Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public

5 April 2023

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Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 5 April 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		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 11 Finance Report	Mark Chidgey	
	9.3)	Monthly Maternity Report	Tracy Fennell	
	9.4)	Learning from Deaths Report	Dr Nikki Stevenson	Ranj Mehra
	9.5)	Board Assurance Framework and Risk Appetite	David McGovern	
Items for Decision				
10.	Financial Strategy		Mark Chidgey	
Wallet Items for Information				
11.	Committee Chairs Reports		Committee Chairs	
	11.1) Finance Business Performance Committee – **Verbal**			
Closing Business				
12	Questions from the Public		Sir David Henshaw	
13	Any other Business		Sir David Henshaw	

Date and Time of Next Meeting

Wednesday 3 May 2023, 9:00 – 11:00

Meeting	Board of Directors in Public
Date	Wednesday 1 March 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
RM	Rajan Madhok	Non-Executive Director
LD	Lesley Davies	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
MS	Matthew Swanborough	Chief Strategy Officer
HKen	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
CM	Chris Mason	Chief Information Officer
SS	Sally Sykes	Director of Communications & Engagement
HKer	Helen Kerss	Guardian of Safe Working (item 9.4)
PM	Paul Mason	Director of Capital Planning (item 9.5)
EM	Eileen Hume	Deputy Lead Public Governor

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH attended the meeting virtually and therefore requested SI take the Chair for this meeting. SI welcomed all present to the meeting. No apologies were received.	
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 25 January were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story from a patient who was a visually impaired wheelchair user who suffered hearing loss and had a rare inherited neurodegenerative condition. The video story described her difficult experience in the Trust. NS stated the concerns raised by the patient were valid and would ensure the video story was shared with the Patient Safety Quality Board. NS added there were other aspects to consider through appropriate job planning to ensure doctors had sufficient time to prepare for clinics in advance. TF stated this patient was actively engaged in one of the Patient Experience Strategy groups and had been supporting the Trust to suggest reasonable adjustments. TF added as part of the Patient Experience Strategy, wayfinding events had been organised for patients to find their way around the hospital and this had been beneficial to understand the improvements needed. CC queried about improving the approach for junior doctor training regarding accessibility. DS stated the education and development programme team had been creating real life case studies based on both patient and staff stories. SR commented interactive training can be more impactful than learning through online training modules. 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 had recently taken place with the Integrated Care Board (ICB). DH added the meeting discussed Wirral's recovery from COVID and the wider Wirral system issues. DH also updated good progress in agreeing our future approach to patients with 'no criteria to reside', following a meeting with Wirral system CEOs and Chairs to discuss the creation of a single discharge unit and the Home First programme.	

	JH stated the ICB meeting had been beneficial to discuss current challenges and where stronger collaborative working was required. JH added it was important the Trust was proactive regarding the wider Wirral system issues. 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) action on 1-2 March had been paused as the RCN entered into negotiation with the Government. The British Medical Association (BMA) issued formal notice of 72 hours of continuous action from 13-15 March for junior doctors. Further North West Ambulance action was also planned on 6 and 20 March. 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 the Trust had seen less infection control challenges throughout January with COVID and flu incidents being at the lowest point since the start of the pandemic. JH stated that, following the assurance of compliance and approval provided at the January Board of Directors meeting, the Trust had been informed that its compliance was also approved by the Local Maternity & Neonatal System and ICB. As a result, the Trust would receive the full financial benefit of £0.559m. JH reported the Trust declared 1 serious incident in December and no Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS). JH gave an update on the recent Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board, Cheshire and Merseyside ICB and Wirral Place Based Partnership Board. SL commented the Finance Business Performance Committee noted the 2023/24 increase in Clinical Negligence Scheme for Trusts (CNST) cost and queried how this worked with the MIS rebate. JH stated the £0.559m MIS rebate was for 2022/23 and a rebate may occur for 2023/24. JH added for 2023/24 the Trust had budgeted for the rebate, but should the Trust not receive the rebate there would be an additional cost of circa £600k. The Board **NOTED** the report.	
8	**Chief Operating Officer's Report**	

HKen provided an overview of the Trust's current performance against the elective recovery programme for planned care as well unscheduled care.

HKen highlighted in January the Trust attained 99.2% against a plan of 98.3% for outpatients and for elective admissions 99.1% of activity was delivered against a target of 96.0%. HKen provided an update on the number of patients waiting for referral to treatment.

HKen stated the Faster Diagnosis Standard was 76.24% in December against a target of 75% and explained the 2 week waits performance declined in December due to another increase in referrals.

HKen reported unscheduled care type 1 performance was up 4.23% in December and the Trust ranked 22nd out of 42 Trusts in the North west. The Trust continued to perform well in terms of overall 4-hour performance and is ranked 5th out of the 42 Trusts.

HKen added a new Ambulance Arrival Zone would open in early March and would provide 12 spaces for patients admitted via ambulance thus removing a proportion of corridor care.

HKen stated 35% of the total bed base was occupied by patients that required 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 queried about the patients with no criteria to reside and if there was an update regarding the Home First expansion.

HKen stated Home First was live and already accepting 50 patients a month. The business case to expand Home First had been approved. HKen added improvements would be seen from July onwards given the timescales required to scale up the initiative.

SI also queried if the Trust risked increased emergency department (ED) attendances because of the UECUP and creating additional challenges discharging patients in future.

JH stated the number of ED attendances generally remained static and the Trust was not an outlier in increased admissions.

RM queried if there was generally capacity in other care settings to discharge patients to.

HKen stated there was availability but there were challenges negotiating care packages due to specific criteria set by care settings which made some patients ineligible.

	JH commented there was an appetite from Wirral system CEOs/Chairs to create a discharge unit with one team overseeing discharge and communication with external care providers. JH added the transfer of social care to Wirral Council from 1 July would make discharge easier with one point of contact instead of communicating with individual care providers. SI queried if there was a shared willingness across other Wirral system partners to create a discharge unit. HKen stated at the previous CEO/Chairs meeting in February there was a positive appetite for the discharge unit and the next meeting on 13 March would discuss more detailed operational plans. The Board **NOTED** the report.	
9	**Board Assurance Reports** **9.1) Quality and Performance Dashboard** TF highlighted the number of C diff and gram-negative bacteraemia were reducing. SR commented this was positive and was due to the strong infection, prevention, and control measures in place at the Trust. SR added if C diff cases had been higher, combined with a high percentage of bed occupancy, there was a greater risk of a hospital acquired outbreak. DS highlighted sickness absence and staff turnover remained outside Trust target. DS stated sickness absence was driven by short-term absence, and the updated Management Attendance Policy launch had been paused to consider MIAA recommendations following an internal audit. DS also stated the key drivers for staff turnover were flexible working and burnout. These themes had been evidenced in the initial analysis of the NHS Staff Survey, the full results of which will be available next week. DS also highlighted mandatory training remained achieved Trust target and appraisal compliance had reduced to 86% against Trust target of 88%. SI queried the Trust's approach to mandatory training and if modules were specific to certain roles. DS stated the Trust was in the process of reviewing mandatory training to ensure it aligned with the core skills training framework and refreshed training may be amended. DS added that this has the added benefit of enabling new employees from other NHS organisations to transfer their training record to the Trust.	

The Board **NOTED** the report.

9.2) Month 10 Finance Report

MC reported the Trust was reporting a deficit of £6.066m, an adverse variance against budget of £6.271m. The variance was attributed to over-spends on employee costs, driven largely by underperformance 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.

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

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

MC added capital had changed to amber from green due to the Trust requesting £5m be transferred from the 2022/23 to 2023/24 financial year. MC also added cash had changed to amber due to Trust forecasting to be under the minimum cash balance between Q3/Q4 2023/24.

SL queried if the Trust was confident in the forecast position owing to the ongoing impact of industrial action.

MC stated there may be movements and this would be managed within the forecast position.

SL also queried the approach to paying staff taking part in industrial action.

DS stated the agreement was there would be reduction in pay the following month after industrial action.

SI queried the Trust's cash balance risk and if this was a nationwide issue.

MC stated this was a nationwide issue and some Trusts would drop below the minimum required cash balance between Q1-Q2 2023/24, and the Trust has forecast this would happen between Q3-Q4.

The Board:

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

9.3) Monthly Maternity Report

TF provided the perinatal clinical surveillance data linked to quality and safety of maternity services. TF stated there were no areas of concern to raise this month.

TF stated after the publication of the MBRRACE (Mothers and Babies: Reducing the Risk through Audits and Confidential Enquiries) report in November 2022, the Trust was identified as having a higher-than-expected neonatal mortality rate.

SR highlighted a review of the neonatal deaths that occurred in 2020 was undertaken. SR explained all these babies' care was subject to scrutiny internal to and external to the Trust and to appropriate external reporting. SR added the Trust was not an outlier for perinatal mortality rates.

The Board **NOTED** the report.

9.4) Guardian of Safe Working Report

HKer provided details of the number of doctors/dentists in training, details of the exception reports submitted for the reporting period by speciality and grade as well as details of breaches of safe working hours and fines incurred.

LD queried if junior doctors were now involved in their rotas.

NS stated junior doctors had been involved in their rotas in obstetrics and gynaecology. The Emergency Department rota was complex and there were regularly gaps. NS added the rota was being redesigned and a number of Clinical Fellows being recruited to fill the gaps.

HKen stated the Medicine Division rota would be reviewed next and agreed to involve HKer and junior doctors in this.

DS commented it was important to increase the visibility of locum shifts to improve the experience of junior doctors and to fill gaps. DS stated that around 70% of gaps were filled through the Trust's scheduling app but required a proactive approach. DS added there had been practical issues with Medical Resourcing based at Clatterbridge. A request has been made for the team to move to Arrowe Park, but space is limited and a resolution is awaited.

RM queried if gaps in the rota occurred due to sickness absence.

DS stated there were gaps for a combination of reasons including vacancies, maternity leave, and sickness absence. DS added the Emergency Department rota was complex and both Medical Resourcing and the Division were addressing this.

	JH stated the Trust had no control over the number of junior doctors it receives each year, and whilst the rotas remain static the fill rate is unpredictable at each junior doctor change meaning there are gaps in the rotas which require backfilling. JH added this was a nationwide issue and the Trust had limited influence over this. The Board **NOTED** the report. **9.5) Estates, Facilities and Capital Update** PM provided an update on the Estates, Facilities and Capital service provision performance metrics. SL acknowledged the number of patient meals served as well as portering patient moves and queried if there was any comparison data with other Trusts regarding this and costings. PM stated the Trust submitted an annual return to the Estates Returns Information Collection (ERIC) and provided a comparative score to other Trusts. MS agreed to provide comparative data regarding Estates and, Facilities performance metrics to the Estates and Capital Committee. LD queried the switchboard call handling volumes specifically the number of missed/lost calls and what was being done to reduce this. MS stated in January 52% of incoming calls were unanswered and 59% of internal calls were unanswered. MS added there was a telephony improvement project ongoing to reduce both the number of directory and ward numbers. PM stated the Trust was working with Cisco to understand other system improvements as well. SL queried the reactive estates maintenance response times and if the resource gaps within the maintenance team was due to sickness. PM stated this was not the case and there was greater amount of short-term sickness absence in domestic staff. SI queried the NHS's commitment to net zero and queried the Trust's approach to sustainability. MS agreed to provide an update regarding the Trusts green plan to the Estates and Capital Committee. SR commented it was positive to see the National Cleaning Standards score regularly be above the 95% target and this demonstrated good infection, prevention, and control measures.	Matthew Swanborough Matthew Swanborough

	The Board **NOTED** the report. **9.6) Digital Healthcare** CM provided a progress update on the development of operational plans to deliver the Digital Strategy strategic priorities of the Trust over the next 12 months. CM stated of the 37 projects within those programmes – 13 were green, 2 were amber, 14 were red, 11 were blue (complete) and 2 were grey (paused). CM added there had been no requested changes to plan in the last period. CM highlighted risks affecting delivery of projects were being managed within the Digital Healthcare Team and the greatest risk to delivery was technical issues surrounding specific image sources not storing to the new PACS solution. The Board **NOTED** the report. **9.7) Productivity and Efficiency Update** MS provided an update on the current 22/23 CIP position and identified plans to date, along with the ongoing work to identify further CIP schemes. MS also updated on the progression of the 7 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. The Board **NOTED** the report.	
10	**Committee Chairs Reports** **10.1) Quality Committee** The Board **NOTED** the report. **10.2) People Committee** The Board **NOTED** the report. **10.3) Charitable Funds Committee** The Board **NOTED** the report. **10.4) Audit and Risk Committee** The Board **NOTED** the report.	

	10.5) Council of Governors The Board **NOTED** the report. **10.6) Finance Business Performance Committee** SL stated that the Committee spent significant time discussing and reviewing the financial plan for next year. Further work is required on this, and SL requested that the Board delegate authority to the Committee to approve the financial plan for submission to the ICB, given the timescales involved. The Board: • **NOTED** the report • **APPROVED** delegated authority for the Committee to approve the financial plan	
11	**Questions from the Public** No other questions from the public were raised.	
12	**Any other Business** No other business was raised.	

(The meeting closed at 11:00)

Action Log
Board of Directors in Public
5 April 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	Complete. A refreshed version is due for presentation in a Board report in April	April 2023
2.	25 January 2023	6 & 8	To organise a strategic away day for the Board to consider current and future strategic considerations, and the Liverpool Hospital Services Review	David McGovern	In progress. To be held in place of the June Board Seminar	June 2023
3.	1 March 2023	9.5	To provide comparative data regarding Estates and Facilities performance metrics to the Estates and Capital Committee	Matthew Swanborough	Complete. Scheduled for April Estates and Capital Committee.	April 2023
4.	1 March 2023	9.5	To provide an update regarding the Trust's green plan to the Estates and Capital Committee	Matthew Swanborough	Complete. Scheduled for April Estates and Capital Committee.	April 2023

Board of Directors in Public
5 April 2023

Item No 7

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 March. 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	**Infection, Prevention and Control (IPC) Update** The Trust has seen variable numbers of COVID cases over the previous month, COVID cases raised by 16 % across Wirral at its highest peak compared to previous figures. This is reflective of the national picture – noting statistical variance rather than spikes in cases across health and social care settings.

	Nationally there have been an increase in the number of COVID outbreaks hence the Trust continues to reiterate the importance of adhering to good IPC principles such as hand washing and wearing of Surgical Repellent Face Masks (SRFM) when visiting or caring for COVID positive patients. The Trust continues to see very small numbers of flu cases, and this has remained static for the previous few months both locally and nationally. The Trust has also seen a 61.5% reduction in the number of C Difficile cases compared to previous months.
1.2	**Christine McGuinness officially opens Sensory Suite at Arrowe Park Hospital** This month the Surgical Elective Admissions Lounge (SEAL) opened one of the first adult sensory suites in the country. The unit is designed to help adults with autism and additional needs who are undergoing elective surgery. Christine McGuinness TV personality visited the hospital to officially unveil the suite. Christine has been extensively raising awareness of autism after her 3 children were diagnosed with autism and her own diagnosis as an adult. Becky Brumpton, Ward Sister on SEAL led the campaign to raise funds for the unit. Further funds have now been raised to replicate the facility at the Clatterbridge Elective Surgical Centre.
1.3	**Friends and Family Test (FFT) Update** Following the significant work undertaken as part of the Patient Experience Strategy the Trust has seen improvements in FFT across several areas. All areas (ED, Outpatients, Inpatients and Maternity) have been benchmarked and currently sit above national averages (NHSE data Dec 22). ED has seen an 11 % increase in FFT recommend scores to an 86% recommend rate compared to the national average of 73%.
1.4	**Macmillan Quality Environment Mark (MQEM) Assessment** Ward 30 at Arrowe Park Hospital has been awarded a Level 4 on their first Macmillan Quality Environment Mark (MQEM) Assessment. The MQEM award recognises cancer environments that go above and beyond to create welcoming and friendly spaces for patients. MQEM is the first award of its kind in the UK and has been designed in collaboration with people living with cancer. The Trust will retain this level of award for 3 years.
1.5	**Serious Incidents** The Trust declared 4 serious incidents in January, which occurred within the Acute, Women & Children's, Surgery and Diagnostics and Clinical Support Divisions. 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 was one RIDDOR incident reported to the Health & Safety Executive (HSE) in January. All RIDDOR incidents are subject to a local review investigation to ensure appropriate action is taken to prevent a similar reoccurrence.

1.6	**National Institute for Health Care research (NIHR) Research Leadership Programme** Angela Kerrigan (Consultant midwife) has been successful in securing 1 of 15 places on the National Institute for Health Care research (NIHR) Research Leadership Programme. The programme enables nurses and midwives to identify research priorities that relate to the challenges impacting on patient care. Successful individuals are expected to represent their profession to influence the healthcare research landscape, lead capacity and capability making innovative changes to research policy and practice. As a result, Angela will utilise 0.4 WTE of her consultant role supporting research and support driving forward the Trust Research and Innovation Strategy.
1.7	**System and Place** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** The Leadership Board met on 3 March and discussed a number of key system issues. A discussion on preparations for and considerations associated with upcoming junior doctors industrial action took place. The discussion provided an opportunity for system leaders to be updated on discussions amongst Trust Medical Directors and promoted the need for clarity with the public, partners and workforce, consistency of approach and response and the paramount importance of patient safety. System communications will be led by the ICB Medical Director and cascaded to Trust Medical Directors. An update was received on progress toward achievement on the elimination of patients waiting greater than 78 weeks for treatment by the end of March 2023. Solid progress was being made, however, industrial action was noted to be a destabilising factor and risk to delivery. The Board was also briefed on implementation of the Mutual Aid Hub whose priorities included minimising variation in access and inequalities across Cheshire and Merseyside and will, going forward, include the coordination of shared, equitable access to the independent sector. The group also discussed progress in responding to the Liverpool Clinical Services Review. The principles previously discussed by CMAST were reiterated: the need to respond to the review's recommendations; the need for this to be done in sight of partners; and for wider system implications to be considered. The conclusions of a national visit were also shared which had provided assurance on progress and the collaborative approach to system delivery within C&M. Finally, the group noted that the first meeting of the ICB led aspect of the review and related to Women's Health had taken place and that as well as CMAST members being present in their own right at this committee CMAST was represented through the appointment of the Wirral Trust Medical Director following an ICB request. The Leadership Board were informed that CMAST had been successful in its bid to the Provider Collaborative Innovators Scheme. The offer includes access to national policy development, peer support and a bespoke support offer which is to be confirmed.

	CMAST Leadership Board will also meet at the end of the month in order to avoid Easter bank holidays in April. **Help shape Cheshire and Merseyside Health and Care Partnership Strategy** Cheshire and Merseyside Health and Care Partnership has launched a survey to seek the views of partners, people, and communities on the priorities within their interim strategy. The development of Cheshire and Merseyside Health and Care Partnership provides a once-in-a-lifetime opportunity to combine efforts and collective resources to make real improvements to the lives of people and communities. Cheshire and Merseyside Health and Care Partnership want to hear your thoughts on the priorities and the experience of living and accessing services in Cheshire and Merseyside. Please visit the campaign webpage to review the interim strategy and answer the survey questions (https://www.cheshireandmerseyside.nhs.uk/get-involved/share-your-views/)

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

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Board of Directors in Public
5 April 2023

Item 8

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

For planned care activity volumes, it highlights the Trust's performance against the targets set for this financial year.

For unscheduled care, the report details performance and highlights the ongoing challenges with long length of stay patients and the impact this has on Urgent and Emergency Care (UEC) performance. The report also highlights the number of patients who remain in the department for longer than 12 hours since arrival and the key performance metrics for the Emergency Department (ED).

It is recommended that the Board 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			

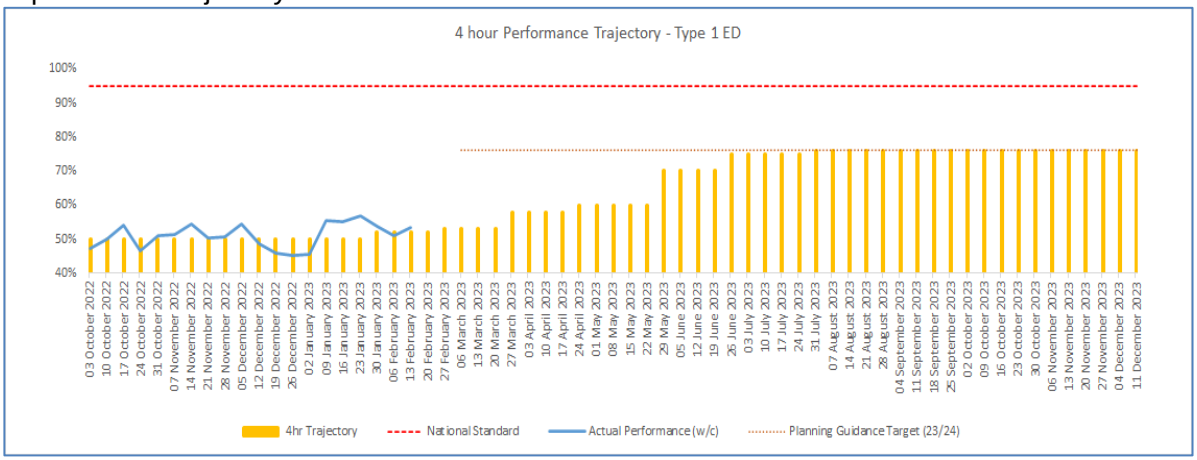
1	Introduction / Background
1.1	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the National Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to clear the backlog 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 February 2023, the Trust attained 106.0% against a plan of 108.5% for Outpatients. For elective admissions 108.7% of activity was delivered against a target of 102.6%. **Outpatient activity by POD** **Elective activity by POD** In line with the Trust recovery plans elective activity for February was positive notwithstanding the significant pressure on hospital occupancy and the impact on elective outpatient appointments and theatre lists due to Industrial Action.
2.2	**Priority 2 Performance (P2)** The Trust did not meet the P2 month end trajectories for February with the final position reporting 107 P2 breaches against a month end plan of 6. 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 are in place.
2.3	**Referral to Treatment** The national standard is to have no patients waiting over 104 weeks in February 2023 and to eliminate routine elective waits of over 78 weeks by April 2023 and 65 week waits by March 2024. The Trust's performance at the end of February against these indicators was as follows: • 104+ Week Wait Performance – zero patients waiting • 80+ Week Wait performance – 45 patients with a plan of 0 (local C&M target) • 78+ Week Wait Performance - 66 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 and complex patients) • 52+ Week Wait Performance - 1280 patients • Waiting List Size - there were 40,039 patients on an active RTT pathway which is higher that the Trust's trajectory of 31,607 (local C&M target) WUTH have also been supporting neighbouring Trust's by offering mutual aid to treat very long waiting patients through the Cheshire and Merseyside Surgical Centre.
2.4	**Cancer Performance**

	Target	Actual
New	102.3%	101.3%
F/UP	111.0%	108.0%
Combined	108.5%	106.0%

	Target	Actual
Day Case	104.5%	112.1%
Inpatients	93.4%	92.1%
Combined	102.6%	108.7%

	Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 4 to date: • 2 Week Waits – 2WW performance remains below trajectory and the national standard. Colorectal, Urology, Gynaecology and Breast services performance remains low and 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 72.76% in January against a National target of 75% mainly linked to the 2 WW performance. • 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 remains a focus for 23/24. • The Surgical working group commenced in February and was successful in its multi-disciplinary approach in the management of patient pathways @ 104 and 62 days with reductions in the number of patients waiting longer than 62 and 104 days for treatment.
2.5	**DM01 Performance – 95% Standard** In February 90.29% 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 apart from Urology. Endoscopy achieved 96% and is one of the highest performing units in the region. Additional capacity was secured for Urology and improvements against the 6-week target was evident from February. Once the cystoscopy backlog is cleared, the Trust will achieve DM01 compliance and there is a trajectory in place to do so.
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 220 per day, and being the largest challenge in C&M. Industrial action across several disciplines continues to significantly impact elective recovery and will do so moving forward. On strike days, elective activity is being managed patient by patient to ensure minimal disruption to our patients whilst maintaining safe standards of care across the hospital sites, but there are large numbers of patients being cancelled on these days.

3.0	**Unscheduled Care**
3.1	**Performance** February Type 1 performance was reported at 52.02 %, which is line with the internal 4-hour improvement trajectory. 

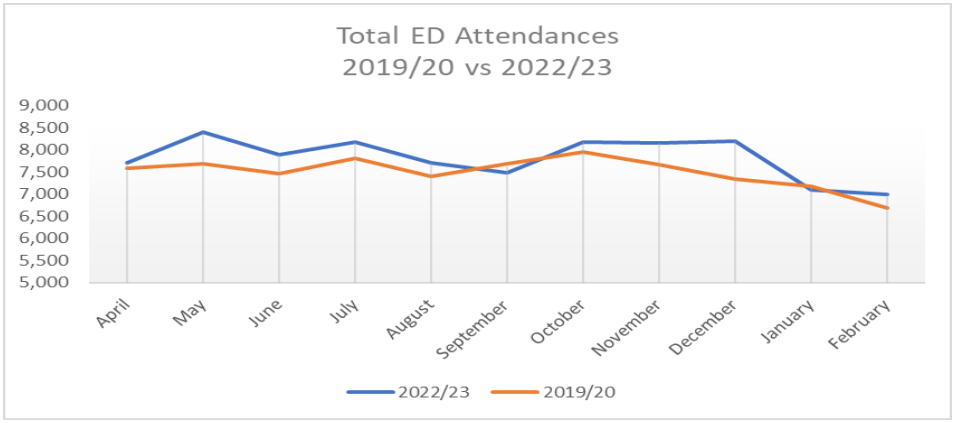
Type 1 ED attendances:

- 7,087 in January (avg. 228/day)
- 6,989 in February (avg. 250/day)
- 9% increase from previous month

Type 3 ED attendances:

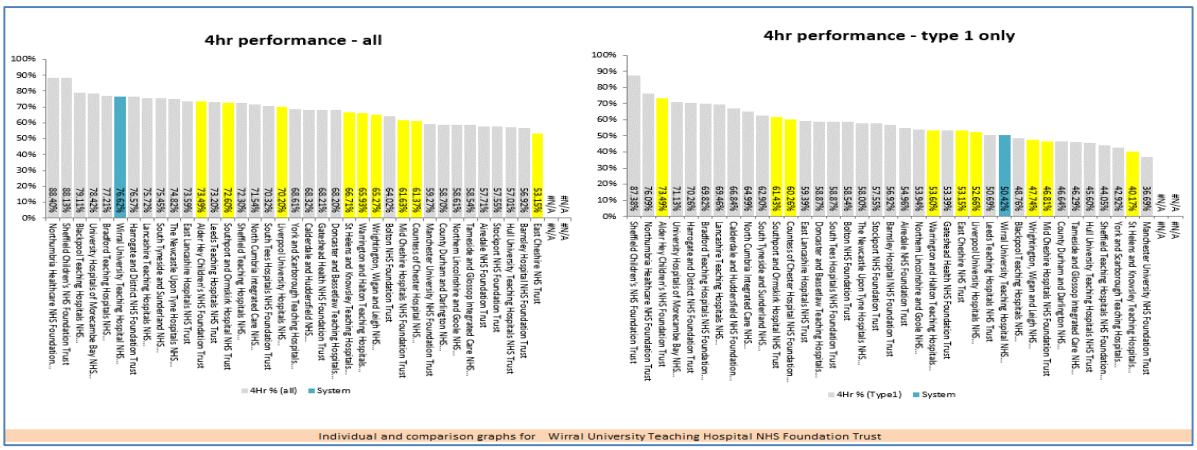
- 2,557 in January
- 2,573 in February
- 1% increase

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



The increase in Type 1 and Type 3 attendances has been seen across the North West for the month of February, with one of the significant challenges being an increase in a run of ambulance conveyances on some of the days through the month.

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 Trust will continue to focus on the improvement of the delivery of the 4 hour target however as per the national UEC recovery guidance published in January 2023, the Trust will look to focus on the improvement of ambulance handover time (15 minutes) and the reduction in the number of patients breaching the 12 hour decision to admit.

The Trust is continuing to work on several schemes to improve flow through the Trust including working with NHS England on the national model for SDEC services, review of the SPA service and the implementation of the new discharge hub.

3.2 Changes to the capture of 4-hour performance

	NHS England has requested that from April 2023, activity provided by the Urgent Treatment Centre (UTC) is reported against the organisation responsible for the service. Historically WUTH has reported Type 1 (A&E) and Type 3 (UTC) attendances under WUTH 'All Type' attendances for the 4-hour performance target for the Arrowe Park site, this will cease as of 1st April 2023. The change in reporting will result in the Trust only reporting Type 1 attendances, which will result in a deterioration of the 'All Type' performance position that is reported nationally but will not affect the type 1 reporting.
3.3	**Risks and mitigations to improving performance** Patient flow through the hospital continues to be a challenge, leading to frequent overcrowding in the Emergency Department. The lack of patient flow is resulting in increased waiting times for patients waiting for a bed (the number of 12-hour decisions for admission remains high). The Trust is responding to the days of increased pressure by introducing the Full Capacity Protocol, which speeds up the transfer of patients out of the department, but there are days when a large proportion of patients wait longer than 12 hours. In recent weeks the Trust has seen a significant increase in demand for mental health patients which often exceeds the capacity of the mental health unit based in the department, posing an increased risk to patients and staff. This is also impacting on the ability to achieve 4 and 12 hour performance. The Trust is working with CWP to manage the increase in demand as a priority. However, patients often wait longer than 12 hours for a bed in the department. The Trust meets with CWP daily to discuss patient priority across the geographical area to ensure those that are of highest risk are allocated a bed as a priority. Concerns remain regarding the potential ongoing industrial action (IA) and the need to reallocate workforce from other areas to support ED. The potential for further dates of IA is likely to have a negative impact on performance as fewer medics are available to see patients. The impact will be monitored closely however patient safety remains the focus during these times.

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. In addition, the ongoing increase in the number of mental health patients waiting longer than 12 hours for treatment in ED has been escalated to health partners but is a risk to patients and staff whilst waiting for assessment/treatment. 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
5 April 2023

Item: 9.1

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

Report Purpose and Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of February 2023

It is recommended that the Board:

- notes performance to the end of February 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

1	Narrative
1.1	Of the 51 indicators that are currently reported against thresholds (excluding Use of Resources): - 33 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 - March 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'.

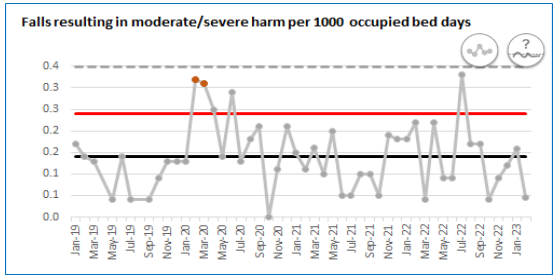
Issues / limitations
SPC charts should only be used for 15 data points or more. Some of the WUTH metrics only apply from 2022, so will take time to build up.
The national template does not support including a target where it is variable over time, eg a reducing trajectory for RTT long waiters
Larger 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.

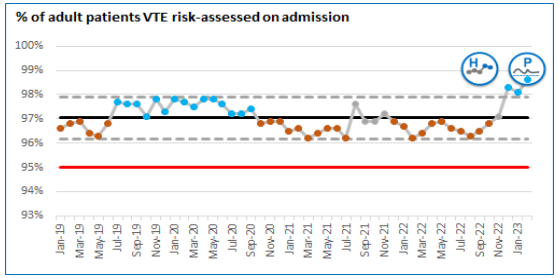
Metrics not included:

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)

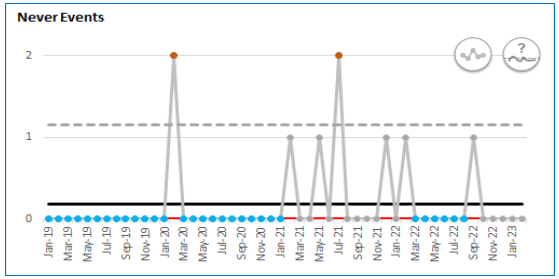
Safe - Avoiding Harm



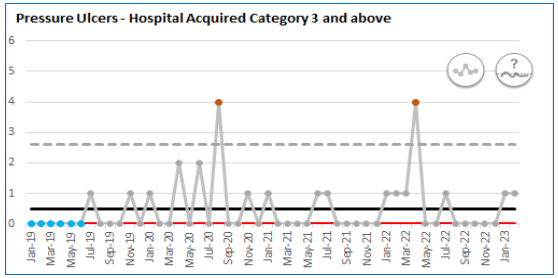
Feb-23
0.05
Variance Type
Common cause variation
Threshold
≤0.24
Assurance
Hit & miss target subject to random variation



Feb-23
98.6%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Performance consistently achieves the target



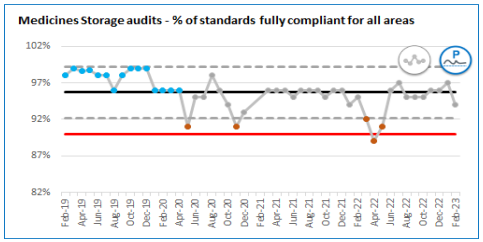
Feb-23
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation



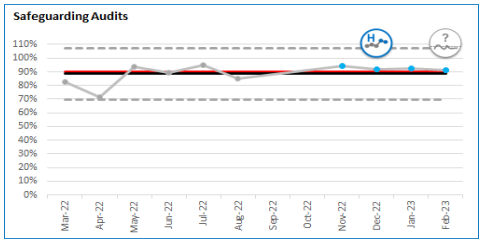
Feb-23
1
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

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 (PSLP) 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. This is alongside a targeted approach for staff to attend training and supporting the Practice Educators to provide staff with direct education in practice. Expected Impact: no hospital acquired category 3, 4, and unstageable pressure ulcers due to lapses in care.

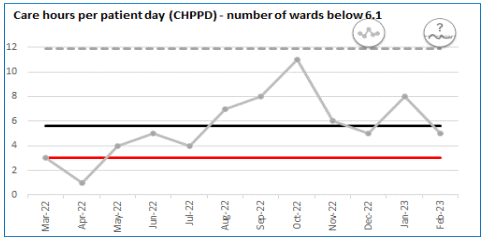
Safe - Assurance Audit



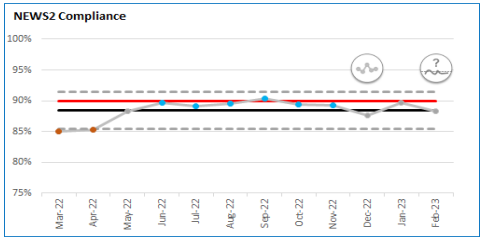
Feb-23
94%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target



Feb-23
91.1%
Variance Type
Special cause variation - improving
Threshold
≥90%
Assurance
Hit & miss target subject to random variation



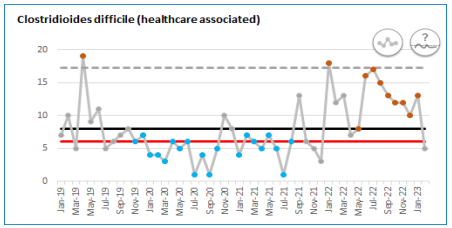
Feb-23
5
Variance Type
Common cause variation
Threshold
≤3
Assurance
Hit & miss target subject to random variation



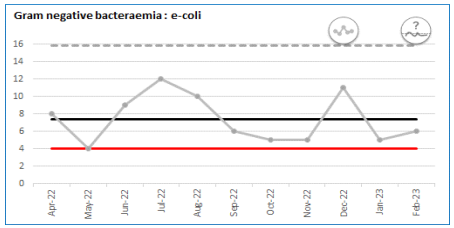
Feb-23
88.3%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

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: 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
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 in the areas of lower than threshold CHPPD. 2 wards, 21 and 36, had a CHPPD of 6 which is equal to 6 minutes below the threshold. Ward 22 CHPPD was 5.8; this ward had a significant number of patients with no criteria to reside. Similarly ward M1, CHPPD 5.3, had a high proportion of patients with no criteria to reside. Healthcare professional input will not be required at the same level or frequency to that of an acute area. Ward 38, CHPPD of 5.8 for February, has had a CHPPD below <6.1 for 13 months. Staff moves to support escalation areas and outstanding CSW vacancies is an influencing factor. CSW vacancies have been appointed to following successful trust wide recruitment events. There have been no patient harms associated with staffing levels on this ward. 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.	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 taken place in March 2023. Solutions to recording challenges continue to be explored; this is particularly evident for those patients who have been assessed to be exempt, such as patients on an end-of-life pathway; and those transferring from assessment areas to base wards. Daily reviews of NEWS2 compliance continues with escalated to ward areas as necessary. Staff engagement and education regarding the standards required continues. Governance processes have been strengthened to invite areas to Patient Safety Learning Panel where NEWS2 noncompliance has been identified. Expected impact: the expectation is for all areas to achieve greater than 90% for completing NEWS2 observations by Q4.

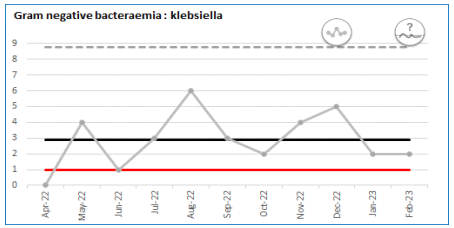
Safe - Infection Control



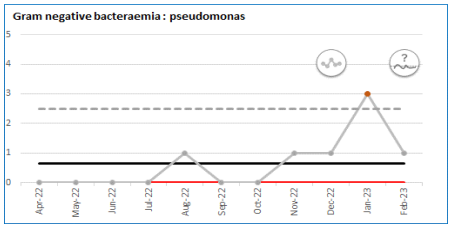
Feb-23
5
Variance Type
Special cause variation - concerning
Threshold
≤6
Assurance
Hit & miss target subject to random variation



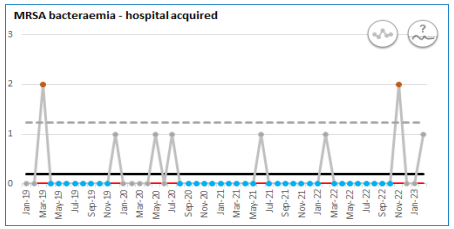
Feb-23
6
Variance Type
Common cause variation
Threshold
≤4
Assurance
Hit & miss target subject to random variation



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



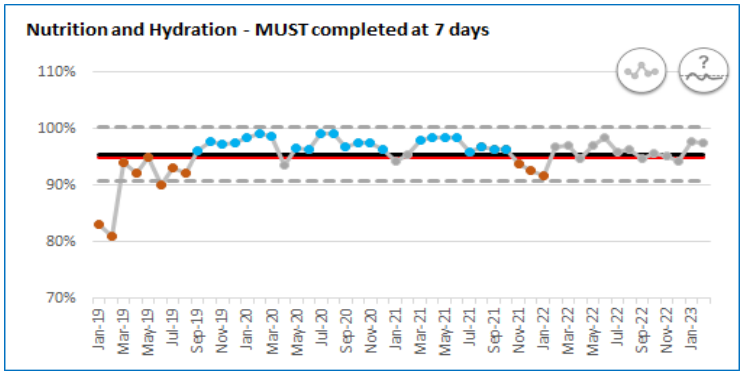
Feb-23
1
Variance Type
Special cause variation - concerning
Threshold
≤9 for 2022/23
Assurance
Hit & miss target subject to random variation



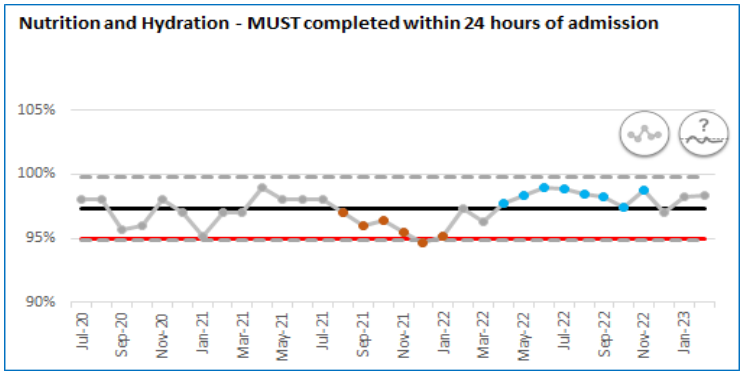
Feb-23
1
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Clostridioides difficile (healthcare associated): Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved
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 February 2023 that was hospital-onset-healthcare associated; following IPC/Microbiology review it was determined that this was probably due to aspiration pneumonia and could not have been avoided. The other case was community-onset-healthcare associated. Key priorities identified from previous cases determined to be avoidable continue to be progressed within the Trust and with the wider Wirral community teams. Inclusive of appropriate antibiotic prescribing, urinary catheter care and management, prevention and treatment of urinary tract infections, management of continence, and aseptic non-touch technique. The 'Gloves off' campaign and a focus on good hand hygiene will 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 pseudomonas: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	One case in February 2023, making a cumulative seven 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 not being achieved.	An MRSA bacteremia was identified from the admission swabs and blood cultures obtained from a patient who had transferred from WUTH to another acute hospital. The MRSA has been apportioned to us as culture was positive within 2 days of transfer to the receiving hospital. A local PIR has been completed: Appropriate screening was undertaken on admission to WUTH for MRSA; results identified that MRSA was not isolated from nose/groin. The patient had several lines in situ, one insertion site bled on removal due to trauma but settled. MRSA screening swabs due on the day of transfer were not completed has been identified as a learning point. Causative factor has been undetermined. Improvements have been identified to enable staff to follow screening requirements as per policy. Expected Impact: targeted interventions will help to reduce the risk of MRSA bacteraemia.

Effective - Nutrition



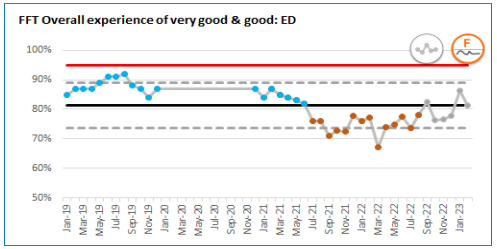
Feb-23
97.5%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



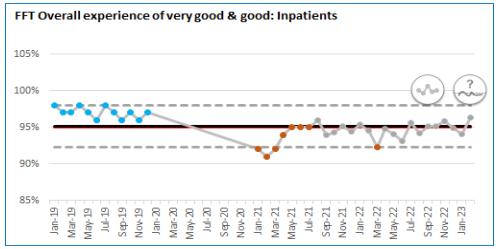
Feb-23
98.3%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

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

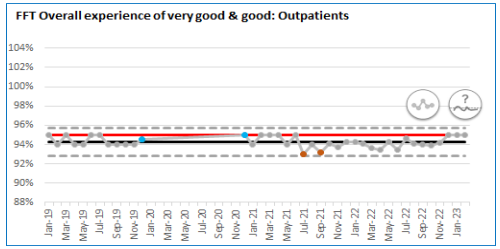
Caring - Patient Experience



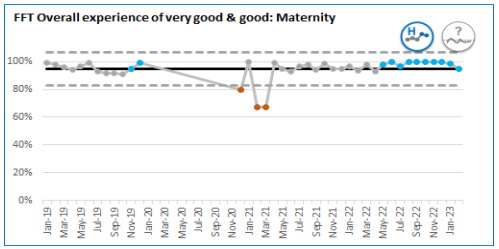
Feb-23
81.4%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target



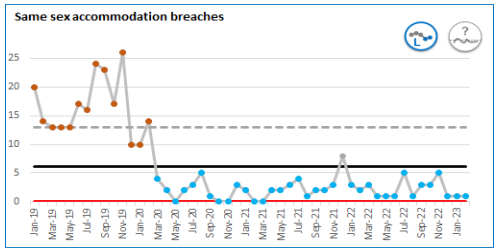
Feb-23
96.3%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Feb-23
95.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Feb-23
95.5%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Feb-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 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:

Promise Groups, established as part of our Patient Experience Strategy, held monthly focus on identifying improvement opportunities to improve people's experience of our services.

Outpatients have, for the second consecutive month, achieved the target of >95%. Inpatients score of 96.3%, has improved on last month score of 94.0%, achieving target for the first time this quarter. Volunteers have visited wards to conduct FFT surveys and laminated QR codes have been introduced to increase the opportunity for feedback in these areas.

FFT score for ED remains below the Trust threshold of 95%. However, improvement has been sustained within ED achieving 81.4%, within the threshold of common cause variance. Operational pressures continue to impact on the FFT score; waiting times continue to be reported as an area of challenge. We monitor our performance against the national average; we consistently perform higher or in line.

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

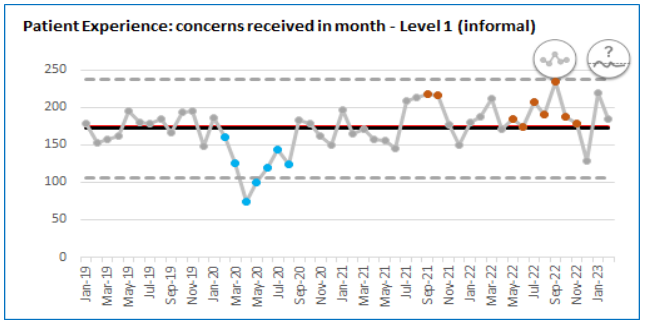
Breaches are often due to patients waiting more than 24 hours for transfer from critical care areas inclusive of Coronary Care Unit (CCU) to general wards; there was 1 such breach in CCU in February 2023. The breach did not cause any delays or refused admissions to CCU. The patient's privacy and dignity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

System challenges resulting in high levels of activity and a high proportion of patients with no criteria to reside have continued throughout February 2023, this has impacted on the ability to deliver same sex accommodation.

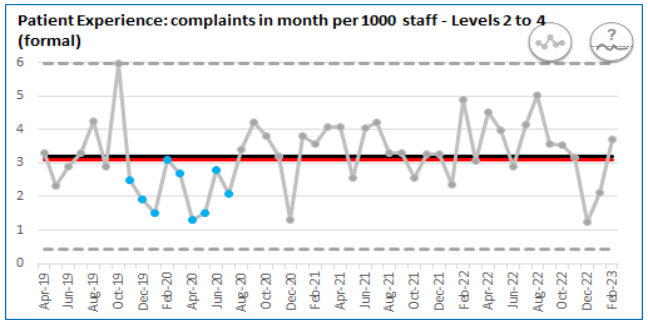
Processes are in place that enable joint working with ICU, CCU, Patient Flow Team, and Divisional Directors; each breach is risk assessed and concerns are managed promptly via bed capacity and operational meetings. This enables daily oversight of individual patients requiring a stepdown and the length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

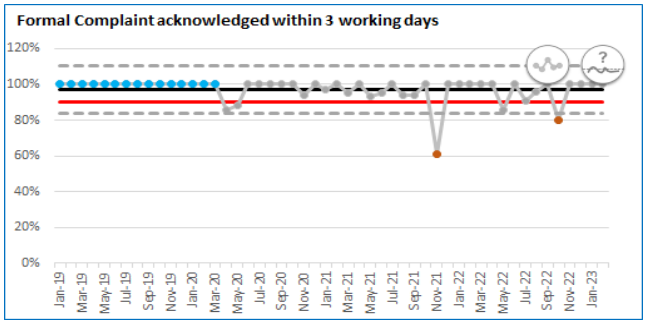
Responsive - Complaints



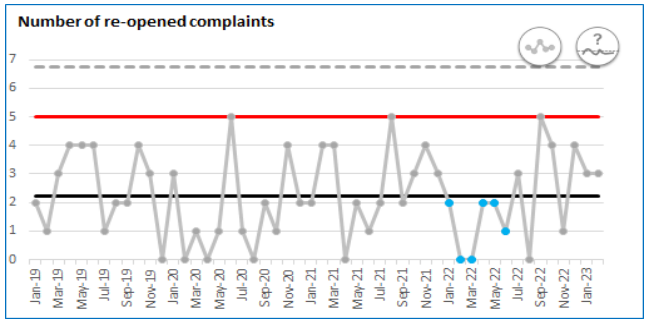
Feb-23
185
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation



Feb-23
3.69
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation



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



Feb-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 not 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:

During February 2023, 20 new formal complaints were registered (compared with 12 in January) and 18 were closed. There often appears to be an increase in complaints after December as a sessional variation.

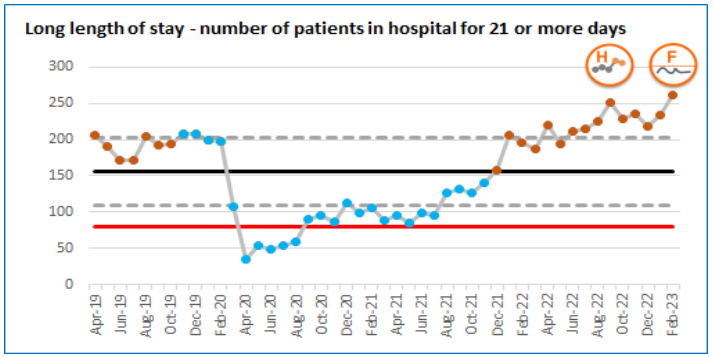
The main themes from complaints continue despite divisional plans in place to address. The main continuing causes of complaints are communication / staff attitude and capacity pressures. During the start of Q4 the number related to communication has increased further.

The capacity pressure complaints continue to be heavily focused on the Emergency Department and aligned to a growing theme of treatment delays.

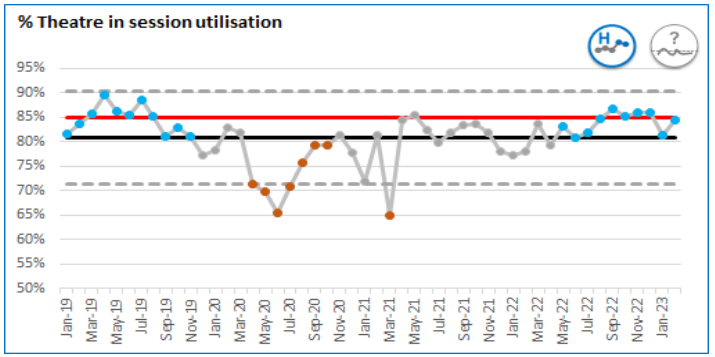
Weekly complaints management meetings with all divisions continue to take place focusing on the management of complaints and the learning from complaints remains a key source of intelligence considered within Patient Safety and Quality Board.

Expected Impact: to achieve a reduction in formal complaints by year end.

Effective - Productivity



Feb-23
262
Variance Type
Special cause variation - concerning
Threshold
≤79
Assurance
Performance consistently fails to achieve the target



Feb-23
84.6%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Issues:

Long Length of stay (21+): Special cause variation - High concerning. Performance consistently fails to achieve the target, including the most recent month.

% Theatre in-session utilisation: Special cause variation - High improving. Achieving the threshold is hit & miss, with the most recent month not being achieved.

Action & Expected Impact:

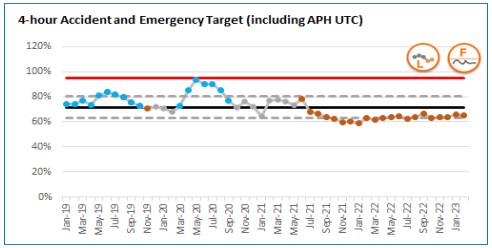
Narrative provided in separate COO Report to the Board

The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. Overall February performance was 84.6%, an improvement from January's 81.5% and just 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 "Think Big Challenge" within the Surgical Division.
January saw a decrease in on the day cancellations from 70 in January to 64 in February. Of the 64 on the day cancellations that were recorded in February 53% of the cancellations reflected non clinical cancellations. Predominant reasons include list overrunning and bed availability postoperatively.
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.
Backfilling process being reviewed as part of the new theatre floor plans to support increase in backfill requests for core capacity over 50-weeks (above establishment) to support increase in session delivery. There is a risk of late cancellations which will need careful management.

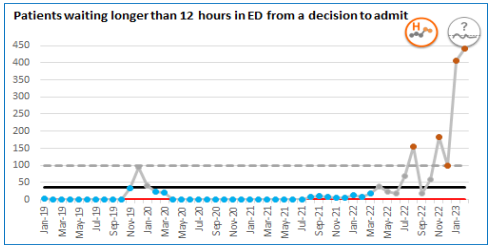
Actions:
- Maintain the daily TCI meeting to prevent cancellations on the day for inpatients and risk further reduction in in-session utilisation
- Continue to attempt to deliver above core capacity through backfills and additional requests for sessions
- Identify change process for backfills to support 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.

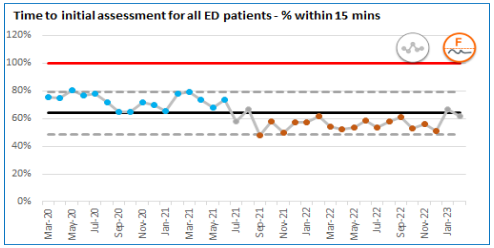
Responsive - Urgent Care



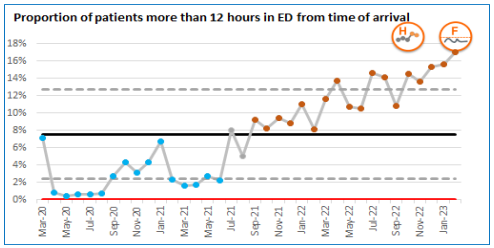
Feb-23
64.8%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target



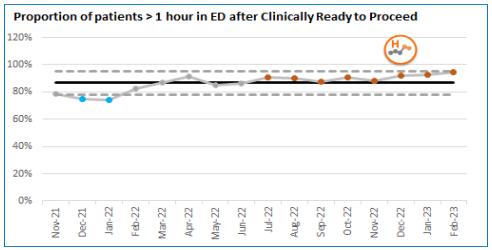
Feb-23
442
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation



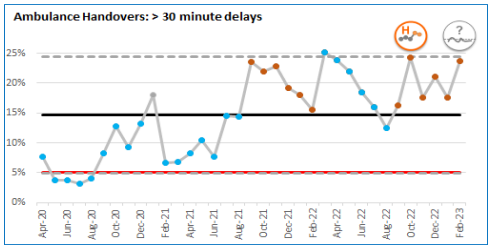
Feb-23
61.3%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target



Feb-23
17.0%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target



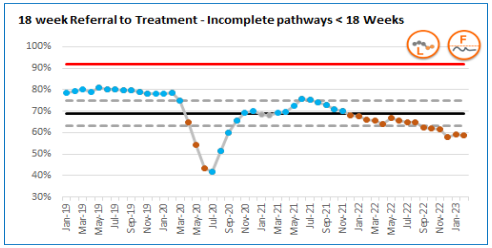
Feb-23
94.6%
Variance Type
Special cause variation - concerning
Threshold
TBC
Assurance



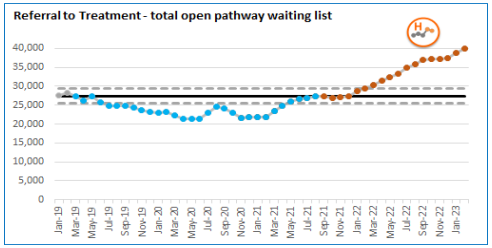
Feb-23
23.7%
Variance Type
Special cause variation - concerning
Threshold
≤5%
Assurance
Hit & miss target subject to random variation

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: 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

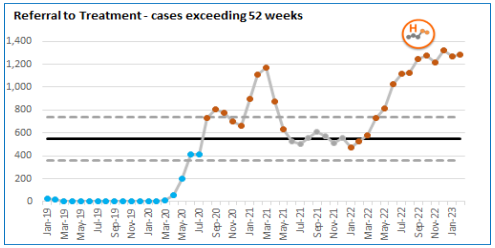
Responsive - Elective Care - RTT



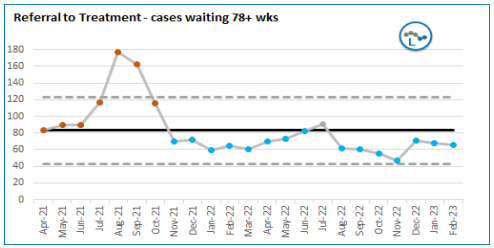
Feb-23
58.50%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target



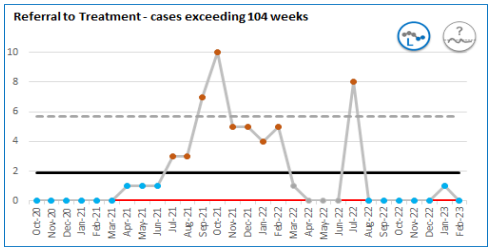
Feb-23
40039
Variance Type
Special cause variation - concerning
Threshold
≤31352
Assurance
Trajectory target not appropriate for SPC Assurance reporting



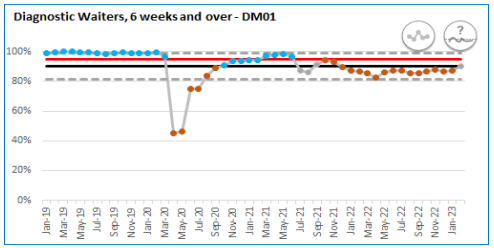
Feb-23
1280
Variance Type
Special cause variation - concerning
Threshold
520
Assurance
Trajectory target not appropriate for SPC Assurance reporting



Feb-23
66
Variance Type
Special cause variation - improving
Threshold
≤55
Assurance
Hit & miss target subject to random variation



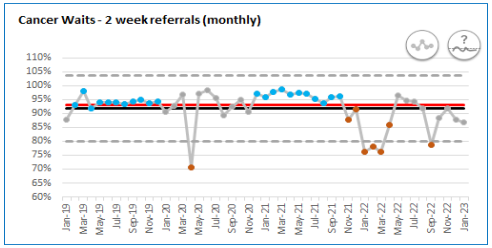
Feb-23
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation



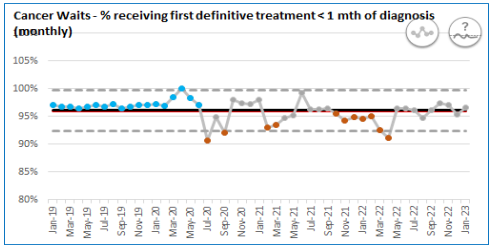
Feb-23
90.3%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

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: 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

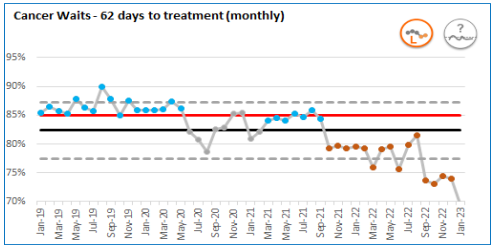
Responsive - Elective Care - Cancer (monthly - 1 mth in arrears)



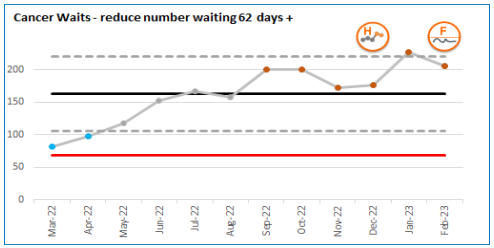
Jan-23
86.9%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation



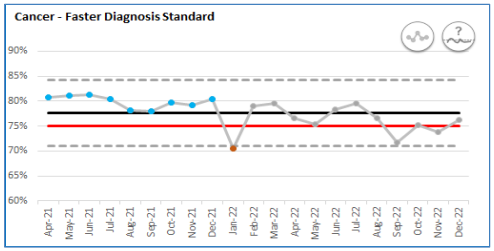
Jan-23
96.6%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation



Jan-23
69.6%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation



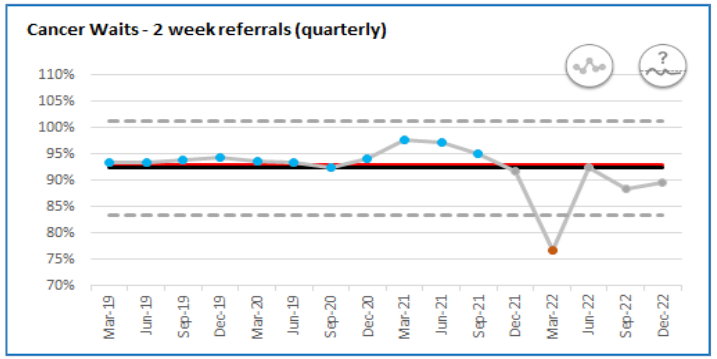
Jan-23
206
Variance Type
Special cause variation - concerning
Threshold
195
Assurance
Performance consistently fails to achieve the target



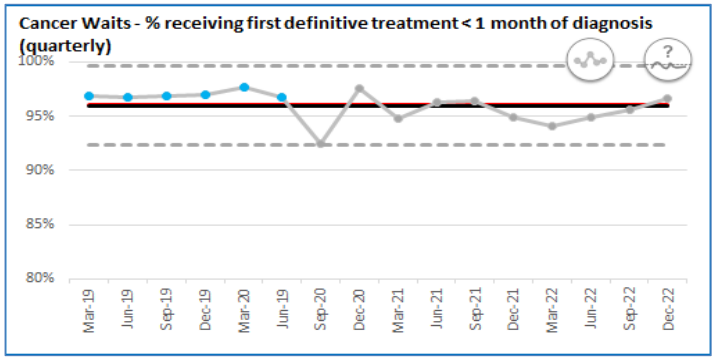
Dec-22
76.2%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

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 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

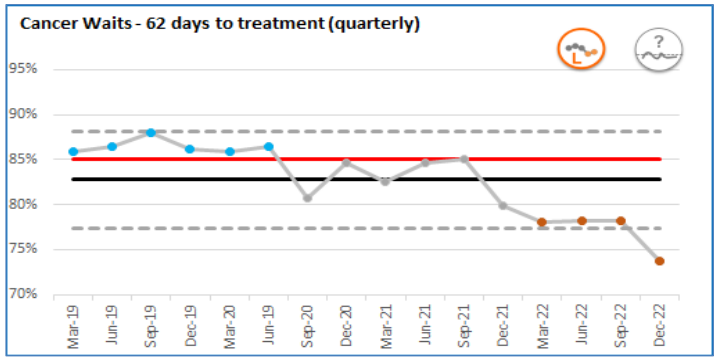
Responsive - Elective Care - Cancer (quarterly)



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



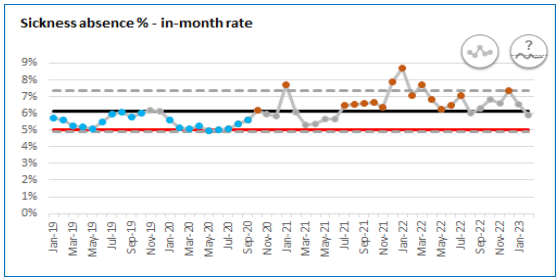
Dec-22
96.6%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation



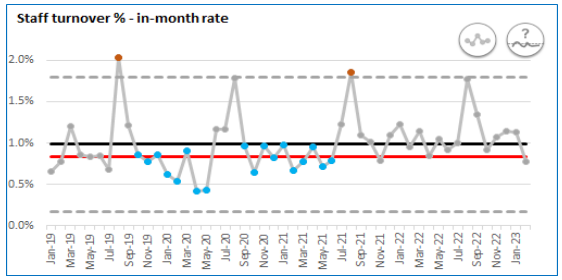
Dec-22
73.8%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation

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

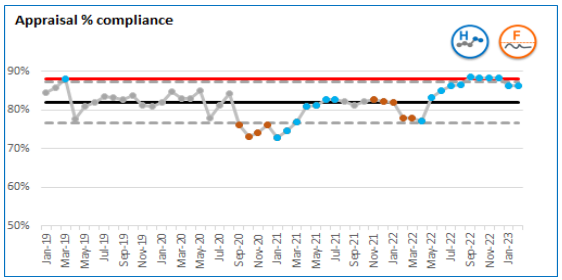
Safe - Workforce



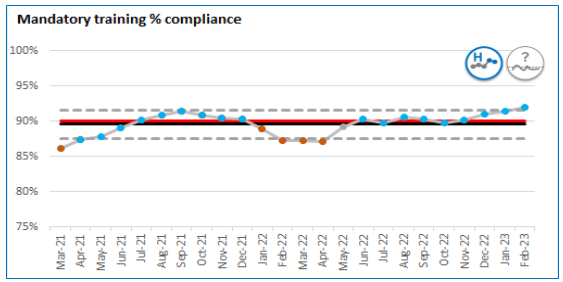
Feb-23
5.91%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Hit & miss target subject to random variation



Feb-23
0.77%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation



Feb-23
86.24%
Variance Type
Special cause variation - improving
Threshold
≥88%
Assurance
Performance consistently fails to achieve the target



Feb-23
91.95%
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.

MIAA Findings
The findings of the 2022/23 sickness absence review undertaken by MIAA have been shared with the Trust. Areas of good practice have been identified along with agreed recommendations to include a communication exercise around the importance of following processes as described in the Trust Management Attendance Policy along with a review of reconciliation processes to ensure records are maintained through ESR.

Managing Attendance Policy
Further review of this policy remains ongoing and will incorporate the findings from the MIAA audit.

End of Flu Vaccine Campaign
We have reached the end of the Trust's flu campaign for this winter. Current reported uptake amongst frontline Healthcare Workers is 62.7%, compared to a Cheshire and Merseyside average of 51.3%.

Wellbeing Week: Disabilities and Long-Term Conditions (13-17th March)
To celebrate Wellbeing Week and National Neuro Diversity Week the Occupational Health and Workforce Wellbeing Department supported by the Sunflower Disability Network arranged for a variety of services to offer support and information across both sites and via virtual sessions, focused on the theme of Disabilities and Long-Term Conditions. Staff also had the opportunity to join the following online sessions:

- Mini Manager's essentials session: Supporting staff with disabilities and long-term conditions.
- Menopause staff network

Expected Impact - the impact of high sickness 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 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

Staff turnover % in-month rate: Common cause variation. Achieving the threshold is hit & miss, with the most recent month 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:
Focus on how we can sustain a valuable workforce continues through the Strategic Retention Group. Members are examining how we can retain staff and by ensuring the retention delivery plan supports the NHS People Promise. Some examples of the work underway include:

- Retention Self-Assessment Tool initially completed by N&M and CSW staff Groups now extended to AHPs and Corporate Staff
- Development of Internal Transfer process to support Development & Career progression initially for Band 5 Nurses and CSW's
- Stay Conversations underway for N&M, CSW and Corporate Staff now extended to AHP staff.
- CSW celebration event upon successful completion of Care Certificate planned for April 2023.

Staff Survey and the People Strategy:
Staff Survey results were released across the Organisation on 9th March, 2023 as anticipated. HR Business Partners are to co-facilitate divisional events that will engage staff and managers to understand how the staff survey results reflect the culture of the organisation and ensure that we that we align this with our plans for 2023/24 to ensure this has a positive impact on turnover.
Where we have areas of high turnover we will specifically probe to seek and understand what is causing this and what measures can be considered to improve the situation.
The Trust has significantly improved development opportunities and continue to roll these out for staff to access across the Organisation.
The Trust remains committed to continuing to embed the Leadership Qualities framework and subsequent development offer.
Coaching and mentoring training continues to be rolled out across the Organisation.
Other key projects include, the perfect start, flexible working, workforce planning and controls programme.

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.
The impact of the work outline above will achieve a downwards trend towards the <10% turnover target, the number or % of staff leaving within the first 12 months and voluntary turnover.
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 also reduce as Turnover improves over time.

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.

Work continues to transform appraisal and management supervision at the Trust. The proposed new process together with documentation for Appraisal and 'Check-ins' as one continuous annual cycle was approved at Workforce Steering Board on 9th March following a successful pilot. The new process is designed to be holistic and incorporate wellbeing discussions as an integral element, it 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

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).

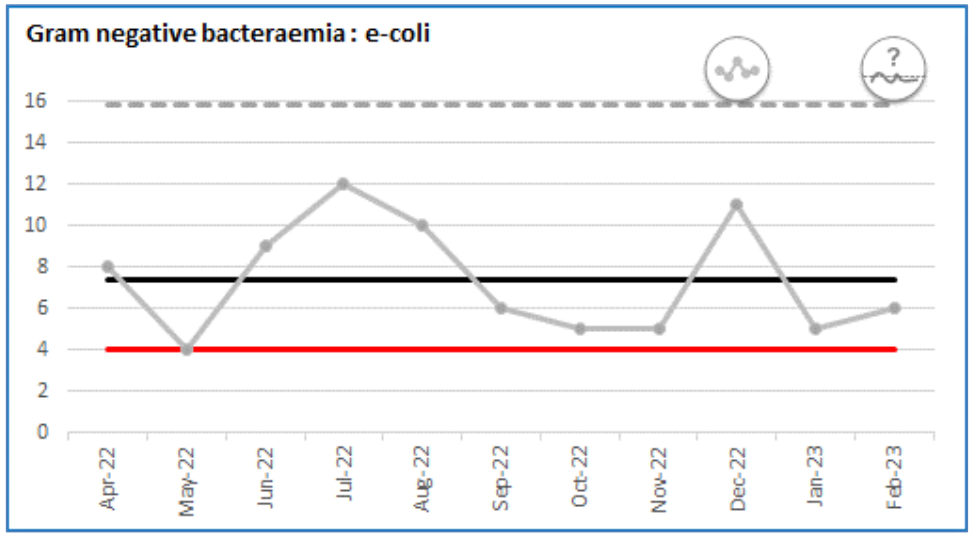
The threshold for *E-coli* bacteraemia is 56, which equates to a maximum 4 per month. From April 2022 to February 2023, 81 cases have been reported; 6 patients were diagnosed with an *E-coli* bacteraemia in February 2023.

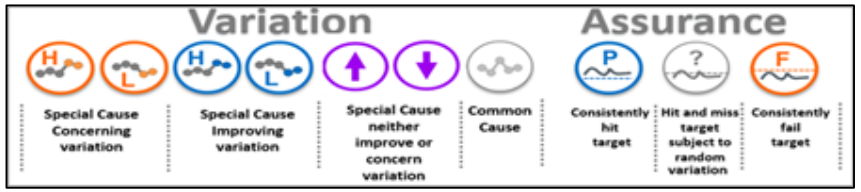
Action:

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

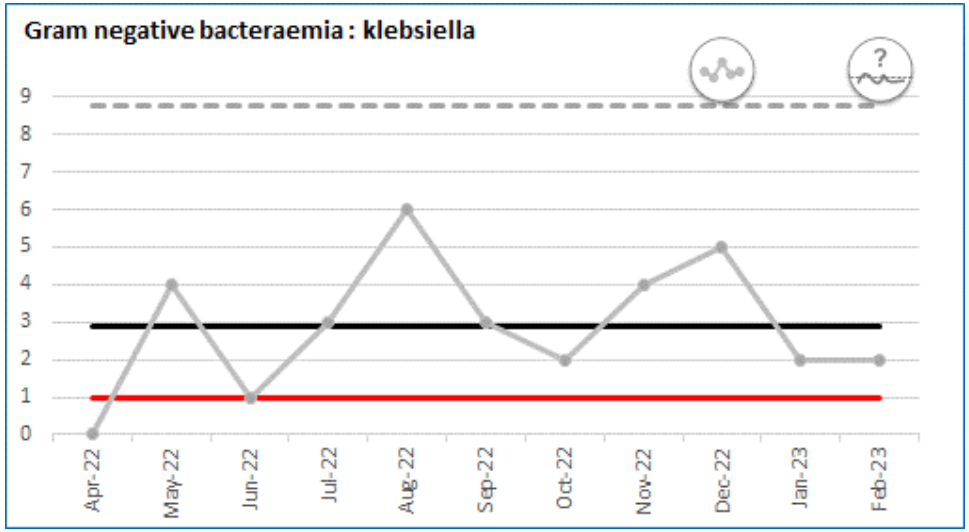
Performance Issue:
For 2022-23 the Gram-negative blood stream infection objective is separated into individual targets for *E-coli, klebsiella* and *pseudomonas*. Thresholds are derived from a baseline of the 12 months ending November 2021 (the most recent available data at the time of calculating the 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 patients diagnosed in February 2023. Since April 2022, 32 patients have been diagnosed and reported. The 2022-23 maximum threshold for the year has been exceeded.

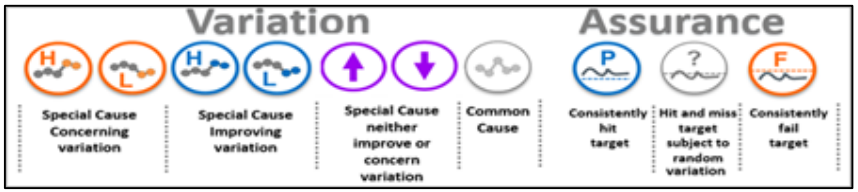
Action:
Klebsiella is a gut organism and common sources identified during the RCA process relate to the management of indwelling devices and intra-abdominal complexities.

1 case has been reviewed in February 2023 that was hospital-onset-healthcare associated; following IPC/Microbiology review it was determined that this was probably due to aspiration pneumonia and could not have been avoided. The other case was community-onset-healthcare associated.

Key priorities identified from previous cases determined to be avoidable continue to be progressed within the Trust and with the wider Wirral community teams. Inclusive of appropriate antibiotic prescribing, urinary catheter care and management, prevention and treatment of urinary tract infections, management of continence, and aseptic non-touch technique. The 'Gloves off' campaign and a focus on good hand hygiene will be promoted.

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





MRSA Bacteraemia – hospital acquired

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:

Healthcare providers have been set the challenge of demonstrating '*zero tolerance'* of MRSA Bloodstream Infections. All MRSA blood stream infections are subject to a post infection
review (PIR).

From April 22 to February 23, 3 cases have been reported, 2 in November 22 and 1 in February 23.

Action:

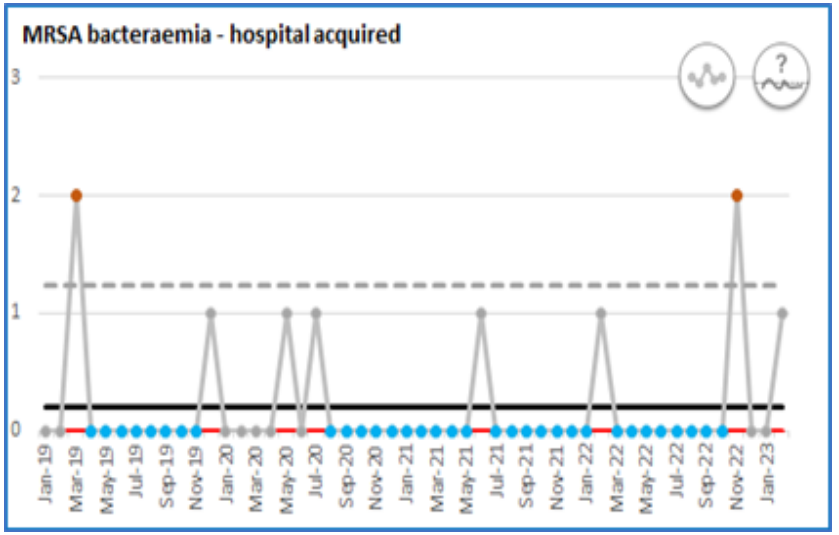
An MRSA bacteremia was identified from the admission swabs and blood cultures obtained from a patient who had transferred from WUTH to another acute hospital. The MRSA has been apportioned to us as culture was positive within 2 days of transfer to the receiving hospital.

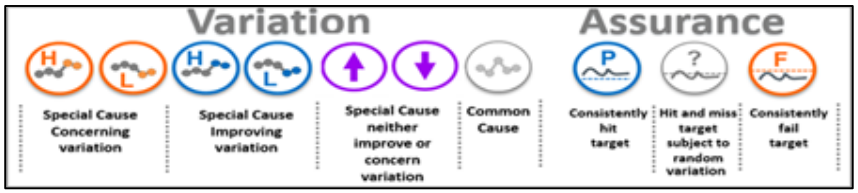
A local PIR has been completed: Appropriate screening was undertaken on admission to WUTH for MRSA; results identified that MRSA was not isolated from nose/groin. The patient had several lines in situ, one insertion site bled on removal due to trauma but settled. MRSA screening swabs due on the day of transfer were not completed has been identified as a learning point. Causative factor has been undetermined.

Improvements have been identified to enable staff to follow screening requirements as per policy.

Expected Impact:

Targeted interventions will help to reduce the risk of MRSA bacteraemia.





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 February 2023.

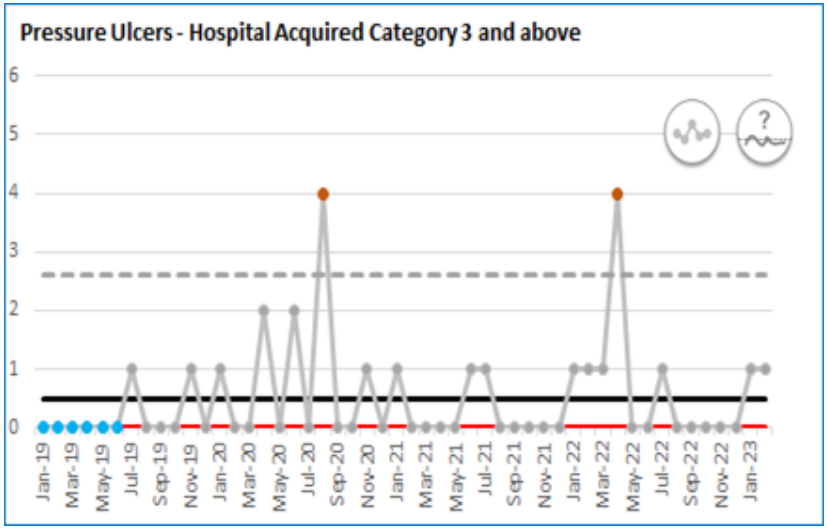
Action:

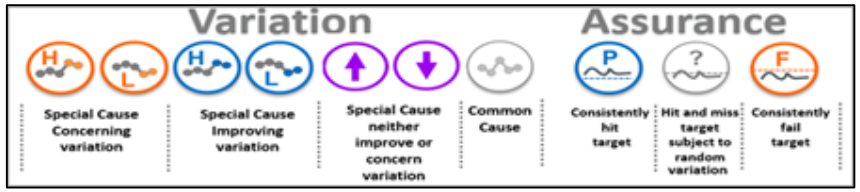
Following scrutiny at the Patient Safety Learning Panel (PSLP) lapses in care that contributed to the development of the patient's pressure damage have been identified. On review a pressure ulcer prevention plan was not put in place within the initial 24 hours of the patient's hospital stay, which met 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. This is alongside a targeted approach for staff to attend training and supporting the Practice Educators to provide staff with direct education in practice.

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 February the indicator is 5.91% and demonstrates common cause variation.

Long term sickness absence accounts for 1.32%, whilst short term sickness absence is more of a challenge at 4.59% in February 2023.

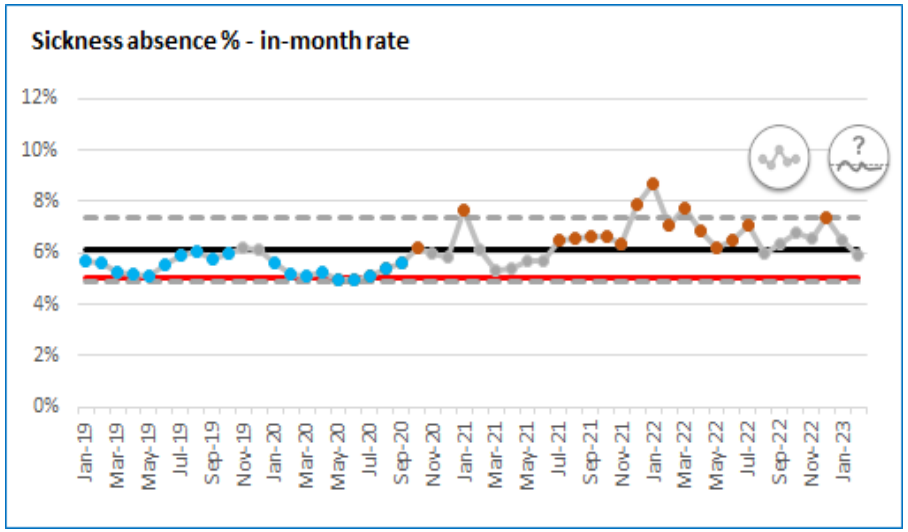
Additional Clinical Services are the staff group with the highest absence rate (8.74%) followed by Estates and Ancillary (8.09%) and this staff group are a particular area of focus. Medicine and Corporate Divisions are reporting sickness absence as under the Trust 5% target at 4.89% and 4.92% respectively.

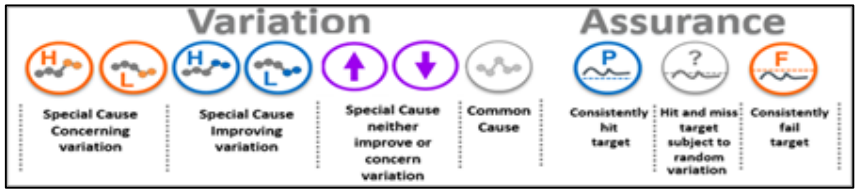
The highest sickness absence levels remain in Facilities, albeit an improved position in attendance was reported in February. A downward trend in the number of long terms cases in Facilities is beginning to emerge.

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.





MIAA Findings
The findings of the 2022/23 sickness absence review undertaken by MIAA have been shared with the Trust. Areas of good practice have been identified along with agreed recommendations to include a communication exercise around the importance of following processes as described in the Trust Management Attendance Policy along with a review of reconciliation processes to ensure records are maintained through ESR.

Managing Attendance Policy
Further review of this policy remains ongoing and will incorporate the findings from the MIAA audit.

End of Flu Vaccine Campaign
We have reached the end of the Trust's flu campaign for this winter. Current reported uptake amongst frontline Healthcare Workers is 62.7%, compared to a Cheshire and Merseyside average of 51.3%.

Wellbeing Week: Disabilities and Long-Term Conditions (13-17th March)
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The impact of high sickness 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.

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Staff turnover %

Executive Lead: Deborah Smith, Chief People Officer

Performance Issue:

The Trust threshold for turnover is 0.83%. For February 2023 the indicator was 0.77% and demonstrates common cause variation.

The following staff groups have high turnover in February:

- Add Professional & Technical (2.26%)
- Nursing & Midwifery (1.09%)
- Allied Health Professionals (0.99%)

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:

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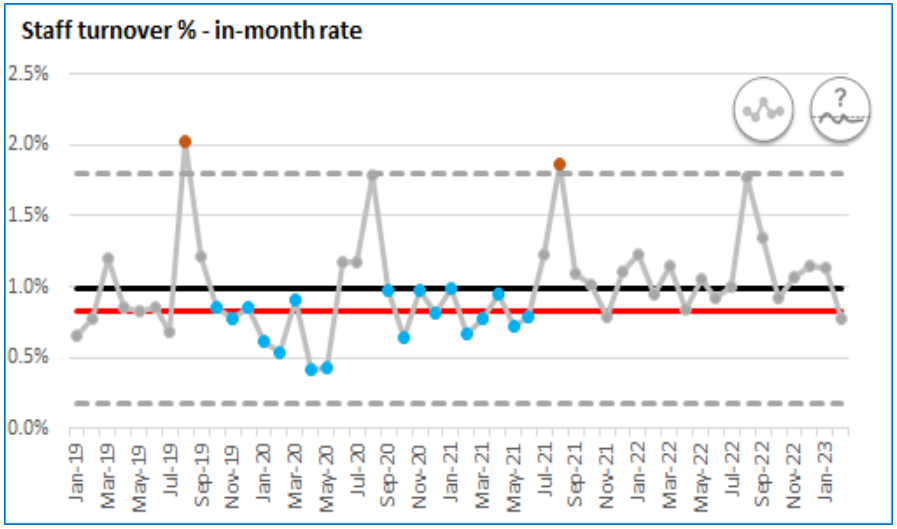

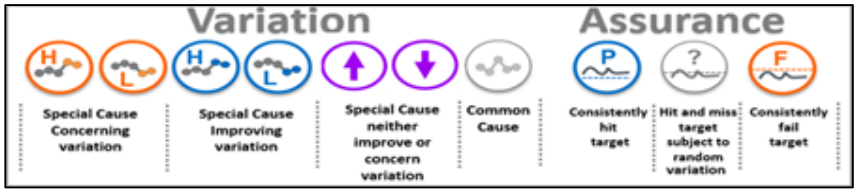

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Staff Survey and the People Strategy

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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 February 2023 were 5: Wards 21, 22, 36, 38 and M1 rehab.

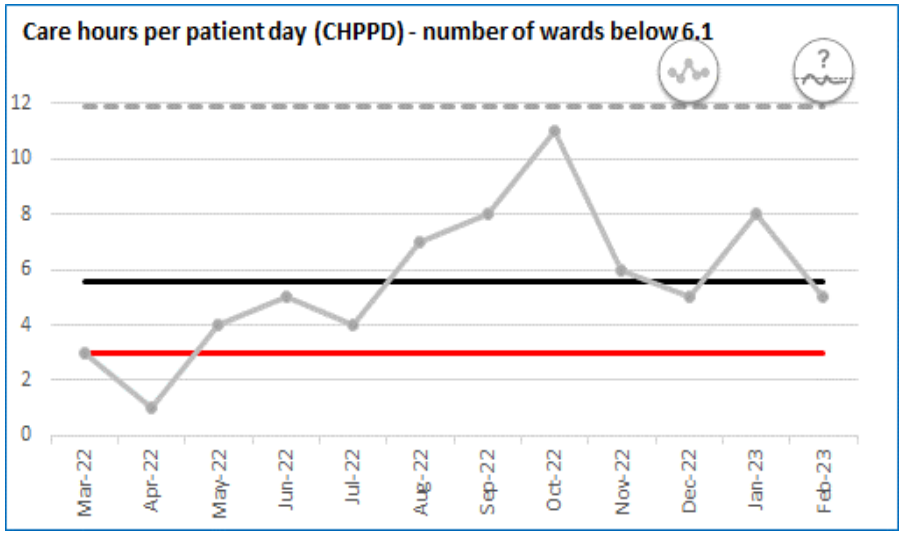
Action:
The CHPPD tracker is one of the safer staffing measures to monitor if any areas are consistently recording CHPPD <6.1. The CHPPD data is triangulated with further staffing metric data to monitor the impact on care. Impacts on care are being monitored and have remained minimal in the areas of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

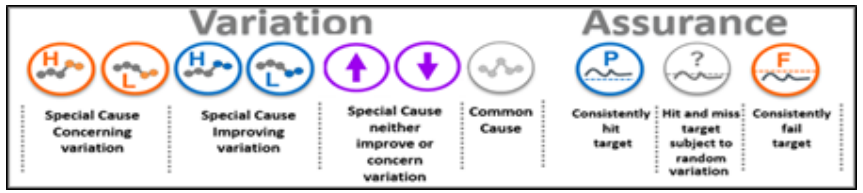
2 wards, 21 and 36, had a CHPPD of 6 which is equal to 6 minutes below the threshold. Ward 22 CHPPD was 5.8; this ward had a significant number of patients with no criteria to reside. Similarly ward M1, CHPPD 5.3, had a high proportion of patients with no criteria to reside. Healthcare professional input will not be required at the same level or frequency to that of an acute area.

Ward 38, CHPPD of 5.8 for February, has had a CHPPD below <6.1 for 13 months. Staff moves to support escalation areas and outstanding CSW vacancies is an influencing factor. CSW vacancies have been appointed to following successful trust wide recruitment events. There have been no patient harms associated with staffing levels on this ward.

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 February performance was 84.6%, an improvement from January's 81.5% and just 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 "Think Big Challenge" within the Surgical Division.

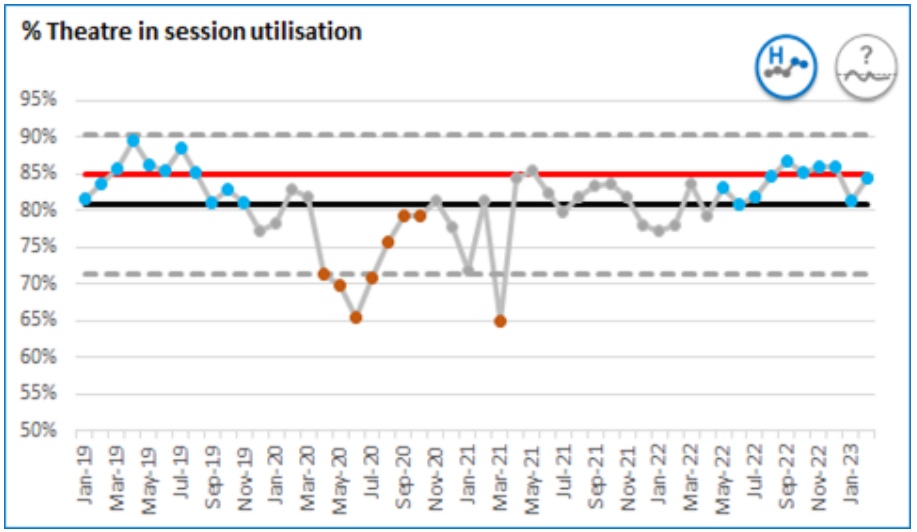
January saw a decrease in on the day cancellations from 70 in January to 64 in February. Of the 64 on the day cancellations that were recorded in February 53% of the cancellations reflected non clinical cancellations. Predominant reasons include list overrunning and bed availability postoperatively.

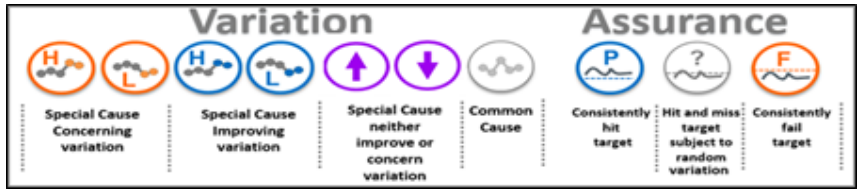
Theatre scheduling meeting is now locking down to 4 weeks and moving forward further from 4 weeks in some areas. This enables patients to be booked 4 weeks ahead.

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

Action:

- Maintain the daily TCI meeting to prevent cancellations on the day for inpatients and risk further reduction in in-session utilisation
- Continue to attempt to deliver above core capacity through backfills and additional requests for sessions
- Identify change process for backfills to support above





• 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 February 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.

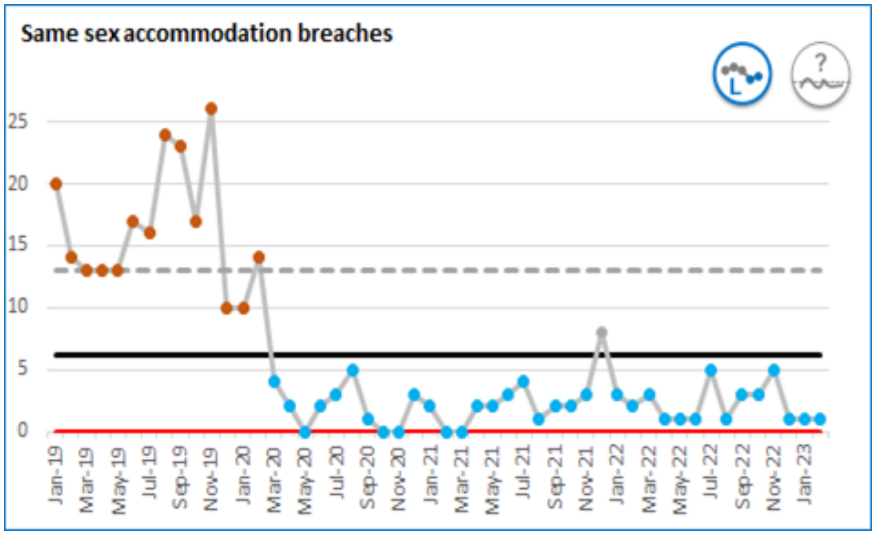
Action:

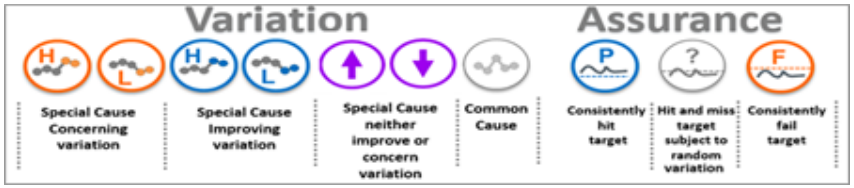
System challenges resulting in high levels of activity and a high proportion of patients with no criteria to reside have continued throughout February 2023, this has impacted on the ability to deliver same sex accommodation.

Processes are in place that enable joint working with ICU, CCU, Patient Flow Team, and Divisional Directors; 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 February 2023 was:

- Emergency Department (ED) – 81.4% (below threshold)
- Inpatients – 96.3% (above threshold)
- Outpatients – 95.01% (above threshold)
- Maternity 95.05% (above threshold)

Action:

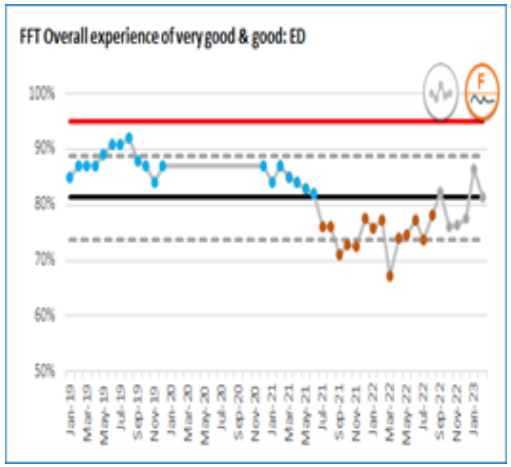
Promise Groups, established as part of our Patient Experience Strategy, held monthly focus on identifying improvement opportunities to improve people's experience of our services.

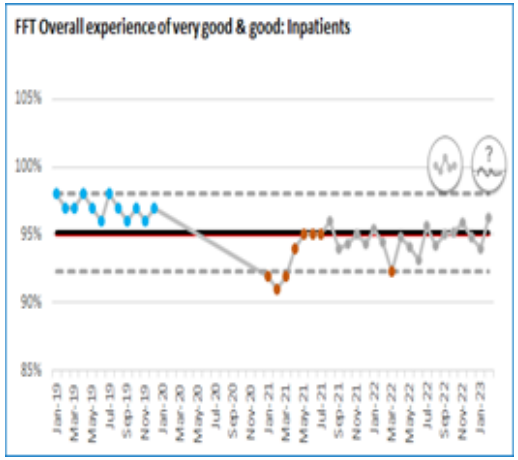
Outpatients have, for the second consecutive month, achieved the target of >95%. Inpatients score of 96.3%, has improved on last month score of 94.0%, achieving target for the first time this quarter. Volunteers have visited wards to conduct FFT surveys and laminated QR codes have been introduced to increase the opportunity for feedback in these areas.

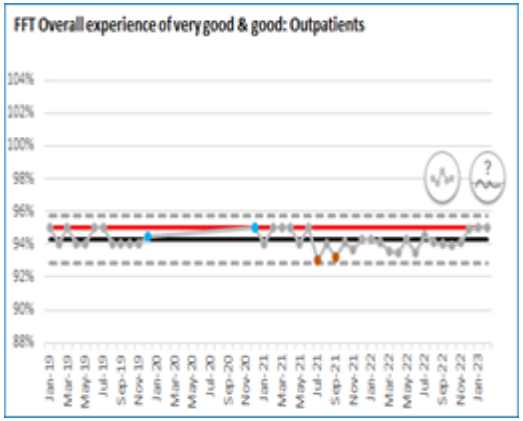
FFT score for ED remains below the Trust threshold of 95%. However, improvement has been sustained within ED achieving 81.4%, within the threshold of common cause variance. Operational pressures continue to impact on the FFT score; waiting times continue to be reported as an area of challenge. We monitor our performance against the national average; we consistently perform higher or in line.

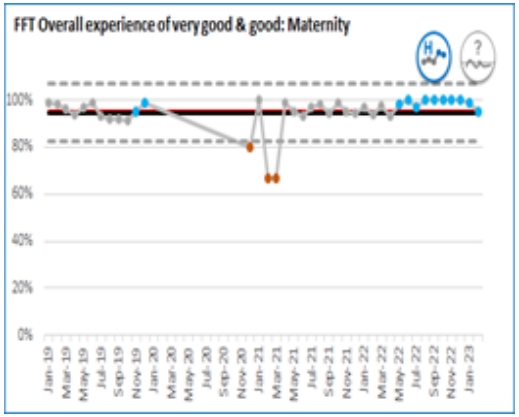
Expected Impact:

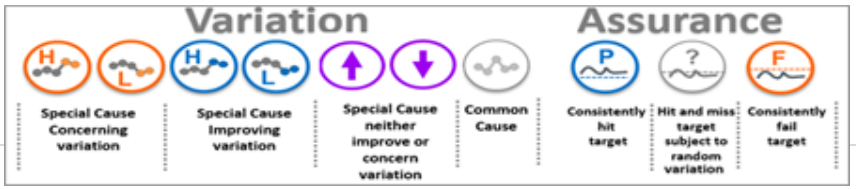
Improved FFT scores within the ED and an expectation to reach the Trust target for Outpatients in Q4.











Responsive

Number of complaints received in month per 1000 staff

Executive Lead: Medical Director

Performance Issue:

The Trust has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per 1000 staff. The rate for February 2023 was 3.69.

Action:

During February 2023, 20 new formal complaints were registered (compared with 12 in January) and 18 were closed. There often appears to be an increase in complaints after December as a sessional variation.

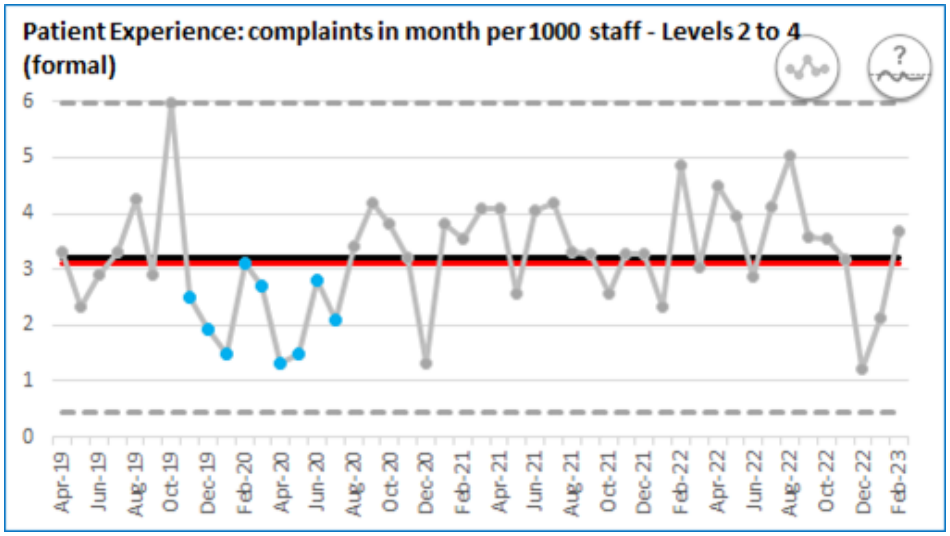
The main themes from complaints continue despite divisional plans in place to address. The main continuing causes of complaints are communication / staff attitude and capacity pressures. During the start of Q4 the number related to communication has increased further.

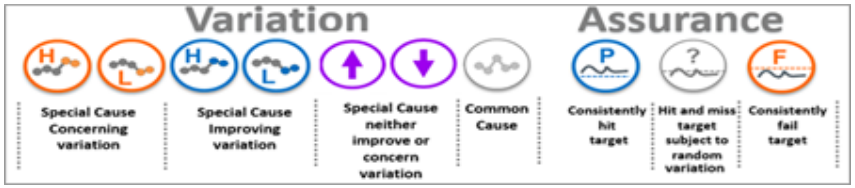
The capacity pressure complaints continue to be heavily focused on the Emergency Department and aligned to a growing theme of treatment delays.

Weekly complaints management meetings with all divisions continue to take place focusing on the management of complaints and the learning from complaints remains a key source of intelligence considered within Patient Safety and Quality Board.

Expected Impact:

To achieve a reduction in formal complaints by year end.





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 February 2023 was 1.7% below target at 88.3%.

Action:

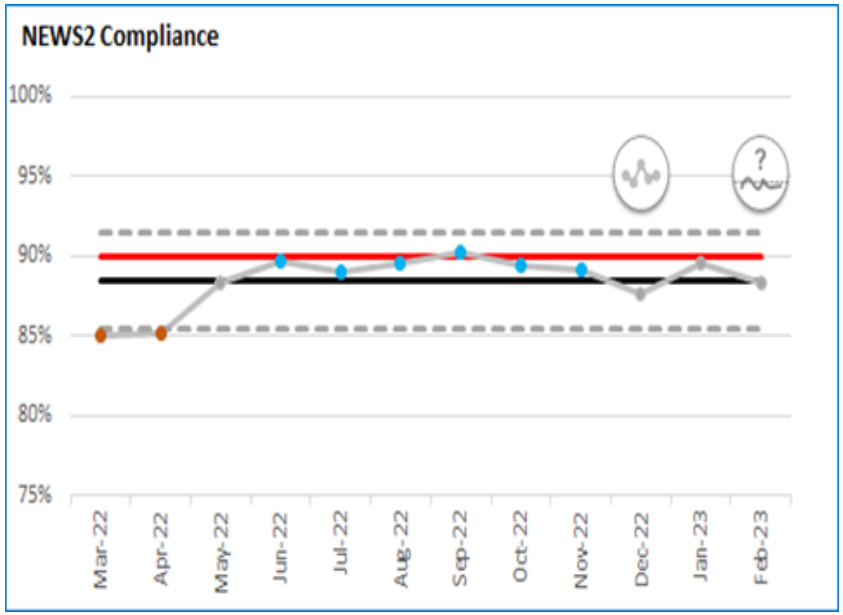
Sustained improvement in compliance of recording NEWS2 since April 2022 continues to be achieved. This has been achieved through the Deteriorating Patient Quality Improvement Faculty led by the Chief Nurse creating a trust wide change, in conjunction with focused workstreams.

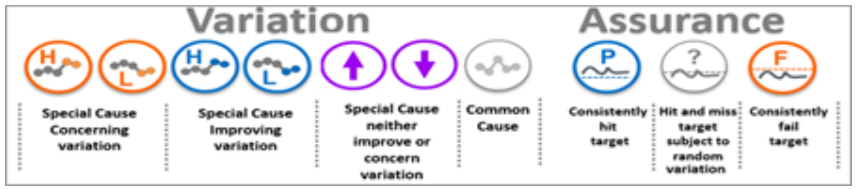
The model of care for patient with no criteria to reside has been amended in accordance with their clinical requirements. One change is the reduction in observations being recorded for those with a NEWS2 score of 0 – 4 from 12 hourly to once daily. Compliance in the recording of NEWS2 score 0-4 continues 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 taken place in March 2023. Solutions to recording challenges continue to be explored; this is particularly evident for those patients who have been assessed to be exempt, such as patients on an end-of-life pathway; and those transferring from assessment areas to base wards.

Daily reviews of NEWS2 compliance continues with escalated to ward areas as necessary. Staff engagement and education regarding the standards required continues. Governance processes have been strengthened to invite areas to Patient Safety Learning Panel where NEWS2 noncompliance has been identified.

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:

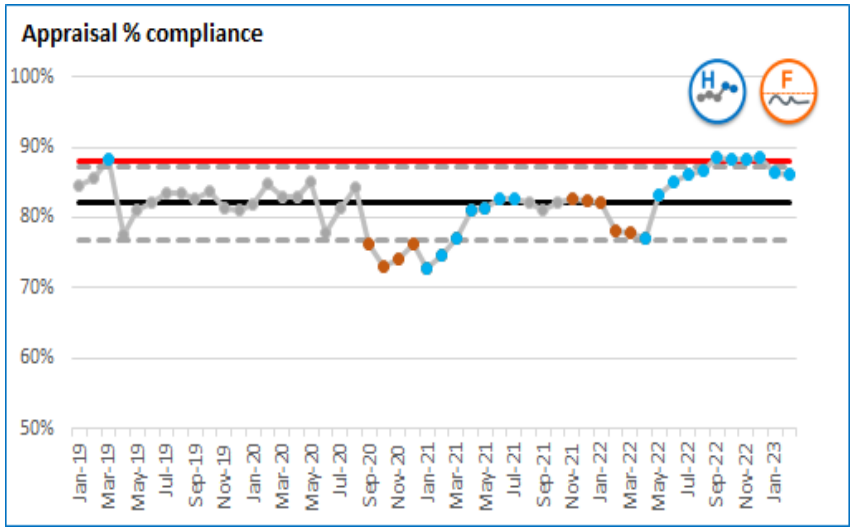
The target for annual appraisal compliance is 88%. Compliance has been achieved over a number of months, however at the end of February 2023 86.24% of the workforce had received an appraisal in the last 12 months.

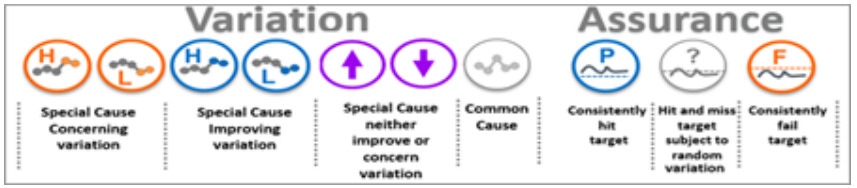
From a Divisional perspective, both Clinical Support and Women & Children's have achieved the Trust target. Acute Division are the lowest with 82.01% compliance.

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.

Work continues to transform appraisal and management supervision at the Trust. The proposed new process together with documentation for Appraisal and 'Check-ins' as one continuous annual cycle was approved at Workforce Steering Board on 9th March following a successful pilot. The new process is designed to be holistic and incorporate wellbeing discussions as an integral element, it 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

March 2023
Upated 24-03-23

	Indicator	Objective	Director	Threshold	Set by	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-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	0.22	0.04	0.22	0.09	0.09	0.33	0.17	0.13	0.04	0.09	0.12	0.16	0.05	0.13	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	96.2%	96.4%	96.8%	96.9%	96.6%	96.5%	96.3%	96.5%	96.8%	97.1%	98.3%	98.1%	98.6%	97.1%	
	Never Events	Safe, high quality care	CN	0	SOF	1	0	0	0	0	0	0	1	0	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	12	13	7	8	16	17	15	13	12	12	10	13	5	128	
	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	6	81	
	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	2	32	
	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	1	7	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	1	0	0	0	0	0	0	0	0	2	0	0	1	3	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	1	1	4	0	0	1	0	0	0	0	0	1	1	7	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	95%	92%	89%	91%	96%	97%	95%	95%	95%	96%	96%	97%	94%	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%	91.1%	89%	
	Mandatory Training compliance	Safe, high quality care	CPO	≥90%	WUTH	87.2%	87.2%	87.17%	89.21%	90.39%	89.73%	90.59%	90.34%	89.78%	90.25%	90.98%	91.38%	91.95%	92.0%	
	Sickness Absence % (12-month rolling average)	Safe, high quality care	CPO	≤5%	SOF	6.53%	6.70%	6.79%	6.83%	6.89%	6.94%	6.90%	6.87%	6.87%	6.89%	6.85%	6.70%	6.65%	14.4%	
	Sickness Absence % (in-month rate)	Safe, high quality care	CPO	≤5%	SOF	7.05%	7.73%	6.84%	6.23%	6.50%	7.08%	5.98%	6.33%	6.81%	6.60%	7.37%	6.52%	5.91%	6.56%	
	Staff turnover % (rolling 12 month rate)	Safe, high quality care	CPO	≤10%	WUTH	13.9%	14.1%	14.1%	14.4%	14.4%	14.1%	13.9%	15.29%	14.01%	14.37%	14.51%	14.44%	14.35%	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	5	6	

	Indicator	Objective	Director	Threshold	Set by	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	2022/23	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	96.7%	96.9%	94.6%	97.1%	97.9%	95.7%	96.5%	94.8%	95.6%	95.2%	94.3%	97.8%	97.5%	96.1%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	97.3%	96.3%	97.7%	98.2%	98.9%	98.5%	98.1%	97.7%	97.0%	98.7%	97.0%	98.2%	98.3%	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	195	187	220	194	211	214	226	251	229	236	218	234	262	262	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	77.9%	83.7%	79.3%	83.1%	80.9%	82.0%	84.7%	86.8%	85.3%	85.9%	86.0%	81.5%	84.6%	81.5%	

	Indicator	Objective	Director	Threshold	Set by	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	2022/23	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	2	3	1	1	1	5	1	3	3	5	1	1	1	23	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	77.3%	67.2%	74.0%	74.7%	77.4%	73.6%	78.2%	82.4%	76.2%	76.5%	77.7%	86.5%	81.4%	78.0%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	94.5%	92.3%	94.8%	94.1%	93.1%	95.6%	94.2%	95.1%	95.1%	95.9%	94.9%	94.0%	96.3%	94.8%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	94.1%	93.6%	93.5%	94.3%	93.5%	94.6%	94.1%	94.0%	94.0%	94.2%	94.96%	95.05%	95.01%	94.3%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	93.5%	97.7%	93.1%	98.0%	100.0%	96.9%	100.0%	100.0%	100.0%	100.0%	100.0%	98.5%	95.5%	98.4%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-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	63.1%	61.5%	63.1%	63.4%	64.5%	62.3%	63.6%	66.4%	62.7%	63.9%	64.0%	65.7%	64.8%	64.0%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	7	17	39	24	17	69	155	18	59	182	99	405	442	1509	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	100%	National	61.7%	54.0%	52.5%	53.5%	58.6%	53.6%	57.9%	60.9%	52.8%	55.8%	51.2%	66.6%	61.3%	56.8%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	0%	National	8.1%	11.6%	13.7%	10.7%	10.5%	14.6%	14.1%	10.8%	14.5%	13.6%	15.4%	15.6%	17.0%	13.7%	
	Proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed	Safe, high quality care	COO	TBD	National	82.4%	86.9%	91.2%	85.1%	86.1%	90.6%	90.2%	87.3%	90.7%	88.5%	92.1%	92.4%	94.6%	89.9%	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	15.5%	25.2%	23.9%	21.9%	18.5%	16.0%	12.5%	16.2%	24.3%	17.5%	21.0%	17.6%	23.7%	19.4%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	≥92%	SOF	65.89%	65.38%	64.08%	66.72%	65.46%	64.80%	64.77%	62.40%	61.85%	61.57%	57.75%	58.97%	58.50%	58.50%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	29445	30430	31504	32373	33306	34933	35742	37030	37157	37188	37460	38911	40039	40039	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	525	582	730	811	1028	1119	1122	1245	1279	1219	1321	1266	1280	1280	
	Referral to Treatment - cases waiting 78+ wks	Outstanding Patient Experience	COO	NHSEI Plan Trajectory 2022-23	National	65	60	70	73	82	91	62	60	55	47	71	68	66	66	
	Referral to Treatment - cases exceeding 104 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	5	1	0	0	0	8	0	0	0	0	0	1	0	0	
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥95% (from April 2022)	SOF	86.4%	85.2%	82.8%	86.0%	87.2%	87.5%	85.3%	85.3%	86.8%	88.0%	86.7%	87.4%	90.3%	86.7%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	78.0%	76.2%	85.8%	96.6%	94.6%	94.4%	91.9%	78.7%	88.3%	92.0%	87.9%	86.9%	-	89.7%	
	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	95.1%	92.6%	91.2%	96.5%	96.4%	96.1%	94.7%	96.2%	97.3%	97.0%	95.3%	96.6%	-	95.7%	
	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	79.3%	75.9%	79.2%	79.6%	75.7%	79.9%	81.5%	73.8%	73.1%	74.4%	74.0%	69.6%	-	76.1%	
	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	81	97	118	152	167	158	200	200	173	177	227	206	206	
	Cancer - Faster Diagnosis Standard	Outstanding Patient Experience	COO	≥75% within 28 days	National	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	187	211	170	185	174	207	191	234	187	178	128	219	185	187	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	MD	≤3.1	WUTH	4.87	3.05	4.50	3.96	2.88	4.13	5.02	3.57	3.54	3.17	1.23	2.12	3.69	3.44	
	Formal Complaint acknowledged within 3 working days	Outstanding Patient Experience	MD	≥90%	National	100%	100%	100%	86%	100%	91%	96%	100%	80%	100%	100%	100%	100%	96%	
	Number of re-opened complaints	Outstanding Patient Experience	MD	≤5 pcm	WUTH	0	0	2	2	1	3	0	5	4	1	4	3	3	3	
	% of formal complaints closed within 40 working days	Outstanding Patient Experience	MD/CN				17%	7%	18%	31%	14%	24%	38%	22%	22%	22%	23%	33%		
	% of informal concerns closed within 3 working days	Outstanding Patient Experience	MD/CN				67%	66%	70%	73%	73%	88%	68%	50%	61%	73%	79%	69%		
	% of informal concerns converted to formal complaints	Outstanding Patient Experience	MD/CN				1%	1%	0%	2%	0%	1%	1%	1%	1%	1%	3%	1%		
	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%	88.3%	89%	

Quality Performance Dashboard

March 2023
Upated 24-03-23

	Indicator	Objective	Director	Threshold	Set by	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-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	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	1575	1666	21	59	85	110	147	213	257	328	363	400	437	437	
	% Appraisal compliance	Safe, high quality care	CPO	≥88%	WUTH	78.0%	77.9%	77.2%	83.2%	85.2%	86.2%	86.7%	88.58%	88.25%	88.36%	88.43%	86.39%	86.24%	86.2%	

	Indicator	Objective	Director	Threshold	Set by	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	2022/23	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	-0.1	0.1	-1.0	-0.4	-0.2	-0.4	-0.5	-0.6	-0.9	-0.7	-1.2	-0.4	-0.3	-0.3	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	-0.5	-0.3	-0.9	0.3	-1.2	-0.6	-0.7	-0.9	-0.8	-0.6	-1.1	0.1	0.0	0.0	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	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	Not reported	
	CIP Performance (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	78.61%	91.33%	7.26%	45.26%	47.60%	57.50%	51.00%	55.00%	45.00%	49.00%	21.77%	28.88%	12.00%	12.00%	
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	-8.0%	-15.0%	-43.9%	-316.0%	-88.0%	-218.8%	-216.0%	-233.0%	-171.0%	-142.0%	-121.0%	-101.0%	-91.0%	-91.0%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-18.6	-20.0	-21.4	-12.0	-16.6	-16.4	-21.4	-23.5	-26.0	-38.0	-37.9	-38.2	-35.2	-35.2	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	76.2%	100.0%	0.7%	1.4%	4.0%	8.7%	13.0%	17.9%	25.3%	31.5%	38.4%	41.1%	52.6%	52.6%	

Metrics Added

Metrics Amended

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 9.2**
5 April 2023

Title	M11 Finance Report
Area Lead	Mark Chidgey, CFO
Author	Robbie Chapman, Deputy CFO
Report for	Information

Report Purpose and Recommendations

At M11 the Trust is reporting a deficit of £6.346m, an adverse variance against budget of £6.312m. This variance is attributed to overspends on employee costs, driven largely by under-performance in respect of recurrent Cost Improvement Plans (CIP), the unfunded element of the national pay award, 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 the Board:

- Notes the report.
- Notes that without further mitigation the forecast position remains 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 M11 the Trust is reporting a deficit of £6.346m, an adverse variance against budget of £6.312m. The dashboard below highlights the key drivers of the year to date (YTD) and forecast position.

Key Performance Indicator	In Mnth (£'000)	RAG Rating	YTD (£'000)	RAG Rating	FOT (£'000)	RAG Rating
Financial Stability - Breakeven	-£40	🔴	-£6,321	🔴	-£6,800	🔴
Key Drivers of Variance						
104% Activity Recovery	£0	🟠	£0	🟠	£0	🟠
Escalation beds & Corridor Care	-£517	🔴	-£5,835	🔴	-£6,328	🔴
Bank & Agency	-£1,115	🔴	-£15,527	🔴	-£17,379	🔴
Non Pay (Operating Expenditure)	-£120	🔴	-£1,248	🔴	£1,400	🟢
Cost Improvement (Recurrent)	-£509	🔴	-£7,444	🔴	-£7,751	🔴
Other	£2,221	🟢	£23,733	🟢	£23,258	🟢

3. Clinical Income & Activity

3.1. Refer to Appendix 1, Statistical Process Charts (SPC) charts for Day Case, Elective and Outpatient Activity.

3.2. Key drivers:

- Clinical Income - £34.090m in M11 and £370.849m YTD, an adverse variance of £0.280m for the year. This is primarily a reflection of block contracts which are in place.
- ERF – £0.0m in M11 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 2022/23.

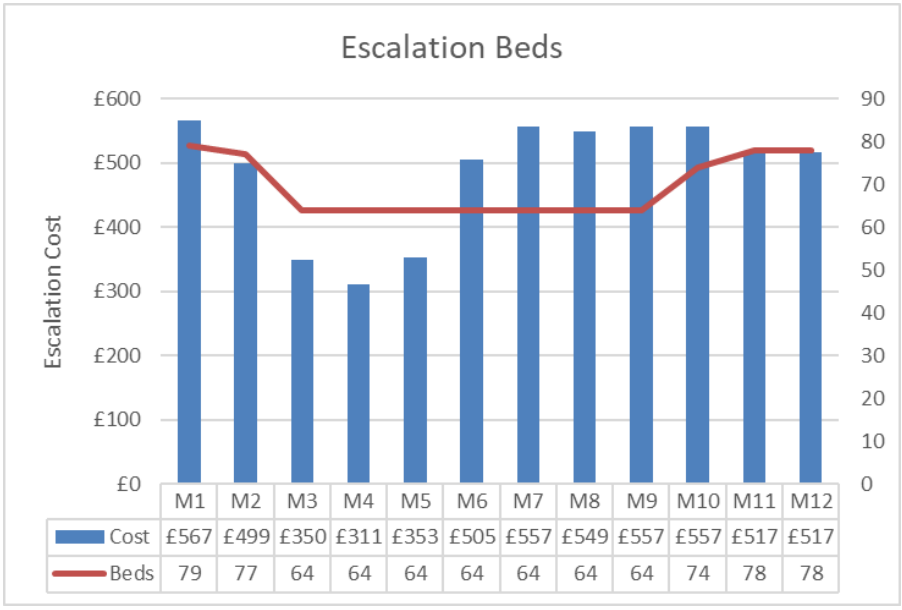
- Other Income - £3.555m in M11 and £37.170m YTD, a positive variance to plan of £2.108m for the year. This relates to the release of deferred income in respect of international nurse recruitment and teledermatology and the recharge of energy costs to Clatterbridge Cancer Centre. All of these costs are 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



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Cost	£567	£499	£350	£311	£353	£505	£557	£549	£557	£557	£517	£517
Beds	79	77	64	64	64	64	64	64	64	74	78	78

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 78 additional beds were open in M11, an increase of 4 beds from M10. Nursing and medical cover was provided by premium cost bank and agency staff. The forecast position assumes these costs will continue until the end of the year.
- Ambulance Arrival Zone/Corridor care – The Trust has invested in additional staffing at an average cost of £0.110m per month to manage the flow of patients between ambulances and the Emergency Department. Staffing was provided through bank and agency, at a premium cost for these areas.

4.3. Mitigations and corrective actions

- Escalation wards – A 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.

- Ambulance Arrival Zone/Corridor care – A business case to establish a new ambulance arrival zone to create additional care spaces within the Emergency Department and recruit substantively to the nursing posts was approved by FBPAC. This will deliver savings from run rate of £0.3m per year.

5. Bank and Agency

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

5.2. Key drivers

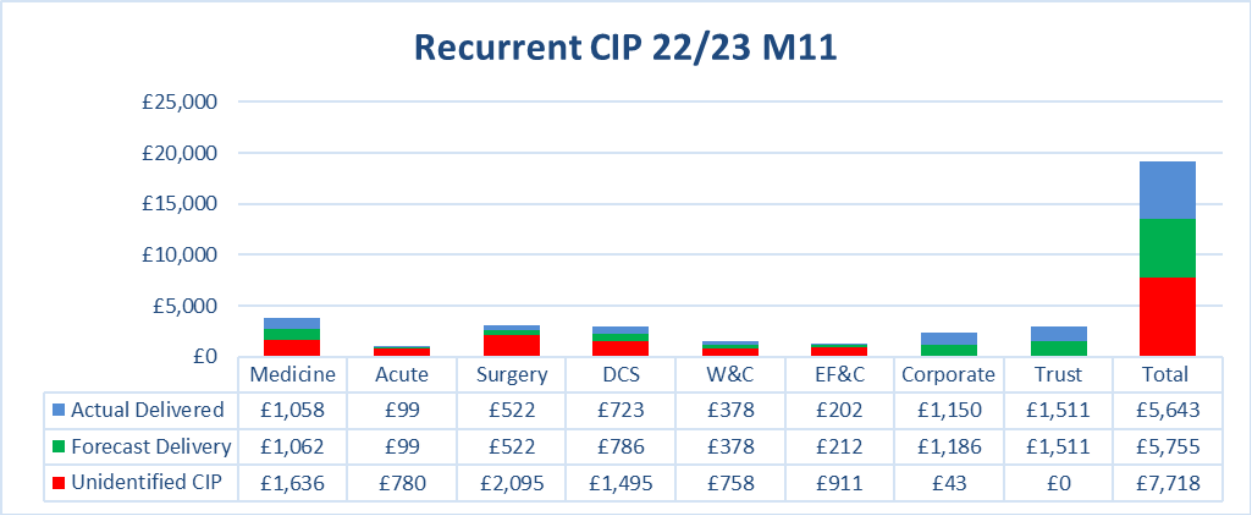
- Bank & Agency - costs excluding escalation were £1.115m in M11 and £15.527m YTD, which is then offset by an underspend of £14.665m in respect of substantive staff. Bank expenditure, driven by higher than planned levels of sickness and vacancies across the Trust. There was no increase in agency spend from M10 to M11 but 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 was corrected and, as expected, costs have come down in M11.

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 the Finance, Business, Performance and Assurance Committee (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 their Objective Structured Clinical Examinations (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 2023/24.

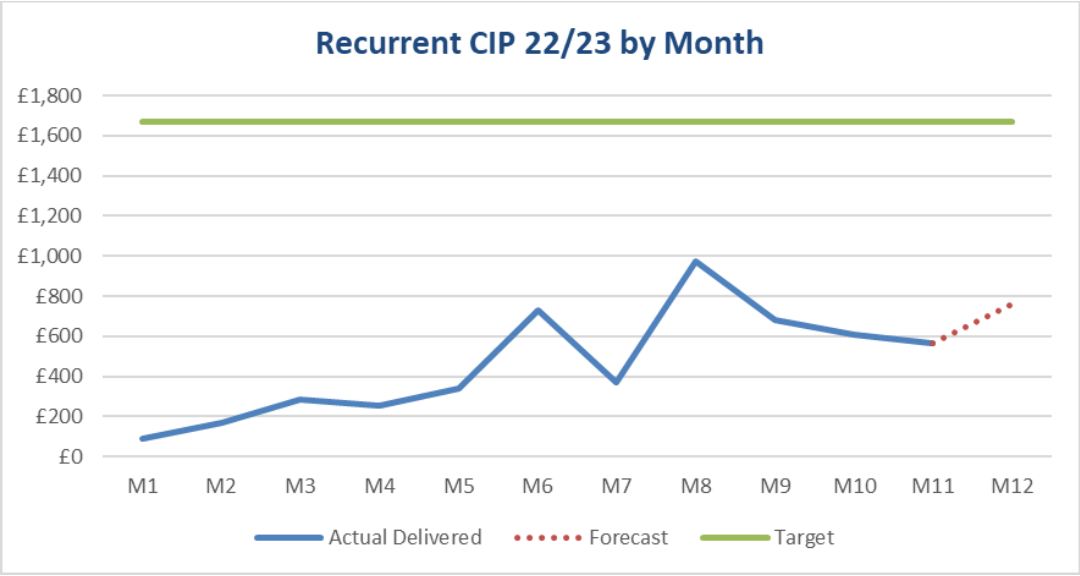
6. CIP

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	£786	£378	£212	£1,186	£1,511	£5,755
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 M11 was £20.67m which is £0.6m behind plan. We are currently forecasting an improved year end cash balance of £16.22m which is primarily because of receipt of Public Dividend Capital (PDC) funding. The reduction in the cash balance compared with 2021/22 is being driven by the under-delivery of CIP and the current deficit position.

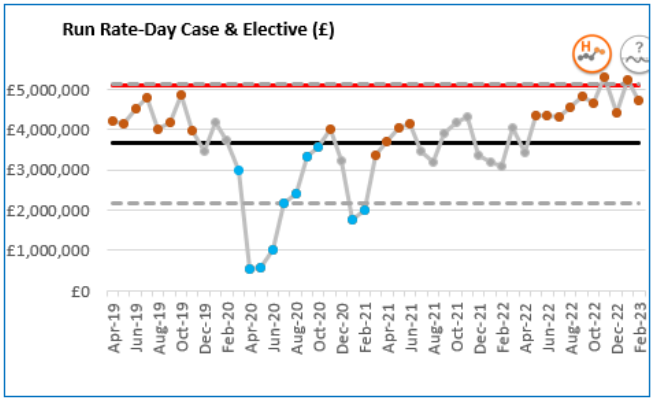
7.3. Since M10 there have been several changes to the capital plan as national funding via PDC has been awarded for various schemes. At M11 the capital plan is as follows:

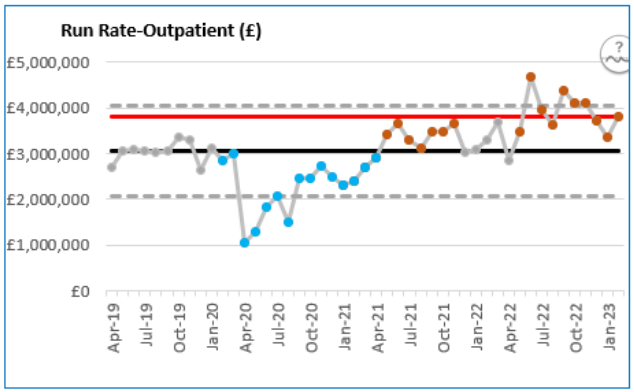
Revised capital plan 2022/23	
IT - various schemes	1,976
Medical equipment	289
Facilities equipment	93
Bathroom refurbishment	100
Ventilation works	400
Flooring	80
Fire compartmentation	400
Backlog maintenance	599
Ward 1 - Renal Unit refurbishment	2,800
Modular theatre build completion	3,182
UTC (included in backlog maintenance in spend table)	215
Initial CDEL allocation	**10,134**
Heating and chilled water pipework replacement	2,132
Total CDEL	**12,266**
Modular theatre - phase 2	14,954
UECUP	8,000
CDC	4,212
Breast screening	273
Robot	2,047
Cyber	145
Diagnostics Digital	372
CT Scanner	1,000
MRI Bariatric Head Coil	16
Gastroscopes	292
Endoscopy AI and Digital Assessment	94
Total PDC	**31,405**
TOTAL CAPITAL PLAN 22/23	**43,671**

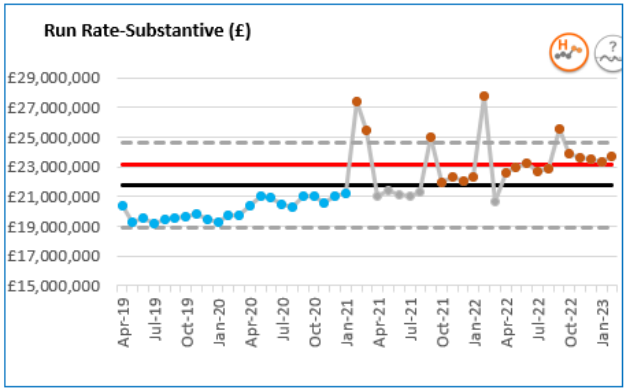
7.4. The principal reason for the reduction in value is the agreement reached with the Department for Health and Social Care (DHSC) for £5.0m of the PDC for UECUP to be reprofiled from 2022/23 into 2023/24. All additional PDC schemes anticipated at M10 are now confirmed and no further movements are expected in the plan value.

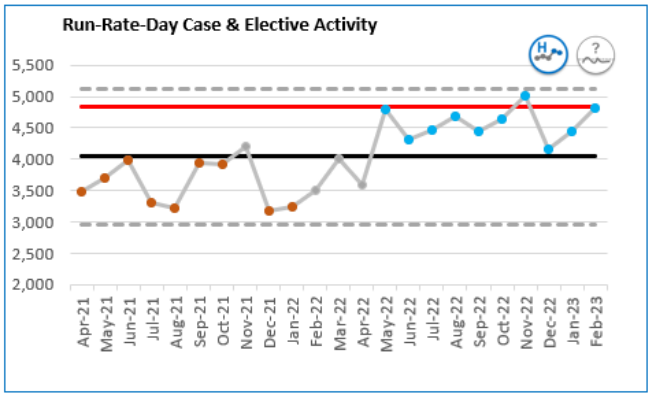
7.5. Spend is currently behind plan. The key areas of underspend are UECUP and phase two of the theatres. Mitigations have been implemented and further mitigations are currently being considered

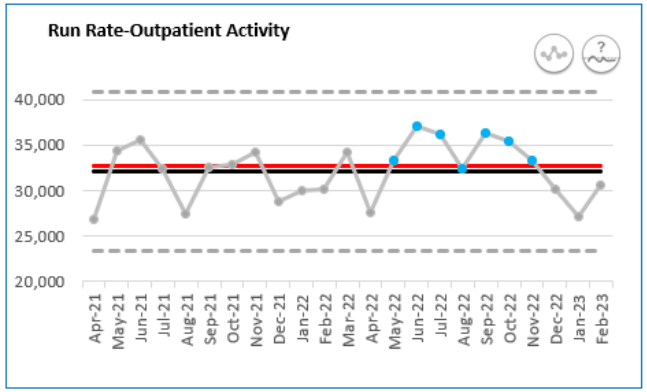
Appendix 1 – SPC Charts

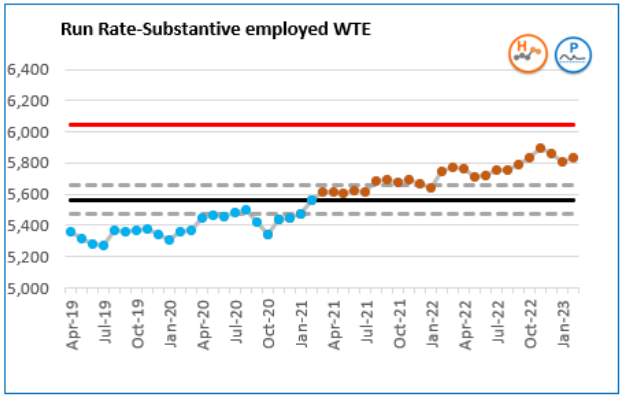


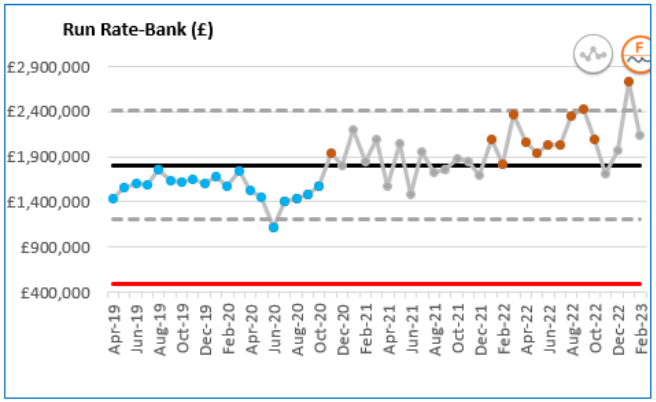


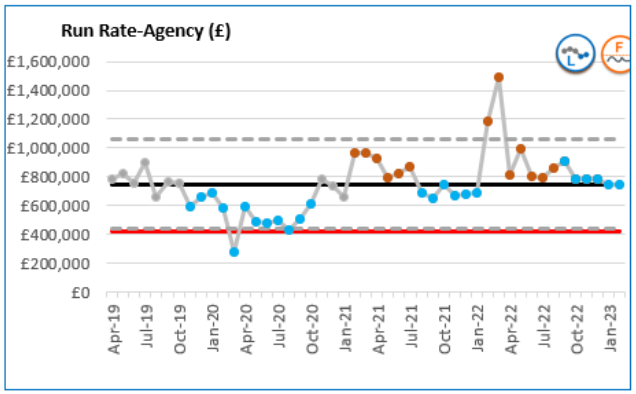


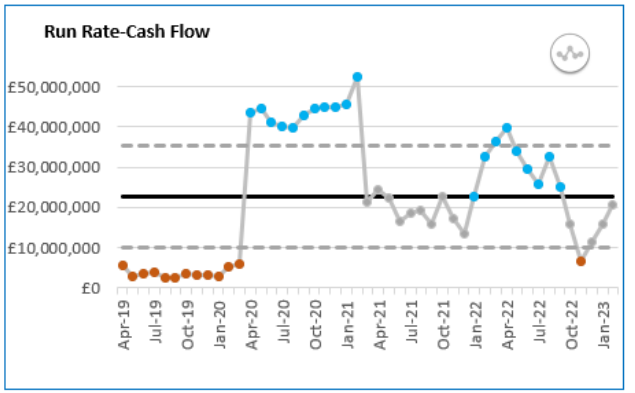












Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public

05 April 2023

Item 9.3

Title	Monthly Maternity Report
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and AHPs , Director of Infection Prevention and Control
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 (February 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 May 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 February 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 was one serious incident declared in February 2023 and one HSIB declared from an incident 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 review of Quarter 3 Neonatal Unit Dashboard there were three reported neonatal deaths. The Neonatal Safety Champion therefore undertook a review of the neonatal of all cases. All these cases were subject to scrutiny both internally and external to the organisation and to relevant external reporting. The reviews indicated that in 2 out of 3 cases, no care issues were identified. In one case learning was identified for both a partnering Trust that transferred the patient and WUTH. 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 in February 2023). In the media several maternity units around the country have been highlighted as having inadequate ventilation processes to safely expel/or control leakage of Nitrous Oxide/Entonox and the potential risk of harm to staff who are subject to excessive exposure. NHSE have released new guidance *Minimising time weighted exposure to nitrous oxide in healthcare settings in England* (2 March 2023). The Executive Management Team at WUTH have had oversight of the risk, mitigations and actions taken and a gap analysis has been undertaken on all aspects of health and safety legislation. A full report will be provided within the Maternity Quarterly Report in May 2023.

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 May 2023.

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

Board of Directors in Public
5 April 2023

Item 9.4

Title	Learning from Deaths Report (Q3 2022-23)
Area Lead	Dr Nikki Stevenson, Executive Medical Director
Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board of Directors with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q2 2022-2023.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths
- The Trust SHMI for the 12 months to June 2022 is 1.06 (within expected range)
- HSMR on the latest available data is 98.1(within expected range)
- HSMR has been showing a rising trend for the past 3 quarters. This is in line with the national trend.
- The Mortality review group (MRG) meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner.
- MRG continues to review Telstar Health data (formerly Dr Foster) to benchmark nationally and highlight areas of concern.
- Learning form mortality reviews is fed back to clinical areas by the Divisional Mortality leads.

It is recommended that the Board:

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

Key Risks

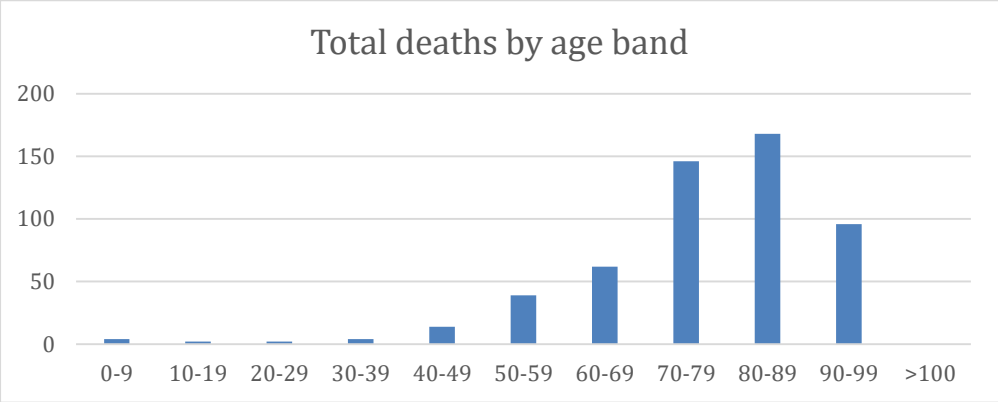
- BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

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

Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
30 March 2023	Quality Committee	As above	Information

1	Narrative
1.1	To provide a summary of the mortality review process, care issues, learning and current mortality comparator statistics. This paper is for adult and perinatal mortality. Wirral University Teaching Hospital is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework: • Preventing people from dying prematurely. • Treating and caring for people in a safe environment and protecting them from avoidable harm. Wirral University Teaching Hospital uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a 'warning' of potential problems and help identify areas for investigation. The Medical Examiner service provides independent scrutiny for all deaths that occur within WUTH, and escalates any concerns for a mortality review, coordinated through the Trust Mortality Group. Additionally, a random 5% of non-escalated deaths are selected for a "quality assurance" mortality review. Lessons learnt from mortality reviews are fed back to each clinical Division via the Divisional Mortality leads who attend the Mortality Review Group. **Patient demographics** There was a total of 533 deaths in Q2 2022-23. This is a rise from the previous quarter (446) but in line with national trends and coincided with a large number of admissions for Influenza, particularly during December 2022. As per previous trends most recorded deaths are in the over 60 age group and the vast majority fall into the "White British" Ethnic band.



Ethnicity	Number of deaths
White - British	476
White - Irish	5
White - Any other White background	10
Mixed - Any other mixed background	1
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	0
Other Ethnic Groups - Chinese	2
Black/ Black British	0
Not stated/ Not known	39
Total	446

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The overall SHIMI for WUTH on the latest available data (Sept 21-Oct 22) is 1.06 which is within the " as expected" range. SHIMI for WUTH has been relatively stable in the "expected" range for several quarters now.

Factors impacting SHIMI

1. Specific diagnostic groups

SHIMI can be broken down into specific diagnostic groups to highlight any areas of concern. During Q3 the diagnostic group of "Secondary Malignancy" had a significantly raised SHIMI. When reviewed in detail the in-hospital deaths were as expected, but there were 10 deaths post discharge that have increased the SHIMI for this group. MRG have agreed to review these 10 deaths in more detail to look for any trends or lessons learnt.

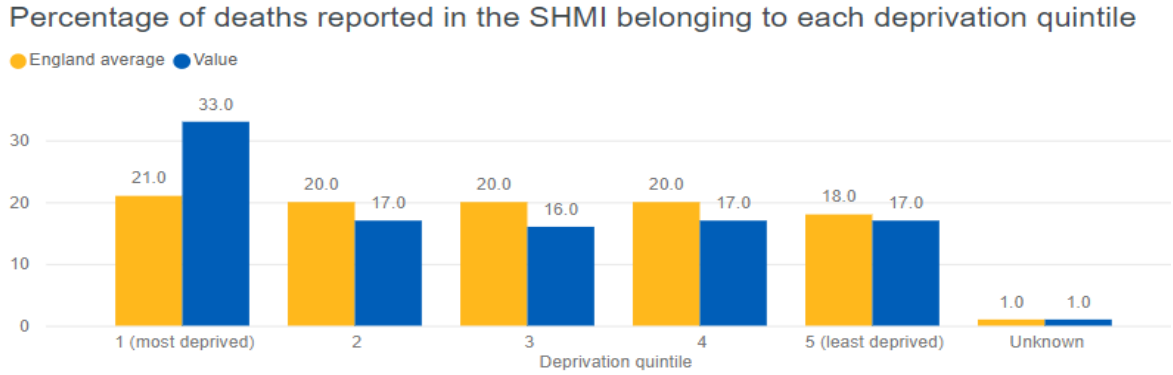
Previously the diagnostic group of Pneumonia had been highlighted as an outlier and work is ongoing to audit deaths in this group to understand the drivers behind this

2. Impact of deprivation on SHIMI

The Trusts continues to have a higher-than-average percentage of spells from the most deprived areas. Potential additional risks/complexities associated with these patients, is not factored into the SHMI calculation unlike HSMR, and will lead to a higher SHIMI.

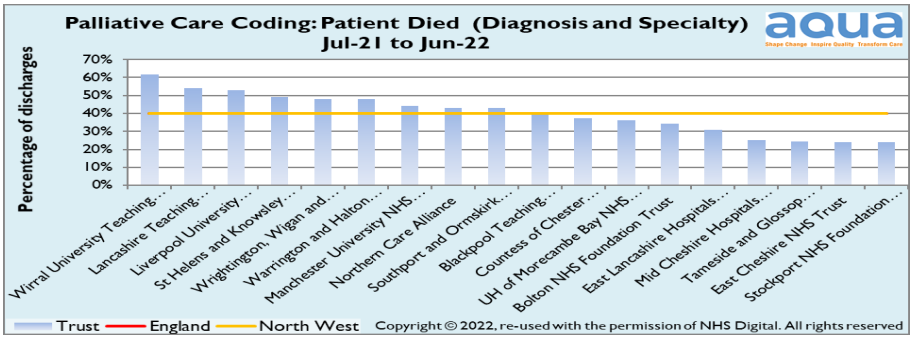
SHMI contextual indicators

Indicator	Value	England average
Deprivation		
Percentage of provider spells in deprivation quintile 1 (most deprived)	39.0	23.1
Percentage of provider spells in deprivation quintile 2	15.5	20.5
Percentage of provider spells in deprivation quintile 3	14.8	19.0
Percentage of provider spells in deprivation quintile 4	15.2	17.9
Percentage of provider spells in deprivation quintile 5 (least deprived)	12.3	16.3
Percentage of provider spells where the deprivation quintile cannot be determined	3.2	3.2
Percentage of deaths in deprivation quintile 1 (most deprived)	33.0	21.0
Percentage of deaths in deprivation quintile 2	17.0	20.0
Percentage of deaths in deprivation quintile 3	16.0	20.0
Percentage of deaths in deprivation quintile 4	17.0	20.0
Percentage of deaths in deprivation quintile 5 (least deprived)	17.0	18.0
Percentage of deaths where the deprivation quintile cannot be determined	1.0	1.0



3. Palliative care coding

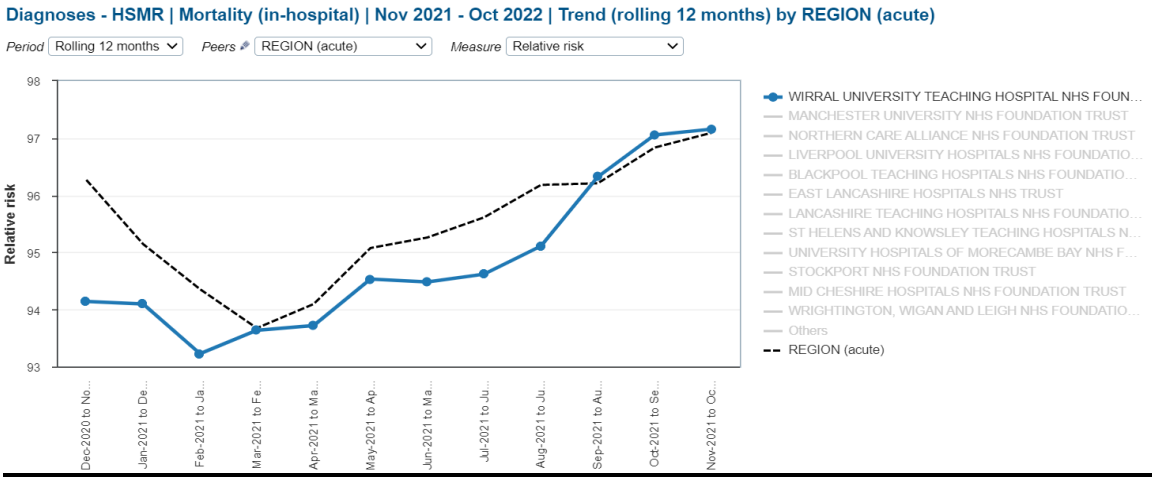
As discssed in previous reports WUTH continues to have a higher than average number of patients who have a palliative care code (after being reviewed by palliative care). A large number of patients with this code will increase the SHIMI as the SHIMI model does not exclude these patients (unlike HSMR)



A previous deep dive into palliative coding in 2021 had given assurance around current practice. However MRG has agreed to undertake an other deep dive into our palliative care coding and the factors that drive this.

Hospital Standardised Mortality Ratio (HSMR)

The HSMR for the latest available is 98.1. This is in the expected range, but has been rising for the past few quarters in line with the national and regional picture.



At a national level Telstar Health analysis suggests several factors that may be leading to an upward trend in HSMR. These include:

- Increased acuity of patients, because of the covid -19 pandemic
- Emerging workforce pressures within trusts and primary care nationally
- The HSMR model doesn't include risk adjustments for COVID-19 relevant casemix factors, such as obesity and ethnicity, which have been found to have a notable impact on patient pathways and outcomes
- Delays to elective treatment means that some patients may have deteriorated, due to postponed treatment
- Ambulance response times have deteriorated, potentially leading to more acutely ill patients and delays to care

Mortality Dashboard

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

19 cases escalated by the ME to the mortality review group have undergone a review during Q3. These cases have been reviewed using a revised PMR template (13 cases) or via the Royal College of Physicians Structured Judgement review tool (6 cases). Three (3) cases were escalated to the Serious Incident Review panel for discussion as to whether a Serious Incident should be declared. None of these cases reached the threshold to be declared as a Serious Incident

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 22 deaths were reviewed in Q3 (4%) using the PMR template. None of these cases identified any cause for concern.

Summary of all Adult in patient deaths and case reviews							
	Total Adult In-patients Deaths	Total Reviewed by Med Examiner or MEO	Total No of cases escalated for review by Medical Examiner	Total No of SJR's opened from cases escalated	Serious Incidents opened following MRG review	Quality assurance PMR's undertaken	Total number of case reviews by MRG
Q4 (21-22)	477	477	33	7	1	21	54
Q1 (22-23)	414	414	21	6	0	25	46
Q2 (22-23)	446	446	19	4	2	26	45
Q3 (22-23)	533	533	19	6	0	22	41

Grading of Adult Care and avoidability following SJR review in Q3 (Includes SJRs opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
	2	2		

During Q3, 3 deaths were reported in patients identified as having a Learning disability. All of these deaths have been reviewed using the SJR template and have also been referred for external review through the national LeDeR programme.

Learning Disability Mortality Reviews				
	Total No. of LD Deaths	No. reviewed using SJR	Problems in Health care Identified in this Quarter	Referred to National LeDeR Programme
Q4 (21-22)	4	4	0	4
Q1 (22-23)	4	4	0	4
Q2 (22-23)	2	2	1	2
Q3 (22-23)	3	3	0	3

Perinatal and Neonatal deaths

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

During Q3 there was one stillbirth reported and four Neonatal deaths reported. All these cases will undergo a PMRT review as per the usual process. Internal review has not identified any cause for concern in these cases.

	Stillbirths	Neonatal Deaths	Paediatric deaths	Cases sent for PMRT review
Q4 (21-22)	2	1	0	3
Q1 (22-23)	1	0	0	1
Q2 (22-23)	0	1	0	1
Q3 (22-23)	1	4	1	6

Outcome of PMRT reviews reported in Q3				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, likely affected outcome
		0	2	0

Both of PMRT reviews done in Q3 were graded as Grade C (care issues may have affected outcome).

One case was due to a delay in recognising an abnormal blood test result on the Neonatal care unit. Actions have been put in place to prevent this occurring again.

The second case was a delay in NWAS transfer of a baby to WUTH from an external organisation rather than care issues at WUTH. This has been fed back to NWAS and the transferring hospital

sLearning identified through review of mortality reviews during Q2

Learning for mortality is derived from 3 main sources

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

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

Learning theme	Source	Action taken
Medication delays and errors	Mortality reviews	All cases are feedback via the Medications safety Pharmacist (who is a member of MRG) to

		relevant areas and MSOP committee that has oversight of medication safety across the Trust.
Delays in discharge home (Patients without criteria to reside)	Mortality reviews	Work ongoing at system level to address delays in discharge.
Multiple ward moves	Mortality reviews	Ward moves audit commenced to learn lessons and look at process around bed allocation
Poor documentation	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads.
Poor documentation around MCA and DNACPR decisions	Mortality reviews	All these cases are feedback to individual teams and the Trust CPR committee. MCA training and has been refreshed across all areas recently and audits of DNACPR forms strengthened to ensure better compliance.

Dr Telstar Health (Dr Foster) Data

The Telstar Health (formerly Dr Foster) dashboard informs the Trust of any new CUSUM alerts and any diagnosis/ procedures with significantly high mortality.

During Q3 deaths in the diagnostic group “Secondary Malignancies” were highlighted as having a higher-than-expected SHIMI, although for in hospital deaths the SHIMI as in the expected range. MRG is coordinating a case note review into ten post discharge deaths to look for lessons learnt and trends this SHIMI group and will report back in due course.

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

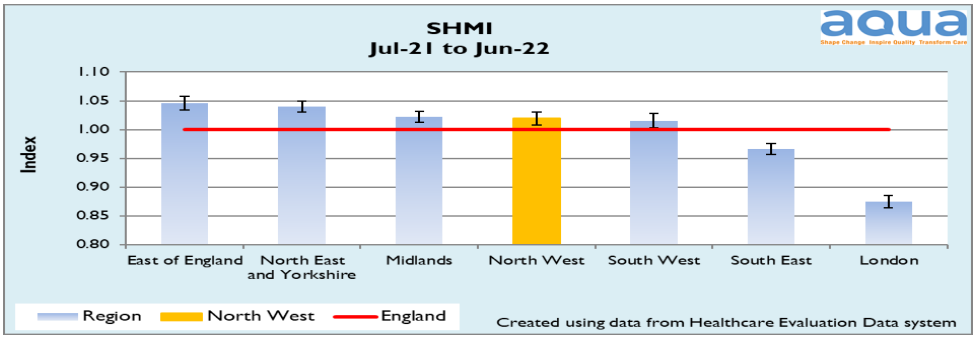
Diagnostic Group	Quarter Highlighted	Alert type	Work undertaken	Outcome/ Learning
COPD	Q3 21-22	High SHIMI	Review by Clinical Lead	Data reviewed with GIRFT and national COPD audit data. No concerns identified via GIRFT or National COPD audit. High SHIMI due to deaths post discharge form hospital. New virtual ward service began in Sept 2022 that will improve post discharge care and

				support for COPD patients.
Cerebral vascular Disease	Q3 21-22, Q4 21-22	High SHIMI	Review By Clinical Lead	On review in hospital deaths were as expected. SSNAP data (national benchmarking) did not show any cause for concern. Latest SHIMI data did not highlight this diagnostic group as a concern. After discussion at MRG decision made to not review further, but keep this diagnostic group under review.
Pneumonia	Q2 22-23	High SHIMI	Case note audit	Ongoing
Secondary Malignancy	Q3 22- 23	High SHIMI	Case note audit	Ongoing

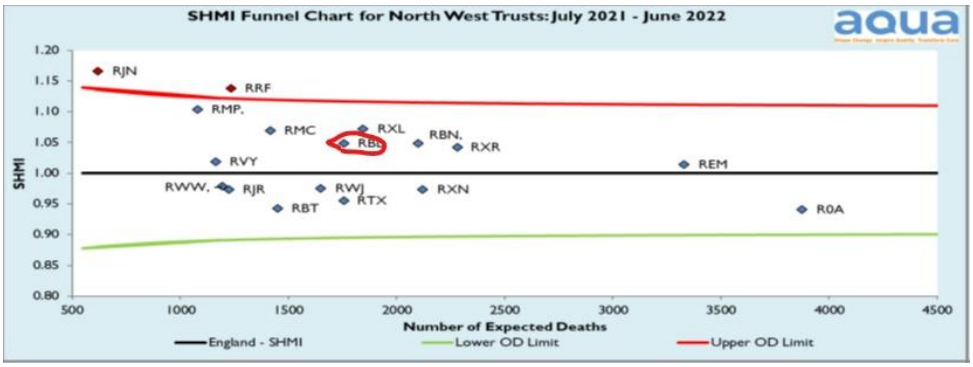
AQUA

AQUA is an NHS care quality improvement organisation that reviews and benchmarks mortality across the North West and produces a quarterly report. The latest repost was published in Dec 2022 and highlights the following.

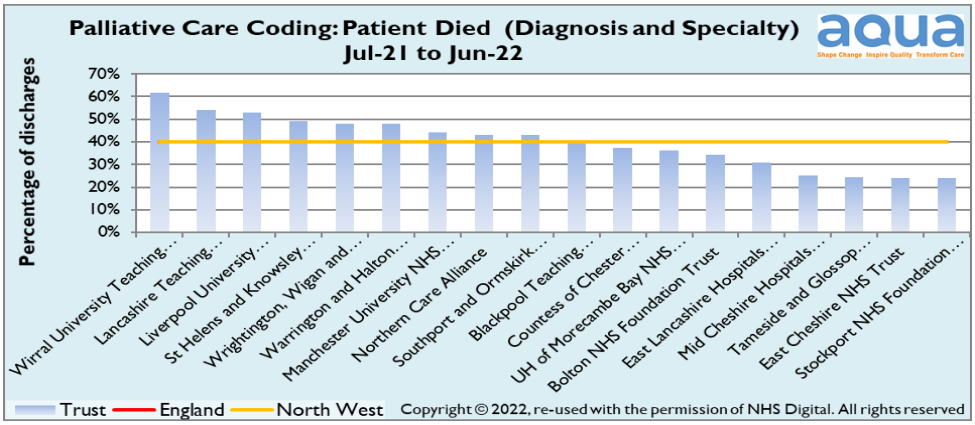
- SHIMI across the NW of England is higher than the national average



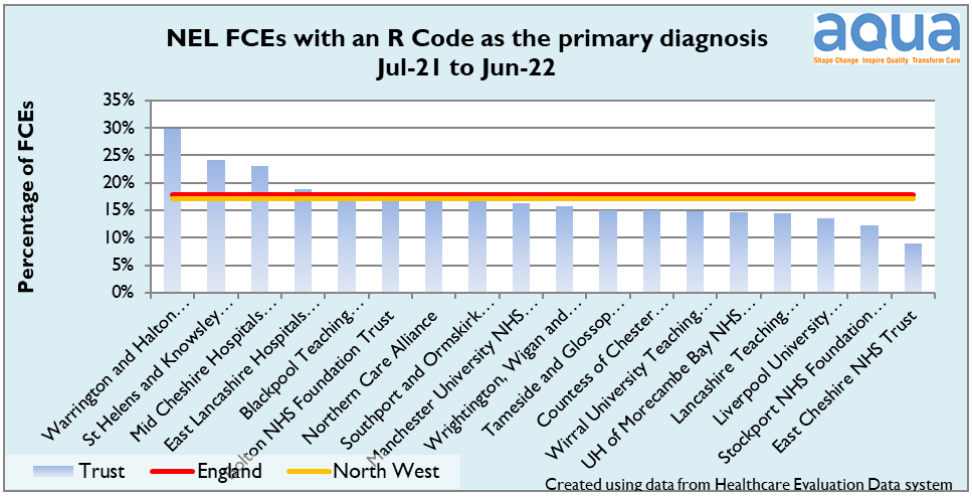
WUTH SHIMI is within expected range



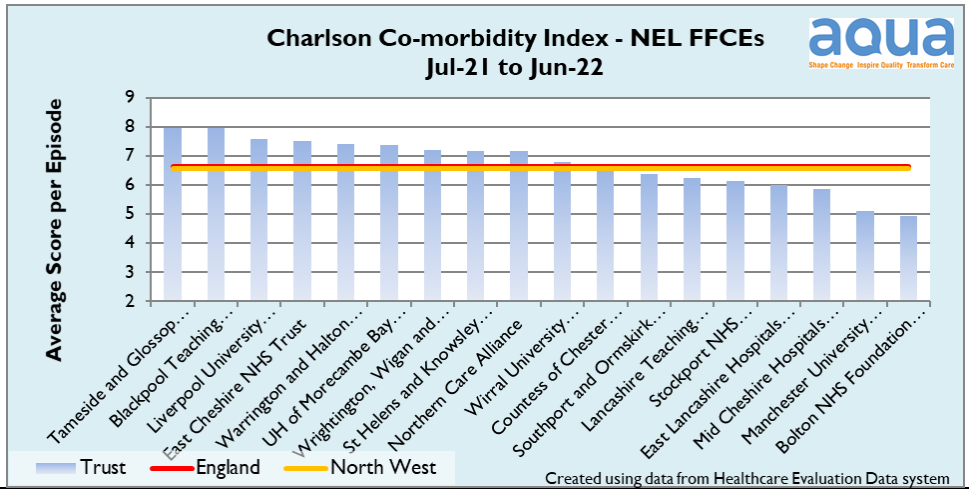
- WUTH has the highest rate of palliative care coding across the North West (as discussed earlier this is an area for further focus and investigation)



- WUTH has a lower-than-average (better) incidence of “R codes”.
A high level of R codes may indicate lack of access to senior decision makers and a later commencement of appropriate treatment.



- Coding of co-morbidities at WUTH has improved when compared to previous reports. Poor coding will impact on SHIMI and HSMR



2	Conclusion
	Mortality indicators are both within the “As expected” range, although HSMR has been showing an upward trend for several quarters (in line with the national picture). The Medical Examiner continues to provide scrutiny for all death and helps to identify learning and escalate concerns to the Mortality Review group. Benchmarking form Telstar Health and AQUA has identified two areas for further scrutiny. • Diagnostic group for “Secondary Malignancy” • A higher-than-average rate of palliative care coding This work will be coordinated through the Mortality Review Group and fed back in due course.

Report Author	Dr Ranjeev Mehra, Deputy Medical Director
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Board of Directors in Public

05 April 2023

Item 9.5

Title	Board Assurance Report and Risk Appetite Statement
Area Lead	David McGovern, Director of Corporate Affairs
Author	David McGovern, Director of Corporate Affairs
Report for	Approval and Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board with an update on work carried out to refresh the Board Assurance Framework and the Board Risk Appetite Statement.

It is recommended that the Board:

- Approve the annual refreshment of the Board Assurance Framework.
- Approve the annual review of the Board Risk Appetite Statement.
- Note future reporting arrangements for the Board Assurance Framework.

Key Risks

This report relates to these key Risks:

- Ensuring good governance to support the well led requirements.

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
N/A	Previous Board Meetings	BAF and Risk Appetite Statement	Approval

1	Narrative
1.1	**Background**

	The Board has previously considered and approved the Trust's Risk Management Strategy at the end of 2022. It was noted that work would be carried out to refresh the approach to the Board Assurance Framework (BAF) and establish consistent reporting on both the BAF and the Board's Risk Appetite Statement in line with the Strategy. The establishment of effective risk management systems is vital to the successful management of the organisation and is recognised as being fundamental in ensuring good governance. The Risk Management Strategy incorporates the board assurance arrangements and sets out how the effective management of risk will be evidenced and scrutinised to provide assurance to the Board. The Board Assurance Framework (BAF) is a key component of this. The proposed reporting format, together with the actions being taken to populate this, is included within this report. The Strategy also includes the Trust's Risk Appetite Statement and notes that this will be subject to annual renew.
1.2	**Board Assurance Framework Refresh** The BAF is used to record and report the principal risks, controls, and assurances to the board. The established BAF report format is attached at Appendix One along with a fuller explanation of the high-level changes that have been incorporated into this refreshed version. Following previous Board discussion, the BAF has now been subject to a full review to ensure that it is fit for purpose and properly reflects the current position of the Trust's corporate objectives. Key changes to note in the refreshed BAF include: • The reduction in the total number of strategic risks from 17 to 12. • The restating and merging of the People risk. • The restating of risks relating to Finance, Leadership and Governance and Partnerships. • The merging of previous separate risks relating to ICT, Infrastructure, Estates and Business Continuity. • Ensuring that removed risks are properly contained within the sub sections of reframed risks. Board is asked to note that the refresh has also included the further development of action planning in relation to strategic risks. This work is continuing over the coming months and will be fully reported to all forums required as part of BAF reporting. **Enhancements to the BAF Reporting Process** Board members will recall that current reporting requirements for the BAF are as follows: - Bi-Monthly Reports to the Board. - Reports to each meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy. - Reporting to every other meeting of relevant Board Committees.

	- Bi-Monthly Reporting to the Trust Management Board; and - Bi-Monthly Reporting to the Risk Management Committee. Following this review it is recommended that the reporting process is enhanced with the introduction of additional focussed 'deep dives' by the Audit and Risk Committee into 2 strategic risks at each of its meetings. Risk owners will be invited to these meetings to discuss and provide further assurance in regard to progress against actions.
1.3	**Risk Appetite Statement Refresh** The Risk Management Strategy requires that the Board agree and review annually the Trust's Risk Appetite Statement to ensure that decision-makers across the organization are clear regarding the level of risk they are permitted to expose the organisation to, and where to escalate and target action in improving controls. The statement will include: • Risk appetite - the amount of risk that the Trust is willing to seek or accept in the pursuit of its strategic objectives, which will form part of the annual planning process and be set out in relation to each strategic objective. • Risk tolerance - the boundaries of risk taking outside of which the Trust is not prepared to venture in the pursuit of its strategic objectives. The Risk Appetite Statement was originally considered at a board development session in October 2021. The discussion and feedback provided by members was used to frame the agreed risk appetite statement attached at Appendix Two. Following review, it is recommended that the current Statement continues to be fit for purpose and reflective of the current strategic objectives and plans for the Trust. The Board is asked to consider this position and identify any changes or amendments to the current Statement.
1.4	**ICB and System** At its meeting on 23rd February the ICB approved its own approach to Risk Management, Board Assurance Reporting, and its Risk Appetite Statement. The Statement is attached to this report at Appendix 3. Work will continue to monitor progress on this work and in particular to ensure future alignment between the Trust and the ICB when its full BAF is produced.
1.5	**Next Steps** Work will continue to populate the BAF action plan and to implement consistent Board and Committee reporting. The Audit and Risk Committee will continue to oversee progress against the BAF in line with its responsibilities and enhanced reporting will commence from April 2023. The Executive Team will continue to work to develop and refine the BAF action plan for consideration by the Board. It should be noted that this will be subject to continuous review by the Executive Team and the relevant committees.

2	Implications
2.1	The approval of the arrangements proposed does not present any significant risk but will provide the Board with the necessary framework to manage strategic risk effectively.

3	Conclusion
3.1	It is recommended that the Board: • Approve the annual refreshment of the Board Assurance Framework. • Approve the annual review of the Board Risk Appetite Statement. • Note future reporting arrangements for the Board Assurance Framework.

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NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework
April 2023

Item 9.5

Contents

1. Introduction

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

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

Baker Tilly 2021

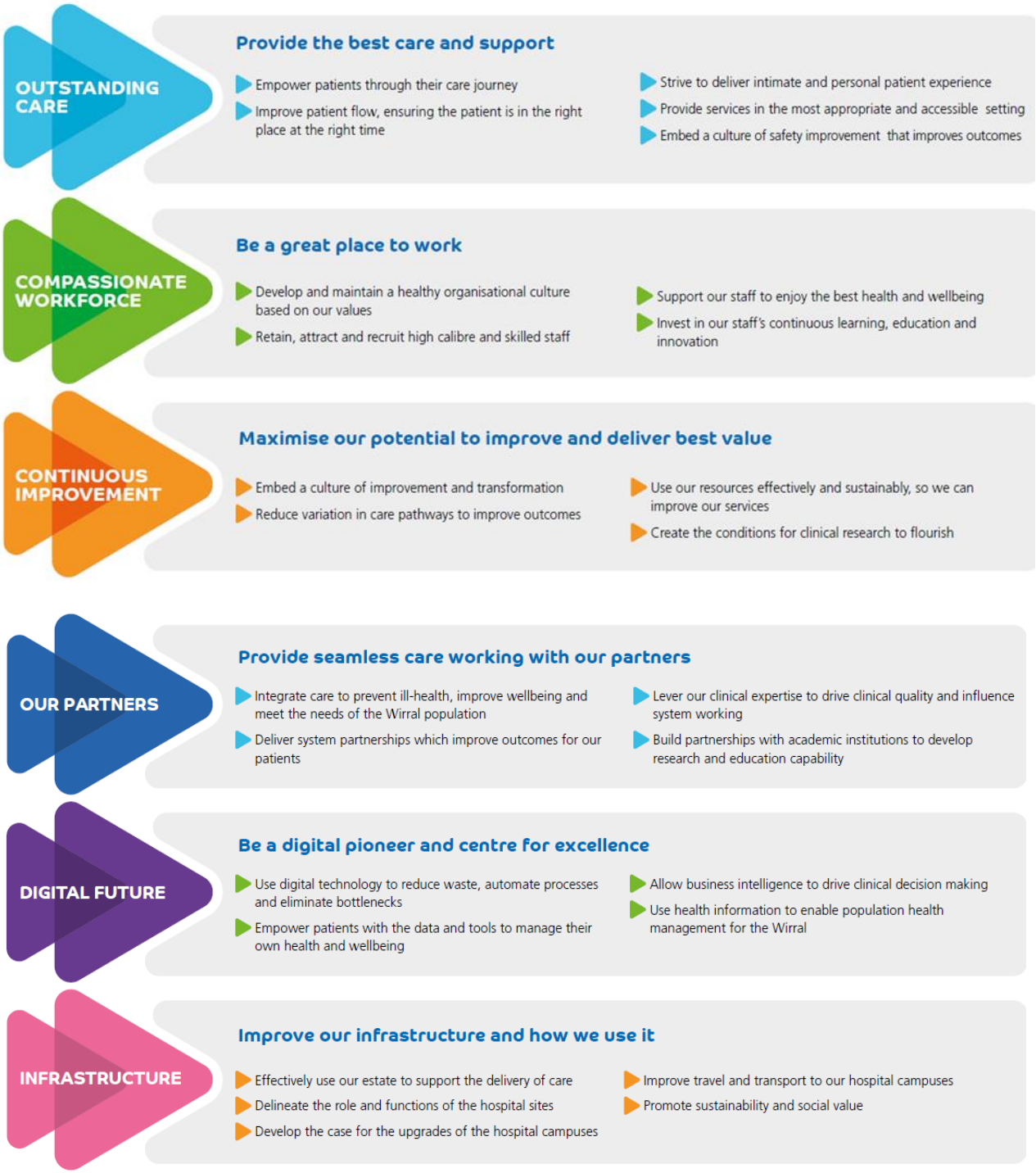
2. Vison, Strategy and Objectives

2.1 Our Vision

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

2.2 Our Strategic Objectives

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



3. Our Risk Appetite

3.1 Risk Appetite Statement

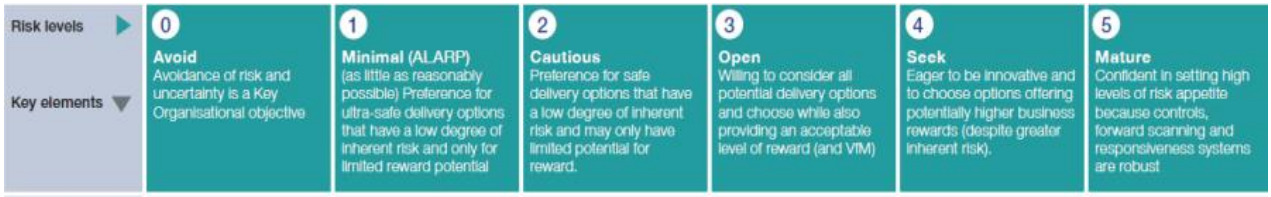
The Trust endeavours to establish a positive risk culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

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

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

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

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



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

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

4. Operational Risk Management

4.1 Operational Risk Management

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

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

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

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

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

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

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

The Trust shall achieve this by:

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

5. Creating and Monitoring the BAF

5.1 Creation of the BAF

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

5.2 Monitoring the BAF

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

- Bi-Monthly Reports to the Board.
- Reports to each meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy.
- Additional Audit and Risk Committee focus on 2 risks at each meeting.
- Reporting to every other meeting of relevant Board Committees.
- Bi-Monthly Reporting to the Trust Management Board; and
- Bi-Monthly Reporting to the Risk Management Committee.

5.3 Annual Refresh 2023

The Risk Management Strategy outlines that the BAF will be subject to annual refreshment that will take place in March each year for approval in April.

6. Update Report

6.1 April 2023

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

The controls, assurance, and actions for each of the current strategic risks have been reviewed with Executive Team members and these changes will be reflected in the next iteration to Board.

6.2 Changes to the previous version

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

All changes are highlighted in the report and register.

6.3 Recommendations

Board is asked to:

- Note and approve the suggested changes to the BAF following annual refreshment.

BOARD ASSURANCE FRAMEWORK 2023-24									
BAF DASHBOARD 2023-24									
Strategic Priority	**Risk No**	**Risk Description**	**Lead**	**Committee**	**Initial Score**	**April/June 2022**	**July/ September 2022**	**October/ December 2022**	**January/ March 2023 Current**
Outstanding Care	1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	Chief Operating Officer	Quality and Board	20 (4 x 5)	16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)
Outstanding Care	2	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	Chief Operating Officer	Quality and Board	16 (4 x 4)	16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)
Outstanding Care	3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	Medical Director	Quality	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 3)
Compassionate Workforce	4	If the Trust fails to effectively plan for, recruit, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy	Chief People Officer	People	12 (4 x 3)	N/A	N/A	N/A	12 (4 x 3)
Compassionate Workforce	5	Failure of the Trust to have the right culture, organisational conditions/structure or resources to deliver our priorities for our patients and service users.	Chief People Officer	People	12 (4 x 3)	N/A	N/A	N/A	12 (4 x 3)
Compassionate Workforce	6	If issues affecting staff experience are not effectively addressed, this will adversely impact on staff motivation, engagement and satisfaction.	Chief People Officer	People	16 (4 x 4)	N/A	N/A	N/A	12 (4 x 3)
Continuous Improvement	7	If the Trust's approach to value and financial sustainability and Planning are not embedded, this may impact on the achievement of the Trust's financial, service delivery and operational plans.	Chief Finance Officer	FBP	16 (4 x 4)	N/A	N/A	N/A	16 (4 x 4)
Continuous Improvement	8	Failure to deliver sustainable efficiency gains due to an inability to embed service transformation.	Chief Operating Officer	Board	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)
Continuous Improvement	9	Failure to have strong leadership and governance systems in place.	Chief Executive Officer	Board	12 (4 x 3)	N/A	N/A	N/A	9 (3 x 3)
Our Partners	10	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability.	Chief Executive Officer	Board	12 (4 x 3)	N/A	N/A	N/A	12 (4 x 3)
Digital Future and Infrastructure	11	If the Trust fails to robustly implement and embed infrastructure plans including digital and estates, this will adversely impact on our service quality and delivery, patient care and carer experience.	Chief Strategy Officer	FBP and Board	16 (4 x 4)	N/A	N/A	N/A	16 (4 x 3)
Infrastructure	12	Risk of business continuity in the provision of clinical services due to a critical infrastructure or supply chain failure therefore impacting on the quality of patient care.	Chief Finance Officer	Capital, FBP and Board	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (3 x 3)

Appendix – Risk Scoring Matrix

Risk Scoring and Grading:

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

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

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

Appendix – Risk Appetite Scoring Matrix

1. Our Risk Appetite

1.1 Risk Appetite Statement

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

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

Risk levels ▶ / Key elements ▼	0	1	2	3	4	5
	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	**Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Outstanding Care – Provide the best care and support.	Various	The Trust has an OPEN risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation. The Trust has MINIMAL risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed. We have a SEEK appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.
SO2: Compassionate Workforce – Be a great place to work.	OPEN	The Trust Board has an open risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Trust is an employer of choice.
SO3: Continuous improvement – Maximise our potential to improve and deliver best value.	OPEN	The Trust Board is prepared to accept risk in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and ensuring we deliver our goals and targets.
SO4: Our partners – Provide seamless care working with our partners.	SEEK	The Trust Board recognises there may be an increased inherent risk faced with collaboration and partnerships, but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.
SO5: Digital Future – Be a digital pioneer and centre for excellence.	SEEK	The Trust Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: Infrastructure - Improve our infrastructure and how we use it	OPEN	The Trust Board has an open risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.

ICB Overarching Risk Appetite

Purpose

The ICB must take risks to achieve its aims and deliver beneficial outcomes to patients, the public and other stakeholders. The ICB aims to create an environment in which risk is considered as a matter of course, appropriately identified and controlled by elimination, or reduction to an acceptable level and at acceptable cost.

The ICB Board is responsible for determining the nature and extent of the risks it is willing to accept. This statement sets out the Board's strategic approach to risk-taking by defining its risk appetite thresholds.

Core Statement

The ICBs Overall Risk appetite is OPEN – We are willing to consider all delivery options and may accept higher levels of risk to achieve improved outcomes and benefits for patients.

The ICB has no tolerance for safety risks that could result in avoidable harm to patients.

Our ambitions to improve the health and wellbeing of our population and reduce inequalities can only be realised through an enduring collaborative effort across our system. We will not accept risks that could materially damage trust and relationships with our partners.

We will pursue innovation to achieve our transformational objectives and are willing to accept higher levels of risk which may lead to significant demonstrable benefits to our patients and stakeholders, while maintaining financial sustainability and efficient use of resources. We will support local system / providers to take risks in pursuit of these objectives within an appropriate accountability framework.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 10**

05 April 2023

Title	Financial Strategy
Area Lead	Mark Chidgey, Chief Finance Officer
Author	Charlotte Archer, Strategy and Business Planning Manager
Report for	Approval

Report Purpose and Recommendations

The purpose of this report provides an overview of the approach undertaken to develop our Financial Strategy. The Financial Strategy is appendix 1.

- Our strategic development journey culminates with the launch of the Financial Strategy, as the final of eight enabling strategies. This strategy underpins and supports the delivery of all previous strategies developed over the last three years.
- The three-year time scale to deliver our Financial Strategy allows a focused and driven approach, aligning to the final stages of delivery of Our 2021-2026 Strategy.
- Our Financial Strategy demonstrates our commitment to maximise our potential to improve and deliver best value, and comprises Four Elements, aligned to our Continuous Improvement strategic objective: Processes, Culture and Innovation, Zero-based Budgeting, Productivity-based Budgeting, and Prioritisation & Collaboration.
- Our Financial Strategy has been developed through engagement with the finance team and wider workforce across our five clinical divisions, and corporate teams. This approach has enabled us to gain a clear understanding of our current situation and our priorities over the next three years. This document assesses where we are now, outlines where we want to be through the development of priorities for each Element and details how we are going to get there within the next steps section.
- Feedback from the engagement was then used to formulate our three-year priorities for each of the Financial Strategy Elements.
- Our staff are the enablers to wider organisational transformation and will be supported by the finance and procurement teams to translate the financial strategic priorities into operational plans for each year of the strategy. Progress in delivering the strategy will be monitored through the Finance, Business, Performance and Assurance committee (FBPAC).
- The Finance Strategy will launch in April 2023, with the new financial year and next steps include the development and implementation of the financial annual operational delivery plan, and medium-term Financial Model.

It is recommended that the Board of Directors:

- Approve the Financial Strategy

Key Risks
This report relates to these 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**
28/03/23	Executive Team meeting	WUTH Financial Strategy	Accepted

Author	Charlotte Archer, Strategy and Business Planning Manager
Contact Number	X7459
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Financial Strategy

2023 - 2026

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Foreword

I am pleased to introduce you to our Financial Strategy which sets out our strategic direction for the next three years, that will deliver our Continuous Improvement strategic objective:

to maximise our potential to improve and deliver best value

*As the NHS is tax-payer funded, we all have a responsibility to ensure we deliver best value for money services, therefore, **our Financial Strategy is everyone's business**. The Trust must continuously review and improve the way it uses its resources so that we can maximise the benefits to our patients for every pound that we spend. Our Financial Strategy will support the long term financial sustainability of our services and enable us to plan for the investment we need to deliver our strategic priorities. This will be achieved through the four elements of the strategy, which focus on the roles and responsibilities of the wider Trust, the finance function, and working with partners. This strategy will set out how the Trust, working with its system partners, will address the current financial gap to support the delivery of high quality, sustainable care for the population.*

Mark Chidgey
Chief Finance Officer

Contents

Wirral University Teaching Hospital NHS Foundation Trust

Introduction

Our journey to maximise our potential to improve and deliver best value

Our strategic development journey culminates with the launch of the **Financial Strategy**, as the final of eight enabling strategies. This strategy underpins and supports the delivery of all previous strategies developed over the last three years. The three year time scale to deliver our Financial Strategy allows a focused and driven approach, aligning to the final stages of delivery of *Our 2021-2026 Strategy.* Furthermore, this approach has also enabled us to develop our Financial Strategy with the benefit of post-pandemic knowledge and in-line with the changing landscape of NHS funding streams nationally with the introduction of Integrated Care Boards (ICBs).

Our Financial Strategy demonstrates our commitment to maximise our potential to improve and deliver best value, and comprises Four Elements, aligned to our Continuous Improvement strategic objective: Processes, Culture and Innovation, Zero-based Budgeting, Productivity-based Budgeting, and Prioritisation & Collaboration.

Our Financial Strategy has been developed through engagement with the finance team and wider workforce across our five clinical divisions, and corporate teams. This approach has enabled us to gain a clear understanding of our current situation and our priorities over the next three years. This document assesses where we are now, outlines where we want to be through the development of priorities for each Element and details how we are going to get there within the next steps section.

Finance at WUTH is led by our Chief Finance Officer (CFO), driven by our Finance Team, managed by our budget holders across each division, and delivered by all staff across our organisation.

As NHS care is free at the point of delivery, finance may not be at the forefront of our minds. However, without finance, we would be unable to provide healthcare services for our patients. Therefore, financial sustainability and delivering best value is central to ensuring continued healthcare provision to the population we serve.

Following a time of considerable change for the NHS, with the implementation of Integrated Care Systems (ICSs) and the introduction of ICBs as the new funding structure, the Trust is working with its partners across Wirral Place to redesign services to drive improved outcomes and operational performance whilst also supporting system wide financial sustainability. Wirral Place, and Cheshire and Merseyside Integrated Care system is facing significant financial challenges with overall deficits reported. We have therefore developed our Financial Strategy to not only reflect our own priorities, but to acknowledge and address these system challenges.

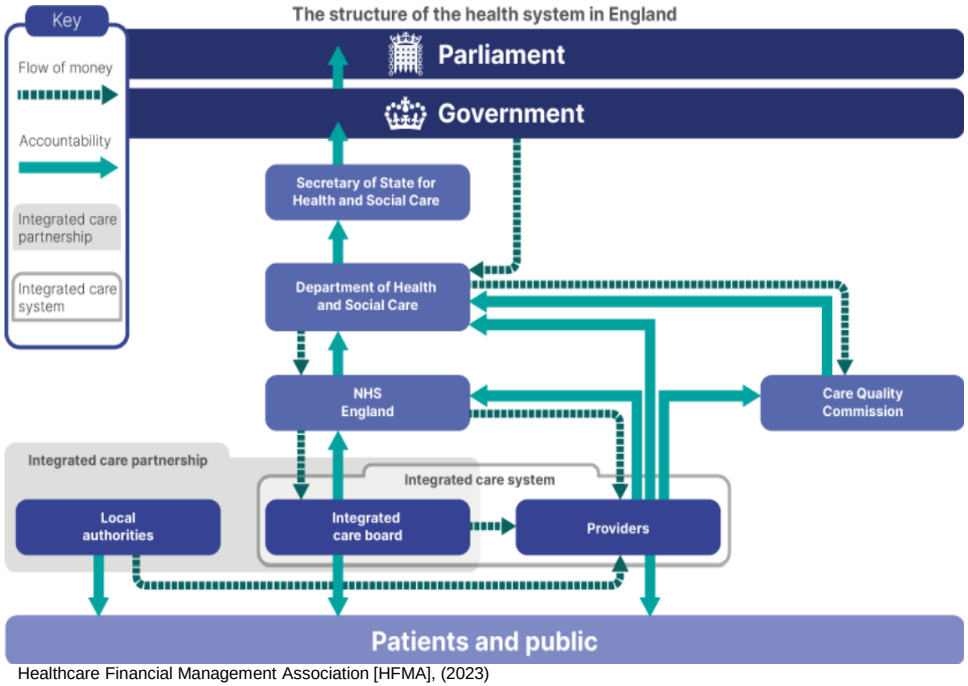
National Finance Context

Wirral University Teaching Hospital NHS Foundation Trust

Integrated working

Health Services across England are funded from the Department for Health and Social Care's budget, with funding streams illustrated in figure 1. The majority of this budget is passed to NHS England, and the remainder funds public health, local authority grants, training and development and regulation of care.

Figure 1 – The Structure of the Health System in England



Healthcare Financial Management Association [HFMA], (2023)

The introduction of ICSs and ICBs was brought forward by the white paper: *Integration and innovation: working together to improve health and social care for all,* with implementation of this new structure from 1st July 2022, allowing NHS England to set financial allocations and other financial objectives at a system level.

Reset & Recovery

Post-pandemic operational planning nationally prioritises on reducing backlogs, increasing capacity, growing the workforce, and expanding joined up healthcare. These national priorities are not only central to strategic and operational planning, but also carry with them considerable financial implications.

External Factors

The NHS manages within overall resource limits that are determined by the government each year, and there is challenged to meet unlimited demand, with finite resource. Furthermore, recent years have seen a time of considerable change not only for the NHS, but for the country in general, which has introduced further pressures through external factors such as:

- Learning to live with COVID-19 Pandemic
- Inflation and cost of living crisis
- European Union Exit
- Industrial Action

Local Finance Context

Wirral University Teaching Hospital NHS Foundation Trust

Integrated Working

As we face the challenge of social, economic and public health recovery from the COVID-19 pandemic and look to tackle the inequalities and vulnerabilities it has exposed, the case for collaborative working is stronger than ever. Cheshire and Merseyside (C&M) ICS is made up of nine 'Places', Wirral being one of the nine.

Wirral Place-based Partnership comprises Wirral University Teaching Hospital (WUTH), Primary Care Partnership Wirral, Wirral Community Health and Care (WCHC) NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Council, and the Voluntary, Community, Faith and Social Enterprise (VCFSE).

Working collaboratively with these partner organisation is facilitated by integrated commissioning, which is delivered through the Cheshire & Merseyside Integrated Care Board.
Since this commissioning Model was introduced in July 2022, at WUTH, we have been working on a number of collaborative programmes with our partner organisations across Wirral Place and the wider ICS:

- £10.6 million funding for collaborating with regional partners for operating theatres at the new South Mersey elective Hub at our Clatterbridge Hospital site.
- The Urgent and Emergency Care Upgrade Programme (UECUP) is a £36 million collaboration between the Department of Health and Social Care, WUTH, and WCHC for a new emergency facility at Arrowe Park Hospital to provide one front door to our patients.

Demographics

It is important to consider the demographic of the patients we serve, in order to understand how that might affect the financial pressure on the services we provide:

- Wirral has a total population of approximately 324,000. Wirral has an older demographic, with 22% of the population aging 65 years or older, this is higher than the national average of 18.5%.
- 72,204 people live with a long term illness in Wirral, this is 22.6% of the people who live here, compared to 17.6% across England.

External Factors

At the end of the 2022/23 financial year, the Trust's exit run-rate at WUTH is a deficit of £40 million. This is driven by:

- underachievement of Cost Improvement Programme (CIP) targets,
- continuation of escalated bed capacity,
- high levels of bank and agency workforce expenditure.

The challenges of the NHS finance regime mean that a minimum CIP target of 5% must be achieved in the coming years, and the Trust has had to manage inflation pressures, for example, energy costs.

Background

Developing Our 2021 – 2026 Strategy

Our previous strategic focus was upon our top three priorities: patient flow, outpatients and peri-operative medicine. Our Clinical Divisions aligned their operational plans to support improvements in each of these three areas. However, clear strategic objectives for all to work towards, aimed to ultimately deliver our vision were not defined. Therefore, our Trust Board decided further work was needed to create a new, clear and meaningful strategic direction.

Our journey to develop our new strategic direction began early 2020, through a robust process of research and engagement as described.

Our 2021-2026 Strategy launched October 2020 outlining our intentions and setting out our specific strategic objectives to focus progress over the next five years.

Our Vision, Values and Foundations

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Our Vision and Values set out what our patients can expect from us. Underpinning our Vision and Values, and aligning to the Trust objectives and priorities are the Foundations: Getting the Basics Right, Better, and Best. Alignment to our Vision, Values and Foundations is key to the successful delivery of our Financial Strategy.

Our Vision

together we will

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

Our Values

caring for everyone

- Acting with kindness, compassion and empathy with everyone
- Being friendly, welcoming, approachable and remembering the simple things like a greeting and a smile
- Being considerate of the needs of others
- Listening to ideas, opinions, thoughts and feelings of others
- Taking personal responsibility and accountability for the care that you deliver

embracing **teamwork**

- Working within and across teams to provide the best possible quality of care and experience for our patients, families, carers and colleagues
- Communicating effectively within teams
- Recognising the value of everyone's role, contribution, skills and abilities
- Supporting colleagues within the team when needed
- Engaging in opportunities to develop and grow the team

respect for all

- Being honest and open, including honesty about what we can and cannot do
- Being polite and professional with everyone, introducing ourselves by name, saying please and thank you
- Listening to patients, families and colleagues
- Respecting cultural and individual differences
- Ensuring we treat everyone the way we would want to be treated ourselves and dealing with poor behaviour

committed to **improvement**

- Actively seeking new ways of working to enable improvement
- Working together to improve services for our patients, families and carers
- Taking personal responsibility and ownership of things that need to improve
- Being positively receptive to change and improvement
- Celebrating our achievements

Our Foundations

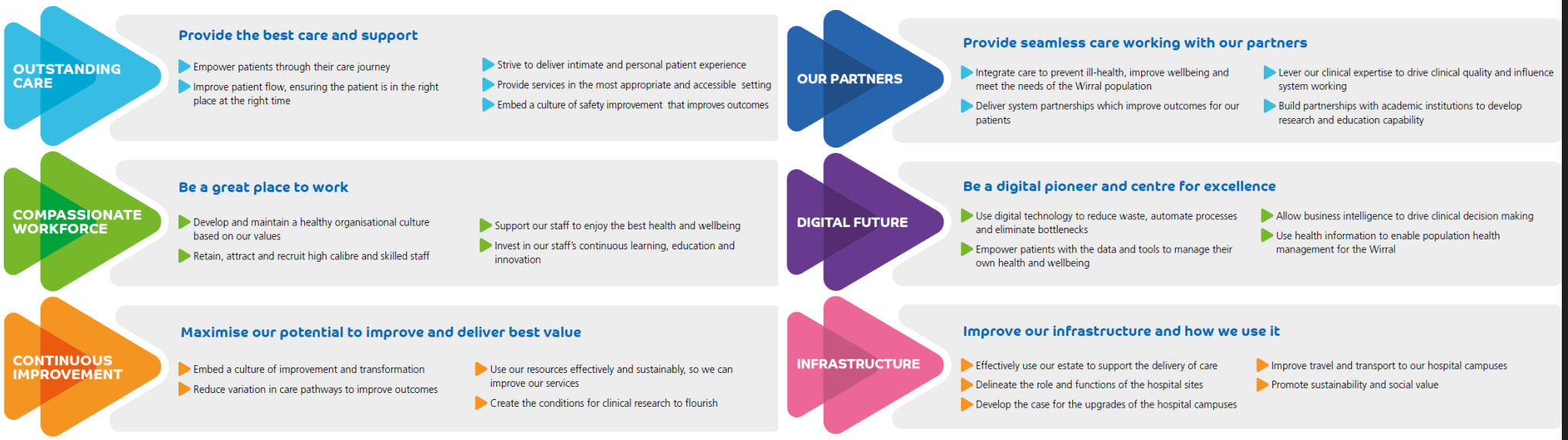
Getting the Basics Right → Better → Best

8

Our 2021-2026 Objectives and Priorities

Wirral University Teaching Hospital NHS Foundation Trust

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



Enabling Strategies

Strategic Framework: Our Enabling Strategies

Our 2021-2026 Strategy will be delivered through eight Enabling Strategies as shown. This strategy will set out our road map of financial priorities for the next three years.

The Financial Strategy is the final piece in our suite of enabling strategies. Launching this strategy last consolidates and underpins all of our Enabling Strategies, with the benefit of learning from the new changes to national funding structures.

Our Financial Strategy will support the long term financial sustainability of our services and enable us to plan for the investment we need in our workforce, estate, equipment and infrastructure. The Trust must continuously review and improve the way it uses its resources so that we can maximise the benefits of our patients for every pound that we spend.

Developing our Financial Strategy

2023 - 2026

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Our Financial Journey

Where we are now and where we want to be

Over the last three years, finances have been affected considerably across the NHS by external factors; despite this, we have continued to prioritise high-quality patient care. However, it is now time to look to future planning for our financial journey, and to consider where we are now, and where we want to be in three years.

We need to firstly understand our starting point by reflecting upon our financial journey over the past three years, recognising the key milestones achieved, and the challenges that remain. We recognise through acknowledging our lessons learnt that there is a requirement for a strategic priority within this Financial Strategy to demonstrate how we will support our staff to utilise the finance function at WUTH to aid clinical decision making and provide safe, outstanding care for our patients.

This section of the document introduces the Four Elements of the strategy, which have been developed through engagement with our Finance and Procurement teams, and wider engagement with our Clinical and Corporate Divisions. These Elements encompass all required areas of focus to enable us to progress from where we are now to where we want to be over the next three years, through alignment to our Continuous Improvement strategic objective and our Clinical Service Strategy 2021-2026 priorities.

Key Financial Achievements Over the Past Three Years

Reflection to shape the development of our Financial Strategy 2023-2026

Wirral University Teaching Hospital NHS Foundation Trust

Team Restructure

Completed restructure of Finance and Procurement team in 2021, delivering 10.3% recurrent savings whilst strengthening customer support for all teams and reducing financial reporting timetable from WD8 to WD1 in from April 2023.

Head of Internal Audit Opinion

In 21/22 the Trust received substantial assurance in the Head of Internal Audit Opinion, indicating that there is a good system of internal control designed to meet the organisation's objectives and that controls are generally being applied consistently. This was the first time the Trust has received an opinion at this level. In addition, the Trust's Treasury Management review received "High Assurance", the highest possible level of assurance and the only instance of the Trust receiving this rating.

Capital Management Group

Introduced new governance framework for approval of capital programmes and ongoing management through Capital Management Group. Increased transparency in respect of all procurement and provided clear lines of accountability for all major capital works.

Level 1 Accreditation

The Trust reached One NHS Finance Level 1 Accreditation, and is working towards achieving Levels 2 and 3 by 2024/25.

Apprenticeship Programme

Created new apprenticeship programme utilising Apprentice Levy funding, recruiting 4 apprentices from local community with innovative programme of rotation across all aspects of finance whilst studying for accountancy qualifications.

Business Development and Investment Sub-Committee

Introduced the strategic review of business case process, creating Business Development and Investment Sub-Committee (BDISC), streamlining remaining process and introduced suite of supporting documentation. Prevented the development of business cases that are not aligned with strategic objectives of the organisation.

Cost Improvement Programmes

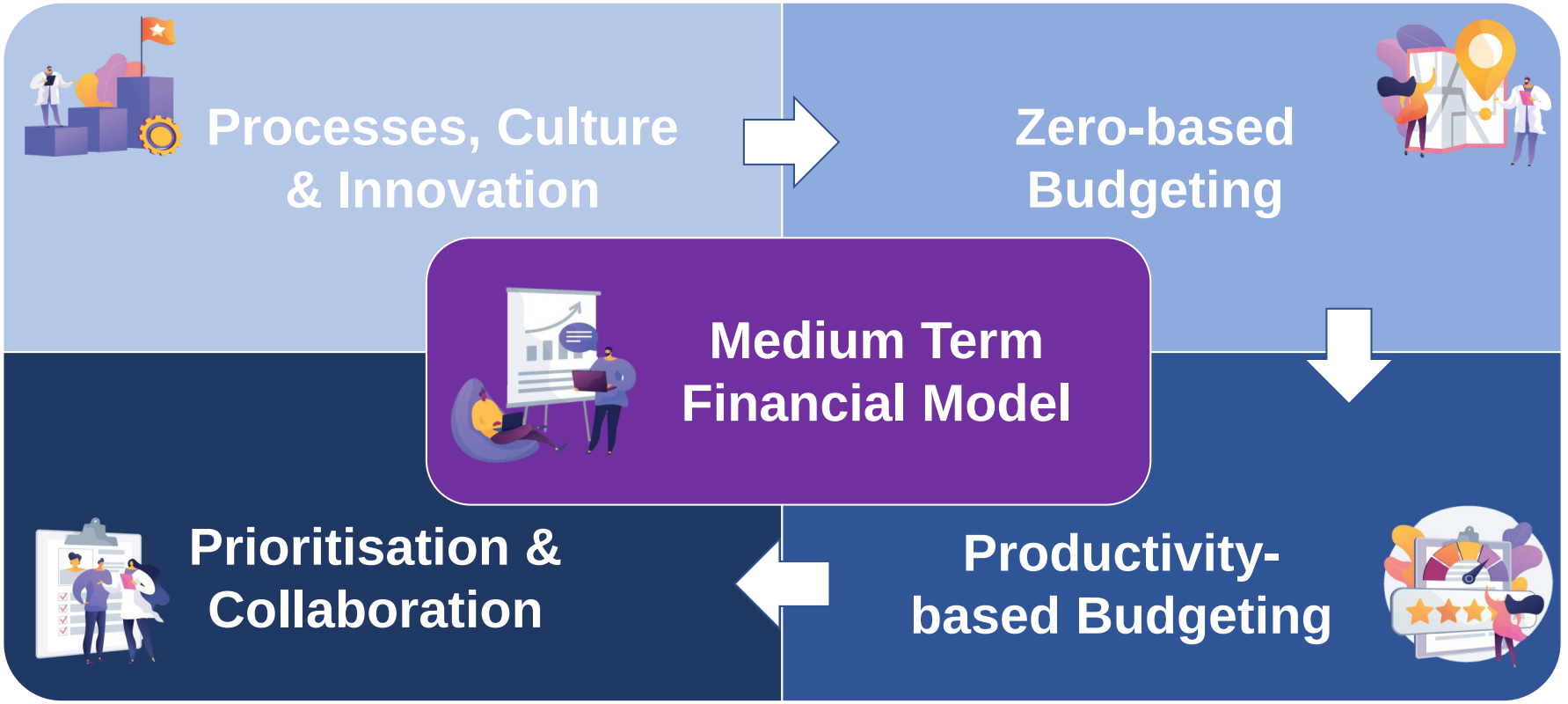
Implementation of new CIP governance and reporting processes to bring in line with national best practice. Created Cheshire & Merseyside Cost Improvement Programme & Efficiency Group, chaired fortnightly by WUTH DCFO, to bring together Trusts across the ICS to share successful schemes and identify opportunities for joint working.

Better Care Fund

Wirral Health and Care Partners have the largest pooled fund within Cheshire & Merseyside. This is delivering improved outcomes for our communities and delivered cost effectively for a number of years. NHS providers have been jointly reporting for the last 3 years, with an agreed single 'system' approach to financial planning and recovery.

The Four Elements of our Financial Strategy

Wirral University Teaching Hospital NHS Foundation Trust



Processes, Culture & Innovation

Defining the Element of Processes, Culture & Innovation:

"We know our business and have the skills and commitment to drive continuous improvement. We support a financially literate culture throughout the Trust and the delivery of sustainable, high-quality patient care."

This Element of the Financial Strategy reflects the impact of finance across the whole organisation, with focus on the wider workforce. Processes, Culture and Innovation emphasises how everyone, in every capacity has a responsibility to understand and can impact upon finance.

Throughout the strategy development process, engagement workshops were carried out across our finance and procurement teams, and the wider workforce across our clinical and corporate divisions. Detailed outputs from these engagement sessions are recorded in appendix 1 of this strategy.

When discussing the priority areas for Processes, Culture & Innovation, the following themes arose:

- Communication
- Financial literacy
- Information sharing
- Encouraging trust-wide engagement
- Trust-wide methodologies

These themes, and the feedback received throughout engagement were used to form the priorities of the strategy.

Zero-based Budgeting

Wirral University Teaching Hospital NHS Foundation Trust

Defining the Element of Zero-based Budgeting:

"All costs need to be justified each year. No costs should be incurred unless they are affordable and add value to the services we provide."

This Element of the Financial Strategy focuses on the finance function across the Trust, and specifically ways of working that continually re-assess each year to ensure that everything we do adds value.

Throughout the strategy development process, engagement workshops were carried out across our finance and procurement teams, and the wider workforce across our clinical and corporate divisions. Detailed outputs from these engagement sessions are recorded in appendix 1 of this strategy.

When discussing the priority areas for Zero-based Budgeting, the following themes arose:

- Data-driven decision making
- Making information visible
- Having procedures in place for measurement, assessment and benchmarking of current position

These themes, and the feedback received throughout engagement were used to form the priorities of the strategy.

Productivity-based Budgeting

Defining the Element of Productivity-based Budgeting:

"We must improve our processes to deliver more activity with less resource. This approach will enable us to address unproductive activities and expand areas of advantage."

This Element of the Financial Strategy focuses on optimising the finite resources we are allocated by identifying the areas that function effectively, and those that could be improved.

Throughout the strategy development process, engagement workshops were carried out across our finance and procurement teams, and the wider workforce across our clinical and corporate divisions. Detailed outputs from these engagement sessions are recorded in appendix 1 of this strategy.

When discussing the priority areas for Productivity-based Budgeting, the following themes arose:

- Identifying efficiencies and inefficiencies
- Identifying effectiveness and ineffectiveness
- Best use of staff time and estates
- Workforce sustainability
- Identifying opportunities for improvement
- Financial sustainability

These themes, and the feedback received throughout engagement were used to form the priorities of the strategy.

Prioritisation & Collaboration

Defining the Element of Prioritisation:

"We need to change as our environment changes, rather than just do what we have always done. In doing so, we can ensure that our allocation of limited resources are fully focussed on the delivery of our strategy."

This Element of the Financial Strategy focuses on the financial position of WUTH across Wirral and the wider healthcare system.

Throughout the strategy development process, engagement workshops were carried out across our finance and procurement teams, and the wider workforce across our clinical and corporate divisions. Detailed outputs from these engagement sessions are recorded in appendix 1 of this strategy.

When discussing the priority areas for Prioritisation and Collaboration, the following themes arose:

- Understanding our position
- Working with partners
- Streamlining and economies of scale
- Collaborating to address system-wide problems and inefficiencies

These themes, and the feedback received throughout engagement were used to form the priorities of the strategy.

Strategy Development Engagement

Wirral University Teaching Hospital NHS Foundation Trust

Our Financial Strategy is broken down into Four Elements aligned to our Continuous Improvement strategic objective: Processes, Culture & Innovation, Zero-based Budgeting, Productivity-based Budgeting, and Prioritisation & Collaboration

All outputs from the wider engagement were reviewed and a thematic analysis completed. These themes were then reviewed by the finance and procurement teams to develop the key priority areas of focus for the strategy

Our Financial Strategy will shape operational and strategic plans across the Trust over the next three years and guide or journey to benefit our patients

During the workshop, our strategic foundations model of getting the basics right, better and best was used to map out our priorities over the next 5 years

The Chief Finance Officer discussed the development of the Four Elements of the Financial Strategy at Leaders in Touch Forum, and the priorities developed with the finance and procurement teams were reviewed and ratified by the Finance management team

December 2022 → **March 2023**

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Financial Strategy
Key Priorities

2023 - 2026

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Key Priorities

Where we want to be: The Four Elements of the Financial Strategy

The priorities detailed within this section of the document reveal where we want to be in the next three years to achieve maximum benefits across our organisation, to benefit our patients, staff and the population of Wirral.

The priorities are broken down into the Four Elements of the Financial Strategy which are aligned to deliver our Continuous Improvement strategic objective. The detailed outputs from each of the strategy development workshops are recorded in Appendix 1.

Processes, Culture & Innovation

Wirral University Teaching Hospital NHS Foundation Trust

- Encourage a positive culture towards finance at WUTH by celebrating successes and innovations, and reducing negative connotations, through changing our language and approach to staff communication
- Introduce a competency framework to develop financial literacy, understanding of procurement and training opportunities for all roles across the Trust, making finance everyone's business, and achieving Level 3 finance accreditation
- Improve engagement with clinical teams by tailoring financial information to develop understanding of their financial position and trend forecasting at speciality or directorate level
- Introduce a Trust-wide platform for patients and staff to nurture innovative and sustainable ways of working to drive continuous improvement and high-quality patient care

Zero-based Budgeting

Wirral University Teaching Hospital NHS Foundation Trust

- Introduce a methodology to understand the requirements of our target operating model, prioritising a fixed level of resource between functions, and facilitating a gap analysis to inform strategic future planning
- Promoting and utilising digital platforms and Trust-wide procedures to carry out data-driven assessment of current financial position, and what resources are required to deliver our services
- Introduce Zero-Based Budgeting as standard practice for all financial planning procedures, ensuring that we understand the impact of investment, that we are adding value, and can identify opportunities to optimise or redirect our resources

Productivity-based Budgeting

Wirral University Teaching Hospital NHS Foundation Trust

- Develop and embed Trust-wide KPIs to understand the effectiveness and efficiency of our activity to inform financial decision making processes
- Engage clinical teams in managing cost, to ensure costing models are accurate, reflective of the actual experience of clinicians, and that the outputs are used to allocate resources to services
- Work with budget holders to improve understanding of the financial impact of decision making, including workforce, procurement and contract management
- Ensure that changes and improvements made to productivity-based budgeting practices are sustained, and the benefits are realised year on year supporting us to transform for the future

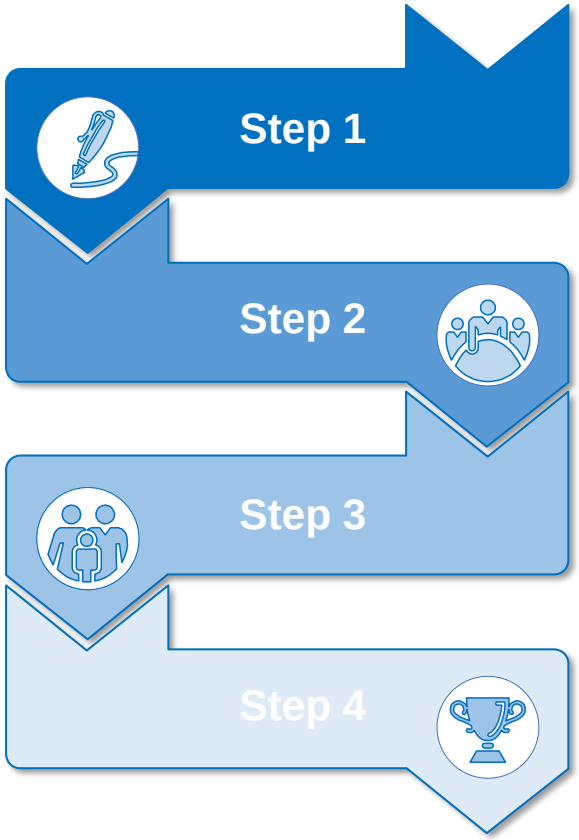
Prioritisation & Collaboration

Wirral University Teaching Hospital NHS Foundation Trust

- Supporting the Trust to strategically review services, and their current and future financial position. Using this to inform the Trust's position within both Wirral Place and Cheshire and Merseyside Integrated Care System
- Facilitate decision making using financial information to aid identification of opportunities for collaboration, understanding the areas we can influence, the areas we can expand, and the areas that may be better led by partner organisations
- Anticipate and influence commissioning at system level and align to the wider strategic direction for population need

Next Steps

How we Get to Where we Want to Be: Implementation, Monitoring and Review



Our staff are the enablers to wider organisational transformation, and will be supported by the finance and procurement teams to translate the financial strategic priorities into operational plans for each year of the strategy.
Progress in delivering the strategy will be monitored through the Finance, Business, Performance and Assurance committee (FBPAC).

Underpinned by our key priorities, an output from our Financial Strategy will be a Medium-Term Financial Model that will, for a three year period, action our financial position, CIP plans, and Capital Programmes.

Our Financial strategic priorities will be carefully selected through robust governance processes involving all key stakeholders across the organisation as part of our annual planning cycle. This will ensure our financial priorities remain relevant to the evolving needs of our patients, support the development of clinical services and support financial sustainability in an ever-changing financial landscape.

Delivery of the operational and strategic priorities will be driven and monitored through existing comprehensive governance structures, providing organisational transparency whilst ensuring the delivery of financial transformation, within agreed timescales and cost constraints.

Appendices

Glossary of Terms
Strategic Alignment
Staff Engagement Outputs

Glossary of Terms

Wirral University Teaching Hospital NHS Foundation Trust

Cheshire and Merseyside Integrated Care System (C&M ICS)
An Integrated Care System brings together the NHS organisations, councils and wider partners in a defined geographical area to deliver more joined up approaches to improving health and care outcomes. Cheshire and Merseyside is one of the largest ICSs in England Within each ICS there is an Integrated Care Partnership and an Integrated Care Board.

Culture
That complex whole comprising of what we know, our beliefs and our behaviours. All of which are learnt. Because culture is acquired and not fixed, it can change.

Finance
The management of our available resources (money), through activities such as budgeting, forecasting, planning and prioritising.

Innovation
The process of generating methods, products or ways of working.

Productivity-based Budgeting (as an element of this strategy)
"We must improve our processes to deliver more activity with less resource. This approach will enable us to address unproductive activities and expand areas of advantage.**"**

Strategy
A plan of action that provides clear direction for all to work towards.

Wirral Place
Local health and social care partners working together across Wirral to improve health and care outcomes and reduce inequality for our population Wirral Place is one of nine boroughs in the region of the Cheshire and Wirral Integrated Care System.

WUTH
Wirral University Teaching Hospital Foundation Trust.

Zero-based Budgeting (as an element of this strategy)
"All costs need to be justified each year. No costs should be incurred unless they are affordable and add value to the services we provide.**"**

Strategic Alignment of Our Four Elements

The Financial Strategy Elements are aligned to delivering the Continuous Improvement priorities specifically, but they will also support the delivery of all Trust strategic objectives.

	Continuous Improvement Priorities	
	Embed a culture of improvement and transformation	Use our resources effectively and sustainably, so we can improve our services
Processes, Culture & Innovation	✔	
Zero-based Budgeting		✔
Productivity-based budgeting		✔
Prioritisation & Collaboration	✔	✔

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Appendix 1: Staff Engagement Outputs

Engagement Outputs