Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public

7 June 2023

together we will

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Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 7 June 2023
Time	09:00 – 11:00
Location	Boardroom, 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	
Items for Decision and Discussion				
5.	Patient Story		Vic Peach	
6.	Chairs Business and Strategic Issues – **Verbal**		Sir David Henshaw	
7.	Chief Executive Officer's Report		Janelle Holmes	
8.	Board Assurance Reports			
	8.1)	Integrated Performance Report	Executive Directors	
	8.2)	Chief Finance Officer Report	Mark Chidgey	Robbie Chapman
	8.3)	Chief Operating Officer Report	Hayley Kendall	
	8.4)	Productivity and Efficiency Update	Hayley Kendall	
	8.5)	Monthly Maternity Report	Vic Peach	Jo Lavery
	8.6)	6 Month Safe Staffing Report	Vic Peach	
	8.7)	Freedom to Speak Up Annual Report	Debs Smith	Tracey Nolan
	8.8)	Guardian of Safe Working Annual Report	Dr Nikki Stevenson	
	8.9)	Board Assurance Framework	David McGovern	
9.	Committee Chairs Reports			
	9.1)	Audit and Risk Committee	Steve Igoe	
	9.2)	Quality Committee	Dr Steve Ryan	
	9.3)	People Committee - **Verbal**	Lesley Davies	
10.	Modern Slavery Statement		David McGovern	

11.	Cheshire and Merseyside ICB Joint Forward Plan	Matthew Swanborough

Closing Business

12.	Questions from Governors and Public	Sir David Henshaw
13.	Meeting Review	Sir David Henshaw
14.	Any other Business	Sir David Henshaw

Date and Time of Next Meeting

Wednesday 14 June 2023, 10:00 – 11:30 (Annual Report and Accounts)

Meeting	Board of Directors in Public
Date	Wednesday 3 May 2023
Location	The Training Room, 2nd Floor, Elm House, Clatterbridge Hospital

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Deputy Chair
CC	Chris Clarkson	Non-Executive Director
SLO	Sue Lorimer	Non-Executive Director
RM	Professor Rajan Madhok	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
JH	Janelle Holmes (from 9:55)	Chief Executive
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell (from 10:00)	Chief Nurse
DS	Debs Smith (from 10:00)	Chief People Officer
MC	Mark Chidgey	Chief Finance Officer
HK	Hayley Kendall	Chief Operating Officer
MS	Matthew Swanborough	Chief Strategy Officer

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
SS	Sally Sykes	Director of Communications and Engagement
EH	Eileen Hume	Lead Public Governor
PI	Paul Ivan	Public Governor
AT	Ann Taylor	Staff Governor
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 9.3

Apologies:

SR	Dr Steve Ryan	Non-Executive Director

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed all present to the meeting. Apologies are noted above.	
2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	

3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 5 April 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 with down syndrome. The patient was subsequently diagnosed with dementia and had to leave employment, he was non-verbal and now had complex care needs. The video story described his parents' story, and his experience of the new Sensory Suite at Arrowe Park Hospital. DH commented about the positive story and the impact the new Sensory Suite can have on patients. DH requested thanks be passed directly onto the team for their work. The Board **NOTED** the patient story.	
7	**Chief Executive Officer's Report** JH highlighted the Care Quality Commission (CQC) undertook a focused inspection of Maternity Services w/c 24 April. The inspection focused on well led and safe domains, inspection teams visited both the Arrowe Park, and Seacombe Birth Centre and a number of interviews held. Informal feedback was expected on 3 May with formal feedback expected in the coming months. JH provided an industrial action update and explained on 2 May the NHS Staff Council voted to accept the latest government pay offer for Agenda for Change staff, which would now be implemented. Royal College of Nursing voted against the pay offer, and it was anticipated their members would be re-balloted for further nationwide industrial action. The British Medical Association (BMA) still had a mandate for industrial action for Junior Doctors, however future dates were unconfirmed. The BMA were likely to ballot Consultants in the next few weeks. JH gave an infection prevention and control (IPC) update and reported the Trust had seen less challenges relating to flu and COVID cases. JH added there had been changes to national guidance on 1 April and Trust polices had been amended to reflect this. A new IPC Board Assurance Framework was released on 17 April and the Trust was undertaking a gap analysis. JH stated the Anaesthetic Department had successfully reaccredited with the Royal College of Anaesthetists Anaesthesia Clinical Services Accreditation.	

	JH reported the Trust declared 4 serious incidents in March and three Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS). JH updated on the Urgent and Emergency Care Upgrade Programme (UECUP) and the signing ceremony on the 22 March 2023. JH added phase 2 of the Modular Theatres at Clatterbridge was progressing and on 20 April two modular theatres were delivered and installed allowing for fitout to commence. The project remained on track. JH referenced the recent Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board and noted the NHS Delivery and Continuous Improvement Review: report of the findings and recommendations had been published. CC queried the number of theatres at Clatterbridge once phase 2 was complete. HK stated there would be 10 theatres at Clatterbridge and a number of other theatres would be refurbished. DH queried if the facilities at Clatterbridge were used by other Trusts. HK stated the Countess of Chester used Clatterbridge regularly and had feedback about the environment and equipment. HK added another hospital in Cheshire and Merseyside was keen to use the facilities at Clatterbridge. DH requested congratulations and thanks be passed onto the Anaesthetic Department for being successfully reaccredited with the Royal College of Anaesthetists. The Board **NOTED** the report.	
8	**Chief Operating Officer's Report** HK provided an overview of the Trust's current performance against the elective recovery programme for planned care and unscheduled care. HK highlighted in March 2023 the Trust attained 110.08% against a plan of 115.1% for outpatients and for elective admissions 110.0% of activity was delivered against a target of 105.5%. HKen provided an update on the number of patients waiting for referral to treatment and priority two performance. HK stated the Faster Diagnosis Standard was 79.81% in February against a target of 75%. HK added 2 weeks wait performance remains below trajectory and the national standard.	

	HK reported unscheduled care type 1 performance was 53.7%, which was in line with the 4-hour improvement trajectory. The increase in Type 1 and Type 3 attendances was significant in March 2023, returning to numbers seen throughout 2022. HK highlighted 28% of the total hospital bed base was occupied by patients that required another care setting. The Trust had a Hospital Flow Programme focussed on improving this position and improving patient and family experience through the urgent care pathways. HK stated ongoing industrial action continues to be a challenge for the Trust and the emergency department, which was likely to have the potential to adversely impact on performance due to staff reductions. DH commented it was positive to hear about the Hospital Flow Programme and noted 237 patients had a long length of stay. HK stated dropping below 160 patients would be challenging until the Home First expansion was complete for September. HK added several patients did not want to leave the hospital and the Trust had to take appropriate steps to address this. SL noted the new Ambulance Arrival Zone was operating and queried if the handover time had improved. HK stated there had been some problems initially which had been resolved. Positive feedback had been received and a standard operating procedure was being embedded. HK added the Trust was expecting improvements for 15-20minute handovers and explained 12hr breaches could continue until the improvements were made. NS commented it was anticipated the number of informal/formal complaints would increase with regard to access to timely treatment. The Board **NOTED** the report.	
9	**Board Assurance Reports** **9.1) Quality and Performance Dashboard** NS highlighted the total amount of level 1 (informal) concerns received in month had increased and was a seasonal pattern. NS stated informal concerns related to communication, capacity, and access to treatment. Staff attitude was an emerging theme and at the Leaders in Touch meeting in April staff were reminded about Trust behaviours and values.	

	TF reported the number of C difficile and gram-negative bacteraemia cases had increased in month. However, this was not expected to be a sustained increase. TF noted the ongoing actions to maintain improvements. TF added the number of care hours per patient day (CHPPD) was improving and this was due to the low Registered Nurse (RN) vacancy rate at the Trust. DH commented about the age demographic of employees at the Trust, particularly the retirement of nurses and it was important to monitor this regularly. DS agreed and highlighted the retention of staff through flexible working and retirement options was a key component of the People Strategy. DS highlighted sickness absence continued to reduce in month but remained above Trust target. Staff turnover also remained above Trust target with more staffing retiring in March as expected. DS added appraisal and mandatory training compliance was achieved in month. SI commented about the upcoming pension changes set out by Government and queried if there had been any increase in the number of staff retiring. DS stated there had not been an increase at this point and the Trust already had flexible retirement options available. DH queried if there was any metrics available regarding the number of staff retiring and returning as agency/bank locums. DH also suggested the Trust consider creating an agency/bank company to avoid paying fees to agencies. DS stated that reporting on this is limited but agreed to circulate the metrics and stated there were enhanced controls in place regarding agency/bank staff. The Board **NOTED** the report. **9.2) Month 12 Finance Report** MC reported the Trust was reporting a deficit of £6.346m, an adverse variance against budget of £6.312m. The variance was attributed to over-spends on employee costs, driven by underperformance in respect of recurrent Cost Improvement Plans (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.	Debs Smith

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

SL commented the Trust had achieved the forecasted deficit position for 2022/23 and the Trust was now in the process of finalising the financial plan for 2023/24.

The Board **NOTED** the report.

9.3) Quarterly Maternity Report

JL provided an update on oversight of the quality and safety of Maternity Services at the Trust. JL highlighted submission of the Maternity Incentive Scheme (MIS) Year 4 was submitted to NHSR by 2 February 2023 and the Trust declared compliance with the 10 Safety Action Standards.

JL gave an update on the Final Ockenden Report and an overview of the three-year delivery plan for maternity and neonatal services.

JL provided the perinatal clinical surveillance data and stated the Trust was not an outlier for neonatal deaths and stillbirths. One serious incident was declared in February 2023 and one Health Care Safety Investigation Branch was declared from an incident in January 2023.

JL reported the exposure to Entonox, noting test results indicated there were no concerns to exposure in 10 rooms, however 1 room was a cause of concern, and this room has been decommissioned until all assurances are in place.

CC noted bereavement support was available to parents and queried if support was also available for staff.

TF stated Pastoral Support Nurses and Maternity Advocates provided bereavement support to both parents and staff.

The Board:

- **NOTED** the report; and
- **NOTED** the submission and the Trust's compliance with Year 4 of the Maternity Incentive Scheme; and
- **NOTED** the Ockenden report update; and
- **NOTED** the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals"; and
- **NOTED** the workforce update with specific reference to the Continuity of Carer model of maternity care and the Trusts

	position to implement this model as a default model of care subject to approval to improving the midwifery establishment; and • **NOTED** the Trusts position in relation to exposure to Entonox	
10	**Declarations of Interest and Fit and Proper Persons Annual Update** DM provided a year-end update on the register of interests, the register of gifts and hospitality, and the fit and proper persons (FFP) regime compliance. DM stated compliance for declarations of interest was 90%, above the best practice figure of 85% and an improvement on the position last year when compliance was 20%. DM highlighted 41 roles/individuals were subject to the annual refreshment for FFP. Annual returns had been received for 39 roles and 2 roles were currently unfilled. SI noted the positive compliance rate for declarations of interest and commented about ensuring gifts and hospitality declarations continued to be declared as the Trust develops its research and innovation agenda with partners. The Board: • **NOTED** the Register of Interests at Appendix 1 and 2 and the Register of Gifts and Hospitality at Appendix 3; and • **NOTED** the update on Fit and Proper Persons	
11	**Committee Chairs Reports** **11.1) People Committee** The Board **NOTED** the report. **11.2) Quality Committee** The Board **NOTED** the report. **11.3) Estates and Capital Committee** The Board **NOTED** the report. **11.4) Council of Governors** The Board **NOTED** the report. **11.5) Finance Business Performance Committee** The Board **NOTED** the report.	

12	**NHS Delivery and Continuous Improvement Review and Recommendations** The Board **NOTED** the report.	
13	**Questions from Governors and Public** No questions were raised.	
14	**Any other Business** No other business was raised.	

(The meeting closed at 10:45)

Action Log
Board of Directors in Public
7 June 2023

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	5 April 2023	5	A report on external communications, particularly social media, to be brought to a future meeting	David McGovern	In progress. Scheduled for July.	July 2023
2.	5 April 2023	9.1	Information on the transformation work being undertaken in facilities to be brought to a future meeting	Matthew Swanborough	In progress. This information will be provided to a future Board Seminar.	September 2023
3.	3 May 2023	9.1	To share any metrics available regarding the number of staff retiring and returning as agency/bank locums	Debs Smith	In progress. A verbal update will be provided at the June meeting.	June 2023

Board of Directors in Public **Item 7**
7 June 2023

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

Report Purpose and Recommendations
This is an overview of work undertaken and important recent announcements in May. It is recommended that the Board of Directors: • Note the report

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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

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

1	**Narrative**
1.1	**Industrial Action Update** The announcement of the 2022/2023 pay award resulted in increased Trade Union activity. In Wirral University Teaching Hospital ballots undertaken by the following unions currently have a mandate for action:

	• Hospital Consultants and Specialists Association (HCSA) – Junior Doctors • British Medical Associate (BMA) – Junior Doctors • Unite the Union – Pathology The Chartered Society of Physiotherapy (CSP) and British Dietetic Society (BDS), who did have a mandate for action, have accepted the recent pay award proposal. The Royal College of Nursing (RCN) mandate has expired, and a new ballot has been opened, which closes on 23 June 2023. A ballot of Consultant members has also been opened by the BMA, which closes on 27 June 2023. The Trust has not yet received any formal notification of further dates for industrial action from any unions holding a mandate, however, a recent announcement has been made by the BMA that further junior doctor action will take place between 14th and 17th June 2023. At the time of writing, the Trust awaits the formal notification from the BMA.
1.2	**Infection, Prevention and Control (IPC) Update** The impact of respiratory infections on the hospital remains extremely low in line with the national picture. Due to the changing picture the World Health Organisation has recently announced that COVID-19 is no longer a Public Health Emergency of International Concern, hence in England the national team have stepped the NHS down from a level 3 incident. As a result, COVID data will no longer be collected, and IPC guidance is expected to change particularly in relation to outbreak management. The Trust awaits further guidance.
1.3	**Registered Nurse (RN) vacancy rates** The Trust has seen a continued reduction in Registered Nurse (RN) vacancy rates over the past 2 years, predominantly due the success of recruiting 280 nurses via the international recruitment programme. In March, the Trust has celebrated the lowest vacancy rate to date, noting the RN vacancy rate at 1.31% and the ward-based RNs rate at 0.74%.
1.4	**Family Integrated Care Award (FICare)** The WUTH Neonatal Team have been awarded the highest green standard of the Family Integrated Care Award (FICare). This was awarded following a rigorous assessment on 23 May 2023 by a panel of experts. FICare is a model of neonatal care that promotes a culture of partnership working between families and staff. This accreditation helps the team assure parents that high standards of integrated care are in place to achieve the best outcomes for the baby and family.
1.5	**Digital Healthcare receives excellence in informatics accreditation** Congratulations to the Digital Healthcare Team who achieved the prestigious Informatics Skills Development Network Level 1 accreditation for "excellence in informatics" at the Connect Conference held at The Grand Hotel in Blackpool in March.
1.6	**Clatterbridge Hospital redevelopment bid** In September 2021, the Trust, in conjunction with Clatterbridge Cancer Centre NHS FT, submitted a bid to the Department of Health and Social Care (DHSC) for the redevelopment of the Clatterbridge Hospital campus. This was part of the DHSC 8 New Hospitals programme.

	In late May 2023, the Trust was informed by DHSC that it had not been selected as one of the 8 New Hospitals. The DHSC had received 128 bids from NHS organisations and prioritised bids carrying significant safety risk relating to Reinforced Autoclaved Aerated Concrete (RAAC). The DHSC thanked the Trust for the bid submission and to continue to work with our Integrated Care Board to explore funding mechanisms.
1.7	**Research and Innovation Education Morning** The Trust held its first Research and Innovation Event on 19 May. The event was opened by the Trust Board Chair and included internal and external speakers from Alder Hey Innovation centre and the Director of Research for Cheshire and Merseyside ICB. The Event showcased the benefits of Research and Innovation for both patients and staff as well as underlining the commitment of the Trust Board to promoting a research culture across the Wirral Healthcare system.
1.8	**Serious Incidents and Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS)** The Trust declared 2 serious incidents in April. 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. There was one incident reported to the Health and Safety Executive (HSE) in April. All RIDDOR incidents are subject to a local review investigation to ensure appropriate action is taken to prevent a similar reoccurrence.
1.9	**System and Place** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** The Leadership Board met on 5 May and a number of key system issues were discussed this month: The Board started its meeting by reflecting on the latest position in respect of industrial action. Hearing from Chris Douglas MBE, Director of Nursing and Care at the ICB, the Board explored the system impact and ICB and regional arrangements for oversight and coordinated response. Linked to this discussion the Board shared intelligence on wider union activity and contact with Boards. The Board agreed to follow up on this outside of the meeting, sharing intelligence and approaches, follow up will take place with individual trusts to understand potential impact. The Board received an update on the work taking place within the CMAST programme for Elective Recovery and Transformation focussed on outpatients. A significant number of C&M patients waiting for treatment are outpatients and this area has rightly, attracted an amount of national planning focus for 2023/4 delivery. A number of planned initiatives and relative performance were discussed.

	The Board then went on to discuss options for and development of a business case for a North Mersey Elective Hub. This programme relates to a multi-year investment from national monies that was signed of by NHSE England in the spring of 2022. Parameters including geographies were set at that time however, detailed plans to release already committed investments needed to be developed this year. A discussion on the need for enhanced capacity and treatment in gynaecology and ophthalmology were discussed and supported in principle. The Board also received final draft copy of the CMAST Annual Work Plan, which has been requested by the ICB for consideration it its Board meeting in May. The plan sets out CMAST's operating environment, approach and priorities and goes on to describe the scope, delivery priorities and any applicable targets for each of CMAST programmes through 2023/4. The Board provided their endorsement to this document and reflected on the need to include CMAST's contribution to the ICB's Financial Recovery Plan as had recently been committed too.

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

Report Author	Janelle Holmes, Chief Executive
Email	Janelle.holmes@nhs.net

Board of Directors in Public
7 June 2023

Item 8.1

Title	Integrated Performance Report
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 April 2023.

It is recommended that the Board of Directors:

- notes performance to the end of April 2023

Key Risks

This report relates to the key risks of:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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	Following further discussion with the Executive Team and the Board, the performance metrics for inclusion, format and title of the report have amended. The metrics are now grouped under the responsible Executive Director, with the relevant CQC domain noted against each metric.

	Please note that the commentary relating to the Chief Operating Officer's metrics can be found in item 8.3, Chief Operating Officer's Report. Grouping the metrics by CQC domain shows the following breakdown for the most recently reported performance: **Summary of latest performance by CQC Domain:**

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	5	2	7
Effective	0	1	1
Caring	2	2	4
Responsive	3	18	21
Well-led	1	2	3
Use of Resources	2	2	4
All Domains	13	27	40

2	Implications
2.1	The issues and actions undertaken for those metrics that are not meeting the required standards are included in additional commentaries and reports.

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

Report Author	John Halliday, Assistant Director of Information
Contact Number	0151 604 7540
Email	john.halliday@nhs.net

Integrated Performance Report - May 2023

Approach

The metrics for inclusion have been reviewed with the Executive Director team.
Performance is represented in SPC chart format to understand variation, and a summary table indicating performance against standards.
The metrics are grouped into Executive Director portfolios, with individual metrics showing under their CQC Domain.
Commentary is provided at a general level and by exception on metrics not achieving the standards set.

Summary of latest performance by CQC Domain:

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	5	2	7
Effective	0	1	1
Caring	2	2	4
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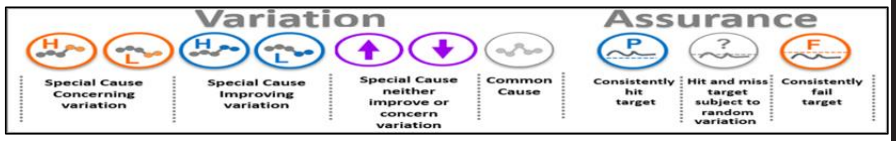
Well-led	1	2	3
Use of Resources	2	2	4
All Domains	13	27	40

Key to SPC Charts:



Issues / limitations

SPC charts should only be used for 15 data points or more. Some of the reported metrics only apply from 2022, so will take time to build up.
SPC format does not support including a target where it is variable over time, eg a reducing trajectory for long waiters.
Alternative formats of charts are included where they are more appropriate.

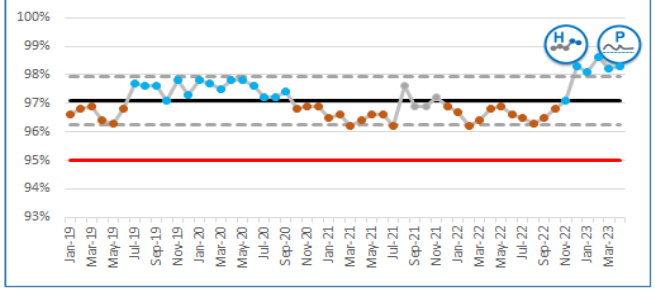
Changes to Existing Metrics:

Metric	Amendment
Clostridioides difficile (healthcare associated)	A new phe target for 2023/24 is yet to be confirmed
Pressure Ulcers - Hospital Acquired Category 3 and above	Change to measure the number of hospital acquired lapses in care Cat 3 and above included HA unstageable
% Appraisal compliance	Likely change of the target threshold to 90% from Q3 2023/24

Medical Director (1)

CQC Domain : Safe

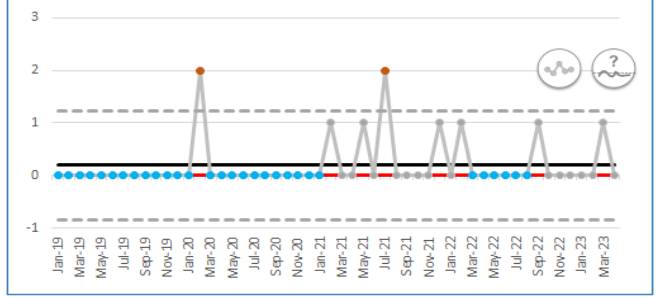
% of adult patients VTE risk-assessed on admission



April-23
98.3%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe

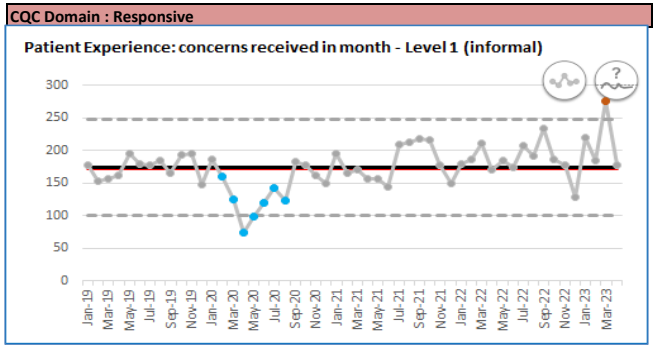
Never Events



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

CQC Domain : Responsive

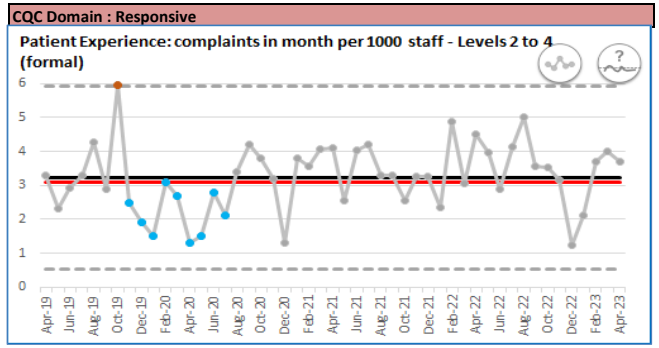
Patient Experience: concerns received in month - Level 1 (informal)



April-23
178
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

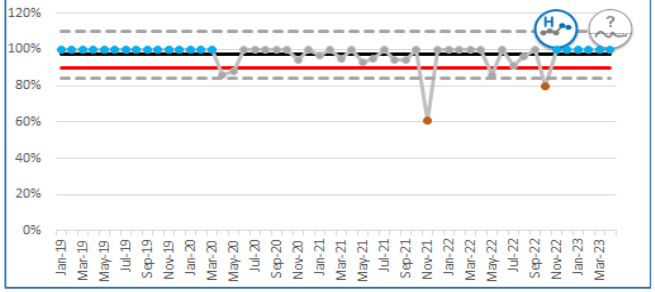
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)



April-23
3.7
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

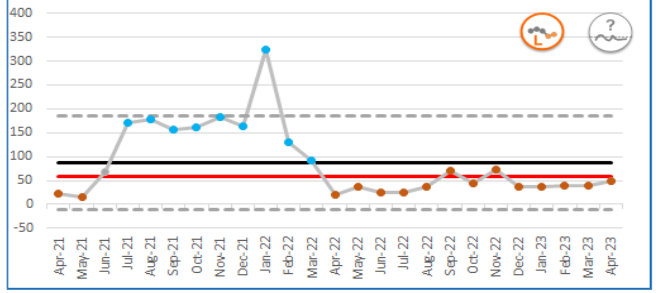
Formal Complaint acknowledged within 3 working days



April-23
100%
Variance Type
Special cause variation - improving
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led

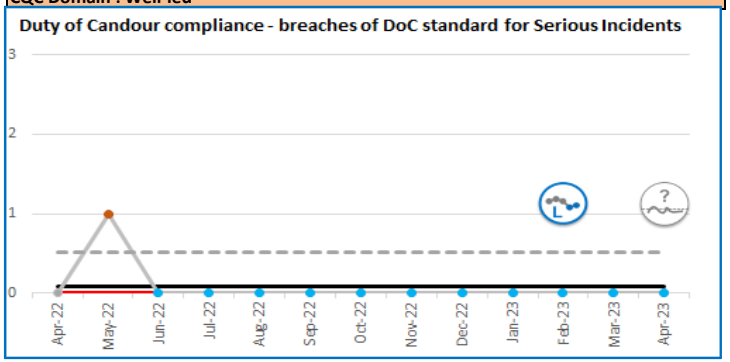
Number of patients recruited to NIHR studies



April-23
18
Variance Type
Special cause variation - concerning
Threshold
59 per mth (700 pa)
Assurance
Hit & miss target subject to random variation

Medical Director (2)

CQC Domain : Well-led



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

Medical Director – for June 2023 BoD

Patient Experience: concerns received in month – Level 1 (informal)

Narrative:
The Trust has set a maximum threshold of 173 informal concerns to be received per month. For April 2023 there were 178 received.

Actions:

Communication failure continues to be one of the most common reasons provided for informal concern. Each division is seeking to address this by review of the divisional communication plans. A high-level communication plan and expected standards has been discussed and will report via PSQB. This will allow oversight of key performance measures around communication with patients, and relatives where appropriate, on admission or transfer across the Trust.

Risks to position and/or actions:

The rate of informal concerns has returned to within natural variation limits, following the spike in March 2023. Whilst there was a significant increase in concerns raised during March the main themes are reoccurring around communication with patients and carers.

Patient Experience: complaints in month per 1000 staff – Levels 2 to 4 (formal)

Narrative:
The Trust has set a maximum threshold rate of 3.1 complaints in month per 1000 staff. For April 2023 the rate was 3.7.

Actions:

Further work is being completed to increase oversight of complaint themes and delivery of associated actions. This will be completed both at Divisional Level and through Patient Safety Quality Board. The current rate of complaints per 1000 staff is slightly above threshold, however has demonstrated the seasonal variation observed in previous years, expecting variations during the last years of pandemic.

During March and April there has been an increase in re-opened complaints and to further understand this position a complainant experience survey has been initiated to understand the experience of raising a complaint and the extent to which complaints are satisfactorily answered. This will also report through the Patient Safety and Quality Board.

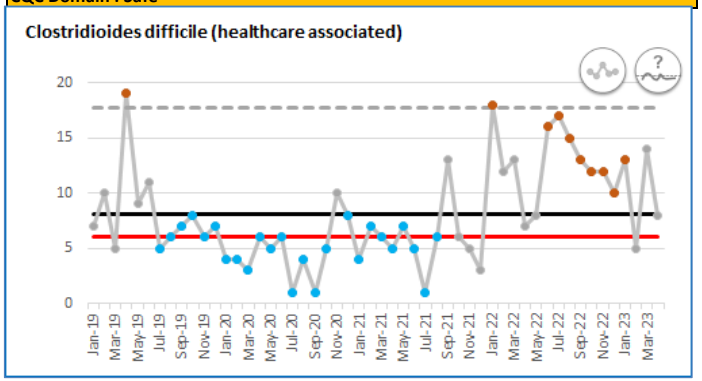
Risks to position and/or actions:

The number of complaints received can be due to a range of factors including but not limited to gaps in care. There were 235 complaint investigations initiated during 2022/23 with 86 being fully upheld. Full analysis and any additional actions will be provided through the complaints annual report.

Number of patients recruited to NIHR studies
Narrative: The Trust has set an internal target of recruiting 700 patient per year, or an approximate 59 per month. For April 2023 there were 18 recruited. **Actions:** Review of all current portfolio studies to understand recruitment barriers and confidence around future trajectory. This will be coordinated by the Research Operational Group. **Risks to position and/or actions:** Research team may require expansion in order to achieve recruitment targets.

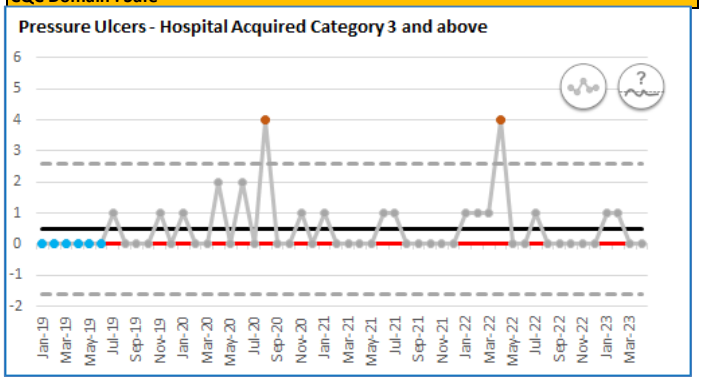
Chief Nurse

CQC Domain : Safe



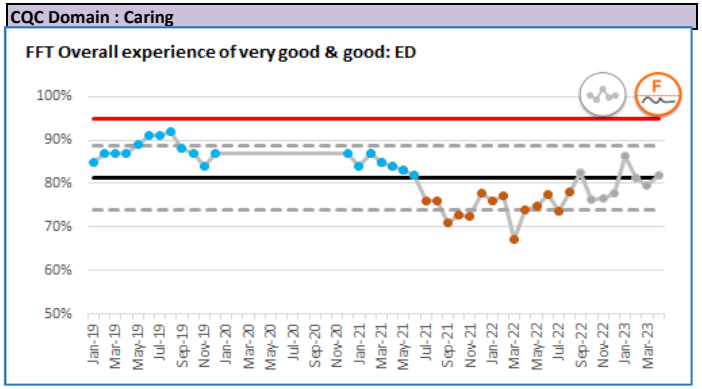
April-23
8
Variance Type
Common cause variation
Threshold
≤6
Assassurance
Hit & miss target subject to random variation

CQC Domain : Safe



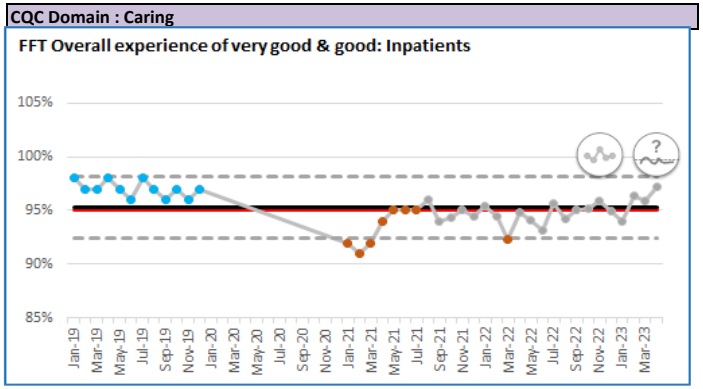
April-23
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



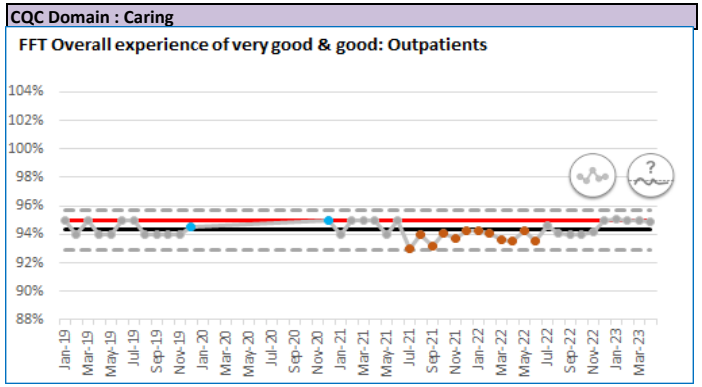
April-23
81.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring



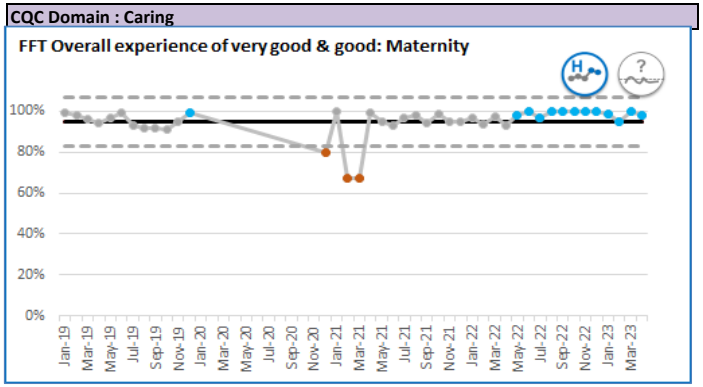
April-23
97.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



April-23
94.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



April-23
95.0%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse – for June 2023 BoD

Overall position commentary

The Trust exceeded its monthly clostridioides difficile threshold by 2 in April 2023. However, the Trust continues to see a downward trend in the number of positive cases reported over the past 12 months. In line with the IPC key priorities the Trust has developed an IPC improvement work plan to further reduce the incidence of CDT over the forthcoming months. To enable oversight and enhance assurance mechanisms the Trust is developing an IPC dashboard within BI to enable visibility across the Trust of key metrics aligned to the IPC Improvement plan.

Pressure ulcers, category 3 and above, that have developed in our care has not exceeded the threshold for exception reporting this month having achieved no pressure ulcers being reported in April 2023. Despite achieving this standard, the trust is striving to reduce this incidence of Pressure Ulcers further through the delivery of a 12-month Improvement work plan overseen by the Tissue Viability Steering Group reporting to Patient Safety Quality Board.

The Friends and Family Test (FFT) is one measure of patient experience, the Trust continues to remain above the national average for FFT figures. However, to enable a richer source of feedback the Trust Patient Experience Strategy and associated Promise groups gains wider feedback from patients and families. The strategy then provides the structure to work in partnership with patients and families to drive improvements across the Trust. Partner organisations have congratulated our approach to patient experience and inclusion.

Clostridioides difficile (healthcare associated)

Narrative:
The national maximum threshold for 2023-24 for the Trust is 71. The monthly threshold was for below 5 or 6 each month, and in April 2023 there were 8 cases, exceeding the monthly threshold by 2.

Actions:

- Review of current improvement plan against learning from thematic review of C *Diff* investigations to determine any gaps and make corrective actions.
- Implementation of a deep cleaning programme (HPV) in additional to cleaning in response to areas with known infections.
- Review processes for use of side rooms to enable prompt isolation.
- Consider the feasibility of having C *Diff* patient cohort area.
- Develop IPC dashboard that incorporates local intelligence, such as light pen results completed at a time in time, inclusive of standards determined within the 36-point checklist.
- Chief Nurse to chair the C *Diff* RCA review and learning meetings to strengthen the process and add credence to the importance of the learning.
- Review Tendable question set and audit schedule against the 36-point checklist.

Risks to position and/or actions:

- Annual threshold may be exceeded.
- Bed occupancy levels may inhibit the ability to implement the deep cleaning schedule and immediate isolation of patients.
- Required additional equipment may not be immediately accessible to enable all ward-based equipment to remain on the wards when deep cleans are being completed reducing the effectiveness.

FFT Overall experience of very good and good.

Narrative:

The Trust monitors FFT experience across a range of care settings, with a target rating of a minimum 95% for good or very good.

Performance against the 95% threshold for April 2023 was:

- Emergency Department (ED) – 81.8% (below threshold)
- Inpatients – 97.2% (above threshold)
- Outpatients – 94.9% (below threshold)
- Maternity 95.0% (above threshold)

Actions:

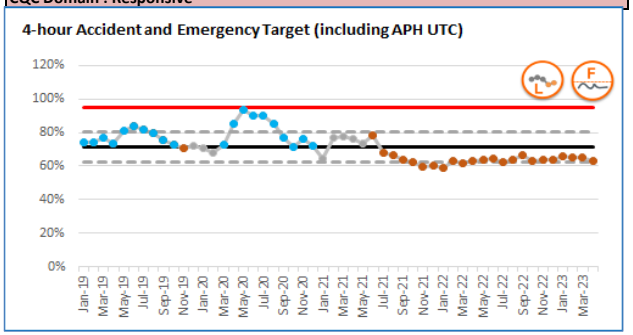
- Improve access to provide feedback via FFT; volunteers to visit ED and out-patient areas.
- Monitor ED FFT performance against national average; we consistently perform higher or in line with this.
- Proactively respond to feedback, make immediate rectifications when able to and encourage participation through Promise groups.

Risks to position and/or actions:

- Bed occupancy impacting on the length of time patients remain within ED.

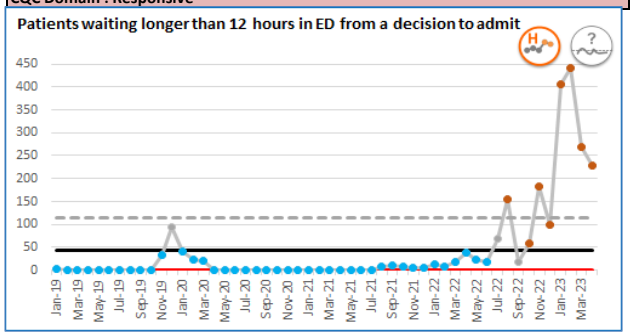
Chief Operating Officer (1)

CQC Domain : Responsive



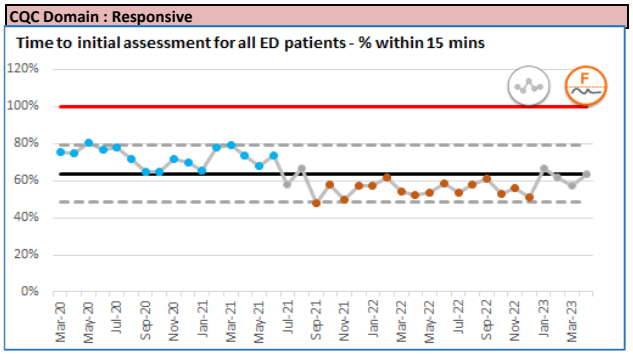
April-23
63.2%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



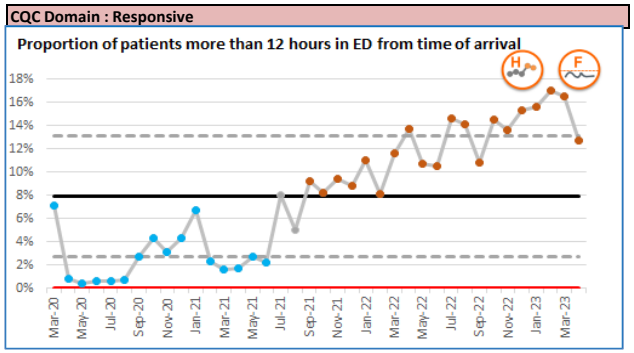
April-23
229
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



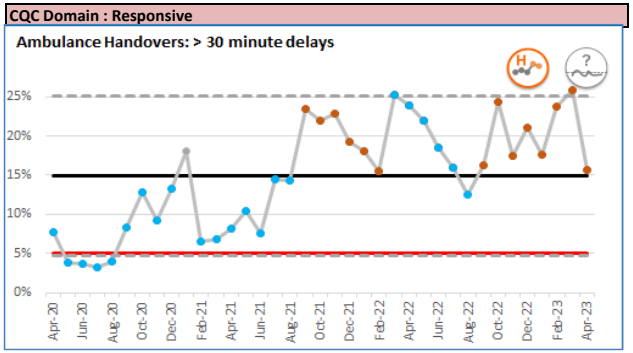
April-23
63.5%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



April-23
12.7%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

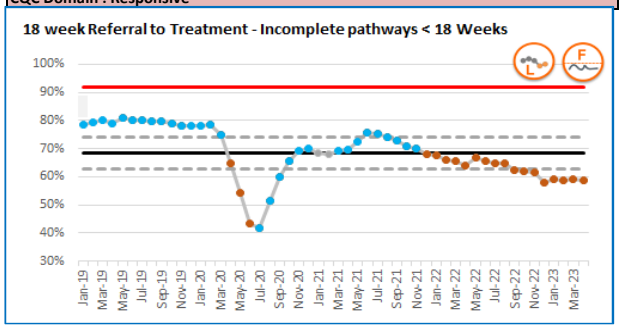
CQC Domain : Responsive



April-23
15.6%
Variance Type
Special cause variation - concerning
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

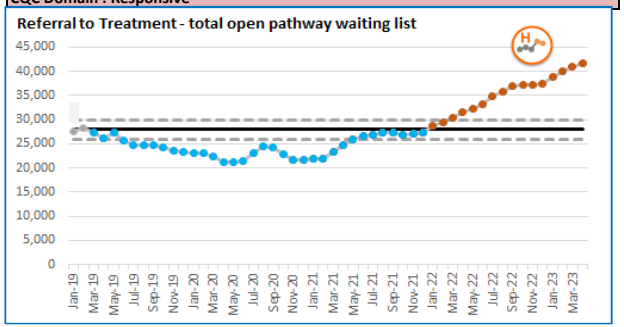
Chief Operating Officer (2)

CQC Domain : Responsive



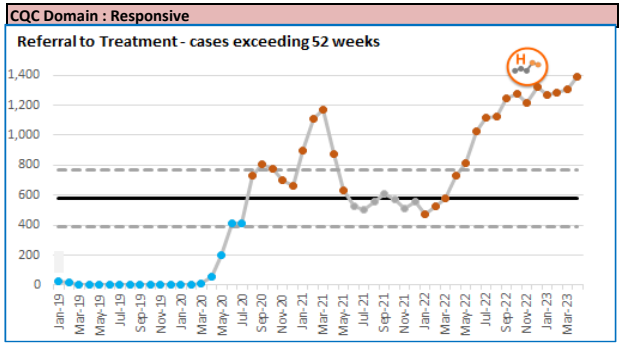
April-23
58.49%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



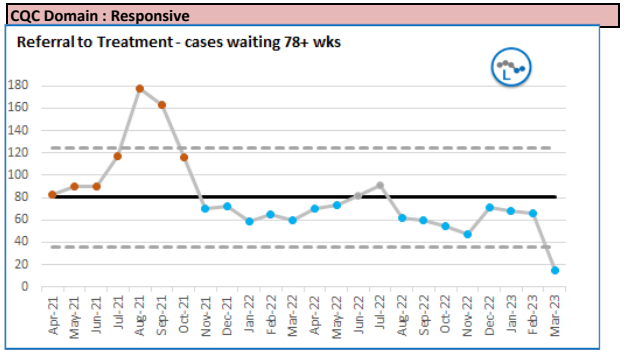
April-23
41721
Variance Type
Special cause variation - concerning
Threshold
≤ 39104
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



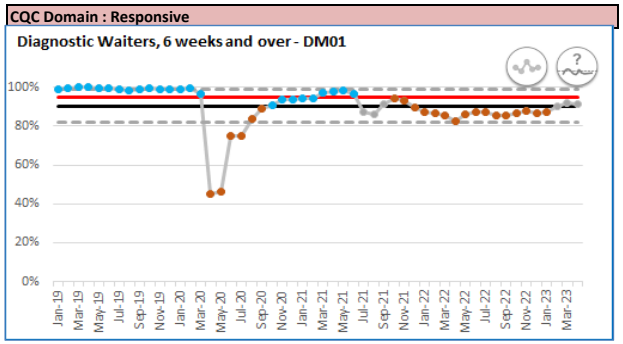
April-23
1388
Variance Type
Special cause variation - concerning
Threshold
1360
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



April-23
15 (all choice / complex)
Variance Type
Special cause variation - improving
Threshold
0 (exc choice / complex)
Assurance
Hit & miss target subject to random variation

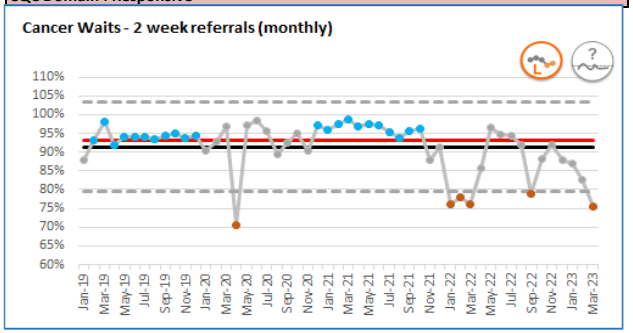
CQC Domain : Responsive



April-23
91.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

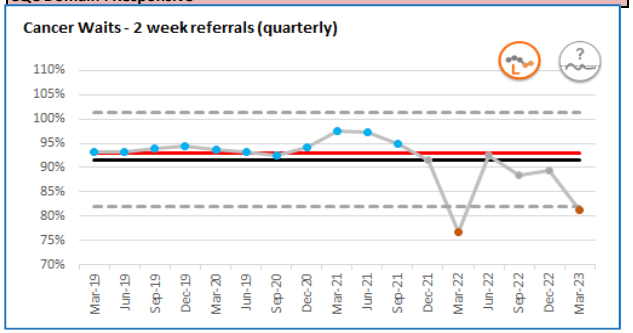
Chief Operating Officer (3)

CQC Domain : Responsive



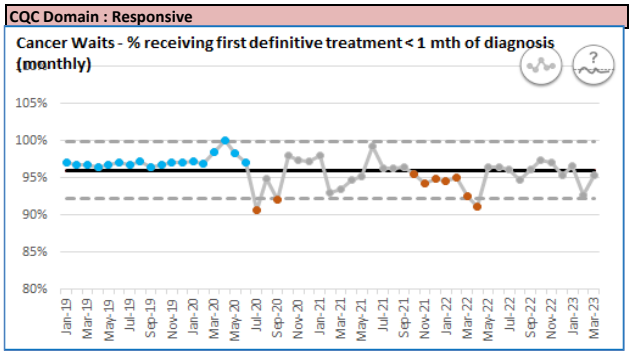
March-23
75.6%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



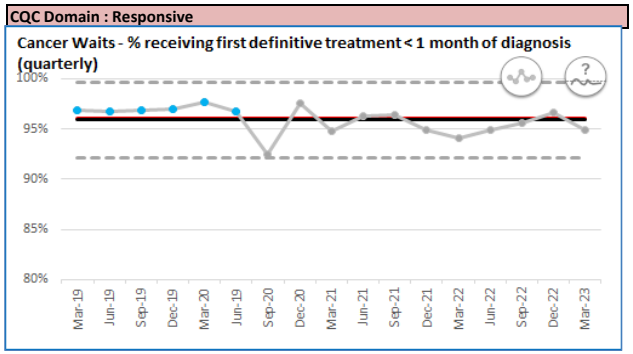
March-23
81.3%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



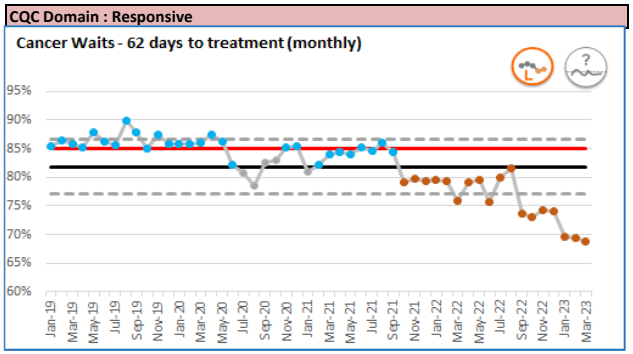
March-23
95.3%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



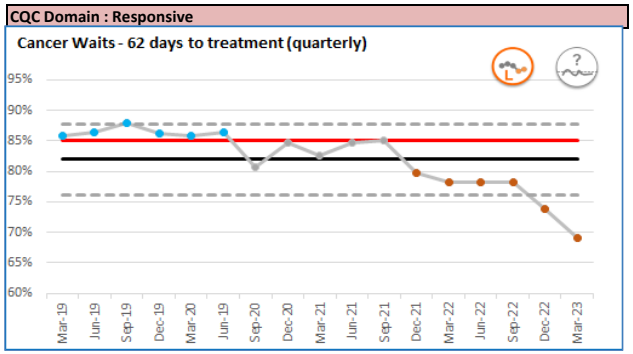
March-23
94.9%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



March-23
68.8%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation

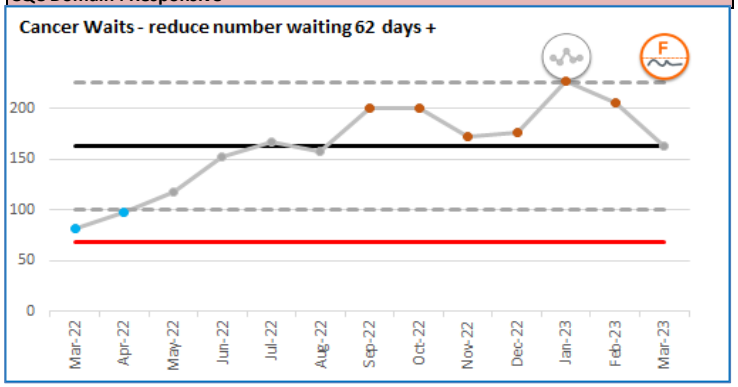
CQC Domain : Responsive



March-23
69.2%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation

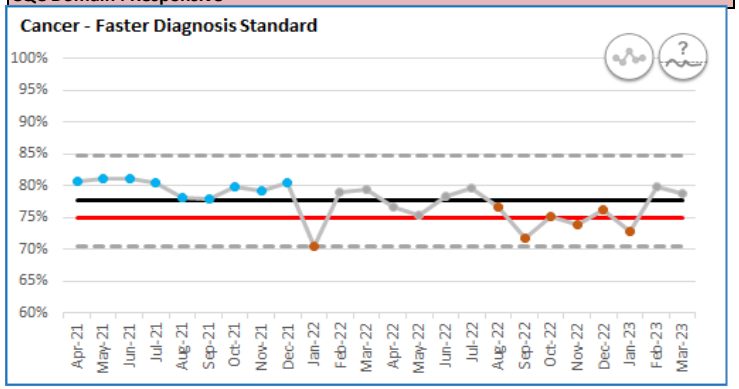
Chief Operating Officer (4)

CQC Domain : Responsive



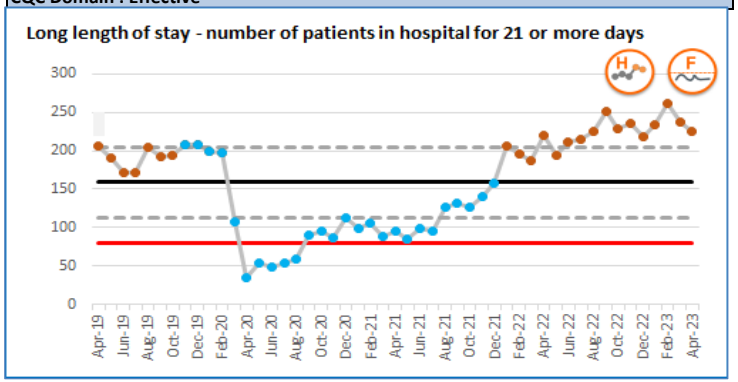
March-23
163
Variance Type
Special cause variation - concerning
Threshold
100
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



March-23
78.9%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

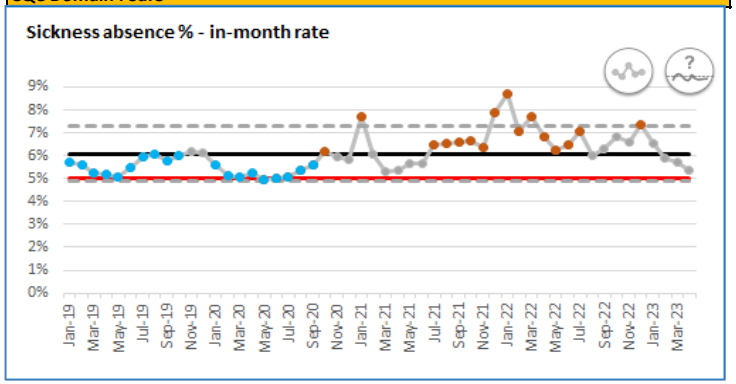
CQC Domain : Effective



April-23
226
Variance Type
Special cause variation - concerning
Threshold
≤79
Assurance
Performance consistently fails to achieve the target

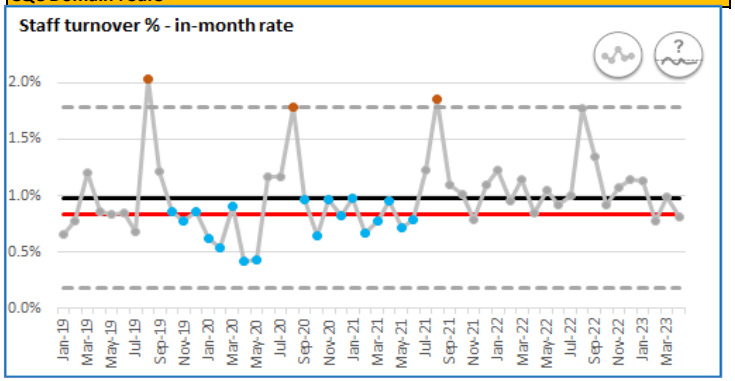
Chief People Officer

CQC Domain : Safe



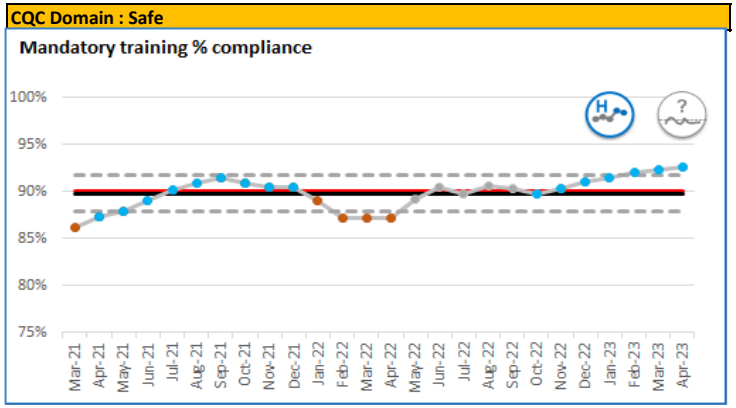
April-23
5.39%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



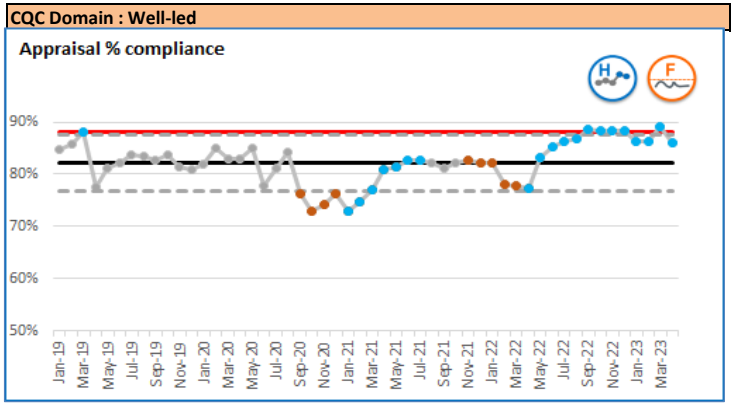
April-23
0.81%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



April-23
92.59%
Variance Type
Special cause variation - improving
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led



April-23
86.04%
Variance Type
Special cause variation - improving
Threshold
≥88%
Assurance
Performance consistently fails to achieve the target

Chief People Officer – for June 2023 BoD

Overall position commentary

Overall, The Trust's People KPIs are continuing to improve with mandatory training maintaining compliance for six consecutive months. In month turnover rate is also below the Trust target. Sickness absence has steadily reduced for four consecutive months, with an overall 2% reduction since December 22. Whilst appraisal rate has slipped below target in April, compliance has been achieved in 5 out of the last 8 months and is significantly higher than this time last year. The focus now is to maintain consistency in improvements across all areas of the Trust.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For April 2023 the indicator was 5.39% and demonstrates common cause variation. Long term sickness absence accounts for 1.29%, whilst short term sickness absence is more of a challenge at 4.10% in April 2023.

Additional Clinical Services are the staff group with the highest absence rate (8%) followed by Estates and Ancillary (7.04%).

Pleasingly, both Corporate and Medicine Divisions are now reporting sickness absence as under the Trust 5% target at 4.07% and 4.64% respectively. Worthy of note is Estates, Facilities & Capital Division who have almost halved their sickness rate in 4 months to 6.66% (compared to 12.28% December 22).

Anxiety, Stress and Depression remains the highest reason for long term sickness absence, equating to 16%. The category ' Gastrointestinal problems' was the highest reported reason for short-term sickness, followed by 'Cold, Cough and Flu-Influenza' and 'Infectious Diseases'.

Actions:

- 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.
- The recent Sickness Absence MIAA Audit recommendations, which focused on manager compliance with Policy, are being implemented
- Several bespoke attendance management training sessions have been delivered.
- Preparation for the re-launch of the Trust's EAP (Healthassured) to improve awareness and increase uptake across the organisation.
- Clinical Psychotherapist led wellbeing sessions are being trialed with a view to roll out across the Trust.
- Work has begun on the transformation of the delivery of Occupational Health and Wellbeing Services to align to the Grow OH Strategy.
- Return to work guidance for all staff with respiratory illness including COVID 19 has been updated and communicated Trust wide.
- Review of data gathered via the wholistic health checks offered to staff in March to inform future actions to support colleagues.

Risks to position and/or actions:

The management of sickness absence is primarily management led supported by the HR team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels and staff morale / engagement. The Trust continues to promote a positive attendance culture by investing in, and focusing on, employee health and wellbeing initiatives to help mitigate this risk by preventing ill health and supporting people to balance work whilst minimising the impact of any ill health symptoms, where possible.
Work continues on delivering the agreed year 2 deliverables within the People Strategy with a number of workstreams which will support attendance across the Trust – such as the modernisation of Occupational Health and Wellbeing service, development of the Trust's flexible working offer and the development of the employee perfect start.

Appraisal % compliance

Narrative:
The target for annual appraisal compliance is 88%. Compliance has been achieved in 5 out of the last 8 months and is significantly improved since this time last year. At the end of April 2023 compliance was at 86.04% of the workforce having received an appraisal in the last 12 months.

Feedback from the 2022 staff survey indicated that appraisal conversations were not consistently adding value for all members of staff and that the annual implementation was not robustly embedded in the Trust. This led to a full review and redesign of the appraisal process. The new process and approach to appraisal was designed by a diverse range of staff groups and roles in December 2022 and piloted during January and February 2023. Following a successful pilot, the new process which incorporates management supervision conversations, referred to as 'Check Ins' provides a more person-centered approach which focuses upon both individuals, 'Contribution (including performance against objectives) and Wellbeing and Development'. Feedback from staff and managers involved in the pilot advises that the new approach and process is more valuable and supportive.

The new process was launched in April 2023, which includes new step by step templates, user friendly guidance and further developmental documentation to aid both staff and managers in the process. An extensive number of awareness sessions have been added to the training directory over the next three months to aid the launch of the new process; these are a mixture of open sessions and targeted sessions for areas of lower compliance.

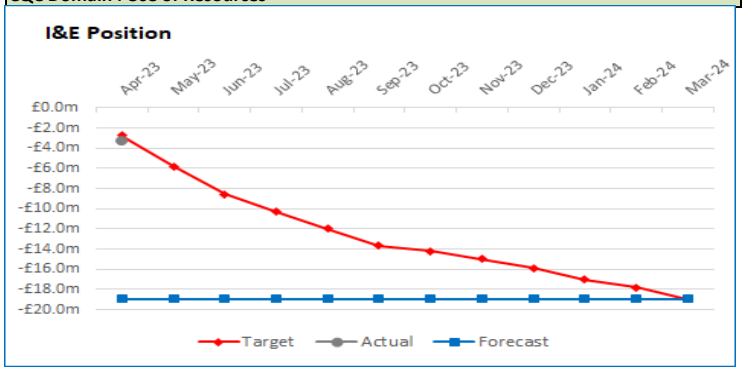
Actions:
- Engagement with Divisional Triumvirates to determine where additional awareness sessions and support is required.
- Ongoing launch and implementation of the new process and communications plan to promote the newly developed process.
- All staff out of compliance to be targeted directly with provision of information on new approach..
- All managers of staff out of compliance will also receive a targeted email with links and a request for them to schedule their appraisal within the current reporting period.
- Refreshed policy is currently progressing through workforce governance processes and is anticipated to be available for launch at end of June.
- ESR developments are underway in collaboration with the national ESR team to simplify recording of appraisals within the ESR system. It is anticipated that this will be available from July 2023.

Risks to position and/or actions:

Capacity to undertake annual Appraisal and record within ESR continue to be challenged by operational pressures. This may be further exacerbated in the short term with the launch of the new approach, whilst managers and staff familiarise themselves with the new process and documentation. However, the new process is in direct response to staff feedback (ref Staff Survey 2022) and is anticipated to provide a more time efficient and person-centered approach (also incorporate wellbeing conversations). It is anticipated that the above actions will mitigate this risk.

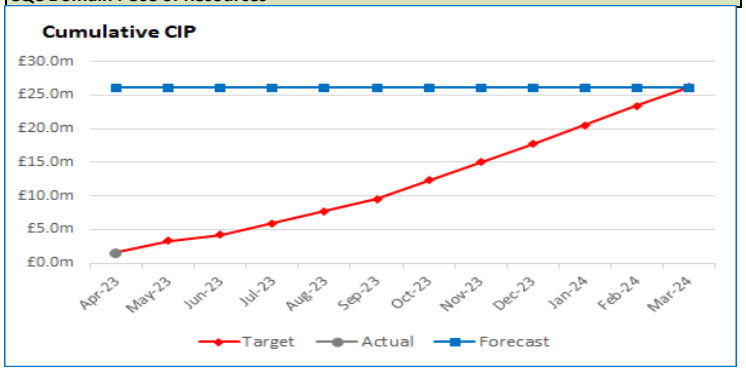
Chief Finance Officer

CQC Domain : Use of Resources



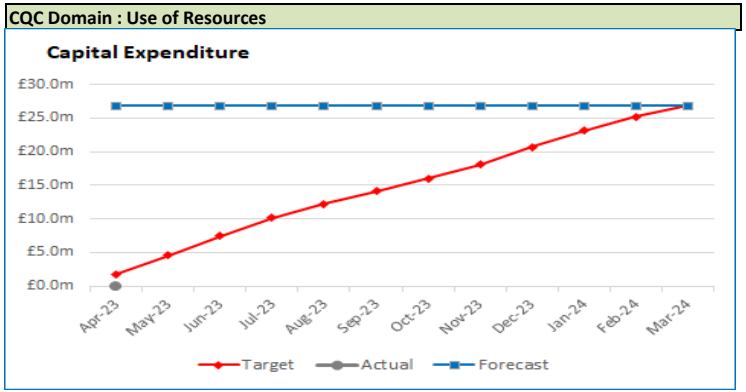
April-23
-£3.3m
Variance
Position worse than plan
Month Target
-£2.8m

CQC Domain : Use of Resources



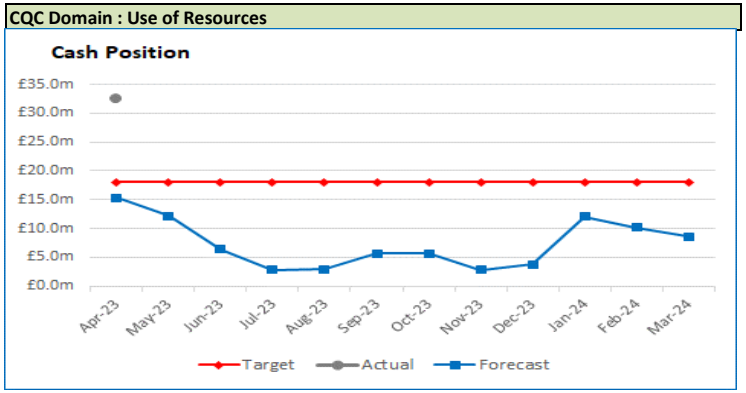
April-23
£1.3m
Variance
Position worse than plan
Month Target
£1.6m

CQC Domain : Use of Resources



April-23
£0.0m
Variance
Position not worse than plan
Month Target
£1.8m

CQC Domain : Use of Resources



April-23
£32.5m
Variance
Position better than plan
Month Target
£18.0m

Chief Finance Officer

Executive Summary

In summary, the Trust is forecasting, with risks, that the financial plan for 2023/24 will be achieved. The key internal risks are CIP achievement and maximising elective capacity whilst the main external risk is the impact of continued strike action. Failure to achieve the financial plan would place significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP).

As the Trust annual plan is a deficit of £18.6m, management of risks against this plan do not deliver long-term financial sustainability. The significant financial improvement required for sustainability will be delivered through the medium term finance strategy approved by the Board in April 2023. Quarterly updates will be provided to the Board on progression of the strategy and the underlying financial position.

The risk ratings for delivery of statutory targets in 2023/24 are:

Statutory Financial Targets	RAG (M1)	RAG (Forecast)	Target Measure	Section within this report / associated chart
Financial Stability			Achieve in-year financial plan	I&E Position
Agency Spend			Agency spend <= 3.7% of total pay	I&E Position
Financial Sustainability			Medium term financial recovery plan	N/A (quarterly update)
Financial Efficiency			Variance from efficiency plan	Cumulative CIP
Capital			Capital spend on track and within CDEL limit	Capital Expenditure
Cash			Positive Trust cash balance	Cash Position

Note – Financial stability is an in-year measure of achievement of the (deficit) plan whereas financial sustainability reflects the longer term financial position of the Trust and recovery of a break-even position.

I&E Position

Narrative:

At the end of April 2023, Month 1, the Trust has reported a deficit of £3.4m against a plan of £3.1m. The main drivers of this adverse variance of £0.3m variance are:

- Strike action, which resulted in both additional expenditure and reduced income.
- Mitigations that have not yet identified for the additional efficiency target agreed with the ICB.

The £0.3m adverse variance has been mitigated by underspends on non-pay expenditure that have resulted from lower than planned activity levels.

The table below summarises this I&E position at M1. This variance is viewed as recoverable in future months and therefore the forecast position remains achievement of the agreed plan (£18.6m deficit).

	Annual Plan	Month 1		
Cost Type	**23/24**	**Plan**	**Actual**	**Variance**
Clinical Income from Patient Care Activities	£440.1m	£35.9m	£34.3m	-£1.6m
Other Operating Income	£28.4m	£3.0m	£2.9m	-£0.0m
Total Income	**£468.6m**	**£38.9m**	**£37.2m**	**-£1.7m**
Employee Expenses	-£339.0m	-£28.7m	-£29.1m	-£0.4m
Operating Expenses	-£169.1m	-£14.4m	-£12.7m	£1.7m
Non Operating Expenses	-£5.9m	-£0.5m	-£0.2m	£0.3m
CIP	£26.2m	£1.6m	£1.3m	-£0.3m
Adjusted Financial Position	£0.6m	£0.0m	£0.0m	£0.0m
Total Expenditure	**-£487.2m**	**-£42.0m**	**-£40.7m**	**£1.3m**
Total	**-£18.60m**	**-£3.078m**	**-£3.415m**	**-£0.338m**

Key variances within the position are:
Clinical Income – £1.2m of the variance relates to planned-care activity cancelled due to strike action and £0.4m relates to PbR excluded drugs and so is offset by operating expenses.
Operating expenses – The underspend mirrors the variances within clinical income.
Employee expenses – The Trust incurred additional expenditure in supporting the safe delivery of care during strike action.
CIP – see separate report.

It is confirmed that the Trust achieved the agency cap as 2.7% of total pay costs related to agency spend compared to a maximum target of 3.7%.

Risks to position:
The main risks to the I&E position are:-

- The Trust fails to fully deliver the recurrent Cost Improvement Programme (see below and separate agenda item).
- Continuation of strike action, with a consequential impact on both expenditure and income (elective activity).
- That the reducing trajectory of patients with no criteria to reside is either not maintained and/or reverts to previous levels.

Actions:
- Full identification and delivery of CIP schemes.
- Maximising elective capacity and recovery.
- Minimising the financial consequences of strike action whilst maintaining the safety of services.

Cumulative CIP

Narrative:
M1 showed strong actual performance with £1.3m actually delivered in month, albeit this is below the target level of £1.6m.

Risks to position:
- That the momentum on identification and delivery of schemes is not sustained.
- That the capacity of the Trust is not sufficient to deliver across all improvement agendas.

Actions:
- Continuation of the Productivity and Improvement Programme as described in agenda item 8.3.

Capital Expenditure

Narrative:
The Trust cumulative target expenditure to the end of April was at £1.8m. There was minimal capital expenditure in M1 and therefore the Trust is underspent against trajectory.

The Capital Programme for 2023/24 which has been endorsed by the committees for Finance, Business & Performance (FBPAC), and Estates and Capital is now appended for final board approval.

The level of capital available for equipment replacement and infrastructure update is very limited and could be committed many times over. As a consequence there will need to be continued review of both schemes and prioritisation decisions. It is proposed that the Board agrees to delegate the approval of any variations to the capital expenditure budget to FBPAC. Monitoring of risks associated with delivery of capital schemes and the overall programme will continue to be reported through the Estates and Capital Committee.

Risks to position:

- That delays and increased costs of significant schemes, such as UECUP, result in the diversion of funding from equipment replacement and the update of infrastructure with a consequential impact on quality of care.

Actions:

- Board to approve the 2023/24 Capital Programme (attached).
- Board to confirm delegation of approval of variation to the capital expenditure budget to FBPAC.
- CFO, with executive team to continue to work with divisions to manage re-prioritisation of schemes within the agreed budget.
- Estates and Capital Committee to continue to monitor progress and risks from capital projects.

Cash Position

Narrative:

The underlying deficit position places increasing pressure on the Trust's ability to maintain a positive cash balance. At the start of 2023/24 cash resources appear strong £32.5m but this is before payment of £18.0m of capital creditors accrued in 2022/23. Payment of these creditors combined with a forecast deficit of £18.6m means that a positive cash balance is only possible by active daily management of the level of debtors and creditors.

Risks to position:

- Achievement of the cash trajectory will place delivery of the Public Sector Payment Policy at risk.
- Failure to achieve the full recurrent CIP plan would mean that the cash trajectory cannot be achieved.
- The low level of cash headroom that the Trust is working within increases the impact of any delayed payment of income due to the Trust.

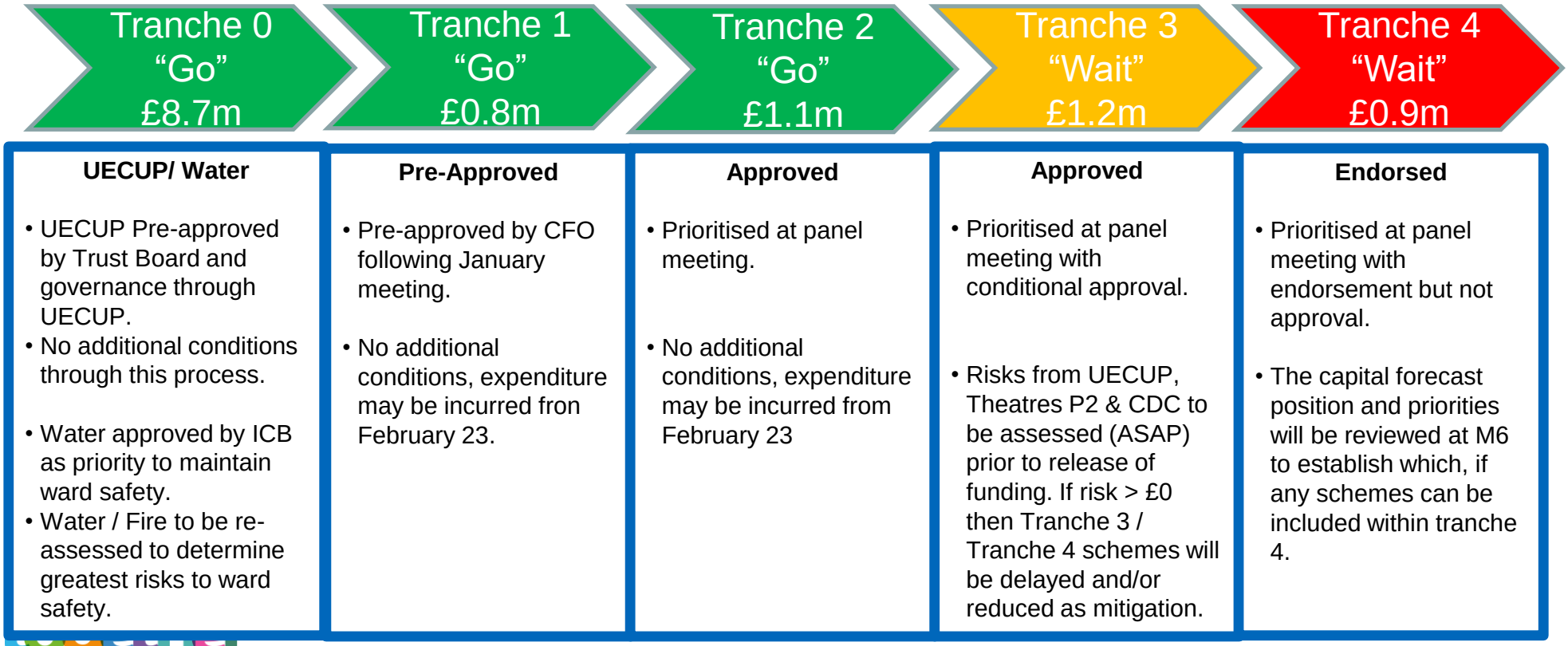
Actions:

- Continued daily monitoring and forecasting of the Trust cash position and PSPP performance.
- Monitoring and escalation of any aged debt delays.
- Confirmation of NHSE process should the Trust be required to request additional cash resource.

1. Summary of Capital Expenditure Plan as reviewed by FBPAC and Estates & Capital Committees

NHS Wirral University Teaching Hospital NHS Foundation Trust

Total Capital Expenditure Budget for Approval - £12.685m



we will

Board of Directors in Public **Item No 8.3**
7 June 2023

Title	Chief Operating Officer's Report
Area Lead	Hayley Kendall, 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.

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** In April 2023, the Trust attained an overall performance of 99% against plan for outpatients and an overall performance of 91% against plan for elective admissions as shown in the table below: 2023/24 Plan Activity Type | Target for Apr | Actual for Apr | Performance Outpatient New | 10,204 | 9,841 | 96% Outpatient Follow Up | 25,975 | 25,933 | 100% Total outpatients | **36,179** | **35,774** | 99% Day case | 3,753 | 3,426 | 91% Inpatients | 588 | 517 | 88% Total | **4,341** | **3,943** | 91% The leading cause for underperformance of the elective plan was the significant numbers of patients that had their treatment cancelled due to the junior doctor's industrial action, which was in the region of 350 patients across the days. The elective plan would have been delivered if the industrial action did not take place.
2.2	**Referral to Treatment** The national standard is to have no patients waiting over 104 weeks in March 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 April against these indicators was as follows: • 104+ Week Wait Performance – zero • 78+ Week Wait Performance - 15 • 65+ Week Wait Performance - 357 • 52+ Week Wait Performance - 1388 • Waiting List Size - there were 41,721 patients on an active RTT pathway which is higher that the Trust's trajectory of 39,104 WUTH have continued to support neighbouring Trusts by offering mutual aid to treat very long waiting patients through the Cheshire and Merseyside Surgical Centre.
2.3	**Cancer Performance**

	Full details of cancer performance is 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. Breast performance was the most challenged tumour group with continued significant increase in referrals on the 2 weeks wait pathway. Accommodating all patients within the 14 days was a challenge during April, however recovery against the target in May for Breast is on plan. • Faster Diagnosis Standard – was 78.86% in March against a National target of 75% by March 2024 which is positive for patient experience receiving timely diagnosis. • 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 2023/24. • The surgical working group, focussing on cancer pathways and long waiting patients, commenced in February and continues with its multi-disciplinary approach in the management of patient pathways at 104 and 62 days, with Urology achieving their trajectory. Further work is ongoing with Colorectal to improve the patient pathway.
2.4	**DM01 Performance – 95% Standard** In April 91.62% 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 non-endoscopy modalities achieved the 95% compliance target apart from Urology which relates to cystoscopy. Endoscopy achieved 93.4% despite significant cancellations due to industrial action and remains one of the highest performing units in the region. Additional capacity continues in Urology and improvements against the 6-week target has been 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.
2.5	**Risks to recovery and mitigations** The clinical divisions are continuously working through options to reduce the backlogs of patients awaiting elective treatment and good progress is being made to improve waiting times for patients. These include the recruitment of new staff, with a focus on consultants, additional activity outside of core capacity. The two major risks to the delivery of the elective recovery programme is the continually high bed occupancy levels and any future impact of industrial action. Industrial action across several disciplines significantly impacted elective recovery in April. On strike days, elective activity was being managed patient by patient to ensure minimal disruption to our patients whilst maintaining safe standards of care across the hospital sites, but there were, unfortunately, large numbers of patients cancelled.

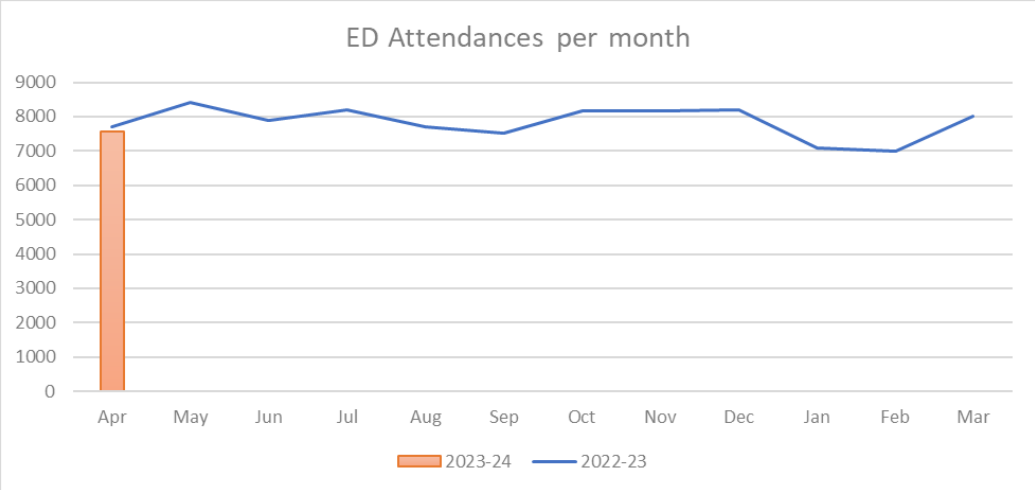
3.0	**Unscheduled Care**
3.1	**Performance** April Type 1 performance was reported at 50.78%, which is below the 4-hour improvement trajectory. Type 1 ED attendances: • 8,018 in March (avg. 259/day) • 7,572 in April (avg. 252 /day)

- 2% reduction from previous month

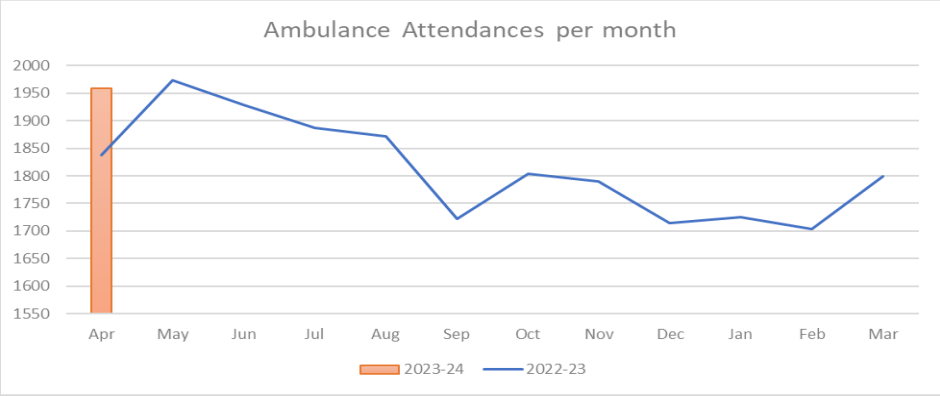
Type 3 ED attendances:

- 2,929 in March
- 2,749 in March
- 3% reduction from previous month

ED Attendances by month 2023/24 compared to 2022/23:

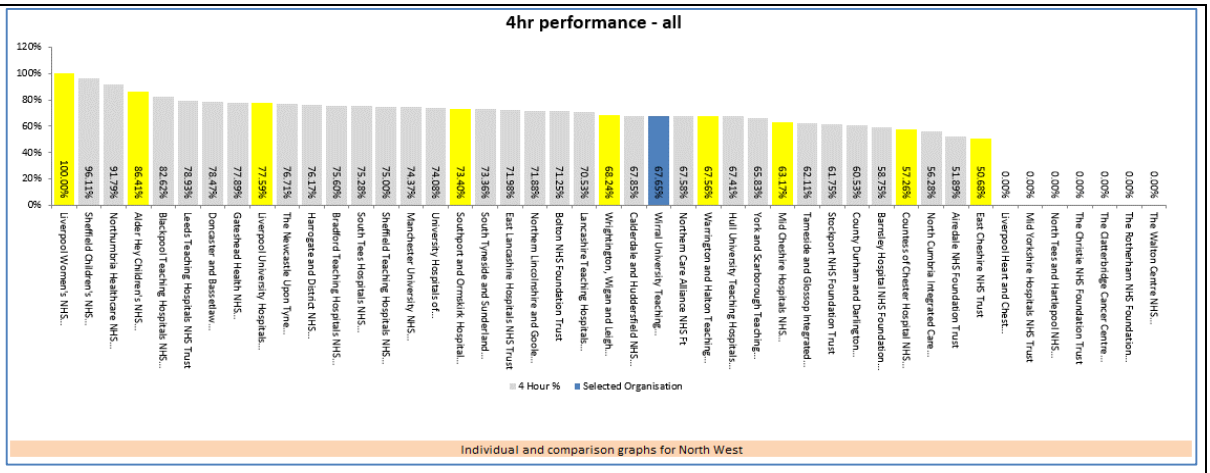


The Trust saw a slight decrease in Type 1 and Type 3 attendances compared to the previous month, however the department saw a significant increase in ambulance attendances. The demand from ambulance attendances was significantly higher than in March and was above April 2022 levels. The Trust is currently working with NWAS colleagues to understand the increase in demand and to forecast whether this demand is likely to continue. This demand resulted in the ambulance arrival zone exceeding capacity on a number of occasions, resulting in at times, patients being cared for in the space for walk in patients.



The impact on the increase in ambulance demand impacts on the ability to provide timely handover to release crews however the Trust remains focused on improving the handover performance with action plans in place.

The graphs below demonstrates Wirral's 4-hour performance for all attendances (blue bar) plotted against other acute providers in C&M (yellow bars):

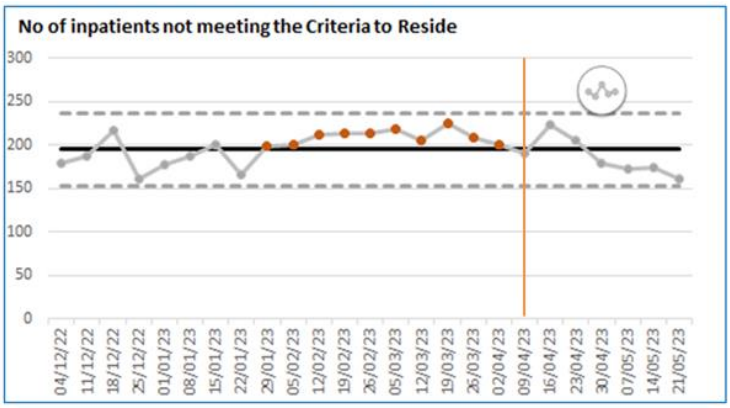


The Trust will continue to focus on the improvement of the delivery of the 4-hour target however as per the national UEC recovery guidance published in January 2023, the Trust will look to focus on the improvement of ambulance handover time (15 minutes) and the reduction in the number of patients breaching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

The ability to enable timely handover will continue to remain a challenge when the department is overcrowded. The Trust is continuing to look at new ways of working and is currently reviewing how the department are implementing ambulatory care and reverse cohorting at times of pressure. The plan would be to implement the polices over the coming months.

3.2 **Discharge Hub development and no criteria to reside**

Since April 2023 the Trust has been developing the creation of the Wirral Discharge Hub which will see the Trust directly leading the complex discharge function, in collaboration with the Local Authority. The transactional improvement work on complex discharges also commenced in April with a view to reducing the number of patients remaining in an acute hospital bed that no longer had a criteria to reside. Since this improvement work commenced the Trust has seen a significant decrease in the number of patients awaiting discharge on complex pathways demonstrated by the SPC below:



The transformational arm of developing the Discharge Hub is progressing well and the project remains on track for implementation in July 2023.

3.3 **Risks and mitigations to improving performance**

Patient flow through the hospital remains the highest risk in delivering a timely UEC pathway and the delivery of the Trust's elective recovery programme. The non-criteria to reside remains the most prominent issue in reducing bed occupancy and good progress is being made to improving this position. Industrial action remains the second biggest risk to the delivery of the Trust plans and will be managed through the Trust's EPRR arm.

	The Trust continues to experience a significant increase in demand with mental health patients, which often exceeds the capacity of the mental health unit based in the ED, posing an increased risk to patients and staff. The Trust continues to work with the local mental health provider to manage the increase in demand and consider how patients can be treated safely and access alternative services where appropriate. The Trust is seeking short-term and long-term response from the local provider to support the increase in demand.

4.0	Conclusion
	The Board should note that although there has been positive improvements in the no criteria to reside position the hospital occupancy remains the most significant challenge. Whilst there is a refreshed Hospital Flow Improvement Programme aiming to deliver improved patient pathways and reduced time for patients in ED, there are still challenges with delivering a number of the UEC metrics. Elective recovery remains a strong point and improvements have been seen across the cancer metrics.

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Board of Directors in Public
07 June 2023

Item 8.4

Title	Productivity and Efficiency Update
Area Lead	Hayley Kendall, Chief Operating Officer
Author	Hope Lightfoot, Associate Director of Productivity, Efficiency & PMO
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board with an update on the current 2023/24 Productivity and Improvement Programme and identified plans to date, along with the ongoing work to identify further schemes to deliver a programme that supports the financial sustainability of the organisation. This report will provide an update on the nine transformation programmes.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key risks:

- Delivery of a sustainable financial position

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

1 CIP Performance YTD

For 2023/24, the Trust has a Cost Improvement Target of £26m. As at the 24th May 2023, 287 opportunities had been submitted by divisional teams with a recurrent in year value of £23.337m against a target of £26.172m. Table 1 below details the forecast divisional split against the target set:

Table 1

	In year position		
Division	**Target**	**Forecast**	**Gap**
Medicine	£5,063	£5,225	£162

Acute	£1,672	£1,848	£176
Surgery	£6,203	£6,396	£193
DCS	£4,332	£2,239	(£2,093)
W&C	£2,130	£1,391	(£739)
Corporate	£2,510	£2,303	(£207)
Estates	£2,783	£2,456	(£327)
COVID	£1,481	£1,479	£0
Trust	**£26,174**	**£23,337**	**(£2,835)**

In month 1, the Trust delivered £1.301m against a target of £1.630m with the main variances being detailed in the following table:

Table 2 details the divisional split at Month 1.

Table 2

Division	In Mnth 1 Target	In Mnth 1 Delivered	Variance
Medicine	£57	£15	(£42)
Acute	£25	£4	(£21)
Surgery	£280	£256	(£24)
DCS	£54	£64	£10
W&C	£26	£42	£16
Corporate	£782	£774	(£8)
Estates	£289	£23	(£266)
COVID	£117	£123	£6
Trust	**£1,630**	**£1,301**	**(£329)**

The full year transacted position at month 1 is detailed in table 3 below:

Table 3

Transacted CIP @M1		
Division	**In Mnth**	**YTD**
Acute	£4	£42
Medicine	£15	£175
Surgery	£256	£2,853
DCS	£64	£770
W&C	£42	£393
Estates	£24	£213
Corporate	£774	£1,747
COVID	£123	£1,479
Total	**£1,301**	**£7,672**

Table 4

Part Year Effect						
Workstream	**Target**	**Red**	**Amber**	**Green**	**Blue**	**Total Identified**
Diagnostics	**£1,000**	£1	£163	£611	£520	**£1,295**
Medicines Optimisation	**£2,048**	£50	£1,355	£157	£0	**£1,562**
Non PBR Income & SLA Management	**£1,000**	£1,045	£104	£47	£100	**£1,296**
One Patient Record	**£2,600**	£107	£41	£0	£208	**£356**
Patient Flow	**£7,000**	£1,592	£1,456	£193	£20	**£3,261**
Procurement	**£4,000**	£668	£1,224	£711	£1,331	**£3,934**
Space Utilisation	**£1,000**	£228	£14	£0	£0	**£242**
Think Big	**£4,000**	£466	£1,085	£232	£2,358	**£4,141**
Workforce	**£7,700**	£720	£3,034	£590	£3,135	**£7,479**
Total	**£30,348**	**£4,877**	**£8,474**	**£2,541**	**£7,672**	**£23,466**

2 Waste Activity Value Efficiency (WAVE): Best value. Best care. Best WUTH.

For 2023/24, transformation workstreams have been established, with the aim of leading and supporting the delivery of major change and cost saving projects across several areas, within the Trust. The WAVE programme is nine workstreams designed to meet the increasing demand for our services, whilst driving value for money throughout the Trust and being the best at making things better.

The four aims of WAVE are:

- Embed “Zero Waste” culture and empower everyone to challenge waste.
- Maximise elective activity through improved productivity.
- Focus our expenditure on services that add value for patients.
- Improve efficiency and drive down costs wherever possible.

The WAVE programme is home to several teams across the Trust, working together to drive improvement and being the best at making things better:

- Productivity & Efficiency and Project Management Office (PMO)
- Operational Financial Management
- Service Improvement
- Digital Health Care Team (DHT)
- Quality Improvement

Starting from June there will be a monthly **WAVE** theme to encourage engagement across the organisation and provide opportunities for staff to propose ways to be more efficient. This will be a starting point with an intention to use feedback from our staff to identify other key themes for improvement to continue our progress. Themes include:

- Energy
- Patient Care
- Equipment
- Facilities
- Paperless

Each workstream has an Executive Lead and lead Director, to direct and manage the development of a plan and implementation of schemes. Workstreams are accountable for the delivery of identified schemes, with targets and the delivery of savings or additional revenue held within individual Divisions.

The 9 transformation workstreams are as follows:

- **Think Big Programme:** Improving theatre, endoscopy and outpatient productivity to deliver more elective activity, reduce waiting lists, improve patient experience and maximising our core session utilisation.
- **Hospital Wide Flow:** Improving hospital flow and patient experience to optimise pathways to get the best possible hospital journey for our patients and treating patients in the right place at the right time, reducing escalation capacity.
- **Workforce:** Ensure sustainable workforce models are embedded within the Trust to deliver optimal patient care by improving recruitment and retention, safe staffing, and best practice and reducing the requirement for premium work.
- **Diagnostics and Reporting:** Reduce reliance on outsourcing and increase internal resilience to deliver timely and accurate reporting to support informed decision making by standardising reporting and embedding a sustainable workforce model.
- **Medicines Optimisation:** Ensuring patients get the right medicines at the right time to embed value-based prescribing and continue best practice by optimising clinical effectiveness and safely reduce wastage of medicines.
- **SLA Management:** Ensure our SLA's are reflective of the services we provide to deliver sustainable care across Wirral by working with clinical and non-clinical staff to ensure value for money.
- **Technology:** Make the best use of the technology within WUTH, reducing the reliance on paper based processes and ensure accurate patient data by utilising digital technology to drive innovation.
- **Space Utilisation:** Make the best use of our estate to deliver accessible services to patients by reviewing our service delivery methods and locations.
- **Procurement:** Improving quality at a lower cost within the patient pathway to deliver value-based procurement by standardising produces and reducing waste.

3 Quality Impact Assessment

All new or existing projects, programmes, savings projects that are worked up in outline and have a potential impact on workforce and/or clinical services are required to undertake a quality impact assessment (QIA) and equality impact assessment (EIA).

They support quality governance by assessing the impact on quality to inform and enable appropriate decision-making.

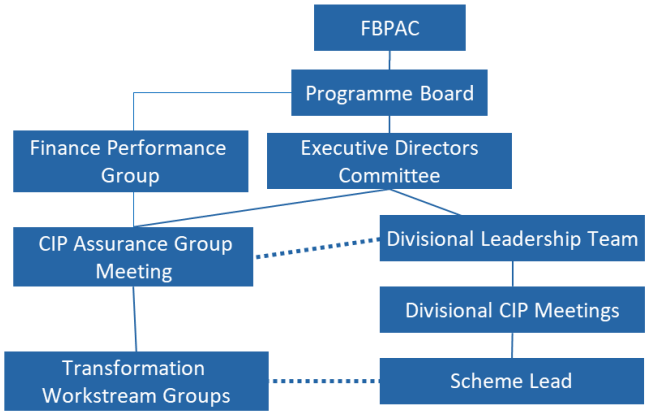
To do this effectively, the right information is needed in order to understand the potential risks to quality and plans must be put in place to ensure action is taken before quality deteriorates or to prevent changes taking place if the risk is too high.

An impact assessment on quality and safety is completed in the planning stage and signed off prior to a change or a project moving into an 'active' phase in line with the project gateways, covering:

- Patient Safety
- Clinical effectiveness

	• Patient experience • Equality and Diversity • Non-Clinical organisational impact • Staff experience The impact on equality and diversity listed above will be assessed on whether people could be treated differently in terms of race, religion, disability, gender, sexual orientation, pregnancy, gender reassignment, civil partnerships, or age. This supports the Trust in meeting its obligations under the Equality Act 2010 to undertake equality analysis. The QIA panel consists of the following advisory roles: • Deputy Chief Nurse • Deputy Medical Director • Deputy Chief People Officer • Head of Quality Improvement • Inclusion and Diversity Lead • Deputy Director of Patient Safety and Governance • Associate Director of Productivity, Efficiency & PMO • Project Leads

4	**Governance**
	The governance and reporting of cost improvement and productivity has been enhanced, with workstream reporting and overall CIP programme reporting on a fortnightly basis to the CIP Assurance Group and monthly to Programme Board. **CIP Assurance Group** To ensure that the work programmes deliver against the target a fortnightly CIP meeting has been introduced, chaired by the Chief Operating Officer, with attendance from Deputy Chief Finance Officer, Divisional Directors, Associate Director of Prod/Eff &PMO and all Corporate support leads. This monitor's weekly project progress report produced by the PMO, weekly finance updates from the operational financial management team and a focused discussion on overdue milestones, key project risks and issues and escalations to Programme Board. **Divisional meetings and Workstream meetings** Fortnightly Divisional CIP meetings are in place with attendance from divisional leads, PMO, finance and corporate support services. **Programme Board** Taking place monthly the Programme Board, chaired by the Chief Executive, receives assurance from each workstream detailing both programme level schemes and divisional CIP projects. High level summaries are provided with divisional updates includes against each of the trust wide workstreams. This forum receives escalations, risks and issues from the CIP Assurance Group. **Reporting** To ensure accurate capture and consistency of reporting, the Finance Team carry out all aspects of CIP reporting, completed through the Finance Business partners aided by

	a CIP transaction tracker. Project management reporting is completed by the PMO and Divisions via Smartsheets. Diagram 1 below details the governance structure. **Diagram 1: Productivity Structure** 

5	Next Steps
	The Executive team will be launching WAVE in the coming weeks via a number of forums to ensure wide communication across the Trust. In addition, the terms of reference for the Programme Board are being reviewed in line with best practice, and terms of reference for the CIP Assurance Group are in development.

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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 8.5**

07 June 2023

Title	Monthly Maternity Report
Area Lead	Tracy Fennell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing and Midwifery (W&C)
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide a monthly update to the Board of Directors of key metrics reported to the Local Maternity and Neonatal System (LMNS) via the Maternity Dashboard.

Included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report (Appendix 1) providing an overview of the latest (April 2023) key quality and safety metrics.

The last quarterly Maternity update to the Board of Directors was received in May 2023, with the next quarterly Maternity update being presented to the Board of Directors in August 2023.

This monthly paper also includes a completed medical staffing risk assessment, which is a requirement advised within the Ockenden Report (Part 2).

This paper reports Terms of Reference have now been agreed for the newly introduced Divisional Maternity & Neonatal Quality & Safety Assurance Group. This group will provide enhanced assurance around neonatal issues and performance to the Board of Directors as outlined in the recently published NHSE Three-year delivery plan (30 March 2023).

The paper also advises the Trust Neonatal Service has just achieved Family Integrated Care (FICare) Model accreditation (green) following reassessment on 25 May 2023.

It is recommended that the Board:

- Notes the report;
- Approves both the risk assessment and the updated medical staffing guidance (both of which have been approved / ratified within the W&C Division) as detailed in action 2.2 of the Ockenden report; and
- Notes the alignment of both maternity and neonatal governance within the W&C Division with the implementation of the Maternity & Neonatal Quality & Safety Assurance Group

Key Risks

This report relates to these key Risks:

- Board Assurance Framework references 1,2,4

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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 of Directors.			

1	Perinatal Clinical Surveillance Quality Assurance Report
	The Perinatal Clinical Surveillance Quality Assurance report for April 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 region (Appendix 1). There are no areas of escalation to note in this reporting period.

2	Ockenden Part II Report
	As presented to the Board of Directors previously, there was one essential action from Part 2 of the Ockenden Report that the Trust was not fully compliant with - this was essential action 2.2: *"In trusts with no separate consultant rotas for obstetrics and gynaecology (O and G), there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level".* There is a regionally agreed an Escalation and Divert Policy for Maternity Services which is now supported by the revised version of the O&G Medical staffing guidance. (Appendix 2) Given the birth rate, WUTH does not warrant a separate O&G medical rota, a risk assessment specifically related to this has been completed (See Appendix 3). Protocols to assess safe medical staffing levels are in place. The review and update of the Medical Staffing Guidance provides guidance thus reducing the risk. The guidance revisions include a review of O&G rota requirements and escalation procedures to cover gaps, whilst utilising the Royal College of Obstetricians and

	Gynaecologists (RCOG) tool. The guidance also includes recommendations regarding O&G medical staffing in key areas including the Delivery Suite. The essential Ockenden action – 2.2 clearly states that the Board of Directors agree both the risk assessment and the medical staffing guidance (both of which have been through an approval / ratification process within the W&C Division).

3	Maternity and Neonatal Assurance
	To further enhance and provide assurance to the Board of Directors in line with guidance set out in the 3-year plan it has been proposed to introduce a Divisional Maternity and Neonatal Quality & Safety Group as a subgroup of the Patient Safety Quality Board reporting to Quality Committee. This will provide further divisional focus and scrutiny to the quality and safety of maternity and neonatal care. The NHSE Three-year delivery plan further enhances the importance of maternity and neonatal collaboration, and that the Board executive/s and non-executive/s have clear oversight of both services.

4	Family Integrated Care
	Family Integrated Care (FICare) is a model of neonatal care that promotes a culture of partnership working between families and staff. Following the release of the FICare Accreditation Tool in late 2021, WUTH Neonatal Unit was assessed in May 2022 achieving an amber status. WUTH was reassessed on 25 May 2023 now has achieved green status. Prior to FICare there was not an approved model of care adopted by the Neonatal Network. The four areas of focus identified within the assessment are - • parental education and support • staff education and support • Neonatal environment • psychosocial support for parents and staff.

4	Recommendations
	On review of the Perinatal Clinical Surveillance Quality Assurance Report there are no reported areas of concern. Further updates will be included in the monthly maternity report to the Board of Directors in July 2023. The Board of Directors are requested to- • agree both the risk assessment and the medical staffing guidance (both of which have been approved / ratified within the W&C Division). • to support the revised governance arrangements, aiding visibility of both maternity and neonatal services to the Board of Directors for discussion and oversight. • note the progress with the FiCare Accreditation and reassessment due in May 2023. An update will be provided to the BoD in August 2023 in the quarterly report.

5	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 Maternity Update to Board of Directors in July 2023. The quarterly report to the Board of Directors will include both maternity and neonatal updates in line with the transformation and the Three-year delivery plan moving forwards. The next quarterly maternity and neonatal update will be provided in August 2023. The Board of Directors note the Neonatal Unit has achieved green FiCare Accreditation following reassessment in May 2023.

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Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	No escalation from SCN / LMNS on outlier report
	Outlier for rates of neonatal deaths as a proportion of birth	no	No escalation from SCN / LMNS on outlier report
	Rates of HIE where improvements in care may have made a difference to the outcome	no	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of SI's	no	x 1 SI declared in Feb 2023; in progress
	Progress on SBL care bundle V2	no	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP. Awaiting confirmation and launch of SBL3
	Outlier for rates of term admissions to the NNU	no	The rate of avoidable term admissions remains low. Regular multi-disciplinary reviews of care take place
Service user and staff	MVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints. Since 20/08/2022, there was no breached complaint responses outstanding and active complaints with the division investigated and responded to well within timescales; To date all breached complaints have been addressed and there is nil to escalate.
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey in progress
	CQC National survey	no	Nil to report this month
	Feedback via Deanery, GMC, NMC	no	Nil to report this month
	Poor staffing levels	no	There are 1.2 wte vacancies in the maternity Band 5/6 staff group: > 2%; workforce paper submitted to exec tam and the continued roll of MCoC model outlining the safe staffing requirements; Band 5 advert for newly qualified Midwives in progress and in addition temporary maternity leave in acticipation of staffing gaps; it should be noted likely to be recruited via newly qualified midwives in September 2023.
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Quality & Safety Lead (8a Clinical Governance) in post commenced April 2023; NNU Matron appointed in Jan 2023
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates
	False declaration of CNST MIS	no	Externally audited by MIAA. MIS Year 4 submission and declaration submitted by 12 noon on 2nd February 2023
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month
Safety and learning culture	Lack of engagement in HSIB or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterly meeting held in Feb 2023; nil to escalate
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident.
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all SI's, local reviews, rapid reviews, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress. Trust wide lessons learnt forum has commenced reviewing themes from SI's, complaints and audits.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations.
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. No exceptions to report. Three year single delivery plan for maternity and neonatal services published 30th March 2023 - gap analysis in progress and will monitored via WUTH CG structure and BoD
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture.
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework.
	Never Events which are not reported	no	No maternity or neonatal never events in January 2023
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales.
Governance processes	Unclear governance processes		Clear governance processes in place that follow the SI framework - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated.
	Business continuity plans not in place	no	Business continuity plans in place.
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month.
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	N/a
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Wirral University Teaching Hospital NHS Foundation Trust

Clinical Guidance

Guideline (P3): Medical staffing (including locum staff) in Obstetrics and Gynaecology including the Consultant Obstetrician duties on the Delivery Suite

Ref: P3

Version Number: 8.1

Full Name & Designation of Guidance Author(s)	Dr L Shaw, Consultant O&G
Version:	9
Ratified by:	1. WCGM
Date Ratified:	TBC
Date Published:	TBC
Date for Review:	June 2024
Target Audience:	All staff working in the Women and Children's Division
Links to other Guidance	

CONTENTS

1.0 INTRODUCTION

Maternity services at Wirral University Teaching Hospital NHS Foundation Trust (WUTH) deliver approximately 3,200 babies per annum and the Neonatal service provides Level 3 Neonatal facilities.
The maternity service currently has 13 consultants who provide 60.5 hours of direct presence on Delivery Suite in line with Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. This document demonstrates how 60.5 hours of Delivery Suite presence is achieved and how consultant presence is evidenced. This is particularly important when there are periods of competing workload, and this document clearly outlines clear processes for escalation and the mitigation of any risk.

2.0 BACKGROUND

Given the number of births at WUTH there is no separate Obstetric & Gynaecology rotas. It is therefore important to ensure job planning is flexible, supportive to differing careers / aspirations and engaging with medical staff.
Staff wellbeing should be prioritised and appropriate supervision and support provided in the clinical setting to meet required competencies.
The importance of multidisciplinary team working cannot be underestimated as positive team working promotes good information flow, effective communication and clinical prioritisation. This in turn ensures timely and effective escalation of clinical concerns, staffing issues and other concerns impacting on quality and safety that are likely to impact on the clinical setting.

3.0 ARRANGEMENTS FOR ENSURING ADEQUATE STAFFING COVER:

Advice and detail regarding ward round provision and handover / huddles are included in the RCOG guidance (May 2022). 60.5 hours of planned Obstetric and Gynaecology (O&G) consultant cover is provided across all seven days of the week, with 24/7 emergency consultant cover availability

3.1 Weekday Cover

3.1.1 Hot Week

13 Consultants rotate so that one consultant provides 42.5 hours of this cover each week.

This week of dedicated Delivery Suite work is termed the “Hot Week” and is from 08:30 -17:00hours Monday to Friday (with an additional30 minutes handover for the ‘on call O&G consultant’).

3.1.2 Weekday Evenings & Overnight

9 O&G Consultants cover the out of hours on call rota.

At 17:00hours, the on call O&G consultant (covering the night) will receive handover with the outgoing hot week consultant until 17:30hours. This handover also includes any input from the multidisciplinary team.

The O&G consultant attends the maternity unit at 20:30hours to conduct the evening multidisciplinary (MDT) handover and ward round, which includes all women on Delivery Suite, women undergoing induction of labour (IOL) and all new admissions during the day to the maternity ward.
This provides additional resident cover of a minimum of 10 hours. An acute ward round of the gynaecology ward is also undertaken when required, which should include any gynaecology patient who is acutely unwell.

3.2 Weekend Cover

There is 8 hours cover provided with a 2.5 hour MDT morning ward round and a 1.5 hour evening MDT ward round (on both Saturday and Sunday).

This above cover is further demonstrated below in Table 1

Table 1:

	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Hours
Hot Week	08.30 - 17.00	08.30 - 17.00	08.30 - 17.00	08.30 - 17.00	08.30 - 17.00			42.5 hours
Resident on call component	17.00 - 17.30 2030 ward round (minimum 1h30)	17.00 - 17.30 2030 ward round	17.00 - 17.30 2030 ward round	17.00 - 17.30 2030 ward round	17.00 - 17.30 2030 ward round	08.30 - 11.00 2030 ward round	08.30 - 11.00 2030 ward round	18 hours
							TOTAL	**60.5 hours**

Delivery Suite facilities include IT access enabling the consultant to access both their e-mails and the electronic patient record system (CERNER Millenium). In the near future it is anticipated that access to the system that records all fetal heart rate traces will be accessible both on and off site.

Delivery Suite work for the O&G consultants includes: -

- Provide direct supervision to doctors in training
- Provide teaching opportunities for the MDT
- Conduct Obstetric/Gynaecology ward rounds including the early pregnancy unit (EPU), Fetal Medicine unit (FMU) ward rounds, including Maternity Triage
- Liaise with the Neonatal service team
- Provide emergency cover for Gynaecology emergencies when the need arises.

In addition to the above the consultant should be in attendance if the following emergencies arise as per RCOG guidance (see Table 2 & Table 3): -

Table 2:

Situations in which the consultant MUST ATTEND
GENERAL
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
OBSTETRICS
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
Caesarean birth for major placenta praevia / abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <28/40
Premature twins (<30/40)
4th degree perineal tear repair
Unexpected intrapartum stillbirth
Eclampsia
Maternal collapse e.g septic shock, massive abruption
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated
GYNAECOLOGY
Any laparotomy

Table 3:

Situations in which the consultant must ATTEND unless the most senior doctor present has documented evidence as being signed off as competent. In these situations, the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor undertaking the procedure.
GENERAL
Any patient in obstetrics OR gynaecology with an EBL >1.5litres and ongoing bleeding#
OBSTETRICS
Trial of instrumental birth
Vaginal twin birth
Caesarean birth at full dilatation
Caesarean birth for women with a BMI >40
Caesarean birth for transverse lie
Caesarean birth at <32/40
Vaginal breech birth
3rd degree perineal tear repair
GYNAECOLOGY
Diagnostic laparoscopy
Laparoscopic management of ectopic pregnancy

Figure 6. Situations when the on-call consultant must attend unless the most senior doctor present is signed off as competent.

 # This includes women in early pregnancy. Consultants should be informed earlier than 1.5 litres if the woman is haemodynamically unstable, has a low body weight, has a low starting haemoglobin, if there is a rapid rate of bleeding or if there are other complexities regarding her care. Should the consultant choose not to attend in person, there should be a full discussion regarding resuscitation of the patient and ongoing management. This should be documented along with the reasons why the consultant has not attended.

O&G Consultant presence out of hours supports the multidisciplinary team with heightened activity, support of complex cases optimising care and outcomes supporting decision making and avoidance in many instances a conflict of priorities.

3.3 Process for Delivery Suite Cover in the Event of Leave

If any annual or other leave occurs when a consultant is rostered to be on a Delivery Suite week then the whole week must be swapped with either another available consultant, or if the cover is for 1-2 days, then a swap can be made with a consultant on non-clinical duties. This should be done a minimum of six weeks in advance, to allow elective activity to be rearranged. It is agreed that no more than six consultants should be off at any one time.

If the O&G consultant covering Delivery Suite is off sick they should inform the Service Co-ordinator and Clinical Service Lead as soon as possible. The Service Co-ordinator will ensure Delivery Suite is then covered by allocating another consultant from either (in order of preference):-

1. Administrative session
2. Gynaecology Clinic
3. Gynaecology Theatres
4. Antenatal Clinic

If the consultant who is absent is due to be on call and provide direct Delivery Suite cover during that time (i.e., evenings and weekends), another consultant will be allocated with agreement to cover the on call.

3.4 Process of Contacting Delivery Suite On-Call Consultant

During working hours of 08:30-17:00hours the O&G consultant is contactable via the consultant on call bleep (to be collected in the reception area of delivery suite by consultant on call).
At other times, they can be contacted by mobile phone. Consultant mobile numbers are available from switch board and a laminated mobile number sheet is available in all areas. It is the consultant's responsibility to ensure their mobile numbers are up to date.

Out of hours 17.00 - 08:30hours, the on-call consultant is contacted via the hospital switch board either through their mobile or home phone numbers. The agreed standard for the timeframe taken for an on-call consultant to attend the hospital in an emergency is 30minutes. Any Consultant who lives more than 30 minutes away should be resident for the duration of their on-call to ensure this standard is met.

3.5 Process of arranging locum cover

If a member of the junior / middle grade medical staff is due to be on call and is unable to come into work for whatever reason then the on call arrangements are as follows;

1. Offer the locum cover to junior medical staff in first instance. If a doctor agrees to cover the shift, then they are relieved of their planned daytime duties, to accommodate sufficient compensatory rest.
2. If no doctor is available to cover the shift, then the medical staffing officer will contact an approved locum agency and the clinical service lead or consultant on call will approve the locum, having reviewed the locums CV. Wherever possible a core group of locums known to the department are to be used. The locum orientation pack should be provided to the locum with orientation and introductions prior to the shift commencing.
3. If this occurs out of hours, then junior medical staff are contacted with regards to their availability.
4. If no-one is available to cover the shift, then the on call consultant will remain resident on the unit and a second O&G consultant will provide additional off site on call support should this is required.
5. Where the junior/middle grade doctor absence is anticipated to be prolonged, cover will be provided either by alteration to the rota frequency (not to be less than 1:7) or locum agency staff. Locum nights will not be consolidated into a single period to avoid a doctor having to work more than 5 consecutive night on calls.
6. Where there is more than two doctors off long term affecting both on call tiers (SHO and registrar) short term adjustments to rotas will be necessary to avoid the possibility of a shift having locums covering both the SHO and registrar tier/s.

3.6 Contingency Plan for severe O&G Consultant staff shortage (please read in conjunction with the Policy for the Suspension and Divert of Maternity Services – Policy P2)

a. Directorate Managers and Clinical Director must ensure that duty rotas allow for adequate planned staffing.
b. During sudden peaks in activity or where there are unexpected staff absences, the Directorate Manager and Clinical Director should review activity in all clinical areas, identify priority and move staff to priority area accordingly.
c. Staff on training, supervision duties, undertaking audits or projects, or working from home will be called in to the unit to support the needs of the service.
d. Consider allocating consultants from other NHS duties.
e. Consideration to the suspension/divert of maternity/gynaecology services for example,. planned non-urgent induction of labour, routine clinics and non-urgent theatre lists must be discussed with the Directorate Manager and Maternity Bleep holder.
f. Consideration to the suspension and divert of Maternity Services as detailed in the Cheshire & Merseyside Escalation & Divert Policy must be made when indicated

NOTE: Within normal working hours discussion regarding escalation and potential divert can be discussed with the Local Maternity & Neonatal System (LMNS) in an attempt to arrange an urgent Gold command meeting. The purpose of such a meeting would be to seek mutual aid if available to prevent any potential divert / suspension of maternity services.

4.0 Monitoring of the O&G Consultant presence on the Delivery Suite.

The hours of O&G Consultant presence on the Delivery Suite are monitored via the Obstetric dashboard, which is reviewed monthly at the Divisional Quality & Safety Board (DQSB) meeting.

In addition, an annual report is undertaken by the Clinical Service Lead (CSL) which is presented to the Women's Clinical Director (CD) and the DQSB meeting.

Any long-term consultant staffing deficit will be addressed through discussion with the CD / Medical Director (MD) and a business plan written outlining the required service requirements.

5.0 REFERENCES

Department of Health. (2007). *Maternity Matters: Choice, access and continuity of care in a safe service*.

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child

Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour*.

Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetists, Royal College of Midwives, Royal College of Paediatrics and Child Health. (2008). *Standards for Maternity Care: Report of a Working Party.*

Ockenden D, (2020) Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust

Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology. Barber JS, Cunningham S Mountfield J, Yoong W, Morris E June 2021 (Updated May 2022)

4.0 RELATED DOCUMENTS

P2 Policy for the Escalation & Divert of Maternity Services

MONITORING COMPLIANCE WITH THE GUIDELINE	
Minimum requirement to be monitored	Auditable Standards – See below
Process for monitoring	Audit of Guideline
Responsible individual/group/committee	W&C Divisional Quality & Safety Board
Frequency of monitoring	Annually
Responsible individual/group/committee for review of audit findings	Obstetric & Gynaecology Audit Meeting and the W&C Divisional Q&S Board meeting
Responsible individual/group/committee for development of action plan	Audit Lead in conjunction with the CSL & Women's CD
Responsible individual/group/committee for monitoring of action plan	Maternity & Neonatal Clinical Governance Group

COMPLIANT WITH:	
1.	Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour
2.	Ockenden – Part 1 & 2
3.	Standards outlined in the RCOG – Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology.

AUDITABLE STANDARDS:	
1.	An annual audit is conducted to assess compliance with 60.5 hours of consultant presence on Delivery Suite per week
2.	All short-term short falls are filled with direct Delivery Suite cover
3	All ongoing short falls are escalated to the Clinical Director and contingency / business plans developed accordingly
4.	An O&G consultant attends Delivery Suite in person when there is eclampsia, ongoing major obstetric haemorrhage, maternal collapse,

	caesarean section for major praevia, vaginal twin delivery, any return to theatre or upon senior midwifery / junior doctor request. This process must be reviewed quarterly.

Previous Review History

Document Review History			
Version	**Reviewed Date**	**Reviewed By**	**Approved By**
1	December 11	M Ellard	DCGSG
2	January 2012	M Ellard/N Gul	DCGSG
3	August 2013	M Ellard	DCGSG
4	December 2014	J Weetch	DCGSG
5	June 2016	M Ellard	DCGSG
6	November 2016	M Ellard	DCGSG
7	June 2020	M Ellard	DCGSG
8	June 2021	A Lawrence	DCGSG
8.1	Jan 2023	L Shaw	DCGSG
9	May 2023	D Edwards	W&C Q&S Board

Current Review History

Date Published	Version No	Review Date	Parties Consulted	Reviewed by	Approved by	Summary of main changes
April 2023	8.1	June 2024		Libby Shaw (Cons O&G)	DCGSG	Inclusion of RCOG consultant attendance table (very minor changes from previous document – version 8)
May 2023	9	June 2024	W&C Senior Management team	Debbie Edwards (Strategic Advisor - Maternity & Neonatal services)	TBC	Changes following a risk assessment and the required changes (as per the May 2023 RCOG document) and as outlined in Part 2 of the Ockenden report.

Risk Assessment regarding the current Obstetrics and Gynaecology

on call rota provision at Wirral University Teaching Hospital NHS Foundation Trust.

Purpose:
The overall purpose of the risk assessment is to outline risk associated with the absence of a separate obstetric and gynaecology rota for the safe delivery of Maternity services at Wirral University Teaching Hospital NHS Foundation Trust (WUTH).

The drafting of the risk assessment is in response to the Trust being non-compliant with essential action number 2.2: Safe staffing and not having previously had a risk assessment (agreed at Trust Board) and for not having a separate Obstetric & Gynaecology rota covering the Trust's maternity service. The essential action also indicates the need for an escalation protocol for periods of competing workload which requires Trust Board approval.

Background:
Part 2 of the Ockenden report (April 2022) outlined essential actions, which have previously been presented at Trust Board including the status of compliance against each of the essential actions. The Trust was not fully compliant with essential action 2.2 which states under the heading of safe staffing that the Trust should have an escalation protocol and risk assessment should the Trust not have separate rota/s for Obstetrics and Gynaecology.

A separate document was not developed but included in existing local policies which have been reviewed and updated to clearly reflect the process of escalation and the process for ensuring safe staffing levels in obstetrics and gynaecology. These relate to midwifery and medical staffing in obstetrics and gynaecology and are policies P2 & P3.

There have been no reported incident of patient harm that relate to a lack of appropriate escalation, lack of consultant presence at times of heightened workload.

At present given the number of births at WUTH there is no indication for a separate obstetric and gynaecology rota, this is not currently mandated therefore this risk has not been scored.

The Trust Director of Midwifery supported the development and implementation of the regional Maternity Divert policy, which was introduced into the Trust in 2018, and more recently in 2021 the Trust adopted the updated Cheshire & Merseyside Maternity Divert policy. This policy clearly outlines the process of escalation within maternity services. The region also introduced weekly (as a minimum) Gold Command meetings in 2021 assessing the status of maternity services regionally.

Current position:
The Women and Children's Division have recently reviewed and updated two separate documents (Policy numbers P2 – Midwifery staffing and P3 Medical staffing in obstetric and gynaecology, to further support timely and effective escalation and these documents are based on the latest guidance from the Royal College of Midwives (RCM, 2022) and the Royal College of Obstetricians and Gynaecologists (RCOG) - Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (May 2022).

Assessment:
The following risk assessment has been undertaken with consideration of existing processes and guidance on the timely escalation of competing workload and the effective prioritisation of workload (including that of the RCM and RCOG).

Issue	Risk	Mitigation / Comments	Risk Rating
No separate Obstetric and Gynaecology on call rota exists in WUTH, as outlined in essential action 2.2 Ockenden Report (Part 2), April 2022: All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals. In trusts with no separate consultant rota for obstetrics and gynaecology there must be a risk assessment undertaken.	1.1 A failure to manage a clinical situation resulting in patient harm when prioritising competing workload in the obstetrics and gynaecology setting, due to staffing levels falling below the minimum levels for all health professionals.	i) The Cheshire & Merseyside Escalation & Divert policy was adopted to support the Trust at times of heightened activity ii) A separate document was not developed but included in existing local policies which have been reviewed and updated to clearly reflect the process of escalation and the process for ensuring safe staffing levels in obstetrics and gynaecology. These relate to midwifery and medical staffing in obstetrics and gynaecology and are policies P2 & P3. iii) There have been no reported incident of patient harm that relate to a lack of appropriate escalation, lack of consultant presence at times of heightened workload. iv) Audit/s have been undertaken to assess the adherence of consultants attending the maternity unit when clinically indicated /required to do so (as per RCOG Guidelines)	4 x 1 = 4 Residual risk with mitigation 2 x 1 = 2

			v) On call consultants are not required to undertaken elective work including elective surgery or elective clinics and do not work off site during the day. vi) Consultants undertake twice daily ward rounds and weekend ward rounds which provides senior leadership and, in some instances, pre-empts any problems, these also provide additional support to junior staff/middle grade staff. vii) Two band 7 midwives are on duty at any one time which includes the supernumerary labour ward shift coordinator / bleep holder out of hours. viii) MDT handovers taken place at the end of shift with the potential to call an MDT huddle during the shift should the need arise – this includes medical staff from obstetrics & gynaecology, midwives, neonatology staff, theatre and anaesthetic staff. ix) Separate elective and emergency teams work in theatre which further mitigates any risk / delay in performing an emergency caesarean section. x) MDT training through Prompt – supports multidisciplinary working and clear processes for timely and		

		effective escalation. Training also includes importance of active listening and situational awareness. Compliance with the training is over 95% of staff. xi) Effective flexible job planning is in place with any rota gaps filled as per RCOG guidance outlined in policy P3. xii) Where there is a need to roster a locum to cover a gap in the rota the Locum orientation plack is shared to further orientate and support the individual.	
	1.2 A failure to demonstrate compliance with essential action 2.2 Ockenden Report (Part 2), April 2022.	Whilst this was an initial risk the Trust will be complaint once the risk assessment and P3 policy have been seen and signed off at Trust Board in August 2023.	1 x1 = 1
	1.3 Consultant requesting to continue covering both specialities – obstetrics and gynaecology	Skillset kept up to date to provide emergency cover in both specialities. Out of 13 consultants 7 cover obstetrics which is supported, and competencies maintained.	N/A
	1.4 The need for additional resource should the need for a separate rota be mandated	At present given the number of births at WUTH there is no indication for a separate obstetric and gynaecology rota, this is not currently mandated therefore this risk has not been scored.	N/A

All of the above risks identified have been reviewed and scored appropriately below using the Trust Risk Matrix and the overall risk score was calculated and noted below. The risk score includes a range of risk scoring dependent on interpretation of the impact.

Support through effective escalation locally and regionally as per the Escalation and Divert policy and with adherence to local policy a summary of the impact and risk of the above with mitigation is 2 x 1 = 2.

Recommendation/s:
Following a review of the above risk/s it is recommended that

- Approval of policies that have been reviewed and updated as detailed above will be ratified at the next DMB meeting in May 2023.
- Approval of the policy for medical staffing in obstetrics and gynaecology (Policy P3) and the risk assessment detailed above to be presented and agreed at the next monthly Board meeting in June 2023.
- Continue to work locally and regionally in ensuring effective escalation in the event of heightened workload within maternity services.
- The divisional triumvirate to explore with the executive team the potential of a buddy system with neighbouring organisations to support the provision of a second opinion should this be requested by the patient.

Completed by :

Dr Libby Shaw, Consultant Obstetrician and Gynaecologist / Clinical Lead for Maternity services
Dr Mustafa Sadiq, Consultant Obstetrician and Gynaecologist / Clinical Director for Women's services
Jo Lavery, Divisional Director of Nursing and Midwifery / W&C Division
Debbie Edwards, Strategic Advisor for Maternity & Neonatal Services

Date: 22 May 2023

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.6**

07 June 2023

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

Report Purpose and Recommendations

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

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

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to the key risk:

- Risk 1598: Clinical Support Work (CSW) staffing levels are inadequate due to high levels of vacancies and sickness combined with extreme bed pressures; having potential detrimental impact on patient safety, fundamental care not being delivered to the desired standard, staff satisfaction and patient experience.
- Risk 1599: Registered nurse (RN) staffing levels are at risk of falling below optimal numbers due to attrition, the need to respond to unplanned demand, and staff absence.

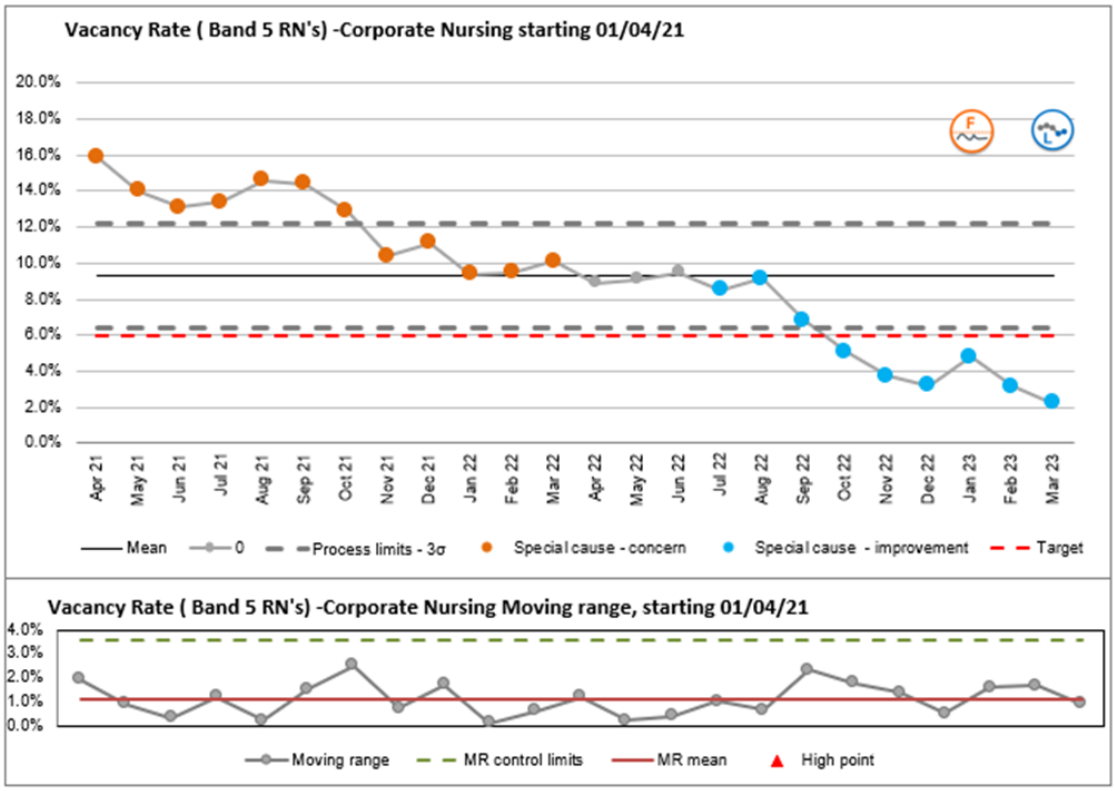
Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes

Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	Yes

1	Narrative
1.1	**Background** Trusts are required to comply with the National Quality Board (NQB 2016) guidance, which states that providers: • Must deploy sufficient suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively. • Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service to always keep them safe. • Must use an approach that reflects current legislation and guidance where it is available. These expectations form part of 'Developing Workforce Safeguards' (NHSI 2018), along with other recommendations for consideration to provide a triangulated approach for the review of staffing requirements. Trusts must demonstrate that they have used the following three components as part of their safe staffing reviews: • Evidence-based tools (where they exist). • Professional judgement. • Outcomes.
1.2	**Governance** Alongside the regulatory requirement to undertake a formal 6 monthly review of nurse staffing establishments, a bi-monthly safe staffing report is presented to the People Committee. The bi-monthly report provides an oversight regarding the visibility of safe staffing assurances including any known consequence on patient care, safety, or experience. Included is a comprehensive dashboard providing a month-by-month review of a range of patient outcome measures, workforce data, care hours per patient day (CHPPD) data, shifts that are 'red flags', and patient experience metrics. Risks are identified with mitigations and plans being put in place to enhance staffing assurances. The bi-monthly report provides narrative and statistical process control (SPC) charts based on the data within a staffing assurance dashboard, included as appendix 1 of this report.
1.3	**Vacancy** **Registered Nurses (RN)** The recruitment of internationally educated nurses has been a significant success with a total of 280 nurses recruited and enabled to successfully register with the Nursing and Midwifery Council during 2021 and 2022. This has resulted in sustained improvement and the lowest vacancy rate for Band 5 RN posts recorded in M12 at 2.25% (chart 1). Focus on retention alongside local RN, and consideration of international, recruitment is a key priority to maintain the positive position.

Chart 1: Vacancy Rate for Band 5 RN Trust Wide



The significant achievement in relation to the RN vacancy rate improvement is evident in the comparative data across the region with the Trust reporting one of the lowest RN vacancy rates (table 1).

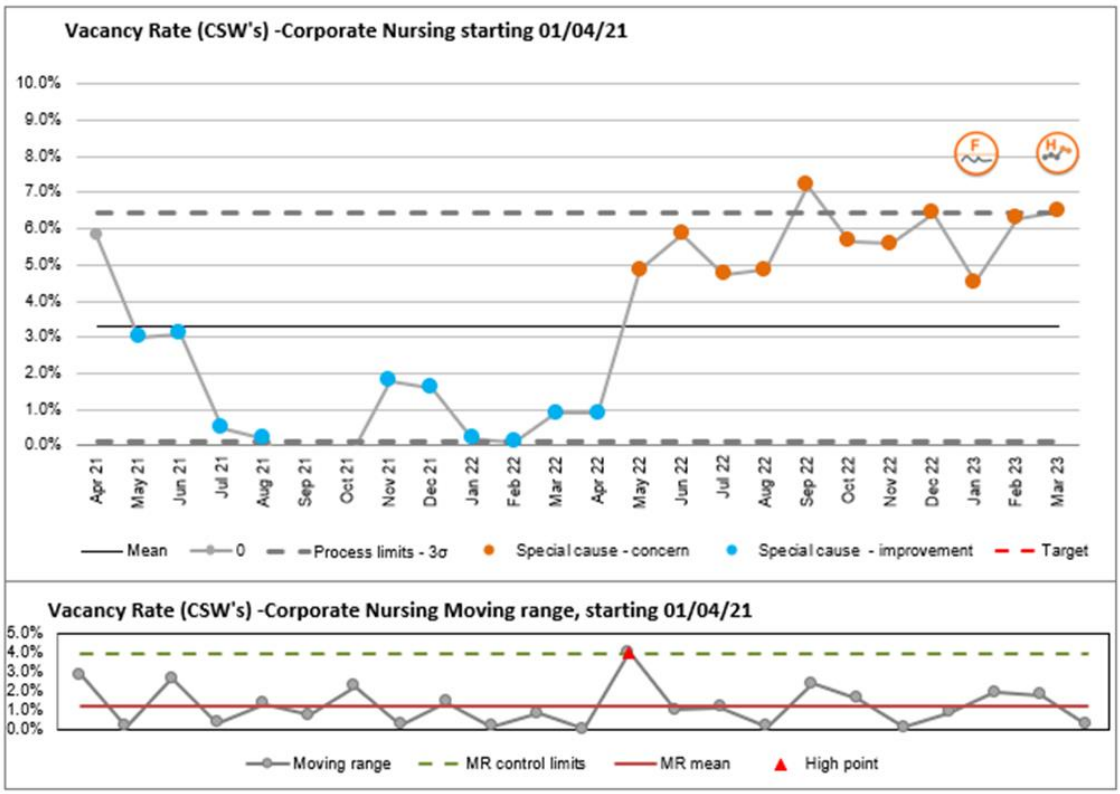
Table 1: Regional Comparison of RN and Clinical Support Worker (CSW) Vacancy Rates (N.B *These are the current available figures- M 10).

Trust Name	Sector	HCSW vac rate M10	HCSW vac WTE M10	RN vac rate M10	RN vac WTE M10
Southport And Ormskirk Hospital NHS Trust	Acute	17.00%	75.7	4.00%	40
Countess of Chester Hospital NHS Foundation Trust	Acute	16.30%	141.4	6.20%	76
Lancashire Teaching Hospitals NHS Foundation Trust	Acute	15.00%	225	0.40%	10
Manchester University NHS Foundation Trust	Acute	14.50%	485.8	3.40%	307
Mid Cheshire Hospitals NHS Foundation Trust	Acute	14.30%	126.3	8.40%	129
Warrington and Halton Teaching Hospitals NHS FT	Acute	11.10%	64.8	16.10%	196
East Lancashire Hospitals NHS Trust	Acute	10.30%	158.6	8.60%	237
Liverpool University Hospitals NHS Foundation Trust	Acute	10.10%	192.2	8.60%	318
Bolton NHS Foundation Trust	Acute	9.80%	70.6	11.10%	223
East Cheshire NHS Trust	Acute	7.70%	28.5	8.50%	63
Northern Care Alliance NHS Foundation Trust	Acute	7.70%	209.4	0.00%	1
Tameside and Glossop Integrated Care NHS FT	Acute	6.20%	40.1	4.70%	54
Wrightington, Wigan and Leigh NHS Foundation Trust	Acute	5.60%	62.7	4.60%	87
Wirral University Teaching Hospital NHS Foundation Trust	Acute	4.80%	41.7	2.90%	49
Blackpool Teaching Hospitals NHS Foundation Trust	Acute	4.40%	56	4.60%	112
Stockport NHS Foundation Trust	Acute	4.30%	38.3	11.70%	211
St Helens And Knowsley Teaching Hospitals NHS Trust	Acute	1.70%	15.4	7.90%	161
University Hospitals of Morecambe Bay NHS FT	Acute	0.00%	0	4.20%	94

Clinical Support workers (CSW)

As highlighted in the last report CSW vacancy rates increased in 2022 – 2023 (chart 2). This was due to an increased establishment, this aligns with the need to balance the establishments with cohorts of internationally recruited nurses supporting the CSW workforce whilst awaiting their registration, and the attrition of staff to retail and hospitality sectors following the Covid – 19 pandemic.

Chart 2: CSW Vacancy Rate Trust Wide



Effective recruitment and retention of CSWs continues to be an area of focus, even though we have comparatively lower vacancies than a high proportion of our regional peers (table 1).

Collaborative system wide recruitment events for CSWs have been led by our teams, the success is evident in curtailing the upward vacancy trend (chart 2). Understanding the specific areas of need for CSWs has enabled targeted recruitment, and individual conversations, to attract staff with the right skills and interests. This is evident in the improving position of inpatient CSW vacancies (table 2). Therefore, bimonthly reporting has commenced to disaggregate the inpatient CSW vacancies from the Trust total. The success of the focused recruitment approach for inpatient areas will be replicated to non-bed-based areas, such as theatres, to improve recruitment where needed.

Table 2: CSW Ward Based Vacancies

CSW In-patient Vacancies		
Month	WTE vacancies	%
Nov 22	83.88	12.92
Dec 22	61.37	9.37
Jan 23	48.97	7.49
Feb 23	42.49	6.50
March 23	31.41	4.8

2 Establishment Review

2.1 Process

The Trust has a standardised approach to establishment setting within the adult inpatient wards. This consists of reviewing an 80 plus indicator establishment template that enables triangulation and scrutiny across nurse sensitive indicators, acuity and dependency results, workforce metrics, quality impact measures, and financial and operational plans. These templates are used to consult with each localised leadership team inclusive of ward managers, matrons, and associate directors of nursing. Proposals are then presented by the Divisional Nurse Director of each division at a confirm and challenge meeting with the Chief Nurse, Deputy Chief Nurse and supporting specialist leads and finance representatives.

The Trust undertakes acuity and dependency audit within the adult inpatient areas in line with guidance every 6 months using the Shelford SNCT audit tool.

Specialist areas such as Critical Care, Maternity services, Children's services, and the Emergency Department have specialist specific establishment reviews aligned to the appropriate national guidance. These specialist areas also undertake a confirm and challenge session with the Chief Nurse, Deputy Chief Nurse and specialist leads to ensure a consistent approach across the organisation.

2.2 Establishment Review Outcome

Outcome details of the establishment reviews for each inpatient ward is provided in table 3. This has been reviewed by the Chief Nurse and Chief Finance Officer for overall approval.

Table 3: Establishment Review Outcomes by Ward

Division	Number of beds	Ward	Establishment review proposal	Acuity Audit results (Recommend WTE)	Funded Establishment (WTE)	Proposed Establishment WTE	Outcome (Finance approval)
Surgical Division	22	10	No Change	27.99	28.7	28.7	N/A
	25	11	Change of Model	38.64	37.94	37.94	Approved-cost neutral
	16	12	No Change	8.69	38.96	38.96	N/A
	8	WAFFU	No Change	N/A			
	37	14	No Change	43.97	56.84	56.84	N/A
	20	17	No Change	23.8 SEU 34.01 Ward Total 57.81	48.91	48.91	N/A
	30	18	No Change	48.36	43.93	43.93	N/A
	31	20	No Change	43.86	44.69	44.69	N/A
	26	M2 ortho	No Change	9.95	23.24	23.24	N/A
Medical	30	21	No Change	56.2	41.88	41.88	N/A
	31	22	No Change	45.63	41.66	41.66	N/A
	26	23	Reduce	37.67	43.66	40.68	Approved-cost neutral

	23	24	No Change	30.09	32.07	32.07	N/A
	22	25	No Change	35.66	48.95	48.95	N/A
	33	26	No Change	54.06	40.45	40.45	N/A
	29	27	No Change	44.26	41.72	41.72	N/A
	23	30	No Change	36.23	37.85	37.85	N/A
	29	32	No Change	47.27	68.75*	68.75*	N/A
	7	CCU	No Change	13.39			
	26	33	No Change	41.11	37.58	37.58	N/A
	34	36	No Change	51.62	51.76	51.76	N/A
	45	37&38	No Change	6.95 Wd 37 59.82 Wd 38 Total 66.77	65.13	65.13	N/A
	40	M1	No Change	67.07	49.23	49.23	N/A
	30	CRC	No Change	47.92	40.7	40.7	N/A
	27	M3	No Change	41.95	35.1	35.1	N/A
Acute	27	AMU	Change of Model	37.26	53.8	53.8	Approved-cost neutral
	16	MSSW	Reduce	22.56	30.04	27.4	Approved-cost neutral
		UMAC	Reduce	N/A	30.53	27.32	Approved-cost neutral
	10	CDU	Uplift	N/A	15.52	16.84	Approved-cost neutral
	24	OPAU	No Change	38.98	41.68	41.68	N/A
Women's & Children's	8	Ward 54	No Change	17.96	15.19	15.19	N/A
	21	Childrен's Ward	No Change	N/A	48.4	48.4	N/A
	Maternity Service		No Change	N/A	141.65	141.65	N/A

As displayed (table 3) there is 1 ward (CDU) identified as requiring an uplift:

3 wards reduced their funded establishment model. 2 additional wards changed their skill mix model. Overall, no further investment has been required following the establishment review, changes have remained cost neutral.

Ward 23 reduced the overall establishment but increased the leadership on the ward with the introduction of an additional band 6 to support the leadership required across the wider Stroke Service; this was also cost neutral.

Emergency Department (ED)

The ED utilised the new EDSNCT to complete the acuity and dependency review: having gained formal training and competency sign off to utilise the newly licenced tool. The department undertook 3 audits across different months to establish a baseline. As expected, due to the unpredictable nature of the ED, there was a degree of variance in the acuity and dependency of the patients across each of the 3 audits. The primary outcome of the EDSNCT, from the 3 audits conducted, indicated that the department would benefit from introducing a staffing model that is aligned to increased periods of activity.

This is a similar recommendation to the outcome reviews undertaken by NHS England Emergency Support Care Improvement Team (ESCIT), which identified 14:00 hours as a peak time. In response the proposal is to change the shift model to introduce a new shift (potentially from 10:00 hours to 22:00 hours), utilising resources within the current establishment. The change in shift model will support with the increased activity period, enable preparation of the department before peak activity, and provide additional resilience to enable staff to take required breaks.

ED is currently undergoing significant remodelling and will be required to flex the staffing model over a fast-changing environment due to construction works. This is due to the multimillion-pound capital investment in the new Emergency and Urgent Care centre. It is anticipated that the new environmental layout will support staff efficiencies. Due to the current anticipated challenges for this establishment period, there were no recommended changes to the funded establishment, staffing remains static to ensure visibility and patient safety whilst the department is accommodated over several defined areas. Audit results are displayed in appendix 2.

Maternity Services

Maternity services use a safe staffing tool, Birth Rate plus. The recommend staffing levels updated March 2023 based on the findings of Birth Rate plus, incorporating the move to the continuation of care model (CoC) are provided below (table 4).

The table provides details of the baseline staffing required for the implementation of CoC according to defined levels: The CoC levels are 55%, increasing to 75%, and 100% of the caseload / continuity teams and core services. An allowance of 24% uplift and 12.5% community travel are included in the staffing figures. The baseline uses the annual births figures and in the latest review the birth rates have been adjusted from 3009 to 2972 (2570 Delivery Suite births; 310 Eden Birth Centre; 92 Seacombe Birth Centre / Home / Born Before Arrival).

Table 4: Recommended Staffing Levels

	55% CoC	75% CoC	100% CoC
Core Hospital			
Intrapartum core	25.31	20.02	13.40
**Numbers per shift for DS*	*4.55*	*3.60*	*2.41*
Additional wte to provide a minimum of 4 per shift		1.86	8.48
Maternity Ward	33.54	31.51	28.98
**Numbers per shift for the ward*	*6.03*	*5.67*	*5.21*
Outpatients/Triage/DAU	21.14	21.14	21.14
Core Community	16.05	10.11	2.69
Caseload Teams	42.66	58.17	77.56
Total Clinical wte *RMs & PN MSWs*	**138.69**	**142.81**	**152.25**
Additional Specialist and Management wte (10%)	**13.87**	**14.28**	**15.22**

Recommendations from the review indicates that skill mix in postnatal services, inclusive of Midwifery Support Workers (MSW), is considered in the whole time equivalent (WTE) total. Birth Rate plus indicates that 10% of the midwifery staffing model comprises of MSWs, as the CoC model is implemented the reduction of core community staff is evident (table 4). As part of the implementation consideration must be given to how the baseline 10% allocation to the hospital and community is deployed. MSWs attached to the caseload teams will be in addition to the midwives. Care must be taken not to apply 10% to only Core staffing as this may reduce the midwifery total to an inappropriate level. Professional and management judgement will assist with a suitable allocation.

The current funded establishment is 141.65 WTE; evidencing the achievement of the first CoC target of 55% and is on trajectory to meet 75% CoC by quarter 2 2022/2023. The Executive Management Team receives a regular update on the assurance process in relation to the plethora of Maternity Improvement programs / 3-year plan and the move to a continuity of care model.

There is no change proposed to the funded establishment.

Children's Services

Children's services have specific RCN guidance in relation to staffing levels set against required patient to RN ratios, which incorporate guidance on acuity levels and alignment to children's age. This guidance is incorporated as part of the professional

	judgement in determining staffing levels day to day for the Children's ward and the Paediatric Assessment Unit. A formal mechanism to capture and monitor compliance against this guidance is not yet in place; the aim will be to embed a formal process in preparation for the next 6 monthly staffing review. A paper-based data capture system has been piloted to inform this establishment review. Based on a professional review model and initial results of the pilot there are no changes proposed to the funded establishment. **Critical Care** A formal review of non-medical staffing was undertaken in M9 22/23. The review identified the following 3 points in relation to the funded establishment: 1) Staffing did not meet the Faculty of Intensive Care Medicine (2021) guidance on staffing levels. 2) Staffing did not provide enough senior roles to allow and encourage career progression on the unit. 3) Skill mix did not provide enough senior cover to support a relatively junior workforce. The review recommended: • 2.61 WTE band 7 RNs to meet the senior nurse requirements, inclusive of supernumerary supervision and education, for the Faculty of Intensive Care Medicine (2021) guidelines to be achieved. • 70.17 WTE RNs to cover 24/7. • Unit manager hours to fulfil the management duties of the unit. In response to the recommendations the following was agreed: • Increase the number by 4.22 WTE band 7, providing 2 supernumerary senior nurses in the clinical areas and 1 supernumerary senior nurse for managerial duties. • Reduce establishment of RNs band 5 by 5.82 WTE and band 6 by 1.64 WTE • Technician post band 3 post remains funded. The changes in the model have been agreed via Executive Management Team and through vacancy control panel processes. These establishment recommendations have been taken forward and have resulted in a proposed changed establishment model that meets safe staffing requirements within the agreed funded establishment. Details are included as appendix 3.
2.3	**Skilled workforce** There are robust processes in place to monitor training compliance to provide assurance that the Trust has a skilled workforce in place to maintain patient safety. The processes and systems include ESR, monthly compliance reports for mandatory training, compliance reports for role essential and role specific training, which are governed through the Education Governance Group. As a university teaching hospital with a dedicated clinical skill labs and specific divisional based practice educators the delivery of practical training to support staff to achieve clinical competencies is facilitated.

The Trust currently has a mandatory training compliance rate of 86% M1 2023/24: Nursing and Midwifery mandatory training is demonstrated in table 5.

Table 5: Mandatory Training Compliance M1 2023 / 2024 Nursing and Midwifery

Division	Staff Group	#	%	#	%
408 Acute Care Div	Nursing and Midwifery Registered	2056	92.99%	155	7.01%
408 Clinical Support Div	Nursing and Midwifery Registered	1140	97.19%	33	2.81%
408 Corporate Support Div	Nursing and Midwifery Registered	641	95.67%	29	4.33%
408 Estates, Facilities & Capital Div	Nursing and Midwifery Registered	9	100.00%		0.00%
408 Medicine Div	Nursing and Midwifery Registered	4614	94.01%	294	5.99%
408 Surgery Div	Nursing and Midwifery Registered	4112	95.38%	199	4.62%
408 Women and Children's Div	Nursing and Midwifery Registered	2759	93.84%	181	6.16%
408 Acute Care Div	Nursing and Midwifery Registered	2056	92.99%	155	7.01%
TOTAL		**15331**	**94.51%**	**891**	**5.49%**

A review of the content and methods of delivery for role essential training is currently underway. Systems and processes will be developed to align training to lessons learned from patient safety incidents alongside the implementation of the Patient Safety Incident Reporting Framework.

Appropriate skill mix is an indicator within the establishment template and is a daily consideration when rostering staff and at daily staffing meetings.

Patient to RN and CSW ratios are a vital consideration when setting establishments. For general adult inpatient wards, areas are monitored on a 1:8 daytime nurse to patient ratio; and 1:10 evening ratio. This information is captured for all shifts within the safer staffing oversight tool and is visible on the bi portal for all staff, demonstrating an open and transparent approach to safe staffing data. Any shifts that do not meet the RCN guidelines are highlighted and monitored for themes and trends.

3 Quality Metrics

In conjunction with this report bi-monthly reports are provided to the People Committee providing assurance that the Trust fulfils the regulatory requirements in line with NHSI Developing Workforce Safeguards (NHSI 2018), CQC Essential Standards and the National Quality Board's Safe Sustainable and Productive Staffing Guidance (NQB 2016).

The data contained the bi-monthly reports provides details of themes and trends, inclusive of key quality staffing metrics to monitor special cause variation and sustained

improvements or declines. In addition, the narrative on mitigation and improvement actions is provided for metrics that do not meet an established rating of green or amber within the safe nurse staffing dashboard (appendix 1).

Safe Nurse Staffing Dashboard

The Safe Nurse Staffing Dashboard contains 46 nurse staffing metrics, providing a holistic presentation of aspects that influence safe staffing provision and impact measures (appendix 1).

Table 6: Safe Nurse Staffing Dashboard Summary, provides a summary of the RAG rating against the 46 indicators.

		Safe staffing (Nursing) Dashboard summary		
		Indicator RAG status		
		Red	Amber	Green
Qrt 1	April	11	16	18
	May	9	15	21
	June	7	18	20
Qrt 2	July	9	14	23
	August	10	18	18
	September	8	19	19
Qrt 3	October	10	16	20
	November	9	16	21
	December	10	17	19
Qrt 4	January	9	15	22
	February	6	20	20
	March	10	19	17

In M11 the lowest number of red indicators for the financial year were recorded, and all 6 red indicators (table 6) had improved within the indicator thresholds (appendix 1).

In the last 6 months the overall care hours per patient day (CHPPD), the measure of how many health care professional hours on average a patient receives within an area, has exceeded required standards (7.6 and 7.8, appendix 1). The Trust has a local target of a maximum 3 wards to have a Care Hours Per Patient Day (CHPPD) of <6.1. A reduction from 11 wards in M7 to 5 wards in M11 and M12 is evident (appendix 1).

M12 the number of RN red shifts achieved the lowest number (162) compared to the previous 12 months. Similarly, the RN red shift impact number of falls (3) was the lowest for the previous 12 months, resulting in 0 falls with harm (appendix 1). The number of RN red shifts for medication errors / misses reduced from 4 in M7 to 0, with 1 being reported in M12. Formal complaints where staffing is an issue increased from 2 in the first half of the year to 3 in the last 6 months. Missed breaks reduced from 68 M7 to be consistently lower from M8 to M12 (26) (appendix 1).

	Total number of staffing incidents range from 37 to 87: Similarly, staff moves increased significantly in M12 following a previous decline (appendix 1). Further scrutiny is required by divisional nurse directors to understand the themes and trends within the staffing incidents given the reduced vacancy rate for RN's overall and ward based CSWs. The number of RN red impact shifts that had uncovered requests for patients requiring 1:1 special increased in the last 6 months of 2022 / 2023 (appendix 1). This demonstrates a high level of dependency for patients within our care in conjunction with a consistent high occupancy rate in M12 95.9% (appendix 1). **Serious Incidents (SI)** In the last 6 months the number of SIs that may have identified staffing as a contributory factor has reduced to 3 from 7 in the preceding 6 months (appendix 1). Increased professional scrutiny of SI where staffing is a contributory factor will be applied by divisional nurse directors and senior nurses to provide robust assurance that all learning is being implemented across the areas; this will be reported through the divisional performance reviews and lessons learned forum.

4	**Conclusion**
4.1	The Trust has applied effective governance processes to ensure visibility and scrutiny of nurse safe staffing from ward to board. Through these processes it is concluded that daily staffing monitoring continues, with a good system of internal control being applied constantly to ensure gaps are filled and managed effectively in line with the Safe Staffing Escalation Policy. The Trust has met the requirements in line with the Developing Workforce Safeguards (NHSI 2018) to undertake the mandatory acuity, dependency, and establishment review for adult wards. National staffing guidance for specialist areas is established across the NHS, we continue to be proactive in piloting and adopting newly developed staffing resource tools which is evident in being one of the primary pilot sites for Birth Rate plus.

5	**Recommendation**
	Children's services are to continue to explore appropriate systems and processes to capture acuity and dependency data routinely demonstrating adherence with RCN ratio guidance. Emergency Department are to agree an auditing schedule for the use of the EDSNCT, to support with the reconfiguration of the department during the upgrade process and embed the process of using acuity and dependency tools to help inform staffing establishments. Retention and retirement data will be included as part of the next establishment template data reviews for all areas to ensure effective staffing provision.

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Appendix 1: Safe Staffing Board Assurance Dashboard

	Safe Staffing Board Assurance Dashboard 2022/2023														
Data Source	Indicator	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Spark line
Corporate Nursing	Care Hours Per Patient Day - Total	8.3	8.4	8.6	8.4	8	8	7.8	7.6	7.8	7.7	7.6	7.7	7.6	
Corporate Nursing	Care Hours Per Patient Day - Registered Nurses	4.3	4.3	4.7	4.4	4.2	4.2	4.1	4	4.1	4.1	4.1	4	4	
Corporate Nursing	Care Hours Per Patient Day - CSW's	3.4	3.4	3.3	3.4	3.2	3.2	3.1	3	3.1	3.1	3	3.1	3.1	
Corporate Nursing	Number of ward below 6.1 CHPPD	3	1	4	5	4	7	8	11	6	5	8	5	5	
Corporate Nursing	National Fill rates RN Day	84%	86%	86%	90%	88%	88%	87%	87%	90%	88%	90%	90%	88%	
Corporate Nursing	National Fill rates CSW Day	93%	94%	90%	96%	92%	91%	94%	94%	96%	92%	91%	95%	93%	
Corporate Nursing	National Fill rates RN Nights	87%	90%	90%	94%	92%	94%	93%	91%	93%	91%	94%	93%	91%	
Corporate Nursing	National Fill rates CSW Nights	97%	98%	95%	99%	96%	97%	97%	95%	98%	95%	97%	101%	102%	
Corporate Nursing	Nurse Ratio Day : Number of Shifts above 1:8	124	117	98	78	106	97	76	93	77	73	88	106	100	
Corporate Nursing	Nurse Ratio Night : Number of Shifts above 1:10	209	180	126	126	137	117	134	150	117	137	89	89	121	
Informatics	Trust Occupancy Rate	89.70%	90.70%	92.10%	93.30%	92.80%	93.16%	93.52%	93.91%	95.03%	95.04%	96.48%	96.90%	95.96%	
Informatics	Occupancy Rate - APH	91.33%	92.70%	92.60%	94.60%	93.60%	94.27%	94.52%	95.54%	96.36%	96.06%	97.92%	98.24%	97.57%	
Informatics	Occupancy Rate - CBH	70.07%	74.10%	80.20%	79.80%	80.30%	79.88%	81.95%	80.46%	82.41%	80.35%	83.46%	82.17%	80.62%	
Workforce	Vacancy Rate (Band 5 RN's)	10.05%	8.91%	9.10%	9.49%	8.50%	9.12%	6.82%	5.07%	3.71%	3.17%	4.77%	3.13%	2.25%	
Workforce	Vacancy rate (Band 5 inpatient wards)	6.94%	6.48%	5.82%	6.86%	6.21%	7.31%	5.21%	3.88%	3.18%	2.54%	3.59%	1.67%	0.74%	
Workforce	Vacancy Rate - All RN (All grades)	4.80%	4.27%	4.23%	4.49%	3.30%	3.66%	2.51%	2.83%	1.33%	1.38%	2.82%	1.89%	1.31%	
Workforce	Vacancy Rate (CSW's)	0.92%	0.90%	4.86%	5.85%	4.75%	4.86%	7.21%	5.65%	5.59%	6.44%	4.53%	6.28%	6.49%	
Workforce	Sickness Rate - RN	7.34%	6.03%	5.48%	5.61%	6.19%	5.13%	6.39%	6.90%	6.05%	6.88%	6.05%	5.17%	5.47%	
Workforce	Sickness Rate - CSW	11.50%	11.41%	10.32%	10.55%	10.91%	10.02%	10.42%	10.40%	9.75%	10.93%	11.39%	9.14%	8.48%	
Workforce	Absences Rate - RN	0.55%	0.35%	0.11%	0.09%	0.11%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Workforce	Absences Rate- CSW	0.57%	0.32%	0.24%	0.13%	0.04%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
Corporate Nursing	Number of Professional Judgment Red Shifts	3	9	16	13	0	10	12	37	23	23	47	35	43	
Corporate Nursing	Number of RN Red Shifts *	404	323	249	235	359	305	310	327	228	272	239	168	162	
Corporate Nursing	RN Red Shift Impact : Number of Falls	9	19	7	6	11	9	11	23	16	6	10	7	3	
Corporate Nursing	RN Red Shift Impact : Number of Falls with Harm	2	1	0	0	0	2	1	0	1	0	1	0	0	
Corporate Nursing	RN Red Impact : Meds Errors / Misses	0	0	0	1	0	0	0	4	0	0	0	0	1	
Corporate Nursing	RN Red Impact : Patient relative complaints	0	1	0	2	0	2	1	0	0	0	0	2	2	
Corporate Nursing	RN Red Impact : Staffing incident submitted	7	4	1	8	4	3	8	6	0	1	1	8	2	
Corporate Nursing	RN Red Impact : Special 1:1 (uncovered)	5	9	2	7	0	4	5	16	12	17	7	5	11	
Corporate Nursing	RN Red Impact: Missed Breaks	65	26	11	11	23	21	25	68	26	39	25	25	26	
Corporate Nursing	RN Red Impact: Delayed / Missed Obs	159	97	44	61	108	119	59	141	51	103	70	27	121	
Corporate Nursing	RN Red Impact: Delayed / Missed nMEWS	208	112	43	77	107	131	76	179	35	36	51	59	103	
Corporate Nursing	RN Red Impact: Delayed / Missed Pressure Care	116	68	33	29	37	91	44	116	66	87	53	22	51	
Corporate Nursing	RN Red Impact : Delayed Meds	77	69	35	29	70	112	66	125	46	109	69	43	112	
Governance support	Number of SI's where staffing has been a contributing factor	2	2	1	1	0	1	0	0	0	1	0	1	1	
Corporate Nursing	Total Number of staffing incidents	71	62	49	44	102	72	86	49	37	50	37	47	87	
Complaints team	Formal complaints in relation to staffing issues	1	0	0	0	1	0	0	0	0	1	0	2	0	
Complaints team	Informal Concerns raising staffing levels as an issue	0	0	0	0	0	1	0	0	0	0	0	1	0	
Corporate Nursing	Patient Experience feedback raising staffing levels as a concern	5	3	2	1	6	4	7	5	5	4	4	5	3	
Corporate Nursing	Staff Moves	226	236	235	222	240	191	226	181	150	163	164	169	291	
NHS Professionals	Number of RN hours requested	39643	32877	29141	27333	29853	27964	27683	29056	26201	28021	32564	29924	33254	
NHS Professionals	Number of CSW hours requested	39454	35620	32429	32201	33987	36537	32575	35300	33615	35629	41151	33668	38334	
NHS Professionals	% of requested filled RN's	61.48%	59.97%	67.89%	72.60%	69.21%	69.77%	73.38%	71.44%	74.31%	59.86%	74.41%	77.62%	76.92%	
NHS Professionals	% of requested CSW filled	72.90%	76.36%	80.34%	84.30%	81.91%	78.44%	83.43%	83.80%	85.29%	72.67%	76.10%	83.24%	81.72%	
NHS Professionals	% of Agency staff used RN	15.33%	15.74%	15.06%	8.99%	9.96%	8.31%	6.58%	8.53%	7.94%	7.51%	5.05%	4.82%	4.00%	
NHS Professionals	Number of Agency RN hours	6079	5174	4388	2456	2972	2323	1821	2478	2080	1260	1645	1442	1331	
NHS Professionals	% of Agency staff used CSW	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	

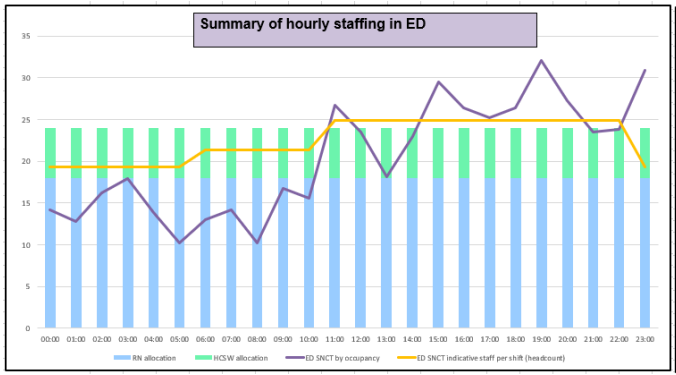
** The National Safe Staffing submission reports the total actual hours filled against the agreed funded establishment. RN Red shifts are defined as shifts that are below both the agreed funded establishment and below the agreed minimum staffing model.*

*Blue text denotes where an amendment to the previous figures has been made following a review of establishment figures. These figures are correct at the time of the divisional sign off process at the beginning of each month for the retrospective month

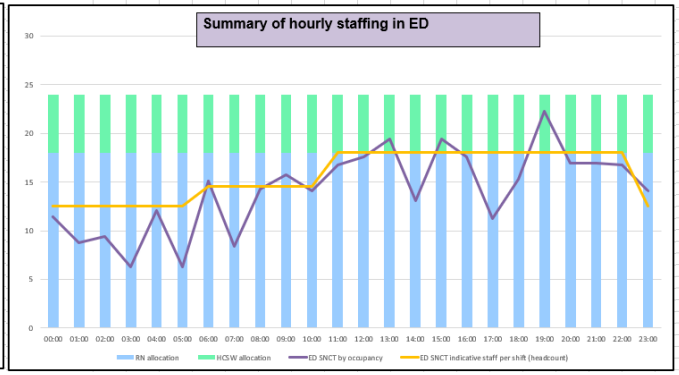
Appendix 2 EDSNCT Results

Levels	Sep	Nov	Feb/Mar
Level 0: Walk-in patient.	38.6%	40.0%	33.6%
Level 1a: Acutely ill, unstable, likely to deteriorate.	21.7%	15.2%	20.4%
Level 1b: Stable but dependent on support for basic needs.	24.2%	32.9%	34.8%
Level 1c: Patients who are in a physiologically STABLE condition but are requiring additional intervention to mitigate risk and maintain safety	11.8%	10.1%	9.4%
Level 2: Requires therapeutic support in HDU settings.	3.2%	1.6%	1.4%
Level 3: Requires therapeutic support in ITU settings.	0.5%	0.2%	0.4%
Total number of patients	1732	1661	1664

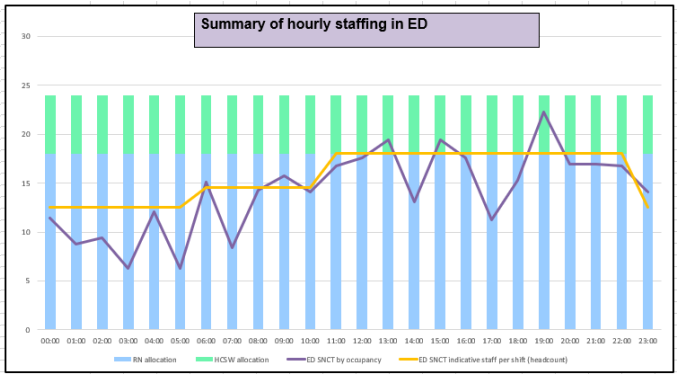
Audit 1: Sept



Audit: 2 Nov



Audit 3: Feb / Mar



Appendix 3: Critical Care Review Establishment Models

Original Model

Position Title	Band	Budget WTE
808810-B8a Qualified Nurse	Band 8a	1.00
808700-B7 Qualified Nurse	Band 7	8.39
808600-B6 Qualified Nurse	Band 6	23.71
808500-B5 Qualified Nurse	Band 5	54.13
810300-B3 Unqualified Nurse	Band 3	9.05
825940-B4 Admin & Clerical (Support to Clinic	Band 4	1.00
825930-B3 Admin & Clerical (Support to Clinic	Band 3	1.00
810200-B2 Unqualified Nurse	Band 2	0.43
827200-B2 Support Staff	Band 2	1.34
Total Staffing		**100.05**

Proposed Model

Position Title	Band	Proposed Budget WTE
Qualified Nurse Band 8a	Band 8a	1.00
Qualified Nurse Band 7	Band 7	11.87
Qualified Nurse Band 6	Band 6	23.78
Qualified Nurse Band 5	Band 5	48.30
Unqualified Nurse Band 3	Band 3	6.76
CSW Band 2	Band 2	3.14
Band 4 Admin - Data Coordinator	Band 4	1.00
Band 3 Admin - Unit Administrator	Band 3	1.00
Band 3 - Technician	Band 3	1.00
Band 2 - Housekeeper	Band 2	1.49
Total Staffing Required		**99.34**

Title	Freedom to Speak Up Report Annual Report
Area Lead	Deb Smith – Chief People Officer / Executive Lead for FTSU
Author	Hayley Curran – Associate Director for OD & Tracey Nolan FTSU Guardian / Just and Learning culture Lead
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board of Directors with a 12 monthly update of Freedom to Speak Up (FTSU) 2022/23.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

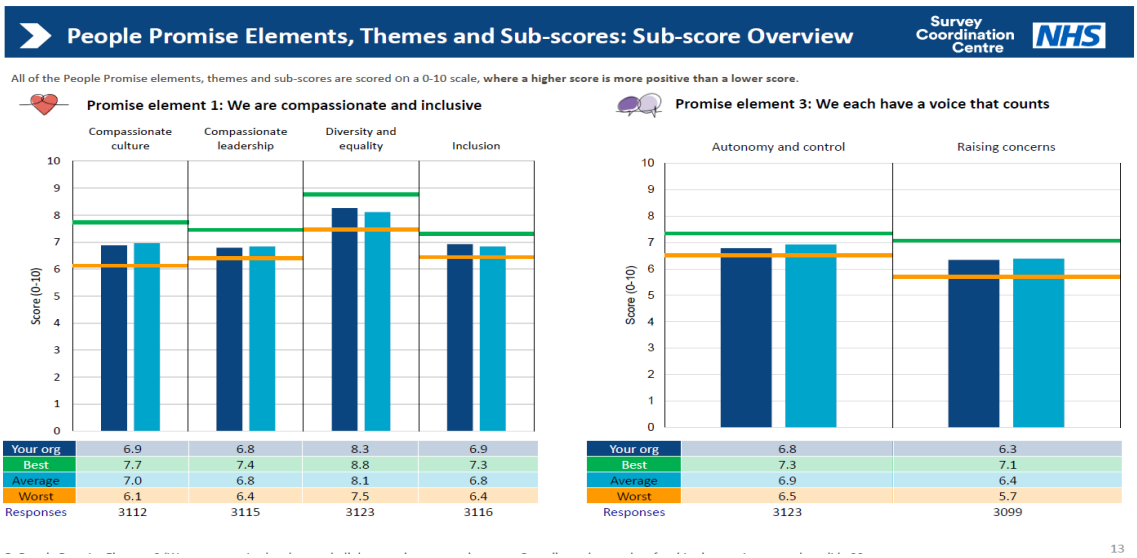
- Concerns raised may identify potential or actual risks, however these are managed on an individual basis and escalated to appropriate management representatives as necessary

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
31 May 2023	People Committee	As above	As above

1	Narrative
1.1	Revised NGO guidance for 2022 ("Freedom to Speak Up: A Guide for Leaders in the NHS and Organisations delivering NHS Services" 2022) highlights that reporting activity should now be on a bi-annual basis and therefore this report seeks to meet those requirements and outline FTSU activity for 2022/23. This report provides an overview of activity data for 12 months 2022/23 and work undertaken to progress the agenda in line with national policy and best practice guidance. Data is presented in a way that maintains the confidentiality of individuals who speak up. **Staff Survey and FTSU** The NHS Staff Survey has undergone significant changes to align the questions to the NHS People Promise. As a result, some of the questions which previously comprised the FTSU Index were removed from the 2022 survey. The National Guardian's Office continues to work together with colleagues from NHS England and Improvement on including speaking up questions in the NHS Staff Survey. Last year's (2021) survey included a new question asking whether workers feel safe to speak up about anything that concerns them in their organisation. The question remains in this year's (2022) survey and is accompanied by a new follow-up question: *'If I spoke up about something that concerned me, I am confident my organisation would address my concern.'* The response to these questions feeds into the results for promise element one and three as detailed below. Overall results from WUTH in relation to staff raising concerns suggest that we are comparable to other acute trusts as demonstrated by the results for the two NHS People Promise elements detailed below.  The National Guardian's Office will look at future results of relevant FTSU questions in the NHS Staff Survey as part of a broader and more holistic view of the speaking up landscape in healthcare. Additionally, the National Guardian's Office is working with colleagues to present the results of this year's NHS Staff Survey on the Model Health

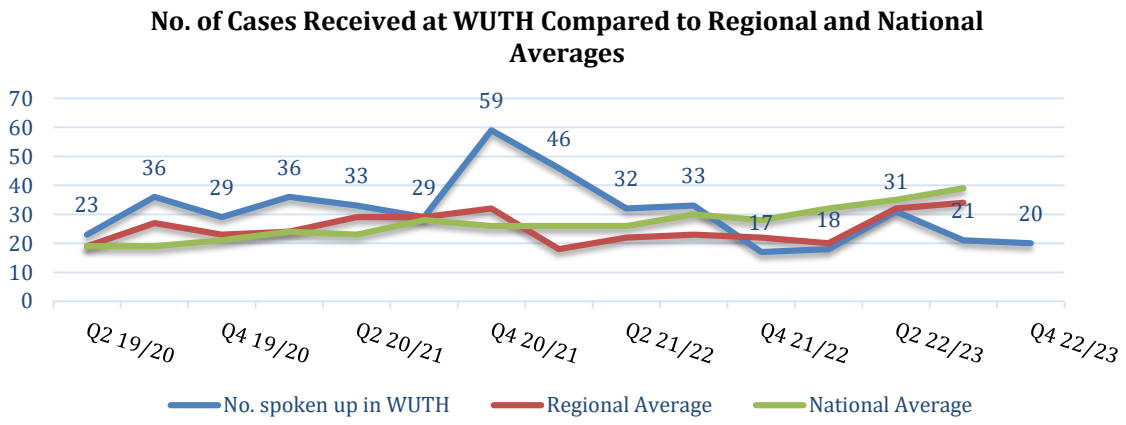
	System, so Freedom to Speak Up Guardians in trusts will be able to use this tool to include in annual reports going forward once this is available.

2	FTSU Activity – Assessment of Cases

Number of People Speaking Up

The number of people speaking up to FTSU Guardians has decreased slightly over the past year with 90 people speaking out in 22/23 compared to 128 staff speaking up in 21/22. The chart below demonstrates that WUTH staff raise fewer concerns than the regional and national average hospitals similar in size. Regional and national data is not available for Q4 at the time of reporting.

Data is submitted to the National Guardians Office (NGO) on a quarterly basis and the charts below allow comparison between the overall number of people speaking up against regional and national Trusts of similar size.



Additional communications will take place to promote the FTSU service during 2023/24 and this will continue to be supported by the new Freedom to Speak up Guardian who commenced in post in Feb 23. It is anticipated that increased visibility around the Trust and promoting the service at key events such as corporate induction may result in a rise in concerns raised.

Concerns Raised by Theme

The table below sets out the concerns raised during 22/23 by theme. Q2 saw a peak in attitudes and behaviours, accounting for 33% of all concerns raised during that quarter. Bullying and harrasment remains low with an overall percentage of 10% of the total concerns raised, this should be viewed as positive and also appears to be decreasing across the year. It is important to note that concerns can often span numerous themes.

New NGO reporting guidance (Recording Cases and Reporting Data, 2022), requires organisations to update the themes recorded and monitored, using new data categories from 1 April 2022. This change is reflected in the table below.

Table1 Concerns raised by theme, quarterly breakdown

Themes	Q1 22/23 Total	% of total raised	Q2 22/23 Total	% of total raised	Q3 22/23 Total	% of total raised	Q4 22/23 Total	% of total raised	TOTAL	% of total raised
Attitudes and behaviours	8	22.22%	21	43.75%	13	30.95%	11	29.73%	53	32.52%
Bullying or harassment	1	2.78%	9	18.75%	2	4.76%	4	10.81%	16	9.82%
Other inappropriate behaviour	2	5.56%	7	14.58%	3	7.14%	9	24.32%	21	12.88%
Equipment and maintenance	0	0.00%	0	0.00%	3	7.14%	0	0.00%	3	1.84%
Staffing	0	0.00%	1	2.08%	1	2.38%	1	2.70%	3	1.84%
Policies, procedures and processe	7	19.44%	3	6.25%	2	4.76%	8	21.62%	20	12.27%
Patient Safety	3	8.33%	1	2.08%	5	11.90%	2	5.41%	11	6.75%
Patient Experience	7	19.44%	0	0.00%	3	7.14%	1	2.70%	11	6.75%
Performance Capability	0	0.00%	1	2.08%	2	4.76%	1	2.70%	4	2.45%
Service Changes	2	5.56%	1	2.08%	0	0.00%	0	0.00%	3	1.84%
Other	2	5.56%	2	4.17%	0	0.00%	0	0.00%	4	2.45%
COVID-19	1	2.78%	0	0.00%	0	0.00%	0	0.00%	1	0.61%
Worker safety or wellbeing	3	8.33%	2	4.17%	8	19.05%	0	0.00%	13	7.98%
Total	36		48		42		37		163	

Total themes raised over the last year (%)

Note: Many concerns have more than one theme so the numbers in the chart will not correlate with the number of cases raised.

Data requirements changed last year to include the introduction of following 2 categories:

- “Other inappropriate behaviour” category
- Worker safety or wellbeing

Other inappropriate behaviour is defined in the new guidance as:

- Any case that includes an element that may indicate a risk of other inappropriate attitudes or behaviours that do not constitute bullying or harassment. This can be a current or past matter and may identify risks or be about actual events
- Where the person raising the case believes there is an element of other inappropriate attitudes or behavioursto be interpreted broadly
- The focus should be on the perceptions of the person bringing the case

Examples of other inappropriate attitudes or behaviours may include:

- Actions contrary to an organisation's values
- Incivility

WUTH had already been monitoring wellbeing and worker safety as separate themes, however will now combine for the purposes of national reporting.

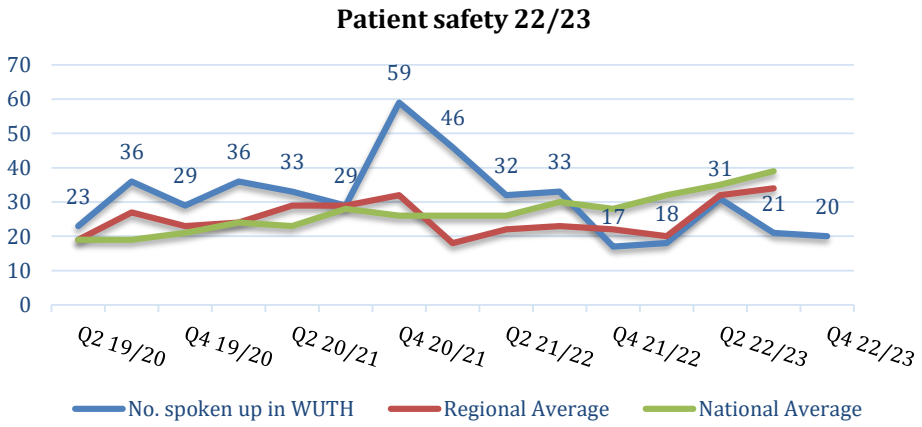
The last 12 months continues to see attitudes and behaviours as the highest reported theme which rose to 21 cases (37.5%) in Q2. Other inappropriate behaviour accounted for a further 37.5% of cases across the 12-month period. Policies, procedures, and processes were also significantly high within Q1(22.58%). Q4 continues to evidence attitudes and behaviours as the highest reported theme (30%).

It is important to note that as per the NGO guidance, “bullying or harassment” is recorded where cases may indicate a risk or incident of bullying or harassment or where the person raising the case believes there is an element of bullying or harassment. The National

Guardians Office (NGO) requires the term to be interpreted broadly and to be focussed on the perceptions of the person bringing the case. "Bullying" was reported in 10% of cases across a 12-month period.

FTSU Patient Safety Data

The graph below highlights the % of cases concerning patient safety for the 12-month period compared to the regional and national average. 9% of all Freedom to speak up concerns were around patient safety, lower than both regional and national average, although regional and national data is unavailable for Q4.

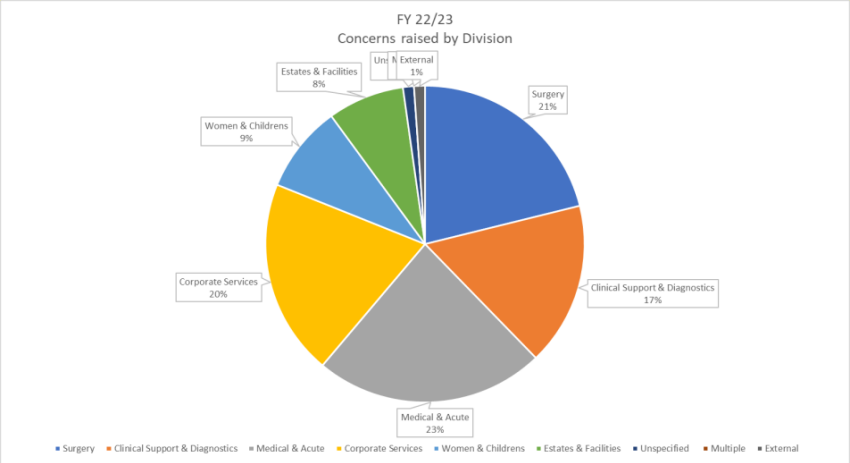


Concerns Raised by Division

Table 2 below shows the concerns raised by Division by quarter

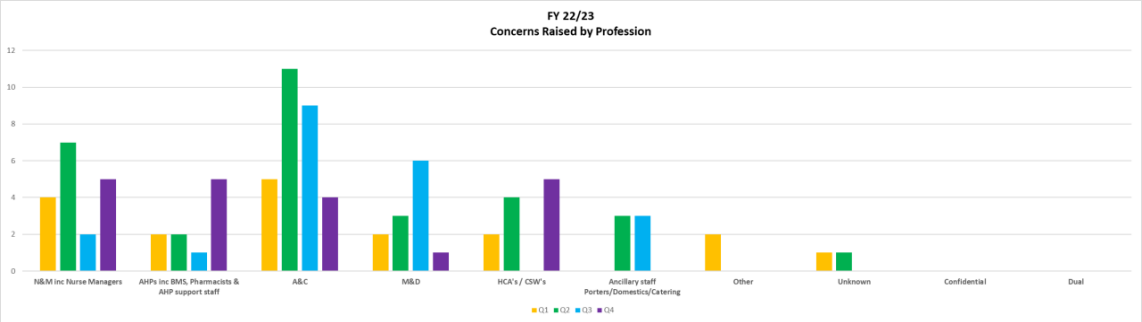
Division	Q1 22/23 Total	% of total	Q2 22/23 Total	% of total	Q3 22/23 Total	% of total	Q4 22/23 Total	% of total	TOTAL	% of total raised
Surgery	5	27.78%	5	16.13%	7	33.33%	2	10.00%	19	21.11%
Clinical Support & Diagnostics	2	11.11%	3	9.68%	4	19.05%	6	30.00%	15	16.67%
Medical & Acute	2	11.11%	10	32.26%	1	4.76%	8	40.00%	21	23.33%
Corporate Services	5	27.78%	9	29.03%	4	19.05%	0	0.00%	18	20.00%
Women & Childrens	3	16.67%	1	3.23%	2	9.52%	2	10.00%	8	8.89%
Estates & Facilities	0	0.00%	3	9.68%	2	9.52%	2	10.00%	7	7.78%
Unspecified	1	5.56%	0	0.00%	0	0.00%	0	0.00%	1	1.11%
Multiple	0	0.00%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
External	0	0.00%	0	0.00%	1	4.76%	0	0.00%	1	1.11%
Total	18		31		21		20		90	

Total themes raised by Division (%)



Concerns Raised by Profession

The following table highlights the concerns raised by professional group with new categories identified in new NGO guidance.



The highest group of staff raising concerns across the 12-month period are from Administrative and Clerical roles with 29 staff (32%) of staff raising concerns across the year. The second highest occupational group of staff to raise concerns to FTSU Guardians are Nursing and Midwifery staff, who have raised 18 concerns across the year.

Anonymous Concerns

1 anonymous concern was received in Q1 22/23 regarding car parking and 1 was received in Q2 22/23 regarding the behavior of a fellow colleague. Anonymous reporting continues to remain low which is particularly pleasing to see, as this demonstrates psychological safety within the workplace. Staff are encouraged in the first instance to discuss their concerns with their line manager where possible. One case resulted in a member of staff who was highly distressed speaking with FTSU and as a result building up the courage to discuss their concerns with the person directly resulting in a very powerful learning experience for both parties.

Disadvantageous or Demeaning Treatment as Result of Speaking Up

None were reported across 12-month period

Time Taken to Close Cases

The average time taken to close cases across the year was 13 days – most cases are quickly resolved resulting in staff feeling happy with an outcome and managers being

	receptive to the concern being raised. Time taken to close cases has decreased in the second half of the year, this will continue to be monitored. **Lessons Learned** **Mental Health** Staff experiencing poor mental health may at times feel unable to communicate their concerns directly with line management. Cases have been received where staff want to share how they feel / their circumstances with management and were happy to discuss the best way forward, however, struggled to say the words themselves or pick up the phone. A particular case in Q4 saw a member of staff distressed and upset by colleague's comments in relation to sexuality and gender identity. Following an initial meeting with the FTSU guardian, the staff member was encouraged to speak to the person in question, which resulted in another colleague coming forward with similar concerns. Both staff have been supported by the LGBTQ + network as well as on going support from the FTSU guardian. This case highlighted the importance and impact that support via the staff network can provide, and this will now be further embedded into the FTSU process to ensure support is offered appropriately.

3.0	Progressing the FTSU Agenda
	Significant development of the FTSU agenda has been led nationally via the National Guardians Office (NGO) in 2022 with both national guidance and policy being updated and relaunched by NHS England. This included: • National Guardian Reporting and Recording Guidance – February 2022 • FTSU Guidance - June 2022 • FTSU Reflection and Planning Tool for Trust Boards - June 2022 • Updated FTSU Policy – June 2022 To support the development of these a gap analysis was undertaken to develop a FTSU development plan that not only ensures that the Trust remains aligned to national FTSU requirements, but also continues to improve and provide a quality FTSU service at WUTH. In addition to the above documents the gap analysis also incorporated CQC requirements, findings from an internal review and learning from NGO case reviews. The following objectives were identified as part of an annual action plan. 1. **Review Governance and reporting structures for FTSU Guardians** – Through this objective reporting and oversight arrangements have been strengthened to ensure robust Board assurance. In addition, a process for triangulating FTSU cases with employee relations cases and patient safety incidents has been established in line with Trust Just and Learning Culture. 2. **Ensure the Trust is up to date with national and local guidance, policy and best practice** – In addition to the gap analysis undertaken to inform an action plan which addresses the gaps, this work also includes implementation of NGO reflection and planning tool for Board. Actions associated with this objective also included a review of the FTSU Champion and Guardian roles to ensure they were operating within the guidance launched in April 2021. This has been completed and WUTH is in line with recommendations made. There are plans in place to relaunch the role of the FTSU champion and ensure that we have champions in key areas to offer support to staff.

	3. **Raise awareness of FTSU Guardians, Champions, and Speak Up Agenda across the organisation** – Following the national rebranding of FTSU the Trust have updated all the branding and promotional campaigns to reflect the national programme. The new posters have been placed around the hospital. New pull up banners have been purchased and are used for induction and other key events. The importance of speaking up and the FTSU service is included within the Trust welcome event for new starters, with the FTSU Guardian promoting key messages and holding a stall as part of the World Café event. FTSU Guardian has delivered a Speak Up session to pharmacy staff to promote the importance of speaking up and the support available. Regular walk abouts are undertaken in both Arrowe Park as well as Clatterbridge to promote the importance of speaking up and being visible to staff. As of 30th April 2023 83.61% of staff have completed their level 1 speak up training and 80.36% of line managers / supervisors have completed the level 2 module Speak up Listen Up. Compliance continues to be high when compared with regional Trusts and seeks to promote awareness and support to all staff. The level 3 module remains under review and work will be undertaken to ensure integration across the Trust. 4. **Identify groups potentially facing barriers to speaking up and work towards addressing those barriers** – This objective seeks to engage staff from minority groups who are potentially less likely to speak up. Within the last 12 months FTSU champions are present within all the staff networks. The work of the FTSU champions is particularly important to promote the FTSU agenda and to further champion the agenda amongst staff with protected characteristics. In addition, work is ongoing to review data from other sources such as staff survey to identify staff groups that may be facing barriers to speaking up. 5. **Review effectiveness of FTSU process** – Continuous improvement is paramount to developing a FTSU culture. A survey tool has been developed to provide a feedback loop following the closure of FTSU cases The data identified by this feedback survey will also be incorporated into future reporting from April 2023 onwards.

4	**Conclusion**
	The number of people speaking up to FTSU Guardians has decreased over the 12-month period. Considerable work has been undertaken during the year to implement national FTSU policy and guidance including a gap analysis, development of an annual action plan and establishment of new policy and processes that triangulate FTSU cases with employee relations and patient incidents to determine themes and opportunities for learning. Work continues to enhance reporting and provide board assurance of the FTSU agenda. The new FTSU guardian/Just and Learning culture lead continues to build and develop the role, promoting the service, regular walkabouts to ensure visibility and membership within key groups such as Lessons learnt, and Patient Safety Incident Response

	Framework meeting (PSIRF) will ensure that the FTSU agenda continues to be heard and the promotion of this significant role continues to be raised.

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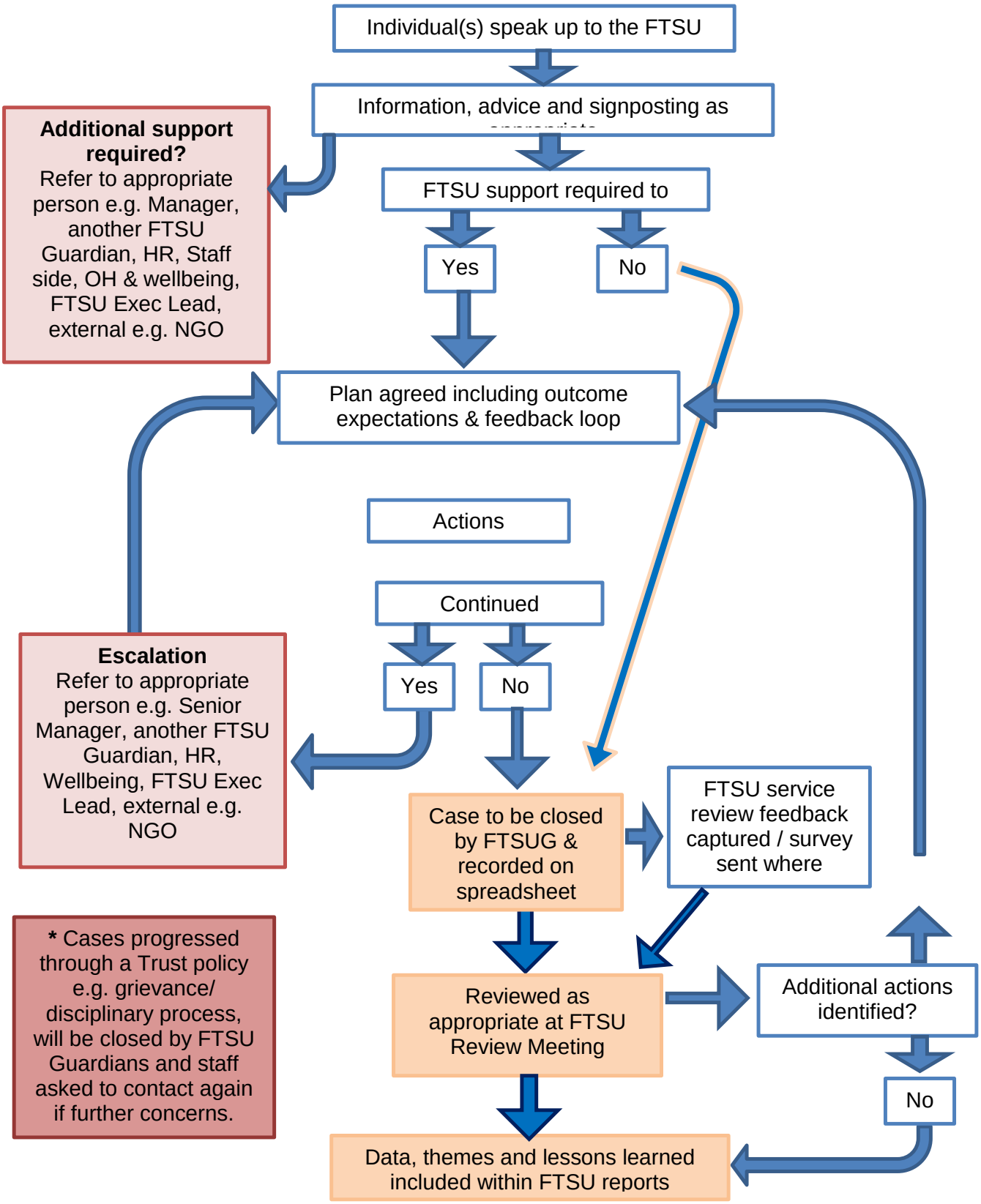
Freedom to Speak Up Guardian Governance Arrangements
October 2022



Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 8.8**

07 June 2023

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

Report Purpose and Recommendations

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

The purpose of this report is to provide:

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

It is recommended that the Committee:

- Note the report

Key Risks

This report relates to these key risks:

- n/a

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	No
Our partners: provide seamless care working with our partners	No

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
31 May 2023	People Committee	As above	Information

1	Narrative
1.1	The annual report is a formal requirement in order to provide People Committee and the Board of Directors assurance of the working conditions of doctors in training (junior doctors). Safeguarding the working hours and educational experiences of junior doctors is an integral part of ensuring both patient and staff safety.

High level data

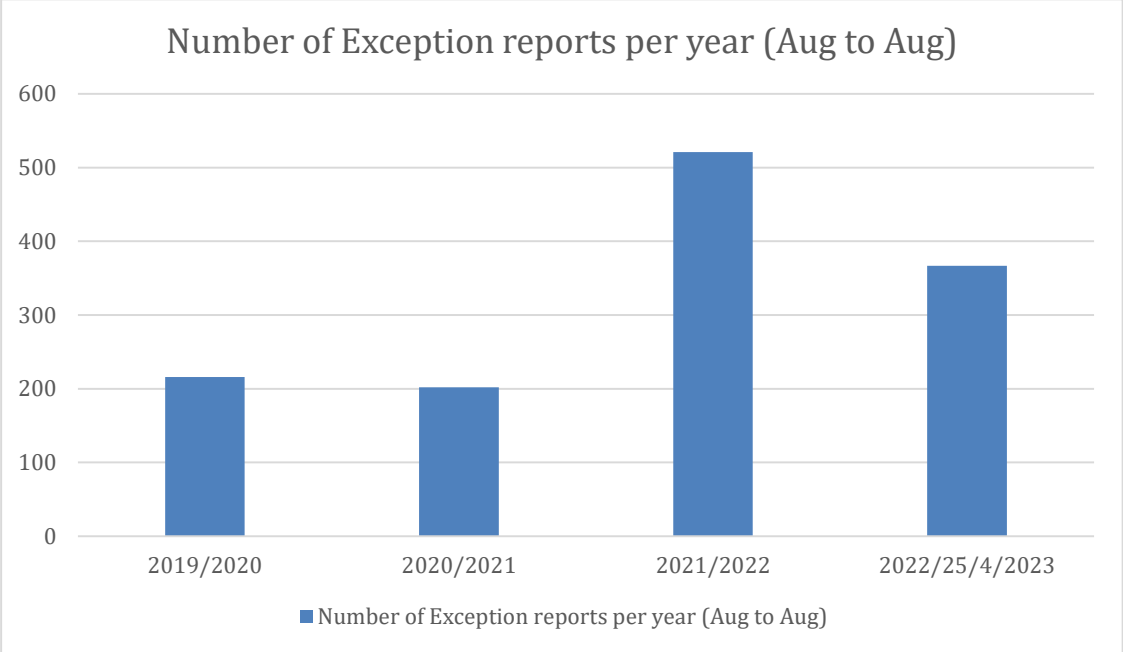
Number of doctors / dentists in training (total): 568.4 WTE
Number of doctors / dentists in training on 2016 TCS (total): 568.4 WTE

Trainees within the Trust

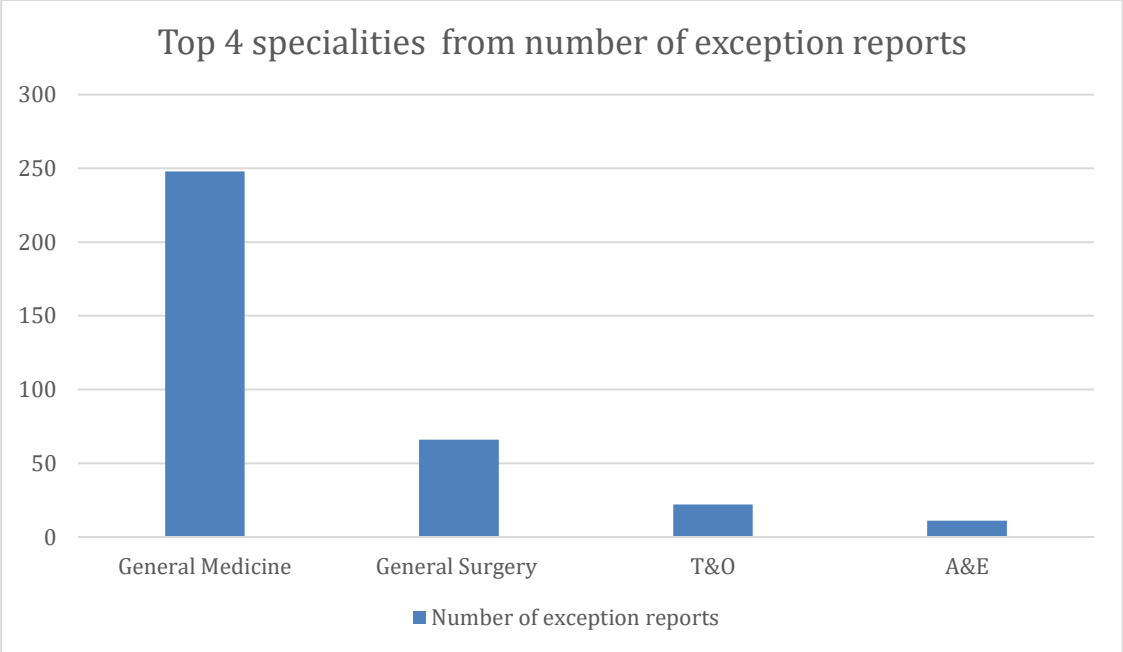
Specialty	Grade	Q1	Q2	Q3	Q4	Total gaps (average WTE)	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
A&E	ST1-ST8	5.8	6	7.2	7.6	6.65	2214	43
Medicine	ST1-ST8	13.2	4.6	4.8	4.8	6.85	2281	44
Surgery	ST1-ST8	6	2.2	1.2	3.2	3.15	1049	21
W&C	ST1-ST8	1.2	3.4	2.6	1	2.05	683	13
Anaesthetics	ST1-ST8	3.4	2.8	2.8	1	2.5	832	16
Radiology	ST1-ST8	1.2	0.2	0.2	1.4	0.75	250	5
Total		**30.8**	**19.2**	**18.8**	**19**	**21.95**	**7309**	**142**

Exception reports

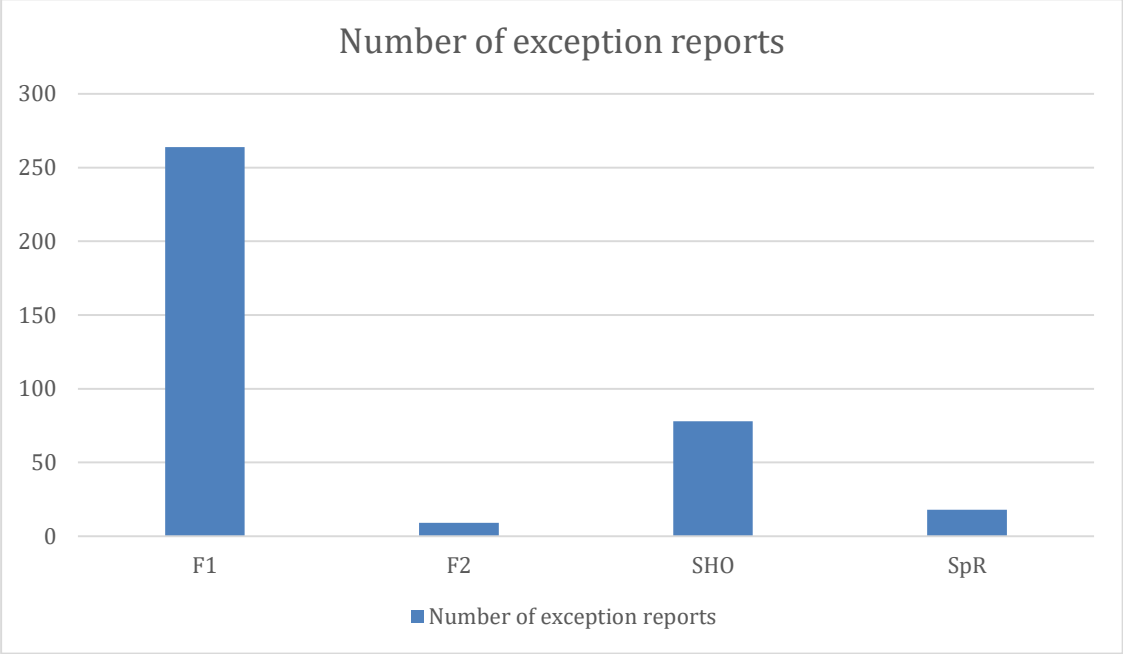
Exception reporting is a mechanism by which doctors receive compensatory time or payment for working outside of the work schedules. The graphs demonstrate the exception reporting system. The data has been collected from August to August, as this period is when the junior doctors rotate and will capture each year's group.



Since the current Guardian of Safe Working started in the role in 2020 there has been an increase in exception reports. The trust has been very supportive and encourages junior doctors to complete exception reports, they provide important information about the reality faced by junior doctors.



General medicine and general surgery rotas continue to have the highest levels of exception reporting.



Foundation doctors continue to complete the highest rate of exception reporting. As a trust all grades are supported to submit exception reports.

Guardian fines

Guardian fines are applied if there is a continued breach of the junior doctor contract. This year two fines have been issued to the surgical division due to breach of contract with juniors shifts exceeding the 13-hour shift rule. This was in relation to the Trauma and Orthopaedic SHO carrying the Urology bleep as well. Another issue in Trauma and Orthopaedic occurred when juniors were staying after their night shift to complete the post take ward rounds, again breaching the 13-hour rule.

Junior doctor forum

The JDF meets every 8 weeks, it is blended i.e., both in person and via Team. This is to encourage maximum participation because of varying junior doctor's shift patterns. It is an open platform, and everyone is welcome. Minutes and action plan are then uploaded to the junior doctors Microsoft team's area to ensure effective communication. There have been a variety of projects over the last year including:

- Digital Medical handover
- IMT 3 clinics organised via Microsoft teams.

Wellbeing

The health and wellbeing of junior doctors is vitally important, both for staff engagement and patient safety. Several initiatives have been completed including:

- Update to the medical registrar's room on both the 2nd and 3rd floor
- Reduction in the numbers of outstanding annual leave and study leave approvals. The guidelines aim is for the requests to be approved within 5 working days, which is continued working progress. However, the number of outstanding requested has reduced from 500 to below 100
- Work schedules are now issued in a more timely manner
- Improvement in car parking arrangements at trust induction

	• Continued commitment to ensure upgrade to the doctor's office (mess) on the 2nd floor. This was delayed due to funding allocation

3	Conclusion
3.1	Exception reporting system is now embedded in the junior doctors practice; however, we need to continue to support the juniors to report. It is recognised that there is national under reporting. Rotas are incredibly complicated and the needs for both the trust and juniors are always changing. However, junior doctor's forum is well established, with effective communication between junior doctors and senior trust management. We will continue to support the junior doctors' compliance of their terms and conditions in order to maintain our reputation as a teaching hospital.

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NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework
April/June 2023

Item 8.9

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

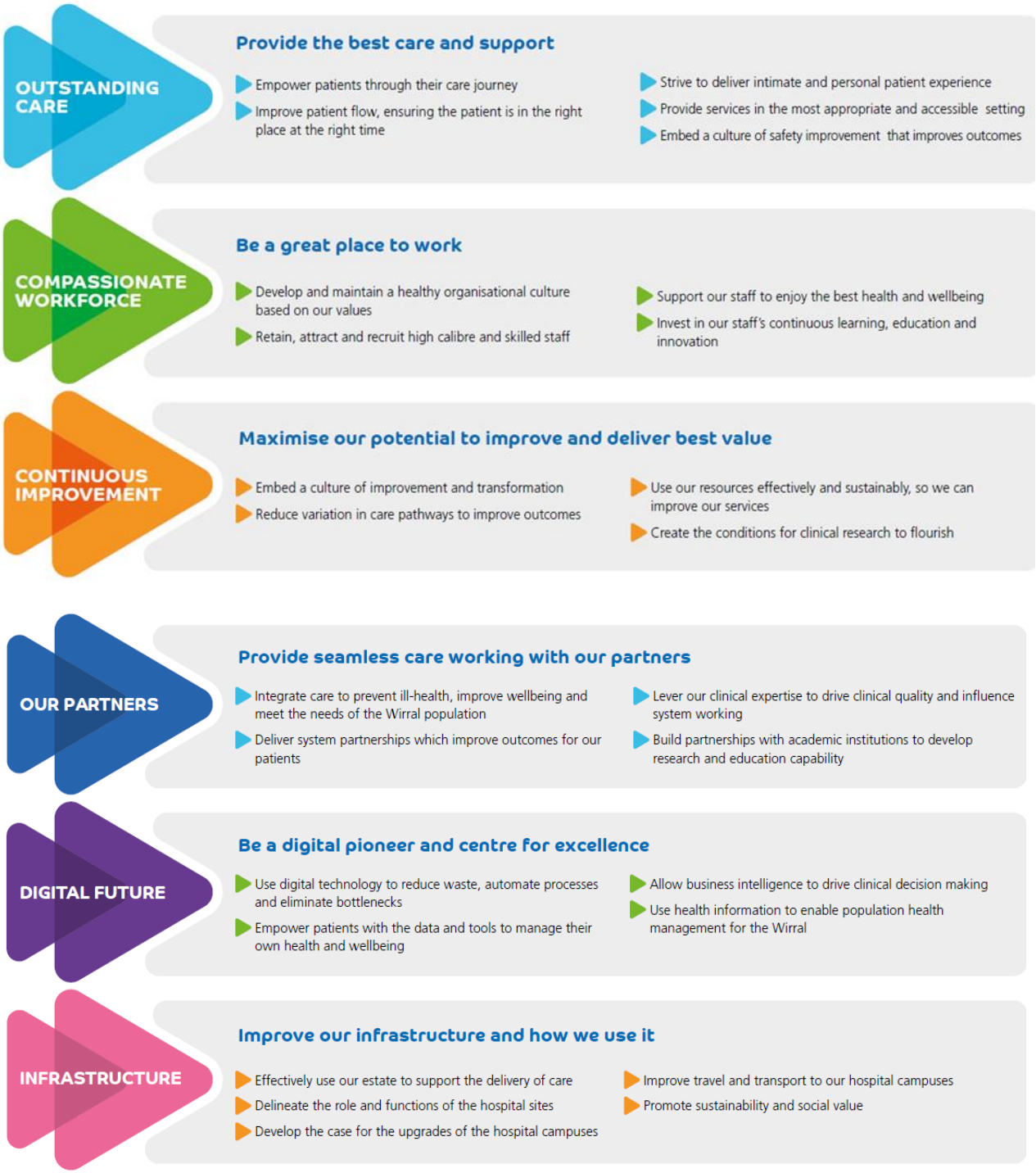
2. Vison, Strategy and Objectives

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

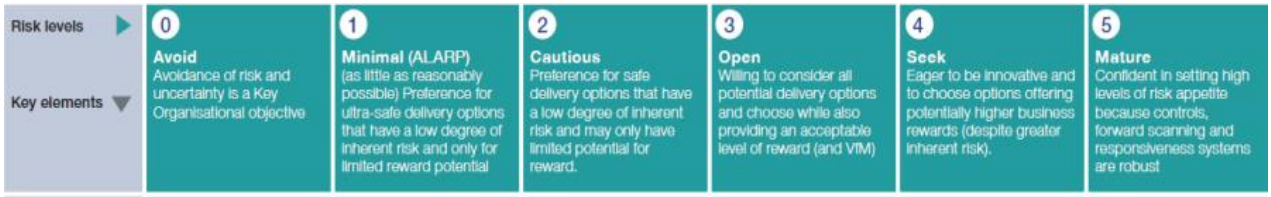
The Trust endeavours to establish a positive risk culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

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.

4.2 Risk Categorisation

All BAF Risk are further identified by the following risk categories:

- Reputational risk. **R**
- Operational risk. **O**
- Strategic risk. **S**
- Compliance risk. **C**
- Financial risk. **F**

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 other 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

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-June 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.

6.3 Recommendations

Board is asked to:

- Note and approve the changes to the BAF.

BOARD ASSURANCE FRAMEWORK 2023-24									
BAF DASHBOARD 2023-24									
Strategic Priority	**Risk No**	**Risk Description**	**Lead**	**Committee**	**Original Score**	**April/June Current**	**July/ September**	**October/ December**	**January/ March**
Outstanding Care **R, O, C, F**	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 **R, O, C, F**	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 **R, O, C, F**	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)	12 (4 x 3)
Compassionate Workforce **O, C, F**	4	Failure to effectively plan for, recruit, reduce absence of, 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	16 (4 x 4)	9 (3 x 3)	N/A	N/A	9 (3 x 3)
Compassionate Workforce **R, O, C, F**	5	Failure of the Trust to have the right culture and organisational conditions/structure to deliver our priorities for our patients and service users.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	N/A	N/A	9 (3 x 3)
Compassionate Workforce **R, O**	6	Failure to maintain our positive staff experience will adversely impact on staff motivation, engagement and satisfaction.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	N/A	N/A	9 (3 x 3)
Continuous Improvement **R, O, F**	7	Failure to embed the Trust's approach to value and financial sustainability and Planning may impact on the achievement of the Trust's financial, service delivery and operational plans.	Chief Finance Officer	FBP	16 (4 x 4)	16 (4 x 4)	N/A	N/A	16 (4 x 4)
Continuous Improvement **R, F**	8	Failure to deliver sustainable efficiency gains due to an inability to embed service transformation and change.	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 **R, O, S**	9	Failure to have strong leadership and governance systems in place.	Chief Executive Officer	Board	12 (4 x 3)	9 (3 x 3)	N/A	N/A	9 (3 x 3)
Our Partners **R, S, F**	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)	12 (4 x 3)	N/A	N/A	12 (4 x 3)
Digital Future and Infrastructure **R, O, C, F**	11	Failure to robustly implement and embed infrastructure plans including digital and estates will adversely impact on our service quality and delivery, patient care and carer experience.	Chief Strategy Officer	FBP and Board	16 (4 x 4)	12 (4 x 3)	N/A	N/A	12 (4 x 3)
Infrastructure **R, O, C**	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 Strategy Officer	Capital, FBP and Board	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)

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

Strategic Priority	Outstanding Care						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Chief Operating Officer	20 (4 x 5)	16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	⬇

Controls	Assurance
• Annual preparation and presentation of a system wide Winter plan in line with the National UEC Recovery Action. • Full participation in the Unscheduled Care transformation programme which includes working with Wirral Community Trust to reduce the numbers of patients attending the ED department who can have their care needs met away from ED. • Onsite support from Wirral Community Trust with the Chief Operating Officer focusing on admission avoidance and supporting early and timely discharge. • Monitoring of ED improvement plan and Wirral system urgent care plan by system Chief Operating Officers including Director of Adult Social care. • Health Economy CEO oversight of Executive Discharge Cell. • Additional spot purchase care home beds in place. • Participation in C&M winter room including mutual aid arrangements. • NWAS Divert Deflection policy in place and followed. • Rapid reset programme launched with a focus on hospital flow and discharge. • Continued communications out to primary care and to Wirral residents around only use A+E for urgent care requirements. • Regular meetings with the divisional leadership teams to ensure actions for improvement are delivered.	• Trust Management Board (TMB) Assurance • Divisional Performance Review (DPR) • Executive Committee • Wirral Unscheduled Care Board • Weekly Wirral COO • Board of Directors • Finance Business and Performance Committee

Gaps in Control or Assurance	Actions
• The Trust continues to be challenged delivering the national 4 hour standard for ED performance. • The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criterion to reside means the Trust occupancy is consistently above 95%, making the delivery of the four target very challenging.	• There is one overall Emergency Department Improvement Plan in place which focusses on ambulance turnaround times, time patients spend in the department and all other national indicators. Following the completion of several service improvements the operational plan for ED will be revised to include new areas of focus as the new leadership team for that area commence in post. • Develop with Wirral system partners a response to the Improving Urgent and Emergency Care Services released in January 2023.

Progress
Key Changes to Note • Further gaps in controls identified. • Additional action added relating to a system wide response required on delivering against the new national measures for improving urgent and emergency care, released in January 2023.

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

Strategic Priority	Outstanding Care						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Chief Operating Officer	16 (4 x 4)	16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	↓

Controls	Assurance
• Clinical harm reviews in place for long waiting patients, full divisional and trust oversight of the overdue follow-up appointments by specialty, the specialities utilise the national clinical prioritisation process which is monitored weekly in divisions. • Utilising of insourcing and LLP to provide capacity to achieve the new national targets . • Access/choice policy in place. Detailed operational plans agreed annually. • Weekly review via the performance meeting, chaired by the COO, on key targets and indicators with agreed actions and mitigations. • Full engagement in the Cheshire and Merseyside Elective Recovery Programme	• Performance Oversight Group (Weekly) • Divisional Access & performance Meetings (weekly) • Think big programme • Monthly Divisional Board meetings • Divisional Performance Reviews • Trust Management Board (TMB) • NHSI/E oversight of Trust improvement plan • There are several specialities whereby recovery plans do not achieve reasonable waiting times in year. These are subject to a full service review with the COO and action plans as required.

Gaps in Control or Assurance	Actions
• There are several specialities whereby recovery plans do not achieve reasonable waiting times in year. These are subject to a full service review with the COO and action plans as required. • National challenge relating to medical staff rates of pay creating uncertainty with regards to additional capacity. • Industrial Action is creating a significant gap in plans to achieve the 2023/24 access targets	• Continue with delivery of mitigation plans for scheduled care, managing the risk with the utilisation of the national policy on clinical prioritisation. • Explore alternative avenues of providing additional core surgical capacity to reduce the backlog of long waiting patients.

Progress
Key Changes to Note • Further gaps in controls identified relating to the impact of Industrial Action • Additional action added.

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

Strategic Priority	Outstanding Care						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Medical Director	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	↑

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

Gaps in Control or Assurance	Actions
• Fully complete and embedded patient safety and quality strategies • Industrial action impacts	• Complete implementation, monitoring and delivery of the patient safety and quality strategies. • Implementation of PSIRF • Monitoring Mental Health key priorities • Complete delivery of the Maternity Safety action plan

Progress
Key Changes to Note • Additional actions added.

BAF RISK 4	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy

Strategic Priority	Compassionate Workforce						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	N/A	N/A	9 (3 x 3)	⟷

Controls	Assurance
• **International nurse recruitment.** • **CSW recruitment initiatives.** • **CSW apprenticeship recruitment.** • **Targeted recruitment initiatives such as recruitment campaigns and international recruitment.** • **Vacancy management and recruitment systems and processes.** • **TRAC system for recruitment.** • **E-Rostering systems and procedures used to plan staff utilisation.** • **E-rostering and job planning to support staff deployment.** • Retention Working Group has been established. • Facilitation in Practice programme. • Training and development activity. • Exit interview process. • Utilisation of NHS England and NHS National Retentions programme resource to review and implement evidence based best practice. • Identification and set up of task and finish groups for the following Staff Groups - Medical and Dental, AHP's and Corporate. The current Nurse and CSW Recruitment & Retention Group is also being reviewed to have an enhanced focus on retention, work continues in this group.	• **Workforce Steering board and People Committee oversight.** • **Internal Audit.**

Gaps in Control or Assurance	Actions
• **National shortages in certain roles and full rollout of clinical job planning are pending workforce planning processes.** • Availability of required capabilities and national shortage of staff in key Trust roles. • Talent management and succession planning framework is yet to be implemented.	• **Monitor impact of retention and recruitment initiatives.** • **Retention working group action plan.** • Identification and review in progress of workforce data sources: ESR reporting, Exit Surveys and Staff Survey to determine priorities and inform the delivery action plan. • **Roll out of clinical job planning.** • **Transfer of OH Services.** • **Actions from National Staff Survey.**

Progress
Key Changes to Note • **N/A**

BAF RISK 5	Failure of the Trust to have the right culture and organisational conditions/structure to deliver our priorities for our patients and service users.

Strategic Priority	Compassionate Workforce						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	N/A	N/A	9 (3 x 3)	⟷

Controls	Assurance
• Year one of the People Strategy. • National Staff Survey. • Pulse Surveys.	• Workforce Steering board and People Committee oversight. • Internal audit.

Gaps in Control or Assurance	Actions
	• Year 2 of flexible working policy. • Implementation of the Perfect Start. • Staff Engagement Framework.

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

BAF RISK 6	Failure to maintain our positive staff experience will adversely impact on staff motivation, engagement and satisfaction.

Strategic Priority	Compassionate Workforce						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	N/A	N/A	9 (3 x 3)	⟷

Controls	Assurance
• Just and Learning Culture. • Merseycare Development Programme. • Leadership Masterclasses. • Just and Learning culture associated policies. • Lessons Learnt forums. • FTSU Policy Review. •	• Workforce Steering board and People Committee oversight. • Internal Audit. • PSIRF Implementation Group. • Lessons Leant Forums. •

Gaps in Control or Assurance	Actions
• N/A	• Just and learning Communications Plan. • Provision for mediation and facilitated conversations. • SOP for supporting staff affected by unplanned events. • Launch Patient and Syllabus Training.

Progress
Key Changes to Note • Addition of controls.

BAF RISK 7	Failure to embed the Trust's approach to value and financial sustainability may impact on the achievement of the Trust's financial, service delivery and operational plans

Strategic Priority	Continuous Improvement						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Chief Finance Officer	16 (4 x 4)	16 (4 x 4)	N/A	N/A	16 (4 x 4)	⟷

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document.	• Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • Monthly COO checks and monitoring.

Gaps in Control or Assurance	Actions
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Limited assurance on delivery as plans are in early stages and timelines for delivery still subject to change. • Uncertainty of impact of industrial action	• Finalise estates strategy and agree priority programmes. • CFO to present a full review of Forecasting to the FBPAC. • Continue delivery of CIP programme and maintain oversight of divisional progress. Ongoing. • Complete benchmarking and productivity opportunities review pack. • Develop CIP opportunities to include all trust wide strategic and transformational plans. • Review and develop CIP Governance and Accountability.

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

BAF RISK 8	Failure to deliver sustainable productivity gains due to an inability to embed service transformation.

Strategic Priority	Continuous Improvement						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Chief Strategy Officer	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↑

Controls	Assurance
• Programme Board oversight. • Service improvement team and Quality Improvement team resource and oversight. • QIA guidance document implemented as part of transformation process. • Implementation of a programme management process and software to track delivery. • Quality impact assessment undertaken prior to projects being undertaken.	• Quarterly Board assurance reports, Monthly Programme Board chaired by CEO to track progress. • COO monthly tracking of individual projects with scrutiny at programme board meetings. • Rotational presentations by divisions to FBPAC meetings with effect from October 2021. Monthly CIP report to FBPAC. • MIIA internal audit review of Cost Improvement Programmes, which highlighted an audit opinion of moderate assurance. • External audit report.

Gaps in Control or Assurance	Actions
• Lack of protected time due to conflicting priorities in service delivery, particularly in relation to clinical staff. • Lack of clarity on H2 arrangements and financial arrangements for 2022/23 period. • Historic estate infrastructure system working. • Lack of clarity on financial arrangements for 2022/23 period. • Historic estate infrastructure. • Ability to deliver system wide change across Wirral NHS organisations. • Lack of clarity on H2 arrangements and financial arrangements for 2022/23 period, limits level of assurance in board and committee reports.	• Implementation and delivery of Cost improvement and Transformation Programmes for 22/23 and delivery of 22/23 Improvement Programme to plan. • Implementation of revised Cost Improvement approach.

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

BAF RISK 9	Failure to have strong leadership and governance systems in place.

Strategic Priority	Continuous Improvement						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Chief Executive Officer	12 (4 x 3)	9 (3 x 3)	N/A	N/A	12 (4 x 3)	↓

Controls	Assurance
• Board oversight and governance reporting. • Board Development Programme. • Well led and maturity assessments in place. • Board Appraisal and Development Plans. • Clear recruitment process. • NHS Code of Governance. • Forward plan and work programme.	• Board and Committee reporting. • Development Programme. • Assessment and Adoption of the NHS Code. • Internal Audit.

Gaps in Control or Assurance	Actions
• N/A	• Continuous review of Governance structure and reporting.

Progress
Key Changes to Note • Additional control added.

BAF RISK 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.

Strategic Priority	Our Partners						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Chief Executive Officer	12 (4 x 3)	12 (4 x 3)	N/A	N/A	12 (4 x 3)	⟷

Controls	Assurance
• WUTH senior leadership engagement in ICS through Director of Strategy and CEO. • Wuth Strategic intentions are aligned with the ICS, for example ensure master plans and decisions are taken as a system to optimise the way we use public estate across Wirral to deliver organisation and ICS objectives. • National guidance on PLACE based partnerships Legislation framework. • ICS design framework. • ICS Body governance. • Input of Trust CEO and Director of Strategy into Outline of the ICP Structure.	• CEO and Director of Strategy updates to Board and Executive Director meetings. • Chair, CEO and Chief Strategy Officer attendance at Healthy Wirral Partners Board. • Secondment of Head of Strategic Planning to develop ICP/Place operating model. • ICS Chair updates, ICS meetings, ICS Self-assessment submission. • CMAST CEO and Directors of Strategy meetings. • Healthy Wirral Partners Board.

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

Progress
Key Changes to Note • Additional actions identified.

BAF RISK 11	Failure to robustly implement and embed infrastructure plans including digital and estates will adversely impact on our service quality and delivery, patient care and carer experience, and our ability to transform services in line with our aspiration to be a leader in our ICS.

Strategic Priority	Digital Future and Infrastructure						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Chief Finance Officer	16 (4 x 4)	12 (4 x 3)	N/A	N/A	12 (4 x 3)	⟷

Controls	Assurance
• Assessment of Capital requests. • Capital bid process. • Capital Contingency. • Risk management via Ulysses. • Reporting to Capital and Estates Committee.	• Funding approvals. • Scale of projects versus resources. • Capital Committee. • Governance structures for key projects.

Gaps in Control or Assurance	Actions
• N/A	• Continue to track delivery. • Further develop reporting. • Continual reassessment of requests.

Progress
Key Changes to Note • N/A

BAF RISK 12	Risk of business continuity and the provision of clinical services due to a critical infrastructure supply chain failure therefore impacting on the quality of patient care.

Strategic Priority	Infrastructure						
Review Date	31/03/23	Initial Score	April/June Current	July/ September	October/ December	January/ March	Direction of Travel
Lead	Chief Strategy Officer	12 (4 x 3)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	↑

Controls	Assurance
• Implementation of capital programme, which includes remedial works at Clatterbridge. • Senior Clinician input in key decisions around key areas such as critical care. • Estates Strategy. • Agreed 3 year Capital Programme. • Business Continuity Plans. • Stock capital process. • Procurement and contract management. • Bespoke digital healthcare team. •	• Capital Committee oversight. • FBP oversight of capital programme implementation. • Board reporting. • Internal Audit Plan.

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

Progress
Key Changes to Note • Additional actions identified.

Appendix – Risk Scoring Matrix

Risk Scoring and Grading:

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

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

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

Appendix – Risk Appetite Scoring Matrix

Board of Directors in Public **Item 9.1**
7 June 2023

Report Title	Committee Chairs Reports - Audit and Risk Committee
Author	Steve Igoe, Chair Audit and Risk Committee

Overview of Assurances Received

This report updates on the work of the Audit and Risk Committee at its meeting on 27 April 2023.The work of the Audit and Risk Committee as well as being documented in its terms of reference is prescribed by Accounting /Auditing Standards and Regulatory requirements.

Internal Control and Risk Management

Regular reports were received relating to Financial Assurance and Procurement Spend controls.

The Committee was provided with an update on transactional issues relating to losses, special payments, and outstanding debts. Following queries raised previously by the Committee in relation to stock losses the new Head of Pharmacy attended to explain to the Committee the reasons for such losses and the systems used by WUTH to minimise exposure to such losses. Discussion also took place into the opportunities to recycle medicines including internationally where possible. The Committee was assured by the detailed analysis and presentation from Pharmacy. The procurement spend report was discussed and the Committee noted:

- That the Trust had exceeded the model health system metrics target for spend control and process efficiency.
- That there is a robust process to identify and reduce ad-hoc spend.
- That the use of national and regional frameworks has reduced incidents of non-compliant spend.

Review of Accounting Policies

The Assistant Director of Finance introduced a detailed paper on Accounting Policies to be used to construct the WUTH Accounts for the year to 31 March 2023.She confirmed that there were no material changes to the policies this year. The Committee noted the report and agreed to review the position further in the light of receiving the External Audit report following the Audit of the Trust's accounts.

Review of Management Estimates

All financial statements include a range of valuation items in their construction. The Deputy Chief Finance Officer took the Committee through the relevant valuation estimates impacting on this year's accounts. Those estimates this year relate to:

1) Annual Leave accrual
2) Flowers provision
3) Employee relations /Tribunals outcomes and costs
4) Clinical Support Workers salary adjustments
5) Consultants' income

The Committee discussed the need and calculation of the provisions and approved them.

Draft 2022/23 Accounts

The draft accounts were briefly discussed. The Assistant Director of Finance had prepared a paper which unfortunately had not been circulated with the papers. Nonetheless the detail included therein was discussed. It was noted that the Committee will again consider these accounts in detail prior to recommending approval to the Board. It was agreed that a detailed reconciliation of the statutory position to that reported to the Board on a management accounts basis would be helpful.

Internal Audit Progress and Reports

The Committee received the regular report from the Internal Audit Service. Outcomes were as follows:

1) Sickness absence – Moderate Assurance
2) ESR HR/payroll controls – Moderate Assurance
3) HR & Wellbeing service payroll review /3rd party assurance -Substantial Assurance
4) Recruitment review – Substantial Assurance
5) Assurance Framework Opinion (not rated)

Internal Audit follow up report and WUTH Audit tracker

The Committee noted the progress in resolving issues raised through the Audit process .In its detailed discussions that fact that a number of items were now substantially overdue was noted .As a result the Committee asked that for any such items outstanding in September i.e. older than 22/23 then the relevant Executive Director should attend the Committee and explain the position , the reasons for the delay and confirm that they will be resolved as soon as possible .The Committee agreed that no outstanding actions should persist for any longer than the previous year.

Head of Audit Opinion

The Committee received the Annual Head of Audit Opinion. This states:

"*The overall opinion for the period 1st Aril 2022 to 31st March 2023 provides Substantial Assurance, 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 is a positive outcome, and the Committee commended the Executive on the work done in supporting and enhancing the overall control environment throughout the year.

Anti-Fraud service annual report and work plan

A detailed analysis of the work done during the year was included within the report. The outcome reported was positive. Specifically, the self- assessment against the Government Functional Standard 013 for Counter Fraud showed the Trust rated green for 12 of the thirteen standards with an amber rating for only one related to training which will be addressed this year.
The Anti-Fraud Work Plan for 2023/24 was presented to the Committee and approved.

Board Assurance Framework

The BAF was discussed by the Committee which noted in detail the contents. It was agreed that at future meetings the Committee would undertake a deep dive into one/two of the risks on a rolling basis to obtain further assurance on the identification and management of the same.

The Committee approved the submission of the BAF to the Board and confirmed the ongoing management of risk as appropriate.

Register of interest and gifts and hospitality

A detailed update was presented on the Trust's management of its register of interests. As at 31st March there were 1459 members of staff who fell within the disclosure categories set out in the Trust's policy. Of these 1311 had completed the relevant declaration. This comprised 90% of the relevant population compared to just 20% the previous year. The Committee noted this as a herculean task and colleagues were commended for their significant efforts in this area.
In terms of hospitality and gifts it was noted that further work is required in this area although a detailed policy is available. The committee noted that with the work of the Trust expanding in various Research areas this will inevitably expose the Trust to potential new risks not previously experienced.

Annual Governance Statement (AGS)

A draft of this year's AGS was discussed by the Committee. It was noted that there are a number of areas in the tabled version yet to be updated and that much of the content is prescribed. The Committee noted the current version recognising that it would have a further opportunity to comment at its next meeting.

Annual Report of the Committee including its effectiveness review

The Committee considered the detailed report which provided an overview of the work of the Committee during the year and a commentary on its effectiveness. An assessment against the Committee's terms of reference was also conducted along with recommendations for any amendments.

The Committee received a positive effectiveness assessment and other than a minor change in relation to locus of responsibility for clinical audit falling under the quality committee confirmed its terms of reference.

The Committee confirmed that it is properly composed, with appropriate skills and has met a sufficient number of times to conduct its business. The Committee has reviewed its work and confirms that it has discharged its duties in line with the authority delegated to it by the Board via its terms of reference and is therefore operating effectively.

Cycle of Business

The work plan of the Committee for 23/24 was received and noted.

Internal Audit Charter

The MIAA Internal Audit Charter was received and noted.

Board of Directors in Public
7 June 2023

Item 9.2

Report Title	Committee Chairs Report – Quality Committee
Author	Dr Steven Ryan, Chair of Quality Committee

Items for Escalation/Action

- The Committee seeks regular assurance via key reports scheduled in its work plan. The reports are overseen by the Medical Director and Chief Nurse together with their colleagues, and particularly the Deputy Director of Quality Governance. This month the key reports were:
    1. Patient Safety Quality Board Key Issues
    2. Serious Incident Panel Chairs Report
    3. Quality and Performance Dashboard
- Although only one Serious Incident report was signed off in month, it highlighted an ongoing concern about risk of falls, that, when 1:1 care was compromised by staff being pressed into other duties in busy clinical areas with high acuity levels, falls risk could be increased. Although the statistical process control chart shows that moderate and severe fall rates are within control limits for much of the time, they are reaching the upper control limit at times. Quality improvement & training work overseen by the Chief Nurse aims to prevent falls due to lapses in care processes and there are early positive indicators of effect. The outcome of the work will continue to be monitored at each meeting of the Committee.
- The Committee noted that for this year's Commissioning for Quality and Innovation Standards (CQUINS), the Trust would likely achieve 4, partially achieve 2 and fail to achieve 2. Reasons for non-achievement were noted and assurance was received that although no longer a commissioned CQUIN, the Trust would aim to meet the required standard of care inputs and their recording for two areas: the standard related to detection of liver fibrosis in patients at risk of harm from alcohol and the treatment of community acquired pneumonia. The Committee asked for an update on the timetable for this at its next meeting.
- The Committee noted a high level of patient concerns (level 1) were recorded in March. It was agreed to explore any systematic reasons for this and to continue to monitor this metric through the Dashboard.
- Improvement in the timeliness of responding to patient complaints was noted. However, an issue had been identified in the initial quality of the draft responses (in some cases), which was leading to delays. As a result, feedback and specific training were being given to departments to improve the quality of drafts.

New/Emerging Risks

- Following a Never Event and concerns about the use of 2 clinical informatics systems with limited connectivity, the Committee received an overview of the work being undertaken in the Surgery Division, to bolster governance and reporting. The Committee requested an update on the action plan at its next meeting.
- The Committee noted the key risks under its purview on the Board Assurance Framework. It acknowledged that despite its understanding of effective internal systems of control and quality improvement, factors external to the Trust meant that the level of risk should remain high.

Overview of Assurances Received

- An updated position on harm reviews indicated that 1698 such reviews undertaken since January 2018, in which 9 patients had been identified who came to moderate harm. This was across Cancer (1 patient), Priority 1 & 2 (3 patients) and Priority 3 (5 patients). This gave assurance that the harm surveillance mechanisms are suitably calibrated with on-going oversight.
- There was good evidence that the reformed Clinical Outcomes Group (which reports to this Committee via the Patient Safety and Quality Board) was getting to grips with its areas of delegated work and oversight. This includes oversight of our Commissioning for Quality and Innovation Standards (CQUINS – see above).
- The Draft Quality Accounts for 2022/23 were presented and the Committee were assured that they are an honest and fair reflection of the achievements and challenges that we have had oversight-of through the year. The Committee determined that the draft was a good basis for the final report to be prepared.
- The Committee were assured that there continues to be effective oversight of infection prevention and control measures, important given our lack of isolation facilities and high levels of occupancy. This oversight is to be enhanced with a specific Business Intelligence Portal.

Annual Report of the Committee & Statement of Effectiveness

The Committee confirms that it is properly comprised with the appropriate skills, and has met a sufficient number of times to conduct its business. The Committee has reviewed its work and confirms that it has discharged its duties in line with the authority delegated to it by the Board via its Terms of Reference, and is therefore operating effectively. The Chair thanked the members of staff who had prepared and presented high quality reports that enabled the Committee to discharge its duties.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public

07 June 2023

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

Report Purpose and Recommendations

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

It is recommended that the Board:

- Approves the updated statement for 2023-24.

Key Risks

This report relates to these key Risks:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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

Governance journey

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

1	Narrative
1.1	The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency both in the organisation and within its supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act. The requirement for an annual statement is set out in Section 54 of the Act, specifically addressing the requirement for transparency in the supply chain. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The Act requires that the statement is approved annually by the Board of Directors. This year's statement has been updated in discussion with the Director of Corporate Affairs and the Assistant Director of Finance – Head of Procurement. The Board are asked to review the statement at section 1.2 and provide approval. Following this, it will be signed by the Chair and the CEO and published on the Trust website.
1.2	**Modern Slavery and Human Trafficking Act 2015 Annual Statement – 2022** Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business. The aim of this statement is to demonstrate that the Trust follows good practice, and all reasonable steps are being taken to prevent slavery and human trafficking. Wirral University Teaching Hospital NHS Foundation Trust provides a comprehensive range of high quality acute care services, our more than 6,200 strong workforce serves a population in excess of 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider Northwest footprint. We operate across two main sites, these being Arrowe Park Hospital in Upton and Clatterbridge Hospital in Bebington. We also provide a range of outpatient services from community locations at St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey. The Trust has well established and robust recruitment and vetting procedures and seeks to ensure that suppliers operate in accordance with the provisions of the Modern Slavery Act. The Trust has a total non-pay spend of c.£130m on goods, equipment and services. The Trust aims to achieve value for money and to promote social values through its contracting and purchasing activity, and the effective utilisation of the Trust's spend contributes significantly to the quality of the patient environment and patient care. The Trust supports the eradication of Modern Slavery through its procurement procedures and processes and is clear that it expects all potential suppliers to be fully compliant with the provisions of the Modern Slavery Act. The Trust recognises that whilst there are laws in place to punish incidents of modern slavery, there is an opportunity to use its purchasing power to help prevent, identify and manage the risks of it occurring in its supply chain by adopting new processes and procedures in both its procurement activity and supplier management.

	The Trust has adopted a number of measures already, which include: • The use of Public Sector Frameworks where there is strong awareness of and monitoring for Modern Slavery in the supply chain. • The mandatory exclusion of any bidder that has been convicted of a human trafficking offence, and the Trust's contracts include • The inclusion of terms and conditions conferring a legal responsibility on Contractors to support that same objective to eradicate slavery and human trafficking. We acknowledge that these measures can be strengthened in line with the Procurement Policy Note PPN02/2023 (Tackling Modern Slavery in Government Supply Chains) so that: • There is a better and wider understanding of the risk and the sectors identified as being at high risk of modern slavery. • We identify and manage the risks when procuring new contracts-using a proportionate and risk assessed approach. • Risks are managed in existing contracts and arrangements. • Procurement staff are appropriately trained so that there is a consistent level of understanding of the issues; that they are able to recognise and effectively manage procurement activity where there is a potential risk and are able to deploy mitigating strategies to reduce the possibility of modern slavery occurring in the Trust's supply chain. Our approach will be monitored and reviewed in line with the provisions of the Trust's Procurement Strategy.

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

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

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

Board of Directors in Public **Item 11**

07 June 2023

Title	Cheshire and Merseyside ICB Joint Forward Plan
Area Lead	Matthew Swanborough, Chief Strategy Officer
Author	Matthew Swanborough, Chief Strategy Officer
Report for	Approval

Report Purpose and Recommendations

The appended 5 year Cheshire and Merseyside ICB Joint Forward Plan (JFP) describes how Cheshire and Merseyside Integrated Care Board (ICB), partner NHS trusts and our wider system partners will work together to arrange and provide services to meet our population's physical and mental health needs.

The Joint Forward Plan contains the actions the ICB will take as an Integrated Care System (ICS) to deliver the priorities identified in:

- The Cheshire and Merseyside draft interim Health and Care Partnership Strategy
- The Joint Local Health and Wellbeing Strategies of our nine Place based Health and Wellbeing Boards
- The priorities outlined by NHS England in The NHS Long Term Plan and the national NHS Planning guidance for 2023-24

The Joint Forward Plan aims to improve the health and wellbeing of the Cheshire and Merseyside population, improve the quality of services, and make efficient and sustainable use of NHS resources.

The ICB are required to approved and publish the Joint Forward Plan by the end of June 2023.

It is recommended that the Board of Directors:

- Endorse the Joint Forward Plan of the Cheshire and Merseyside ICB

Key Risks

This report relates to these key Risks:

- Partnership working

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**
6th June 2023	Executive Committee	As above	Noted. Request to be presented at Public Board meeting

Author	Matthew Swanborough, Chief Strategy Officer
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www.cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

Cheshire and Merseyside

Joint Forward Plan

SUMMARY – DRAFT VERSION 1.5






1. About this document

We know that people's lives are better when organisations that provide health and care work together, particularly at the times when people need care most.

This document – our Joint Forward Plan (JFP) – describes how Cheshire and Merseyside Integrated Care Board (ICB), our partner NHS trusts and our wider system partners will work together to arrange and provide services to meet our population's physical and mental health needs.

This Joint Forward Plan contains the actions we will take as an Integrated Care System (ICS) to deliver the priorities identified in:

- The Cheshire and Merseyside draft interim Health and Care Partnership Strategy
- The Joint Local Health and Wellbeing Strategies of our nine Place based Health and Wellbeing Boards
- The priorities outlined by NHS England in The NHS Long Term Plan and the national NHS Planning guidance for 2023-24 (Appendix 1)

Our Joint Forward Plan aims to:

- improve the health and wellbeing of our population.
- improve the quality of services.
- make efficient and sustainable use of our resources.

We are committed to working on all three of these aims simultaneously to best meet our population's needs and to reduce inequalities in access and outcomes.

These aims also align to our statutory duties as an ICB. The details of these statutory duties can be **found here**.

Our Joint Forward Plan aligns with the recently published Hewitt Review (April 2023), which considers the future development of Integrated Care Systems in England. The review supports taking a 'whole system approach' to addressing wider determinants of health, and a shift of focus away from treating problems towards maintaining good health. These two themes align with our statutory duty and also our local commitment to integrate services to benefit our population.

Our approach to developing this Joint Forward Plan

The Cheshire and Merseyside Integrated Care Board was formally established in July 2022. We have already made significant progress, but we are still in a developmental phase and we have considerable work to do to further develop our plans and priorities. This Joint Forward Plan should be read in this context.

Whilst the responsibility to develop this plan sits with NHS Cheshire and Merseyside, and our NHS Providers, we have adopted a collaborative approach to developing this plan. We drew on the wide range of expertise, knowledge, and experience of our health and care professional leaders and partners to help us identify ways to improve integration and innovation. This will help us to deliver better outcomes for our population.

This 2023-2028 Cheshire and Merseyside Joint Forward Plan describes at a summary level the approach we are taking to tackle the current challenges we face in recovering access to services following the Covid 19 pandemic.

It also outlines a programme of radical transformation across our health and care system to address longstanding issues of inequalities in outcomes and financial sustainability.

This JFP builds on our draft interim Health Care Partnership Strategy. The strategy is built around four core strategic objectives:

- Tackling Health Inequalities in outcomes, experiences and access (our eight Marmot principles).
- Improving population health and healthcare.
- Enhancing productivity and value for money
- Helping to support broader social and economic development.

These objectives support us to work towards achieving our vision and mission. The draft interim Health Care Partnership Strategy is broadly focused and contains many priorities. The HCP recognise the need to decide what to prioritise to enable progress to be made. Our residents provided feedback on the draft interim strategy during March and April 2023 which supported this view.

Figure 1: Cheshire and Merseyside Health Care Partnership Vision and Mission

The HCP Strategy is currently in draft form and will be finalised later in 2023, in recognition of this ongoing work we have identified a number of priorities which contribute to making early progress against the ambitions outlined in the draft interim Strategy.

When the priorities in the HCP Strategy are finalised, we will refresh these priorities in our updated Joint Forward Plan, which will be published in March 2024.

Figure 2: Cheshire and Merseyside Priorities

HCP Strategic Objectives	Cross reference to the HCP areas of focus	Priorities	Core plans *	Metric
Tackling Health Inequalities in outcomes, experiences, and access (our eight Marmot principles)	• Give every child the best start in life • Enable all children, young people and adults to maximise their capabilities and have control over their lives • Ensure a healthy standard of living for all • Tackle racism, discrimination and their outcomes • Pursue environmental sustainability and health equity together.	All our Places are actively engaged in the All Together Fairer Programme	**2**	Increase % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage Reduce hospital admissions as a result of self-harm (15-19 years)
		Supporting the safety of vulnerable Women and Children	**2**	Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing Violence Against Women and Girls
Improve population health and healthcare	• Improve early diagnosis, treatment and outcome rates for cancer • Improve satisfaction levels with access to primary care services • Provide high quality, accessible safe services • Provide integrated, accessible, high quality mental health and wellbeing services for all people requiring support.	In relation to preventing ill Health we will focus on: • Increase rates of Early detection of Cancer • Work towards MECC (Making Every Contact Count) • Encourage *'Healthy Behaviours'* with a focus on smoking/alcohol/ physical activity • Ensure access to safe, secure, and affordable housing	**1,2,3**	Core20PLUS5 priorities including cancer, cardiovascular disease and children and young people's mental health services
			2,3	Increased sign up to the NHS prevention Pledge
			2,3	Reduction in Smoking prevalence. Reduction in the % drinking above recommended levels. Increase the % who are physically active.
Enhancing productivity and value for money	• Develop a financial strategy focused on investment on reducing inequality and prioritise making greater resources available for prevention and wellbeing services	Deliver our agreed financial plans for 23/24 whilst working towards a balanced financial position in future years	**1**	Financial strategy and recovery plan in place by Sept 2023
Helping to support broader social and economic development	• Embed, and expand, our commitment to social value in all partner organisations • Develop as key Anchor Institutions in Cheshire and Merseyside, offering fair employment opportunities for local people • Implement programmes in schools to support mental wellbeing of young people and inspire a career in health and social care	Develop as key Anchor Institutions and progress advancing at pace the associated initiatives.	**2**	Grow the number of anchor framework signatories to 25
		Embed and expand our commitment to Social Value	**2**	Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%)
		• Developed focused work in schools around encouraging careers in Health and Social Care • Ensure a Health and Care workforce that is fit for the future.	**2**	To be finalised in advance of the final publication in June 2023 Publish a Strategic Workforce Plan by March 2024
		Achieve Net Zero for the NHS carbon Footprint by 2040	**2**	For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

***1. Delivery against NHS Operational plan and Long-Term Plan (See appendix 1)**

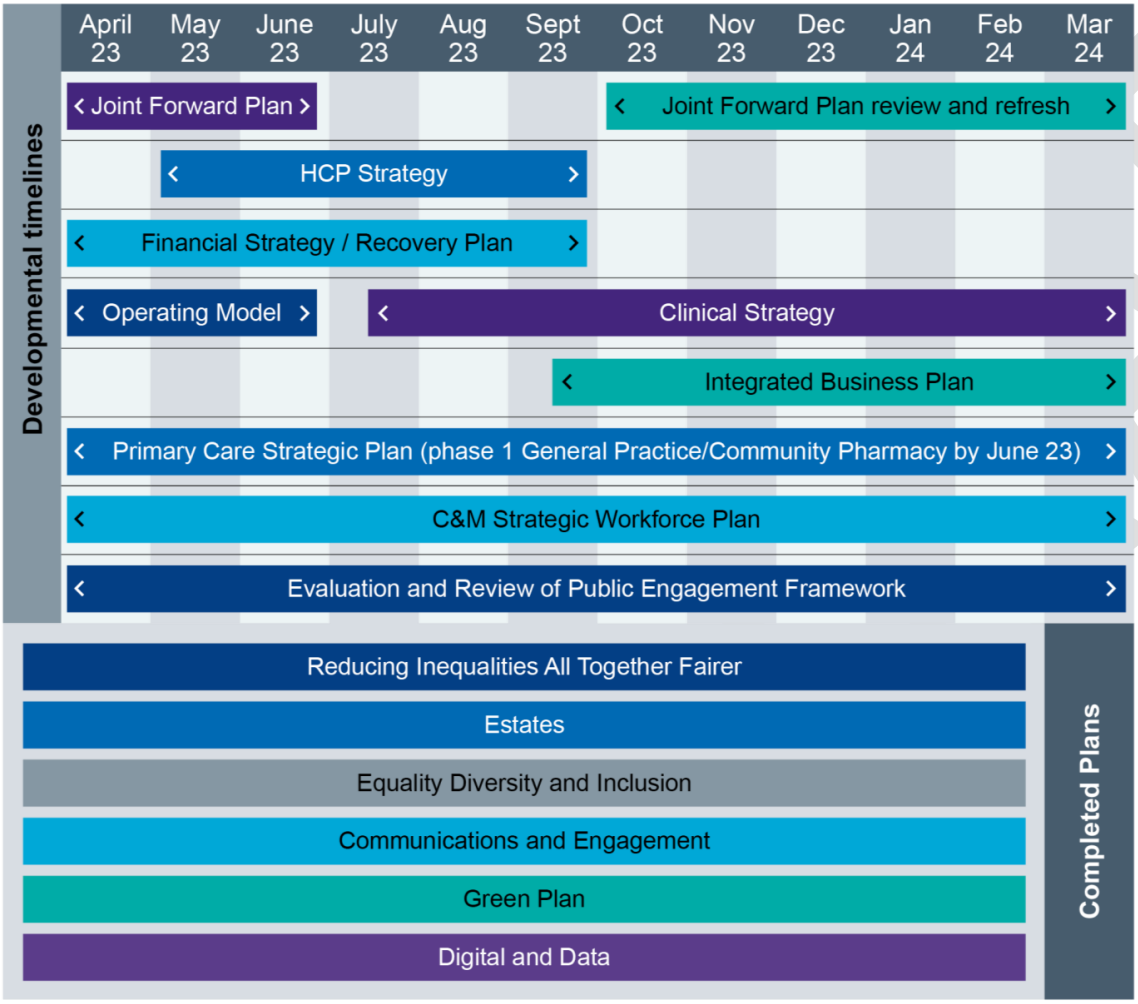
***2. Delivery against the Marmot Beacon Indicators / All Together Fairer (See appendix 2)**

***3. Core20PLUS5 (See appendix 3)**

Whilst this summary document is relatively short, it is underpinned by significant activity across all of the priorities included in the table above. There are various links within this document which provide access to more detail about specific work programmes.

In developing this Joint Forward Plan, we recognise that we are in a developmental phase as an Integrated Care System and that there are some key pieces of planning and strategy work which we will need to align.

We intend to develop a fully integrated business plan during 2023/24 that will incorporate the key strategic plans we have either already developed or intend to develop during this year. These will be reflected in the next iteration of this Joint Forward Plan in March 2024.The table below shows our completed plans and outlines our developmental timeline for 2023/24.



2. How we work as partners for the benefit of our population

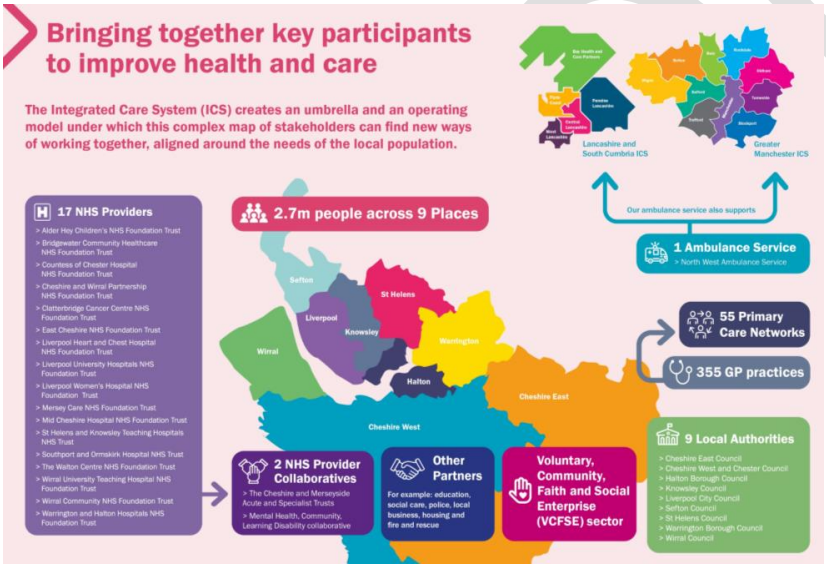
Cheshire and Merseyside is one of the largest Integrated Care Systems in England, with a large number of stakeholders working together to improve the health and care of our population.

The figure below illustrates how we are configured at a Cheshire and Merseyside level.

Some of the ways we come together in the Cheshire and Merseyside system are:

- The Cheshire and Merseyside Health and Care Partnership (HCP). This is a statutory joint committee between NHS Cheshire and Merseyside Integrated Care Board and our nine Local Authorities which also includes a wide range of partners from across the health and care system. This Board works together to support partnership working and is responsible for producing our Health and Care Partnership Strategy
- The NHS Cheshire and Merseyside Integrated Care Board. This is a statutory NHS organisation responsible for managing the NHS budget and arranging for the provision of health services whilst supporting the integration of NHS services with our partners.
- Our nine Place Based Partnerships. These work locally to support the integration of health and care services in support of local Joint Health and Wellbeing Strategies

Figure 3: Cheshire and Merseyside Integrated Care System

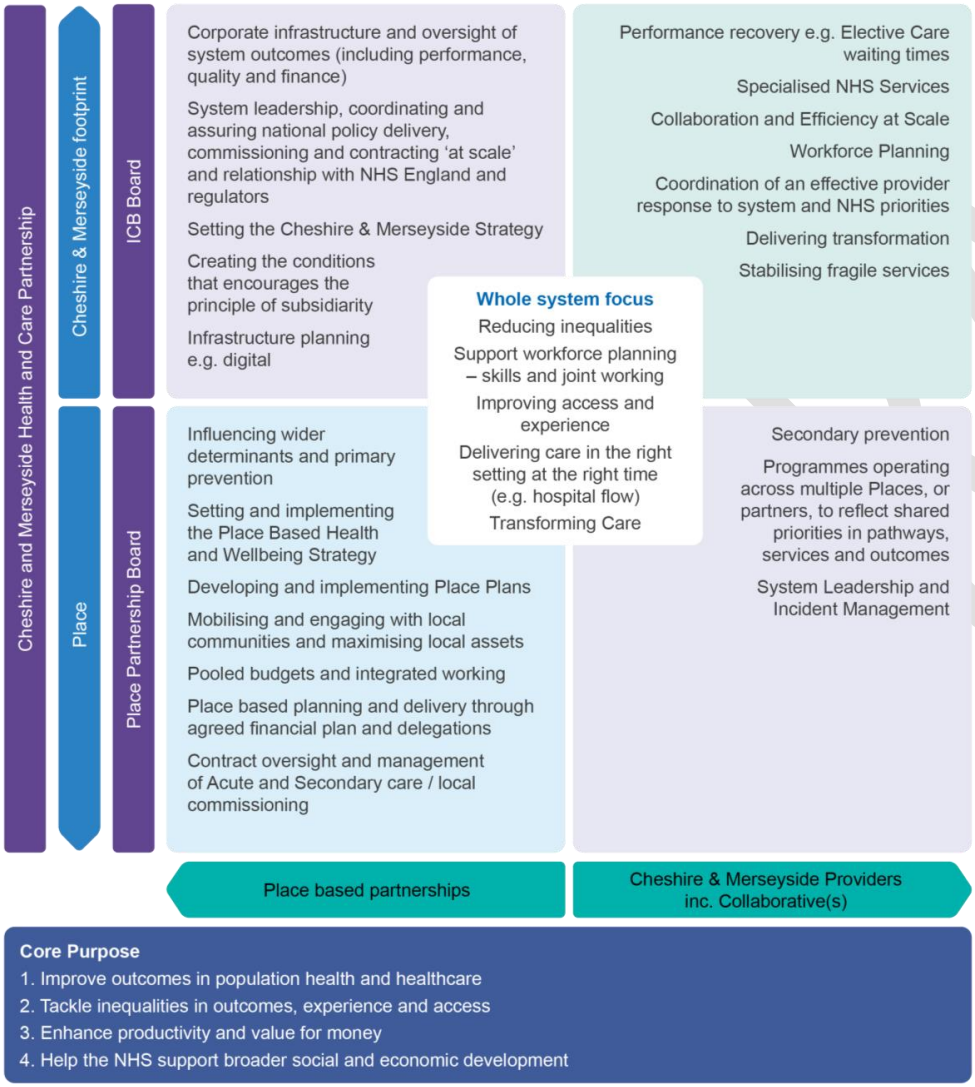


Through our Place based partnerships and the communities within them we are committed to the principle of subsidiarity. This means that we want to make decisions as locally as possible. Our Places and communities are the 'engine room' which drive change by designing and delivering services around the needs of the local population.

Complementary to this principle of subsidiarity, our large ICS provides opportunities to work at scale where appropriate. This enables us to share best practice and to work collectively to deliver efficiencies and manage change. As an example, our two NHS Provider Collaboratives support our NHS providers to work together to deliver service improvement and enhance sustainability.

The picture below shows how we apply the principle of subsidiarity to decision making in our Places and the communities within them, whilst realising the benefits of working at scale in certain areas through our Health and Care Partnership, or ICB-wide programmes or through our two Provider Collaboratives.

Figure 4: Decision making and subsidiarity in Cheshire and Merseyside



Communications and Engagement

As system partners we are committed to engaging with people and communities. We know that harnessing the knowledge and experience of those who use and depend on the local health and care system can help improve outcomes and develop better, more effective services including removing or reducing existing barriers to access.

We are committed to working with those with lived experience to understand the impact of health inequalities and to support us in designing and implementing solutions to address these.

Our Green Plan

Climate change poses a threat to our health as well as our planet. Across Cheshire and Merseyside, we are committed to achieving net zero by 2040 (or earlier). The ICB and NHS Trusts and many Local authority partners have well established plans to achieve this.

Complementary to these local plans, NHS Cheshire and Merseyside has a strong system level Green Plan, and we work collaboratively as system partners to maximise the impact of our initiatives.

Our planet will continue to warm until circa 2060 we will continue climate adaptation / mitigation work to ensure we can continue to provide access to quality health and care for our population even as the climate changes. Including work to tackle air pollution, increased access to mental health services, coastal and other flooding, vector-borne diseases / prep for changing patterns of disease / sustained heat and high temperatures / impact on patients and on workforce, etc.

We will:

Reduce the emissions we control directly (the NHS Carbon Footprint), achieving net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

Supporting wider social and economic development

Supporting social and economic development is one of our strategic objectives. We are working together on a plan for improving health including addressing wider determinants. Wider determinants, also known as social determinants, are a diverse range of social, economic, and environmental factors which impact on people's health.

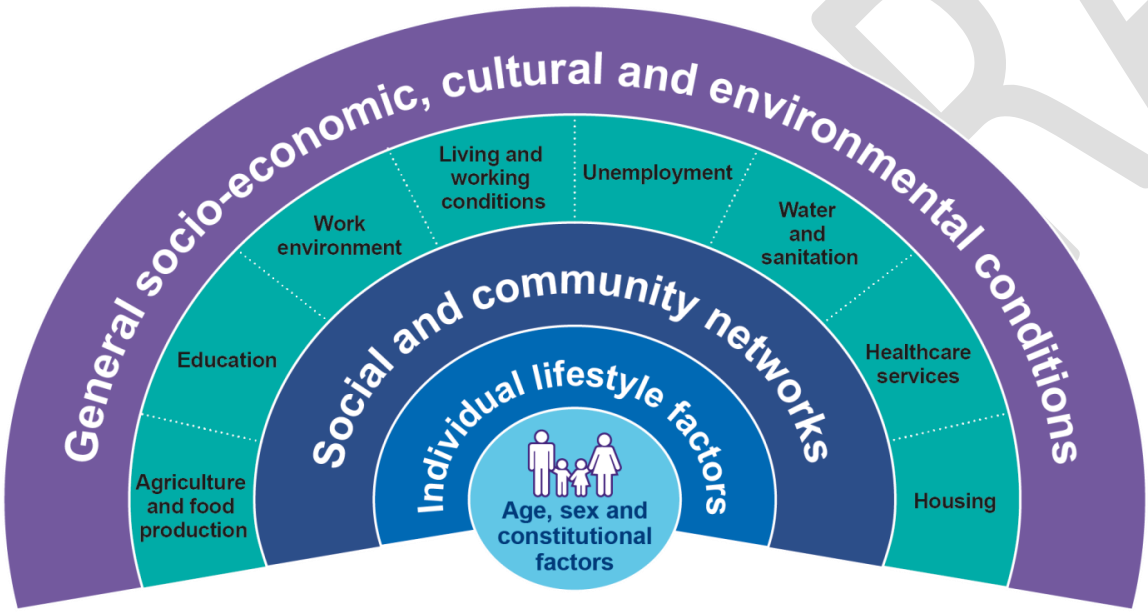
We will:

Increase the number of Anchor Framework signatories to 25 by the end of March 2024

And:

- Embed, and expand, our commitment to social value
- Develop as key Anchor Institutions within Cheshire and Merseyside
- Use an asset and strengths-based approach to planning
- Share data and insights, so resource can be targeted
- Ensure service, pathway and care model redesign is undertaken in collaboration
- Develop outcomes-focused funding models and contracts
- Support health and care professionals to think about care and support holistically
- Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%).

Figure 5: Wider social determinants of health and health inequalities, Dahlgren and Whitehead 1991



Safeguarding our population

Safeguarding is a shared responsibility across the health and care economy. Our teams work with colleagues from across the NHS, Local Authorities, the Police, and other partner agencies to drive improvements through local and regional partnership working to embed responsive safeguarding practice. This enables us to address national and local priorities and influence safe and effective care and commissioning.

Effective safeguarding at both system and organisational levels relies on systems that ensure safeguarding is integral to daily business.

We are committed to:

- Strengthening Collaboration and Communication
- Improving Training and Awareness
- Early Identification and Intervention
- Strengthening Partnership Working
- Enhancing Monitoring and Evaluation
- Empowering Service Users
- Promoting a Culture of Safeguarding

We will:

Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing Violence Against Women and Girls.

3. Our approach to improving Population Health

Our established Population Health Board oversees our Population Health programme of work. The aims of this are to improve health outcomes and reduce health inequalities by embedding a sustainable system-wide shift towards focusing on prevention and reducing health inequality. Our newly appointed Director of Population Health plays a key leadership role in this work.

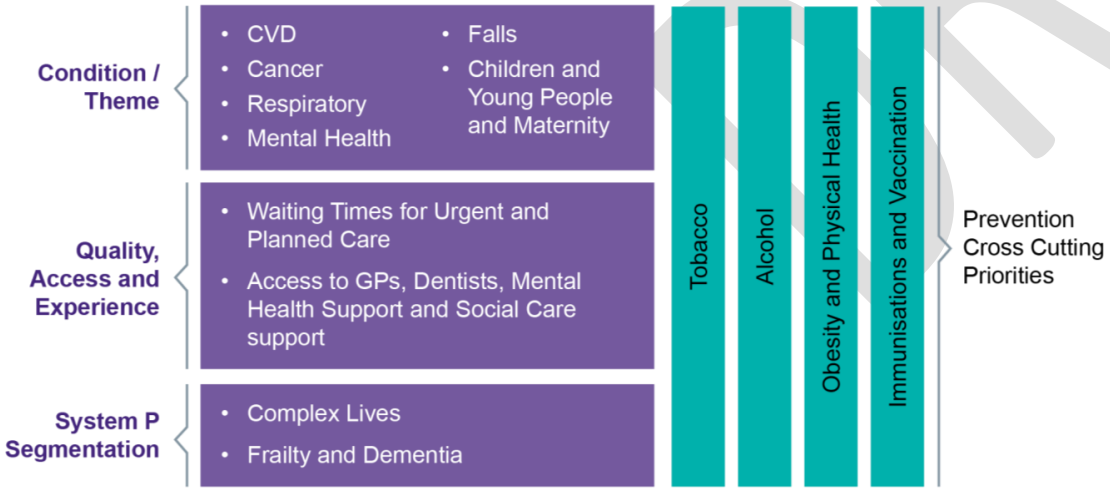
Figure 6 provides a summary of the areas which our analysis tells us that our population experience worse outcomes when compared to the "England average", and where our people have told us their experience of accessing care does not meet their expectations.

We know that it is often the wider social determinants of health which are the cause of these poorer outcomes and this is why we are committed to addressing these wider determinants and to promote good health.

In line with the Hewitt Review recommendations, as an ICB we intend to increase year on year the proportion of our budget being spent on prevention. Over time we expect that this will improve the health of our population, whilst helping to address the variation and inequality in access and outcomes we see across Cheshire and Merseyside.

The following programmes describe how we are approaching this.

Figure 6: Population Health needs and cross cutting prevention themes in Cheshire and Merseyside



Strategic Intelligence

Strategic business intelligence is vital to underpin, inform and drive a coordinated and sustainable population health management approach across ICS programmes.

As outlined in our Digital and Data Strategy, we will build on our CIPHA and System P Programmes to enhance our strategic intelligence functionality. This will enable us to better identify areas for targeted interventions and monitor progress.

All Together Fairer

The primary objective of the draft interim Health Care Partnership Strategy is to reduce health inequalities, this commitment is at the heart of all of our programmes of work. This includes through our established All Together Fairer programme where we aim to improve population health and reduce population level inequalities in health, by focussing on the social determinants of health across Cheshire and Merseyside and supporting action at Place level. The All Together Fairer programme supports the eight Marmot principles, which are to:

1. Give every child the best start in life.
2. Enable all children, young people, and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination, and their outcomes.
8. Pursue environmental sustainability and health equity together.

An example is how we will work together to support our population to access safe, secure, and affordable housing.

> We know that access to safe, secure, and affordable housing has a huge impact on the health of our population, and also that providing the right accommodation in the community supports people with a mental health condition or learning disability to access services in a more appropriate environment. A number of partners across our Health and Care Partnership provide excellent services which support our population to meet their housing needs.
>
> Within the NHS many of our services such as community nursing services often involve visiting people at home. We can 'Make Every Contact Count' by using these interactions as opportunities to sign-post people to other local services which can help improve the environment they live in, impacting positively on their overall health and wellbeing.

We will measure the success of the All Together Fairer programme in the 2023-28 period against the 22 beacon indicators in the Marmot indicator set *(Appendix 2)*.

We will:

- **Increase the % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage**
- **Reduce hospital admissions as a result of self-harm (15-19 years)**

Core20PLUS5: System-wide action on healthcare inequalities

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities. It identifies focus clinical areas requiring accelerated improvement. Making progress against these areas is a cross-cutting, system-wide responsibility, and delivery against priority clinical area objectives sits with respective ICS programmes and workstreams.

Our Population Health Programme strategic intelligence and system leadership will strengthen the oversight and monitoring of progress against the Core20PLUS5 clinical priorities *(Appendix 3)*.

We will: Focus on delivery of the CORE20PLUS5 clinical priorities with an emphasis on:

- **Increasing the proportion of cancers diagnosed at an early stage (stage 1 or 2)**
- **Increasing the percentage of patients with hypertension treated to NICE guidance to 77% by March 2024**
- **Improving access, and equity of access, to Children and Young Peoples Mental Health services (0-17).**

System-wide action on Prevention and Making Every Contact Count

We are committed to working collaboratively as a system. As part of this commitment, we are embedding the philosophy of Making Every Contact Count. This is an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors. This can support people in making positive changes to their physical and mental health and wellbeing.

We are also focusing on evidence-based and high impact interventions which include:

- Reducing smoking prevalence
- Reducing harm from Alcohol
- All Together Active Physical Activity Strategy
- Promoting Healthy Weight
- Increasing Health Checks
- Mental Wellbeing.

We will monitor our progress against key system objectives using an integrated framework that is currently being co-produced by system partners, and will incorporate key metrics in ICS, ICB and Marmot (All Together Fairer) dashboards.

We will:

- **Reduce smoking prevalence**
- **Reduce the % drinking above recommended levels**
- **Increase in the % who are physically active.**

NHS Prevention Pledge

Our providers are delivering against the 14 core commitments in the NHS Prevention Pledge. We are strengthening our focus on prevention, social value, and inequalities, embedding Making Every Contact Count (MECC) at scale, and supporting participating Trusts to achieve Anchor Institution charter status.

We are also exploring how we interpret the Pledge in a primary care setting, which involves considering how it may apply to colleagues such as GPs, dentists, optometrists, and pharmacists. This may provide further opportunities for partners to take early action to support health and wellbeing across a broader range of health and care settings.

We will:

Increase sign up to the NHS Prevention Pledge.

Vaccination and Immunisation

We plan to work with NHS England, UK Health Security Agency (UKHSA) and Place based commissioning teams to strengthen screening and immunisation uptake, and to reduce inequalities.

We will:

Work with partners to strengthen screening and Immunisation uptake and reduce inequalities.

4. How we will improve our services and outcomes

We have adopted a life course approach to improving services and outcomes.

Starting Well – Living Well – Ageing Well

We are already working hard to improve services and outcomes for our residents through a wide range of programmes. The table below summarises our core areas of focus. Further details of our work can be accessed by clicking against the appropriate link.

Theme	Heading	Focus	Drivers	Link	Cross Cutting
Starting Well	**Maternity & Women's Health**	Reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury. Deliver the actions from the Ockenden report Workforce development All women have personalised and safe care Reduce inequalities in access and outcomes Women's Health and Maternity (WHaM) programme Gynaecology Network Estate - Women's Health Hubs	Core20PLUS5 All Together Fairer Long Term Plan	Click to Access	Personalised Care and supporting Self Care Supporting Our Carers and Vulnerable Groups
	Children and Young People Beyond Programme	Emotional wellbeing and mental health Learning difficulties, disabilities and autism Diabetes Epilepsy Respiratory / asthma Healthy weight and obesity Oral health Estate - Women's Health Hubs	Core20PLUS5 All Together Fairer Long Term Plan	Click to Access	
Living Well Ageing Well	**Physical Health**	Cancer Cardiovascular Disease (CVD) Community health services Diabetes Elective Recovery Neurosciences Respiratory Stroke Urgent & Emergency Care Accessing Adult Social Care	Core20PLUS5 NHS Operational Plan Long Term Plan	Click to Access	
	Mental Health	Improving Mental health access and outcomes Continued investment in Mental Health Improved choice A new community-based Mental Health offer PCNs to have Mental Health Practitioners More comprehensive crisis pathways Improved access for children and young people Suicide Prevention Dementia	Core20PLUS5 NHS Operational Plan Long Term Plan	Click to Access	
	Neurodiversity	Learning Difficulties, Disability & Autism (LDDA) Attention Deficit Hyperactivity Disorder (ADHD)			
	End of Life Care (EOLC)	Access to information to support EOLC Access and sustainability palliative /EOLC services Specialist Workforce development Engaging with people	Long Term Plan	Click to Access	
Cross Cutting	Primary Care - General Practice / Dental / Optometry /Community Pharmacy Diagnostics - Priority supporting Recovery and Restoration				

5. Our Workforce

Our plans recognise the importance of investing in our workforce.

To achieve Cheshire and Merseyside Health and Care Partnership's strategic priorities we need to change the way we work. We will have new teams, new roles, and we will need to work across multiple organisations and Places.

In 2022/23 the Cheshire and Merseyside People Board, which has a broad membership across Cheshire and Merseyside stakeholders, agreed a set of ambitious Workforce Priorities for 2022-25 (see below).

Our system Workforce Strategy and the programme to support delivery of these priorities will be further developed during 2023/24.

Systemwide Strategic Workforce Planning to:	Creating New Opportunities across C&M to:	Promoting Health and Wellbeing to:	Maximising and valuing the skills of our staff to:	Creating a positive and inclusive culture to:
• Ensure a health and care workforce that is fit for the future • Smarter workforce planning linked to population health need • Creation of a 5-, 10- and 15-year integrated workforce plan • Developing a greater triangulation and monitoring between workforce / productivity / activity / finance.	• Grow our own future workforce • Increased focus on apprenticeships • Embed New Roles • Review barriers to recruitment • Work with the further and higher education sector • PCN Development • Greater links with social care and primary care • Ensuring an effective student experience.	• Ensure appropriate health and wellbeing support for all staff • Ensure good working environment • Focus on retention. • Preventing burnout • Ensuring appropriate supervision and preceptorship is available.	• Understand the impact of 5 generations working together/ changing expectation of the workforce • Developing career options at different stages of our lives and across health and social care • Responding to reviews / staff surveys and recommendations in a positive manner.	• Ensure proactive support of inclusion and diversity as a priority • Collaborative and inclusive system leadership • Understanding the barriers for staff / future employees • Development of learning and restorative practice.

Developing our culture and leadership

We plan to adopt, apply, and invest in the following areas to develop our culture, workforce, and ways of working as a system.

We will:

- **Ensure a Health and Care workforce that is fit for the future.**

  And:

- **Publish a Strategic Workforce Plan by March 2024**
- **Create new opportunities across health and care providers**
- **Promote health and wellbeing of all workforce**
- **Maximise and value the skills of our workforce**
- **Create a positive and inclusive culture**
- **Ensure digital upskilling for the whole workforce**
- **Further develop our partnerships with Health Education Institutes (HEI's), further education providers and school**

Cultural transformation

- Organisational and system redesign necessary for integration
- Competence and capability development to deliver integrated ways of working.
- Team cohesion to drive resource optimisation through sustainable collaboration.
- Growth mindset to stimulate systems leadership thinking and practice.
- A shared cultural identity values and behaviours premised on the principles of public service founded by the NHS Constitution, Equality Act and Nolan Principles

Talent management

- Talent management for effective capacity, demand and supply planning mapped to population health / market trends.
- Robust succession planning strategies for business-critical roles and hard to fill roles specifically.
- Reward and recognition strategies to ensure that success is rewarded and celebrated and improve staff engagement and retention.

Leadership development

- Resilient collective (systems) leadership evidenced in the continual enablement of integration for improved health and care integration.
- Compassionate and inclusive leadership cultures towards improving health inequalities.
- Culturally competent leadership to drive cultural competence in decision making for integration.
- Clinical leadership for integration towards health creation models of care

6. System development

Our Integrated Care System is geographically large and comprises a wide range of partners. This is reflected in how we apply our intention to distribute leadership to the most appropriate point in the system, which in many cases is as locally as possible.

In line with the concept of a "self-improving system" described in the Hewitt Review we intend to develop our capabilities and be ambitious in developing our leadership, workforce and improvement approaches alongside the plans already outlined in this document.

In early 2023/24 we will be delivering work to develop and embed an agreed operating model for our system, working alongside system partners. Part of this will involve considering how we can work more efficiently as a system to enable the integration of services across health, care and our wider partners and communities, within our Places and our communities to prosper whilst working collectively at a Cheshire and Merseyside level when it makes most sense to do so.

Clinical and Care Professional leadership

We have developed a Clinical and Care Leadership Framework which outlines how clinical and care leaders across Cheshire and Merseyside will be involved in key aspects of ICS decision making.

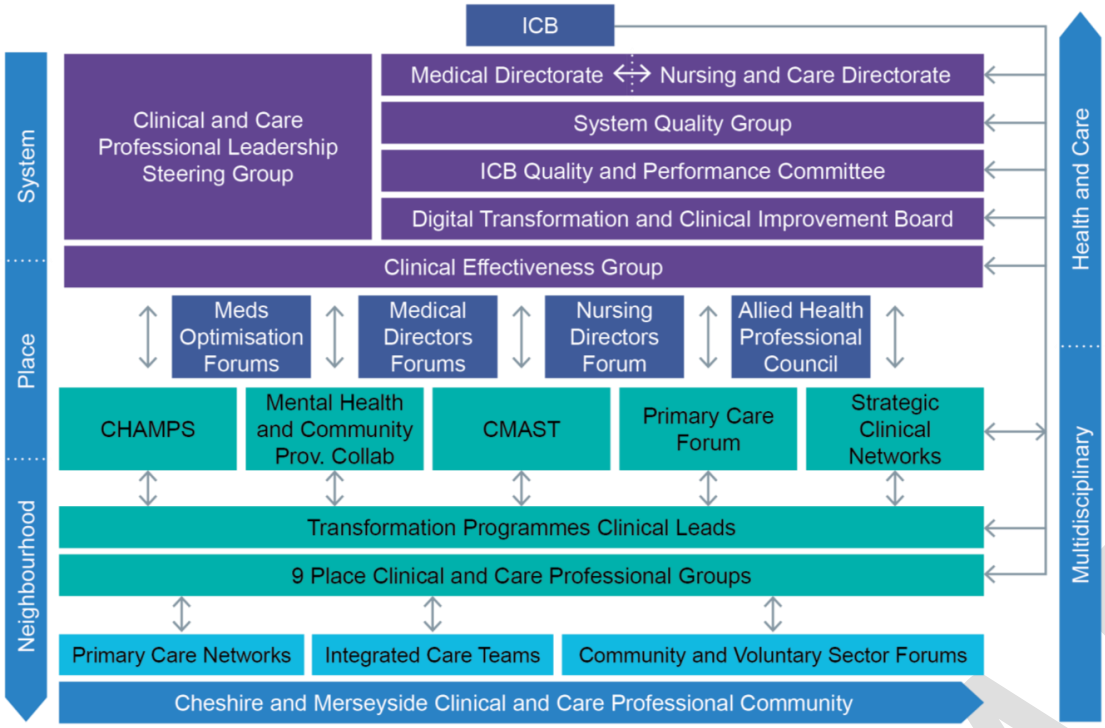
The framework was developed collaboratively with a wide range of clinical and care professionals and in partnership with the Innovation Agency. It will:

- Empower our leaders to work across traditional organisational boundaries
- Support specific groups of clinicians and care professionals to connect their particular areas of work to the ambitions of the ICS
- Create an environment where distributed leadership can thrive
- Maintain and develop the depth and breadth of clinical leadership we currently have, including development of our future leadership to be more reflective the diverse Cheshire and Merseyside population we serve
- Build on the expertise of existing clinical and care professional networks
- Enable clinical and care professionals to collaborate for improved health and care outcomes for people in Cheshire and Merseyside.

We will:

Develop a Cheshire and Merseyside Clinical Strategy by March 2024.

Figure 7: Clinical and Care Leadership in Cheshire and Merseyside



Quality Improvement

The government and public rightly expect Integrated Care Boards and their respective systems to ensure that the services we commission provide the highest standards of care. The development of our system quality strategy is being informed by the National Quality Board (NQB) guidance. The NQB publication 'Shared Commitment to Quality' provides a nationally agreed definition of quality and a vision for how quality can be effectively delivered through ICSs.

Quality Principles

We will work together as a system to improve quality and use the key principles for Quality Management, as set out by the NQB, in developing our approach to deliver care that is:

- Safe
- Effective
- A Positive Experience
- Responsive and Personalised
- Caring
- Well-led
- Sustainably Resourced
- Equitable

Our Provider Collaboratives

Effective collaboration and system working requires us to continually evolve, develop, improve and partner to further embed progress and capacity within the ICS and ultimately to provide more and better care to our residents and patients.

In Cheshire and Merseyside, we have two provider collaboratives:

- Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST)
- Mental Health, Community and Learning Disability and Community Provider Collaborative (MHLDC)

Our collaboratives are leading a range of work programmes which support delivery of the Cheshire and Merseyside HCP strategic priorities.

Our Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST) programmes and key areas of focus are listed below:

- Elective Recovery and Transformation
- Clinical Pathways
- Diagnostics
- Finance, Efficiency and Value
- Workforce

Our Mental Health Learning Disabilities and Community Provider Collaborative (MHLDC) is a joint working arrangement between the nine providers of community, mental health and learning disabilities services. The work programme priorities for 2023/24 are:

- Community urgent care:
  - Urgent community response teams
  - Intermediate care
  - Roll out of Urgent Treatment Centre specification
  - Virtual Wards
- Community services for children and young people
- Access to care, fragile services and community waiting times
- Population health and prevention
- Mental health transformation
- Workforce transformation

We will:

Work with our collaboratives on a range of work programmes which support delivery of the HCP strategic priorities.

Our VCFSE Transformation Programme

In Cheshire and Merseyside we are fortunate to have a strong and engaged Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector across our nine Places. This is supported by established local infrastructure organisations providing skills, knowledge, and capacity to enable two-way communications and engagement between local neighbourhoods and the health and care system.

The new health and care structures which have recently been established provide an opportunity to transform services and make a lasting difference to patients and communities. VCFSE partners will play a vital role in transformation programmes with a focus on:

- Embedding VCFSE as key delivery partners
- Supporting investment in the VCFSE both financially and organisationally
- Building on VCFSE infrastructure and assets

We will:

Focus on embedding the VCFSE as a key delivery partner.

Our Places

Our nine Cheshire and Merseyside Places have been working collectively since before the formation of ICS in 2022, working through local partnership arrangements to deliver against the priorities in their local joint health and wellbeing strategies.

We have used a 'Place Development Assessment Framework' to support our Place Partnerships in their development, applying learning from other geographies. There are 4 key domains:

- Ambition and Vision
- Leadership and Culture
- Design and Delivery
- Governance

Place Partnerships have developed detailed plans to improve local services and outcomes.

We will:

As part of our Operating Model we will enable our nine Places to most effectively deliver functions and decision making at a local level.

Evolving our Commissioning and Corporate Services

We are developing a single suite of commissioning policies across Cheshire and Merseyside by March 2024, and we will publish new policies as soon as these are completed and have been through the relevant engagement and governance processes required.

The Health and Care (2022) Act has created provisions for NHS England to delegate functions relating to the planning/commissioning of certain services to Integrated Care Boards. In April 2023 the ICB took on responsibility for dental, ophthalmic and pharmacy services, and we are planning for future delegation of Specialised Services from April 2024.

We have a number of programmes of work designed to support our system to improve consistency and value for money as its functions evolve. These include:

- Corporate infrastructure: we are reviewing the licenses and applications in use across our nine places, to improve consistency and realise operational and financial efficiencies.
- Commissioning support functions: we are reviewing all services currently provided to the ICB by Midlands and Lancashire Commissioning Support unit for consistency and value for money.

Research and Innovation

As described in our draft interim Health Care Partnership Strategy we have an ambitious vision for research in Cheshire and Merseyside. Our ICS is investing in the clinical leadership to realise this ambition with Director and Deputy Director of Research to work closely with our stakeholders to develop the best performing research network in the country.

We are working closely as a system involving the CHAMPS public health collaborative, our academic institutions, HCP partners (including population health), research partners (including National Institute for Health and Care Research, National Cancer Research Institute and Academic Health Science Network) and industry.

We will:

- **Establish a Cheshire and Merseyside Research Development Hub**
- **Create a network of research champions across our system**
- **Deliver annual learning events to showcase latest research and to enable the sharing of skills, toolkits and research to support in-house evaluation of projects**
- **Contribute to the development of a North West Secure Data Environment for research.**

Digital and Data

Cheshire and Merseyside ICS published its three year Digital and Data Strategy in November 2022 following endorsement from the NHS Cheshire and Merseyside Board. We are committed to using digital and data to improve outcomes and services for our residents.

The strategy describes an ambition to improve the health and well-being of our region now and into the future by incorporating digital and data infrastructure, systems, and services throughout the pathways of care we provide.

This requires 'levelling up' our digital and data infrastructure to help address the significant inequalities so clearly faced by parts of our population and to ensure we successfully support all we serve.

We are committed to turning 'intelligence into action' by using increasingly sophisticated ways of understanding the health and care needs of our population, and then finding and intervening for those in greatest need to improve their health and care outcomes in an equitable way.

We will:

Work in partnerships to deliver the goals outlined in the Digital and Data Strategy, including making the Share2Care (shared care record) platform available in all NHS and Local Authority Adult Social Care providers, by March 2024.

Effective use of resources

In line with many other systems Cheshire and Merseyside faces significant financial challenges. As a system, we are spending more money on health and care services then we receive in income. We must take action to improve the long-term sustainability of the Cheshire and Merseyside health and care system by managing demand and transforming the way we use services, staff, and buildings.

As part of the Cheshire and Merseyside draft interim Health Care Partnership Strategy there is a commitment to developing a system-wide financial strategy during the first half of 2023-24 to:

- Determine how we will best use our resources to support reduction in inequalities, prevention of ill health and improve population health outcomes
- Support health and care integration
- Identify key productivity and efficiency opportunities at both a Place and ICS footprint
- Outline system-wide estates and capital requirements and plans

As recommended in the Hewitt Review, we are focussed on ensuring we are getting best value from our investments and increasing the proportion of our ICB budgets allocated to prevention of ill health.

We will:

Agree a financial strategy and recovery plan by September 2023 which details how we will move to a sustainable system-wide financial position in Cheshire and Merseyside

Finance Efficiency and Value Plans

As part of our wider development of a system financial strategy, we have established an Efficiency at Scale programme. One of our provider collaboratives, CMAST, is hosting the programme on behalf of the ICB. The programme works across the NHS and links with partners from the wider system as appropriate.

The key areas of focus for the Efficiency at Scale programme are:

- Consolidating financial systems, approaches and capacity across organisations where appropriate, including financial ledgers.
- Delivering a structured procurement workplan to reduce influenceable spend across all providers.
- Building on existing medicines optimisation projects to deliver a more sustainable approach to pharmacy capacity and resourcing across Cheshire and Merseyside.
- Specific discrete workforce projects, for example a collaborative staff bank for Health Care Assistants.

This complements wider work on our financial strategy and recovery plan where system partners work to reduce costs, through ICB, Place, provider and partner led plans.

Capital plans

We have developed a Capital Plan which describes how we will use available capital funding to invest in our buildings and infrastructure. This is publicly available to view at: INSERT LINK TO CAPITAL PLAN

Our capital plans will be routinely shared with members of the Cheshire and Merseyside Health and Care Partnership and the nine Health and Wellbeing Boards in Cheshire and Merseyside.

We will continue working in partnership to deliver against our Capital plans.

Estates

Cheshire and Merseyside Health and Care Partnership's Estates Strategy sets out our system commitment for the next five years. We are committed to the NHS, local government and other agencies working together to deliver our Estates Plan and take steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them.

Our focus for delivery will primarily be in eight key areas:

- Fit for Purpose
- Maximising Utilisation
- Environmentally Sustainable
- Value for Money and Social Value
- Services and Buildings in the right place
- Flexibility
- Technology
- Working in Partnership

During the year we will be supporting our nine Place Partnerships and Primary Care Networks to ensure our focus areas translate into deliverable local plans.

All Age Continuing Health Care

The ICB is accountable for the fair and equitable commissioning of All Age Continuing Health Care (AACC) to support the assessed needs of our residents. We are accountable for the quality, safety and financial assurance of the continuing care provided.

We have recently reviewed the services we provide to people who receive Statutory funded continuing care. This review will have a range of benefits. It will improve the appropriateness of the care provided, meaning care is of higher quality. By providing more appropriate solutions, we also expect to improve the value for money of the services we provide meaning our funding can go further.

We will:

Complete the review and work with partners to establish an equitable model for delivery of services across Cheshire and Merseyside.

7. Our Place Plans

Click her to see our Place plans. (link to be added).

8. Glossary

An online glossary of terms has been developed by NHS Cheshire and Merseyside and can be accessed through this link:

cheshireandmerseyside.nhs.uk/get-involved/glossary/

9. Summary of Outcomes

In addition to the priorities outlined in Section 1 there are a range of additional outcomes the plans outlined in this document will deliver and can be accessed by clicking here (link to be added).

10. Links to our partners plans

Click here to find links to the strategic plans of our NHS Provider and Local Authority Partners. (link to be added).

Appendix 1 NHS Operational Plan and Long-Term Plan

Nation NHS Objectives

	Area	Objective
Recovering our core services and improving productivity	Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
LTP and transformation	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

*ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published.

Appendix 2 Marmot 8 principles and 22 Beacon indicators

The tables below highlight the principles describing how we intend reducing inequalities and the indicators we will use to measure progress.

Marmot 8 principles	
1	Give every child the best start in life.
2	Enable all children, young people, and adults to maximise their capabilities and have control over their lives.
3	Create fair employment and good work for all.
4	Ensure a healthy standard of living for all.
5	Create and develop healthy and sustainable places and communities.
6	Strengthen the role and impact of ill-health prevention.
7	Tackle racism, discrimination, and their outcomes.
8	Pursue environmental sustainability and health equity together.

22 Beacon Indicators

Life expectancy		Frequency	Level	Disagg.	Source
1	Life expectancy, female, male	Yearly	LSOA	IMD	ONS
2	Healthy life expectancy, female, male	Yearly	LA	IMD	ONS
Give every child the best start in life					
3	Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development)*	Yearly	LA	NA	DfE
4	Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception)	Yearly	LA	FSM status	DfE
Enable all children, young people and adults to maximise their capabilities and have control over their lives					
5	Average Progress 8 score**	Yearly	LA	FSM status	DfE
6	Average Attainment 8 score**	Yearly	LA	FSM status	DfE
7	Hospital admissions as a result of self-harm (15-19 years)	Yearly	LA	NA	Fingertips, OHID
8	NEETS (18 to 24 years)	Yearly	LA	NA	ONS
9	Pupils who go on to achieve a level 2 qualification at 19	Yearly	LA	FSM status	DfE
Create fair employment and good work for all					
10	Percentage unemployed (aged 16-64 years)	Yearly	LSOA	NA	LFS
11	Proportion of employed in permanent and non-permanent employment	Yearly	LA	NA	LFS
12	Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter***	-	-	-	NHS, local government
13	Percentage of employees earning below real living wage	Yearly	LA	NA	ONS
Ensure a healthy standard of living for all					
14	Proportion of children in workless households	Yearly	LA	NA	ONS
15	Percentage of individuals in absolute poverty, after housing costs	Yearly	LA	NA	DWP
16	Percentage of households in fuel poverty	Yearly	LA	NA	Fingertips OHID
Create and develop healthy and sustainable places and communities					
17	Households in temporary accommodation****	Yearly	LA	NA	MHCLG / DLUHC
Strengthen the role and impact of ill health prevention					
18	Activity levels	Yearly	LA	IMD	Active lives survey
19	Percentage of loneliness	Yearly	LA	IMD	Active lives survey
Tackle racism, discrimination and their outcomes					
20	Percentage of employees who are from ethnic minority background and band/level***	-	-	-	NHS, local government
Pursue environmental sustainability and health equity together					
21	Percentage (£) spent in local supply chain through contracts***	-	-	-	NHS, local government
22	Cycling or walking for travel (3 to 5 times per week)~	Yearly	LA	IMD	Active lives survey

** Children achieving a good level of development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.*

*** Both the Progress 8 and Attainment 8 scores are proposed for inclusion. Progress 8 scores at local authority level demonstrate that schools with a negative average score require systematic intervention. Attainment 8 shows the percentage achievement of school-leavers and is a more sensitive measure of annual change within schools.*

**** These indicators will require the NHS and local authorities to establish new data recording and collection methods. We have factored the social value indicators into the 2022/23 work programme to align with the rollout of the Anchor Institute Charter. It will also require definitions of "local" in both the local supply chain and employment. All contracts, direct and subcontracted, should be analysed and included. This should be reviewed after the first year of implementation. Collecting ethnicity data related to employment should also be reviewed after the first year of implementation.*

***** To be used to demonstrate annual changes, interpretation to factor in population changes.*

~ Active Lives Survey states the length of continuous activity is at least 10 minutes.

Appendix 3 Core20PLUS5