance reporting. The target for the most recent month was not achieved.	Narrative provided in separate COO Report to the Board
RTT cases exceeding 104 weeks: Special cause variation - Low improving. Trajectory target not appropriate for SPC Assurance reporting. The target for the most recent month was achieved - the single 104+ case was a Mutual Aid transfer from LUFT.	Narrative provided in separate COO Report to the Board
Diagnostic waiters 6 weeks and over: Special cause variation - Low concerning. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board

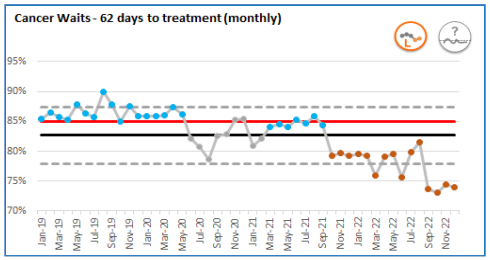
Responsive - Elective Care - Cancer (monthly - 1 mth in arrears)



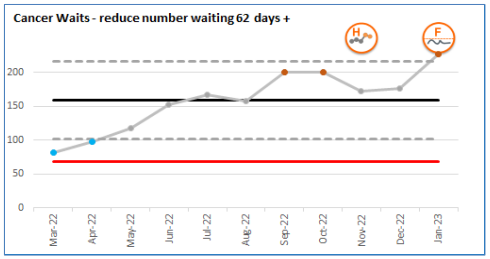
Dec-22
87.9%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation



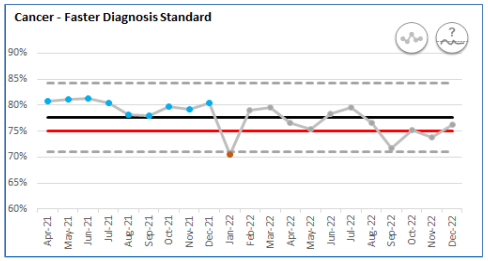
Dec-22
95.3%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation



Dec-22
74.0%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation



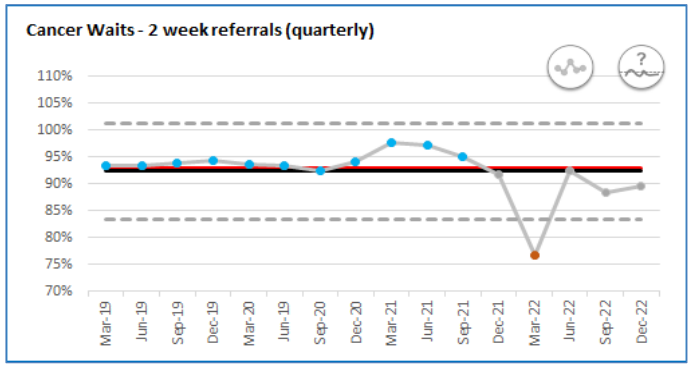
Jan-23
227
Variance Type
Special cause variation - concerning
Threshold
195
Assurance
Performance consistently fails to achieve the target



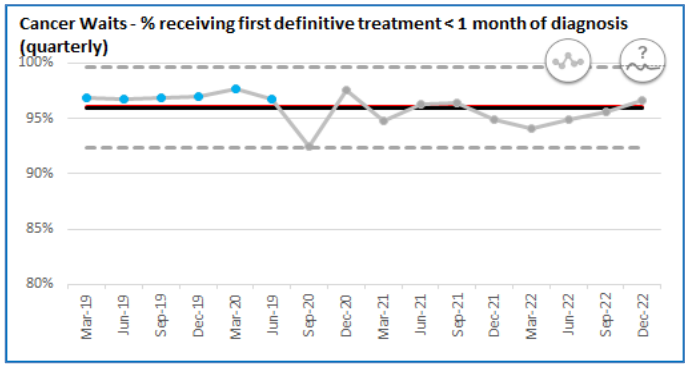
Dec-22
76.2%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Cancer waits - 2 wk refs (monthly): Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board
Cancer waits - % treated < 1 month of diagnosis (monthly): Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board
Cancer waits - 62 days to treatment (monthly): Special cause variation - Low concerning. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board
Cancer waits - reduce number waiting 62 days+ : Special cause variation - High concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
Cancer - Faster Diagnosis standard: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	Narrative provided in separate COO Report to the Board

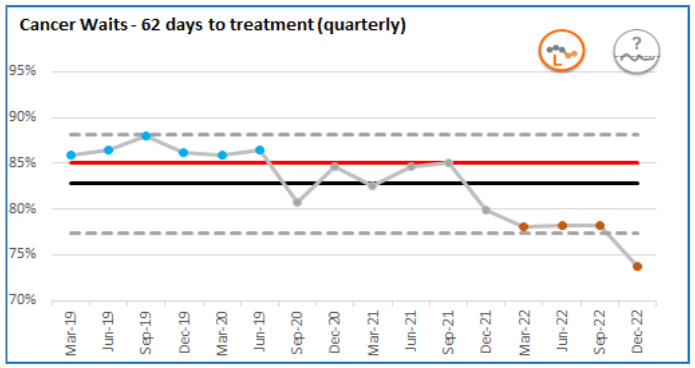
Responsive - Elective Care - Cancer (quarterly)



Dec-22
89.5%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation



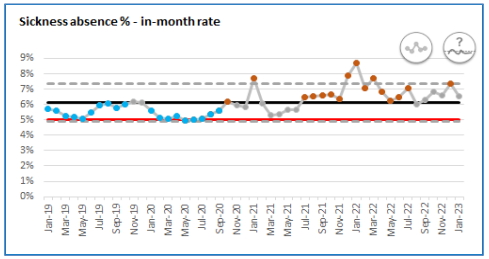
Dec-22
96.6%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation



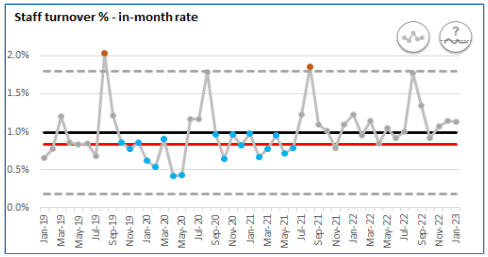
Dec-22
73.8%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Cancer waits - 2 wk refs (quarterly): Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board
Cancer waits - % treated < 1 month of diagnosis (quarterly): Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	Narrative provided in separate COO Report to the Board
Cancer waits - 62 days to treatment (quarterly): Special cause variation - Low concerning. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board

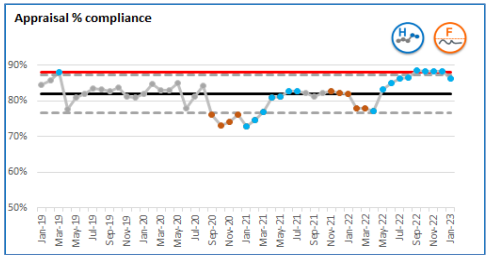
Safe - Workforce



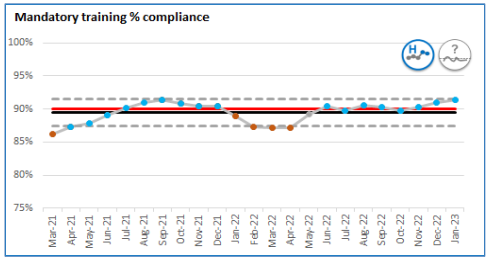
Jan-23
6.52%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Hit & miss target subject to random variation



Jan-23
1.13%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation



Jan-23
86.39%
Variance Type
Special cause variation - improving
Threshold
≥88%
Assurance
Performance consistently fails to achieve the target



Jan-23
91.38%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Issues:	Actions:	Expected Impact:

Sickness absence % in-month rate: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

Monitoring of the Sickness Attendance KPI and associated actions is on-going via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews. Managers continue to be supported by HR.

Targeted Support
The highest sickness absence levels are within Facilities who are actively putting measures in place to address, supported by their HR Team and a dedicated Welfare and Wellbeing lead. Although, they have seen an increase in long term cases, the highest proportion % sickness absence in Facilities and Support Services continues to be attributed to short term absence. All are reviewed as part of monthly deep dives and cases are managed and progressed, as appropriate. Additional work is being undertaken to improve team dynamics and more proactive welfare support.

March Attendance Letter
The HR Services Team are supporting with a targeted patterns of absence letter to be sent out this month, making staff aware of the support available and ensuing they can take advantage of this to help maintain their attendance in work.

MIAA Sickness Absence Review
The Audit contained some positive findings and was broadly satisfied with the Policy, Training, Recording mechanisms and Reporting from local to Board level. The review identified issues around management application of the policy and associated processes.

Development Sessions
The first mini managers essential sessions have launched this month which focus on the recent changes to flexible working arrangements. Flexible working can benefit both staff and the Trust and help reduce absenteeism. Other indirect business benefits are expected to be achieved through improved job satisfaction and wellbeing.

Upcoming workshops in March include Attendance Support Policy, Building Resilience and Attendance Management.

Flu Vaccine
The Flu Vaccine Programme continues. Current uptake amongst frontline Healthcare Workers is 62.2%, compared to a Cheshire and Merseyside average of 51.1%.

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. We continue to appropriately prioritise workforce wellbeing and our commitment to mental health support.

Staff turnover % in-month rate: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

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.

Current Interventions to support retention include:

The Retention Delivery Plan was agreed with the Strategic Retention Group and priorities determined. Some examples of work underway include:
- A CSW staff satisfaction survey
- Review of a new buddy system to support new CSWs.
- Compliance with Exit interviews
- Delivery of the Trust Long Service awards; first face to face long service awards event held since 2019. Held in February the event celebrated staff that have given 25- and 40-years' service.
- Leading Teams programme launched across the Trusts to build leadership skills of ward managers, first line managers across WUTH.

Staff Survey and the People Strategy
The initial 2022 NHS Staff Survey results have been received and will be published on 9th March 2023 on the Staff Survey Coordination Website. This is the second year the results will be reported against the seven People Promise elements, thus providing new trend data for the first time. Longer term trend data remains available for the two themes of Staff Engagement and Morale, key questions, and the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators. The Trust will receive its local benchmark report under embargo by 21st February 2023 for internal operational purposes and it will be used to inform retention strategies in 2023 and beyond. Plans for large scale divisional engagement events are underway that will result in improvement plans. There are also other programmes of activity within the People Strategy Delivery Plan that impact on staff experience including health and wellbeing initiatives, reward and recognition, flexible working, improvements in integration and diversity and the 'perfect start' which will also help minimise turnover.

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.

Appraisal % compliance: Special cause variation - High improving. Performance consistently fails to achieve the target, with the most recent month not being achieved.

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. Divisions that are below Trust target of 88% have produced improvement trajectories and have confirmed expected date, this is closely managed via Divisional Performance Reviews.

In addition to the work that HRBPs are undertaking with divisional triumvirates, the Learning and Development team are also directly contacting all staff that are out of compliance / due out of compliance this month to prompt them to complete their appraisal. Its is anticipated through these top-down and bottom-up approaches it will prompt actions and achievement of Trust target in the short-term.

Work continues to transform appraisal and management supervision at the Trust. Following a successful 'hackathon event' in December 2022 in which a cross section of staff were engaged to design a new process for annual appraisal and quarterly management supervision, a pilot has commenced to test the new approach. The outcome of the pilot and recommendations for implementation will be presented at Workforce Steering Board and People Committee in March and if approved the new process will be launched from April 2023. The new process will be underpinned by a refreshed policy, improved recording process and enhanced guidance for staff and managers including training and videos that can be access 'on demand'.

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.

Mandatory training % compliance: Special cause variation - High improving. Achieving the threshold is hit & miss, with the most recent month being achieved.

No narrative on action as metric achieved

Safe Domain

Clostridioides difficile (Healthcare Associated)

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:
The *Clostridioides difficile* (CDI) threshold set for 2022-23 is 72 - equaling a monthly maximum threshold of 6 cases.

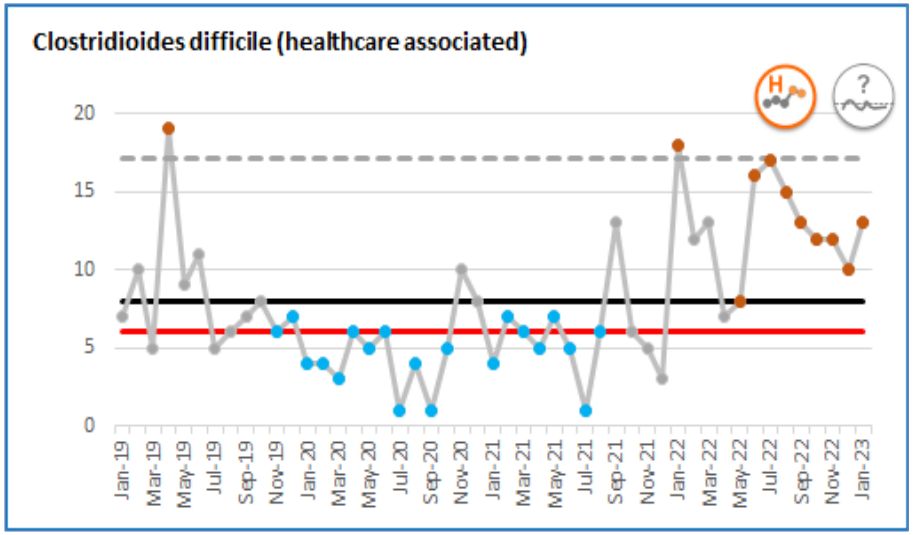
The monthly threshold of 6 has been exceeded each month since April 2022, with 13 cases reported in January 2023. A total of 123 cases since April 2022.

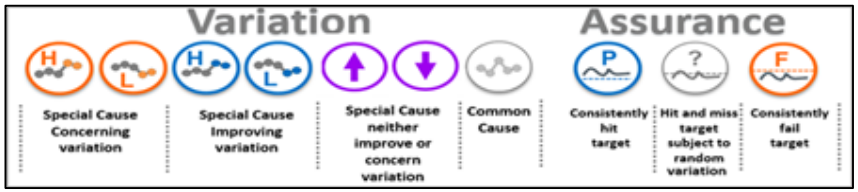
Action:

Governance processes continue to be in place monitoring the CDI improvement plan, which is directly overseen by the Chief Nurse / DIPC. Collaboration with healthcare partners continues with system wide challenges being addressed through the multi-agency Health Protection Board for Wirral.

Q3 evidenced positive outcomes with a sustained reduction in the number of CDI's. There were a slightly higher number noted in January however this is statistical variation as lower numbers have been seen in the early weeks of February. An outbreak was identified on 1 ward in January with 3 cases of the same CDI strain. Immediate actions were taken, and improvements made to address cleaning standards, patient isolation and IPC practices.

Enhanced auditing of the cleaning standards continues to drive improvements across the Trust. Collaborative working with facilities teams supports a proactive approach to achieve required standards consistently.





Delays in isolation remains a challenge. The IPC team is working closely with patient flow and wards to embed the revised isolation priorities and manage the flow as effectively as possible. The prevention of transmission of infection remains a priority during the current bed capacity challenges evident throughout the Trust.
Expected Impact: Sustained reduction in patients diagnosed with healthcare associated *Clostridioides difficile* by Q4.

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

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:

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

The threshold for *E-coli* bacteraemia is 56, which equates to a maximum 4 per month. From April 2022 to January 2023, 75 cases have been reported; 5 patients were diagnosed with an *E-coli* bacteraemia in January 2023.

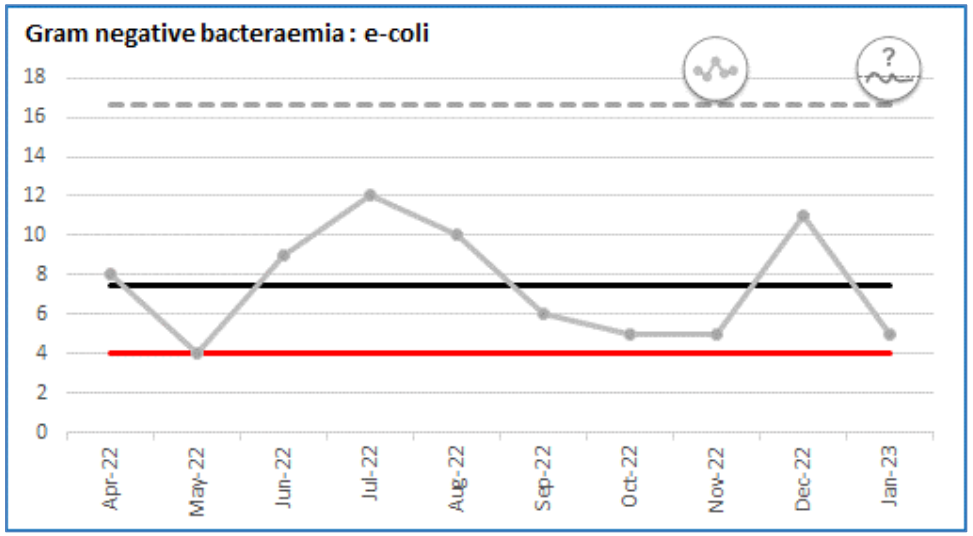
Action:

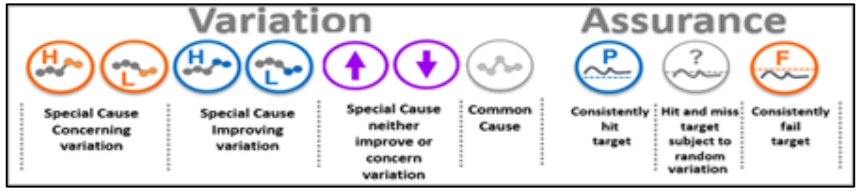
Individual case scrutiny continues enabling learning opportunities to be identified and remedial actions to be put into place where required.

Many blood stream infections are diagnosed in severely ill patients with no indication that there is a clinical omission in care. Process to determine if a bacteraemia can be avoided have been reviewed. This has resulted in the streamlining of cases, prioritising those where the source of the bacteraemia is unknown or / and the care of the patient is likely to have contributed to the infection. Future scrutiny will determine areas for focus.

Key priority areas that may contribute to the reduction of E-*coli* bacteraemia are progressing within the Trust and as a Wirral wide system approach. This includes appropriate antibiotic prescribing, urinary catheter care and management, and aseptic non-touch technique.

Expected Impact:
The number of patients diagnosed with an *E-coli* bacteraemia is reduced to below the monthly threshold.





Gram-Negative bloodstream infections - klebsiella

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:
For 2022-23 the Gram-negative blood stream infection objective is separated into individual targets for *E-coli, klebsiella* and *pseudomonas*. Thresholds are derived from a baseline of the 12 months ending November 2021 (the most recent available data at the time of calculating the figures). The maximum threshold for *Klebsiella* is set at 19, with equates to an alternating threshold of 1 and 2 per month for monitoring purposes.

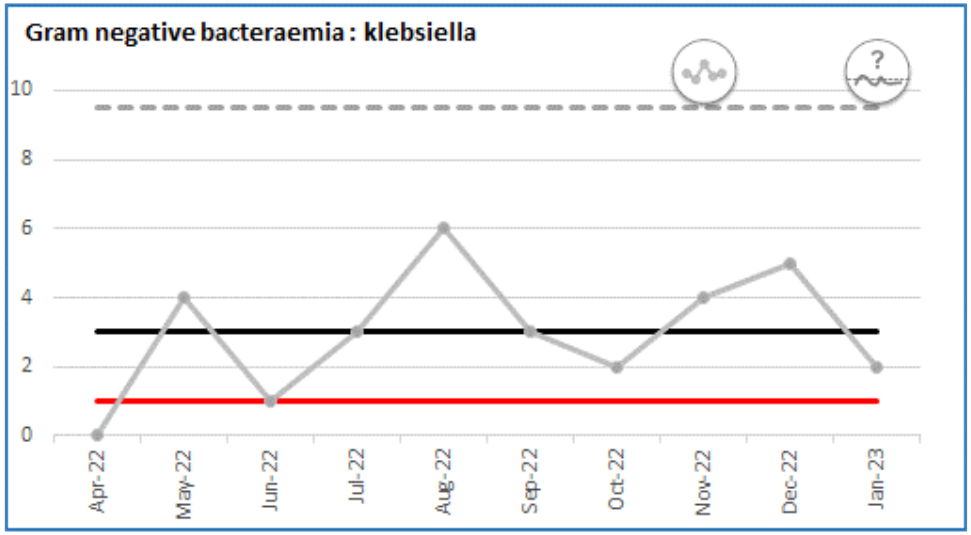
There were 2 cases reported in January 2023. Since April 2022, 30 cases have been reported. Therefore the 2022-23 maximum threshold for the year has been exceeded.

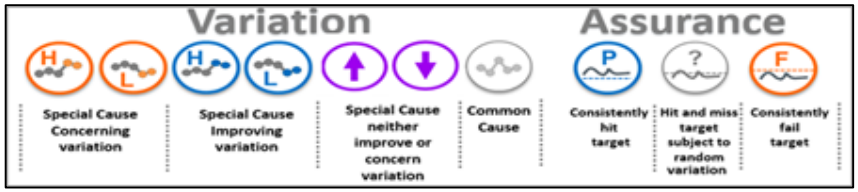
Action:
Klebsiella is a gut organism and common sources identified during the RCA process relate to the management of indwelling devices and intra-abdominal complexities.

1 case has been reviewed in January 2023 that was hospital onset healthcare-associated; the other was community onset healthcare associated. Learning from the hospital onset case has identified it to be associated with catheter care, recognizing the complexities of the patient condition. Opportunities for learning have been shared with the Continence Steering Group for trust wide communication.

Key priority areas that may contribute to the reduction of *Klebsiella* bacteraemia are progressing within the Trust and as a Wirral wide system approach. This includes appropriate antibiotic prescribing, urinary catheter care and management, and aseptic non-touch technique.
In addition, the 'Gloves off' campaign continues to be promoted.

Expected Impact:
The number of patients diagnosed with a *Klebsiella* blood stream infection is reduced to below the monthly threshold.





Pressure Ulcers – hospital acquired category 3 and above

Executive Lead: Tracy Fennell, 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 2022-23.

1 hospital acquired category 3 pressure ulcer has been reported in January 2023.

Action:

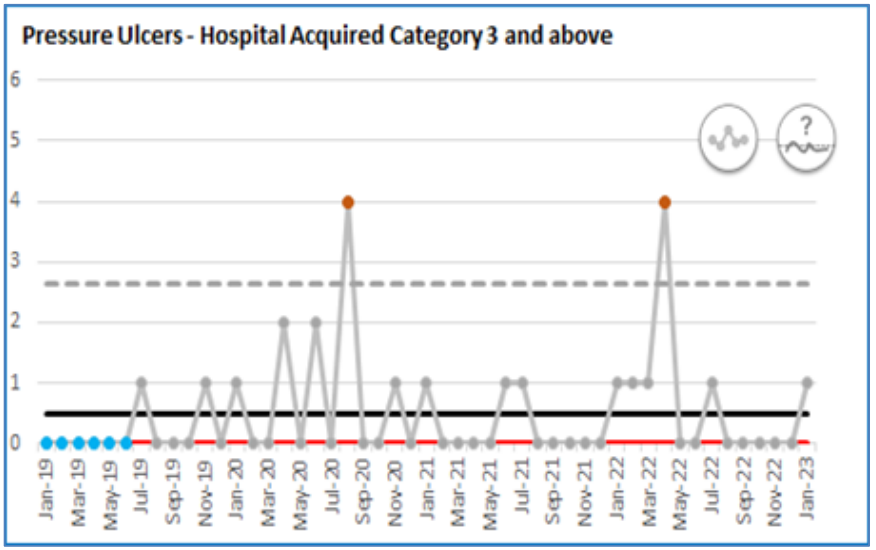
Following scrutiny at the Patient Safety Learning Panel lapses in care that contributed to the development of the patient's pressure damage have been identified. On review a pressure ulcer prevention plan was not put in place within the initial 24 hours of the patient's hospital stay, which met the individual patient's needs.

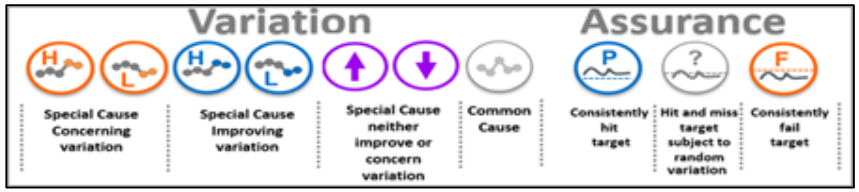
Tissue Viability Team have worked directly with nursing staff within the clinical area to address the specific areas for improvement. In addition, staff have been requested to complete the tissue viability e learning modules that are available on ESR.

This has also been reviewed via the Patient Safety Learning Panel and learning fed into the Tissue Viability Steering Group for action.

Expected Impact:

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





Sickness absence % (in-month rate)

Executive Lead: Deborah Smith, Chief People Officer

Performance Issue:

The Trust threshold for sickness absence is 5%. For January the indicator is 6.52% and demonstrates common cause variation.

Long term sickness absence accounts for 1.46%, whilst short term sickness absence is more of a challenge at 5.06% in January 2023.

Additional Clinical Services are the staff group with the highest absence rate (10.03%) followed by Estates and Ancillary (9.88%) and this staff group are a particular area of focus.

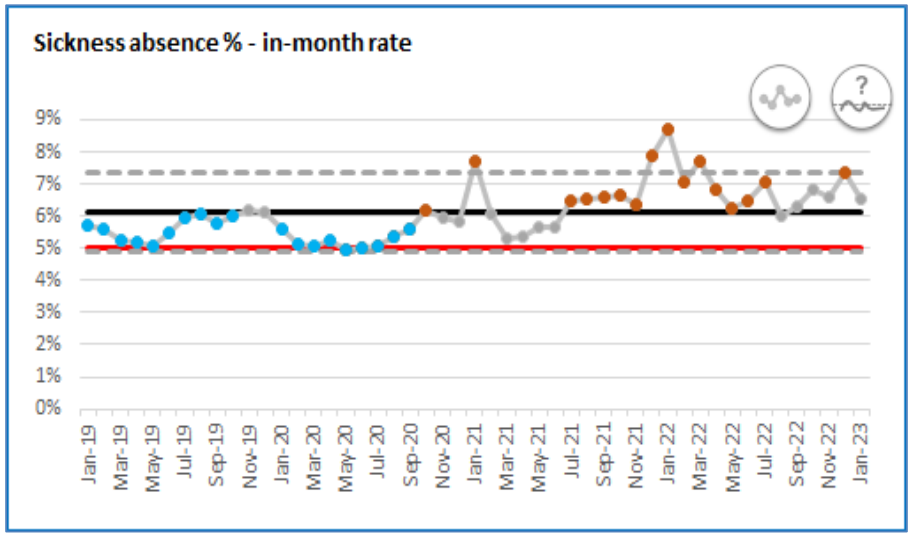
Anxiety, Stress and Depression remains the highest reason for long term sickness absence. The category 'Cold, Cough and Flu-Influenza' was the highest reported reason for short-term sickness, followed by 'Gastrointestinal problems' and 'Infectious Diseases'.

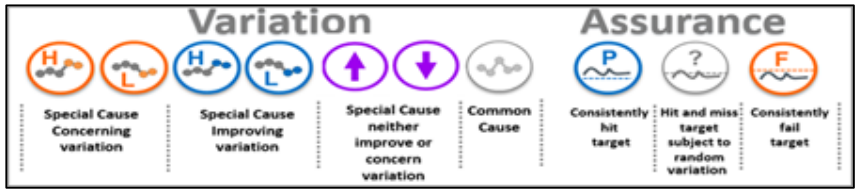
Action:

Monitoring of the Sickness Attendance KPI and associated actions is on-going via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews. Managers continue to be supported by HR.

Targeted Support

The highest sickness absence levels are within Facilities who are actively putting measures in place to address, supported by their HR Team and a dedicated Welfare and Wellbeing lead. Although, they have seen an increase in long term cases, the highest proportion % sickness absence in Facilities and Support Services continues to be attributed to short term absence. All are reviewed as part of monthly deep dives and cases are





managed and progressed, as appropriate. Additional work is being undertaken to improve team dynamics and more proactive welfare support.

March Attendance Letter
The HR Services Team are supporting with a targeted patterns of absence letter to be sent out this month, making staff aware of the support available and ensuing they can take advantage of this to help maintain their attendance in work.

MIAA Sickness Absence Review
The Audit contained some positive findings and was broadly satisfied with the Policy, Training, Recording mechanisms and Reporting from local to Board level. The review identified issues around management application of the policy and associated processes.

Development Sessions
The first mini managers essential sessions have launched this month which focus on the recent changes to flexible working arrangements. Flexible working can benefit both staff and the Trust and help reduce absenteeism. Other indirect business benefits are expected to be achieved through improved job satisfaction and wellbeing.

Upcoming workshops in March include Attendance Support Policy, Building Resilience and Attendance Management.

Flu Vaccine
The Flu Vaccine Programme continues. Current uptake amongst frontline Healthcare Workers is 62.2%, compared to a Cheshire and Merseyside average of 51.1%.

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.

We continue to appropriately prioritise workforce wellbeing and our commitment to mental health support.

Staff turnover %

Executive Lead: Deborah Smith, **Chief People Officer**

Performance Issue:

The Trust threshold for turnover is 0.83%. For January 2023 the indicator was 1.13% and demonstrates common cause variation.

The following staff groups have high turnover in January:

- Allied Health Professionals (1.68%)
- Add Professional & Technical (1.56%)
- Nursing & Midwifery (1.32%)

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.

Current Interventions to support retention include:

The Retention Delivery Plan was agreed with the Strategic Retention Group and priorities determined. Some examples of work underway include:

- A CSW staff satisfaction survey
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- Compliance with Exit interviews
- Delivery of the Trust Long Service awards; first face to face long service awards event held since 2019. Held in February the event celebrated staff that have given 25- and 40-years' service.
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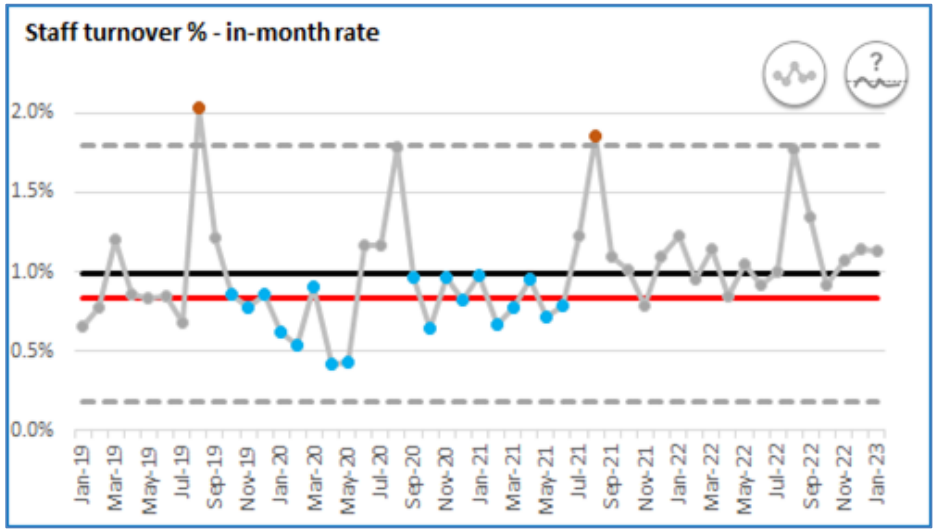

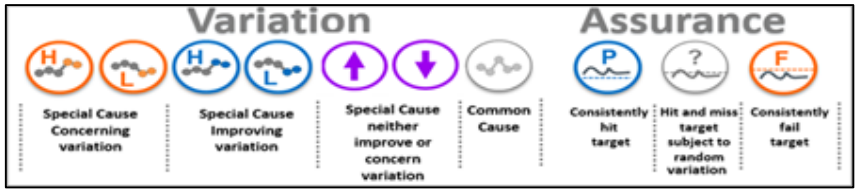

Staff Survey and the People Strategy

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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: Tracy Fennell, 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 3 wards to be below this threshold.

The number of wards for January 2023 were 8: Wards 20, 22, 24, 27, 36 and 37 all with CHPPD 5.9. Ward 38 - CHPPD 5.7. Ward M1 - CHPPD 5.2.

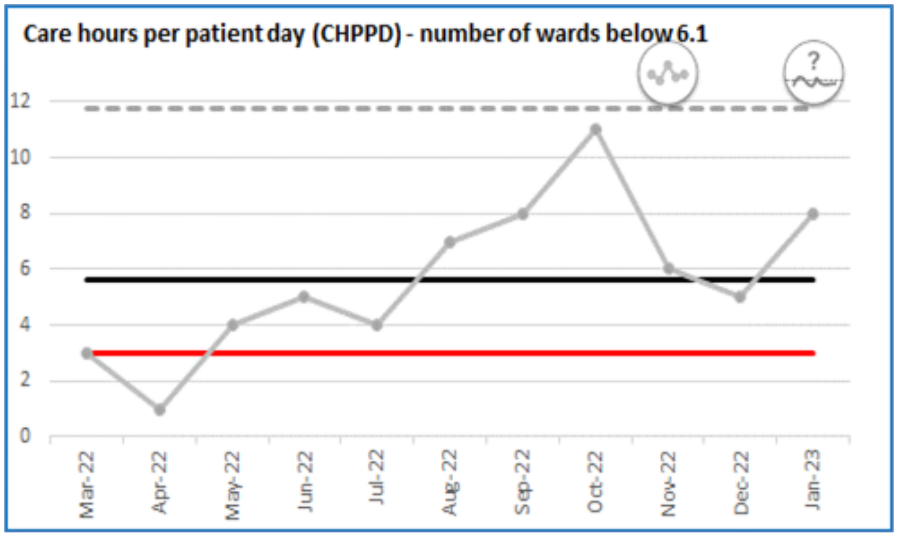
Action:
The CHPPD tracker is one of the safer staffing measures to monitor if any areas are consistently recording CHPPD <6.1. The CHPPD data is triangulated with further staffing metric data to monitor the impact on care. Impacts on care are being monitored and have remained minimal with the areas of lower than threshold CHPPD.

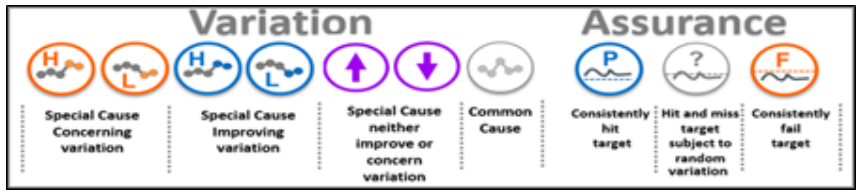
January, with 8 wards below the required threshold is lower than the highest point, which occurred in October 2022 (11), and the same as September 2022. 6 of the wards had a CHPPD of 5.9, only 0.2 below the required threshold. Wards 20, 24 and 27 have not been below threshold since November 2022.

Wards 22, 36, 38, and M1 have had consecutive months of a CHPPD of < 6.1. Ward M1 provides care to patients who do not have the criteria to reside. Healthcare professional input will not be required at the same level or frequency to that of an acute area.

All wards with a CHPPD consistently < 6.1 are overseen by the Matron. Daily allocation of staff is considered on a trust wide perspective, risk managed, and professional judgement applied to maximise staffing resource to maintain patient safety.

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





Effective Domain

Theatre in session utilisation %

Executive Lead: Hayley Kendall, Chief Operating Officer

Performance Issue:
The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. Overall January's performance was 81.5%, down from December's 86% and below the target threshold.

Focus remains on improving utilisation of core sessions as part of planning for 2023/24 and is one of the key priorities of the Surgery Division.

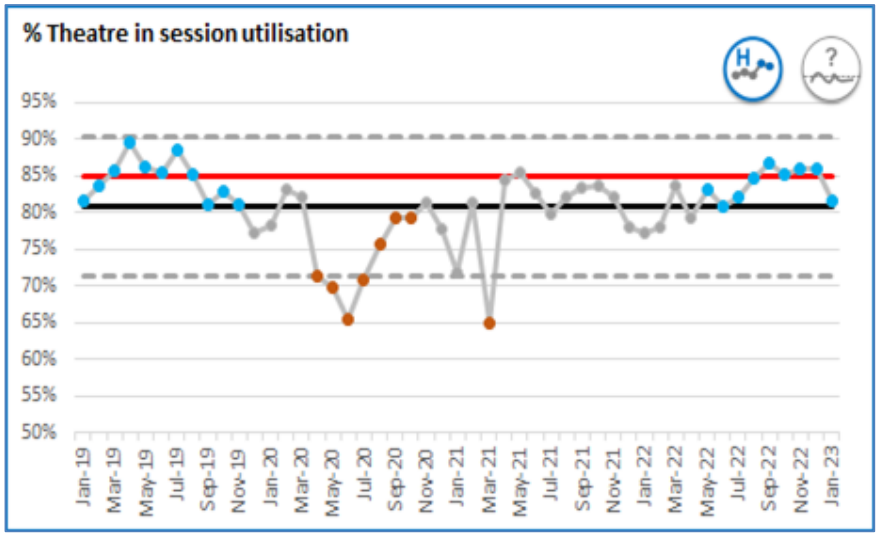
There has been a decrease in on the day cancellations from 76 in December to 70 in January. Of the 70 in January, 51% of the cancellations reflected non-clinical cancellations. Predominant reasons include list over-running and bed availability post-operatively.

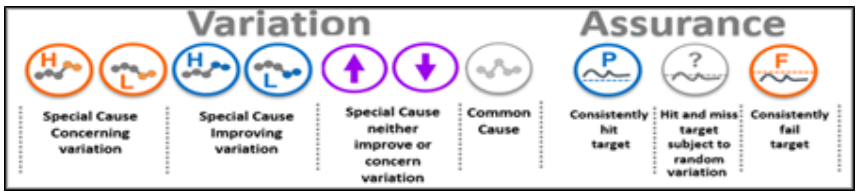
The theatre scheduling meeting is now locking down to 4 weeks and moving forward further from 4 weeks in some areas. This enables patients to be booked 4 weeks ahead.

The backfilling process is being reviewed as part of the new theatre floor plans to support increasing 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 the above



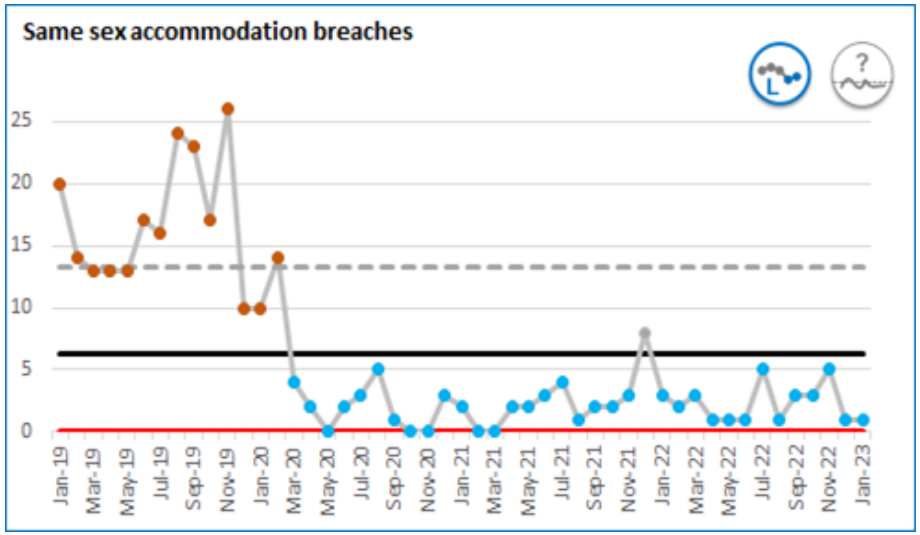


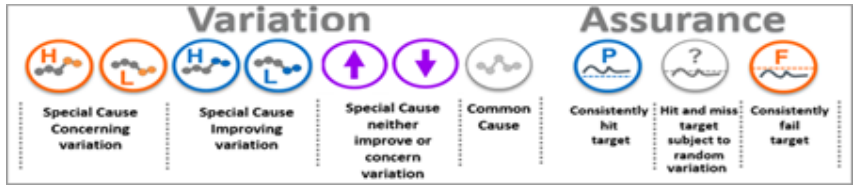
• Think Big Challenge in Surgery to focus on efficiency and productivity gains including supporting an increase in planned session utilisation • Ensure protected elective beds remain protected for elective activity
Expected Impact: Increase in in-session utilisation and an increase in case throughput.

Caring Domain

Same sex accommodation breaches

Executive Lead: Tracy Fennell, 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. Breaches are often due to patients waiting more than 24 hours for transfer from critical care areas inclusive of Coronary Care Unit (CCU) to general wards; there was 1 such breach in CCU in January 2023. The breach did not cause any delays or refused admissions to CCU. The patient's privacy and dignity needs were met whilst the person waited for transfer to a base ward.
Action: Delivering same sex accommodation is a high priority. It is recognised that system challenges resulting in high levels of activity and a high proportion of patients with no criteria to reside, which continued throughout January 2023, has an impact on the ability to deliver same sex accommodation. Processes are in place that enable joint working with ICU, CCU, Patient Flow Team, and Divisional Directors and each breach is risk assessed and concerns are managed promptly via bed capacity and operational meetings. This enables daily oversight of individual patients requiring a stepdown and the length of time waiting.
Expected Impact: Same sex accommodation breaches are minimised and all patients are transferred to their specialty bed within 24 hours of discharge.





Friends & Family Test – Overall Experience

Executive Lead: Tracy Fennell, 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 January 2023 was:

- Emergency Department (ED) – 86.5% (below threshold)
- Inpatients – 94.0% (below threshold)
- Outpatients – 95.05% (above threshold)
- Maternity 98.5% (above threshold)

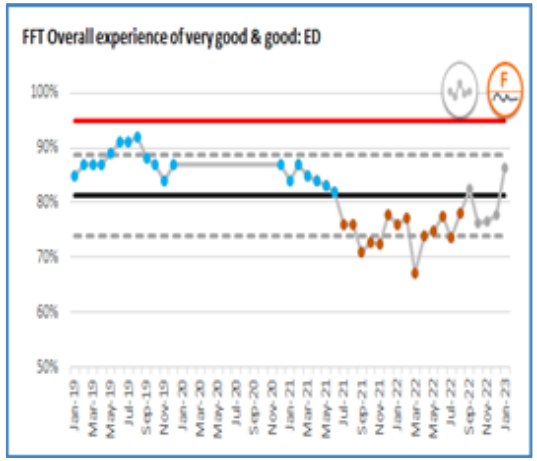
Action:
Each of the Patient Experience Strategy promise groups focuses on identifying patients' experience improvement opportunities.

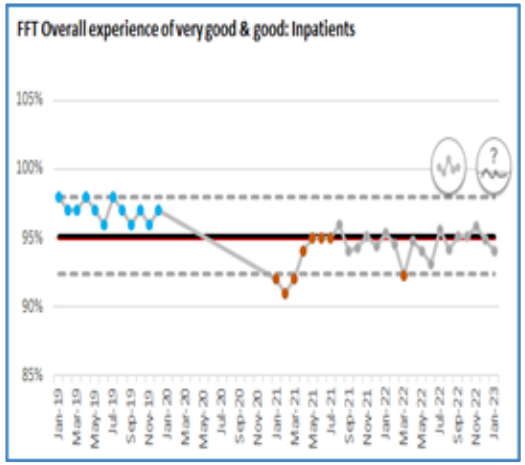
Operational pressures within the Emergency Department, consistent with the national position, has impacted on the FFT score. FFT score for ED remains below the Trust threshold of 95% however a significant improvement has been noted this month to 86.5% from 77.7% December 2022. Waiting times continue to be reported as an area of challenge.

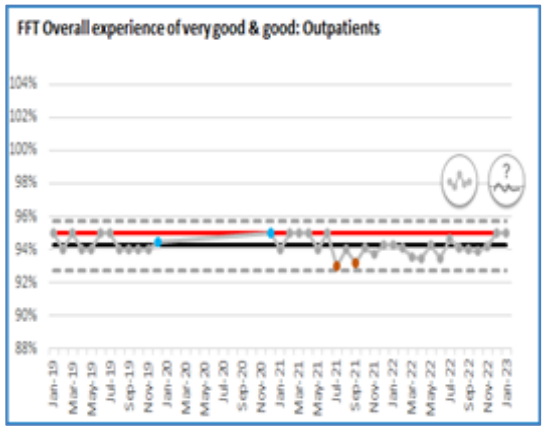
Outpatients have achieved the target of >95% for the first time since June 2021.

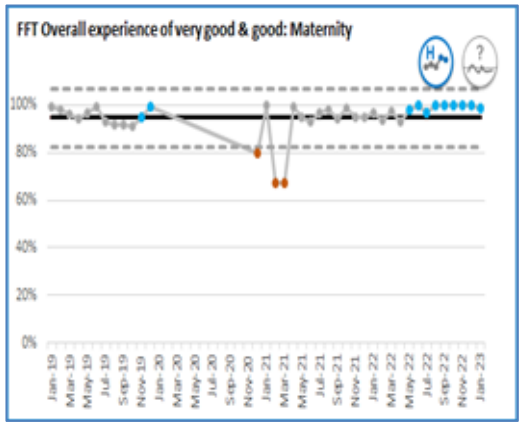
Inpatients FFT score of 94.0%, 1.0% below threshold, is consistent with previous months. Volunteers are visiting wards to conduct FFT surveys and laminated QR codes have been introduced to increase the opportunity for feedback in these areas.

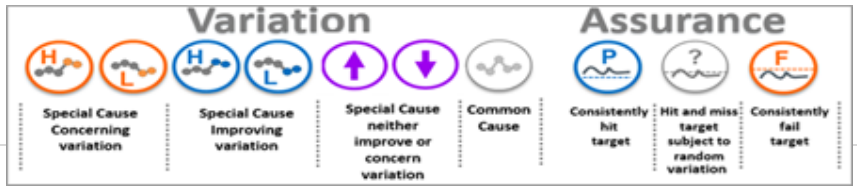
Expected Impact:
Improved FFT scores within the ED and an expectation to reach the Trust target for Outpatients in Q4.











Responsive

NEWS2 Compliance

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:

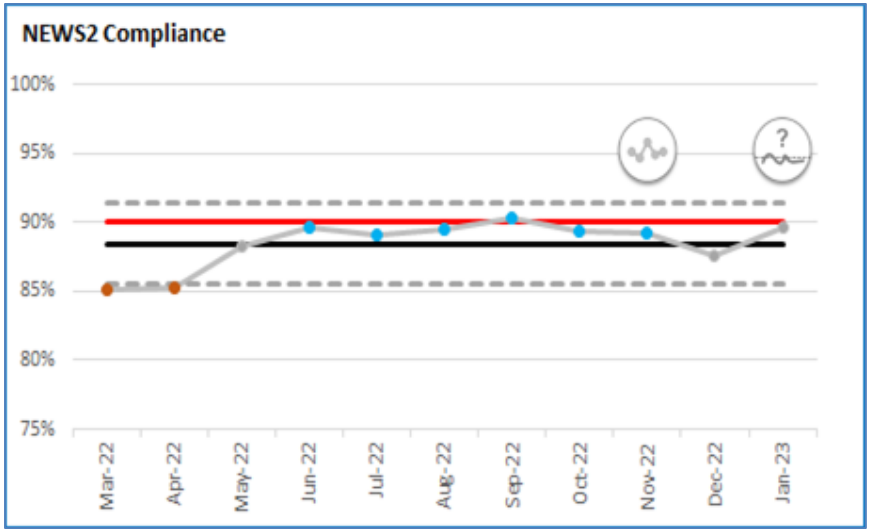
A threshold of greater than 90% compliance with NEWS2 patient observations conducted within national guidelines and Trust NEWS2 policy has been set. Compliance is measured by a rolling programme of monthly ward audits: with the standard achieved in September. Compliance for January 2023 was marginally below target by 0.4% at 89.6%.

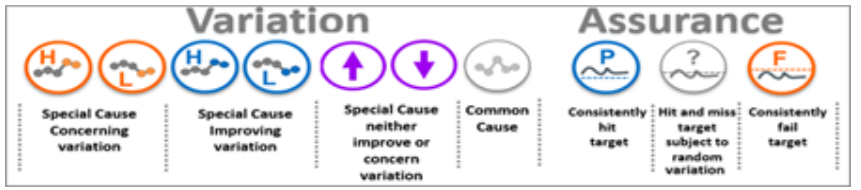
Action:
NEWS2 compliance with the recording NEWS2 observations is reported to the Executive Management Team fortnightly within nursing quality metrics.

Sustained improvement in compliance of recording NEWS2 since April 2022 continues to be achieved. This has been achieved through the Deteriorating Patient Quality Improvement Faculty led by the Chief Nurse creating a trust wide change, in conjunction with focused workstreams.

The model of care for patient with no criteria to reside has been amended in accordance with their clinical requirements. One change is the reduction in observations being recorded for those with a NEWS2 score of 0 – 4 from 12 hourly to once daily. Compliance in the recording of NEWS2 score 0-4 continues to be the area of challenge, this may be impacted upon the compliance requirements remaining twice daily not once daily for this population. Changes to the BI portal have been requested.

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





Well-led

Appraisal compliance %

Executive Lead: Deborah Smith, Chief People Officer

Performance Issue:

The target for annual appraisal compliance is 88%. Compliance has been achieved over a number of months, however at the end of January 2023 86.39% 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.

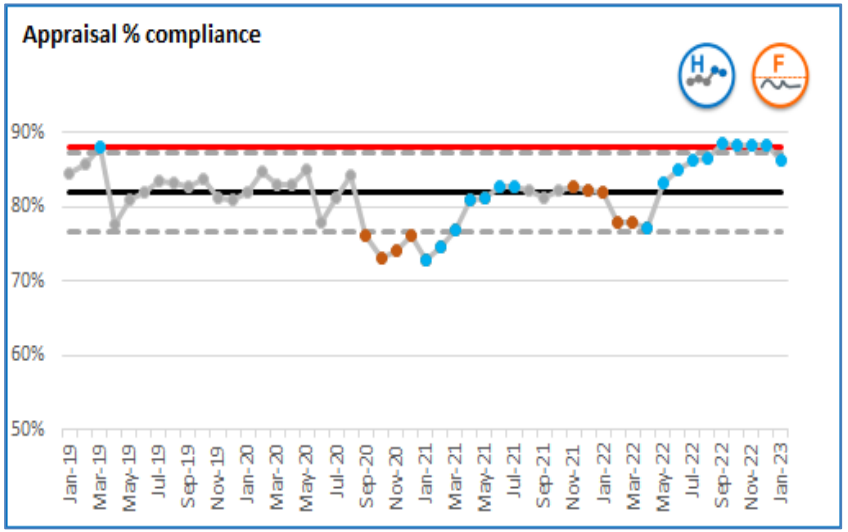
Please note that Medical appraisal is currently excluded from the above figures.

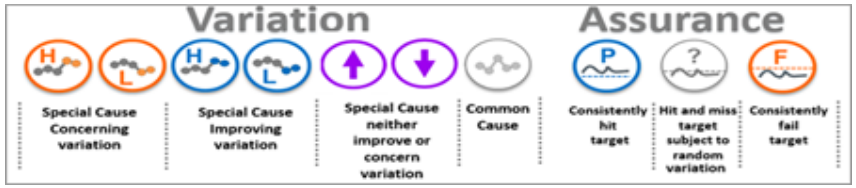
Action:

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. Divisions that are below Trust target of 88% have produced improvement trajectories and have confirmed expected date, this is closely managed via Divisional Performance Reviews.

In addition to the work that HRBPs are undertaking with divisional triumvirates, the Learning and Development team are also directly contacting all staff that are out of compliance / due out of compliance this month to prompt them to complete their appraisal. Its is anticipated through these top-down and bottom-up approaches it will prompt actions and achievement of Trust target in the short-term.

Work continues to transform appraisal and management supervision at the Trust. Following a successful 'hackathon event' in December 2022 in which a cross section





of staff were engaged to design a new process for annual appraisal and quarterly management supervision, a pilot has commenced to test the new approach. The outcome of the pilot and recommendations for implementation will be presented at Workforce Steering Board and People Committee in March and if approved the new process will be launched from April 2023. The new process will be underpinned by a refreshed policy, improved recording process and enhanced guidance for staff and managers including training and videos that can be access 'on demand'.
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.

Quality Performance Dashboard

February 2023
Upated 16-02-23

	Indicator	Objective	Director	Threshold	Set by	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	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	0.18	0.22	0.04	0.22	0.09	0.09	0.33	0.17	0.13	0.04	0.09	0.12	0.16	0.14	
	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	96.7%	96.2%	96.4%	96.8%	96.9%	96.6%	96.5%	96.3%	96.5%	96.8%	97.1%	98.3%	98.1%	97.0%	
	Never Events	Safe, high quality care	CN	0	SOF	0	1	0	0	0	0	0	0	1	0	0	0	0	1	
	Clostridioides difficile (healthcare associated)	Safe, high quality care	CN	Maximum 72 for 2022-23. Max 6 cases per month	WUTH	18	12	13	7	8	16	17	15	13	12	12	10	13	123	
	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	10	6	5	5	11	5	75	
	Gram negative bacteraemia : klebsiella	Safe, high quality care	CN	Maximum 19 for 2022-23. Max 1 case per month	National	-	-	-	0	4	1	3	6	3	2	4	5	2	30	
	Gram negative bacteraemia : pseudomonas	Safe, high quality care	CN	Maximum 9 for 2022-23. Max 0 cases per month	National	-	-	-	0	0	0	0	1	0	0	1	1	3	6	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	1	0	0	0	0	0	0	0	0	2	0	0	2	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	1	1	1	4	0	0	1	0	0	0	0	0	1	6	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	94%	95%	92%	89%	91%	96%	97%	95%	95%	95%	96%	96%	97%	95%	
	Safeguarding Audits	Safe, high quality care	CN	≥90%	WUTH	-	-	82.6%	71.6%	93.5%	89.6%	94.7%	85.0%	No audits completed	No audits completed	94.4%	91.7%	92.4%	89%	
	Mandatory Training compliance	Safe, high quality care	CPO	≥90%	WUTH	89.0%	87.2%	87.2%	87.17%	89.21%	90.39%	89.73%	90.59%	90.34%	89.78%	90.25%	90.98%	91.38%	91.4%	
	Sickness Absence % (12-month rolling average)	Safe, high quality care	CPO	≤5%	SOF	6.48%	6.53%	6.70%	6.79%	6.83%	6.89%	6.94%	6.90%	6.87%	6.87%	6.89%	6.85%	6.70%	14.4%	
	Sickness Absence % (in-month rate)	Safe, high quality care	CPO	≤5%	SOF	8.72%	7.05%	7.73%	6.84%	6.23%	6.50%	7.08%	5.98%	6.33%	6.81%	6.60%	7.37%	6.52%	6.63%	
	Staff turnover % (rolling 12 month rate)	Safe, high quality care	CPO	≤10%	WUTH	13.7%	13.9%	14.1%	14.1%	14.4%	14.4%	14.1%	13.9%	15.29%	14.01%	14.37%	14.51%	14.44%	14.4%	
	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	5	4	7	8	11	6	5	8	6	

	Indicator	Objective	Director	Threshold	Set by	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	2022/23	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	91.7%	96.7%	96.9%	94.6%	97.1%	97.9%	95.7%	96.5%	94.8%	95.6%	95.2%	94.3%	97.8%	96.0%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	95.2%	97.3%	96.3%	97.7%	98.2%	98.9%	98.5%	98.1%	97.7%	97.0%	98.7%	97.0%	98.2%	98.0%	
	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	206	195	187	220	194	211	214	226	251	229	236	218	234	234	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	77.2%	77.9%	83.7%	79.3%	83.1%	80.9%	82.0%	84.7%	86.8%	85.3%	85.9%	86.0%	81.5%	81.5%	

	Indicator	Objective	Director	Threshold	Set by	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	2022/23	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	3	2	3	1	1	1	5	1	3	3	5	1	1	22	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	75.9%	77.3%	67.2%	74.0%	74.7%	77.4%	73.6%	78.2%	82.4%	76.2%	76.5%	77.7%	86.5%	77.7%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	95.4%	94.5%	92.3%	94.8%	94.1%	93.1%	95.6%	94.2%	95.1%	95.1%	95.9%	94.9%	94.0%	94.7%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	94.3%	94.1%	93.6%	93.5%	94.3%	93.5%	94.6%	94.1%	94.0%	94.0%	94.2%	94.96%	95.05%	94.2%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	96.6%	93.5%	97.7%	93.1%	98.0%	100.0%	96.9%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	98.6%	

Quality Performance Dashboard

February 2023
Upated 16-02-23

	Indicator	Objective	Director	Threshold	Set by	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	2022/23	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	≥95%	National	59.1%	63.1%	61.5%	63.1%	63.4%	64.5%	62.3%	63.6%	66.4%	62.7%	63.9%	64.0%	65.7%	64.0%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	13	7	17	39	24	17	69	155	18	59	182	99	405	1067	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	100%	National	57.3%	61.7%	54.0%	52.5%	53.5%	58.6%	53.6%	57.9%	60.9%	52.8%	55.8%	51.2%	66.6%	56.3%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	0%	National	11.0%	8.1%	11.6%	13.7%	10.7%	10.5%	14.6%	14.1%	10.8%	14.5%	13.6%	15.4%	15.6%	13.3%	
	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	73.9%	82.4%	86.9%	91.2%	85.1%	86.1%	90.6%	90.2%	87.3%	90.7%	88.5%	92.1%	92.4%	89.4%	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	18.0%	15.5%	25.2%	23.9%	21.9%	18.5%	16.0%	12.5%	16.2%	24.3%	17.5%	21.0%	17.6%	18.9%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	≥92%	SOF	67.57%	65.89%	65.38%	64.08%	66.72%	65.46%	64.80%	64.77%	62.40%	61.85%	61.57%	57.75%	58.97%	58.97%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	28665	29445	30430	31504	32373	33306	34933	35742	37030	37157	37188	37460	38911	38911	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	475	525	582	730	811	1028	1119	1122	1245	1279	1219	1321	1266	1266	
	Referral to Treatment - cases waiting 78+ wks	Outstanding Patient Experience	COO	NHSEI Plan Trajectory 2022-23	National	59	65	60	70	73	82	91	62	60	55	47	71	68	68	
	Referral to Treatment - cases exceeding 104 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	4	5	1	0	0	0	8	0	0	0	0	0	1	1	
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥95% (from April 2022)	SOF	87.3%	86.4%	85.2%	82.8%	86.0%	87.2%	87.5%	85.3%	85.3%	86.8%	88.0%	86.7%	87.4%	86.3%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	76.2%	78.0%	76.2%	85.8%	96.6%	94.6%	94.4%	91.9%	78.7%	88.3%	92.0%	87.9%	-	90.0%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	-	-	76.7%	-	-	92.5%	-	-	88.4%	-	-	89.5%	-	90.1%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	94.6%	95.1%	92.6%	91.2%	96.5%	96.4%	96.1%	94.7%	96.2%	97.3%	97.0%	95.3%	-	95.6%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	-	-	94.1%	-	-	94.9%	-	-	95.6%	-	-	96.6%	-	95.7%	
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	79.6%	79.3%	75.9%	79.2%	79.6%	75.7%	79.9%	81.5%	73.8%	73.1%	74.4%	74.0%	-	76.8%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	-	-	78.1%	-	-	78.2%	-	-	78.2%	-	-	73.8%	-	76.7%	
	Cancer Waits - reduce number waiting 62 days +	Outstanding Patient Experience	COO	NHSEI 2022/23 plans trajectory - revised 07/10/22	National	n/a	n/a	81	97	118	152	167	158	200	200	173	177	227	227	
	Cancer - Faster Diagnosis Standard	Outstanding Patient Experience	COO	≥75% within 28 days	National	70.5%	78.9%	79.5%	76.7%	75.4%	78.3%	79.6%	76.6%	71.8%	75.2%	73.8%	76.2%	-	75.9%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	MD	≤173 per month	WUTH	180	187	211	170	185	174	207	191	234	187	178	128	219	187	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	MD	≤3.1	WUTH	2.34	4.87	3.05	4.50	3.96	2.88	4.13	5.02	3.57	3.54	3.17	1.23	2.12	3.41	
	Formal Complaint acknowledged within 3 working days	Outstanding Patient Experience	MD	≥90%	National	100%	100%	100%	100%	86%	100%	91%	96%	100%	80%	100%	100%	100%	95%	
	Number of re-opened complaints	Outstanding Patient Experience	MD	≤5 pcm	WUTH	2	0	0	2	2	1	3	0	5	4	1	4	3	3	
	NEWS2 Compliance	Outstanding Patient Experience	MD/CN	≥90%	WUTH	-	-	85%	85.2%	88.3%	89.7%	89.1%	89.6%	90.3%	89.4%	89.2%	87.6%	89.6%	89%	

Quality Performance Dashboard

February 2023
Upated 16-02-23

	Indicator	Objective	Director	Threshold	Set by	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	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	0	0	0	0	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	1445	1575	1666	21	59	85	110	147	213	257	328	363	398	398	
	% Appraisal compliance	Safe, high quality care	CPO	≥88%	WUTH	82.0%	78.0%	77.9%	77.2%	83.2%	85.2%	86.2%	86.7%	88.58%	88.25%	88.36%	88.43%	86.39%	86.4%	

	Indicator	Objective	Director	Threshold	Set by	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	2022/23	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	2.3	-0.1	0.1	-1.0	-0.4	-0.2	-0.4	-0.5	-0.6	-0.9	-0.7	-1.2	-0.4	-0.4	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	1.9	-0.5	-0.3	-0.9	0.3	-1.2	-0.6	-0.7	-0.9	-0.8	-0.6	-1.1	0.1	0.1	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	2.0	2.0	2.0	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	
	CIP Performance (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	78.70%	78.61%	91.33%	7.26%	45.26%	47.60%	57.50%	51.00%	55.00%	45.00%	49.00%	21.77%	28.88%	28.88%	
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	-4.3%	-8.0%	-15.0%	-43.9%	-316.0%	-88.0%	-218.8%	-216.0%	-233.0%	-171.0%	-142.0%	-121.0%	-101.0%	-101.0%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-16.2	-18.6	-20.0	-21.4	-12.0	-16.6	-16.4	-21.4	-23.5	-26.0	-38.0	-37.9	-38.2	-38.2	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	59.0%	76.2%	100.0%	0.7%	1.4%	4.0%	8.7%	13.0%	17.9%	25.3%	31.5%	38.4%	41.1%	41.1%	

Metrics Added

Metrics Amended

Board of Directors in Public **Item 9.2**
01 March 2023

Title	M10 Finance Report
Area Lead	Mark Chidgey, CFO
Author	Robbie Chapman, Deputy CFO
Report for	Information

Report Purpose and Recommendations

At M10 the Trust is reporting a deficit of £6.066m, an adverse variance against budget of £6.271m. This variance is attributed to overspends on employee costs, driven largely by under-performance in respect of recurrent CIP, the unfunded element of the national pay award and the continued use of escalation wards staffed at premium rates, and by increases in energy prices. This is offset by:

- reductions in non-pay spend in M1-6, specifically clinical supplies, as a result of reduced elective activity compared to plan.
- release of deferred income.

The Trust has the potential to exceed the elective recovery target but consistent with national guidance, no additional income has been assumed from the Elective Recovery Fund (ERF).

It is recommended that Board:

- Notes the report
- Notes that without further mitigation the forecast position has deteriorated to a £6.8m deficit

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 meeting.

1. Statutory Responsibilities and Key Financial Risks

Key Financial Targets	RAG	Target Measure
Financial Efficiency	🔴	Variance from efficiency plan
Financial Stability - Breakeven	🔴	Variance from breakeven
Agency spend	🔴	10% reduction vs 19/20
Capital	🟠	Capital spend on track and within CDEL limit
Cash	🟠	Trust cash balance

2. Executive Summary

2.1. At M10 the Trust is reporting a deficit of £6.066m, an adverse variance against budget of £6.271m. The dashboard below highlights the key drivers of YTD and forecast position

Key Performance Indicator	In Mnth (£'000)	RAG Rating	YTD (£'000)	RAG Rating	FOT (£'000)	RAG Rating
Financial Stability - Breakeven	£50	🟢	-£6,271	🔴	-£6,800	🔴
Key Drivers of Variance						
104% Activity Recovery	£0	🟠	£0	🟠	£0	🟠
Escalation beds & Corridor Care	-£557	🔴	-£5,318	🔴	-£6,328	🔴
Bank & Agency	-£1,575	🔴	-£14,412	🔴	-£17,379	🔴
Non Pay (Operating Expenditure)	£978	🟢	-£1,679	🔴	£1,400	🟢
Cost Improvement (Recurrent)	-£610	🔴	-£4,500	🔴	-£7,751	🔴
Other	£1,814	🟢	£19,638	🟢	£23,258	🟢

3. Clinical Income & Activity

3.1. Refer to Appendix 1, SPC charts for Day Case & Elective and Outpatient Activity.

3.2. Key drivers:

- Clinical Income - £33.481m in M10 and £336.760m YTD, an adverse variance of £0.617m for the year. This is primarily a reflection of block contracts which are in place.
- ERF – £0.0m in M10 and £0.0m YTD. National data confirms that the Trust is delivering above the target level of 104% and that this reduces to marginally below when out patient follow ups are capped at 85%. It has been confirmed that there will be no ERF financial variations transacted in M1-M6 and it is expected that the same will apply for M7-M12.

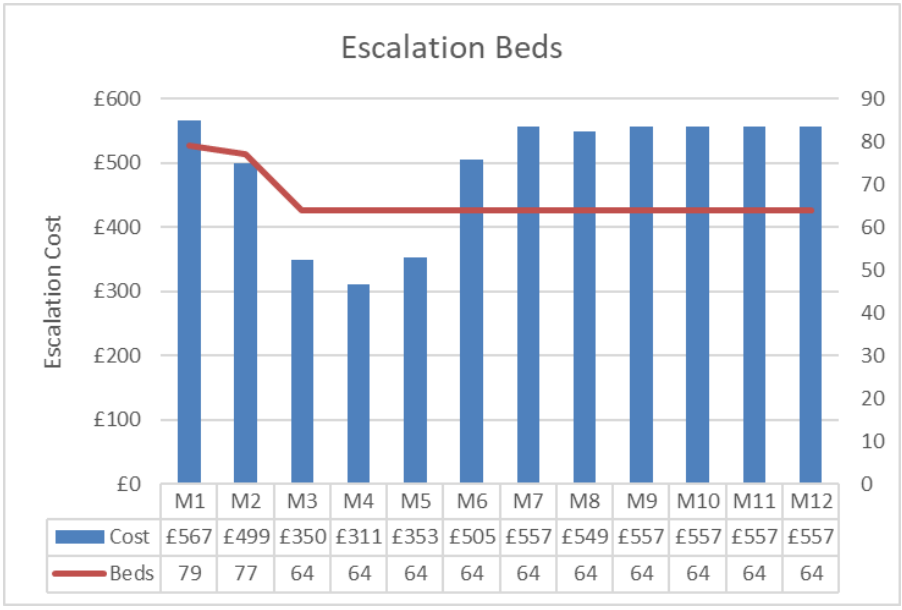
- Other Income - £3.131m in M10 and £31.814m YTD, a positive variance to plan of £1.801m for the year. This relates to the release of deferred income in respect of international nurse recruitment and teledermatology and the recharge of energy costs to Clatterbridge Cancer Centre. All of these costs are offset by increases in expenditure.

3.3. Mitigations and Corrective Action

- Elective activity - The improvement programme is monitored through the Programme Board.

4. Escalation Costs

4.1. Chart for Escalation Beds



N.B. Chart above is for escalation beds. The red line is the number of beds in escalation (actual and forecast) and the blue bars reflect cost (actual and forecast)

4.2. Key drivers

- Escalation wards - A total of 64 additional beds remain open with nursing and medical cover being provided by premium cost bank and agency staff. The forecast position assumes these costs will continue until the end of the year. The impact of winter is being partially mitigated by the mobilisation of the virtual wards and additional beds within surgery, as per the winter plan.
- Corridor care – The Trust has invested in additional staffing at a cost of £0.110m per month to manage the flow of patients between ambulances and the Emergency Department. There are also 4 additional beds open at a cost of £0.021m per month. Staffing is being provided through bank and agency, at a premium cost for these areas. The forecast position for the division assumes this cost will continue until the end of the year.

4.3. Mitigations and corrective actions

- Escalation wards - Business case for Ward M3 and 4 beds on W26 to be staffed substantively at reduced cost was submitted for approval. It was agreed that the nursing posts within these wards could be recruited substantively but funding would

be on a non-recurrent basis whilst de-escalation plans were developed. Bed modelling is currently underway to inform the longer term requirements for Medicine.
- Corridor care - Plans to establish a new ambulance arrival zone which will create additional care spaces within the Emergency Department. Business case developed for consideration around staffing was approved by Execs and will be submitted to FBPAC for approval.

5. Bank and Agency

5.1. Refer to Appendix 1, SPC charts for Bank, Agency and substantive employed.

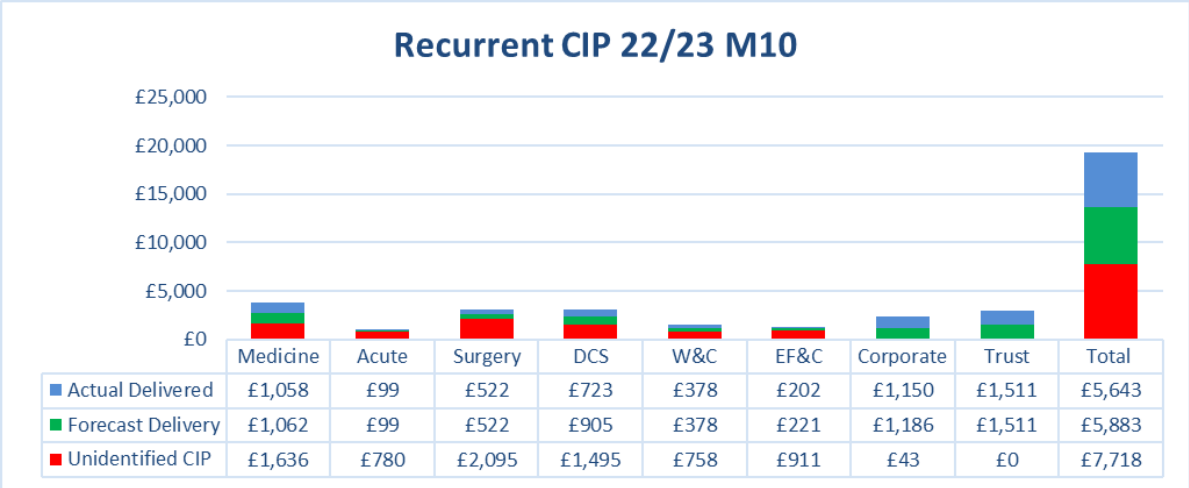
5.2. Key drivers

- Bank & Agency - costs excluding escalation were £1.575m in M10 and £14.412m YTD, an adverse variance of £19.730m which is then offset by an underspend of £13.291m in respect of substantive staff. Bank expenditure, driven by higher than planned levels of sickness and vacancies across the Trust. There was a £0.035m increase in agency spend from M9 to M10 and the Trust is still spending more than the national target specified by NHSE. The majority of agency spend relates to medical staff.
- Bank spend – an error was identified in M10 whereby some medical bank costs were being treated as substantive costs from M1 to M8. This led to substantive costs being overstated by £0.425m and bank costs being understated by the same amount. This has now been corrected and will be adjusted for on a monthly basis but it does lead to an apparent spike in bank costs in M10 that will come down in M11 onwards.

5.3. Mitigations and corrective actions
- Business case for recruitment of substantive consultants to replace agency in General Medicing on agenda for approval. Business case for Gastroenteorology, one of the biggest areas of agency spend, is due at the next meeting of FBPAC.
- The working group investigating junior doctor and rota opportunities has continued to meet. Key outcomes will be:
    - agreement on optimal and minimum staffing levels
    - map numbers required to cover service (and training)
    - compare numbers to establishment
    - develop plans for filling gaps
    - review the out of hours rotas / cover and rota structures.
- International Nurses coming into post in Acute. Awaiting completion of OSCE.
- Review of current rosters and flexible working arrangements in Acute to enable a more effective roster to be built. This is a key CIP opportunity for 23/24.

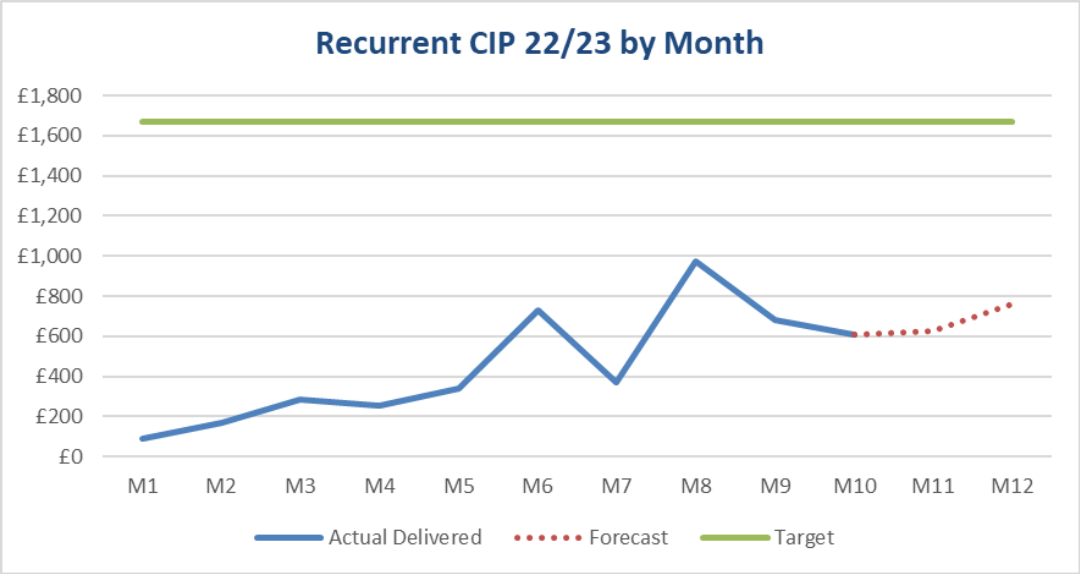
6. CIP

6.1. The chart below shows the delivery of CIP by division.



	Medicine	Acute	Surgery	DCS	W&C	EF&C	Corporate	Trust	Total
Actual Delivered	£1,058	£99	£522	£723	£378	£202	£1,150	£1,511	£5,643
Forecast Delivery	£1,062	£99	£522	£905	£378	£221	£1,186	£1,511	£5,883
Unidentified CIP	£1,636	£780	£2,095	£1,495	£758	£911	£43	£0	£7,718

6.2. Recurrent CIP by month and forecast



6.3. Mitigations and corrective actions:

- The 8 transformation programmes are tracked and monitored through the monthly programme board, chaired by the Chief Executive. Each Executive lead produces a monthly highlight report that summaries progress of clinical KPIs and financial KPIs. Divisional CIP performance is reviewed and discussed, and action plans produced. CIP escalations are raised through programme board, providing divisions the opportunity to ask for additional support from the Executive team, and highlighting any blockers. Corporate teams are challenged on their monthly CIP performance and discuss in year opportunities and future schemes.
- Bi weekly meetings remain in place with cross divisional representation/ finance/ procurement & PMO.
- Mobilisation of virtual wards and quantification of benefits. In November there were in excess of 90 patients treated on the virtual wards who would have otherwise been in a hospital bed.
- Progress on increasing productivity and reducing costs in Endoscopy, through appointment of a clinical fellow, consultants returning from absence and a consultant coming out of training to deliver lists independently.
- Continuous work to identify and maxmise activity in the medical day unit.
- ED medical workforce model agreed across Operational and Clinical teams. This is being developed into a business case for approval by the Executive Team.

- W&C piloting the Robotic Process Automation, identifying manual processes which can be undertaken by bots and release staff hours.

7. Capital and Cash

7.1. Refer to Appendix 1, SPC chart for cash.

7.2. The cash balance at the end of M10 was £15.78m which is £9.119m behind plan. We are currently forecasting an improved year end cash balance of £15.342m which is primarily because of PDC drawdown funding. The reduction in the cash balance is being driven by the under-delivery of CIP and the current deficit position.

7.3. Since M8 there have been several changes to the capital plan as funding via PDC has been awarded for various schemes. At M10 the capital plan is as follows:

Revised capital plan 2022/23	
IT - various schemes	1,976
Medical equipment	219
Facilities equipment	93
Bathroom refurbishment	10
Ventilation works	400
Flooring	80
Fire compartmentation	400
Backlog maintenance	795
Ward 1 - Renal Unit refurbishment	2,800
Modular theatre build completion	3,182
UTC (included in backlog maintenance in spend table)	215
Initial CDEL allocation	**10,170**
Heating and chilled water pipework replacement	2,132
Total CDEL	**12,302**
Modular theatre - phase 2	14,954
UECUP	13,000
CDC	4,212
Cyber	145
Diagnostics - Image Sharing	312
Mammography equipment	273
Total PDC	**32,896**
TOTAL CAPITAL PLAN 22/23	**45,198**

7.4. In M11 we expect further changes because of additional PDC allocations for a surgical robot, a CT scanner, MRI Bariatric Head Coil and Gastroscopes.

7.5. Spend at M10 is as follows:

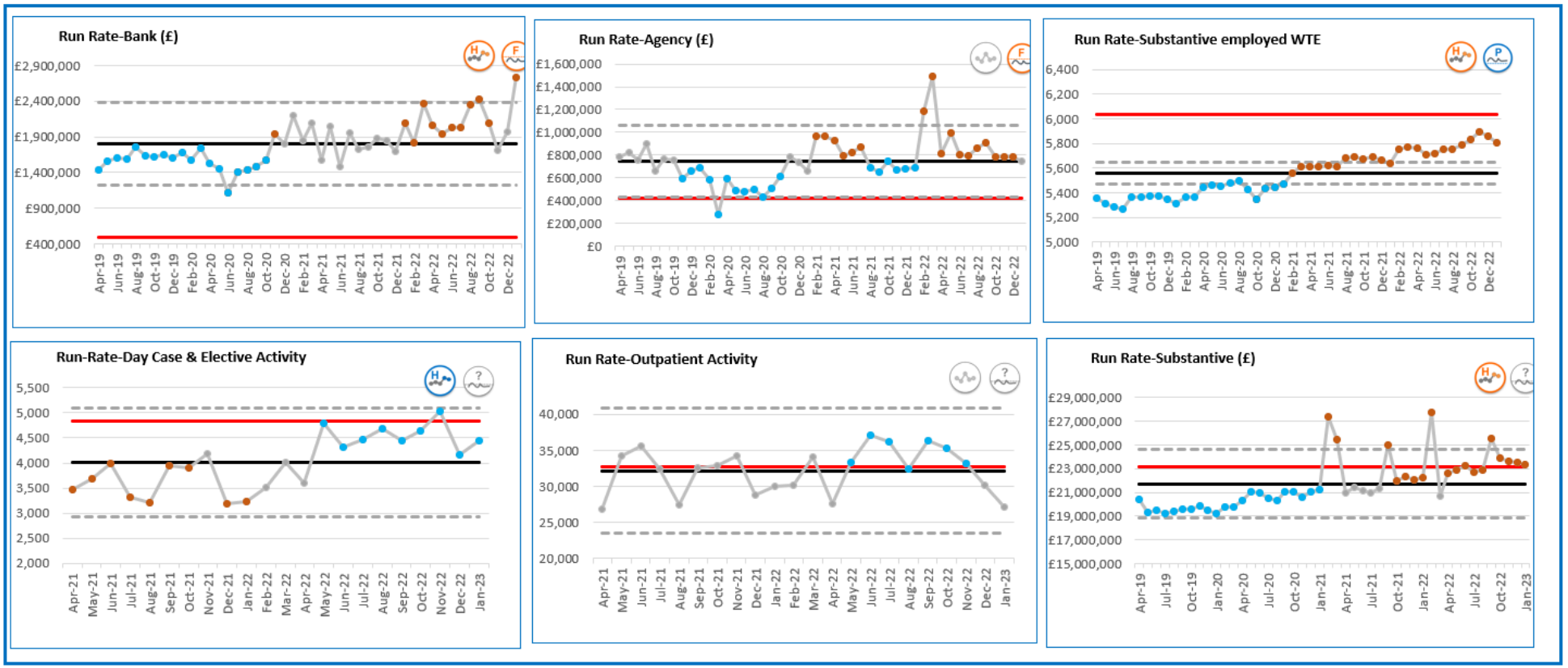
Scheme	Plan spend @ M10	YTD spend	Variance
IT - various schemes	1,250	705	- 545
Equipment (including Aseptics)	312	247	- 65
Ward 1 - Renal Unit refurbishment	2,120	2,711	591
Modular theatre build completion	3,560	3,560	-
Backlog maintenance	888	1,215	327
Heating and chilled water pipework	2,132	1,420	- 712
Modular theatre - phase 2	11,954	4,284	- 7,670
UECUP	13,900	4,114	- 9,786
CDC	-	316	316
Cyber	-	-	-
Diagnostics - Image Sharing	-	-	-
Mammography equipment	-	-	-
NHSE/I TOTAL CAPITAL PLAN 22/23	**36,116**	**18,572**	**- 17,544**

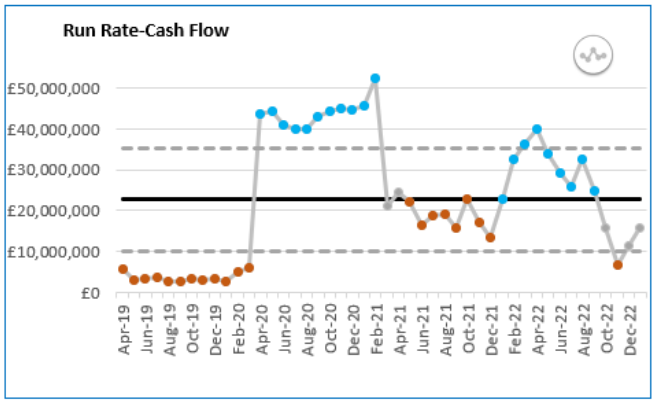
7.6. Spend is currently £17.544m behind plan. The key areas of underspend are UECUP and phase two of the theatres.

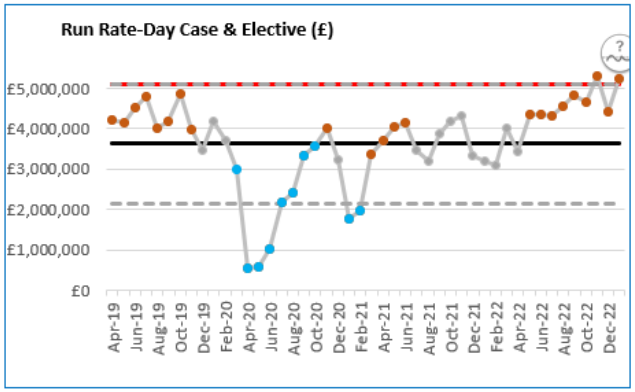
7.7. The Trust originally requested a reduction in PDC for 22/23 from £18m to £13m which was approved in October 2022. However, prolonged negotiations in respect of stage 4 of the contract with Tilbury Douglas has impacted on the spend run rate. This delay in signing and the impact on the spend profile has been discussed at length with DHSC and the Trust submitted a further request to amend the draw down to £8m which is the expected spend value at 31 March 2023. A decision is yet to be made by the Capital and Cash Team.

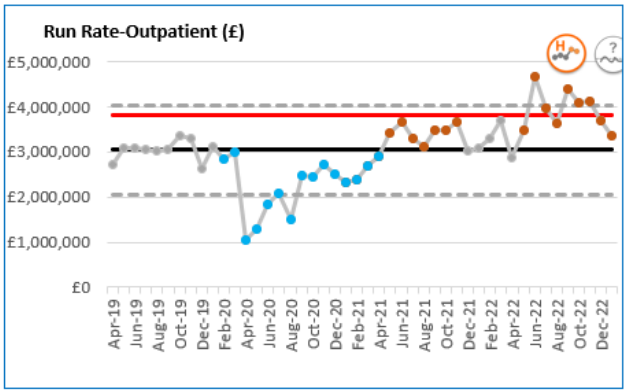
7.8. A series of delays relating to design sign off, preliminary works and unexpected groundwork problems have resulted in the expected completion date being pushed back to October 2023. This has led to an increase in the cost of the scheme as well as an impact on the spend profile. Whilst there is currently contingency within the overall scheme to cover the additional cost, it is anticipated that spend will be c£7m short of the full scheme value at the year end. Mitigations have been implemented and further mitigations are currently being considered.

Appendix 1 – SPC Charts









Board of Directors in Public **Item 9.3**

01 March 2023

Title	Monthly Maternity Report
Area Lead	Tracy Fennell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing and Midwifery (W&C)
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 (January 2023) key quality and safety metrics.

The last quarterly Maternity update to the Board of Directors was presented in January 2023 with the next quarterly Maternity update being presented to the Board of Directors in April 2023.

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
	The Perinatal Clinical Surveillance Quality Assurance report for January 2023 reports that the Trust 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 are no serious incidents to report in January 2023. The last HSIB quarterly report confirmed that the Trust continues to report all cases meeting the criteria for review, and that Duty of Candour was reported as 100% for these cases. Following the approval from Board of Directors in January 2023 the MIS Year 4 was signed off as compliant by the Chief Executive. The declaration form was submitted to NHS Resolution by 2 February 2023. A further update on MIS Year 5 will be presented to the Board of Directors in future months. After the publication of the MBRRACE-UK (Mothers and Babies: Reducing the Risk through Audits and Confidential Enquiries across the UK) in November 2022, the Trust was identified as having a higher-than-expected neonatal mortality rate (and hence extended perinatal mortality rate). The Neonatal Safety Champion therefore undertook a review of the neonatal deaths that occurred in 2020. All these babies' care was subject to scrutiny internal to and external to the organisation and to appropriate external reporting. The reviews indicated that in 8 out of 10 cases, no care issues were identified. In one case care issues may have contributed to the death but the issues related to an external organisation. In one further case care issues that would not have made a difference to outcome were noted. Learning was identified and shared in the last 2 cases, across agencies if necessary. Ten neonates died in 2020 as a result of: • Lethal malformations (4) • Admission to the emergency department critically unwell with unexpected conditions (2) • Sudden unexpected death in infancy at home (1) • Complications of prematurity (3) Currently the Trust is not an outlier for perinatal mortality rates. The Board can be assured that perinatal deaths are subject to appropriate reporting and scrutiny & learning (consistent with our recent Maternity Incentive Scheme submission). Review of these deaths does not indicate any signal of a systematic quality of care issues in 2020.

3	Conclusion
	On review of the Perinatal Clinical Surveillance Quality Assurance Report there are no reported areas of concern. Further update will be included in the Quarterly Maternity Update to Board of Directors in April 2023.

Author	Jo Lavery, Divisional Director of Nursing & Midwifery (W&C)
Contact Number	0151 604 7523
Email	Jo.lavery@nhs.net

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. No current cases
	Number of SI's	no	None in progress; SI declared in Feb 2023
	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. Awaiting confirmation and launch of SBL3
	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. Since 20/08/2022, no breached complaint responses outstanding and active complaints with the division investigated and responded to well within timescales
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey in progress
	CQC National survey	no	Nil to report this month
	Feedback via Deanery, GMC, NMC	no	Nil to report this month
	Poor staffing levels	no	There are 2.2 wte vacancies in the maternity Band 5/6 staff group: > 2% and a workforce paper has been prepared for presenting in January 2023 and the continued roll of MCoC model outlining the safe staffing requirements
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Quality & Safety Lead (8a Clinical Governance) post - interviews in Feb 2023 and appointment made; awaiting HR checks and expected to commence March/April 2023
	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. MIS Year 4 submission and declaration submitted by 12 noon on 2nd February 2023
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil 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 with excellent MDT attendance. Quarterly meeting held in Feb 2023; nil to escalate
	Lack of transparency	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. Trust wide lessons learnt forum has commenced reviewing themes from SI's, complaints and audits.
	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. No exceptions to report. East Kent 'Reading the Signals@ published. Presented to BoD in Feb 2023; awaiting single delivery plan expected March 2023
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 January 2023
	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 - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. 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	Nil to report this month.
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	N/a
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 9.4**

01 March 2023

Title	Guardian of Safe Working Report
Area Lead	Dr Nikki Stevenson, Medical Director and Deputy CEO
Author	Helen Kerss, Guardian of Safe Working
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide an update on compliance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

The Guardian of Safe Working is a senior person, independent of the management structure, within the organisation by whom the doctor in training is employed. The Guardian is responsible for protecting the safeguards outlined in the 2016 TCS for doctors and dentists in training.

This report provides:

- Details of the actual number of doctors in training
- Details of the exception reports submitted for the reporting period by speciality and grade
- Details of breaches of safe working hours and fines incurred.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

- BAF Risk 3: Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	No
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**
31 January 2023	People Committee	As above	Information

1	Narrative

There are currently a total of 288 doctors/dentists in training in the Trust. The number of gaps present in the trainee medical workforce continues to be a focus for the Trust to ensure compliance with the safe working directive and to reduce overall locum and agency spend.

To monitor compliance with the working hours directive, Doctors/Dentists in Training (DIT) continue to submit exception reports via the appropriate process and in accordance with the 2016 Terms and Conditions of Service. This report details a summary, exception reports and locum bookings submitted for the Q3 2022/2022 (October to December).

High level data for Wirral University Teaching Hospital NHS Foundation Trust

Number of doctors / dentists in training (total): 295 (284.8WTE)
Number of doctors / dentists in training on 2016 TCS (total): 295 (284.8WTE)
Amount of time available in job plan for guardian to do the role: 1 PA/4 hours per week
Admin support provided to the guardian (if any): 1.0 WTE
Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

Exception reports (regarding working hours)

Exception reports by department				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E	0	9	9	0
General Medicine	0	85	80	5
General Practice	0	4	4	0
General Surgery	0	19	19	0
Psychiatry	0	7	7	0
T&O	0	9	9	0
Total	0	133	128	5

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	89	84	5
F2	0	6	6	0
SHO	0	32	32	0
SPR	0	6	6	0

Total	0	133	128	5

Exception reports by Rota				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A and E F2 LIFT weeks 2023	0	2	2	0
A and E F2 and SHO 2022	0	3	3	0
A&E SPR 2022	0	4	4	0
Medicine F1 Rota 2022	0	44	43	1
Medicine F1 Rota LIFT MT	0	5	5	0
Medicine F1 Rota LIFT WF	0	3	3	0
Medicine WE F1 2022	0	15	11	4
GPST Ger Med 2022	0	6	6	0
GP F2 2022	0	4	4	0
Medicine T1 General 2022	0	9	9	0
Medicine IMY3 2022	0	1	1	0
Medicine SpR x 19 2020	0	1	1	0
Psych F1	0	7	7	0
Renal	0	1	1	0
Surgical F1 Rota 2020	0	9	9	0
Surgical F1 2022 LIFT MT	0	6	6	0
Surgical T1 1:10 2022	0	4	4	0
T&O SHO 2020	0	9	9	0
Total	0	133	128	5

Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
F1	20	26	31	7	0	5
F2	1	1	4	0	0	0
SHO	4	13	13	2	0	0
ST3-8	3	1	1	1	0	0
Total	28	41	49	10	0	5

Exception reports (regarding training/academic issues)

Exception reports by department				
Department	No. exceptions carried over	No. exceptions raised	No. exceptions closed	No. exceptions outstanding

	from last report			
A&E	0	2	2	0
General Medicine	0	1	1	0
Total	0	3	3	0

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
SpR	0	3	3	0
Total	0	3	3	0

Exception reports by rota				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E SpR 2022	0	2	2	0
Medicine IMY3 2022	0	1	1	0
Total	0	3	3	0

Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
SpR	1	1	0	1	0	0
Total	1	1	0	1	0	0

As Guardian of Safe Working, I will review each exception report regarding working hours in line with the junior doctor's contract. Following review of the exception report the following suggestion may help

- Greater visibility of locum shifts available – hopefully reducing the last-minute panic to fill vacant shifts
- Involvement of juniors in rota designs – this would give the trust a great insight into what is happening on the ground

Work schedule reviews

There have been no work schedule reviews this quarter.

Vacancies

This is the number of vacant shifts which could occur due to sickness, maternity leave gaps on rotas.

Vacancies by month

Specialty	Grade	Oct	Nov	Dec	Total vacant shifts (average)	Number of shifts uncovered
A&E	F2-ST8	428	379	570	459	0*
Medicine	F1-ST8	109	125	170	134.6	0*
Surgery	F1-ST8	70	87	57	71.3	0*
Women's and Children's	ST1-2	20	24	28	24	0*
Total		627	615	824	689	

*Vacancy shifts filled by agency/bank

Fines

There have been no fines issued this quarter.

2	Conclusion
	Most of the exception reports have been due to working hours, with only 3 being due to missed education opportunity. The Trust continues to support junior doctors to complete exception reports as it gives the trust a greater understanding of what is happening on the ground with the workforce.

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Contact Number	Via switchboard
Email	hkerss@nhs.net

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 9.5**

01 March 2023

Title	Estates, Facilities and Capital Update
Area Lead	Paul Mason, Director of Estates, Facilities and Capital Planning
Author	Matthew Williams, Estates Operations Compliance Manager Clare Jefferson, Associate Director of Estates, Facilities and Capital Governance and Sustainability
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide assurance to the Board of Directors on the Estates, Facilities and Capital service provision performance metrics, that align to the strategic objectives of the Trust.

It is recommended that the Board:

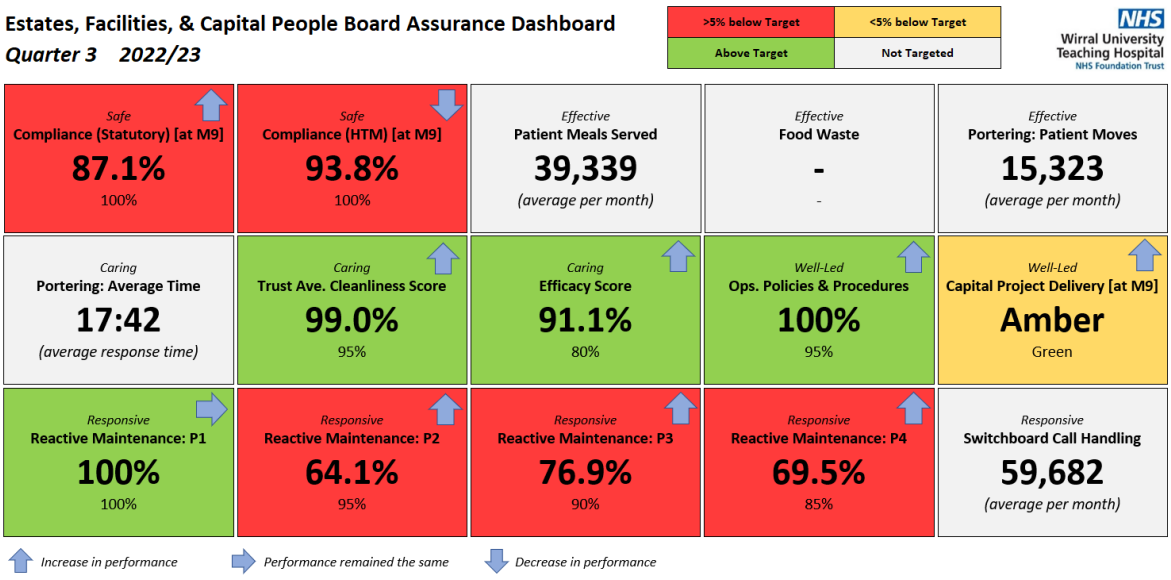
- Note the report

Key Risks

This report relates to these key Risks:

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

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

1	Narrative
1.1	**Background** Estates, Facilities and Capital (E, F & C) hold frequent operational, tactical, and strategic meetings which all report into a monthly senior leadership Performance Review meeting. A dashboard of metrics is reviewed during this meeting and those which align most closely to the CQC five questions are presented within this assurance report. The dashboard is continuously improving with new metrics being identified to encompass the full-service portfolio of Estates, Facilities, and Capital. Some metrics have internal targets, whilst others are for information and assurance purposes and can be measured against the previous month/quarter.
1.2	**Scope** For the Board of Directors assurance report, Estates, Facilities and Capital (E, F & C) provide an assurance dashboard measured against a defined set of Key Performance Indicators. The assurance dashboard is aligned to the CQC five questions: **Safe** – adherence to technical standards/statutory compliance **Effective** – performance of our services **Caring** – patient experience **Responsive** – response times estates maintenance **Well-led** – people performance
1.3	**EF&C Board Assurance Dashboard**  For the KPI's that have not achieved the target measure, we have exception reporting and internal governance processes to action as appropriate and escalate.
1.4	**Measure: Safe** (Technical Standards & Audit) Key Performance indicators: ➢ **Estates Compliance (Statutory)** ○ Whilst there has been an improvement in the volume and frequency that inspections are undertaken, there is still work to do the demonstrate that the estate is compliant

	to statutory and mandatory legislation. There is a strategic plan to undertake an intrusive Mechanical and Electrical Asset Survey to determine the volume, type, and age of assets, however, this cannot be funded this fiscal year. o Estates are currently mobilising a new comprehensive, all-encompassing water management contract to ensure compliance with statutory legislation, approved codes of practice, and health and safety guidance. ➢ **Estates Compliance (HTM)** o As with Compliance (Statutory), the asset survey will identify assets that are required to be maintained under Health Technical Memoranda (HTM) mandatory guidance. Accompanied with SFG-20 maintenance software, Estates will be able to formulate Planned Preventative Maintenance (PPM) job plans, skill and labour requirements, and frequency of tasks. This will also support accurate predictions of backlog and life cycle maintenance of the estate. ➢ **HTM Authorising Engineer Appointments & Safety Committees** o Number of Authorising Engineers (AE) Appointed and Safety Committee Governance Meetings as per the requirements of the Health Technical Memoranda. The Trust have appointed one external Authorising Engineer per HTM. An AE is defined as an independent engineer or other appropriately experienced and qualified individual appointed to take responsibility for the effective management of the safety guidance recommended by the Department of Health.
1.5	**Measure: Effective** (Performance of our services) Key Performance indicators: ➢ **Patient meals served** o 118,016 patient meals were served in Q3, at an average of 39,339 per month. 119,144 patient meals were served in Q2. No complaints were received regarding patient meals within Q3. ➢ **Portering Patient moves** o Porters carried out 45,968 patient moves in Q3, at an average of 15,323 per month. This is an increase on the 43,560 moves performed in Q2. No complaints were received regarding portering within Q3. ➢ **Food Waste** o *See section 1.10 below*
1.6	**Measure: Caring** (Patient Experience) Key Performance indicators: ➢ **National Cleaning Standards (Trust Average Cleanliness Scores)** o The cleanliness audit score is represented as a percentage score of internal verification that a safe standard has been achieved. The Trust achieved an average score of 99.0% in Q3, which is an improvement on 98.0%, and 98.9% in Q1 and Q2, respectively. All scores for 2022/23 have been above the target of 95% o C-Diff outbreak: Facilities are working in partnership with our clinical colleagues, and Infection, Prevention and Control, on a rapid improvement plan which is being embedded into business as usual. ➢ **Portering Response times** o Portering/Patient moves took on-average 17 minutes 42 seconds in Q3. There was a 5.5% increase in the number of patient moves in Q3 compared with Q2.
1.7	**Measure: Responsive** (response times) Key Performance indicators:

	➢ **Reactive Estates Maintenance response times** o % of reactive work orders that have been completed within the respective SLA timeframe. Priority 1 [P1] – 4 Hours: 100% Priority 2 [P2] – 3 days: 64.1% Priority 3 [P3] – 7 days: 76.9% Priority 4 [P4] – 21 days: 69.5% 5,080 reactive work orders were raised in Q3, which is a 6.5% increase on the previous quarter. Work orders are typically completed within the following 24/48 hours of the SLA expiring. o Whilst high percentages of work orders are completed, there are significant resource gaps within the maintenance team to ensure that work orders are completed within the internal SLA targets stated above. The Estates team have undertaken a labour loading exercise that identifies a shortfall of maintenance tradespersons. There has also been an increase in requests of resource to support the Clatterbridge Modular Theatres and UECUP Capital projects. ➢ **Switchboard Call Handling Volumes** o The number of calls received by the switchboard on average, per month was 60,229 in Q3. 180,686 calls were received in Q3 compared with 195,367 for the previous quarter.
1.8	**Measure: Well-led** (People Performance) Key Performance indicators: ➢ **Operational policies and procedures in date** o Currently, all policies and procedures in Estates, Facilities, and Capital are in date and published to the wider Trust ➢ **Capital Project Delivery** o RAG rating for Capital projects against delivery timeframes and financial constraints is Amber. *See section 1.9 below*
1.9	**Capital Projects** The 22/23 capital programme was initially made up of 32 schemes in total. Seven schemes have been deferred, two schemes have been cancelled, and three schemes added which has determined a delivery plan of 26 schemes in total. ➢ Clatterbridge Modular Theatres Phase 1: o Handover completed 4th November 2022. Final snagging in progress with defects recorded and managed. ➢ Clatterbridge Modular Theatres Phase 2: o Next milestone is the arrival of the piling rigs due 13th Feb 2022, followed by foundation completion ready for the arrival of the modules in mid/late Feb 2022. ➢ Urgent Treatment Centre: o Phase 3 to complete installation ready for builders and sterile cleans. Nurse call installed and to be commissioned 20th Feb 2022. UTC project including re-establishment of Ward 43 completes on the 20th Feb 2022 ➢ Other projects in Q4 22/23: o Final phase of Low Carbon Steel Pipework in the location of maternity plant rooms is underway. o Fire compartmentation works are progressing on the third floor of Arrowe Park Hospital. This will support fire and smoke spread reduction across the third-floor areas and improve evacuation if necessary

1.10	**Food Waste** WUTH has recently published its Green Plan, which outlines the Trust's sustainability commitments as part of wider NHS Net Zero aims and the Catering Department can play an important role in supporting the Trust's efforts. Food Waste is estimated to cost the NHS £238 Million per annum and catering services produce 6% of the NHS annual carbon emissions. WUTH was pleased to be selected as one of twenty Trusts across England to participate in a 4-week Food Waste data collection pilot scheme. **Pilot at Arrowe Park** The Catering Department collated both production and plate waste from **Wards 20 and 21** throughout January and has submitted the findings back to NHS England for further analysis. The initial data has provided valuable insight to help inform decisions for a key project the Trust is undertaking to improve the current patient catering services. Early estimations suggest that the **Food Waste costs WUTH in the region of £165,000 per annum**, with an average ward meal service producing around 7kg of waste per session. It is impossible to reach a catering model which produces zero waste; however, the data provides the Trust a good baseline position to make measurable improvements. Not only will these improvements have a positive impact on patient experience, but also provide efficiency opportunities for us to reduce food waste and reduce the financial impact across the organisations.
1.11	**Urgent and Emergency Care Upgrade Programme (UECUP)** ➢ UECUP A&E Upgrade phase 1 enablement completed. Commencement of phase 2 underway with steel frames being erected for the extension. ➢ Stage 4 contract due to conclude by the end of Feb 2023 ➢ Delays to programme due to poor ground conditions.

2	**Implications**
2.1	The information provided in this report is based on the data we have available and is limited to assets already captured in our systems. We are continuously improving our data collection to further improve our reporting and assurance. Whilst great advances have been made over the past 12-months, we continue to identify assets and equipment that require incorporating into the Trust's maintenance framework to demonstrate our statutory and mandatory obligations.

3	**Conclusion**
3.1	E F & C have matured the safety group meetings and have introduced additional meetings to cover the range of Health Technical Memoranda (HTM), ensuring prompt multi-divisional oversight of critical infrastructure and risk management. E F & C continue to progress the monthly Safety, Health, and Environment (SHE) meeting which provides a forum for escalations from the safety group meetings. The SHE meeting is responsible for providing assurance in relation to the HTMs to the Trust Health and Safety Management Committee, and Infection Prevention and Control Group.

	A key improvement in this area has been the governance of the external Authorising Engineer Audits, for which a comprehensive internal audit action tracker has been developed and is monitored through to action completion. Any associated risks highlighted from these audits are added to the Trust Risk Register and reviewed on a regular basis. The approach is our baseline assurance reporting with the information that is currently captured across the departments. Our aspiration is to produce a high-level Power BI Dashboard which will visualise the key Board Assurance metrics to be accompanied by an exception report, as required.

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Board of Directors in Public **Item 9.6**
1 March 2023

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

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 Surgical Centre at Clatterbridge
- Replacement of the wired network infrastructure across the estate
- Robotic Process Automation for streamlining of back-office processes
- Development of an in-house data warehouse to initially deliver clinical reporting
- Completion of migration to the new Phillips PACS solution
- Introduction of a Learning Management System to baseline staff educational needs.

Monitoring delivery:

Appendix A shows the RAG status for each of our Digital Programmes. Of the 42 projects within those programmes – 13 are currently green, 2 are amber, 14 are red,11 are blue (complete) and 2 are grey (paused)

Of the 14 projects currently showing as red, 9 sit under the Innovation portfolio, 2 under foundations, 2 under digital education and 1 under digital intelligence. DPSOC is currently reviewing the main themes affecting project progress, which include supply chain issues, a factor that is reflected across the UK economy in general. From an assurance perspective, issue updates and any escalations are captured through fortnightly project performance meetings.

Changes to plan:

There have been no requested changes to plan in the last period.

Financials:

Projects within the 22/23 schedule are funded from a combination of 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.

High Level Risks

- Risks affecting delivery of projects are currently being managed within the Digital Healthcare Team. The greatest risk to delivery currently is technical issues surrounding specific image sources not storing to the new PACS solution.

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** **Digital Foundations highlights** Availability of Network during the period stands at 99.99% with no reported incidents. There was a relatively short outage of the telephony system of 1 hour on January 30th. In future the improvements made as part of the Telephony upgrade programme will improve resilience in this area. **Digital Education Highlights** Approximately 150 employees were trained over December and January with 10 DNA's in December and 20 in January. We are looking to identify any trends across staff groups with regards to DNA's and will raise accordingly with those areas. We are also looking at average class sizes with the intention of minimising single person sessions and maximizing the coverage of our training resources. **Digital Intelligence** The team continues to reach high standards in terms of it's statutory reporting, hitting 100% of its requirements on time in January. Usage of the BI Portal continues to consistently rise with over 12,000 page hits in January. A substantial comms campaign is being planned in for 2023, along with the migration of many existing reports to the Portal platform. **DHT Workforce** The team are compliant for both appraisals and mandatory training. January saw the launch of the DHT Values and Behaviours which further develops upon those of the Trust. Over 130 staff attended group discussions supported by colleagues in OD, over a 6 month period in the latter half of 2022 and gave feedback on their experiences of working in the team. Suggestions for areas of improvement were made and also examples of where good practice needs to continue. All information was collated under the themes of Leadership for all and the DHT Values & Behaviours have now been published to all staff across the department. Familiarisation sessions are planned in for the months ahead. **High scoring Risk** The greatest risk currently is regarding the current Trust PACS system which approaching full capacity. The mitigation is to implement the new Phillips PACS system, which is on target to go live in late February.

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.

	Conclusion
3.1	We continue to make good progress on our digital programme for 2022/23 ite the various challenges. We continue to work with our suppliers to resolve these issues.

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Appendix A: Digital Healthcare Team – Delivering Our Strategy

Digital Healthcare Team

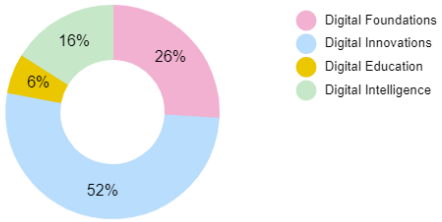
PMO Home Page

Digital Healthcare Team Home Page

Digital Strategy

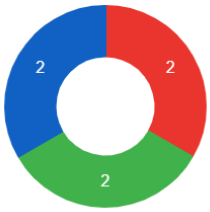
Active Digital Foundations Projects	Active Digital Innovations Projects
4	17

Active Digital Education Projects	Active Digital Intelligence Projects
2	8



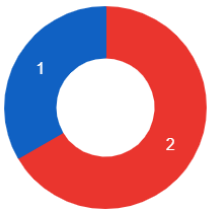
GREEN	On programme, within budget, will deliver agreed benefits
AMBER	One or more of the project criteria are either in or forecast to enter exception, but a recovery plan is in place or proposed to reach a green status
RED	One or more of the project criteria are in exception and no plan has yet been agreed to resolve the situation, or the plan being proposed involves a change to the agreed programme, budget, or benefits
GREY	Project has officially paused.
BLUE	Project is delivered

Digital Foundations Overall Programme RAG



Digital Innovations Overall Programme RAG

Digital Education Overall Programme RAG

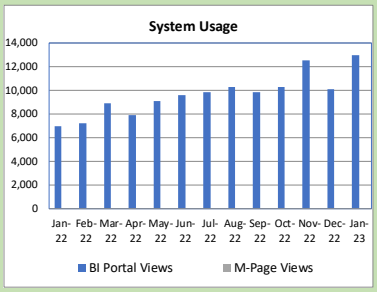


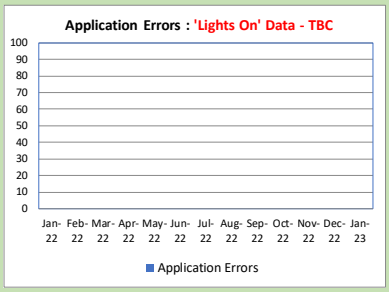
Digital Intelligence Overall Programme RAG

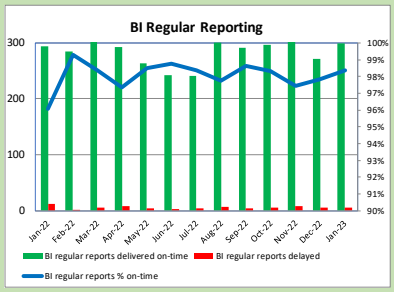
Appendix B: Service Delivery Dashboard

DHT - Business Continuity and Service Delivery | **February 2023**

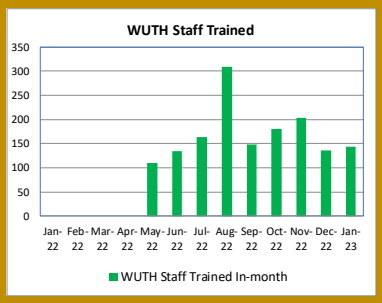
Digital Intelligence

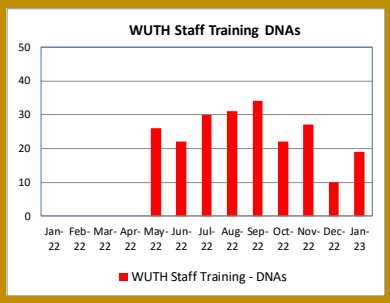






Digital Education

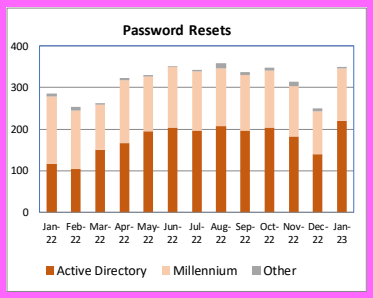


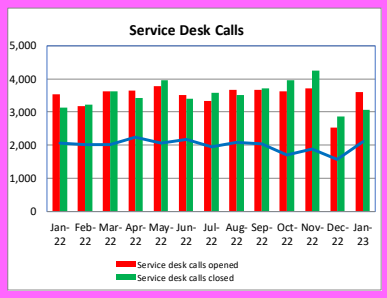


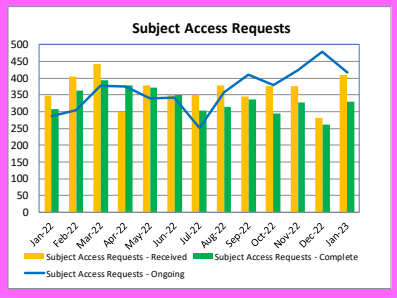
Network Availability

January 2023 - network availability 99.99%
No known reports within core infrastructure.

Digital Foundations







System Downtime

Telephony service outage 30th Jan for one hour.
Telephony upgrade programme to improve resilience & bring into the supported platform.

System Performance & Utilization

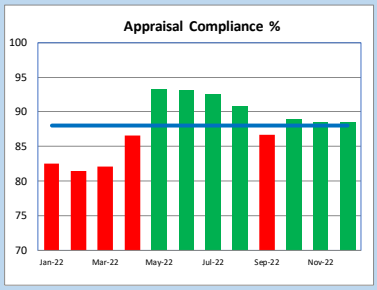
Performance	SLA	Q1 avg.	Q4 avg.	Jan	Feb	Mar
System Availability	99.90%	100.00	100	100	100	100
Incident Free Time	x	99.82	100	99.62	99.84	100

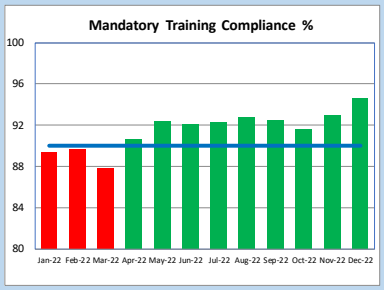
Cyber Security - TBC

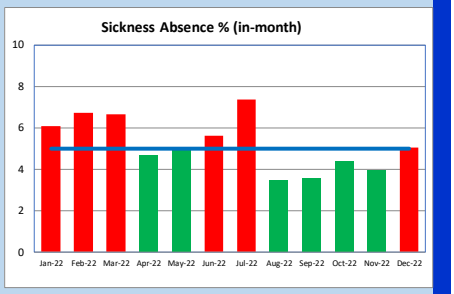
DHT - Business Continuity and Service Delivery | **February 2023**

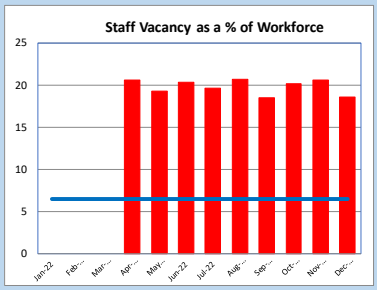
DHT Workforce Metrics

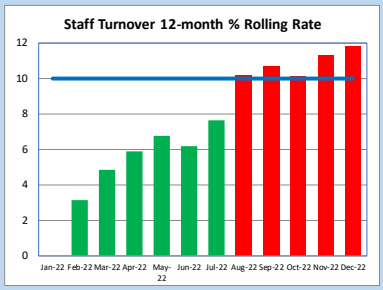
(reported 1 month in arrears)

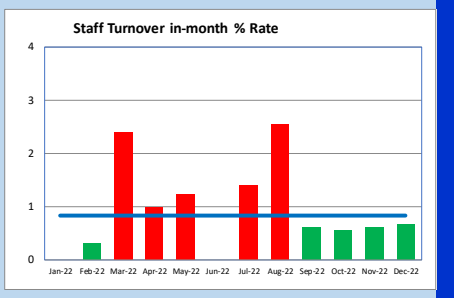












Wirral University Teaching Hospital
NHS Foundation Trust

22/23 Productivity & Efficiency Update

Board of Directors in Public

1 March 2023

together we will

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Purpose and Recommendations

Wirral University Teaching Hospital NHS Foundation Trust

- The purpose of this report is to provide the Board of Directors with an update on current 22/23 CIP position and identified plans to date, along with the ongoing work to identify further CIP schemes.
- This report also includes an update on the progression of the transformation programmes and delivery to date, detailing financial savings up to the value of £6.7m through budget reduction, income generation, cost avoidance and run rate reduction.
- It is recommended that the Board of Directors:
    - Note the report

Approach

Wirral University Teaching Hospital
NHS Foundation Trust

- For 21/22 and YTD 22/23, the cost improvement approach has been focussed on recurrent Divisional level schemes.
- Given the CIP and budget performance mid year, there was a requirement to alter the approach to the identification, planning and delivery of cost improvement for the remainder of 22/23.
- This approach includes the introduction of cross cutting Workstreams, led by an Executive Director, supporting cost improvement delivery across multiple Divisions. Further management controls will be undertaken to manage and reduce the run rate.
- The 7 transformation programmes are tracked and monitored through the monthly programme board, chaired by the Chief Executive.
- Each Executive lead produces a monthly highlight report that summaries progress of clinical KPIs and financial KPIs. Divisional CIP performance is reviewed and discussed, and action plans produced. This allows for timely action to deal with slippage on plans or any unanticipated adverse impact on patient experience or quality of service. CIP escalations are raised through programme board, providing divisions the opportunity to ask for additional support from the Executive team, and highlighting any blockers.
- Corporate teams are challenged on their monthly CIP performance and discuss in year opportunities and future schemes.
- The finance team have developed transformation trackers which detail financial improvements including budget reductions, income generation, run rate reductions and cost avoidance.

Transformation Programmes

Wirral University Teaching Hospital
NHS Foundation Trust

Programme	Exec Lead	Delivered
Outpatient Utilisation	Hayley Kendall	£0.122m
Patient Flow	Hayley Kendall	£0.405m
Workforce	Debs Smith	£0.312m
Endoscopy	Hayley Kendall	£0.100m
Medicines Management	Nikki Stevenson	£0.451m
One Patient Record	Mark Chidgey	£-
Theatre Utilisation	Hayley Kendall	£-
	Total	**£1.390m**

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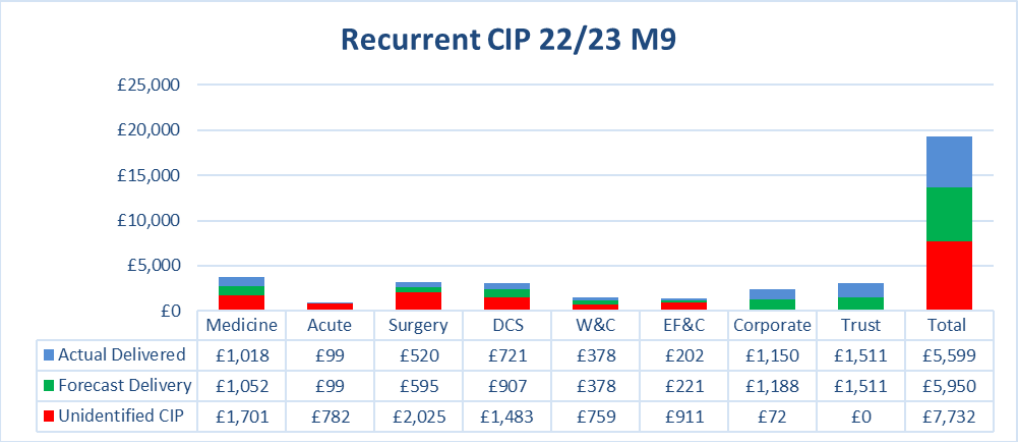
Month 9 CIP Position

Wirral University Teaching Hospital
NHS Foundation Trust

- An in year saving of £5.6m has been transacted for 22/23 against a target of £13.8m
- The forecast outturn for 22/23 remains at £5.9m
- The medicine division continue to deliver the largest CIP across the clinical divisions.
- A significant number of Medicine Optimisation CIPs have delivered in month, increasing the forecast outturn and mitigating a reduction in under delivery across other divisions.



	Medicine	Acute	Surgery	DCS	W&C	EF&C	Corporate	Trust	Total
Actual Delivered	£1,018	£99	£520	£721	£378	£202	£1,150	£1,511	£5,599
Forecast Delivery	£1,052	£99	£595	£907	£378	£221	£1,188	£1,511	£5,950
Unidentified CIP	£1,701	£782	£2,025	£1,483	£759	£911	£72	£0	£7,732

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Month 9 Over-all Position

Wirral University Teaching Hospital NHS Foundation Trust

Workstream	Delivered	
CIP	5,600	Outpatients and Meds Optimisation budget reductions included in figures
Outpatients	-	Include in CIP due to budget reduction
Theatres	-	
Endoscopy	100	
Flow	405	
Workforce	312	
Medicines Optimisation	242	£209k included in CIP due to budget reduction
One Patient Record	-	
Grand Total	**6,659**	

Outpatients Productivity

Savings delivered through reducing off site rental charges for outpatient activity, streaming lining of admin and clerical staff

Wirral University Teaching Hospital
NHS Foundation Trust

Enabling Projects:

- PIFU
- Advice & Guidance
- Partial Booking
- Stratification of Overdue Follow Ups
- Clinical Outcome Form completion & accuracy
- Sessions delivered vs plan and utilisation
- Job Plan vs OPC templates
- Off site clinics utilisation
- Room Utilisation
- Vital Hub Project Suite
- BOTs
- Admin & Clerical
- Nursing

together we will

KPIs

•PIFU - 5% (all pts following an attendance)
•A&G – 16% (all new GP OP referrals)
•Partial Booking – 2% DNA rate reduction
•Stratification of overdue follow ups - 100% of 8 weeks+ overdue reviewed and PTL updated
•WLI spend reduction – 10%

Target: £200k
Delivered: £122k

Budget Reductions	Division	Type of Saving	Total
Admin & Clerical VCH	Corporate	Budget Reduction	49
Admin & Clerical Band 2's	Corporate	Budget Reduction	44
RTT Phase 1	Corporate	Budget Reduction	28
Total			**122**

Patient Flow

Savings delivered through increasing patients through virtual wards for frailty and respiratory and the prevention of further escalation costs

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Enabling Projects:

- Same day emergency care
- SBAR Handover
- Push Model
- Weekend Discharge
- Communication & Education to Support Discharge
- Implementation of Non CTR Model
- Virtual Wards
- Model Board Rounds
- Review of day case utilisation rates
- Reducing admissions & LOS on Paediatric ward

KPIs

- 4 hour A&E target
- No of waits > 12 hours from DTA
- Ambulance handover % <15 mins
- Ambulance handover % <30 mins
- Ambulance handover % <60 mins
- Discharges % before 12
- Discharges % before 16:00
- Number of patients discharged from DHC
- Utilisation of virtual wards
- Reduction of escalation rates

Target: £300k
Delivered: £405k

Cost Avoidance	Division	Description	Total
Virtual Wards-Frailty	Medicine	Number of patients YTD: 150	192
Virtual Wards-Respiratory	Medicine	Number of patients YTD: 325	212
Total			**405**

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Workforce

Savings delivered through a reduction of temporary staffing across corporate, estates and facilities, HR, and medical and nursing workforce

Wirral University Teaching Hospital NHS Foundation Trust

Enabling Projects:

- Workforce Planning-A project to implement a standardised methodology and process for producing an annual (or multi-year) workforce plan, aligned to business planning and financial planning.
- Job Planning-A project to review and redesign systems and processes to ensure job planning is available to all relevant staff groups and that job plans link to planned and delivered activity. Ultimately, to deliver level 4 of the 'meaningful use, standards.
- Rostering-A project to review and redesign systems and processes to ensure rostering is available to all relevant staff groups and that rosters link to capacity and demand. Ultimately, to deliver level 4 of the 'meaningful use, standards
- Temporary Staffing-A project to review and redesign systems and processes to improve provision of temporary staffing across all staff groups, in line with the NHS England Agency Rules Toolkit

KPIs

10% reduction in business as usual agency spend
Level 4 of rostering meaningful use standards
Level 4 of job planning meaningful use standards

Target: £2.083m
Delivered: £312k

Run Rate Reductions	Division	Description	Type of Saving	Total
Agency Spend		Trustwide reduction in spend	Run Rate Reduction	216
Bank Spend		Trustwide reduction in spend	Run Rate Reduction	36
Security Staffing - ED	E&F	Cease agency from October	Run Rate Reduction	60
Escalation Rates - ED	Acute	Reduction in shifts going to stage 4 escalation	Run Rate Reduction	0
Total				**312**

Endoscopy

Savings delivered through increasing of points on a list and reduction in outsourcing and WLI spend

Wirral University Teaching Hospital
NHS Foundation Trust

Enabling Projects:

- Endoscopy points per list
- Endoscopy lists plan vs actual
- Endoscopy procedures plan vs actual
- Endoscopy cases plan vs actual

Points Per Session	Room / Time											
	End Rm 01		End Rm 02		End Rm 03		End Rm 04		End Rm 05	End Rm 06		Average Points
Date	AM	PM	AM	PM	AM	PM	AM	PM	AM	AM	PM	
2023-01-05	12.0	10.0	10.0	12.0	11.0	11.0	9.5	7.5	10.0		10.0	10.3
2023-01-06	11.5	10.5	9.3	9.0	7.5	8.0	9.0	4.0	8.0	7.0	11.0	8.6
2023-01-07	11.5	12.0	11.0	12.0	12.0	11.0			7.0			10.9
2023-01-08	10.5	11.0	11.0	12.0	12.0	12.0						11.4
2023-01-09	12.0	12.0	11.0	12.5	10.0	12.5	10.0	9.5	9.5	8.5	11.5	10.8
2023-01-10	11.0	11.0	9.0	11.5	9.0	11.5	11.5	10.5	8.2	11.0	10.0	10.4
2023-01-11	10.7	12.0	11.0	10.0	2.5	5.0	7.0	9.5	11.5	5.0	4.5	8.1
2023-01-12	11.5	12.0	12.0	10.5	10.5	11.0	8.5	9.5	10.0	10.0		10.5
2023-01-13	10.5	12.5	11.5		5.0	3.0	12.0	12.0	11.0	11.5	11.5	10.1
2023-01-14	11.0	12.0	11.0	12.8	9.5	11.0			4.0			10.2
2023-01-15	12.0	12.0	12.0	11.0	12.0	8.5						11.2
2023-01-16	10.0	9.5	11.5	11.0	6.5	8.5	10.5	9.0	11.5	10.5	7.0	9.6
2023-01-17	10.5	10.5	10.0	6.0		11.0	10.0	3.0	10.5	8.5	4.5	8.4
2023-01-18	9.5	5.0	5.0	4.5		3.0			9.0		4.0	5.7

KPIs

- Increasing of core session utilisation
- Increasing points on a list
- Reduction of insourcing spend
- Reduction of outsourcing spend
- Reduction of WLI spend

Target: £100k
Delivered: £100k

Run Rate Reductions	Division	Type of Saving	Total
Core	Medicine	Run Rate Reduction	- 17
WLI	Medicine	Run Rate Reduction	16
Your World	Medicine	Run Rate Reduction	31
Agency	Medicine	Run Rate Reduction	-
Insourcing	Medicine	Run Rate Reduction	70
Total			**100**

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Medicine Optimisation

Savings delivered through contract changes, bio similar changes and product changes

Wirral University Teaching Hospital
NHS Foundation Trust

Enabling Projects:

Adalimumab Reference price
Contract Changes - Tranche 2
Contract Changes - Tranche 1
Contract Changes - Tranche 3
Renal Linelocks
DOAC packsize change
Established Homecare VAT saving
Recycling Scheme
TCAM
WHH Hospice Provision
Aseptic suits CIP
DOAC switch
Ozurdex Commercial Offer
Faricimab AMD

Enabling Projects Cont.

Biosimilar ranibizumab
Contract Changes - Tranche 4
Biosimilar rituximab
Commercial Offers
Coolsticks instead of Ethylchloride
New Homecare Opportunity
Minor Drugs Schemes
Paper prescriptions move to cerner
Pill School
Romiplostim dose banding
SLA review

together we will

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Medicine Optimisation Finance

NHS
Wirral University Teaching Hospital

Target: £220k
Delivered: £451k

Division	Budget Reduction Savings
Acute	1,380
DCS	123,809
Medicine	72,598
Surgery	9,140
Women's & Children's	1,777
Grand Total	**208,704**

together we will

Budget Reductions	Description	Type of Saving	Total
Adalimumab Reference price	Commissioners charged national reference price for adalimumab which was introduced to incentivise biosimilar switch. Inflated cost applied in pharmacy since 2019 and therefore reference price was in the runrate of the CCG HCD block, maintaining this income is cost pressure avoidance. Further work required to understand if there is additonal CIP due to increased use of adalimumab. This is the best value biologic drug for rheumatology, gastroenterology, and dermatology inflammatory conditions.	Budget Reduction	97
Contract Changes - Tranche 2	Changes in drug contract prices which provide a saving.	Budget Reduction	42
Contract Changes - Tranche 1	Changes in drug contract prices which provide a saving.	Budget Reduction	36
Contract Changes - Tranche 3	Changes in drug contract prices which provide a saving.	Budget Reduction	14
Renal Linelocks	Switch from Taurolock linelocks to cheaper Citralock product for dialysis patients.	Budget Reduction	-
DOAC packsize change	Apixaban packsize switched to 20 tablets from 60 tablets. Reduce overall Trust drug expenditure on this drug. To ensure CIP is not overestimated due to prescribing of apixiban being displaced by prescribing of edoxaban, any additional spend on edoxaban has been taken into account	Budget Reduction	14
DOAC Switch	Product Switch	Budget Reduction	6
Total			**209**

Cost Avoidance	Description	Type of Saving	Total
Recycling Scheme	Unused medications are returned from wards. Requires workforce to maintain recurrence of saving year on year. Non-recurrent scheme delivered annually	Cost Avoidance	242
Total			**242**

One Patient Record

Programme launch scheduled for 12/01/23 following development of clear timeline and scope for delivery.
Savings anticipated from reduction of offsite storage through scanning accreditation

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Enabling Projects:

- Electronic letters to neighbouring organisations
- Powercharts ECG
- Electronic Booking Form
- Pre Op Assessment
- Vitalslink
- Seca Scales
- Inpatient Referral Optimisation
- Growth Charts
- ERS integration
- Oncology Prescribing
- Zesty: Patient Portal
- Medical Imagining

Enabling Projects:

- Clerking Documentation
- Electronic Consent
- British Scanning Standards
- Electronic Management of Paper Documentation
- Scanning SLA Governance

KPIs

- Investigate & identify all remaining paper elements of the Health Record
- Identify electronic solutions for all remaining paper
- Implement workflows to enable the EPR to act as a single source of Truth
- Negate the need for paper case notes to be used across the Trust

Target: £60k
Delivered: £0k

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Theatre Programme

Wirral University Teaching Hospital
NHS Foundation Trust

Enabling Projects:
Booking & Scheduling
Pre-Op Assessment
Theatre Utilisation
Outpatient Utilisation
National Standards
Process & Governance

Progress to date for Think Big Surgical Challenge launch on 7th February 2023

- Action Plan creation ongoing
- Updated Steering Group Meeting scheduled
- Updated Terms of Reference drafted
- Task & Finish group activity continues including;
  - OTD Cancellations RCA Study
  - Booking & Scheduling Productive Partners pilot feedback
  - Pre-Op Process Mapping workshop

KPIs
TBC

Target: £220k
Delivered: £0k

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Board of Directors in Public
1 March 2023

Item 10.1

Report Title	Quality Committee Update
Author	Steve Ryan, Chair of Quality Committee

This report provides a summary of business conducted during a meeting of the Quality Committee held on 19 January 2023.

Overview of Assurances Received

The Quality Assurance Committee is provided with a series of regular reports, which provide triangulated and overlapping insights to give a rich picture of quality and safety across the organisation. This gives an opportunity to identify themes of concern to address and areas of improvement progress. They give assurance on how issues are identified and how learning and improvement engendered. The relevant reports are:

- Patient Safety Quality Board Key Issues Report
- Serious Incident Panel Chair's Report
- Quality and Patient Safety Intelligence Report (Q2 2022/23
- Complaints Report (Q2 2022/23)
- Quality and Performance Dashboard
- Learning from Deaths Report
- Board Assurance Framework

The reports to the Committee this month gave assurance that the Trust is developing its approach to quality and safety in line with the new national Patient Safety Incident Response Framework: In particular identifying themes for improvement work, without waiting for serious incidents to manifest themselves; whether this be from intelligence gained from low or no-harm incidents or complaints. A good example of this is in the improvement work on falls prevention where potential signals have been picked up, despite our comparative data not exceeding nationally set limits. A part of this issue relates to vacancies in clinical support workers. The Chief Nurse who is working with colleagues from across Wirral has taken action to boost recruitment.

Signals have also been picked up in relation to correct application of the Mental Capacity Act (MCA) in all cases and the Mental Health Strategy Group led by the Chief Nurse will provide oversight of improvements.

Mortality rates (Summary Hospital Mortality Indicator and Hospital Standardised Mortality Rate) lie within the accepted national reference rates. Except in one case outlier alerts for diagnostic groups have been examined and no care issues have been identified. The most recent alert - related to a coded diagnosis of pneumonia is being reviewed using a case note clinical audit. Case reports reviewed by the Mortality Review Group had identified MCA compliance as a learning issue. One case report identified the risks of poor care as a result of care having to be delivered in one of our escalation corridors. This supports retaining the current high likelihood and impact for this risk in our Board Assurance Framework, which was reviewed by the Committee.

Maternity Incentive Scheme (Year 4)

The Committee received a joint presentation from the Director of Midwifery and the Clinical Director for Maternity Services. This presentation outlined the process by which evidence was identified, reviewed and assured to support a fully compliant declaration by the Chief Executive Officer following the Trust Board reviewing the submission at its January meeting- prior to submission toe NHS Resolution before 12:00 on 2nd February. The Committee judged that a fully-compliant declaration was supported by the evidence. A senior member of the Local Maternity and Neonatal System attended the item.

The Committee recommends that the Trust Board authorises the Chief Executive Officer to sign the submission to NHS Resolution.

Mersey Internal Audit Agency Review of the Wirral Individual Safe Care Every Time (WISE) Ward Accreditation/Assurance Mechanisms

The review was to provide assurance on the effectiveness of the Ward Accreditation Framework, the validity of the results produced and reported, and the effectiveness of the organisational processes. The audit opinion was of substantial assurance. One medium and two minor areas for further improvement were identified which the Trust can readily address.

Cancer Services Annual Report 2021/2022

Although containing information from nearly one year ago, the key points made in this report remain pertinent. The impact of the Covid pandemic with delays to presentation for assessment and treatment has brought high pressure to these services. The data on access to cancer services is presented each month to the Trust Board who will be aware of the measures undertaken to increase capacity to meet the increased referral rate (of around 25% above pre-pandemic levels). A positive highlight of the report was the developments in personalized care and stratified follow-up, including cancer remote surveillance. These developments have been supported by innovations in digital pathways through our patient portal.

Controlled Drug Accountable Officer (CDAO) Annual Report

The Committee received this report from the Director of Pharmacy and Medicines Optimisation which outlined the systems, processes and outcomes for the oversight of the use of controlled drugs. The Committee felt the report gave good assurance on the controls in place but noted that there was the need for continuing vigilance and that societal factors acting on individuals could increase the potential risk of breaches. A proactive approach to communicating the need for compliance with controls was welcomed.

Other comments from the Chair

The Committee received appropriate and detailed documentation in relation to the items it considered on 19 January 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.

Board of Directors in Public
1 March 2023

Item 10.2

Report Title	People Committee Update
Author	Lesley Davies, Chair of People Committee

Overview of Assurances Received

- The committee was given good assurance of the work being undertaken across the major areas of work this year to ensure the trust is in a best position possible regarding staffing, education and training and work on staff welfare and wellbeing
- It was excellent to hear of the significant uptake and participation in the annual staff survey which averaged 48% and is a substantial improvement on last year. The committee expressed its thanks to those who supported to roll out of the survey and the personal advocacy that had such a positive impact on the uptake.
- Sickness absence continues to be slightly above target and it was reassuring to see the work taken by the team to identify any specific areas of concern and where absence is a persistent issue and the action taken to support divisions and work on reducing episodes.
- It was also excellent to receive confirmation that the high retention of nurses recruited from overseas has been sustained and the success of the programme continues to have a positive impact on the safe care of patients. Of particular note is the Trust's success in reducing the number of Care Support Worker (CSW) vacancies; this is particularly reassuring given the nationally picture. This success is a testament to the excellent work by the staff to ensure that WUTH is an employer of choice and an attract place to work. This Committee however note that focus must remain on the retention of this staff group.
- A focus has, and continues to be, on bank and agency staff usage and the committee reviewed a deep dive into this area. Assurance was given on the excellent work being carried out to make sure patient care, always at the forefront of the work, is being reviewed alongside workforce planning issues, rostering, job planning and temporary staffing.
- At each People Committee information is provided on employee relation cases being dealt with by the Trust. The reports provided are of an extremely high standard and the work in the area impressive. It is heartening to see the relatively low number of cases brought against the Trust and the thorough work undertaken throughout the process to deal fairly and efficiently with each case.
- The committee also received good assurance from the Guardian of Safe Working on the exception reporting regarding working hours by junior dentists and doctors. Again, good assurance was received on the management of exception reporting and the number of additional hours being worked by staff in total and individual level with no major areas of concern identified across the Trust
- Significant work is being undertaken on the education and training programmes offered by the Trust; mandatory, specialist and future proofing the Trust's operation

New/Emerging Risks

- It has been comprehensively reported by the Trust, but an ongoing risk is industrial action
- The experience of our staff living with disabilities has emerged as an area which requires focused improvement. A new 'Action on Disability' working group has been established and this matter will be a key area of priority within the delivery of year 2 of the People Strategy.

The People Committee thanked the staff for their work which was genuinely impressive both in terms of thoroughness, likely impact and dedication which is evident in the evidence provided of the work being carried out.

Board of Directors in Public
1 March 2023

Item 10.4

Report Title	Audit and Risk Committee Update
Author	Steve Igoe, Chair of Audit and Risk Committee

Overview of Committee Activity

Losses and special payments

The Committee was provided with an update on Losses and special payments recorded up to 31 December 2022.

A number of "normal "losses were reported however the more significant issue related to a not insignificant loss arising from high-cost drugs. These were not physical losses but rather medications prepared that were unable to be used due to patients not attending for infusion. The Committee has requested a detailed deep dive in pharmacy as to ongoing stock losses which currently stand at £157,934.

Total debtor balances have reduced over recent months however the most significant debt relates to an amount owed by Wirral borough Council as a contribution to the cost of population health 21/22 data. The CFO confirmed that the Council now accept the validity of the debt but that there is a query over the calculation. A further update will be presented to the Committee at its next meeting.

Procurement spends control and waivers

The Trust continues to perform well in relation to Model Health System Targets for procurement. the use of national and regional frameworks has reduced the incidence of non-compliant spend. Further internal controls have been introduced to strengthen the reporting on procurement waivers. Two waivers were noted which with better planning should not have required a retrospective authorisation. The CFO was tasked with reinforcing across the hospital the need for any waivers to be prospective and on an exceptional basis.

Internal audit and Anti-Fraud

Work continues through the Trust's Anti-Fraud service provided by MIAA**,** specifically focussing on; strategic governance, Counter fraud activities and holding to account. Overall, there were two referral queries outstanding at the end of the period comparted with one at the start.
A positive Internal Audit summary report was received and discussed in detail by the Committee.

The following reviews were received:

- Wirral Individual Safe care every time (WISE) ward accreditation process – Substantial Assurance.
- Risk Management core controls – Substantial Assurance.
- HFMA improving financial sustainability checklist - non-standard report with positive outcome.
- Assurance Framework survey (BAF) - non-standard report with positive outcome.

Internal Audit tracker

The Committee tracks recommendations from previous audit work and resolution of those recommendations. A substantial number had been completed for this meeting however a similar

number had not been completed and of these some areas were requesting substantial delays to the implementation of agreed actions. The Committee whilst recognising operational challenges was not minded to agree to a number of these and instead asked for a revised completion date at the end of Q2 23/24.These will continue to be monitored independently by the Board secretary and reported to each Audit Committee meeting.

Internal Audit Plan
The Committee discussed the detailed internal audit plan for 23/24 which had been constructed based upon discussions with the Executive, Chair and Non-Executive directors and a thorough review of the Trusts BAF and Risk register. The plan was approved by the Committee subject to some realignment of the work programme to reflect activity being undertaken in the Trust.

External Audit Strategy for the financial statements year ended 31 March 2023
Azets, the external auditors introduced and set out in detail their audit strategy for the audit of the Trust's year-end account to 31 March 2023.
The external audit of every entity's account follows statutory requirements and is undertaken in according with International Financial Reporting standards and Auditing Standards.
Significant risks identified which are required to be rebutted by the Auditors were highlighted as:

- Management override of controls
- Fraud in revenue recognition
- Fraud in non-pay expenditure
- Valuation of land and buildings
- Implementation of IFRS 16 (lease accounting)

These are not unique to WUTH and will be highlighted in the audit strategy for all corporate entities regardless of operating sector.
The Committee also discussed the reporting timetable and value for money work to be done to underpin the year end reporting

Re-appointment of Azets
The Committee discussed the option of re appointing Azets at the end of the current financial accounting period. Governors may well remember that they were appointed on a 3-year contract with the option of an extension based on performance. The Committee discussed the current market for audit services and concluded that the current climate was not conducive to re – entering the market to procure these services and that Azets had produced a good service performance over previous engagements .The Committee were therefore minded to recommend the re – appointment of Azets to the Council of Governors and to extend the contract in line with the original extension terms .The external Audit fee for 23/24 was also discussed .The Committee noted that despite accounting for cost inflation at 9.3%, by reducing the base fee by £15,000 Azets were seeking an audit fee of £124,800 for the year to 31 March 2023. This is an increase of £400 or 0.3%. Again, the Committee agreed to recommend the fee for approval to the Council of Governors.

Going concern assessment
The assessment of the Trust as a going concern is a fundamental principle in producing a set of accounts for the Trust at 31 March each year. In most organisations, this is implicit however the Audit Committee in this Trust has for a number of years required the rationale for this judgement to be specifically set out and approved by the Audit Committee on behalf of the Board. A detailed paper was prepared by the CFO and discussed in detail at the Committee. The Committee approved the paper and resolved to assure that Board that the use of the Going Concern judgement was appropriate in the construction of the year end accounts to 31 March 2023.

Review of accounting policies
The CFO confirmed to the Committee that there are no proposed changes to the accounting policies for the Trust for the year end accounts to 31 March 2023.

Review of Material Management Estimates
As noted in the External Audit strategy presentation the areas on valuation and estimate are considered high risk in all audits as they typically involve estimation of financial sums based upon experience and calculation. The Trust highlighted for the Committee the key valuations and estimates likely to have a bearing upon the construction of the accounts for the current year. They are:

- Annual leave provision
- Overtime and annual leave (flowers)
- Employee relations/ ET's
- Clinical support worker bandings

These will be reviewed in detail as part of the year end accounts process including by External Audit.

Bad Debt Policy
The Committee approved an updated policy on the management of Bad Debt by the trust.

Other Comments by the Chair
The Audit and Risk Committee is functioning as I would expect from a mature and self-aware organisation which is a significant improvement on where it was some years ago. The nature of the conversation is professional, and risk focussed and reflects the growing enhancements to the overall control environment. A tone set by the Board and implemented across the Trust through the various operating units.

The positive external and internal audit feedback provides substantive evidence to this effect.

Statement of Assurance

As Chair of the Committee and supported by my fellow Non-executive Directors on the Committee, I can confirm that we are assured on the processes and controls in place to understand and enhance the internal control and risk management activities within the trust. We are also assured as to the delivery of value for money through the activities of the Trust.

Board of Directors in Public
1 March 2023

Item 10.6

Report Title	Committee Chairs Reports - Finance Business Performance Committee
Author	Sue Lorimer, Non-Executive Director

Overview of Assurances Received

- **Financial Plan 2023/24**

  The Committee spent a large part of the meeting going scrutinising the draft operational plan for 2023/24. MC took the Committee through a set of slides which set out clearly the movement from the 2022/23 plan to the 2023/24 plan. The initial plan showed a deterioration of £72m comprised mainly of a shortfall in income from central adjustments (£14m), a reduction in ot her income (£17m), underachieved 2022/23 CIP (£10m), reversal of 2022/23 balance sheet support (£10m), escalation pressures (£5m), unfunded pressures from 2022/23 (£9m), energy costs (£9m) other pressures (£7m) and new investments requested from divisions (£12m). offset by a required CIP of 3.7% (£20m).
  This initial plan was not acceptable and the Trust, in line with other Cheshire and Merseyside Trusts increased its CIP to £26m ie 5% and executives held check and challenge sessions with divisions regarding the investments put forward for funding. These sessions released a further £11m giving a revised draft plan of a deficit of £55m.
  Further interaction with the ICB has resulted in additional income reducing the planned deficit to £27m. The income includes £13m fair share of the Elective Recovery Fund and relies on the Trust delivering elective performance of 107%.
  The executive team now plan to undertake a second round of check and challenge meetings and will focus on productivity improvements.
  Clearly, the Committee, while being assured of the robustness of the figures and the process, were not satisfied with the outcome and expressed concerns about the potential impact on cash and the ambition to achieve a CIP of 5%.

- **M10 Finance Report**

  The Committee noted the deficit to end of January of £6.1m with a forecast deficit of £6.8m. The drivers of the deficit remain as in previous months with 64 escalation beds remaining open due to pressure from ED and circa 200 patients in bed with no criteria to reside.
  MC notified the Committee that the Trust had asked to move £5m into 2023/24 in respect of the UECUP scheme. He confirmed after the meeting that this had been approved.

- **Staffing Costs**

  The Committee received information on the levels of remuneration paid to medical staff in order to support non elective pressures and to reduce the elective backlog. While accepting the need for the input the Committee expressed concern at the rates being paid. The Committee were assured that these costs are regularly scrutinised and that the need for every locum post was regularly reviewed and wherever possible locums were employed directly to reduce the cost of agency commission.

The Committee also received an analysis of the increase in substantive appointments against posts occupied by agency staff. The Committee noted that the reduction in agency staff was not in line with the increase in substantive staff and MC undertook to gain further analysis for the next meeting of the Committee.

- **Approach to 3 Year Capital Planning Process**

  The Committee received a proposed approach to 3 year capital planning and were happy to approve. CC said he was satisfied that capital planning had improved significantly in terms of taking health and safety risks into account. This will now also go for approval to the Estates and Capital Committee.

- **CIP Performance**

  HL took the Committee through CIP performance to month 10. CIP achieved was £5.6m with a year end forecast of £5.9m.The Committee noted the significance of the required increase in performance required in 2023/24 to £26m

- **Business Cases**

  The Committee approved the business case for additional nursing in the emergency department at a value of £1,339,673. This would provide 31.34 posts to nurse patients on 2 corridors which would become the ambulance arrival zone when complete. These costs have been taken into account in operational budget-setting for 2023/24. The Committee approved the business case for 2 new Consultant Urologist posts and associated support staff and non-pay costs at a total cost of £1,685,000. This would be funded from income for activity within the Surgical Hub.

- **Access Targets**

  The Committee reviewed performance on the access targets within the Quality and Performance Dashboard. A&E and ambulance handovers continue to be a significant challenge while elective performance compares well with peers within Cheshire & Merseyside.

New/Emerging Risks

The level of CIP required for 2023/24 is high risk at 5% and needs to be brought to the attention of the Board of Directors.

Items for Escalation/Action

- The following items require the approval of the Board:
  - ED Nursing business case
  - Urology Consultants business case
  - The Committee will require delegated authority to approve submission of the final cut of the operational plan for 2023/24 which is due for submission on 27th March 2023. However, the Committee recommends that the Board approve the level of CIP to be incorporated into the plan