NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

6 March 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 - 24 Jan.pdf
- 4 Action Log - Public Board.pdf
- 7 Chief Executive Officer Report.pdf
- 8.1 WUTH IPR SPC Dashboard - Feb 2024 - 5 CFO.pdf
- 8.1.1 CFO Commentary M10.pdf
- 8.2 Chief Operating Officer Report.pdf
- 8.3 BoD_2324 Integrated Performance Report - March 2024.pdf
- 8.3.1 WUTH IPR SPC Dashboard - Feb 2024 - Intro v2.pdf
- 8.3.2 WUTH IPR SPC Dashboard - Feb 2024 - 1 COO update.pdf
- 8.3.3 WUTH IPR SPC Dashboard - Feb 2024 - 2 MD.pdf
- 8.3.4 WUTH IPR SPC Dashboard - Feb 2024 - 3 CN.pdf
- 8.3.5 CN Commentary - Jan 2024 data.pdf
- 8.3.6 WUTH IPR SPC Dashboard - Feb 2024 - 4 CPO.pdf
- 8.3.7 CPO Commentary - for March BoD - Final.pdf
- 8.4 Productivity and Efficiency Update.pdf
- 8.5 BAF February -March 2024.pdf
- 8.6 Quarterly Maternity and Neonatal Services Report.pdf
- 8.7 Learning from Deaths Report.pdf

- 8.8 Guardian of Safe Working Report.pdf
- 9 Green and Sustainability Plan.pdf
- 10 Accountable Officer Controlled Drugs Annual Report.pdf
- 11 Transfer of Care Discharge Hub.pdf
- 11.1 Non-criteria to reside Jan-Dec 23 Unscheduled Care Board Feb 24 HW.pdf
- 12.1 People Committee.pdf
- 12.2 Quality Committee.pdf
- 12.3 Estates and Capital Committee.pdf

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 6 March 2024
Time	09:00 – 11:00
Location	Hybrid

Page	Agenda Item			Lead	Presenter
	1.		Welcome and Apologies for Absence	Sir David Henshaw	
	2.		Declarations of Interest	Sir David Henshaw	
5-14	3.		Minutes of Previous Meeting	Sir David Henshaw	
15	4.		Action Log	Sir David Henshaw	
	Items for Decision and Discussion				
	5.		Patient Story	Dr Nikki Stevenson	
	6.		Chairs Business and Strategic Issues – **Verbal**	Sir David Henshaw	
16-18	7.		Chief Executive Officer Report	Janelle Holmes	
	8.		Board Assurance Reports		
19-25		8.1)	Chief Finance Officer Report	Mark Chidgey	
26-33		8.2)	Chief Operating Officer Report	Hayley Kendall	
34-49		8.3)	Integrated Performance Report	Executive Directors	
50-59		8.4)	Productivity and Efficiency Update	Hayley Kendall	
60-82		8.5)	Board Assurance Framework	David McGovern	
83-89		8.6)	Quarterly Maternity Report	Dr Nikki Stevenson	Jo Lavery
90-98		8.7)	Learning from Deaths Report Q2 2023/24	Dr Nikki Stevenson	Dr Ranj Mehra
99-102		8.8)	Guardian of Safe Working Report Q3 2023/24	Dr Nikki Stevenson	Dr Alice Arch
103-112	9.		Green and Sustainability Plan	Matthew Swanborough	Paul Mason/ Clare Jefferson
113-122	10.		Accountable Officer Controlled Drugs Annual Report	Dr Nikki Stevenson	
123-145	11.		Transfer of Care Discharge Hub	Hayley Kendall	
	Committee Chairs Reports				
146-147	12.	12.1)	People Committee	Rajan Madhok	
148-150		12.2)	Quality Committee	Dr Steve Ryan	

151-152	12.3)	Estates and Capital Committee	Sir David Henshaw
	12.4)	Council of Governors – **Verbal**	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 3 April 2024, 09:00 – 11:00

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 24 January 2024
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
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
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.6
MSa	Mustafa Sadiq	Consultant – item 8.6
SLa	Sharon Landrum	Workforce Engagement and Inclusion Lead – item 9
RC	Richard Crockford	Deputy Director of Quality Governance – item 10
SS	Sally Sykes	Director of Communications and Engagement
SH	Sheila Hillhouse	Lead Public Governor
AT	Ann Taylor	Staff Governor
PB	Phillipa Boston	Staff Governor
DG	Debby Gould	LMNS Quality and Safety Lead – item 8.6

Apologies:

RM	Professor Rajan Madhok	Non-Executive Director
LD	Lesley Davies	Non-Executive Director

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

2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 6 December were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** The Board received a video story consisting of a compilation of staff who work across Estates, Facilities and Capital focussed on 'Hello, my name is ….' The video story also described some of the staff's main tasks, why people should work at the Trust and an interest fact out their role. DS commented the video story demonstrated a sense of team work and a variety of roles that was not commonly known about outside of the NHS. DS added the video would also be used for recruitment opportunities across social media. The Board **NOTED** the story.	
6	**Chairs Business and Strategic Issues** DH provided an update on recent matters and highlighted the local MP for Wallasey, Dame Angela Eagle and Wirral Council CEO, Paul Stuart visited the Cheshire and Merseyside Surgical Centre at Clatterbridge on 12 January. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH gave an industrial action update and explained three days of junior doctor strike action took place in December 2023, followed by a further 6 days in early January 2023. The UNISON industrial action dispute relating to retrospective re-banding for Clinical Support Workers (CSWs) continues. Talks have stalled because parties are unable to agree on what constitutes the difference between a band 2 CSW and a band 3 CSW. JH reported the Trust's Occupational Health Service had continued to maintain the standards to meet the Safe Effective Quality Occupational Health Service (SEQOHS) annual re-accreditation requirements.	

	JH stated there were no Patient Safety Incident Investigations (PSIIs) opened in the months of November and December 2023 under the Patient Safety Incident Response Framework (PSIRF). JH added there was one Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) reported to the Health and Safety Executive in the months of November and December 2023. JH highlighted that the Board of Directors in 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. 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 1 December and the Place Based Partnership Board (PBPB) on 21 December. SR queried the impact of the CSW industrial action on clinical areas. JH stated the impact so far had been creating operational pressures only, particularly combined with winter pressures and staff taking annual leave post-Christmas and New Year before the end of the financial year. The Board **NOTED** the report.	
8	**Board Assurance Reports** **8.1) Chief Finance Officer Report** MC highlighted the Trust was forecasting a significant risk of £4.50m to achievement of the 2023/24 financial plan. The key internal risks related to 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. MC provided an update on the month 9 statutory targets and the RAG rating for each, highlighting that financial stability and financial sustainability were red, while agency spend, capital, cash and financial efficiency were green. MC added at a future meeting he would present a revised financial forecast following coordination with the ICB and other providers. DH queried whether the Trust would have achieved its annual deficit plan if there had been no continued strike action or under-utilisation of elective capacity by NHS partners.	

	MC stated this was correct. DH also queried if other providers could use the Cheshire and Merseyside Surgical Centre instead. HK stated the Trust was using the available space and accepting mutual aid patients from other providers. SL queried if the NHS partner had delivered their sessions as planned for January. HK stated the agreed rota had been delivered and projected to until March. MC stated an agreement for 2024/25 was being sought with the ICB to ensure the Trust was not financially impacted due to lost activity by other NHS partners. SI queried the reforecast process. MS stated the reforecast position was done internally in line with a national guidance that all Trusts within Cheshire and Merseyside needed to follow in respect of the regional financial position. The Board **NOTED** the report. **8.2) Chief Operating Officer Report** HK highlighted in November the Trust attained an overall performance of 105% against plan for outpatients and an overall performance of 98% for elective admissions. HK explained underperformance continued to be related to the impact of large-scale cancellations for industrial action, and underutilisation of Cheshire and Merseyside Surgical Centre by other regional Trusts. HK reported type 1 unscheduled care performance was 45.55% which was below the 4hr improvement trajectory. HK explained there was an improvement plan in place for each of the urgent and emergency care quality standards. HK stated compliance with the national standard for 15-minute ambulance handovers had deteriorated towards the end of the November. Compliance with ambulance handover continues to be reviewed daily to ensure that delays to crew handover are kept to a minimum. HK highlighted there continued to be challenges for patients with mental health needs notable for children and young people. SL queried the instance involving a patient being cared for on the Children's ward for over a month awaiting a community placement.	

	HK stated this specific case related to a young person who had presented with mental health concerns, and this was now being dealt with through legal routes. HK added that the Trust has made it clear that the additional behavioural support on the ward will not be covered by the Trust. The Board **NOTED** the report. **8.3) Integrated Performance Report** NS highlighted the number of C Diff cases had exceeded the yearly threshold and the Trust was seeking clarity regarding the 2024/25 threshold. NS added Friends and Family Test for ED had reduced, noting this was likely due to increased Emergency Department attendances and car parking complaints. DS highlighted appraisal, mandatory training and staff turnover in month met Trust target, however sickness absence remained above target although stable. DS added Workforce Steering Board in December discussed the controls already in place to manage sickness absence and considered a number of additional controls to reduce this further. DS explained the revised Attendance Management Policy had been approved and a comprehensive training programme would be rolled out to support managers to understand the new policy. JH stated the Executive Team met with the ICB on Tuesday regarding the NHS Oversight Framework and proposed an update be provided to a future meeting regarding the assurance process. The Board: • **NOTED** the report; and • **APPROVED** 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. **8.4) Board Assurance Framework (BAF)** DM summarised the BAF covering current high level and strategic risks within the Trust for January, explaining following the last report changes have been incorporated where scorings have changed, or actions been completed/added. SI queried the refresh of risk maturity and if there was an evidence base for ensuring existing risks remained appropriate. DM stated BAF would be subject to full annual refresh to ensure the strategic risks remained appropriate. DM added this refresh will take place in March for approval in April along with the Risk Management Strategy that includes risk maturity.	Janelle Holmes

	The Board **NOTED** the current version of the BAF. **8.5) Freedom to Speak Up (FTSU) Reflection and Planning Tool** DS gave an overview of the tool, explaining it has been designed to help identify strengths and areas of work that require further work. DS stated two notable actions related to improving the identification of individuals reporting detriment and evaluating FTSU training/awareness sessions. SI queried whistleblowing and prescribed disclosures and if there had been any to ensure appropriate triangulation with FTSU concern. DS stated there had been no formal prescribed disclosures. DS added there were a number of mechanisms in place for staff to raise a concern. DH suggested it would be beneficial to produce a visual diagram of the mechanisms available for staff to raise a concern. The Board **NOTED** the report. **8.6) Monthly Maternity and Neonatal Services Report (including Maternity Incentive Scheme Year 5 Annual Declaration)** JL and MSa gave an overview of the ten Clinical Negligence Scheme for Trusts (CNST) Safety Actions as part of the Maternity Incentive Scheme Year 5. The presentation outlined how the ten safety actions, which have all been assessed as compliant, had been met and provided details of the evidence. JL also informed members of the rigour of the review process, explaining assurance had been provided from Quality Committee, as well as the LMNS who had observed both Quality Committee and were observing this section of the meeting. SR commented as NED Maternity Safety Champion he had been assured regarding the evidence and that there was good leadership as well as positive culture within Maternity Services. HK queried the neonatal medical workforce action, specifically the requirement for a Neonatologist. JL stated a statement of case had been submitted and was progressing through the appropriate approval routes. DH queried what was next for Maternity Services, specifically how to design a future maternity pathway to address health	Debs Smith Jo Lavery

	inequalities that could be used as an exemplar. DH proposed this be considered and an updated provided. JL commented full implementation of the Continuity of Career model would provide better outcomes for babies and mothers. NS stated the local area neonatal service provision remained unclear, specifically for providing level 3 services following the independent Liverpool acute service review. NS added there were also capital and estate limitations for the existing neonatal unit. DG commented she had enjoyed working with JL, MSa and the team and stated the submission was well deserved and an accurate reflection. Members thanked JL and MSa for the presentation and their involvement in collating evidence as well as everyone in Maternity Services for their continued hard work. The Board: • **NOTED** the report; and • **APPROVED** the compliance document for the submission of the declaration form to NHSR, following a positive recommendation from Quality Committee on 18 January	
9	**Equality Diversity and Inclusion (EDI) Bi-Annual Report (including Gender Pay Gap Report)** SLa gave an overview of the report, explaining all regulatory reporting requirements were up to date with forthcoming parts on track for completion. SLa also gave an update on the EDI activities undertaken so far within 2023/24 as part of the principles and objectives of the Trust's People Strategy and EDI Strategic Commitment. SLa referenced the Gender Pay Gap Report, which was also included, and this would be submitted by no later than 30 March in line with national reporting guidance. DS commented People Committee met on 22 January to review the EDI Bi-Annual Report and Committee members had fed back about the importance of measuring impact. DS confirmed that this is covered in the second bi-annual report but would be covered in both going forwards. The Board **NOTED** the report.	
10	**Complaints Annual Report** RC gave an overview of the report, explaining 95% of complaints were acknowledged within the national target of 3 working days.	

	However, only 25% of complaints received a response within 40 working days. RC highlighted to support Divisions KPIs would be reviewed including moving to a web-based system that will facilitate the use of real-time dashboards. RC added the key themes related to communication as well as treatment/procedures and learning took place through either Divisional shared learning and individual feedback and reflection. NS commented the Trust compared well to other Acute Trusts, explaining complaints per 1000 staff averaged 10 per quarter whereas the national average was 20. SL noted medication featured in 18% of complaints and queried this. NS stated this related to prescribing delays around pain relief due to overcrowding in the Emergency Department and when corridor care was provided. NS added there was now an identified doctor on each shift to ensure pain relief was prescribed and administered in a timely manner. DH queried the current backlog of complaints and the trajectory for ensuring this was reduced. RC stated there had been circa 100 residual complaints open following the pandemic and these had been resolved. Typically the Trust has 40 complaints at any one time and presently there were 48. RC added the Governance Support Unit continued to work proactively with Divisions to ensure the number of open complaints did not increase due to operational pressures. DS queried the reporting on complaints, specifically if any equality monitoring data was captured, and if so, had there been any evidence of different outcomes for specific inclusion groups. RC stated this was data was not captured currently. DH requested this be reviewed to consider capturing equality monitoring data as part of the complaints process. The Board **NOTED** the report.	Dr Nikki Stevenson
11	**Governance Update** CH provided the annual review of the Research and Innovation Committee's Terms of Reference, and the refreshed Statement of Purpose for approval.	

	CH indicated there was a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at Board level. Lesley Davies currently holds this role, and it was proposed that Sir David Henshaw, as Chair of Estates and Capital Committee, was appointed to this Champion role to provide alignment with portfolios. CH provided an update on the walkabout schedule and explained from April prior to each Public Board meeting, each NED would be paired with an Exec for a walkabout to a different area of the hospital. The Board: • **APPROVED** the Statement of Purpose; and • **APPROVED** the Research and Innovation Committee's Terms of Reference; and • **APPROVED** Sir David Henshaw as NED Champion for Security Management; and • **NOTED** further arrangements for NED visibility and engagement.	
12	**Committee Chairs Reports** **12.1) People Committee** The Board **NOTED** the report. **12.2) Finance Business Performance Committee** The Board **NOTED** the report. **12.3) Research and Innovation Committee** The Board **NOTED** the report.	
13	**Questions from Governors and Public** SH commented about further developing relationships between Governors and NEDs. DH proposed Governors join NEDs on hospital walkabouts from April when the new programme begins and a networking event. No questions were raised.	
14	**Meeting Review** Members commented the meeting went well and covered a variety of topics. No comments were made.	

15	**Any other Business** No other business was raised.	

(The meeting closed at 10:45)

Action Log
Board of Directors in Public
6 March 2024

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	24 January 2024	8.3	To provide an update regarding the NHS Oversight Framework assurance process	Janelle Holmes	Complete. Scheduled for March meeting.	March 2024
2.	24 January 2024	8.5	To produce a visual diagram of the mechanisms available for staff to raise a concern	Debs Smith	Complete. The Associate Director of Organisational Development has produced a diagram that will be publicised to staff.	March 2024
3.	24 January 2024	8.6	To consider a future maternity pathway to address health inequalities that could be used as an exemplar	Jo Lavery	Complete. Included within the Maternity Report.	March 2024
4.	24 January 2024	10	To consider capturing equality monitoring data as part of the complaints process	Dr Nikki Stevenson	Complete. The complaint process will see the launch of the Customer Services Web Module in March 2024, and this will allow improved data capture of protected characteristics from 2024/25. The annual complaints report for 2023/24 will aim to extract as much data around protected characteristics as is available from trust sources such as Ulysses (complaint record) and Cerner (EPR) and this will be presented within the report but may have some limitations where information has not been captured historically. This will see an improvement in the next annual report and full reporting against protected characteristics within the 2024/25 annual report.	March 2024

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
6 March 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 February. 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. Junior Doctor strike action has taken place in from 24 to 28 February 2024.

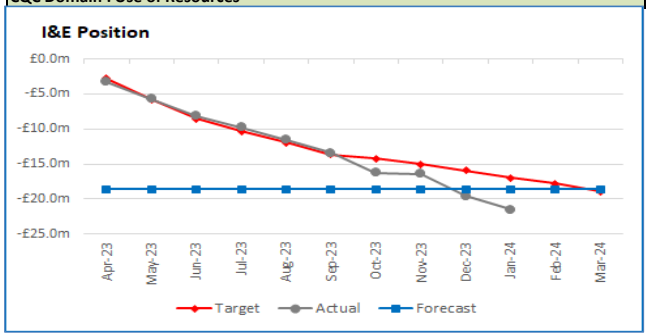
	In a separate matter, the UNISON industrial dispute relating to retrospective re-banding for Clinical Support Workers continues. Following a ballot, UNSION have received a further mandate for strike action. As per previous reports, the Trust has made a third offer to UNISON. The offer includes agreement on UNISON's key demand, a backstop date of April 2018 for any retrospective regrading. In order to implement this, the Trust must work within a framework that is in line with the national NHS Agenda for Change job evaluation scheme. This will allow those who have worked above their current band to receive the pay they deserve. UNISON have not accepted this position and have asked to the Trust to step outside of the national framework. We remain committed to ending this dispute and hope to meet with UNISON in the coming weeks to find a resolution. 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	**Patient Safety Incident Investigations (PSIIs) and Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS)** There was one Patient Safety Incident Investigation (PSII) opened in January 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. Duty of Candour has been commenced in line with legislation and national guidance. There was one RIDDOR reportable event reported in the month January. 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.
1.3	**Leadership Competency Framework** On 28 February, NHS England (NHSE) launched its board level leadership competency framework (LCF). This was accompanied by a revised chair appraisal framework. Part of a planned suite of management and leadership development training, tools and resources for NHS organisations, the LCF will form the cornerstone of NHSE's future support and development offer to board members and aspirant directors. The leadership competency framework for board members: • sets out **aspirational competencies** to support leadership and management development, recognising that not all leaders will meet all competencies at all times. • applies to **all board members of NHS provider organisations, integrated care boards (ICBs) and NHSE's board**. • **applies equally to non-executive directors (NEDs) and executive directors**, and **applies to them in their role as members of unitary boards**. • **recognises the 'extremely demanding' nature of board members' roles** and aims to support and help leaders and organisations in this context.

	The LCF competencies are expected to be used in 2023/24 board member appraisals. A board appraisal framework for other board members will be published in the autumn. The LCF can be found here: NHS England » NHS leadership competency framework for board members.
1.4	**Together Awards** Our Together Awards 2024 for WUTH staff will take place on 22 March. This will be an evening to celebrate the outstanding work of our staff and teams throughout the past year. Nominations were open for the following categories and winners were shortlisted in each category. Team Excellence Award – Patient Care Team Excellence Award – Support Services Research and Innovation Award Improvement Award Volunteer of the Year Employee of the Year – Patient Care Employee of the Year – Support Services Learner of the Year Equality, Diversity and Inclusion Award *new for 2023/24 Waste Activity Value Efficiency Award *new for 2023/24 Patient Choice Award I wish to thank everyone who nominated colleagues for this year's awards and a huge congratulations to those who were nominated.
1.5	**Fuller Inquiry Phase 2** The Fuller Inquiry was established in November 2021 to investigate how an individual was able to carry out inappropriate and unlawful actions in the mortuaries of Maidstone and Tunbridge Wells NHS Trust, and why they went unnoticed. The first phase concluded in November 2023, with the publication of the Phase 1 report. Phase 2 has now been launched to look at the broader national picture and to consider related procedures and practices in other hospital and non-hospital settings which ensure the dignity and safeguard the security of the deceased. WUTH will comply with any and all requests made by the inquiry.
1.6	**System and Place Updates** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** The Leadership Board met on 2 February and explored a number of important issues, as follows: • The Leadership Board received an update from the ICB about the current, in year, financial priorities where it was indicated that contact would be made with a number of Trusts in the week ahead to ensure that support was in place to maximise delivery of this year's financial plan. The system's aim is to retain control of its own financial position and mitigations to financial risk, a view which

	was endorsed by the Leadership Board. Further discussions included current finance assumptions for 2024/5 with a priority being to secure a shared view on the delivery of recurrent CIP so as to address the system's underlying deficit. The Board endorsed a system focus on the top 3 to 5 factors that had greatest potential to reduce cost, supporting transformation, while improving system flow. • The Leadership Board considered the current position with the system LIMS procurement and was informed that a revised investment profile would support a mixed revenue and capital investment. This meant that lead Trust Executives had been asked to brief their Board in February, moving toward Board decision in March. Such an expanded time horizon would align with the programme moving into an implementation phase. • The Board was provided with an update in the work of the CYP Alliance. This work provided an important focal point for the CYP agenda, supported existing CMAST work programmes such as in elective and diagnostics by providing a particular CYP focus and catalyses action with and through partners through its dual anchoring in the work of both C&M provider collaboratives. The Board reflected upon the impact of delayed access to CYP services including in dental, the need to prioritise the well-being of children and young people and the potential for this to act as prevention when it came to future demand for adult medicine. Wider health inequalities were also discussed which could now be seen presenting as problems in many of the region's young mothers. The Leadership Board was assured by the focus on this agenda at the recently established ICB CYP Committee. • Finally, a discussion took place on the impact of pressures in hospital ED departments, the impact on paramedic crews and vehicle's availability and response times and the need for action with relation to non-criteria to reside. A small group of CEOs agreed to discuss the best way to make progress on these interlinked issues within C&M. • The Board's next meeting expects to welcome Trust Chairs as well as CEOs looking ahead to priorities and goals for 2024/5. **Place Based Partnership Board (PBPB) Update** The Place Based Partnership Board (PBPB) met on the 22 February 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 outcome of phase one review of intermediate care services and approving the Wirral Place Governance Manual.

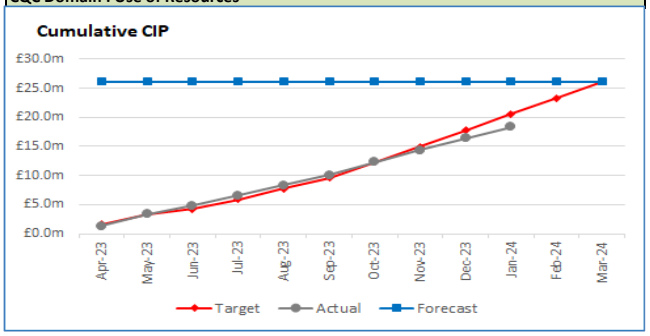
Chief Finance Officer

CQC Domain : Use of Resources



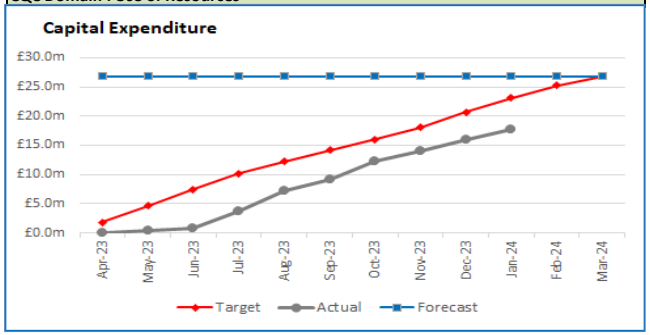
Jan-24
-£21.5m
Variance
Position worse than plan
Target
-£17m

CQC Domain : Use of Resources



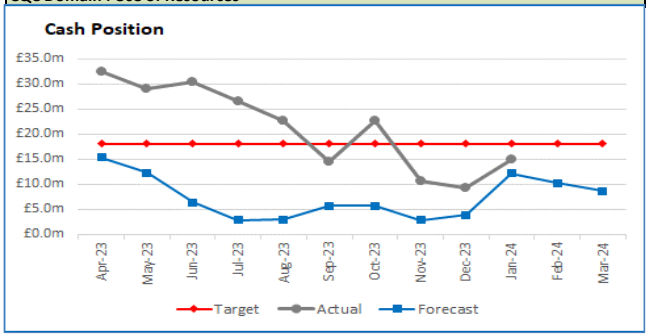
Jan-24
£18.31m
Variance
Position worse than plan
Target
£20.56m

CQC Domain : Use of Resources



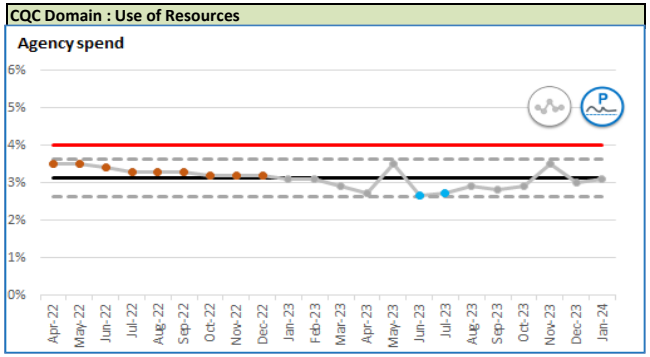
Jan-24
£17.76m
Variance
Position not worse than plan
Target
£23.1m

CQC Domain : Use of Resources



Jan-24
£14.99m
Variance
Position worse than plan
Target
£18.0m

CQC Domain : Use of Resources



Jan-24
3.1%
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 (M10)	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.

The Board is asked to:

- Note the assurance that mitigations are in place to achieve all statutory financial targets other than Financial Stability. This is a national issue with discussions ongoing at ICS and national level as to mitigations and consequence.
- Note that through pre-existing contracts the Trust has adopted the new national energy framework.

I&E Position

Narrative:

At the end of January 2024, M10, the Trust has reported a deficit of £21.5m against a plan of £17.0m, the resultant variance of £4.5m is a deterioration on the M9 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 M10:

Month 10	In Month			Year to Date		
Cost Type	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£37.6m	£36.2m	-£1.3m	£370.0m	£360.4m	-£9.6m
Other Operating Income	£3.7m	£5.0m	£1.3m	£33.3m	£34.2m	£0.9m
Total Income	**£41.3m**	**£41.3m**	**-£0.0m**	**£403.3m**	**£394.6m**	**-£8.8m**
Employee Expenses	-£29.9m	-£30.7m	-£0.8m	-£295.7m	-£296.9m	-£1.2m
Operating Expenses	-£14.7m	-£14.3m	£0.4m	-£139.7m	-£138.1m	£1.6m
Non Operating Expenses	-£0.5m	-£0.2m	£0.4m	-£5.3m	-£3.4m	£1.9m
CIP	£2.8m	£2.0m	-£0.8m	£20.5m	£18.5m	-£2.0m
B/S Release	£0.0m	£0.0m	£0.0m	£0.0m	£3.9m	£3.9m
Total Expenditure	**-£42.3m**	**-£43.2m**	**-£0.9m**	**-£420.2m**	**-£416.0m**	**£4.2m**
Total	**-£1.0m**	**-£1.9m**	**-£0.9m**	**-£16.9m**	**-£21.5m**	**-£4.5m**

Key variances within the position are:

Clinical Income – £9.6m 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 £1.6m 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 £2.0m behind plan at M10 and outturn is forecast to be £3.0m below plan. The forecast full year effect of CIP is in line with plan but this is dependent on full delivery of remaining schemes in M11 and M12.

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 in line with M9 but agency spend has continued to increase in value.

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 failure to implement mitigations.

- 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 £2.0m CIP in M10 which is an adverse variance to plan of £0.9m. The YTD position is £18.5m against a target of £20.5m and the forecast for in year effect of CIP is £23.2m, £3.0m below target. The full year effect of the schemes remain in line with target but this is dependent on a number of schemes being implemented in M11 and M12.

Risks to position:
- That the momentum on 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.
- Non recurrent measures to mitigate the recurrent shortfall.

Capital Expenditure

Narrative:
There have been no further changes to the capital plan since the Board approved variations resulting from new funding in M9:

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 M10 the capital programme is £5.3m behind plan and is forecast to be on plan by year end:

Scheme	Plan spend @ M10	YTD spend	Variance
Backlog maintenance	1,064	403	-661
Medical equipment and corporate schemes	1,729	973	-756
Heating and chilled water pipework	2,380	2,510	130
IT equipment	550	208	-342
UECUP - Trust funding	3,216	-	-3216
UECUP - PDC	10,000	9,790	-210
CDC	4,108	3,703	-405
Diagnostics Digital	49	-	-49
CDC - equipment	-	98	98
PDC - Ultrasound equipment	-	72	72
NHSE/I TOTAL CAPITAL PLAN 23/24	**23,096**	**17,757**	**- 5,339**

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 January the cash balance was £15.0m. 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.

Energy Contract

Narrative:

NHSE has worked alongside Crown Commercial Service (CCS), to develop a new national approach to buying energy. They believe that this will result in greater value for money, price stability and efficiencies in procurement. The aim is to eventually align all NHS Trusts' energy contracts to this one bespoke NHS Basket. NHSE expects all Trusts to commit to this Framework whilst not yet mandating it. Within the Cheshire & Merseyside ICS, WUTH is one of 7 Trusts currently procuring energy from CCS Framework Agreement and there will be an expectation that all remaining Trusts sign up to the NHS Basket.

The Trust Board has already approved contracts with CCS for the provision of both Gas and Electricity. It is anticipated that the new NHSE basket through CCS for Cheshire & Merseyside ICS should realise significant savings from 1st April 2025.

Existing customers are the first tranche of Trust who are able to access the new CCS NHS basket. It is confirmed to that the CFO has authorised the relevant variations within existing contracts to enable the Trust to access the national scheme.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 8.2**
6 March 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

Report Purpose and Recommendations

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

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

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 ED Improvement Plan and the 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 continue, 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. The Trust has a strong elective recovery position within the region. 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 to ensure delivery of timely ambulance handover.

2	Planned Care
2.1	**Elective Activity** In January 2024, the Trust attained an overall performance of 101% 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 Jan	Actual for Jan	Performance
Outpatient New	12,909	12,748	99%
Outpatient Follow Up	31,765	32,248	102%
Total outpatients	**44,674**	**44,996**	101%
Day case	4,654	4,756	102%
Inpatients	808	615	76%
Total	**5,462**	**5,371**	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 January against these indicators was as follows: • 104+ Week Wait Performance – 0 • 78+ Week Wait Performance – 7 (pre-submission) • 65+ Week Wait Performance - 398 • 52+ Week Wait Performance - 1855 • Waiting List Size - there were 40,930 patients on an active RTT pathway which is higher that the Trust's trajectory of 37,322 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 3 to date:

Quarter	3
Period	01/10/2023 - 31/12/2023

Target	Indicator	Threshold	October-23		November-23		December-23		Quarter 3	
			Actual	Predicted	Actual	Predicted	Actual	Predicted	Actual	Predicted
28 Day Wait	GP or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	75.00%	69.96%	N/A	69.88%	N/A	73.36%	N/A	70.93%	N/A
31 Day Wait	Decision to Treat/Earliest Clinically Appropriate Date to Treatment	96.00%	94.14%	N/A	86.73%	N/A	91.63%	N/A	90.58%	N/A
62 Day Wait	GP Urgent Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	70.19%	N/A	70.27%	N/A	74.72%	N/A	71.79%	N/A

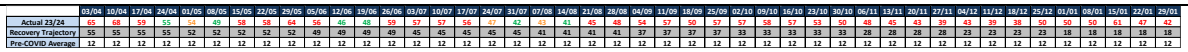
Sub Targets (Not National Standards):

Target	Indicator	Threshold	October-23		November-23		December-23		Quarter 3	
			Actual	Predicted	Actual	Predicted	Actual	Predicted	Actual	Predicted
28 Day Wait	Breast Expected to be >=90%	90.00%	95.97%	N/A	95.05%	N/A	94.68%	N/A	95.25%	N/A
28 Day Wait	Skin Expected to be >=90%	90.00%	85.14%	N/A	81.97%	N/A	90.58%	N/A	85.56%	N/A
62 Day Wait	Trust Position Expected to be >=70% by End March 2024	70.00%	70.19%	N/A	70.27%	N/A	74.72%	N/A	71.79%	N/A

- 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 January 2WW performance was 83.8%.
- FDS – was 73.36% in December (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.
- 62 day performance is currently below trajectory with 150 patients against a plan of 156 for January.

	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	04/12	11/12	18/12	25/12	01/01	08/01	15/01	22/01	29/01
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	164	143	153	191	191	174	175	168	150
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	163	163	163	163	156	156	156	156	156
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	51	51	51	51	51	51	51	51	51

- 104 day long waiters – performance is above trajectory at 42 against a plan of 18 for January.



	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	04/12	11/12	18/12	25/12	01/01	08/01	15/01	22/01	29/01
Actual 23/24	65	68	59	55	61	49	58	58	64	56	46	48	59	57	57	56	47	42	41	41	45	48	54	57	50	57	57	58	57	53	50	48	45	43	39	43	39	38	50	50	61	47	42
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	23	23	23	23	18	18	18	18	18
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	12	12	12	12	12	12	12	12	12

The Trust is achieving the National requirement to achieve 70% for 62-day waiters (by March 2024) and remains focussed on reducing the total number of 62 and 104 day long waiters to pre-covid levels.

The continued multi-disciplinary approach to improving the efficiency of cancer pathways is working well and is being rolled out across the most challenged tumour groups.

2.4 DM01 Performance – 95% Standard

In January (pre-submission) 94.46% 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. WUTH remains on track to achieve 95% by March 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 has been medical staff industrial action, given the significant volumes of patients cancelled during strike 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.

The main area of concern in delivering 65 weeks by the end of March 2024 is Gynaecology which is the specialty that has taken the longest to recover from the pandemic, this has been flagged to the ICB as an area of concern.

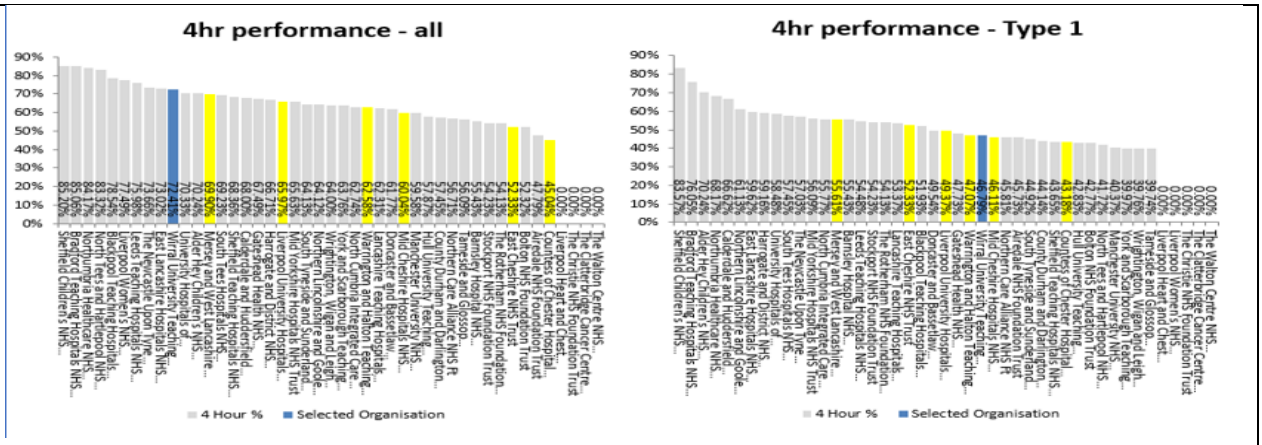
3.0 Unscheduled Care

3.1 Performance

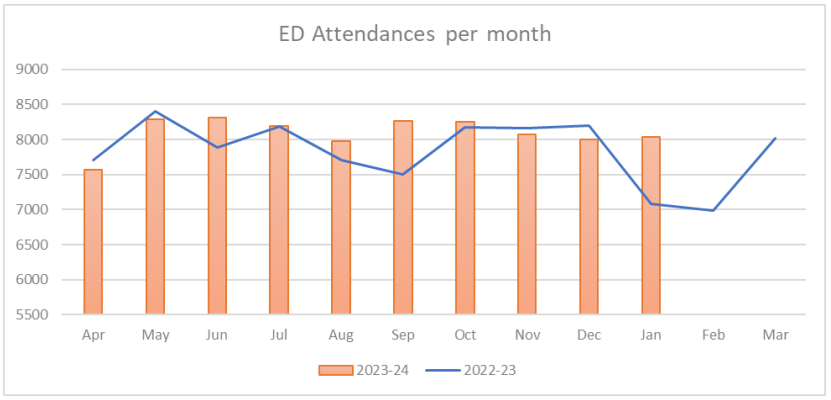
January Type 1 performance was reported at 46.82%, with the combined performance for the Wirral site at 73.63%:

Type 1 ED attendances:	Type 3 ED attendances:
• 8,000 in December (avg. 258/day) • 8,035 in January (avg. 259/day) • 0.4% increase from previous month	• 3,484 in December • 3,217 in January • 8% decrease from previous month

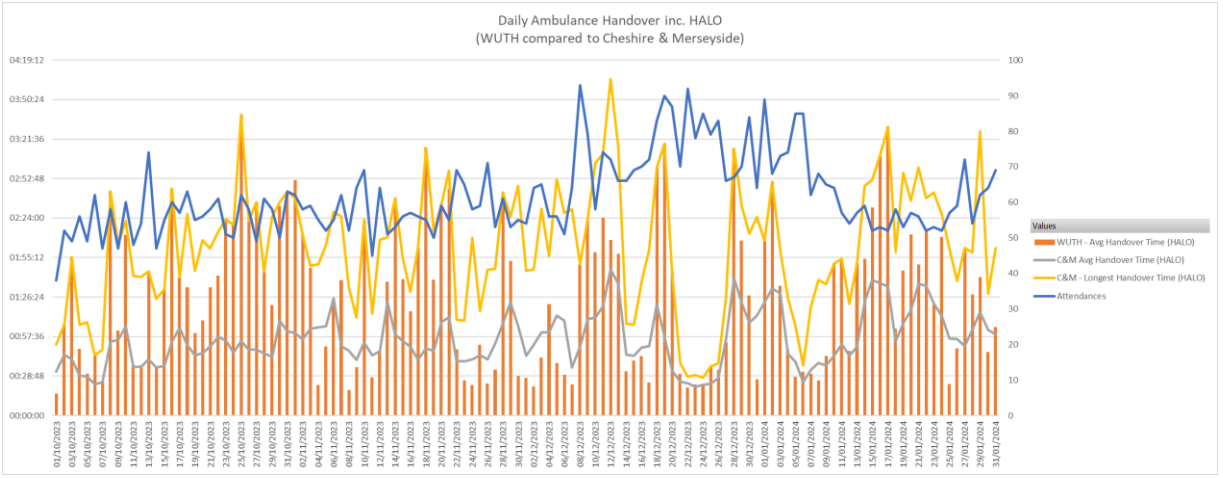
The graphs below demonstrate Wirral's 4-hour performance for all attendances (blue bar) plotted against other acute providers in C&M (yellow bars) and Type 1 performance only:



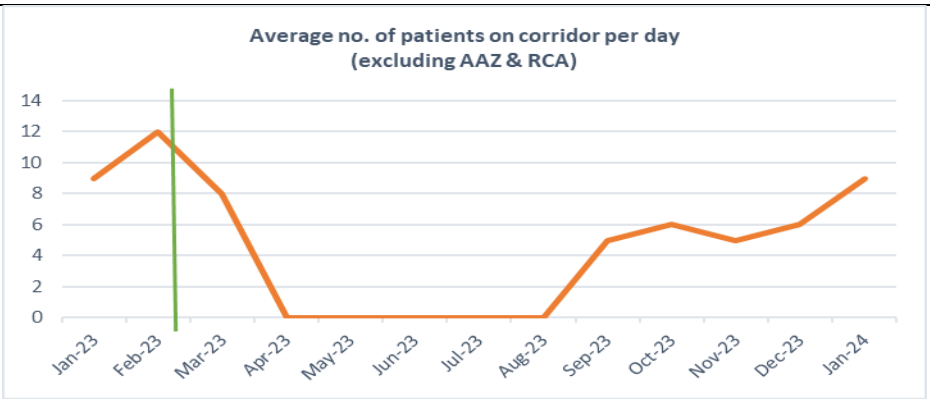
A&E type-1 attendances remained high during the month of January 2024, significantly higher than 2023-24.



In January, compliance with the national standard for 15-minute ambulance handovers continued to remain a challenge with an average daily handover of 92 minutes (65-minute average for Cheshire & Merseyside). 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 January, the Trust also saw an increase in the number of average patients receiving corridor care.



Opening of AAZ (12 ambulance spaces permanently staffed by ED)

Although the Trust has provided dedicated capacity in ED to support ambulance handover (18 spaces), the Trust continues to see corridor care.

Due to the handover performance, the Trust has been highlighted by NHS England (NHSE) as a Trust of concern along with two other NHS Trusts in Cheshire and Merseyside. NHSE has offered the Trust the support of the Advancing Quality Alliance (AQuA). The Trust had an initial meeting and agreed the terms of reference for the review, ambulance handover processes and ambulance conveyance avoidance. The Trust has implemented a new continuous flow process, learning from other hospitals within the region, with the aim of delivering early moves in ED and embedding the process as business as usual and not escalation actions.

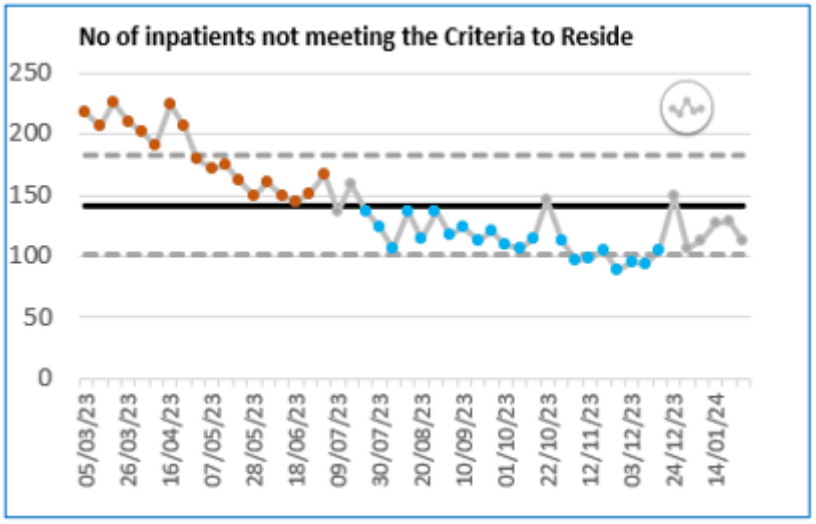
Meetings with system partners, observing processes and process mapping are planned throughout February. It is expected that the findings and recommendations will be shared by the end of March.

Urgent & Emergency Care Upgrade Programme (UECUP)

Phase 2 of the UECUP work is still scheduled for April 2024. Operational plans are in place to ensure that the impact on the running of the department is minimised, with a focus on avoiding delays in ambulance handovers. Preparatory work is currently underway in the current ED estate to enable a smooth transition to the new resus area and what will be the new Paediatric Emergency Department when the project is completed in summer 2025.

3.2 **Transfer of Care Hub development and no criteria to reside.**

As expected, the number of patients who do not meet the criteria to reside rose slightly to 105 at the end of January. However, this is a positive recovery from the early rise in the month after Christmas and the junior doctors' industrial action, when the figure had reached 138.



The Transfer of Care Hub working group is now working with system partners to focus on the four main reasons for complex delays in discharge. The pathways currently being reviewed are bariatrics, delirium, non-weight bearing patients and homelessness.

The Transfer of Care Hub has also been selected as one of the pilot hubs to test the new national codes for patients who do not meet the criteria to reside issued by the Department of Health and Social Care (DHSC). Initial feedback from the DHSC is that the pilot has been successful, and the Trust has received positive feedback on the engagement and running of the Hub. DHSC colleagues are planning to visit the Trust in March.

3.3 Mental Health

In January, the Trust saw an increase in demand for patients attending the ED with mental health conditions. Although demand increased, there was not as long a wait for admission to a specialist mental health bed as last winter.

The pressure from children and young people (CYP) presenting to the ED with learning difficulties or mental health problems that do not require medical treatment remains. The Trust has escalated each CYP attendance/admission through appropriate escalation routes with recent cases reaching senior levels in the Trust and at Place. The Trust is in the process of requesting a multi-professional forum to collaboratively develop a response to how future presentations are to be managed and supported.

3.4 Risks and mitigations to improving performance

The Trust continues to make progress in implementing the actions from the improvement plans for each of the urgent and emergency care quality standards. The action plans have been shared with AQuA and it is anticipated that the plans will be updated once the recommendations from the AQuA review are available.

The risk remains that winter pressures continue with the high level of acuity of patients attending the ED. 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 planned for February presents a significant challenge to capacity and flow across the hospital. However, the Trust continues to ensure that robust plans are in place to ensure the safety of patients and staff through Emergency Preparedness and Response (EPRR).

4	Implications
4.1	**Patients** • The paper outlines good progress with elective recovery but still waiting times for elective treatment are 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. The cost of providing corridor care is above the Trust's financial plan.
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**

06 March 2024

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

Report Purpose and Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of January 2024.

It is recommended that the Board:

- notes performance to the end of January 2024

Key Risks

This report relates to the key risks of:

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

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

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

1	Narrative
1.1	Following further discussion with the Executive Team and the Board, the performance metrics for inclusion, format and title of the report have been amended. The metrics are 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	4	19	23
Well-led	2	1	3
Use of Resources	2	3	5
All Domains	15	28	43

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 - February 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
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Responsive	4	19	23
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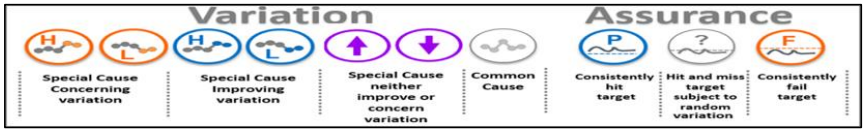
All Domains	15	28	43

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.

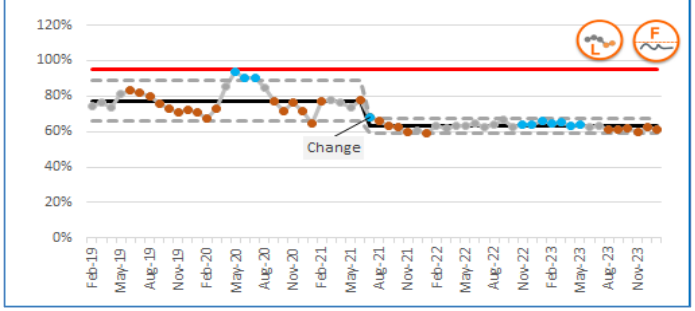
Changes to Existing Metrics:

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
Ambulance handover	Metric calculation amended to show % within time-band

Chief Operating Officer (1)

CQC Domain : Responsive

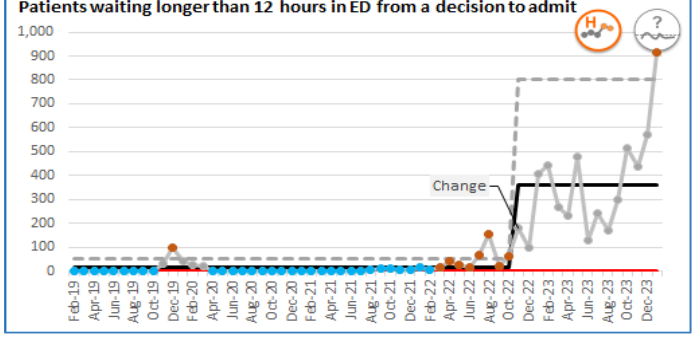
4-hour Accident and Emergency Target (including APH UTC)



Jan-24
61.2%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

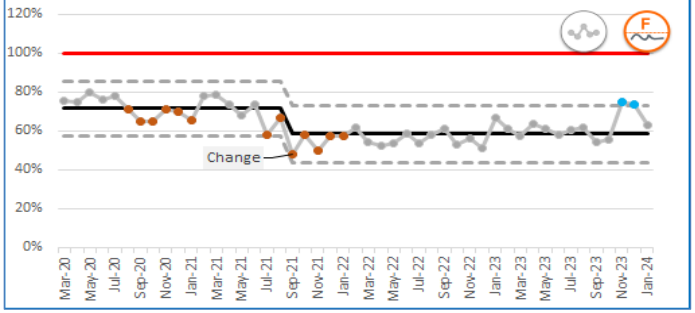
Patients waiting longer than 12 hours in ED from a decision to admit



Jan-24
915
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

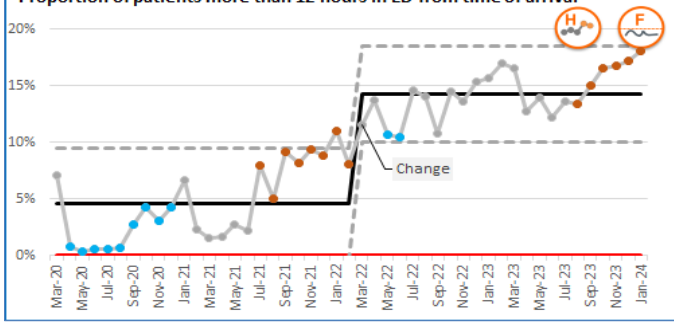
Time to initial assessment for all ED patients - % within 15 mins



Jan-24
63.0%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

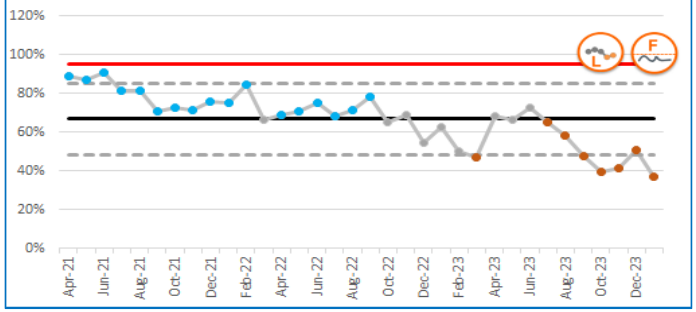
Proportion of patients more than 12 hours in ED from time of arrival



Jan-24
18.1%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

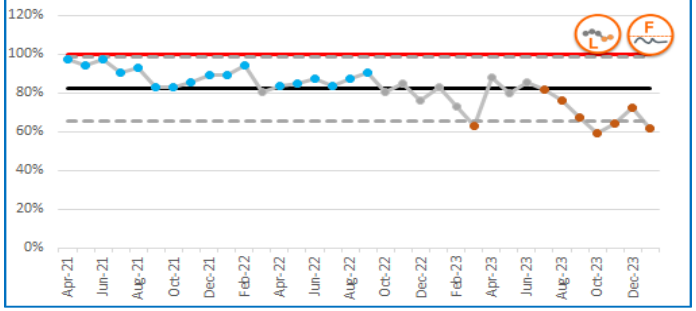
Ambulance Handovers: % < 30 mins



Jan-24
36.8%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Ambulance Handovers: % < 60 mins

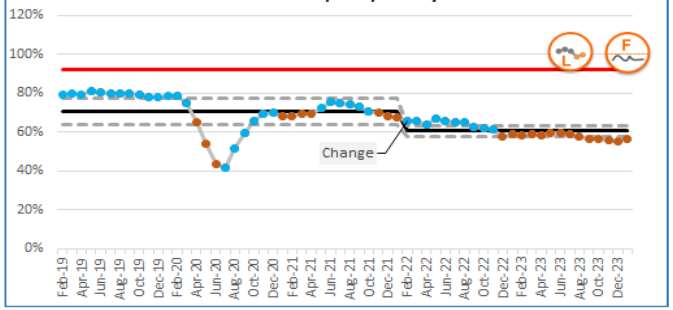


Jan-24
61.4%
Variance Type
Special cause variation - concerning
Threshold
100%
Assurance
Performance consistently fails to achieve the target

Chief Operating Officer (2)

CQC Domain : Responsive

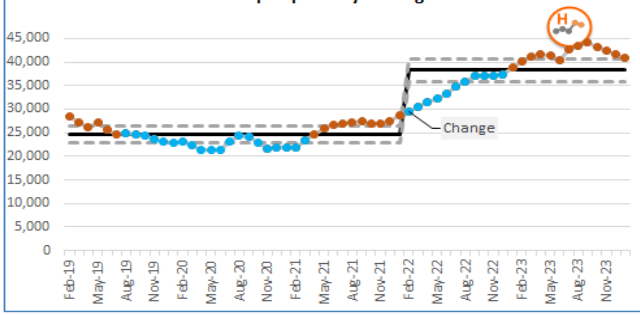
18 week Referral to Treatment - Incomplete pathways < 18 Weeks



Jan-24
56.58%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

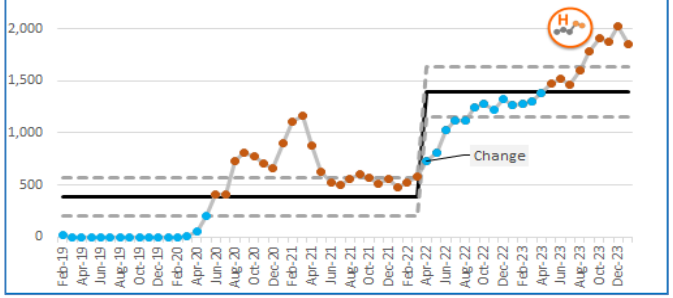
Referral to Treatment - total open pathway waiting list



Jan-24
40930
Variance Type
Special cause variation - concerning
Threshold
≤ 37322
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

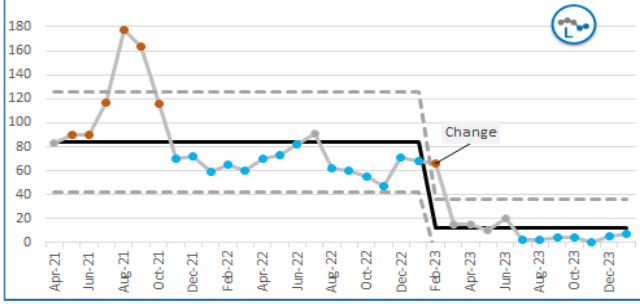
Referral to Treatment - cases exceeding 52 weeks



Jan-24
1855
Variance Type
Special cause variation - concerning
Threshold
1330
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

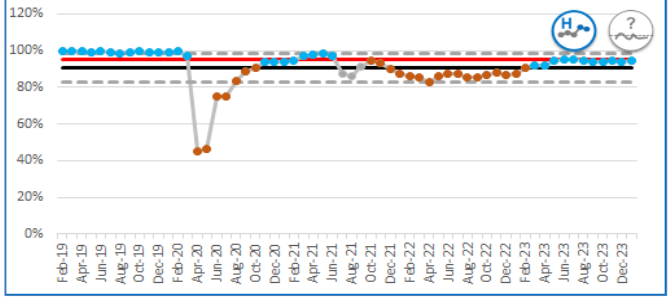
Referral to Treatment - cases waiting 78+ wks



Jan-24
7
Variance Type
Special cause variation - improving
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

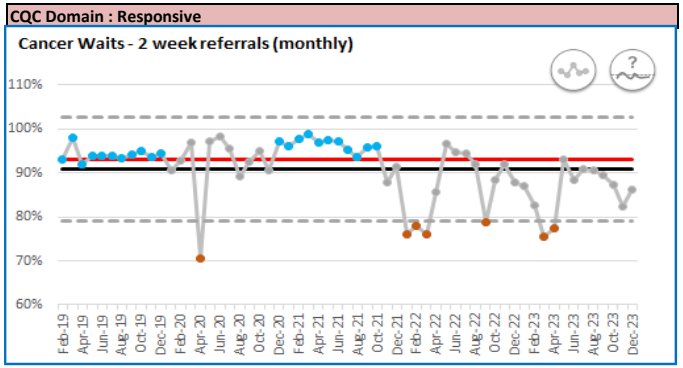
Diagnostic Waiters, 6 weeks and over - DM01



Jan-24
94.4%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

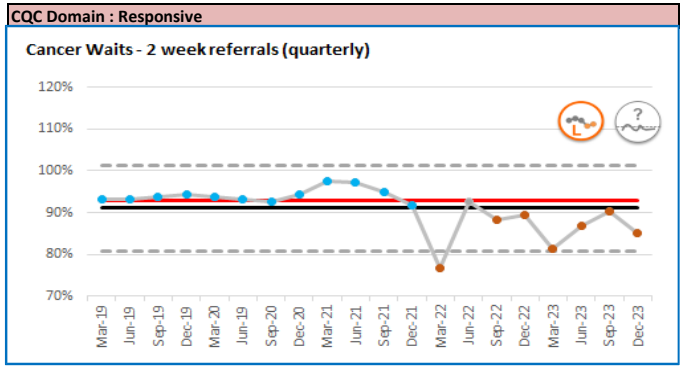
Chief Operating Officer (3)

CQC Domain : Responsive



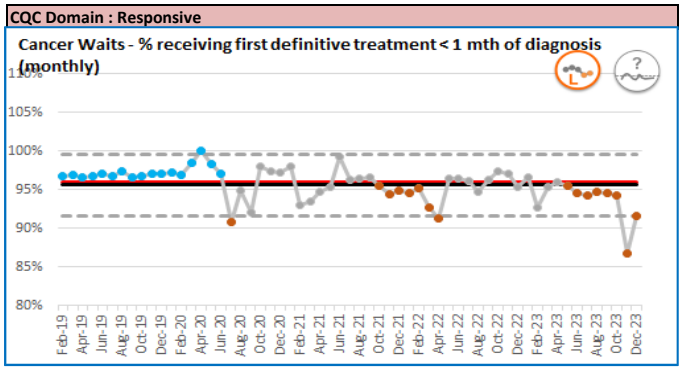
Dec-23
86.1%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



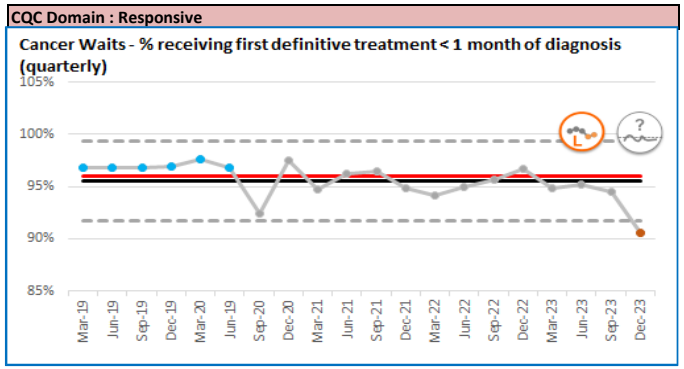
Dec-23
85.1%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



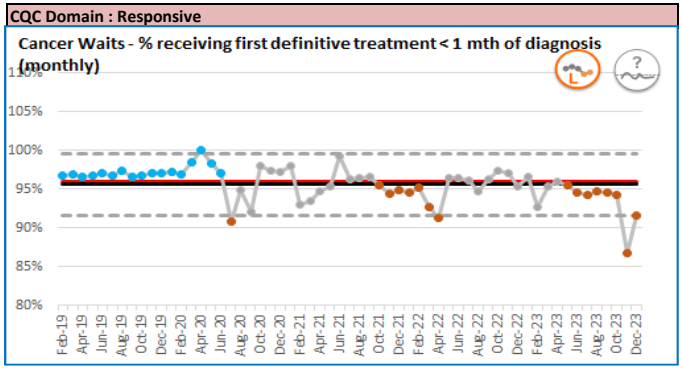
Dec-23
90.6%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



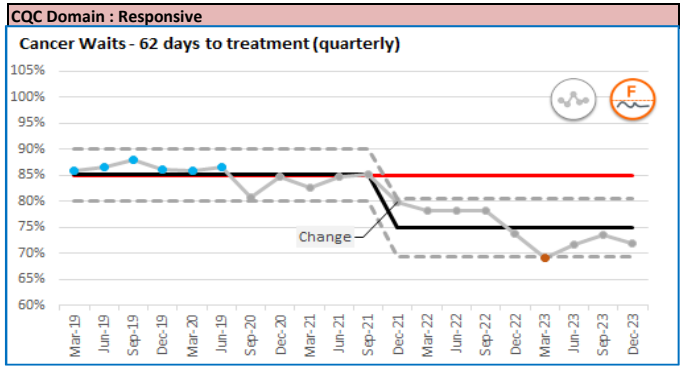
Dec-23
90.6%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Dec-23
74.7%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

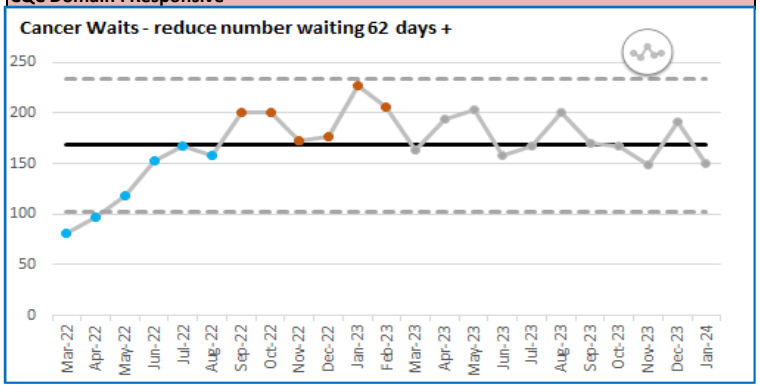
CQC Domain : Responsive



Dec-23
71.8%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

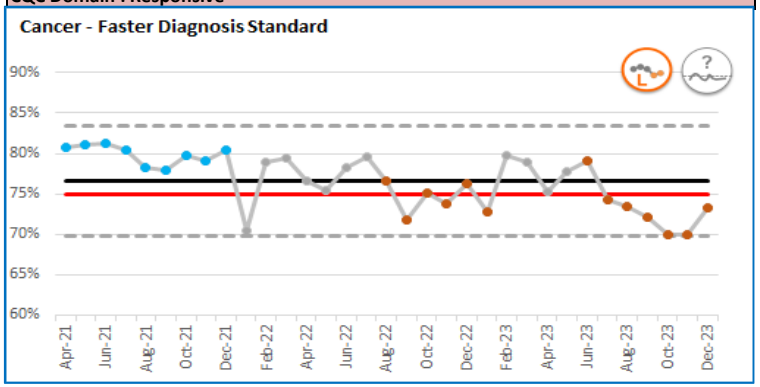
Chief Operating Officer (4)

CQC Domain : Responsive



Jan-24
150
Variance Type
Common cause variation
Threshold
156
Assurance
Trajectory target not appropriate for SPC Assurance reporting

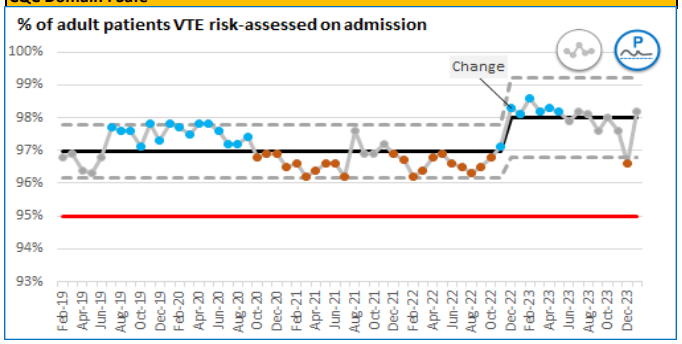
CQC Domain : Responsive



Dec-23
73.4%
Variance Type
Special cause variation - concerning
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

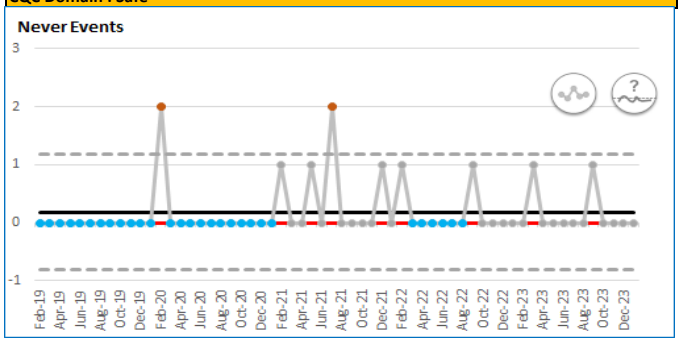
Medical Director (1)

CQC Domain : Safe



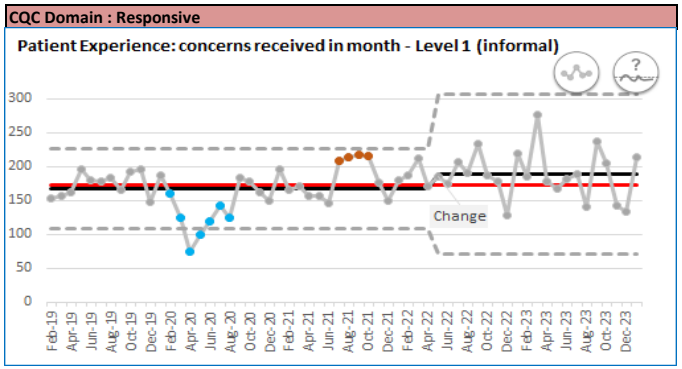
Jan-24
98.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



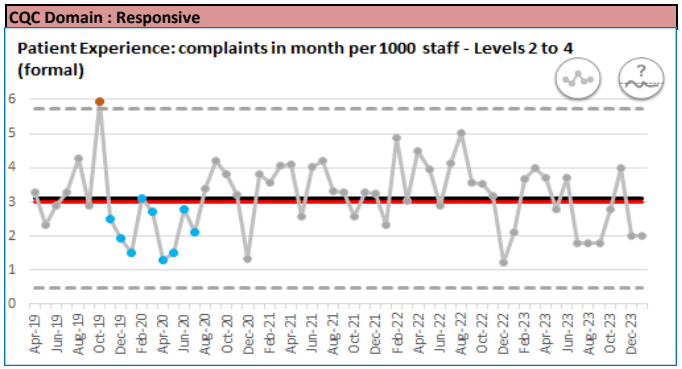
Jan-24
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



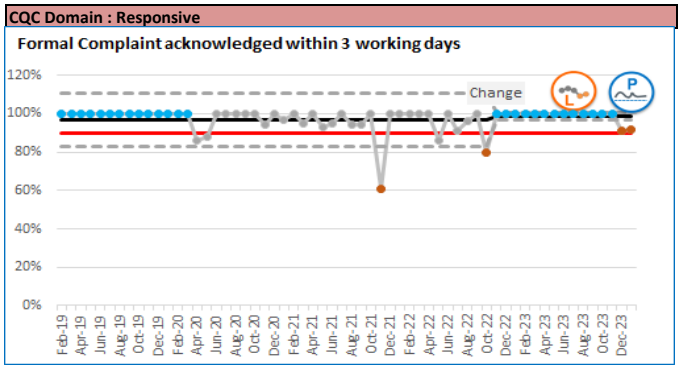
Jan-24
214
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



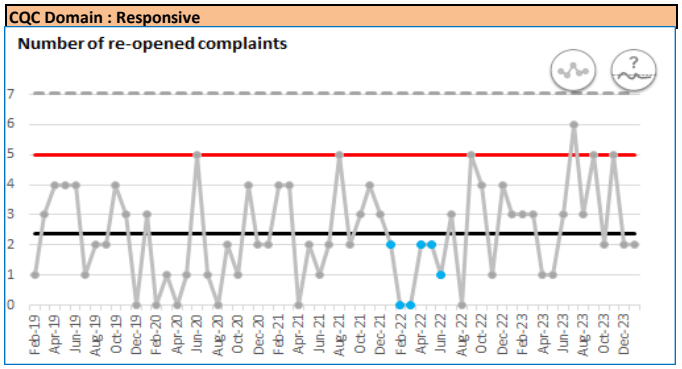
Jan-24
2.0
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Jan-24
92%
Variance Type
Special cause variation - concerning
Threshold
≥90%
Assurance
Performance consistently achieves the target

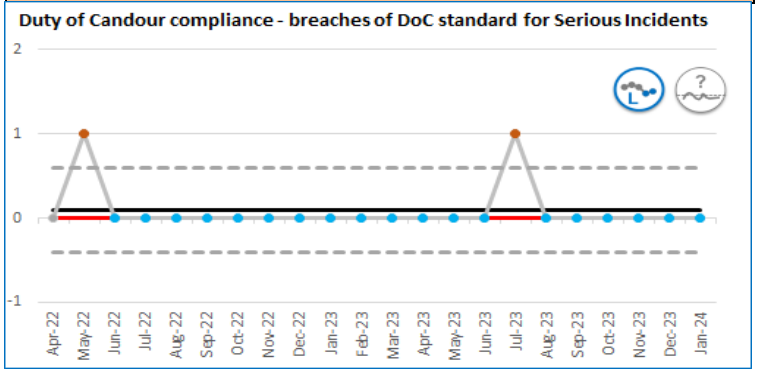
CQC Domain : Responsive



Jan-24
2
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

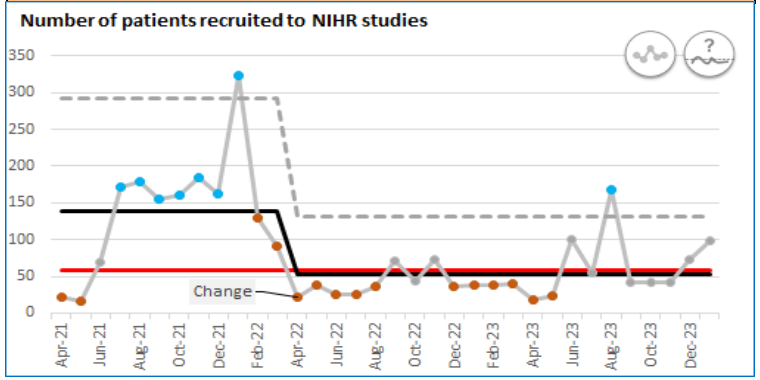
Medical Director (2)

CQC Domain : Well-led



Jan-24
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led

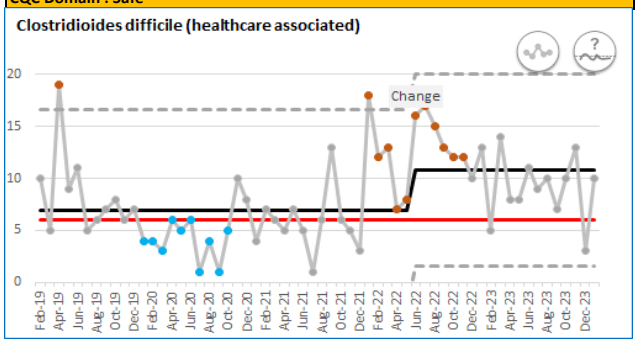


Jan-24
98
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse

CQC Domain : Safe

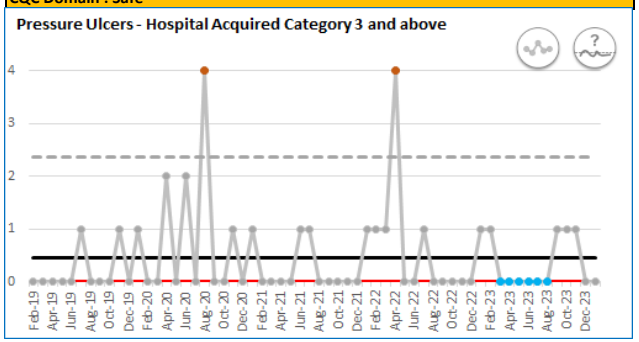
Clostridioides difficile (healthcare associated)



Jan-24
10
Variance Type
Common cause variation
Threshold
≤6
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

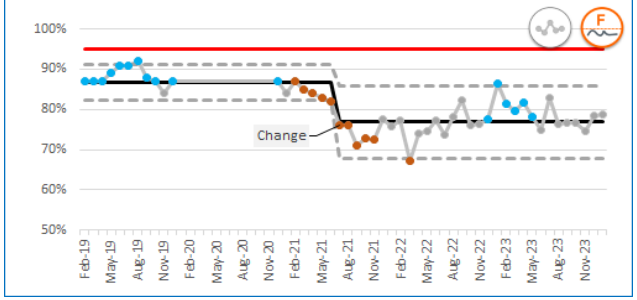
Pressure Ulcers - Hospital Acquired Category 3 and above



Jan-24
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

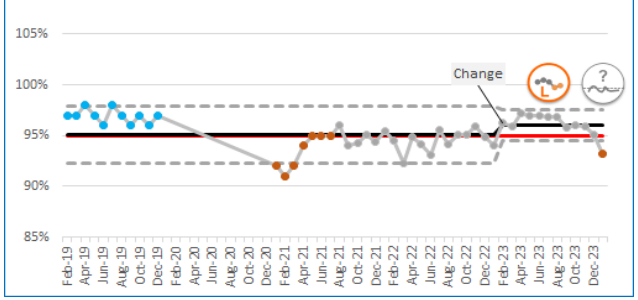
FFT Overall experience of very good & good: ED



Jan-24
78.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

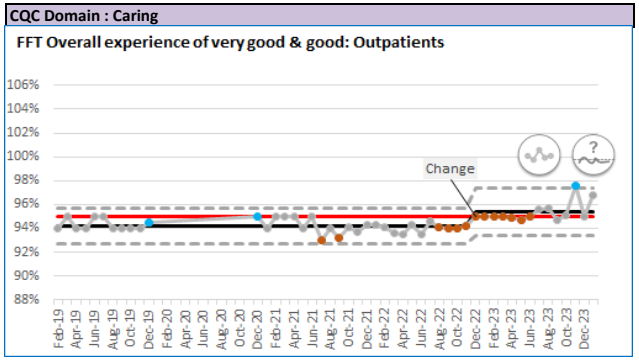
FFT Overall experience of very good & good: Inpatients



Jan-24
93.2%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

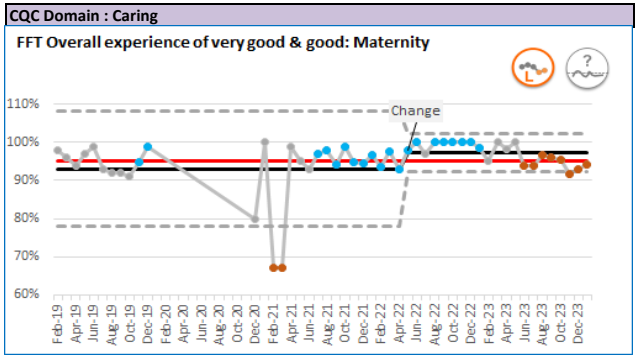
FFT Overall experience of very good & good: Outpatients



Jan-24
96.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

FFT Overall experience of very good & good: Maternity



Jan-24
94.1%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse – Jan 2024 data

Overall position commentary

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 18 at the end of January 2024 we have seen an overall decrease of 34 when compared to the same period in 2023/24. 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 weekly in The Trust bulletin with monthly related themes and newsletters to improve awareness to staff as per the agreed IPC communication and engagement strategy.

During January Outpatients was the only area to achieve the local target of ≥95% for the Friends and Family Test (FFT). The three remaining areas did not achieve this target with Inpatients scoring 93.2%, Emergency Department (ED) 78.8% and Maternity at 94.1%. A comparison with the latest available NHSE benchmarking data (December 2023) demonstrates that WUTH were in line with or above the National average.

***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 January 2024 there were 10 patients diagnosed with CDT, exceeding the monthly threshold by 4.

Actions:

- The Bi-weekly DIPC MDT CDT improvement group continues with learning from *C difficile* rapid evaluations of care discussed and learning disseminated to the divisions.
- Priority focuses continue to concentrate on Decluttering to enhance effective cleaning of the environment, education regarding cleaning of medical devices, prompt isolation of patients with symptoms, Sampling in a timely manner and robust 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 18.
- Bed occupancy has inhibited 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.

Analysis of the patient comments for inpatient services indicates that their reasons for providing a negative response is linked to their initial experience within ED, highlighting waiting times, delays and communication.

Actions:

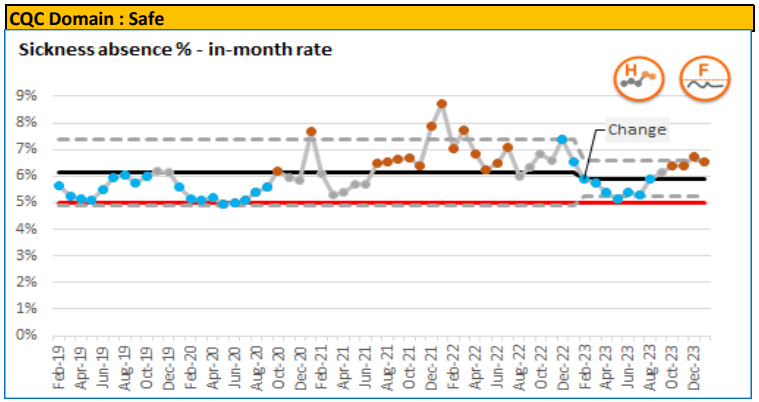
- Continued focus on providing people with access to provide feedback via FFT: volunteers are visiting ED and out-patient areas at varied times and days.
- Monitor FFT performance against national average: we perform similar or above the national average since December 2022.
- Proactively respond to feedback, making immediate rectifications when able to and encourage patient and carer participation through Patient Experience Promise groups.
- Continue coproduction with patients via patient experience strategy

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.
- Whilst car parking continues to be a theme of negative feedback this has shifted from a subcategory of the inability to find a car parking space to frustrations related to pay machines and parking charges. These comments have been shared with the Capital Estates and Facilities Division

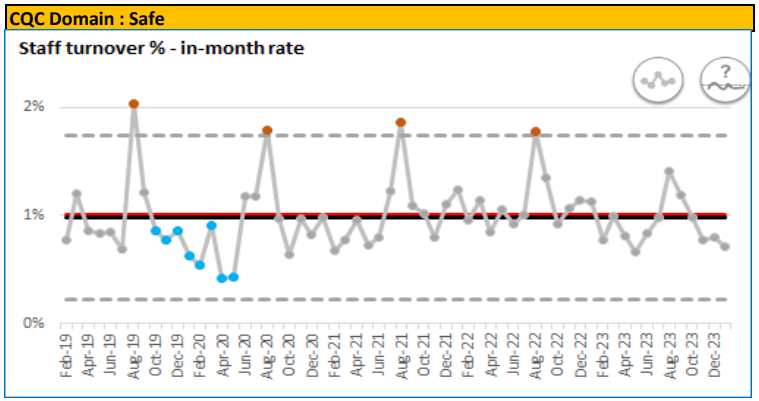
Chief People Officer

CQC Domain : Safe



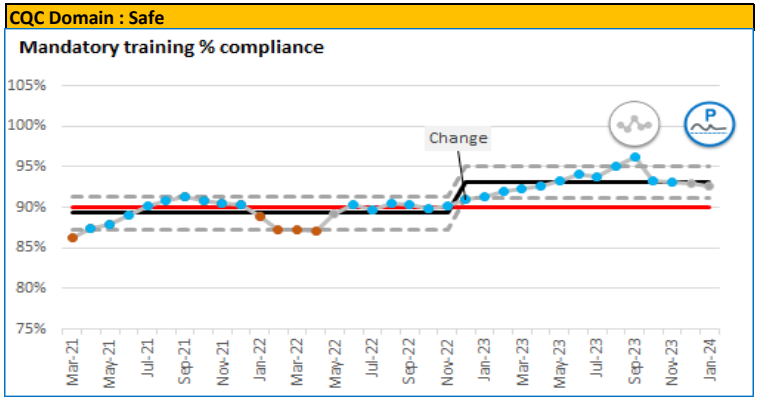
Jan-24
6.53%
Variance Type
Special cause variation - concerning
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe



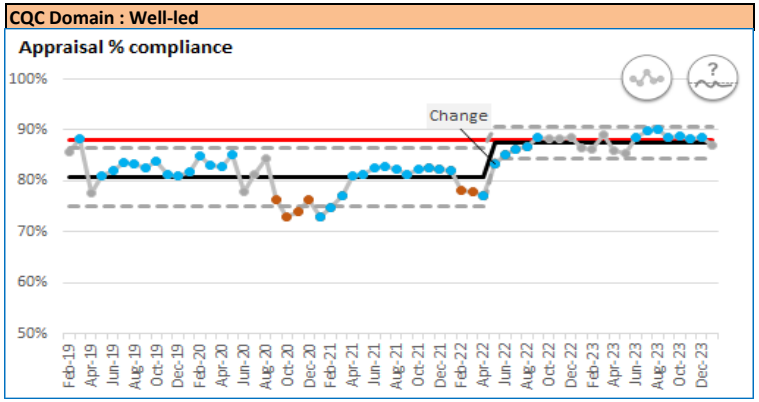
Jan-24
0.71%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



Jan-24
92.59%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led



Jan-24
87.05%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – for Feb 2024 BoD

Overall position commentary

Despite winter pressures and formal industrial action, the Trust's People KPIs for mandatory training remains on target and continues to be achieved.

Work continues through the Strategic Retention Group. Staff turnover has continued to improve and is within target at 0.71%.

Sickness absence remains above target and is an area of concern. Industrial action is adversely affecting the ability of line managers to manage sickness absence, and this is most challenging in Medicine and Surgery Divisions.

Appraisal compliance has dipped this month to 87.05% and is now below the KPI for the first time since May 2023.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For January 2024 the indicator remained at 6.53%, 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 chest / respiratory problems are the most commonly occurring reasons for short term sickness absence which is reflective of seasonable variation. The most commonly occurring reason for long-term absence is anxiety/stress/depression.

Focus remains on supporting the health and wellbeing of our workforce.

Actions:

- As part of our ongoing commitment to staff wellbeing, and as a proactive supportive intervention, enhanced access to counselling was made available to staff during early February, via an onsite 'drop in' approach.
- Additional sessions for both counsellors and physicians have been made available.
- The Trust facilitated telephone counselling calls to almost 200 staff during January 2024.
- Professional Nurse Advocate 'wellbeing walkabouts' continue during ongoing Industrial Action to support staff.
- New Employee Assistance Programme Health Assured Wisdom (Learn, grow, thrive) – app has been launched. The app is designed to help staff track their wellness, improve their mental health and stay resilient during tough times.
- Appraisal and Check-In Meetings for Reviewers course is being delivered in February, focusing on the importance of having regular and meaningful conversations with team members about their wellbeing.
- The impact of the seasonal absence pattern work has been undertaken and it highlights that circa 70% staff that were written to have not had a period of absence this year during the winter period.

- Additional Psychoeducation sessions have been launched for 2024 commencing in March 2024 delivered by OH Clinical Psychotherapist focusing on 'Building Personal Resilience and Wellbeing', 'Treatment of Low Mood', 'Awareness & Treatment Options for Social Anxiety', 'Awareness & Treatment Options for PTSD' and 'Introduction & Treatment Options for Health Anxiety'.

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 promotion 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. Work has commenced on refining year 3 deliverables which will include delivering against the Grow OH and Wellbeing strategy as set out in the NHS People Plan to improve the health and wellbeing services for our people, to keep them safe and healthy and able to provide good care to our patients.

Appraisal % compliance

Narrative:

The threshold for Appraisal compliance is 88% and for the month of January' 24 compliance dropped below the threshold by to 87.05%, demonstrating common cause variation.

Appraisals have dipped below the Trust target for the first time since May 2023. Corporate Division (90.19%) and Women & Children Division (92.51%) remain above target.

Clinical Support Division dropped to 87.99% and Estates and Facilities Division dropped to 87.92% in January 2024, both were above target prior to this. Surgery Division remains below target but has improved in-month from 86.18% to 87.05%. The lowest performing division is Medical Division who have dropped by over 5% in month from 86.77% to 81.63%. Acute Division have dropped by over 3% in month from 86.81% to 83.51%; both have been particularly affected by winter pressures and ongoing industrial action.

Whilst the introduction of the new appraisal approach (launched in April 2023) has had a positive impact upon appraisal compliance, a drop in compliance in January 2024 can be attributed to the impact of industrial action.

Actions:

- Divisional leaders and HR continue to identify areas of lower performance and work with service leads to address compliance gaps.
- The Learning and Development (L&D) Team contacts all individuals that are out of compliance and due to become out of compliance with details about the appraisal process. Contact is also made with all line managers each month to actively highlight gaps in compliance and provide information and guidance on the process.
- Development for managers continues with online resources and guidance made available together with formal management training.
- The intranet has a comprehensive suite of guidance and 'on-demand' learning resources that brief staff and managers on the new process.
- A new appraisal 'portlet' has been developed in collaboration with the national ESR Team. This makes recording appraisal easier for managers with a short step by step video to assist them in recording appraisals.
- The L&D Team have offered short-term interim support to divisions to support with recording of appraisals during periods of significant system pressures and ongoing industrial action.
- Planning is underway to roll out a series of 'Appraisee' awareness sessions which will run alongside manager training to brief staff and help further embed the new approach.

Risks to position and/or actions:

- Ongoing system pressures and industrial action continues to be a risk to capacity for managers and staff to have quality appraisal discussions. To help mitigate this, the OD Team will work in collaboration with HR to provide targeted awareness sessions for teams / services that are particularly lower in compliance.

Wirral University Teaching Hospital
NHS Foundation Trust

Productivity and Efficiency Update

Board of Directors – 6th March 2024

Hayley Kendall
Chief Operating Officer

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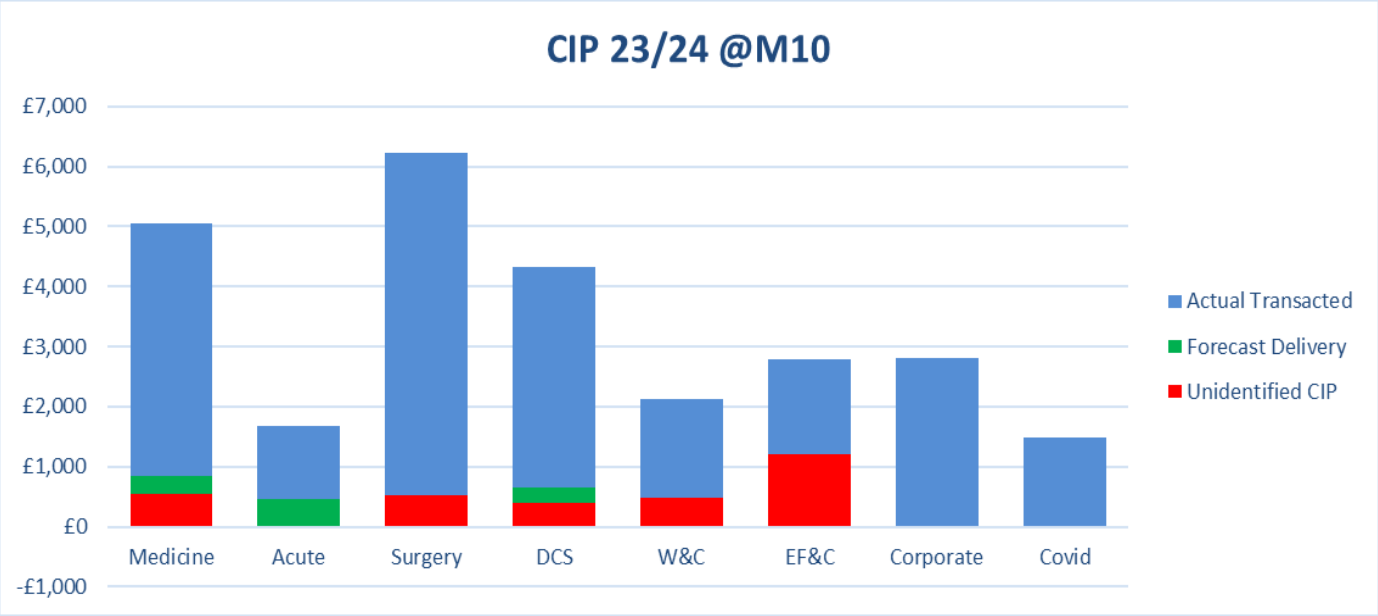
CIP Month 10 Position

Wirral University Teaching Hospital NHS Foundation Trust



	Month 10		
Division	In Mnth Target	In Mnth Delivered	Variance
Medicine	£774	£361	-£413
Acute	£208	£172	-£37
Surgery	£636	£454	-£183
DCS	£506	£353	-£153
W&C	£234	£137	-£97
Corporate	£112	£127	£15
Estates	£212	£162	-£50
COVID	£122	£124	£2
Trust	£2,804	£1,888	-£916

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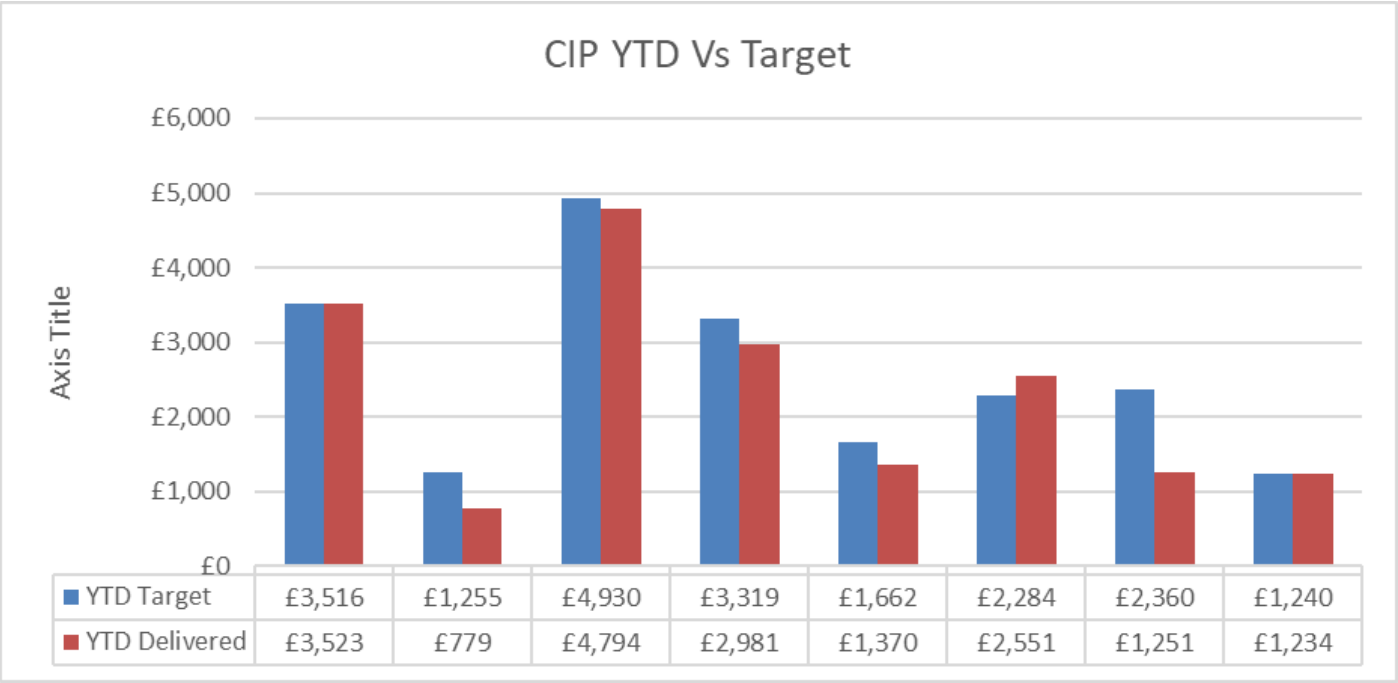
CIP YTD Position



	Year to Date		
Division	YTD Target	YTD Delivered	Variance
Medicine	£3,516	£3,523	£7
Acute	£1,255	£779	-£477
Surgery	£4,930	£4,794	-£136
DCS	£3,319	£2,981	-£337
W&C	£1,662	£1,370	-£292
Corporate	£2,284	£2,551	£267
Estates	£2,360	£1,251	-£1,109
COVID	£1,240	£1,234	-£6
Trust	**£20,566**	**£18,483**	**-£2,083**

Transformation Workstream Forecast Position

Wirral University Teaching Hospital NHS Foundation Trust

Part Year Effect					
Workstream	Red	Amber	Green	Blue	Total Identified
Diagnostics	£0	£0	£20	£1,571	**£1,591**
Medicines Optimisation	£0	£109	£263	£855	**£1,228**
Non PBR Income & SLA Management	£10	£0	£5	£1,501	**£1,516**
One Patient Record	£250	£4	£59	£517	**£830**
Patient Flow	£0	£0	£0	£3,534	**£3,534**
Procurement	£0	£11	£8	£2,820	**£2,839**
Space Utilisation	£0	£0	£0	£365	**£365**
Think Big	£0	£0	£26	£3,394	**£3,420**
Workforce	£10	£60	£18	£7,880	**£7,968**
Total	**£270**	**£185**	**£398**	**£22,437**	**£23,290**

Part Year Effect			
Division	Target	Forecast	Gap
Diagnostics	£1,000	£1,591	£591
Medicines Optimisation	£2,048	£1,228	-£820
Non PBR Income & SLA Management	£1,000	£1,516	£516
One Patient Record	£2,600	£830	-£1,770
Patient Flow	£7,000	£3,534	-£3,466
Procurement	£4,000	£2,839	-£1,161
Space Utilisation	£1,000	£365	-£635
Think Big	£4,000	£3,420	-£580
Workforce	£7,700	£7,968	£268
Total	**£30,348**	**£23,290**	**-£7,058**

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RAG Movement

Wirral University Teaching Hospital NHS Foundation Trust

Month 9 Position					
Directorate	Red	Amber	Green	Blue	Total PY Identified
Medicine	£0	£0	£297	£4,228	**£4,525**
Acute	£0	£0	£7	£1,211	**£1,218**
Surgery	£15	£66	£0	£5,705	**£5,786**
DCS	£0	£122	£30	£3,787	**£3,938**
W&C	£0	£0	£0	£1,643	**£1,643**
Corporate	£250	£0	£59	£2,809	**£3,118**
Estates	£6	£0	£30	£1,553	**£1,588**
COVID	£0	£0	£0	£1,481	**£1,481**
Total	**£271**	**£188**	**£422**	**£22,417**	**£23,298**

Month 10 Position					
Directorate	Red	Amber	Green	Blue	Total PY Identified
Medicine	£0	£0	£297	£4,228	**£4,525**
Acute	£0	£0	£7	£1,211	**£1,218**
Surgery	£15	£66	£0	£5,705	**£5,786**
DCS	£0	£118	£28	£3,787	**£3,933**
W&C	£0	£0	£0	£1,643	**£1,643**
Corporate	£250	£0	£59	£2,809	**£3,118**
Estates	£5	£0	£8	£1,573	**£1,585**
COVID	£0	£0	£0	£1,481	**£1,481**
Total	**£270**	**£185**	**£398**	**£22,437**	**£23,290**

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Productivity and Efficiency 2024/25 Workstreams

Productivity & Efficiency Workstreams 24/25

Wirral University Teaching Hospital NHS Foundation Trust

R Chapman	H Kendall	D Smith	N Stevenson	N Stevenson	M Chidgey	M Chidgey	M Swanborough	H Kendall
Productivity £4m	Site Capacity £2m	Workforce £2m	Diagnostics & Reporting £1m	Medicines Optimisation £1m	Non-Pay Spend £1m	Digital Innovation £1.5m	Estates & Facilities £1m	Admin & Clerical £1.0m

Opportunities

Wirral University Teaching Hospital NHS Foundation Trust

Productivity: £4m

- Improve efficiency in theatres, outpatients and endoscopy to utilise core sessions and reduce non-core costs.
- Optimise ward calibration and agree a target model of care to reflect national standards with robust e-rostering modelling and controls.
- Develop robust job planning policy to ensure alignment between demand and capacity and the delivery of annual activity targets.

Site Capacity: £2m

- Free up beds across the Trust by ensuring we treat patients in the right beds at the right time and closing escalation beds
- Improving discharges and delivering best in class Length of Stay (LOS) including assessment model
- Establishment of virtual wards and front door consultant delivered services to reduce G&A bed admissions

Workforce: £2m

- Utilising our existing workforce to address challenges of capacity and reducing the reliance on temporary staffing
- Reduction of medical bank and agency spend and embedding a sustainable workforce models
- Review of junior doctors rotas to ensure alignment between demand and resource requirements delivering fit for purpose rosters that do not rely on additional non-core spend

Opportunities

Wirral University Teaching Hospital NHS Foundation Trust

Medicines Optimisation: £1m

- Safely reduce our drug and prescribing spend
- Identify product switches in line with best practice and regional benchmarking
- Reducing spend on high-cost drugs in line with national guidance

Non-Pay Spend: £1m

- Reduce non-pay spend by standardising products across the Trust and improving quality at a lower cost.
- Increased use of data analytics to identify cost improvement opportunities.
- Collaborate with system partners to increase purchasing power and achieve greater economies of scale.
- Reduce waste identified by staff and patients.

Diagnostics & Reporting: £1m

- Ensure efficient use of our diagnostic service
- Reduce the reliance on outsourced support delivering improved value for money and quality
- Ensuring our capacity for internal services is maximised
- Maximise opportunities brought about by the Community Diagnostic Centre

Opportunities

Wirral University Teaching Hospital NHS Foundation Trust

Digital Innovation: £1.5m

- Complete One Patient Record initiative to ensure clinicians are able to access all medical records digitally.
- Utilise digital technology to improve services and minimise manual processes and reduce cost.
- Improve data quality and reporting to enable better decision making.

Estates & Facilities: £1m

- Ensuring our footprint is fully utilised and reduce the reliance on off site space and temporary accommodation

Admin & Clerical: £1.0m

- Implementation of digital dictation and voice recognition
- Implementation of Robotic Process Automation
- Develop the optimal workforce model that embraces skill mix and delivers quality patient administration
- Deliver an outpatient scheduling solution that delivers maximum efficiency and use of staff

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework February/March 2024

Item

1 Board Assurance Framework
David McGovern Director of Corporate Affairs

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

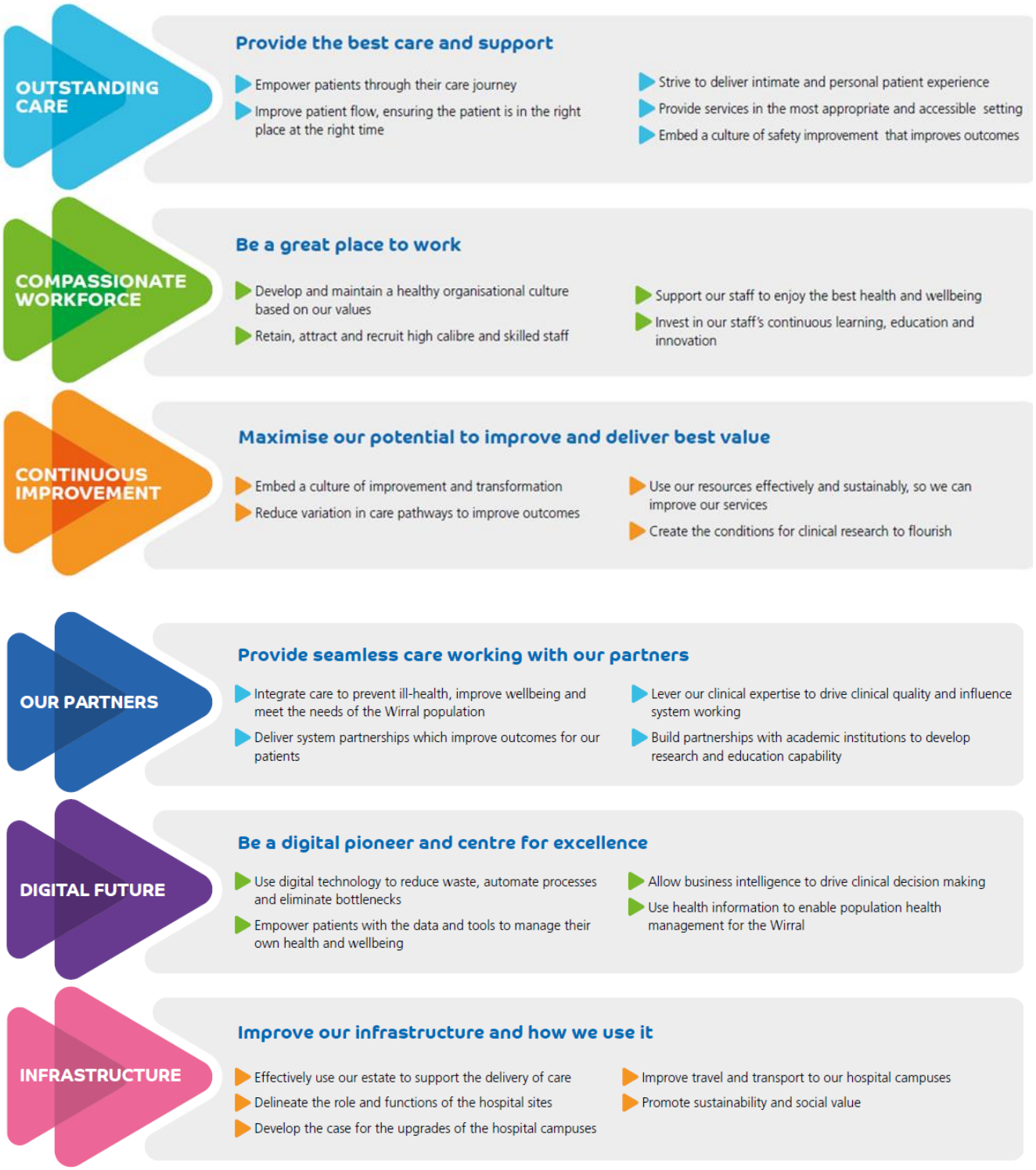
2. Vison, Strategy and Objectives

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

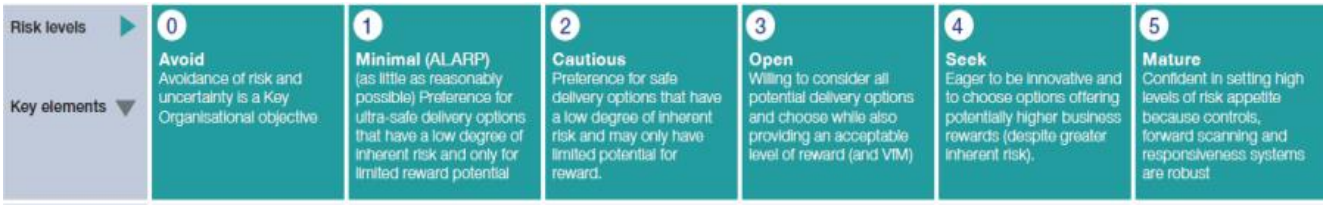
The Trust endeavours to establish a positive risk culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

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 2024

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.

The timeline for this refreshment is as follows:

- Initial review by the Executive Team – 12th March;
- Presentation to Divisional Boards – Ongoing throughout February and March;
- Initial consideration by Risk Management Committee – 12th March;
- Committee consideration throughout March;
- Trust Management Board review – 26th March; and
- Board review and approval (along with the Risk Management Strategy) – 3rd April.

6. Update Report

6.1 January-March 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. In light of the full review now being commenced there are only minor additions to this version and no changes to current scoring.

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.
- Note the process for the annual refreshment 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)	12 (4 x 3)	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	Target	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24 Current
1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	20 (4 x 5)	**TBD**	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)	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)	**TBD**	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)	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)	**TBD**	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)	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)	**TBD**	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)	**TBD**	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)	**TBD**	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)	**TBD**	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 (4 x 2)
8	Failure to deliver sustainable efficiency gains due to an inability to embed service transformation.	16 (4 x 4)	**TBD**	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 (3 x 3)
9	Failure to have strong leadership and governance systems in place.	12 (4 x 3)	**TBD**	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)	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)	**TBD**	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)	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)	**TBD**	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 (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)	**TBD**	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)	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	01/02/24	Initial Score	Last Month	Current	Target
Lead	Chief Operating Officer	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)	TBD

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 • **Implementation of continuous flow model to improve egress from ED.**	• 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 • **System 4 hour performance response to deliver 76% in March.**

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	01/02/24	Initial Score	Last Month	Current	Target
Lead	Chief Operating Officer	16 (4 x 4)	12 (3 x 4)	12 (3 x 4)	TBD

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
• 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 • **2 specialities are challenged in delivery of 65 and 75 weeks.**	• 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. • **Utilisation of the LLP to deliver the gap in recurrent capacity.**

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	01/02/24	Initial Score	Last Month	Current	Target
Lead	Medical Director	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	TBD

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 • Availability of Consultants, specifically within the Medicine Division given current workforce pressures	• 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	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	TBD

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	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	TBD

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 actual impact of 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	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	TBD

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
• The actual impact of national and local industrial action.	• 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	01/02/24	Initial Score	Last Month	Current	Target
Lead	Chief Finance Officer	16 (4 x 4)	12 (4 x 2)	8 (4 x 2)	TBD

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. • **CFO presents quarterly forecasts to FBPAC and Trust Board.** • **H2 plans submitted and approved by Board**

Gaps in Control or Assurance	Actions
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Uncertainty of impact of industrial action • **2024/25 Plan not yet approved / not compliant**	• 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. • **Further review and challenge of 24/25 plan.**

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	01/02/24	Initial Score	Last Month	Current	Target
Lead	Chief Strategy Officer and Chief Operating Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	TBD

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. • Ability to deliver system wide change across Wirral NHS organisations.	• Implementation of revised Cost Improvement approach **through the WAVE programme.** • Integration of Quality and Service Improvement function from 2024/25 • **Strong Governance through PMO working of all schemes, risk and outputs.**

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	01/02/24	Initial Score	Last Month	Current	Target
Lead	Chief Executive Officer	12 (4 x 3)	8 (4 x 2)	8 (4 x 2)	TBD

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
• Recruitment of a CNO.	• Continuous review of Governance structure and reporting. • CQC Inspection readiness programme. • Commencement of Well Led review.

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	01/02/24	Initial Score	Last Month	Current	Target
Lead	Chief Executive Officer	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)	TBD

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. • **Agreed Governance Structures and reporting now signed off following initial development by WUTH.**

Gaps in Control or Assurance	Actions
• 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	01/02/24	Initial Score	Last Month	Current	Target
Lead	Chief Finance Officer and Chief Strategy Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	TBD

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 • **Information Assurance Group to report to the Audit and Risk Committee.**

Progress
Key Changes to Note • N/A

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

Strategic Priority	Infrastructure				
Review Date	01/02/24	Initial Score	Last Month	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	TBD

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. • **Shortage of medications.**	• 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 • N/A

Appendix – Risk Scoring Matrix

Risk Scoring and Grading:

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

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

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

Appendix – Risk Appetite Scoring Matrix

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

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 8.6**

06 March 2024

Title	Quarterly Maternity and Neonatal Services Report
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

Report Purpose and Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in December 2023 and an extended monthly report in January 2024 along with presentation requesting the Board of Directors approval to the sign off of MIS Year 5. The following paper provides a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

This paper provides a specific update regarding MIS Year 5/6, Saving Babies Lives (SBLv3), an update Three Year Delivery plan, Maternity Continuity of Carer (MCoC) together with an update on the Perinatal Culture Leadership initiative, CQC Maternity Survey and the Trusts position with research.

Also included in the paper is the Maternity Workforce 6 monthly update and the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (January 2024) key quality and safety metrics.

It is recommended: -

- Note the report.
- Note the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3.
- Note the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals".
- Note the 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.
- Note the 6 monthly workforce report.
- Note the progress in maternity and neonatal service with research and quality improvement initiatives.
- Note the CQC Maternity Survey report.
- Note the Perinatal Cultural leadership initiative and commitment to the programme.

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**
March 2024	Maternity & NNU Assurance Board	Quarterly Maternity and Neonatal Services Report	For information
March 2024	Patient Safety and Quality Board	Quarterly Maternity and Neonatal Services Report	For information

1	Maternity Incentive Scheme (MIS) Year 5
	The declaration for MIS Year 5 was submitted as approved by the Board of Directors in January 2024 to NHSR by 1st February 2024 noon. There have been no guidelines released on MIS Year 6 and publication is expected in late Spring 2024.

2	Saving Babies Lives v Three (SBLv3) Safety Action 6 of the MIS year 5 Scheme
	The Saving Babies' Lives Care Bundle (SBLCB) launched in July provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle (SBLCBv3) was redeveloped to include a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. The Three-Year Delivery Plan for Maternity and Neonatal Services also sets out that providers should fully implement Version 3 of the SBLCB by March 2024. An

	implementation tool was developed nationally to support its implementation. Maternity services and commissioners completed a baseline assessment of current practice for WUTH in September 2023 and since then a review of the 300 pieces of evidence has taken place by the LMNS along with feedback given. As of November 2023, all outstanding audits and requested evidence have been submitted to the NHS Future platform and will be reviewed in December 2023 by the LMNS. There is a requirement by NHSE to report the implementation tool to the Board of Directors evidencing the Trusts compliance position to date, included at **Appendix 1**. Current compliance is 81% overall and the requirement is to be 100% compliant by the end of March 2024. All additional evidence was submitted by 16th February 2024 to the NHS Future platform and will be reviewed by the LMNS/ICB in February 2024, with an opportunity to have a further upload evidence if required. WUTH remains on target to meet SBLv3.

3	**Ockenden Review of Maternity Services: Final Report – Update on Trust compliance with the Immediate and Essential Actions / Recommendations**
	An initial gap analysis outlining compliance against these recommendations detailed within the 15 Immediate and Essential Actions (IEA's) was reported to the Board of Directors in December and updates have been provided quarterly. The gap analysis is included at **Appendix 2** and remains in the same RAG rated position as fully compliant.

4	**Three Year Delivery Plan – Maternity and Neonatal**
	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 3** and is RAG rated accordingly. The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion • Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support • Standards and structures that underpin safer, more personalised, and more equitable care. Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress is monitored via the Maternity and Neonatal Quality assurance board and WUTH continues to implement within the timescales. The Equity and equality guidance for local maternity services is the pathway followed to address health equalities and is also part of the three-year delivery plan.

5	**Implementing a Continuity of Carer Model of Maternity Care**
	The Maternity Service continues to deliver care via two models of maternity care – one that is traditional in its approach, and the other a Continuity of Carer (CoC) Model of care. Women being cared for by a team of midwives under the Continuity of Carer model appreciate the benefits of improved outcomes and experience compared to those cared for by a traditional model. As a provider WUTH has six maternity continuity of carer teams and in line with upskilling programs and safe staffing levels. A further team was launched in February

	2024 and further teams are anticipated in 2024, subject to identifying additional funding. A comprehensive review of MCoC is being undertaken that will be presented to the Board of Directors on completion and data is being collated on the outcomes for women. There is a delay to this piece of work as there has been a regional request to broaden and publish the findings as research. The workforce report is attached at **Appendix 4**.

6	**Maternity CQC Survey**
	The Care Quality Commission (CQC) conduct and annual national survey of maternity services, which in 2023 produced some positive results for Wirral Women and Children's Hospital at **Appendix 5 and 6**. The 2023 survey is split into eight sections to identify the women's maternity experience. The overall results indicate that Wirral Women and Children's Hospital has been providing quality care to expectant and new mothers. The hospital has received a 'better' rating in the 'Care at home' section and has been rated 'somewhat better' for the section 'Care in hospital after birth.' The Trust has also been providing better than average care for expectant and new mothers, as per the patients' responses.

7	**Maternity and Neonatal Research/Innovation Update**
	As requested at the January 2024 Trust Board of Directors an update is provided on current research and innovation within maternity and neonatal services as outlined below: - • Reproductive Health is one of the research priority speciality areas with an active portfolio. There are currently 5 studies open to recruitment. • A study opening soon- includes researching the implementation of the enhanced model of continuity of carer. • A study recently closed to recruitment- Evolve, which evaluated the implemented of the Saving Babies Live Version 2 care bundle. • Participation in the neoGASTRIC trial which is looking at whether routinely measuring gastric residual volumes (checking what is in the stomach before feeding) helps babies safely get to full feeds more quickly. • Additional externally funded posts for Neonatal service include a Clinical Psychologist for both patient and staff members (NNU), an Occupational Therapist for developmental care and a Breast-Feeding Lead. • Additional externally funded posts for maternity services include a Pelvic Health Specialist Lead Midwife to implement a new service in line with the three year delivery plan. A number of initiatives within the service include: - • Research boards have been put up across all areas of maternity. The boards are in both patient and staff areas in order to provide information on all current research studies. • Research link/champion roles are being launched soon, aiming to identify individual members of staff to act as a champion for research in their clinical areas, promoting the studies to patients and ensuring staff are aware of research activity in their clinical areas.

	• Research and innovation updates have been added to the Midwives Annual update to provide awareness and promotion. • Consultant Midwife is on the NIHR Senior Research Leader programme 23-26 working on local objectives to nurture and embed a culture of research across maternity and the wider W&C division, working with colleagues across the NW region and supporting the NW regional research network. This also includes working with the national research team at NHSE supporting national workstreams from the CMiDO office. • There is a close working relationship with the Research & Innovation department, with staff supporting the promotion of a research culture across the Trust as a whole.

8	**Perinatal Culture and Leadership Programme**
	As outlined in the Three-Year Delivery Plan by April 2024 a perinatal culture and leadership programme to all maternity and neonatal leadership quadrumvirates including the neonatal, obstetric, midwifery and operational leads was offered and mandated as part of MIS Year 5. WUTH's quad is included in Wave 2 which commenced in November 2023 and the programmes has three main aims: - nurture a positive safety culture. - enable psychologically safe working environments. - build compassionate leadership to make work a better place to be. This programme includes a diagnosis of local culture and practical support to nurture culture and leadership. As outlined on NHS Resolutions Year 5 Maternity Incentive Scheme, a summary report of the programme is attached at **Appendix 7**. The quad has committed to designated time a series of workshops and action learning sets which have enabled shaping a positive culture of care working and learning together as a quadrumvirate, accompanied by individual time to focus on personal development needs. In addition, all quad members have completed an individual 360' diagnostic, with a supported feedback session and accepted the invitation to undertake the SCORE survey at **Appendix 8**. As a result of the survey feedback cultural conversations have been facilitated and an action plan produced on the five key improvement areas to include: - • Efficient and effective communication and engagement. • Promoting courageous conversations in line with Trust values and behaviours. • Open, fair transparent Equality, Diversity and Inclusion recruitment. • Actively promoting wellbeing of oneself and of all others. • Visible leadership.

9	**Perinatal Clinical Surveillance Quality Assurance Report**
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 9** and provides an overview of the latest (January 2024) 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 Oct 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. Maternity has initiated in addition to Maternity and Newborn Safety Investigations (MNSI) an external review initiated there were three term still births in the later end of 2023. An update will be provided at the next quarterly Maternity and Neonatal Services report to the findings.

10	**Patient Safety Incident Investigations (PSSI's) & Maternity and Newborn Safety Incidents (MNSI)**
	Patient Safety Incident Investigations (PSSI's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSSI's across the region. There were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in January 2024 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 January 2024 for Neonatal services.

11	**Implications**
11.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
11.2	**People** • Compliance and confirmation via the LMNS/ICB WUTH have 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. • Progress with the three-year delivery plan supports birthing people and their families with quality improvements to deliver safer, more personalised, and more equitable care.
11.3	**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 continue to be explored.
11.5	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
6 March 2024

Item 8.7

Title	Learning from Deaths Report (Q2 2023-24)
Area Lead	Dr Nikki Stevenson, Executive Medical Director
Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board of Directors with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q2 23-24.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths
- The Trust SHMI for the latest available 12 month period (July 2022- June 2023) is 1.07 (within expected range)
- HSMR on the latest available data is 96.7 (within expected range)
- The Mortality review group (MRG) meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner.
- MRG continues to review Telstar Health data (formerly Dr Foster) to benchmark nationally and highlight areas of concern.
- Learning form mortality reviews is fed back to clinical areas by the Divisional Mortality leads.

It is recommended that the Board:

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

Key Risks

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

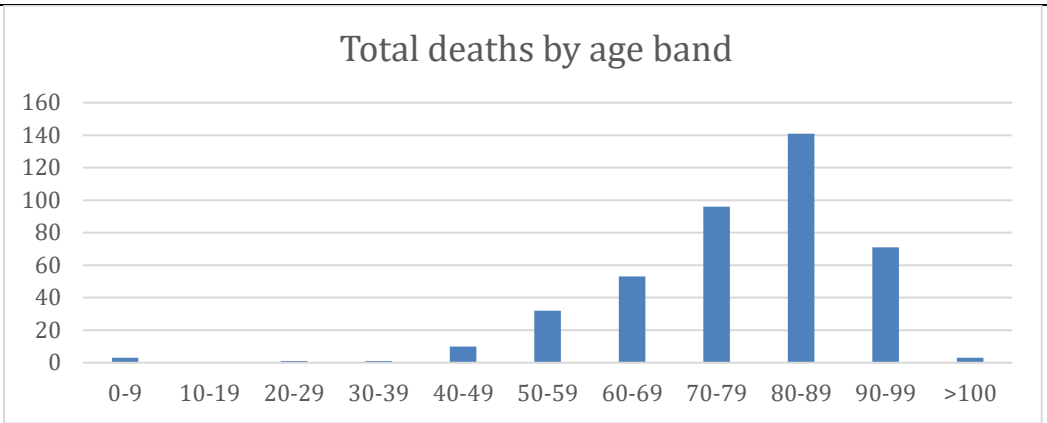
Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	No

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
29/01/2024	Quality Committee	As above	Information

1	**Narrative**
1.1	To provide a summary of the mortality review process, care issues, learning and current mortality comparator statistics. This paper is for Adult and perinatal mortality. Wirral University Teaching Hospital is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework: • Preventing people from dying prematurely. • Treating and caring for people in a safe environment and protecting them from avoidable harm. Wirral University Teaching Hospital uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a 'warning' of potential problems and help identify areas for investigation. The Medical Examiner service provides independent scrutiny for all deaths that occur within WUTH, and escalates any concerns for a mortality review, coordinated through the Trust Mortality Group. Additionally, a random 5% of non-escalated deaths are selected for a "quality assurance" mortality review. Lessons learnt from mortality reviews are fed back to each clinical Division via the Divisional Mortality leads who attend the Mortality Review Group. **<u>Patient demographics</u>** There was a total of 411 deaths in Q2 23-24. As per previous trends most recorded deaths are in the over 60 age group and the vast majority fall into the "White British" Ethnic band.



Ethnicity	Number of deaths
White - British	379
White - Irish	0
White - Any other White background	6
Mixed - Any other mixed background	0
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	0
Other Ethnic Groups - Chinese	0
Black/ Black British	0
Not stated/ Not known	26
Total	456

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The overall SHIMI for WUTH on the latest available data (12 months to June 2023) is 1.07 which is within the " as expected" range. SHIMI for WUTH has been relatively stable in the "expected" range for several quarters now.

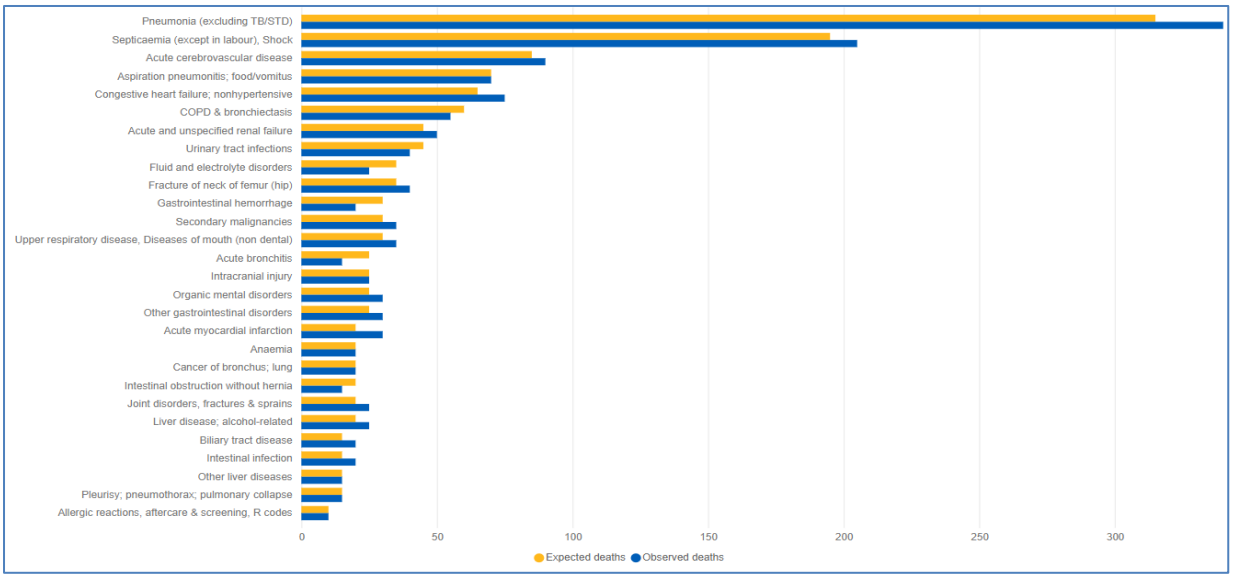
Factors impacting SHIMI

1. Specific diagnostic groups

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

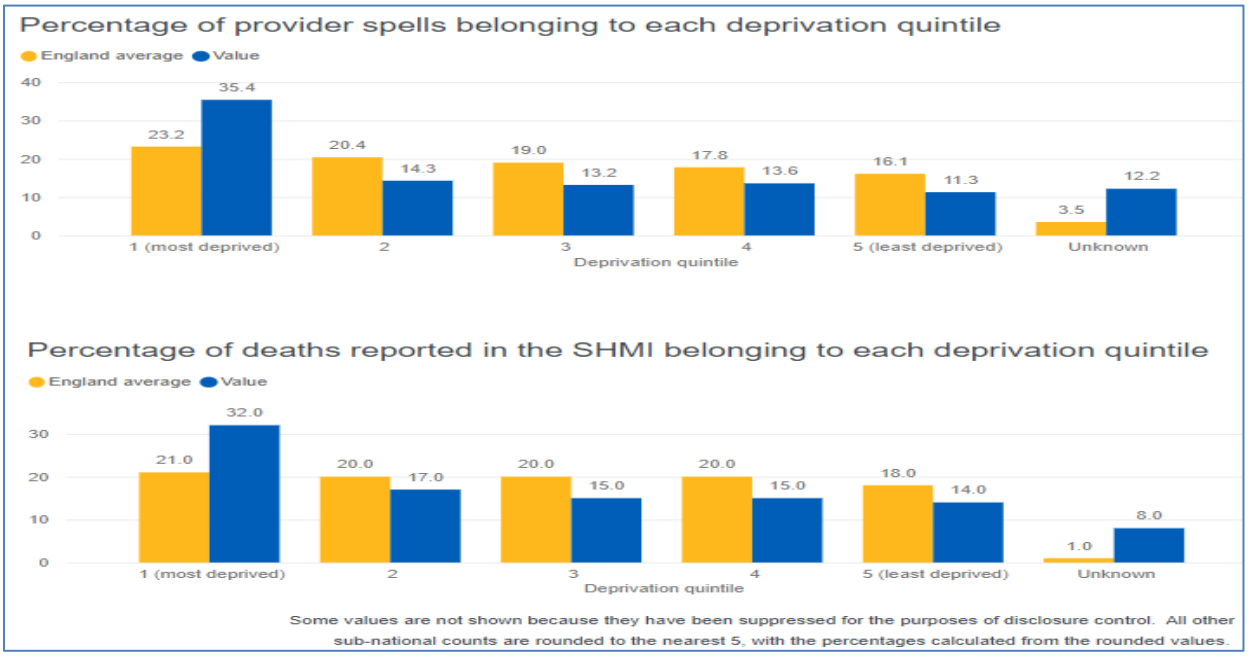
There are no individual diagnostic groups that were statistical outliers during Q2. Deaths in the diagnostic groups for Pneumonia and Sepsis have more observed

deaths than expected and work is ongoing around these deaths to better understand and improve care.



2. Impact of deprivation on SHIMI

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

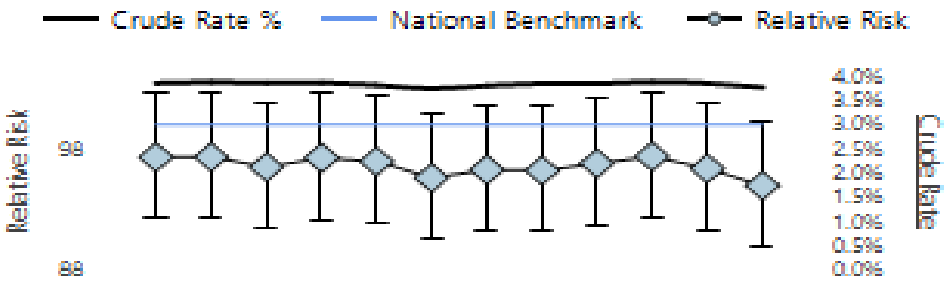


3. Palliative care coding

As discussed in previous reports WUTH continues to have a higher than average number of patients who have a palliative care code (after being reviewed by palliative care). A large number of patients with this code will impact on SHIMI as the SHIMI model does not exclude these patients (unlike HSMR). Recent reviews have shown that palliative care coding remains appropriate and is a reflection of a proactive palliative care service.

Hospital Standardised Mortality Ratio (HSMR)

The HSMR for the latest available is 96.7. This is in the expected range, and slightly lower than the previous quarter.



Summary of all Adult in patient deaths and case reviews						
	Total Adult In-patients Deaths	Deaths reviewed by ME service (%)	Total No of cases escalated for review by Medical Examiner	Total No of SJR's opened from cases escalated	Quality assurance PMR's opened	Total number of case reviews opened by MRG
Q3 (22-23)	533	100%	19	6	22	41
Q4 (22-23)	503	100%	17	2	15	32
Q1 (23-24)	456	100%	24	10	26	50

Q2 (23-24)	411	100%	16	7	13	29

Mortality Dashboard

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

16 cases escalated by the ME to the mortality review group have undergone a review during Q2. These cases have been reviewed using a revised PMR template, or via the Royal College of Physicians Structured Judgement review tool.

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 13 deaths were reviewed in Q2 (3%) using the PMR template. None of these cases identified any cause for concern.

During Q2 6 escalated mortality reports were discussed at MRG with the grading as below.

Grading of Adult Care and avoidability following review in Q2 (Includes reviews opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
Number of cases	5	1	0	0

During Q2 four (4) deaths were reported in patients identified as having a Learning disability. All of these deaths will be reviewed using the SJR template and have also been referred for external review through the national LeDeR programme.

Learning Disability Mortality Reviews				
	Total No. of LD Deaths	No. reviewed using SJR	Problems in Health care Identified in this Quarter	Referred to National LeDeR Programme
Q3 (22-23)	3	3	0	3
Q4 (22-23)	2	2	1	3
Q1 (23-24)	10	10	0	10
Q2 (23-24)	4	4	0	4

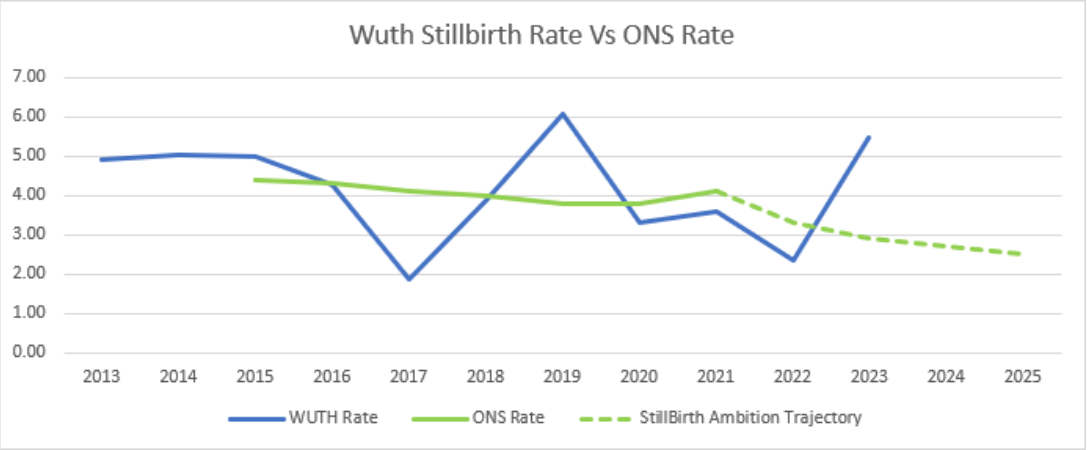
Perinatal and Neonatal deaths

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

	Stillbirths	Neonatal Deaths	Paediatric deaths	Cases sent for PMRT review
Q3 (22-23)	1	4	1	6
Q4 (22-23)	2	1	0	3
Q1 (23-24)	0	2	1	3
Q2 (23-24)	3	2	0	5

During Q2 there were 2 neonatal deaths and 3 stillbirths. There were no paediatric deaths.

The still birth rate has increased over the past few months, and has been over the ONS rate for the past few months. The Division has been proactively investigating this and has put in place an action plan to keep track of progress. The PMRT reviews have not fed back any cause for concern, although not all cases have yet been reviewed through the PMRT process.



Outcome of PMRT reviews reported in Q2				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues,likely affected outcome
	1	4	1	0

Learning Identified from PMRT reviews.

There were 6 PMRT case reports finalised during Q2. All but one of the cases were adjudged to have good care, or minor care issues that would not have affected the outcome.
One case was graded as “C”, where it was felt care issues may have affected the outcome. This was in relation to an issue with continuity of care between community midwives and the maternity triage at WUTH. The process has been reviewed and strengthened to ensure in future continuity of care is better maintained.

Learning identified through review of mortality reviews during Q2

Learning for mortality is derived from 3 main sources.

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

Specific learning and themes identified during Q2 as well as actions taken are listed in the table below.

Learning theme	Source	Action taken
Poor documentation/ copying and pasting of medical documentation	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads.
Poor documentation around MCA and DNACPR decisions	Mortality reviews	Continues to be a theme, although less frequent than in previous quarters. All these cases are feedback to individual teams and the Trust CPR committee. MCA training and has been refreshed across all areas recently and audits of DNACPR forms strengthened to ensure better compliance.
Poor practice around Lasting Power of Attorney (LPA), Mental capacity and consent to treatment	Mortality review	Focus on staff mandatory training, with audit of knowledge underway. Monitored through safeguarding group.
Issues around maternity Triage and continuity of care	PMRT	Process reviewed and strengthened to ensure better continuity of care. Monitored through PSQB

External Benchmarking Data

Dr Telstar Health (Dr Foster) Data

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

There were no CUSUM alerts identified in Q2.

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

Diagnostic Group	Quarter Highlighted	Alert type	Work undertaken	Outcome/ Learning
Pneumonia	Q2 22-23	High SHIMI	Case note audit	Audit completed. Only 30% of patients in this group were felt to have pneumonia. Issues identified around sputum culture and smoking cessation advice. Audit to be discussed at Respiratory team meeting and action plan to address issues identified will be developed.
Secondary Malignancy	Q3 22- 23	High SHIMI	Case note audit	Small numbers of cases. On review on emerging themes and diagnostic group no longer a cause for concern
Non-Infective Gastroenteritis	Q4 22-23	High SHIMI	Case note review	Small numbers, but 6 of the 7 cases had different final diagnosis. No concerns in care identified.

Mortality indicators (SHIMI and HSMR) are both within the “as expected” range. There are no individual diagnostic groups that are statistical outliers during Q2. The Medical Examiner continues to provide scrutiny for all death and helps to identify learning and escalate concerns to the Mortality Review group.

The Mortality Review Group continues to meet every 2 weeks to review appropriate cases and ensure learning themes and trends are captured and fed back to clinical areas. Benchmarking form Telstar Health has not identified any areas of concern during Q2.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.8**

06 March 2024

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

Executive Summary and Report Recommendations

The purpose of this report is to give assurance to Board of Directors that doctors and dentists in training are safely rostered and that their working hours are compliant with the terms and conditions of service (TCS).

This report covers the period 30th September to 31st December 2023 (Q3 2023-24) and outlines the following:

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

There are a small number of exception reports outstanding which will be closed with the support of the newly appointed Guardian of Safe Working. The Trust continues to support junior doctors to complete exception reports as it gives a greater understanding of workforce and training issues.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

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

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

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
25/01/2024	People Committee	As above	Information

1 Narrative

Dr Alice Arch has been successful in her appointment as Guardian of Safe Working and commenced in post on 1st November 2023.

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

High level data for Wirral University Teaching Hospital NHS Foundation Trust

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

Exception reports (regarding working hours)

Exception reports by department

Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E	0	7	5	2
General Medicine	0	61	49	12
General Surgery	0	18	18	0
Special Surgery	0	1	1	0
T&O	0	9	6	3
Women & Children's	0	5	4	1
Total	0	101	83	18

Exception reports by grade

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	92	77	15
F2	0	2	2	0
SHO	0	21	20	1
SPR	0	1	1	0
Total	0	116	100	16

Exception reports by Rota

Rota	No. exceptions carried over	No. exceptions raised	No. exceptions closed	No. exceptions outstanding

	from last report			
A&E 20% Fellow	0	4	3	1
A&E F2 LIFT Weeks	0	3	2	1
A&E SHO	0	0	0	0
DCT Rota	0	0	0	0
Gen Paeds SpR 0.6 WThF	0	0	0	0
Gen Paeds T1	0	5	4	1
Medicine F1	0	42	37	5
Medicine F1 LIFT MT	0	0	0	0
Medicine F1 LIFT WF	0	0	0	0
Medicine IMY2	0	1	1	0
Medicine SHO	0	5	4	1
Medicine SHO LIFT MT	0	0	0	0
Medicine SHO 0.8 MTWTh	0	2	2	0
Medicine T1 General	0	0	0	0
Renal	0	1	1	0
Paediatrics Basic Hours	0	0	0	0
Surgical F1	0	18	18	0
Surgical F1 LIFT WF	0	0	0	0
Urology	0	1	1	0
Clatterbridge Fellow	0	1	0	1
GP F2	0	1	1	0
GP F2 LIFT MT Card WE	0	8	3	5
T&O Extra F1	0	1	0	1
Trauma & Orthopaedics	0	8	6	2
Total	0	101	83	18

Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
F1	11	9	5	20	10	6
F2	1	0	0	2	3	6
SHO	6	3	3	7	3	6
ST3-8	0	0	0	0	0	0
Total	18	12	8	29	16	18

Exception reports (regarding training/academic issues)

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

Exception Reports

There are a large number of exception reports in medicine, and this has been due to a small number of individuals of junior doctors (F1) raising multiple exception reports. These individuals have met with their Educational Supervisors and appropriate support has been put in place to address.

Additionally, several junior doctors raised exception reports due to covering the hour change on Sunday 27th October 2024.

	Work schedule reviews There have been no work schedule reviews this quarter. **Vacancies** There are a number of vacant shifts which occur, for example, due to sickness or parental leave gaps on rotas which can contribute to exception reports. The majority of these vacant shifts were within the Emergency Department. Vacancies are covered by doctors on flexible contracts and via the collaborative bank to minimise risks to patients or doctors in training. Medical staffing reviews are underway in several specialities. **Fines** We are in the process of raising fines against Surgery T&O. Several exception reports have been raised following handovers repeatedly running over. This position is being closely monitored.

2	Implications
2.1	**Patients** • The role of the safe working hours is designed to reassure junior doctors and the Trust that rotas and working conditions are safe for doctors and patients.
2.2	**People** • The Guardian ensures that issues of compliance with safe working hours are addressed by the doctor and the Trust as appropriate. It provides assurance to the board of the employing organization that doctors' hours are safe. • The guardian works in collaboration with the Director of Medical Education and Local Negotiating Committee to ensure that the identified issues within exception reports, concerning both working hours and training hours, are properly addressed by the Trust.
2.3	**Finance** • The Guardian distributes monies received as a consequence of financial penalties to improve the training and working experience of all doctors. There have been no financial penalties this quarter.
2.4	**Compliance** • This report provides assurance and compliance as per contractual obligations with NHSE and the NHS employers.

Green and Sustainability Plan Update

Board of Directors
March 2024
Version 1.0

Green Plan Update
Context

Wirral University Teaching Hospital
NHS Foundation Trust

In October 2020, NHSE published the Delivering a Net Zero NHS guidance (image, right).

All NHS Trusts in England were subsequently required to develop and publish their own local Green Plans; a document that would outline how they intend to deliver a reduction in **Carbon Footprint to Net Zero** against a 1990 baseline, by 2040 (80% by 2028-32).

The WUTH Green Plan was submitted to the ICS ahead of the 14th January 2022 deadline, this contributed to the development of system plans (C&M Green Plan Green Plan - NHS Cheshire and Merseyside) , and the national guidance was updated in July 2022.

Green Plan | Wirral University Hospital NHS Foundation Trust (wuth.nhs.uk)

The WUTH Green Plan (baseline data 2020/21) contains a number of actions which are tracked and monitored via the Sustainable Development Group. The carbon footprint data is collected annually (last updated with 2021/22 data).

together we will

Green Plan Update
Our Progress

Wirral University Teaching Hospital
NHS Foundation Trust

Green Plan Action Progress

2020/21	2021/22
79 Not Started/Limited Progress	51 Not Started/Limited Progress
30 Started or Partially Completed	61 Started or Partially Completed
10 Complete or Ongoing	16 Complete or Ongoing

The data collection for the 2022/23 Green Plan refresh will be taking place in January 2024, the first draft of the 2023 refreshed Green Plan should be ready for March 22nd 2024.

Green Plan Video

A promotional video of the Green Plan was communicated to staff on World Environment Day in June 2023, https://youtu.be/mLCPtJGpLIc

World Environment Day today	Today is World Environment Day which is celebrated annually to encourage awareness and action for the protection of the environment. To find out how WUTH will be taking action to reduce our impact on the environment, please watch our **WUTH Green Plan video**. If you would like to be part of WUTH's Green Journey, why not join our **Green Champions Network**? For more information or any questions please contact the WUTH Sustainability Team on **wuth.sustainability@nhs.net** and be sure to follow us on Twitter @GreenerWUTH.

together we will

wuth.nhs.uk

Sustainability Update
Key Updates – Staff engagement

Wirral University Teaching Hospital
NHS Foundation Trust

Sustainable Development Group (SDG)

A Sustainable Development Group has been set up which meets bi-monthly and is attended by various departmental representatives such as; Workforce, Digital Healthcare Team, Estates, Facilities & Capital (inc. Travel & Transport and Waste representatives), Infection Prevention Control, Pharmacy, Finance-Procurement, Catering and Communications. The purpose of the meeting is to provide a structured and open forum for key sustainability stakeholders within the Trust to ensure there are robust arrangements in place to effectively and proactively manage all aspects of sustainability and is a tracking and monitoring forum for the Trust Green Plan. A formal governance reporting route has yet to be established.

Green Champions Network

The Green Champions Network was introduced to WUTH in May 2023 it is a low-cost initiative to drive down our carbon footprint and deliver efficiencies spread across the organisation through monitoring things like waste, energy and behaviours. The Network brings together like-minded individuals to discuss ways of changing behaviours and practices at a local level. Relevant items raised by the champions are discussed at the Sustainable Development Group.

together we will

Sustainability Update
Key Updates – Energy

Wirral University Teaching Hospital
NHS Foundation Trust

Estates Energy Plan (2023-2026)

In May 2023 the WUTH Sustainability Team launched an Energy Plan which aligns to our Estates Strategy and addresses key themes such as integration, data benchmarking, assurance and sustainability. The plan outlines our three-year approach, setting out our ambitions to adapt our energy philosophies from one of sole import to a hybrid model of import and self-generation whilst maintaining business continuity for service users.

WUTH Heat Decarbonisation Plan (HDP)

It is an NHSE requirement for all Trust's to develop a HDP by March 2024, in addition to this many of the grants within the Public Sector Decarbonisation Scheme are conditional on a HDP being produced. A HDP has been drafted for WUTH which sets out how the Trust intends to replace fossil fuel reliant heating systems with low carbon alternatives such as heat pumps. The HDP will be a living document and as part of the plan we commissioned a heat distribution survey at Arrowe Park Hospital (November 2023). The next steps will be to formalise the draft plan with the Estates team and seek approval through Trust governance.

Insite Pilot

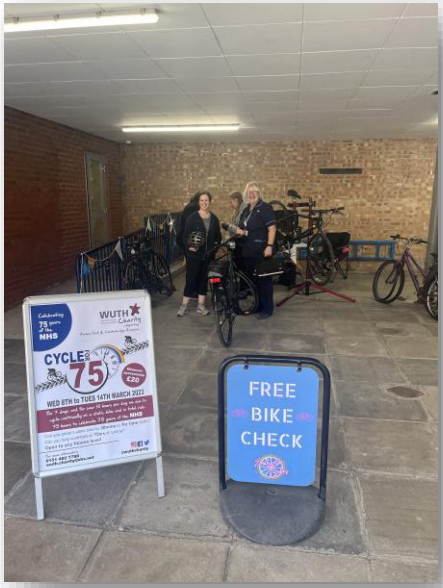
WUTH has completed a Letter of Authorisation (November 2023) to take part in the InSite pilot which is a project between NHSE and the Energy Systems Catapult to build a new national energy database. InSite aims to address sector challenges, many of which burden Trusts. These include evidence gaps on real costs and outcomes of decarbonisation and energy efficiency interventions, as well as non-automated, inconsistent and isolated data.

Sustainability Update
Key Updates – Travel & Transport/ Medical Gases

Wirral University Teaching Hospital
NHS Foundation Trust

Active Travel - Dr Bike Sessions

In February 2023 we hosted two Dr Bike Sessions; one at Arrowe Park Hospital which was ran by Energise Cycles and one at Clatterbridge Hospital (including partner organisations on the Clatterbridge site) which was ran by Just Riding Along. The sessions included a free bike maintenance service and were popular with our staff, we will be hoping to arrange more sessions for Spring 2024.



Active Travel - Liverpool City Region (LCR) Combined Authority, Big Bus Consultation, APH

In July 2023 a member of the LCR Combined Authority reached out for our support in promoting a public consultation into the franchising of bus services. They held a stall in the main reception of APH to gather feedback from passing members of staff, patients and visitors.

Anaesthetic Gases - Nitrous Oxide Reduction, CGH

In April 2023 the WUTH Sustainability Team collaborated with the Estates Department in addition to Clinical Leads to switch off a Nitrous Oxide Manifold at our Clatterbridge site which will reduce the amount of Nitrous Oxide that is wasted, it is estimated to reduce our carbon footprint by 100 tonnes CO2e per year. Nitrous Oxide is a gas commonly used as an anaesthetic and analgesic agent that has an environmental impact 300 times that of Carbon Dioxide.

Sustainability Update
Key Updates – Greenspace & Biodiversity

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Tatton Flower Show 2023 Garden

In October 2023 WUTH Charity received an award-winning show garden from the 2023 Tatton Flower Show which has been installed on the Clatterbridge site, the garden's theme "Constructing Minds" is based on the hidden issues of mental health for construction workers and has been designed as a calming space to help those struggling with their mental health.

No Mow Campaign

In July 2023, a "No Mow" Campaign was introduced at our Clatterbridge Site in certain areas to support Biodiversity. A member of our Grounds Team also noticed that we had Wild Bee Orchids growing on site which are uncommon and a protected species, so we placed signage in this area also.

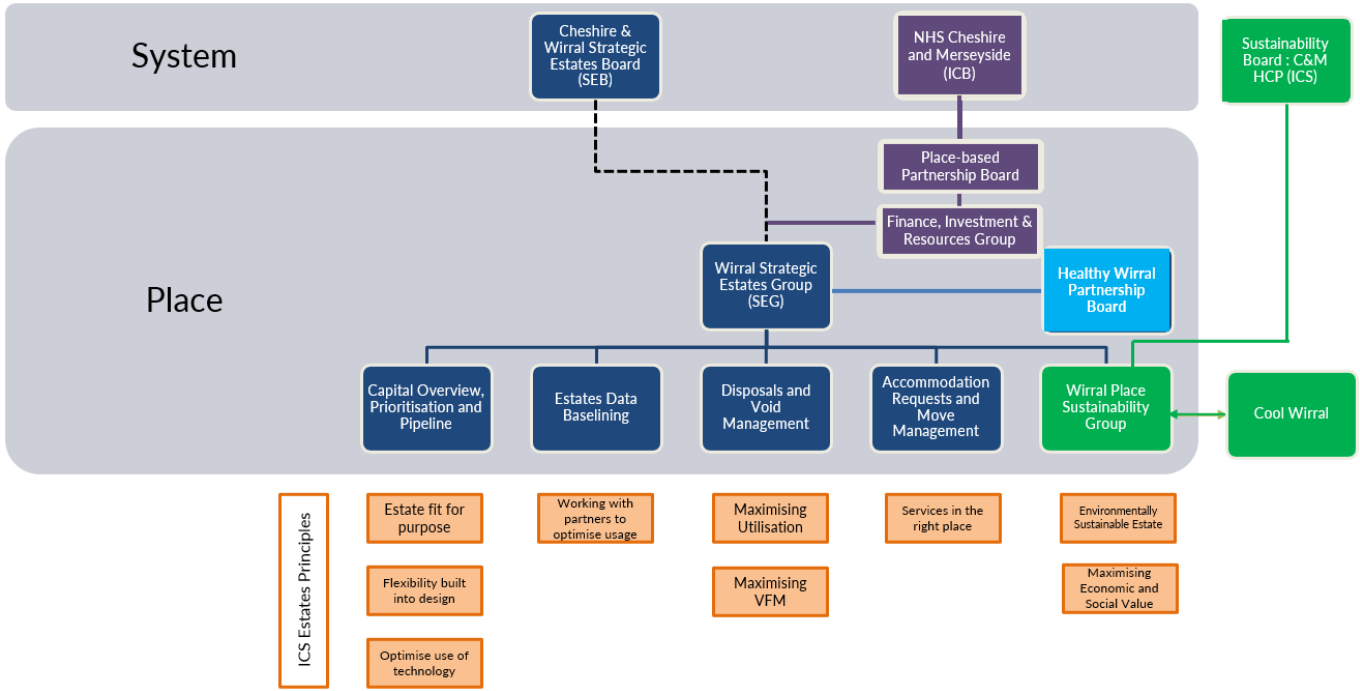
Sustainability Update
Key Updates – External engagement

Wirral University Teaching Hospital
NHS Foundation Trust

- **Wirral Place Sustainability Group**
  WUTH Chairs the Wirral Place Sustainability Group which was established in October 2022 to bring together Sustainability Leads across Wirral from the NHS and Local Authorities.

- **C&M Sustainability Board**
  Established to promote delivery of the Greener NHS programme, enable collaborative system green planning and to inform the ICB Estates Strategy. Reports into the Health and Care Board which in turn feeds into NHS C&M's Executive Board.

- **Cool Wirral**
  WUTH is part of the Cool Wirral Partnership which co-ordinates local action on climate change. The partnership is supported by Wirral Council and meets three times a year.



Sustainability Update
Key Updates – External engagement

Wirral University Teaching Hospital
NHS Foundation Trust

- **NHSE Climate Change Risk Assessment (CCRA) Tool**
  WUTH was one three C&M NHS organisations to pilot the NHSE's CCRA tool, a number of improvements were recommended. It is hoped that a revised version of the tool will be published 2024/25 which will be used to support Climate Adaptation Planning at WUTH.

- **Tree Planting at Clatterbridge Site**
  There is a requirement as part of the CDC project to plant 41 extra-heavy standard native trees on the Clatterbridge Site to achieve Biodiversity Net Gain. The WUTH Sustainability Team are working with the Wirral Council to implement this, as it ties in with their Biodiversity Strategy commitment to plant 210,000 trees by 2030 increasing the Wirral "Green Canopy".

- **Waste Management Research, Liverpool John Moore's University (LMJU)**
  LMJU contacted the WUTH Sustainability Team with an opportunity to get involved in a research project focused on improving sustainable healthcare waste management within NHS Trust's in the Northwest. Clatterbridge Cancer Centre are already collaborating with them as are another Trust based in Liverpool, this is funded by THIS Institute, University of Cambridge. The results of this research will be extremely useful to feed into the Trust Waste Management Plan that is currently being drafted.

Sustainability Update
Plan for 2024/25

Wirral University Teaching Hospital
NHS Foundation Trust

March 2024

Heat Decarbonisation Plan

To be launched in April 2024

May 2024

Waste Management Plan

WUTH Sustainability Team is working with Facilities & Support Services to conduct a gap analysis between our current waste disposal practises and the new NHS Clinical Waste Strategy and HTM 07-01: Safe & sustainable management of healthcare waste. To be launched in May 2024.

Sept 2024

Energy Campaign

WUTH Sustainability Team to work with Estates to develop a "Switch it off" campaign for staff engagement, this is to be launched in September 2024

Dec 2024 – March 2025

WUTH Green Travel Plan

Develop a WUTH Green Travel Plan following on Liverpool City Region consultation work.

WUTH Climate Adaptation Plan

Develop a WUTH Climate Adaptation Plan using NHSE Climate Change Risk Assessment Toolkit

together we will

wuth.nhs.uk

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 11**

6 March 2024

Title	Controlled Drug Accountable Officer Report
Area Lead	Chris Green, Director of Pharmacy and Medicines Optimisation
Author	Amy Janvier, Lead Pharmacist Procurement and Medicines Supply
Report for	Information

Report Purpose and Recommendations

This report provides the Board of Directors with an overview of Controlled Drug (CD) activity during 2022/23. It is a national requirement for Trusts to employ a Controlled Drugs Accountable Officer (CDAO) and that the CDAO provides assurance around CD management to Trust Boards or their delegated committee. The Trust CDAO is the Director of Pharmacy and Medicines Optimisation.

CD incidents are monitored in the Trust on a daily basis and incidents of note and trends are escalated to the CDAO. In addition, it is a legal requirement that Wirral University Teaching Hospital NHS Foundation Trust (WUTH) report any incidents or concerns regarding the management of controlled drugs within the organisation to the CD Local Intelligence Network (CDLIN) every quarter. 211 incidents involving CDs were reported in 2022-23. No patients came to harm. The Trust is noted by the regional team to be a high number, low harm reporter indicative of an open reporting culture.

Quarterly audits of controlled drugs were undertaken during 2022/23. The standards audited relate to CD legislation reflected in the Trust CD policy. Compliance was Q1 98%, Q2 97%, Q3 98% and Q4 97%for 2022/23. This is a sustained improvement across all quarters compared to 2022/23.

The recommendations from the report will continue to support improvements in compliance with legislation, patient experience and safety, and monitoring of usage trends to highlight potential diversion:

- CD incidents review and trend analysis will continue with actions to prevent further incidents being implemented and any learning from incidents shared
- Ward and department CD audits will continue to be undertaken and presented to MSOP on a quarterly basis. Areas of non-compliance to be cascaded by Matrons to relevant Ward Managers. Divisional Directors of nursing will be held accountable for improved performance via MSOP.
- WUTH will work with Wirral Place to support the safe prescribing and management of CDs across all areas of Healthcare on Wirral

It is recommended that the Board:

- Note the report and recommendations

Key Risks
This report relates to these key Risks: • Controlled Drugs as their description implies, are subject to a number of legislative controls regarding their procurement, storage, prescribing, supply and administration. • Because of their pharmacological properties, these drugs are unfortunately an attractive proposition to anyone wishing to abuse or misappropriate them and therefore are amongst the highest risk medicinal products which are handled by the Pharmacy team.

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

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	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**
29/01/2024	Quality Committee	As above	Information

1	Narrative
1.1	**Introduction** In accordance with the Controlled Drugs Regulations 2013, Wirral University Teaching Hospital NHS Foundation Trust (WUTH) has an Accountable Officer (AO) for controlled drugs who has responsibility for the safe use and management of controlled drugs. The CDAO is the Director of Pharmacy and Medicines Optimisation. It is the CDAO's responsibility to report CD incidents and near misses to the Regional CD Local Intelligence Network (CDLIN) and risk asses them against the specific CDLIN risk stratification system. The CDAO must also produce an annual report for the Board of Directors or its delegated committee to provide assurance around the management of CDs within WUTH. During 2022/23, WUTH had 3 areas within the Pharmacy Department holding a wide range of CDs; the Pharmacy Dispensary and Aseptic Unit on the Arrowe Park Hospital site and Central Pharmacy Stores at Clatterbridge. In addition, the pharmacy satellite dispensaries stock gabapentin, pregabalin and tramadol which

	are schedule 3 CDs. These CDs are to be ordered in a CD order book, have additional prescription requirements but are not required to be stored in a CD cupboard. The pharmacy satellites do not stock schedule 2 CDs. CDs are supplied to over 80 wards and departments within WUTH. The Trust holds two Home Office Controlled Drug Licences which permit the supply of CDs to external organisations such as Wirral Hospice St Johns. There is a requirement to meet a range of standards covering procurement, receipt, storage, security, supply and destruction of CDs. These standards are applied across all Trust CD activity and their attainment gives external assurance that CD processes are tightly controlled.
1.2	**Monitoring of CD Incidents and Usage Trends** All incidents are monitored on a daily basis by the Trust Medicines Safety Officer (MSO) and incidents of note and trends including CDs are escalated to the CDAO. In addition, incidents are submitted to the CDLIN for review across the health economy. There were 211 incidents involving CDs reported across WUTH between April 2022 and March 2023 compared to 201 reported the previous year. CD incident reports continue to show an upward trend (table 1). WUTH is noted to be a "high number, low harm reporter" (in line with National Reporting and Learning System evidence) and it is considered to be good practice to submit all incidents reported rather than simply those of concern. Incident reporting of CD issues has continued to be encouraged and the increased number of incidents reported maybe due to substance misuse team reviewing every patient admitted, launch of electronic prescribing of syringe drivers and continued completion of CD incidents following audits in wards and departments. **Table 1: CD Incidents Reported April 2015 – March 2023**

Financial Year	Number of incidents	percentage increase on previous year
2022-23	211	↑5%
2021-22	201	↑24%
2020-21	161	↓4%
2019-20	169	↑1%
2018-19	167	↑9%
2017-18	153	↑82%
2016-17	84	↑30%
2015-16	65	-

Figure 1 shows the breakdown of the 211 incidents reported for the 2022-23 year into quarters.

Figure 1: 2022-23 CD incident reports by quarter

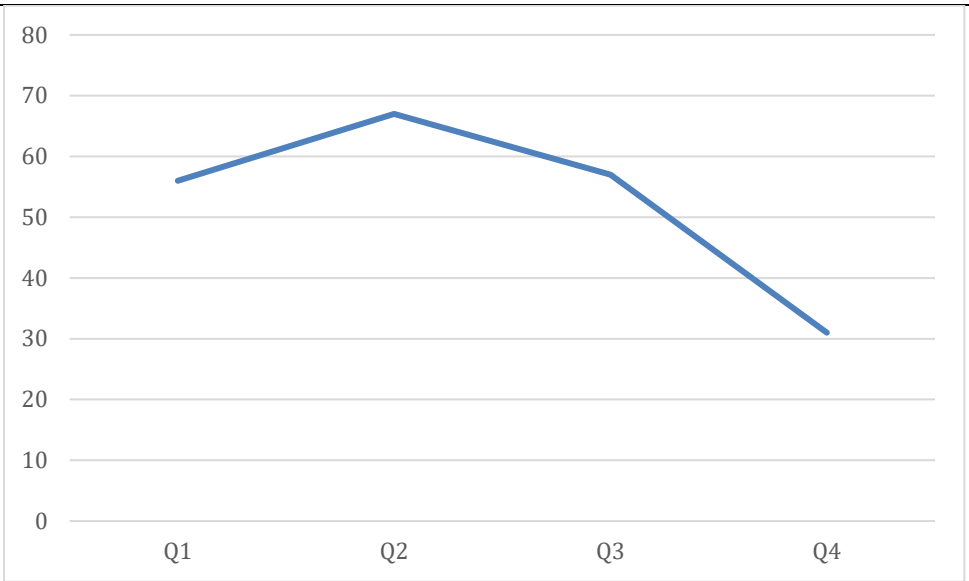
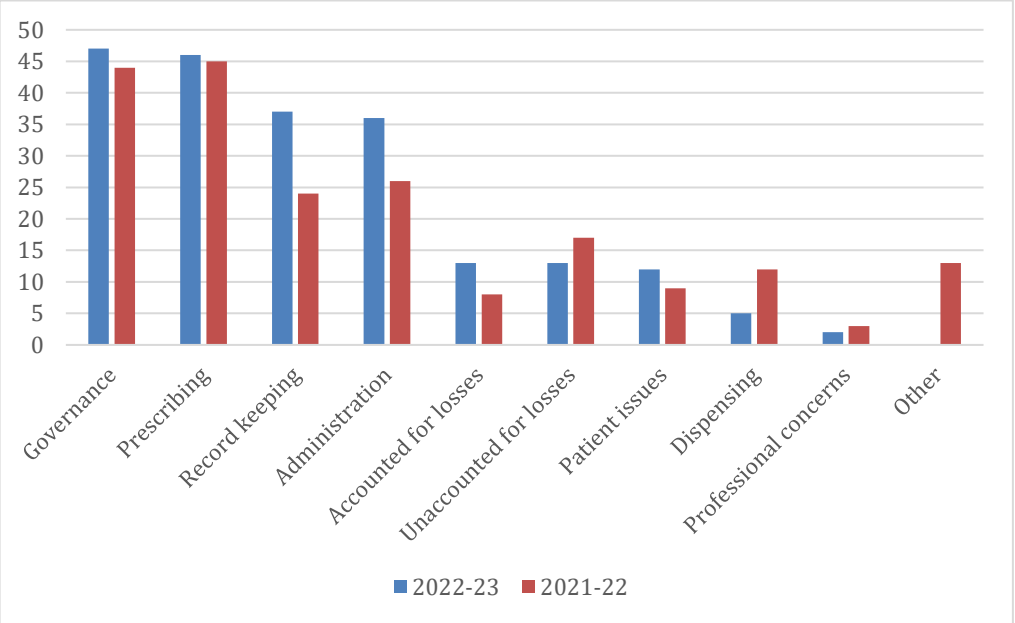


Figure 2 shows the break down in type of incident reported in CDLIN categories for the year 2022-23 compared to 2021-22.

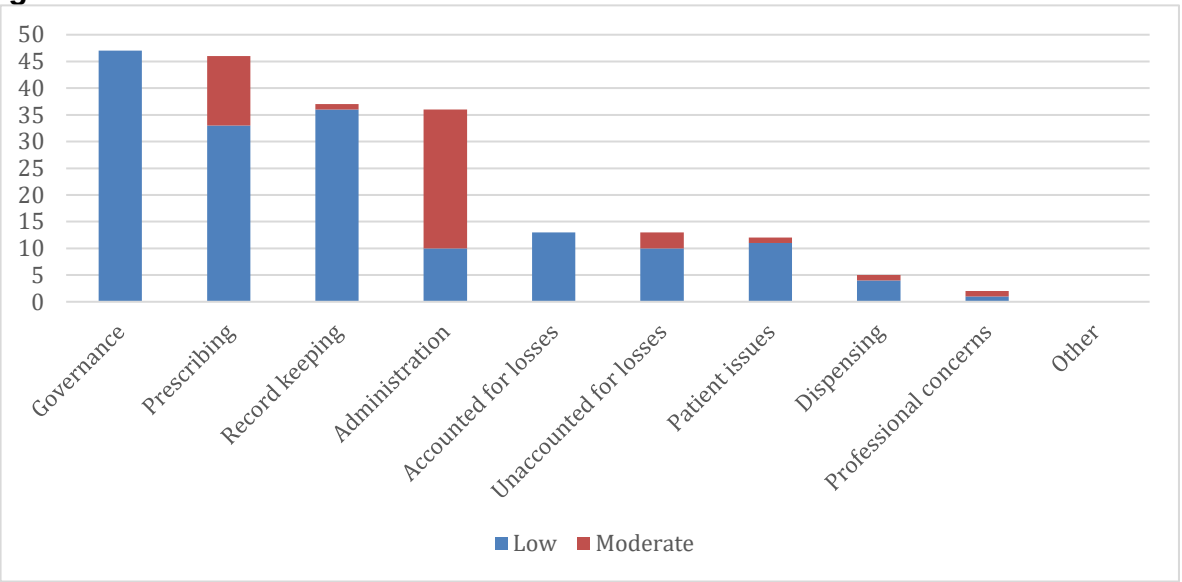
Figure 2: Categories of CD Incidents Reported



The CDLIN risk stratification system is a nationwide tool used for the stratification of CD incidents being reported into the national incident reporting system. Incidents classed as low are one-off incidents such as a broken ampoule, CD record book error and CD discrepancies that are accounted for in daily practice e.g. liquid spill. The CDLIN classes any prescribing or administration incidents in which the patient received an incorrect medicine (including modified release preparations instead of immediate release) as moderate even if no harm was caused to the patient. This differs to other national grading systems.

According to the CDLIN risk stratification system of the 211 incidents reported at WUTH, 165 were classed as low and 46 as moderate (figure 3). There were no incidents reported as high or extreme.

Figure 3: Risk stratification of incidents 2022/22



Governance (n=47) issues were the most common incident type reported. Governance incidents include all incidents that have occurred because trust policy relating to the safe and secure handling of medicines has not been followed. Policies and procedures relating to the management of CDs from delivery into the trust until they are used, disposed of or given to patients on discharge are more extensive than those for other medicines. This is because there is additional legislation that covers CDs and CDs are considered high risk medicines both in terms of clinical use and for risk of diversion. Examples of governance incidents include CDs not locked away in a CD cupboard, CD deliveries not dealt with immediately, leaving CDs in the transport bag, patient's own CDs found in bedside lockers, expired CDs not removed from ward / department and CD stock checks not completed correctly. The incidents were all scored as low using the CD LIN classification and spread across a range of wards/departments. No trends have been identified with wards, staff or the products involved.

Prescribing incidents (n=46) were the second most common incident type reported. Incidents in which patients did not receive an incorrectly prescribed controlled drug were risk assessed as low. Themes within the prescribing category include:

- Prescribing of methadone without confirmation or documentation of the patient's usual prescription in line with the trust pathway (n=11). For the majority of patients, the prescription was appropriate but clear documentation of dose confirmation was not completed.
- Medicines for use in theatre only, including IV morphine, were not discontinued from the patients' prescriptions prior to transfer to a ward (n=9). These incidents have been discussed at theatre governance meetings and information circulated to staff to remind them of the correct processes and checks that need to be completed prior to moving a patient to a ward.
- Syringe driver incidents (n=6). Prescribing of syringe drivers moved from paper onto Wirral Millennium in March 2022. The palliative care team have been closely monitoring the change and incident reporting has been encouraged to highlight any risks or additional training that staff may need.

Although some of the prescribing incidents are classed as moderate because patients received an incorrect medicine or an incorrect dose no harm came to any patients.

Record keeping incidents (n=37) include entries on incorrect pages of the CD record books, CDs not written out of the record books when given to patients on discharge and doses administered not recorded correctly either in the CD record book or on Wirral Millennium.

Administration incidents (n=36) are mostly classified as moderate under CDLIN guidance as previously stated. Administration incidents classed as low included patients not receiving a dose of a CD medicine that they were prescribed or problems when trying to set up a syringe driver for administration. The number of administration incidents reported has increased in 2022-23. Themes within the administration category include:

- Extra doses being given (n=5) e.g. due to oral and subcutaneous breakthrough doses being given, oxycodone injection given to a patient with an epidural.
- Incorrect doses due to medicines being diluted prior to administration (n=4) and staff not correctly calculating how much volume would then need to be administered. Additional information is to be added to the pre-built lorazepam injection order sentence on Wirral Millennium following the incident involving lorazepam.
- Patients not receiving a dose of their prescribed medicine (n=3).

Morphine and oxycodone continue to be the drugs most commonly involved in the administration errors reported.

Nurses involved in administration errors are asked to reflect on any errors made to gain learning for mitigation strategies and were deemed necessary, attend further training.

A contributing factor for administration errors has been identified in the AO report since 2016, which is that Wirral Millennium (WM) does not always fully display the prescription without needing to 'hover over' the medicine which means that all of the details are not "face up" and available without this added step. This was a risk register entry at WM go live as it conflicts with national guidance requiring electronic prescribing and medicines administration record to have "face up" medicines description. To date, Cerner have not committed to providing a fix for this direct patient safety issue and therefore this remains as a residual risk.

Accounted for losses (n=13). These incidents include breakages or spillages and when the missing controlled drugs have been found and are accounted for following an initial report of a discrepancy.

Unaccounted for losses (n=13). Incidents which are originally reported as discrepancies (accounted for or unaccounted for losses) are investigated promptly by pharmacy staff. Mainly these are found to be due to poor documentation or sometimes due to incorrect administration and not actual CD losses. 5 of the unaccounted for losses were oxycodone liquid discrepancies within the 10% (25ml) tolerance permitted within the CD policy. Oxycodone 5mg/5ml liquid is supplied in a 250ml bottle. Often patients are prescribed small doses of 1.25 – 2.5ml. During dose administration there maybe a small amount of liquid lost, e.g. a small amount of liquid on the end of the syringe, but if multiple small doses are given out of a bottle these losses can add up to become 5 – 10ml in total. Bungs are supplied to wards and departments with CD liquids and staff are encouraged to use them to aid the use of oral syringes to reduce liquid losses during administration. Liquid CD measures to support ward staff accurately measuring remaining CD liquid stock volumes are being procured.

5 incidents were related to discrepancies with patient's own medicines that had been brought into the trust. Poor packaging may have been a cause for some of the discrepancies with a tablet or capsule being lost due to the foil strips being damaged. Documentation not being clearly completed may also have led to reported discrepancies.

Incident reports of individual tablets or ampoules missing (n=3) are likely to have been dropped or disposed of by mistake but this cannot be definitively proven. Where losses cannot be accounted for there are no trends or repeat areas and losses tend to be of 1 tablet, capsule or ampoule. There were no repeating areas that raised a concern in this regard during the year. Records of CD losses are maintained and wards and departments are continually monitored for trends to mitigate the risk of misappropriation.

The MediSin bulletins sent out by the Medicines Safety team have been used to highlight particular areas of CD management to improve compliance with policy or to raise awareness of changes to prevent incidents occurring e.g. similar packaging for different size oxycodone vials and the more widespread use of midazolam buccal for seizures. A series of CD podcasts are planned to reinforce expected practice at ward level.

Monitoring CD Usage Trends

The 'Abusable Drug Investigational Software' (ADIoS) is used to monitor usage trends of CDs across the Trust including prescribing on FP10 community dispensed prescriptions. Abnormal usage trends are reviewed, investigated by the Lead Pharmacist Procurement and Medicines Supply and any areas of concern are escalated to the CDAO.

There have again been numerous movements and re-naming of wards and departments throughout the Trust over the last year. Throughout each move/opening/closure the audit trail and security of CDs and CD stationery has been maintained, however it is noteworthy that the moves and changes in specialty / area location makes the monitoring of usage trends in a given area much more difficult.

Misappropriation of CDs by Trust Staff

During 2022/23 there was one investigation into potential misappropriation of CDs by staff in the Trust in a ward temporarily opened as a contingency area. Following a period of regular stock counting by pharmacy no further discrepancies were noted and the investigation was closed.

Following identification of potential misappropriate of CDs by staff in the Trust, external investigations can take a prolonged period of time. In December 2022 a nurse pleaded guilty at Wirral Magistrates Court to stealing tablets from an Arrowe Park ward area in June 2021 and the NMC fitness to practice hearing for another nurse identified as misappropriating medicines in October 2020 is scheduled for May 2023.

Pharmacy staff from WUTH were asked to present at the January 2023 LIN meeting to the Northwest region about identifying and investigation into potential diversion of CDs within the trust.

1.3	**Assurance Audits** **Quarterly Ward/Department CD Stock Checks by Pharmacy Staff** It is a requirement of the Department of Health Safer Management of CDs Guidance that pharmacy staff regularly check records of CD stocks held on every ward or department against their actual stock. The quarterly pharmacy CD audits are in addition to the monthly CD audits matrons complete using the Perfect Ward app. As well as a stock check the pharmacy quarterly ward / department CD checks cover the following areas of practice which are also subject to regulation: • Security of CDs e.g. management of keys and controlled stationary, ensuring daily CD counts have been completed • Correct documentation in terms of entries and corrections These checks have been completed quarterly for quarters 1 to 4 2022-23 in accordance with CQC best practice guidance. Compliance was 98% in quarter 1, 97% in quarter 2, 98% in quarter 3 and 97% in quarter 4. Results are presented quarterly to Medicines Safety Optimisation Meeting. Compliance has consistently improved over recent years with further improvement demonstrated this year compared to 2021-22 results. This has resulted from an improved performance and accountability framework with the Chief Nurse emphasizing importance of compliance with legislation and holding their teams to account for compliance. As described previously, correct documentation is still the key issue highlighted from quarterly audits. The quarterly audits are supported via regular perfect ward audits which allows immediate non-compliance feedback offering targeted education opportunities e.g. in theatres and the emergency department. **Quarterly CD Stock Checks in the Pharmacy Department** The WUTH Pharmacy Department is also subject to quarterly CD checks in all stockholding areas by a member of pharmacy staff who work in a different area of the department. These were all completed for 2022/23 without any stock discrepancies being noted. Although not a legal requirement, full CD stock checks are being carried out in Arrowe Park dispensary each month in line with the recommendation made by General Pharmaceutical Council Inspector in 2016. In addition, CD stock levels are checked each time a CD is dispensed or a delivery is received into the pharmacy department which ensures stock levels are managed in real time. Expired stock schedule 2 controlled drugs are destroyed in pharmacy with a member of staff who works elsewhere in the Trust delegated by the Accountable Officer in accordance with CD regulations. Arrowe Park and Clatterbridge Pharmacy Departments both hold an Environment Agency T28 (Sorting and denaturing of controlled drugs for disposal) Waste Exemption which allows the Trust to dispose of these medicines in accordance with Waste Legislation. **CQC Self-Assessment** The CQC self-assessment tool is completed annually and was undertaken in March 2023. A RAG rating is used to highlight any areas of CD management which may need improvement. The assessment results were mostly green and comparable to the 2021/22 assessment. All areas pertaining to process and procedures were green.

	The 3 areas which were red were: • have there been significant CD events in the last year • have there been incidents involving CD prescribing in the last year • have there been incidents involving a lapse in CD management in the last year There have been incidents which fall into the above categories which gives a rating of 'red' for these questions. The incidents concerned were reported via the trust incident reporting system and to the LIN.
1.4	**Changes in Legislation / Policy** From 1 April 2022, there has been a mandatory requirement to complete the patient registry for patients prescribed licensed or unlicensed cannabis-based products (CBPM) for medicinal use in the United Kingdom. The trust has one patient who has been prescribed a licensed CBPM for epilepsy and the patient's Consultant has completed the registry entry.
1.5	**Controlled Drug Home Office Licence** A CD Home Office Licence is required to allow the Pharmacy Aseptic Unit and Pharmacy Stores at Clatterbridge to supply CDs to external customers. The licence renewal applications were submitted in July 2022 and a both premises were inspected by a Home Office Inspector in March 2023. Licences were re-issued with no recommendations for actions to improve compliance. The Home Office CD Annual Returns were completed and submitted in January 2023.
1.6	**CQC Annual Report** The 2021 report was published in July 2022. There were 4 recommendations included within the report: • **Providers need to ensure their governance of controlled drugs is up to date and fit for purpose.** Good board-level engagement in relevant organisations is an essential element of ensuring the safer management of controlled drugs. • **Health and care staff need to make sure they provide shared care in line with best practice guidance.** Learning from incidents should be shared across local areas to support this work. • **Designated bodies should fully engage with controlled drugs local intelligence network (LIN) activities.** • **Providers should use the available data sources and tools to better understand prescribing risks and issues with controlled drugs.** Once those risks and issues are identified, local collaboration can help to create action plans and interventions to promote safer care. Information provided in this report illustrates compliance with the first 3 recommendations and work is planned to continue with good CD governance, learning from incidents and engagement with the LIN. Opiate and other controlled drug prescribing has been highlighted as an area of concern across Wirral from national data. Work has begun

	through the Wirral Wide Opiate meetings to ensure CD prescribing is appropriate and safe for patients across both primary and secondary care.
1.7	**LIN Activity** Following the Shipman report the Cheshire and Merseyside LIN was established and is led by the NHS England Area Team Accountable Officer, Dr Devina Halsall. The LIN met virtually four times in 2022/23 and shared information and learning about the prescribing and management of CDs in the local geographical area. There was WUTH representation at the meetings and WUTH were asked to present in January 2023 about the experience of investigating potential CD diversion. The CDAO has a statutory duty to submit quarterly occurrence reports to the LIN with information about any issues identified regarding prescribing or abuse of CDs. Incident occurrence reports were submitted in line with LIN guidance throughout 2022/23.
1.8	**Training** The medicines management induction and mandatory training sessions contain information on opiates as they are a high-risk class of medicines and information on medicine diversion. Induction sessions are attended by all staff starting work at WUTH. Opiate and controlled drug training continues to be provided to F1s and non-medical prescribers. Training is also provided to ward and pharmacy staff.

2	**Conclusion**
2.1	The management of CDs continues to be monitored by the Trust AO via incidents reported through the Trust incident reporting system and the ADIoS software. There has continued to be improvement in CD management at ward level during the year and Divisions should be commended on the efforts made to improve practice and comply with legislation. The recommendations will continue to support improvements in compliance with legislation, patient experience and safety, and monitoring of usage trends to highlight potential diversion: • CD incidents review and trend analysis will continue with actions to prevent further incidents being implemented and any learning from incidents shared • Ward and department CD audits will continue to be undertaken and presented to MSOP on a quarterly basis. Areas of non-compliance to be cascaded by Matrons to relevant Ward Managers. Divisional Directors of nursing will be held accountable for improved performance via MSOP. • WUTH will work with Wirral Place to support the safe prescribing and management of CDs across all areas of Healthcare on Wirral

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 11**

06 March 2024

Title	Transfer of Care Hub Discharge Story
Area Lead	Hayley Kendall, Chief Operating Officer
Author	Helen Walker, Associate Director of Improvement
Report for	Information

Executive Summary and Report Recommendations

The presentation has been developed to describe the pathway of improvement that has delivered the Transfer of Care Hub under the Trust's single leadership. The presentation details the statistically significant improvement in the number of patients occupying a hospital bed that do not have a criteria to reside and the steps that have delivered this.

It is recommended that the Board of Directors:

- To note the demonstrable progress made in the development of the Transfer of Care Hub and receive future updates as required

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

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

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

27/2/24	Executive Leadership Team	Transfer of Care Hub: Discharge Story	Information

1	Implications
1.1	**Patients** • Positive impact on patients being discharged that no longer require an acute admission, providing capacity for patients that do require an acute admission to the hospital.
1.2	**People** • Improved morale and work experience with new processes reducing delays.
1.3	**Finance** • System wide financial benefits of reducing patient with no criteria to reside and reducing the risk of requiring additional escalation beds.
1.4	**Compliance** • Positively impacts on both elective and UEC compliance metrics.

Wirral University Teaching Hospital
NHS Foundation Trust

Transfer of Care Hub: Discharge Story

January to December 2023

together we will

Introduction

WUTH are committed to a journey of flow continuous improvement. The Hospital Wide Flow programme launched in April 2023, is aimed to support in treating the **right patient, in the right place, at the right time**. This programme of work focusses upon improving internal processes and working with system partners to ensure a joined-up approach to safe, timely patient discharge.

Significant sustained reduction in the number of non-criteria to reside (NCTR) patients residing in acute hospital beds is multifactorial. The establishment of the Transfer of Care Hub has been the primary driver to this achievement. Our WUTH discharge story is outlined within this document:

- Hospital Wide Flow Scope and Governance
- Transfer of Care Hub
- Outcomes
- System Partner Feedback
- Summary and Benefits

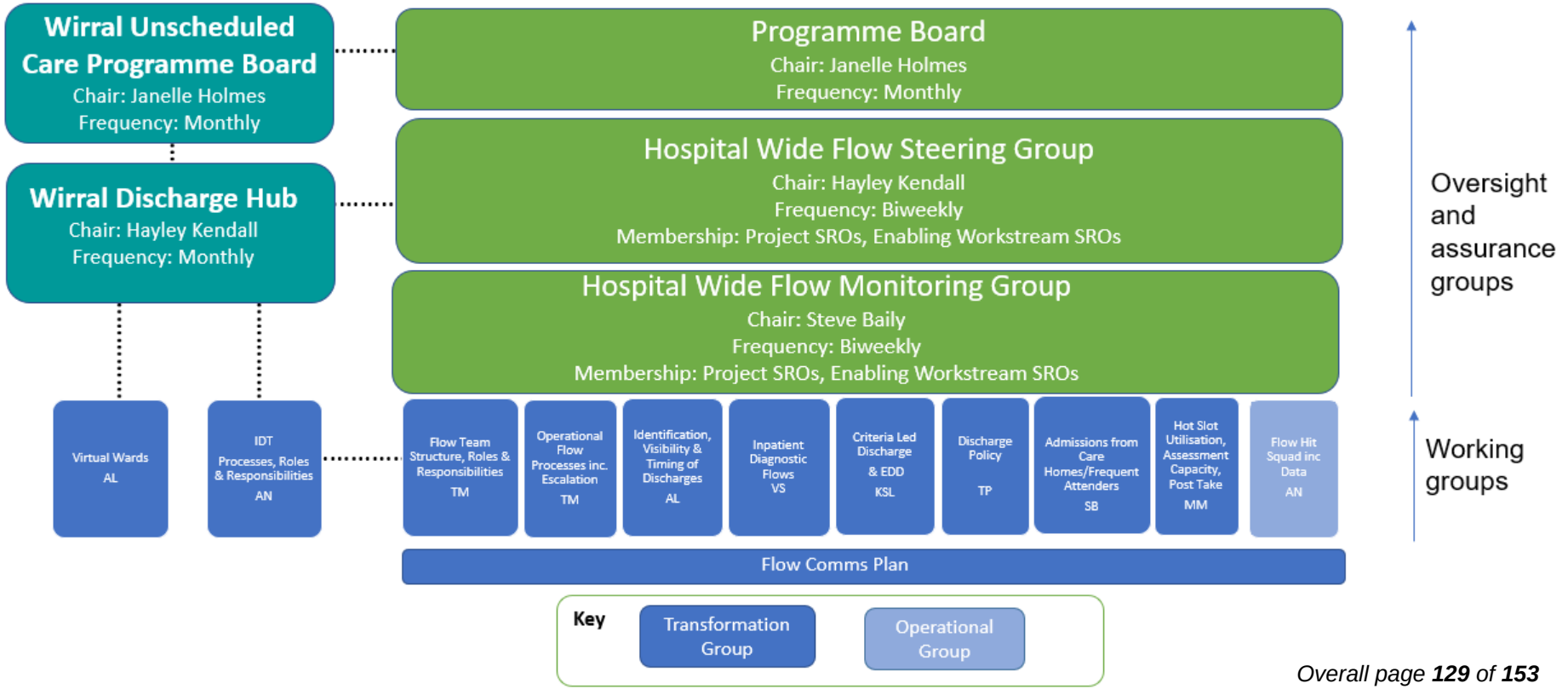
Hayley Kendall,
Chief Operating Officer

Contents

Wirral University Teaching Hospital NHS Foundation Trust

Background

Hospital Wide Flow Programme Scope and Governance Structure
Launched April 2023



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Transfer of Care Hub

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Transfer of Care Hub

Timeline Overview of Improvement, 2023/24

NCTR 240

April
Established Transfer of Care Hub (ToCH) in shadow form with Discharge Director

May
Governance processes, including Discharge Hub Operational Group establishment

June
Top 30 patient tracking list and Safe Transfer of Care Workshops with Care Home partners

NCTR 160

July
ToCH established, Social Care TUPE to WBC and Trusted Assessor TUPE to WIUTH

August
Daily tracking, monitoring and oversight of complex discharges

September
Daily validation of patient pathways and Care Home Placement Officer commenced

October
Demand exercise by ward for P1-3 discharge support with subsequent ToCH team restructure

November
Commenced twice weekly team 2 & 3 huddles (focus 0-7 days NCTR patients)

NCTR 110

December
Embedded daily workflow and ongoing monitoring

Enablers

- **Leadership within ToCH**
- **Enhanced system oversight and collaboration**
- **Robust processes for patient tracking**

Key: Q1 Q2 Q3

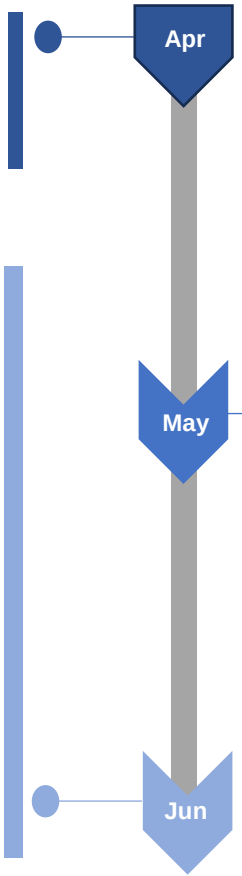
Transfer of Care Hub

Deep Dive into Timeline of Improvement, Q1 2023/24

Wirral University Teaching Hospital NHS Foundation Trust

- **Shadow Hub took ownership of the Top 30 progress chasing and discharge tracking**
- Escalation process for Domiciliary Care circulating > 24 hours agreed
- Established Hub transition 9-week plan

- Social work team commenced using 3 conversation model (reduced reliance on assessment paperwork)
- Commenced twice weekly Hub 'Top 30' review meetings (Tuesday/Thursday)
- Teams Top 30 tracking list
- Inaugural WUTH/ Care Homes Safe Transfer of Care workshops commenced
- Commenced dialogue with Wirral Housing Options on homeless pathway
- Discharge Cell meeting discussion now consider the top delays in WUTH; Home First & CICC
- Standard Operating Procedure for Wirral Discharge (ToCH) being drafted with key partners
- Ensured access to Teams; NHS Mail; Cerner for those TUPE who require it (supported by DPIA)
- Hub Director joined Care Market oversight group meeting



- Shadow Hub took ownership of the Top 30 reporting
- Commenced development of weekly no C2R & Discharge data pack
- Hub Team Leads meetings established
- Scope key daily workflow processes to enable timely discharge
- Discharge Hub Operational Group established (Chair Deputy COO)
- Discharge Trackers attend afternoon ward huddles
- Weekly whole Hub Team catch ups commenced
- Introduced SToC document concept (remove N2A/Ds)
- Commenced Professionals meetings for very complex discharges
- Commenced point prevalence meetings to expedite P1/2 discharges

Transfer of Care Hub

Deep Dive into Timeline of Improvement, Q2, 2023/24

Wirral University Teaching Hospital NHS Foundation Trust

Jul

- **ToCH established**
- Social Care Team TUPE to WBC
- Trusted Assessor TUPE to WUTH

Aug

- Established weekly ToCH team leads meetings
- Commenced daily validation of the new (0 days) no C2R patients and sign posting to pathways
- Hub leads modelled daily discharge flow by pathway required (reducing the backlog)
- Care Home Placement Officer commenced
- Complex discharge Checklist initiated: sent to Wards, Flow Team, DHC four times a day/ 7 days a week
- Collaborated with intermediate care wards at CBH to improve model of transfer

Sept

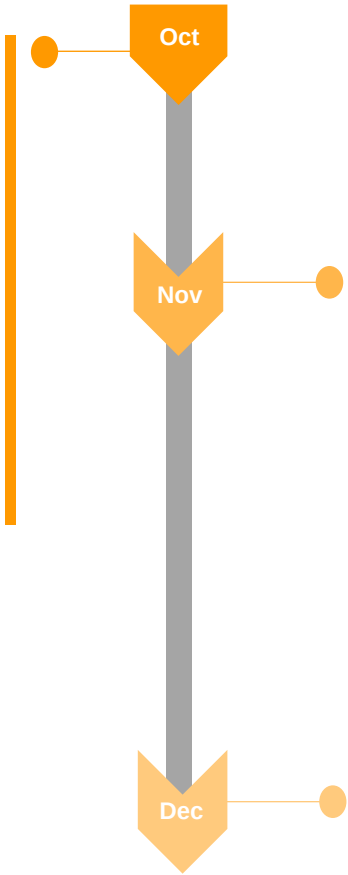
- Engaged Organisational Development team to support Team Leads development
- Business Support Manager commenced in role
- Discharge list: to track daily complex discharges, delay and cancellations, wait list for D2A, HomeFirst, Age UK activity, out of area patients and community readmissions
- Tracker for weekly discharge outcomes, so monitor actual discharges by pathway & by service
- Hub Daily workflow tracker to support command meetings

Transfer of Care Hub

Deep Dive into Timeline of Improvement, Q3, 2023/24

Wirral University Teaching Hospital NHS Foundation Trust

- Hub Team Leads Development Day
- Undertook demand exercise by ward for P1-3 discharge support to understand Hub structure required
- Established Hub Teams 1, 2, 3 supporting agreed wards
- Major Hub ‘dump the junk’ exercise over four weeks
- Created space to store incontinence products to use when discharging patients to Care Homes
- First Domiciliary Care WUTH event
- Hub monthly Quality Board established and first meeting
- Daily Team 1-3 no C2R list circulated within Hub
- Project group established to focus on complex discharge pathways including Delirium, Non-weight-bearing, Bariatric and Homelessness



- ToCH teams moved to co-locate as ‘Teams’
- WBC Hub service manager appointed on secondment basis
- Commenced twice weekly team 2&3 huddles (focus 0-7 days no C2R patients)

- Scoped hub refurbishment (co-locate Nurse & professional leads, Trusted Assessors & Care Home Placement Officer)
- Team huddles commenced Tuesdays and Thursdays to review and validate no C2R patients 0-7 days
- TTH tracker visibility within ToCH
- TV screens located for Team ‘command’ working, computers, keyboards/mouse ordered
- Age UK SPA ‘go live’ 4/12 to give enhanced support for people going home and link wider VCSEF organisations
- Embedded daily workflow and ongoing monitoring
- Sent Questionnaire to Care Homes to ascertain feedback on improvements
- National Pilot site for adopting the new NCTR pricing model with DHSC.

Transfer of Care Hub

Summary and Next Steps

Wirral University Teaching Hospital NHS Foundation Trust

- WUTH have proactively undertaken a significant amount of work in the first three quarters of 2023/24 to ensure the **right patient, is treated in the right place, at the right time.**
- This has included: the establishment of the ToCH, embedded leadership, refinement of processes to ensure robust patient oversight and tracking, commitment to collaborative and partnership working.
- Outcomes are reflected in Section 3.
- WUTH ambition is to continue this work to further drive down the number of NCTR patients residing in acute hospital beds and reduce the length of stay for this patient group further.
- Therefore, an overview of ongoing work is outlined to the right.

Q4

- NCTR and status capture (via Cerner)
- Safe Transfer of Care document – agreed at CDDA 18/1/24 as priority
- Therapists joining twice weekly Team 2 and 3 huddles. Team 1 huddles to commence 22/1/24
- B6 Discharge Coordinators/Social Work Development Programme
- Commenced workflow admin development (embed workflow and reporting responsibilities)
- Age UK target wards 21, 22 and 31
- Establish Care Home discharge ‘wellness’ calls
- Maximise Age UK going home service for HomeFirst discharges
- MCA training for Discharge Coordinators
- SNOPSs to collocate with Hub Team - complete
- Delirium pathway workshop – recovery in community
- Bariatric pathway through acute and rehabilitation
- Second Trusted Assessor and WCB Professional Lead due to commence in March 2024
- Department of Health and Social Care visit March 2024

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Outcomes

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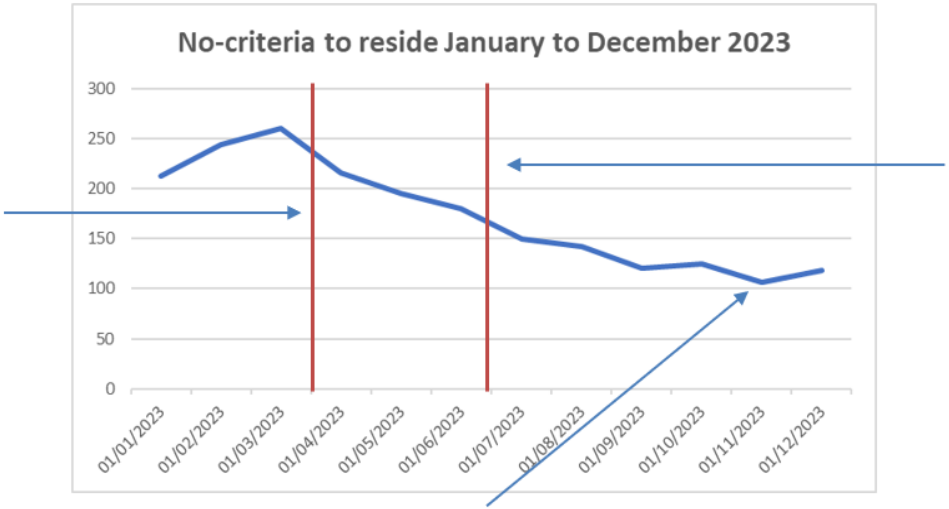
NCTR Position

- WUTH established Transfer of Care Hub in shadow form with Discharge Director.
- Executive Discharge Cell commenced.
- Focus on improved pathways and processes and escalations.
- Visibility of data and where delays were occurring.



100 no-criteria to reside patients achieved from 260 at its highest point

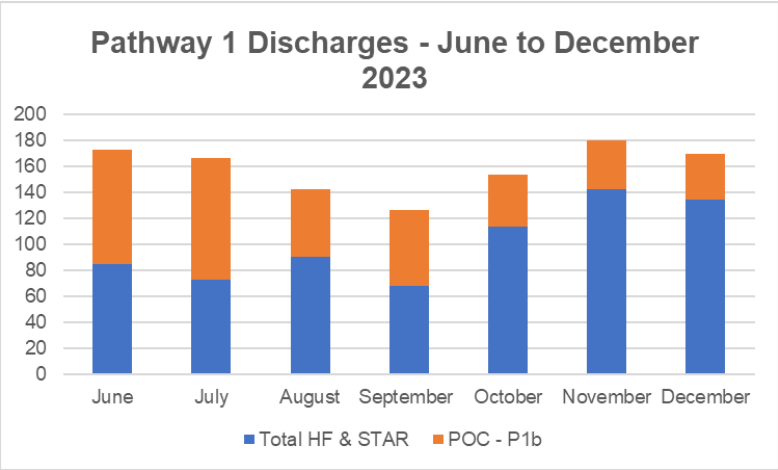
- Formal establishment of the Transfer of Care Hub at WUTH.
- Social workers transfer back to LA and come under single WUTH leadership structure in collaboration with LA.
- New reporting arrangements introduced.
- Reduced transactional hand offs between organisations.

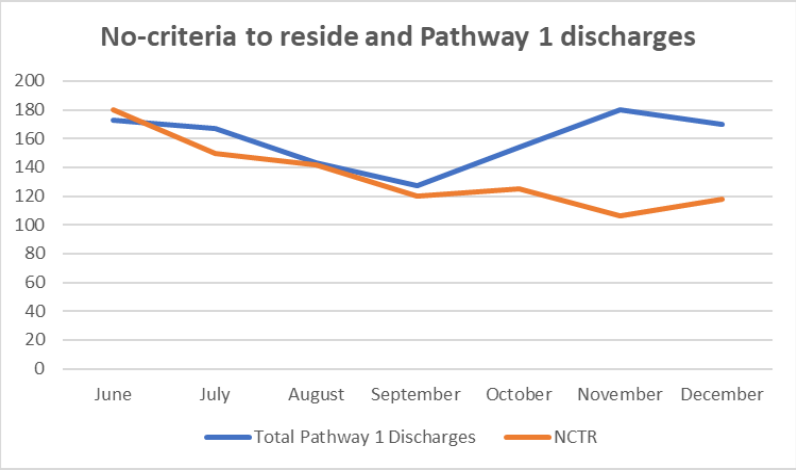
Pathway 1 Discharges

Discharge Service		June	July	August	September	October	November	December
		full month	full month	full month	full month	full month	full month	full month
Home First	P1a	55	33	42	50	100	141	118
Homefirst - Hybrid	P1a	*	*	*	*	*	*	17
STAR	P1a	30	23	18	11	14	2	0
STAR HomeFirst HCA	P1a	0	17	31	7	0	0	0
	Total HF & STAR	**85**	**73**	**91**	**68**	**114**	**143**	**135**
POC	P1b	88	94	52	59	40	37	35
Overall P1 total		173	167	143	127	154	180	170

- Home First has had a significant impact on capacity to reduce the non-criteria to reside position.
- This has been offset by the reduced numbers of packages of care, so the net pathway 1 discharge volumes have not changed

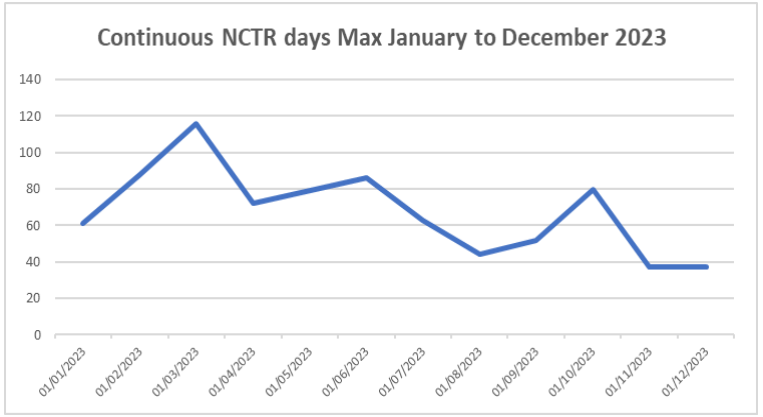
Pathway 1 Discharges



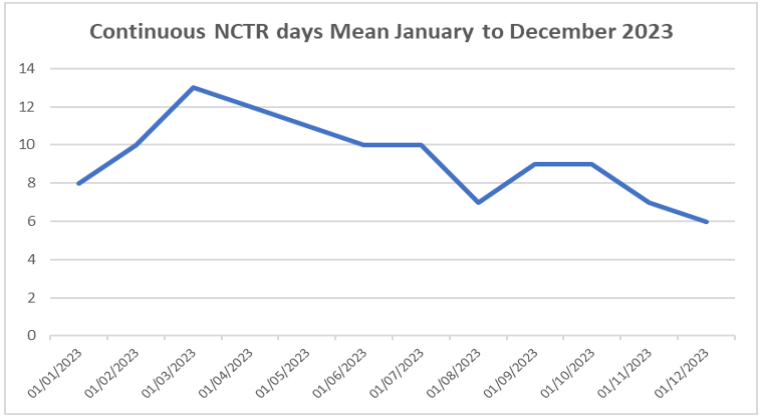


- In summary the number of pathway 1 discharges from WUTH have not changed over the period.
- There has been a shift from packages of care to Home First, this has led to surplus capacity in the domiciliary care market.
- Utilising the data it seems that the streamlining of processes has had the largest impact in reducing the number of beds occupied by patients that do not have a criteria to reside, in addition to reducing the length of stay for patients with no criteria to reside.

NCTR - Length of time to discharge



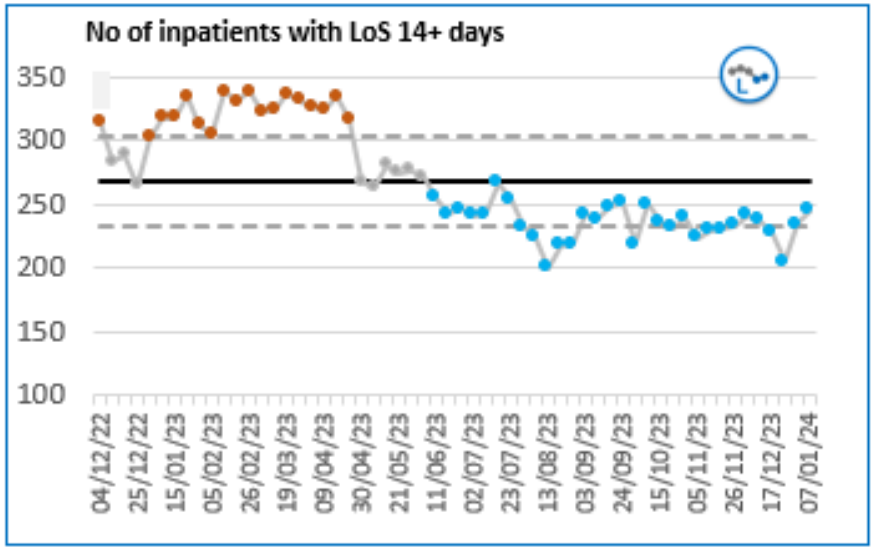
Maximum continuous NCTR –
Reduced from 116 to 37 days

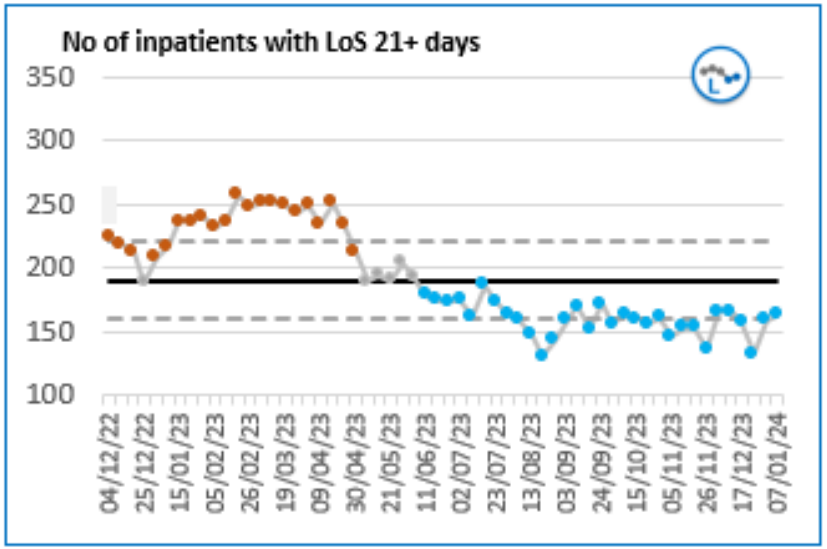


Continuous NCTR mean –
Reduced from 13 days to 6 days

- Demonstrated a reduction in length of stay for patients from the point of meeting NCTR.

Long LoS Hospital Wide





14+ & 21+ day LOS charts illustrate the sustained nature of the reduction over the last 12 months

Performance compared with other C&M Places

Wirral University Teaching Hospital NHS Foundation Trust

Daily Percentage of ALL Beds Occupied by Non-Criteria to Reside Patients Not Discharged

Latest Date: 04 February 2024

	Trust	Trajectory	Current	PP Var
1	Wirral	24%	16.1%	-8%
2	East Cheshire	26%	18.0%	-8%
3	Countess of Chester	18%	18.1%	0%
4	Mersey and West Lancs	20%	18.7%	-2%
5	LUHFT	26%	24.6%	-1%
6	Mid Cheshire	16%	25.0%	9%
7	Warrington & Halton	25%	27.5%	3%
	Total	23%	21.5%	-1%

Provider	Trajectory	Current	Var
Countess of Chester	18%	18.1%	0%
East Cheshire	26%	18.0%	-8%
LUHFT	26%	24.6%	-1%
Mersey and West Lancs	20%	18.7%	-2%
Mid Cheshire	16%	25.0%	9%
Warrington & Halton	25%	27.5%	3%
Wirral	24%	16.1%	-8%
Total	**23%**	**21.5%**	**-1%**

Discharge SITREP: 04/02/2024

Please note: The old 10% target has been replaced by trajectories from the individual Provider Operational plans

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System Partner Feedback

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System Partner Feedback

Wirral University Teaching Hospital NHS Foundation Trust

ToCH Quality Board

- The ToCH launched monthly Quality Board in October 2023 to ensure patient stories, system partner feedback and incidents are monitored and actioned to ensure the highest standard of care and safe transfer for patients.

Safe Transfer of Care Feedback Questionnaire

- A series of Safe Transfer of Care workshops have been undertaken hosted by the Local Authority and attended by WUTH, Care Home partners, Domiciliary Care and Community Pharmacy. The purpose of the workshops was to build working relationships between the providers, understand each other's requirements and identify areas for improvement.
- Following a number of actions being undertaken to enhance the transfer of patients out of hospital, WUTH actively sought system partner feedback via questionnaire circulated by the Local Authority. Feedback will be used to highlight further areas of improvement.
- The questionnaire was circulated in December 2023 for initially a two weeks period and then extended for a further two weeks in January 2024 to maximise the number of responses.
- 6 Care Home and Domiciliary providers returned completed questionnaires.

Safe Transfer of Care Feedback Questions

Overview of Questionnaire Results

- 66.7% reported improved communication between WUTH and their service (remaining 2 selected neither agree or disagree).
- 100% of respondents value the role of the Trusted Assessor.
- 66.7% reported the quality of information about patients being discharged from hospital has improved.
- 66.7% confirmed that they know how and who to contact at the hospital if they have any queries (remaining 2 selected neither agree or disagree).
- Additional comments provided include:

"The communication has improved and the quality of discharges"

"Discharge information has improved and the quality of the service"

"The Trusted Assessor is very valued by Elderholme and makes Transfers quicker and communicates well"

"I am aware that the Care Home Placement Officer is ensuring the right referrals are being placed"

Wirral University Teaching Hospital
NHS Foundation Trust

Summary and Benefits

Summary and Benefits

- Significant progress has been made in reducing the NCTR position at WUTH.
- There has been no change in the volume of Pathway 1 discharges from WUTH.
- The Transfer of Care Hub has been instrumental in achieving these statistical improvements.
- The length of time patients are waiting from discharge ready to actual discharge has significantly reduced and maps with the transactional improvements in the Transfer of Care Hub and other improvement programmes from our Wirral partners.
- The Home First service has been considerable in supporting the improved NCTR position and has been a great success as well as significant improvements in the care market sufficiency project.
- The above has been offset by a reduction in the number of Pathway 1 discharges to a package of care.
- To improve the performance further we need to maximise the package of care discharges to achieve the next stretch target for NCTR.

Quality Benefits	
Patient	• Significant and sustained reduction in the number of NCTR patients residing in acute hospital beds and for reduced bed days, resulting in patients being cared for in the most appropriate setting. • Acutely unwell patients being treated in the most appropriate setting due to increased access to hospital beds. • Safe transfer of care.
System	• M3 escalation ward sustained closure. • Appropriate allocation of resource to care for patients. • Collaboration and partnership working.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 12.1**
6 March 2024

Report Title	Committee Chairs Reports – People Committee
Author	Rajan Madhok, Non-Executive Director and Meeting Chair

This report updates on the work of the People Committee at its meeting on 22 and 25 January 2024.

Items for Escalation/Action

- The Committee noted the Substance Misuse Team and HR Business Partner were supporting three employment relations cases regarding alcohol misuse. The Head of Occupational Health and Workforce Wellbeing would provide further information on what support is in place to support staff regarding alcohol and plans for future wellbeing initiatives.
- The Committee received the Safe Staffing Report and acknowledged the ongoing challenges due to the Clinical Support Worker industrial action. There have been no patient safety issues identified as a result and this continued to be closely monitored.

New/Emerging Risks

- No new/emerging risks identified.

Overview of Assurances Received and Committee Activity

- The Committee received the Equality Diversity and Inclusion Bi-annual Report which provided an overview of the Trust's Equality Delivery System (EDS) position and a summary of actions undertaken within 2023/24 to progress the agenda further. The Committee noted the strong progress but requested further information to measure the impact and positive effect of this work. The Equality Diversity and Inclusion Bi-annual Report also included the Gender Pay Gap Report, and the Committee noted there were improvements in many areas, and recognised that further work was needed, not just within the Trust but in the system to ensure parity.
- The Committee received the Workforce Key Performance Report which provided an update on current workforce performance, key drivers of underperformance and the actions taken to improve performance. The Committee noted there was risk was around the impact of ongoing industrial action to the achievement of the KPIs, and that while mitigations are in place, performance may be impacted over time. The report also included a deep dive into Allied Health Professionals (AHPs) and the work ongoing to reduce turnover for this staff group. The Committee were given good assurance that there has been an improvement overall in turnover.
- The Chief People Officer updated the Committee on the three priorities for the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Workforce Group, and the priority work streams for the Cheshire and Merseyside Scaling People Services. Further updates and

areas of development for the Trust would be provided to the Committee when appropriate. The Chief People Officer highlighted the Board of Directors had approved a new payroll provider and this piece of work will move to the implementation phase from February 2024.

- The Committee received the Employee Relations Report and was given good assurance on the management of the Trust's disciplinary and grievance processes.
- The Committee received an update on Workforce Planning and was given good assurance against actions agreed to support workforce planning as part of the People Strategy, and around workforce redesign to ensure that everything is in place in the future that the Trust requires. The Committee commended the joint working between different directorates to ensure a holistic approach. The Deputy Chief People Officer would provide a further update in May.
- The Committee received the Guardian of Safe Working Report and noted the majority of exception reports were in General Medicine and from junior doctors (F1). A new Guardian of Safe Working, Dr Alice Arch had been appointed in November 2023 replacing Dr Helen Kerss.

Other comments from the Chair

- The Occupational Health and Wellbeing team have again successfully achieved the SEQOHS accreditation, which is a benchmark for a Safe, Effective, and Quality Occupational Health Service.
- The Estates, Facilities and Capital Deep Dive into people KPIs, including controls and wider assurance was deferred to the next meeting.
- The Committee thanked the staff for its continued work.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 12.2**
6 March 2024

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

Items for Escalation/Action

- Mental Health: A Deep-dive into unscheduled mental healthcare provision was presented. This provided an overview of the current capacity and demand challenges for the provision of care for those with primary mental health needs in the Emergency Department (ED) at Arrowe Park Hospital. There can be overcrowding, prolonged stays in the department for those waiting for inpatient mental health care, provision of care outside an appropriate setting and knock on effects to the care of all patients. Overseen by our joint Mental Health Transformation Board with Cheshire and Wirral Partnership Trust, recommendations set out changes needed in care pathways and in staffing models to improve the provision of mental health care in the ED. The Committee supported these recommendations.

  It was also noted that Children and Young People with significant behavioural care needs (not all of which relate to a mental health disorder) frequently couldn't access the care provision they need in a timely manner. As a result such children are admitted to the paediatric ward, which is the most immediate place-of-safety for them. Often this results in an extended stay for them in a less-than ideal environment. This situation has been escalated to the Integrated Care Board at Place and Region.

- Care Quality Commission (CQC) Action Plan and Inspection Readiness: One element of the outstanding CQC action plan is agreed not-to-be-completed this financial year; mitigations remaining in place. That is the environment of the neonatal unit, which requires structural work. In three other areas actions remain overdue as a result of further delays in implementing actions and the governance support team is working with relevant teams to address the delays. Work with the divisions is progressing to gain robust assurance on the 16 actions that have been identified as completed at divisional level. A commendable scheme was presented detailing how the Trust is ensuring that staff were prepared for an inspection. This is so that they understand howthe CQC inspects services so that they can best outline both excellence in care and how challenges are identified and dealt with.

New/Emerging Risks

- No new risks were identified

Overview of Assurances Received

- Patient Safety Incident Reporting Framework (PSIRF): Through a specific report and through intelligence gathered from other reports, the Committee gained assurance that the PSIRF was becoming embedded in the organisation and achieving the shift in safety culture which was intended by its implementation. Review and reflection is on-going as the Trust

develops this methodology. In particular the recruitment and training of 8 patient partners for safety and 41staff who will receive training as patient-engagement leads will build on this good start.

- Quality and Safety of Maternity Services and Maternity Services Incentive Scheme declaration: The Committee received a comprehensive report from the Divisional Director of Nursing and Midwifery supported by the Clinical Director for Maternity Services. This detailed the current state assessment against the ten safety actions set out by the Clinical Negligence Scheme for Trusts' Year 5 Maternity Incentive Scheme. This involved over 400 individual line of enquiry requiring to be evidenced. The Committee has had a thorough oversight over many months of the process of seeking, assimilating and assessing the evidence. In addition the Cheshire and Merseyside Local Maternity and Neonatal System (LMNS) confirmed the Trust's compliance with the actions have tested the quality of the evidence. The Final submission was presented to the Trust Board to support Chief Executive sign off on the 24th January with the LMNS in attendance (virtually).

- Equality, Diversity and Inclusion B-Annual Report: The Committee received this report and noted the significant progress having been made, particularly through the work of and engagement through the Patient Promise Groups. The Committee noted the report and also the continued work necessary to build on that progress and also the need for visible Board-level commitment to this agenda. The report was subsequently present to the Trust Board Public Meeting on 24th January.

- Cancer Services: The Committee received the Cancer Services Annual report prior to its presentation to the Trust Board in Public on 6th March. The Committee gained assurance on the approach and actions taken in recovering, maintaining and developing high quality cancer services access. The Committee also noted that Wirral is an area of high cancer prevalence and the challenges to service provision post pandemic and following industrial action. Staff commitment and pride in the care they give and partnership working with other trusts and organisations has been essential to these achievements. A high level of assurance was given with metrics describing patient outcomes and experience.

- Special Educational Needs (SEND) services and Trust Wide Improving Services for Children Group (TWISCh): The Committee received a helpful and detailed report giving assurance that significant progress had been made in this area. Firstly the Trust's interaction with local partners in preparation for a re-inspection of SEND services for children on the Wirral was noted. Secondly the progress in waiting times and waiting list management for our Community Paediatric Service was noted, as was a business case for enhancing staffing to deliver better progress. Progress has been made in the Trust clinicians completing Education and Health Care Plans in agreed timescales and the quality of these plans remains high. There is a significant redesign process in place for access to diagnosis and intervention for children with neurodiverse needs. This will particularly need careful communication and engagement with families, as the model is moving away from a single diagnostic point that triggers access to services.

- Mortality oversight: The Committee remains assured that oversight of the review of mortality rates and individual deaths remains robust, giving a high level of assurance that unusual incidents and trends would be identified. Additionally robust processes for the scrutiny of maternity and neonatal mortality are in place with significant reporting to and oversight of external partners. Mortality reviews for maternity and neonatal services are also presented to the Trust Mortality Review Group.

Other comments from the Chair

- The reports provided to the committee were high quality and contained the necessary detail for the committee to test the assurances that were provided. Additionally authors and area

leads were able to respond to enquiries to assist the committee in formulating its opinion on assurance.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 12.3**
6 March 2024

Report Title	Committee Chairs Report – Estates and Capital Committee
Author	Sir David Henshaw, Chair of Estates and Capital Committee

This report updates on the work of the Estates and Capital Committee at its meeting on 31 January 2024.

Items for Escalation/Action

- The Chair noted the Deep Dive of reasons for increase of Estates Sickness Absence Rates by the People Committee

New/Emerging Risks

- The Committee noted the increasing backlog maintenance risks and requested ongoing monitoring through the Committee. The Committee also noted the delivery timetable risks related to UECUP.

Overview of Assurances Received and Committee Activity

- The Associate Director of Estates provided assurance to the Committee on the performance and risks related to Capital and Estates. This included the Estates Divisions performance against key metrics and indicators, such as maintenance, financial performance and statutory compliance.
- This highlighted the improvements made across the Division in relation mandatory training, statuary and HTM compliance. The report also detailed the increases in reactive maintenance requests and turnaround times for delivery of reactive maintenance for P2 (3 working days) -P4 (21 working days) requests and ongoing steps to manage maintenance across the Trust.
- The A/Director also described the delivery of the Estates Recover Plan across Q3 and improvements made the Divisions financial position.
- The Committee also noted the increase in sickness absence across the Division, in recent months, and agreed with the requirement for a Deep Dive focussing on reasons for sickness absence, by the People Committee in April 2024.
- The Committee was also appraised of the recent review of the Divisions risks, with the Chair of Risk Management Committee, resulting in additional detail of risks and actions as well as rescoring of risks, in line with recent improvements and developments.
- The Deputy CFO detailed the Capital Programme financial position at month 9, noting the underspend due to UECUP, with consideration given to bringing forward schemes from 24/25. The Committee noted the significant delivery of the £31m capital programme across 23/24 and improvements that it was making to the infrastructure across the campuses.
- The Associate Director of Estates detailed the progress with the 23/24 Capital Programme, which includes the 9 remaining capital (infrastructure) projects. This included information on the completion of the Phase 2 Modular Theatres construction in early October 2023 and detail of progress with the delivery of the Community Diagnostic Centre at Clatterbridge Hospital.
- The COO provided an update on the Urgent and Emergency Care Upgrade Programme (UECUP) and detailed progress with the construction as well as highlighting the programme

status and steps taken to manage completion delays, including support from NHSE advisors.

- The Committee discussed the approach in relation to the Frontis Building and Your Housing Group, including the recent independent valuation of the building. The Committee supported the next steps with discussions with Your Housing Group.
- The Deputy CFO detailed the revised approach to capital planning for 24/25 – 26/27, detailing the use of budgets for key areas of infrastructure and equipment, with responsibility through Executive leads.
- The Committee also reviewed progress with the Green Plan delivery across the Trust and progress made with sustainability across the campuses.
- The Committee noted the following reports:
    - Estates Division Performance Report
    - Capital Programme Financial Position
    - 23/24 Capital Programme Report
    - UECUP Progress Report
    - Frontis Building Update
    - 24/25-26/27 Capital Programme Approach
    - Green Plan – Annual delivery Report