Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 6 September 2023
Time	9:00 – 11:00
Location	Hybrid

	Agenda Item	**Lead**	
1.	Welcome and Apologies for Absence	Steve Igoe	
2.	Declarations of Interest	Steve Igoe	
3.	Minutes of Previous Meeting	Steve Igoe	
4.	Action Log	Steve Igoe	
	Items for Decision and Discussion		
5.	Patient Story	Tracy Fennell	
6.	Chairs Business and Strategic Issues – **Verbal**	Steve Igoe	
7.	Chief Executive Officer Report	Janelle Holmes	
8.	Board Assurance Reports		
	8.1) Integrated Performance Report	Executive Directors	
	8.2) Chief Finance Officer Report	Mark Chidgey	
	8.3) Productivity and Efficiency Update	Hayley Kendall	
	8.4) Chief Operating Officer Report	Hayley Kendall	
	8.5) Quarterly Maternity Report	Tracy Fennell	Jo Lavery
	8.6) Learning from Deaths Report	Dr Nikki Stevenson	
	8.7) Guardian of Safe Working	Dr Nikki Stevenson	
	8.8) Board Assurance Framework	David McGovern	
9.	2022-23 Annual Submission to NHS England North West: Appraisal and Revalidation	Dr Nikki Stevenson	
10.	Employee Experience Update	Debs Smith	
11.	Biannual Report for Estates, Facilities and Capital	Matthew Swanborough	
12.	Freedom to Speak Up and Fit and Proper Persons	David McGovern	

13.	NED Engagement Proposals	David McGovern
14.	Board of Directors' Terms of Reference	Cate Herbert
15.	Committee Chairs Reports	
	15.1) Quality Committee	Dr Steve Ryan/Dr Nikki Stevenson
	15.2) Charitable Funds Committee – **Verbal**	Sue Lorimer
	15.3) People Committee	Lesley Davies
	15.4) Estates and Capital Committee – **Verbal**	Sir David Henshaw
	15.5) Council of Governors – **Verbal**	Sir David Henshaw
	15.6) Finance Business Performance Committee	Sue Lorimer

Closing Business

16	Questions from Governors and Public	Steve Igoe
17	Meeting Review	Steve Igoe
18	Any other Business	Steve Igoe

Date and Time of Next Meeting

Wednesday 4 October 2023, 09:00 – 11:00

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 5 July 2023
Location	Hybrid

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Deputy Chair
SR	Dr Steve Ryan	Non-Executive Director
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
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
DS	Debs Smith	Chief People Officer
MS	Matthew Swanborough	Chief Strategy Officer
TF	Tracy Fennell	Chief Nurse
MC	Mark Chidgey	Chief Finance Officer

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.4
RI	Paul Ivan	Public Governor
RT	Robert Thompson	Public Governor

Apologies:

JH	Janelle Holmes	Chief Executive
HK	Hayley Kendall	Chief Operating Officer

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

	The minutes of the previous meeting held on the 7 June 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 mother and daughter. The video described the daughter's positive experience of personalised care at Arrowe Park Hospital following admission to A&E with tonsillitis and a subsequent burst ulcer in the neck. RM queried if the Trust was celebrating and sharing learning from positive patient stories to patients and staff. TF stated the Patient Experience Strategy Promise Groups had been receiving the patient stories, as well as videos on what to expect when visiting the hospital. Feedback so far has been positive and indicated that this has reduced patient anxiety. TF added all patient stories were shared throughout the Trust to spread learning, and a library of patient stories is maintained. NS stated the Trust had historically focussed on negative incident reporting and was beginning to focus on positive incident reporting as well. The Board **NOTED** the patient story.	
6	**Chairs Business and Strategic Issues** DH updated the Board of Directors on recent matters and highlighted he had met with the Chair of Wirral Community Health Care NHS FT regarding collaboration and partnership opportunities. DH also highlighted the recent visit from Professor Sir Stephen Powis, National Medical Director of NHSE. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** NS also highlighted the recent visit from Professor Sir Stephen Powis, National Medical Director of NHSE. NS then gave an industrial action update and explained the most recent Royal College of Nursing (RCN) ballot did not return a mandate for industrial action. NS stated the Trust received formal notification from the BMA that junior doctor's industrial action will take place from 13 to 18 July 2023, and action for consultants was likely to take place on 20 to 21 July 2023.	

	NS reported the Surgical Elective Admissions Lounge (SEAL) had been shortlisted for a HSJ Patient Safety Award in the Learning Disabilities Initiative of the Year category. NS stated Getting It Right First Time (GIRFT) selected the Cheshire & Merseyside Surgical Centre to be accredited as a Stand-Alone Hub. The accreditation process would take 16 weeks and include a site visit. NS explained the Trust has been successfully accredited as Veteran Aware by the Veteran Covenant Healthcare Alliance. NS reported the Trust declared 5 serious incidents in May and 2 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS). NS highlighted St Helens and Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital NHS Trust will merge and become one new Trust known as Mersey and West Lancashire Teaching Hospitals NHS Trust. NS referenced the recent UK Covid-19 Inquiry public hearings for module 1, noting these started on 13 June and will conclude on 21 July. Module 1 will investigate government planning and preparedness and will examine the period between June 2009 and 21 January 2020. CC queried the impact of the upcoming Consultant industrial action. NS stated there would be a greater impact from the junior doctor industrial action due to this taking place for 5 days over the weekend. NS added the consultant industrial action was for 2 days and Christmas cover arrangements were planned. NS highlighted both industrial action periods would impact on elective activity. The Board **NOTED** the report.	
8	**Board Assurance Reports** **8.1) Integrated Performance Report (IPR)** NS highlighted the performance against the 4hr A&E standard and the number of patients waiting longer than 12 hours in ED remained a concern and continues to be below target. NS noted that bed occupancy remained high. NS also highlighted the increased number of ambulance attendances which were above 2022/23 averages. NS reported there continued to be improvements regarding DM01 performance and the faster diagnosis standard achieved target in month. NS added the delivery of the cancer standards remained challenging in some subspecialities.	

	DH requested a session open to all members for the purposes of providing assurance regarding unscheduled care demand. SR queried the 62 days to treatment figures, and what length of delay patients are facing beyond 62 days. NS stated the Chief Operating Officer had previously reported on this, and the numbers were generally small but depended on patient requirements. SI queried the referral to treatment standards for cases 52 weeks waiters and when this was likely to begin falling. NS stated there was a full trajectory in place. The first national requirement being the elimination of 65+ week waiters by March 2024. NS confirmed that the impact of industrial action was being assessed against the plans. SI also queried the upcoming winter period given the 4hr A&E target and ambulance handover delays were already deteriorating during summer. NS stated winter planning had already started. NS added the Trust would be in a better position this winter due to the Executive oversight of the Wirral Discharge Hub as well as the expansion of Home First to provide capacity for additional patients. NS explained the number of re-opened complaints had been included and noted this met the threshold in month. NS also explained the number of patients recruited to NIHR studies remained below threshold. SI queried if a breakdown of the number of open studies could be circulated to understand the totality and spread of open studies. TF reported achievement of the C diff trajectory remains challenging and was above threshold in month. A deep dive was being undertaken to understand the wider learning to reduce instances of C diff across the Trust. A dashboard was now in place to provide a live position across the Trust. TF also reported the FTT overall experience for inpatients and maternity was above threshold, however for ED and outpatients it was below threshold. DS highlighted mandatory training compliance and staff turnover in-month met threshold. Sickness absence in-month continued to improve towards threshold and short-term absence had reduced. DS added there was a continued focus on staff wellbeing and the employee assistance programme had been relaunched. DS also highlighted appraisal compliance had not met threshold in-month, and a deep dive on this was scheduled with assurance provided to Workforce Steering Board in July.	Hayley Kendall Dr Nikki Stevenson

	DH requested DS provide a comparison to how the Trust compares regionally regarding sickness absence. The Board **NOTED** the report. **8.2) Chief Finance Officer Report** MC highlighted at the end of May 2023, Month 2, the Trust reported a deficit of £5.8m against a plan of £5.8m, the resultant variance of £0.0m was an improvement on the M1 position. The position assumes £0.5m of income to mitigate lost activity caused by industrial action. This has been agreed with the ICB as a planning assumption but would not be transacted ahead of national guidance. MC provided an update on the month 2 statutory financial targets and the RAG rating for each, highlighting that financial stability, agency spend financial efficiency, capital and cash were all rated green, and financial sustainability was red. MC summarised the risks to position and actions for the I&E position, CIP, capital expenditure and cash position. The Board discussed the Trust's financial sustainability, noting the annual plan was a deficit of £18.6m and the management of risks against this alone would not deliver long-term financial sustainability of the Trust. The Board also discussed the importance of focussing on the financial deficit through a robust CIP delivery and acknowledged the Trust may be driven by the ICB in regard to this. The Board requested MC provide a report on the approach taken regarding finance, which can also be provided to the ICB. The Board **NOTED** the report. **8.3) Chief Operating Officer Report** NS stated unscheduled care and elective recovery performance had been discussed in the IPR and did not wish to raise anything further. DH noted the significant increase in demand with mental health patients exceeding the capacity of the mental health unit in ED. DH queried this position in regard to a CQC inspection. NS stated the Trust was not a mental health Trust and would be able to provide assurance on the necessary steps taken to support mental health patients. TF stated guidance and an action had been issued by NHSE for Trusts that did not provide mental health services and the Trust	Debs Smith Mark Chidgey

	would be able to evidence its position and any justifiable gaps for the CQC. RM commented about the importance of understanding the Trust's narrative for a CQC inspection as well as building an evidence base to demonstrate meeting the requirements. NS stated the Governance Support Unit were collating evidence and monthly engagement meetings with the CQC continue to take place and were helpful for preparing the Trust for an inspection. LD suggested it would be beneficial for NEDs to be assigned a specific department/area of the Trust as well as to have opportunities to walkabout. DH requested MS consider this. The Board **NOTED** the report. **8.4) Monthly Maternity Report** JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services. JL stated there were no areas of concern to raise this month. SR commented the Safety Champion meeting took place on Monday and there continued to be a robust level of assurance in Maternity. The Board **NOTED** the report.	Matthew Swanborough
9	**Trust Annual Operational Plan** NS gave an overview of the Plan, highlighting the 2023/24 strategic priorities and operational plans for activity and performance, quality, workforce and financial as well as the risks to delivery. DH queried if there was a half yearly review of progress planned. MS stated a review would be undertaken by the Executive Team on progress against the plan and presented to Board in November. The Board **NOTED** the report.	
10	**Elective Recovery Self-certification** NS provided an overview of the Trust's self-certification against the elective care priorities set out by NHSE for 2023/24. NS summarised current performance against the elective recovery programme for planned care and standard reporting for unscheduled care. NS highlighted there were no concerns regarding not meeting any of the standards by March 2024,	

	however outpatients and cancer pathway re-design had been rated amber for in progress. DH noted there should be consideration of space utilisation, particularly where there may be quieter periods. SI queried if there were any challenges for the Trust in regard to the elective recovery programme. NS stated changes to bowel cancer tests may increase the number of colorectal referrals. DH queried if the increase in ED and ambulance attendances was due to the late presentation of symptoms in patients. NS stated patient nursing needs were becoming more complex and this was exacerbated by delays to discharge due to social care provisions or mental health concerns. The Board **NOTED** the report.	
11	**Charity Strategy 2023/26** MC presented the Charity Strategy for approval and summarised the five objectives as well as the roadmap. SL commented the Charity Team felt supported and continued to raise the profile of the Charity with staff as well as local businesses. DS commented it was positive to see a roadmap for the Charity and that her focus as Chief People Officer is on ensuring the operating model and annual plan reflected the changed landscape of fundraising. The Board **APPROVED** the Charity Strategy and Mission Statement.	
12	**Committee Chairs Reports** **12.1 People Committee** The Board **NOTED** the report. **12.2) Audit and Risk Committee** The Board **NOTED** the report. **12.3) Charitable Funds Committee** The Board **NOTED** the report. **12.4) Finance Business Performance Committee**	

	DH noted the backlog maintenance risks and queried if there were any alternative funding options available outside of the normal funding routes. MC stated these were limited but would provide an update on this to the next Estates and Capital Committee on this. The Board **NOTED** the report. **12.5) Research and Innovation Committee** The Board **NOTED** the report.	Mark Chidgey
13	**Questions from Governors and Public** No questions were raised.	
14	**Meeting Review** Discussion took place around inviting senior colleagues to future meetings who can inform the Board about their experience to provide more triangulation. DH commented the Committees were receiving a greater level of detail and providing assurance to the Board. DH proposed it may be beneficial for NEDs to be involved in the turning the hospital inside out programme. DH requested DM consider how this could work. SI suggested it may also be beneficial for NEDs to have Board to Board opportunities regarding collaboration and partnerships, similar to Exec to Exec with other Trusts. DM stated this is being considered with some partners and the NEDs would be involved as progress towards this type of meet up is made. No other comments were made.	David McGovern
15	**Any other Business** No other business was raised.	

(The meeting closed at 11:00)

Wirral University Teaching Hospital
NHS Foundation Trust

Action Log
Board of Directors in Public
6 September 2023

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	5 July 2023	8.1	To arrange a session open to all members for the purposes of providing assurance regarding unscheduled care demand and winter pressures.	Hayley Kendall	Complete. Scheduled for October Board.	October 2023
2.	5 July 2023	8.1	To provide a breakdown of the number of open studies to understand the totality and spread	Dr Nikki Stevenson	In progress. The Research and Innovation Committee will receive this information at their September meeting and report back to the Board.	November 2023
3.	5 July 2023	8.1	To provide a comparison to how the Trust compares regionally regarding sickness absence	Debs Smith	Complete.	September 2023
4.	5 July 2023	8.2	To provide a report on the approach taken regarding finance, which can also be provided to the ICB	Mark Chidgey	Complete. Scheduled for September meeting.	September 2023
5.	5 July 2023	8.3	To develop an approach for NEDs to be assigned a specific department/area of the Trust as well as to have opportunities to walkabout	David McGovern	Complete. Scheduled for September meeting.	September 2023
6.	5 July 2023	12.4	To provide an update to Estates and Capital Committee regarding alternative funding options for estates and capital requirements	Mark Chidgey	Complete. Provided to Estates and Capital Committee on 2 August.	August 2023
7.	5 July 2023	14	To consider how NEDs can be involved in the turning the hospital inside out programme	Matthew Swanborough	Complete. To be considered as part of the Board Away Day.	September 2023

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
6 September 2023

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

Report Purpose and Recommendations
This is an overview of work undertaken and important recent announcements in July and August. It is recommended that the Board 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	**Maternity Services at Trust rated 'Good' by CQC with areas of 'Outstanding' practice** The recent Care Quality Commission (CQC) inspection of Maternity Services at the Trust rated the services as ‘Good’ for safe care and ‘Good’ for well-led services, with

	areas of outstanding practice being reported in the Trust's joint work with Wirral Maternity and Neonatal Voices Partnership. The planned visit by inspectors was carried out on 24 and 25th April 2023 and the inspection focussed on the safe and well-led key questions of their inspection regime. CQC had previously rated Maternity Services as good overall and this latest inspection demonstrates the huge strides in maintaining this rating, and further improvements in safety made by the Trust.
1.2	**Visit by Wirral Council leaders** On 8 August the Trust received a visit from Wirral Council CEO, Paul Satoor, and Wirral Council Leader, Paul Stuart, to view the progress on the new Urgent Emergency Upgrade (UECUP) site. During their visit, they called in at the Operational Centre for Patient Flow, and heard how the improvements in relationships and partnership working have positively impacted patient flow within the hospital, with significant reductions in patients with no criteria to reside. Paul and Paul also visited The Retreat and commented on the improvement in the space and the wellbeing provision for our staff. It was a great opportunity to showcase some of the work that the Trust is doing, and how much we can all achieve working together.
1.3	**WUTH shortlisted for another Health Service Journal (HSJ) Award** The Trust has been announced as a finalist for another award in the HSJ 2023 Awards. This is the second WUTH project to be shortlisted this year, and this time it's for the Cheshire and Merseyside Surgical Centre at Clatterbridge, in the Provider Collaborative of the Year category. The collaboration between Wirral University Teaching Hospital and Countess of Chester Hospital was born through a shared ambition of the clinical and operational teams to reduce waiting lists as quickly and safely as possible. It was realised with support from Cheshire and Merseyside ICB and funding from NHS England following a successful bid for a total of £25 million from the Targeted Investment Fund.
1.4	**Industrial Action Update** The national pay dispute relating to Consultants and Junior Doctors is on-going, resulting in discontinuous strike action taken by both staff groups. There have been several episodes of Junior Doctor strike action since March 2023 and the BMA re-ballot relating to Junior Doctors closes on 31st August 2023. To date, there have been 2 episode of Consultant strike action, most recently in August 2023. The next dates of Consultant strike action have been announced as 2nd to 4th October 2023. Planning and mitigating actions take place via the Trust's EPRR route. During the period of Industrial Action the Trust has seen a decrease in elective activity due to the redeployment of staff to other areas in the Trust to ensure patient safety. Activity that

	did continue was in relation to patients requiring priority treatment, such as maternity services and patients undergoing cancer treatment. In a separate matter, UNISON have balloted Clinical Support Workers (CSWs) in the Trust for industrial action in a dispute relating to retrospective re-banding. A collective grievance was submitted by UNISON on 3rd May 2023, which stated that some band 2 CSWs are working at a higher level than their current band. The issues raised are, in essence, a re-banding claim and are being dealt with as such. On 4th May 2023 a commitment was made in writing to CSWs to ensure they are paid the correct band for the work they are being asked to undertake. An initial Partnership Working Group took place on 30th June 2023. The proposed process for delivering the commitment was put to Trade Union colleagues, as well as an offer to consider retrospective re-banding to December 2022, which is the date that CSW job descriptions were last reviewed with Trade Unions. Unfortunately, Trade Union colleagues have withdrawn from the Partnership Working Group unless the Trust agrees for any re-banding to be backdated to 1 April 2018. April 2018 is the date that a number of Trusts in Grater Manchester backdated re-banding, following UNISON raising the issue in that region in 2019. The UNISON ballot returned a mandate for strike action. The first episode of discontinuous strike action will take place from 31st August to 2nd September 2023, followed by further action from 11th September 2023 to 14th September 2023. UNISON have declined to meet to discuss the dispute unless the Trust agrees for any re-banding to be backdated to 1 April 2018.
1.5	**Serious Incidents and Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS)** The Trust declared five serious incidents in July. 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 were no incidents reported to the Health and Safety Executive (HSE) in July. All RIDDOR incidents are subject to a local review investigation to ensure appropriate action is taken to prevent a similar reoccurrence.
1.6	**Covid-19 Public Inquiry – Submission of information to assist the understanding of procurement arrangements for equipment and supplies during the pandemic** The UK Covid-19 Public Inquiry, will include an examination of the response of the health and care sector in relation to the procurement and distribution of key equipment and supplies, including personal protective equipment (PPE), ventilators and oxygen. The Inquiry Chair requested information from organisations that are likely to have important information to share and this includes NHS Trusts. The Trust responded in July 2023, through an online survey, by providing data such as the type and quantity of PPE and equipment purchased, the suppliers used, the method of procurement and the total cost. In addition, qualitative information was also provided relating to specific challenges faced and estimates of additional costs incurred to support the response to the pandemic. The information is intended to support the Chair in organising and planning for this focus area of the inquiry.
1.7	**Updated NHSE Enforcement Guidance Published**

	Following a consultation carried out in late 2022, NHSE have now published updated enforcement guidance, which describes NHSE's enforcement powers and approach in relation to ICBs, NHS trusts, foundation trusts, licensed independent providers of NHS services, and licensed NHS controlled providers. The changes in this updated version reflect new legislative, statutory and policy requirements, including NHSE's statutory accountability for the oversight of both integrated care boards (ICBs) and NHS providers: • Introduction of a two-tier approach to ICB enforcement, which ensures parity with NHS provider organisations. This means that undertakings would be used where there is reasonable suspicion of ICB failure to discharge its functions, while directions would follow where NHSE is satisfied there is a failure. • Revisions to the language to reflect the change from Monitor to NHS England as the regulatory body for NHS foundation trusts. • The extension of the provider licence to NHS trusts. Enforcement powers in relation to providers has not changed, but is aligned to the principles of the overside framework. The guidance is available here.
1.8	**System and Place** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** The Leadership Board met on 4 August and considered a number of issues which included the culmination of work on: • The outcome from an expressions of interest process for endoscopy hubs and prioritisation of associated system funding. • Laboratory Information Management Systems (LIMS) long term consolidation approach, system hosting and potential for shared decision making going forward. The Board supported the recommendations put to it, supporting two endoscopy hub locations in Cheshire and Merseyside applying for system capital and agreed to request delegation from Trust Boards to support CMAST decision making on the recommended approach for LIMS decision making. Further discussions focussed on an update provided on the joint work being progressed across the two C&M provider collaboratives on intermediate care, discharge optimisation and admissions avoidance. In year approaches to CMAST clinical leadership – to be built into Trust job plans and union discussions with Trusts with relation to band 2 staff and the duties they are undertaking. The Leadership Board had planned to receive an update on the approach to Specialised Commissioning in the North West however this discussion had to be deferred due to the volume of preceding business.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.1**

06 September 2023

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

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	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 been amended. The metrics are now grouped under the responsible Executive Director, with the relevant CQC domain noted against each metric.

	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	4	3	7
Effective	0	1	1
Caring	2	2	4
Responsive	4	18	22
Well-led	2	1	3
Use of Resources	5	0	5
All Domains	17	25	42

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.

Integrated Performance Report - August 2023

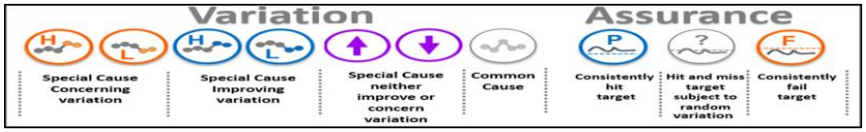
Approach

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	4	3	7
Effective	0	1	1
Caring	2	2	4
Responsive	4	18	22
Well-led	2	1	3
Use of Resources	5	0	5
All Domains	17	25	42

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.

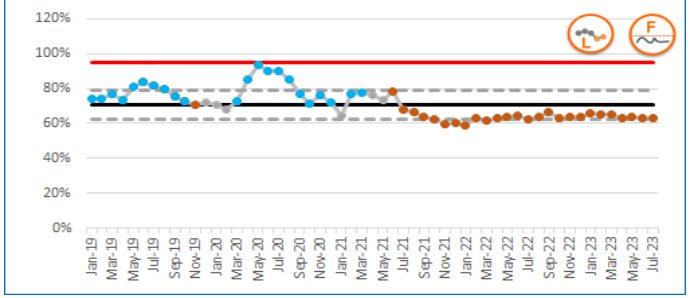
Changes to Existing Metrics:

Metric	Amendment
Clostridioides difficile (healthcare associated)	Threshold target for 2023/24 is now confirmed - maximum 71 cases for the year.
% Appraisal compliance	Likely change of the target threshold to 90% from Q3 2023/24

Chief Operating Officer (1)

CQC Domain : Responsive

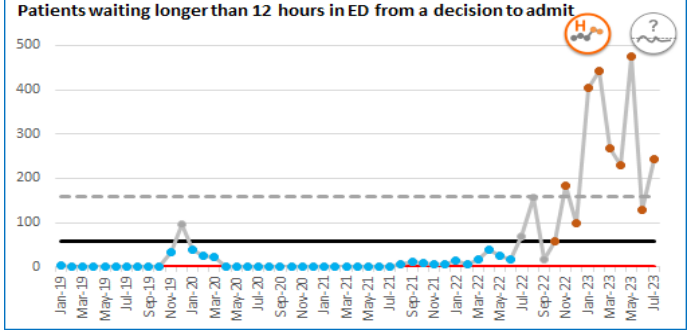
4-hour Accident and Emergency Target (including APH UTC)



July-23
63.1%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

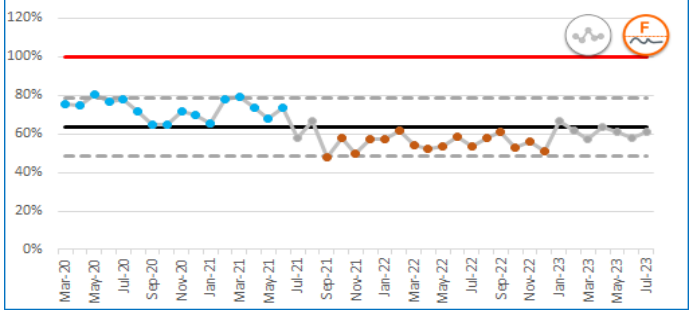
Patients waiting longer than 12 hours in ED from a decision to admit



July-23
243
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

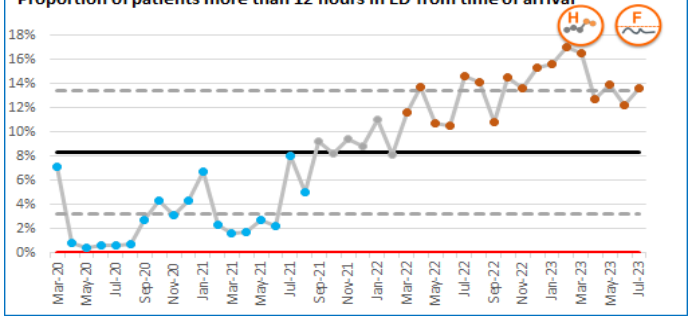
Time to initial assessment for all ED patients - % within 15 mins



July-23
60.8%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

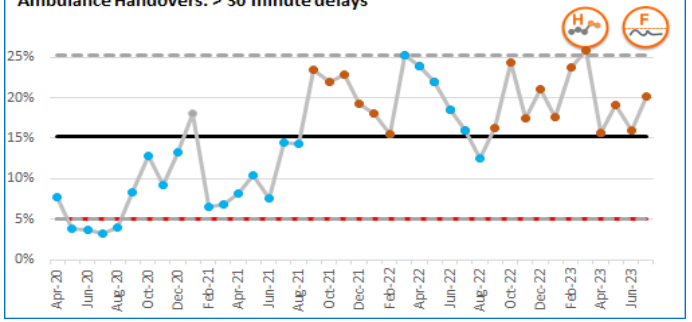
Proportion of patients more than 12 hours in ED from time of arrival



July-23
13.6%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

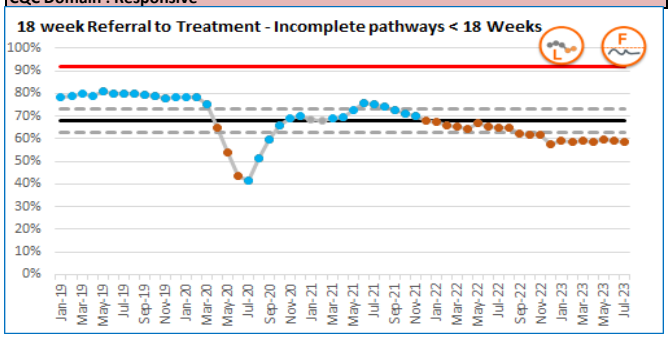
Ambulance Handovers: > 30 minute delays



July-23
20.1%
Variance Type
Special cause variation - concerning
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

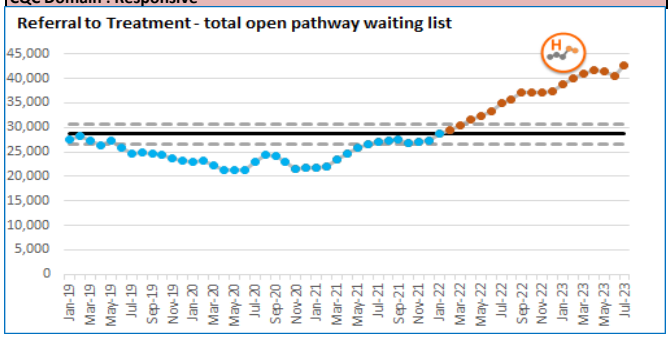
Chief Operating Officer (2)

CQC Domain : Responsive



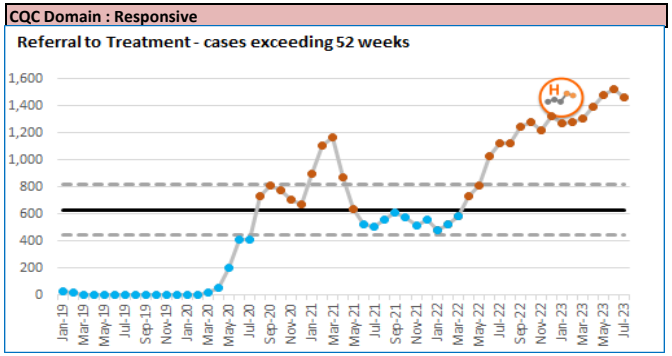
July-23
58.76%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



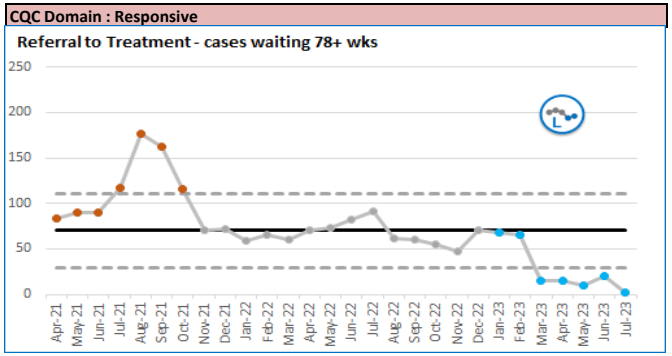
July-23
42632
Variance Type
Special cause variation - concerning
Threshold
≤ 39104
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



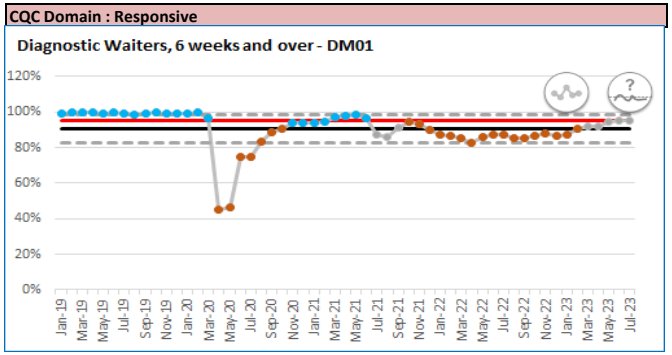
July-23
1459
Variance Type
Special cause variation - concerning
Threshold
1330
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



July-23
20
Variance Type
Special cause variation - improving
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

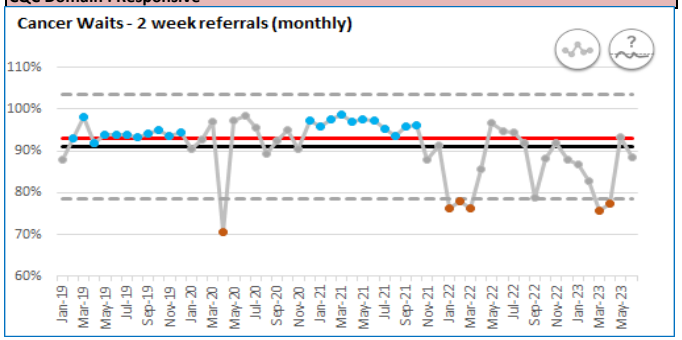
CQC Domain : Responsive



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

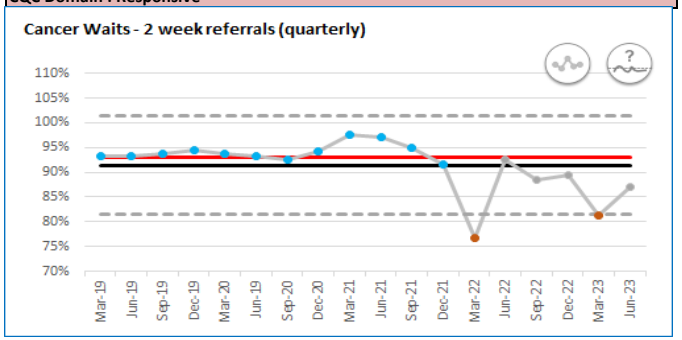
Chief Operating Officer (3)

CQC Domain : Responsive



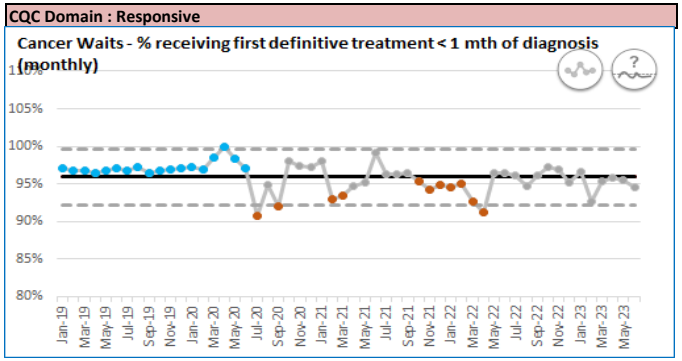
June-23
88.5%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



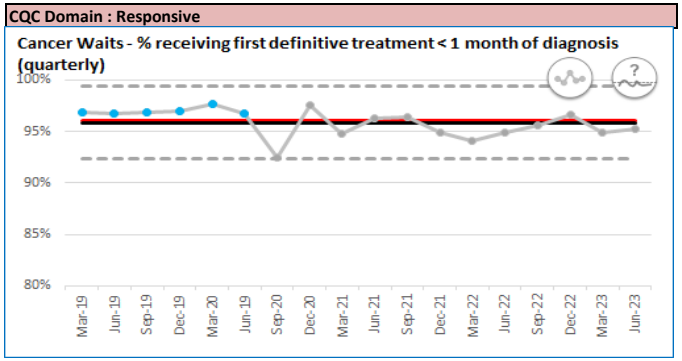
June-23
86.9%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



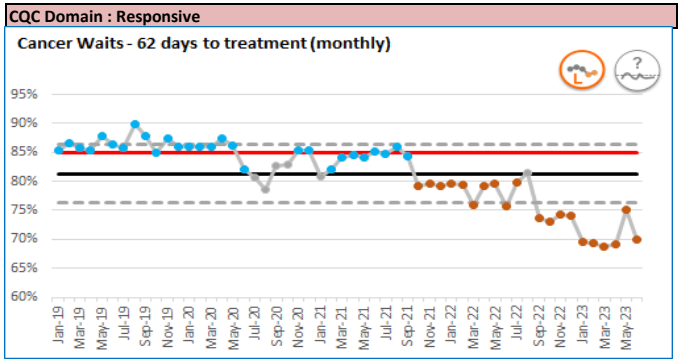
June-23
94.5%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



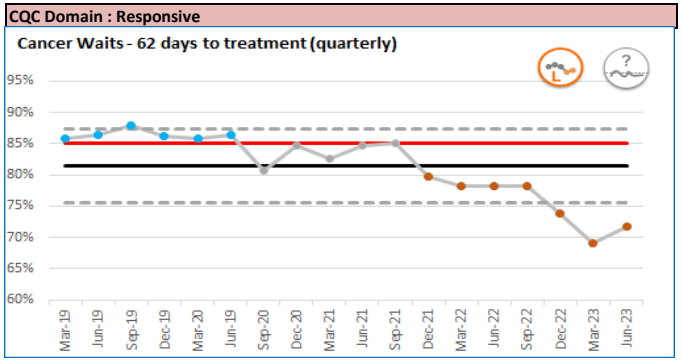
June-23
95.2%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



June-23
70.0%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation

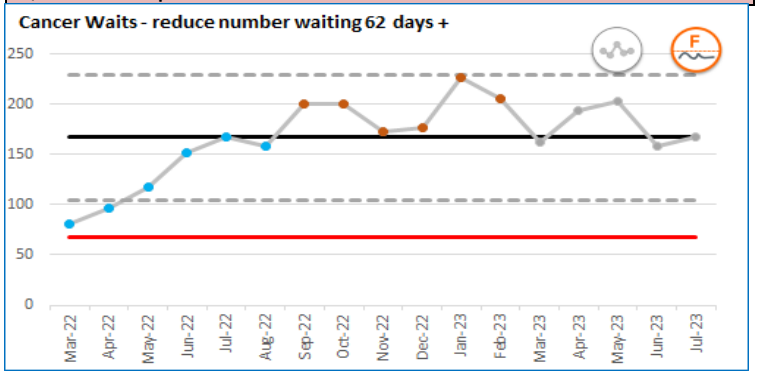
CQC Domain : Responsive



June-23
71.7%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation

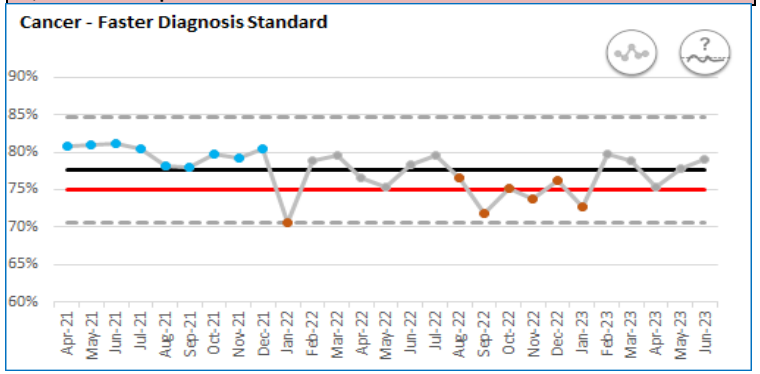
Chief Operating Officer (4)

CQC Domain : Responsive



July-23
167
Variance Type
Common cause variation
Threshold
100
Assurance
Performance consistently fails to achieve the target

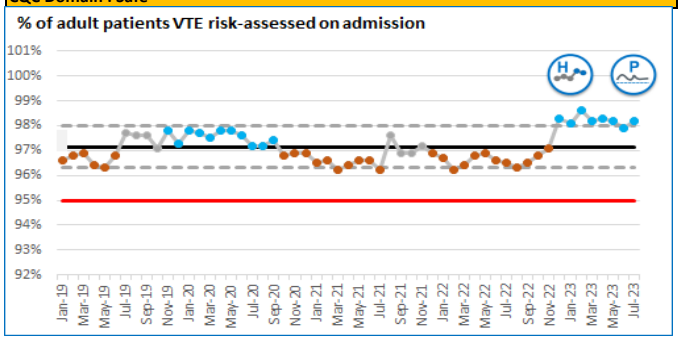
CQC Domain : Responsive



June-23
79.1%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

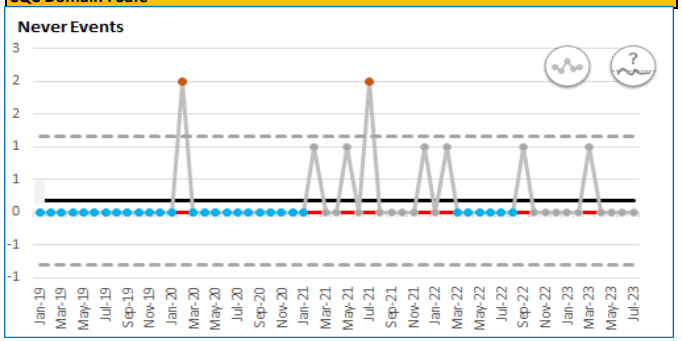
Medical Director (1)

CQC Domain : Safe



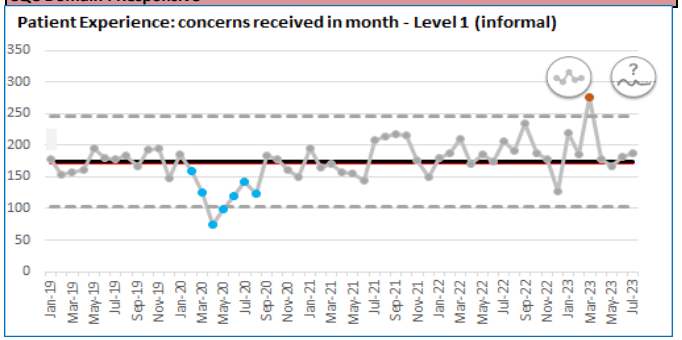
July-23
98.2%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



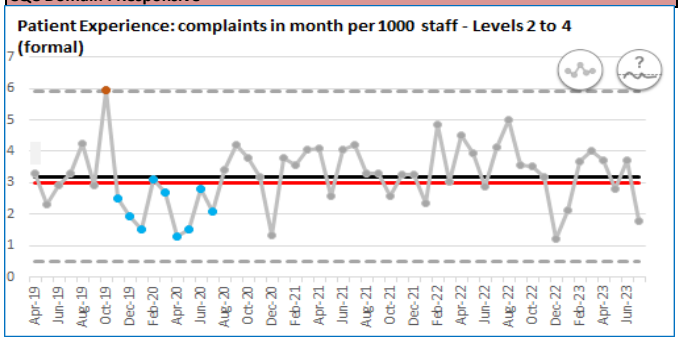
July-23
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



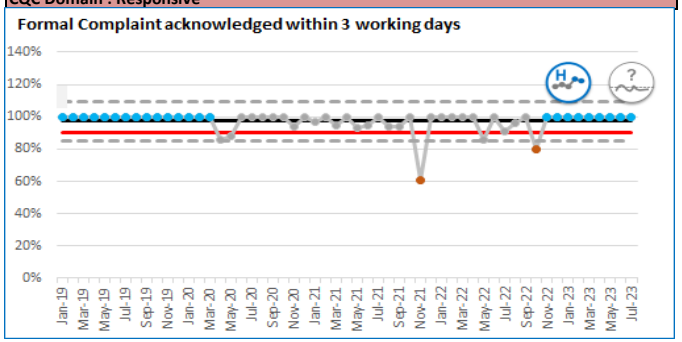
July-23
188
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



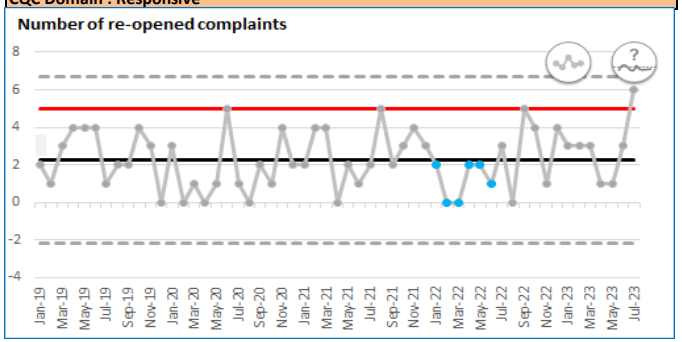
July-23
1.8
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



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

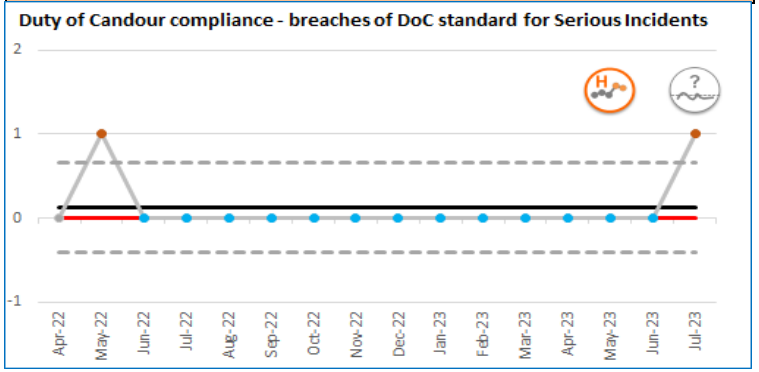
CQC Domain : Responsive



July-23
6
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

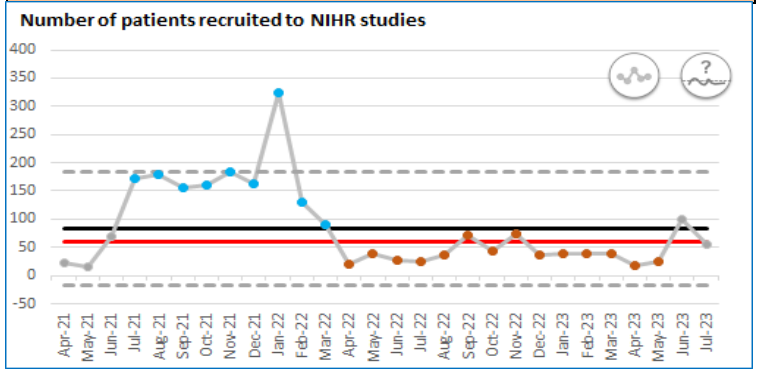
Medical Director (2)

CQC Domain : Well-led



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

CQC Domain : Well-led

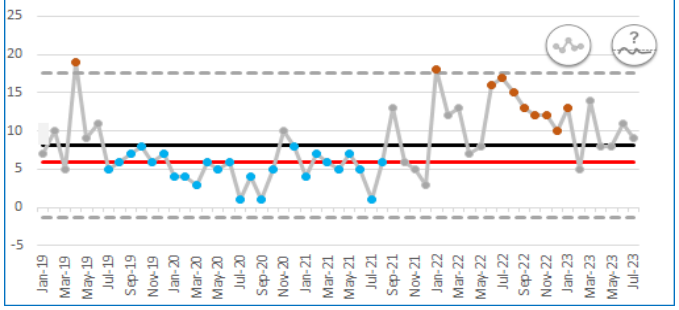


July-23
55
Variance Type
Common cause variation
Threshold
59 per mth (700 pa)
Assurance
Hit & miss target subject to random variation

Chief Nurse

CQC Domain : Safe

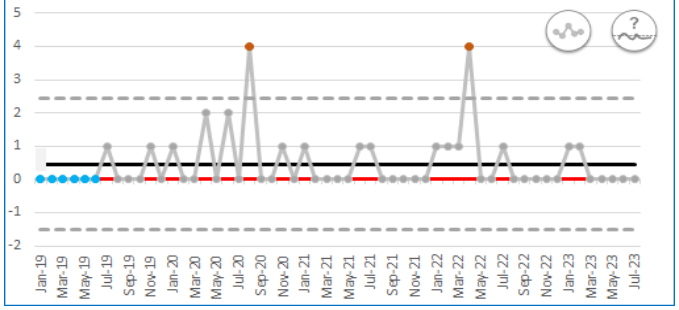
Clostridioides difficile (healthcare associated)



July-23
9
Variance Type
Common cause variation
Threshold
≤6
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

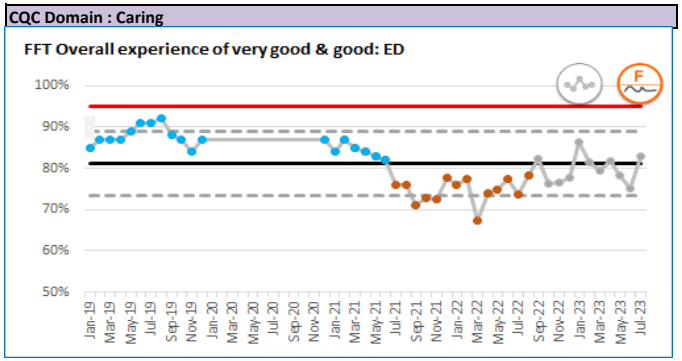
Pressure Ulcers - Hospital Acquired Category 3 and above



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

CQC Domain : Caring

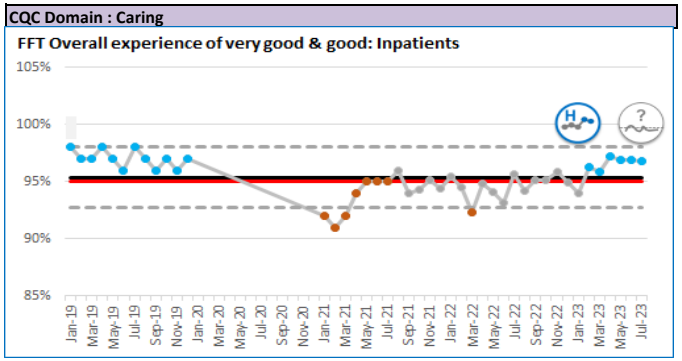
FFT Overall experience of very good & good: ED



July-23
83.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

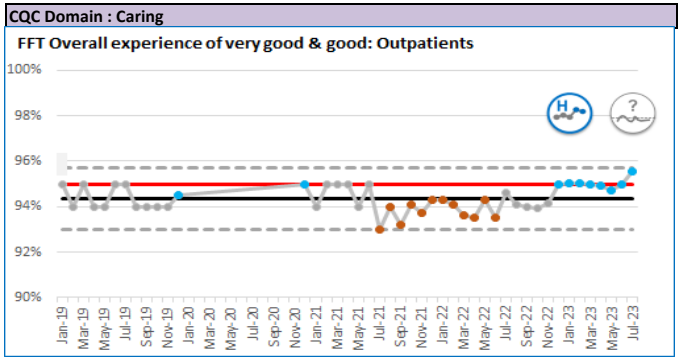
FFT Overall experience of very good & good: Inpatients



July-23
96.8%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

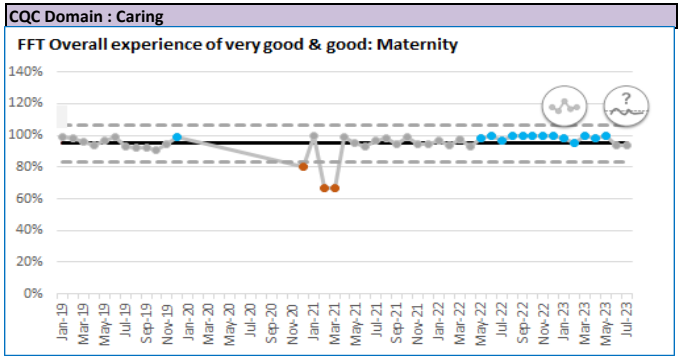
FFT Overall experience of very good & good: Outpatients



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

CQC Domain : Caring

FFT Overall experience of very good & good: Maternity



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

Chief Nurse – for Sept 2023 BoD

Overall position commentary

The Trust exceeded its monthly clostridioides difficile threshold by 3 in July 2023. However, the downward trend in the number of positive cases reported over the past 12 months continues. In line with the IPC key priorities the Trust IPC improvement work plan is has been revised aimed to further reduce the incidence of CDT over the forthcoming months . The development of an IPC dashboard within BI has taken place enabling visibility of key metrics aligned to the IPC improvement plan and enhancing trust wide assurance mechanisms.

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 July 2023.

The Friends and Family Test (FFT) for Inpatients and Outpatients has exceeded the required threshold. Maternity FFT is 1.0% below the required target. Emergency Department (ED) has not achieved target in month at 83.0%, however, the continued improvement since September 2021 has been sustained. All areas are above the national benchmark for FFT with the exception of Maternity services that is equal to the national average.

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 July 2023 there were 9 cases, exceeding the monthly threshold by 3. The Trust has reduced its rate from 66 per 100,000 bed days in Q2 2022 to 39 per 100,000 bed days

Actions:

- Dynamic IPC improvement plan is in place, with mechanisms to cross reference learning from C *Diff* investigations to make necessary adaptions to actions for improved outcomes.
- Proactive and reactive deep cleaning programme (HPV) underway.
- Processes for use of side rooms to enable prompt isolation.
- Priority focus on cleaning , decluttering, hand hygiene and gloves off campaign
- Use of newly developed IPC dashboard that incorporates local intelligence to ensure priority areas are targeted and improvement measures are responsive to intelligence.

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 July 2023 was:

- Emergency Department (ED) – 83.0% (below threshold)- above national average
- Inpatients – 96.8% (above threshold)- above national average
- Outpatients – 95.5% (above threshold) – above national average
- Maternity 94.0% (below threshold)- equal to national average

Actions:

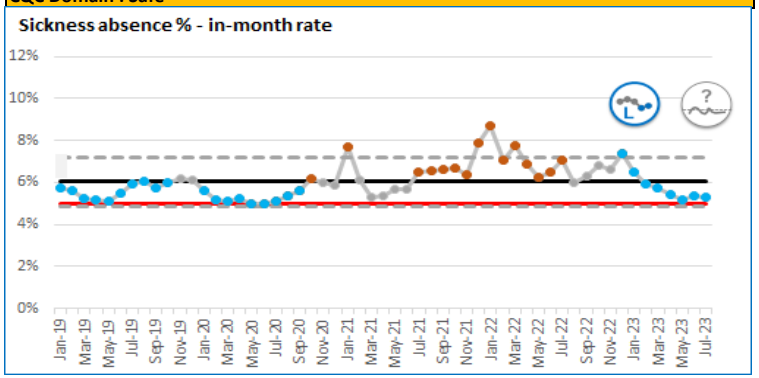
- Continued focus on providing people with access to provide feedback via FFT; volunteers are visiting ED and out-patient areas at varied times and days.
- Monitor FFT performance against national average; we consistently perform higher or in line with this since December 2022.
- Proactively respond to feedback, make immediate rectifications when able to and encourage participation through Patient Experience Promise groups.

Risks to position and/or actions:

- Bed occupancy impacting on the length of time patients remain within ED. Processes in place operationally to prevent this where possible.
- Car parking facilities impacting on patients' ability to easily access outpatients' appointments on time at the Arrowe Park Hospital site. Actions progressing to address this.

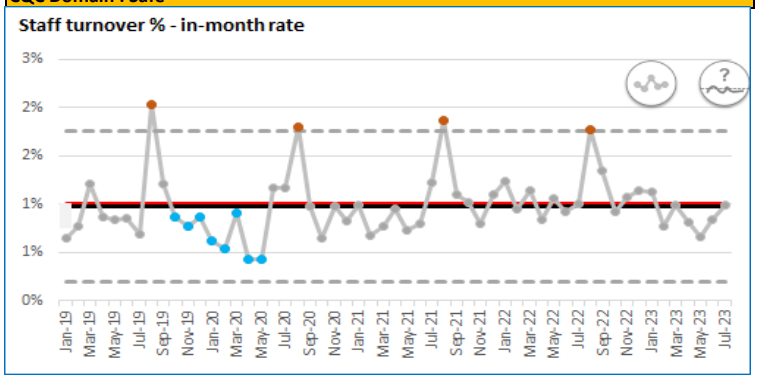
Chief People Officer

CQC Domain : Safe



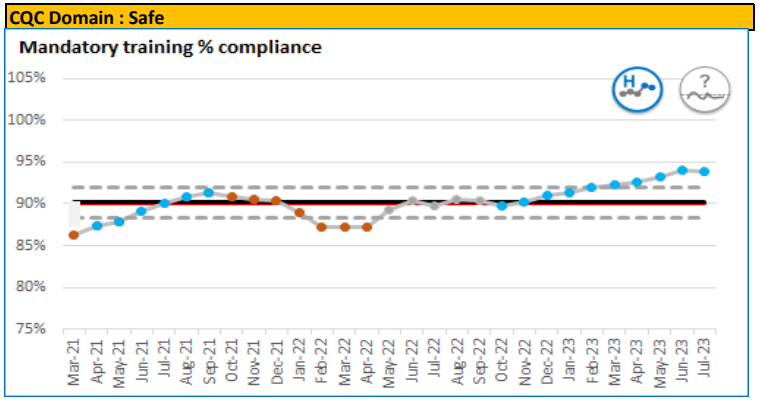
July-23
5.31%
Variance Type
Special cause variation - improving
Threshold
≤5%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



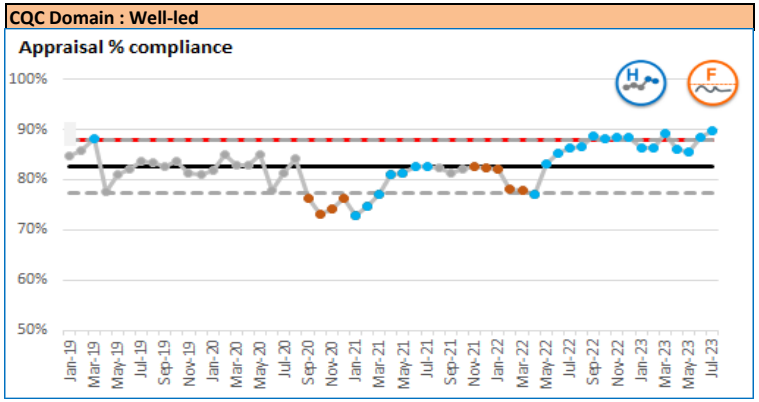
July-23
0.98%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



July-23
93.80%
Variance Type
Special cause variation - improving
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led



July-23
89.79%
Variance Type
Special cause variation - improving
Threshold
≥88%
Assurance
Performance consistently fails to achieve the target

Chief People Officer – for Sept 2023 BoD

Overall position commentary

Overall, the Trust's People KPIs are continuing to demonstrate improvement trends. Mandatory training compliance has been achieved for 9 consecutive months and appraisal completion remains compliant. For the first time in 2023 / 2024, the July 2023 the indicator was slightly above threshold at 0.98%. Sickness absence was above target at 5.31%. This is a 1.77% reduction compared to July 2022 and is in line with the Cheshire and Wirral average of 5.36%.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For July 2023 the indicator was 5.31% and demonstrates special cause variation – improving and is in line with the Cheshire and Wirral average of 5.36%.

The position is mainly driven by short term sickness absence. Gastrointestinal problems, anxiety/stress/depression and cold/flu are the most commonly occurring reasons for short term sickness absence amongst the workforce.

Pleasingly, Clinical Support, Corporate and Medicine Divisions are reporting sickness absence within the Trust 5% threshold.

Actions:

- A deep dive of Clinical Support Worder sickness has been completed. Consideration has been given to reasons why and remedial actions that can be applied such as referrals to the Trust's dedicated specialist resource available via Occupational Health and the Trust's Employee Assistant Programme (EAP).
- Targeted letters have again been issued based on historical data to support staff to attend work during the summer holiday period.
- Estates and Facilities are currently exploring additional ways to support their staff to attend work by exploring more creative forms of flexible working such as introducing term-time contracts. Some of the expected benefits include – improved attendance during peak holiday periods, improved service delivery planning, reduced overtime / bank spend and improved retention.
- Increased number of staff hitting policy triggers and final stage Attendance Management Hearings held.
- WUTH Wellbeing Week was held during July, the main theme centered around Mental Health with a timetable of wellbeing surgeries and support services on site.
- Effective utilisation of the Trust's EAP has increased uptake across the organisation and is enabling staff to access support more quickly.
- Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy' have been delivered across the Trust and based on the positive feedback further modules are currently in development.

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 transforming and the modernisation of Occupational Health and Wellbeing service to align to the GROW OH Strategy, development of the Trust's flexible working offer and the development and implementation of the WUTH employee perfect start.

Staff Turnover % compliance

Narrative:

The Trust threshold for turnover is 0.83%. For the first time in 2023 / 2024, the July 2023 the indicator was slightly above threshold at 0.98%. This demonstrates a common cause variation.

The position is mainly driven by turnover in the Add Professional & Technical staff group and the Additional Clinical Services staff group. A thematic review of exit interviews is underway and will be reported to Workforce Steering Board in September 2023.

Th most commonly occurring known destination on leaving is for employment in other NHS Organisations and, whilst the reasons for leaving vary, better reward package, relocation and promotion are the commonly occurring themes. Pleasingly we are seeing a reduction in staff leaving due to flexible working and work life balance.

Actions:

- Focusing on how we can sustain a valuable workforce continues through the Strategic Retention Group. Some examples of the work underway include:
    - Launch of the 3-month internal transfer pilot for band 5 Registered Nurses and Clinical Support Workers.
    - The electronic resignation and exit interview pilot has been completed and is in the process of review.
    - Career clinics have recommenced within Nursing and Midwifery.
    - A library of inspirational career stories is being developed, to demonstrate career development opportunities across the workforce.
    - Listening events have been held with Band 6 Nurses and the themes have been used to support the training plan for the new Band 6 Aspirant role and support personalised development plans for the current band 5 Nurses.
    - An equality impact assessment has been completed to consider retention factors that may impact staff with protective characteristics. All Retention Task and Finish Groups are determining relevant actions as a result of the assessment.

- Leadership Masterclass are being utilised to promote inclusivity, shared lived experiences and how we can better support each other. AJ Jackson has been secured as part of Inclusion Week.

Risks to position and/or actions:

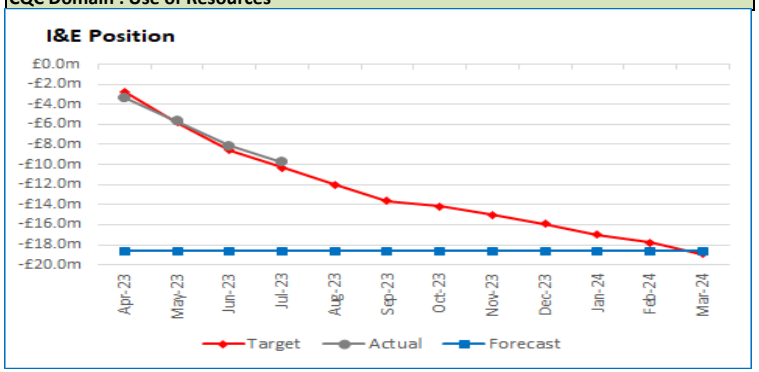
The impact of the work outlined above will achieve a downwards trend towards the <10% turnover target, the number or % of staff leaving within the first 12 months and voluntary turnover.

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

Work continues delivering the agreed year 2 deliverables within the People Strategy with a number of workstreams which will help support retention across the Trust – such as the development of the Trust's flexible working offer and launch of the new FW brochure, the development of the WUTH employee perfect start, delivering a programme of work to improve the experience of our disabled staff and developing our just and learning culture.

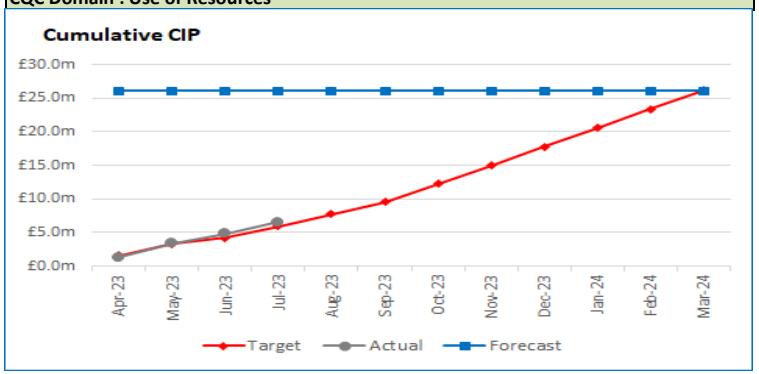
Chief Finance Officer

CQC Domain : Use of Resources



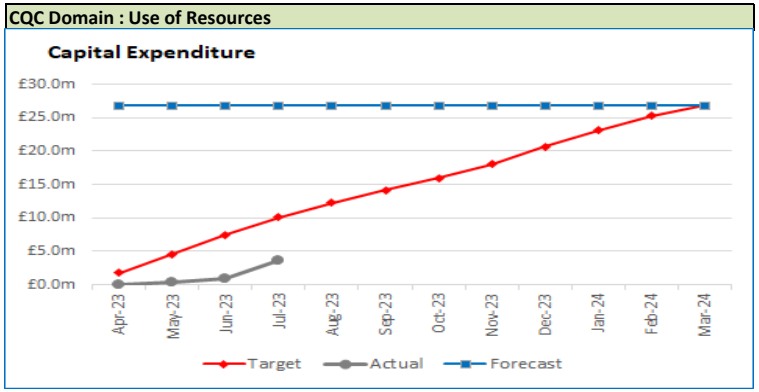
July-23
-£9.78m
Variance
Position better than plan
Target
-£10.32m

CQC Domain : Use of Resources



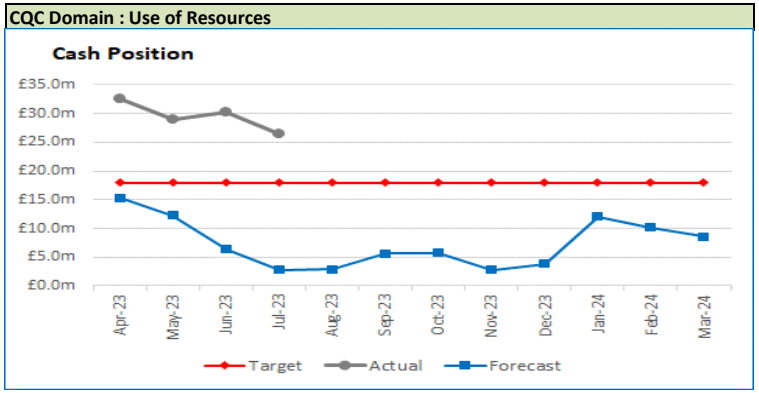
July-23
£6.62m
Variance
Position better than plan
Target
£5.90m

CQC Domain : Use of Resources



July-23
£3.7m
Variance
Position not worse than plan
Target
£10.1m

CQC Domain : Use of Resources



July-23
£26.5m
Variance
Position better than plan
Target
£18.0m

Chief Finance Officer

Executive 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 alone 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 (M4)	RAG (Forecast)	Target Measure
Financial Stability			Achieve in-year financial plan
Agency Spend			Agency spend <= 3.7% of total pay
Financial Sustainability			Medium term financial recovery plan
Financial Efficiency			Variance from efficiency plan
Capital			Capital spend on track and within CDEL limit
Cash			Positive Trust cash balance

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 July 2023, Month 4, the Trust has reported a deficit of £9.8m against a plan of £10.3m, the resultant variance of £0.5m is an improvement on the M3 position. The position assumes £1.7m of income to mitigate lost activity caused by industrial action. This has been agreed with the ICB as a planning assumption but will not be transacted ahead of national guidance.

The table below summarises this I&E position at M4:

Month 4	Annual Plan	In Month			Year to Date		
Cost Type	23/24	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£440.1m	£36.4m	£35.2m	-£1.2m	£146.3m	£143.0m	-£3.3m
Other Operating Income	£28.4m	£3.4m	£3.4m	£0.1m	£12.8m	£12.8m	£0.0m
Total Income	**£468.5m**	**£39.7m**	**£38.6m**	**-£1.1m**	**£159.0m**	**£155.8m**	**-£3.2m**
Employee Expenses	-£339.0m	-£28.8m	-£28.6m	£0.2m	-£117.3m	-£117.2m	£0.1m
Operating Expenses	-£168.5m	-£13.8m	-£13.1m	£0.7m	-£55.8m	-£53.8m	£2.0m
Non Operating Expenses	-£5.9m	-£0.5m	-£0.3m	£0.2m	-£2.1m	-£1.2m	£0.9m
CIP	£26.2m	£1.6m	£1.8m	£0.1m	£5.9m	£6.6m	£0.7m
Total Expenditure	**-£487.2m**	**-£41.5m**	**-£40.3m**	**£1.2m**	**-£169.3m**	**-£165.6m**	**£3.7m**
Total	**-£18.6m**	**-£1.7m**	**-£1.6m**	**£0.1m**	**-£10.3m**	**-£9.8m**	**£0.5m**

Key variances within the position are:

Clinical Income – £3.3m adverse variance relates to planned-care activity cancelled due to strike action, capacity at the CMSC not taken up by ICS partners and lower than planned case mix in Surgery. There has also been a reduction in PbR excluded drugs but this is offset by operating expenses.
Operating expenses – The underspend mirrors the variances within clinical income.
Non-operating expenses – Actual Public Dividend Capital payments are lower than budgeted due to improvements in the initial planning assumptions on which the plan was based.
Cost Improvement Programme – CIP remains ahead of profile but with an increasingly challenging target across the year.

It is confirmed that the Trust's agency costs were 2.8% of total pay costs compared to a maximum target of 3.7%.

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

- The Trust fails to fully deliver the recurrent Cost Improvement Programme.
- 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:

M4 continued our strong performance with £1.8m delivered in month against a plan of £1.6m. The Trust is ahead of the year to date plan of £5.9m by £0.7m.

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.

Capital Expenditure

Narrative:

The Trust has spent £3.7m against a cumulative target expenditure of £10.1, an underspend of £6.4m. This is primarily driven by delays in respect of the Urgent and Emergency Care Upgrade Programme (UECUP) and Clinical Diagnostic Centre (CDC) schemes.

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 is continued review of both schemes and prioritisation decisions. 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:

- 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 increasingly places pressure on the Trust's ability to maintain a positive cash balance. At M4 achieving a cash resources of £26.5m has only been possible because not all accrued expenditure from 2022/23 has been transacted as payments and there is continued daily management of working capital balances.

Risks to position:

- Reductions in cash balances place delivery of the Public Sector Payment Policy (PSPP) at risk.
- Failure to achieve the full recurrent CIP plan will negatively impact the cash trajectory.
- 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.
- The Trust has registered a formal complaint relating to Barclays Bank with the Finance Ombudsman. Barclays has not transacted requested changes to the approved signatories and this means that the Trust cannot access in excess of £1m of charitable funds for schemes for premature babies, cancer patients and NHS staff.

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.
- Continue to seek resolution of the Barclays Bank complaint directly and through the Finance Ombudsman.
- Provide short-term cash support to ensure charitable funds schemes are not delayed.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.3**
06 September 2023

Title	Productivity and Efficiency Update
Area Lead	Hayley Kendall, Chief Operating Officer
Author	Hayley Kendall, Chief Operating Officer
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 as well as providing assurance on the full year programme and forecast.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key risks:

- Delivery of a sustainable financial position

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

1	CIP Performance
	For 2023/24, the Trust has a Cost Improvement Target of £26m. In planning for the year the process was to identify savings in excess of the £26m given a number of schemes have longer lead in times. As well as the divisional targets apportioned the programme was also developed at a workstream level through the development of the WAVE Programme, explored further in the paper. There has been significant progress made

towards the achievement of the £26m target and at month 4 performance is in excess of the CIP target set.

1.1 Divisional CIP position at month 4

	Year to Date		
Division	YTD Target	YTD Delivered	Variance
Medicine	£267	£902	£635
Acute	£83	£33	-£50
Surgery	£1,355	£1,614	£259
DCS	£588	£960	£371
W&C	£285	£548	£263
Corporate	£1,722	£1,748	£26
Estates	£1,124	£334	-£790
COVID	£499	£499	£0
Trust	£5,923	£6,637	£715

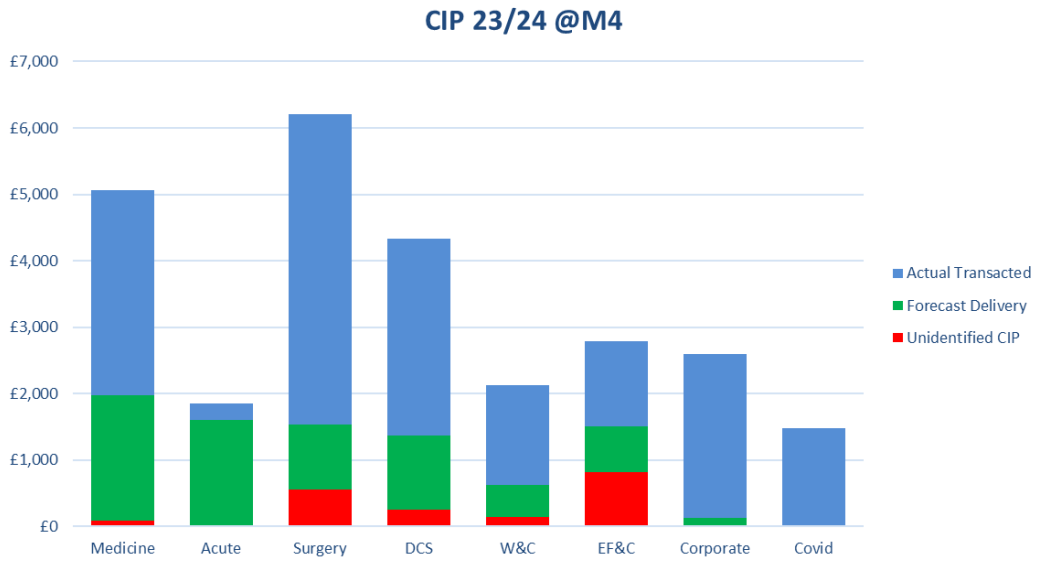
At the end of month 4 the Trust has delivered £6.637m against a target of £5.923m recurrently. This does not include any non-recurrent savings. Estates is the only division to not be achieving the target set out at the start of the year.

1.2 CIP transacted at month 4

Transacted CIP @M4						
Division	M1	M2	M3	M4	YTD	Fy Transacted
Medicine	£15	£280	£301	£306	£902	£3,090
Acute	£4	£12	£10	£7	£33	£244
Surgery	£256	£320	£579	£459	£1,614	£4,671
DCS	£64	£309	£236	£350	£960	£2,969
W&C	£42	£132	£87	£287	£548	£1,498
Corporate	£774	£827	£58	£89	£1,748	£2,458
Estates	£18	£84	£83	£148	£334	£1,279
COVID	£123	£123	£123	£123	£493	£1,481
Total	£1,296	£2,088	£1,478	£1,770	£6,631	£17,689

At the end of month 4 £17.689m has been transacted from budgets as recurrent savings. This is 68% of the full year target of £26.1m and great performance and assurance less than halfway through the financial year.

1.3 CIP position by division



There are three divisions that have a moderate level of CIP unidentified, with the largest proportion being in Estates.

1.4 CIP at workstream level

Part Year Effect					
Workstream	Red	Amber	Green	Blue	Total Identified
Diagnostics	£1	£92	£9	£1,255	**£1,358**
Medicines Optimisation	£0	£1,336	£40	£54	**£1,430**
Non PBR Income & SLA Management	£12	£139	£197	£1,311	**£1,659**
One Patient Record	£490	£50	£209	£208	**£957**
Patient Flow	£0	£70	£293	£3,534	**£3,896**
Procurement	£0	£189	£327	£2,539	**£3,055**
Space Utilisation	£0	£2	£118	£306	**£426**
Think Big	£148	£228	£105	£2,692	**£3,173**
Workforce	£42	£547	£2,589	£5,790	**£8,969**
Total	**£693**	**£2,653**	**£3,887**	**£17,689**	**£24,922**

At month 4 the workstreams are forecasting to deliver a part year effect of £24.922m. Over the next month all workstreams will be reviewed to bring the transacted position closer to the forecast to provide assurance on the forecast position, given there is still over £3m of schemes in the red and amber risk category.

1.5 Quarter 2 forecast

Given that the quarter two plan significantly increases from quarter one there has been robust process to forecast the delivery against the increased plan for quarter two.

Division	Q2 Target	Q2 Forecast	Q2 Transacted
Acute	£368	£428	£38
Corporate	£257	£281	£266
COVID	£370	£370	£370
DCS	£1,223	£1,011	£855
Estates	£582	£483	£385
Medicine	£325	£1,043	£918
Surgery	£1,544	£1,363	£1,223
W&C	£647	£642	£524
Total	**£5,316**	**£5,622**	**£4,579**

There has already been good progress in delivering the quarter 2 plan with 86% of the target already transacted out of budgets at the start of month 5. It should be noted that the forecast for quarter two is to exceed the plan by £306k.

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

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	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.
3.1	**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 Executive Directors, Deputy Chief Finance Officer, Divisional Directors, Associate Director of Prod/Eff and 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.
3.2	**Divisional meetings and Workstream meetings** Fortnightly Divisional CIP meetings are in place with attendance from divisional leads, PMO, finance and corporate support services.
3.3	**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. The terms of reference are under review with a view to expanding the scope of the Board.
3.4	**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.

4	**Conclusion and Recommendation**
	The paper has provided robust evidence to suggest that the CIP is achieving the plan set out at the start of the year and forecasts good progress against the annual savings target. There is strong assurance on the governance of the programme and visibility within the organisation. The Board of Directors is asked to note the report and receive the next update in quarter three.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 8.4**
6 September 2023

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

Report Purpose and Recommendations

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

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

For unscheduled care, the report details performance and highlights the ongoing challenges with achievement of the national waiting time standards.

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

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 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 treat the backlog of patients awaiting their elective care pathway. In addition, medical staff industrial action is having a significant impact on the level of elective activity undertaken and the number of patients that the Trust has not been able to treat. 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. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance.

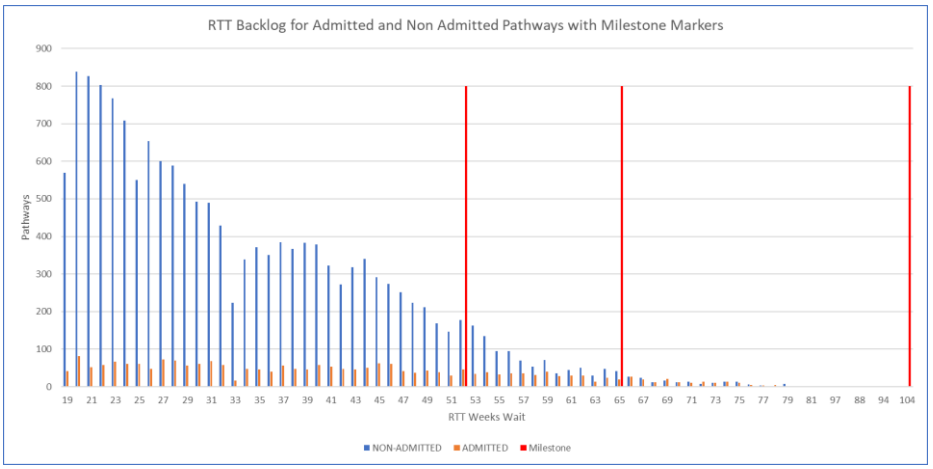
2	Planned Care
2.1	**Elective Activity** In July 2023, the Trust attained an overall performance of 96% against plan for outpatients and an overall performance of 84% against plan for elective admissions as shown in the table below: The Trust was on plan to achieve the activity plan in July but was impacted by industrial action.
2.2	**Referral to Treatment** The national standard is to have no patients waiting over 104 weeks from 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 July against these indicators was as follows: • 104+ Week Wait Performance – zero • 78+ Week Wait Performance - 2 • 65+ Week Wait Performance - 317 • 52+ Week Wait Performance - 1459 • Waiting List Size - there were 42,632 patients on an active RTT pathway which is higher that the Trust's trajectory of 39,510.

2023/24 Plan			
Activity Type	Target for Jul	Actual for Jul	Performance
Outpatient New	12,041	11,585	96%
Outpatient Follow Up	30,298	29,146	96%
Total outpatients	**42,339**	**40,731**	96%
Day case	4,390	3,603	82%
Inpatients	665	641	96%
Total	**5,055**	**4,244**	84%

It is becoming increasingly difficult to accommodate all 78 week breaches with the significant loss of elective activity due to industrial action.

An in-depth analysis of waiting list size has been undertaken and key actions to address are underway.

The graph below illustrates current RTT Backlog for admitted and non-admitted patients at the key milestones of 52, 65, 78 and 104 weeks:



WUTH have continued to support neighbouring Trusts by offering mutual aid to treat very long waiting patients through the Cheshire and Merseyside Surgical Centre and this will continue through the year.

2.3 Cancer Performance

Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 2 to date:

- 2 Week Waits – performance at the end of July is 89.2% which is below the required standard of 93% but still positive, two main areas of under performance are Gynaecology and Colorectal.
- Faster Diagnosis Standard – was 79.12% in June against a National target of 75% by March 2024 which is positive for patient experience receiving timely diagnosis.
- NSS Numbers – remains zero against an initial plan of 4.
- 31 Day Treatment Numbers - above trajectory and expected to continue.
- 62 Day Performance – not achieving the national standard, however 62-day long waiters' backlog was 176 against a 194 trajectory for July which is positive improvements:

	03/04	10/04	17/04	24/04	01/05	08/05	15/05	22/05	29/05	05/06	12/06	19/06	26/06	03/07	10/07	17/07	24/07	31/07
Actual 23/24	177	193	193	194	182	175	175	182	203	191	162	155	158	161	163	165	167	176
Recovery Trajectory	210	210	210	210	205	205	205	205	205	200	200	200	200	194	194	194	194	194
Pre-COVID Average	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51

- 104 Day Long Waiters – performance is slightly above trajectory at 42 against a trajectory of 45 for July and work continues with Colorectal's MDT approach to achieve plan:

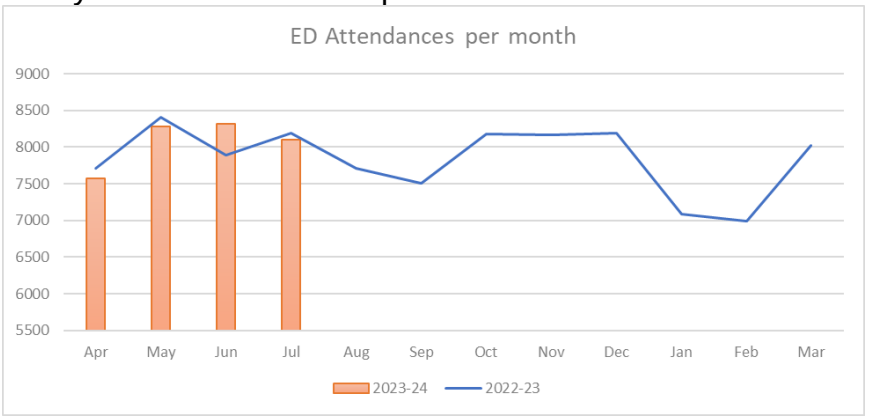
	03/04	10/04	17/04	24/04	01/05	08/05	15/05	22/05	29/05	05/06	12/06	19/06	26/06	03/07	10/07	17/07	24/07	31/07
Actual 23/24	65	68	59	55	54	49	58	58	64	56	46	48	59	57	57	56	47	42
Recovery Trajectory	55	55	55	55	52	52	52	52	52	49	49	49	49	45	45	45	45	45
Pre-COVID Average	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12

	As with all Trusts across Cheshire and Merseyside 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 challenge 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. Colorectal remains focussed in the workstreams to improve the patient pathway and positive results are beginning to yield, although performance in this area remains a concern.
2.4	**DM01 Performance – 95% Standard** In June 95.10% 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% and requirement for Trust's to achieve 95% by March 2025. This is a great achievement for the Trust and is the first acute Trust in Cheshire and Merseyside to achieve the national standard.
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 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 major risk to the delivery of the elective recovery programme is the impact of industrial action. On strike days, elective activity is being managed patient by patient to reduce disruption to our patients whilst maintaining safe standards of care across the hospital sites, with a focus to keep patient cancellations to an absolute minimum.

3.0	**Unscheduled Care**
3.1	**Performance** July Type 1 performance was reported at 50.51%, which is below the 4-hour improvement trajectory.

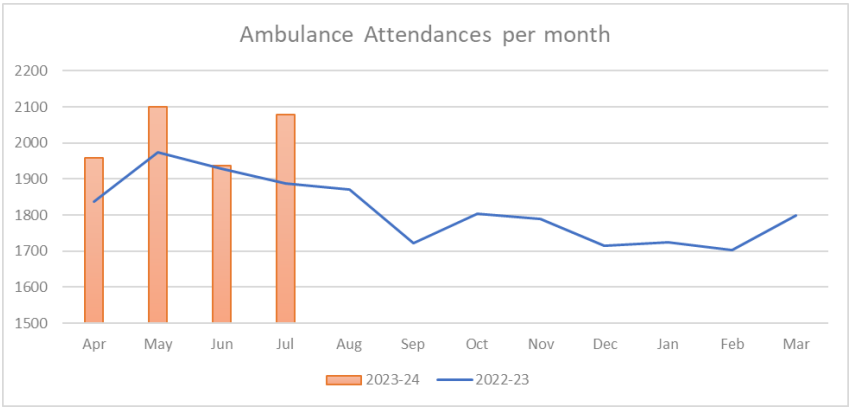
Type 1 ED attendances:	Type 3 ED attendances:
• 8,312 in June (avg. 277/day) • 8,192 in July (avg. 264 /day) • 3% reduction from previous month	• 2,949 in June • 2,906 in July • 1% reduction from previous month

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



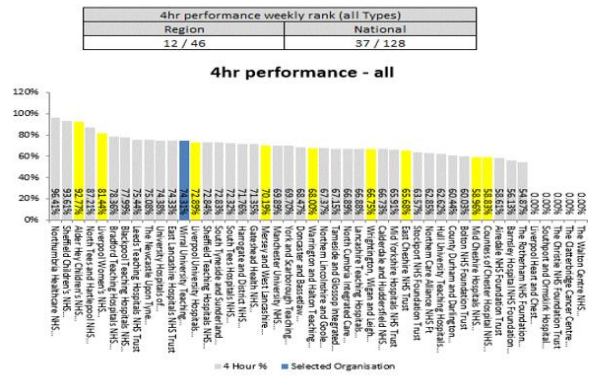
The Trust saw a slight decrease in Type 1 and Type 3 attendances compared to the previous month, although both figures were higher than the previous year. The department continued to see an increase in ambulance attendances. The Trust has engaged with NWAS and introduced a monthly meeting to discuss attendances, attendance type and areas for improvement and collaboration. The increase in activity has been linked to an increase in Category 2 conveyances, i.e. the acute nature of patients arriving at A&E has increased. The increase in category 2 attendances is not unique to the Trust. However, the Trust has been able to manage demand within the ambulance arrival zone in on most days, preventing corridor care.

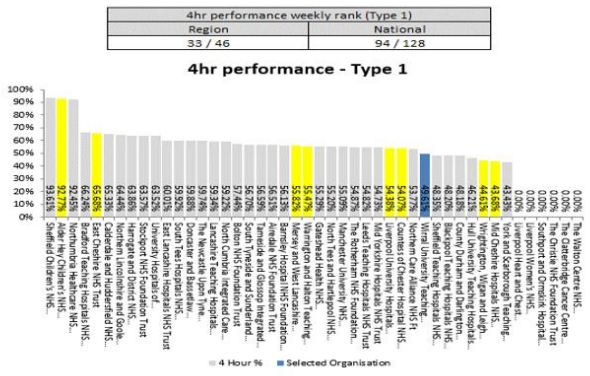
The graph below shows the ambulance attendances per month compared to the previous year.



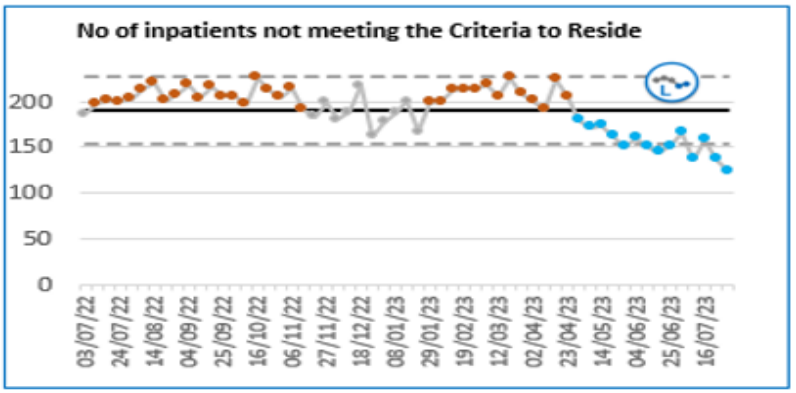
The Trust has also seen a positive improvement in ambulance handover times within 15 minutes. Although this remains a challenge, the Trust continues to focus on improvement actions and is working closely with NWAS to ensure that actions and efficiencies are implemented across both organisations.

The graphs below demonstrate Wirral's 4-hour performance for all attendances (blue bar) plotted against other acute providers in Cheshire and Merseyside (yellow bars) and Type 1 performance only:





The Trust will continue to focus on improving the achievement of the 4 hour standard for Type 1. There is a robust action plan in place covering staffing, estates and streamlining clinical pathways. The Chief Operating Officer has met with the clinical and operational leadership teams to test the improvement plan.

	The Trust is now seeing an improved position with a reduction in the number of patients waiting longer than 12 hours following a decision to admit. The improved process and early escalation has helped to reduce the number of breaches.
3.2	**Transfer of Care Hub development and no criteria to reside** The Trust went live with the Transfer of Care Hub in July 2023. Following the implementation of the Hub and the transfer of responsibility for the management of non-criteria to reside patients, the Trust has seen a significant reduction in the patients waiting placement outside of the hospital. This has had a positive impact on hospital occupancy and flow across the Trust. The reduction can be seen in the SPC graph below.  The Trust continues to work with system partners to ensure that the criteria to access beds meets the needs of our patients and that delays are reduced. The Trust has held joint events with care homes with the Local Authority across Wirral to gain insight and look at ways to improve discharges outside of current admission times. Reducing the number of patients that are deemed to have no criteria to reside has enabled the Trust to further reduce the number of escalation beds. The Trust will continue to seek to reduce the number of escalation beds without impacting on the flow of patients from the Emergency Department.
3.3	**Risks and mitigations to improving performance** The Trust continues to experience a significant pressure with the increasing number of mental health patients, which often exceeds the capacity of the mental health unit based in the Emergency Department, 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 to consider how patients can be treated safely and access alternative services where appropriate. The Trust is seeking a short and long term response from the local provider to manage the increase in demand as these demands can not be left with the Emergency Department to manage. The next phase of building works for UECEUP, due to start in February 2024, increases the risk due to the impact on capacity to manage the number of mental health patients in the department therefore the Trust has requested a plan from our mental health partners to how these patients can be treated and discharged in a timelier way. The industrial action continue to challenge our departments productivity and ability to function to deliver timely care in line with the Urgent and Emergency Care national standards, however it is expected that the action plan that is in place will mitigate for the days of reduced staffing.

4.0	Conclusion
	The Board should note the positive improvements in the no criteria to reside position in the hospital and that hospital occupancy remains the focus. Whilst there is a refreshed Hospital Flow Improvement Programme aiming to deliver improved patient pathways and reduced time for patients in Emergency Department, 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 of 62, 104 day waits as well as achievement of the Faster Diagnosis Standard.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.5**

06 September 2023

Title	Quarterly Maternity and Neonatal Services Report
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and AHPs Director of Infection Prevention and Control
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Information

Report Purpose and Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in July 2023, with the following paper providing a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

This paper provides a specific update regarding Year 5 of the Maternity Incentive Scheme (MIS), together with an update on Saving Babies Lives (SBLv3) one of the ten safety actions included in the MIS, together with an update on the Care Quality Commissioners (CQC) inspections of maternity services.

An update is also provided on the three-year delivery plan, maternity continuity of carer implementation and the workforce position and the staffing requirements to continue to pursue this model.

The paper summarises an update on the Midwifery workforce and continuity of carer model.

It is recommended: -

- Note the report.
- Note the 'Good' rating following the publication of the CQC inspection reports to include both Arrow Park Hospital and Seacombe Birth Centre for safe and well-led.
- Note the progress of the Trust's position with Year 5 of the Maternity Incentive Scheme and Saving Babies Lives v3.
- Note the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals".
- Note 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.
- Note the MatNeoSIP quality improvement works underway in maternity and neonatal services.

Key Risks

This report relates to these key Risks:

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

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**
Sept 2023	Maternity & NNU Assurance Board		For information

1	Maternity Incentive Scheme (MIS) Year 5
	A detailed MIS update is included to Board of Directors Quarterly Maternity Services update, which will further inform Trust declaration with the MIS due for submission before a deadline of 1 February 2024. Now in its fifth year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. NHS Resolution in conjunction with NHSE/I confirmed the relaunch of the Year 5 MIS revised version in July 2023 **(Appendix 1)**. The Women's & Children's Division has continued with its work to progress the 10 safety actions based on the previous requirements. At the July 2023 Board of Directors, it was updated WUTH was on track to meet the requirements of each safety action and since the revised version a gap analysis has been completed **(Appendix 2**) following the publication for Year 5. The compliance will be monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. A further compliance update will be included in the October 2023 Maternity monthly update report. Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS and the declaration will also be required to be signed off by the ICB.

2	Saving Babies Lives Version 3
	The Saving Babies' Lives Care Bundle – Version 3 (SBLCB) is included within the paper **(Appendix 3)** providing detail of evidence-based best practice for antenatal care. This supports providers and commissioners of maternity care across England, to achieve an overall aim of reducing perinatal mortality. SBL Version 3 of the care bundle has been developed to include an additional element on the management of pre-existing diabetes in pregnancy, based upon data from the National Pregnancy in Diabetes (NPID) audit. To meet all the elements of SBLv3 at WUTH, funding of additional obstetric and midwifery hours is required. A business case has been developed to support this and has been submitted to meet and deliver the additional care provision. The Three-Year Delivery Plan for Maternity and Neonatal Services also sets out that providers should fully implement Version 3 of the SBLCB by March 2024. An implementation tool has been developed nationally to support its implementation. Maternity services and commissioners are required to complete a baseline assessment of current practice, and there is a requirement to also outline the improvements required to meet overall compliance. also relates to the implementation of SBLCB and requires providers to use the tool as the basis for evidencing quarterly quality improvement discussion/s. SBLCB is safety standard 6 of the MIS scheme and compliance will be monitored quarterly by the LMNS and ICB which will provide further assurance of compliance with the maternity incentive scheme.

3	Ockenden Review of Maternity Services: Final Report – Update on Trust compliance with the Immediate and Essential Actions / Recommendations
	An initial gap analysis outlining compliance against these recommendations detailed within the 15 Immediate and Essential Actions (IEA's) was reported to the Board of Directors in April 2022 and updates have been provided quarterly. The gap analysis is included at **Appendix 4** and remains in the same RAG rated position as fully compliant.

4	Three Year Delivery Plan – Maternity and Neonatal
	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 5** and is RAG rated accordingly. The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion • Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support • Standards and structures that underpin safer, more personalised, and more equitable care. Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress will be monitored

	via the Maternity and Neonatal Quality assurance board and updates will be provided in the quarterly Board of Directors report.

5	CQC Maternity Inspection
	A Care Quality Commission (CQC) Inspection for both the Maternity Arrowe Park site and Seacombe Birth Centre in Wallasey took place on 24 and 25 April 2023. The inspection was part of the national review into maternity safety currently underway by the CQC. The Care Quality Commission (CQC) inspection of Maternity Services at Wirral University Teaching Hospital Trust rated the services as 'Good' for safe care and 'Good' for well-led services, with areas of outstanding practice being reported in the Trust's joint work with Wirral Maternity and Neonatal Voices Partnership. Among the many positive findings in the report, the CQC noted that: • Staff are competent and feel valued and supported. • There is clear and visible leadership, including Maternity Champions at Board level. • The service has a positive culture, with openness, honesty, and strong commitment to safety. • The Leadership Team have the skills and abilities to manage the service well. • There is a positive culture within the service where people, their families and staff felt they could raise concerns. • Staff are committed to improving services to ensure people receive a high standard of care. • Engagement and involvement with women, families, and birthing people was strong – especially the partnership working with Wirral Maternity and Neonatal Voices Partnership, which was rated as outstanding. • Care is individualised, compassionate and personalised. • The team had a commitment to training and research. • The service is committed to improvement, innovation and continued learning. • The Trust was the only service within the local maternity services network to offer 4 birth choices to woman and birthing people. The reports are included at **Appendix 6 and 7**.

6	The Perinatal Clinical Surveillance Quality Tool (PCSQ) Assurance Report
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 8** and provides an overview of the latest (July 2023) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services. The dashboard is provided for information and there is no indication to escalate any of the metrics to the Board of Directors.

7	The Northwest Coast Outlier Report
	In previous reports to the Board of Directors the Northwest Coast Outlier report was included proving assurance WUTH was not an outlier against each of the metrics. The data collection for this report discontinued as of 31 March 2023. A revised Northwest region perinatal dashboard and Northwest maternity surveillance heat map is currently being developed to include key maternity quality and safety measures. The purpose of the dashboard is to highlight concerns or issues identified via the dashboard and heatmap as analysed by the NW regional maternity and analytics team and discussed with the appropriate LMNS and provider Trust with the aim being, to seek assurances and agree what support may be required from the regional team. Examples of good practice will be used to share learning across the region. Data collection from the NW regional team commenced in July 2023 and the dashboard is expected to be available to providers later in the year. In the absence of the Northwest benchmarking data, the Trust continues with local oversight and monitoring of a wide range of maternity and neonatal metrics from current dashboards. Exceptions from these metrics are reported at Patient Safety Quality Board and Quality Committee. In addition to the maternity and neonatal safety champions, a newly introduced Maternity & Neonatal Assurance Group will also have oversight of this.

8	Serious Incidents (SI's) & Health Care Safety Investigation Branch (HSIB)
	Serious incidents (SI's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). SI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity SI's across the region. There were no serious incidents or HSIB cases declared in July 2023 for maternity services. There were no serious incidents declared in July 2023 for Neonatal services.

9	Implementing a Continuity of Carer Model of Maternity Care
	The Maternity Service continues to deliver care via two models of maternity care – one that is traditional in its approach, and the other a Continuity of Carer (CoC) Model of care. Women being cared for by a team of midwives under the Continuity of Carer model appreciate the benefits of improved outcomes and experience compared to those cared for by a traditional model. As a provider WUTH has six maternity continuity of carer teams and the seventh team was launched in July 2023 as planned, however the team was paused within two weeks of its roll out due to several contributing factors in line with ensuring safe staffing levels. Progress with further CoC teams being launched will be subject to a full review of staffing levels and upskilling programs completed. A comprehensive review of CoC is being undertaken that will be presented to the Board of Directors in January 2024 it has been agreed further roll out of the teams will be paused until the review has been completed. Listening Events are being held with staff and feedback is being sought

	from patients along with patient and infant outcomes to identify what the recommended approach for further roll out of CoC will be.

10	Workforce update
	As previously presented to Board of Directors a workforce review using the Birthrate+ tool was undertaken in 2021 and reviewed in March 2023. The midwifery staffing oversight report that covers staffing and safety issues will be seen at People Committee in September 2023. In line with BAPAM standards a neonatal medical and nursing workforce paper will be presented to the Board of Directors in October 2023 to provide an update on the Trust's position.

11	Newborn and Infant Physical Examination (NIPE) Training Requirements
	Appendix 9 included within the papers is the guidance published in July 2023 for NHS providers of maternity and neonatal services on training requirements regarding newborn and infant physical examination (NIPE). The purpose of this report is to provide the Board of Directors assurance the NIPE screening programme guidance requirements ensuring only trained and competent individuals who meet the requirements of the NHS England NIPE clinical guidance have been met at WUTH.

12	Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)
	The Maternity and Neonatal Safety Improvement Programme aims to improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England. As part of the MatNeoSIP WUTH have initiated the following quality improvement projects: - • Optimisation and stabilisation of the preterm infant • Early recognition and management of deterioration of women and babies • Smoke free pregnancy • Triage Birmingham Symptom Obstetric Triage System (BSOT's) • OASI care bundle in line with the Three-Year delivery plan • Enhanced Maternity Care ongoing development with collaboration with HDU practice facilitator.

13	Maternity Escalation and Divert update
	The weekly C&M Gold Command meetings continue to identify demand and capacity 'hotspots' in a timely manner, and have improved provider collaboration within C&M. This has positively impacted on the need for maternity providers to formally divert services to another provider. There were no diverts from WUTH in 2022 or up until end of July 2023, with WUTH supporting other providers on a number of occasions with mutual aid within the region.

14	Conclusion
	The next BOD paper will continue to update on the delivery of safe maternity and neonatal services to include an update on progress with the Maternity Incentive Scheme Year 5 and NHSE Three-year delivery plan. An update will be provided on the neonatal nursing staffing position in line with the requirements of MIS Year 5. An update will continue to be provided on the Maternity Continuity of Carer Implementation Plan.

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Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.6**

06 September 2023

Title	Learning from Deaths Report (Q4 2022-23)
Area Lead	Dr Nikki Stevenson, Medical Director and Deputy CEO
Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide Board of Directors with Learning from Deaths Report and reports on deaths observed in Q4 2022-2023.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths
- The Trust SHMI for the 12 months to Dec 2022 is 1.06 (within expected range)
- HSMR on the latest available data is 96.3 (within expected range)
- HSMR has fallen slightly this quarter after following the national trend of rising for the previous 3 quarters
- The Mortality review group (MRG) meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner.
- MRG continues to review Telstar Health data (formerly Dr Foster) to benchmark nationally and highlight areas of concern.
- Learning form mortality reviews is fed back to clinical areas by the Divisional Mortality leads.

It is recommended that the Board:

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

Key Risks

This report relates to these key risks:

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

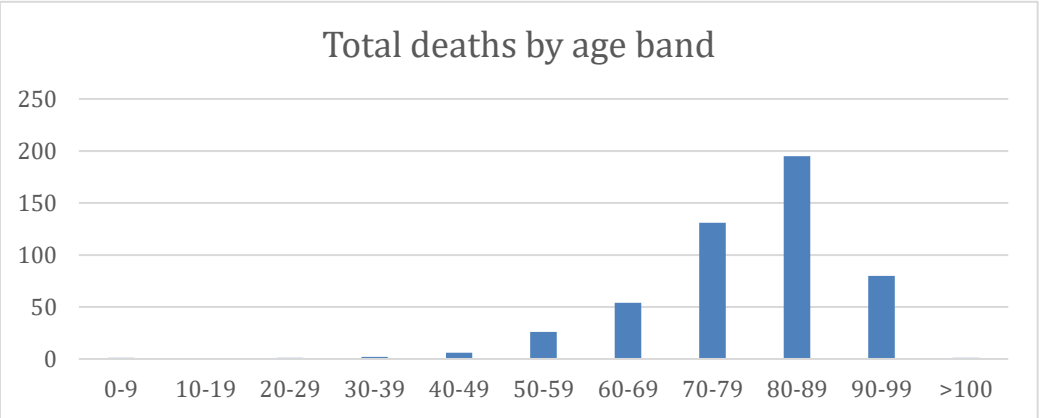
Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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	No
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

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

1	Narrative
1.1	To provide a summary of the mortality review process, care issues, learning and current mortality comparator statistics. This paper is for Adult and perinatal mortality. Wirral University Teaching Hospital is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework: • Preventing people from dying prematurely. • Treating and caring for people in a safe environment and protecting them from avoidable harm. Wirral University Teaching Hospital uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a 'warning' of potential problems and help identify areas for investigation. The Medical Examiner service provides independent scrutiny for all deaths that occur within WUTH, and escalates any concerns for a mortality review, coordinated through the Trust Mortality Group. Additionally, a random 5% of non-escalated deaths are selected for a "quality assurance" mortality review. Lessons learnt from mortality reviews are fed back to each clinical Division via the Divisional Mortality leads who attend the Mortality Review Group. **Patient demographics** There was a total of 503 deaths in Q4 2022-23. This is a slight reduction from Q3 (533).

As per previous trends most recorded deaths are in the over 60 age group and the vast majority fall into the “White British” Ethnic band.



Ethnicity	Number of deaths
White - British	458
White - Irish	3
White - Any other White background	6
Mixed - Any other mixed background	0
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	2
Other Ethnic Groups - Chinese	1
Black/ Black British	0
Not stated/ Not known	33
Total	503

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The overall SHIMI for WUTH on the latest available data (Jan22- Dec22 is 1.06 which is within the “ as expected” range. SHIMI for WUTH has been relatively stable in the “expected” range for several quarters now.

Factors impacting SHIMI

1. Specific diagnostic groups

SHIMI can be broken down into specific diagnostic groups to highlight any areas of concern.

The only diagnostic group that is currently a statistical outlier is Non-Infective Gastroenteritis. However, there are a small number of deaths in this group (7) and most seem to have been coded incorrectly as 6 of the 7 cases had a different final diagnosis.

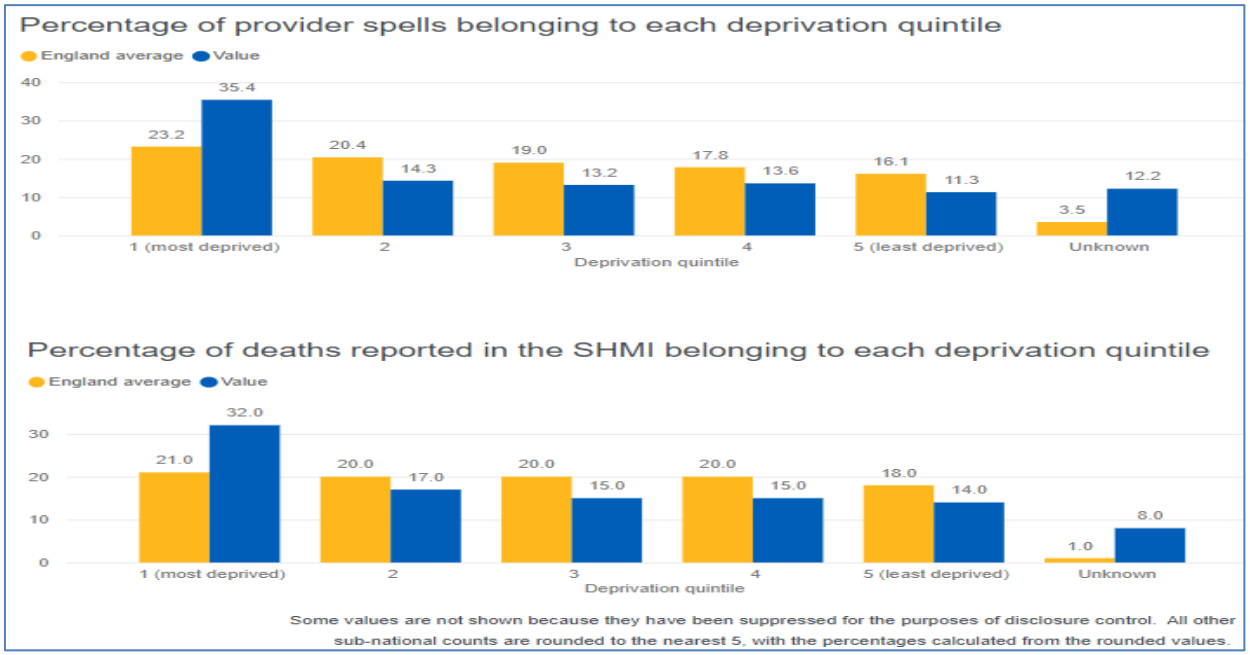
Deaths in the diagnostic group Pneumonia remain higher than expected as in previous quarters. An audit of 100 pneumonia deaths has been completed and will be discussed at the Respiratory department meeting to develop an action plan. Initial feedback has show that only 30% of the deaths attributed to pneumonia were in the correct diagnostic group. Pneumonia management remains a key priority for the Clinical Outcomes Group.

Deaths in the diagnostic group Sepsis are higher than expected, but not statistically significant. A sepsis improvement group has been set up this quarter to focus on sepsis care and to drive improvement in KPI's.

Deaths in the diagnostic group Cerebrovascular Disease are higher than expected (when compared to similar stroke units). The Stroke service are currently reviewing this data and comparing with other data sources (SSNAP data)

2. Impact of deprivation on SHIMI

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



3. Palliative care coding

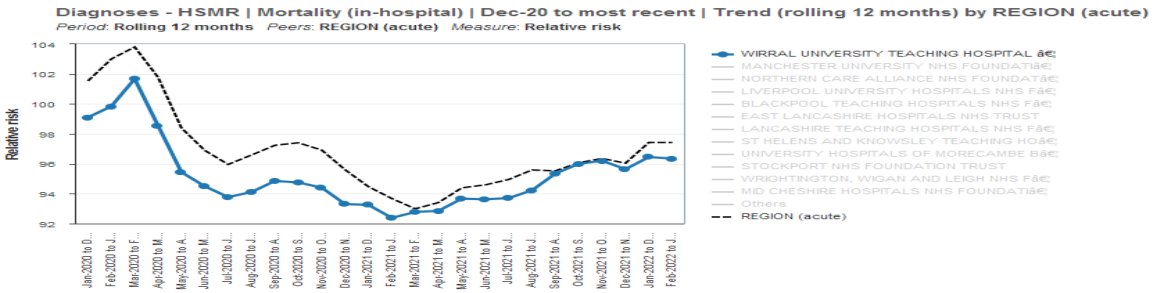
As discssed in previous reports WUTH continues to have a higher than average number of patients who have a palliative care code (after being reviewed by palliative care). A large number of patients with this code will impact on SHIMI as the SHIMI model does not exclude these patients (unlike HSMR).

A review of 100 patients under the palliative care team has confirmed the following;

- All patients were appropirate to be reviewed by palliative care, with 31% know to be in the final year of life prior to admission to hospital
- Of the patients reviewed 33% were discharged home with ongoing supprt from the community palliative care service
- WUTH is not an outlier for the percentage of patients dying in hospital when compared to C&M acute Trusts
- For patients who were underpalliative and subsequently died in hospital 91% had documneted evidence that their preferred place of death was WUTH.

Hospital Standardised Mortality Ratio (HSMR)

The HSMR for the latest available is 96.3. This is in the expected range, and has stabalised after rising for several quarters.



Mortality Dashboard

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

17 cases escalated by the ME to the mortality review group have undergone a review during Q4. These cases have been reviewed using a revised PMR template (15 cases) or via the Royal College of Physicians Structured Judgement review tool (2 cases). One case was escalated to the Serious Incident Review Panel and subsequently declared as a Serious Incident. This will be reviewed as per SI process and a SI report will be signed off by the SI panel in due course.

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 15 deaths were reviewed in Q4 (3%) using the PMR template. None of these cases identified any cause for concern.

Summary of all Adult in patient deaths and case reviews							
	Total Adult In-patients Deaths	Total Reviewed by Med Examiner or MEO	Total No of cases following for review by Medical Examiner	Total No of SJR's opened from cases escalated	Serious Incidents opened following MRG review	Quality assurance PMR's undertaken	Total number of case reviews by MRG
Q1 (22-23)	414	414	21	6	0	25	46
Q2 (22-23)	446	446	19	4	2	26	45
Q3 (22-23)	533	533	19	6	0	22	41
Q4 (22-23)	503	503	17	2	1	15	32

During Q4 6 SJR reports were discussed at MRG with the grading as below. The case that was graded as Grade 3 (care issues definitely affected outcome) was referred to SI panel (as above)

Grading of Adult Care and avoidability following SJR review in Q4 (Includes SJRs opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
	3	2		1

During Q4, 2 deaths were reported in patients identified as having a Learning disability. All of these deaths have been reviewed using the SJR template and have also been referred for external review through the national LeDeR programme.

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

Perinatal and Neonatal deaths

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

During Q4 there was one stillbirth reported and four Neonatal deaths reported. All these cases will undergo a PMRT review as per the usual process. Internal review has not identified any cause for concern in these cases.

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

Outcome of PMRT reviews reported in Q4				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, likely affected outcome
		4	2	0

Learning Identified from PMRT reviews.

There were 2 cases graded as “C” during Q4.

Case one learning.

The mother did not report reduced fetal movements, however, did report a change in pattern which should have been referred for further investigation. Learning shared with all midwives – any change in pattern of foetal movements requires referral and this is as per Tommys guidance.

Case 2 learning

Delay in transfer of mother from external organisation. Delays in WUTH around administration of antibiotics and delivery in theatre. This has been shared with the department in included in daily huddles as key learning.

Any PMRT reports graded a “C” or “D” will be discussed at the Serious Incident Review Panel to consider if they meet the threshold to be declared as a serious incident and to ensure actions are in place to address gaps in care.

Learning identified through review of mortality reviews during Q4

Learning for mortality is derived from 3 main sources

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

Specific learning and themes identified during Q4 as well as actions taken are listed in the table below.

Learning theme	Source	Action taken
Medication delays and errors	Mortality reviews	All cases are feedback via the Medications safety Pharmacist (who is a member of MRG) to relevant areas and MSOP committee that has oversight of medication safety across the Trust.
Delays in discharge home (Patients without criteria to reside)	Mortality reviews	Work ongoing at system level to address delays in discharge.
Poor documentation/ copying and pasting of medical documentation	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads.
Poor documentation around MCA and DNACPR decisions	Mortality reviews	All these cases are feedback to individual teams and the Trust CPR committee. MCA training and has been refreshed across all areas recently and audits of DNACPR forms strengthened to ensure better compliance .

External Benchmarking Data

Dr Telstar Health (Dr Foster) Data

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

There was an alert during Q4 for Non Infective Gastro enteritis with 7 cases highlighted.

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

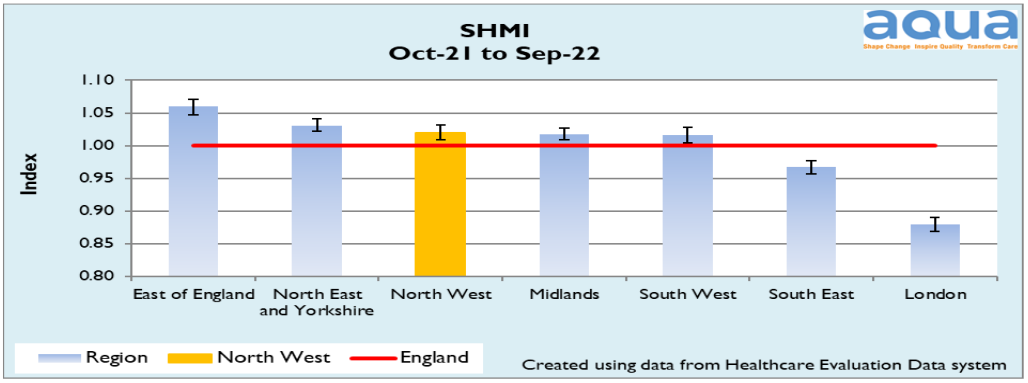
Diagnostic Group	Quarter Highlighted	Alert type	Work undertaken	Outcome/ Learning
Pneumonia	Q2 22-23	High SHIMI	Case note audit	Audit completed. Only 30% of patients in this group were felt to have pneumonia. Issues identified around sputum culture and smoking cessation advice. Audit to be discussed at Respiratory team meeting and action plan to address issues

				identified will be developed.
Secondary Malignancy	Q3 22-23	High SHIMI	Case note audit	Ongoing
Non-Infective Gastroenteritis	Q4 22-23	High SHIMI	Case note review	Small numbers, but 6 of the 7 cases had different final diagnosis. No concerns in care identified.

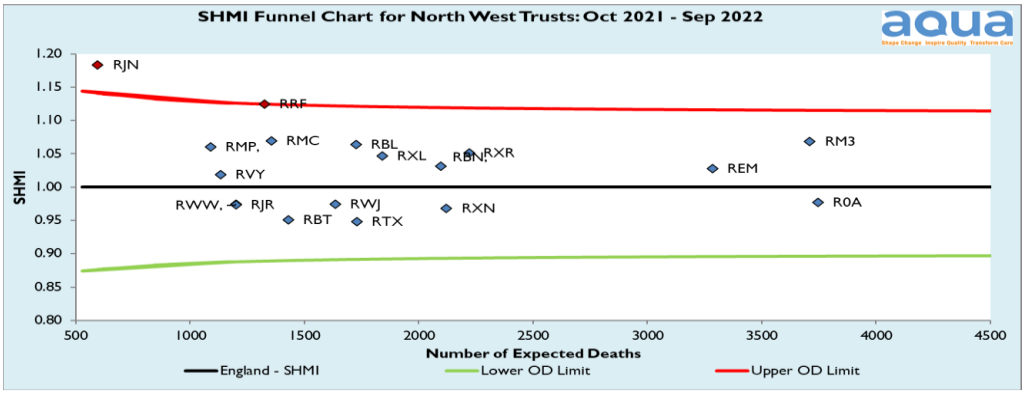
AQUA

AQUA is an NHS care quality improvement organisation that reviews and benchmarks mortality across the North West and produces a quarterly report. The latest repost was published in March 2023 and highlights the following

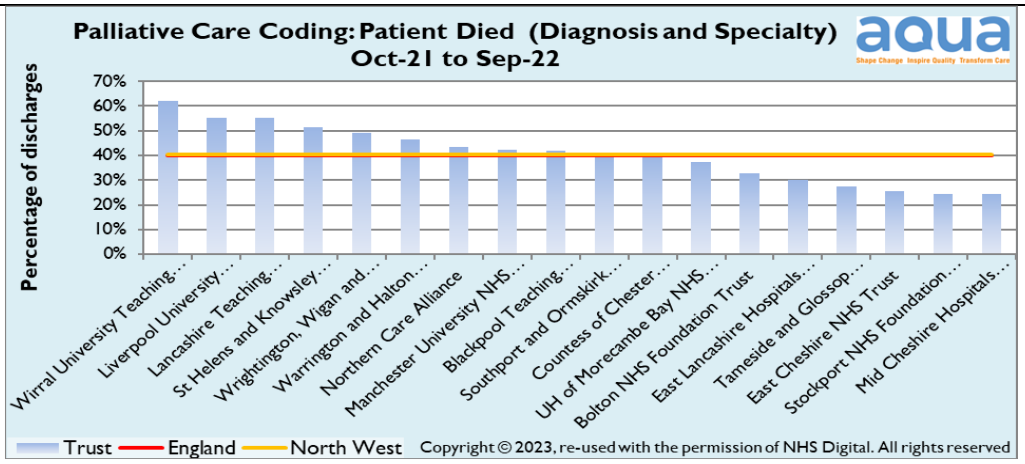
- SHIMI across the NW of England is higher than the national average



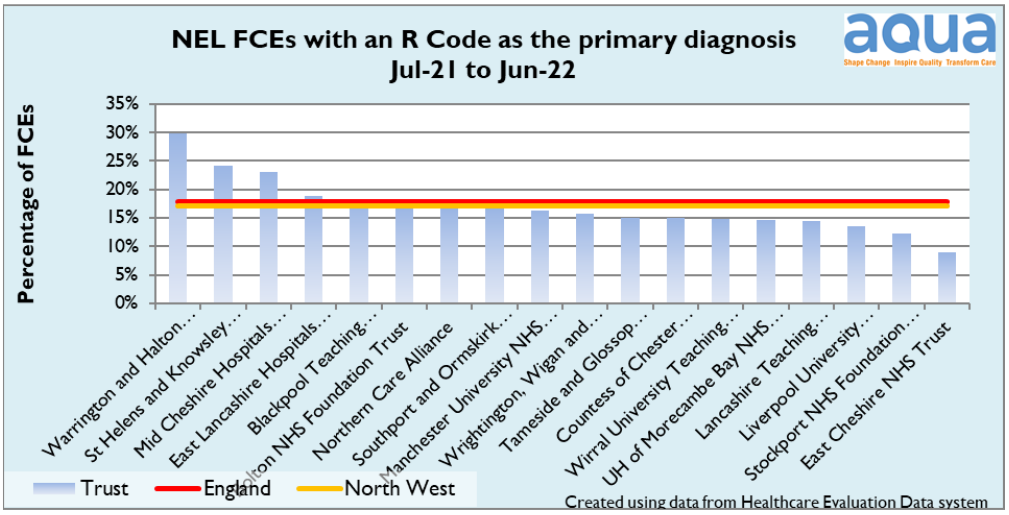
- WUTH SHIMI is within expected range



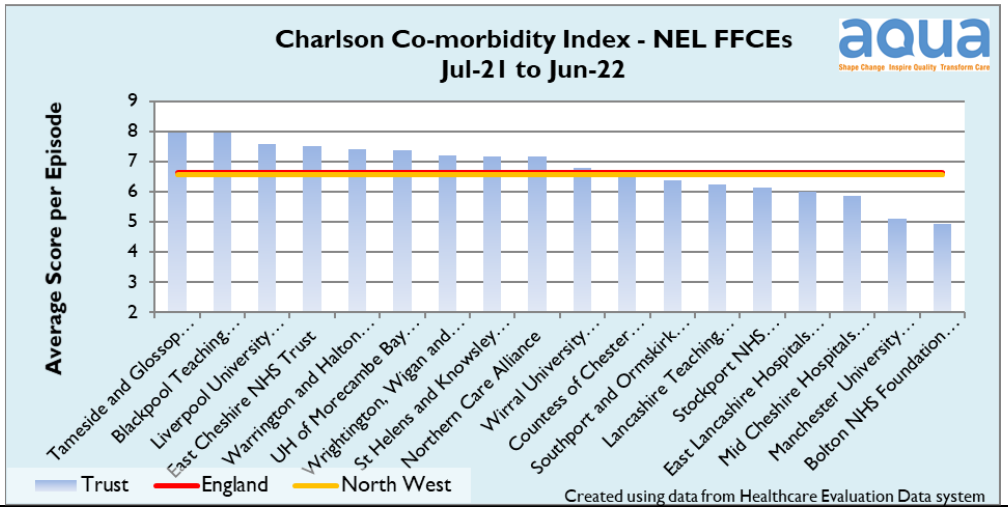
- WUTH has the highest rate of palliative care coding across the North West



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



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



3	Conclusion
3.1	Mortality indicators are both within the “As expected” range. SHIMI is higher than

	HSMR but this appears to be due to the higher than average palliative care coding at WUTH. A review of palliative care coding has shown this to be appropriate and a reflection of a proactive palliative care team. The Medical Examiner continues to provide scrutiny for all death and helps to identify learning and escalate concerns to the Mortality Review group. The Mortality Review Group continues to meet every 2 weeks to review appropriate cases and ensure learning themes and trends are captured and fed back to clinical areas. Benchmarking form Telstar Health and AQUA has identified two areas for further scrutiny: • Deaths due to Non infective Gastroenteritis • Death due to Cerebrovascular disease

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.7**

06 September 2023

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

Report Purpose and Recommendations

The purpose of this report is to give assurance to the Board of Directors that doctors and dentists in training are safely rostered and that their working hours are compliant with the terms and conditions of service (TCS). This report covers the period 1st April to 30th June 2023 (Q1 2023/24) and outlines the following:

- Actual number of doctors in training.
- Exception reports submitted for the reporting period by specialty and grade.
- Breaches of safe working hours and fines incurred.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

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

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

1	Narrative
	To monitor compliance with the working hours directive, Doctors/Dentists in Training (DIT) continue to submit exception reports via the appropriate process and in accordance with the 2016 Terms and Conditions of Service.

High level data for Wirral University Teaching Hospital NHS Foundation Trust

Number of doctors / dentists in training (total): 283 (271.6 WTE)
Number of doctors / dentists in training on 2016 TCS (total): 283 (271.6 WTE)
Amount of time available in job plan for guardian to do the role: 1 PA/4 hrs per wk
Admin support provided to the guardian (if any): 1.0 WTE
Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

Exception reports (regarding working hours)

Exception reports by department				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E	0	9	9	0
General Medicine	0	52	52	0
General Surgery	0	13	13	0
Special Surgery	0	3	3	0
T&O	0	2	2	0
Total	0	79	79	0

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	59	59	0
F2	0	1	1	0
SHO	0	13	13	0
SPR	0	6	6	0
Total	0	79	79	0

Exception reports by Rota				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A and E F2 and SHO 2022	0	1	1	0
A and E 20% Fellow 2023	0	2	2	0
A and E F2 LIFT wks 2023	0	1	1	0
A&E SpR 2022	0	5	5	0
DCT Rota 2020	0	3	3	0
Medicine F1 Rota 2022	0	33	33	0
Medicine F1 Rota 2023	0	12	12	0
Medicine F1 2022 LIFT MT	0	2	2	0
Medicine SHO 2023	0	1	1	0
Medicine IMY3	0	1	1	0
Renal	0	2	2	0
Stroke T1	0	1	1	0
Surgical F1 Rota 2022	0	7	7	0
Surgical F1 2022 LIFT WF	0	5	5	0
Surgical T1 1:10 2020	0	1	1	0
T&O SHO 2020	0	2	2	0
Total	0	79	79	0

Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
F1	19	14	18	8	0	0
F2	0	0	1	0	0	0

SHO	5	3	5	0	0	0
ST3-8	3	1	2	0	0	0
Total	27	18	26	8	0	0

Exception reports (regarding training/academic issues)

Exception reports by department				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Total	0	0	N/A	0

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Total	0	0	N/A	0

Exception reports by rota				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Total	0	0	N/A	0

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

Work schedule reviews

There have been no work schedule reviews this quarter.

Vacancies

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

Vacancies by month						
Specialty	Grade	April	May	June	Total vacant shifts (average)	Number of shifts uncovered
A&E	F2-ST8	984	571	592	2147	882
Medicine	F1-ST8	234	184	201	619	118
Surgery	F1-ST8	109	116	109	334	31
Women's and Children's	F2-ST8	45	48	49	142	8
Total		1372	919	951	3242	

Fines

There have been no fines issued this quarter.

2	**Conclusion**
	Most of the exception reports have been due to working hours.

	The Trust continues to support junior doctors to complete exception reports as it gives the trust a greater understanding of what is happening on the ground with the workforce. The current Guardian of Safe Working has stepped down from the role from and including 1st September 2023. The role is currently out to advert.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework

July/September 2023

Item 8.8

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

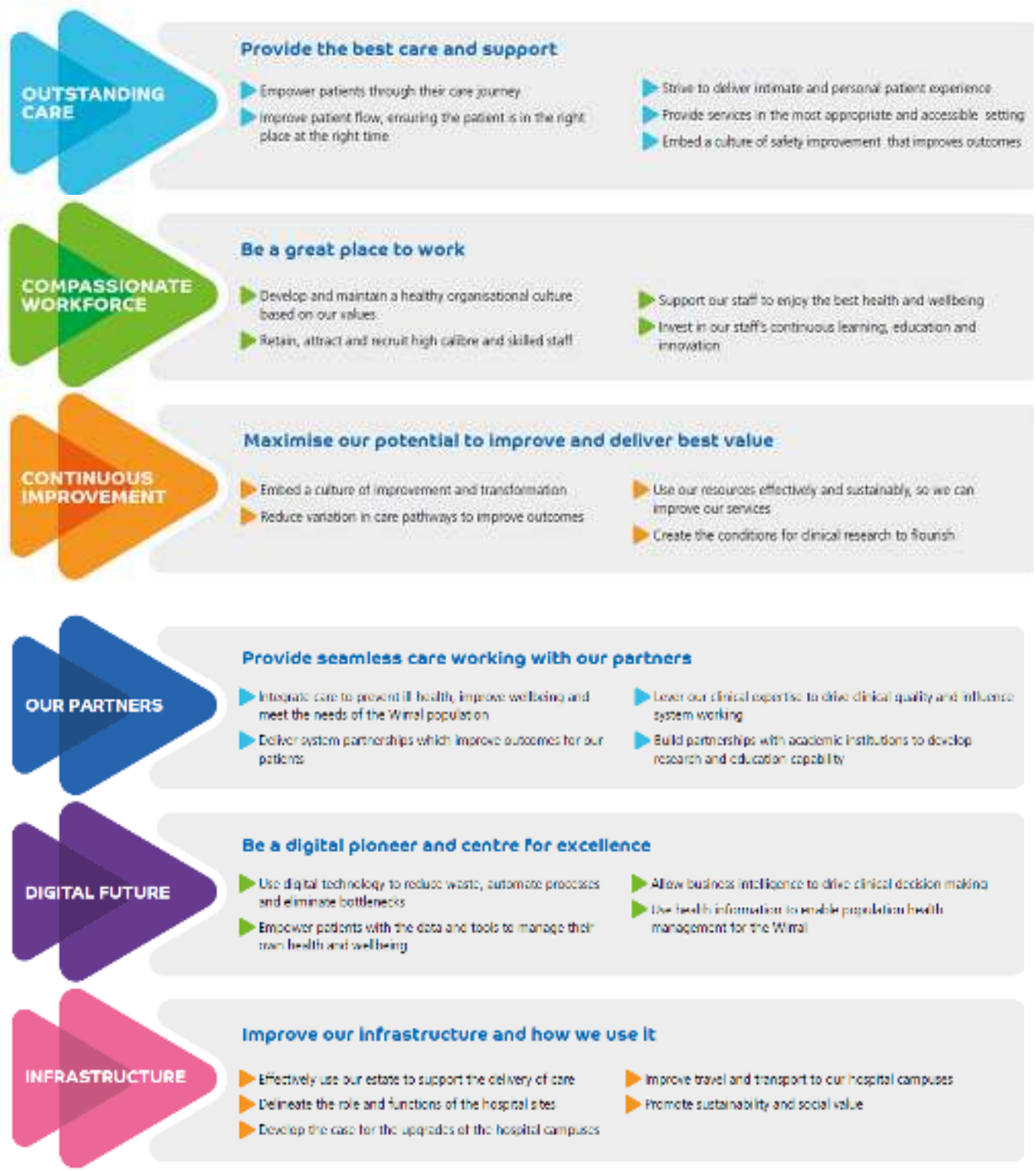
2. Vison, Strategy and Objectives

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 July-September 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**	**October/ December 2022**	**January/ March 2023**	**April/June 2023**	**July/ September 2023 Current**
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)	20 (4 x 5)	20 (4 x 5)	16 (4 x 4)	12 (4 x 3)
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)	20 (4 x 5)	20 (4 x 5)	16 (4 x 4)	12 (3 x 4)
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)	12 (4 x 3)	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)	N/A	9 (3 x 3)	9 (3 x 3)	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)	N/A	9 (3 x 3)	9 (3 x 3)	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)	N/A	9 (3 x 3)	9 (3 x 3)	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)	N/A	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Continuous Improvement **R, F**	8	Failure to deliver sustainable efficiency gains due to an inability to embed service transformation and change.	Chief Strategy Officer	Board	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)	9 (3 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)	N/A	9 (3 x 3)	9 (3 x 3)	8 (4 x 2)
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)	N/A	12 (4 x 3)	12 (4 x 3)	9 (3 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)	N/A	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)
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)	12 (4 x 3)	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	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Chief Operating Officer	20 (4 x 5)	20 (4 x 5)	20 (4 x 5)	16 (4 x 4)	12 (4 x 3)

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 • Full unscheduled care programme chaired by CEO

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. • Response to the national 10 high impact actions in preparation for winter • Design of a more streamlined UEC pathway

Progress
Key Changes to Note • 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	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Chief Operating Officer	16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	16 (4 x 4)	12 (3 x 4)

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 • Impact of industrial action	• 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	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Medical Director	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	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 from September • Maternity self-assessment • Clinical Outcomes Group • CQC Maternity inspection

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 • Ongoing review of IPC arrangements • CQC preparedness programme and mock inspections • Appointment of patient safety champions

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	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Chief People Officer	16 (4 x 4)	N/A	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives, including apprenticeship recruitment. • Vacancy management and recruitment systems and processes, including TRAC system for recruitment. • E-rostering and job planning to support staff deployment. • Strategic Retention Group in place and year 1 programme delivered. • Retention Task and Finish Groups in place for all relevant staff groups. • Facilitation in Practice programme. • Training and development activity, including launch of leadership development programmes aligned to the Trust LQF. • Utilisation of NHS England and NHS National Retentions programme resource to review and implement evidence based best practice. • Effective utilisation of the Trust's EAP has increased uptake across the organisation and is enabling staff to access support more quickly. • Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy' have been delivered across the Trust. • Career clinics have recommenced within Nursing and Midwifery	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy.

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. • Incorporation of NHS workforce plan into Strategy. • A 3-month pilot of the internal transfer for band 5 Registered Nurses and Clinical Support Workers has been launched • The electronic resignation and exit interview pilot has been completed and is in the process of review.

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	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Chief People Officer	16 (4 x 4)	N/A	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Just and Learning Culture Group in place and year 1 programme of work delivered. • Leadership Qualities Framework and associated development programmes and masterclasses. • Just and Learning culture associated policies. • Revised FTSU Policy. • Triangulation of FTSU cases, employee relations and patient incidents. • Lessons Learnt forum.	• Workforce Steering board and People Committee oversight. • Internal Audit. • PSIRF Implementation Group. • Lessons Leant Forums. • Increased staff satisfaction rates relating to positive action on health and wellbeing.

Gaps in Control or Assurance	Actions
• The potential for national and local industrial action	• Just and learning Communications Plan. • Provision for mediation and facilitated conversations. • SOP for supporting staff affected by unplanned events. • Launch Patient and Syllabus Training. • Embed the new approach to coaching and mentoring • Embed new supervision and appraisal process • Develop and implement the WUTH Perfect Start • Targeted promotion of FTSU to groups where there may be barriers to speaking up. • Completion of national FTSU Reflection and Planning Tool •

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	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Chief People Officer	16 (4 x 4)	N/A	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Year 2 of flexible working policy. • Implementation of the Perfect Start. • Develop an Engagement Framework • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • Leadership Qualities Framework and associated development programmes and masterclasses. • Bi-annual divisional engagement workshops • Staff led Disability Action Group.	• 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. • Develop an Engagement Framework • Embed the WUTH LQF and associated development offer • Deliver year 2 of the flexible working programme • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • Launch of new CEO Award • Launch 'Employee of the Month' and 'Team of the Month' awards • Development of staff stories library.

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	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Chief Finance Officer	16 (4 x 4)	N/A	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)

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. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • 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. • Execs to agree recovery plan to achieve 23/24 financial plan.

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	• 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 3 year CIP Plan to include all trust wide strategic and transformational plans.

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	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Chief Strategy Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)	9 (3 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 • N/A

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

Strategic Priority	Continuous Improvement					
Review Date	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Chief Executive Officer	12 (4 x 3)	N/A	12 (4 x 3)	9 (3 x 3)	8 (4 x 2)

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. • CQC Inspection readiness programme.

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	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Chief Executive Officer	12 (4 x 3)	N/A	12 (4 x 3)	12 (4 x 3)	9 (3 x 3)

Controls	Assurance
• WUTH senior leadership engagement in ICS. • 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	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Chief Finance Officer and Chief Strategy Officer	16 (4 x 4)	N/A	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)

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 of 23/24 schemes through Capital Management Group and Capital Committee • Prepare for 24/25 capital schemes as part of 3 year capital programme • Further develop reporting to Capital Committee • Deep dive of Estates risks related to backlog maintenance, through Capital Committee • Continual reassessment of requests through Capital Management Group

Progress

Key Changes to Note

- Delays in completion of all phases of the Urgent and Emergency Upgrade Programme (UECUP), with notification made to Trust Board and NHS England.
- Assessment of potential future delays to the UECUP Programme undertaken by Trust
- Deep dive completed on risk related to Lifts across Arrowe Park Hospital campus

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	30/06/23	Initial Score	October/ December	January/ March	April/June	July/ September Current
Lead	Chief Strategy Officer	12 (4 x 3)	16 (4 x 4)	12 (4 x 3)	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 and funding. • Board reporting. • Internal Audit Plan.

Gaps in Control or Assurance	Actions
• Delays in backlog maintenance.	• Develop Arrowe Park master plan and Prioritisation of estates improvements. • Asset audit. • Implementation of the new Capital Assets and Facilities system. • Deep dive of Estates risks related to backlog maintenance, through Capital Committee • Heating and ventilation programme. • Replacement of generators. • Assessment of business continuity to address increasing critical infrastructure risks to be undertaken in August and September 2023.

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**	□	**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

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

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 9**

06 September 2023

Title	2022-2023 Annual Submission to NHS England Northwest Appraisal and Revalidation
Area Lead	Dr Catherine Hayle, Medical Appraisal Lead
Author	Dr Catherine Hayle, Medical Appraisal Lead & Cheryl Chaffe, Medical Appraisal & Revalidation Manager.
Report for	Approval

Report Purpose and Recommendations

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

WUTH has a process in place for appraisal of senior medical staff which is quality assured and compliant with the Annual Organisational Audit (AOA) standards monitored by NHS England. This report refers to the appraisal year April 2022 - March 2023. The report was presented to and ratified by the People Committee in July.

It is recommended that the Board:

- Approve the report

Key Risks

This report relates to these key risks:

- Compliance with regulation to ensure that all clinicians are appraised and validated

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	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**
12 July 2023	RO Meeting	2022-2023 Annual Submission to NHS England North West WUTH	Information
20th July 2023	People Committee	2022-2023 Annual Submission to NHS England North West WUTH	Ratification

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

	• relationship with patients • working with colleagues • probity • health To be revalidated a doctor must collect a folder of supporting information, participate in annual appraisal in the workplace and collect independent feedback from colleagues and patients (where applicable). This multi-source feedback or 360-degree feedback must be completed at least once in a 5-year revalidation cycle. The doctor must declare all the roles they have and organisations they work in as the appraisal must cover all aspects of their work (Whole Practice Appraisal). Supporting information must be provided for all roles so that the appraiser can review this. This is the appraisal process which over a five-year period will enable the Responsible Officer to make a positive recommendation of fitness to practise to the General Medical Council.
1.2	The statement of compliance was reviewed by the People Committee on the 20th July, and all amends noted by that Committee have been incorporated into this documents. This statement is therefore submitted for approval to the Board, following which it should be signed off by the Chief Executive of the Designated Body's Board and submitted by 31st October 2023.

NHS England North West

Medical Directorate
Professional Standards Team

2022-2023 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Contents

Introduction:
The Annual Organisational Audit (AOA) has been stood down for the 2022/23 year. A refreshed approach is in development. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for assurance visits to Designated Bodies.

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

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

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

c) act as evidence for CQC inspections.

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

This completed document is required to be submitted electronically to NHS England North West by **31st October 2023** and should be sent to england.nw.hlro@nhs.net

Section 1: General

2022-2023 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	**Wirral University Teaching Hospital, NHS Foundation Trust.**
What type of services does your organisation provide?	Wirral University Teaching Hospital is a busy Acute NHS Foundation Trust. The Trust comprises of Arrowe Park and Clatterbridge Hospitals, and the Wirral Women and Children's Hospital.

	Name	**Contact Information**
Responsible Officer	Dr Nicola Stevenson	n.stevenson2@nhs.net Direct dial: 0151 604 7710 Internal extension: 8912
Medical Director	Same as above	
Medical Appraisal Lead	Dr Catherine Hayle	catherine.hayle@nhs.net Direct dial: 0151 552 1892 Internal extension: 8656 (Palliative Care) 2740 (Appraisal & Revalidation)
Appraisal and Revalidation Manager	Cheryl Chaffe	cheryl.chaffe@nhs.net Medical Appraisal & Revalidation Team. Ext:2740 DD 0151 604 7461
Additional Useful Contacts	Anita Kane Medical Staff Appraisal Coordinator	anitakane@nhs.net Appraisal and Revalidation Team DD 0151 604 7461

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes

If yes, who is this with?

Organisation: Wirral Hospice St John's. **Please describe arrangements for Responsible Officer to report to the Board:** Dr Stevenson is also Responsible Officer for Wirral Hospice St John's. An RO Board Report is prepared each year, in collaboration with the Medical Director of Wirral Hospice St John's (Dr Emma Longford). Dr Stevenson visits Wirral Hospice St John's periodically to meet with Dr Longford and review the Hospice's clinical governance processes. **Date of last RO report to the Board:** 28th November 2022. **Action for next year:** None required

Section 2a: Appraisal Data

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

Total number of doctors with a prescribed connection as at 31 March 2023?	420
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023?	297 (Consultant, SAS, Specialty Doctors) 4 Locum Consultants 2 (Senior Clinical Fellows) 78 (Juniors on Trust grade contracts) Total = 381
Total number of agreed exceptions granted between 1 April 2022 and 31 March 2023?	6 Parental Leave / Sickness
Total number of missed appraisals* between 1 April 2022 and 31 March 2023?	16 Total. 9 Seniors (6 approved, 3 unapproved) 7 Juniors (ARCP)
Total number of appraisers as at 31 March 2023?	67

Doctors employed on trust-grade contracts (e.g. trust grade doctors / clinical fellows) are provided with an annual local ARCP, which is run by the Director of Medical Education. Of this group 7 did not engage with the process. These doctors have now left the Trust.

*A missed appraisal is an appraisal that is not completed and no exception has been granted in that appraisal year (1 April 2022-31 March 2023).

Section 2b: Revalidation Data

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

Total number of recommendations made to the GMC between 1 April 2022 and 31 March 2023?	**57**
Total number of positive recommendations submitted between 1 April 2022 and 31 March 2023?	52
Total number of recommendations for deferral submitted between 1 April 2022 and 31 March 2023?	5
Total number of recommendations for non-engagement submitted between 1 April 2022 and 31 March 2023?	0
Total number of recommendations submitted after due date between 1 April 2022 and 31 March 2023?	1*

*NB This doctor connected to WUTH on their revalidation date, which was a Sunday.

Section 3: Medical Governance
Concerns data

How many doctors have been through the Maintaining High Professional Standards (MHPS) or equivalent process between 1 April 2022 and 31 March 2023?	1
How many doctors have been referred to the GMC between 1 April 2022 and 31 March 2023?	2 Trust, 4 external.
How many doctors have been referred to the Practitioner Performance Advice Service (PPA) between 1 April 2022 and 31 March 2023?	2
How many doctors have been excluded from practice between 1 April 2022 and 31 March 2023?	2

Organisational Policies

List your policies to support medical appraisal and revalidation	**Implementation date**	**Review date**
Policy Reference: 215 Senior Medical Staff Appraisal Policy	1st April 2023	27th February 2026

List your policies to support MHPS and managing concerns	**Implementation date**	**Review date**
Policy Reference: 298 Procedure for handling concerns about the conduct, performance and health of Medical & Dental staff.	27th May 2022	24th June 2025
Policy Reference: 243 Remediation Policy (Medical Staff)	Under review	
Policy Reference: 385 Fairness at Work Policy (Grievance Procedure)	April 2023	18th April 2026

Other relevant policies	**Implementation date**	**Review date**
Policy Reference: 250 Study / Professional Leave and Special Leave for Senior Medical Staff	27th April 2023	5th May 2026

How do you socialise your policies?

All Trust policies and procedures can be found on the Trust Intranet site. Trust guidance & information, useful links page. Policies and Procedures | Wirral University Hospital NHS Foundation Trust (wuth.nhs.uk)

The Trusts Senior Medical Appraiser Policy has also been uploaded onto the L2P platform under 'Resources' section.

When policies are reviewed and updated they are circulated by NHS mail via the global address book by the Trust Policy Coordinator.

All appraisers and doctors have been informed of recent changes to the Senior Medical Staff Appraisal Policy via email, and in-person updates at Appraiser Support Groups. The Medical Appraisal Lead speaks to Medical Board annually and sought feedback on proposed changes in advance.

Section 4: General Information

The board / executive management team can confirm that:

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

Yes - Dr Stevenson remains in post. Dr Stevenson has accessed all necessary training and engages regularly with the Responsible Officers Network via NHSE/I North as well as the GMC RO Reference Group.
Action for next year (1 April 2023 – 31 March 2024). Ongoing engagement with RO Network events.

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

Yes - WUTH has a system in place for appraisal of senior medical staff which is quality assured. In keeping with national guidance, an electronic appraisal system (L2P) was launched in June 2022 for appraisals from August 2022. This approach has minimised the administrative burden on our doctors, as well as providing a comprehensive revalidation dashboard to support the RO and wider team in preparation of revalidation recommendations. We have a well-resourced Appraisal & Revalidation Department, comprising the Medical Appraisal Lead (2PA), Appraisal & Revalidation Manager (1.0 WTE), 3 Senior Appraisers (1PA each) and an Appraisal Administrator (0.6WTE).
If No, please provide more detail:

4.3 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained?

Yes
If yes, how is this maintained? The Trust Workforce Information Dept provides a monthly starter & leavers report taken from ESR to ensure accuracy. The Recruitment team also provide the A&R dept a weekly starters report taken from Trac for all medical starters, in addition a monthly pipeline report is run at the beginning of every month. With the above processes in place a SOP has been created for accurately managing connections, which are reviewed at least monthly.
If no, what are you plans to implement a record keeping process? (Action for next year (1 April 2023 – 31 March 2024). N/A

4.4 Do you have a peer review process arranged with another organisation?

If yes, when was the last review? No, although we have close links with Clatterbridge Cancer Centre and provide appraisal training for their appraisers. Additionally, we carried out a review of our departmental processes against the Framework of Quality Assurance for Responsible Officers and Revalidation in 2018. We plan to repeat this during the 2023/24 appraisal year.

4.5 Is there a process in place to ensure locum or short-term placement doctors working in the organisation are supported, including those with a prescribed connection to another organisation?

Yes Agile and trust grade doctors sit within the ARCP system led by Professor Barrett (Director of Medical Education) and supported by Dr Richard Latten (Deputy Director of Medical Education).

The Appraisal & Revalidation Manager has strong links with the Medical Education Team and attends the ARCP process to review evidence and inform revalidation recommendations.

Monthly workforce report reviewed by Appraisal & Revalidation Manager and the Lead for Medical Education and Workforce Transformation on a monthly basis to ensure all doctors are included in their appropriate appraisal system.

4.6 How do you ensure they are supported in their continuing professional development, appraisal, revalidation, and governance?

Trust doctors are overseen by the DME and Deputy DME who hold an ARCP each June / July for these doctors.

Revalidation awareness sessions are being developed to ensure these doctors are aware of revalidation requirements and how the local ARCP process informs revalidation. This session will be delivered jointly between senior medical appraisers and the medical education team.

Earlier this year we were given the opportunity to host an educational event as part of the General Medical Council (GMC) 'Welcome to UK practice' workshops. These workshops have been designed by the GMC to help support doctors whose primary medical qualification has been gained outside of the UK and have recently commenced working in the UK. The session was well received, and we are looking to repeat the session again later in the year.

Professor James Barrett, Director of Education, supported by three Clinical Tutors work alongside Educational Supervisors and Senior Clinicians, to ensure all training grade staff receive the support and guidance they require. Teaching sessions are run within the Education Centre, in addition to a full lunchtime teaching programmes open to all postgraduate trainees.

The hospitals Clinical Skills Lab offer dedicated training programmes to all trainees.

Section 5: Appraisal Information

5.1 Have you adopted the Appraisal 2022 model?

Yes – We have implemented the L2P Electronic Appraisal system, the configuration of the system reflects the domains set out in the Medical Appraisal Guide 2022.
If no, what are your plans to implement this? (Action for next year (1 April 2023 – 31 March 2024).

5.2 Do you use MAG 4.2?

No – The MAG form is no longer in use.
If yes, what are your plans to replace this? (Action for next year (1 April 2023 – 31 March 2024).

5.3 Please describe any areas of good practice or improvements made in relation to appraisal and revalidation in the last year (1 April 2022 to 31 March 2023).

The Trust previously used the semi-programmed PDF "MAG form", created by NHS England to store the appraisal and associated supporting information along with a series of interconnected spreadsheets to manage the process. In June 2022, we successfully implemented the electronic appraisal system, L2P. The previous MAG form was at the point of becoming obsolete as the format was no longer in line with new national guidelines. The management process was underpinned by Excel spreadsheets and this approach had a number of flaws that created risks for the Trust, it was unnecessarily labour intensive, and made it harder to deliver the full value that the appraisal process has to offer. The Trust purchased the software from L2P for an initial 2-year period with the option of extending this for a further 2 years. The L2P platform manages the end-to-end process across all the parties required to interact in a timely manner to complete an appraisal, and the full revalidation cycle. A web-based platform is a much more secure way of storing confidential information related to our doctors. The data stored is encrypted and can only be viewed by individuals with appropriate access rights. The platform is also fully integrated with smartphones and tablets. There is a built-in Appraisal Checklist tool that guides the doctor to let them know exactly what is required of them in completing any given page of the appraisal and to our own standards. The implementation of L2P has addressed data breach risks and has provided a seamless process for effective, compliant Medical Appraisal & Revalidation. Appraiser refresher days focusing on mental health and self-care principles.

5.4 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)?

- Benchmarking against FQA and associated action plan (as described in section 4.4)

Information Governance

An Information Governance SOP is to be produced as a framework for the Trust's senior medical appraisal systems and procedures. This will include standard processes covering data protection, data sharing, requests for data, improving the quality and accuracy of data, the security of data and the management of appraisal records.

The A&R Manager will work with the Trust's Information Governance department in the production of the SOP to access their skills and knowledge, to ensure all information is up to date and accurate, that we are following national guidance and that we are legally compliant.

Risk Management

A 'Task Group' has been assigned to look at streamlining Risk Management processes and reporting. The group, which includes a senior appraiser, have regular meetings and are looking at future developments with an upgrade of the Ulysses system to link to ESR, this will improve most of the common issues raised around reporting accuracy.

The Risk Management team are to launch excellent reporting in the coming months. They are also going provide an evidence guidance document with a suite of examples that can be used as evidence, the document will be uploaded to L2P under the 'Resources' section of the L2P system.

Quality Assurance

We have reinstated the quality assurance of appraiser performance using our excellence tool.

All appraisers must attend at least one of the two ASG meetings annually.

The doctors provide feedback (anonymously) after their appraisal. The results are collated into a report which is reviewed by the Lead Medical Appraiser and is given to the appraiser for them to use in their own appraisal.

The A&R Manager observes the appraiser at least once in a 5 year cycle and provides a written feedback report for the appraiser. The appraiser should use this in their own appraisal.

The appraiser's outputs are reviewed by either a senior appraiser or the appraisal lead for Appraisal and Revalidation for quality, and feedback is given as appropriate.

All appraisers receive an annual performance review report annually summarising the above data. This should be used as supporting information in the appraiser's own appraisal.

Intranet update

A full review of the Trust's Intranet site is planned for later this year. This is to ensure all the information contained on the platform is up to date and accurate.

5.5 How do you train your appraisers?

The A&R Team deliver a one-day Appraiser Training Day (ATD) for new appraisers. It is mandatory to have attended this course prior to commencing as an appraiser (including for doctors who have acted as appraisers in other trusts).

All appraisers are members of the Appraiser Support Group (ASG), which meets 6-monthly to discuss operational issues and provide updates re. locally, regional or national developments. The ARM, MAL and Senior Appraisers are available for support on an ongoing basis, and will quality assure the appraisal process (giving feedback to appraisers as necessary).

An Appraiser Refresher Day (ARD) is delivered annually to provide appraisers with an opportunity to refresh their skills and maintain their fitness to practise as an appraiser. The same day is run twice to maximise attendance.

5.6 How do you Quality Assure your appraisers?

There are several quality assurance and performance measures in place, appraisers receive annual feedback from the doctors they have appraised and are encouraged to attend the Appraiser Support Group meetings.

We provide an appraisal sign-off process within WUTH. The purpose of the sign-off process is for quality assurance of the appraisal, and also to ensure line managers are aware of any specific actions required to support the doctor in their role (e.g. job plan review, support for specific PDP objectives). The sign-off process provides an important opportunity to thank the doctor for their contributions and highlight important achievements, as well as ensuring all necessary steps are taken to support the doctor in achieving a rewarding and sustainable working life.

The appraisal is reviewed and signed off by the following in sequence:

- Appraisal & Revalidation Manager
- Clinical Lead
- Medical Appraisal Lead or Senior Appraiser
- Associate Medical Director
- Responsible Officer (prior to revalidation, or on request)

New appraisers undergo a face-to-face performance review with a senior appraiser after their first three appraisals and are observed once by the A&R Manager.

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

5.7 How are your Quality Assurance findings reported to the board?

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

5.8 What was the most common reason for deferral of revalidation?

Usually, reasonable circumstances that could account for a doctor having incomplete supporting information and needing more time to meet the requirements might include long term sickness or parental leave.

5.9 How do you manage doctors that are difficult to engage in appraisal and revalidation?

If a doctor has been given sufficient opportunity and support to engage in appraisal but has failed to do so, this will be discussed at the monthly RO meeting. Every effort will be made for all reasonable local processes to commence to rectify the doctor's failure to engage. The A&R dept will offer support with appraisal templates, appraisal guidance, L2P system support, clarification on policy timescales and liaising between appraiser and doctor to explore availability and support with room bookings. Doctors who require additional support with appraisal preparation may be allocated a senior appraiser to provide in-person support throughout the year until they are confident in the process.

A missed or incomplete appraisal can only be counted as 'approved' if clear documentary evidence of approval by the Medical Appraisal Lead or RO exists. The RO will write to doctor to advise them of the importance to engage fully with the annual appraisal process so that their ability to be revalidated is not put at risk. Also, a reminder that having an annual appraisal is a contractual obligation, and that a missed appraisal can affect their pay progression and eligibility to apply for an Employer Based Award.

Section 6: Medical Governance

6.1 What systems and processes are in place for monitoring the conduct and performance of all doctors?

The Trust has a Responsible Officer Advisory Group (ROAG) which reports to the People Committee via the Head of HR. The statutory responsibilities remain with the Responsible Officer with regards to the Medical Workforce. This relates to the appraisal, revalidation, and fitness to practise concerns.

The Responsible Officer (RO) has a key role in ensuring the effective implementation of the Responsible Officer Regulations in their designated body. The advisory group will support the role of the RO and provide the opportunity for greater calibration of decision-making and the involvement of lay members. The group will provide input to the decision-making with regard to appraisal, revalidation recommendations, performance concerns about doctors, employment processes and any other aspects relevant to the RO Regulations. Since it is an advisory group, final decisions rest with the RO.

The Responsible Officer Advisory Group will consider key items requiring decision-making to support the role of the RO, including:

Concerns regarding a doctor and the application of the Trusts MHPS or other, relevant policies, including but not limited to:

- Police investigations
- Safeguarding
- Behaviour/Conduct
- Fitness to practise
- Health matters
- Capability

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

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

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

Furthermore, if required, a letter is sent from the RO requiring the individual to reflect on a specific incident or concern, this is uploaded on to their appraisal record in L2P.

6.2 How is this information collated, analysed and shared with the board? (Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors).

A disciplinary register is kept of all cases. The register logs the nature of allegation, the case manager, names of investigators, welfare and support contact , a record of the case progress and outcome.

The Responsible Officer Advisory Group (ROAG) supports the role of the RO and provides the opportunity for greater calibration of decision-making and the involvement of lay members. The provision of a forum for ensuring that the process of raising and acting on concerns is monitored for consistency and fairness, and in keeping with both internal and external guidance. The group will provide input to the decision-making with regard to appraisal, complex revalidation recommendations, performance concerns about doctors, employment processes and any other aspects relevant to the RO Regulations. Since it is an advisory group, final decisions rest with the RO.

A report is submitted to the People Committee which is held bi-monthly . All MHPS cases have a non-Executive Director assigned to the case, who receives updates on progress and monitors progress against timescales.

6.3 How do you ensure that any concerns are managed with compassion?

All serious concerns are raised with the RO as per the MHPS Policy and discussed at the Responsible Officer Advisory Group (ROAG). The Trust MHPS Policy was recently updated in May 2022 and is consistent with the application of 'just culture' principles,

which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology is applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

Formal meetings are supported by HR, for example considering any reasonable adjustments and help to identify and remove barriers which may impact on engagement. Policies and practices are subject to an equality impact assessment and reviewed with just and learning principles in mind. Colleagues about whom a concern is raised are allocated a supportive mentor from within the organisation and provided with information about Occupational Health support and our Employee Assistance Programme.

6.4 How do you Quality Assure your system for responding to concerns?

A disciplinary register is maintained in respect of all employment relations cases. For MHPS cases the register will record the nature of the allegation(s), the case manager, investing officer, the appointed welfare and support contact, and is updated on a frequents basis with regards to progress of the case and any concluding outcomes.

The Responsible Officer Advisory Group (ROAG) supports the role of the RO and provides the opportunity for greater calibration of decision-making and the involvement of lay members. The provision of a forum for ensuring that the process of raising and acting on concerns is monitored for consistency and fairness, and in keeping with both internal and external guidance. The group will provide input to the decision-making with regards to appraisal, revalidation recommendations, performance concerns about doctors, employment processes, and any other aspects relevant to the RO Regulations. Since it is an advisory group, final decisions rest with the RO.

6.5 How if this Quality Assurance information reported to the board?

An employee relations report is submitted (anonymised) to the People Committee. This committee meets on a bi-monthly basis. The report includes lessons learnt outcomes. All MHPS cases have a Non-Executive Director assigned to the case and will receive updates with regards to the progress of the investigation.

6.6 What is the process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility)?

Information flows to support governance and Responsible Officer Statutory Function are facilitated by the A&R Team via the NHS Medical Practice Information Transfer form.

A welcome letter is sent out to all new doctors joining the Trust from the RO informing them of the specific responsibilities to obtain information about doctors taking up new posts and as such, the need to formally request confirmation of the following details from their previous Responsible Officer:

- Revalidation date
- The date of your last appraisal
- Any previous concerns that have now been resolved
- Any current investigation about your practice in progress
- Any current restrictions on practice
- Any unresolved actions/referrals in relation to the GMC

6.7 What safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination?

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

Formal meetings are supported by HR for example support management to ensure reasonable adjustment are in places as required and help identify and remove barriers which may impact on engagement. Policies and practices are also reviewed in line with current and emerging EDI challenges and risks. The Trust has an incident reporting process where any concerns raised including concerns raised via Appraisal and Revalidation process are investigated. The Trust has Safeguarding , LADO (Local Authority Designated Officer) in place and staff are made aware that they can raise concerns via this route.

6.8 Please describe any areas of good practice or improvements made in relation to medical governance in the last year (1 April 2022 to 31 March 2023)

Presentation at Appraiser Refresher Day around Risk Management from Deputy Medical Director. Additional training available to medical staff to help with imminent move towards PSIRF (Patient Safety Incident Response Framework). Clinical Outcomes Group has been set up to focus on improving patient outcomes.

6.9 Have you any plans for any changes/ improvements in the coming year (1 April 2023 to 31 March 2024)

Transition to PSIRF from current serious incident framework. This will provide a greater focus on learning and actions to improve outcomes and reduce the burden of administration.

Section 7: Employment Checks

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

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

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

All appointments to the organisation are subject to full and rigorous pre-appointment checks that include satisfactory references, occupational health clearance, qualification and professional registration checks, Disclosure & Barring Service (DBS) clearance and the legal right to work in the UK. Agency workers are sourced through agencies on the HTE or CCS framework which gives us assurance that these workers have met satisfactory checks. Compliance is checked before booking a temporary external worker.

In addition, in 2022/23 the Trust has undertaken a review of the medical and dental staff group with reference to the recording of DBS certification and subsequent barring level relevant to the job role. As part of the review, the Trust established recording gaps on individual's ESR record and as such, embarked on a systematic approach to revalidate DBS Checks and record the corresponding barring level, certification number and issue date. This project has concluded for the Trust's medical and dental staff group with the exception of those absent, which will be completed on their return.

Do you collate EDI data around recruitment and /or concerns information?

Yes

If yes, how do you use this information?' This data is collected through the Trac application system. This data is reviewed by the Workforce Directorate who are responsible for ensuring EDI is embedded across all systems, process and people policies and that the strategic commitment is driven through the people strategy delivery plan. They are responsible for monitoring and reporting progress.

Workforce Steering Board are responsible for overseeing progress of delivery and providing Board assurance via the Trust's People Committee.

The Trust has a Equality Diversity and Inclusion (EDI) Steering Group, this group has responsibility for monitoring and reporting progress against EDI statutory requirements and driving delivery of subsequent actions in line with the strategic commitment.

Section 8: Summary of comments and overall conclusion

Engagement in medical appraisal has remained strong during the 2022/23 appraisal round. We have now moved to an online platform (L2P), which was launched in August 2022. This transition has run smoothly, with broadly positive feedback from doctors and appraisers. Our Appraisal & Revalidation Manager is now well established in post, and has joined the Network-wide A&R Manager group. With the appointment of a replacement Appraiser & Revalidation Administrator and third Senior Appraiser, our Appraisal & Revalidation Department is now fully established.

The Senior Medical Staff Appraisal Policy has undergone a significant review to reflect new processes and has been approved following robust scrutiny and discussion at JLNC.

HR and Clinical Governance processes remain strong, with the main focus for the year ahead being the implementation of the Patient Safety Incident Response Framework (PSIRF) and completion of the Remediation Policy review. Additional actions for the year ahead are outlined within Section 5.4.

Overall conclusion: Despite ongoing challenges relating to clinical pressures and industrial action, medical appraisal processes remain strong within WUTH, with excellent rates of compliance and below average revalidation deferrals. We look forward to the year ahead with clear objectives and strong foundations on which to build ongoing progress.

Section 9: Statement of Compliance:
The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body
[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: ……..…….

Name: ……

Role: ……..

Date: ……..

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 10**

06 September 2023

Title	Employee Experience Update
Area Lead	Debs Smith, Chief People Officer
Author	Hayley Curran, Associate Director for Organisational Development
Report for	Information

Report Purpose and Recommendations

Positive employee experience and staff engagement have been proven to have strong links with positive organisational and individual outcomes. The NHS People Promise sets out the experience that all employees across the NHS should expect.

The paper sets out the approach to understanding employee experience in Wirral University Teaching Hospital and provides an overview of the feedback received from our employees about their experience in Q1 and Q2.

It is recommended that the Board:

- Note the report

Key Risks

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

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	No

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

1 Narrative

1.1 Background

Positive employee experience and staff engagement have been proven to have strong links with positive organisational and individual outcomes. Research by the Staff Experience and Engagement team at NHS England recently found that employee engagement components, in particular involvement, have a positive correlation with lower patient mortality, lower sickness levels and lower patient complaints. This follows on from a suite of studies over recent years by academics and the Kings Fund, specific to the health care setting.

The NHS People Promise (appendix 1) sets out the experience that all employees across the NHS should expect. The themes and words that make up Our People Promise have come from those who work in the NHS.

1.2 Measuring Employee Experience

1.2.1 National Surveys

NHS Trusts are required to measure employee experience on at least a quarterly basis, via the National Quarterly Pulse Survey (NQPS) and the National Staff Survey (NSS). The NQPS is much shorter than the NSS and is intended to be a brief 'pulse check' of the experience of the NHS workforce, as opposed to the more thorough and detailed NSS.

The table below sets out the 2023 / 2024 timetable of NQPS and NSS in Wirral University Teaching Hospital.

Table 1: NQPS and NSS Timetable

2023 / 2024	Survey	Opens	Closes	Results Received
Q1	NQPS	1 April 2023	30 April 2023	Early May 2024
Q2	NQPS	1 July 2023	31 July 2023	Early August 2024
Q3	NSS	Late September 2023	Late November 2023	February - March 2024
Q4	NQPS	1 January 2024	31 January 2024	Early February 2024

Whilst the NSS is a well-established process across the NHS, the NQPS is a more recent introduction and has been implemented gradually across the NHS. Nationally, response rates have been low.

1.2.2 Developing Employee Experience Measures

Whilst the national surveys referred to above are the primary measures of employee experience across the NHS, and results are reported nationally and regionally, it should be noted that there are other important indicators of employee experience across the Trust. These include, but are not limited to, themes from Freedom to Speak Up, employee relations trends and new starter feedback. The Workforce Engagement and Inclusion Team are in the process of developing reporting methods to include these indicators in future employee experience reports.

2 Implications

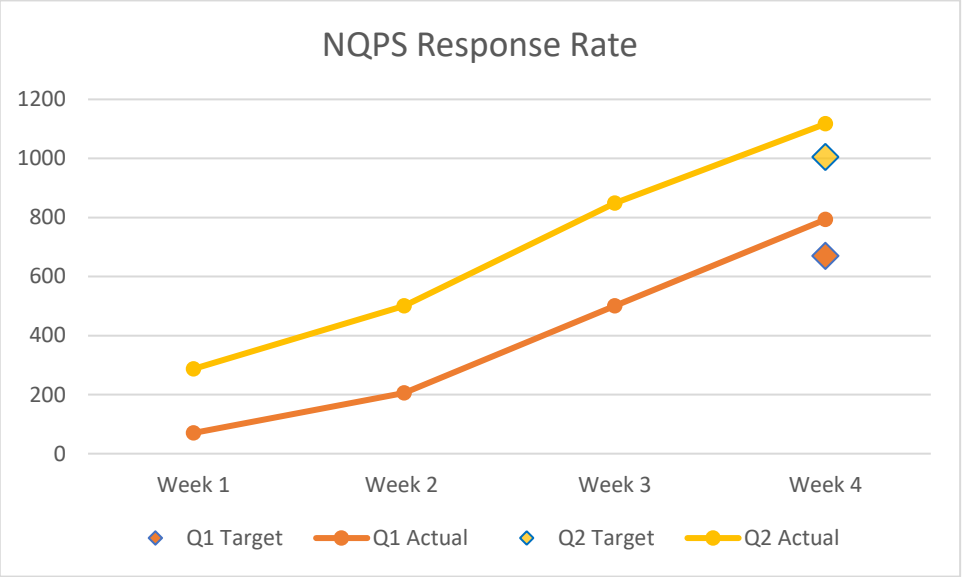
2.2 Employee Experience Q1 and Q2 2023/2024

The information below sets out the feedback received on employee experience at Wirral University Teaching Hospital, in the first half of 2023 / 2024.

2.2.1 Survey Response Rate

In April 2023, the newly formed Workforce Engagement and Inclusion team re-launched the NQPS across the Trust. The diagram below demonstrates response rates in Q1 and Q2 2023 / 2024 against the agreed trajectory.

Diagram 1: Survey Response Rate



As a result of focused campaigning and promotion, there has been an improved response rate from Q1 to Q2 and in both quarters, the agreed trajectory has been exceeded. Furthermore, the Trust response rate is significantly higher than the regional average. The Trust Q2 response rate was 17% compared to a regional response rate of around 10%.

2.2.2 Employee Engagement

Both the NQPS and the NSS provide an overall engagement score, which is comprised of three components:

1. Motivation
2. Involvement
3. Advocacy

The engagement score is used as an internal measure to determine the impact of the Trust's People Strategy. We have seen positive improvements in our staff engagement scores between Q1 and Q2, which shows that, despite national workforce disputes across the NHS, employees at Wirral University Teaching Hospital are feeling more engaged.

Table 2: Trust Engagement Score

2023 / 2024	Total Engagement Score	Breakdown		
		Motivation	Involvement	Advocacy
Q1	6.41	6.84	6.08	6.3
Q2	6.62	6.88	6.43	6.55

The engagement score is also a useful tool to benchmark against other NHS Trusts. The table below shows the Trust's engagement score for Q2 2023 / 2024 compared to national average and demonstrates good performance.

Table 3: Engagement Score Comparison

Q2	Total Engagement Score	Breakdown		
		Motivation	Involvement	Advocacy
WUTH	6.62	6.88	6.43	6.55
National Average	6.45	6.69	6.33	6.32

Wider Employee Experience

Beyond the engagement score, the NQPS provides information on employee experience across a range of areas.

Overall, staff generally reported feeling more positive in Q2 however, feedback around support from managers, high workload and burnout were common themes. When asked directly what staff would like to feedback to senior leaders, either in the Trust or the national NHS team, communication and management visibility were common themes and represent opportunities for further improvement in our employee experience.

Key areas of focus in the first half of 2023 / 2024 have included increasing positive narrative across the workforce and supporting staff involvement in improvements.

Positive progress in relation to these areas are demonstrated by the responses to the NQPS questions in the table below. Staff are more likely to recommend the Trust as a place to receive care and as a place to work. Staff also feel increasingly able to make improvements in their areas of work.

Table 4: Key Areas of Focus

Question	2023 / 2024	
	Q1	Q2
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	59%	64%
I would recommend my organisation as a place to work	49%	53%
I am able to make improvements happen in my area of work	48%	53%

2.3 Continuously Improving Employee Experience

Ensuring the continuous improvement of employee experience is a core element of the People Strategy and the Trust's strategic objective to be a great place to work.

As well as measuring employee experience, the NQPS and the NSS will be used as engagement tools. Divisional workshops will be held at least bi-annually to enable divisional leadership teams to engage staff directly in making improvements based on the feedback provided via the surveys. The next workshops will take place in September 2023.

	The People Strategy priorities for 2023 / 2024 include the development and implementation of an Engagement Framework, which will set out the key principles of engaging staff and enabling a sense of belonging in the Trust. This is accompanied by an engagement plan for 2023 / 2024, which sets out a range of activities including: • Launch of new CEO Award • Launch 'Employee of the Month' and 'Team of the Month' awards • Creating a library of positive staff stories. • Staff led Disability Action Group. The delivery of the wider People Strategy priorities for 2023 / 2024 will also make a positive contribution towards employee experience. Developments such as the flexible working programme, new appraisal approach, 'Perfect Start' and leadership development programs will enhance the experience of our employees.

3	Conclusions
3.1	• As a result of focused campaigning and promotion, NQPS response rates across the Trust are above trajectory and significantly higher than regional average. • Despite national workforce disputes across the NHS, employees at Wirral University Teaching Hospital are feeling more engaged. • Overall, staff generally reported feeling more positive in Q2. • Areas for continued focus include management support and visibility, burnout, and communication. • Following a focus on increasing positive narrative across the workforce and supporting staff involvement in improvements, employees are more likely to recommend the Trust as a place to receive care and as a place to work. • Our employees also feel increasingly able to make improvements in their areas of work. • Developing employee experience will continue to be a key priority. • The results of the NQPS and the NSS will be used in Divisional workshops to involve staff directly in making improvements based on the feedback provided via the surveys. • An Engagement Framework has been developed, which includes a plan of work for 2023 / 2024, already in implementation. • The delivery of the wider People Strategy priorities for 2023 / 2024 will also make a positive contribution towards employee experience.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 11**

06 September 2023

Title	Biannual Report for Estates, Facilities and Capital
Area Lead	Matthew Swanborough, Chief Strategy Officer Paul Mason, Director of Estates, Facilities and Capital Planning
Author	Matthew Williams, Estates Operations Compliance Manager
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide assurance to Board on the Estates, Facilities and Capital service provision performance, that align to the strategic objectives of the Trust and the Division. The report is also to provide an overview of capital works across the 23/24 financial year.

It is recommended that the Board:

- Note the report

Key Risks

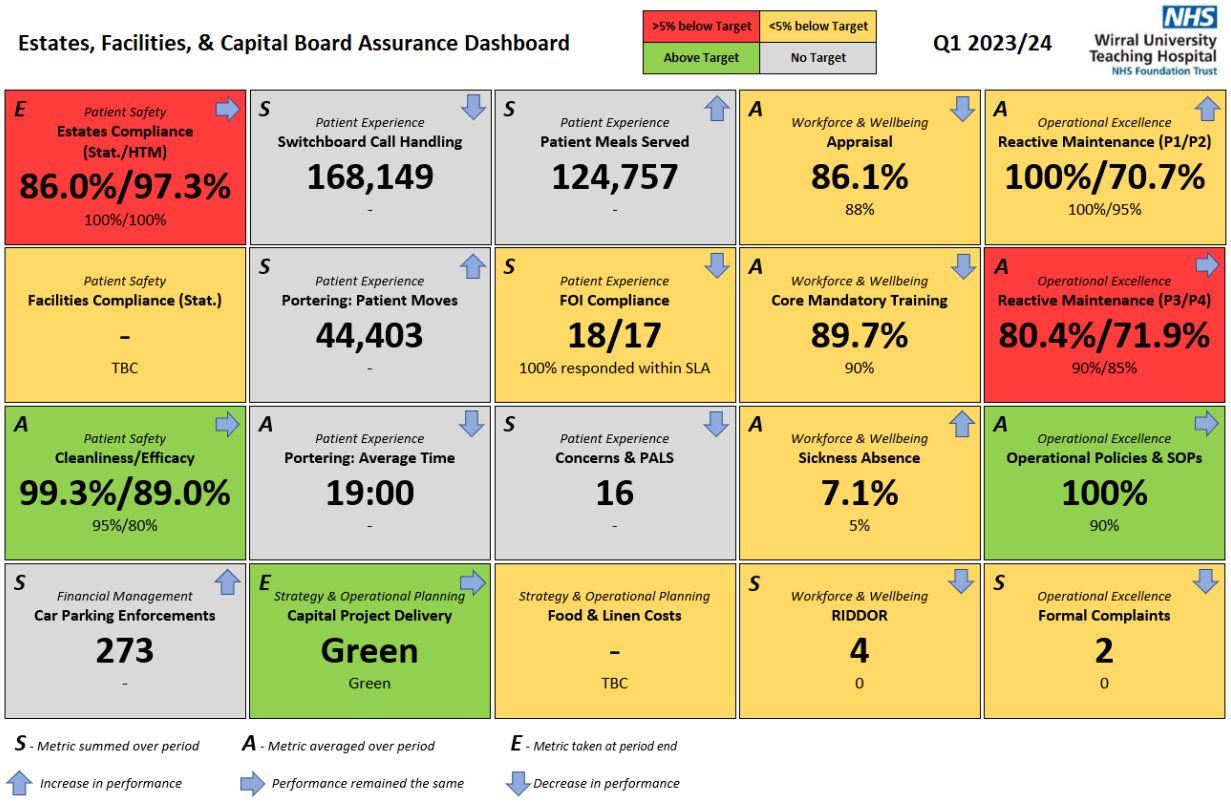
This report relates to these key Risks:

- None

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

1	Narrative
1.1	**Background** Estates, Facilities, and Capital (E, F, & C) hold frequent operational, tactical, and strategic meetings which all report into a monthly senior leadership Performance Review meeting. A dashboard of metrics is reviewed during this meeting and those which align most closely to the six domains and the CQC five key questions are presented within this assurance report. The dashboard is continuously improving with new metrics being identified to encompass the full-service portfolio of E, F, & C. Some metrics are statutory, some have internal targets, whilst others are for information and assurance purposes and can be measured against the previous month/quarter. The data presented in this report covers Q1 2023/24 (abbreviated Q1), and has been compared against Q4 2022/23 (abbreviated Q4).
1.2	**Scope** E, F, & C Management review a monthly assurance dashboard measured against a defined set of Key Performance Indicators. The assurance dashboard is aligned to both the six domains: • Financial Management • Operational Excellence • Patient Safety • Patient Experience • Strategy & Operational Planning • Workforce & Wellbeing and the CQC five key questions at Public Board level: • Safe – adherence to technical standards/statutory compliance • Effective – performance of our services • Caring – patient experience • Responsive – response times estates maintenance • Well-led – people performance
1.3	**E, F, & C Board Assurance Dashboard** The dashboard is made up of several tiles that represent one (or in some cases, two) metrics aligned to the key performance indicators. Each tile is coloured depending on performance against target: • Tiles in **Red** indicate that performance is below the target by greater than 5%. • Tiles in **Amber** indicate that performance is below the target by 5% or less. • Tiles in **Green** indicate that performance is at, or above the target value. • Tiles in **Grey** indicate that there is no target for this metrics and therefore cannot be compared or RAG rated. Each tile contains a letter (S, A, E) in the top left corner. • S indicates that the value shown is the sum of the values of each month, over the quarter indicated in the top right corner. • A indicates it is an average value for the quarter

	• E indicates the value has been taken at the end point of the final month of the quarter, and therefore is the most recent indication of performance Furthermore, each tile is supported by an arrow in the top right corner. This shows whether the performance has improved, stayed the same, or decreased since the previous month.   For the KPI's that have not achieved the target measure, we have exception reporting and internal governance processes to action as appropriate and escalate.
1.4	**Measure: Patient Safety / Safe** Key Performance Indicators: ➢ **Estates Compliance (Statutory/HTM)** Estates have made measurable progress to improve statutory and HTM Compliance and estimate that we have undertaken approximately 86.0% on periodic inspections across statutory maintained assets. There have been vast improvements with the involvement of Authorised Engineers and the undertaking of actions from their annual Audits. Estates are utilising the additional functions of the Computerised Maintenance Management System, and are developing and implementing: ➢ Reactive Work Order Notification System – **Implemented** ➢ Point of Work Risk Assessments (Dynamic) – **Implementing** ➢ Planned Preventative Maintenance (PPM) and Statutory Inspection Schedules – **Implemented** ➢ Integration with Power BI Dashboards – **Implemented**

	Estates are in control of reactive work order scheduling and have seen gradual improvements in SLA performance across all four priorities (P1-P4). Further labour support is required to address challenges. Estates are demonstrating that compliance, service delivery, management, auditing, reporting, and monitoring requirements are clearly set out as part of the statutory adherence obligations. ➢ National Cleaning Standards (Trust Average Cleanliness Scores) & Efficacy o The cleanliness audit score is represented as a percentage score of internal verification that a safe standard has been achieved. The Trust achieved an average score of 99.3% in Q1, which is well above the internal target of 95%. All scores for 2022/23 were above the target of 95%. o Efficacy Audits are a management tool to provide assurance that the correct cleaning procedures are consistently delivered to satisfy IPC and safety standards. The functional areas are selected at random each month. The Trust achieved a score of 89.0% in Q1 which is well above the 80% internal target. Areas that score below 80% will require an improvement plan with remedial actions to achieve the required standard. The area will then be re-audited within a reasonable timeframe to ensure the target score has been achieved. ➢ Facilities Compliance (Soft Facilities Management) o This measure is still being developed in line with section 1.9 below
1.5	**Measure: Patient Experience / Effective** Key Performance Indicators: ➢ Switchboard Call Handling o The internal switchboard answered and redirected 168,149 calls in Q1. 764,950 calls have been answered and facilitated in 2022/23, at an average of 63,764 calls per month. ➢ Patient meals served o 124,757 in-patient meals were served in Q1, at an average monthly value of 41,586. ➢ Portering: Patient moves & Average Time to complete request o Porters carried out 44,403 patient moves in Q1 at an average of 19 minutes from transport requested to transport completed. 178,480 moves were carried out in 2022/23 at an average time of 17 minutes 2 second transportation. ➢ Concerns & PALS o Concerns and PALS refers to the number of calls received by the Patient Advice and Liaison Service to help with any queries patients, their families, and their carers have regarding the NHS, or health related questions. PALS also helps to improve the NHS by listening to your concerns and suggestions. The service received 16 calls in Q1, and 51 calls in 2022/23.
1.6	**Measure: Strategy & Operational Planning / Financial Management** Key Performance Indicators: ➢ Capital Project Delivery o Capital Project delivery is RAG rated on the programme delivery and financial progress of each project. The Capital Project Delivery is self-assessed as Green for Q1. There are currently 12 schemes in the delivery plan for 2023/24, of which three have been completed in Q1. The total value of schemes is approx. £18M. o Notable Capital projects delivered in 2022/23 include the CGH Modular Theatres Phase 1, Ward 1 Renal unit, and Facilities Staff changing areas. ➢ Car Parking Enforcements

	○ There were 273 enforcement tickets issued in Q1 for cars that were not parked appropriately across the two Trust campuses. This has increased from 254 tickets issues in Q4. ➢ Food and Linen Costs ○ See section 1.10 below
1.7	**Measure: Operational Excellence / Responsive** Key Performance Indicators: ➢ Reactive Estates Maintenance response times ○ % of reactive work orders that have been completed within the respective internal SLA timeframe listed below. Priority 1 [P1] – 4 Hours: 100% Priority 2 [P2] – 3 days: 74.7% Priority 3 [P3] – 7 days: 83.4% Priority 4 [P4] – 21 days: 80.0% 4,790 reactive work orders were logged by the Estates Helpdesk in Q1. The total number of reactive work orders for 2022/23 was 19,070, with peak months being May, November, and January, usually indicating seasonal changes in temperature across the site. Work orders are typically completed within the following 24/48 hours of the SLA expiring. ○ Whilst high percentages of work orders are completed, there are some resource gaps within the maintenance team to ensure that work orders are completed within the internal SLA targets stated above. The Estates team have undertaken a labour loading exercise that identifies a shortfall of maintenance tradespersons. There has also been an increase in requests of resource to support the Clatterbridge Modular Theatres and UECUP Capital projects. ➢ Operational policies and procedures in date ○ Currently, all policies and procedures in E, F, & C are in date and published to the wider Trust. ➢ Formal Complaints ○ There were two formal complaints in Q1 that were delt with and responded to accordingly.
1.8	**Measure: Workforce & Wellbeing / Well led** Key Performance Indicators: ➢ Appraisal (Contribution Framework) ○ The Trust has implemented a different appraisal format this year which focuses on an individual's 'Contribution, Wellbeing, and Development'. Appraisals establish how people are performing against those expectations throughout the year, offer recognition and guide people to improve where they're falling short. On average, 86.1% of E, F, & C staff have had an appraisal within the 12 months, which is slightly below the 88% Trust target. This has declined from the 87.7% average of 2022/23. ➢ Core Mandatory Training ○ The Trust has a requirement to ensure that staff are competent, capable, and safe through the provision of our mandatory training and performance management system. The Trust is therefore committed to the provision of the highest standards of safe and effective patient care. Staff, on average, have completed **89.7%** of the Mandatory Training within ESR. Training has recently dropped below Trust's target of 90%, but this may be linked to the introduction of new training modules within ESR.

	➢ Sickness Absence o Sickness absence was on average 7.1% for the month of Q1, the lowest value since recording began in April 2022. The highest absence was 12.3% in December 2022. ➢ RIDDOR o RIDDOR puts duties on employers (the Responsible Person) to report certain serious workplace accidents, occupational diseases and specified dangerous occurrences (near misses). There have been four RIDDOR reportable incidents in Q1 across E, F, & C. The last reported incident prior to Q1 was in August 2022.
1.9	**Facilities, Clinical Engineering, and Sustainability Statutory Compliance** E, F, & C have undertaken an exercise to understand the reporting requirements for Statutory compliance within Facilities and Support Services, Clinical Engineering, and Energy and Sustainability. A list of metrics was derived and will look to be input into the dashboard in the near future, to demonstrate abidance with relevant acts, legislation, and mandatory guidance. The division will, from Q3-4, begin to report on: Facilities & Support Services • Food Safety Management Policy (Hazard Analysis Critical Control Point (HACCP)) • Fridge/Freezer Temperature Monitoring • Catering Department Health & Safety Audits Clinical Engineering • Patient Hoist Thorough Examinations Sustainability • Display Energy Certificates • Quality Certification for an existing CHP Scheme • Greener NHS Quarterly Data Submission [Mandatory]
1.10	**Food and Linen Costs** Analysis has been conducted on Food and Linen Costs from the 2021/22 Estates Returns Information Collection (ERIC). The self-assessed data was submitted in June 2022 with values for the previous fiscal year 2021/22. 'Food costs' (inpatient meal provision) includes staff and provisions costs but excluded management costs. An in-patient meal is defined as either breakfast, midday or evening meal order (or any substitute or alternative for any such meals) received by an in-patient (wards and departments). The higher the cost per inpatient meal the less cost efficient the service is and the greater the potential savings to be generated. For 2021/22, WUTH's Food Cost (£/meal) was estimated at £5.26, which is below the benchmark value of £5.31. The costs, however, was above the peer median of £4.58, which compares similar Trusts of size, spend, and clinical type/delivery. There are many reasons that the Food costs may differ from Trust to Trust, but one of the main factors is that other Trust calculate their food costs differently to WUTH, and exclude provisions such as dishwasher maintenance/replacement, crockery and cutlery replacement, and food transport costs between sites.

	The ERIC return is due for 2022/23 in August 2023, so a recent indication of food and linen costs will be available once this has been submitted by Facilities and Support Services and calculated by NHS England.

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

4	Conclusion
	E, F, & C will continue to hold frequent operational, tactical, and strategic meetings and will continue to report into a weekly/monthly senior leadership Performance Review meeting. E, F, & C have matured the safety group meetings and have introduced additional meetings to cover the range of Health Technical Memoranda (HTM), ensuring prompt multi-divisional oversight of critical infrastructure and risk management. E, F, & C continue to progress the monthly Safety, Health, and Environment (SHE) meeting which provides a forum for escalations from the safety group meetings. The SHE meeting is responsible for providing assurance in relation to the HTMs to the Trust Health and Safety Management Committee, and Infection Prevention and Control Group. A key improvement in this area has been the governance of the external Authorising Engineer Audits, for which a comprehensive internal audit action tracker has been developed and is monitored through to action completion. Any associated risks highlighted from these audits are added to the Trust Risk Register and reviewed on a regular basis. The approach is our baseline assurance reporting with the information that is currently captured across the departments. Our aspiration is to produce a high-level Power BI Dashboard which will visualise the key Board Assurance metrics to be accompanied by an exception report, as required.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

2023/24 Capital Programme Update (Month 3)

Board of Directors
September 2023

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23/24 Project Delivery Plan

Wirral University Teaching Hospital NHS Foundation Trust

- The Trust's Estates Capital Team, along with its Internal and External Partners, are currently engaged on 12 projects (Excl. UECUP build)

- To undertake and manage works the Trust employs:

  - 1 x Programme Manager/Senior Capital Project Manager
    - Supported by 2 part time external Project Managers for Theatres and Clatterbridge Diagnostics Centre.
  - 1 x Senior Capital Project Manager
  - 1 x Capital Project Manager

- The financial value of the projects currently being worked is over £18M (construction value).

23/24 Delivery Plan

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

ID	Scheme Type	Project Description
1	22/23 Divisional Scheme	CGH Modular Theatres (9 and 10)
2	22/23 Divisional Scheme	CGH Theatres Internal Reconfiguration
3	22/23 Divisional Scheme	Phase 2 CGH Electrical Infrastructure
4	23/24 Estates Scheme	Heat/Cooling Piped Services
5	22/23 Divisional Scheme	Ophthalmology light refurb
6	23/24 Estates Scheme	Phase 3 Fire Compartmentation (2nd and 1st Floors) at APH
7	22/23 Estates Scheme	Trust wide Flooring (phase 2)
8	22/23 Estates Scheme	Trust wide patient bathrooms
9	22/23 Divisional Scheme	Clatterbridge Diagnostics Centre
10	23/24 Estates Scheme	Cal 2 Boiler Replacement
11	23/24 Divisional Scheme	Doctors Mess Refurbishment
12	23/24 Estates Scheme	Plate Heat Exchangers at CGH
	Multi-Year Scheme	UECUP

Clatterbridge Theatres Phase 2

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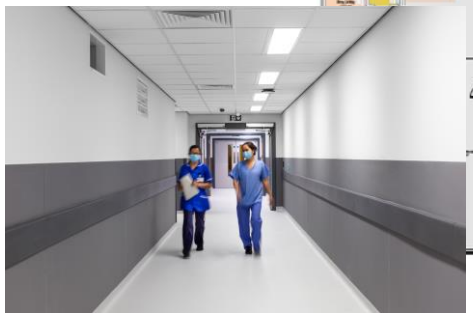
Wirral University Teaching Hospital
NHS Foundation Trust

Additional Modular Theatres and Refurbishments – Clatterbridge Hospital

- 2 Year Programme which includes the installation of 2 x additional modular operating theatres and further refurbishment of the theatre complex at Clatterbridge Hospital. Includes:
  - 2 x Theatres
  - 6 x Recovery bays
  - Anaesthetic Rooms
  - Additional consultation rooms
  - Lay up Rooms
  - Stores
  - Offices
- Project Complete – end Sept 2023
- Cost: £14.9m

Architectural Plan and photo



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Clatterbridge Theatres Phase 2

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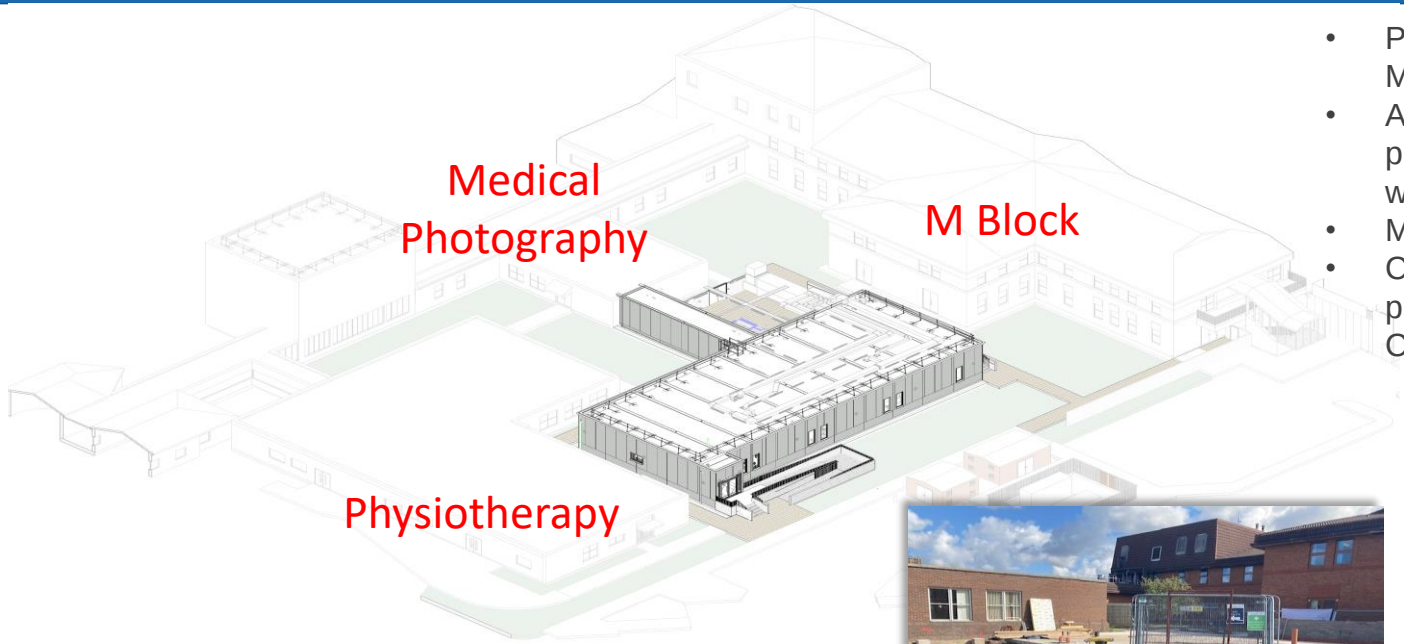
Clatterbridge Diagnostics Centre (CDC) Modular Construction

Wirral University Teaching Hospital NHS Foundation Trust



- Programme Handover end of March 24.
- As of July 23, the foundations piles and slab are progressing well.
- Modules are in manufacture.
- Critical equipment in procurement with MTX Contracting.

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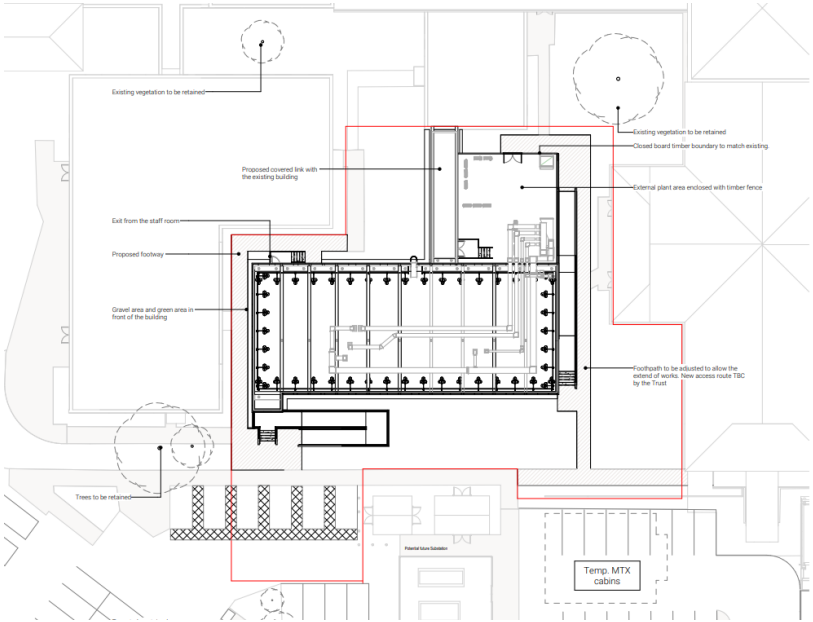
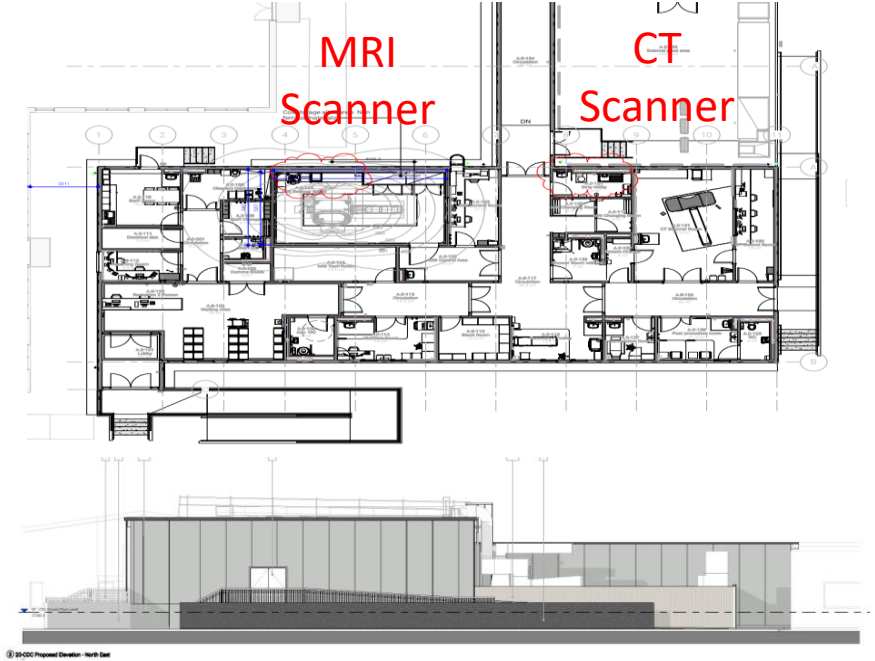
Clatterbridge Diagnostics Centre

Wirral University Teaching Hospital
NHS Foundation Trust



Layout Position



Side Elevation

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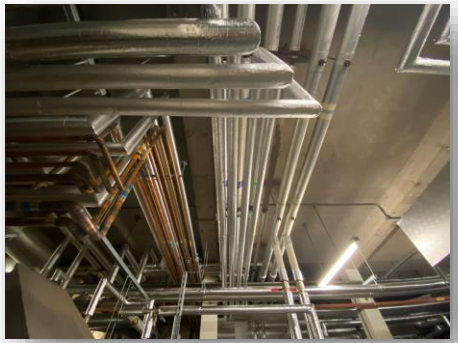
Low Carbon Steel Replacement Year 2 of 3 Women and Childrens (W&C)

Wirral University Teaching Hospital NHS Foundation Trust

- Ward areas in W&C require pipework replacement.
- The first step is to undertake a minor refurbishment of ward 31 (old Renal) to create a decant space, whilst undertaking works.
- The plan above details the ward movements in and out of ward 31.
- Programme to complete heating and cooling in financial year 23/24.



23/24 Fire Risk Reduction and Improvements

Wirral University Teaching Hospital NHS Foundation Trust

- Replacement and upgrade of Fire Doors
- Installation of Dry Risers and Fire hydrants
- Repair to fire compartmentation
- Upgrade of Fire Dampers

REINFORCE – repair breaches to compartmentation

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UECUP

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Urgent and Emergency Care Upgrade Programme (UECUP) at APH

- New clinical model for urgent and emergency care and redevelopment of 4,000sqm of buildings
- New UTC, Minors, Majors, Paediatric A&E, Resuscitation, Mental Health, Ambulance canopy and assessment area. Also new staff spaces and patient waiting rooms
- FBC approved by Department of Health in July 2022.
- Enabling works completed November 2022, including road and ambulance canopy
- Main works commenced early December 2022, with new build component of the redevelopment completing in Q4 of 23/24.

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UECUP

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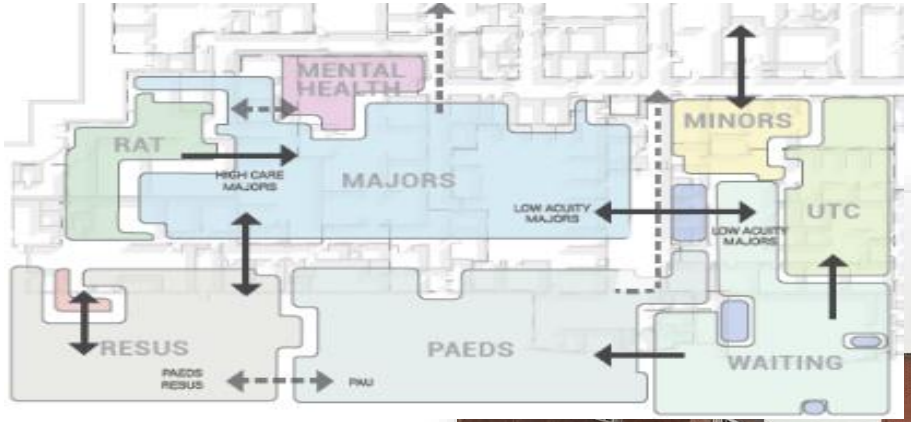

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Junior Doctor's Mess development

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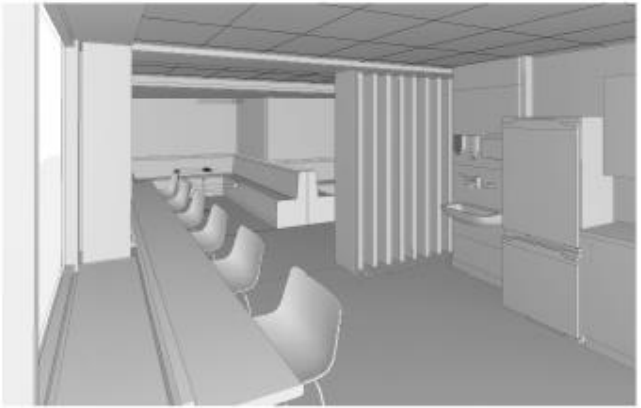

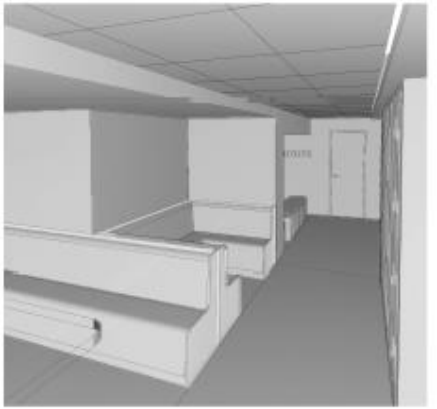

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Junior Doctor's Mess development

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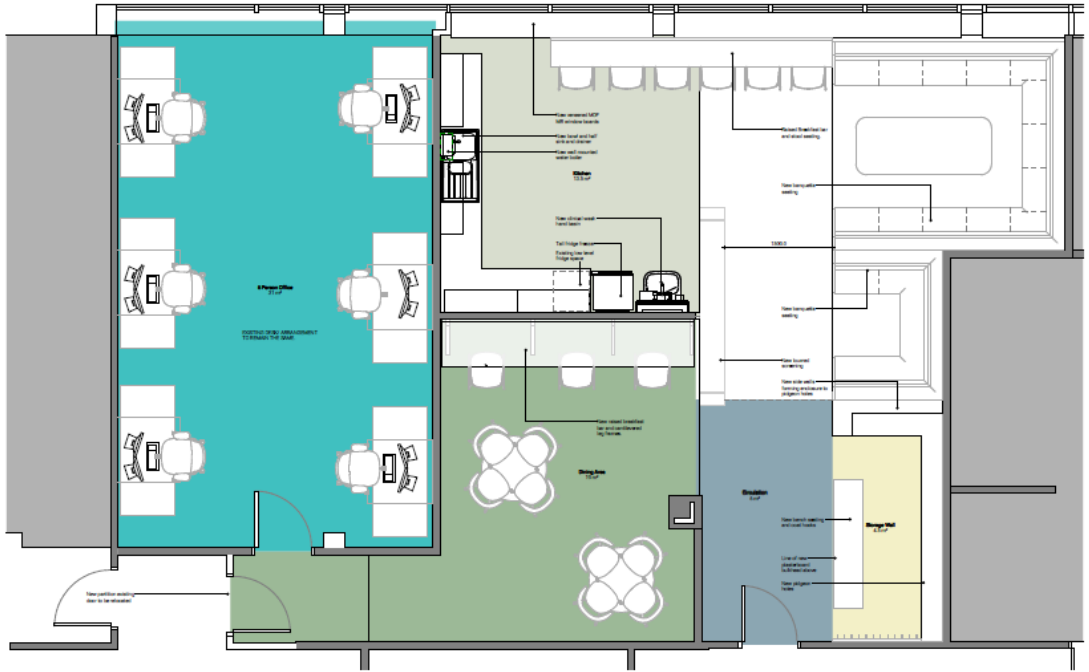

PLAN - PROPOSED

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Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 12**
6th September 2023

Title	Freedom to Speak Up and Fit and Proper Persons
Area Lead	David McGovern, Director of Corporate Affairs and Debs Smith, Chief People Officer
Author	David McGovern, Director of Corporate Affairs and Debs Smith, Chief People Officer
Report for	Information and Assurance

Report Purpose and Recommendations

The purpose of this report is to provide members with an update in relation to the outcome of the trial of Lucy Letby and provide assurance in regard to the Trust's focus on patient safety, Freedom to Speak Up (FTSU) and Fit and Proper Persons (FPP).

It is recommended that the Board:

- Note the report; and
- Adopt the new framework for Fit and Proper Persons.

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

Freedom to Speak up reports are brought to Board biannually, and Fit and Proper Persons reports are brought at least annually.

This is the first report responding specifically to the outcome of the Lucy Letby trial, and the letter sent to NHS Trusts following this.

1	Narrative
1.1	Board will be fully aware of the outcome of the recent trial of Nurse Lucy Letby and in particular commentary and discussion in regard to the strength of processes as they relate to Freedom to Speak Up (FTSU) and Fit and Proper Persons (FPP). This report is presented to provide Board with assurance in relation to the Trust's processes and governance in this regard.

2	Background
2.2	Following the delivery of the verdict NHSE have written to all NHS organisations to ask that we consider our approach to FTSU and FPP and ensure that proper assurance is provided to Boards in regard to its prioritisation and the efficacy of our processes. This letter is attached at Appendix 1 for information. In particular Boards are asked to consider: • All staff have easy access to information on how to speak up. • Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme. • Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place. • Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well. • Boards are regularly reporting, reviewing and acting upon available data. • Boards are aware of, and have adopted, the newly refreshed NHSE Fit and Proper Person Framework.

2	Progressing the FTSU Agenda
	A significant development of the Freedom to Speak Up (FTSU) agenda was led by 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 Following launch of the national policy and guidance updates, a gap analysis of all recommendations was undertaken. Internal process and governance have been aligned to new national requirements. Areas highlighted through the gap analysis have been addressed and the Board remains updated on progress via bi-annual reports.

In addition, work is ongoing to further embed a culture of speaking up through the implementation of a Just and Learning Culture, which is a strategic priority within the People Strategy. Through this programme of work, learning from FTSU, Patient Safety Incidents, Employee Relations Cases, Safeguarding cases, complaints and student feedback are now reviewed on a quarterly basis to determine if there are any emerging themes. This is fed into the new quarterly Lessons Learnt forum.

Furthermore, FTSU governance arrangements have recently been reviewed. FTSU is reported as follows:

- Biannual FTSU Report to Board
- Biannual FTSU Report to People Committee and Workforce Steering Board
- FTSU data reported quarterly via Patient Safety report.
- FTSU data reported quarterly to the National Guardians Office.
- Quarterly triangulation of FTSU learning themes with other sources of data to feed into Lessons Learnt Forum.
- Quarterly meeting between FTSU Lead Guardian and Non-Executive Director FTSU Lead.

It should also be noted that the FTSU Lead Guardian regularly engages with regional and national networks to ensure the Trust remain aligned to future developments.

Further to the work undertaken over the last 12-months, consideration has been given to the areas highlighted in the NHS England letter.

All staff have easy access to information on how to speak up.

- All staff are required to undertake an e-learning package as part of their role essential training to ensure they are aware of the FTSU process.
- All managers are required to complete a further eLearning package 'Listen Up' to ensure they are able to support staff in raising concerns and create a culture in which speaking up is encouraged.
- The importance of speaking up and how to raise concerns is now included within the Trust welcome event for new starters, with the FTSU Guardian promoting key messages and holding a stall for further engagement at the event.
- FTSU awareness is a module on the Manager Essentials programme, to ensure managers are aware of their role in listening up and supporting a speak up culture.
- The FTSU Lead Guardian undertakes regular 'walk abouts' across both Arrowe Park and Clatterbridge sites to promote the importance of speaking up and being visible to staff.
- FTSU resources and guidance on the intranet and posters / leaflets regularly distributed across Trust sites.

Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.

- FTSU Lead Guardian coordinates the quarterly thematic review with a wide range of stakeholders including HR, Patient Safety, Safeguarding, etc.

In addition, the following activities will also be implemented:

- Updated FTSU awareness session for HR and Wellbeing staff.
- Promoted via 'Leaders In Touch' and cascaded via Team Brief.

Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up.

- FTSU Guardian attends staff network events to ensure staff identified as 'minority' or as having 'protected characteristics' know about the role and how to refer / signpost individuals to speak up.
- We have FTSU champions throughout the Trust including champions in all staff networks.
- Regular review of staff experience data such as staff survey to identify staff groups that have poorer experiences and that may be facing barriers to speaking up.

In addition, the following activities will also be implemented:

- Promotional Materials reproduced in different languages.
- Additional awareness sessions for key staff groups such as internationally recruited, nurses, Estates and Facilities.
- FTSU walk abouts during night shifts and weekends.

Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

- The Just and Learning Culture programme of work is in place via the People Strategy, which works to create psychological safety and normalises 'speaking up'.
- FTSU Champions are in place across the Trust to promote speaking up and acting as a first point of contact and signposting.

In addition, the following activities will also be implemented:

- Recruit more and further develop the role of FTSU Champions.
- Promote positive staff stories of speaking up, sharing at key events and forums.
- Promotion via staff meetings and various network meetings.
- Increasing senior leader visibility to encourage speaking up.

Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.

- A robust governance reporting mechanism is in place.
- A survey tool has been developed to provide a feedback loop following the closure of FTSU cases. The data identified by this feedback survey is now incorporated into Bi-annual reporting with particular focus upon reporting if an individual has experienced any detriment because of peaking up.

Boards are regularly reporting, reviewing, and acting upon available data.

	• Reporting and oversight arrangements have been strengthened to ensure robust Board assurance. • The process for triangulating FTSU cases with employee relations cases and patient safety incidents has been established in line with Trust Just and Learning Culture feeding into the quarterly Lessons Learnt Forum.

3	**Fit and Proper Persons Test Framework**
1.2	NHSE published a new Fit and Proper Persons Test (FPPT) Framework on 2nd August, which, on top of current requirements, introduces standardised board member reference, and requires FPPT checks to be part of an individual's Electronic Staff Record (ESR). ICB, CQC and NHSE board members are now also required to comply with FPPT. Crucially, the framework makes specific the roles which the enhanced FPPT applies to, something which in the past has been left open to interpretation. The FPPT is now clearly situated within the range of measures organisations take to assure themselves of their board members' ongoing effectiveness, including appraisal processes, effective recruitment, and board development. Whilst implementation of the full framework is required by 31st March 2024, use of the board member template for all new appointments is required by the 30th September. WUTH's current Fit and Proper Persons Test Policy is under review in light of this framework, and it is expected to be brought to the October Board meeting for approval. In the meantime, and given the prominence of this requirement, it is requested that the Board formally adopt the new FPPT Framework for implementation. The new framework can be found here: NHS England Fit and Proper Person Test Framework for board members. The enhanced Board Member template can be found here, whilst the other key guidance documents and appendices to the framework are here.

4	**Conclusion**
4.1	Board are asked to note the contents of the report, and to adopt the FPPT Framework.

Report Author	David McGovern, Director of Corporate Affairs
Email	David.mcgovern2@nhs.net

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

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communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

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Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 13**

06 September 2023

Title	NED Engagement Proposal
Area Lead	David McGovern, Director of Corporate Affairs
Author	Cate Herbert, Board Secretary
Report for	Approval

Report Purpose and Recommendations

Following discussions at the July Board, this report presents a proposal for NED engagement within the Trust, with each NED partnering with a different division and working with the senior team there to ensure visibility and involvement.

It is recommended that the Board of Directors:

- Approves the proposal

Key Risks

This report relates to these key Risks:

- NED engagement/visibility supports the requirements of well-led and understanding culture

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

1	Narrative
1.1	Board engagement within the Trust supports the requirements of well-led, and specifically the new well-led Quality Statements included in the CQC's Single Oversight Framework, which is expected to come into force in the next several months. Board

	visibility also ties to ensuring NEDs have a feel for the culture, morale, and working environment within the Trust, and allows the Board further insight into both patient and staff experience – all of which support better decision making.
1.2	In order to support this, it is proposed that NEDs partner with divisions for 12 months, after which time they will rotate to another division. NEDs will then engage with the relevant Triumvirate (and Corporate Governance) to facilitate visits and other meaningful methods of engagement within the divisions. This could include “back to the floor” visits, a scheduled one-on-one walkabout, or observing a divisional meeting. We would encourage NEDs to visit at least quarterly, in coordination with the Triumvirate, to foster familiarity with the division. Proposals for the first 12 months, from October 2023, are as follows: Sir David Henshaw – Acute Steve Igoe – Medicine Lesley Davies – Corporate Steve Ryan – Women’s and Children’s Sue Lorimer – Surgery Chris Clarkson - Estates and Facilities Rajan Madhok – Diagnostics and Clinical Support
1.3	Unannounced visits are a good means of gauging the day to day operations of the divisions. However, NED engagement - in all forms - cannot be allowed to have an operational impact, given the demands and operational pressures on staff. Therefore, to allow unannounced visits to take place, NEDs are asked to consult first with the Triumvirate. While this means the visit would be announced to those senior managers, no one else on the teams would be informed. This is to ensure minimal impact during that visit, both to preserve safe staffing levels, and in case of demand pressures, e.g. full capacity issues, high ED attendances, etc. This will be especially important in the winter months as demand increases from its already high levels.
1.4	Recording visits This element of NED involvement forms part of Board development, and needs to be recorded from a Corporate Governance perspective. NEDs are welcome to make their own arrangements with the Triumvirates, but are requested to inform the Board Secretariat of their visit so that this can be captured for audit trail/recording purposes.

2	**Implications**
2.1	This proposal follows discussions from the July Board, and supports the requirements of well-led. With the increased visibility and access to the hospital, the Board will benefit from a greater understanding of the excellent work from staff, the experiences of the patients, and the challenges that both face.

3	**Conclusion**
3.1	Board are asked to approve the proposal.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 14**

06 September 2023

Title	Board of Directors' Terms of Reference
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 Terms of Reference for the Board of Directors for approval.

It is recommended that the Board of Directors:

- Approves the Terms of Reference

Key Risks

This report relates to these key Risks:

- The Trust should ensure that there is robust governance processes and documentation in place to support effective decision making and delivery of objectives.

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

1	Narrative
1.1	**Terms of Reference** As part of the wider governance review, a formal Terms of Reference for Board of Directors has been created which consolidates information set out in the Trust Constitution. The Terms of Reference is attached at Appendix 1.

2	Implications
2.1	Clear terms of reference support effective decision making and good governance.

3	Conclusion
3.1	It is recommended that the Board of Directors approve the Terms of Reference.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors
Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Constitution** **Standing Orders** **Scheme of Reservations and Delegations**

Review Date: TBD
Issue Date: TBD
Version: 1.0
Authorisation Date: TBD

1. Constitution

The Board of Directors is established to set the strategic direction of the Trust, to set and guide the delivery of the Trust's values, mission, and culture, and is responsible for the overall performance of the Trust. It is derived from NHS Act 2006 and as amended by the Health and Social Care Acts 2012 and 2022. This document should be read in conjunction with the Acts and the Trust Constitution.

2. Authority

The Board of Directors' authority is set out in the Trust Constitution and is derived from the legislation noted above.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Board within the scope of its authority.

The Board is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Board will establish Committees with delegated authority to carry out specific functions and may request that any item be considered first or further by a Committee.

3. Objectives and Duties

The general duty of the Board of Directors and of each Director individually is to act with a view to promoting the success of the Trust, so as to maximise the benefits for the members of the Trust and as a whole for the public.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy

- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Board and the organisation

The main duties of the Board of Directors, underpinning these three roles, are as follows:

- To set the strategic direction of the Trust within the overall policies both regionally and nationally, to define its annual and longer-term objectives, and to agree sufficiently resourced plans to achieve these
- To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary
- To ensure effective financial stewardship through value for money, financial control and financial planning and strategy
- To ensure that high standards of corporate governance are implemented and maintained, to support compliance with its statutory and regulatory requirements, and to support high standards of transparency, probity, and integrity in the conduct of the business of the whole Trust
- To ensure that high standards of clinical governance are implemented and maintained, to ensure clinical services are effective and safe, and take into account patient experience
- To appoint, appraise and remunerate senior Executives
- To ensure that there is effective dialogue and partnership working between the Trust and the local community on its plans and performance and that these are responsive to the community's needs

The Board of Directors delegates duties and responsibilities to Board Committees and to the Trust Executive Team in accordance with the Trust's Standing Orders, Schemes of Reservations and Delegations and Standing Financial Instructions.

4. Equality and Diversity

The Board of Directors will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches. The Board will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Board of Directors shall consist of:

- a Non-Executive Chair; and
- not more than seven other Non-Executive Directors; and
- not more than seven Executive Directors,

At least half of the Board of Directors, excluding the Non-Executive Chair, shall at all times comprise Non-executive Directors.

One of the Executive Directors shall be the Chief Executive. The Chief Executive shall be the Accounting Officer.

One of the Executive Directors shall be the Director of Finance.

One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

One of the Executive directors is to be a registered nurse or a registered midwife.

Attendance at meetings will be monitored and shall be reported in the Annual Report.

6. Attendance

Meetings of the Board of Directors may be attended by:

- Director of Corporate Affairs
- Board Secretary
- Other officers of the Trust as requested by the Board of Directors.

Meetings of the Board of Directors shall be held in public may be attended by any member of the Trust, the public, or staff who have notified the Board Secretary in advance.

Meetings of the Board of Directors in private, held under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, may be attended by a non-Board member, only at the request of the Board.

7. Conflicts of Interest

Not withstanding the definition of material interests applicable to Directors as set out in the constitution, due consideration of interests will be regularly monitored.

Both Executive and Non-Executive Directors may not take part in any discussions or decisions which pertain to their own employment, performance, or remuneration.

It will be for the Chair of the Board to determine whether or not it is appropriate for Directors to be in attendance to advise on these matters. In such circumstances where that person is in attendance, they will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

A quorum shall be six Directors, including at least three executive Directors (one of whom must be the Chief Executive, or another executive Director nominated by the Chief Executive) and at least three non-executive Directors (one of whom must be the Chair or the Deputy Chair).

An Officer in attendance for an executive Director but without formal acting up status may not count towards the quorum.

Meetings of the Board of Directors shall be held at least three times in each financial year at such times and places that the Board of Directors may determine.

Meetings shall be open to the public unless the Board of Directors in its absolute discretion decides otherwise in relation to all or part of such meetings for reasons of commercial confidentiality or on other proper grounds. Private sessions of the Board will be held under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960.

9. Reporting

The Board of Directors will develop a Cycle of Business where scheduled items throughout the year will be presented.

The minutes of all meetings shall be formally recorded and presented to the next meeting for approval.

The agenda prior to any meeting of the Board of Directors will be provided to the Council of Governors, and a copy of the approved minutes as soon as is practicable afterwards.

The agenda and supporting papers of each meeting shall be displayed on the Trust website.

The Board has established a number of assurance Committees and will receive regular Chair's updates from those Committees.

The Trust reports activity externally through Trust's annual report and accounts. This shall be laid before Parliament annually and published in line with national guidance.

10. Conduct of Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Board of Directors, unless there are exceptional circumstances authorised by the Chair.

Authors of papers must use the standard template.

Presenters of papers can expect all Members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Members may question the presenter.

11. Other Committees

The Board of Directors acting as corporate Trustee has established the Charitable Funds Committee.

12. Effectiveness Review

As part of the annual performance review process outlined in the Board Effectiveness and Evaluation Policy, the Board of Directors shall review its collective effectiveness annually.

13. Review

The Board of Directors shall review its Terms of Reference as required and at least annually.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
6 September 2023

Item No 15.1

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

Items for Escalation/Action

Special Educational Needs and Disabilities (SEND)

- The Committee received a report on Special Educational Needs and Disabilities (SEND). The Trust provides care for children and young people (CYP) through its Community Paediatric Service.
- The oversight and leadership of the services for these CYP is through the local authority and the Integrated Care Board. A previous inspection by the Care Quality Commission and Ofsted had highlighted the need for improvement in SEND services. Subsequently the lead organisations developed a transformation programme with its partners including the Trust. The Trust is fully engaged with relevant components of the transformation programme. As part of the transformation work, considerable engagement with families, service users, schools, social care and the voluntary sector have helped to shape the 2023 Priority Plan.
- One area of transformation and improvement relates to the high caseload for CYP living with SEND who receive input from our Community Paediatric Service. This has led to the risk of CYP with neurodevelopmental disorders who use the service waiting too long for clinical follow-up. As a result, a full a clinical risk validation exercise for all CYP receiving care has been completed to enable clinical prioritisation. As a result moving some CYP have been transitioned to patient-family-initiated follow-up and others have been referred to follow-up to primary care, where appropriate. In addition, at regional level, a pan-Mersey care pathway bringing primary care deeper into these pathways is being developed (currently medication can only be prescribed by specialists, not general practitioners). As well as those waiting for follow-up care, there are excessive waits to access initial assessments, which these actions will also help address.
- Issues of this nature and scale are prevalent across much of England and vacancies in Community Paediatrician posts are a key driver of these difficulties. The Trust has unsurprisingly also had difficulty making suitable appointments to vacancies in its community paediatric consultant posts. A further resource request is currently being developed to address these workforce issues.
- These issues are also having an impact on the timeliness of Education and Health Care Plans, provided by Trust clinicians, being provided within 42 days of a request. However the quality of the reports provided are consistently high.
- The Committee suggests that this area could form the basis of a Board Seminar.

Impact of pressures in the Emergency Department

- The continued pressure and long waits for patients in the Emergency Department (ED) was discussed in a number of reports. The high level of acute mental health care need has

previously been highlighted to the Board and our mental health transformation work, led by the. The Chief Nurse is investigating solutions with partners to mitigate the risk of this on-going issue.

- Long stays in ED for some patients who are already receiving essential multiple daily medications prior to attending, present an additional challenge for the care teams in ED in ensuring all these medicines are provided on a timely basis. These patients should ordinarily be on inpatient wards where medication systems for this timeframe have long been in place. The Acute and pharmacy teams are being tasked to develop an action plan to address this issue. On going work to improve unscheduled care pathways will also help address this issue.

New/Emerging Risks

- No new risks were identified at the meeting

Overview of Assurances Received

- The Committee received the Patient Experience Strategy Annual Report, which was presented by the Chief Nurse. This report gave a high level of assurance of the development and delivery of the strategy. Key highlights include the high level of patient and citizen engagement, which is shaping the delivery strategy through co-production within the Promise Groups. The link to improving positive patient feedback through the Friends and Family Test has also been demonstrated.

- Assurance on learning lessons was received through the Quality and Patient Safety Intelligence Report for Quarter 4 2022/23. Our attention was drawn to the work which is moving us towards a good position in the implementation of the national Patient Safety Incident reporting Framework (PSIRF)- ensuring effective learning and action by the thematic consideration of incident reports and other intelligence. The Lessons Learned Forum identified high-level themes in May. These themes were then mapped against improvement and assurance work already underway, but also identified areas for further focus. An example of further focus is adherence to policies and procedures: Work will be done to understand the key issues that are associated with lapses and improvements developed. Other areas of work include transfer of care between clinical areas, health inequality and acute mental health care. In the latter case we already benefit from partnership work with Cheshire and Wirral Partnership Trust - for example support to improve recorded compliance with the Mental Capacity Act.

- Through the Patient Safety Quality Board Key Issues Report and the Integrated Performance Report, the Committee received assurance that quality improvement work was seeing a reduction in patient falls. However further insight is being sought around the potential causes of lapses in “bay tagging”, which were highlighted following a serious incident the Committee received.

- The Chief Nurse gave an update on *Clostridiodes difficile*. Although the Statistical Process Control (SPC) chart had demonstrated a continued fall in the incidence of *C diff* from its peak in July 2022. Despite this but given the high level of risk factors in the population we serve, the high level of bed occupancy and the relative lack of isolation facilities (e.g. single rooms), she is developing a priority action plan to address and weaknesses or gaps in our control processes.

- The Committee received an update on the CQC action plan. Assurance was received that actions are in place for all 3 overdue actions and progress is expected at the next meeting of the Committee in 2 months. Five actions had been given extended deadlines. Assurance of the actions being embedded following completion is always sought.

Other comments from the Chair

- The Lesson Learned Forum had also highlighted Management of Violence and Aggression as on of its themes. The Committee sought assurance that this issue is one that the Board is fully sighted-on through its sub-committees. Feedback was given that the relevant elements of this will be reported through the Risk Management Committee and also raised, through the Health and Safety Committee. A report will be provided to the Trust Board later this year so that it can seek the necessary assurance.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
6 September 2023

Item 15.3

Report Title	People Committee
Author	Lesley Davies

Overview of Assurances Received

- The People Committee received the committee's regular standing reports which were well detailed and provided good assurance against key indicators including completion rate of appraisals, mandatory training, and absence management. The committee also asked how assurance would be provided on the effectiveness of the new process and it was confirmed that staff will be surveyed to provide feedback on the process and the value of the appraisal system.
- Information was also received by the committee on the Trust's submission for the 2022-23 Annual Submission to NHS England North West: Appraisal and Revalidation. The final submission demonstrated a high level of compliance with very few non-complete appraisals; these, in the main, related to parental leave or extension of the process for the compilation of further evidence. The committee took good assurance from the information provided.
- The Trust's volunteering programme continues to be successful in its recruitment and the retention of volunteers and the committee thanked staff for their work in this area. Further information on the distribution of the volunteers across the Trust will be provided at a future meeting.
- The committee discussed, in some detail, the current status regarding Care Support Workers (CSW), both in terms of numbers in post and vacancies and the current risks regarding retention and industrial action. Given the importance of this role for the Trust, the committee will continue to revisit progress in this area at its future meetings.
- The committee had a detailed discussion with regard to the progress being made against the People Strategy Year 2 objective for the implementation of the workforce planning process and also the impact and link of the Trust's plan to the NHS workforce plan. The committee asked for an area/directorate of the Trust to be invited to attend a future meeting to demonstrate the impact of the planning process and highlight the progress being made, including any known or expected impact of AI. This would ensure that the committee is provided with qualitative information and assurance on the impact of the changes rather than just a focus on the quantitative information provided in future reports.
- It was also agreed that the Trust would investigate the potential of setting up a WUTH Apprenticeship Training Academy and explore the potential benefits this would bring the Trust. A future meeting is being arranged with the CPO, Training team and Chair of the People Committee to discuss the potential and next steps.
- The committee was also update on the current and planned industrial action

Comments from the Chair

- Feedback from committee members has been extremely positive regarding the depth of the discussion and the work of the committee. Members are keen to add value whilst gaining the required level of assurance.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 15.6**
6 September 2023

Report Title	Committee Chairs Report – Finance Business Performance Committee
Author	Sue Lorimer, Chair of Finance Business Performance Committee

Items for Escalation/Action

- The Committee were pleased to see that good financial performance had continued to month 4 with a deficit of £9.8m, a positive variance of £0.5m against plan. The position includes accrued income in respect of activity lost due to industrial action and this practice is in line with the rest of the ICB. Elective activity income has underperformed by £3.6m to M4 due to industrial action and the continued under-utilisation of the Countess of Chester surgical sessions. The Committee was informed that discussions were taking place with Warrington and Mid Cheshire to address the underutilisation.
- The Committee noted several financial issues had arisen in the Estates department and requested that more information is brought back to the Committee from the deep dive exercise that is currently being undertaken.
- The Committee were informed that the Estates and Capital Committee had discussed the risks around the relatively low backlog maintenance and medical equipment budgets and whether there were any options to increase funding. None were identified but the Trust is prepared to take up any opportunities that might become available later in the year.
- The Committee considered the financial forecast for the year based on performance for the first quarter. It appears that an adverse variance of £8.1m is the most likely scenario when considering £3.7m of costs that have arisen outside of planning assumptions and £4.4m comprising income shortfall and additional costs which were in planning assumptions. The best-case scenario is currently an adverse variance of £2.2m and the executive team are seeking mitigations as far as possible.
- The Committee reviewed a set of expenditure controls directed by the ICB and were pleased to note that almost all the controls on the list were already in place at the Trust. The Executive Team provided verbal assurance that the controls were being implemented rigorously.
- The Chief Finance Officer provided to the Committee a very helpful presentation on the medium-term finance strategy. The Committee agreed that the assumptions on costs and CIP were reasonable, and the model had identified a deficit of some £28m by year 3. This is the gap which needs to be addressed through strategic initiatives such as partnering and collaboration. The Director of Corporate Affairs undertook to include this on the agenda for the Board Awayday on 22nd September.
- The Committee noted the CIP programme was continuing well with excellent performance to month 4. A total value of schemes of £6.6m has been delivered against a plan of £5.9m. The forecast for the year as at M4 is £24.9m against a target of £26.2m. While this is still a shortfall on target it is a huge achievement for the teams and the programme. Executive challenge continues in those areas where there is a shortfall. The Committee discussed the good performance in the Medicine Division, and it was agreed that Divisional representatives be invited to the next meeting to present on their achievements.
- The Chief Operating Officer presented a paper on elective performance including Cancer. While elective performance is one of the best in the region, we are behind plan at M4 due to Industrial action. Gastroenterology, Ophthalmology, Gynaecology and Colorectal are all experiencing pressure on Referral to Treatment performance. Recovery plans are in place and a service review is taking place in Colorectal.

- The Committee reviewed and approved the changes in the Board Assurance Framework.

New/Emerging Risks

- The Committee noted the increasing risk to activity plans as Industrial Action continues.