Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public

25 January 2023

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Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 25 January 2023
Time	09:00 – 11:00
Location	Board Room, Education Centre, Arrowe Park Hospital

Agenda Item			Lead	Presenter
1.	Welcome and Apologies for Absence		Sir David Henshaw	
2.	Declarations of Interest		Sir David Henshaw	
3.	Minutes of Previous Meeting		Sir David Henshaw	
4.	Action Log		Sir David Henshaw	
5.	Patient Story		Tracy Fennell	
Operational Oversight and Assurance				
6.	Chair's Business and Strategic Issues – **Verbal**		Sir David Henshaw	
7.	Chief Executive Officer's Report		Janelle Holmes	
8.	Chief Operating Officer's Report		Hayley Kendall	
9.	Board Assurance Reports			
	9.1)	Quality and Performance Dashboard	Executive Directors	
	9.2)	Month 8 Finance Report	Mark Chidgey	
	9.3)	Quarterly Maternity Services Report	Tracy Fennell	Jo Lavery
	9.4)	Learning from Deaths Report (Q2 2022/23)	Dr Nikki Stevenson	Dr Ranj Mehra
	9.5)	Freedom to Speak Up Report (Q1-Q2 2022/23)	Debs Smith	Sharon Landrum
Wallet Items for Information				
10.	Communications and Engagement Report		Debs Smith	Sally Sykes
11.	Committee Chairs Reports		Committee Chairs	
	11.1)	Finance Business Performance Committee		

Closing Business

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

Date and Time of Next Meeting

Wednesday 1 March 2023, 9:00 – 11:00

Meeting	Board of Directors in Public
Date	Wednesday 7 December 2022
Location	Board Room, Education Centre, Arrowe Park Hospital

Members present:

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

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
SS	Sally Sykes	Director of Communications and Engagement
CM	Chris Mason	Chief Information Officer
SH	Sheila Hillhouse	Lead Public Governor
TC	Tony Cragg	Public Governor
RT	Robert Thompson	Public Governor
AM	Alan Morris	Public Governor
PB	Phillipa Boston	Staff Governor
CD	Chris Davies	Local Authority Governor
SL	Sharon Landrum	Workforce Diversity and Inclusion Lead/ Freedom to Speak Up Guardian (item 13)

Apologies

LD	Lesley Davies	Non-Executive Director

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed all present to the meeting. Apologies are noted above.	

2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 2 November were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story of the experience of a mother and son, who had been referred to A&E. The story described the son's experience at the hospital, as well as the excellent care and attention by staff. The Board **NOTED** the patient story.	
6	**Chair's Business and Strategic Issues** DH updated the Board of Directors on recent matters and highlighted the challenges, including the continuing high number of patients in hospital with no criteria to reside and the upcoming industrial action across the NHS. SL queried if the Trust would be impacted by the upcoming industrial action. DS stated the Royal College of Nursing ballot retuned a mandate for industrial action but there would be no industrial action at Wirral University Teaching Hospital on 15 or 20 December. DS highlighted that industrial action was likely to occur in January and the Royal College of Nursing was required to provide 14 days' notice. DS added the UNISON ballot did not return a mandate for industrial action. HK commented the industrial action at Liverpool may increase the number of ED attendances as well as ambulance diversions to the Trust. HK added the Trust would be prepared for this situation as well as the North West Ambulance Service industrial action. SR queried if industrial action would have an impact on any mental health Trusts. DS stated she was unsure but agreed to find out and provide an update by email.	Debs Smith

	DH commented due to the setting up of Wirral Place the CEO and Chair's meeting had been postponed and queried if it was possible to set up one. JH agreed to progress this. The Board **NOTED** the update.	Janelle Holmes
7	**Chief Executive Officer's Report** JH provided an Infection Prevention Control (IPC) update and explained COVID cases continue to reduce both across the community and in hospital. JH stated the Trust had developed surge plans to accommodate expected rises in respiratory viruses throughout the winter period. JH highlighted Victoria Smerdon, Consultant Orthoptist, part of the Orthoptic Clinical Placement Expansion Team received the award for Innovative Provision of Placements at the 2022 Chief Allied Health Professions Officer Awards. JH reported the Trust declared one serious incident in October and two RIDDORs. JH highlighted the Trust had an unannounced visit from Wirral Borough Council Environmental Health Services on the 15th November 2022 at Clatterbridge Hospital and the Trust was successful in maintaining its 5/5 food hygiene rating. JH stated the Department of Health and Social Care had confirmed details of the £500m Adult Social Care Discharge Fund. Wirral Metropolitan Borough Council had been allocated £1.5m and Cheshire & Merseyside ICB had been allocated £19.2m of which £2.1m was allocated to Wirral Place. JH also noted the COVID-19 public inquiry had commenced, and as part of this, the Trust will receive a questionnaire regarding the impact on healthcare systems and would respond accordingly. DH queried if there had been any progress regarding the Trust temporarily occupying an external venue to provide additional bed capacity. MS stated no appropriate venues including hotels were in a state to occupy. The Frontis Building at Arrowe Park was also not viable. JH explained NHSE acknowledged the issue was widespread across the UK and were keen to enable and support transformation. JH highlighted the Trust had recruited Clinical Support Workers (CSW) to provide domiciliary care through Home First and was considering establishing a CSW agency/bank team to scale up the scheme.	

	HK commented 20 patients were waiting for basic care packages and the Trust could deliver this through Home First. HK added a meeting with the Community Trust Chief Operating Officer was planned for w/c 12 December to discuss the proposal. The Board discussed the challenges around discharges and social care provision. RM queried if it was possible for local or voluntary organisations to support patients at home. HK stated those organisations were unable to provide scheduled planned care and whilst able to provide other services, the Trust cannot discharge patients without a scheduled care plan. CC commented he recently attended a CMAST meeting and heard a good example of St Helen's working together with a community provider to provide care in the community. The Board **NOTED** the report.	
8	**Chief Operating Officer's Report** HK provided an overview of the Trust's current performance against the elective recovery programme for planned care as well unscheduled care. HK highlighted in October 2022 the Trust attained 97.1% against a plan of 100.4% for outpatients. For elective admissions 91.0% of activity was delivered against a target of 105.8%. HK stated unscheduled care performance had ongoing challenges with long length of stay patients and reiterated the impact this has on urgent and emergency care performance. Performance against the 4-hour standard for type 1 attendances decreased from 54.70% in September to 49.36 % for October. HK explained the Trust continued to have high bed occupancy due to patients remaining in beds with no criteria to reside. HK added a Wirral Discharge Challenge, working with partners across the system to safely discharge patients who were medically fit to leave acute hospital care, was taking place w/c 5 December. SR noted the 2 week wait for cancer referrals continued to increase and queried if this resulted in any missed cancer diagnoses during COVID and if there was an impact on treatment. HK commented there had been no significant increase in cancer treatment being sought despite the increase in referrals.	

	SR was aware of plans to give GPs direct access to tests to speed up cancer diagnosis and queried how this was progressing. HK stated the relevant teams were involved in the process and design of tests for GPs. NS added feedback from the Cancer Alliance Group indicated there may be issues with capacity and the reporting of tests which need to be completed in a timely manner. JH commented challenges continue regarding unscheduled care, but improvement continues, however it was important to protect the improvement work as much as possible by ensuring elective activity continues. The Board **NOTED** the report.	
9	**Board Assurance Reports** **9.1 Quality and Performance Dashboard** TF highlighted a reduction in the number of C. difficile and other gram-negative bacteraemia cases, and this was due to a strong infection prevention and control focus by all staff. NS stated the number of patients recruited to NIHR studies continued to remain low and the Trust was unlikely to meet the 700 cumulative total for 2022/23. DS reported the people metrics, explaining sickness absence remained above the 5% target. Two staff groups had high sickness absence and assurance had been sought from the relevant Divisions. Appraisal and mandatory training compliance remained static. DS added all three metrics were likely to be a challenge throughout the winter. DS also reported staff turnover remained above the 10% target and data showed work/life balance was a reason for leaving. SR asked about short-term sickness and if any evidence pointed to repeat episodes. DS stated the Attendance Management Policy was in place to identify repeat episodes of short-term sickness and managers would have conversations with the staff member to determine any underlying concerns. DS added the policy was being revised to include an informal stage and more robust mechanisms. SR noted the care hours per patient day had continued to increase since May and enquired what the cause of this was. TF stated this was caused by a shortage of Clinical Support Worker (CSW) and highlighted two recruitment events had taken place and	

	100 CSW's had been appointed. TF added the increase in this metric had not caused any harm to patients. The Board **NOTED** the report. **9.2 Month 7 Finance Report** MC reported the Trust was reporting a deficit of £3.931m, an adverse variance against budget of £4.769m. The variance was attributed to overspends on employee costs, underperformance in respect of recurrent CIP, the unfunded element of the national pay award, the continued use of escalation wards staffed at premium rates, and by increases in energy prices. MC stated this was offset by reductions in non-pay spend, specifically clinical supplies, because of reduced elective activity compared to plan as well as the release of deferred income. MC highlighted the Trust had the potential to exceed the elective recovery target but, consistent with national guidance, no additional income had been assumed from the Elective Recovery Fund (ERF). SL queried why the forecast position remained a £6m deficit and not an £8m deficit. MC stated this was due to the Trust's current run rate, combined with the ongoing balance sheet release measures and non- recurrent CIP towards the end of the of the year. SL requested MC include an actual/variance position in future narratives to ensure this was clear. DH queried the structural deficit. MC stated in future the Trust would need to focus on reviewing the services provided, as well as integration and transformation. This would be reflected in the Trust's future Finance Strategy. JH commented the Executive Team had started to discuss the rationale that supports the Trust's potential future transformation, including the integration of services. SI queried if the Trust would be financially impacted by other Trusts who reported a deficit position. MC stated there would be no transfer of deficits between Trusts in Cheshire and Merseyside and the financial position reported at the end of the year would be the overall ICB position. SR noted recurrent CIP displayed a higher forecast from month 10 to 12 and queried if this was achievable.	Mark Chidgey

	MC stated each scheme had been scrutinised and appropriately RAG rated. Schemes rated green had been included in the forecast. The Board: • **NOTED** the report and; • **NOTED** that without further mitigation the forecast position remains a £6m deficit and; • **APPROVED** the reduction in the capital programme budget of £4.6m to reflect the rephasing of UECUP and other changes **9.3 Monthly Maternity Report** TF provided the key metrics reported to the Local Maternity and Neonatal System (LMNS) via the Maternity Dashboard, which were linked to the quality and safety of Maternity Services at the Trust. TF also provided the Perinatal Clinical Surveillance Quality Assurance report, providing an overview of the October key quality and safety metrics. TF stated there were no areas of concern to raise this month. The Board **NOTED** the report. **9.4 Digital Healthcare Update** CM provided a progress update on the development of operational plans to deliver the Digital Strategy strategic priorities of the Trust over the next 12 months. CM stated of the 37 projects within those programmes – 14 were currently green, 8 were amber, 8 were red and 7 were blue (complete). CM added resourcing shortages within the Integration and Development areas continue to cause issues for ongoing projects. However, processes were in place to alleviate pressure on teams by prioritising accordingly. The Board **NOTED** the report.	
10	**Governance and Regulation Update** DM provided an update regarding recently published governance and regulation documents, including the new Code of Governance, and on the upcoming review of the provider license and enforcement guidance, which were open for consultation. DM added a self-assessment and action plan against the new code was being undertaken to determine any gaps can be reviewed and amended as required prior to compliance from April 2023.	

	DM also added the Trust would respond to both consultations and report back to the Board once the licence and the enforcement guidance had been published. The Board **NOTED** the report.	
11	**CQC Adult In Patient Survey and National Cancer Patient Experience Survey Results** TF highlighted the adult in patient survey reviewed the experiences of patients aged 16 years and older who stayed at least 1 night in hospital as an inpatient, excluding people admitted to maternity or mental health units. TF stated the findings demonstrated a continued improvement in patient experience responses and the 2 lowest scoring responses were consistent with known operational pressures regarding waiting times and waiting lists. TF also highlighted the National Cancer Patient Experience Survey reviewed the experiences of patients aged 16 years and older with a primary diagnosis of cancer who were admitted as an inpatient or day case patient. TF stated the findings also demonstrated continued improvement in patient experience responses. The Trust had been identified as above or equal to the national average in most responses. There were 2 questions that were below the national average, and these have been shared with the specific groups and improvement plans devised. SL noted for nursing the Trust compared well with the other Trusts in the region and queried the typical questions from the survey. TF stated a range of questions were asked regarding nurses including if patients felt safe or cared for and it was positive the Trust was in the top 5 for the Cheshire and Merseyside. The Board **NOTED** the reports.	
12	**Equality, Diversity, and Inclusion (EDI) Annual Report** SL provided a summary of the annual EDI activity undertaken throughout 2021/22 as well as an annual summary of workforce data at the Trust in line with the annual and regulatory reporting cycle. DS provided an update on the Inclusion Strategy 2018-22 including an overview of achievement against the Trust's key priorities and outcomes during the period. DS added a new People Strategy had been developed with EDI embedded within it, along with a new Strategic Commitment for workforce EDI.	

	DS stated a future Board Seminar topic would be on the Strategic Commitment and what it meant for the Board. SR noted the 5.8% improvement of staff believing the Trust provides equal opportunities for career progression or promotion. DS commented this feedback was positive but further improvement was needed to improve the diversity of staff above band 7. The Board **NOTED** the report.	
13	**Fit and Proper Persons Update** DM presented a refreshed version of the Fit and Proper Persons Policy following approval at the Audit and Risk Committee on 16 November. The Policy was fully revised and adopted in October 2021 subject to an annual refresh. DM also stated the main addition to the Policy had been to provide a clearer definition of the roles that would be subject to the policy in future, which were listed in the appendix. DM added a process was now in place to complete annual checks and this would commence in December for all relevant Directors and Senior Leads. The Board: • **APPROVED** the annual refresh of the Policy; and • **NOTED** the process for annual renew of compliance with the policy	
14	**Risk Management Strategy** DM presented a refreshed version of the Risk Management Strategy following approval at the Audit and Risk Committee on 16 November. The Strategy was last refreshed and approved in October 2021. DM added MIAA carried out a review of the strategy and the accompanying processes in March 2022. The overall opinion was of substantial assurance and a small number of areas were highlighted to further enhance the Strategy. The Board **APPROVED** the annual refresh of the strategy.	
15	**Quality and Safety Strategy** NS presented the new enabling strategy, Quality and Safety Strategy for approval and explained the strategy formed one of eight enabling strategies, through which the 2021-2026 Strategy would be delivered.	

	NS added the Quality and Safety Strategy comprised three pillars, aligned to the 2021-2026 Strategy and was essential to build and embed a culture of improvement to continuously enhance the services and care the Trust provides to the Wirral population. NS stated the Quality & Safety Strategy had been developed through a series of engagement workshops with staff and external partners, in addition to engagement with over 230 patients, staff and external stakeholders. The approach enabled the Trust to gain a clear understanding of the current situation and priorities over the next four years. The Board **APPROVED** the strategy.	
16	**WUTH Charity Annual Report and Accounts 2021/22** The Board **NOTED** the report.	
17	**Communications and Engagement Report** The Board **NOTED** the report.	
18	**Committee Chairs Reports** **18.1 Audit and Risk Committee** The Board **NOTED** the report. **18.2 People Committee** The Board **NOTED** the report. **18.3 Quality Committee** The Board **NOTED** the report. **18.4 Estates and Capital Committee** The Board **NOTED** the report. **18.5 Research and Innovation Centre** The Board **NOTED** the report.	
19	**Questions from the Public** TC commented he observed the Estates and Capital Committee on 5 December and was assured regarding the UECUP programme and other capital projects. TC also commented the duration to see a GP was 3 weeks near his residence.	

	SH commented the duration to a see a GP was less than 3 weeks near her residence. SH also thanked the staff for their continued work. NS commented primary care network leads acknowledged the situation was difficult and there were challenges recruiting and retaining GP's, which was further exacerbating the delay seeing patients. No other questions from the public were raised.	
20	**Any other Business** No other business was raised.	

(The meeting closed at 11:15)

Action Log
Board of Directors in Public
25 January 2023

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	31 August 2022	9.3	To include the due dates against the mitigating actions on the Board Assurance Framework	David McGovern	In progress. Due dates will be fully included as part of the refresh of the BAF in time for the annual update which will be presented at a Board Seminar in February	February 2023
2.	2 November 2022	9.4 & 15	Further detail to be provided in the next Estates update around meal wastage, and around statutory compliance.	Paul Mason	In progress. Due to be included in the next quarterly update.	March 2023
3.	7 December 2022	6	To circulate information relating to industrial action impacting on mental health Trusts.	Debs Smith	Complete. Circulated by email on 9 December.	December 2022
4.	7 December 2022	7	To set up a CEO and Chair's meeting	Janelle Homes	Complete. Meeting set up for 8 February.	January 2023
5.	7 December 2022	9	To include in the narrative of the finance report a statement regarding the actual/variance forecast position	Mark Chidgey	Complete.	January 2023

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 7**
25 January 2023

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

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

Key Risks
N/A

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

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

1	**Narrative**
1.1	**Industrial Action Update** The announcement of the 2022/2023 pay award resulted in increased Trade Union activity and a number of Trade Unions have balloted for Industrial Action. In Wirral University Teaching Hospital, ballots undertaken by Unison, Unite and the Royal College of Midwives did not return a mandate for Industrial Action. Ballots undertaken by both the Royal College of Nursing (RCN) and the Chartered Society of Physiotherapy (CSP) did return a mandate for action.

	The RCN will take strike action in the Trust from 8am to 8pm on 18th and 19th January 2023. This follows RCN strike action in a number of Merseyside Trusts on 15th and 20th December 2022. The CPS have not yet issued formal notification of specific dates for action at the Trust. The Hospital Consultants and Specialists Association and the British Medical Association currently have open ballots. They close on 20th January 2023 and 20th February respectively. In addition to the Industrial Action involving Trust employees, the Trust has been impacted by the North West Ambulance strike action on 21st and 28th December 2022, and 11th January 2023. Further NWAS strike action will take place on 23rd and 24th January 2023. Extensive planning has taken place in relation to Industrial Action, led by the Trust EPRR Lead, and partnership working mechanisms are in place with Staff Side colleagues to ensure that patient safety and staff support are prioritised.
1.2	**Infection, Prevention and Control (IPC) Update** The Trust has seen a number of infection control challenges throughout December due to the increasing number of winter viruses circulating. Despite the reduced numbers of COVID cases in the hospital (15-25), larger numbers of patients acutely unwell with flu required hospitalisation. This resulted in 4 wards being converted to flu cohort areas in mid-late December. These numbers have since reduced from 75 in December to approximately 30 patients with flu occupying hospital beds in early January. The Trust has also seen an increased number of children attending the hospital with respiratory viruses, and this spiked during December due to the awareness campaign associated with Streptococcus A. The Trust did not see any pressure on Paediatric beds due to the need to admit and children with Streptococcus A, although larger numbers of admissions were required due to other children's respiratory viruses such as Respiratory Syncytial Virus (RSV) and Acute Bronchitis. Cases of norovirus and C.difficile have also been seen during the period, however there has been no spread of this to other areas by ensuring strict infection control measures. A steady continued reduction in the number of C.difficile cases is now being seen due to the actions taken as part of the Wirral wide and Trust CDT improvement plans.
1.3	**Oxygen Cylinders** Nationally there have been supply issues with portable oxygen cylinders. The Trust has monitored local supply daily throughout this period enabling any potential risks to be mitigated with local action. As a result, no mutual aid requests have been required, and no patient safety incidents related to oxygen have been reported. Governance of medical gases is being monitored via the Medical Gases Group overseen by the Chief Nurse and is reporting through Patient Safety Quality Board.
1.4	**Acuity & Dependency Audit** The Trust was due to commence Shelford Acuity and Dependency studies from the beginning of January to inform the Chief Nurse 6-month staffing review. This has been deferred due to the requirement to provide a robust accurate consecutive 21-day acuity study as the ability to do this will be impacted by planned North-West Ambulance and

	RCN industrial action. Due to this, Acuity and Dependency studies are now planned to commence in late January although this will need to be actively reviewed if more industrial action risks accuracy of the audits.
1.5	**Patient Experience Strategy Update** As part of the work led through the Patient Experience Strategy the Trust has commenced the work to support patients' pre-admission with orientation videos of clinical areas. Pilot videos have recently been filmed in our Endoscopy Unit and Surgical Elective Admissions Unit (including the sensory area used to support those with learning disability and autism). This initiative aims to ease the anxiety of patients attending for treatment. These are currently being viewed and evaluated in partnership with MENCAP colleagues to ensure they are suitable for all groups of patients who may require treatment.
1.6	**Renal Dialysis Unit at Arrowe Park Hospital** In December 2022, the Trust opened the new Renal Dialysis Unit at Arrowe Park Hospital, following a £2.8m capital investment, which relocated the Unit to new premises on the Ground Floor of Arrowe Park Hospital. This major upgrade included new ward areas, procedural rooms, waiting areas and staff rooms, along with new ventilation and air conditioning systems, improving patient experience and staff wellbeing.
1.7	**Urgent and Emergency Care Upgrade Programme at Arrowe Park Hospital** Throughout autumn 2022, preliminary and enabling works were undertaken to prepare for the construction of the new urgent and emergency care precinct at Arrowe Park Hospital. This enabling works included the formation of a new road and patient drop off, relocation of ambulance bays and construction of a new ambulance canopy, relocation of the main Accident and Emergency Department reception and entrance and relocation of the Urgent Treatment Centre. Following the completion of these enabling works in November 2022, Tilbury Douglas Constructions commenced Phase 2 construction of the new Urgent and Emergency Care Precinct. This phase includes the construction of the new paediatric emergency suite and waiting areas, resuscitation rooms and bereavement suite. Further phases are due to commence from the autumn of 2023.
1.8	**Accreditations and Awards** The Trust has been successful in gaining the NHS Pastoral Care Quality Award. This has been awarded to recognise the Trust's work in international recruitment and its commitment to providing high-quality pastoral care to internationally educated nurses during recruitment processes and during their employment. The Digital Healthcare Team in July was assessed by the North West Informatics Skills Development and achieved the Excellence in Informatics Level 1 accreditation and was now working towards achieving level 2. The Library and Knowledge Services Team were awarded a Service Improvement Award by Knowledge and Library Services North. The team received the award for their outstanding work in creating online video tutorials to support staff and students to access the basic and advanced features of the new discovery platform, known as the Knowledge Hub.

1.9	**Serious Incidents** The Trust declared 3 serious incidents in November, which occurred within the Medicine Division. The Serious Incident Panel report and investigate under the Serious Incident Framework to identify learning. Duty of Candour has been commenced in line with legislation and national guidance. **Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS)** There was one RIDDOR incident reported to the Health & Safety Executive (HSE) in November. All RIDDOR incidents are subject to a local review investigation to ensure appropriate action is taken to prevent a similar reoccurrence.
1.10	**Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** The CMAST Leadership Board met on an informal basis in both December and January. On 2 December the group considered the current facts and planned responses to then proposed strike action in a discussion led by the ICB workforce team. Further business considered by the Board included: • A review and proposed refresh of the ongoing work on pathology hubs being led by the Diagnostics Programme Board – we expect this refresh to result in an updated timetable for delivery that may, in time, require Trust decision making • Outcomes and conclusions of the Clinical Pathways Programmes, to date, on orthopaedics. This included a number of collaborative and improvement initiatives that did not require significant service change. Clinically and operationally led collaborative recommendations for optimising current system capacity were commended by the Board • A discussion on the impact and imperatives in urgent and emergency care arising from recent system pressures • NHSE Provider Collaborative Innovator Scheme expressions of interest process The Board next met on 6 January as a shorter meeting in recognition of the ongoing significant operational pressures. The discussion was used to provide space for sharing and reflection covering the following areas: • Current system pressures, hospital discharges and the ICB role as a system coordinator and convenor • Reflection from recent strike experiences and a look forward to proposed future industrial action • Cheshire and Merseyside orientation on the anticipated approach to responding to NHSE Planning requirements
1.11	**Hewitt Review** In November, the Chancellor announced an independent review into the efficiency, autonomy, and accountability of integrated care systems (ICSs), led by Rt Hon Patricia Hewitt.

	According to the terms of reference, published in early December, “the review will consider how the oversight and governance of ICSs can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social Care, and on the availability and use of data across the health and care system for transparency and improvement. It will cover ICSs in England and the NHS targets and priorities for which integrated care boards (ICBs) are accountable, including those set out in the government’s mandate to NHS England. In particular it will consider and make recommendations on: • how to empower local leaders to focus on improving outcomes for their populations, giving them greater control while making them more accountable for performance and spending • the scope and options for a significantly smaller number of national targets for which NHS ICBs should be both held accountable for and supported to improve by NHS England and other national bodies, alongside local priorities reflecting the particular needs of communities • how the role of the Care Quality Commission (CQC) can be enhanced in system oversight.” Interim findings were due on 16 December to feed into the 2023/24 planning guidance, with a draft report by the 31 January 2023 and a final report by 15 March 2023.

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

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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 8**
25 January 2023

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

Report Purpose and Recommendations

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

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

For unscheduled care, the report details performance and highlights the ongoing challenges with long length of stay patients and the impact this has on Urgent and Emergency Care (UEC) performance. The report also highlights the number of patients who remain in the department for longer than 12 hours since arrival and the key performance metrics for the Emergency Department (ED) and the hospital occupancy challenges given the very high volumes of patients in the acute bed base that do not have a criteria to reside.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

- Delivering timely and safe care for patients awaiting elective treatment
- Performance against the core UEC standards

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

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

1	Introduction / Background
1.1	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the National Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to clear the backlog of patients awaiting their elective care pathway and benchmarks well within Cheshire and Merseyside in terms of elective performance. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. Through the pandemic unscheduled care performance was extremely challenged and this continues with the high bed occupancy levels within the Trust which in turn impacts on the elective recovery programme.

2	Planned Care
2.1	**Elective Activity** For FYE 2022/23 the elective activity has been profiled against the corresponding periods in 2019/20. In December 2022, the Trust attained 101.1% against a plan of 109.8% for Outpatients. For elective admissions 116.2% of activity was delivered against a target of 109.0%. **Outpatient activity by POD** **Elective activity by POD** In line with the Trust recovery plans elective activity for December was positive notwithstanding the significant pressure on hospital occupancy.
2.2	**Priority 2 Performance (P2)** The Trust did not meet the P2 month end trajectories for December with the final position over reporting 111 P2 breaches against a month end plan of 18. All P2 patients are reviewed by the clinical team to ensure the most urgent patients are prioritised for treatment but due to the significant increases in demand it is challenging to accommodate P2 patients within the timeframes required. There are significant challenges within two specialities namely Urology and Colorectal and specialty level recovery plans have been developed across the areas for presentation to the Chief Operating Officer in January 2023.
2.3	**Referral to Treatment**

	Target	Actual
New	111.0%	94.3%
F/UP	109.2%	104.0%
Combined	109.8%	101.1%

	Target	Actual
Day Case	111.1%	117.6%
Inpatients	98.1%	108.8%
Combined	109.0%	116.2%

	The national standard is to have no patients waiting over 104 weeks in December 2022 and to eliminate routine elective waits of over 78 weeks by April 2023 and 52 week waits by March 2024. The Trust's performance at the end of December against these indicators (pre RTT freeze and final validation) was as follows: • 104+ Week Wait Performance – zero patients waiting • 84+ Week Wait performance – 17 patients with a plan of 0 (local C&M target) • 78+ Week Wait Performance - 74 patients with a plan to be compliant with zero patients waiting longer than 78 weeks by the end of the financial year • 52+ Week Wait Performance - 1313 patients • Waiting List Size - there were 37,616 patients on an active RTT pathway which is higher that the Trust's trajectory of 31,454 (local C&M target)
2.4	**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 – 2WW referrals continue to rise with the volume received in October 2021 being 1758 compared to October 2022 @ 1968 (November data unavailable at the time of writing this report). Colorectal, Urology, Gynaecology and Breast services have seen significant increases in the number of patients referred on the 2 weeks wait pathway and accommodating all patients within the 14 days is a challenge. • Faster Diagnosis Standard – was 75.16% in October against a target of 75%. Performance is becoming challenging given the increase in 2 WW referrals. • All other targets - all targets for the quarter are predicted to be non-compliant apart from 31-day subsequent drug in line with the recovery trajectory. As with all Trusts across C&M delivery against the 31- and 62-day indicators remains a priority but given the increases in demand the recovery of performance against the targets will be a longer term improvement plan. • Colorectal have commenced a weekly working group to completely review pathways which is being led by the Divisional Director.
2.5	**DM01 Performance – 95% Standard** In November 88.00% of patients waited 6 weeks or less for their diagnostic procedure for those modalities included within the DM01 a 1.2% improvement from October. This is against the national standard of 95%. All modalities achieved the 95% compliance target with the exceptions of barium and urology. Endoscopy achieved 95.8% which is a huge achievement given the performance in the previous quarter. Additional capacity has been secured for urology and improvements against the 6-week target will be evident from December. It should be noted that the cystoscopy backlog includes planned patients exceeding six weeks from their target scope date. This is a change in year as previously planned patients were not on an active waiting list (standard across the NHS) and they now are included to ensure the Trust is sighted on this patient group. Once the cystoscopy backlog is cleared, the Trust will achieve DM01 compliance.
2.6	**Risks to recovery and mitigations** The clinical divisions are progressing through their plans outlined in the previous updates including insourcing, outsourcing and the exciting progress made with the Cheshire and Merseyside Surgical Centre (Clatterbridge) providing much needed additional theatre capacity which has now opened. The major risk to the delivery of the elective recovery programme is the continually high bed occupancy levels and the risk that this poses to maintaining the ringfenced and

	protected elective beds, particularly given the number of patients that do not have a criteria to reside still being in the region of 200 per day. The Chief Operating Officer has direct oversight of this challenge, and the use of the elective beds does not form part of the Trust's Winter Plan. The impact of the high occupancy has led to cancellations of surgical routine patients in January following the unprecedented demand over the Christmas and New Year period and the need to ensure the safety of the site. The Royal College of Nursing strike action across two days in January will significantly impact elective and cancer services with all patients being cancelled on the two days.

3 Unscheduled Care

3.1 Performance

December Type 1 performance was down by 1.91% on December and we rank 25th out of 41 Trusts in the Northwest (includes Children's Hospitals), however the Trust continues to perform well in terms of overall 4-hour performance and is ranked 5th out of the 41 Trusts.

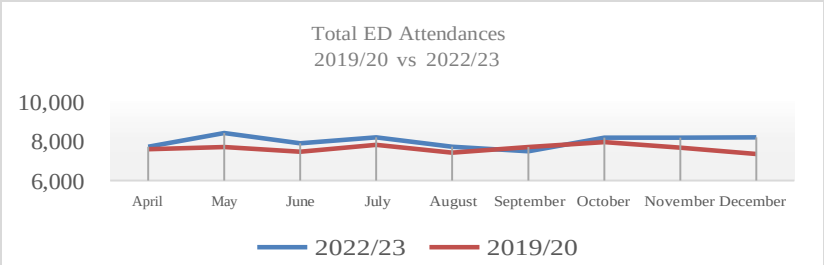
Type 1 ED attendances:

- 8,167 in November (avg. 272/day)
- 8,195 in December (avg.264 /day)
- 2.9% decrease per day in month

Type 3 ED attendances:

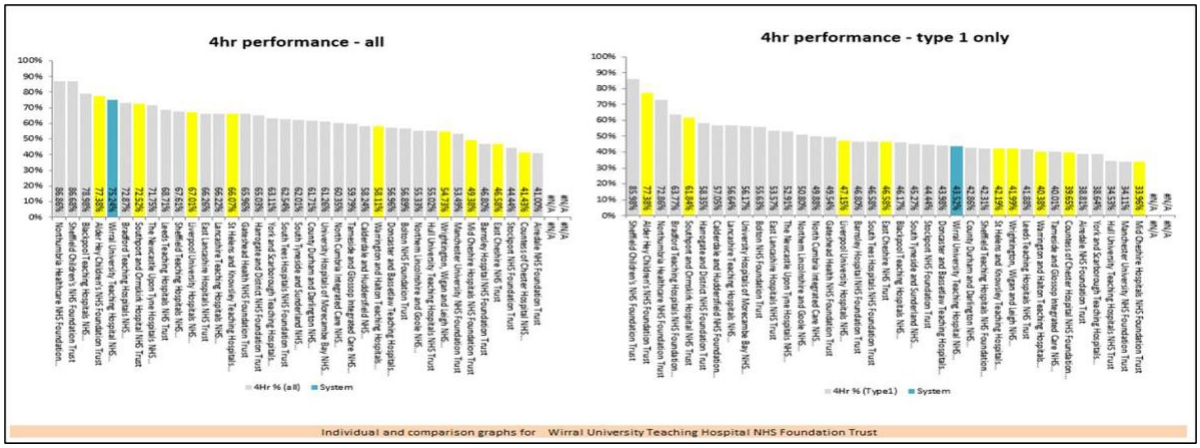
- 3,078 In November
- 3,903 in December
- 26% increase

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



Month	2022/23	2019/20	YoY Variance	% Var
April	7,707	7,585	122	1.6%
May	8,407	7,696	711	9.2%
June	7,891	7,455	436	5.8%
July	8,185	7,813	372	4.8%
August	7,713	7,407	306	4.1%
September	7,483	7,691	-208	-2.7%
October	8,169	7,948	221	2.8%
November	8,167	7,665	502	6.5%
December	8,195	7,345	850	11.6%

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



Phase 2 of the works, the relocation of the existing Urgent Treatment Centre (UTC) to the old Discharge Lounge is continuing to progress. The handover to the UTC team is expected to take place early January, allowing work on the new CDU and Ambulance Arrival Zone to start earlier than planned.

The final report of the GP trial with SPA was presented in December with a number of key findings that came out of the trial. The results of this trial will feed into the same day emergency care (SDEC) transformation for new pathways that do not currently exist. The trial also demonstrated the need for all pathways to be clearly identifiable and for clinicians in the community to refer into the most appropriate service as there were a significant number of patients diverted away from the hospital.

The Trust led a multi-agency discharge event (MADE) in early December which focused on reducing the number of NCTR patients and accelerating discharges for those patients on pathway 0. The event was successful, particularly for patients with complex needs. The Trust and system partners have noted a number of actions and findings which will be reviewed in early January. The action plan has also been developed to ensure that areas of opportunity to improve flow from hospital are followed up and addressed.

3.2 Risks and mitigations to improving performance

UECUP Phase 1 works were completed in November. Phase 2 has commenced following the opening of the new ambulance bay and ambulance entrance. The new ambulance entrance is further from the main department whilst UECUP works are ongoing. The new entrance is isolated from the reception area and the ambulance triage nurse, but actions have been taken to reduce the risk and is reviewed daily. Security for staff on the new walk-in entrance in ED has been implemented as there is no clear line of sight across the whole pathway due to the number of corners and poor visibility. There is now a large foyer area which is a risk to the department at the front of the new entrance where patients can potentially congregate before going to reception or the waiting room. This is currently mitigated with dedicated security in the department and options are being drawn up to reduce the space with a temporary wall.

Concerns moving into winter that the boarding time in department will increase due to bed pressures and the risk of increasing 12 hour decision to admit (DTA) and this is something experienced through December and early January. The Trust is reviewing the Trust escalation policy to ensure prompt action is taken when ED is facing extreme

	pressure and has implemented the Full Capacity Protocol regularly through December, sharing risk across the Trust. Occupancy of the ED is a major concern with excessive numbers of patients in the waiting room and patients experiencing delays on corridors. This is directly linked to the occupancy of the hospital with a significant contributor being patients that do not have a criteria to reside which pre-pandemic was below 100 and now resides at 200 patients per day.

4.0	Conclusion
	The Board of Directors should note that with 35% of the total bed base occupied by patients that require another care setting there is a significant risk of not improving performance across the UEC pathways and the elective programme, and not being able to provide the optimal patient experience at times of high demand through the ED. The Chief Operating Officer along with the Clinical Divisions and system partners are continuing to consider alternative ways of working to mitigate and reduce risks raised with the surge in demand experienced during December and early January. At present there are few systemwide solutions to resolve the current challenge with the criteria to reside patients occupying acute beds and this has been escalated through Place and the Integrated Care Board.

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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
25 January 2023

Item No: 9.1

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

Report Purpose and Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of November 2022.

It is recommended that the Board:

- notes performance to the end of November 2022

Key Risks

This report relates to the key Risks of:

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

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

1	Narrative
1.1	Of the 49 indicators that are currently reported against thresholds (excluding Use of Resources): - 31 are off-target or failing to meet performance thresholds - 18 are on-target Following the discussions with the Executive Team and the Board as part of the Performance Management Framework Review, the metrics included in the Quality & Performance dashboard have been assessed for continued inclusion, alongside the relevant thresholds.

	Some thresholds only apply from April 2022 onwards as they are components from the 2022/23 operational plans. Further development work is continuing to clarify the precise definitions and thresholds on a small number of metrics. Amendments to previous metrics and/or thresholds are detailed below the dashboard.

2	Implications
2.1	The issues and actions undertaken for those metrics that are not meeting the required standards are included in the additional exception reports or covered within the Chief Operating Officers Report.

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

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Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	2022/23	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	CN	≤0.24 per 1000 Bed Days	WUTH	0.19	0.18	0.18	0.22	0.04	0.22	0.09	0.09	0.33	0.17	0.13	0.04	0.09	0.14	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	97.2%	96.9%	96.7%	96.2%	96.4%	96.8%	96.9%	96.6%	96.5%	96.3%	96.5%	96.8%	97.1%	96.9%	
	Never Events	Safe, high quality care	CN	0	SOF	0	1	0	1	0	0	0	0	0	0	1	0	0	1	
	Clostridioides difficile (healthcare associated)	Safe, high quality care	CN	Maximum 72 for 2022-23. Max 6 cases per month	WUTH	5	3	18	12	13	7	8	16	17	15	13	12	12	110	
	Gram negative bacteraemia : e coli	Safe, high quality care	CN	Maximum 56 for 2022-23. Max 4 cases per month	National	-	-	-	-	-	8	4	9	12	10	6	5	5	70	
	Gram negative bacteraemia : klebsiella	Safe, high quality care	CN	Maximum 19 for 2022-23. Max 1 case per month	National	-	-	-	-	-	0	4	1	3	6	3	2	4	28	
	Gram negative bacteraemia : pseudomonas	Safe, high quality care	CN	Maximum 9 for 2022-23. Max 0 cases per month	National	-	-	-	-	-	0	0	0	0	1	0	0	1	3	
	MRSA bacteraemia hospital acquired	Safe, high quality care	CN	0	National	0	0	0	1	0	0	0	0	0	0	0	0	2	2	
	Pressure Ulcers Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	0	1	1	1	4	0	0	1	0	0	0	0	5	
	Medicines Storage Trust wide audits % of standards fully compliant for all areas Trust wide	Safe, high quality care	CN	≥90%	WUTH	96%	96%	94%	95%	92%	89%	91%	96%	97%	95%	95%	95%	96%	94%	
	Safeguarding Audits	Safe, high quality care	CN	≥90%	WUTH	-	-	-	-	82.6%	71.6%	93.5%	89.6%	94.7%	85.0%	No audits completed	No audits completed	94.4%	89%	
	Mandatory Training compliance	Safe, high quality care	CPO	≥90%	WUTH	90.5%	90.4%	89.0%	87.2%	87.2%	87.17%	89.21%	90.39%	89.73%	90.59%	90.34%	89.78%	90.25%	91.0%	
	Sickness Absence % (12 month rolling average)	Safe, high quality care	CPO	≤5%	SOF	6.24%	6.40%	6.48%	6.53%	6.70%	6.79%	6.83%	6.89%	6.94%	6.90%	6.87%	6.87%	6.89%	14.5%	
	Sickness Absence % (in month rate)	Safe, high quality care	CPO	≤5%	SOF	6.37%	7.86%	8.72%	7.05%	7.73%	6.84%	6.23%	6.50%	7.08%	5.98%	6.33%	6.81%	6.60%	6.64%	
	Staff turnover % (rolling 12 month rate)	Safe, high quality care	CPO	≤10%	WUTH	13.2%	13.4%	13.7%	13.9%	14.1%	14.1%	14.4%	14.4%	14.1%	13.9%	15.29%	14.01%	14.37%	14.5%	
	Care hours per patient day (CHPPD) number of wards below 6 1	Safe, high quality care	CN	No of wards ≤3	WUTH	-	-	-	-	3	1	4	5	4	7	8	11	6	6	

	Indicator	Objective	Director	Threshold	Set by	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	2022/23	Trend
Effective	Nutrition and Hydration MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	93.8%	92.6%	91.7%	96.7%	96.9%	94.6%	97.1%	97.9%	95.7%	96.5%	94.8%	95.6%	95.2%	95.7%	
	Nutrition and Hydration MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	95.5%	94.6%	95.2%	97.3%	96.3%	97.7%	98.2%	98.9%	98.5%	98.1%	97.7%	97.0%	98.7%	98.0%	
	Long length of stay number of patients in hospital for 21 or more days	Safe, high quality care	MD / COO	Maintain at a maximum 79 (Revised April 2022)	WUTH	141	157	206	195	187	220	194	211	214	226	251	229	236	218	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	82.0%	77.9%	77.2%	77.9%	83.7%	79.3%	83.1%	80.9%	82.0%	84.7%	86.8%	85.3%	85.9%	81.5%	

	Indicator	Objective	Director	Threshold	Set by	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	2022/23	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	3	8	3	2	3	1	1	1	5	1	3	3	5	21	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	72.4%	77.7%	75.9%	77.3%	67.2%	74.0%	74.7%	77.4%	73.6%	78.2%	82.4%	76.2%	76.5%	76.7%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	95.1%	94.4%	95.4%	94.5%	92.3%	94.8%	94.1%	93.1%	95.6%	94.2%	95.1%	95.1%	95.9%	94.8%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	93.7%	94.3%	94.3%	94.1%	93.6%	93.5%	94.3%	93.5%	94.6%	94.1%	94.0%	94.0%	94.2%	94.1%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	94.7%	94.6%	96.6%	93.5%	97.7%	93.1%	98.0%	100.0%	96.9%	100.0%	100.0%	100.0%	100.0%	98.7%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	2022/23	Trend
Responsive	4 hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	≥95%	National	59 5%	60 6%	59 1%	63 1%	61 5%	63 1%	63 4%	64 5%	62 3%	63 6%	66 4%	62 7%	63 9%	63 8%	
	Patients waiting longer than 12 hours in ED from a decision to admit	Outstanding Patient Experience	COO	0	National	6	6	13	7	17	39	24	17	69	155	18	59	182	662	
	Time to initial assessment for all patients presenting to A&E % within 15 minutes	Safe, high quality care	COO	100%	National	49 8%	57 2%	57 3%	61 7%	54 0%	52 5%	53 5%	58 6%	53 6%	57 9%	60 9%	52 8%	55 8%	55 2%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	0%	National	9 4%	8 8%	11 0%	8 1%	11 6%	13 7%	10 7%	10 5%	14 6%	14 1%	10 8%	14 5%	13 6%	13 1%	
	Proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed	Safe, high quality care	COO	TBD	National	78.9%	74.6%	73.9%	82.4%	86.9%	91.2%	85.1%	86.1%	90.6%	90.2%	87.3%	90.7%	88.5%	89.1%	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	22 8%	19 2%	18 0%	15 5%	25 2%	23 9%	21 9%	18 5%	16 0%	12 5%	16 2%	24 3%	17 5%	19 1%	
	18 week Referral to Treatment Incomplete pathways < 18 Weeks	Safe, high quality care	COO	≥92%	SOF	70 14%	67 84%	67 57%	65 89%	65 38%	64 08%	66 72%	65 46%	64 80%	64 77%	62 40%	61 85%	61 57%	57 75%	
	Referral to Treatment total open pathway waiting list	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	27046	27406	28665	29445	30430	31504	32373	33306	34933	35742	37030	37157	37188	37460	
	Referral to Treatment cases exceeding 52 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	510	557	475	525	582	730	811	1028	1119	1122	1245	1279	1219	1321	
	Referral to Treatment cases waiting 78+ wks	Outstanding Patient Experience	COO	NHSEI Plan Trajectory 2022-23	National	70	72	59	65	60	70	73	82	91	62	60	55	47	71	
	Referral to Treatment cases exceeding 104 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	5	5	4	5	1	0	0	0	8	0	0	0	0	0	
	Diagnostic Waiters, 6 weeks and over DM01	Safe, high quality care	COO	≥95% (from April 2022)	SOF	93 0%	89 8%	87 3%	86 4%	85 2%	82 8%	86 0%	87 2%	87 5%	85 3%	85 3%	86 8%	88 0%	86 2%	
	Cancer Waiting Times 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	87.9%	91.4%	76.2%	78.0%	76.2%	85.8%	96.6%	94.6%	94.4%	91.9%	78.7%	88.3%	92.0%	90.3%	
	Cancer Waiting Times 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	-	91 63%	-	-	76 7%	-	-	92 5%	-	-	88 4%	-	-	90 4%	
	Cancer Waiting Times % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	94.3%	94.8%	94.6%	95.1%	92.6%	91.2%	96.5%	96.4%	96.1%	94.7%	96.2%	97.3%	97.0%	95.7%	
	Cancer Waiting Times % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	-	94 85%	-	-	94 1%	-	-	94 9%	-	-	95 6%	-	-	95 3%	
	Cancer Waiting Times 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	79.7%	79.3%	79.6%	79.3%	75.9%	79.2%	79.6%	75.7%	79.9%	81.5%	73.8%	73.1%	74.4%	77.1%	
	Cancer Waiting Times 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	-	79 38	-	-	78 1%	-	-	78 2%	-	-	78 2%	-	-	78 2%	
	Cancer Waits reduce number waiting 62 days +	Outstanding Patient Experience	COO	NHSEI 2022/23 plans trajectory - revised 07/10/22	National	n/a	n/a	n/a	n/a	81	97	118	152	167	158	200	200	173	177	
	Cancer Faster Diagnosis Standard	Outstanding Patient Experience	COO	≥75% within 28 days	National	79.2%	80.5%	70.5%	78.9%	79.5%	76 7%	75 4%	78 3%	79 6%	76 6%	71 8%	75 2%	73 8%	75 9%	
	Patient Experience: Number of concerns received in month Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	177	149	180	187	211	170	185	174	207	191	234	187	178	184	
	Patient Experience: Number of complaints received in month per 1000 staff Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	3 27	3 26	2 34	4 87	3 05	4 50	3 96	2 88	4 13	5 02	3 57	3 54	3 17	3 56	
	Formal Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	61%	100%	100%	100%	100%	100%	86%	100%	91%	96%	100%	80%	100%	95%	
	Number of re opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	4	3	2	0	0	2	2	1	3	0	5	4	1	2	
	NEWS2 Compliance	Outstanding Patient Experience	MD/CN	≥90%	WUTH	-	-	-	-	85%	85 2%	88 3%	89 7%	89 1%	89 6%	90 3%	89 4%	89 2%	89%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	2022/23	Trend
Well led	Duty of Candour compliance breaches of the DoC standard for Serious Incidents	Outstanding Patient Experience	CN	0	WUTH	-	-	-	-	-	0	1	0	0	0	0	0	0	1	
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	700 for FY 22/23 (cumulative 59 per month until year total achieved)	National	958	1121	1445	1575	1666	21	59	85	110	147	213	255	326	354	
	% Appraisal compliance	Safe, high quality care	CPO	≥88%	WUTH	82 7%	82 3%	82 0%	78 0%	77 9%	77 2%	83 2%	85 2%	86 2%	86 7%	88 58%	88 25%	88 36%	88 4%	

	Indicator	Objective	Director	Threshold	Set by	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	2022/23	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	07	06	23	01	01	10	04	02	04	05	06	09	07	12	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	10	09	19	05	03	09	03	12	06	07	09	08	06	11	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	20	20	20	20	20	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	
	CIP Performance (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	77 21%	48 24%	78 70%	78 61%	91 33%	7 26%	45 26%	47 60%	57 50%	51 00%	55 00%	45 00%	49 00%	21 77%	
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	25 1%	67%	43%	80%	15 0%	43 9%	316 0%	88 0%	218 8%	216 0%	233 0%	171 0%	142 0%	121 0%	
	Cash liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	159	180	162	186	200	214	120	166	164	214	235	260	380	379	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	36 3%	48 0%	59 0%	76 2%	100 0%	07%	14%	40%	87%	13 0%	17 9%	25 3%	31 5%	38 4%	

Metrics Added

Metrics Amended

Safe Domain

Wirral University Teaching Hospital NHS Foundation Trust

Clostridioides difficile (Healthcare Associated)

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:

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

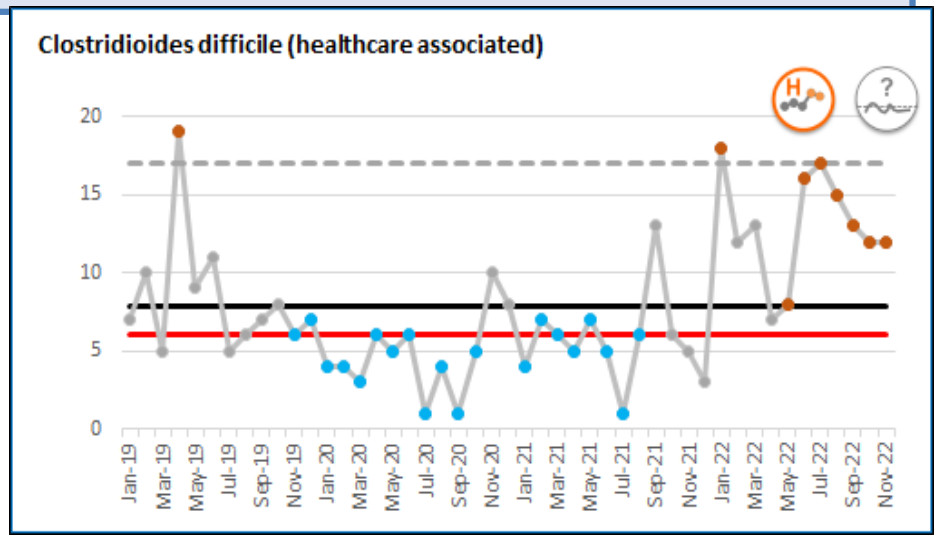
The monthly threshold of 6 has been exceeded each month since April, with 12 cases reported in November. A total of 100 cases since April 2022.

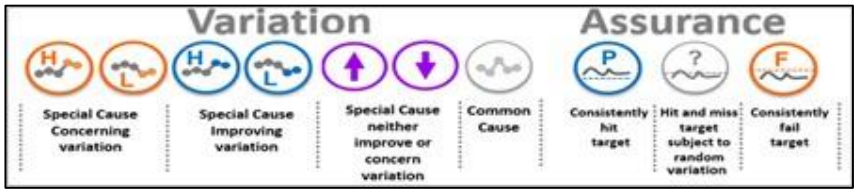
Action:

The CDI quarterly report and improvement plan is governed via the IPC group and directly overseen by the Chief Nurse / DIPC. The Q3 report has continued to evidence positive outcomes with a sustained reduction in the number of CDI's. Collaboration with healthcare partners continues with system wide challenges being addressed through the multi-agency Health Protection Board for Wirral.

Enhanced auditing of the cleaning standards has helped to drive improvements, resulting in a proactive approach and clearly defined roles and responsibilities of the cleaning teams and the ward staff. This has promoted immediate rectification and improvement in the effectiveness environmental cleaning process.

Review of IPC isolation priorities have strengthened clinical teams' decision making to enable a risk assessed approach to inform the order of patient isolation. This will ensure the transmission of infection between





patients is minimised during the current bed capacity challenges evident throughout the Trust.
Expected Impact: Sustained reduction in patients diagnosed with healthcare associated *Clostridioides difficile* by Q4.

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

Executive Lead: Tracy Fennell, Chief Nurse

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

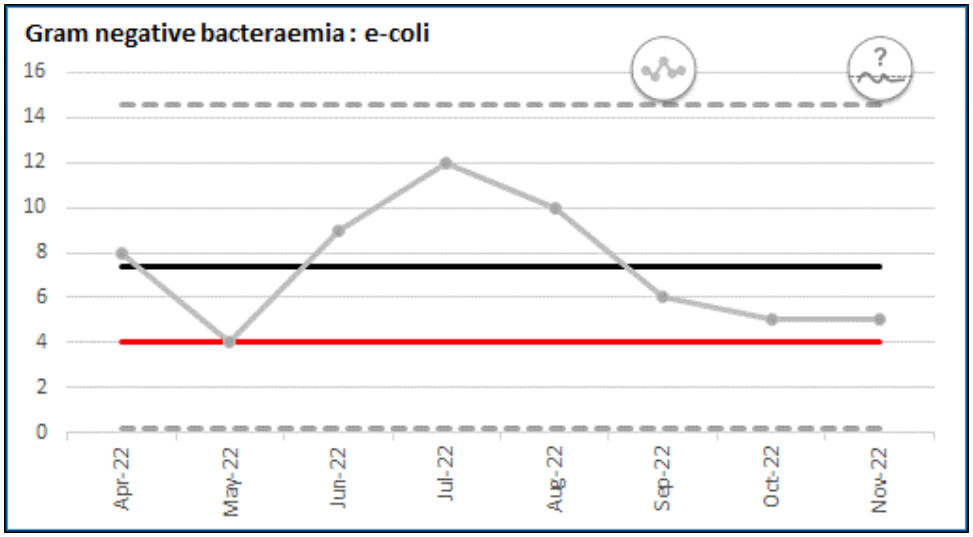
The threshold for *E-coli* bacteraemia is 56, which equates to a maximum 4 per month. From April-December 2022, 61 cases have been reported; 5 patients were diagnosed with an *E-coli* bacteraemia in November 2022.

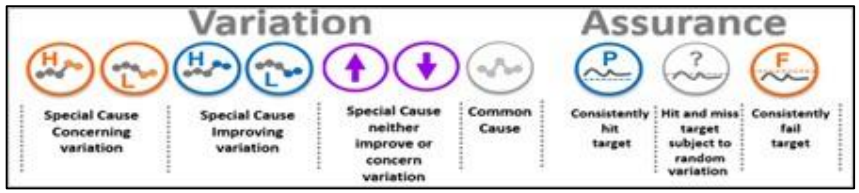
Action:
Individual case scrutiny continues that enables learning opportunities to be identified and remedial actions to be put into place where required.

Many blood stream infections are diagnosed in severely ill patients with no indication that there is a clinical omission in care. Review of the process to determine if a bacteraemia can be avoided is taking place. This will enable heightened focus on patients identified with infections that could be avoided and establish the cause that will inform effective action planning to avoid further cases.

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

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





Gram-Negative bloodstream infections - klebsiella

Executive Lead: Tracy Fennell, Chief Nurse

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

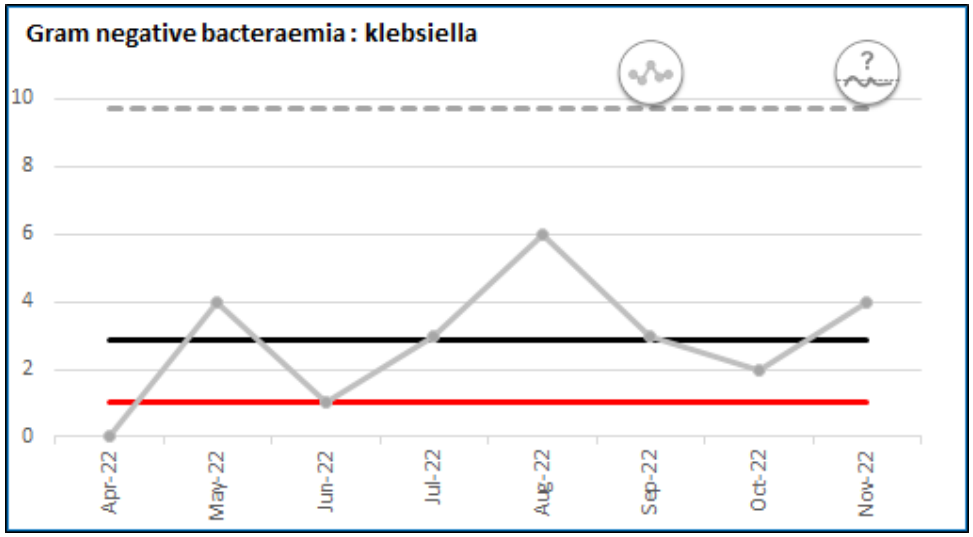
There were 4 cases reported in November 2022, against a threshold of 2. Since April 2022, 28 cases have been reported. Therefore the 2022-23 maximum threshold has been exceeded.

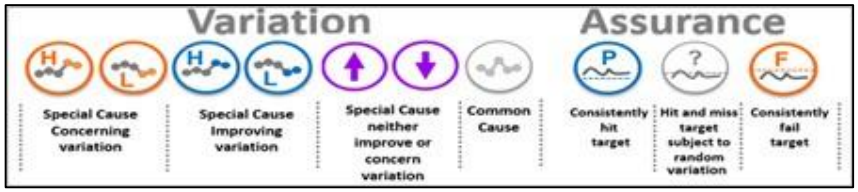
Action:
Klebsiella is a gut organism and common sources identified during the RCA process relate to the management of indwelling devices and intra-abdominal complexities.

Individual scrutiny of each case continues to enable learning opportunities to be identified and remedial actions to be put into place to avoid future harms. Recent reviews have not identified any specific causative factors that could have prevented the blood stream infection.

Effective infection prevention control measures by the multi-disciplinary team are essential. Therefore, the programme of work on aseptic non-touch technique (ANTT) and the 'Gloves off' campaign both have a focus on improved hand hygiene for all staff. ANTT competency framework ensures assessment for all staff undertaking clinical procedures to strengthen the prevention of device-associated infections.

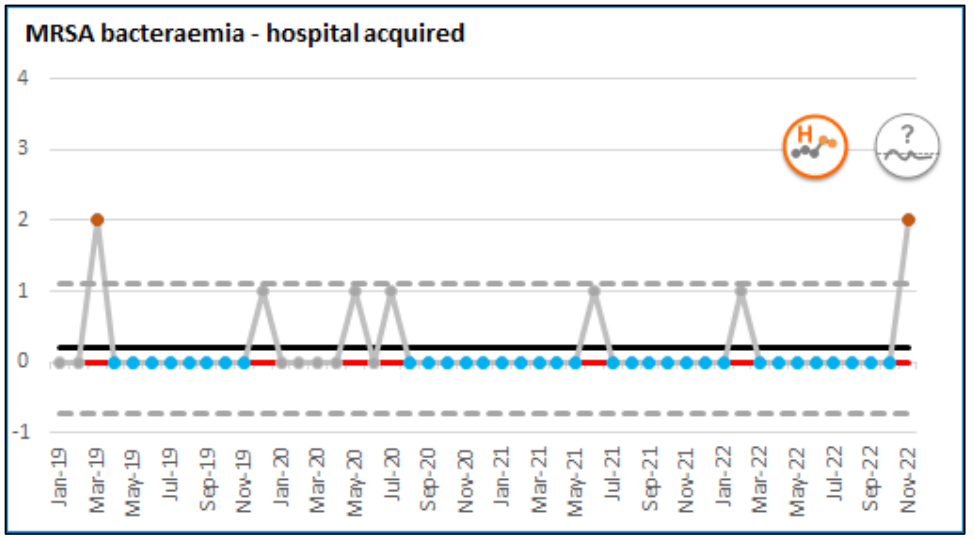
Expected Impact:
The number of patients diagnosed with a *Klebsiella* blood stream infection is reduced to below the monthly threshold.

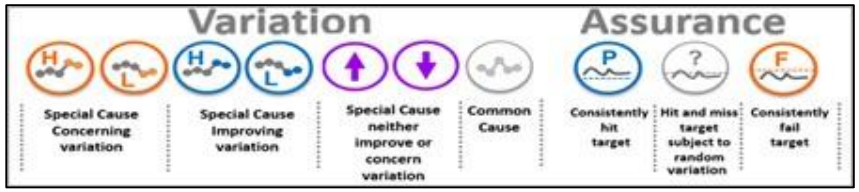




MRSA Bacteraemia – hospital acquired

Executive Lead: Chief Nurse
Performance Issue: Healthcare providers have been set the challenge of demonstrating '*zero tolerance'* of MRSA Bloodstream Infections. All MRSA blood stream infections are subject to a Post Infection Review (PIR). WUTH reported 2 MRSA bacteraemia cases in November 2022. The most recent case before that was in February 2022.
Action: Review of both patients journey prior to diagnosis of the MRSA bacteraemia has been completed: A source of infection was not determined in one case. However, aseptic non-touch technique and blood culture collection training for staff was highlighted as a recommendation. The second case, the patient was diagnosed with a MRSA bacterium when known to be MRSA colonised. Determination of the source of infection is agreed to be most probably due to insertion of a urinary catheter or cannula. Urinary catheter care / management and aseptic non-touch technique are key priority areas of focus within the Trust and as a Wirral wide system.
Expected Impact: Targeted interventions will help to reduce the risk of MRSA bacteraemia.





Sickness absence % (in-month rate)

Executive Lead: Deborah Smith, Chief People Officer

Performance Issue:

The Trust threshold for sickness absence is 5%. For November the indicator is 6.60% and demonstrates common cause variation.

Long term sickness absence accounts for 1.24%, whilst short term sickness absence is more of a challenge at 5.36% in November 2022.

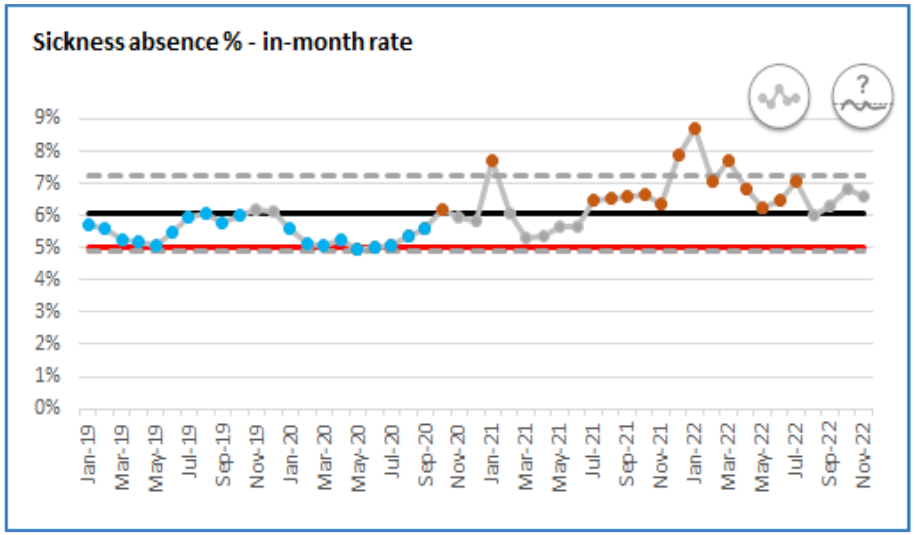
Estates and Ancillary are the staff group with the highest absence rate (10.41%) followed by Additional Clinical Services (9.17%) and this staff group are a particular area of focus.

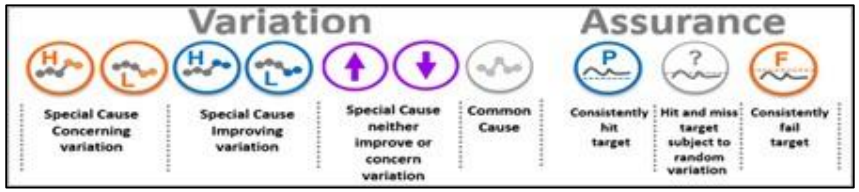
Anxiety, Stress and Depression remains the highest reason for long term sickness absence. The category 'Gastrointestinal problems' was the highest reported reason for short-term sickness, followed by 'Cold, Cough and Flu-Influenza' and 'Infectious Diseases'.

Action:

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

Targeted Support
The highest sickness absence levels remain within Facilities, who are being supported by their HR Team. Facilities are undertaking an analysis of the drivers of the sickness absence and measures in place to address. It is also anticipated that new Attendance Management Policy triggers when implemented, will further support with the persistent short-term absence which is most disruptive to the service.





Managing Attendance Policy
The extensively revised Attendance Management Policy has now been agreed at Policy Pay Terms & Conditions and is progressing via the governance route. In parallel to this, work is progressing on the launch element.

Workforce Wellbeing
The newly appointed Wellbeing Specialist Practitioner will be focusing on reviewing the Trust Health and Wellbeing offer in the Trust, with an immediate focus on supporting staff during and following Industrial Action.

Development
As part of the Leadership for All approach a suite of stand-alone sessions development sessions have been designed. The next upcoming session in January is Building Personal Resilience.

Flu Vaccine
The Flu Vaccine Programme continues. Current uptake amongst frontline Healthcare Workers is 57%, compared to a Cheshire and Merseyside average of 49%.

Expected Impact:

The impact of high sickness is increased pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance and safety.

Risks to Trust financial management, quality, patient safety and operational performance due to cost of sickness absence, expense of bank and agency cover will reduce as the sickness absence is gradually improved over time. We continue to appropriately prioritise workforce wellbeing and our commitment to mental health support.

Staff turnover %

Executive Lead: Deborah Smith, Chief People Officer

Performance Issue:

The Trust threshold for turnover is 0.83%. For November 2022 the indicator was 1.07% and demonstrates common cause variation.

The following staff groups have high turnover in November:

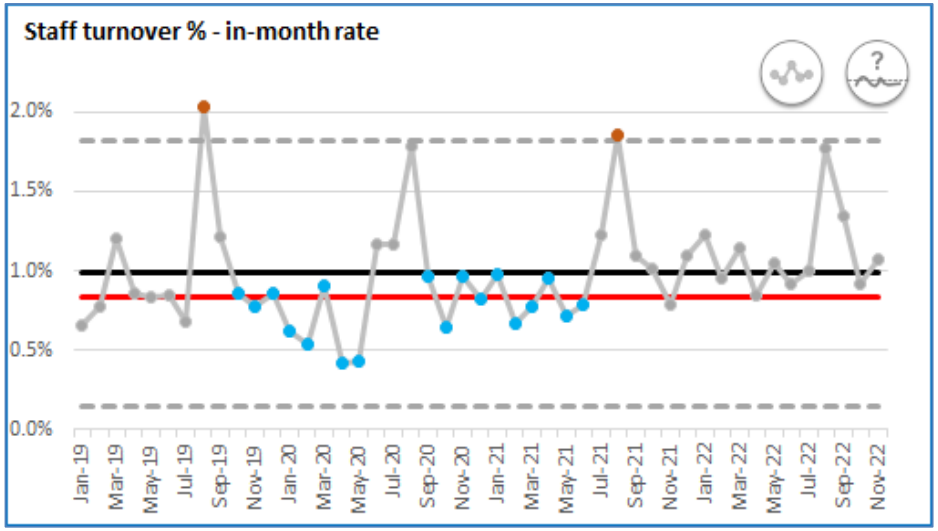
- Add Professional & Technical (2.08%)
- Admin & Clerical (1.56%)
- Allied Health Professionals (1.19%)

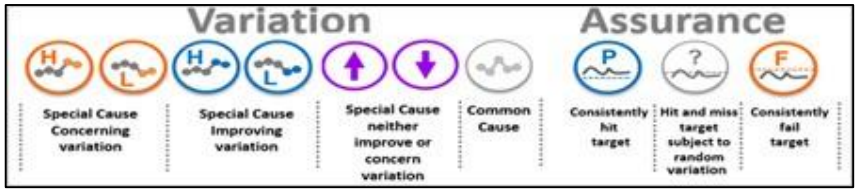
Actions:

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

Current Interventions to support retention include:

- The Retention Delivery Plan was agreed with the Strategic Retention Group and priorities determined.
- Work has commenced with the HR Team and the National ESR Team to improve leaver reasons accuracy in ESR.
- The completed Nursing and Midwifery Retention Self-Assessment Tool has been submitted to the Northwest and ICB Retention Group. Feedback is currently awaited from the Northwest and ICB Retention Group.
- Expressions of interest are currently being sought for the new Leading Teams programme. This is a 6-month programme aimed at staff who have responsibility for leading others as part of their job.
- Use of apprenticeship for HCSW posts. At present there have been 6 cohort starts with a 6-month retention rate of 85%.





Staff Survey and the People Strategy

The Staff Survey closed in November 2022 with a response rate of 48%. Findings will be reported in early 2023 and will be used to inform retention strategies in 2023 and beyond.

There are also other programmes of activity within the People Strategy Delivery Plan that impact on staff experience including health and wellbeing initiatives, reward and recognition, flexible working and improvements in integration and diversity which will also help minimise turnover.

Expected Impact:

The impact of high Turnover increases pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance, and safety.

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

Care Hours Per Patient Day – number of wards below 6.1

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:
The Trust monitors the number of wards that are below a care hours per patient day (CHPPD) threshold of 6.1. The metric for the Trust overall is set at a maximum of 3 wards to be below this threshold.

The number of wards for November 2022 were 6 as follows: Ward 37 - CHPPD 6, Ward 18 - CHPPD 5.9, Ward 22 - CHPPD 5.8, Ward 36 and 38 - CHPPD 5.7 and Ward M1 - CHPPD 5.6.

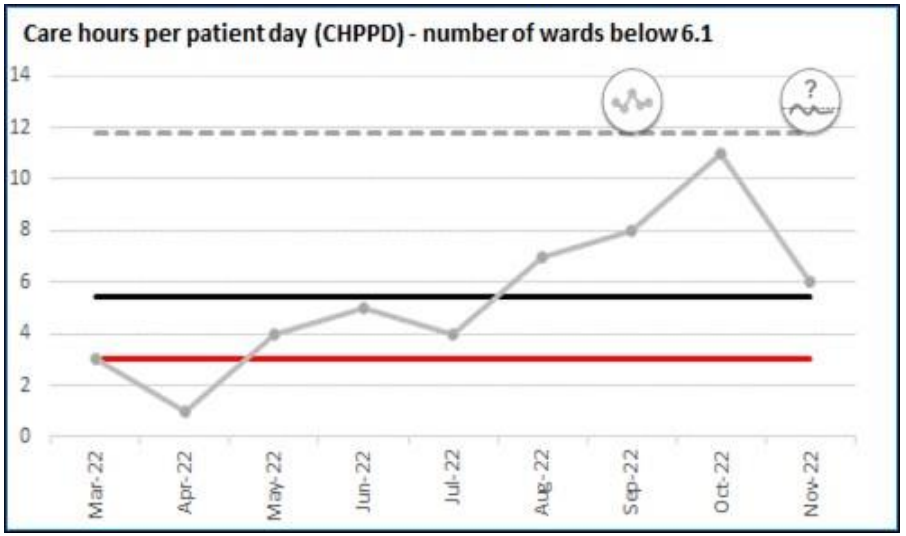
Action:
A CHPPD tracker is one of the safer staffing measures, which has been in place since May 2022, to monitor if any areas are consistently recording CHPPD <6.1. The CHPPD data is triangulated with further staffing metric data to monitor the impact on care. Impacts on care are being monitored and have remained minimal with the areas of lower than threshold CHPPD.

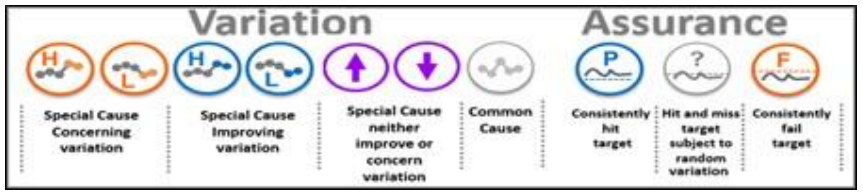
November, with 6 wards below the required threshold is the lowest number of wards below threshold each month since July 2022. Ward 18 has had 2 consecutive months below threshold with a variance of 0.1, equivalent to 6 minutes of nursing care, in November. Ward 22 and 36 have had consecutive months of a CHPPD of <6.1.

Ward M1 provides care to patients who do not have the criteria to reside. Healthcare professional input will not be required at the same level or frequency to that of an acute area. Ward 38 staffing levels had a CHPPD consistently <6.1 since November 2021, this is a result of clinical support worker (CSW) shortfalls created by staff moves to support higher risk staffing challenges across the Trust. Oversight has been provided by the Matron and professional judgement is that the ward has remained safe.

Successful system wide recruitment events have been led by the Trust. A focus on recruitment and retention for CSW and in-patient RN band 5's continues.

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





Caring Domain

Same sex accommodation breaches

Executive Lead: Tracy Fennell, Chief Nurse

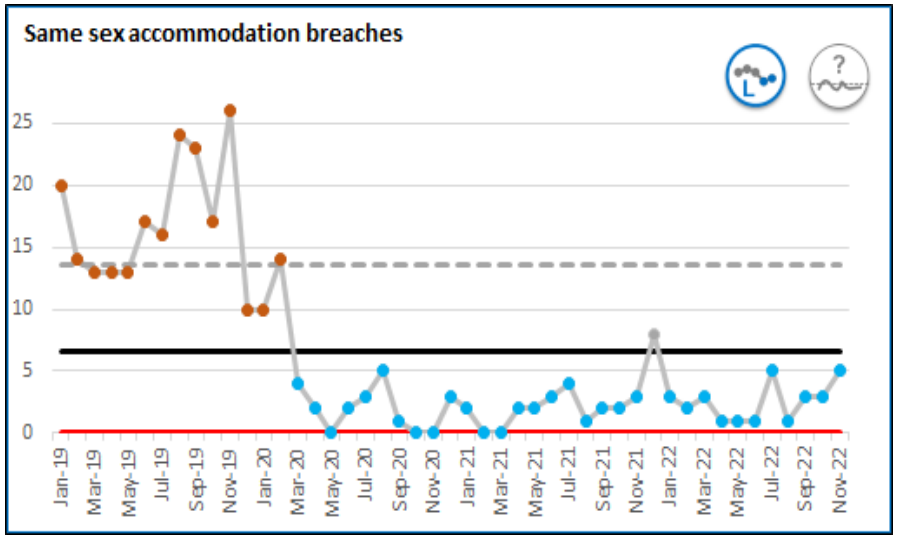
Performance Issue:
The national standard is set that providers should deliver same sex accommodation, except where it is considered in the overall best interests of the patient or reflects personal choice.

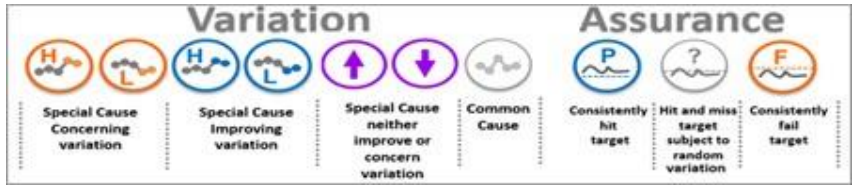
Breaches are often due to patients waiting more than 24 hours for transfer from critical care areas inclusive of Coronary Care Unit (CCU) to general wards; there were 5 such breaches in November 2022. (Intensive Care Unit (ICU) 2 and CCU 3). The breaches did not cause any delays or refused admissions to these areas as sufficient ICU and CCU capacity has been available. Patient's privacy and dignity needs are met whilst the person awaits transfer to the specialty areas and the teams ensure their specialty care is not compromised due to a lengthened critical care stay.

Action:
Delivering same sex accommodation is a high priority. It is recognised that system challenges resulting in high levels of activity and a high proportion of patients with no criteria to reside, which continued throughout November 2022, has an impact on the ability to deliver same sex accommodation.

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

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





Friends & Family Test – Overall Experience

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:
A Trust standard of 95% is set for achieving an overall experience rating of very good or good for each of the main care settings.

Performance against the 95% threshold for November 2022 was:

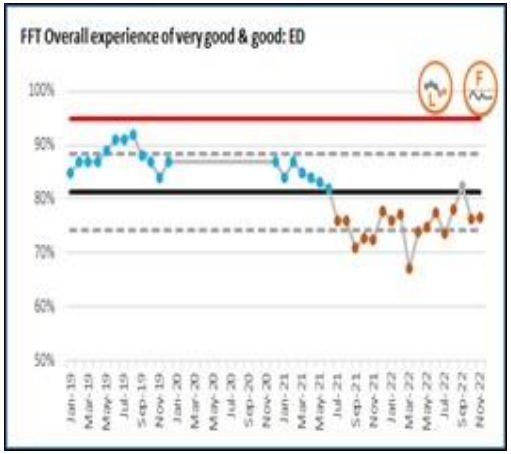
- Emergency Department (ED) – 76.5% (below threshold)
- Inpatients – 95.9% (above threshold)
- Outpatients – 94.2% (below threshold)
- Maternity 100% (above threshold)

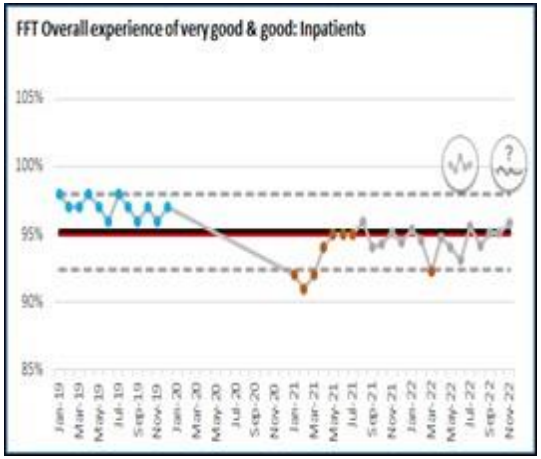
Action:
The Patient Experience Strategy has established 5 strategic promise groups; Welcome, Safe, Inclusive, Care, and Supported. Each promise group has a focus on identifying patients' experience improvement opportunities.

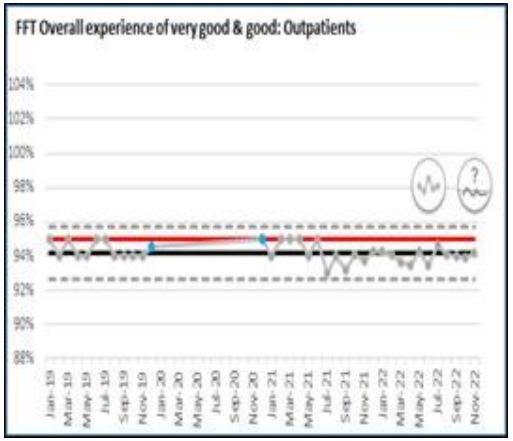
Operational pressures within the Emergency Department, consistent with the national position, is impacting on the FFT score. FFT score for ED remains below the Trust threshold of 95% however is in line with the national average scores for ED. Waiting times are consistently reported to be an area of challenge. Effective communication to patients remains a priority focus for the Divisional Triumvirate.

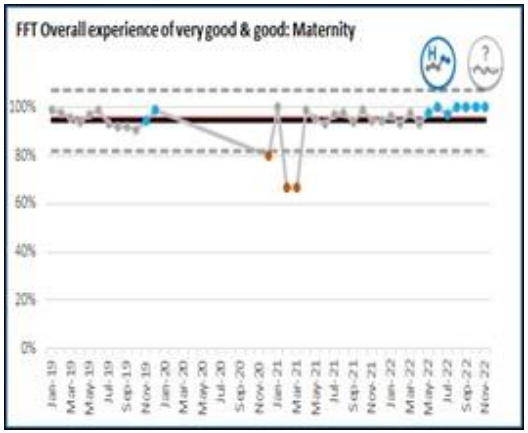
Out-patients FFT score of 94.2%, 0.8% below threshold, is consistent with previous months. Additional touch screen kiosks and feedback volunteers have been introduced to increase the opportunity for feedback in this area.

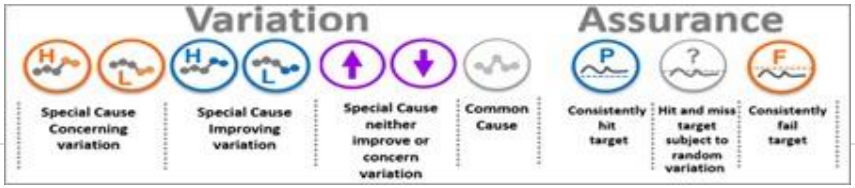
Expected Impact:
Improved FFT scores within the ED and an expectation to reach the Trust target for Outpatients in Q4.







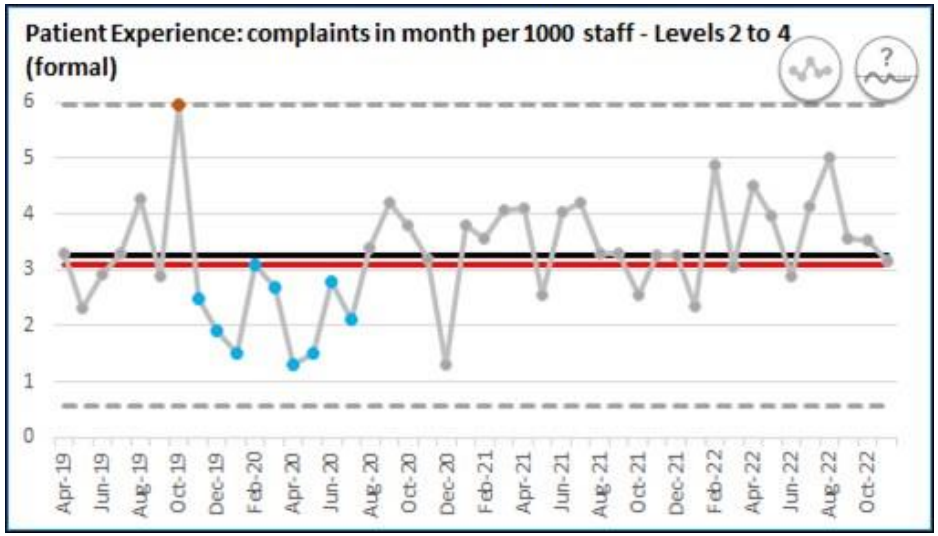


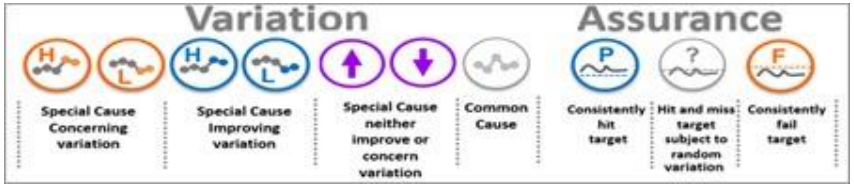


Responsive

Number of complaints received in month per 1000 staff

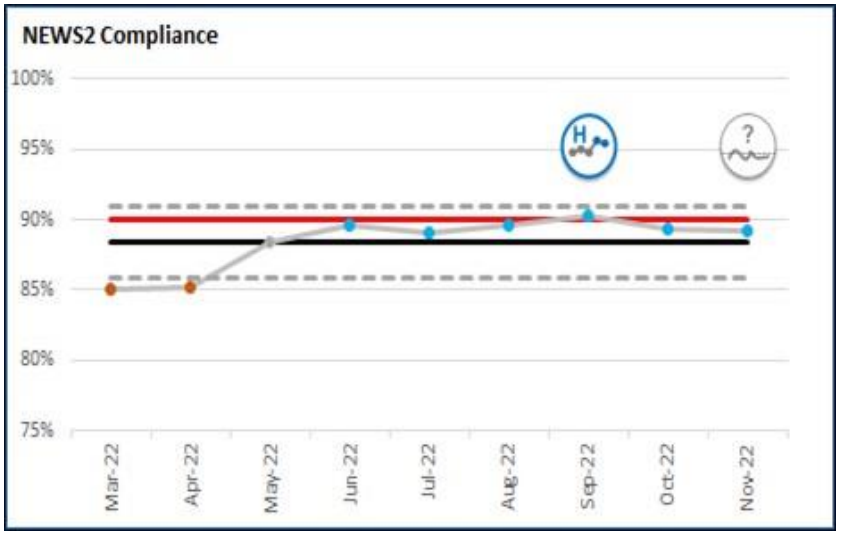
Executive Lead: Tracy Fennell, Chief Nurse
Performance Issue: The Trust has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per 1000 staff. The rate for November 2022 was marginally above this at 3.17.
Action: Complaints received continue to remain lower than the national average for 2020/21. During November 2022, 20 new formal complaints were registered: this was slightly above WUTH's expected/historical monthly average activity for 2021/22 (18). 32 complaints have been closed in November. Achieving a 39% increase over October, as a positive response to the current focus on reducing the number of active complaints being investigated and overall response times. Divisional plans are in place to address the concurrent causes of complaint (communication / staff attitude and capacity pressures) and the ways in which these can be addressed, as well as any seasonal surges in numbers. Weekly complaints management meetings with all divisions continue to take place. The purpose of these meetings is to support management of complaint responses and to identify and address barriers to completion as early as possible.
Expected Impact: Reduction in the response times and sustained improvement towards achieving the internal threshold by end of Q4.

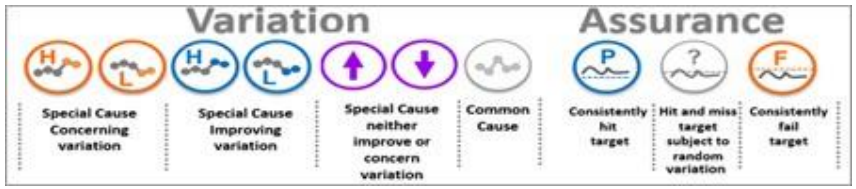




NEWS2 Compliance

Executive Lead: Tracy Fennell, Chief Nurse
Performance Issue: A threshold of greater than 90% compliance with NEWS2 patient observations conducted within national guidelines and Trust NEWS2 policy has been set. Compliance is measured by a rolling programme of monthly ward audits: with the standard achieved in September. Compliance for November 2022 was marginally below target by 0.8% at 89.2%.
Action: NEWS2 compliance with the recording NEWS2 observations is reported to the Executive Management Team fortnightly within nursing quality metrics. The Deteriorating Patient Quality Improvement Faculty, led by the Chief Nurse, has overseen quality improvement projects across several wards and an initiative resulting in trust wide change. In conjunction with a focused workstream the Trust has sustained improvement in compliance of recording NEWS2 since April 2022. As a response to the high proportion of patients with no criteria to reside the model of care for this patient population has been amended in accordance with their clinical requirements. One change is the reduction in observations being recorded for those with a NEWS2 score of 0 – 4 from 12 hourly to once daily. Compliance has reduced in the recording of NEWS2 score 0-4, this is most probably because of the clinically agreed change in care requirements for those with no criteria to reside. Further review is being undertaken to determine the impact of the change in model of care for no criteria to reside patients on the compliance rates and establish suitable solutions for resolve.
Expected Impact: The expectation is for all areas to achieve greater than 90% for completing NEWS2 observations by Q4.





Appendix 2 Quality Performance Dashboard - SPC Version - January 2023

Approach

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

Issues / limitations

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

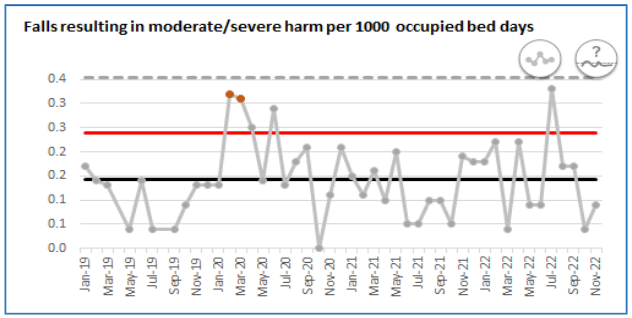
Next steps - following the December 2022 BoD

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

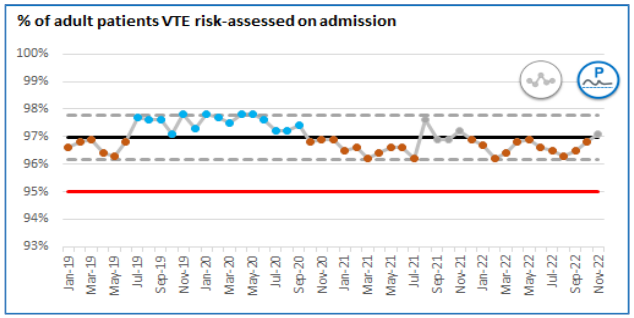
Note - Metrics not yet included:

CQC Domain	Indicator
Well-led	Duty of Candour compliance - breaches of the DoC standard for Serious Incidents
Well-led	Number of patients recruited to NIHR studies
Use of Resources	I&E Performance (monthly actual)
Use of Resources	I&E Performance Variance (monthly variance)
Use of Resources	NHSI Risk Rating
Use of Resources	CIP Performance (YTD Plan vs Actual)
Use of Resources	NHSI Agency Performance (YTD % variance)
Use of Resources	Cash - liquidity days
Use of Resources	Capital Programme (cumulative)

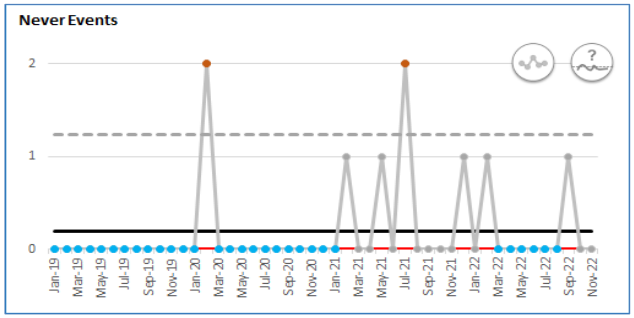
Safe - Avoiding Harm



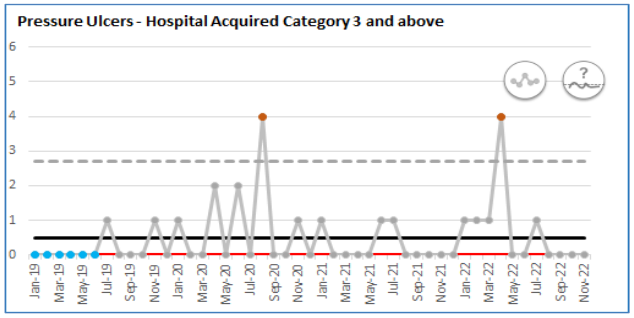
Nov-22
Common cause variation
≤0.24
Hit & miss target subject to random variation



Nov-22
Common cause variation
≥95%
Performance consistently achieves the target



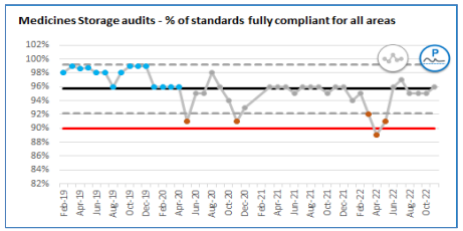
Nov-22
0
Variance Type
Common cause variation
0
Hit & miss target subject to random variation



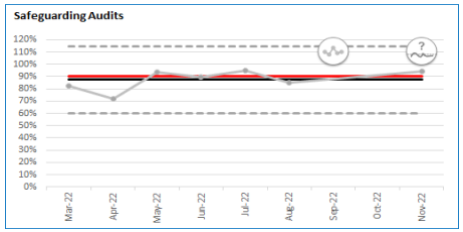
Nov-22
0
Variance Type
Common cause variation
0
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Falls resulting in harm: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved
VTE risk-assessment on admission: Common cause variation. The target threshold is consistently achieved, including the most recent month.	No narrative on action as metric achieved
Never events: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved
Pressure ulcers HAI category 3: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved

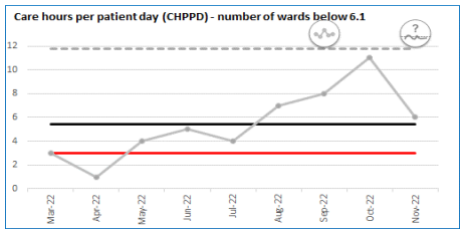
Safe - Assurance Audit



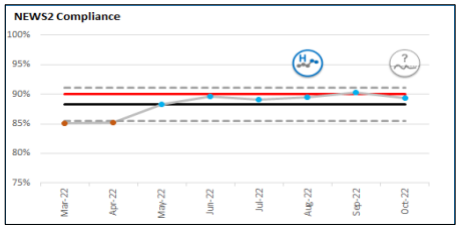
Nov-22
96%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target



Nov-22
94.4%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation



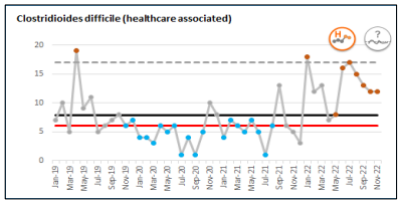
Nov-22
6
Variance Type
Common cause variation
Threshold
≤3
Assurance
Hit & miss target subject to random variation



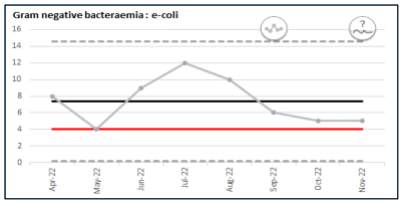
Nov-22
89.2%
Variance Type
Special cause variation - improving
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Medicines storage audits: Common cause variation. The target threshold is consistently achieved, including the most recent month.	No narrative on action as metric achieved
Safeguarding audits: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved
Care hours per patient day: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	A CHPPD tracker is one of the safer staffing measures, which has been in place since May 2022, to monitor if any areas are consistently recording CHPPD <6.1. The CHPPD data is triangulated with further staffing metric data to monitor the impact on care. Impacts on care are being monitored and have remained minimal with the areas of lower than threshold CHPPD. November, with 6 wards below the required threshold is the lowest number of wards below threshold each month since July 2022. Ward 18 has had 2 consecutive months below threshold with a variance of 0.1, equivalent to 6 minutes of nursing care, in November. Ward 22 and 36 have had consecutive months of a CHPPD of <6.1. Ward M1 provides care to patients who do not have the criteria to reside. Healthcare professional input will not be required at the same level or frequency to that of an acute area. Ward 38 staffing levels had a CHPPD consistently <6.1 since November 2021, this is a result of clinical support worker (CSW) shortfalls created by staff moves to support higher risk staffing challenges across the Trust. Oversight has been provided by the Matron and professional judgement is that the ward has remained safe. Successful system wide recruitment events have been led by the Trust. A focus on recruitment and retention for CSW and in-patient RN band 5's continues. Expected Impact: a reduction in the number of wards with a consistent CHPPD of <6.1 by Q4.
NEWS2 Compliance: Special cause variation - High improving. Achieving the threshold is hit & miss, with the most recent month not being achieved.	NEWS2 compliance with the recording NEWS2 observations is reported to the Executive Management Team fortnightly within nursing quality metrics. The Deteriorating Patient Quality Improvement Faculty, led by the Chief Nurse, has overseen quality improvement projects across several wards and an initiative resulting in trust wide change. In conjunction with a focused workstream the Trust has sustained improvement in compliance of recording NEWS2 since April 2022. As a response to the high proportion of patients with no criteria to reside the model of care for this patient population has been amended in accordance with their clinical requirements. One change is the reduction in observations being recorded for those with a NEWS2 score of 0 – 4 from 12 hourly to once daily. Compliance has reduced in the recording of NEWS2 score 0-4, this is most probably because of the clinically agreed change in care requirements for those with no criteria to reside. Further review is being undertaken to determine the impact of the change in model of care for no criteria to reside patients on the compliance rates and establish suitable solutions for resolve. Expected impact: the expectation is for all areas to achieve greater than 90% for completing NEWS2 observations by Q4.

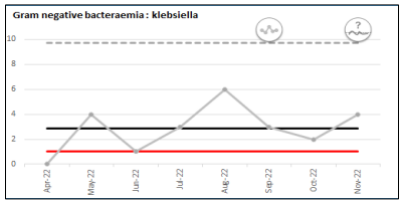
Safe - Infection Control



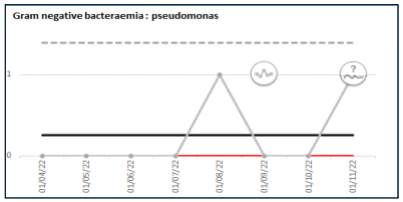
Nov-22
12
Variance Type
Special cause variation - concerning
Threshold
≤6
Assurance
Hit & miss target subject to random variation



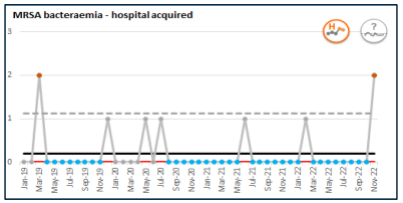
Nov-22
5
Variance Type
Common cause variation
Threshold
≤4
Assurance
Hit & miss target subject to random variation



Nov-22
4
Variance Type
Common cause variation
Threshold
≤1
Assurance
Hit & miss target subject to random variation



Nov-22
1
Variance Type
Common cause variation
Threshold
≤9 for 2022/23
Assurance
Hit & miss target subject to random variation



Nov-22
2
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

Issues:

Clostridioides difficile (healthcare associated): Special cause variation - High concerning. Performance consistently fails to achieve the target, including the most recent month.

Gram-negative bacteraemia e-coli: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

Gram-negative bacteraemia klebsiella: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

Gram-negative bacteraemia pseudonomas: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

MRSA bacteraemia: Special cause variation - High concerning. Achieving the threshold is hit & miss, with the most recent month being achieved.

Action & Expected Impact:

The CDI quarterly report and improvement plan is governed via the IPC group and directly overseen by the Chief Nurse / DIPC. The Q3 report has continued to evidence positive outcomes with a sustained reduction in the number of CDI's. Collaboration with healthcare partners continues with system wide challenges being addressed through the multi-agency Health Protection Board for Wirral.

Enhanced auditing of the cleaning standards has helped to drive improvements, resulting in a proactive approach and clearly defined roles and responsibilities of the cleaning teams and the ward staff. This has promoted immediate rectification and improvement in the effectiveness environmental cleaning process.

Review of IPC isolation priorities have strengthened clinical teams' decision making to enable a risk assessed approach to inform the order of patient isolation. This will ensure the transmission of infection between patients is minimised during the current bed capacity challenges evident throughout the Trust.

Expected impact: sustained reduction in patients diagnosed with healthcare associated Clostridioides difficile by Q4.

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

Many blood stream infections are diagnosed in severely ill patients with no indication that there is a clinical omission in care. Review of the process to determine if a bacteraemia can be avoided is taking place. This will enable heightened focus on patients identified with infections that could be avoided and establish the cause that will inform effective action planning to avoid further cases.

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

Expected impact: the number of patients diagnosed with an E-coli bacteraemia is reduced to below the monthly threshold.
Klebsiella is a gut organism and common sources identified during the RCA process relate to the management of indwelling devices and intra-abdominal complexities.

Individual scrutiny of each case continues to enable learning opportunities to be identified and remedial actions to be put into place to avoid future harms. Recent reviews have not identified any specific causative factors that could have prevented the blood stream infection.

Effective infection prevention control measures by the multi-disciplinary team are essential. Therefore, the programme of work on aseptic non-touch technique (ANTT) and the 'Gloves off' campaign both have a focus on improved hand hygiene for all staff. ANTT competency framework ensures assessment for all staff undertaking clinical procedures to strengthen the prevention of device-associated infections.

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

One case in case in November 2022, making a cumulative two for the year-to-date. This is well within the trajectory of a maximum nine for the full year 2022-23.

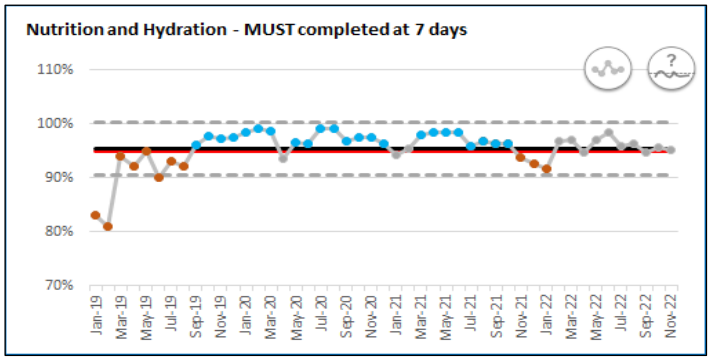
Review of both patients journey prior to diagnosis of the MRSA bacteraemia has been completed:

A source of infection was not determined in one case. However, aseptic non-touch technique and blood culture collection training for staff was highlighted as a recommendation.

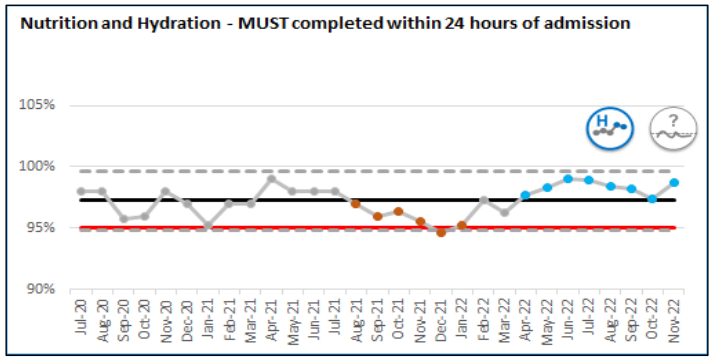
The second case, the patient was diagnosed with a MRSA bacterium when known to be MRSA colonized. Determination of the source of infection is agreed to be most probably due to a insertion of a urinary catheter or cannula. Urinary catheter care / management and aseptic non-touch technique are key priority areas of focus within the Trust and as a Wirral wide system.

Expected impact: targeted interventions will help to reduce the risk of MRSA bacteraemia.

Effective - Nutrition



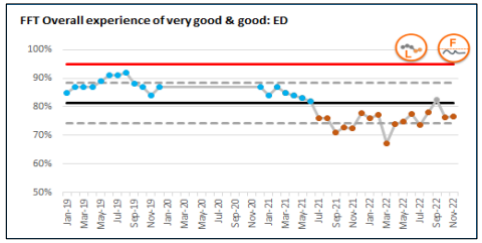
Nov-22
95.2%
Variance Type
Common cause variation
≥95%
Hit & miss target subject to random variation



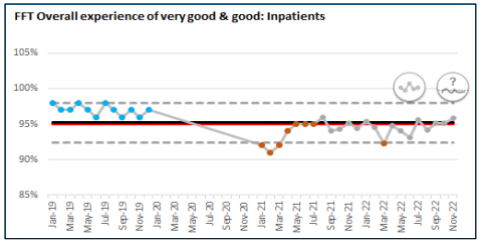
Nov-22
98.7%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

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

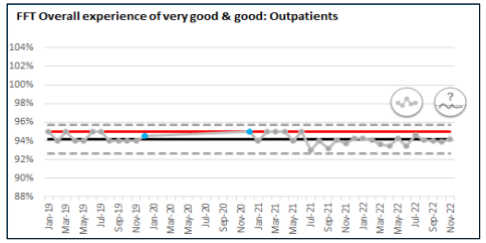
Caring - Patient Experience



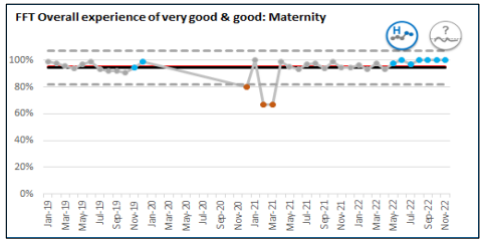
Nov-22
76.5%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target



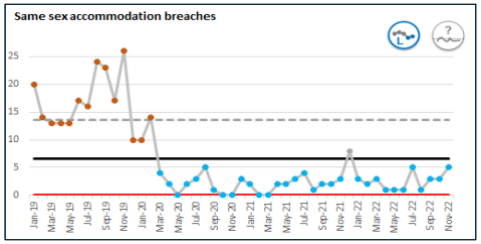
Nov-22
95.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Nov-22
94.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Nov-22
100.0%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Nov-22
5
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

Issues:

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

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

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

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

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

Action & Expected Impact:

The Patient Experience Strategy has established 5 strategic promise groups; Welcome, Safe, Inclusive, Care, and Supported. Each promise group has a focus on identifying patients' experience improvement opportunities.

Operational pressures within the Emergency Department, consistent with the national position, is impacting on the FFT score. FFT score for ED remains below the Trust threshold of 95% however is in line with the national average scores for ED. Waiting times are consistently reported to be an area of challenge. Effective communication to patients remains a priority focus for the Divisional Triumvirate.

Out-patients FFT score of 94.2%, 0.8% below threshold, is consistent with previous months. Additional touch screen kiosks and feedback volunteers have been introduced to increase the opportunity for feedback in this area.

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

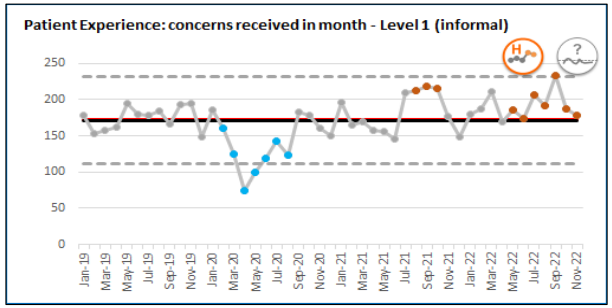
Breaches are often due to patients waiting more than 24 hours for transfer from critical care areas inclusive of Coronary Care Unit (CCU) to general wards; there were 5 such breaches in November 2022. (Intensive Care Unit (ICU) 2 and CCU 3). The breaches did not cause any delays or refused admissions to these areas as sufficient ICU and CCU capacity has been available. Patient's privacy and dignity needs are met whilst the person awaits transfer to the specialty areas and the teams ensure their specialty care is not compromised due to a lengthened critical care stay.

Delivering same sex accommodation is a high priority. It is recognised that system challenges resulting in high levels of activity and a high proportion of patients with no criteria to reside, which continued throughout November 2022, has an impact on the ability to deliver same sex accommodation.

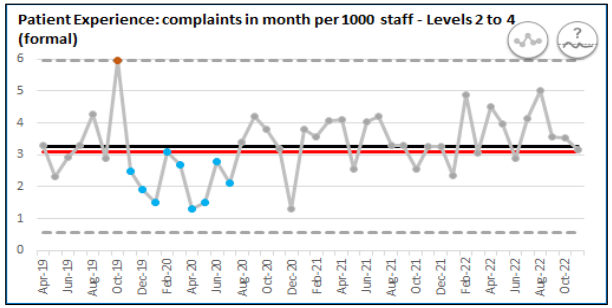
Processes are in place that enable joint working with ICU, CCU, Patient Flow Team, and Divisional Directors and each breach is risk assessed and concerns are managed promptly via bed capacity and operational meetings. This enables daily oversight of individual patients requiring a stepdown and the length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

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

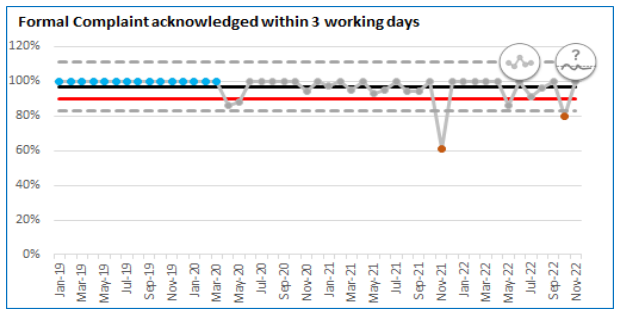
Responsive - Complaints



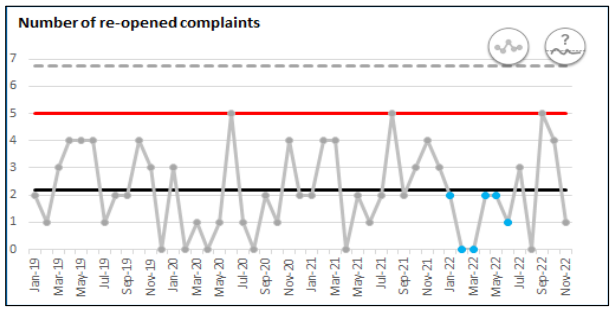
Nov-22
178
Variance Type
Special cause variation - concerning
Threshold
≤173
Assurance
Hit & miss target subject to random variation



Nov-22
3.17
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation



Nov-22
100%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation



Nov-22
1
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

Issues:

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

Complaints in-month per 1000 staff: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

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

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

Action & Expected Impact:

Complaints received continue to remain lower than the national average for 2020/21. During November 2022, 20 new formal complaints were registered: this was slightly above WUTH's expected/historical monthly average activity for 2021/22 (18).

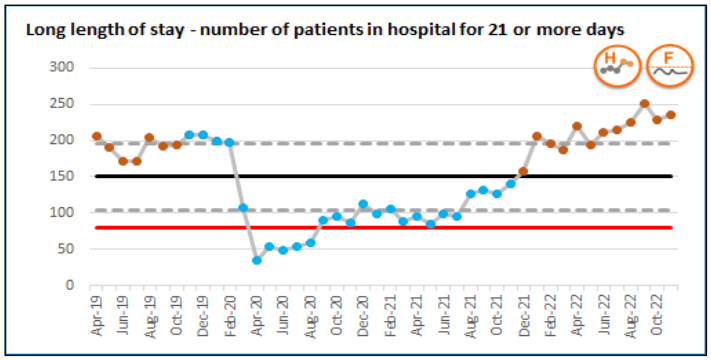
32 complaints have been closed in November. Achieving a 39% increase over October, as a positive response to the current focus on reducing the number of active complaints being investigated and overall response times.

Divisional plans are in place to address the concurrent causes of complaint (communication / staff attitude and capacity pressures) and the ways in which these can be addressed, as well as any seasonal surges in numbers.

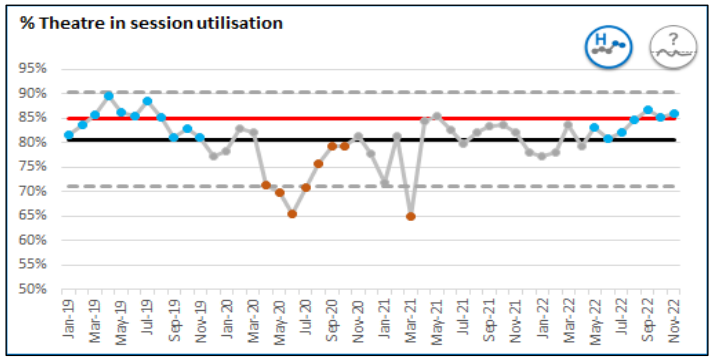
Weekly complaints management meetings with all divisions continue to take place. The purpose of these meetings is to support management of complaint responses and to identify and address barriers to completion as early as possible.

No narrative on action as metric achieved

Effective - Productivity



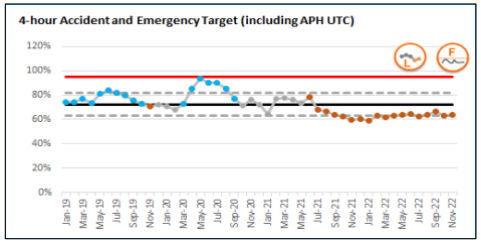
Nov-22
236
Variance Type
Special cause variation - concerning
≤79
Performance consistently fails to achieve the target



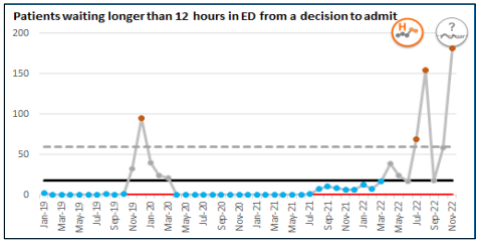
Nov-22
85.90%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Long Length of stay (21+): Special cause variation - High concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
% Theatre in-session utilisation: Special cause variation - High improving. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved

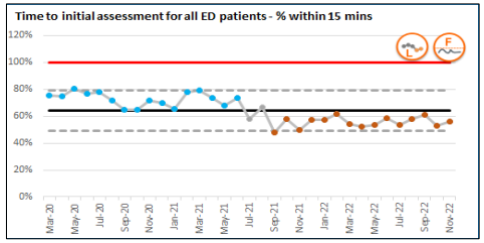
Responsive - Urgent Care



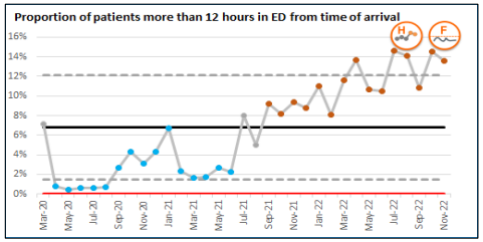
Nov-22
63.9%
Variance Type
Special cause variation - concerning
≥95%
Performance consistently fails to achieve the target



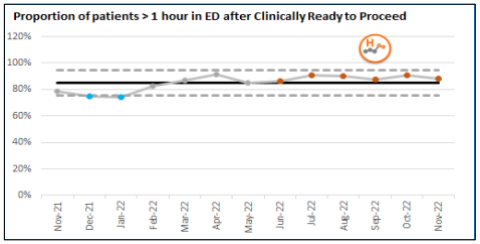
Nov-22
182
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation



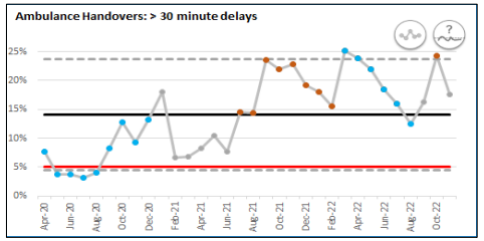
Nov-22
55.8%
Variance Type
Special cause variation - concerning
Threshold
100%
Assurance
Performance consistently fails to achieve the target



Nov-22
13.6%
Variance Type
Special cause variation - concerning
0%
Performance consistently fails to achieve the target



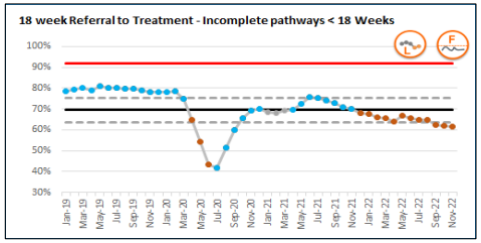
Nov-22
88.5%
Variance Type
Special cause variation - concerning
Threshold
TBC
Assurance



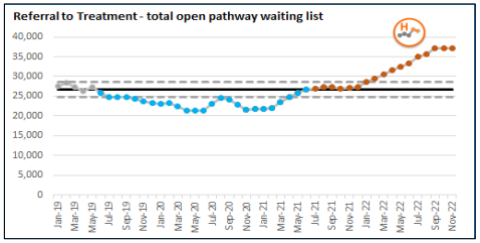
Nov-22
17.5%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Hit & miss target subject to random variation

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

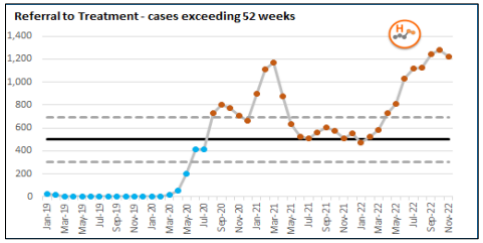
Responsive - Elective Care - RTT



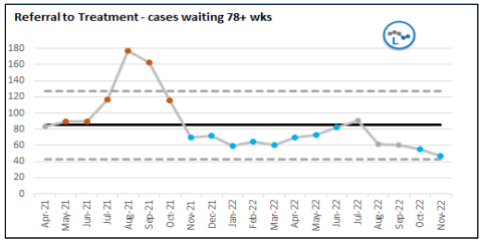
Nov-22
61.57%
Variance Type
Special cause variation - concerning
≥92%
Performance consistently fails to achieve the target



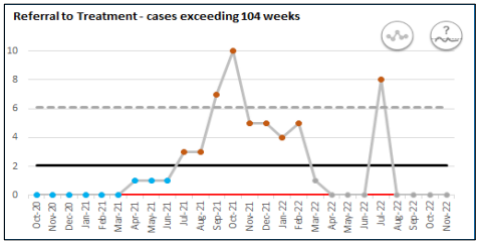
Nov-22
37188
Variance Type
Special cause variation - concerning
≤31352
Trajectory target not appropriate for SPC Assurance reporting



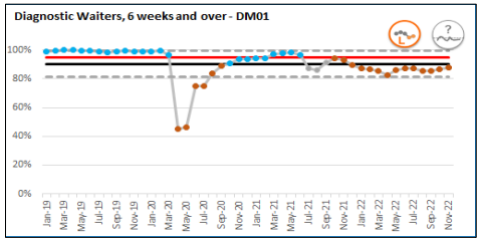
Nov-22
1219
Variance Type
Special cause variation - concerning
520
Trajectory target not appropriate for SPC Assurance reporting



Nov-22
47
Variance Type
Common cause variation
≤55
Hit & miss target subject to random variation



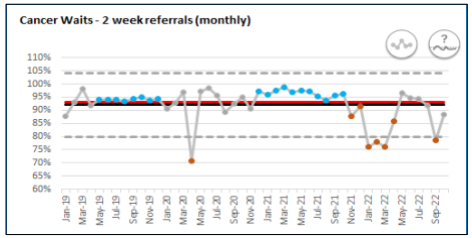
Nov-22
0
Variance Type
Common cause variation
0
Hit & miss target subject to random variation



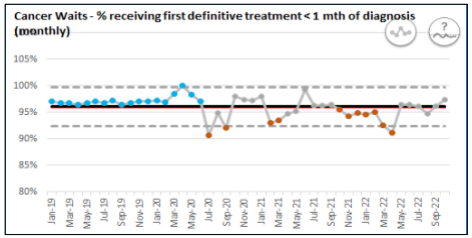
Nov-22
86.0%
Variance Type
Special cause variation - concerning
≥95%
Hit & miss target subject to random variation

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

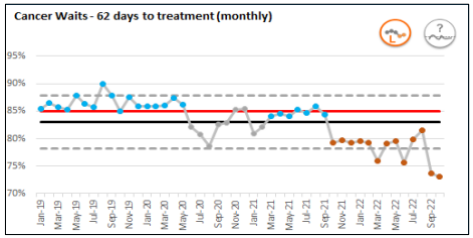
Responsive - Elective Care - Cancer (monthly - 1 mth in arrears)



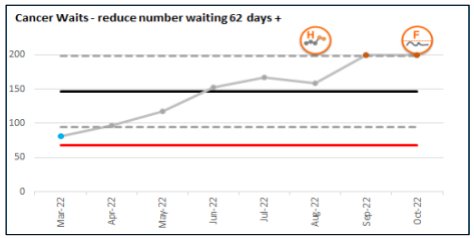
Oct-22
88.3%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation



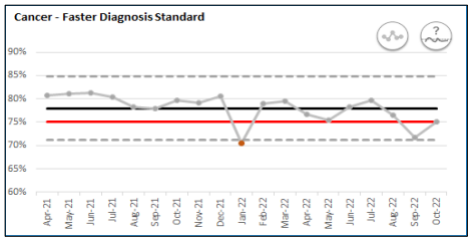
Oct-22
97.3%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation



Oct-22
73.1%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation



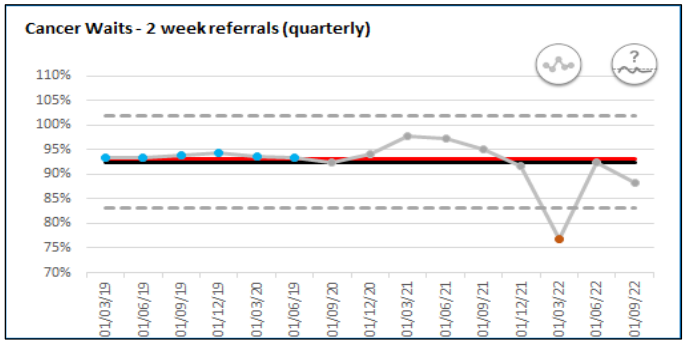
Oct-22
200
Variance Type
Special cause variation - concerning
Threshold
195
Assurance
Performance consistently fails to achieve the target



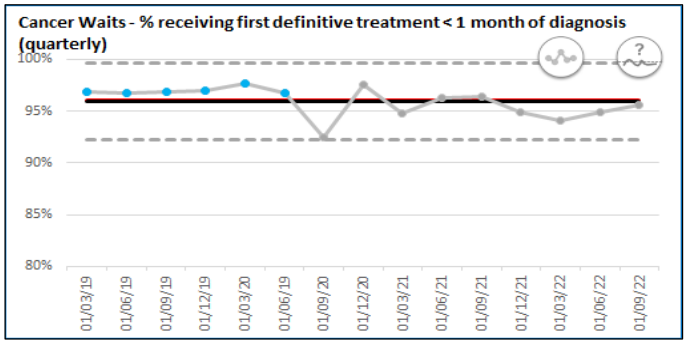
Oct-22
75.2%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

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

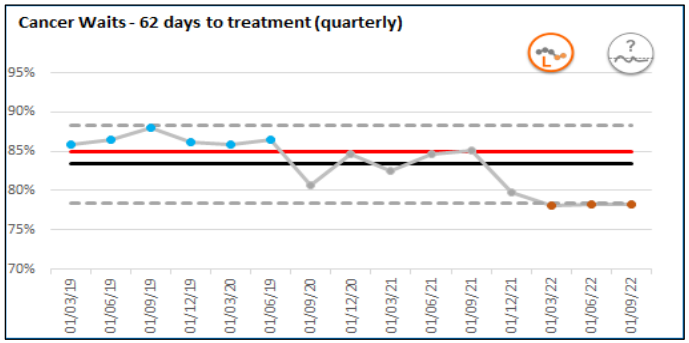
Responsive - Elective Care - Cancer (quarterly)



Sept-22
88.4%
Variance Type
Common cause variation
≥93%
Hit & miss target subject to random variation



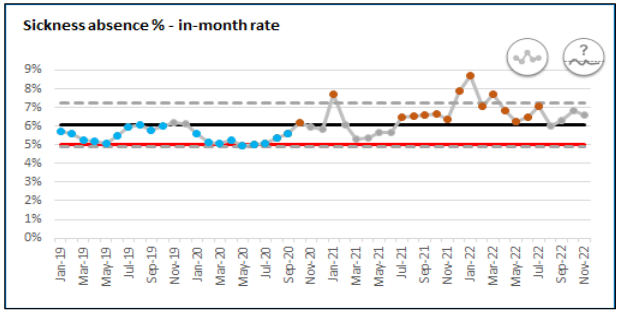
Sept-22
95.6%
Variance Type
Common cause variation
≥96%
Assurance
Hit & miss target subject to random variation



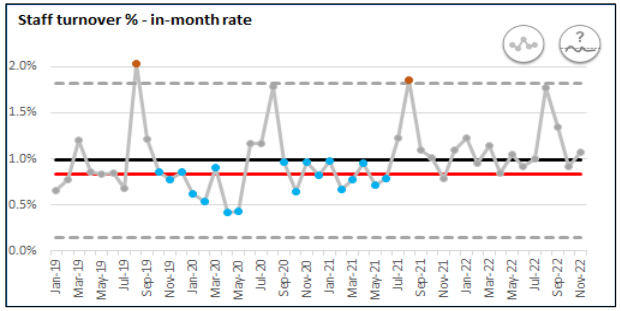
Sept-22
78.2%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation

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

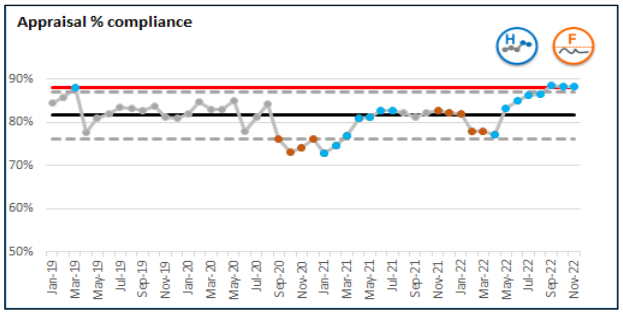
Safe - Workforce



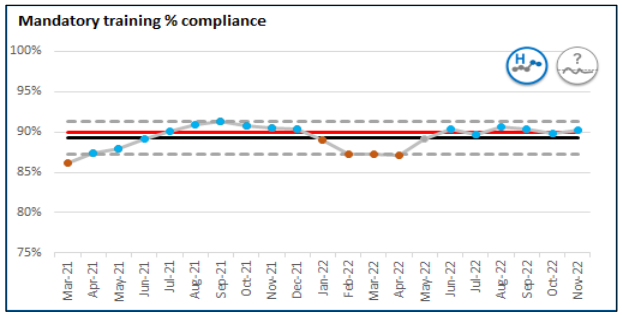
Nov-22
6.60%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Hit & miss target subject to random variation



Nov-22
1.07%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation



Nov-22
88.36%
Variance Type
Special cause variation - improving
Threshold
≥88%
Assurance
Performance consistently fails to achieve the target



Nov-22
90.25%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Issues:	Actions:	Expected Impact:
Sickness absence % in-month rate: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Monitoring of the Sickness Attendance KPI and associated actions is on-going via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews. Managers continue to be supported by HR.	

Targeted Support
The highest sickness absence levels remain within Facilities, who are being supported by their HR Team. Facilities are undertaking an analysis of the drivers of the sickness absence and measures in place to address. It is also anticipated that new Attendance Management Policy triggers when implemented, will further support with the persistent short-term absence which is most disruptive to the service.

Managing Attendance Policy
The extensively revised Attendance Management Policy has now been agreed at Policy Pay Terms & Conditions and is progressing via the governance route. In parallel to this, work is progressing on the launch element.

Workforce Wellbeing
The newly appointed Wellbeing Specialist Practitioner will be focusing on reviewing the Trust Health and Wellbeing offer in the Trust, with an immediate focus on supporting staff during and following Industrial Action.

Development
As part of the Leadership for All approach a suite of stand-alone sessions development sessions have been designed. The next upcoming session in January is Building Personal Resilience.

Flu Vaccine
The Flu Vaccine Programme continues. Current uptake amongst frontline Healthcare Workers is 57%, compared to a Cheshire and Merseyside average of 49%.

Expected Impact:
The impact of high sickness is increased pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance and safety.
Risks to Trust financial management, quality, patient safety and operational performance due to cost of sickness absence, expense of bank and agency cover will reduce as the sickness absence is gradually improved over time. We continue to appropriately prioritise workforce wellbeing and our commitment to mental health support.

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

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

Current Interventions to support retention include:

- 1The Retention Delivery Plan was agreed with the Strategic Retention Group and priorities determined.
- 1Work has commenced with the HR Team and the National ESR Team to improve leaver reasons accuracy in ESR.
- 1The completed Nursing and Midwifery Retention Self-Assessment Tool has been submitted to the Northwest and ICB Retention Group. Feedback is currently awaited from the Northwest and ICB Retention Group.
- 1Expressions of interest are currently being sought for the new Leading Teams programme. This is a 6-month programme aimed at staff who have responsibility for leading others as part of their job.
- 1Use of apprenticeship for HCSW posts. At present there have been 6 cohort starts with a 6-month retention rate of 85%.

Staff Survey and the People Strategy
The Staff Survey closed in November 2022 with a response rate of 48%. Findings will be reported in early 2023 and will be used to inform retention strategies in 2023 and beyond.

There are also other programmes of activity within the People Strategy Delivery Plan that impact on staff experience including health and wellbeing initiatives, reward and recognition, flexible working and improvements in integration and diversity which will also help minimise turnover.

Expected Impact: the impact of high Turnover increases pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance, and safety.

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

Appraisal % compliance: Special cause variation - High improving. Performance consistently fails to achieve the target, though the most recent month was achieved.

No narrative on action as metric achieved

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

No narrative on action as metric achieved

Board of Directors in Public **Item 9.2**
25 January 2023

Title	Month 8 Finance Report
Area Lead	Mark Chidgey, Chief Finance Officer
Author	Robbie Chapman, Deputy Chief Finance Officer
Report for	Information

Report Purpose and Recommendations

At M8 the Trust is reporting a deficit of £4.670m, an adverse variance against budget of £5.368m. This variance is attributed to overspends on employee costs, driven largely by under-performance in respect of recurrent CIP, the unfunded element of the national pay award and the continued use of escalation wards staffed at premium rates, and by increases in energy prices. This is offset by:

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

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

It is recommended that the Board:

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

Key Risks

This report relates to the following key risk:

- PR3: failure to achieve and/or maintain financial sustainability.

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

Governance journey

This is a regular update provided to each FBPAC meeting.

1. Statutory Responsibilities and Key Financial Risks

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

2. Executive Summary

2.1. At M8 the Trust financial position is a deficit of £4.670m which is an adverse variance to plan of £5.368m. The dashboard below highlights the key drivers of year to date (YTD) and forecast positions.

Key Performance Indicator	In Mnth (£ 000)	RAG Rating	YTD (£ 000)	RAG Rating	FOT (£ 000)	RAG Rating
Financial Stability - Breakeven	-£599		-£5,368		-£6,000	
Key Drivers of Variance						
104% Activity Recovery	£0		£0		£0	
Escalation beds & Corridor Care	-£521		-£4,212		-£6,328	
Bank & Agency	-£735		-£11,904		-£17,379	
Non Pay (Operating Expenditure)	-£1,384		£1,249		£3,727	
Cost Improvement (Recurrent)	-£174		-£5,989		-£8,202	
Other	£2,215		£15,487		£22,182	

3. Clinical Income & Activity

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

3.2. Key drivers

- Clinical Income - £33.557m in M8 and £269.738m YTD, an adverse variance of £0.133m for the year. This is primarily a reflection of block contracts which are in place.
- ERF – £0.0m in M8 and £0.0m YTD. National data confirms that the Trust is delivering above the target level of 104% and that this reduces to marginally below when outpatient follow ups are capped at 85%. It has been confirmed that there will be no ERF financial variations transacted in M1-M6 and it is expected that the same will apply for M7-M12.
- Other Income - £3.318m in M8 and £27.217m YTD, a positive variance plan of £1.933m for the year. This relates to the release of deferred income in respect of

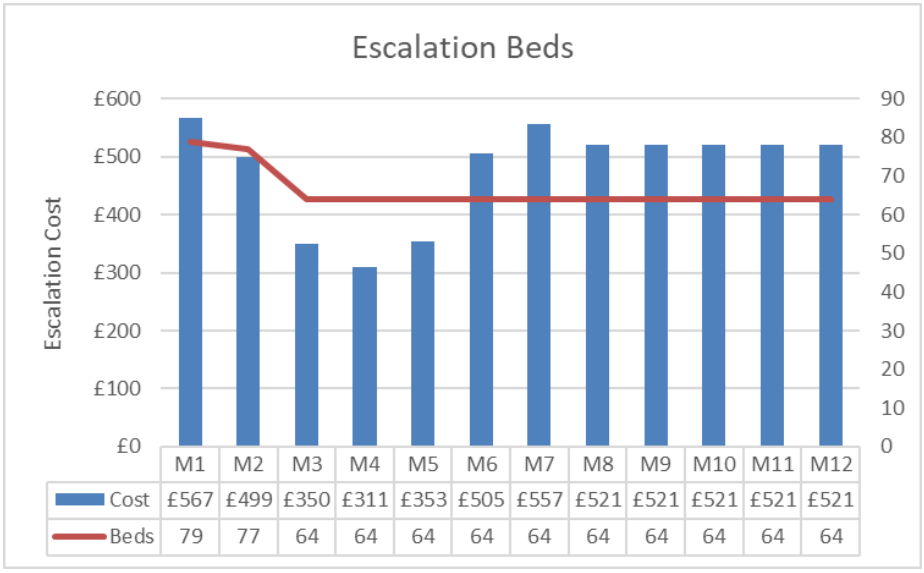
international nurse recruitment and teledermatology and the recharge of energy costs to Clatterbridge Cancer Centre. All of these costs are offset by increases in expenditure.

3.3. Mitigations and Corrective Action

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

4. Escalation Costs

4.1. Chart for Escalation Beds



	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Cost	£567	£499	£350	£311	£353	£505	£557	£521	£521	£521	£521	£521
Beds	79	77	64	64	64	64	64	64	64	64	64	64

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

4.2. Key drivers

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

4.3. Mitigations and corrective actions

- Escalation wards – A business case for escalation wards to be staffed substantively at reduced cost was approved by Executives and posts are out for recruitment. Bed modelling is currently underway to inform the longer-term requirements for Medicine.
- Other Escalation Capacity - A new ambulance arrival zone has been implemented which will create additional care spaces within the Emergency Department. The business case for associated staffing is in the final stages of development and will be submitted to Executives for consideration.

5. Bank and Agency

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

5.2. Key drivers

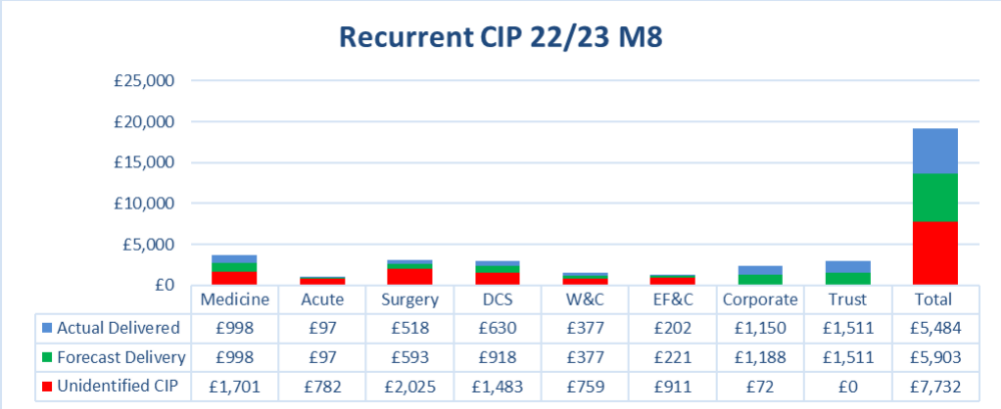
- Bank & Agency - costs excluding escalation were £0.735m in M8 and £11.904m YTD, an adverse variance of £11.584m which is then offset by an underspend of £10.288m in respect of substantive staff. Bank expenditure is driven by higher than planned levels of sickness and vacancies across the Trust. There has been a £0.003m reduction in agency spend from M7 to M8 but still in excess of national target for reductions. The majority of agency spend relates to medical staff.

5.3. Mitigations and corrective actions

- The Statement of Case for substantive recruitment of consultants in respect of Gastroenterology, Cardiology and GIM to recruit substantively and reduce agency use was supported by the Business Case panel (BDISC) in November and will progress to Full Business Case. The Haematology Statement of Case has not been supported with alternative options now been developed.
- The working group investigating junior doctor and rota opportunities has continued to meet and the outline plan will feed into the Workforce transformation programme.
- Targeted work in Acute in conjunction with HR around sickness levels.
- International Nurses coming into post in Acute.
- Review of current rosters and flexible working arrangements in Acute to enable a more effective roster to be built.

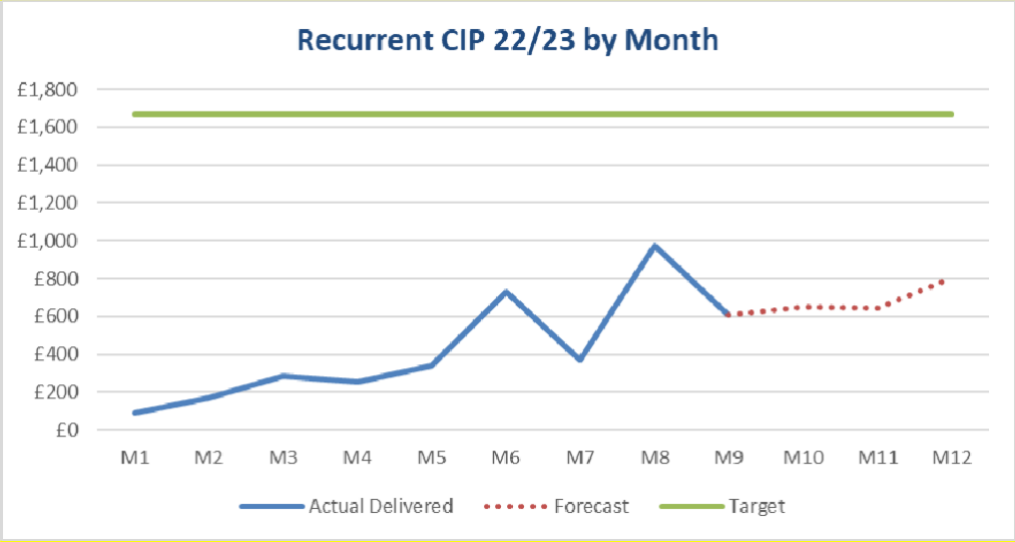
6. Cost Improvement Programme (CIP)

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



	Medicine	Acute	Surgery	DCS	W&C	EF&C	Corporate	Trust	Total
Actual Delivered	£998	£97	£518	£630	£377	£202	£1,150	£1,511	£5,484
Forecast Delivery	£998	£97	£593	£918	£377	£221	£1,188	£1,511	£5,903
Unidentified CIP	£1,701	£782	£2,025	£1,483	£759	£911	£72	£0	£7,732

6.2. Recurrent CIP by month and forecast



6.3. Mitigations and corrective actions

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

7. Capital and Cash

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

7.2. The cash balance at the end of M8 was £6.5m which is £8.2m behind plan. We are currently forecasting a year end cash balance of £6.3m. Drawdown of Public Dividend Capital (PDC) will improve cashflow before the year end. The reduction in the cash balance is being driven by the under-delivery of CIP and the current deficit position.

7.3. The Trust's 22/23 revised Capital Delegated Expenditure Limit (CDEL) is £44.463m.

7.4. An underspend of £0.5m is forecast against CDEL at M8 in line with the aggregated Integrated Care System (ICS) plan. This takes forecast spend to £43.981m. The

revision to forecast is made on the understanding that the CDEL will be re-turned to the Trust in 23/24.

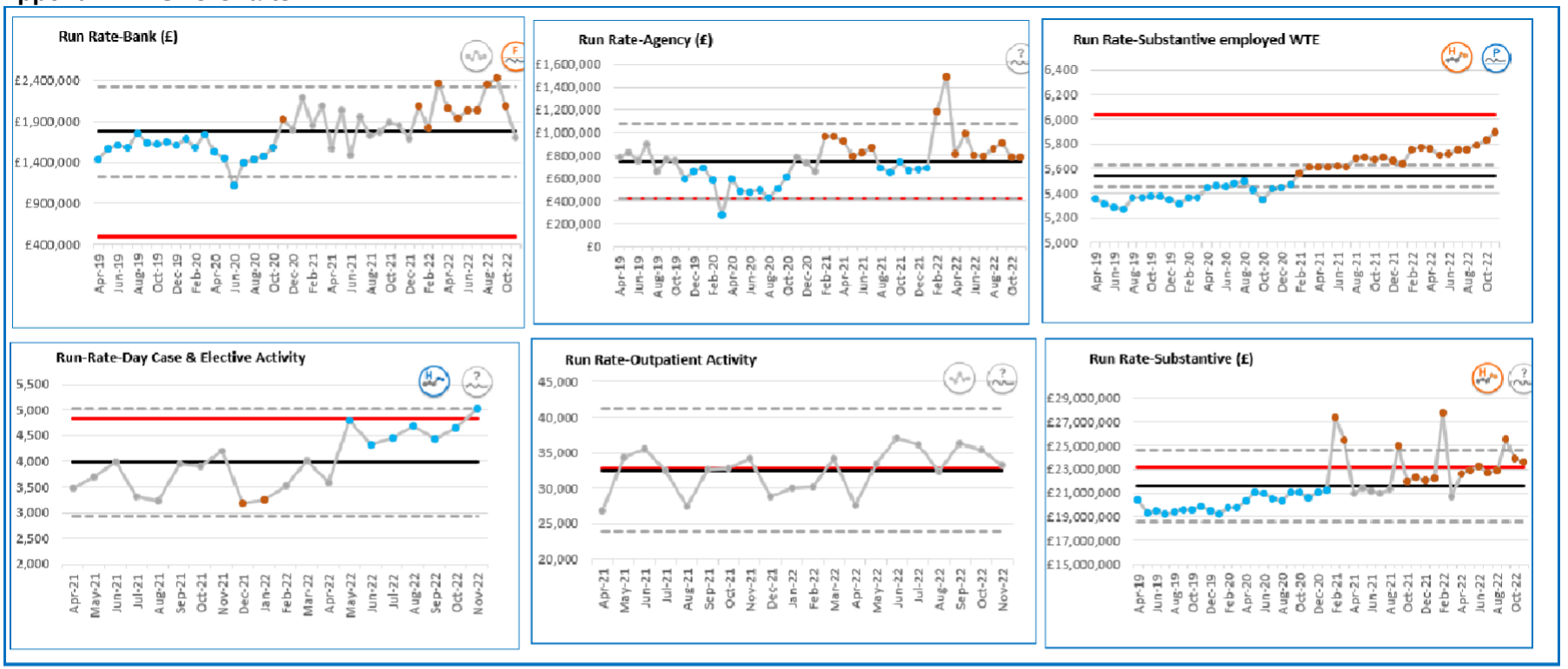
Spend at M8 is as follows:

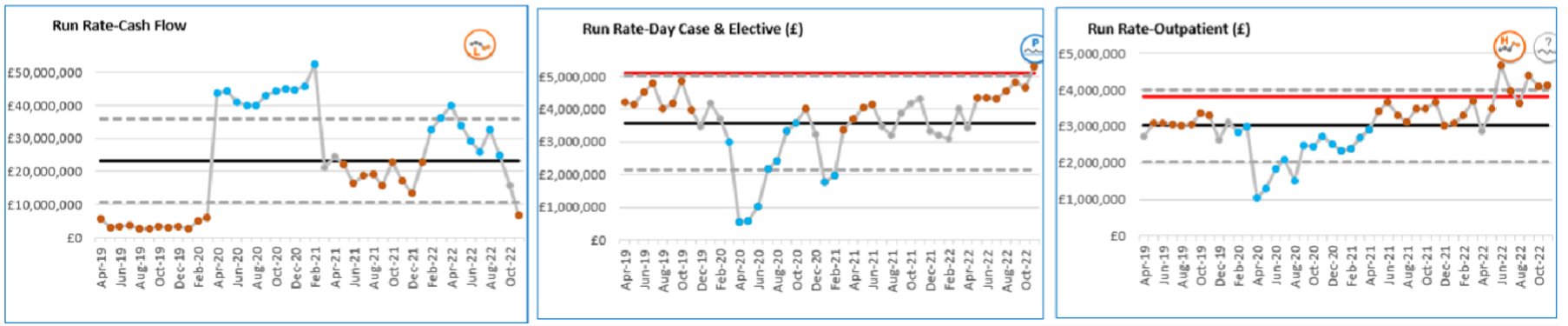
Description	Planned spend FOT	Planned spend YTD	Actual spend YTD	Variance
Ward 1	£ 2,800	£ 2,120	£ 2,680	-£ 560
Equipment	£ 228	£ 780	£ 225	£ 555
Estates schemes including Theatres Phase 1	£ 4,464	£ 2,880	£ 3,868	-£ 988
IT schemes	£ 1,976	£ 1,250	£ 220	£ 1,030
UECUP	£ 13,000	£ 9,900	£ 2,747	£ 7,153
Pipework	£ 2,132	£ 2,132	£ 1,297	£ 835
Modular Theatres Phase 2	£ 14,954	£ 7,862	£ 3,008	£ 4,854
CDC	£ 4,212	£ -	£ -	£ -
UTC	£ 215	£ -	£ 72	-£ 72
	£ 43,981	£ 26,924	£ 14,117	£ 12,807

7.5. Spend is currently £12.8m behind plan. The key areas of underspend are the Urgent and Emergency Care Upgrade Programme (UECUP) and phase two of the new theatre's development. Formal approval for UECUP has now been received. Formal sign off of the Guaranteed Maximum Price contract (GMP) is still to be completed, however spend is anticipated to increase significantly over the coming months.

7.6. The contract awards have now been made for phase two of the theatres. Delivery of the modular build is expected early in the new year however, with the internal reconfiguration works commenced, expenditure will start to increase in the next month.

Appendix 1 – SPC Charts





Key

- Target or Budget
- Mean
- Upper /Lower Limit
- Actual/Forecast

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9.3**

25 January 2023

Title	Quarterly Maternity Services Report
Area Lead	Tracy Fennell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's') and Debbie Edwards, Strategic Advisor for Maternity and Neonatal Services (Women's and Children's')
Report for	Approval

The purpose of this report is to provide a quarterly update to the Board of Directors with further oversight of the quality and safety of Maternity Services at Wirral University Teaching Hospital (WUTH). The last Quarterly Maternity Services Report was provided in October 2022.

This paper provides an update on Year 4 of the Maternity Incentive Scheme referencing the evidence collated and summarising this for the declaration submission.

This paper provides an update regarding Part 2 of the Ockenden report, together with an overview following the publication of 'Reading the Signals' Maternity and Neonatal Services in East Kent – the Report of an independent investigation.

A further update is provided regarding the Maternity Continuity of Carer Implementation Plan, and the workforce requirements to fully implement this model of care, in line with Birth Rate Plus recommendations.

Please note, owing to the number of appendices accompanying this report these have been appended separately.

It is recommended that the Board:

- Note the report
- Note the Ockenden report update
- Note the publication of the East Kent Services Report
- 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
- Approve Trust compliance with year 4 of the Maternity Incentive Scheme and to note the supporting evidence prior to the Chief Executive sign off of the Trust declaration form and submission to NHSR by noon on 2nd February 2023

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

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

1	**Maternity Incentive Scheme (MIS) Year 4**
	A detailed Maternity Incentive Scheme (MIS) update is included in the paper which will support the Trusts declaration with the MIS which is due for submission before the 2 February 2023. Now in its fourth year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive that discounts provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS reward is provided to Trusts that meet all 10 safety standards designed to improve the quality, 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 4 MIS in May 2022 following its pause in 2021-22. The W&C Division continued with its work to progress and fully implement the 10 safety actions. At the October 2022 Board of Directors meeting an update was provided confirming that WUTH was on track to meet the requirements of each safety action, with the declaration and submission due in January 2023. This deadline has since changed and has been extended to noon on 2 February 2023. Provider compliance with the 10 Safety Action Standards across Cheshire &Merseyside has been monitored closely by both the LMNS and NHSE/I, with the Integrated Care Board (ICB) also having oversight of compliance. The supporting evidence includes a Presentation (Appendix 1).

	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. An updated gap analysis was completed following a review meeting with the Chief Nurse in July 2022. Appendix 2 includes an updated Gap Analysis and is RAG rated accordingly.

3	**Reading the Signals: Maternity and Neonatal Service in East Kent the Report of an Independent Investigation**
	In February 2020, the UK Government commissioned Dr Bill Kirkup to undertake a review into maternity and neonatal services (between 2009 and 2020) in two hospitals within the Southeast of England region: the Queen Elizabeth Queen Mother Hospital (QEQM) at Margate, and the William Harvey Hospital (WHH) in Ashford, Kent. Both services incorporate East Kent Hospitals NHS Foundation Trust.

The report found that during this period those working within maternity and neonatal services too often provided clinical care that was suboptimal which often led to significant harm. Staff failed to listen to the families involved and acted in ways which made the experience of families unacceptable and distressingly poor. The report identifies 4 key areas for action which to address and improve patient safety in maternity and neonatal services.

Content

The report sets out the findings of the Panel's Investigation of maternity services at East Kent Hospitals University NHS Foundation Trust, by:

- Describing how those responsible for the provision of maternity services failed to ensure the safety of women and babies, leading to repeated suboptimal care and poor outcomes – in many cases disastrous.
- Highlighting an unacceptable lack of compassion and kindness, impacting heavily on women and families both as part of their care and afterwards, when they sought answers to understand what had gone wrong.
- Delineating grossly flawed teamworking among and between midwifery and medical staff, and an organisational response characterised by internal and external denial with many missed opportunities to investigate and correct devastating failings.

Key areas for action

The report has not sought to make multiple detailed recommendations, with its author noting that NHS Trusts already have many maternity safety recommendations and action plans resulting from previous initiatives and investigations. Instead, it identifies 4 broad areas for action, based firmly on its findings but with much wider applicability. These include:

1. **Monitoring safe performance – finding signals among noise**

Recommendation:

- The prompt establishment of a Task Force, with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals amongst noise, to display significant trends and outliers, for mandatory national use.

2. Standards of clinical behaviour – technical care is not enough

Recommendations:

- Those responsible for undergraduate, postgraduate, and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.
- Relevant bodies, including Royal Colleges, professional regulators, and employers, be commissioned to report on how the oversight and direction of

	clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance. **3. Flawed teamworking – pulling in different directions** Recommendations: • Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with reference to establishing a common purpose, objectives, and training from the outset. • Relevant bodies, including Health Education England (HEE), Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development. **4. Organisational behaviour – looking good while doing badly** Recommendations: • The Government is to reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies. • Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their board/s. • NHSE is to reconsider its approach to poorly performing trusts, with reference to leadership. **East Kent Hospitals University NHS Foundation Trust** The report also makes one recommendation specific to the Trust: • The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input. The report findings of the East Kent maternity and neonatal services report is included in Appendix 3 with an overall summary included in Appendix 4. Further communication has been received from NHSE/I (Appendix 5) which provides detail of a single delivery plan. This plan will be published for maternity and neonatal services to bring together the actions required from both the East Kent report; Part 1 & 2 – Ockenden report; the Long-Term Plan and the Maternity Transformation Programme deliverables.

4	**The Perinatal Clinical Surveillance Quality Tool (PCSQ) Assurance Report**
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in Appendix 6 and provides an overview of the latest (December 2022) key quality and safety metrics.

	The purpose of this report is to provide a monthly update to the Board of Directors of key metrics reported to the Local Maternity and Neonatal System (LMNS) 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 update and information only, with no indication to escalate any areas of concern to the Board to Directors.

	A summary from the Northwest Coast Outlier report for the period October 2021 – November 2022 is included in Appendix 7 and refers to WUTH data from the regional (Northwest Coast) Outlier report. A narrative against each of the metrics is included in the summary report.

6	**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 are no confirmed maternity SI's reported in October, November and December 2022 and no new cases referred to HSIB. Quarterly engagement meetings continue to be held with HSIB, with good engagement with all cases.

7	**Workforce Update 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 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. A consultation with staff has taken place to support staff transitioning to work within a continuity of carer model. This consultation was positively received with plans finalised for the implementation of 100% Maternity Continuity of Carer (MCoC). The target date as guided by NHSE/I date is for each provider to have this as the default model of care was March 2024, however this has been removed pending further review (Appendix 8). As a maternity provider WUTH has 5 MCoC teams with a sixth team who have been upskilled and who will be launched in January 2023. The assurance plans submitted to the LMNS, and NHSE/I indicated the building blocks to upskill would continue with full roll out anticipated by Autumn 2023. The implementation of MCoC within the Trust was initially planned for June 2022, however there were recommendations included in the Ockenden report that have delayed its implementation and this included the need for a further review of the midwifery workforce. As previously presented to the Board of Directors a workforce review using the Birthrate+ tool was undertaken in 2021, and a paper presented to the Workforce Assurance Committee outlining midwifery staffing requirements to deliver 100% MCoC.

	Funding from NHSE/I supported the recruitment of an additional Obstetrician and additional midwifery staff to support the roll out of this model of care. The workforce review has looked at skill mix and the uplift required in the midwifery establishment including an increase in the % uplift to support the additional training needs of each midwife. This uplift review considered sick leave, maternity leave, training, and annual leave and was calculated over a 3 Year period as outlined in the Ockenden recommendations. WUTH received funding to recruit 10.1wte Band 5 midwives in 2021/22 and further funding was anticipated to fund the remainder of the workforce to deliver MCoC however this has not been confirmed. To enable 100% rollout of MCoC the Birth rate plus findings suggesting that the midwifery establishment is required to increase by a further 4.72 wte midwives. A full paper and the associated risk assessment linked to running two models of maternity care will be presented at Executive Team Meeting in February 2023 for consideration. Further updates will be provided in the next Quarterly Maternity Update Paper.

8	Antenatal and New born Screening (ANNB) Programme update
	NHSE/I have outlined plans to undertake Quality Assurance visits to Maternity providers throughout 2023/24. WUTH had a virtual review of the ANNB Programme in 2021 and all actions following the review were completed. However, the Trust is still not meeting the KPI regarding the timeliness of antenatal bookings. The process for completing maternity bookings changed during Covid to telephone bookings and this impacted on the timeliness of booking bloods being taken. Whilst this is monitored closely by the Antenatal and Newborn Screening team and there have been no untoward incidents there is a comprehensive action plan to improve the timeliness of face-to-face bookings and screening bloods in the community. Whilst WUTH has not been notified of a date for a QA visit by NHSE/I, the experience and expertise of the Screening Coordinator has been fully utilised to develop an improvement plan looking at the potential key lines of enquiry (KLOES) of a QA visit. The team are compiling evidence required in preparation for a QA visit. It is proposed that an update is included in the quarterly maternity update to the Board of Directors, to support the oversight of the ANNB Screening Service. This is also added as a standing item to the Maternity Safety Champion Meeting agenda for 2023.

9	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, with WUTH supporting other providers on a number of occasions with mutual aid within the region.

10	Conclusion
	The next Quarterly Maternity Update Paper to the Board of Directors will include an ongoing update on the delivery of safe maternity services at WUTH, a detailed update on the highlights of the single delivery plan following the East Kent Independent Investigation and an update regarding the Continuity of Carer Implementation Plan.

	2022 was a busy successful year for maternity and neonatal services at WUTH and therefore an annual report will be produced and presented to the Board of Directors in April 2023 providing an overview of 2022 performance both in maternity and neonatal services at WUTH.

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Board of Directors in Public **Item 9.5**
25 January 2023

	Learning from Deaths Report (Q2 2022-23)
	Dr Nikki Stevenson, Executive Medical Director
	Dr Ranjeev Mehra, Deputy Medical Director
	Information

Report Purpose and Recommendations

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

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths
- The Trust SHMI for the 12 months to June 2022 is 1.05 (within expected range)
- HSMR on the latest available data is 98.1(within expected range)
- 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 of Directors:

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

Key Risks

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

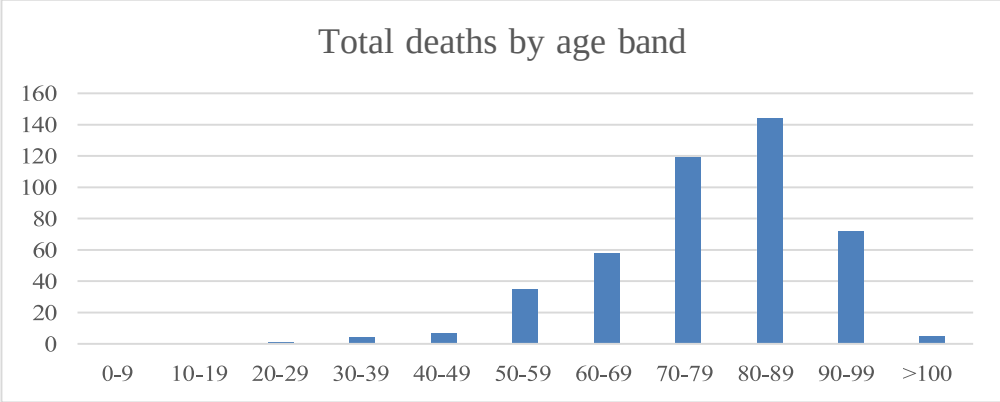
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working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

19 January 2023	Quality Committee	As above	Information

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 446 deaths in Q2 2022-23. Forty six (46) of these deaths were in patients who died within 28 days of a positive COVID-19 swab. There were 6 patients who died after acquiring covid in hospital. This compares to 11 patients in Q1

Category	Female	Male	Total
COVID	26	20	46
Non- COVID	189	211	400
Total			**446**

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	399
White - Irish	1
White - Any other White background	6
Mixed - Any other mixed background	1
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	2
Other Ethnic Groups - Chinese	1
Black/ Black British	3
Not stated/ Not known	33
Total	446

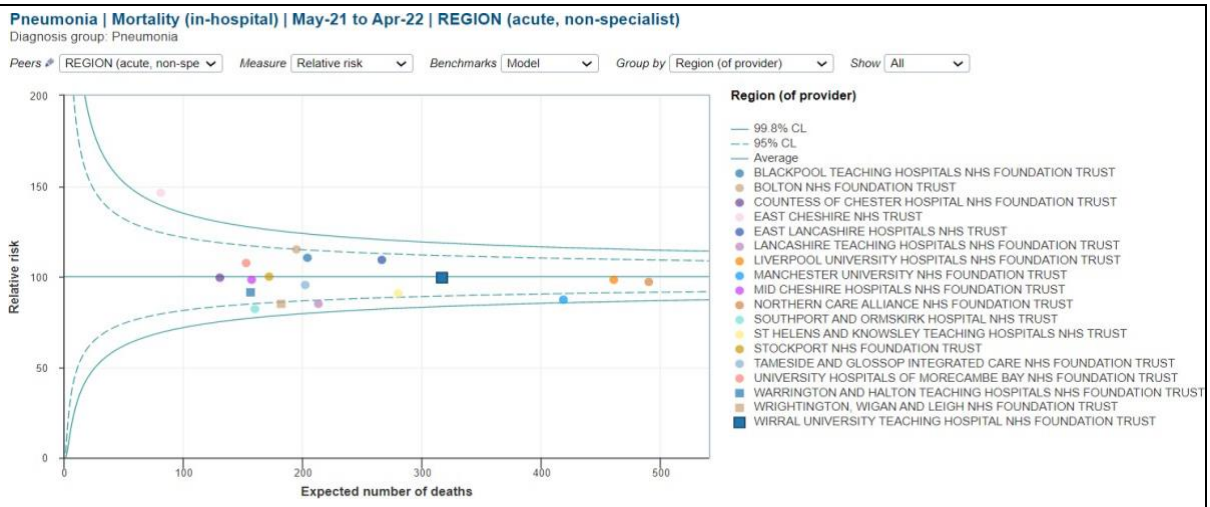
Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The overall SHIMI for WUTH is relatively steady at 1.05 (within acceptable range). This is on the latest available data (July 2021-June 2022)

SHIMI can be broken down into specific diagnostic groups to highlight any areas of concern. During Q2 the diagnostic group of “pneumonia” had a significantly raised SHIMI (1.23).

However, if deaths out of hospital are excluded then the SHIMI for pneumonia falls back to the average for the region.



Further analysis of deaths in this diagnostic group is required to fully understand the rise in SHIMI. This will be a case note audit of 100 cases in this diagnostic group to look at lessons learnt and common themes and will be coordinated through MRG.

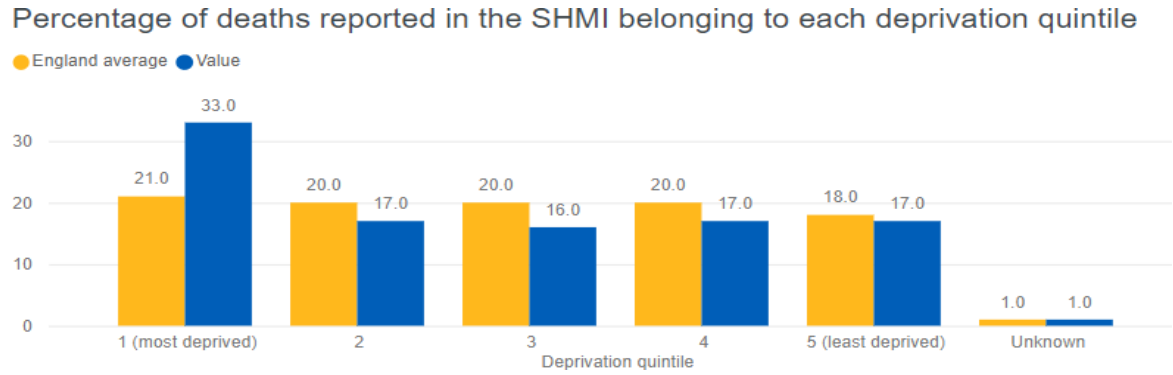
<u>Impact of deprivation on SHIMI</u>

The analysis highlights a notable variance in the percentage of patients from the most deprived quintile, at 39%, compared to an England average figure of 23.1%. The percentage of deaths from the most deprived quintile is also notably higher, at 33%, compared to a peer average of 21%.

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

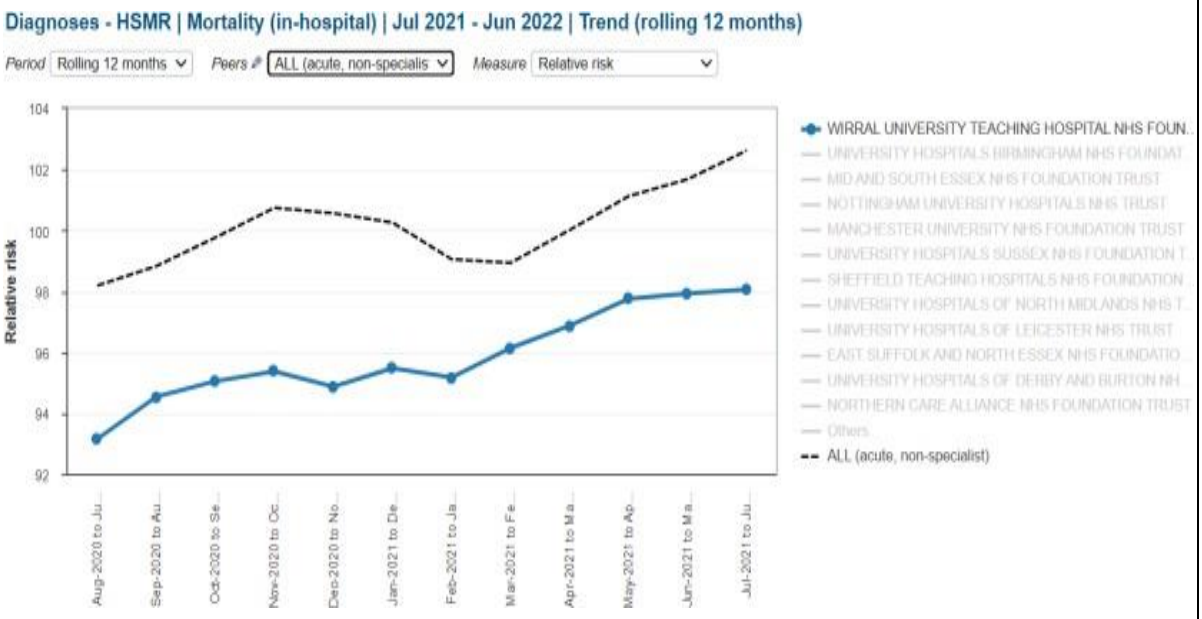
SHMI contextual indicators

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



Hospital Standardised Mortality Ratio (HSMR)

The HSMR for the latest available data has risen to 98.1 from 94.6. This is still in the expected range, and mirrors a national trend of rising HSMR for the past few quarters.



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

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

Mortality Dashboard

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

19 cases escalated by the ME to the mortality review group have undergone a review during Q2. These cases have been reviewed using a revised PMR template (17 cases) or via the Royal College of Physicians Structured Judgement review tool (2 cases). Six cases were escalated to the Serious Incident Review panel for discussion as to whether a Serious Incident should be declared.

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 26 deaths were reviewed in Q2 (6%) using the PMR template. None of these cases identified any cause for concern.

Summary of all Adult in patient deaths and case reviews							
	Total Adult In-patients Deaths	Total Reviewed by Med Examiner or MEO	Total No of cases escalated from 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
Q3 (21-22)	485	485	27	9	1	24	51
Q4 (21-22)	477	477	33	7	1	21	54
Q1 (22-23)	414	414	21	6	0	25	46
Q2 (22-23)	446	446	19	4	2	26	45

Grading of Adult Care and avoidability following SJR review in Q2 (Includes SJRs opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
		2	1	3

All 3 deaths where it was felt care issues affected the outcome were referred to the SI panel for discussion. Of the 3 deaths discussed in this quarter 1 was felt to have met the threshold for a serious incident (death in a patient with learning disabilaties)

During Q2, 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	Referred to National LeDeR Programme

			Identified in this Quarter	
Q3 (21-22)	6	6	3	6
Q4 (21-22)	4	4	0	4
Q1 (22-23)	4	4	0	4
Q2 (22-23)	2	2	1	2

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 Q2 there were no reported paediatric deaths or stillbirths. There was one neonatal death (due to extreme prematurity) that will be reviewed through the PMRT process in due course.

One PMRT report was finalised in Q2 that graded the overall care as Grade A (no care issues)

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

Outcome of PMRT reviews completed in Q1				
	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
	1	0	0	0

Learning identified through review of mortality reviews during Q2

Learning for mortality is derived from 3 main sources

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

Specific learning and themes identified during Q2 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 fast-track discharge home due to lack of availability in community	Mortality reviews	Fed back to End-of-Life lead for on going discussion at system level.
Poor documentation	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads.
Poor documentation around MCA and DNACPR decisions	Mortality reviews	All these cases are feedback to individual teams and the Trust CPR committee. MCA training and has been refreshed across all areas recently and audits of DNACPR forms strengthened to ensure better compliance .

Compared to previous quarters there has been a reduction in issues with communication and failure to recognise a deteriorating patient. Additionally, several reviews have identified areas of good practice, and these have been feedback to the teams looking after patients.

Dr Telstar Health (Dr Foster) Data

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

During Q2 deaths in the diagnostic group “Pneumonia” were highlighted as having a higher than expected SHIMI, although for in hospital deaths the SHIMI as in the expected range. MRG is coordinating a case note review into this SHIMI group and will report back in due course.

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

Diagnostic Group	Quarter Highlighted	Alert type	Work undertaken	Outcome/ Learning
Malignancy of unspecified site	Q2 21-22	CUSM alert	Case note review	Closed. Case note review (8 cases) did not show any concerns with care at WUTH. However, the majority of cases were late cancer presentation, and this raised questions around screening and GP

				access during the pandemic. This review has been shared with the Trust Cancer Lead and the MD of the CCG to discuss any further actions required from a system point of view.
COPD	Q3 21-22	High SHIMI	Review by Clinical Lead	Data reviewed with GIRFT and national COPD audit data. No concerns identified via GIRFT or National COPD audit. High SHIMI due to deaths post discharge form hospital. New virtual ward service began in Sept 2022 that will improve post discharge care and support for COPD patients.
Cerebral vascular Disease	Q3 21-22, Q4 21-22	High SHIMI	Review By Clinical Lead	On review in hospital deaths were as expected. SSNAP data (national benchmarking) did not show any cause for concern. Latest SHIMI data did not highlight this diagnostic group as a concern. After discussion at MRG decision made to not review further, but keep this diagnostic group under review.
Pneumonia	Q2 22-23	High SHIMI	Case note audit	Ongoing

2	Conclusion
	Mortality indicators do not show cause for concern and remain relatively stable. The difference between SHIMI and HSMR can be explained by the relatively high palliative care coding at WUTH and the higher than average deprivation on Wirral when compared to the average for England. The medical examiner continues to provide scrutiny for all adult deaths and escalates concerns to the Mortality Review Group for further review. Learning from these reviews is disseminated through the Trust Divisional structures as well as relevant service leads.

	Perinatal and Neonatal mortality does not show any cause for concern, with all deaths subject to investigation through the Perinatal Mortality Review Tool (PMRT). Telstar Health data has highlighted deaths in the diagnostic group of Pneumonia as an area of focus. This work will be coordinated through the MRG

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Board of Directors in Public **Item 9.5**
25 January 2023

Title	Freedom to Speak Up Report Q1-Q2 2022/23
Area Lead	Deb Smith – Chief People Officer / Executive Lead for FTSU
Author	Hayley Curran – Associate Director for OD & Sharon Landrum, Lead FTSU Guardian/Workforce Diversity and Inclusion Lead
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board of Directors with a 6-monthly update of Freedom to Speak Up (FTSU) matters for Q1 and Q2 2022/23.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key Risks:

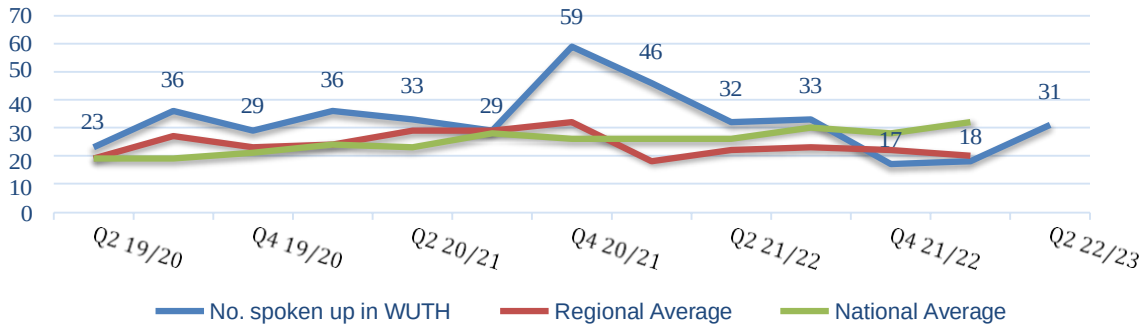
- Concerns raised may identify potential or actual risks, however these are managed on an individual basis and escalated to appropriate management representatives as necessary

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
7 December 2022 (via email)	People Committee	As above	Information

1	Narrative
1.1	Guidance issued by the National Guardians Office (NGO) in July 2019 (“Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts”) states that regular updates should be provided regarding the Freedom to Speak Up (FTSU) agenda and should be presented by the FTSU Guardian. Updates have been

	presented through the workforce governance structure, Trust Management Board, People Committee, and the Board of Directors on a regular basis. Revised NGO guidance for 2022 ("Freedom to Speak Up: A Guide for Leaders in the NHS and Organisations delivering NHS Services" 2022) highlights that reporting activity should now be on a bi-annual basis and therefore this report seeks to meet those requirements and outline FTSU activity for Q1 and Q2 of 2022/23. This report provides an overview of activity data for the first two quarters of 2022/23 and work undertaken to progress the agenda in line with national policy and best practice guidance. Data is presented in a way that maintains the confidentiality of individuals who speak up.

2	**FTSU Activity Assessment of Cases**
	The following activity data relates to Quarter 1 and Quarter 2 of 2022/23. **Number of People Speaking Up** The number of people speaking up to FTSU Guardians has increased significantly with 31 people speaking up in Q2 22/23 as opposed to 18 in Q1. It is also important to note that 1 concern raised within Q2 22/23 was on behalf of a group of staff within one area with a further 2 areas receiving multiple concerns during Q1 and Q2. Additional communications have taken place to promote the FTSU service during Q2 and therefore the increase could be as a result of heightened publicity of the FTSU team. Data is submitted to the National Guardians Office (NGO) on a quarterly basis and the charts below allow comparison between the overall number of people speaking up against regional and national Trusts of similar size. **No. of Cases Received at WUTH Compared to Regional and National Averages**  National and regional reporting data is not currently available for Q2, however based on previous data and trends, numbers of people speaking up within the Trust had fallen below national and regional averages over the last two quarters, however have significantly increased in Q2 22/23. **Concerns Raised by Theme** The table below sets out the concerns raised during Q1 and Q2 by theme.

New NGO reporting guidance (Recording Cases and Reporting Data, 2022), requires organisations to update the themes recorded and monitored, using new data from 1 April 2022.

The chart below encompasses the new data requirements which sees the following changes:

- Introduction of "Other inappropriate behaviour" category
- Worker safety or wellbeing

Other inappropriate behaviour is defined in the new guidance as:

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

Examples of other inappropriate attitudes or behaviours may include:

- Actions contrary to an organisation's values
- Incivility
- Microaggressions

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

Themes	Q1 22/23 Total	% of total raised Q1 22/23	Q2 22/23 Total	% of total raised Q2 22/23
Attitudes and behaviours	8	25.81%	21	37.50%
Bullying or harassment	1	3.23%	9	16.07%
Other inappropriate behaviour	2	6.45%	7	12.50%
Equipment and maintenance	0	0.00%	0	0.00%
Staffing	0	0.00%	1	1.79%
Policies, procedures and processes	7	22.58%	1	1.79%
Patient Safety	3	9.68%	0	0.00%
Patient Experience	0	0.00%	0	0.00%
Performance Capability	2	6.45%	1	1.79%
Service Changes	2	6.45%	1	1.79%
Other	2	6.45%	2	3.57%
COVID-19	1	3.23%	0	0.00%
Worker safety or wellbeing	3	9.68%	13	23.21%

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

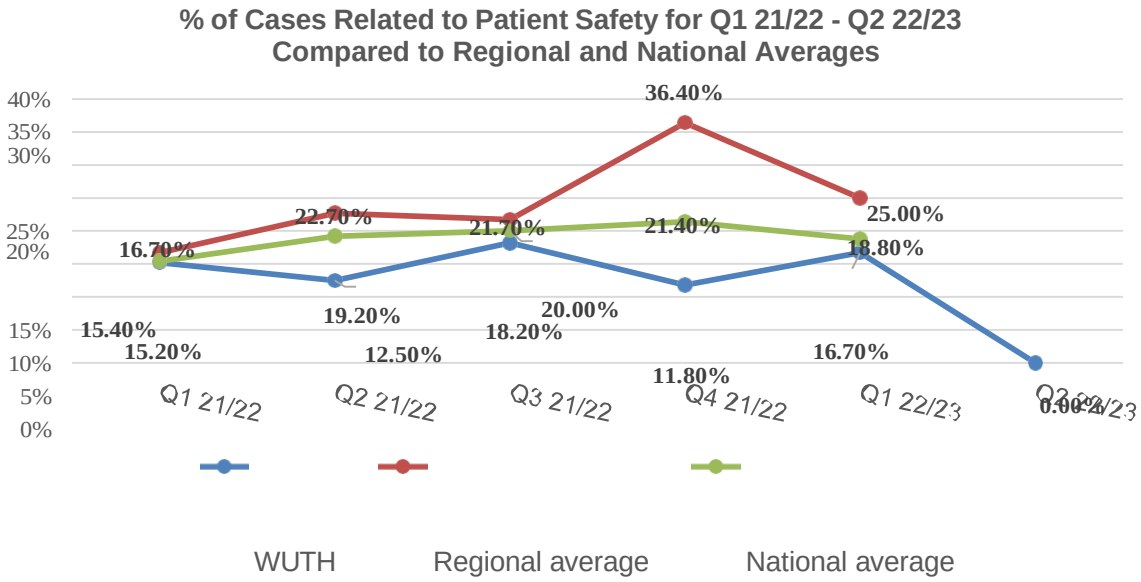
Q1 and Q2 continue to see attitudes and behaviours as the highest reported theme which rose to 21 cases (37.5%) in Q2. Policies, procedures and processes were also significantly high within Q1 7 (22.58%). Within Q2, worker safety or wellbeing was the second highest reported theme and linked particularly to the impact of concerns raised regarding poor attitudes and behaviours.

"Bullying" was reported in only 1 concern in Q1 (3.23% of the total raised), however increased significantly in Q2 with 9 (16.07%).

It is important to note that as per the NGO guidance, "bullying or harassment" is recorded where cases may indicate a risk or incident of bullying or harassment or where the person raising the case believes there is an element of bullying or harassment. The National Guardians Office (NGO) requires the term to be interpreted broadly and to be focussed on the perceptions of the person bringing the case.

FTSU Patient Safety Data

The chart to follow highlights the % of cases concerning patient safety for Q2 22/23, compared with quarterly data from Q1 21/22. None of the concerns raised in Q2 highlighted areas of patient safety as opposed to 16.7% (3 cases) in Q1 22/23.



Concerns Raised by Division

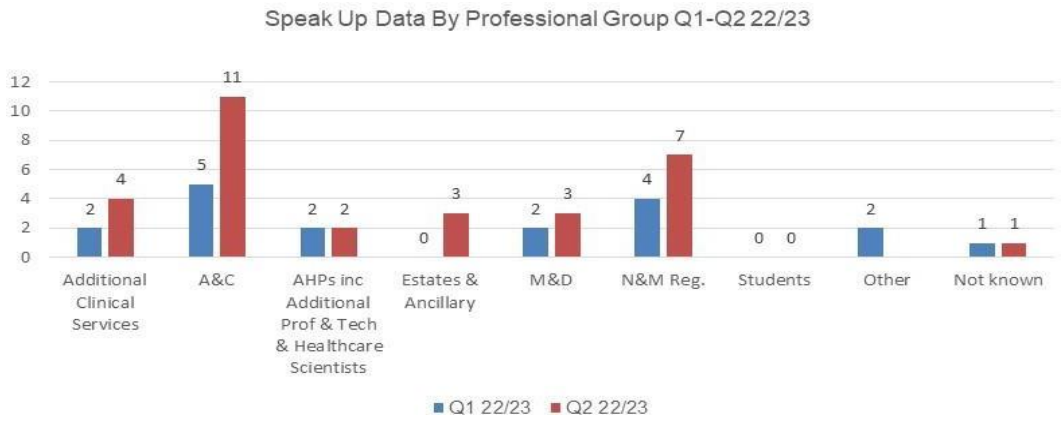
The following table outlines concerns raised by Division.

Division	Q1 22/23	Q2 22/23	Total Q1-Q2 22/23	% of Division for Q1 - Q2 22/23
Surgery	5	5	10	0.78%
Clinical Support & Diagnostics	2	3	5	0.36%
Medical & Acute	2	10	12	0.72%
Corporate Services	5	9	14	2.72%
Women & Childrens	3	1	4	0.58%
Estates & Facilities	0	3	3	0.33%
Unspecified	1	0	1	N/A
Multiple	0	0	0	0.00%
External	0	0	0	0.00%
Total	18	31	49	0.75%

It is important to note that 1 concern raised within Q2 22/23 was from Womens and Childrens and was on behalf of a group of staff.

Concerns Raised by Professional Group

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



The highest group of staff raising concerns in both Q1 and Q2 are from Administrative and Clerical roles with sixteen staff raising concerns in total across the quarters. The second highest occupational group of staff to raise concerns to FTSU Guardians are Nursing and Midwifery staff, who have raised 11 concerns across Q1 and Q2.

Anonymous Concerns

1 anonymous concern was received in Q1 22/23 regarding car parking and 1 was received in Q2 22/23 regarding the behaviour of a fellow colleague. Anonymous reporting continues to remain low which is particularly pleasing to see, especially as the number of cases has increased significantly in Q2 22/23 with reporters comfortable to share their details with FTSU Guardians.

Both anonymous concerns were progressed to the relevant management teams for review and action.

Disadvantageous or Demeaning Treatment as Result of Speaking Up

None were reported in Q1 or Q2.

Time Taken to Close Cases

The average time taken to close case for Q1 and Q2 was 3.0 weeks. This has reduced from 5.8 weeks in Q4 as a number of outstanding cases were closed during that time.

Lessons Learned

Crisis Support

Concerns were raised regarding the perceived lack of immediate support available for staff in “crisis” and access to expert help. This was following a difficult and distressing situation for the person speaking up who wanted to ensure they’d supported their colleague effectively.

Links were made with the Wellbeing Specialist Practitioner who has since developed support options for staff in this scenario, along with additional resources both internally and within the local community. This information has been shared back to the reporter and within their local team as well as across the Trust.

	Mental Health – Reasonable Adjustments to Contact Points Staff experiencing poor mental health may at times feel unable to communicate their concerns directly with line management. Cases have been received whereby staff want to share how they feel / their circumstances with management and happy to discuss the best way forward, however may struggle to say the words themselves or pick up the phone. A particular case in Q2 saw a "third party" used as a vehicle for information, however this was not well received by management and a lack of empathy and understanding in their approach which not only resulted in sickness absence but further reduced trust and communication and may result in questioning continuation in the role. Mental health awareness and a willingness to try and understand the needs of others is critical for staff at present along with understanding the importance of a third person to support speaking up in some cases.

3.0	**Progressing the FTSU Agenda**
	Significant development of the FTSU agenda has been led nationally via the National Guardians Office (NGO) in 2022 with both national guidance and policy being updated and relaunched by NHS England. This included: • National Guardian Reporting and Recording Guidance – February 2022 • FTSU Guidance - June 2022 • FTSU Reflection and Planning Tool for Trust Boards - June 2022 • Updated FTSU Policy – June 2022 To support the development of these a gap analysis was undertaken in order to develop a FTSU development plan that not only ensures that the Trust remains aligned to national FTSU requirements, but also continues to improve and provide a quality FTSU service at WUTH. In addition to the above documents the gap analysis also incorporated CQC requirements, findings from an internal review and learning from NGO case reviews. The following objectives were identified as part of an annual action plan. **Review Governance and reporting structures for FTSU Guardians** – Through this objective reporting and oversight arrangements have been strengthened to ensure robust Board assurance. In addition, a process for triangulating FTSU cases with employee relations cases and patient safety incidents has been established in line with Trust Just and Learning Culture. Ref: to appendix A for an overview of the process. Appointment of a new FTSU Lead Guardian has taken place, with the postholder due to commence in January 2023. **Ensure the Trust is up to date with national and local guidance, policy and best practice** – In addition to the gap analysis undertaken to inform an action plan which addresses the gaps, this work also includes implementation of NGO reflection and planning tool for Board. Actions associated with this objective also included a review of the FTSU Champion and Guardian roles to ensure they were operating within the guidance launched in April 2021. This has been completed and WUTH is in line with recommendations made, however the FTSU Champion network requires relaunch with the introduction of the new Lead Guardian in 2023. The NGO national policy has been adopted and approved via Trust policy, pay terms and conditions. Final ratification via the governance process is expected during Q3.

	This has replaced the existing Trust FTSU policy and ensures WUTH is compliant with NGO guidance. **Raise awareness of FTSU Guardians, Champions and Speak Up Agenda across the organisation** – Following the national rebranding of FTSU the Trust have updated all of its branding and promotional campaigns to reflect the national programme. A campaign using the new branding to raise awareness throughout the Trust was undertaken in Q2; this could be a contributing factor to a significant increase in cases from 18 in Q1 to 31 in Q2. New posters, business cards and pull-up roller banners have been purchased for further enhanced publicity. The importance of speaking up and the FTSU service is included within the Trust welcome event for new starters, with FTSU Guardian promoting key messages and holding a stall as part of the World Café event. FTSU Guardian has delivered a Speak Up session to doctors in training to promote the importance of speaking up and the support available. This has already seen a positive response, with contacts made to the FTSU team as a result. As at 30 September 2022 80.83% of staff have completed their level 1 speak up training and 75.55% of line managers / supervisors have completed the level 2 module Speak up Listen Up. Compliance continues to be high when compared with regional Trusts and seeks to promote awareness and support to all staff. The level 3 module is currently under review and is expected to be rolled out in Q4. **Identify groups potentially facing barriers to speaking up and work towards addressing those barriers** – This objective seeks to engage staff from minority groups who are potentially less likely to speak up. This work includes engaging staff networks to promote FTSU and encourage staff network members to become FTSU champions to further champion the agenda amongst staff with protected characteristics. In addition, work is ongoing to review data from other sources such as staff survey to identify staff groups that may be facing barriers to speaking up. See also section 3 regarding proactive work undertaken to engage with our doctors in training. **Review effectiveness of FTSU process** – Continuous improvement is paramount to developing a FTSU culture. A survey tool to introduce a feedback loop following the closure of FTSU cases is currently in development and is scheduled for launch in Q4. The data identified by this feedback survey will also be incorporated into future reporting from April 2023 onwards.

4	Conclusion
4.1	The number of people speaking up to FTSU Guardians has increased significantly with 31 people speaking up in Q2 22/23 as opposed to 18 in Q1, however this could be attributed to increased awareness of the FTSU agenda following a promotional campaign conducted during Q2. Considerable work has been undertaken during Q1 and Q2 to implement national FTSU policy and guidance including a gap analysis, development of an annual action plan and establishment of new policy and processes that triangulate FTSU cases with employee

	relations and patient incidents to determine themes and opportunities for learning. Work continues to enhance reporting and provide board assurance of the FTSU agenda. Appointment of a new FTSU Lead Guardian has taken place; they will commence in post in January 2023.

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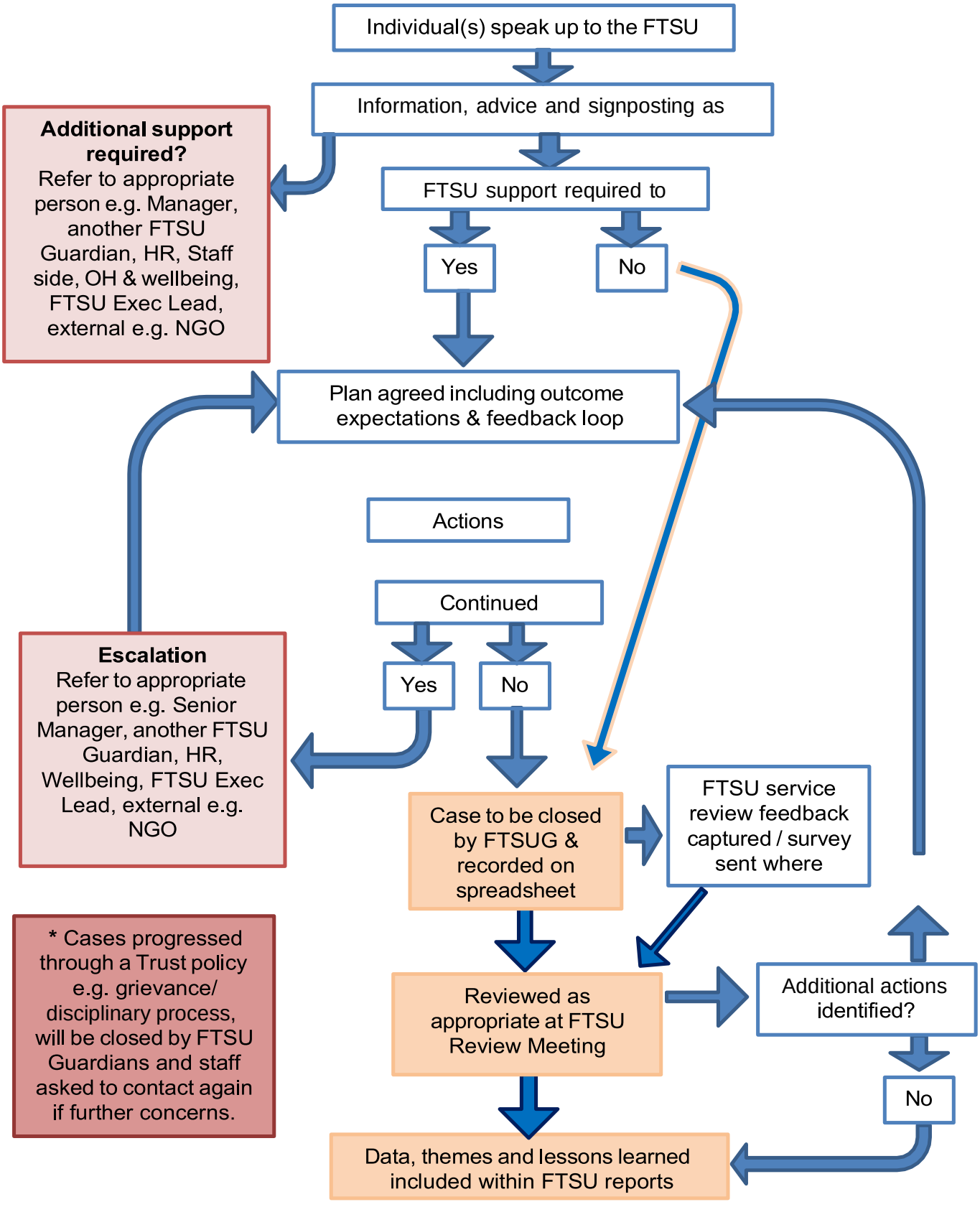
Freedom to Speak Up Guardian Governance Arrangements

October 2022



Board of Directors in Public **Item 10**

25 January 2023

Title	Communications and Engagement Report
Area Lead	Debs Smith, Chief People Officer Sally Sykes, Director of Communications and Engagement
Author	Sally Sykes, Director of Communications and Engagement
Report for	Information

Report Purpose and Recommendations

The purpose of the report is to update the Board on the Trust's communications and engagement activities in December 2022 and January 2023, including media relations, campaigns, marketing, social media, website, employee communications and stakeholder engagement, WUTH Charity and staff communications to support engagement.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

- Risk 1.1 – Unscheduled care demand (communications interventions to support addressing this risk and Trust initiatives like addressing discharges and patient flow)
- Risk 2.1 – Failure to fill vacancies (communications support on recruitment, retention, and reputation)
- Risk 3.4 – Failure of Transformation programmes (communications and engagement, including stakeholders and patients for WUTH Improvement activities for service transformation and elective recovery)
- Risk 6.1 – Estates related risks (Communications, stakeholder, and staff engagement to support delivery of Estates Strategy, Masterplans, and capital programme developments, plus communications for the Urgent and Emergency Care Upgrade Programme)

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

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

1	Narrative
1.1	This is the report of the Director of Communications, Marketing and Engagement, providing an update on the team's work to generate proactive media and social media coverage of WUTH, to keep staff informed of critical matters to help them work safely and to keep patients safe. **Campaigns, media, social media, internal communications, staff engagement communications and stakeholder relations.** **Campaigns** **December and January are busy months for national and regional campaigns, diversity initiatives and awareness raising activities. The NHS is also in focus for winter pressures and seasonal vaccination and disease awareness campaigns.** Our December campaign activity included Home - World AIDS Day, which is marked each year on December 1st. Other December campaign activity encouraged the public to 'Choose Well' when accessing services over the Christmas and New Year period and we highlighted alternatives to A&E during an exceptionally busy period for the hospitals and our staff. Our seasonal campaign output also emphasised the importance of vaccinations for both staff and the public and here's an example of our flu video. The WUTH Sustainability Team produced and eye-catching social media initiative featuring a green advent calendar of actions for people to take to be more environmentally aware during the holiday season. In January, we are supporting the Dry January campaign and the Wirral-wide 'Lower my Drinking' App. Please see links below. **The month of Dry January** **Love Your Liver Month** **Media** The intense and unprecedented pressures on the NHS over the Christmas and New Year period were the subject of significant media attention locally and nationally as all services experienced peak demand. WUTH featured in a story on Sky News about a patient who felt his treatment was not as tailored to his needs as it could have been and the Trust responded with media statements across a range of issues about winter pressures. Medical Director Dr Nikki Stevenson was interviewed on local radio, Radio City, about the extreme pressures and how the public could help by accessing services appropriately.

In positive stories, the Cheshire and Merseyside Surgical Centre was highlighted as an initiative to help reduce waiting times for elective surgery and how the theatres have been built using new techniques designed to facilitate timely construction and commissioning. Click here to view the coverage

WUTH CEO Janelle Holmes also wrote a blog for influential NHS Confederation's 'Winter Watch' series – please see link here to view the blog.

Further coverage of our capital investment and new facilities was secured when our new Dialysis Unit opened its doors, offering a greatly improved environment for patients and staff.

New dialysis ward is opened at Arrowe Park Hospital | Wirral Globe
New dialysis ward opens at Wirral University Teaching Hospital – Birkenhead News

We covered the award of a CBE in the King's New Year's Honours to our Non-Executive Board Member Lesley Davies.

And there was further seasonal positive coverage when Santa visited WUTH - Wirral Globe coverage Santa boards stagecoach grotto bus to visit Arrowe Park Hospital

Industrial Action

We provided media comment to The Wirral Globe on the Trust's extensive preparedness for industrial action as the first Ambulance and RCN strikes were held in December. Further preparations are in hand for the next strikes, including the RCN action involving WUTH on 18 and 19 January 2023.

Awards
Our first in person staff awards, the Together Awards, we held for the first time in three years. 237 entries were received and there were some amazing winners, including strong local support for the Patient Choice award, nominated by the public. Together Awards 2022 | Wirral University Hospital NHS Foundation Trust (wuth.nhs.uk)

The evening was a tremendous success, celebrating the hard work of our colleagues and the WUTH values and behaviours in action.

In other awards **Sarah Thompson, WUTH Chief Clinical Information Officer** (Pharmacy and Medicines) has been selected by the Pharmaceutical Journal as a 'woman to watch 2022'. Sarah Thompson - The Pharmaceutical Journal (pharmaceutical-journal.com)

Congratulations to our Library and Knowledge Services Team who have been awarded a Service Improvement Award by Knowledge and Library Services North - a network of health libraries and information services in the North of England (this network is also known as LIHNN). The team have been awarded this accolade for their outstanding work in creating online video tutorials to support staff and students to access the basic and advanced features of the new discovery platform, known as the Knowledge Hub.

Employee Communications
The 2022 Staff Survey launched on October 3rd and ended on 25th November 2022. Our awareness and promotional activity concentrated on securing participation from staff and demonstrating the difference staff feedback makes to our Trust. We are

	delighted to report that we met our target of 48% response, which is higher than last year and above average for the acute sector. During December we promoted the extensive programme of staff engagement activities for the holiday season and also highlighted interesting cultural and diversity initiatives from our international nurses. We produced the December issue of the Trust's 'In Touch' staff magazine. **Stakeholders** In the new integrated care system, the Wirral Communications Collaborative with partners in health and social care and Wirral Council is meeting monthly and delivering plans for winter communications to signpost patients to services. NHS Cheshire and Merseyside have also been significantly involved in planning for industrial action communications. We shared the Wirral Healthwatch newsletter and it's pleasing to see that they have resumed an onsite presence at Arrowe Park Hospital. To read the latest edition of the HealthWatch Wirral newsletter click here Monthly Newsletter - December, 2022 . **WUTH Charity** We are carrying out a post COVID-19 review to refocus the charity, sponsored by the WUTH Charity Committee, so that we can refresh and adjust our fundraising post-pandemic. In events and fundraising, the following are highlights: **Wirral Winter Ball** – 320 people attended this popular annual event and estimated income to WUTH Charity (after event costs) is £40k- on receipt of outstanding pledges and auction payments. The **WUTH Charity's Christmas Carol Service** - Tuesday 13th December at Christ Church, Port Sunlight, was a huge success and very well attended, raising approximately £2000. WUTH Charity also ran an extensive programme of Christmas events and collections, including on-site activities for staff and patients as well as supporting staff engagement. Funding was provided for patient and staff Christmas presents, including for the children's ward. The team are now planning the 2023-24 programme of events including celebrations for the 75th birthday of the NHS in July 2023.

3	Conclusion
3.1	The Board is asked to note the report.

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Board of Directors in Public
25 January 2023

Item No 11.1

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

Overview of Assurances Received

- The Committee held a shortened meeting due to the need for executives to prioritise operational pressures in the organisation. The Committee noted the deficit to the end of November 2022 as £4.7m, an adverse variance from plan of £5.4m. The adverse variance continued to be caused by underperformance on CIP, the cost of escalation wards staffed at premium rates, increases in energy prices and the national pay award exceeding funding available. The trust continues to forecast a yearend financial outturn of £6m deficit. The Committee received assurance that the forecast position has been discussed with the CFO of the ICB and there would be further discussion regarding the timing of formally changing the forecast. MC said he would also put this in writing to the CFO of the ICB.

- The Committee noted that the income and expenditure deficit had impacted the cash position and that cash balances were £8.2m behind plan. The cash impact is higher than the income and expenditure variance as there were non cash balance sheet items supporting the income and expenditure position. MC said that this had also been raised with the CFO of the ICB and it was likely the trust would need to seek cash support in 2023/24 in the form of loans or PDC.

- The CIP forecast for the year at M8 was £5.9m against a target of £13.9m. The Committee was assured that the organisation is still making best efforts to achieve an improved position and that service transformation and financial savings were now closely aligned.

- The Committee sought assurance on the level of premium rates being paid to locums and agency as this is a key issue affecting the workforce overspend. MC will be providing the details at the next meeting.

New/Emerging Risks

- The significant variance to plan and its impact on the Trust's cash position, while not a new risk is now a certainty.

Items for Escalation/Action

- The Committee recommended that an analysis of the causes of the income and expenditure variance be submitted to the January meeting of the Board of Directors.