NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

24 January 2024

09:00 GMT Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

Only PDFs are attached

- 0 Board of Directors Public Agenda.pdf
- 3 Board of Directors in Public Minutes - 6 December.pdf
- 4 Action Log - Public Board.pdf
- 7 Chief Executive Officer Report.pdf
- 8.1 WUTH IPR SPC Dashboard - Jan 2024 - 5 CFO (M9).pdf
- 8.1.1 CFO Commentary M9.pdf
- 8.2 Chief Operating Officer Report (1).pdf
- 8.3 Integrated Performance Report - Jan 2024.pdf
- 8.3.1 WUTH IPR SPC Dashboard - Jan 2024 - Intro.pdf
- 8.3.2 WUTH IPR SPC Dashboard - Jan 2024 - 2 MD.pdf
- 8.3.3 WUTH IPR SPC Dashboard - Jan 2024 - 3 CN.pdf
- 8.3.4 CN Commentary - Nov figs for Jan 2024 BoD.pdf
- 8.3.5 WUTH IPR SPC Dashboard - Jan 2024 - 1 COO.pdf
- 8.3.5 WUTH IPR SPC Dashboard - Jan 2024 - 4 CPO.pdf
- 8.3.6 CPO Commentary - for Jan BoD.pdf
- 8.4 BAF January 2024.pdf
- 8.5 FTSU Reflection Tool.pdf
- 8.5.1 Board Reflection Tool WUTH Final.pdf
- 8.6 Monthly Maternity & Neonatal Report Jan 2024 Final.pdf

- 8.6.1 Appendix 1 - MIS Compliance report for Board Jan 2024.pdf
- 8.6.2 Appendix 2 - MIS Year 5 Jan 2023 Draft V1.pdf
- 8.6.3 Appendix 3 - Perinatal Clinical Surveillance Quality Assurance Report Jan - Dec 2023.pdf
- 9 EDI Bi-Annual Report.pdf
- 9.1 Gender Pay Gap Report.pdf
- 10 Complaints Annual Report.pdf
- 11 Governance Update.pdf
- 11.1 Sop clean version - Nov 23.pdf
- 11.2 Research and Innovation V2.pdf
- 12.1 People Committee.pdf
- 12.2 FBPAC.pdf
- 12.3 R&I.pdf
- 12.3.1 Copy of Arrowe Park Open Studies 15.01.24.pdf
- 12.3.2 Appendix 2 WUTH open studies 15.01.24 (1).pdf

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 24 January 2024
Time	09:00 – 11:00
Location	Hybrid

Agenda Item			Lead	Presenter
1.		Welcome and Apologies for Absence	Sir David Henshaw	
2.		Declarations of Interest	Sir David Henshaw	
3.		Minutes of Previous Meeting	Sir David Henshaw	
4.		Action Log	Sir David Henshaw	
Items for Decision and Discussion				
5.		Staff Story	Debs Smith	
6.		Chairs Business and Strategic Issues – **Verbal**	Sir David Henshaw	
7.		Chief Executive Officer Report	Janelle Holmes	
8.		Board Assurance Reports		
	8.1)	Chief Finance Officer Report	Mark Chidgey	
	8.2)	Chief Operating Officer Report	Hayley Kendall	
	8.3)	Integrated Performance Report	Executive Directors	
	8.4)	Board Assurance Framework	David McGovern	
	8.5)	Freedom to Speak Up Reflection and Planning Tool	Debs Smith	Tracey Nolan
	8.6)	Monthly Maternity and Neonatal Services Report (including Maternity Incentive Scheme Year 5 Annual Declaration)	Dr Nikki Stevenson	Jo Lavery
9.		Equality Diversity and Inclusion Bi-Annual Report (including Gender Pay Gap Report)	Debs Smith	Sharon Landrum
10.		Complaints Annual Report	Dr Nikki Stevenson	
11.		Governance Update	David McGovern	Cate Herbert
Committee Chairs Reports				
12.	12.1)	People Committee	Lesley Davies	
	12.2)	Finance Business Performance Committee	Sue Lorimer	
	12.3)	Research and Innovation Committee	Sir David Henshaw	

Closing Business

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

Date and Time of Next Meeting

Wednesday 6 March 2024, 09:00 – 11:00

Meeting	Board of Directors in Public
Date	Wednesday 6 December 2023
Location	Hybrid

Members present:

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

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
CM	Chris Mason	Chief Information Officer
CH	Chris Green	Chief Pharmacy Officer
SS	Sally Sykes	Director of Communications and Engagement
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.6
AA	Dr Alice Archer	Guardian of Safe Working – item 8.7
TN	Tracey Nolan	FTSU Lead/Just and Learning Culture Lead – item 8.8
JB	John Brace	Public Governor
RT	Robert Thompson	Public Governor
PI	Paul Ivan	Public Governor
EH	Eileen Hume	Public Governor

Apologies:

RM	Professor Rajan Madhok	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
TF	Tracy Fennell	Chief Nurse

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence**	

	SI welcomed everyone to the meeting and agreed to chair as DH joined remotely. 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 1 November were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Experience Strategy Story** The Board received a video story consisting of a compilation of patient stories relevant to each of the five Patient Experience Strategy promise groups. Each story described their experience in relation to the purpose of the promise group. SI commented it was a positive and powerful video and queried how it was being shared more widely with patients and stakeholder groups. VP stated a version was accessible to staff along with other stories and one version would be used for wider sharing externally with members of the public and stakeholder groups. It was also noted that this had been shared at the Leadership Conference. SR enquired if this sort of story could be used in recruitment. DS stated that she would look into this. The Board **NOTED** the story.	
6	**Chairs Business and Strategic Issues** DH provided an update on recent matters and highlighted progress continued to be made on key areas and the Trust maintained a good relationship with Cheshire and Merseyside system partners. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH gave an industrial action update and explained junior doctors would hold further strike action for three days from 20 December and six days from 3 January. The UNISON industrial action relating	

	to retrospective re-banding for Clinical Support Workers continues and despite further ACAS conciliation, further strike action will continue for 3 weeks throughout December. JH reported the Cheshire and Merseyside Surgical Centre achieved Getting It Right First Time (GIRFT) accreditation, the Endoscopy Team received JAG accreditation, the Cellular Pathology maintained the United Kingdom of Accreditation Service and the Pleural Team were shortlisted in the Macmillan Cancer Support Professionals Excellence Awards for a Whatever It Takes award. JH stated the Cheshire & Merseyside Elective Recovery and Transformation Programme won the Provider Collaboration of the Year at the Health Service Journal Awards and the Trust was also a finalist for the Cheshire and Merseyside Surgical Centre. JH stated the Patient Safety Incident Response Framework (PSIRF) was launched in September and one PSII was opened in October in relation to what would previously have been called a Never Event. Three Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS) were reported to Health and Safety Executive. JH highlighted that the Board of Directors in October approved a contract award to 4Ways Healthcare Ltd, which was negotiated by the Cheshire and Merseyside Radiology Imaging Network for the provision of outsourced out of hours radiology reporting services. JH explained the Thirlwall Inquiry Terms of Reference had been published on 30 October and the Trust was co-ordinating a response to this. JH referenced the public hearings for module 2 of the UK Covid-19 Inquiry and summarised the recent meetings of the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board on 3 November and the Place Based Partnership Board (PBPB) on 23 November. The Board **NOTED** the report.	
8	**Board Assurance Reports** **8.1) Chief Finance Officer Report** MC highlighted the Trust was forecasting, with risks, that the financial plan for 2023/24 will be achieved. At the end of October (Month 7) the Trust reported a deficit of £16.3m against a plan of £14.1m, the resultant variance of £2.2m was a deterioration on the Month 6 position and summarised the key variances to the position. MC provided an update on the Month 7 statutory targets and the RAG rating for each, highlighting that financial stability and financial	

	sustainability were red, capital and cash were amber, and agency spend, and financial efficiency were green. SL queried the financial impact of the under-utilisation of the Cheshire and Merseyside Surgical Centre (CMSC) by the Countess of Chester. MC stated the would be a financial impact of circa £700k a month for the remainder of the year. The financial impact to date was unclear as this was offset by less expenditure on consumables. HK highlighted the Countess of Chester was operating circa 30-40% at CMSC and it was anticipated they would use facility more during January to March due to their own winter bed pressures in the hospital. DH commented this was beyond the Trust's control to influence but would be financially impacted due to the under-utilisation and it was important to ensure maximum usage. JH stated the ICB had reinforced the importance to Cheshire and Merseyside providers to use CMSC and there would be no impact to WUTH on accepting patients whose waiting time was over the agreed national standards and expected clearance thresholds. JH added the ICB were keen for providers to use NHS capacity ahead of contracting work out to the private sector. The Board **NOTED** the report. **8.2) Chief Operating Officer Report** HK highlighted in October the Trust attained an overall performance of 97% against plan for outpatients and an overall performance of 87% for elective admissions. HK stated underperformance continues due to the impact of large-scale cancellations for industrial action, two medical specialities as well as underutilisation of Cheshire and Merseyside Surgical Centre by other regional Trusts. HK stated cancer performance for 2 week waits at the end of October was 84.3% and the Faster Diagnosis Standard in September was 72.09% against a national target of 75% by March 2024. DM01 performance in October was 93.65% against a national target of 90% by March 2024. HK reported type 1 unscheduled care performance was 48.50% which was below the 4hr improvement trajectory, noting the number of patients self-presenting and the number of patient ambulance conveyances in October was higher than in the previous year.	

	SL queried the under-performance in unscheduled care and if the type of patients self-presenting in ED had changed. SL commented the same concerns appeared to remain despite the significant reduction in the number of patents with no criteria to reside. HK stated patients had not changed, under-performance in regard to 4hr performance was driven by internal processes and these were being reviewed to ensure maximum efficiency. HK added the process improvements, along with greater grip and control would improve overall performance for 4hr, 12hr and ambulance handovers. DH congratulated the team for the improvements made to the number of patients with no criteria to reside, noting it was now below 100. DH queried what the impact on the front door would be if all processes were working as they should be.	Hayley Kendall
	HK stated there would be a reduced number of elderly patients arriving by ambulance as these would be diverted to a frailty service. HK agreed to provide an update at the next meeting in regard to services available/options to improve admission avoidance. SR queried how the Trust was dealing with corridor care. NS stated corridor care occurred when the ED had high attendances and acknowledged this was not ideal but was considered the best option for patients. NS added the Deputy Medical Director from the ICB visited the Trust recently and recognised the limitations of ED layout and commented that other Trusts in Cheshire and Merseyside provided care in ambulances instead of on the corridor. DH commented that the CQC might have a negative view if the Trust were providing corridor care during an inspection. NS explained the Trust was keeping the CQC Engagement Officer aware of the approach to corridor care and they had already asked for further information on the Trust's mitigations. NS added the Executive Directors considered it in the patients' best interest to provide care on the corridor instead of in an ambulance when necessary, noting this would have an impact on ambulance handover times and wider complications for the ED.	Hayley Kendall
	HK commented the number of patients on the corridor was tracked and agreed to consider including this metric as an SPC in the Integrated Performance Report. The Board **NOTED** the report. **8.3) Integrated Performance Report**	

	VP highlighted the number of C Diff cases had exceeded the threshold set by NHS in comparison to last year, but the Trust continued to focus on robust infection prevention and control measures. VP added the Friends and Family Test for inpatients, outpatients and maternity all met threshold except for ED. SR queried the external review of infection prevention and control measures of Wirral system partners conducted earlier in the year and if the report was available. VP agreed to follow this up so the report can be shared with Quality Committee. DS highlighted sickness absence in month continued to increase and continued to be driven by short term absence through cold, flu and COVID. The use of the flu and COVID vaccine continued to be encouraged. DS added long term absence was driven by stress/depression and noted that the Occupational Health team have been providing greater mental health support. As a result, long term absence related to mental health had decreased by 3% over the previous 3 months. SR commented it was positive the Trust continued to meet the threshold for appraisal and mandatory training compliance despite the industrial action and other pressures. The Board **NOTED** the report. **8.4) Board Assurance Framework (BAF)** DM summarised the BAF covering strategic risks and the proposed changes to the relevant risk scores following a review of assurances and controls. DM added the next iteration of the BAF would include the risk scores over a 12 month period. SL queried the proposed changes to the financial sustainability risk score. MC highlighted the likelihood score had reduced due the completion and submission of the Trust's H2 plan to ICB, noting there were no changes to the underlying financial plan. MC added additional mitigations had been put in place in regard to elective and estates recovery plans. MC added that with the announcement of the junior doctor strikes, the score may need to be reassessed, but that at this point, the risk can be reduced, and the continuous review will pick up any changes. This is important to show the movement of risk and the continual assessment being conducted by the Trust. JH explained she was pleased to see the BAF being used more dynamically and shared with Divisions.	

SI highlighted the Audit and Risk Committee continued to undertake regular deep dives on BAF risks and there will remain residual risks despite the controls put in place. SI added the external auditor had been complementary of the Trust's approach to discussing risks.

The Board **NOTED and APPROVED** the changes to the BAF.

8.5) Productivity and Efficiency Update

HK reported the year to date position was £12.5m transacted recurrently and the in year effect being £21.8m, equivalent to 84% of the target. HK added plans were in place to deliver an additional £1m non-recurrently in year to bridge a previous month deterioration of £1m in year.

CC commented he regularly attended the monthly Programme Board meeting where each Division's CIP schemes and workstreams were discussed, noting there were constructive and positive conversations.

SR queried the approach and planning for 2024/25.

HK stated early planning had already started to ensure schemes were in place for April. HK added the guidance from NHS detailing required CIP for next year would likely be available in January, but the Finance Business Performance Committee in December would receive several scenarios.

The Board **NOTED** the report.

8.6) Quarterly Maternity and Neonatal Services Report

JL introduced the report and gave an update on Year 5 of the Maternity Incentive Scheme (MIS) with an update on Saving Babies Lives, a key component of the ten MIS safety actions.

JL also gave an update on the three year delivery plan for the service, implementing a Continuity of Carer Model and referenced the 2022/23 Maternity and Neonatal Voices Partnership (MNVP) Annual Report for information.

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

Members thanked JL for the report and for collating the evidence required for documenting compliance.

The Board:

- **NOTED** the report; and

	• **NOTED** the progress of the Trust's position with Year 5 of the Maternity Incentive Scheme and Saving Babies Lives v3; and • **NOTED** the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals;" and • **NOTED** the update to the Continuity of Carer model of maternity care and the Trusts position to implement this model as a default model of care subject to approval to improving the midwifery establishment; and • **NOTED** the Maternity and Neonatal Voices Partnership (MNVP) annual report. **8.7) Guardian of Safe Working Report** NS highlighted the number of exception reports and vacancies covering the period 1 June to 30 September, noting exception reports were due to vacant shifts, sickness, and parental leave. NS added Dr Alice Arch had been appointed Guardian of Safe Working on 1 November following Dr Helen Kerss stepping down. NS stated in future reports Dr Arch would provide a more detailed narrative regarding the exception reporting. HK commented the number of exception reports in ED continued to reduce as gaps in the rota have been addressed and this was welcomed by for junior doctors. SR queried the medicine F1 doctors' exception reports and if these doctors were based in ED. AR stated the majority of these exception reports were located in the Medicine Division and not in ED. AR added she was reviewing the process for raising exception reports to ensure this was efficient for junior doctors. SL noted vacancies were covered by doctors on flexible contracts and queried what this meant. NS stated these doctors had a flexible contract instead of a zero hour contract to allow the Medical Director to remain as their Responsible Officer should they take time away, etc. NS added these were F3 doctors not in training and who had completed their foundation. The Board **NOTED** the report. **8.8) Freedom to Speak Up (FTSU) 6 Month Report** TN summarised the report, noting the number of concerns had increased in Q1 and Q2 and explained the concerns raised by	

	themes and Division. TN added patient safety concerns remained lower than regional and national average, however staff were likely to be reporting these concerns via Ulysses. TN highlighted an additional 20 FTSU champions had been recruited following targeted work in underrepresented areas. DS congratulated TN for the continuing to raise the awareness of FTSU and referenced the recent internal audit review into FTSU which gained substantial assurance. SL noted 46% of concerns raised were from the Diagnostics and Clinical Support Division and queried this. TN stated she met with the Divisional Director to discuss this concern. It has been resolved and not continued into Q3. SR queried the concerns raised in regard to service changes. TN stated this theme continued in Q3 and concerns were regarding changes in service functions within the hospital. Staff felt these were being made to them instead of with them, and this made them feel anxious. TN added managers have been reminded to involve staff early on in future changes. DS added quarterly thematic reviews take place in a Lessons Leant Forum and any learning for future practice is shared with the relevant teams. JH commented that Divisions were actively engaged with FTSU and continue to improve the working environment and support for their teams. SI commented he is the Board lead for FTSU and meets quarterly with TN who also has direct access to him where any concerns could not be resolved. SI also commented it was positive regarding the substantial assurance of the FTSU review. The Board **NOTED** the report.	
9	**NHS Prevention Pledge** DM provided an outline of the work being carried out in Cheshire and Merseyside to oversee the adoption of the NHS Prevention Pledge at regional and Trust level, noting the Trust had committed to an initial 7 pledges. DM highlighted progress updates be reported to the Board on a bi-annual basis and an action plan will be presented to the March 2024 meeting.	

	MS commented an additional enabling strategy was being developed given the increased importance and focus on health inequalities. **The Board:** • **NOTED** the report; and • **NOTED** and **CONFIRMED** the adoption of the Pledge and associated commitments; and • **NOTED** the proposals for future monitoring and reporting of progress.	
10	**Standing Financial Instructions (SFIs)** MC gave an overview of the proposed amendment, explaining Internal Audit carried out a review into Capital Governance and recommended a change to the SFIs to reflect current practices in relation to business cases and other documentation required for capital schemes. The Board **APPROVED** the amendments.	
11	**WUTH Charity Annual Report and Accounts 2022/23** MC presented the 2022/23 Annual Report and Accounts and summarised the key achievements. MC added the Charitable Funds Committee met on 27 November to approve the Annual Report and Accounts and the external auditor gave an unqualified independent examiner report of the accounts. SL commented the report included an impressive amount of activity taken place in year and was engaging to read. The Board **NOTED** the Annual Report and Accounts.	
12	**Comms and Marketing Strategy** DS presented the strategy for approval and summarised how this strategy would support the Trust in its delivery of the strategic objectives. DS added the strategy would be underpinned by a detailed operational plan similar to the other enabling strategies. SR commented that the strategy was good to see and thanked those involved in the process. The Board **APPROVED** the draft Communications and Marketing Strategy.	
13	**Annual Review of Terms of References** CH presented the final Terms of References for approval for Board Assurance Committees following the annual review. The Board **APPROVED** the Terms of References.	

14	**CQC Urgent and Emergency Care Patient Experience Survey Results 2022** The Board **NOTED** the report.	
15	**CQC Adult In Patient Survey Results 2022** The Board **NOTED** the report.	
16	**National Cancer Patient Experience Survey Results 2022** The Board **NOTED** the report.	
17	**Committee Chairs Reports** **17.1) Quality Committee** The Board **NOTED** the report. **17.2) Charitable Funds Committee** The Board **NOTED** the report. **17.3) Audit and Risk Committee** The Board **NOTED** the report.	
18	**Questions from Governors and Public** JB queried the ongoing industrial action and if there was any resolution to this, commenting he was aware of patient's appointments being cancelled. JH stated the impact of industrial action was routinely tracked through a robust risk assessment to ensure there is no patient safety or quality impact. JH explained patient appointments were cancelled or delayed for a number of reasons, including due to annual leave and sickness not just industrial action. JB also queried if the response to the Thirlwall Inquiry Terms of Reference would be made available. DM stated this was confidential at present and would be made publicly available when appropriate. JB also queried if the debt between Wirral Borough Council and the Trust had resolved yet. SI stated the Trust continued to work towards a negotiated settlement regarding this and Audit and Risk Committee continue to be updated on progress.	

	JB also queried the CQC patient surveys, noting some of the mean scores had decreased. VP stated the results of this survey go back a year and the hospital continued to have residual COVID restrictions in place during that time. VP added recent Friends and Family Tests demonstrate good performance in outpatients, inpatients, and maternity. NS highlighted Divisions had been undertaking mock CQC inspections in advance of a future inspection. An action plan had been developed and this was being regularly monitored through appropriate governance routes to ensure improvements were being maintained. EH thanked the Board of Directors and staff for their hard work and continued to feel assured of good progress being made despite the ongoing challenges.	
19	**Meeting Review** No comments were made.	
20	**Any other Business** No other business was raised.	

(The meeting closed at 12:10)

Action Log
Board of Directors in Public
24 January 2024

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	5 July 2023	8.1	To provide a breakdown of the number of open studies to understand the totality and spread	Dr Nikki Stevenson	Complete. Appended to Committee Chair's Report.	January 2024
2.	1 November 2023	11	To provide a deep dive on mental health risks and mitigations	Vic Peach	Complete. To be presented to Quality Committee in January 2024 and will be a future Board Seminar topic.	March 2024
3.	6 December 2024	8.2	To provide an update in regard to services available/options to improve admission avoidance	Hayley Kendall	Complete. Work ongoing with Wirral system partners reported through the Wirral Unscheduled Care Board.	January 2024
4.	6 December 2024	8.2	To consider including corridor care as an SPC in the Integrated Performance Report	Hayley Kendall	Complete. Information on corridor waits and ambulance handover will be included in future COO reports.	January 2024

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
24 January 2024

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

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

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

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

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

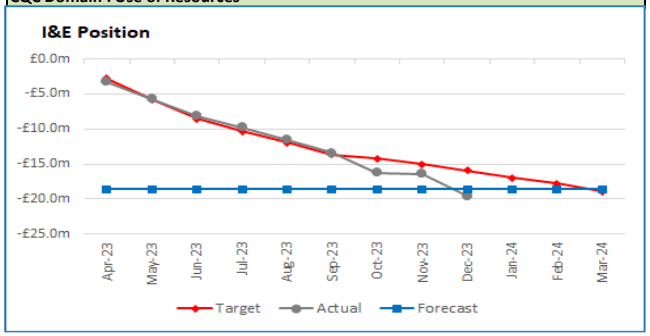
1	**Narrative**
1.1	**Industrial Action Update** The national pay dispute relating to Consultants and Junior Doctors is on-going. Three days of Junior Doctor strike action took place in December 2023, followed by a further 6 days in early January 2023.

	In a separate matter, the UNISON industrial dispute relating to retrospective re-banding for Clinical Support Workers continues. In October 2023 UNISON agreed to the Trust's request to enter into ACAS conciliation and meetings have taken place on four separate occasions, to discuss the Trust's third offer. The third offer includes agreement on UNISON's key demand, specifically a backstop date of April 2018 for any retrospective regrading. For retrospective re-grading to be awarded, the duties that individuals have been undertaking must be sufficient to change the banding of the role. The Trust position on this matter is based on the national NHS framework. Talks have stalled because parties are unable to agree on what constitutes the difference between a band 2 CSW and a band 3 CSW. UNISON asked the Trust to seek national advice on our position. The Trust did so, and the advice confirmed that the Trust position is in line with the national NHS framework. Unfortunately, UNISON have not accepted this position and therefore further strike action has taken place across January 2023 and is likely to extend into February 2023. As with any industrial action, planning and mitigating actions are in place via the Trust's EPRR route and impact across the Trust is carefully monitored. In addition, close and on-going review of any impact to patient care is in place.
1.2	**Accreditations and Awards** **Safe Effective Quality Occupational Health Service (SEQOHS) Accreditation** The Trust's Occupational Health Service has continued to maintain the standards to meet the SEQOHS annual re-accreditation requirements. The Service maintains a full range of regularly reviewed clinical policies, procedures, and protocols to ensure clinical practice is up to date at all times. Accreditation is valid until 2 February 2025, subject to annual renewal.
1.3	**Patient Safety Incident Investigations (PSIIs) and Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS)** There were no PSIIs opened in the months of November and December 2023 under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. There was one RIDDOR reportable event reported in the months of November and December 2023. All RIDDOR reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring.
1.4	**Business Case/Contract Award Updates** The Board of Directors in December approved a business case to invest in the Aseptic Support Unit (ASU) to provide greater efficiency and resilience of supply for the Trust and to other North West Trusts.
1.5	**UK Covid-19 Inquiry module 2 public hearings summary**

	The UK Covid-19 Inquiry public hearings for module 2 began on 3 October 2023 and with the final witness giving evidence on 11 December 2023. Additional hearings for module 2 on Scotland, Wales and Northern Ireland will take place in 2024. Module 2 focused on core political and administrative governance and decision-making for the UK. It will examine the initial response, central government decision making, political and civil service performance as well as the effectiveness of relationships with governments in the devolved administrations and local and voluntary sectors. It will also assess decision-making about non-pharmaceutical measures and the factors that contributed to their implementation. In early December the Inquiry heard from former Prime Minister, Rt Hon Boris Johnson, and then from current Prime Minister, Rt Hon Rishi Sunak MP. Evidence was heard on the 'Eat out to help out' scheme, the timing of lockdowns, the tiering system and what consideration was given to vulnerable and 'at risk' groups.
1.6	**System and Place Updates** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** The Leadership Board met on 1 December and received presentations related to previous discussions on digital and workforce and recommendations for action by involving Trusts. CEOs will now use the next month to engage with their Trust Teams on the suggested priorities and identified areas for action, reporting back at the next Leadership Board with the aim being to secure CMAST agreement for a set of priority activities. Further items of business related to a review of system financial plans following a requirement for refreshed approaches coming from NHSE instructions to systems on 8th November. The collaborative approach and work of the finance community was noted and commended. The Leadership Board also received an update on the work being undertaken in relation to current and live system LIMS procurement. The stages of the process, requirements for Executive and Board engagement and Trust and system decision making to be underpinned by a system approach to risk and gain share were set out. **Place Based Partnership Board (PBPB) Update** The Place Based Partnership Board (PBPB) met on the 21 December and discussed several reports, including quality and performance, finance, and risk reports from a Place perspective. Key among the reports was an update on the system management of key strategic risks as identified in the Place Delivery and Assurance Framework, as well as an update on the progress of the programmes associated with the Wirral Health and Care plan 2023-24.

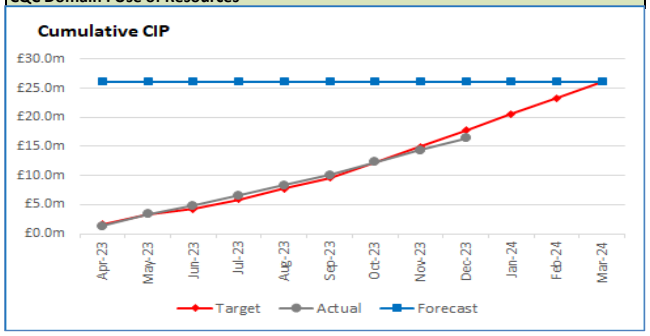
Chief Finance Officer

CQC Domain : Use of Resources



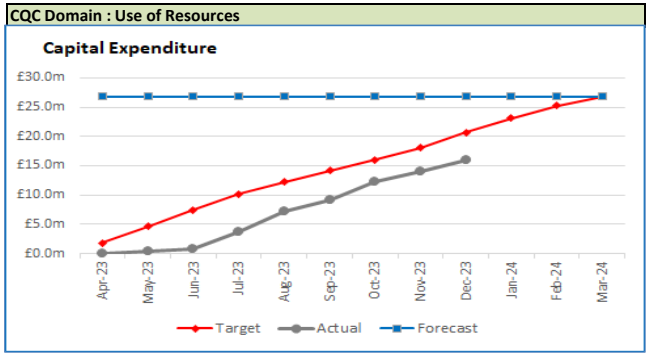
Dec-23
-£19.59m
Variance
Position worse than plan
Target
-£15.91m

CQC Domain : Use of Resources



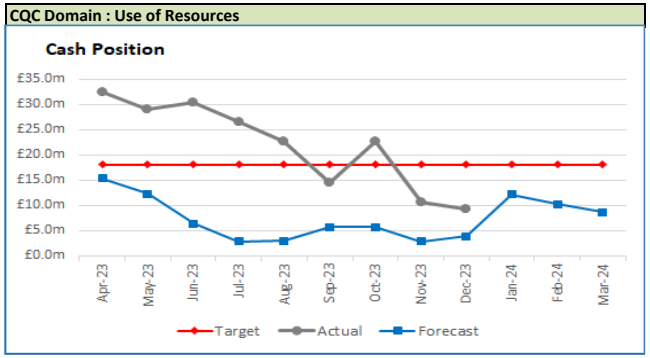
Dec-23
£16.42m
Variance
Position worse than plan
Target
£17.75m

CQC Domain : Use of Resources



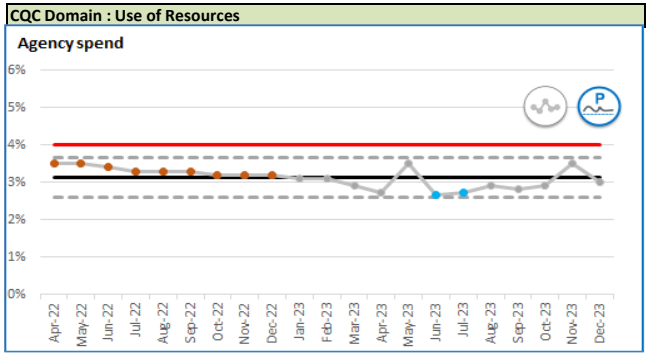
Dec-23
£15.90m
Variance
Position not worse than plan
Target
£20.7m

CQC Domain : Use of Resources



Dec-23
£9.3m
Variance
Position worse than plan
Target
£18.0m

CQC Domain : Use of Resources



Dec-23
3.0%
Variance
Position better than threshold
Threshold
3.7%

Chief Finance Officer

Executive Summary

In summary, the Trust is forecasting a significant risk of £4.50m to achievement of the 2023/24 financial plan. The key internal risks are maximising elective activity, CIP achievement and overspends within Estates, mitigation plans are in place to manage these risks. The main external risks are the impact of continued strike action and under-utilisation of elective capacity by NHS partners. As these risks fall outside of national planning assumptions they are unmitigated. Failure to achieve the financial plan would place significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP).

As the Trust annual plan is a deficit of £18.9m, management of risks against this plan alone do not deliver long-term financial sustainability. The significant financial improvement required for sustainability will be delivered through the medium-term finance strategy approved by the Board in April 2023. Quarterly updates will be provided to the Board on progression of the strategy and the underlying financial position.

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

Statutory Financial Targets	RAG (M9)	RAG (Forecast)	Section within this report / associated chart
Financial Stability			I&E Position
Agency Spend			I&E Position
Financial Sustainability			N/A (quarterly update)
Financial Efficiency			Cumulative CIP
Capital			Capital Expenditure
Cash			Cash Position

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

I&E Position

Narrative:

At the end of December 2023, M9, the Trust has reported a deficit of £19.5m against a plan of £15.8m, the resultant variance of £3.7m is a deterioration on the M8 position. The position includes all expected mitigations against additional costs and reduced income as a result of industrial action. Any further costs incurred or income lost will result in a corresponding deterioration in our financial position.

The table below summarises this I&E position at M9:

Month 8	In Month			Year to Date		
Cost Type	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£37.4m	£35.1m	-£2.3m	£332.5m	£324.2m	-£8.3m
Other Operating Income	£3.3m	£3.1m	-£0.1m	£29.6m	£29.1m	-£0.5m
Total Income	**£40.7m**	**£38.2m**	**-£2.4m**	**£362.1m**	**£353.3m**	**-£8.8m**
Employee Expenses	-£29.5m	-£29.8m	-£0.3m	-£265.8m	-£266.2m	-£0.4m
Operating Expenses	-£14.3m	-£14.9m	-£0.6m	-£125.0m	-£123.8m	£1.2m
Non Operating Expenses	-£0.5m	-£0.6m	-£0.0m	-£4.8m	-£3.3m	£1.5m
CIP	£2.8m	£2.1m	-£0.7m	£17.8m	£16.5m	-£1.3m
B/S Release	£0.0m	£1.8m	£1.8m	£0.0m	£4.0m	£4.0m
Total Expenditure	**-£41.6m**	**-£41.4m**	**£0.2m**	**-£377.9m**	**-£372.8m**	**£5.1m**
Total	**-£0.9m**	**-£3.2m**	**-£2.3m**	**-£15.8m**	**-£19.5m**	**-£3.7m**

Key variances within the position are:

Clinical Income – £8.3m adverse variance relates to planned-care activity cancelled due to strike action, capacity at the CMSC not taken up by ICS partners and underperformance against the elective plan in Surgery. There has also been a reduction in PbR excluded drugs which is offset by operating expenses.
Operating expenses – The underspend is partially due to the corresponding reductions in elective activity. However, this is offset by adverse variances in Estates.
Non-operating expenses –PDC dividend payable was lower than expected and interest payable has increased.
CIP – CIP is £1.3m behind plan at M9 and outturn is forecast to be £2.9m below plan. The full year effect of the CIP is forecast to be in line with plan at £26.2m.

It is confirmed that the Trust's agency costs were 3.4% of total pay costs compared to a maximum target of 3.7%. This is a deterioration against the target from previous months and is mainly driven by increase in escalation beds in from M8 onwards.

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

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

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

Cumulative CIP

Narrative:

The Trust delivered £2.1m CIP in M9 which is an adverse variance to plan of £0.7m. The YTD position is £16.4m against a target of £17.8m and the forecast for in year effect of CIP is £23.3m, £2.9m below target. The full year effect of the schemes remain in line with target.

Risks to position:

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

Actions:

- Continuation of the Productivity and Improvement Programme.

Capital Expenditure

Narrative:

The Board is asked to approve an increase in the capital programme of £4.145m, which reflects additional funding and a net reduction of £0.067m which reflects rephasing of approved schemes:

Description	Approved Plan @ 18 October 23	Proposed Variations	New funding	Revised budget
Internally Generated	£3.965m			**£3.965m**
Urgent Maintenance (ICB)	£2.920m			**£2.920m**
UECUP	£5.800m			**£5.800m**
UECUP - PDC	£10.000m			**£10.000m**
CDC - PDC	£4.108m			**£4.108m**
CDC - PDC P2	£0.106m		£0.040m	**£0.146m**
Diagnostics Digital - PDC	£0.049m			**£0.049m**
LIMS - PDC			£3.258m	**£3.258m**
Endoscopy			£0.775m	**£0.775m**
Breast screening			£0.072m	**£0.072m**
Confirmed CDEL	**£26.948m**	**£0.000m**	**£4.145m**	**£31.093m**
Total Funding for Capital	**£26.948m**	**£0.000m**	**£4.145m**	**£31.093m**
Capital Programme				
Backlog maintenance	£1.366m			£1.366m
Medical equipment	£1.916m			£1.916m
Heating and chilled water pipework replacement	£2.020m	-£0.598m		£1.422m
Additional fire prevention works	£0.900m			£0.900m
IT equipment	£0.750m	£0.060m		£0.810m
Contingency		£0.471m		£0.471m
UECUP - Trust funding	£5.800m			£5.800m
Approved Capital Expenditure Budget	**£12.752m**	**-£0.067m**	**£0.000m**	**£12.685m**
UECUP	£10.000m			£10.000m
CDC	£4.214m		£0.040m	£4.254m
Diagnostics Digital	£0.049m			£0.049m
LIMS - PDC			£3.258m	£3.258m
Endoscopy			£0.775m	£0.775m
Breast screening			£0.072m	£0.072m
Confirmed PDC	**£14.263m**	**£0.000m**	**£4.145m**	**£18.408m**
Total Anticipated Expenditure on Capital	**£27.015m**	**-£0.067m**	**£4.145m**	**£31.093m**

At M9 the capital programme is £4.8m behind plan and is forecast to be on plan by year end:

Scheme	Plan spend @ M9	YTD spend	Variance
Backlog maintenance	964	359	-605
Medical equipment and corporate schemes	1,668	782	-886
Heating and chilled water pipework	2,080	2,371	291
IT equipment	450	199	-251
UECUP - Trust funding	1,368	-	-1368
UECUP - PDC	10,000	8,627	-1373
CDC	4,108	3,396	-712
Diagnostics Digital	49	-	-49
CDC - equipment	-	98	98
PDC - Ultrasound equipment	-	72	72
NHSE/I TOTAL CAPITAL PLAN 23/24	**20,687**	**15,904**	**- 4,783**

We do not currently anticipate any underspend against plan at year end.

The level of capital available for equipment replacement and infrastructure update is very limited and could be committed many times over. As a consequence there is continued review of both schemes and prioritisation decisions. Monitoring of risks associated with delivery of capital schemes and the overall programme will continue to be reported through the Estates and Capital Committee.

Risks to position:

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

Actions:

- CFO, with executive team to continue to work with divisions to manage re-prioritisation of schemes within the agreed budget.
- Estates and Capital Committee to continue to monitor progress and risks from capital projects.

Cash Position

Narrative:

The underlying deficit position places increasing pressure on the Trust's ability to maintain a positive cash balance. At the end of December the cash balance was £9.3m. The large capital programme and a planned deficit of £18.9m means that a positive cash balance is only possible by active daily management of the level of debtors and creditors. This arrangement is not sustainable but does mean the Trust does not need to draw upon additional borrowing from NHSE in 2023/24.

Risks to position:

- Achievement of the cash trajectory will place delivery of the Public Sector Payment Policy at risk.

- Failure to achieve the full recurrent CIP plan would mean that the cash trajectory cannot be achieved.
- The low level of cash headroom that the Trust is working within increases the impact of any delayed payment of income due to the Trust.

Actions:

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

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 8.2**
24 January 2024

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

Executive Summary and Report Recommendations

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

For planned care activity volumes, it highlights the Trust's performance against the targets set for this financial year. The Board should note that industrial action continues to have a significant impact on the ability to deliver the elective plan and a high number of patients cancelled for planned care, with the year-to-date activity position being behind plan.

For unscheduled care, the report details performance and highlights the ongoing challenges with achievement of the national waiting time standards in the Accident and Emergency Department (A&E).

The Board should note the ongoing improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the Trust's Winter Plan to ensure that the increase in demand over the winter can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED.

Elective recovery remains a strong point and improvements have been seen, but medical industrial action remains the highest risk to the elective recovery programme.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

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

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

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

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

1	Introduction / Background
1.1	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the national Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway. There is national recognition of the significant disruption to elective services during that pandemic and more recently, the ongoing and prolonged industrial action. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny.

2	Planned Care
2.1	**Elective Activity** In November 2023, the Trust attained an overall performance of 105% against plan for outpatients and an overall performance of 98% against plan for elective admissions as shown in the table below:

2023/24 Plan			
Activity Type	Target for Nov	Actual for Nov	Performance
Outpatient New	12,912	13,813	107%
Outpatient Follow Up	31,772	32,905	104%
Total outpatients	**44,684**	**46,718**	105%
Day case	4,654	4,640	100%
Inpatients	808	700	87%
Total	**5,462**	**5,340**	98%

Underperformance against plan continues for inpatients, predominantly due to the impact of large-scale cancellations for industrial action. Underperformance relating to the under utilisation of Surgical Centre sessions also continues (relating to another NHS Trust).

	The Trust has submitted a revised financial forecast position that has a reduced level of elective activity included within it for H2.
2.2	**Referral to Treatment (RTT)** The national standard is to have no patients waiting over 104 weeks from March 2023 and to eliminate routine elective waits of over 78 weeks by April 2023 and 65 week waits by March 2024. The Trust's performance at the end of November against these indicators was as follows: • 104+ Week Wait Performance – 0 • 78+ Week Wait Performance – 0 • 65+ Week Wait Performance - 286 • 52+ Week Wait Performance - 1880 • Waiting List Size - there were 42,552 patients on an active RTT pathway which is higher that the Trust's trajectory of 37,718. An in-depth analysis of waiting list size has been undertaken and key actions to address are underway across the divisions, including early escalation to clinical teams and proactively managing patient pathways ahead of breach dates. WUTH have continued to support Trusts across the North West by offering mutual aid to treat very long waiting patients through the Cheshire and Merseyside Surgical Centre and this will continue throughout the year, and will include patients that have waited 78+ weeks. The Trust, via the new National PIDMAS system has also offered to provide mutual aid across two surgical specialities. The ICB has confirmed that treating these very long waiting patients will not affect the Trust's performance position.
2.3	**Cancer Performance** Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 2 to date: • 2 Week Waits – This national standard has now been stood down. However, the Trust continues to measure performance internally to support the delivery of the Faster Diagnosis Standard. At the end of November 2WW performance was 78.1%. • FDS – was 69.81% (freeze date 4.1.24) in November (latest available data) against a national target of 75% by March 2024. This standard has been impacted by industrial action and subsequent inability to maintain the 2WW standard. • 31 day treatment numbers - above trajectory and expected to continue. • 62 day performance is currently below trajectory with 149 patients against a plan of 170 for November.

	03/04	10/04	17/04	24/04	01/05	08/05	15/05	22/05	29/05	05/06	12/06	19/06	26/06	03/07	10/07	17/07	24/07	31/07	07/08	14/08	21/08	28/08	04/09	11/09	18/09	25/09	02/10	09/10	16/10	23/10	30/10	06/11	13/11	20/11	27/11
Actual 23/24	177	193	193	194	182	175	175	182	203	191	162	155	158	161	163	165	167	176	191	183	196	201	184	175	164	170	154	168	177	173	167	145	137	154	149
Recovery Trajectory	210	210	210	210	205	205	205	205	205	200	200	200	200	194	194	194	194	194	188	188	188	188	182	182	182	182	176	176	176	176	176	170	170	170	170
Pre-COVID Average	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51

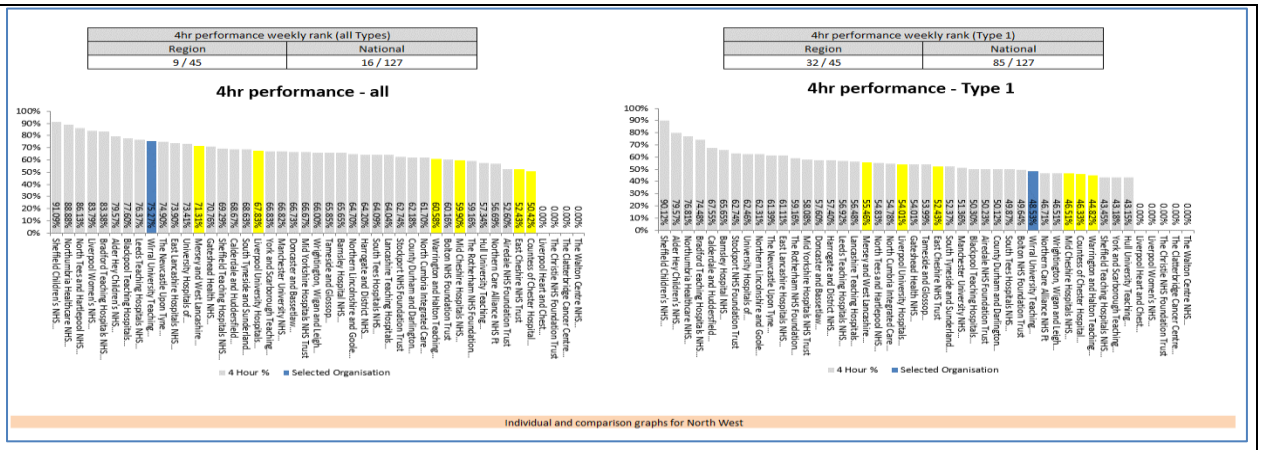
	• 104 day long waiters – performance is above trajectory at 39 against a plan of 28 for November.

	03/04	10/04	17/04	24/04	01/05	08/05	15/05	22/05	29/05	05/06	12/06	19/06	26/06	03/07	10/07	17/07	24/07	31/07	07/08	14/08	21/08	28/08	04/09	11/09	18/09	25/09	02/10	09/10	16/10	23/10	30/10	06/11	13/11	20/11	27/11
Actual 23/24	65	68	59	55	54	49	58	58	64	56	46	48	59	57	57	56	47	42	43	41	45	48	54	57	50	57	57	58	57	53	50	48	45	43	39
Recovery Trajectory	55	55	55	55	52	52	52	52	52	49	49	49	49	45	45	45	45	45	41	41	41	41	37	37	37	37	33	33	33	33	33	28	28	28	28
Pre-COVID Average	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12

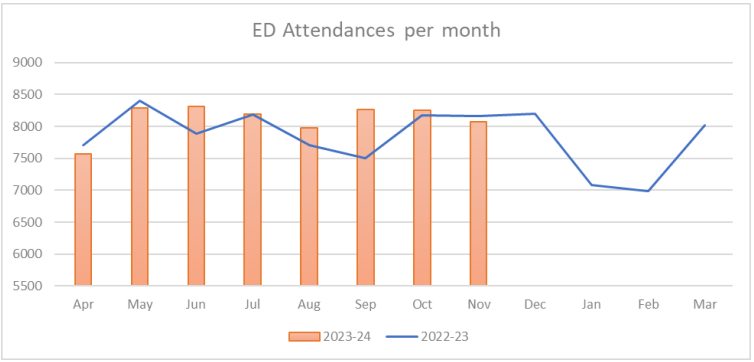
As with all Trusts across C&M delivery of the 31and 62 day indicators remains a priority but given the increases in demand, and the impact of medical industrial action, the recovery of performance against the targets remains a focus for 2023/24. The Trust is performing well when compared to other units but remains focussed on improving waiting times further to improve patient experience.

	There continues to be a multi-disciplinary approach to improving the efficiency of cancer pathways and as expected is supporting decreased waiting times for Colorectal with a similar workstream commencing in Gynaecology.
2.4	**DM01 Performance – 95% Standard** In November 94.68% of patients waited 6 weeks or less for their diagnostic procedure for those modalities included within the DM01. This is against the national standard of 95% and requirement for Trust's to achieve 90% by March 2024. ECHO, CT and Urodynamics remain challenged, however recovery plans are in place with performance predicted to be compliant by the end of February 2024. The Trust has commenced providing mutual aid for a neighbouring Trust for endoscopy given the shorter waiting times at WUTH and significant waits elsewhere.
2.5	**Risks to recovery and mitigations** The clinical divisions are continuously working through options to reduce the backlogs of patients awaiting elective treatment and progress is being made to improve waiting times for patients. These include the recruitment of new staff, with a focus on consultants, additional activity outside of core capacity to ensure reductions in elective waiting times continue. The major risk to the delivery of the elective recovery programme is medical staff industrial action, given the significant volumes of patients cancelled during this action. On strike days, elective activity is being managed patient by patient to ensure minimal disruption to our patients whilst maintaining safe standards of care across the hospital sites, with a focus to keep patient cancellations to an absolute minimum.

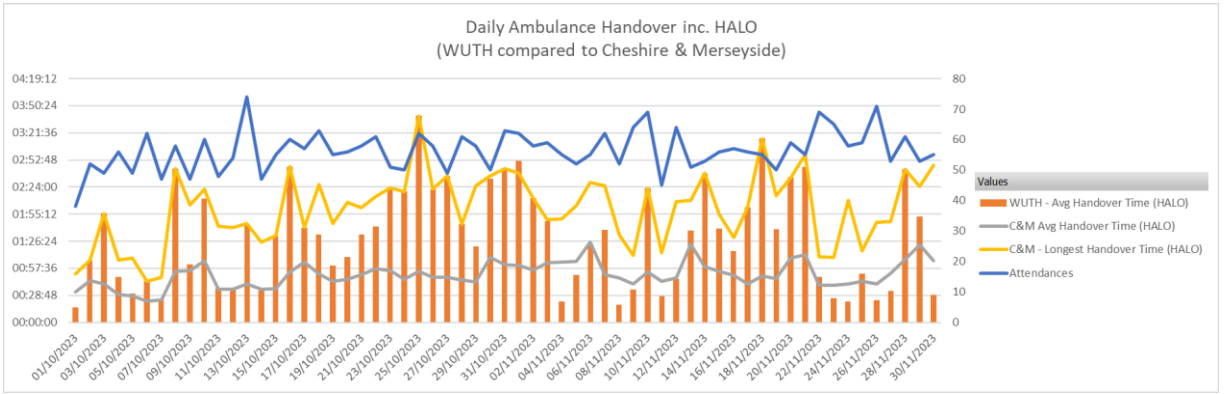
3.0	**Unscheduled Care**
3.1	**Performance** November Type 1 performance was reported at 45.55%, which is below the 4-hour improvement trajectory. The combined performance for the Wirral site was 73.58%: Type 1 ED attendances: • 8,258 in October (avg. 266/day) • 8,070 in November (avg. 260 /day) • 2.3% decrease from previous month Type 3 ED attendances: • 2,836 in October • 2,931 in November • 3% increase from previous month The graphs below demonstrate Wirral's 4-hour performance for all attendances (blue bar) plotted against other acute providers in C&M (yellow bars) and Type 1 performance only:



A&E type-1 attendances reduced during the month of November, acuity of the patients attending A&E remains high.



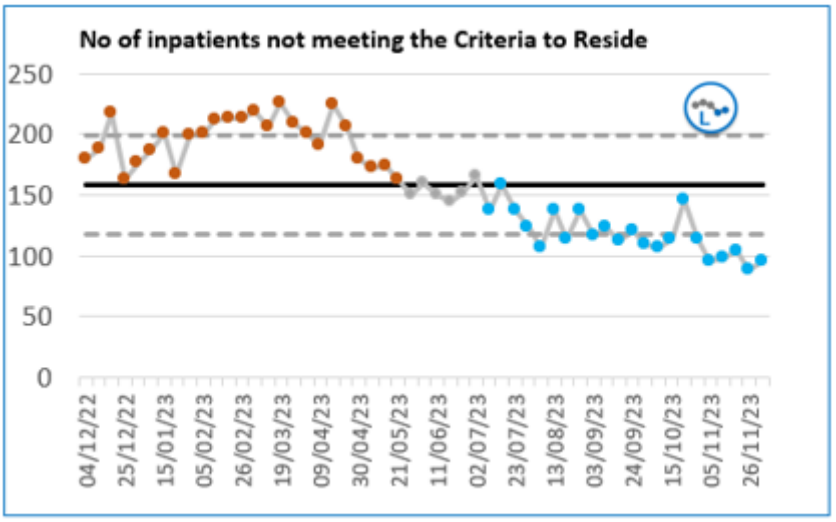
In November, compliance with the national standard for 15-minute ambulance handovers had deteriorated towards the end of the month. In line with national guidance, compliance with ambulance handover at the Trust continues to be reviewed daily to ensure that delays to crew handover are kept to a minimum.



In November, the Trust opened an additional bay in the A&E (Reverse Cohort Area) which provides six additional trolley spaces for handover of patients from ambulance crews and routinely provides nurse staffing for the first corridor. This has increased the Trust's overall capacity to 22 ambulance trolley spaces.

As per the winter plan, the Trust has increased acute bed capacity by opening 16 additional escalation beds.

Although the Trust continues to experience high demand and will continue to exceed the 22 ambulance trolley spaces, the Trust has made positive progress in implementing the actions within the improvement plan. The improvement is evidenced by the North

	West Ambulance Service daily handover reports shown in the graph above. There is daily direct intervention by the COO and Deputy COO. **Urgent & Emergency Care Upgrade Programme (UECUP)** The next phase of the UECUP work is scheduled to take place in March 2024. Operational plans are in place to ensure that the impact on the running of the department is minimised. It is anticipated that with the move, the department will have access to part of the new department, including the new resus area which will be used to provide space for the next phase of construction and the new staff facilities including dedicated training rooms.
3.2	**Transfer of Care Hub development and no criteria to reside.** For the month of November, the number of patients not meeting criteria was further reduced to less than 100.  Further work to reduce the number of patients with no criteria to reside is underway as part of the 2024/25 planning discussions with partners at PLACE which includes a full capacity and demand review of the Wirral system including community beds, Home First and domiciliary care. December performance has been challenged with delays across the festive period.
3.3	**Mental Health** During November the Trust continued with timely flow from A&E for patients with mental health needs. The Trust continues to work with the local mental health provider to ensure that any increase in demand is responded to promptly and risk in ED is minimised. However, the Trust has seen an increase in the number of Children and Young People (CYP) attending A&E with learning or mental health needs that do not require medical intervention. As A&E is not an appropriate setting for a prolonged stay for a child or young person with these needs, admission to the Trust's children's ward may be required. Unfortunately, the services required to support the child or young person back into the community are limited and often involve multiple agencies, leading to delays and a long length of stay. The challenges posed by the lack of service provision have been brought to the Integrated Care Board and the proposed solutions and remedial actions will be included

	in the planning discussions for Wirral 2024/25. This has led to patients being cared for on the Children's ward for over a month awaiting a community placement.
3.4	**Risks and mitigations to improving performance** The Trust continues to focus on implementing the actions from the improvement plans for each of the urgent and emergency care quality standards and has seen recent successes. The risk remains that winter pressures continue with the high level of acuity of patients attending A&E. Added to this is the increase in sickness levels at a time when additional staff are required to support any corridor waits or to open short-term escalation beds. Further medical industrial action poses a significant challenge to the capacity and flow of A&E across the hospital. However, the Trust continues to ensure that robust plans are in place to ensure the safety of patients and staff through the Emergency Preparedness and Response (EPRR) route.

4	**Implications**
4.1	**Patients** • The paper outlines challenges with waiting times for elective treatment longer than what the Trust would want to offer, but given the backlog from the Covid pandemic the Trust is in a strong position regionally in delivering reduced waiting times for patients. The paper also details the extra actions introduced in November to improve UEC performance.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • Cost of recovering activity from medical industrial action to ensure the Trust delivers against the national waiting time targets. The paper details additional resource agreed as part of the winter plan that has been introduced.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets in the main due to the impact of medical industrial action, relating mainly to 65 weeks by the end of March 2024.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.3**

24 January 2024

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

Executive Summary and Report Recommendations

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

It is recommended that the Board:

- Note performance to the end of November 2023; and
- Approve an increase in the capital programme of £4.145m, which reflects additional funding and a net reduction of £0.067m which reflects rephasing of approved schemes

Key Risks

This report relates to the key risks of:

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

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**

This is a standing report to the Board.

1	Narrative
1.1	Following further discussion with the Executive Team and the Board, the performance metrics for inclusion, format and title of the report have been amended. The metrics are grouped under the responsible Executive Director, with the relevant CQC domain noted against each metric. Grouping the metrics by CQC domain shows the following breakdown for the most recently reported performance: **Summary of latest performance by CQC Domain:**

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	5	2	7
Effective	0	1	1
Caring	2	2	4
Responsive	5	17	22
Well-led	3	0	3
Use of Resources	2	3	5
All Domains	17	25	42

2	Implications
2.1	Implications for patients, people, finance, and compliance, including issues and actions undertaken for those metrics that are not meeting the required standards, are included in additional commentaries and reports.

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

Integrated Performance Report - January 2024

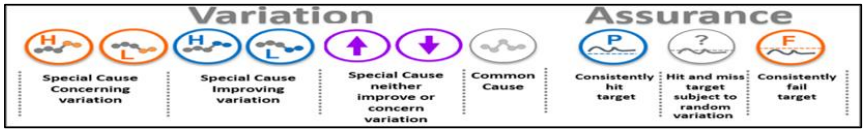
Approach

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

Summary of latest performance by CQC Domain:

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	5	2	7
Effective	0	1	1
Caring	2	2	4
Responsive	5	17	22
Well-led	3	0	3
Use of Resources	2	3	5
All Domains	17	25	42

Key to SPC Charts:



Issues / limitations

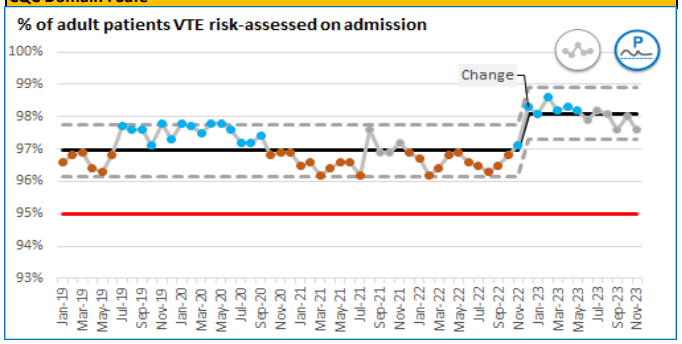
SPC charts should only be used for 15 data points or more. Some of the reported metrics only apply from 2022, so will take time to build up.
SPC format does not support including a target where it is variable over time, eg a reducing trajectory for long waiters.
Alternative formats of charts are included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

Changes to Existing Metrics:

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

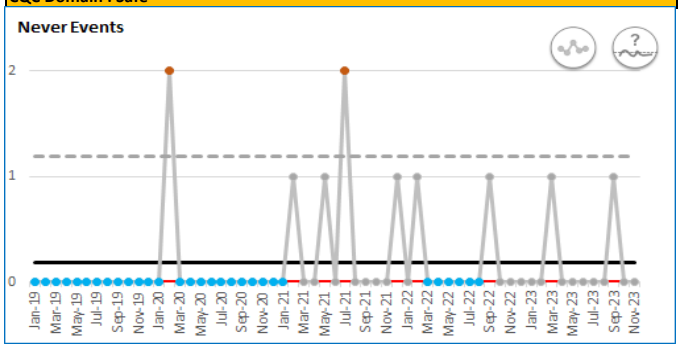
Medical Director (1)

CQC Domain : Safe



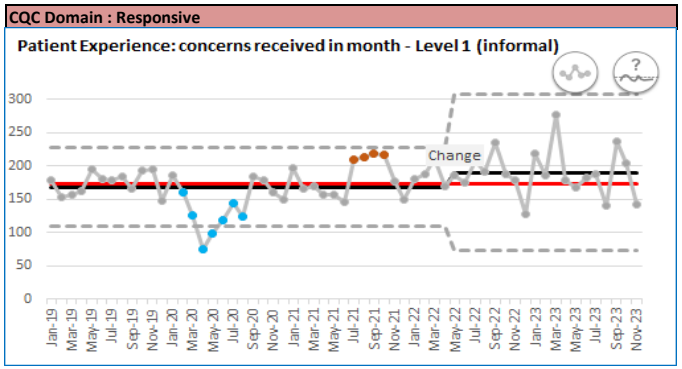
Nov-23
97.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



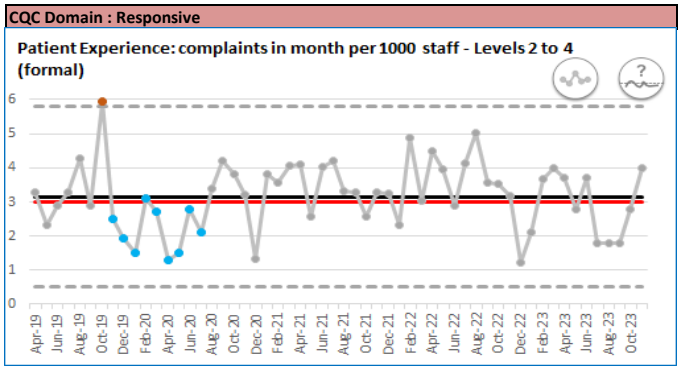
Nov-23
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



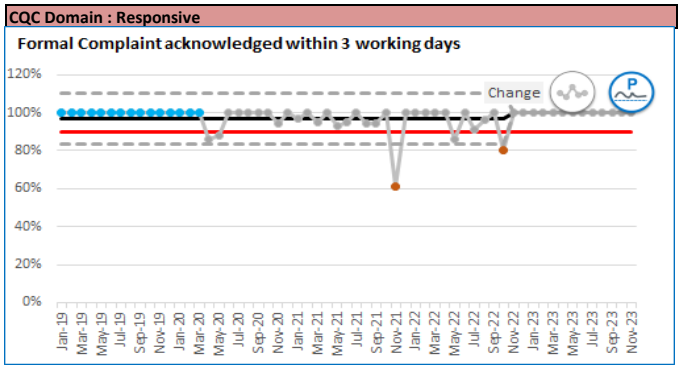
Nov-23
142
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



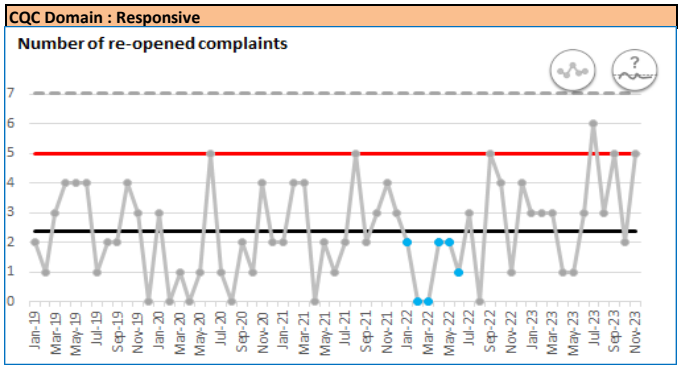
Nov-23
4.0
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Nov-23
100%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

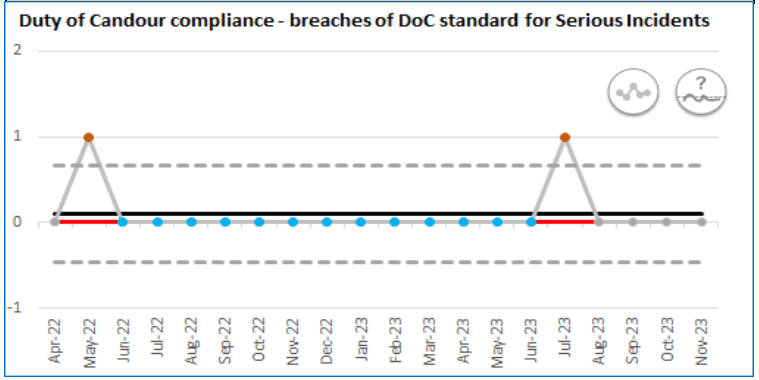
CQC Domain : Responsive



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

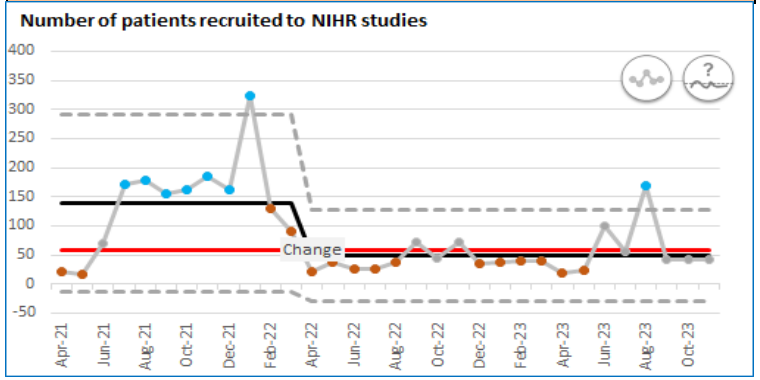
Medical Director (2)

CQC Domain : Well-led



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

CQC Domain : Well-led

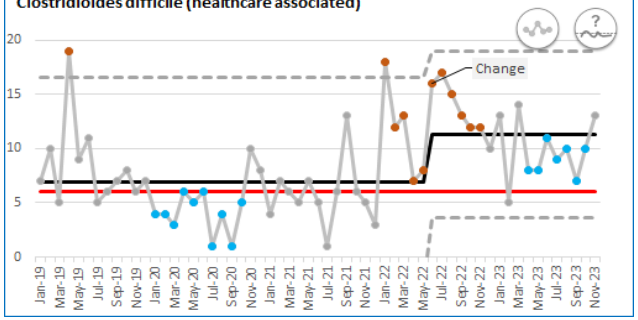


Nov-23
42
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse

CQC Domain : Safe

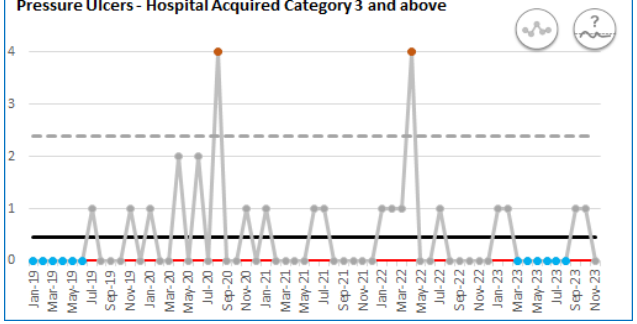
Clostridioides difficile (healthcare associated)



Nov-23
13
Variance Type
Common cause variation
Threshold
≤6
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

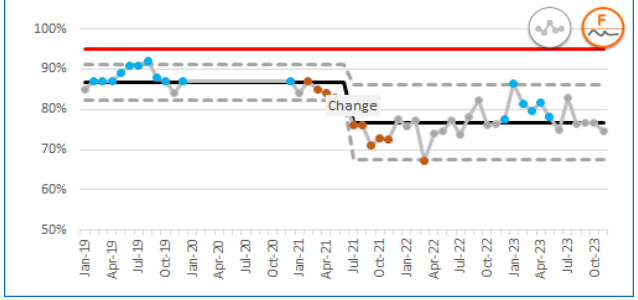
Pressure Ulcers - Hospital Acquired Category 3 and above



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

CQC Domain : Caring

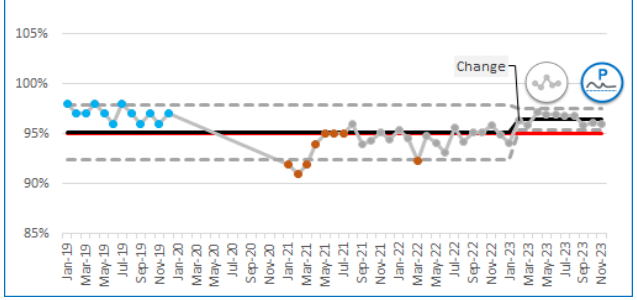
FFT Overall experience of very good & good: ED



Nov-23
74.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

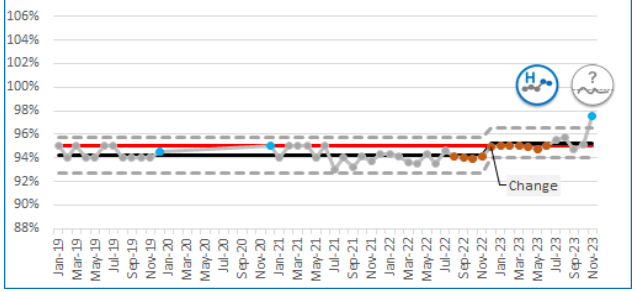
FFT Overall experience of very good & good: Inpatients



Nov-23
95.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Caring

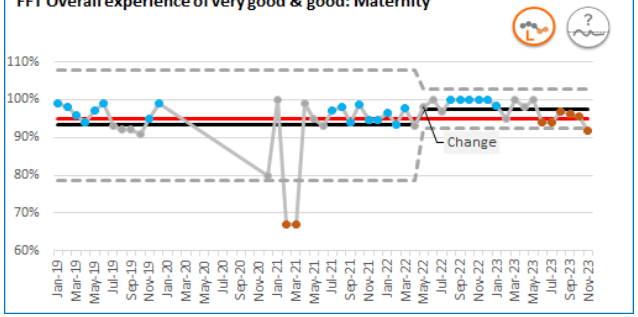
FFT Overall experience of very good & good: Outpatients



Nov-23
97.6%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

FFT Overall experience of very good & good: Maternity



Nov-23
91.8%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse – for Jan 2024 BoD

Overall position commentary

The Trust exceeded its monthly *Clostridioides difficile* threshold by 7 in November 2023. In order to meet the year end objective of 71, the Trust set a local threshold of 6 *Clostridioides difficile* per calendar month and whilst we exceeded this by 7 in November 2023 we have seen an overall decrease of 24 when compared to the same period in 2022/23. The downward trend in the number of positive cases reported over the past 12 months continues. In line with the IPC annual plan, the 5 key priorities identified that underpin the CDT improvement work continue to be communicated in The Trust bulletin with monthly related themes and weekly newsletters to improve awareness to staff as per the agreed IPC communication and engagement strategy.

The Friends and Family Test (FFT) for Inpatients and Outpatients have exceeded the required threshold. Two areas where the target was not achieved was Emergency Department (ED) at 74.7% and Maternity at 91.8%.

***Clostridioides difficile* (healthcare associated)**

Narrative:

The NHS standard contract for 2023-24 identifies the *C.difficile* threshold for each trust; our threshold for 2023-24 is 71. To meet this, we have set internal monthly threshold of 6 each month with 1 month having 1. In November 2023 there were 13 patients diagnosed with CDT, exceeding the monthly threshold by 7.

Actions:

- Dynamic CDT improvement plan is in place, with mechanisms to cross reference learning from *C difficile* investigations to instigate actions from learning outcomes identified at PSIRF.
- Improved processes regarding the use of side rooms to enable prompt isolation.
- Priority focus on cleaning, De-cluttering the environment, Isolation, Sampling, hand hygiene.
- Use of newly developed IPC dashboard that incorporates local intelligence to highlight priority areas where targeted work can be focused to improve patient outcomes.

Risks to position and/or actions:

- Annual threshold has been exceeded by 5.
- Bed occupancy levels may inhibit the ability to implement the HPV proactive and reactive cleaning schedule and the rapid isolation of infected patients.

FFT Overall experience of very good and good.

Narrative:

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

Performance against the 95% threshold for November 2023 was:

- Emergency Department (ED) – 74.74% (below threshold) - slightly below the national average of 82% (using August's Benchmarking)
- Inpatients – 95.93% (above threshold) - above national average of 94% (using August's Benchmarking)
- Outpatients – 99.58% (above threshold) – above national average of 94% (using August's Benchmarking)
- Maternity 91.8% (below threshold) - above national average of 92% (using August's Benchmarking)

Actions:

- Continued focus on providing people with access to provide feedback via FFT: volunteers are visiting ED and out-patient areas at varied times and days.
- Monitor FFT performance against national average: we perform similar or above the national average since December 2022.
- Proactive response to feedback, making immediate rectifications when able, and encourage patient and carer participation through Patient Experience Promise groups.
- Responses shared with Women and Children's Division who have taken the following action:
- Feedback has been provided to Matron, Ward Managers and Deputies and with teams at safety huddles.
- Shared feedback and discussions regarding Trust values and behaviours at team meetings.
- Practice Development Midwife holding discussion with students regarding values and behaviours.

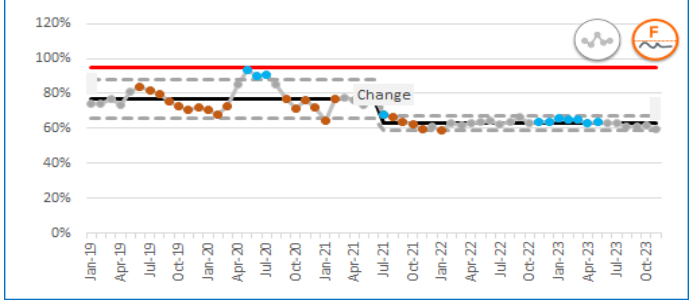
Risks to position and/or actions:

- Bed occupancy impacting on the length of time patients remain within ED: Processes are in place operationally to prevent this where possible.
- Car parking facilities impacting on patients' ability to easily access outpatients' appointments on time at the Arrowe Park Hospital site: organisational strategies are being taken to improve the position.

Chief Operating Officer (1)

CQC Domain : Responsive

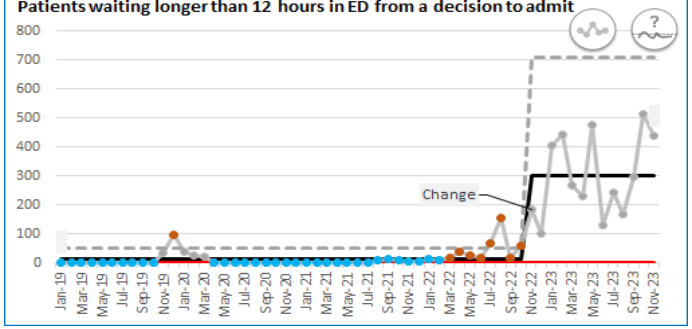
4-hour Accident and Emergency Target (including APH UTC)



Nov-23
59.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

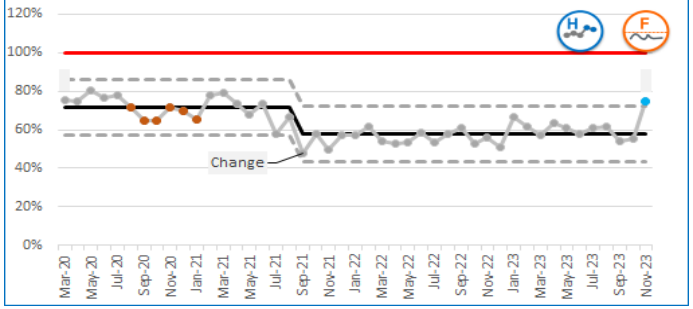
Patients waiting longer than 12 hours in ED from a decision to admit



Nov-23
437
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

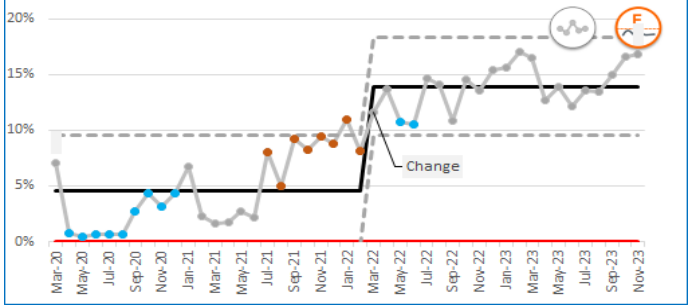
Time to initial assessment for all ED patients - % within 15 mins



Nov-23
74.9%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

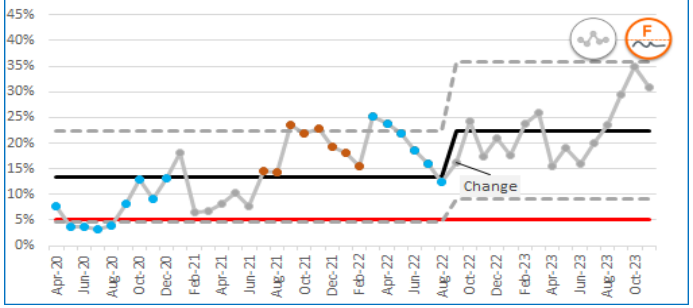
Proportion of patients more than 12 hours in ED from time of arrival



Nov-23
16.8%
Variance Type
Common cause variation
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

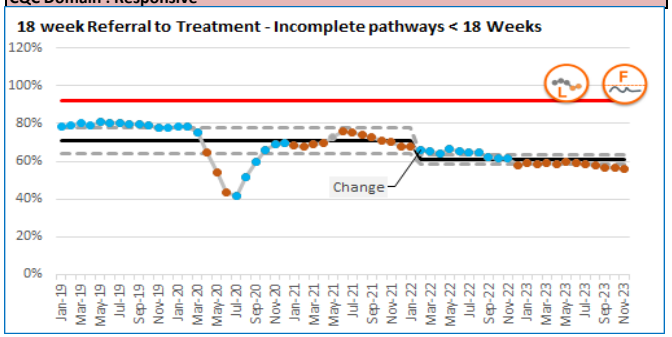
Ambulance Handovers: > 30 minute delays



Nov-23
30.8%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

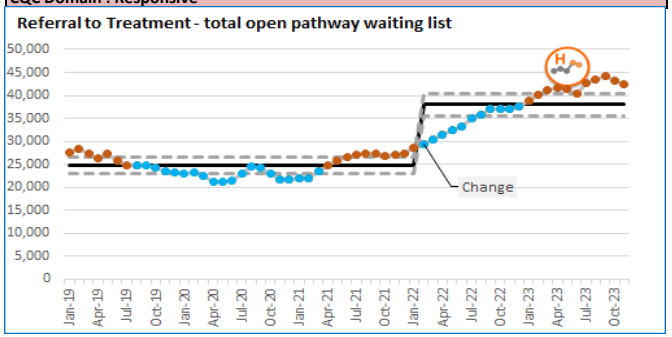
Chief Operating Officer (2)

CQC Domain : Responsive



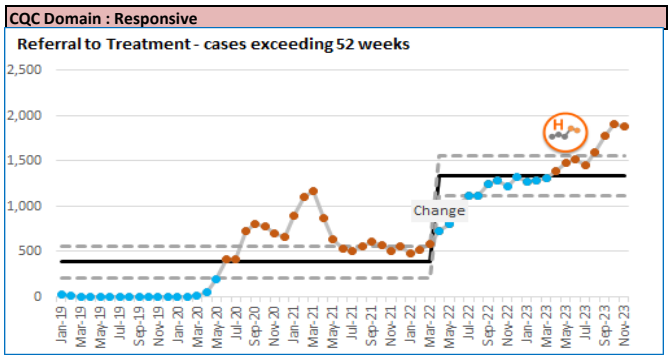
Nov-23
55.93%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



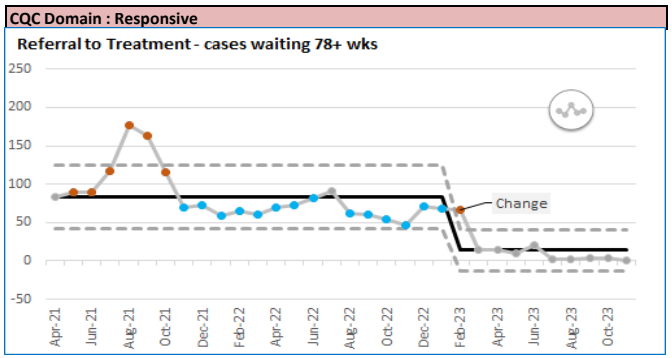
Nov-23
42552
Variance Type
Special cause variation - concerning
Threshold
≤ 39104
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



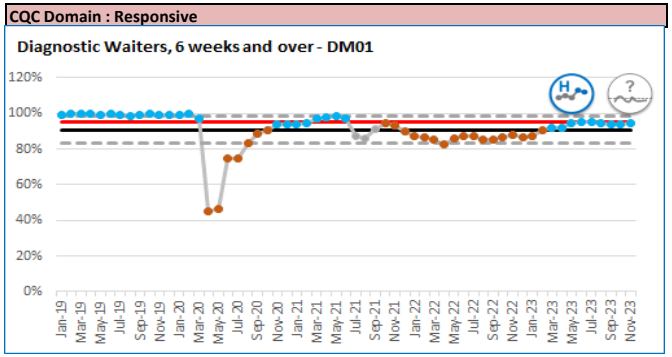
Nov-23
1880
Variance Type
Special cause variation - concerning
Threshold
1330
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



Nov-23
0
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

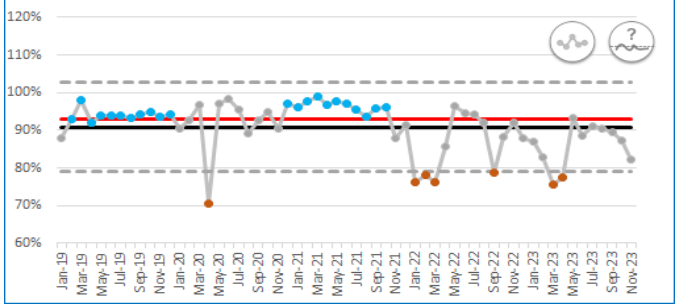


Nov-23
94.7%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

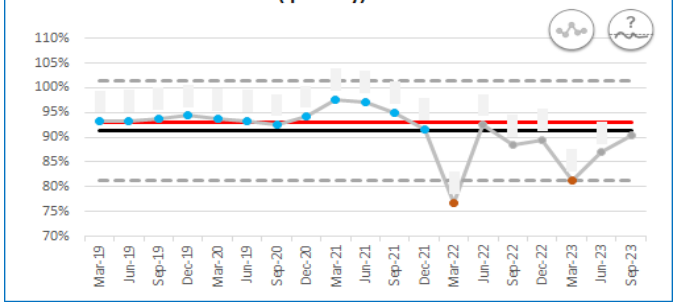
Cancer Waits - 2 week referrals (monthly)



Nov-23
82.6%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

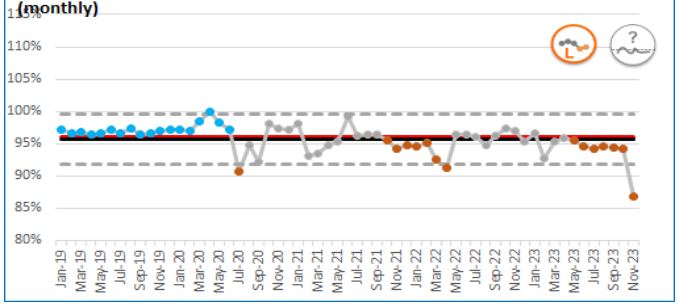
Cancer Waits - 2 week referrals (quarterly)



Sept-23
90.4%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

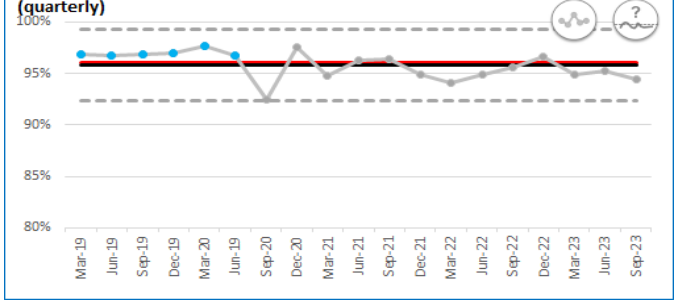
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



Nov-23
86.7%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

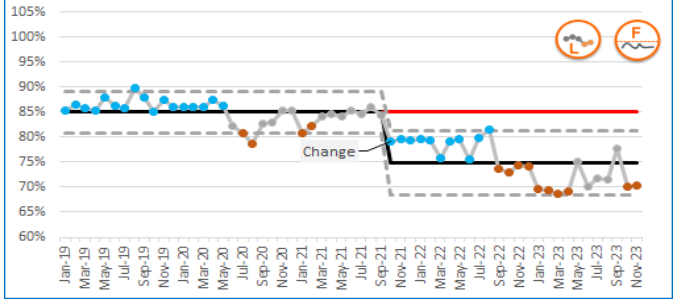
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



Sept-23
94.4%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

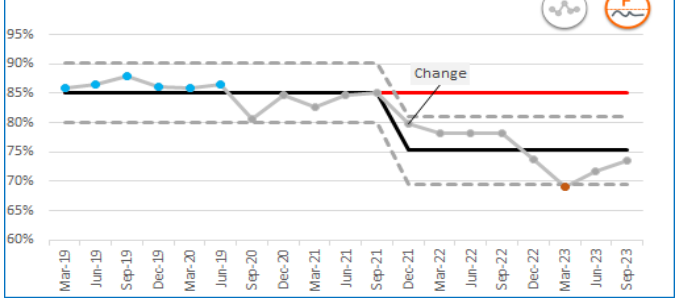
Cancer Waits - 62 days to treatment (monthly)



Nov-23
70.3%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

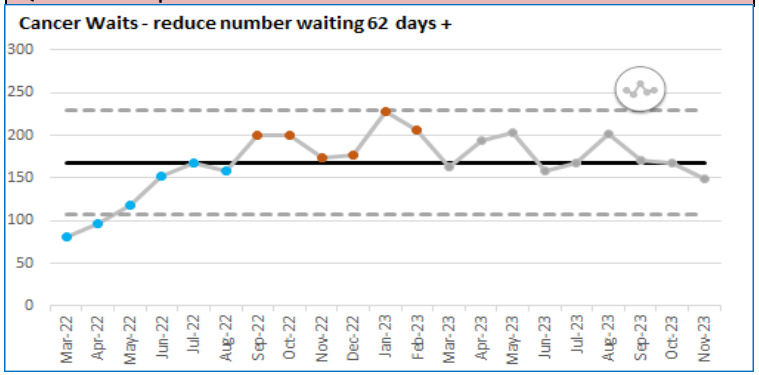
Cancer Waits - 62 days to treatment (quarterly)



Sept-23
73.6%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

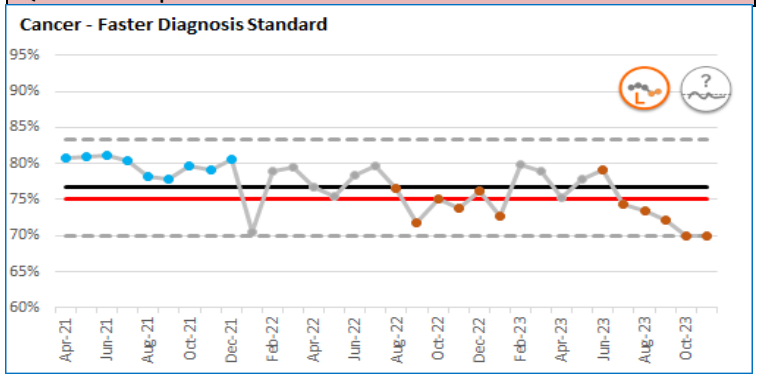
Chief Operating Officer (4)

CQC Domain : Responsive



Nov-23
149
Variance Type
Common cause variation
Threshold
170
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

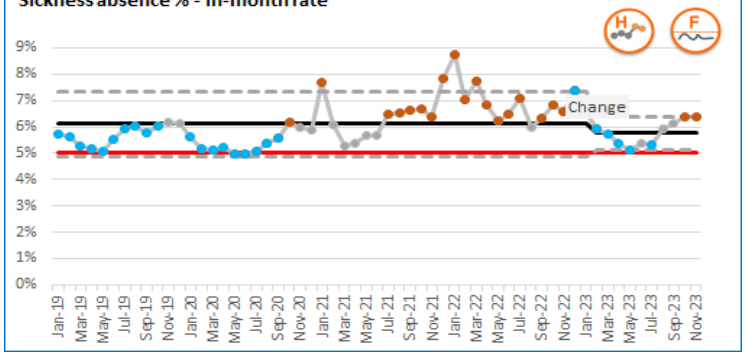


Nov-23
69.9%
Variance Type
Special cause variation - concerning
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

Chief People Officer

CQC Domain : Safe

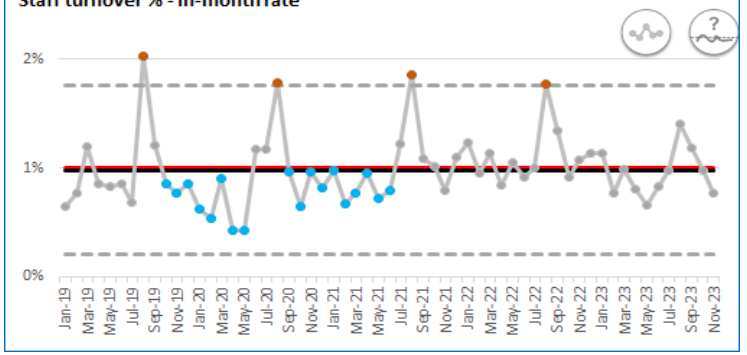
Sickness absence % - in-month rate



Nov-23
6.37%
Variance Type
Special cause variation - concerning
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe

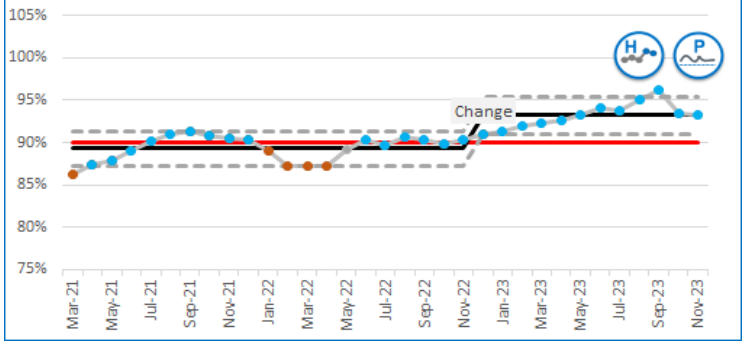
Staff turnover % - in-month rate



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

CQC Domain : Safe

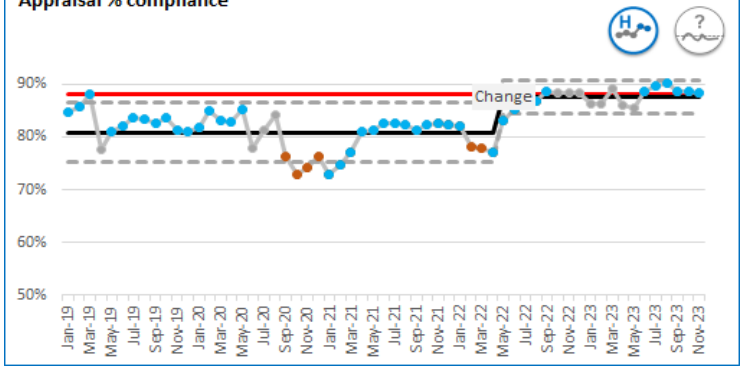
Mandatory training % compliance



Nov-23
93.19%
Variance Type
Special cause variation - improving
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led

Appraisal % compliance



Nov-23
88.28%
Variance Type
Special cause variation - improving
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – for Jan 2024 BoD

Overall position commentary

Despite winter pressures and strike action overall the Trust's People KPIs for both mandatory training, appraisal compliance and turnover continue to be achieved.

Sickness absence remains at 6.37%, which is reflective of flu and Covid-19 circulating, as well as the challenges posed by industrial action.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For November 2023 the indicator remained at 6.37%, demonstrating special cause variation.

The position is mainly driven by short term sickness absence, which accounts for 77% of absences across the Trust. Cold/flu, gastrointestinal problems and COVID are the most commonly occurring reasons for short term sickness absence. The most commonly occurring reason for long-term absence is anxiety/stress/depression. Industrial action is adversely affecting the ability of line managers to manage sickness absence, and this is most challenging in Medicine and Surgery Divisions.

Actions:

- A comprehensive briefing paper reviewing risk number 397 which relates to sickness absence levels across the Trust was undertaken and reported to Workforce Steering Board in December 2023. The recommended target actions were approved. the risk score was also reviewed, and reflective of the level of flu and Covid circulating, the likelihood was appropriately increased.
- The promotion campaign for the uptake of the winter vaccine programme continues and has been further enhanced utilising screen savers, email signatures and a promotional video by Dr Ranjeev Mehra, Deputy Medical Director. The campaign is supported by a roaming vaccinator delivery model, as well as the introduction of 'dial a jab' for targeted delivery, which is experiencing a good uptake.
- Occupational Health have delivered targeted wellbeing following traumatic events in Neonates NICU and A&E, and they are currently planning the next Trust wide Wellbeing surgeries for February 2024 with a 'know your numbers' focus on cardiovascular health.
- The Clinical Psychotherapist is attending WEPP preceptorship programme, Managers Essentials training and Leading Teams programmes. Further ESR sessions are due to be launched via ESR.
- The intranet has been further updated to link to wider Wellbeing support available to staff from the wider community and pomotion of the Trust's EAP has been prioritised following a reduction in uptake during December.

Risks to position and/or actions:

The management of sickness absence is primarily management led as they are responsible for monitoring employee attendance addressing sickness absence and ensuring that the policy is applied consistently, supported by the HR team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels and staff morale / engagement. Effective attendance management is critical and contributes to productivity and patient care. The Trust continues to promote a positive attendance culture by investing in, and focusing on, employee health and wellbeing initiatives to help mitigate this risk by preventing ill-health and supporting people to balance work whilst minimising the impact of any ill-health symptoms, where possible. Managing attendance can also help control costs related to overtime, absenteeism and temporary staffing.

Work continues on the agreed year 2 deliverables within the People Strategy with a number of workstreams that will support attendance across the Trust, this includes the development of the new flexible working brochure, which is available to all staff, and the implementation of WUTH Perfect Start as part of the Trust-Wide Strategic Retention Group.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework
January 2024

Item 8.4

Contents

1. Introduction

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

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

Baker Tilly 2021

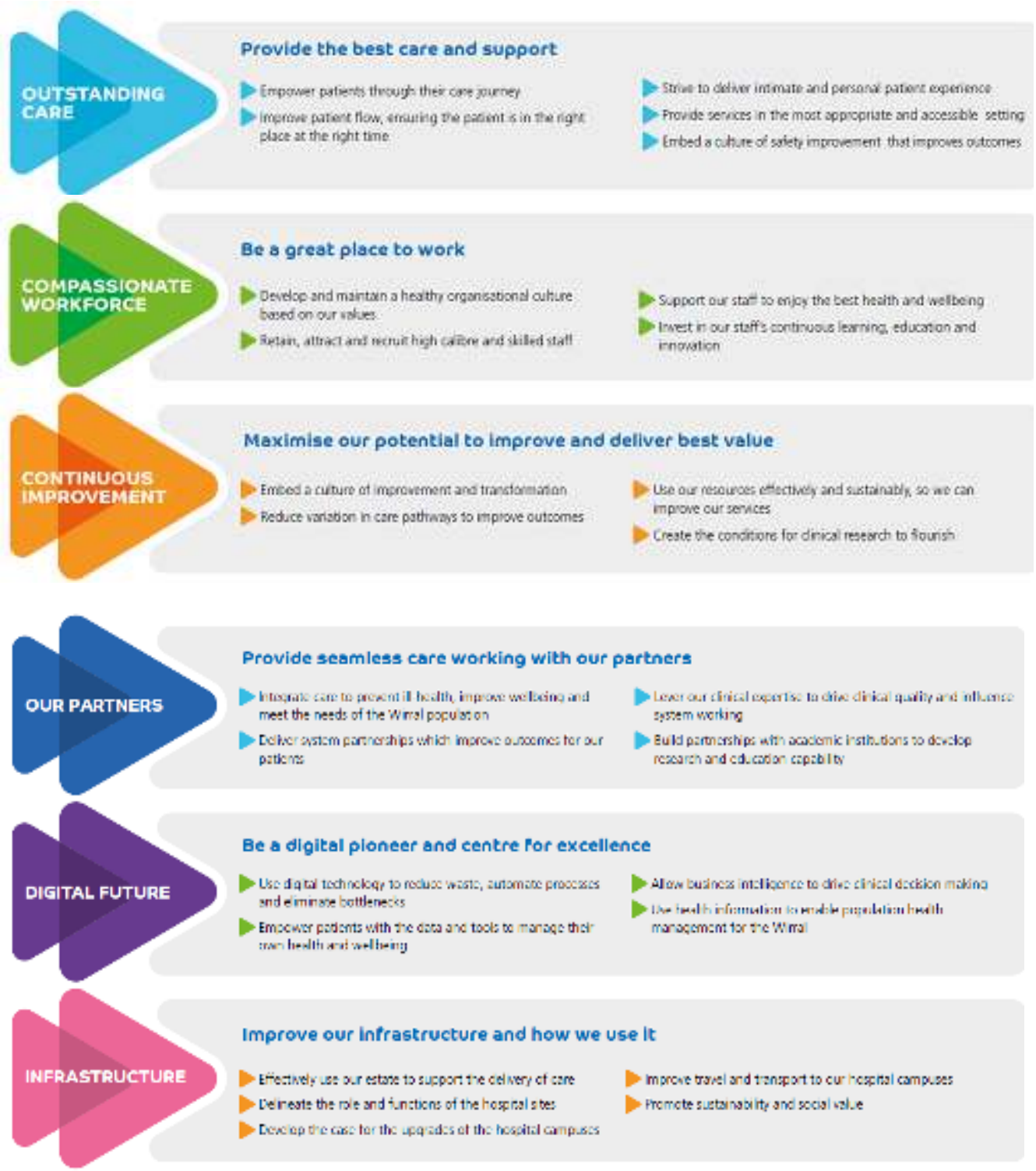
2. Vison, Strategy and Objectives

2.1 Our Vision

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

2.2 Our Strategic Objectives

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



3. Our Risk Appetite

3.1 Risk Appetite Statement

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

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

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

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

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

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

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

4. Operational Risk Management

4.1 Operational Risk Management

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

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

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

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

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

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

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

The Trust shall achieve this by:

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

4.2 Risk Categorisation

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

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

5. Creating and Monitoring the BAF

5.1 Creation of the BAF

The original refreshed version of the BAF was created and approved in September 2021 following discussions and workshops with all Board members. The BAF is updated on a bi-monthly basis and subject to a full refresh on an annual basis.

5.2 Monitoring the BAF

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

- Reports to the Board at each meeting.
- Reports to each meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy.
- Reporting to every meeting of relevant Board Committees.
- Reporting to each meeting of the Trust Management Board.
- Cyclical (at least yearly) circulation to Divisional Boards for information and to raise awareness; and
- Reporting to each meeting the Risk Management Committee.

5.3 Annual Refresh

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

6. Update Report

6.1 January 2023

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

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

6.2 Changes to the previous version

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

It should also be noted that changes have now been made in relation to the frequency of BAF reporting across all fora.

6.3 Recommendations

Board is asked to:

- Note the current version of the BAF.

Board Assurance Framework Dashboard							
Strategic Priority	**Risk No**	**Risk Description**	**Lead**	**Committee**	**Original Score 2022/23**	**Last Month**	**Current**
Outstanding Care **R, O, C, F**	1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	Chief Operating Officer	Quality and Board	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)
Outstanding Care **R, O, C, F**	2	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	Chief Operating Officer	Quality and Board	16 (4 x 4)	12 (3 x 4)	12 (3 x 4)
Outstanding Care **R, O, C, F**	3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	Medical Director	Quality	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)
Compassionate Workforce **O, C, F**	4	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Compassionate Workforce **R, O, C, F**	5	Failure of the Trust to have the right culture and organisational conditions/structure to deliver our priorities for our patients and service users.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Compassionate Workforce **R, O**	6	Failure to maintain our positive staff experience will adversely impact on staff motivation, engagement and satisfaction.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Continuous Improvement **R, O, F**	7	Failure to embed the Trust's approach to value and financial sustainability and Planning may impact on the achievement of the Trust's financial, service delivery and operational plans.	Chief Finance Officer	FBP	16 (4 x 4)	12 (4 x 3)	8 (4 x 2)
Continuous Improvement **R, F**	8	Failure to deliver sustainable efficiency gains due to an inability to embed service transformation and change.	Chief Strategy Officer and Chief Operating Officer	Board	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Continuous Improvement **R, O, S**	9	Failure to have strong leadership and governance systems in place.	Chief Executive Officer	Board	12 (4 x 3)	8 (4 x 2)	8 (4 x 2)
Our Partners **R, S, F**	10	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability.	Chief Executive Officer	Board	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)
Digital Future and Infrastructure **R, O, C, F**	11	Failure to robustly implement and embed infrastructure plans including digital and estates will adversely impact on our service quality and delivery, patient care and carer experience.	Chief Strategy Officer	FBP and Board	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)
Infrastructure **R, O, C**	12	Risk of business continuity in the provision of clinical services due to a critical infrastructure or supply chain failure therefore impacting on the quality of patient care.	Chief Strategy Officer	Capital, FBP and Board	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)

12 Month Trend

Risk No	Risk Description	Initial Score	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	20 (4 x 5)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)
2	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)
3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)
4	If the Trust fails to effectively plan for, recruit, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)
5	Failure of the Trust to have the right culture, organisational conditions/structure or resources to deliver our priorities for our patients and service users.	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)
6	If issues affecting staff experience are not effectively addressed, this will adversely impact on staff motivation, engagement and satisfaction.	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)
7	If the Trust's approach to value and financial sustainability and Planning are not embedded, this may impact on the achievement of the Trust's financial, service delivery and operational plans.	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)
8	Failure to deliver sustainable efficiency gains due to an inability to embed service transformation.	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)
9	Failure to have strong leadership and governance systems in place.	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)
10	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability.	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)
11	If the Trust fails to robustly implement and embed infrastructure plans including digital and estates, this will adversely impact on our service quality and delivery, patient care and carer experience.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)
12	Risk of business continuity in the provision of clinical services due to a critical infrastructure or supply chain failure therefore impacting on the quality of patient care.	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

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

Strategic Priority	Outstanding Care			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Chief Operating Officer	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)

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

Gaps in Control or Assurance	Actions
• The Trust continues to be challenged delivering the national 4 hour standard for ED performance. • The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criterion to reside means the Trust occupancy is consistently above 95%, making the delivery of the four target very challenging.	• There is one overall Emergency Department Improvement Plan in place which focusses on ambulance turnaround times, time patients spend in the department and all other national indicators. Following the completion of several service improvements the operational plan for ED will be revised to include new areas of focus as the new leadership team for that area commence in post. • Develop with Wirral system partners a response to the Improving Urgent and Emergency Care Services released in January 2023. • Response to the national 10 high impact actions in preparation for winter • Design of a more streamlined UEC pathway

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

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

Strategic Priority	Outstanding Care			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Chief Operating Officer	16 (4 x 4)	12 (3 x 4)	12 (3 x 4)

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

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

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

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

Strategic Priority	Outstanding Care			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Medical Director	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)

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

Gaps in Control or Assurance	Actions
• Fully complete and embedded patient safety and quality strategies • Industrial action impacts • Current operational impacts • Capital availability for medical equipment	• Complete implementation, monitoring and delivery of the patient safety and quality strategies. • Monitoring Mental Health key priorities • Complete delivery of the Maternity Safety action plan • Ongoing review of IPC arrangements • CQC preparedness programme and mock inspections • Appointment of patient safety champions

Progress
Key Changes to Note • Additional actions added.

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

Strategic Priority	Compassionate Workforce			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

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

Gaps in Control or Assurance	Actions
• National shortages in certain roles and full rollout of clinical job planning are pending workforce planning processes. • Availability of required capabilities and national shortage of staff in key Trust roles. • Talent management and succession planning framework is yet to be implemented.	• Monitor impact of retention and recruitment initiatives. • Retention working group action plan. • Identification and review in progress of workforce data sources: ESR reporting, Exit Surveys and Staff Survey to determine priorities and inform the delivery action plan. • Roll out of clinical job planning. • Transfer of OH Services. • Actions from National Staff Survey. • Incorporation of NHS workforce plan into Strategy. • A 3-month pilot of the internal transfer for band 5 Registered Nurses and Clinical Support Workers has been launched • The electronic resignation and exit interview pilot have been completed and is in the process of review.

Progress
Key Changes to Note • N/A

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

Strategic Priority	Compassionate Workforce			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

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

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

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

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

Strategic Priority	Compassionate Workforce			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Year 2 of flexible working policy. • Implementation of the Perfect Start. • Develop an Engagement Framework • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • Leadership Qualities Framework and associated development programmes and masterclasses. • Bi-annual divisional engagement workshops • Staff led Disability Action Group.	• Workforce Steering board and People Committee oversight. • Internal audit.

Gaps in Control or Assurance	Actions
	• Year 2 of flexible working policy. • Implementation of the Perfect Start. • Develop an Engagement Framework • Embed the WUTH LQF and associated development offer • Deliver year 2 of the flexible working programme • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • Launch of new CEO Award • Launch 'Employee of the Month' and 'Team of the Month' awards • Development of staff stories library.

Progress
Key Changes to Note • Addition of controls.

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

Strategic Priority	Continuous Improvement			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Chief Finance Officer	16 (4 x 4)	12 (4 x 2)	8 (4 x 2)

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document.	• Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • Monthly COO checks and monitoring. • Recovery plan to achieve 23/24 financial plan and reset complete confirming no change to the plan. • Mitigations and Risk Plan Completed.

Gaps in Control or Assurance	Actions
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Limited assurance on delivery as plans are in early stages and timelines for delivery still subject to change. • Uncertainty of impact of industrial action	• CFO to present a full review of Forecasting to the FBPAC. • Continue delivery of CIP programme and maintain oversight of divisional progress. Ongoing. • Complete benchmarking and productivity opportunities review pack. • Develop 3 year CIP Plan to include all trust wide strategic and transformational plans. • Completion of submission of H2 plan to ICB.

Progress
Key Changes to Note • Change to overall scoring. • Additional actions identified.

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

Strategic Priority	Continuous Improvement			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Chief Strategy Officer and Chief Operating Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

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

Gaps in Control or Assurance	Actions
• Lack of protected time due to conflicting priorities in service delivery, particularly in relation to clinical staff. • Lack of clarity on H2 arrangements and financial arrangements for 2022/23 period. • Historic estate infrastructure system working. • Lack of clarity on financial arrangements for 2022/23 period. • Historic estate infrastructure. • Ability to deliver system wide change across Wirral NHS organisations. • Lack of clarity on H2 arrangements and financial arrangements for 2022/23 period, limits level of assurance in board and committee reports.	• Implementation and delivery of Cost improvement and Transformation Programmes for 22/23 and delivery of 22/23 Improvement Programme to plan. • Implementation of revised Cost Improvement approach. • Integration of Quality and Service Improvement function from 2024/25

Progress
Key Changes to Note • N/A

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

Strategic Priority	Continuous Improvement			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Chief Executive Officer	12 (4 x 3)	8 (4 x 2)	8 (4 x 2)

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

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

Progress
Key Changes to Note • N/A

BAF RISK 10	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability.

Strategic Priority	Our Partners			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Chief Executive Officer	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)

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

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

Progress
Key Changes to Note • N/A

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

Strategic Priority	Digital Future and Infrastructure			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Chief Finance Officer and Chief Strategy Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)

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

Gaps in Control or Assurance	Actions
• N/A	• Continue to track delivery of 23/24 schemes through Capital Management Group and Capital Committee • Prepare for 24/25 capital schemes as part of 3 year capital programme • Further develop reporting to Capital Committee • Deep dive of Estates risks related to backlog maintenance, through Capital Committee • Continual reassessment of requests through Capital Management Group

Progress
Key Changes to Note • Change in Score. • Additional Assurance added.

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

Strategic Priority	Infrastructure			
Review Date	01/01/24	Initial Score	Last Month	Current
Lead	Chief Strategy Officer	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

Controls	Assurance
• Implementation of capital programme, which includes remedial works at Clatterbridge. • Senior Clinician input in key decisions around key areas such as critical care. • Estates Strategy. • Agreed 3 year Capital Programme. • Business Continuity Plans. • Stock capital process. • Procurement and contract management. • Bespoke digital healthcare team. •	• Capital Committee oversight. • FBP oversight of capital programme implementation and funding. • Board reporting. • Internal Audit Plan. • Capital and Audit and Risk Committee Deep Dives. • Assessment of business continuity to address increasing critical infrastructure risks to be undertaken in August and September 2023. • Independent review of risks carried out

Gaps in Control or Assurance	Actions
• Delays in backlog maintenance.	• Develop Arrowe Park master plan and Prioritisation of estates improvements. • Asset audit. • Implementation of the new Capital Assets and Facilities system. • Heating and ventilation programme. • Replacement of generators. • Assessment of business continuity to address increasing critical infrastructure risks to be undertaken in August and September 2023. • Development and review of EPPR plans across all areas.

Progress
Key Changes to Note • Additional actions identified.

Appendix – Risk Scoring Matrix

Risk Scoring and Grading:

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

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

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

Appendix – Risk Appetite Scoring Matrix

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.5**

24 January 2024

Title	Freedom to Speak Up Reflection and Planning Tool
Area Lead	Debs Smith, Chief People Officer
Author	Tracey Nolan, Freedom to Speak Up Lead
Report for	Information

Executive Summary and Report Recommendations

The reflection and planning tool is designed to help identify strengths in the Freedom to Speak Up Guardian, the Board of Directors, and the organisation and identify any gaps that need work addressing and taking forward into this year's Freedom to Speak Up action plan.

The appended reflection and planning tool is an opportunity for the Board of Directors to reflect on its current position and the improvement needed to meet expectations.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key Risks:

- Concerns raised via FTSU process may identify potential or actual risks, however these are managed on an individual basis and escalated to appropriate management representatives as necessary. There are no FTSU risks escalated as part of this report.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	no

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

1	Narrative
1.1	All Executive Directors have a responsibility for creating a safe culture and an environment in which workers can highlight problems and make suggestions for improvement. FTSU is a fundamental part of that. Executives and Board members also understand that an organisational or department culture of bullying and harassment or one that is not welcoming of new ideas or different perspectives may prevent workers from speaking up which could put patients at risk, affect many aspects of their staff's working lives, and reduce the likelihood that improvements of all kinds can be made. Executive Directors understand the impact their behaviour can have on a trust's culture and therefore how important it is that they reflect on whether their behaviour may inhibit or encourage someone speaking up.

2	Implications
2.1	**Patients** • A speaking-up culture benefits staff satisfaction and performance, too which in turns impacts on the care our patients receive.
2.2	**People** • The FTSU guardian/Just and Learning culture Lead continues to build and develop the role, promoting the service, regular walkabouts to ensure visibility and membership within key groups such as Lessons Learnt forum, and Patient Safety Incident Response Framework meeting (PSIRF) and will ensure that the FTSU agenda continues to be heard and the FTSU agenda continues to be promoted across the Trust.
2.3	**Finance** • A speaking-up culture benefits staff satisfaction and performance, too. When people feel that their opinions matter and are valued and acted on, they become more committed, and performance and retention improve.
2.4	**Compliance** • Mersey Internal Audit Authority (MIAA) undertook an audit of FTSU during October 2023. They have recently reported Substantial Assurance.

National Guardian
Freedom to Speak Up

NHS

Freedom to Speak Up

A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	Yes
I have led a review of our speaking-up arrangements at least every two years	Yes
I am assured that our guardian(s) was recruited through fair and open competition	Yes
I am assured that our guardian(s) has sufficient ring-fenced time to fulfil all aspects of the guardian job description	Yes
I am regularly briefed by our guardian(s)	Yes
I provide effective support to our guardian(s)	Yes

I am knowledgeable about Freedom to Speak Up:-

Freedom to Speak up matters are regularly discussed here at WUTH with our Lead FTSU Guardian producing and presenting a report to Trust Board every 6 months with updates on all aspects relating to FTSU. Separate meetings take place with our Lead FTSU Guardian to review progress and identify any support needed and when individual cases / scenarios require escalation.

I have led a review of our speaking up arrangements at least every 2 years:-

Yes, a gap analysis against the new NGO policy and guidance was undertaken in December 2022. A subsequent action plan was completed. Delivery of the action plan is led via the FTSU Lead Guardian and reported via bi-annual FTSU report.

Our guardian was recruited through fair and open completion:-

The role was advertised externally, and the FTSU Guardian was recruited from outside the Trust.

I am assured that our guardian has sufficient ring-fenced time:-

Our Lead FTSU Guardian is 1wte dedicated resource for FTSU and enabling a just and learning culture. The Lead Guardian is further supported by internally appointed FTSU Guardians who ensure cover when Lead Guardian is on leave.

I am briefed regularly by our guardian:-

Bi-monthly meetings are in place with the Lead FTSU Guardian and myself. Meetings are also held with quarterly with the Non-Executive Director FTSU Lead. Bi-annual FTSU reports are produced for Workforce Steering Board, People Committee and the Board of Directors to ensure I and members of the board are sufficiently briefed.

I provide effective support to our guardian:-

Feedback is sought from our Guardian on a regular basis to ensure support provided by myself is effective. Excellent links are also in place with wider members of the Executive Management team and also the Non-Executive Lead for FTSU who are available to the Guardian when required for support.

The FTSU Lead receives regular supervision from their line managers and peer supervision from regional and national FTSU Leads.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	yes
I am confident that the board displays behaviours that help, rather than hinder, speaking up	yes
I effectively monitor progress in board-level engagement with the speaking-up agenda	yes
I challenge the board to develop and improve its speaking-up arrangements	yes
I am confident that our guardian(s) is recruited through an open selection process	Yes
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	Yes
I am involved in overseeing investigations that relate to the board	Yes
I provide effective support to our guardian(s)	yes

I am knowledgeable about FTSU:-

I am kept up to date about the FTSU agenda by our Lead FTSU Guardian and receive regular update reports. I also meet quarterly with our Lead FTSU Guardian to discuss FTSU matters in more detail.

I am confident the board displays behaviours that help rather than hinder speaking up:-

The Board takes its responsibilities to lead by displaying the right values and transparent actions very seriously.We regularly discuss issues related to culture and values and are actively interested in the work of the FTSU team and their work.

I effectively monitor progress in board-level engagement with the speaking up agenda:-

I receive 6-month update reports from our Lead Guardian and support the presentation, discussion and review conversation at Trust Board. I regularly meet the FTSU lead to ensure she is supported and has a direct line of communication with the Board should that be necessary.

I challenge the board to develop and improve its speaking-up arrangements:-

As Senior Independent Director for WUTH, this forms part of my role as NED.

I am confident that our guardian is recruited through an open selection process:-

Our guardian was recruited through fair and open completion. The role was advertised externally, and the Guardian recruited from outside the Trust in line with Trust recruitment process.

I am assured that our guardian has sufficient ring-fenced time to fulfil all aspects of the guardian job description:-

Our Lead FTSU Guardian is 1wte dedicated resource for FTSU and enabling a just and learning culture. The Lead Guardian is further supported by internally appointed FTSU Guardians who ensure cover when Lead Guardian is on leave.

I am involved in overseeing investigations that relate to the board:-

Any investigations relating to the board would be discussed with me by our FTSU guardian and I would have oversight of these.

I provide effective support for our guardian:-

Quarterly review meetings are in place with myself and the Lead FTSU Guardian. If however support was needed outside of these times, I am contactable at any point and am assured that our Lead FTSU Guardian would get in touch as this arrangement is already in place and working well. I am also confident that support for our Guardian is provided by the Chief People Officer, Executive Lead for FTSU and their line manage – Associate Director for Organisational Development. Excellent relationships are in place with wider members of the Executive Management Team should further support be required.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	Yes
We regularly and clearly articulate our vision for speaking up	Yes
We can evidence how we demonstrate that we welcome speaking up	Yes
We can evidence how we have communicated that we will not accept detriment	Yes
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	4
We regular discuss speaking-up matters in detail	Yes

The whole leadership team has bought into FTSU:-

- The FTSU agenda is monitored and reviewed regularly via the Workforce Governance Structure e.g. Workforce Steering Board, People Committee and then into the Board of Directors.
- Triangulation of data takes place, with thematic reviews undertaken of FTSU data that feeds into our Trust Lessons Learnt forum.
- Quarterly FTSU data is incorporated into a Patient Safety Quality Report and reported on at the Trust's Patient Safety and Quality Board.
- Divisional Triumvirates have recently requested quarterly data reporting directly to them following FTSU Lead attending Operational Directors meeting.
- Regular requests from divisional leadership teams to attend key department and divisional meetings to proactively raise awareness of FTSU and offer additional support to staff.
- FTSU Lead has also attended Chief Nurse Check In to promote FTSU to all senior nurses in WUTH and to share with teams.

We regularly and clearly articulate our vision for speaking up:-

- Non-Executive and Executive FTSU Leads produced a video promote FTSU as part of speak up month.
- Regular Trust wide communication articles are shared to promote speaking up, particularly during speak up month.
- The importance of speaking up is emphasised as part of the Trust's induction process, with messages reinforced by Executive Director in attendance and Lead FTSU Guardian present at all induction sessions.
- Regular promotion of speaking up also takes place within key meetings e.g. Leaders in Touch Forum, Chief Nurse Check-in and as part of induction for doctors in training and as part of promotional materials to students, newly qualified nurses and our voluntary and vocational development roles.
- Speaking up and ensuring a just and learning culture is embedded within leadership for all and manager essential development programmes, with our FTSU Guardian in attendance for standalone sessions.
- A dedicated speak up section of the website is in place.
- Our speak up policy and process is approved, in line with the national guidance and available for all staff on the intranet page. We also promote that we encourage staff to speak up, as part of our "Why Choose Us for Work" public facing webpages.
- We have developed FTSU pull up banners, leaflets and business cards, based on the National Guardians office imagery and also purchased pens to give out to staff to support key messages for staff.
- We have integrated the FTSU national e-learning content into our Role Specific Training Matrix and monitor compliance for staff, with 95% of staff completing level 1.

We can evidence how we demonstrate that we welcome speaking up:-

- As detailed above, there are various ways that we promote and encourage staff to speak up including FTSU forming part of induction, manager essentials training and have mandated speak up training for staff as well as senior leaders requesting walkabouts and visits from FTSU Guardian to meet staff and promote support available.

We can evidence how we have communicated that we will not accept detriment:-

- We have incorporated our approach within the revised FTSU policy that was approved in December 2022 and promote via the methods detailed above.

We are confident that we have clear processes for identifying and addressing detriment:-

- We have a central record of staff who raise concerns and where matters raised indicate that detriment may have been suffered as a result of speaking up, this is recorded and reported on separately, within FTSU reporting arrangements.

- We ask all persons using FTSU service to provide feedback about the process. This data allows an additional opportunity to identify potential areas of detriment.
- Both data sets also form part of our regular reporting requirements to the National Guardians Office and included within reporting to Workforce Steering Board, People Committee and the Board of Directors.
- Whilst we have a process for identifying detriment unless the individual specifies who they are, the survey is returned anonymously. This is an area for development.

We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up:-

Promotional video and Trust wide communications have been shared to promote and encourage staff to speak up, particularly during speak up month, with positive feedback received.

- Non-Executive Director FTSU Lead film
- Executive Director FTSU Lead film
- Medical Director Communication
- This is evidenced in the increase in FTSU disclosures.
- There is opportunity to further promote this across the organisation, focusing on positive experiences of having spoken up and creating improvements
-

We regularly discuss speaking up matters in detail:-

- Bi-annual report is submitted through our workforce governance structure and to Board and particularly recently:
- Discussed at November Board
- Discussed at November People Committee
- Bi-annual report to Board, People Committee, WSB

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

1. Further development to the post support survey in which individuals can highlight if they've received detriment as a result of raising a concern. Tool is currently anonymise which makes it difficult to identify the individual that raised they have received detriment as a result of raising a concern.

2. Implement increased communications re: the role of Listening Up and role modelling once a concern is raised emphasising duty for ensuring there is no detriment. Build into leadership training and emphasise further as part of awareness.

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up *OD Lead line managers FTSU Guardian*	Yes
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans - Embedded in Induction and local induction - Embedded in management training and Leadership development programmes - Embedded in LQF - Aligned to Just and Learning Culture multi-year project	Yes
We have adapted our organisational culture so that it becomes a just and learning culture for our workers - Multi-year project to embed Just and Learning Culture	Yes
We support our guardian(s) to make effective links with our staff networks - We have FTSU champions in each of our staff networks - FTSU Guardian has presented FTSU at each network and regularly attends, working closely with engagement and EDI lead to promote speaking and listening up	Yes
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture - Where we have low uptake the guardian targets with walk abouts for example has visited labs and connecting to CSWs who have not raised any concerns in Q2 2023/24	Yes

There are open links between Lead FTSU Guardian, Trust staff networks and the GOSW. However, we acknowledge that there is a new GOSW and whilst an introductory meeting has taken place there is opportunity to build on this.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. FTSU Lead Guardian to forge links with new GOSW to triangulate junior doctor feedback.

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	Yes
We have reviewed the ringfenced time our Guardian has in light of any significant events *– role is full time with support from two other Guardians when lead guardian is on annual leave*	Yes
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	Yes
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	Yes
We have considered all relevant….events:- We have dedicated time-slots for FTSU lead to promote speaking up and listening up, these include: Induction, Management and Leadership Development programmes, Junior Doctor development, Divisional Meetings, Lessons Learnt Forum. An annual calendar of walk abouts and drop in sessions is currently being formed. Further to this FTSU Lead Guardian continues to look for opportunities to promote Speaking and Listening Up. **We have reviewed the ring-fenced time…events:-** • Regular reviews have taken place of the FTSU service leading to implementation of a dedicated post.	

The whole senior team or board has been in discussions about the amount of ring-fenced time needed for our guardian(s)

- The senior team have supported the implementation of a dedicated full time role to support FTSU and just and learning culture, with the new role appointed to in January 2023. Ongoing review required.

We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians:-

- Funding for Freedom to Speak up is via the Trusts OD Budget.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Review of ring-fenced time allocation post 12 months in role.

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	Yes
We can evidence that our staff know how to find the speaking-up policy	Yes

Our organisation's speaking-up policy reflects the 2022 update:-

Our Freedom to Speak Up Policy – Raising Concerns in the Workplace was updated September 2023 and reflects the 2022 update.

We can evidence that our staff know how to find the speaking-up policy:-

Our staff are increasingly raising concerns under the new policy which evidences the fact that they know where to find it. The FTSU guardian rotates around the Trust to promote awareness of the role and policy. The FTSU Lead delivers awareness session's signposting staff to the policy and has distributed promotional FTSU items and posters signpost the FTSU policy. Ongoing and regular comms/screensavers trust wide reference FTSU and the FTSU policy.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. There is opportunity to further develop FTSU awareness across the volunteer workforce. Whilst its covered-on induction for new volunteers and forms part of the mandatory training many existing volunteers have not completed the corporate induction for some time. Action: promote the role of FTSU Guardian and the process for raising concerns in the Volunteer newsletter – Winter Edition.

2

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	Yes
We have an annual plan to raise the profile of Freedom to Speak Up	Yes
We tell positive stories about speaking up and the changes it can bring	3
We measure the effectiveness of our communications strategy for Freedom to Speak Up – via reporting data	Yes

We have used clear and effective comms to publicise our guardian:-

- On appointment of our new Lead FTSU guardian, an introductory communication was shared. Our Guardian introduced herself and her role within the Trust. Following this, photographs in Trust communications have been used to publicise our Guardian. Explaining the role of the guardian and encouraging workers to use the services of FTSU/guardian when needed. Further communications have been sent out promoting FTSU during FTSU month, October with a recent campaign to launch a recruitment drive for FTSU Champions.
- FTSU Lead Guardian regularly attends key meetings and networks to communicate FTSU.

We have an annual plan to raise the profile of FTSU:-

- Communications plan established.

We tell positive stories about speaking up and the changes it can bring:-

We have just started to embark upon this. Further work to do to:

- Generate more staff stories.
- Create anonymised case studies.
- Explore option for Schwartz Round specific to people that have spoken up as part of next years' FTSU month.

We measure the effectiveness of our communications strategy for FTSU:-

- Effectiveness is currently measured by the uptake of staff who contact the speak up service, via feedback from staff during departmental visits and feedback from staff who have used the FTSU service.
- However further work is underway to use Staff survey data to benchmark an increase in awareness and targeting for our communications plan.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Develop collation of staff stories
   - More work to identify and generate staff stories.
   - Create anonymised case studies.
   - Explore option for Schwartz Round specific to people that have spoken up as part of next years' FTSU month.

2. Further develop communications plan using staff survey data to inform areas for increased targeting with communications and engagement.

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	Yes
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	Yes
Our HR and OD teams measure the impact of speaking-up training	1

We have mandated the NGO and HEE training:-

- This is mandated and reported as part of bi-annual reports

FTSU features in the corporate inductions as well as local team-based inductions:-

- The Guardian attends the inductions in person as well as speaking at Junior Drs induction

Our HR and OD teams measure the impact of speaking up:-

- Feedback and evaluation is completed when face to face sessions are delivered as part of induction or manager essential programmes, however not the elearning programmes currently delivered.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Video and awareness to also be incorporated into new electronic local induction tool and links to FTSU site
2. Evaluation of FTSU training / awareness sessions

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	Yes
All managers and senior leaders have received training on Freedom to Speak Up	Yes
We have enabled managers to respond to speaking-up matters in a timely way	Yes
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	Yes

We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared:-

- The FTSU National Guardians Office (NGO) training has been mandated as role specific training in the Trust. The guardian also delivers on all of the manager specific training to help managers to understand the principles and values of FTSU.

All managers and senior leaders have received training on FTSU:-

- Currently 95% compliant for the Listen Up level 2 training for all managers.
- FTSU Guardian speaks on Induction, Manager Essentials and Leading Teams and has led several ‘mini-manager essentials specific to FTSU and Listening Up

We have enabled managers to respond to speaking up matters in a timely way:-

- In line with The NGO Guide for Leaders 2022, the guardian has produced bespoke FTSU training for managers which is delivered by the guardian during management training sessions. Managers are taught the importance of dealing with FTSU matters in a timely and appropriate way. The guardian is available to all managers for bespoke advice relating to the handling of FTSU cases. Average time to close a case is 3days.

We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture:-

- Whilst we have hotspot areas the FTSU Guardian will undertake focused work with the management team to resolve, however its rare that this relates to one individual manager who hasn’t ‘learnt’ from their experience.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	Yes
We use triangulated data to inform our overall cultural and safety improvement programmes	Yes

We have supported our guardian to effectively identify potential areas of concern and to follow up on them:-

We have facilitated a close working relationship between our guardian and our HR and OD team to allow our guardian to identify areas of concern etc. The staff survey, pulse survey and exit interviews are utilised by OD and our guardian to identify areas of concern.

We use triangulated data to inform our overall cultural and safety improvement programmes:-

Guardian chairs the triangulation group on a quarterly basis to identify themes and raise concerns; this feeds into a Trust wide lessons learnt forum.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	Yes
We use this information to add to our Freedom to Speak Up improvement plan	yes

We share the good practice we have generated both internally and externally to enable others to learn	Yes

We regularly identify good practice from others:-

- The guardian sends a survey to all staff who raised concerns asking if they would use the FTSU service again, this has been positive with staff in agreement that they would raise concerns again in the future.
- We use staff scenarios in our reports that go to people committee as well as board to showcase the success stories and good practice.

We use this information to add to our Freedom to Speak Up improvement plan:-

- Our improvement plan is reviewed monthly to ensure we are timely with our actions

We share good practice we have generated internally and externally:-

- We regularly feature in comms to ensure that staff are kept up to date of any initiatives and news. The guardian meets monthly with 2 other guardians to discuss good practice and ideas across 3 hospitals

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	Yes
Our guardian(s) has been trained and registered with the National Guardian Office	Yes

Our Guardian was appointed in a fair and transparent way:-

- Our Guardian was appointed by open competition with the job advertised externally.
- Additional support FTSU Guardians were recruited via an application and interview process.

Our guardian has been trained and registered with the National Guardian's Office:-

- Our Guardian has undertaken all the National Guardian Office training, is registered with The NGO and is an active member of the NGO network.
- Additional support FTSU Guardian has also undertaken NGO training.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	Yes
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	Yes
Our guardian(s) has access to a confidential source of emotional support or supervision	Yes
There is an effective plan in place to cover the guardian's absence	Yes
Our guardian(s) provides data quarterly to the National Guardian's Office	Yes

Our guardian(s) has performance and development objectives in place:-

- The guardian has regular 1-1s with the Associate Director of Organisational Development to ensure performance and development objectives are in place.

Our guardian receives sufficient one to one support :-

- Our guardian receives regular one to one support from the Exec lead for FTSU – meeting bi monthly to ensure they're effectively supported in their role.

Our guardian has access to a confidential source or emotional support or supervision:-

- FTSU Guardian can access Professional Nurse Advocates, colleagues in Occupational Health, peer supervision from NGO's in neighbouring Trusts and via the regional NGO organised support.

There is an effective plan in place to cover the guardian's absence:-

- There is an effective plan in place to cover the guardian's absence with FTSU cover provision provided by another guardian.

Our guardian provides data quarterly to The NGO:-

- Yes

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	Yes
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	Yes
We are assured that confidentiality is maintained effectively	Yes
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	Yes
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	Yes

Our speaking-up case-handling procedures are documented:-

- Our speaking up processes are documented in our FTSU Policy and on our Intranet within the FTSU pages.

We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases:-

- The guardian has engaged with managers and leaders within the Trust by providing FTSU information/guidance sessions.

We are assured that confidentiality is maintained effectively:- • Confidentiality is maintained by the guardian. All records of FTSU cases are stored in a drive which the guardian alone can access (as per NGO guidance). Each person using the FTSU service is asked if they wish for their case to be handled on one of the following basis: - Anonymously, confidentially or openly. Their wishes are complied with. • No concerns raised regarding breaches of confidentiality
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	Yes
We know who isn't speaking up and why	2
We are confident that our Freedom to Speak Up champions are clear on their role	Yes
We have evaluated the impact of actions taken to reduce barriers?	3

We have identified the barriers that exist for people in our organisation:-

- Using the information gathered by the staff survey and pulse surveys.
- Attending our staff network meetings and receiving feedback from our LGBTQ+ , staff with disabilities and long-term conditions and our Black, Asian and Minority Ethnic staff.
- Attending staff group meetings – rotating safety huddles and divisional meetings.
- Walking the floor engaging with staff
- Learning from barriers identified by people speaking up, themes protected characteristics etc.
- Lack of knowledge of FTSU and process. Revised Policy and FTSU pages with supporting trust wide comms including physical posters.

We know who isn't speaking up and why:-

- Our guardian chairs a thematic review meeting and also monitors who is speaking up from staff groups to understand who isn't speaking up. We will learn more about this by triangulating data.
- Because we keep data on who isn't speaking up we are able to target these staff groups to understand why they feel unable to speak up. This is an area for further development.

We are confident that our FTSU Champions are clear on their role:-

- Our Lead FTSU Guardian was recruited against a clear job description and has been supported by the Associate Director of Organisational Development and the previous Lead FTSU Guardian and completed the NGO training.
- Our support Guardian was also recruited against a job description and is regularly supported by the Lead Guardian and undertaken NGO training.
- Our network of FTSU Champions have been given the NGO guidance for Champions / Ambassadors and undertaken internally developed training programme on commencement of their role.
- A recruitment drive for new Champions has taken place and a meeting in the new year is already planned. They will receive training guidance and a regular FTSU meeting to support.

We have evaluated the impact of actions taken to reduce barriers:-

- Impact is evaluated using the data collated and presented within FTSU update reports and monitoring trends and themes of the number of people speaking up and their demographics e.g. roles. There is opportunity for more targeted evaluation.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Whilst we have access to key data such as staff survey which helps us to pinpoint areas for targeting. Not all staff complete the survey and if there is a reluctance to speak up there may also be a reluctance to complete staff survey. Implementation of an annual cycle of walk abouts, drop in events across all services to develop our understanding of this further.

2. Evaluate FTSU initiatives as part of continuous improvement.

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	Yes
We monitor whether workers feel they have suffered detriment after they have spoken up	Yes
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	3
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	Yes

We have carried out work to understand what detriment for speaking up looks and feels like:-

Our process for managing any detriment is set out in our FTSU Policy.

We monitor whether workers feel they have suffered detriment after they have spoken up:-

- Our Guardian communicates with each worker speaking up to find out whether they feel they have suffered detriment after speaking up and ensures that each worker knows what detriment is and that if at any stage they feel they have experienced it that they can raise this and it will be investigated. This is also confirmed in our FTSU Policy.

We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment:-

- Yes we do have a process in place to manage any detriment. There is opportunity to develop this, to move away from anonymous reporting, as set out above.

Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed:-

- Our Non-Executive Director for FTSU receives updates on all cases as part of quarterly meetings and biannual reports or directly, depending on the nature of the concern raised.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Work to improve the identification of detriment and to better understand what this looks and feels like.

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	Yes
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	Yes
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	Yes
Our improvement plan is up to date and on track	Yes

We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture:-

- FTSU is embedded within our 2022 – 2026 people strategy with an underpinning strategic action plan in place to support delivery of key objectives

We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies:-

- As FTSU is embedded within our people strategy, it fits with our organisations overall cultural and improvement strategy and that it supports the delivery of related strategies.

We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation:-

- Our FTSU processes and plans are regularly reviewed with biannual updates shared throughout our governance process.

Our improvement plan is up to date and on track:-

- Our delivery plan is updated monthly and is on track

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1.
2.

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	Yes
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	Yes
Our speaking-up arrangements have been evaluated within the last two years	Yes

We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up:-

- Staff survey results are monitored and reviewed on an annual basis. Feedback from staff using the service is captured and monitored along with feedback received by the FTSU team or to Execs on walk arounds.

Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach:-

- We do follow a Plan Do Study Act methodology together with critical reflection via thematic review of cases with colleagues from other disciplines that are in receipt of concerns raised i.e. HR, Incidents and Safeguarding. We also recognise that there is more work to do to evaluate the effectiveness of some of the FTSU initiatives beyond the feedback from staff survey data.

Our speaking-up arrangements have been evaluated within the last two years:-

- A Merseyside Internal audit review completed in September 2023 confirmed that there was clear evidence that employees felt empowered to raise any concerns at work. The review found that the Trust had a positive culture with high assurance of Speaking up

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. As per action 2 in section seven - Improve the identification of individuals reporting detriment in order to better understand what this looks and feels like and to further support and address concerns.
2.

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	Yes
We have we evaluated the content of our guardian report against the suggestions in the guide	Yes
Our guardian(s) provides us with a report in person at least twice a year	Yes
We receive a variety of assurance that relates to speaking up	Yes
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	Yes

We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need:-

- Guardian reports continue to be reviewed and have changed over the last few years to focus on areas required for assurance. Reviews have also taken place against new NGO guidance and the Executive lead for FTSU checks the guardians report to ensure it provides assurance required**.**

Our guardian(s) provides us with a report in person at least twice a year

- Our guardian provides a report in person to Trust Board twice a year.

We receive a variety of assurance that relates to speaking up:-

- The guardian's report provides assurance of the work carried out by the guardian within the Trust. Feedback is requested form those using FTSU which is included within the guardian's report. The guardian performs 'walk arounds' within the Trust to gain assurance that employees know how and when to access the service. The annual staff survey is used to obtain data relating to speaking up and is evidenced within the guardian's report.

We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement:-

- A lessons learned section is included within the FTSU update reports to provide an overview of the key areas for learning

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1.
2.

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
Improve the identification of individuals reporting detriment in order to better understand what this looks and feels like and to further support and address concerns.	30/03/2024	FTSU Lead Guardian
Establish FTSU 'Listening Up' specific objective for divisional triumvirates for 2024/25 – suggested "Advanced the listening up and speaking up culture within the division by……"	30/04/2024	Executive Director for FTSU
Implement increased communications re: the role of Listening Up and role modelling once a concern is raised emphasising duty for ensuring there is no detriment. Build into leadership training and emphasise further as part of awareness.	31/03/2024	FTSU Lead Guardian
FTSU Lead Guardian to forge links with new GOSW to see if junior Drs are feeding back any concerns.	30/01/2024	FTSU Lead Guardian
Review of ring-fenced time allocation post 12 months in role.	29/02/2024	Associate Director for OD & FTSU Lead Guardian
Promote the role of FTSU Guardian and the process for raising concerns in the Volunteer newsletter – Winter Edition.	29/02/2024	FTSU Lead Guardian
Develop collation of staff stories • More work to identify and generate staff stories. • Create anonymised case studies.	30/12/2024	FTSU Lead Guardian

• Explore option for Schwartz Round specific to people that have spoken up as part of next years' FTSU month.		
Further develop comms plan using staff survey data to inform areas for increased targeting with communications and engagement.	29/02/2024	FTSU Lead Guardian
Video and awareness to also be incorporated into new electronic local induction tool and links to FTSU site	30/06/2024	FTSU Lead Guardian
Evaluation of FTSU training / awareness sessions – include evaluation in bi-annual FTSU report	30/09/2024	FTSU Lead Guardian
Implementation of an annual cycle of walk abouts, drop in events across all services to promote and engage individuals; further developing our understanding of barriers to speaking up.	31/03/2024	FTSU Lead Guardian
Evaluate FTSU initiatives as part of continuous improvement.	31/01/2025	FTSU Lead Guardian

Development areas to address in the next 12–24 months	Target date	Action owner

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1. Well established dedicated Lead Guardian role – 1WTE dedicated support - Promote this as part of FTSU comms	Ongoing	FTSU Lead Guardian
2. Substantial Assurance demonstrated via MIAA assessment	29/02/2024	FTSU Lead Guardian
3. Cases closed within average time of 3-days – Promote this as part of FTSU comms	30/12/2024	FTSU Lead Guardian
4. FTSU is underpinned by robust governance – Reflect this within the Bi-Annual Report	30/04/2024	FTSU Lead Guardian
5. Good support available for FTSU Lead Guardian – Reflect this within Bi-annual report	30/04/2024	FTSU Lead Guardian
6		
7		
8		

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.6**

24 January 2024

Title	Monthly Maternity and Neonatal Services Report including: - • Final submission of Year 5 of the Maternity Incentive Scheme (MIS) and approval from the Board of Directors for sign off the declaration form to NHS Resolution (NHSR)
Area Lead	Dr Nikki Stevenson, Executive Medical Director, Deputy Chief Executive Officer (CEO)
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Approval

Executive Summary and Report Recommendations

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

In addition to the paper a presentation will be delivered to provide assurance to the Board of Directors compliance with the 10 Maternity Safety Actions (MIS) Year 5 that is due for submission before 1 February 2024.

Also included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (November and December 2023) key quality and safety metrics.

It is recommended the Board of Directors:

- To note the report and approve the compliance document for the submission of the declaration form to NHSR, following a positive recommendation from Quality Committee on 18 January

Key Risks

This report relates to these key Risks:

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

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

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
Jan 2024	Maternity & NNU Assurance Board	Monthly Maternity and Neonatal Services Report	For information
Jan 2024	Quality Committee	Monthly Maternity and Neonatal Services Report	For information

1	**Maternity Incentive Scheme (MIS) Year 5**
	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 1 February 2024. At **Appendix 1** is Wirral University Teaching Hospital's completed Board Notification Form for consideration and approval. Now in its fifth 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. At the December 2023 Board of Directors meeting an update was provided confirming that WUTH had met safety actions 2, 3, 4, 5, 6, 7, 8 and 9 to meet the requirements of each safety action, with the declaration and submission due by 1 February 2024. 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 2).**

2	**Perinatal Clinical Surveillance Quality Assurance Report**
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 3** and provides an overview of the latest (November and December 2023) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services. The dashboard is provided for information and whilst there is no indication to escalate any of the metrics to the Board of Directors, it should be noted since there is no longer

	a Northwest coast regional report being produced WUTH is no longer able to report on the benchmarking against other providers for rates such as stillbirth and neonatal deaths. Assurance has previously been provided to the Board of Directors this was escalated via the Local Maternity and Neonatal System (LMNS) for a resolution. However, a Northwest Regional Dashboard Tool for use by Regional Maternity and Neonatal Teams is available to provide bespoke reports for Regional Operational Performance reporting. The Maternity Services Data Set publications have a lag of circa three months and at the time of the report August 2023 data was unavailable to access. On review of the dashboard the Board of Directors should be aware concerns regarding the accuracy of the data sources have been raised regionally, further escalating regionally it remains WUTH is still unable to benchmark against other providers. An update will be provided at the next quarterly Maternity and Neonatal Services report.

3	Serious Incidents (SI's) & Maternity and Newborn Safety Incidents (MNSI)
	Serious incidents (SI's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). SI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity SI's across the region. There were five Patient Safety Investigation Incidents (PSII's) for Maternity declared in November and December 2023 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date two cases will undergo the independent safety investigation. There were no Patient Safety Investigation Incidents (PSII's) declared in November and December 2023 for Neonatal services.

4	Conclusion
	The Board of Directors are requested to approve Trust compliance with Year 5 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 1 February 2024. The next BOD paper will continue to update on the delivery of safe maternity and neonatal services.

5	Implications
5.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
5.2	**People** • Compliance and confirmation via the LMNS/ICB WUTH has that meet all 10 safety standards provides assurance of the improvements to high quality, safe care and the delivery of best practice in both Maternity and Neonatal services. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement.
5.3	**Finance**

	• In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) and deliver Maternity Continuity of Care as the default model, investment into the maternity and neonatal workforce is required and funding options are being explored.
5.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Maternity Incentive Scheme - Year 5

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Regular assurance meetings have taken place with the LMNS since September 2023 with a review of all evidence submitted. Confirmation has been received from the LMNS that WUTH is compliant with all 10 Safety Actions and that this will be communicated to Cheshire & Merseyside Integrated Care System (ICB) for sign off by the Accountable Officer.

There is a requirement that the Trust Board declaration form must then be signed and dated by Ms Janelle Holmes - Chief Executive Officer (CEO) to confirm that: - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

In addition, Ms Holmes and Mr Graham Irwin as Accountable Officer (AO) must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

Once submitted the Trust submission will be subject to a range of external validation points, these include cross checking with: MBRRACE-UK data (safety action 1 standard a, b and c), NHS England & Improvement regarding submission to the Maternity Services Data Set (safety action 2, criteria 2 to 7 inclusive), and against the National Neonatal Research Database (NNRD) and HSIB for the number of qualifying incidents reportable (safety action 10, standard a)). Trust submissions will also be sense checked with the CQC, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death?	Yes
3	For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
4	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
5	Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death?	Yes
6	Were 60% of the reports published within 6 months of death?	Yes
7	Were PMRT review panel meetings (as detailed in standard C) rescheduled due to the direct impact of industrial action, and did this have an impact on the MIS reporting compliance time scales?	N/A
8	Is there an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period.	N/A
9	If PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many meetings in total were impacted?	N/A
10	PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many cases in total were impacted?	N/A
11	Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
12	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	Yes
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	Yes

Safety action No. 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and		

1	Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: ● Neonatal involvement in care planning ● Admission criteria meets a minimum of at least one element of HRG XA04 ● There is an explicit staffing model ● The policy is signed by maternity/neonatal clinical leads and should have auditable standards. ● The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Yes
2	Are neonatal teams involved in decision making and planning care for all babies in transitional care?	Yes
b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater		
3	Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks?	Yes
4	Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks?	Yes
5	Is there evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan?	Yes
6	Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan?	Yes
c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be		
7	Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occuring?	Yes
8	OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation?	N/A

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3		
1	a. Locum currently works in their unit on the tier 2 or 3 rota?	Yes
2	**OR** b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)?	N/A
3	**OR** c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	
4	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	Yes
5	**OR** Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings? https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf	
6	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	Yes
7	**OR** Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings? https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf	N/A
8	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person?	Yes
9	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	Yes
Do you have evidence that the Trust position with the above has been shared:		
10	At Trust Board?	Yes

11	With Board level safety champions?	Yes
12	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
13	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes
	The rota should be used to evidence compliance with ACSA standard 1.7.2.1 (A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients)	
c) Neonatal medical workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes?	No
15	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
16	LMNS?	Yes
17	ODN?	Yes
d) Neonatal nursing workforce		
18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	Yes
19	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	N/A
Was the agreed action plan shared with:		
20	LMNS?	N/A
21	ODN?	N/A

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated	Yes
2	b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include: ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
3	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. Can you provide evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating **100% compliance** with supernumerary labour ward co-ordinator status? The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however **the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.** If the failure to maintain supernumerary status is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard.	Yes
4	d) Have all women in active labour received one-to-one midwifery care?	Yes

5	If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour?	N/A
6	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?	N/A
7	e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period?	Yes

Safety action No. 6

Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?	Yes
2	Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool? Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Progress against locally agreed improvement aims. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.	Yes
3	Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall?	Yes
4	Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements?	Yes

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan?	Yes
2	Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board?	Yes
3	Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions?	Yes
4	Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff?	Yes
5	Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support?	Yes
6	Can you provide the local MNVP's work plan and evidence that it is funded?	Yes
7	Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way?	Yes
8	Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation?	Yes

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2022 to 1st December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	A local training plan is in place for implementation of Version 2 of the Core Competency Framework	Yes
Can you evidence that the plan has been agreed with:		
2	Quadrumvirate?	Yes
3	Trust Board?	Yes
4	LMNS/ICB?	Yes

5	Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England?	Yes
6	Can you evidence service user involvement in developing training?	Yes
7	Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports?	Yes
8	Can you evidence that you promote learning as a multidisciplinary team?	Yes
9	Can you evidence that you promote shared learning across a Local Maternity and Neonatal System?	Yes
Can you demonstrate the following at the end of 12 consecutive months ending December 2023?		
Fetal monitoring and surveillance (in the antenatal and intrapartum period)		
10	90% of obstetric consultants?	Yes
11	90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)?	Yes
12	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres?	Yes
Maternity emergencies and multiprofessional training		
13	90% of Obstetric consultants?	Yes
14	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota?	Yes
15	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives?	Yes
16	90% of maternity support workers and health care assistants attend the maternity emergency scenarios training?	Yes
17	90% of obstetric anaesthetic consultants?	Yes
18	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota?	Yes
19	Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care?	Yes
20	Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area **or** does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members?	Yes
Neonatal basic life support		
21	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
22	90% of neonatal junior doctors (who attend any births)?	Yes
23	90% of neonatal nurses (Band 5 and above who attend any births)?	Yes
24	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
25	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)?	Yes
26	All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024.	Yes
27	Have you declared compliance for any of Q10-Q25 above with 80-90%?	Yes
28	If you are declaring compliance for any of Q10-Q25 above with 80-90%, can you confirm that an action plan has been approved by your Trust Board to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period?	Yes

Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	**Required Standard A.** **Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-**	Yes
2	Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues?	Yes
3	Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)? It must include: • number of incidents reported as serious harm • themes identified and action being taken to address any issues • Service user voice feedback • Staff feedback from frontline champions' engagement sessions • Minimum staffing in maternity services and training compliance	Yes
4	Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.	Yes
Required standard B.		
5	The Trust Board?	Yes
6	LMNS/ICS/Local & Regional Learning System meetings?	Yes
7	Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff?	Yes
8	Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.	Yes
9	**Required standard C.** **Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?**	Yes
10	Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit?	Yes

11	Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024?	Yes
12	Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented?	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN)

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes
2	Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023?	Yes
3	Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023?	Yes
	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:	
4	The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme	Yes
5	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	Yes
	Can you confirm that the Trust Board has:	
6	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution?	Yes
7	Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme?	Yes
8	Sight of evidence of compliance with the statutory duty of candour?	Yes

SUMMARY OF COMPLIANCE WITH SAFETY ACTIONS - MATERNITY INCENTIVE YEAR 5

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	No
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes

QUALITY IMPROVEMENT ACTIONS FOR MATERNITY INCENTIVE SCHEME - YEAR 6

ACTION REF	ACTION	LEAD & DEADLINE	RAG
2.1	WUTH MSDS IT Lead to meet with Director of Midwifery and IT midwifery team to review Scorecard and monthly submissions to identify any improvements/developments	Director of Midwifery 31st January 2024	
3.1	Forward audit plan for transitional care audits to be reviewed and 2024 audit proforma to be completed. Ensure audits are completed monthly on standards identified and report monthly to Maternity & Neonatal Assurance Board.	Quality & Safety Matron - Maternity and Neonatal Services 31st January 2024	
4.1	Ensure business case for additional neonatologist hours goes to Board for consideration as per action plan for Safety Action 4. Update action plan accordingly.	ADN for Children's Services 31st January 2024	
4.2	Safety Action 4 audits including locum use and consultant presence on Delivery Suite to be included in Divisional Forward Audit Plan (FAAP).	Quality & Safety Matron - Maternity and Neonatal Services 31st January 2024	
4.3	Actions for the full implementation of compensatory rest (as per SOP developed based on RCOG guidance) to be agreed and introduced.	Divisional Clinical Director 31st January 2024	
4.4	Specific roles for nurse leads to be developed as per BAPM guidance 9 update of action plan to ensure oversight of these roles and their implementation.	Director of Nursing for Children's Services 31st March 2024	
5.1	Midwifery workforce review with BR+ to be undertaken in 2024 based on a 100% continuity of carer model. Additional staffing identified to date to be supported by Board which will support the Continuity of Carer model.	Director of Midwifery 31st March 2024	
5.2	Staffing paper to Board to clearly articulate midwifery staffing requirements including MSWs.	Director of Midwifery 30th April 2024	
6.1	Full implementation of Saving Babies Lives (SBL) v3 to be completed before the end of March 2024.	Director of Midwifery and Clinical Director 31st March 2024	
6.2	Clinical Leads for each Element of SBL to be reviewed and protected time to be identified to further support quality improvement.	Director of Midwifery 31st January 2024	

6.3	All audits for SBL to be identified and collated into an SBL Audit plan - this needs to also be included on the Divisional FAAP.	Quality & Safety Matron for Maternity and Neonatal services 31st January 2024	
6.4	Ensure that monthly auditing of SBL audits continues and are reported quarterly to the Maternity & Neonatal Assurance Board.	Q&S Matron for Maternity and Neonatal Services 31st January 2024	
6.5	Look at additional funding for support from an audit clerk to manage all 30+ audits required for SBL and MIS.	Director of Midwifery 31st December 2023	
6.6	Monitor the timeliness of policies/pathways required for SBL and prioritise accordingly to ensure all are within timeframe.	Q&S Matron for Maternity and Neonatal Services 31st January 2024	
7.1	Recruitment of MNVP Chair to fill existing gap due to the promotion of the existing Chair.	Director of Midwifery 31st January 2024	
8.1	Ensure all staff are appropriately trained to a minimum of 90% as per Competency Framework by the end of March	Director of Midwifery 31st January 2024	
9.1	Ensure Quad meetings take place in 2024 as per guidance and that discussions/actions are minuted/noted. Feed this to Maternity and Neonatal Assurance Board and escalated any concerns to Board.	Director of Midwifery 31st December 2023	
9.2	Ensure MatNeo Assurance Board meetings take place in 2024 at least bimonthly with the presence of a safety champion/s.	Director of Midwifery 31st December 2023	
10.1	Ensure oversight at Mat Neo Assurance Board in addition to Board of the Trust Claims card for Maternity and Neonatal services and triangulate further with incidents/complaints/compliments.	Director of Midwifery 31st December 2023	

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Year 5

Prepared and Presented by:
Jo Lavery (Director of Midwifery) & Mustafa Sadiq (Clinical Director for Maternity Services)
16th January 2024 – Maternity and Neonatal Assurance Meeting
16th January 2024 – Patient Safety Quality Board (PSQB)
18th January 2024 - Quality Committee
24th January 2024 - Board of Directors

Introduction to MIS Year 5

Wirral University Teaching Hospital NHS Foundation Trust

- To provide an oversight of how the ten safety actions have been achieved at Wirral University Teaching Hospital and details of the evidence
- To demonstrate overall assurance to the Board of Directors compliance with the ten CNST Safety Actions detailed in the Maternity Incentive Scheme (Year 5)
- The LMNS assurance Board signed off compliance with MIS year 5 in December 2023 for WUTH and communicated to the ICB for sign off
- To seek Board of Directors approval today and permission to support the sign off before the final submission to NHS Resolution by 12 noon on 1st February 2024. The following conditions apply:-
    - Trusts must achieve all ten safety actions
    - The declaration form is submitted to the Trust Board today with this presentation detailing position and progress with the maternity safety actions by the Director of Midwifery and Clinical Director
    - The LMNS/ICB representation will be in attendance to confirm oversight by the governance structure/BoD
    - The Board of Directors give permission following today's meeting to the CEO to sign the Board declaration form prior to submission to NHS Resolution
    - In addition to the CEO of the Trust the accountable officer for the ICB will also apprise the safety actions evidence and declaration form
- To provide an update to Board on the MIS scheme in Year 6 and any potential changes

Safety Actions Summary Table

Wirral University Teaching Hospital NHS Foundation Trust

Safety Action	Detail	RAG Rate
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required Safety Action?	
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required Safety Action?	
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	
4	Can you demonstrate an effective system of clinical* workforce planning to the required Safety Action?	
5	Can you demonstrate an effective system of midwifery workforce planning to the required Safety Action?	
6	Can you demonstrate compliance with all six elements of the Saving Babies' Lives care bundle Version 3?	
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	
8	Can you evidence local training plan is in place to ensure that all six core modules of the Core Competency Framework to include all three elements?	
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023 and to NHS Resolution's Early Notification (EN) scheme?	

Safety Action 1 - Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required Safety Action?

Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

- All notifications are made, and surveillance forms submitted using the MBRRACE-UK reporting website
- The service is using the PMRT tool to review the care and all reports are generated via the PMRT
- Reports are available via the Women and Children's Divisional Clinical Governance Team.
- The Trust board has received updates via the quarterly report evidencing that PMRT has been used to review eligible perinatal deaths and that all required Safety Actions have been met
- NHS Resolution will use data from MBRRACE-UK/PMRT to cross reference again the Trusts certification

Safety Action 2 - Are you submitting data to the Maternity Services Data Set (MSDS) to the required Safety Action?

Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

MSDS (Available Live):-

Confirmation of a Maternity Information System & framework reported to NHSE using the self-declaration form

- Criteria 1 - the Trust has reached the threshold of 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) and have passed the data quality criteria (email confirmation received)
- Criteria 2 – the Trusts data demonstrated data contained a valid ethnic category (Mother) for at least 90% of women booked in month
- Criteria 3 – Over 5% of women who have an antenatal plan recorded by 29 weeks also have the continuity of career pathway completed
- Criteria 4 – Over 5% of women recorded as being placed on a Continuity of Carer pathway where both Care Professional ID and Team ID have also been approved

- The Trust submission was submitted for July 2023 data by the end of August 2023
- The submission return has been confirmed as compliance and written evidence received

Safety Action 3 - Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations in Avoiding Term Admissions Into Neonatal Units programme (ATTAIN)? Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

- Transitional Care (TC) was implemented in 2018 jointly both the maternity and neonatal team with a focus on minimising separation of mother and babies with both teams involved in decision making and care planning
- There is an explicit staffing model
- The policies have been fully embedded with auditable Safety Actions and quarterly audits
- An explicit staffing model is in place to ensure TC has 24/7 cover with a Band 4/NNU support on the maternity ward
- Detailed data is available electronically on all terms babies captured via Badgernet to demonstrate the number of admissions to the NNU meeting the TC admission criteria; gestation; reason for admission; length of stay; discharge details

Safety Action 4 - Can you demonstrate an effective system of clinical workforce planning to the required Safety Action?

Safety Action Met

a) Obstetric medical workforce
- Commitment to the RCOG workforce document is demonstrated within the Obstetric Staffing Levels policy a
- The trust is monitoring attendance of consultants for appropriate clinical situations as outlined by the RCOG through monthly audits

b) Anaesthetic medical workforce
- A duty Anaesthetist is available for the obstetric unit 24 hours a day as evidenced in rosters

c) Neonatal medical workforce
- The neonatal unit requires improvement to meet BAPM national Safety Actions and an action plan has been developed to achieve meeting the requirements of the Safety Action by March 2024 (Whilst compliant given the action plan, approval of additional neonatologist post/s required)

d) Neonatal nursing workforce
- The neonatal unit meets the service specification for neonatal nursing as evidence via workforce and evidenced within rosters

Safety Action 5 - Can you demonstrate an effective system of midwifery workforce planning to the required Safety Action?

Safety Action Met

- Birth-rate plus was completed in 2021 with a full report (summary submitted to Board of Directors) to calculate midwifery staffing establishment
- The Board of Directors via reports has been provided evidence of midwifery staffing recommendations from Ockenden and funded establishments
- The delivery suite sister has supernumerary status to ensure there is oversight of all birth activity within the service
- All women in active labour receive one-to-one care
- A midwifery staffing oversight report that covers staffing and safety issues is presented to the Board every 6 months during the MIS Year 5 reporting period (presented to BoD Jan 2023 and August 2023)
- The Board of Directors have been provided quarterly updates in the progress to implement Maternity Continuity of Carer (MCoC) as the default model as the national directive

Safety Action 6 - Can you demonstrate that you are on track to fully implement all elements of the Saving Babies Lives Care Bundle Version 3 Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

Saving Babies' Lives is designed to tackle stillbirth and early neonatal death and a significant driver to deliver the ambition to reduce the number of stillbirths, bringing six elements of care together:-

- Assurance has been given to the BoD via the gap analysis tracker WUTH is on target to fully implement All 6 elements of SBLv3 by 31st March 2024
- Quarterly meetings have been held with the ICB and utilisation of the new national implementation tool
- Using the national implementation and following review of all evidence by the LMNS/ICB WUTH have demonstrated implementation of 81% meeting the minimum requirement of 70% of interventions across all 6 elements overall
- Using the national implementation and following review of all evidence by the LMNS/ICB WUTH have demonstrated implementation of at least 50% of interventions within each of the 6 individual elements

Safety Action 7 – Listen to women, parents and families using maternity and neonatal services to coproduce services with users (MNVP)

Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

Close relationship with maternity team and MNVP lead – weekly meetings	Quarterly meetings and annual report	Live service user update and Q&A on social media
Direct communication pathway with senior midwifery team	MNVP Chair is member of safety champions	15 steps annually with service users
Remuneration and expenses paid	Action plan and work plan jointly produced; CQC noted outstanding practice as part of inspection	Supporting women and families receiving bereavement and neonatal care as well as BAME background

WIRRAL MVP

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Safety Action 8 - Can you evidence the three elements of local training plans and in house one day multi-disciplinary training

Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

- A local training plan is in place to ensure that all six core modules of the Core Competency Framework (V2) and has been agreed with all stakeholders
- Fetal monitoring surveillance (antenatal and intrapartum):- WUTH has demonstrated >90% compliance for 2023
- Maternity emergencies and multi-professional training:- WUTH has demonstrated >90% compliance for 2023
- Neonatal Lift Support:- WUTH has demonstrated >90% compliance for 2023

Safety Action 9 - Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal quality safety issues? Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

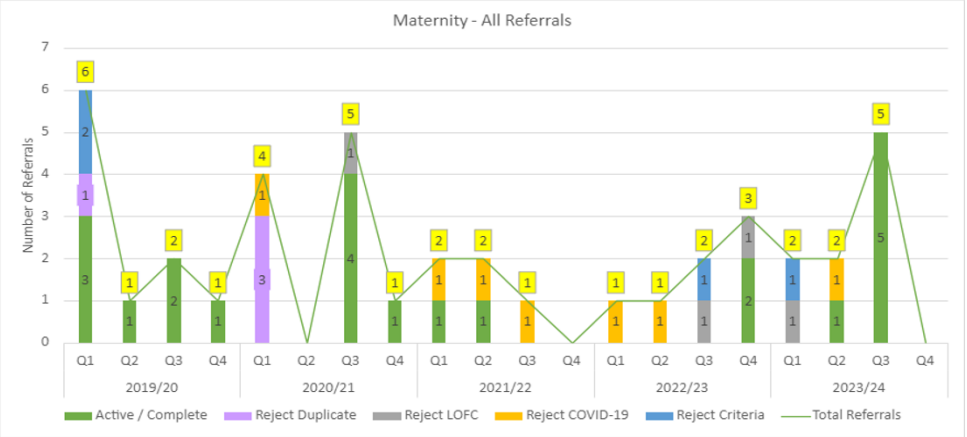
- The dashboard is produced locally monthly and includes; the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance
- The Perinatal Quality Surveillance Model is reported as evidence monthly at Trust Board
- Perinatal deaths are reported in the quarterly learning from death reported to Trust Board
- A comprehensive maternity report is reported to the Board of Directors quarterly
- Safety Board Champions undertake quarterly engagement sessions

Safety Action 10 – Have you reported 100% of qualifying cases to Healthcare Investigation Branch (HSIB) known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023 and to the NHS Resolution's Early Notification (EN) scheme for 2023? Safety Action Met

Wirral University Teaching Hospital NHS Foundation Trust

- All qualifying cases have been reported to HSIB / MNSI in 2023
- Report from HSIB / MNSI evidences the safety action has been met
- All qualifying EN cases have been reported to NHS for 2023
- The Trust Board has had sight of details of all qualifying cases via the quarterly maternity update report along with evidence that families have received information on the role of HSIB / MNSI and EN scheme
- No cases are currently reporting exceptions
- Compliance with duty of candour can be evidenced and promoted with openness and honesty at all levels as an integral part of safety culture

Maternity – All referrals (Trust)



Conclusion

Wirral University Teaching Hospital NHS Foundation Trust

- Wirral University Teaching Hospital (WUTH) is compliant with MIS year 5 and demonstrates all the Safety Actions have been met
- The Women's & Children's divisional clinical governance and wider identified team members have collated all the evidence for each of the ten Safety Actions and can be accessed/reviewed providing assurance of compliance. All evidence has been reviewed by the LMNS/ICB on the NHS Future Platform and confirmed written compliance
- The frequency of board assurance for compliance with the scheme has been demonstrated via the Maternity Quarterly Reports to the Board of Directors
- The process to demonstrate compliance has been fulfilled including:-
  - Maternity and Neonatal monthly assurance meetings: Chief Nurse and Non-Exec Maternity Safety have been present and provided assurance of all the evidence collated
  - Presented at Divisional Quality Management Board
  - Presented to Executive Management Team
  - Presented to Quality Committee followed by Board of Directors with the ICB/LMNS present
- The declaration form to be signed by both CEO and the Accountable Officer of Clinical Commissioning Group/Integrated Care System before submission by 12 noon on 1st February 2024

Recommendations

Wirral University Teaching Hospital NHS Foundation Trust

The Board of Directors approve and give permission for the Trust to sign off compliance with Year 5 of the scheme

Final submission of all of the evidence supporting and demonstrating compliance with all 10 Safety Actions will be by 12 noon on 1st February 2024 using a specific notification template which will be signed off by the Chief Executive Officer

Thank You – Any Questions?

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	na	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available, however system not accessable at time of report; decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised
	Outlier for rates of neonatal deaths as a proportion of birth	na	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available, however system not accessable at time of report; decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised
	Rates of HIE where improvements in care may have made a difference to the outcome	na	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of PSSI's	na	3 cases reported in December 2023 and referrals to MNSI accordingly
	Progress on SBL care bundle V3	no	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP. SBLv3 launched and compliance has been reported at 81% (>70% complaince). Action plan and improvements identified to achieve 100% by 31/3/2024
	Outlier for rates of term admissions to the NNU	na	The rate of avoidable term admissions; regular multi-disciplinary reviews of care take place; NW region outlier report no longer published and awaiting national guidance on monitoring processes
Service user and st	MNVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints; to date all complaints have been addressed for maternity in the target timeframesand there is nil to escalate
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey completed and divisional response has included staff engagement and continuation with the Pulse surveys; Score survey completed for MatNeo and cultural conversations commencing over x 4 sessions; Requirement to report to BOD Feb 2024
	CQC National survey	no	Will be included in report on publication
	Feedback via Deanery, GMC, NMC	no	x 5 Registras on maternity leave; deanary escalation and partial support offerred with effect from Jan 2024
	Poor staffing levels	no	All vacacnies have been recruited into for Band 5 and Band 6 midwives; further retirements anticipated later and in the year. New starters have start dates in jan 2024. <2% vacancy rate; rolling recruitment campaign initiated and all MCoC funding being utilised for staffing purpose as MOU
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Nil of note; full establishment; governance structure review and revised structure implemented to meet requirements and maternity self assessment tool/CQC/Ockenden
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates
	False declaration of CNST MIS	no	MIS Year 5 published 31/5/2023 and submission cycle will be Feb 2024
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month; funding options explored; 2 teams to be launched Feb/March 2024 and final 2 teams by Autumn 2024 subject to safe staffing and upskilling
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterly meetings held and site visit May 2023; nil to escalate
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident
	Learning from PSSI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all SI's, local reviews, rapid reviews, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress. Trust wide lessons learnt forum has commenced reviewing themes from SI's, complaints and audits
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. No exceptions to report. Three year single delivery plan for maternity and neonatal services published 31th March 2023 - gap analysis in progress and will monitored via WUTH CG structure and BoD
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework; PSIRF with effect from 1/9/2023
	Never Events which are not reported	no	No maternity or neonatal never events in December 2023
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales
Governance processes	Unclear governance processes		Clear governance processes in place that follow the SI framework - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated. Additional quality assurance framework agreed with effect from June 2023 to give the BoD addiitonal assurances in monitoring of MIS, Three year delivery plan etc. Awaiting further guidance re: PSIRF and maternity services; Governance structure reviewed and W&S Matron for Maternity vacancy recruited into to meet maternity self assessment tool and lead on SBL and CNST as part of role
	Business continuity plans not in place	no	Business continuity plans in place
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	CQC reports published for maternity sites Seacombe Birth Centre and APH site for the domains Safe and Well led; both sites were rated 'GOOD'
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9**

24 January 2024

Title	Equality, Diversity and Inclusion (EDI) Bi-Annual Report including Gender Pay Gap Reporting 2023
Area Lead	Hayley Rigby, Associate Director for Organisational Development
Author	Sharon Landrum, Workforce Engagement and Inclusion Lead Johanna Ashworth-Jones, Programme Developer Patient Experience and Nurse Quality Indicators
Report for	Information

Executive Summary and Report Recommendations

The Trust is required to fulfil a number of obligations that are outlined within the Equality Act (2010) and within the Public Sector Equality Duty, along with requirements built into the standard NHS contract monitored by commissioners and forms part of the Care Quality Commission's well led inspection.

This report seeks to provide assurances on the progress made in not only complying with required areas, but in upholding the principles and objectives of the Trust's People Strategy and underpinning EDI Strategic Commitment (2022 – 2026):

"To create an inclusive and welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported and celebrated".

This report is the second of a bi-annual reporting cycle delivered within Q3.

Points to note:

- All regulatory reporting requirements up to date with forthcoming elements on track.
- Summary overview of actions undertaken within 2023/24 are detailed in appendix 1.
- Annual Gender Pay Gap Report is delivered alongside this report as part of reporting cycle but detail is provided separately to enable public sharing of this element of the report as per regulation.

It is recommended that Board of Directors:

- Note the report

Key Risks

- None identified

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
22/01/2024	People Committee	EDI Biannual Report	Information
18/01/2024	Quality Committee	EDI Biannual Report	Information
15/11/2023	EDI Steering Group	EDI Biannual Report	Information
20/12/2023	Workforce Steering Group	EDI Bi-Annual Report including Gender Pay Gap Reporting 2023	Approval

1	Narrative
1.1	**Background and Introduction to EDI Requirements** Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the ***general duty*** and all public authorities must adhere to the following obligations: • To eliminate unlawful harassment and victimisation. • To foster good relations between people who share a protected characteristic and those who do not. • To advance equality of opportunity between people who share a protected characteristic and those who do not. In addition to these general duties, there are specific duties which require public bodies to publish relevant, proportionate information showing compliance with the Equality Duty and to set equality objectives. The information that is contained within this report meets the requirement of the specific duties of the PSED. The Trust also takes into consideration national guidance e.g. Model Employer recommendations and has integrated these within action planning and review processes as appropriate. This report is one of two EDI specific bi-annual report. We report as follows: **Biannual report one** – Submission in Q1 and will include updates on: • Trust led EDI projects and progress towards EDI strategic commitment and activities to underpin our PSED commitment. • Annual WRES data and summary for noting. • Annual WDES data and summary for noting. • Workforce demographics

	Biannual report two – Submission in Q3 and will include updates on: • Trust led EDI projects and progress towards EDI Strategic Commitment and activities to underpin our PSED commitment. • Gender Pay Gap reporting. • Equality Delivery System (EDS). Previous report to WSB focussed on workforce related EDI activities, however this updated report also includes updates on work undertaken to advance the EDI agenda for our patients and service users.
1.2	**General Progress Update**  **People Strategy and EDI Strategic Commitment** Since the launch of the new People Strategy and underpinning EDI Strategic Commitment, the Trust is striving to ensure EDI is embedded within all of our people processes and practices. This has resulted in a shift of areas and individuals seeking support to understand how they can advance EDI within their sphere of influence and progressing actions to commence improvements. The annual objectives set out in the People Strategy delivery plan have also been mapped to the EDI Strategic Commitment to ensure EDI is reflected in all strategic people projects. This is reported to WSB and People Committee as part of People Strategy Updates. It is therefore hoped that this will have a positive impact on staff experiences moving forwards. A summary overview of the key areas undertaken and next steps is attached at appendix 1. **Regulatory Reporting Summary Update** • Review of EDI reporting arrangements undertaken and new cycle agreed as detailed in the previous section, encompassing updates and information for review and approval • **EDI activities** and progress of the **EDI Steering Group** and subsequent groups / networks i.e. **Action on Disability Group** and **staff networks**, will continue to be captured and reported via the EDI Steering Board Chairs report into Workforce Steering Board. • The Trust has completed its regulatory reporting requirements required to date, with **Workforce Race and Disability Equality Standards (WRES and WDES)** reporting and action plans approved as part the new cycle of business and now uploaded to the public section of the website. • The **Gender Pay Gap** reporting is due for completion by 30 March 2024 and has been submitted in conjunction with this report as part of our bi-annual reporting schedule. Whilst submitted to WSB in December, the report is awaiting approval due to the standing down of clinical areas at that meeting to support Trust pressures. Approval and completion of the reporting requirements is still however expected by the required national deadline. • An annual review of the Trust against the new national **Equality Delivery System (EDS) 2023** framework is required as part of our standard contract, with completion required by 28 Feb 2024.

	The Trust is currently on track for completion of its second annual review of progress against the revised EDS framework. Evidence has been collated and shared as part of an assessment session held on 12 December with EDI Steering group members and key stakeholders including Healthwatch. Due to organisational pressures however, additional time was provided to support voting from those unable to attend and one to one sessions also held. Outcomes will be reviewed by members of Workforce Steering Board and our Patient and Family Experience Group and approval sought as soon as practicable.
1.3	**Equality Delivery System (EDS) 2023** EDS was introduced by NHS Equality Council in 2010 and part of the NHS standard contract since 2015 *(SC13.5 Equity of Access, Equality and Non-Discrimination).* A new framework was launched in 2022 with a requirement for all NHS organisations to measure EDI performance. The framework is based on 11 outcomes grouped under 3 domains: ○ **Domain 1:** Commissioned or Provided Services ○ **Domain 2:** Workforce health and wellbeing ○ **Domain 3:** Inclusive leadership **Aim** The EDS is designed to support identification of equality and diversity gaps and support achievement of requirements detailed in the background section of this report. It is also designed to support greater understanding of priorities for staff and service users, help identify gaps to better support staff and service users and to enable Integrated Care Boards / Integrated Care Systems to identify health inequalities and support system wide improvement approach. **Process** The process includes: • Evidence gathering to demonstrate if and how we meet the national criteria. • Review of evidence with internal and external stakeholders, against the national criteria. • Trust self-assessment, with stakeholders anonymously selecting the level they feel the Trust is working at, against the national indicators set. • Overall score confirmed. • Peer review of the process undertaken (process currently under regional review). • Ratification and publication of results. • Key actions identified to ensure improvement. **Assessment and Scoring** Two assessment sessions have been held: 1) **Domain one** - led by Corporate Nursing and involving patients and service users on 7 December 2023. 2) **Domains two and three** - led by the Workforce Engagement and Inclusion Team and involving EDI Steering Group members held on 12 December 2023. Stakeholders were asked to review and score how well they feel the Trust is achieving against indicators contained within the national EDS framework. Scores are then added together to obtain ratings for each domain and domain scores are added together to provide an overall Trust score.

	Whilst a number of staff attended the assessment session on 12 December 2023, Divisional representation was minimal due to current pressures within the organisation. In line with the approach taken in 2022 and also congruent with the assessment approach for Domain 1, divisional representatives will have additional time to provide their assessment ratings. Due to operational pressures, approval processes for all Domains has been postponed and therefore will take place as soon as practicable.
1.4	**Workforce Demographics** In line with specific duties under the Equality Act 2010, the Trust is required to publish information relating to employees who share protected characteristics. The demographics of Wirral University Teaching Hospital are attached at appendix 2 and based on data as of 31 March 2023. Moving forward this data will be included as part of EDI biannual report one for 2024/25.
1.5	**Staff Network Update** The Trust currently has five networks available for staff. During the last 12months, networks have been working closer together, with a recognition of a greater need for intersectionality. It is recognised that staff may identify in a number of ways and may want to be involved in a number of networks and keep up to date with and support the wider work taking place. This has provided capacity challenges for staff and in particular, network co-chairs who have also had increased demand to support wider Trust decision making and awareness raising opportunities. In light of this, a new approach was proposed to EDI steering group in October 2023. And later approved by Workforce Steering Board to commence a new "one network" approach, bringing networks together at key intervals throughout the year. Further to this, please note key highlights as follows: 1) **Five staff networks** continue to be in place at WUTH, however network meetings and activity has been reduced over the last few months due to postponement and launch of new way forward. 2) Individual staff network meeting frequency will reduce to quarterly, however a combined "**One Network Event**" will take place and seek to bring networks together to receive and provide information collectively, further build intersectional relationships and awareness as well as offer network specific opportunity to connect. 3) **Loss of three staff network co-chairs:** **i) Ivan Parish from WUTH Sunflowers** has stepped down after two years of service. Ivan is progressing in a new role, within the Digital Healthcare Team and identified as the EDI Lead for DHT. **ii) Lyndsey Squirrell from WUTH's Rainbow Alliance**, has secured the new Staff Side Chair role and is therefore stepping down as co-chair **iii) Maloni Talbot from WUTH's Multicultural network** is unfortunately leaving and. Huge thanks is extended to all three co-chairs for their service and support to networks and the Trust and a recruitment campaign will commence to replace them and gaps existing in other networks too.

	iv) Time for network co-chairs to support network activity previously approved by Workforce Steering Board as 2 days per network. **v)** Staff networks led delivery of 2023/24 **calendar of awareness and celebration**. Key celebrations of note including PRIDE, Black History Month, Ramadan and various divisional culture events lets by our international staff. The Trust has expanded its celebration of Remembrance this November with support from colleagues in the Armed Forces network. This year an onsite service and commemoration will be held and the Trust are also invited to lay a wreath at the Mayors Remembrance service at Birkenhead Townhall Cenotaph. **vi)** A **development plan has been created for network co-chairs**, with co-chairs supported to complete a range of personal development opportunities including EDI training, chairing meetings, minute taking and leadership development. The Trust is keen to support development of network co-chairs and indeed network members and therefore as the role offers additional benefits, an open recruitment opportunity, with expressions of interest sought is felt to be the best way forward. **vii) Co-chair tenures will reduce from two years to one**, with the option to continue if they wish and are re-elected. **viii) A toolkit has been developed** based on NHS Employers guidance. This seeks to standardise network business, including leadership roles. Discussions are underway with network chairs to introduce the toolkit with a particular emphasis on defining the co-chair role and responsibilities. Other voluntary roles we are looking to identify within networks are: i) Administrative / Secretarial Support – someone to support co-ordination of meeting dates and take notes of meetings, including social activities and informal gatherings as the group agrees. ii) Communications Officer – someone to support proactive promotion of the network and its activities, particularly via social media platforms. Advertisements will be placed for current network vacancies and members are asked to share these opportunities and encourage staff to get involved.
1.6	**Equality Analysis** Equality analysis / impact assessments continue to be embedded within our policy approval process. As we strive to ensure EDI is embedded across our organisation, staff are asked to consider any equality related impacting factors. An example of this has been when supporting key priorities identified as part of the Trust's People Strategy. The Trust has been working to improve retention and flexible working opportunities and has established a number of forums to progress. Both workstreams had extensive equality analysis completed, with an additional deep dive undertaken by HR, into key data sources to understand areas of focus moving forwards, with findings reported back to Workforce Steering Board and shared across retention task and finish groups. Key findings and areas for consideration included: • **Limited personal demographic information within ESR -** This was particularly evident for data relating to disability, sexual orientation and religion or belief.

	Heightened focus needs to be placed on encouraging and supporting staff to update personal information contained within ESR and to ensuring an inclusive culture where staff feel able to disclose. • **Improved exit interview and flexible working processes** – both processes have been reviewed and steps taken to improve. This includes new automated processes to apply for flexible working and complete exit surveys, with data to be disaggregated by protected characteristics. A new flexible working toolkit has been developed, with a section dedicated to ED&I, highlighting examples of how flexible working can be utilised to support a range of individual needs and circumstances. Flexible Working Ambassadors have also been introduced to offer additional support. • **Increased engagement required with our LGBTQ+ staff** – analysis identified lower levels of staff engagement with our LGBTQ+ staff in particular and that further focus was needed to improve morale and support retention of staff. In order to further improve how WUTH Board has visibility of the EDI agenda, the Board and committee reporting template has been reviewed and now includes a section dedicated to considering implications of information contained within the report. This includes "People" factors and specifically the question *"Outline the impact on EDI and how this activity/proposal maximises opportunities for inclusion".*
1.7	**Advancement of the EDI Agenda** All of the details shared in appendix 1 seek to advance the EDI agenda and continue to support the achievement of our EDI Strategic Commitment and Public Sector Equality Duties as detailed in the background of this report. EDI Steering group meetings now ask members what they have done to advance the EDI agenda, with members asked to feedback and discuss locally too. This has prompted local sessions to take place with individual Divisions to discuss how managers can advance the agenda and has also been asked of Board members too. Executive Directors now all have EDI objectives and EDI development sessions are scheduled in for Board colleagues throughout the year to ensure our most senior leaders remain updated on key EDI matters and are able to guide policy and decision making within the context of EDI.  EDI is embedded within the Trusts Leadership Qualities Framework and forms a golden thread across all leadership and management development programmes. Furthermore, there are also dedicated sessions focused on EDI on all programmes. **Demographic monitoring of key programmes** – In order to ensure inclusive access and diverse representation at Trust development programmes, demographic monitoring is being implemented across a number of leadership development

programmes. This data has been gathered since June 2023 with the first report presented at WSB in December. It is hoped that with increased monitoring, areas for improvement can be identified and positive action to address be undertaken.

Refresher and update EDI training for Trust trainers - Update / refresher training for trainers / educators to ensure that training at WUTH is delivered in an inclusive and accessible way. The training has been well attended providing key updates on legislation and policy and also key activities and interventions to ensure inclusivity in training delivery.

A pledge form was developed to share the EDI commitment with staff and encourage people to identify one thing they would do differently to advance inclusion at WUTH with a number of staff completing and sharing.

This continues to be shared and promoted at various opportunities, including as reflections on development programmes and is attached at appendix 3.

The Trust is committed to ensuring a positively anti-racist organisation and continues to publicly declare its commitment to that effect, with examples including "Red Card to Racism" day.

A new **Anti-Racism framework** has been launched within the Northwest region and following a gap analysis and recommendations to WSB, approval has now been given from WSB and work will commence in Q4 to progress actions towards achieving bronze status.

Posters have been relaunched to support prevention of abuse and include reference to racial abuse.

A new **NHS EDI Improvement Plan** has been launched detailing six high impact actions that Trusts must achieve. Work is being undertaken to ensure integration and alignment of these and the underpinning actions required within our overarching EDI action plan.

A new dedicated Equality, Diversity and Inclusion Award category has been added to our annual staff awards this year, with advancement and ensuring staff uphold an inclusive approach embedded within all appropriate categories.

A range of Trustwide promotions, initiatives and engagement opportunities has provided a fantastic opportunity for staff and patients to get involved and not only improve patient experience and care, but to support awareness raising and improved experiences for staff too.

The Trust has increased its support to our armed force community and their families, marking Armed Forces Week, Armistice Day and Remembrance Sunday and achieving Veteran Aware Accreditation.

Key stakeholders are working together to best promote and support a variety of events, with our Chaplaincy and Spiritual Care team, leading services, support and working with Catering colleagues to provide sweet treats to recognise religious and spiritual events, which more recently included Diwali.

The Trust has also supported a range of celebration and support on other areas including attendance at PRIDE parades, hosting menopause events and arranging guest speakers as part of Leadership masterclasses, annual leadership conference and much more!

A new workforce co-creation group has also been established to support further improvements in the experiences of our staff with disabilities. Key priorities have been identified with underpinning actions to support achievement. Progress includes:

- collation of internal and external support options available and development of new intrant pages to support accessibility of information.
- Development of new processes to support staff and managers, including easy to follow process maps / flowcharts.
- Review of national health passport option for staff.

WUTH's patient experience strategy is now in its second year and has a clear objective of increasing its engagement, involvement and co-production across the population of Wirral to ensure that it is reflective of the community it serves.

One of the strategy's year two objectives is to widen its non-digital communication acknowledging that Wirral is an area which has significant pockets of digital exclusion within its community. WUTH has attended several community groups, including hosting promotional stands at Asda Woodchurch supermarket and partnership events with Wirral Healthwatch. WUTH has continued its social media platforms and this has been very successful not only as an engagement forum for Wirral's digital enabled community but has provided a mechanism to reach out to some hard to reach groups such as those who have a Mental health condition and wish to engage in a virtual environment.

EDI is paramount to all of the five patient experience strategy promise groups, as these promise group were chosen by patients, staff, carers and other partnership organisations. There is a specific promise group for inclusion however as already highlighted the EDI agenda is not just restricted to this group and underpins the whole strategy with several task and finish groups as follows:

These include:

- **Safe Promise Group: #Hellomynameis re-launch** – The Patient experience strategy "Safe" promise group are progressing the re-launch of this campaign and have also included feedback from WUTH multicultural and Rainbow Alliance staff network members. Network members have shared the importance of people getting their names right, with examples shared where some staff are called by a different, more easy to pronounce name, with no thought behind the significance of this for the individual concerned. The importance of including titles and pro-nouns is also important to support gender inclusion too. This has resulted in this task and finish group having 3 dimensions to the initiative:
  - **1: Orientation** – Hello my name is (Katie Granger)
  - **2: Identity** – Pronunciations of names (Race Equality Matters) and pronouns
  - **3: Combined** – Patient's preferred name

As a result, the campaign has now embedded the Race Equality Matters national campaign materials, providing staff with the opportunity to spell names phonetically, with short videos of staff sharing the importance of their names to encourage colleagues to ensure they pronounce names correctly.

- **Supported Promised Group: Hidden Disabilities –** a new task and finish group has been established to support improvements of patients with hidden disabilities. Whilst this is a new group, an early priority has been identified of ensuring accessible toilets for patients and staff and also seeking to standardise imagery used.

  Following a voting process aimed particularly at our patients, however included staff as well, that the following image was selected as the preferred image to use and links with existing promotions of the Sunflower lanyard initiative and will be included on promotional materials moving forwards.

	• **Care Promise Group: Voice of the Child –** this group was established following a patient story of a young trans person. They highlighted that as a younger person they did not feel they had been given the opportunity to have their voice heard. As part of national directives within safeguarding, one of the key aspects is to ensure that the voice of the child is considered. A review of the processes in place for children and young people to be involved in their healthcare led to a workshop been held young people and parents / guardians with an outcome proposal to develop a communication indicator to support younger people if they wish to have a greater degree of communication with healthcare professionals in relation to their ongoing emotional and physical healthcare needs. • **Inclusive Promise Group: Deaf awareness –** this task and finish group has developed an improvement plan to cover aspects including facilities & equipment, staff training, interpretation & translation provision. WUTH has linked in with the Merseyside society for Deaf People MSDP and attended Deaf club. Several aspects of this workstream align to the Trust's overall requirements to be compliant with the accessible information standard which continues to be a challenge for the Trust. Each clinical area has been provided with a deaf resource pack which includes information on how to access BSL translators, basic sign language and guidance on how to add assessable information alerts to patients records. Deaf awareness sessions have been held for staff, with funding sourced for regular sessions to be offered moving forwards. • **Safe Promise Group: Health passports –** feedback from Mencap and several other service users identified that personal care requirements and reasonable adjustments were not always communicated effectively including the acknowledgment of carers. Following a successful pilot, the task and finish group have now rolled out the passports across the Trust to identify when a patient has a learning disabilities passport in place and / or a carer with a carers passport. • **Inclusive Promise Group: Gender Inclusion –** The task and finish group have contributed to a review of terminology and processes – e.g. now agreed as gender inclusion and requests for improvements on use of pro-nouns and avoidance of mis-gendering on patient records. All of these groups have been implemented as a result of responding to service user feedback. Many of these task and finish groups have also has provided excellent opportunities for staff network members to be involved and shape planning to provide a holistic and joined up approach to a number of fantastic new initiatives and areas of focus to benefit all.
1.8	**Next Steps** Work continues to develop the EDI agenda at WUTH. The next six months will include: • Ratification of the EDS rating for WUTH and improvement actions integrated within associated action plans. • A review of the overarching EDI action plan in conjunction with the new National EDI Improvement high impact action plan, with a view to streamlining areas of focus.

	• Review of 2023 Staff Survey results and friends and family data to further understand staff and patient experience. This data will further inform EDI priorities. • Launch of anti-racist framework and work towards achievement of Bronze status. • Recruitment of new staff network co-chairs with dedicated protected time support. • Launch of the 'One Network' that will further develop an intersectional approach at WUTH, recognising that individuals can identify in a number of ways. • Application completed to progress to Defence Employer Recognition Scheme Silver level. • Continued efforts to support advancement of initiatives and activities to advance inclusion at WUTH for our staff and patients including continued celebration of diversity and awareness raising through delivery of our EDI annual calendar of events. Forthcoming activities and events in the next six months will support: • LGBTQ+ History month – February • Race Equality Week – February • Ramadan and Eid • Chinese New Year – February • International Womens Day – March and more… 

2	Implications
2.1	**Patients** The work undertaken to advance the EDI agenda aims to improve awareness of a range of aspects and celebrate diversity for all. Whilst this should be a positive experience for all, there is also recognition of the diverse nature of our workforce and community and promotion and celebration of some areas, may not be in line with individual values, beliefs and behaviours. Whilst we strive to ensure appropriate values and behaviours are upheld for our workforce, this can be more challenging for our patients.
2.2	**People** As also detailed in section 2.1.
2.3	**Finance** • **N/A**
2.4	**Compliance** This report seeks to provide assurance that WUTH is currently in line with EDI reporting requirements for 2023/24.

Appendix 1 - Workforce Equality, Diversity and Inclusion (EDI) Update Summary – Nov' 2023

Setting Direction

- EDI Strategic Commitment (including objectives) launched for 2022- 2026 and underpins WUTH's People Strategy
- 2023/24 EDI action plan developed and approved
- Staff networks involved in decision making processes and shaping future improvements at WUTH
- Member of regional meeting to support collaborative working with Cheshire & Merseyside EDI Leads, ICB/ICS & NHSE colleagues
- EDI Objectives set for all Executive Directors
- Gap analysis undertaken of new Anti-racism Framework and steps underway to adopt
- Launch of new employee experience cycle

What's next…

- EDS 2023 Self-Assessment
- Implementation of new NHS Improvement Plan
- NHSE EDI Improvement actions integrated with existing EDI action plan
- EDI Objectives agreed for Non-Executive Directors
- Trustwide launch of anti-racism framework

Development, Education and Awareness

- 97.67% compliance with EDI mandatory training (Oct)
- EDI embedded within all leadership for all and manager essential programmes
- Board seminar held on EDI priorities
- Mini manager sessions on supporting disabilities
- Navigator developmental programme for men
- Deaf awareness programmes piloted (inc basic BSL)
- Development plan for network co-chairs
- Staff stories integrated within key meetings and development offerings and website page launched
- Range of national e-learning programmes promoted
- Range of "Drop Everything and Read" sessions held
- Inclusion guest speakers booked for leadership masterclasses and conference

What's next…

- Further Board session
- Deaf awareness; neurodiversity; gender inclusion and LGBTQ+ awareness sessions
- New process and support pathway for disabled staff

Monitoring and Assurance

- Annual monitoring of workforce data with workforce demographics mapped against local population
- Workforce Race and Disability (WRES and WDES) and gender pay gap reporting
- ED&I Bi-Annual reporting
- Trust review against new EDS 2022 framework
- Deep dive into disability data and employee experience
- Enhanced review and monitoring of staff survey data and HR KPI's to support Trust's Strategic Retention and flexible working projects
- Demographic monitoring of volunteers, widening participation and leadership for all programmes
- Re-launch of people pulse to capture staff voice with one of the highest regional response rates in Q2

What's next…

- Focus on improving staff demographics on ESR
- Focus on improving completion of staff survey
- Review and streamlining of EDI Action Plan

Communications

- Regular Trust communications to promote key events and information
- EDI webpages updated with key reports
- Reachdeck software in place to support web accessibility
- Deaf awareness development opportunities
- Launch of #Hellomynameis campaign linked to Race Equality Matters initiative and use of titles and pronouns

What's next…

- Exploration of assistive technology to support communications

Events

- Flag raising for PRIDE month and armed forces week
- Trust involvement in PRIDE parades
- Range of events that support awareness raising for patient and staff support e.g. MENCAP Treating me well events, deaf awareness and menopause
- Support of various national and international awareness days/weeks and months e.g. International Women and Mens day promotional communications and LGBTQ+ history month
- Range of activities to support religious festivals
- Departmental events e.g. Culture Days
- Remembrance Day events, including laying wreaths on site and at local Cenotaph for the first time

What's next…

- New combined staff "one network" approach
- New EDI category in forthcoming staff awards, with inclusion embedded across wider categories

Staff Support

- Five Staff networks continue:
  - LGBTQ+ ; Staff with disabilities and long-term conditions; Multicultural; Menopause & Armed Forces
- EDI team & networks meet new staff at induction
- Network members "buddying" with colleagues
- Staff sharing experiences to help others
- Networks hosting themed meetings & guest speaker sessions held including "Let's Talk Menopause" and "Disordered Eating"
- New staff menopause clinic established with dedicated website, including guidance and support
- Wellbeing Week focused on supporting staff with disabilities
- Provision of Iftar boxes for staff during Ramadan
- Disability engagement event

What's next…

- Reverse mentoring programme
- Development of People Champion role

Accreditations

- Veteran Aware Accreditation
- Merseyside In Touch Navajo LGBTIQA+ Accredited
- Defence Employer Recognition Scheme (DERS) Bronze Level
- Disability Confident Employer

What's next…

- DERS Silver Award attainment
- Attainment of anti-racism framework bronze level

Workforce Composition (data as of 31 March 2023)

Understanding the workforce composition by equality and diversity demographics is important in order to ensure that we are a fair and open organisation and to monitor the effectiveness of our policies and procedures. There has been an increase in the workforce numbers from 6643 staff last year to 6753 this year.

Sex / Gender

79.02% of the WUTH workforce is female and 20.98% is male. The numbers therefore reflect that the largest staff group is nursing, and that this group is predominately female. This is reflective of most NHS Acute Trusts.

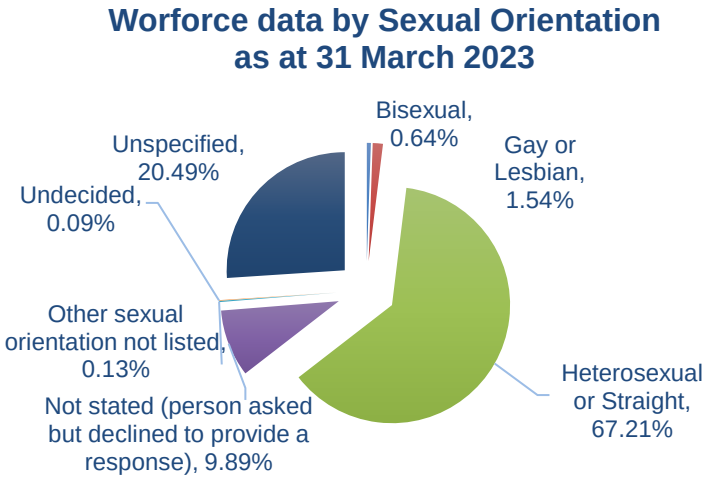
The chart below highlights the breakdown of staff compared with community and demographics.

	Workforce	***LA: Wirral***	***Region: North West***
Male	20.98%	48.11%	49.13%
Female	79.02%	51.89%	50.87%

Sexual Orientation

Charts below highlight the workforce sexual orientation data on 31 March 2023, along with comparative data for community members within the North West.

Sexual Orientation	**% of Workforce**
Bisexual	0.64%
Gay or Lesbian	1.54%
Heterosexual or straight	67.21%
Not stated (person asked but declined to provide a response)	9.89%
Other sexual orientation not listed	0.13%
Undecided	0.09%
Unspecified	20.49%
Grand Total	**100.00%**



Sexual Orientation Data Comparison with Community Demographics

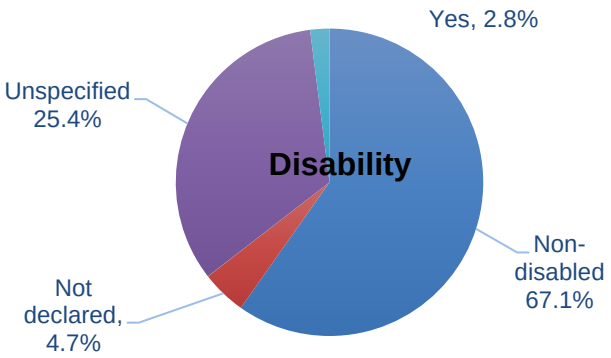
	Workforce	**Region: North West**
Gay / Lesbian / Bisexual	2.18%	1.66%
Heterosexual / straight	67.21%	94.89%
Unknown	30.47%	3.45%

Gender Reassignment / Identity

ESR currently only has the functionality to record male, female or unspecified. The Trust has been working hard to further understand the needs of its staff and patients and as such, understand that more accurate recording options are needed. A number of staff may not identify with a specific gender or have a variation of gender identities and therefore national updates are being awaited that will allow greater options for staff and accurate data in this area. The Trust can only therefore report against the number of staff recorded as male or female. This has been raised at a national level and updates awaited.

Disability

As of the 31st March 2023, the self-reporting rate for those staff with a disability within WUTH is 2.8%. A total of 186 staff have identified they have a disability, with 121 staff in a clinical role and 65 staff in a non-clinical role.



Whilst the % has reduced from 29% last year, the number of staff remaining unspecified also continues to be high with 25.4% of staff still unspecified and therefore work is needed to ensure staff are encouraged and supported to be able to update their disability status within ESR. This would then ensure that data can be truly representative of the disabled staff within the Trust and thus contribute to actions for improvement.

Levels of disabled staff are equal amongst clinical and non-clinical staff; however there are higher levels of non-disabled staff within clinical areas and higher levels of unspecified within non-clinical areas.

Breakdown of workforce data by disability status.

	Total Clinical Staff	% of Clinical	Total Non-Clinical	% of non-clinical	Combined 2023	% overall 2023	% overall 2022
Disabled	121	2.7%	65	3%	186	2.8%	2%
Non-disabled	3187	70.1%	1338	60.7%	4525	67.1%	63.8%
Not declared	217	4.8%	103	4.7%	320	4.7%	4.6%
Unspecified	1019	22.4%	697	31.6%	1716	25.4%	29.5%
TOTAL	4544	100%	2203	100%	6747	100%	100%

Religion or Belief

The chart below highlights the religious beliefs of our workforce compared with the community demographics as of 31 March 2023. The categories are grouped together so as to aid ease of comparison; however it is important to recognise some of the heading below subgroup heading: e.g. Christianity include Catholicism, Anglican etc

	Workforce	***LA: Wirral***	***Region: North West***
Atheism / Not religious	11.45%	21.33%	19.82%
Buddhism	0.40%	0.28%	0.29%
Christianity	42.96%	70.41%	67.25%
Hinduism	1.66%	0.23%	0.54%
Islam	1.17%	0.57%	5.05%
Judaism	0.06%	0.08%	0.43%
Other	7.00%	0.26%	0.27%
Sikhism	0.07%	0.07%	0.13%
Unknown	35.23%*	6.77%	6.20%

*Includes 14.81% of staff who do not wish to disclose

Ethnicity

85.86% of staff are white, 12.28% of staff are Black, Asian, or other Ethnic Group and 1.87% of staff have not stated their ethnic group on ESR. The following chart shows the breakdown of the workforce by ethnicity and compared to community demographics as of 31 March 2023.

Ethnicity Group	WTE	Headcount	%
BAME	780.67	829	12.28%
Not Stated	107.30	126	1.87%
White	4777.01	5798	85.86%
Grand Total	**5664.98**	**6753**	100.00%

Appendix 3

To follow is a full breakdown of staff compared with community demographics.

	Workforce	***LA: Wirral***	***Region: North West***
White - British (inc English, Scottish & Cornish)	83.53%	94.97%	87.08%
White - Irish	0.71%	0.83%	0.92%
White Traveller / Gypsy / Irish Traveller	0.01%	0.02%	0.06%
White - other	1.57%	1.17%	2.15%
Mixed - White & Black Caribbean	0.18%	0.30%	0.56%
Mixed - White & Black African	0.15%	0.17%	0.26%
Mixed - White & Asian	0.22%	0.30%	0.43%
Mixed - Any other mixed background	0.34%	0.25%	0.32%
Asian or Asian British - Indian	6.60%	0.42%	1.52%
Asian or Asian British - Pakistani	0.47%	0.07%	2.69%
Asian or Asian British - Bangladeshi	0.18%	0.27%	0.65%
Asian / Asian British: Chinese	0.34%	0.52%	0.68%
Asian or Asian British - Any other Asian background	1.07%	0.33%	0.66%
Black/African/Caribbean/Black British: African/Black British: Caribbean or Black British - Caribbean	1.33%	0.18%	1.17%
Any other Black African / Caribbean	0.21%	0.04%	0.22%
Arab	0.00%	0.07%	0.35%
Any Other	1.18%	0.10%	0.28%

Age

The chart opposite highlights the workforce demographics, compared with local communities as of 31 March 2023.

	WUTH Staff	**LA: Wirral**	**Region:North West**
Under 25	5.46%	12.99%	14.99%
25-29	10.77%	6.89%	8.15%
30-34	12.01%	6.57%	7.50%
35-39	13.00%	7.36%	7.86%
40-44	11.71%	8.72%	8.99%
45-49	10.80%	9.35%	9.12%
50-54	11.79%	8.60%	8.12%
55-59	11.49%	7.78%	7.15%
60-64	9.27%	8.35%	7.68%
65-69	2.92%	6.54%	5.98%
70+	0.78%	16.86%	14.47%

Inclusion at WUTH

We are committed to ensuring inclusion and want you to:

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Know our EDI Strategic Commitment for 2022 -2026 is "to ensure an inclusive and welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported and celebrated"

Feel – a sense of belonging here at Wirral University Teaching Hospital

Do - One thing differently to create a more inclusive workplace – *turnover to make your pledge today!*

together we will

To show my commitment to ensuring **inclusion** here at Wirral University Teaching Hospital I will:

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

together we will

Why not post on your wall, share with colleagues or via twitter at @wuthstaff

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 10.1**
24 January 2024

Title	Gender Pay Gap Report
Area Lead	Hayley Rigby, Associate Director for Organisational Development
Author	Sharon Landrum, Workforce Engagement and Inclusion Lead
Report for	Information

Executive Summary and Report Recommendations

The gender pay gap is the difference between the average pay of men and women in an organisation.

The Trust is required to publish data about its gender pay gap information on an annual basis.

Data is based on a snapshot date of 31 March each year (for the Public Sector) and is based on six calculations as required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017:

1. mean (average) gender pay gap using hourly pay
2. median gender pay gap using hourly pay
3. percentage of men and women in each hourly pay quarter
4. percentage of men and women receiving bonus pay
5. mean (average) gender pay gap using bonus pay
6. median gender pay gap using bonus pay

Data is required to be submitted by no later than 30 March of the following year and therefore this report is in line with national reporting guidance.

The full report is attached at Appendix A and is based on the snapshot date of 31 March 2023.

Whilst the report was submitted to Workforce Steering Board in December, due to operational pressures, the report was not able to be approved and approval will be sought at February's meeting. This remains in line with national reporting requirements.

It is recommended that Board of Directors:

- Note the report

Key Risks

- None identified

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
15/11/23	EDI Steering Group	Gender Pay Gap Report	Information and review
20/12/23	WSB	Gender Pay Gap Report	For approval – awaiting review

1	Narrative
	In summary, key findings are: 1) Mean gender pay gap has reduced significantly this year from 21.2% last year to 19.4% gap in favour of males. This is the lowest gap seen at Wirral University Teaching Hospital since the gender pay gap reporting commenced. 2) Whilst there is still a gender pay gap in favour of males, the median gender pay gap has also significantly reduced this year from 7.3%, to 5.9% 3) Results this year identify no median bonus pay gap for the first time since reporting commenced, reducing from 5.6% last year to 0% this year 4) The mean bonus pay gap has unfortunately however increased significantly this year, from 16.4% to 21.1%, in favour of males. 5) A significant difference can also be seen in the proportionality of bonus pay, with an 8.7% difference in male colleagues receiving bonus pay, with 10.47% of eligible males receiving, compared with only 1.77% of females. 6) Significantly lower levels of female employees continue to be seen in Consultant positions 7) Lower levels of male staff continue to be present within the workforce demographics at WUTH. 8) Lowest ratio of female staff continues to be seen in the upper quartile

2	Considerations
	Bonus Pay The proportion of staff receiving bonuses is low overall, however those receiving bonuses have increased this year for both males and females. Bonus payments are largely related to local and national clinical excellence awards (CEA) and discretionary points and can be correlated to the number of male consultants who have additional service with the Trust and have therefore reached higher levels of awards. The CEA process and payments have however been different since the arrival of COVID-19 and the impact on service delivery. Therefore, as a result, CEAs were

	evenly distributed to all eligible colleagues on the last two rounds and not linked to an application process. This was in line with national guidance and agreed at JLNC. Pay gaps do however continue as previous awards have been retained by individuals and have increased depending on the level reached at that stage. There are also significantly more male consultants within WUTH and so these factors continue to contribute to the overall bonus gender pay gap. Eligibility of female staff may also be lower as there are significantly higher levels of female staff working at WUTH. Following a review of the bonus pay gap data, it appears that recruitment / retention of male Consultant colleagues with significant service and bonus pay, can affect the statistics quite significantly year on year, due to the low numbers affected. This has been the case this year, with an increased number of male consultants with extended experience and eligibility for bonus pay being recruited. **Gender pay gap by protected characteristic** In line with actions identified from the 2022/23 report, information has now been collected to highlight potential pay gaps between the following staff groups: • disabled and non-disabled colleagues; • Black, Asian and Minority Ethnic (BAME) staff compared with non-BAME colleagues and • LGB+ staff compared with heterosexual or straight colleagues. This is the first time that this information has been collected and is awaiting review by WSB colleagues. Information is in addition to the national reporting collection required and is not there included within our published report for this year. However, seeks to provide data that will support further review within 2024/25 and identify potential additional areas of improvement.

3	Conclusion
	Improvements can be seen in the majority of areas this year, with a number of gaps significantly reducing. Whilst a number of positives can be seen, further exploration and a “deep dive” into bonus pay gap information will be undertaken to support greater identification of areas of focus. 2019 Government recommendations identified key areas that would work to reduce the gender pay gap and women’s progression in the workplace and these are: • create an inclusive culture • support women’s career development • progression for part-time workers • improve recruitment and promotion processes • measure and evaluate policies to support diversity and inclusion A number of actions have been completed over the last few years to support reductions and summary details are contained within the body of the report at Appendix A. The Trust has developed a new People Strategy and ED&I Strategic Commitment “***To create an inclusive and welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported and celebrated”.***

	Key deliverables are currently under discussion to ensure delivery of the ED&I strategic commitment which seeks to ensure ED&I is embedded as a golden thread across our people processes. Key actions for 2024/25 will therefore be: 1) Detailed review and verification of gender pay gap information by disability, ethnicity and sexual orientation, identifying key areas of focus 2) Deep dive within bonus pay gap information to understand any further areas for improvement 3) Continued implementation of the Trust's People Strategy and ED&I strategic commitment deliverables Next steps: • Review and ratification by WSB. • Upload data to the national portal by 30/3/24. • Upload the narrative report (appendix A) to the Trust public section of the website by 30/03/24. • Complete key actions required for 2024/25.

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Wirral University Teaching Hospital
NHS Foundation Trust

Gender Pay Gap Report 2023

Sharon Landrum, Workforce Engagement and Inclusion Lead

November 2023

Contents

1.0 Executive Summary

The gender pay gap legislation introduced in April 2017 requires that UK employers with 250 employees or more publish data about their gender pay gap on an annual basis (based on a snapshot date of 31st March each year for the public sector. Information contained within this report is therefore based on 31st March 2023 data in line with national reporting requirements.

This years' report shows a number of pleasing improvements, with reductions seen in both the mean and median gender pay gaps and no median bonus gender pay gap this year e.g. 0%.

An increase can however be seen in the mean gender bonus pay gap. This is largely due to staff obtaining local and national Clinical Excellence Awards and whilst local awards have been shared equally amongst all eligible staff since COVID-19, previous awards are retained, with levels having increased increased each year. This is in addition to 60% more eligible male Consultants (than females), has resulted in continuous gender pay gaps in favour of males.

Bonus payments are largely related to clinical excellence awards (CEA) and discretionary points and can be correlated to the number of male consultants who have additional service with the Trust and have therefore reached higher levels of awards.

The proportion of staff receiving bonuses is low overall, however continues to be extremely low for female employees. Only 1.77% of eligible female staff have received, compared with 10.47% of male colleagues (an 8.7% difference). There are significantly higher levels of females working at WUTH, along with lower levels of female consultants, which will also contribute to the results in this area.

The number of female employees (78.4%) continues to significantly outweigh the number of males (21.6%). The ratio of female employees is higher in all pay quartiles, with the lowest ration in the highest quartile (71.2%).

2019 Government recommendations identified key areas that would work to reduce the gender pay gap and women's progression in the workplace and these are:

- create an inclusive culture
- support women's career development
- progression for part-time workers
- improve recruitment and promotion processes
- measure and evaluate policies to support diversity and inclusion

A number of actions have been completed over the last few years to support reductions and summary details are contained within the body of the report.

2.0 Background and Introduction – reporting requirements

The gender pay gap legislation introduced in April 2017 requires that UK employers with 250 employees or more publish data about their gender pay gap on an annual basis (based on a snapshot date of 31st March for the public sector).

The gender pay gap shows the difference between the **average** (mean or median) earnings of men and women and is expressed as a percentage of men's earnings.

This report is therefore based on the snapshot date of 31st March 2023 and is based on six calculations as required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 applicable to the public sector:

1. mean (average) gender pay gap using hourly pay
2. median gender pay gap using hourly pay
3. percentage of men and women in each hourly pay quarter
4. percentage of men and women receiving bonus pay
5. mean (average) gender pay gap using bonus pay
6. median gender pay gap using bonus pay

Wirral University Teaching Hospital WUTH) is committed to ensuring that the principles of the Public Sector Equality Duty (PSED) are upheld and that we eliminate discrimination and ensuring working towards advancing opportunities and fostering good relations. This report is therefore vital not only to ensure compliance with national requirements, but to support the Trust in identifying where any gaps my lie and what actions are required to create improvements.

The Trust views analysis of any gaps in gender pay as a valuable tool in identifying levels of equality in the workplace, female / male participation and how effectively talent is being maximised.

The gender pay gap differs from equal pay (which deals with the pay difference between men and women who carry out the same or similar jobs, or work of equal value). Wirral University Teaching Hospital pays staff of different genders equally if they perform the same job or work of similar value.

2.1 Staff included in the gender pay gap data

Data is based on full-pay relevant employees at the snapshot date of 31st March 2023.

2.2 What counts as pay?

The gender pay gap **includes** basic pay, paid leave, allowances, pay for any piecework and bonus pay and **excludes** overtime pay, expenses, pay in lieu of notice, the value of salary sacrifice, redundancy or termination payments, arrears of pay, shift premiums and benefits in kind.

2.3 Median and Mean

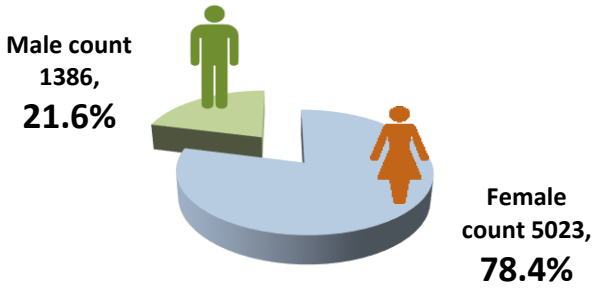
The mean hourly rate is the average hourly wage across the entire organisation so the mean gender pay gap is a measure of the difference between women's mean hourly wage and men's mean hourly wage.

The median hourly rate is calculated by ranking all employees from the highest paid to the lowest paid, and taking the hourly wage of the person in the middle; the median gender pay gap is the difference between women's median hourly wage (the middle paid woman) and men's median hourly wage (the middle paid man).

3.0 Wirral University Teaching Hospital Demographics

The overall gender split within WUTH is shown in figure 1.

The number of female employees significantly outweighs the number of male employees and the split has reduced by 1.2% since last year.



4.0 Wirral University Teaching Hospital's Gender Pay Gap

Gender pay gap calculations are based on the reporting requirements listed above and include bonus pay.

4.1 Median gender pay gap (%)

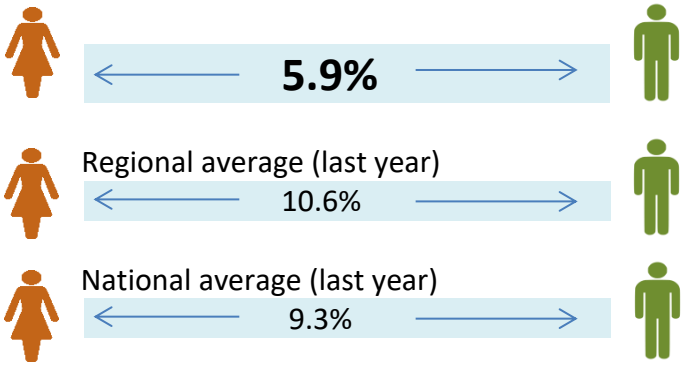
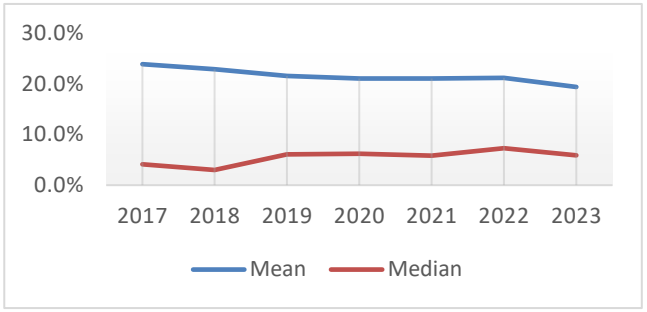
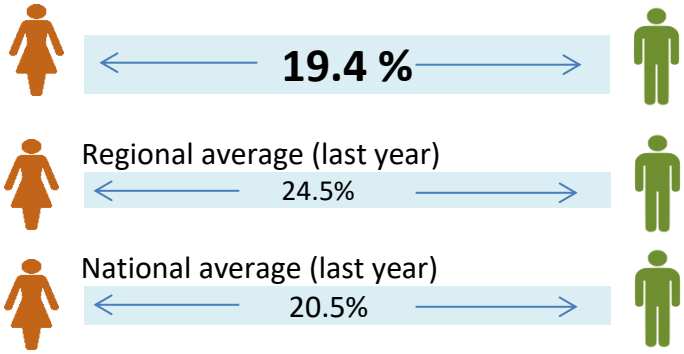


Fig. 2 Gender Pay Gap Annual Comparison



4.2 Mean gender pay gap (%)



Summary of Findings

This years' findings identify that whilst there is still a gender pay gap in favour of males, the gap has reduced significantly this year from 21.2% last year to 19.4% this year and is the lowest gender pay gap recorded since commencement of the reporting requirements. The median pay gap has also reduced from 7.3% last year to 5.9% this year.

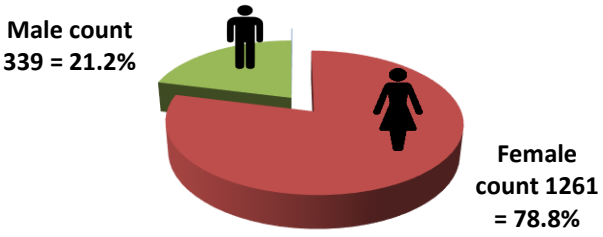
5.0 Salary

WUTH salary quartiles

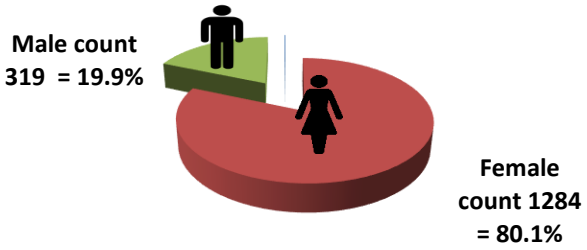
Females are in the majority in all pay quartiles however there is a lower proportion of females in the highest pay quartile, with numbers decreasing in this quarter this year.

There are increases in females in the lowest and upper middle quartiles this year and reductions in the others.

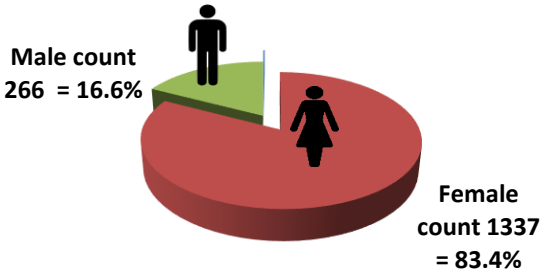
Lowest pay quartile



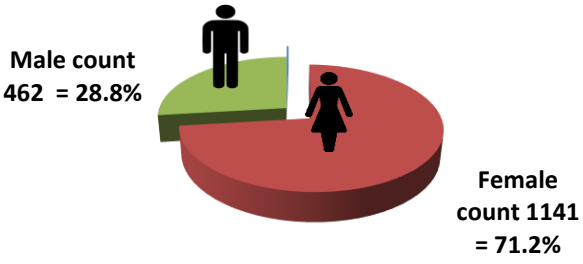
Lower middle pay quartile



Upper middle pay quartile



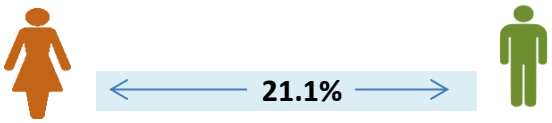
Highest pay quartile



6.0 Bonus pay gender gap

Bonus pay includes clinical excellence awards and discretionary points.

6.1 Mean bonus gap (%)



6.2 Median bonus gap (%)

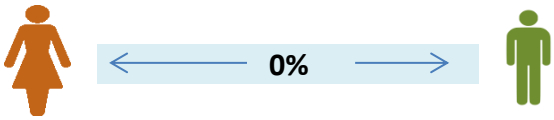
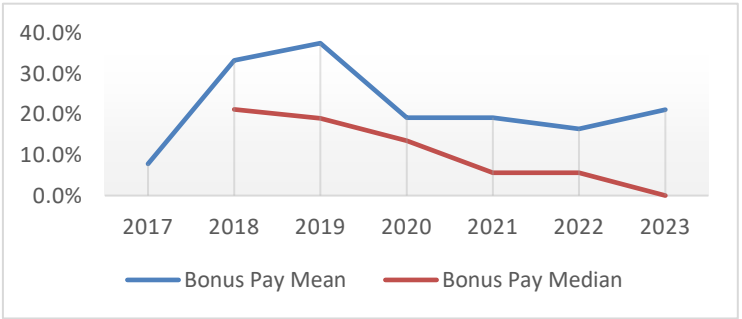


Fig. 3 Bonus Pay Gender Pay Gap Annual Comparison



Clinical excellence award (CEA) payments increase up an agreed framework as service continues. The Trust has a number of male employees with long-service that will therefore receive a higher scale of award.

Due to the impact of COVID-19 on the service, CEAs have been evenly distributed to all eligible colleagues and not linked to an application process. This was in line with national guidance and agreed at JLNC.

7.0 Bonus pay proportions

The proportion of staff receiving bonuses is low overall however whilst data shows an increase in the number of eligible staff receiving bonuses this year, the difference in proportionality of males and females has increased with only 1.77% of female staff (94 females) receiving bonus pay compared with 10.47% of male colleagues (150), resulting in an 8.7% difference this year compared to 5.1% last year.

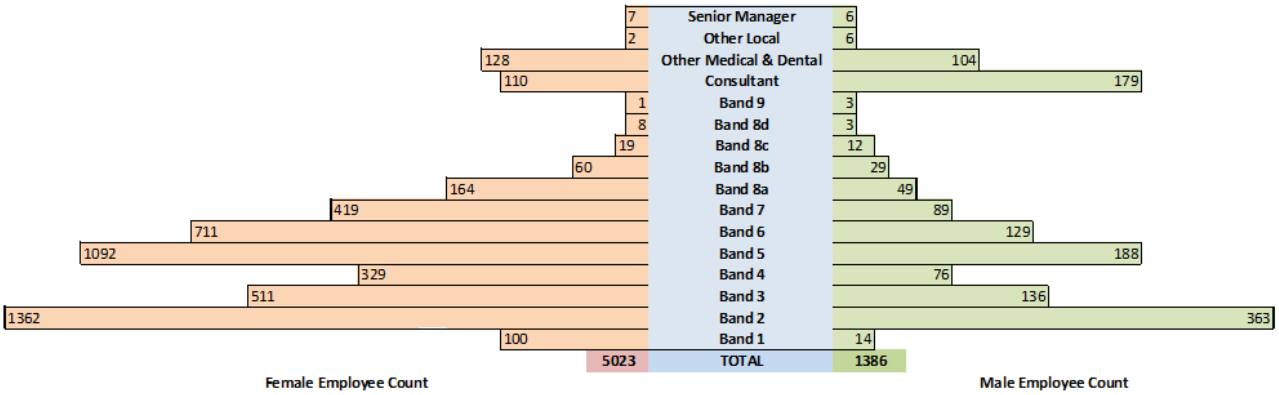
8.0 Additional Data

In addition to the legislative requirements and in order to further analyse data and seek improvements, WUTH have decided to further breakdown data collected per pay bands as follows:

Gender count and mean averages per pay grade

Row Labels	Employee Count	Average Hourly Rate	Employee Count	Average Hourly Rate	Difference in hourly rate
Band 1	100	£15.40	14	£13.87	£1.52
Band 2	1362	£12.09	363	£11.92	£0.17
Band 3	511	£12.51	136	£12.52	£0.00
Band 4	329	£13.20	76	£13.67	-£0.47
Band 5	1092	£16.94	188	£16.74	£0.20
Band 6	711	£20.48	129	£19.52	£0.96
Band 7	419	£23.33	89	£23.10	£0.23
Band 8A	164	£25.90	49	£25.89	£0.01
Band 8B	60	£29.62	29	£29.58	£0.04
Band 8C	19	£36.10	12	£31.71	£4.39
Band 8D	8	£39.99	3	£41.56	-£1.57
Band 9	1	£55.99	3	£48.42	£7.57
Consultant	110	£50.89	179	£52.32	-£1.42
Other Local	2	£7.10	6	£14.21	-£7.11
Other M&D	128	£25.10	104	£24.65	£0.45
Snr Manager	7	£60.24	6	£55.36	£4.88
Grand Total	**5023**	**£17.50**	**1386**	**£21.72**	-£4.22

Fig 4. Gender count per banding



9. Actions Undertaken to Reduce Pay Gaps

The Trust has implemented a number of actions over the last few years to support reduction in pay gaps and these include:

- The Trust removed personal identifiable information from applications for clinical excellence awards and discretionary points in order to remove any potential conscious / unconscious bias from the process. Prior to COVID-19, the application process saw a rise in the number of female applicants.
- Additional engagement and support with female Consultant colleagues regarding application for CEA and support offered as necessary.
- Promotion of male and female role models – the Trust continues to promote and celebrate the achievements of our staff including as part of International Mens and Womens Day and continues to share stories and experiences of female colleagues in Trust communications.
- Two Springboard (personal and professional development programmes for women have been completed, with Navigator, a mens personal and professional development programme completed in 2023.
- The Trust's recruitment team were brought back in-house with effect from April 2020 and an extensive review of workforce monitoring processes and data have taken place and revisions made to ensure robust and effective monitoring.
- The Trust has developed a new People Strategy, with engagement from a variety of staff across the Trust
- A new Equality, diversity and inclusion (EDI) strategic commitment has been developed, to underpin the People Strategy and ensure an EDI lens is placed on deliverables.
- A review has been undertaken of flexible working within the Trust, with stakeholder groups in place to identify key actions to ensure improvements moving forwards
- A menopause staff network was established with a range of activities and guidance developed, including new webpages offering advice and support to staff. A dedicated staff menopause clinic has been established and specialists offering information and support sessions for staff.
- A new armed forces network has been established to support forces families and whilst still new, has already support isolated and worried family members.
- A Strategic Trustwide Retention Group was launched, with a variety of actions completed to support retention of our staff, including career clinics; listening events; exit survey process review and a new Band 5 Registered Nurse transfer process.
- A new leadership qualities framework has been developed, with leadership for all development offerings for staff at all levels
- The Trust is striving to ensure equality, diversity and inclusion is embedded within its core functions and decision-making processes. Awareness raising on the importance of valuing and ensuring equality, diversity and inclusion is included within development programmes and in particular our leadership and management development offerings.
- Range of Trust policies reviewed to ensure best practice is adhered to with regards to family friendly policies and a more flexible approach
- Our flexible working policy and processes have been reviewed, with a new toolkit developed and Flexible Working Ambassadors identified across the Trust
- Wellbeing conversations introduced and linked to appraisal processes
- A new appraisal and check-in process has been launched following Trustwide consultation and engagement

11.0 Summary

In summary, key findings are:

Reduced mean gender pay gap from 21.2% to 19.4%.

1) Reduced median gender pay gap from 7.3% to 5.9%, in favour of males

2) No median bonus pay gap, reducing from 5.6% last year
3) Increased mean bonus pay gap from 16.4% to 21.1%
4) Increased disproportionately of levels of bonus pay, with 1.77% of females in receipt, compared with 10.47% of male colleagues
5) Continued low levels of female employees in Consultant positions
6) Continued lower levels of male staff compared with females overall
7) Lowest ratio of female staff in the upper quartile

A number of improvements can be seen within the gender pay gap data this year, with the lowest mean gender pay seen since commencement of the reporting and no median bonus pay gap.

A number of steps have been taken across the organisation to support workforce wellbeing and worker experiences and support development and personal growth for staff. It is therefore hoped that improvements can continue to be seen.

12.0 Next steps

Key actions for 2023/24 will therefore be:

1) Deep dive into bonus pay information to further understand areas for improvement
2) Continued implementation of the Trusts People Strategy and ED&I strategic commitment deliverables

Appendix B

Additional Gender Pay Gap Information

Table 1 – Gender Pay Gap Information comparing Black, Asian and Minority Ethnic (BAME) staff and non-BAME colleagues

	All staff	Female	Male
Total White staff average hourly pay	£22.06	£21.41	£24.21
Total BAME staff average hourly pay	£24.64	£21.77	£26.95
Pay gap	**11.7%**	**1.7%**	**11.30%**

Table 2 – Gender Pay Gap Information comparing Disabled and non-disabled staff

	All staff	Female	Male
Total Disabled staff average hourly pay	£16.56	£16.70	£16.22
Total non-disabled staff average hourly pay	£18.44	£17.47	£21.95
Pay gap	**-10.2%**	**-4.4%**	**-26.10%**

Table 3 – Gender Pay Gap Information comparing Lesbian, gay, bisexual and non-binary staff (LGB+) staff with heterosexual or straight colleagues

	All staff	Female	Male
Total Heterosexual or straight staff average hourly pay	£18.37	£17.47	£21.81
Total LGB+ staff average hourly pay	£16.94	£17.19	£16.55
Pay gap	**-7.8%**	**-1.6%**	**-24.10%**

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 10**

24 January 2024

Title	Complaints Annual Report
Area Lead	Dr Nikki Stevenson, Executive Medical Director and Deputy CEO
Author	John Molyneux, Head of Complaints
Report for	Information

Executive Summary and Report Recommendations

This report summarises concerns and complaints activity and performance at Wirral University Teaching Hospital NHS Trust (WUTH) for the financial year April 2022 to March 2023.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

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

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

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
21/08/2023	Patient Safety Quality Board	As above	Information

07/09/2023	Quality Committee	As above	Information

1	Narrative
1.1	**Introduction/Background** The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 sets out a complaints process with two stages: local resolution (carried out by the NHS body) and, if the complainant remains dissatisfied, referral to the Parliamentary and Health Service Ombudsman (PHSO). The Trust's Concerns and Complaints Policy places emphasis on local resolution of concerns by frontline staff to avoid concerns escalating to formal complaints unnecessarily. When a formal complaint is raised, a patient experience specialist manages an end-to-end process, acting as a point of contact for the complainant and the investigation lead staff in the divisions. For every complaint received, as part of the registration process, the Patient Experience Team (PET) clarifies and confirms each concern that the complainant would like us to address, and the period within which the investigation of the complaint is likely to be completed. National timescales for complaint responses were removed in the 2009 Regulations and replaced with the ability to agree individual response timescales on a case-by-case basis with the complainant; however, to assist in the production of timely responses, WUTH's complaints policy currently grades concerns and complaints on a scale of 1 to 2, with the following timescales.

Level 1	Level 2
This will be investigated as an informal concern that has the potential to be resolved quickly by front line staff within three working days. Level 1 concerns may be resolved verbally and do not require a written response unless requested by the enquirer. Any such written response may be signed off at departmental / divisional level.	This is a formal complaint that should be acknowledged within three working days of receipt and responded to within 40 working days via a written response signed off by the Trust's CEO. In the absence of the CEO, level 2 complaint responses may be signed off by the CEO's nominated deputy.

1.2	**Complaint Activity** There were 240 complaints formally registered in 2022/23. Although a 12% increase over the 215 registered in 2021/22, this was well below the pre-pandemic 279 received in 2018/19. As noted in the 2021/22 report, there has been a post-pandemic national fall in complaint numbers, which have then been gradually moving back towards pre-pandemic levels. Thus in 2018/19, WUTH averaged around 23 new complaints per month; this fell significantly to 15 in 2020/21, rose to 18 in 2021/22, and to 20 in 2022/23. At the time of writing this report, NHS Digital K041 performance data for 2022/23 was not yet available. However, K041 data for 2021/22 K041 showed a 26% rise in

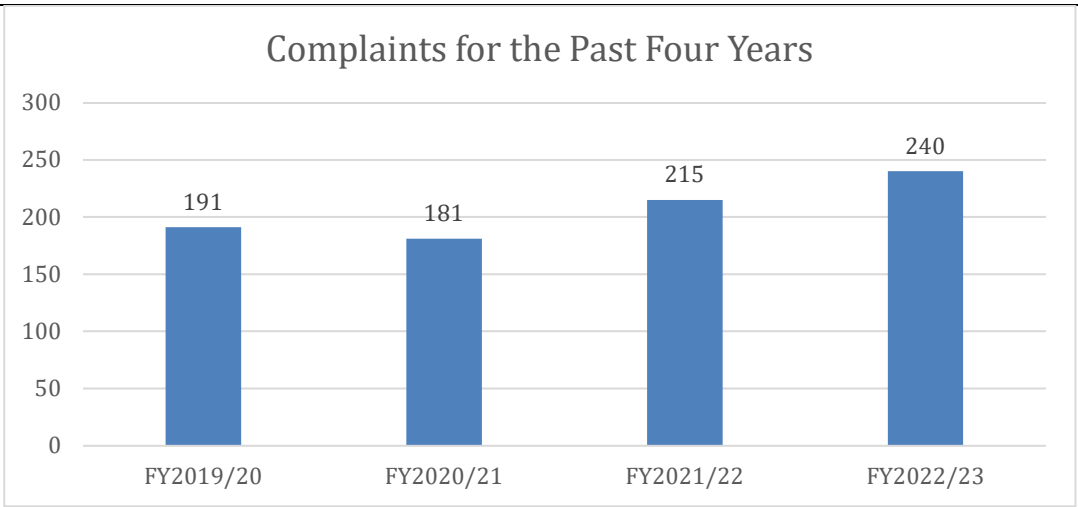
complaints for acute trusts over 2020/21 (although 7% lower than pre-pandemic numbers). Complaints per 1000 staff averaged 10 per quarter. The national average (again, per NHS Digital KO41 data) for acute Trusts in England was 20.

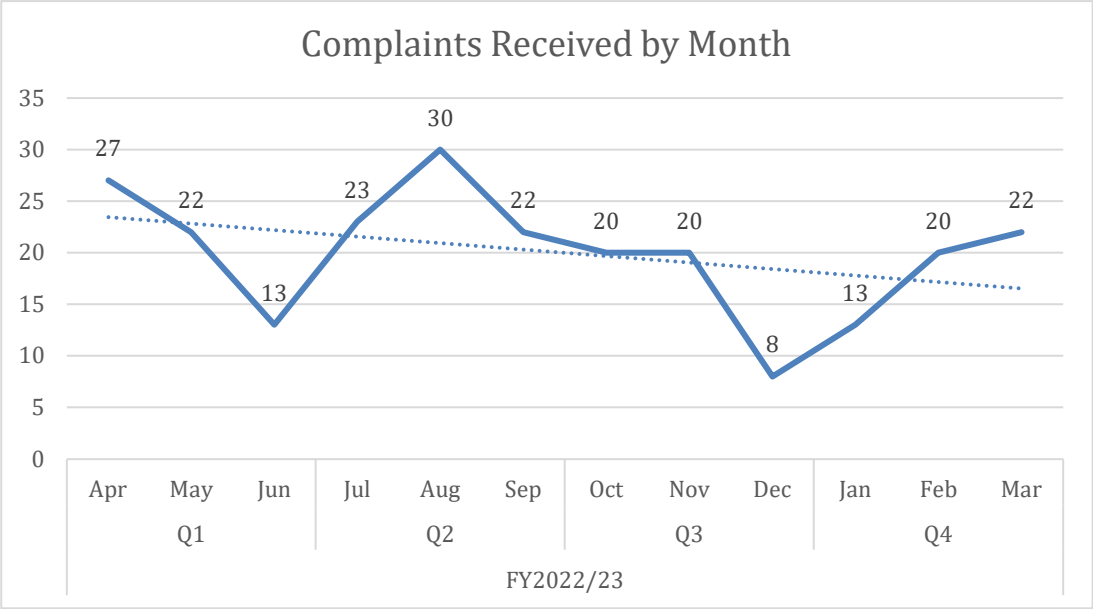
NHS Digital KO41 quarterly data for nearby acute trusts, per 1000 staff, in 2021/22, were as follows.

	Q1	Q2	Q3	Q4
Alder Hey Children's NHS Foundation Trust	**9.5**	**11.0**	**10.7**	**14.9**
Clatterbridge Cancer Centre NHS Foundation Trust	**10.1**	**7.1**	**7.6**	**6.1**
Countess of Chester Hospital NHS Foundation Trust	**14.1**	**14.6**	**16.5**	**13.0**
Liverpool Heart and Chest Hospital NHS Foundation Trust	**4.8**	**7.5**	**2.4**	**8.2**
Liverpool University Hospitals NHS Foundation Trust	**8.1**	**10.0**	**9.2**	**12.0**
Liverpool Women's NHS Foundation Trust	**9.3**	**9.5**	**10.7**	**9.2**
Mid Cheshire Hospitals NHS Foundation Trust	**16.3**	**16.0**	**18.4**	**12.5**
Southport and Ormskirk Hospital NHS Trust	**21.6**	**21.9**	**24.1**	**27.7**
St Helens and Knowsley Teaching Hospitals NHS Trust	**12.7**	**12.1**	**10.6**	**8.8**
Walton Centre NHS Foundation Trust	**15.0**	**12.9**	**16.3**	**16.2**
Wirral University Teaching Hospital NHS Foundation Trust	**10.7**	**10.7**	**8.6**	**9.9**

The patient contact / activity data for the WUTH's 2022/23 Annual Report, excluding total births and diagnostic orders, were as follows.

New outpatient attendances	**140,629**
F/up outpatient attendances	**387,483**
Diagnostic examinations performed	**341,191**
ED attendances	**93,894**
Emergency admissions	**49,529**
Elective day case admissions	**45,893**
Elective planned admissions	**7,380**
Total	**1,065,999**





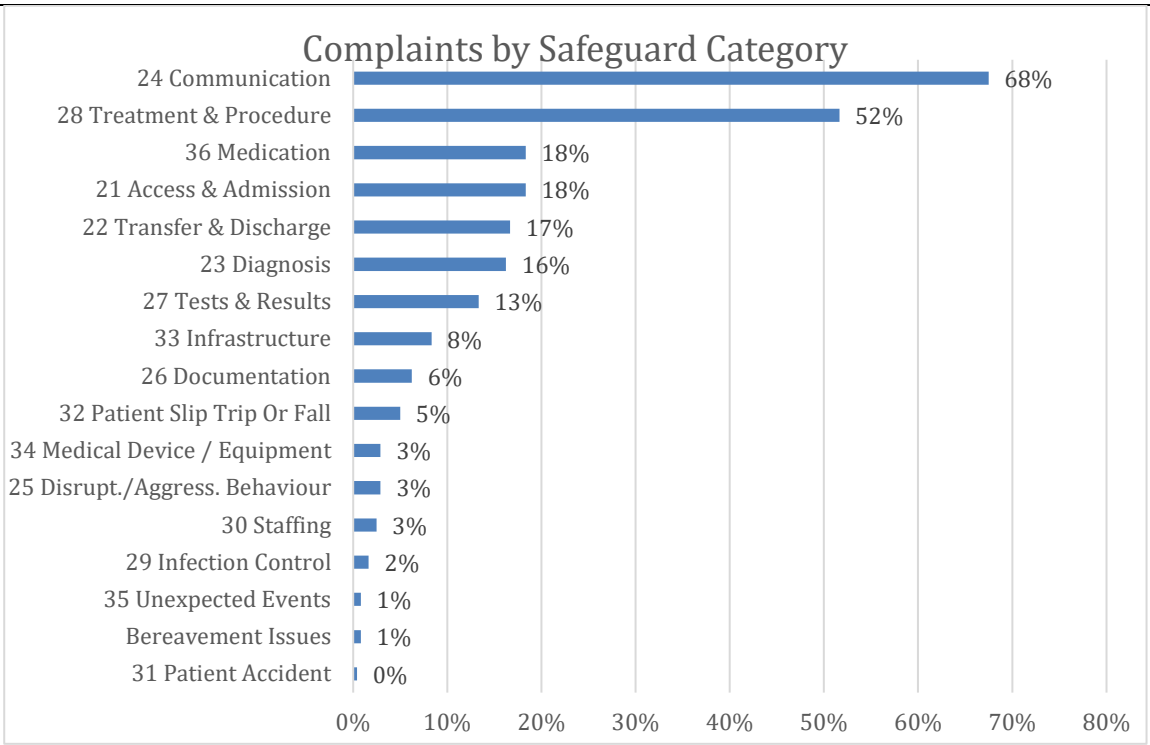
'Communication' remained the highest reported category of complaint, featuring as a component in 68% of cases (down by 1% from 2021/22). In the main this was a communication failure with a patient or relative, and nursing and medical staff attitude.

'Treatment and Procedure' featured in 52% of cases (down by 1%). These were mainly around delays, but also featured sub-categories such as privacy and dignity, failure to assist with hygiene or feeding, end of life care, and hospital acquired pressure sores.

'Access and Admission' featured in 18% of cases (up by 11%). These were sub-categories such as delays in accessing hospital care and cancelled or delayed inpatient and outpatient appointments.

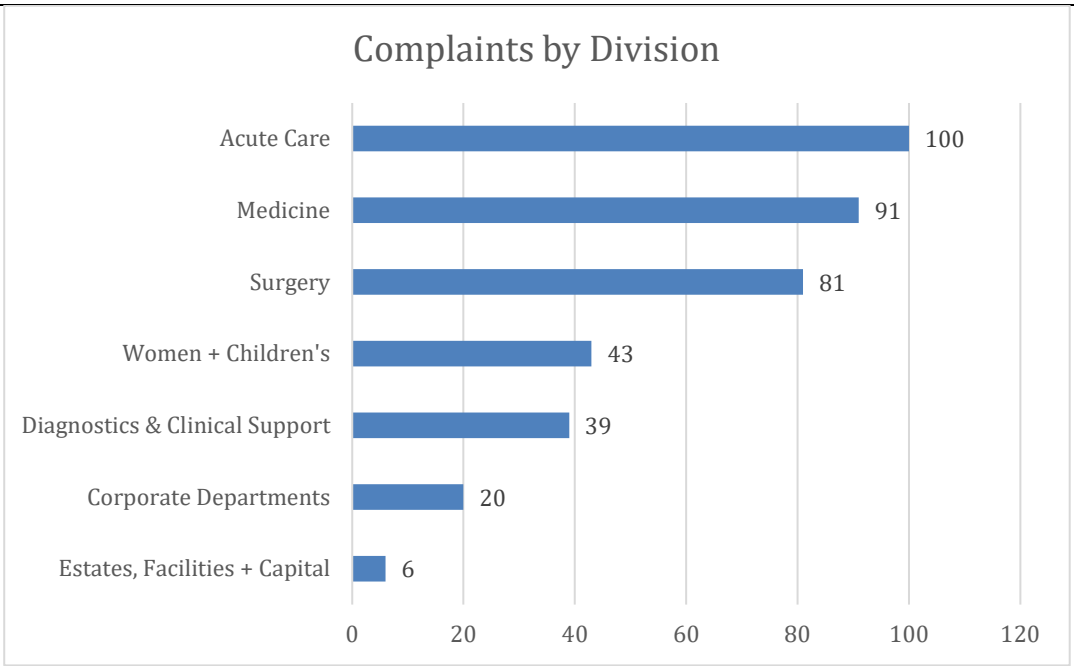
'Medication' featured in 18% of cases (up by 12%). These were often prescribing delays around pain relief.

'Transfer and Discharge' featured in 17% of cases (up by 3%). These were mostly complaints of inappropriate discharge from hospital.

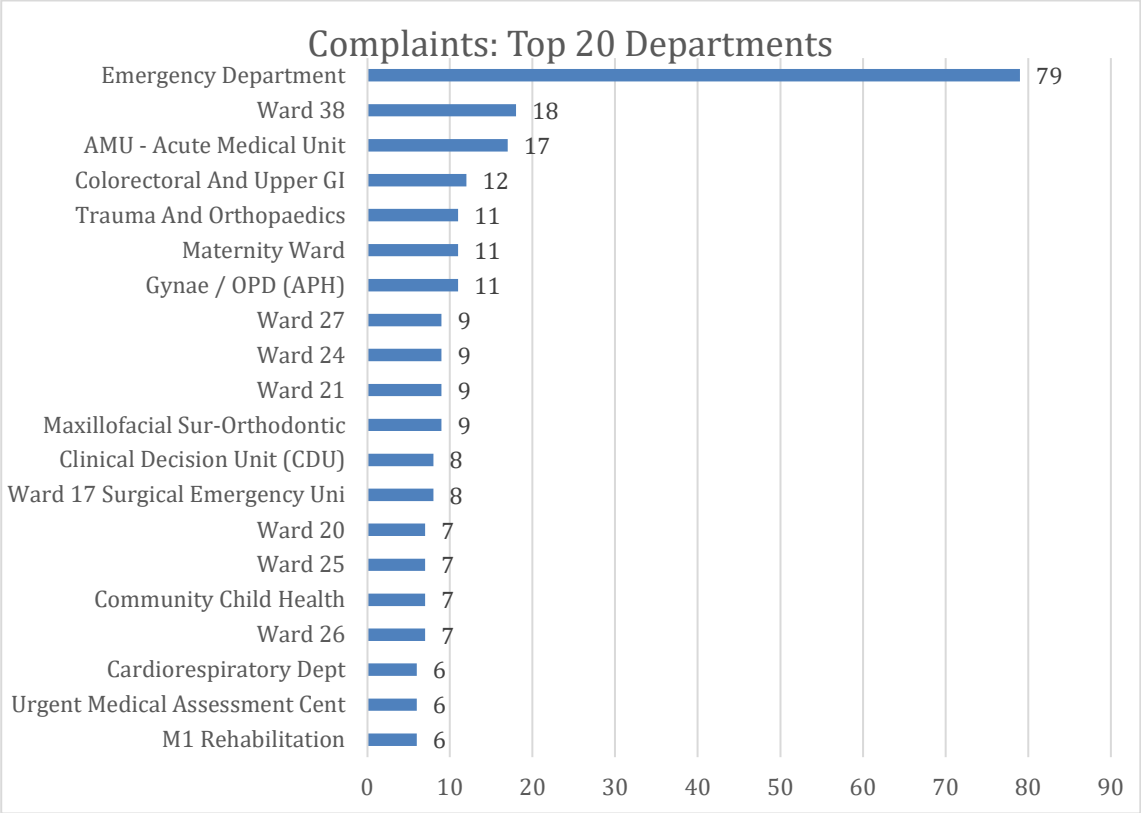


Category	FY2019/20	FY2020/21	FY2021/22	FY2022/23
24 Communication	53%	54%	69%	68%
28 Treatment & Procedure	57%	45%	53%	52%
21 Access & Admission	10%	8%	7%	18%
36 Medication	9%	9%	6%	18%
22 Transfer & Discharge	9%	24%	14%	17%
23 Diagnosis	14%	20%	17%	16%
27 Tests & Results	6%	6%	7%	13%
33 Infrastructure	4%	7%	8%	8%
26 Documentation	2%	6%	4%	6%
32 Patient Slip Trip Or Fall	1%	3%	1%	5%
25 Disrupt./Aggress. Behaviour	3%	2%	2%	3%
30 Staffing	1%	2%	2%	3%
34 Medical Device / Equipment	1%	1%	1%	3%
29 Infection Control	2%	5%	1%	2%
35 Unexpected Events	0%	0%	0%	1%
Bereavement Issues	0%	1%	1%	1%
31 Patient Accident	1%	1%	0%	0%

Acute Care received the most complaints (involved in 100 cases), followed by Medicine (91), Surgery (81), Women and Children's (43), Diagnostics and Clinical Support (39), Corporate Departments (20), and Estates, Facilities and Capital (6).



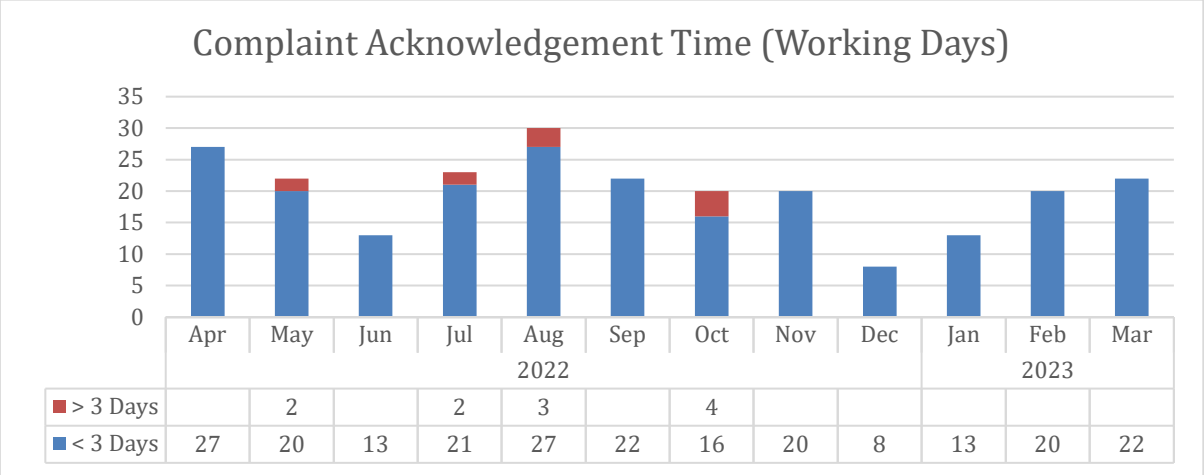
The top 20 areas to receive a complaint are shown in the following chart.

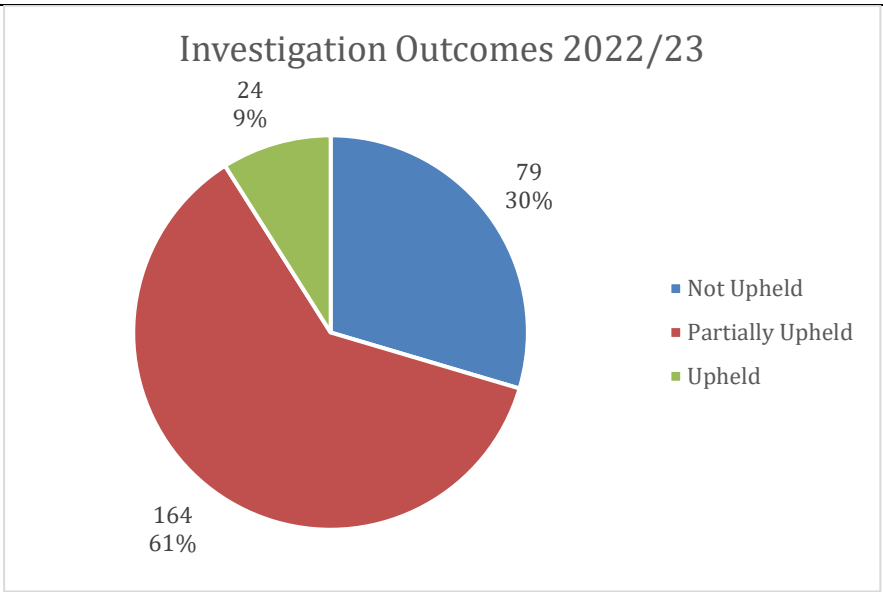


For the ED, most complaints were around ‘Communication’ (46%), ‘Treatment and Procedure’ (32%), ‘Access and Admission’ (29%), ‘Diagnosis’ (19%), and ‘Medication’ (16%).

Ward 38’s complaints were mostly around ‘Treatment and Procedure’ (39%), ‘Communication’ (33%), ‘Transfer and Discharge’ (28%), ‘Medication’ (11%), and ‘Staffing’ (11%).

AMU’s complaints were mostly around ‘Communication’ (47%), Medication (35%), ‘Treatment and Procedure’ (35%), and ‘Transfer and Discharge’ (18%).

	Colorectal and Upper GI's complaints were mostly around 'Treatment and Procedure' (67%, mainly delays), and 'Communication' (58%). Trauma and Orthopaedics received complaints mostly around 'Treatment and Procedure' (55%, delays, complications, and pressure sores), and 'Communication'. Maternity Ward's complaints were mostly 'Communication' (82%), 'Treatment and Procedure (27%, complications and inappropriate treatment), 'Access and Admission' (18%, delays), and 'Tests and Results' (18%, failure to undertake).
1.3	**Complaint Response Timeliness** From October 2020, the Trust's Concerns and Complaints Policy set a routine timescale for responding to complainants of 40 working days. Internal divisional response times are currently set at 23 working days (parallel with an initial acknowledgement target of three working days), with the remaining time then allocated to drafting of the response letter by the PET (following receipt of the divisional investigation) and executive quality assurance and sign-off of that letter by the chief executive officer or deputy. During 2022/23, 95% of complaints registered were acknowledged within the national target of three-working days, with an average acknowledgement time of two working days. The majority (80%) were acknowledged within one working day. However, only 25% of complaints then received a response within 40 working days, a 12% decline in performance from the previous year (although, as previously noted, response numbers / productivity in 2022/23 increased by 42%). 
1.4	**Complaint Outcomes** During 2022/23, 267 complainants received a first response to their concerns (42% more than in 2021/22). Of these, 30% were not upheld, 61% were partially upheld, and 9% were upheld.



There was therefore a 2% increase in upheld and partially upheld complaints during 2022/23 compared with 2021/22.

For comparison, NHS Digital K041 data for 2021/22, for all hospital and community services in England, shows the following outcomes: 36% not upheld, 38% partially upheld, and 27% upheld. While WUTH's percentage rate of 'not upheld' complaints was therefore similar (6% lower), we had a higher percentage (by 23%) of 'partially upheld' complaints.

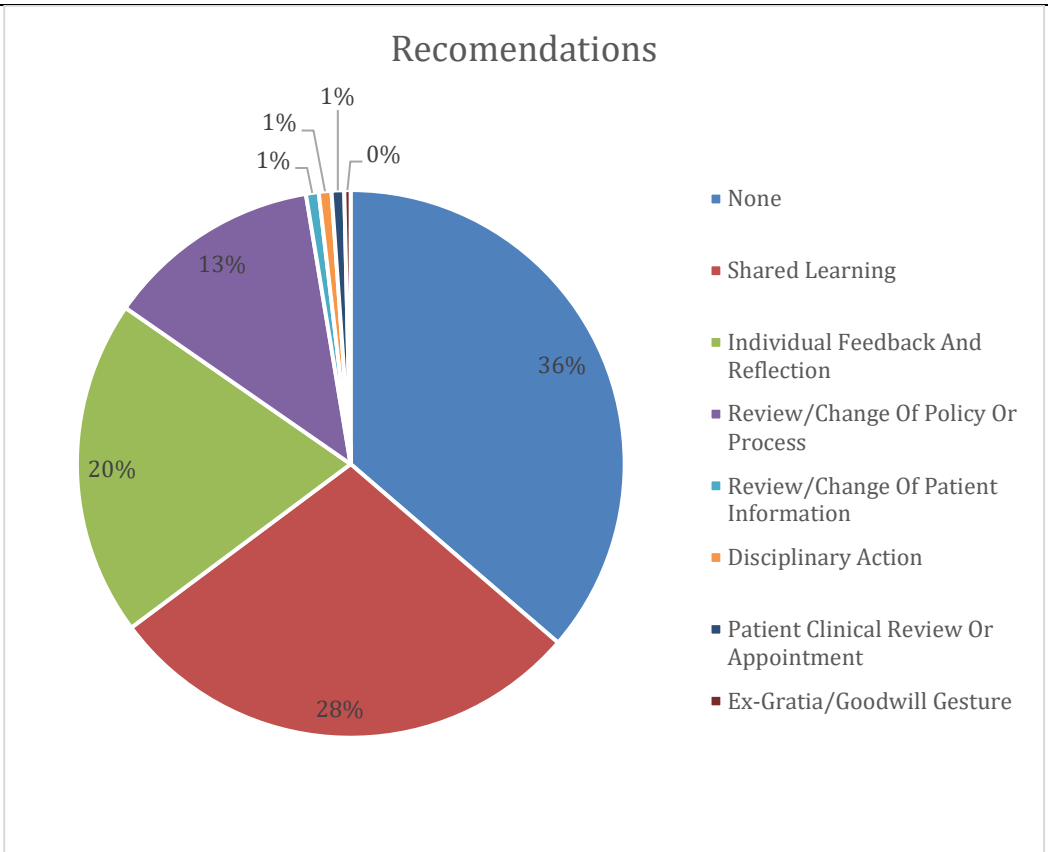
The majority of upheld or partially upheld complaints related to aspects around communication and appointment or treatment delay.

1.5 **Learning from Complaints**

From October 2020, all divisions have been required to submit an action plan with each complaint response, including timescales for completion and identified leads, so that these may then be tracked via Ulysses Safeguard.

Of the 267 complaint responses that received a response in 2022/23, 97 cases were judged not to require any actions.

The broad actions described in the complaint response; are summarised in the following chart.



1.6 **Next Steps for 2023/24**

The divisions that consistently received the highest number of concerns and complaints were Surgery, Medicine, Acute Care, and Women and Children's, indicating the need for targeted interventions in these areas.

The thematic categories of concerns and complaints in 2022/23 remained similar to previous years, with 'Communication' being the most prominent issue. This highlights the importance of addressing communication failures with patients, visitors, and relatives, as well as improving the attitudes of nursing and medical staff.

Additionally, 'Access and Admission' and 'Treatment and Procedure' delays were significant areas of concern and complaint, emphasising the need for process improvements and measures to reduce waiting times in most departments, with Community Child Health and Colorectal and Upper GI featuring particularly highly, but also other departments such as Gynae OPD, Eye Clinic, Urology, and of course the ED.

Divisions need to consider how they can provide assurance as to how actions and learning from complaints are being followed up / tracked.

Divisions need to adhere to policy by appointing single lead investigators who can then coordinate with individual staff.

Divisions need to clarify and consider staff support processes and provide assurance of the same.

To support divisions, the PET / GSU are reviewing KPIs and how these may be tracked more efficiently via Ulysses Safeguard, including moving to the web-based system that will facilitate the use or real-time dashboards.

	To improve the quality of divisional investigations and response timeliness, the PET will continue to roll out complaint investigation and response training to senior management divisional teams. The PET needs to give greater focus on keeping complainants updated during the investigation of their complaint, particularly around anticipated delays**.**

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 11**

24 January 2024

Title	Governance Update
Area Lead	David McGovern, Director of Corporate Affairs
Author	Cate Herbert, Board Secretary
Report for	Approval

Executive Summary and Report Recommendations

This report provides the annual review of the Research and Innovation Committee's Terms of Reference, and the refreshed Statement of Purpose, and a proposal for the Board Security Champion as well as increased NED visibility.

Both the Terms of Reference and the Statement of Purpose have been through an annual refresh and are presented to the Board for approval.

There is now a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. In order to align the Board's appointment to this role to the most appropriate portfolio holder, it is proposed that Sir David Henshaw, as Chair of Estates and Capital Committee, is appointed to this Champion role.

It is recommended that the Board:

- Approves the Statement of Purpose.
- Approves the Research and Innovation Committee's Terms of Reference;
- Approves Sir David Henshaw as NED Champion for Security Management; and
- Notes further arrangements for NED visibility and engagement.

Key Risks

This report relates to these key Risks:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	No
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	No

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
11 Jan 2024	Research and Innovation Committee	Annual Review of Terms of Reference	Approval

1	Narrative
1.1	**Statement of Purpose** CQC require that each Trust registers a statement of purpose, which outlines the Trust's priorities, and gives an overview of all services provided. It is also a requirement of the Code of Governance that the Board has a formally agreed statement of purpose in place, and this serves to fulfill that required. WUTH's statement of purpose has been reviewed over the past few months, with engagement from all areas, and is now presented for approval prior to submission to the CQC.
1.2	**Research and Innovation Committee Terms of Reference** An annual refresh has been undertaken on the Terms of References for Board Assurance Committees. These were provided to each Committee for feedback and all the requested amendments have been made. The Committee reviewed their Terms of Reference on 11th January 2024, and agreed that the document remained fit for purpose. No major changes were made to the document. The Board are therefore asked to note the appended Terms of Reference. As with all other Terms of Reference, this will continue to be a live document and will be reviewed annually in line with good governance practice.
1.3	**NED Champion – Security Management** Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. This is corroborated by the NHS guidance on NED Champion roles as published in 2021. This role has been undertaken by Lesley Davies since 2022. However, Lesley is also the Wellbeing Guardian which is in line with her role as People Committee Chair.

	It is therefore proposed that Sir David Henshaw is appointed as the NED Champion for Security Management given his role as Chair of the Estates and Capital Committee, and his natural involvement in that portfolio, which also manages security.
1.4	**Board Walkabouts** From April, it is proposed that, prior to each Public Board meeting, each NED is paired with an Exec for a walkabout to a different area of the hospital. This is a further enhancement to our current arrangements for visits of this nature and could focus on the area the NED is partnered with, or an area that hasn't been visited for some time. A standing item will then also be added to the Board seminar to allow a place for Board to feedback on the findings of their walkabouts. A schedule to guide these additional visits will be drawn up and arrangements put in place to support them.

2	Implications
2.1	**Patients** • No direct impact on patients
2.2	**People** • No direct impact on people
2.3	**Finance** • No financial implications
2.4	**Compliance** • The NED champion roles support compliance with statutory requirements and NHS guidance • The Statement of Purpose supports compliance with CQC requirements and the Code of Governance.

Wirral University Teaching Hospital
NHS Foundation Trust

Statement of purpose

Health and Social Care Act 2008

Part 1

The provider's name, legal status, address and other contact details

Including address for service of notices and other documents

Please first read the guidance document *Statement of purpose: Guidance for providers*

Statement of purpose, Part 1

Health and Social Care Act 2008, Regulation 12, schedule 3

The provider's business contact details, including address for service of notices and other documents, in accordance with Sections 93 and 94 of the Health and Social Care Act 2008

1. Provider's name and legal status							
Full name[1]	Wirral University Teaching Hospital NHS Foundation Trust						
CQC provider ID	RBL						
Legal status[1]	Individual	☐	Partnership	☐	Organisation	☒	

2. Provider's address, including for service of notices and other documents	
Business address[2]	Arrowe Park Hospital Arrowe Park Road
Town/city	Birkenhead
County	Wirral
Post code	CH49 5PE
Business telephone	01516785111
Electronic mail (email)[3]	n.stevenson2@nhs.net David.mcgovern2@nhs.net Wuth.cqcinformation@nhs.net

By submitting this statement of purpose you are confirming your willingness for CQC to use the **email address** supplied at Section 2 above for service of documents and for sending all other correspondence to you. Email ensures fast and efficient delivery of important information. If you do not want to receive documents by email please check or tick the box below. We will not share this email address with anyone else.

I/we do **NOT** wish to receive notices and other documents from CQC by email	☐

[1] Where the provider is a partnership please fill in the partnership's name at 'Full name' in Section 1 above. Where the partnership does not have a name, please fill in the names of all the partners at Section 3 below

[2] Where you do not agree to service of notices and other documents by email they will be sent by post to the business address shown in Section 2. This includes draft and final inspection reports. This postal business address will be included on the CQC website.

[3] Where you agree to service of notices and other documents by email your copies will be sent to the email address shown in Section 2. This includes draft and final inspection reports.

Please note: CQC can deem notices sent to the email or postal address for service you supply in your statement of purpose as having been served as described in Sections 93 and 94 of the Health and Social Care Act 2008. The address supplied must therefore be accurate, up to date, and able to ensure prompt delivery of these important documents.

Wirral University Teaching Hospital
NHS Foundation Trust

Statement of purpose

Health and Social Care Act 2008

Part 2

Aims and objectives

Please read the guidance document *Statement of purpose: Guidance for providers*.

Aims and objectives
What are your aims and objectives in providing the regulated activities and locations shown in part 3 of this statement of purpose

Principal Purpose

The principal purpose of the Trust is as set out within paragraph 1 of Part 3 of its authorisation as a foundation trust dated 1 July 2007:

"The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England. This does not preclude the provision of cross-border services to other parts of the United Kingdom.'

Vision and Values

As one of the North West's biggest and busiest hospitals our Vision and Values set out what our patients can expect from us.

Our Vision and Values were developed with the feedback of over 2,500 staff, patients and visitors who told us what matters most to them.

Below is a summary of our vision and values

CARING FOR EVERYONE	RESPECT FOR ALL	EMBRACING TEAMWORK	COMMITTED TO IMPROVEMENT
Acting with kindness, compassion and empathy with everyone	Being honest and open, including honesty about what we can and cannot do	Working within and across teams to provide the best possible quality of care and experience for our patients, families, carers and colleagues	Actively seeking new ways of working to enable improvement
Being friendly, welcoming, approachable and remembering the simple things like a greeting and a smile	Being polite and professional with everyone, introducing ourselves by name, saying please and thank you	Communicating effectively within teams	Working together to improve services for our patients, families and carers
Being considerate of the needs of others	Listening to patients, families and colleagues	Recognising the value of everyone's role, contribution, skills and abilities	Taking personal responsibility and ownership of things that need to improve
Listening to ideas, opinions, thoughts and feelings of others	Respecting cultural and individual differences	Supporting colleagues within the team when needed	Being positively receptive to change and improvement
Taking personal responsibility and accountability for the care that you deliver	Ensuring we treat everyone the way we would want to be treated ourselves and dealing with poor behaviour	Engaging in opportunities to develop and grow the team	Celebrating our achievements

Strategic Objectives 2021-2026

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

- We will be a collaborative Healthy Wirral and Integrated Healthcare System (ICS) partner to ensure patients, families, carers, staff and other stakeholders benefit from the value a high performing acute trust can bring to this partnership.

- We recognise that as the Wirral system develops, we and other partners may need to adapt our organisational form to ensure opportunities to improve patient experience and outcomes, staff experience and value for money do not get delayed.

- As part of this collaboration, we will work with partners to develop our infrastructure across Arrowe Park and Clatterbridge Hospitals, working towards the redevelopments of the campuses and well as renewing our equipment. In addition, we will enhance the use of digital across our campuses, using information technology as an enabler to the transformation of clinical and clinical support services

- We will also continue to provide acute and specialist care for residents of Wirral and adjacent counties, improving access to our services and flow across our hospital facilities

- We will work with our commissioners, providers and clinical networks to partner with other NHS providers, where there is a strong clinical and financial case, to improve the provision of care for the Wirral population

- We want the quality of care we provide to be rated 'Outstanding' by the Care Quality Commission (CQC). We believe that an embedded quality and safety programme will increase our capacity and capability to deliver the best care for our patients and are committed to developing the best way to achieve this.
- We will also invest in our staff, ensuring that they are actively engaged and have the opportunities for training and career progression, as well as access to comprehensive wellbeing programmes. This will support us in reducing absences and improving retention of our staff, in the years ahead.

KINDS OF SERVICES PROVIDED

The kinds of services provided for the purposes of the provision of goods and services for the purposes of the health service in England are as set out in the Trust's directory of services (appendix 1). Please also refer to the link below for further detail:

Our Departments | Wirral University Hospital NHS Foundation Trust (wuth.nhs.uk)

Regulated Activities

The Trust is registered to carry out the following regulated activities:

- Diagnostic and screening procedures
- Family planning services
- Assessment or medical treatment for persons detained under the Mental Health 1983 Act
- Maternity and midwifery services
- Nursing Care
- Surgical Procedures
- Termination of pregnancies
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

The nominated individual for these services and locations is Dr Nicola Stevenson, Medical Director, contactable on n.stevenson2@nhs.net or 01516785111

The schedule below sets out the locations of services delivered by the Trust across Arrowe Park and Clatterbridge Hospitals, and the Seacombe Children's Centre.

The addresses of these locations are:

Arrowe Park Hospital
Arrowe Park Road
Upton
Birkenhead
Wirral
CH49 5PE

Clatterbridge Hospital
Clatterbridge Road
Bebington
Birkenhead
Wirral
CH63 4JY

Seacombe Children's Centre
St Paul's Road
Wallasey
CH44 7AN

Overview of Services Provided and Locations

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Acute Division				
Acute Care				
Acute Medical Unit	✓			The Acute Medical Unit (AMU) is a 23-bed unit located on the first floor of Arrowe Park Hospital. Its primary role is to provide rapid definitive assessment, investigation, and treatment for patients admitted medically from the Emergency Department prior to transfer to a specialist base ward or discharge to an appropriate discharge environment. The AMU admits patients 24 hours a day, 7 days a week. Patients stay on AMU for up to 48 hours, during which time a management plan will have been instigated by the consultant-led acute care medical team.
UMAC (Urgent Medical Assessment Centre)	✓			The Urgent Medical Assessment Centre (UMAC) consists of 20 treatment chairs and 5 treatment trolleys. The unit is co-located with the Acute Medical Unit on the first floor of Arrowe Park Hospital. UMAC brings together a single assessment and treatment area for patients referred to WUTH via their GP and patients who present to the Emergency Department who can potentially be treated via a same day unplanned ambulatory care pathway. Co-located with UMAC is the Acute Care Clinic, which provides follow up support to patients discharged from an inpatient ward in order to support a minimal length of stay in the acute setting.
Emergency Department	✓			Arrowe Park Hospital Emergency Department (ED) is the only type 1 urgent care service in the Wirral. It is a consultant-led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients. It is located on the ground floor of Arrowe Park Hospital and consists of a resus facility with 8 cubicles, 6 spaces for high dependency resus patients; 12 ambulance assessment spaces, 14 majors spaces (8 are monitored), 3 mental health rooms, 2 triage cubicles, 9 ambulatory majors assessment cubicles, 1 procedure room, 1 eye treatment room and a 10-bed, 2 chairs Clinical Decisions Unit

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Paediatric Emergency Department	✓			The Children's Emergency Department consists of 1 triage room, 3 treatment cubicles, 2 side rooms and a plaster room for the assessment and treatment of patients under the age of 18 requiring emergency care. Patients under the age of 18 requiring resuscitation are treated in the Emergency Department's main resus facility. The Paediatric Emergency Department is open between 09:00-23:00 Monday-Thursday, and between 10:00-00:00 Friday-Sunday.
Substance Misuse Team	✓	✓		The Substance Misuse Team provides information, advice, care, and treatment for individuals with drug and alcohol problems within the acute hospital setting. Patients are referred to this service as inpatients from hospital wards or the Emergency Department. The aim of the service is to provide appropriate, effective, and safe management of all patients whose misuse of alcohol or drugs is disclosed or discovered during assessment or treatment, and to provide onward referral for community support and care.
Medical Short Stay Ward	✓			The Medical Short Stay Ward (MSSW) is a 16-bed ward co-located with the Acute Medicine Unit on the first floor of Arrowe Park Hospital. The unit provides accommodation for patients presenting with a variety of acute medical illnesses with an estimated inpatient length of stay of less than 72 hours, with resources in place for a multidisciplinary team to facilitate safe early discharge.
Older Person's Assessment Unit	✓			The Older Person's Assessment Unit (OPAU) consists of a 28-bed ward providing specialist assessment to patients over aged 74 and above or those aged 65 and above with at least moderate frailty who present with an acute medical illness. The ward is supported by an enhanced MDT to provide rapid access to Comprehensive Geriatric Assessment with a 'Home First' approach.
Older Persons' Rapid Assessment (OPRA) clinic	✓			The Older Persons' Rapid Assessment (OPRA) clinic is an ambulatory day case clinic which is located in the Medical Day Case Unit on the 2nd floor in Arrowe Park Hospital. The clinic provides rapid access outpatient assessment for frail, older patients who are at risk of hospital admission. It also provides day case treatments for patients, both on a regular and ad hoc basis, such as blood transfusions and iron transfusions in order to prevent an acute hospital stay.

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Frailty At The Front Door	✓			The Frailty at the Front Door team consists of Specialist Nurses for Older People (SNOPs), Physiotherapy, Occupational Therapy and Clinical Support Workers (CSWs). The team proactively manage patients with Moderate-Severe Frailty who attend ED alongside the ED and Medical teams. They initiate comprehensive Geriatric Assessment and use a 'Home First' approach. They are supported by Consultant Geriatricians and work closely with community teams to arrange ongoing assessment, care and support once patients are discharged from hospital.
Frailty Virtual Ward			✓	Virtual Frailty Ward is run in conjunction with Wirral Community Trust. The service is based out of St Cath's Hospital, seeing and treating patients within their own home. The service is staffed with community nursing teams, along with GP, consultant, clinical fellow and Physician Associate input. Patients are admitted from community or from the Acute Trust – avoiding admission or as early supportive discharge to reduce length of stay.
Medicine Division				
General Medical Services				
Cardiology	✓		✓	The department provides inpatient facilities, day case and rapid access and general cardiology outpatient services. The catheter lab provides angiography, cardioversions, pericardial aspirations, pacemaker implants and implantable loop recorders plus a full cardiac testing service. The service also provides CT Angiography in conjunction with the radiography department. Intermediate services provided at St Catherine's Hospital.
Cardio-respiratory Department	✓	✓		The department is the diagnostic arm of cardiology and respiratory services. The department offers a wide range of diagnostic tests including ECG, Autonomic Function Testing, Pacemaker Follow-up clinics, Peri-operative management of ICDs, Transthoracic Echo, Exercise Tolerance Testing, Tilt Testing, 24 hour ECG, 24 hour BP, Cardiomemo and 7 Day Event recording. There is also support within the ultrasound service for the highly specialist Stress and Transoesophageal Echo procedures.

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
				Respiratory testing includes spirometry, full lung studies, Bronchial Provocation Tests, body plethysmography, FeNO assessment, cardiorespiratory exercise testing, Oxygen Saturation monitoring, Sleep Apnoea service, CPAP Issue and review service.
Wirral Integrated Respiratory Service	✓	✓	✓	The COPD, Home Oxygen, Early Supported Discharge (ESD) and Pulmonary Rehabilitation service provides assessment and treatment to patients with respiratory conditions in the community and supports patients on discharge from the Trust. The Trust provides a virtual respiratory ward support patient care outside of hospital
Dermatology	✓	✓	✓	The service has a dedicated purpose built unit housing in patient and day case beds and treatment facilities. Referrals are received from across the Cheshire and Merseyside Cancer Network. Some clinics are delivered at St Catherine's and VCH.
Diabetes and Endocrinology	✓	✓	✓	Outpatient services are provided at APH and CGH sites for patients with a wide range of diabetic and endocrine conditions. Inpatient beds are provided at APH. The diabetic team are supported with both inpatient and outpatient acute podiatry resources. Clinics are held in some community locations.
Gastroenterology	✓	✓	✓	The bed base for Gastroenterology is on the APH site. Outpatient clinics are held at APH, CBH and VCH. At APH Hospital services include facilities for patients bleeding acutely, as well as an endoscopy unit.
Haematology	✓			Dedicated inpatient, outpatient and day case services are provided. There is a day ward facility for the administration of chemotherapy and other treatment therapies.
Palliative Care	✓	✓		A dedicated hospital Supportive & Palliative Care Team provides 7-day face-to-face multidisciplinary advisory service 0900-1700, with out of hours advice from a Consultant in Palliative Medicine available 365 days per year. In addition, there is an 8-bedded Supportive Care Unit on Ward 30, for patients whose care is most appropriately led by a Consultant in Palliative Medicine. We maintain strong links with hospice and community services, and participate in a Wirral-wide

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
				Governance Group and MDT to provide seamless care to patients crossing boundaries.
Renal Services	✓	✓	✓	Renal services are a specialised service with a hub and spoke model of services delivery. The Trust operates as the 'hub', with Countess of Chester Hospital and Clatterbridge as the 'spokes'. This includes general nephrology/pre dialysis service. Renal dialysis is provided at APH, CBH and Countess of Chester. Peritoneal Dialysis and Home Dialysis is provided. Outpatient services are offered on the APH, CBH and Countess of Chester sites.
Respiratory	✓		✓	The Team provide inpatient and outpatient services for a wide range of respiratory conditions and specialist services including Lung Cancer, Mesothelioma, COPD, Asthma, Respiratory infections including TB, Interstitial Lung Disease, Pleural disease and sleep disorders. Day case provision for diagnostic tests and treatments take place in the respiratory lab. Some clinics also take place at VCH and St Catherine's. A wide range of interventional procedures are offered including bronchoscopy, endobronchial US, LA thoracscopy and indwelling pleural catheter insertion
Rheumatology	✓	✓	✓	Outpatient clinics are provided from APH, CGH and VCH sites for patients with a range of rheumatoid conditions. There are dedicated day case treatment facilities on the APH site.
Medicine for the Elderly				
Acute Elderly Wards	✓			Patients are admitted to these wards are above the age of 74 with multi-organ failure. The specialty has Care of the Elderly Consultants with interests in 1) Movement Disorder, 2) Heart Failure, 3) Orthogeriatrics, 4) Gastroenterology 5) Frailty as well as general elderly services. Community Geriatricians work as part of the Medicine for the Elderly Consultant team ensuring cross boundary working between Community/Hospital services.
Acute Stroke Services	✓			Acute stroke services are provided on the APH site. The service is an approved hyper acute stroke unit with the added benefit of 24/7 stroke nurse coordinators. The service also has 7 day consultant stroke physician working. The dedicated

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
				stroke rehabilitation unit is based on the CBH site, with an established early supported discharge team.
Clatterbridge Rehabilitation Centre		✓		
Elderly Care Outpatient Services	✓	✓	✓	
Elderly Rehabilitation Services	✓	✓		Both inpatient and outpatient facilities are provided.
Movement Disorder Service	✓		✓	Provided at Victoria Central Hospital
Stroke Rehabilitation Services	✓	✓		
Corporate Services (clinical)				
Infection Prevention and Control Team	✓	✓	✓	The IPC team operates across both sites (based at Arrowe Park) providing advice and support to ensure we are able to protect our patients, visitors and staff from avoidable infection.
Tissue Viability Service	✓	✓		The Tissue Viability Service operates across both hospital sites (based on Arrowe Park) providing consultation and advice to inpatients, and offering advice where needed to those attending out-patients and lower limb clinics.
Safeguarding Team	✓	✓	✓	The Safeguarding Team operates both sites (based at Arrowe Park) provide advice and support in relation the protection of all vulnerable adults, Children and unborn. The agenda is inclusive of Domestic Abuse, Harmful Practices, Prevent (radicalisation), Mental Capacity Act and Learning disabilities. The Safeguarding Team also provide mandatory education and training to the staff and provide assurance that the organisation is able to discharge its statutory responsibilities across all elements of the safeguarding agenda.
Diagnostic and Clinical Support Division				
Allied Health Professionals				
Dietetic Service	✓	✓		Dietetics provides specialist nutritional advice and support to all areas of the acute and rehabilitation services for all specialties, age groups and directorates within

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
				the Trust. Outpatient services are provided for Gastro, Renal, Diabetic and Paediatric patients.
Occupational Therapy	✓	✓	Schools Millennium Centre	Occupational Therapy provides services to all areas of the acute and rehabilitation services for all specialties, age groups and directorates within the Trust. Children's OT service provided in partnership with Social Services and Education from Clatterbridge, across community settings (satellite clinics, domiciliary and education settings). Outpatient OT is provided for patients with hand conditions from Arrowe Park and Clatterbridge.
Integrated Discharge Team	✓	✓	✓	The Integrated Discharge Team (IDT) is an integrated multi-disciplinary team of social care professionals, nurses, and discharge trackers who triage patients and provide them with information on accessing services to support their discharge from hospital. This includes support in accessing rehabilitation at home or in a care home environment, care support as part of a re-ablement care package, domiciliary care, and more complex healthcare support following discharge from the acute setting.
Patient Flow Team	✓	✓		The Trust's Patient Flow Team is based on the ground floor of Arrowe Park Hospital and consists of a senior nursing team and a dedicated team of Patient Flow Clerks. The team acts as a single, central authority to manage overall flow through the Trust 24 hours a day, 7 days a week in order to support each patient in accessing the right care in the right setting at the right time, and to prevent delays in accessing care at the 'front door' of the hospital (the Emergency Department, the Acute Medicine department, and the Trust's other assessment units).
Physiotherapy	✓	✓	VCH SCH Some GP surgeries	Physiotherapy provides services to all areas of the acute and rehabilitation services for all specialties, age groups and directorates within the Trust. It also provides children's services in partnership with Social Services and Education. Outpatient physiotherapy is provided for MSK, Neuro, Children's from Arrowe Park, Clatterbridge, Victoria Central, special schools, mainstream schools and the

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
			Schools Home	following via sub-contractor: St Catherine's, Victoria Central and some GP surgeries.
Orthotics	✓	✓		Orthotics provides services to inpatients and outpatients requiring assessment for the provision of Orthoses.
Speech & Language Therapy	✓	✓	✓	SLT provides specialist advice and support to all acute and rehabilitation areas and outpatient services to ENT, Head & Neck, and Voice patients.
Pain Therapy Team		✓		Multi-disciplinary team providing specialist advice and management for patients with persistent pain.
Critical Care (ITU/HDU)	✓			The Critical Care Unit consists of a 6 High Dependency bedded unit (all side rooms), and a 12 bedded Intensive Care unit comprising of 3 side rooms, 6 beds in bays and a cordoned off area of 3 beds. Both areas take seriously ill patients for ventilation and multi-organ support from all hospital settings including assessment areas, base wards and theatre. The care on the unit is delivered by Consultant Intensivists, Critical Care Specialist Nurses, and supporting healthcare professionals including Pharmacists and Therapies. There is also a Critical Care Outreach team who provide critical care support, education and clinical skills to all APH ward areas, they are also part of the MET (Medical Emergency Team).
Laboratory Services	✓	✓	✓	Laboratory Services are a regional centre for HERCEPTIN testing and LBC processing. It acts as a referral laboratory for urology work, autoimmune serology testing, plasma viscosity testing and bile acids. Blood Science and Cellular Pathology services are located at APH. There is a Blood Science satellite laboratory at Clatterbridge. Medical Microbiology is a shared service with the Countess of Chester Hospital, located at 11 Bassendale Road, Bromborough.

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Clinical Biochemistry	✓	✓		24/7 service at APH. The laboratory is a UKAS accredited medical laboratory No 8835. A significant automated and non-automated laboratory with POD and tracking system to deliver rapid turn-around times.
Haematology and Blood Transfusion	✓	✓		24/7 service at APH, Transfusion laboratory at APH only. The laboratory is a UKAS accredited medical laboratory No 8835. Including Sickle cell and thalassaemia (SCT) screening programme and the antenatal and newborn (ANNB) screening.
Histopathology	✓			The Cellular pathology lab consisting of Histopathology and Cytopathology. The laboratory is a UKAS accredited medical laboratory No 8836. Accredited by the Human Tissue Authority (HTA), the laboratory is fully licensed and the licence number is 12027
Medical Microbiology			✓	24/7 service at CWMS: 11 Bassendale Road CH62 3QL. The laboratory is a UKAS accredited medical laboratory No 9595.
Point of Care Testing	✓	✓		Services are supported throughout the APH and UTC.
Mortuary Services	✓	✓		APH site with 136 fridge capacity. Capacity of 12 fridges for cold storage at CBH. The mortuary provides a coroners post-mortem examination service and viewing for relatives.
OPAT and IV service	✓			The Outpatient Parenteral Antimicrobial Therapy (OPAT) service is a specialist service which operates from Arrowe Park Hospital. It works in partnership with Wirral Community NHS Trust. The OPAT Team provide a service to allow early discharge of medically stable patients who remain in hospital only because of the need for continued intravenous antibiotics. In this way they support the early discharge of patients and prevent unnecesary admission, resulting in bed days saved to the organisation. The IV Access service provides specialist and general treatments within the vascular access (VA) speciality. These range from line insertion, care and maintenance, troubleshooting, unblocking and removal. They also provide educational and training opportunities for staff, based on service requirement.

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Pharmacy	✓	✓		The Pharmacy service is open seven days a week, with an emergency duty service covering the period when the main pharmacy is closed. The service is delivered across both the Arrowe Park and Clatterbridge sites with the Aseptic Unit located at Arrowe Park and the main Pharmacy Stores located at Clatterbridge. Outpatient and inpatient services are offered at both sites.
Phlebotomy	✓	✓	✓	Services are provided to inpatients and outpatients at both sites as well as in a range of community clinics and patients' own homes.
Radiology	✓	✓	✓	The Radiology Department delivers a service at APH, CBH, VCH; St Cath's and is also the prime provider for diagnostic imaging for Wirral Clinical Commissioning Group. Services are also provided on behalf of other healthcare providers such as Peninsula Health, Clatterbridge Centre for Oncology, and Spire, as well as for the Trust's own patients
Breast Screening and Symptomatic Mammography		✓	✓	CBH, St Catherine's Hospital, Church Road, Birkenhead, CH42 0LQ Countess of Chester Hospital, Liverpool Road, Chester, CH2 1UL – WUTH are the contract holder with SLA with COCH
CT Services	✓	✓		Scanning at CBH for Diagnostics Hub
Dexa			✓	St Catherine's Hospital, Church Road, Birkenhead, CH42 0LQ
Fluoroscopy Services	✓	✓		Services delivered at both APH and CBH sites
Interventional Services	✓			Vascular network – main IR delivered at APH
MRI Services	✓		✓	Some scans done at CCC for Diagnostics Hub
Plain film imaging service	✓	✓	✓	Outpatient services also provided at St Catherine's and Victoria Central Hospital
Ultrasound	✓	✓	✓	Inpatients and outpatients at APH and CBH; outpatients at VCH and St Catherine's
Wirral Limb Centre		✓		Wirral Limb Centre is a district centre providing services for Wirral and Cheshire residents. It provides a consultant led prosthetic service.

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Clatterbridge Diagnostics	✓	✓	✓	Funded by NHSE to provide additional diagnostic capacity to the patients of Wirral and surrounding areas. Providing Ultrasounds, MRI, Plain Film XR, Sprio, FeNO, Phlebotomy, Sleep Studies on the Clatterbridge Cancer Centre site. Providing CT on the Clatterbridge General site. Providing Full Lung Studies and ECHO on the Arrowe Park site. Providing ECG in the community.
Surgery Division				
General Surgery and Urology				
Colorectal Services	✓	✓		The service provides expert management for the whole spectrum of lower GI conditions except for Ileo-anal pouch and exenteration surgery for advanced pelvic malignancy. It provides a tertiary service for complex abdominal wall surgery and support for parenteral nutrition patients on a sub-regional basis. Elective Programme delivered on APH site which is predominately inpatient stay related and CBH which is day case related. Robotic surgery is delivered at APH (Cancer and benign) and CBH (Benign only).
Upper Gastro-Intestinal (UGI)	✓	✓		The service provides an elective programme on APH and CBH for the whole spectrum of benign UGI conditions.
Emergency General Surgery	✓			The 7 day service provides emergency care 12 hours a day and Same Day Emergency Care for GP referrals direct to the unit. 12 hours overnight cover is provided by colorectal and UGI for all adult and paediatric patients.
Urology	✓	✓		Urology provides all aspects of urological care to local Wirral population with both emergency, benign and malignant conditions. Emergency care is provided at APH and other services distributed between APH and CBH. This is a tertiary care cancer centre for 1.2 million population for the south Mersey regions (Wirral, Chester, Warrington) and Isle of Man. We offer robotic surgery on both sites. A significant portion of our diagnostic services and day surgery is offered at Clatterbridge and the Clatterbridge C&M Surgical Centre.
Head and Neck Surgery				
Audiology	✓	✓		The service is operated on an outpatient basis at CBH and APH.

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Ear, Nose and Throat	✓	✓	✓	ENT operates on both APH and CBH sites, on an outpatient and in-patient basis. ENT is also supported by the Audiology department. The service provides ENT and Thyroid surgery and treats both adult and paediatric patients and is a Diagnostic Centre for Head and Neck cancer, which is supported by CNS and SALT personnel. Thyroid cancers are also treated at APH and follow up out-patient clinics are provided for Head and Neck cancer patients after they complete their treatment.
Maxillofacial Surgery and Orthodontics	✓			The service provides outpatients and a range of Oral, Orthognathic, Dentoalveolar and facial skin cancer surgery. They also work with the Countess of Chester Hospital and Aintree Hospital through the provision sessions to support major trauma cases. Joint on call with Aintree
Ophthalmology	✓			The outpatient department supports all aspects of ophthalmology including patients suffering from Age related Macular Degeneration, Glaucoma, Diabetic Retinopathy, Corneal. It provides an acute service for patients on a walk-in basis and via a triage system for the community Optometrists and GPs. Ophthalmic surgery is provided for elective and emergency cases, and shares a 1 in 2 weekend emergency cover with Countess of Chester Hospital.
Trauma and Orthopaedics	✓	✓	✓	The service operates at APH and CBH for both inpatients and outpatients. Fracture clinic and soft tissue injury clinic provided from APH.
Vascular	✓	✓		Vascular service are provided out of the regional hub, Countess of Chester Hospital, with 24/7 cover for Wirral. Outpatients and Surgery is provided at both APH and CGH. The Lymphoedema service is at CBH.
Perioperative medicine	✓	✓	✓	Peri operative medicine supports 14 theatres at APH and 10 theatres plus minor ops room at CGH. Additional services based at APH, include Maternity MRI and Interventional Radiology, Endoscopy, Acute pain, SEAL and Sterile Services. The Surgical Elective Admissions Lounge (SEAL) admits all elective patients on the day of surgery. Perioperative medicine also includes Preoperative Assessment which is provided across both sites and Chronic Pain.

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Paediatric Surgery	✓			Elective surgery for patients 2 – 16 years – General surgery, ENT, Dental, Ophthalmology. Emergency Surgery for patients 2 – 16 years – General surgery, maxillofacial, urology, trauma and orthopaedics. Under 2 years on case by case basis.
Women's and Children's Division				
Breast Services		✓		This is an outpatient breast unit at CBH. The service provides a one stop diagnostic clinic service and is supported by Radiology, Pathology and Clatterbridge Centre for Oncology. The inpatient service is principally elective, for the Oncoplastic management of cancer and benign breast conditions based at Clatterbridge and in partnership with the regional plastic surgery centre at Whiston Hospital, part of the Mersey and South Lancashire Teaching Hospitals Trust. .
Gynaecology	✓	✓		Gynaecology services are provided at APH and CGH. We are a British Society of Gynaecological Endoscopy (BSGE) endometriosis centre, receiving complex cases for tertiary management.
Colposcopy	✓			The Colposcopy Service forms part of the National Screening Programme for Cervical Cancer. It is a dedicated outpatient-based diagnostic and treatment service.
Early Pregnancy Service	✓			This Unit is an "urgent" clinic for pregnancy related problems, occurring from the point of positive pregnancy test to 16 weeks 6 days gestation. Patients present with a variety of problems including PV Bleeding and abdominal pain, previous Ectopic Pregnancy and previous Molar Pregnancy for reassurance USS.
Fertility Service	✓			The following services are provided: full fertility investigations (female and male); lifestyle and pre-pregnancy advice; ovulation induction monitoring; and counselling support.
General Gynaecology Outpatient Clinics	✓			Consultant and Specialist Nurse led clinics are held at APH for patients experiencing gynaecological complaints.

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Gynaecology Assessment Unit	✓			The service enables assessment of patients referred to the hospital via General Practitioner, WIC, Midwives and A&E and internal tertiary referrals with symptoms of a gynaecological nature such as abdominal pain or menorrhagia, severe pain or bleeding in pregnancy, hyperemesis and post-operative concerns
Gynaecology Oncology	✓			This service provides clinical diagnosis and support for gynaecological cancer patients. Providing holistic needs assessment and ongoing support through diagnosis and treatment.
Outpatient Hysteroscopy	✓			This service undertakes investigations and treatment for abnormal uterine bleeding.
Paediatric Outpatient Clinic	✓			This clinic offers services to children and young people up to the age of 18 with gynaecological problems.
Pregnancy Counselling Clinics	✓			This service is no longer delivered.
Urogynaecology	✓	✓		This service provides specialist advice, treatment and care to women with urinary problems. The outpatient clinic offers specialist investigations and procedures such as urodynamics, bladder installations, training for self-catheterisation, bladder scans, pessary clinics and Botox injections to the bladder.

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Obstetric and Maternity Services	✓	✓	✓	Obstetric and Midwifery care is provided across both the acute and community footprint. Women are risk assessed during pregnancy and receive Consultant led care / Shared care if identified as high risk. Alternatively if the woman is identified as low risk she will receive care from the midwife. 50% of women currently receive care from a Continuity of Carer team and the remaining women receive care through a traditional model of care. It is anticipated that all women will receive care through a continuity of carer model within the next 2 years. Antenatal care is provided both in the Antenatal Outpatients Department and in the community setting within a variety of locations including GP surgeries, community hospitals, the woman's own home and children's centres. For those women requiring hospital admission in either the antenatal, intrapartum or postnatal period this is to the Maternity Unit on the Arrowe Park Hospital site. Women also receive postnatal care in the community including their own home.
Community Midwives			✓	These services are delivered at a range of locations in the community at Brassey Gardens, Birkenhead, Bromborough Children's Centre, Rockferry Children's Centre
Additional Specialist Services in pregnancy include Medical Disorders Clinic; High Risk Midwifery team (including midwives who scan); Perinatal Mental Health; Smoking Cessation; Substance use; Teenage pregnancy; Bereavement support service.	✓			These services are delivered on the Arrowe Park Hospital site and are supported by Specialist Midwives working within the specialty.

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Freestanding Midwifery Led Unit – Seacombe Children's Centre.			✓	The Freestanding Midwifery Led Unit (FMLU) is based in Seacombe Children's Centre. Staff working within this unit provide continuity of care to women throughout pregnancy, the birth and postnatal period. The FMLU provide facilities for one woman to give birth there at any one time and includes the provision of a birthing pool, labour aids and a birthing chair. Women are encouraged to go home from the FMLU once they have had their baby, and their care is followed up by a midwife from the birth team. If a situation arises where there is a need to transfer a woman/baby to an obstetric unit, this will be arranged direct with NWAS to the Wirral Women's and Children's Hospital.
Paediatrics	✓	✓	✓	
Paediatric Assessment Unit	✓			Children's assessment unit accepting referrals from primary care. Co-located with Children's Emergency Department.
Children's Ward	✓			This provides inpatient accommodation for 0-16 year olds. The ward also houses the children's day case area and a 2 bedded High Dependency Unit facility.
Children's Outpatients Department	✓		✓	Outpatient clinics in bespoke paediatric settings. Children's outpatient services see referrals from primary care and follow up of children subsequent to hospital admission. They run specialist clinics and joint links with specialist from tertiary centres.

Service	Location			Additional Information / comments (where applicable)
	Arrowe Park (APH)	Clatterbridge (CBH)	Other	
Community Paediatrics			✓	This service provides: • General community paediatric assessment and diagnosis of Neurodevelopmental conditions. • Medical assessments for children who may have been abused, initial health assessments of children taken into care, and the health component of statutory assessments of educational special needs, • Detailed assessment reports to other agencies, including family and criminal justice processes. • Through the system of designated and named doctor, advice on health concerns at multi-agency panels for safeguarding, adoption and fostering The Service is community focussed and is delivered within settings including schools. It is based at St Catherine's Health Centre and clinics are held at local clinics throughout Wirral.
Continuing Care Service		✓	✓	A team of staff who provide care for children and young people with complex health needs within their own home / community settings
Hospital at Home Service	✓		✓	An acute based nursing service which facilitates admission avoidance or shortened length of stay. Care takes place in patient's home.
Neonatal Unit	✓			The Neonatal Unit at Arrowe Park is designated level 3 and as such provides intensive care to babies born at 23 weeks or above.
Neonatal Outreach Team			✓	Specialist nurses who deliver discharge support to babies in the community following discharge from the Neonatal Unit (i.e. oxygen / feeding support).
Newborn Hearing Screening Service	✓			This service is offered for all new-born babies.
Paediatric Audiology		✓	✓	Clinics are provided at St Catherine's Health Centre and VCH

Research and Innovation Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Research and Innovation Strategy 2021-2026** **Research Policies and SoPs** **UK Policy Framework for Health and Social Care**

Review Date: September 2024
Issue Date: TBD
Version: 2.0
Authorisation Date: TBD

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to ensure effective governance in respect of Research and Innovation activity across the Trust.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

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

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives and Duties

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 The primary purpose of the Committee is to drive, promote and support both the research and innovation cultures across the Trust and to ensure strong governance in line with relevant frameworks, policies, procedures and guidelines.

3.2 The Committee is responsible for developing and fostering a close and meaningful relationship between research activity and clinical practice. To this end, the core purpose of the committee is to create an environment across all parts to the Trust to support excellent clinical delivery and promote a culture of service innovation and evidence-based practice.

3.3 The Committee will lead decision-making regarding overall responsibility for research including sponsorship, study prioritisation and resolution of barriers to delivery.

The Committee will undertake the following duties:

3.4 **To develop, review and update the strategic direction and business planning for research and innovation by:**

3.4.1 Leading, contributing, and supporting the delivery of the Trusts strategic objectives, priorities and ambitions;

3.4.2 Developing and delivering the research and innovation strategy, promoting, and establishing collaborative relationships with universities, NHS partners, research and innovation networks and other key stakeholders such as social care and service user and carer groups;

3.4.3 identifying and reviewing changes in legislation and policy or guidance that impacts on the local delivery and management of Research and/or Innovation;

3.4.4 ensuring that service users/carers are involved with research and innovation activities;

3.4.5 monitoring outcomes arising from research and innovation carried out within the Trust and support the integration of findings, outcomes, R&I intelligence into business planning for clinical and corporate divisions;

3.4.6 overseeing, reviewing, and steering research and innovation finance and funding including management of any Research and Innovation fund;

3.4.7 embedding research and innovation at every level of the organisation.

3.5 **To develop and promote NIHR portfolio research by:**

3.5.1 monitoring the Trust's performance against DHSC high level objectives and regional metrics the NIHR high level objectives, including recruitment to portfolio studies;

3.5.2 providing infrastructure to support grant applications primarily for (but not exclusively) NIHR grant applications;

3.5.3 ensuring the communication of key messages regarding the importance of research and innovation as a routine part of clinical practice;

3.5.4 ensuring that a research advice and support service is provided to all Trust staff as required and contributes to new and innovative ways to support research and research related activity.

3.6 **To oversee and direct the activities which support the development of a research into action culture, bringing research and clinical application closer. Activities include:**

3.6.1 ensuring information is widely available regarding all research undertaken within the Trust;

3.6.2 ensuring that headlines from research, evaluation, and research related activity are regularly publicised, to include early findings, progress, and final outcomes;

3.6.3 profiling good practice regarding service improvements based on research findings;
3.6.4 ensuring that the library service resource is fully utilised to enable research application in clinical practice.

3.7 **To oversee and coordinate the activities relating to the development and promotion of innovation within WUTH. These activities will include:**

3.7.1 distributing and maintaining a Trust innovations framework and associated guidance;
3.7.2 developing regular communications to WUTH staff members to ensure they are aware of how to submit ideas and how to apply for innovation funding;
3.7.3 linking with individual staff, teams and/or service areas to generate and prioritise innovative ideas which align to the Trust objectives or which are designed to solve problems which have been identified in our clinical settings;
3.7.4 establishing WUTH as a leading organisation for innovation through a variety of methods e.g. networking, relevant event attendance, hosting of conferences;
3.7.5 identification of potential collaborative partners through external networks.

3.8 **To assure high robust management and governance of research and innovation:**

3.8.1 develop, monitor, and regularly review the Trust's Research and Innovation policies and procedures;
3.8.2 ensure that other research-related policies, guidelines, and standard operating procedures are developed and ratified as and when necessary;

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- A Non Executive Director (Chair)
- 3 other Non Executive Directors
- Medical Director
- Chief Strategy Officer

Where members are unable to attend, they should send a designated nominated deputy.

6. Attendance

Attendance (in a non-voting capacity) will also be expected from the following members of the Trust:

- Deputy Medical Director
- Clinical Lead for Research
- Research and Innovation Manager

Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

Governors may attend to observe.

Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

7. Conflicts of Interest

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

8. Quorum and Frequency

A quorum shall be at least two Non-Executive Directors (including the Chair or Deputy Chair) and one Executive Director.

Meetings shall be held as required but not less than four times per year. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

The Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

10. Conduct of Committee Meetings

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

Authors of papers should use the standard template.

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

11. Performance Evaluation

As part of the Board's annual performance review process, the Committee shall review its collective performance each year.

12. Review

The terms of reference of the Committee shall be reviewed as required and at least annually.

Board of Directors in Public **Item No 12.1**
24 January 2024

Report Title	Committee Chair's Report - People Committee
Author	Lesley Davies, Chair of People Committee

Overview of Assurances Received

- The Committee received a verbal report which highlighted the current dispute with Unison relating to the retrospective re-grading of Clinical Support Workers and which is ongoing. To date, the Trust has engaged in four rounds of ACAS talks in order to resolve the dispute.

- The Committee received good assurance of the work being undertaken to further embed the Just and Learning Culture across the Trust and the continued focus by the executive and staff on ensuring staff feel confident to speak up should issues arise.

- Committee members noted that the number of Freedom to Speak Up cases concerning patient safety was below the national average. The Committee was given assurance that this concern had been picked up by the Workforce Steering Board which had commissioned a piece of work to review whether patient safety concerns were being raised via other routes, notably Ulysses. The Committee will receive a report on the outcomes of this work. In addition, the Freedom to Speak Up Lead has recruited medical FTSP Champions with a focus on the hard-to-reach groups in order to raise awareness.

- The Committee was provided with a deep dive into Medical/Acute Agency Spend, which proved to be an invaluable activity and significantly aided Committee members knowledge and understanding of the challenges within departments to embed culture change and deliver on the Trust's transformation agenda. Medical/Acute are progressing well on the delivery of the CIP challenges and have a clear focus on the need to reduce agency spend and the reliance on this system of delivering services. However, some stubborn challenges that impact on this work are the inability to recruit staff permanent staff to certain roles and the need to change some working practices. The Committee took good assurance from the work being undertaken by staff and thanked them for their openness and honesty throughout their presentation.

- The Committee reviewed performance data and noted the sickness absence which continues to be above the Trust's 5% target. It was noted that the Workforce Steering Committee has commissioned work for December to review the actions being taken above the usual mitigation plans to control sickness absence.

Risk:

- The ongoing industrial action continues to pose a risk to the Trust and, in particular, the ongoing pressure this places on staff across all departments.

Other comments from the Chair

- The Committee thanked the staff for its continued work and for providing good assurance on the key priority areas for the Trust.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 12.2**
24 January 2024

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

Items for Escalation and Action

- The Committee noted that financial performance to month 8 had deteriorated with a deficit of £16.4m achieved against a planned deficit of £15m, an adverse variance of £1.4m. Of this sum £0.6m related to CIP underachievement with the balance related to industrial action and continued under-utilisation of surgical capacity by the Countess of Chester. The committee was assured that the H2 forecast had been submitted to the ICB assuming no further industrial action and an increase in utilisation by the Countess of Chester and this had been clearly stated in the submission. The submission had also assumed risk around the full achievement of CIP and this had been shared with the committee previously. The committee were informed that surgical rotas had been received from the Countess of Chester for January to March 2024 so the position should improve subject to further industrial action. The committee were assured that the Estates and Facilities financial recovery plan was performing well particularly in the areas of Catering and Taxis.
- The Committee approved an amended capital plan for submission to the Board of Directors in January. The changes related to additional PDC funding received and noted the increase from £26.9m to £31.1m.
- The Committee noted the H2 financial and operational submission which had been approved by the Board of Directors earlier in December.
- The Committee received an update on the Cheshire and Merseyside Pathology Network LIMS business case. It was explained that the timetable for approval required a Board of Directors' decision by the end of February 2024 and that electronic approval or an additional committee meeting might be required in advance of that. The Committee agreed that it would be helpful to circulate the case when available along with a summary focussed on the 10 key evaluation questions outlined in the presentation.
- The Committee were pleased to see continued good performance on the 23/24 CIP. There was a shortfall of £0.6m on the target to date of £15m but still a significant achievement for the trust. Forecast achievement is £2.8m short of the target of £26.2m and balance sheet mitigations are being sought to meet the gap. The Committee were pleased to see the progress on development of the 24/25 CIP with circa £8m identified to date. The focus will be on zero based budgeting and the automation and elimination of administrative tasks with a pilot on process automation in Procurement and a focus on outpatient scheduling.
- The Committee noted that performance against Cancer targets was good, particularly in relation to peers in Cheshire and Merseyside. Colorectal and Gynaecology remain a risk as recovery plans are impacted by industrial action.
- The Committee noted the Integrated Performance Report.

New/Emerging Risks

- No new financial risks were identified though risks highlighted in previous financial reports are now beginning to materialise.
- The risk around elective performance and achievement of waiting times targets for Colorectal and Gynaecology are now significant due to continued industrial action.

Overview of Assurances Received

- The Committee received an update on the Limited Liability Partnership (LLP). It focussed on contract progress, the additional activity provided by the LLP and the governance operating between the LLP and the Trust. It was felt to be a positive and professional relationship, aided by Trusthealth, a third party adviser. The contract term ended on 30th November 2023 and the intention is to procure and award a new contract operational from April 2024. The Committee gave their approval for this and considered that this should also be subject to approval by the Board of Directors in the interests of transparency.

Other comments from the Chair

- The Committee considered the BAF scores and requested MC to review risk 7 in light of the risks that have materialised since the H2 submission. The Committee also requested an update on Estates and Digital Infrastructure and a paper on Private Patients. It was noted that the Trust's Chief Information Officer will be attending future meetings to present updates.
- The Committee continue to be assured by the quality of information received and the forward planning undertaken despite the continued operational pressures.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 12.3**
24 January 2024

Report Title	Committee Chair's Report - Research and Innovation Committee
Author	Sir David Henshaw, Chair of Research and Innovation Committee

Items for Escalation/Action

- The Trust remains committed to the Research and Innovation Strategy which was launched in May 2022 and set out the key priorities to Research and Innovation transformation by 2026.

- Due to a change in management, The Research and Innovation Operational Group has been put on hold for the immediate term while changes to the team structure and associated processes have been made. However, the Research and Innovation Manager currently meets with the Clinical Lead for Research and the Deputy Medical Director on a weekly basis, and they meet quarterly with the Medical Director.

- The team of Research Nurses, Clinical Research practitioners and Administrators meet for a weekly 'huddle' with the Research and Innovation Manager.

- The process for approving studies has been revised so that the Divisional Leads are involved only once the study has been through the approval process for R&D, at which point they are given two weeks to declare their opposition to a study being conducted in their department.

- The Trust has identified four priority disease areas to focus on: Cancer, Respiratory Disease, Stroke and Women's Health. These have been chosen in relation to disease prevalence and departmental strengths in the Trust.

- The portfolio of research studies has been rationalised to ensure its effective delivery. Fifteen studies are in the process of being closed due to lack of activity and a further three have been put on hold until research teams have more capacity. There are currently thirty-nine open and recruiting studies on the portfolio.

- There is only one commercial study on the portfolio which is a surgical study of a new type of wound dressing. In line with the recent report by Lord O-Shaunessy, it is important to increase the commercial activity at the Trust. To this effect, two studies are currently in set up (one MSK and one Stroke) and expressions of interest have been sent for two commercial studies in Renal disease.

- The current accumulated recruitment exceeds the monthly accumulated target, but this is largely due to the observational Loneliness study which was active between June and November. However, we are confident the POPPY study of post operative pain in patients having day surgery will boost the numbers to meet the annual target for this financial year.

- The R&I team are more settled after the move to the Wirral Research Hub based on the Clatterbridge campus and plans are in progress for the refurbishment of the site using funds from two successful bids from the NIHR and CRN:NWC which total to £110K.

- We look forward to developing the site to conduct non acute commercial and academic studies which will are relevant to the local population of the Wirral and will help address their local health and social care needs.

Wirral Research Collaborative

WUTH remains as one of the key partners of the Wirral Research Collaborative, but this is still very much in development as an initiative. The Clinical Lead and Research and Innovation Manager attend the monthly meetings when available but are being very conservative on what the Trust can offer at this stage. The current focus is to refurbish the Research Hub which will provide space and WRC partners and other external collaborators to conduct studies. Plans are also being explored for innovation projects to be developed at WUTH.

New/Emerging Risks

Recruitment to studies remains a key risk but having rationalised the portfolio and prioritised key disease areas, it is hopeful that the annual target will be attained.

Other comments from the Chair

The Committee continues to meet on a quarterly basis and provides scrutiny over KPI’s as well as delivery against strategic aims.

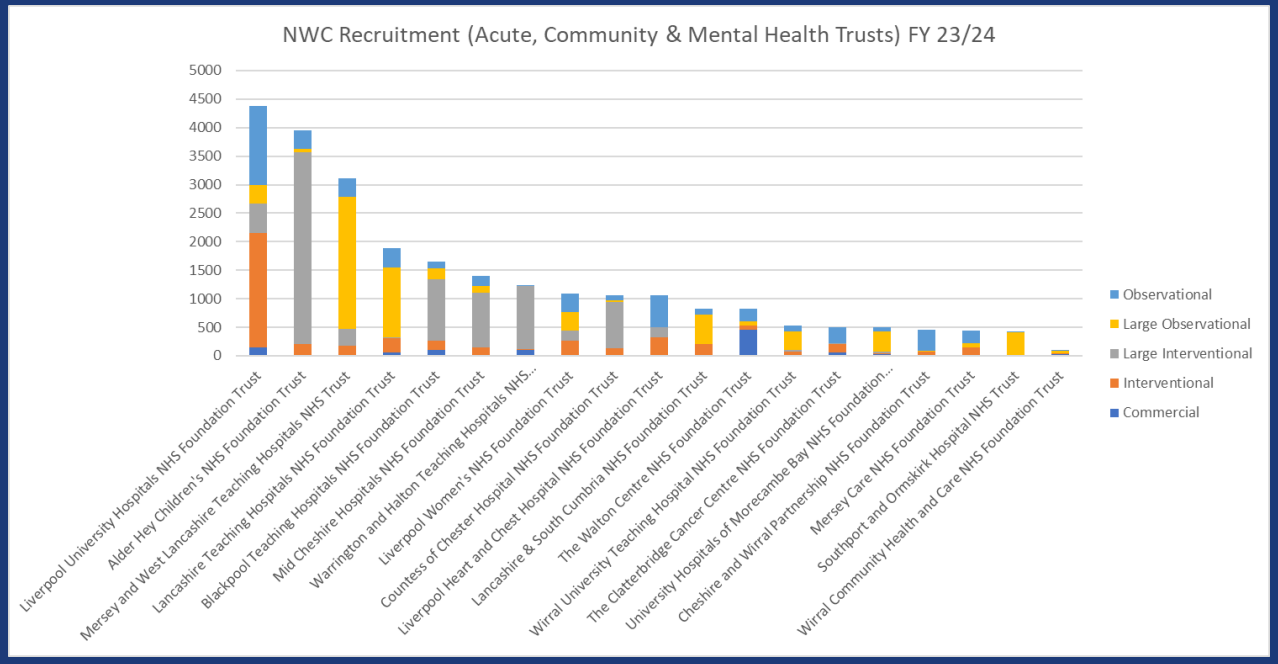
Appended to the report is a list of open research studies.

Managing Specialty	CPMS ID	Short Name	Values Sum of Network Recruitment	Sum of Network Target
Anaesthesia, Perioperative Medicine and Pain Management	**32256**	Perioperative Quality Improvement Programme: Patient Study	163	50
Anaesthesia, Perioperative Medicine and Pain Management Total			**163**	**50**
Cancer	**18067**	Add-Aspirin	30	30
	39201	MITHRIDATE Trial Version 2.0 10-June-2019	1	3
	40854	IP2 - ATLANTA	4	8
	41829	Molecular analysis of the Sloane Project	29	33
	46520	ATNEC	0	9
Cancer Total			**64**	**83**
Cardiovascular Disease	**18234**	Epidemiology, management, outcomes and pathophysiology of SCAD	0	1
Cardiovascular Disease Total			**0**	**1**
Children	**42960**	Fluids Exclusively Enteral from Day 1 (FEED1)	26	30
	44406	SurfON	0	0
	49271	Covid impact on RSV Emergency Presentations: BronchStart	0	1
	54734	Care at the end of life in babies and children (NICU and PICU) WS3b	0	5
	54912	The neoGASTRIC trial	18	72
	44914	(AZithromycin ThErapy for Chronic lung disease 2) (AZTEC2)	8	8
Children Total			**52**	**116**
Critical Care	**35421**	Biomarker-guided duration of antibiotic treatment for sepsis	12	48
	38197	REMAP-CAP	10	1
	30540	GenOMICC	173	500
Critical Care Total			**195**	**549**
Dermatology	**8090**	BADBIR	99	50
	46547	VenUS 6 Compression therapies for treatment of venous leg ulcers V1.0	17	40
Dermatology Total			**116**	**90**
Diabetes	**9689**	DRN 552 (Incident and high risk type 1 diabetes cohort – ADDRESS-2)	48	10
Diabetes Total			**48**	**10**
Genetics	**8630**	Molecular Genetics of Adverse Drug Reactions (MOLGEN)	2	10
Genetics Total			**2**	**10**
Haematology	**14145**	UK Childhood ITP Registry	13	10
Haematology Total			**13**	**10**
Health Services Research	**13550**	Narratives of health and illness for Healthtalkonline 2012	0	0
	57860	Evaluating the Saving Babies Lives Care Bundle Version 2	66	10
Health Services Research Total			**66**	**10**
Hepatology	**5630**	PBC Genetics Study	2	10
Hepatology Total			**2**	**10**
Infection	**14152**	Clinical Characterisation Protocol for Severe Emerging Infection	2754	2
	45388	RECOVERY trial	520	5
Infection Total			**3274**	**7**
Musculoskeletal Disorders	**2879**	GCA Consortium	32	9
	7302	Toxicity from biologic therapy (BSRBR)	103	10
	12689	UKIVAS	8	5
	36354	MONITOR PsA (Cohort)	0	6
	37702	SPEED	0	9
	40029	Investigating Molecular Mechanisms in Articular Cartilage	124	100
	44431	IMID BioResource	11	70
Musculoskeletal Disorders Total			**278**	**209**
Primary Care	**52230**	Measuring Loneliness Study	257	1
Primary Care Total			**257**	**1**
Renal Disorders	**6726**	RADAR	138	30
	11704	The UK Calciphylaxis Study	2	2
	31929	Cholecalciferol in Patients on Dialysis - SIMPLIFIED	49	20
	50088	PHOSPHATE	3	20
	53811	Kidney transplant patient decision making Version 1	3	1
Renal Disorders Total			**195**	**73**
Reproductive Health and Childbirth	**14362**	The Cleft Collective Cohort Studies	0	0
	39901	TTTS Registry	12	10
	40203	C-STICH2 Randomised controlled trial of emergency cerclage	0	0
	42795	LOCI: Letrozole Or Clomifene for Ovulation Induction	20	30
	45312	The Tommy's National Rainbow Clinic Study	23	1
	49947	Smoking, Nicotine and Pregnancy 3 (SNAP 3) Trial	19	30
	56469	Chapter Cohort Study	37	1
Reproductive Health and Childbirth Total			**111**	**72**
Respiratory Disorders	**53700**	LISP - Longitudinal Investigation of Secondary Pneumothorax	7	6
	53971	IMPROVE trial	0	36
	54032	ASPECT	11	21
Respiratory Disorders Total			**18**	**63**
Stroke	**40836**	OPTIMAS Trial	15	13
	50395	TICH-3	3	3
	50451	Huawei Stroke Study	19	18
	50728	Metoclopramide for Avoiding Pneumonia after Stroke (MAPS-2) Trial	1	28
	48029	ENRICH-AF: Edoxaban for IntraCranial Haemorrhage survivors with AF	4	1
Stroke Total			**42**	**63**
Surgery	**38354**	RAPID-I Version 1.0	0	10
	39722	Reduction Of Surgical Site Infection using several Novel Interventions	89	9

Surgery	**42832**	PMCF Study of LiquiBand FIX8® OHMF Device	5	20
	50862	LaCeS2	1	15
Surgery Total			**95**	**54**
Trauma and Emergency Care	**49465**	PARAMEDIC-3	0	0
Trauma and Emergency Care Total			**0**	**0**
Grand Total			**4991**	**1481**

NIHR | Clinical Research Network North West Coast

Total Recruitment 2023/24 – North West Coast – Excluding Primary Care/Non-NHS



Trust	Total Recr
Liverpool University Hospitals NHS Foundation Trust	4384
Alder Hey Children's NHS Foundation Trust	3947
Mersey and West Lancashire Teaching Hospitals NHS Trust	3108
Lancashire Teaching Hospitals NHS Foundation Trust	1893
Blackpool Teaching Hospitals NHS Foundation Trust	1654
Mid Cheshire Hospitals NHS Foundation Trust	1404
Warrington and Halton Teaching Hospitals NHS Foundation Trust	1230
Liverpool Women's NHS Foundation Trust	1094
Countess of Chester Hospital NHS Foundation Trust	1059
Liverpool Heart and Chest Hospital NHS Foundation Trust	1057
Lancashire & South Cumbria NHS Foundation Trust	827
The Walton Centre NHS Foundation Trust	821
Wirral University Teaching Hospital NHS Foundation Trust	530
The Clatterbridge Cancer Centre NHS Foundation Trust	503
University Hospitals of Morecambe Bay NHS Foundation Trust	501
Cheshire and Wirral Partnership NHS Foundation Trust	460
Mersey Care NHS Foundation Trust	438
Southport and Ormskirk Hospital NHS Trust	424
Wirral Community Health and Care NHS Foundation Trust	87