NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

29 January 2025

09:00 GMT Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

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Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 29 January 2025
Time	09:00 – 11:00
Location	Hybrid

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	1.	Welcome and Apologies for Absence	Sir David Henshaw	
	2.	Declarations of Interest	Sir David Henshaw	
5	3.	Minutes of Previous Meeting	Sir David Henshaw	
18	4.	Action Log	Sir David Henshaw	
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	Standing Items			
	6.	Chair's Business and Strategic Issues – **Verbal**	Sir David Henshaw	
19	7.	Chief Executive Officer Report	Janelle Holmes	
23	8.	Board Assurance Framework	David McGovern	
50	9.	Integrated Performance Report	Executive Directors	
	Committee Chairs Reports			
74	10.	Finance Business Performance Committee	Sue Lorimer	
78	11.	People Committee	Lesley Davies	Debs Smith
80	12.	Quality Committee	Dr Steve Ryan	
	Strategic Objective: Outstanding Care			
83	13.	Monthly Maternity and Neonatal Services Report (including Maternity Incentive Scheme Year 6 Annual Declaration)	Sam Westwell	Jo Lavery
86	14.	Learning from Deaths Report Q2 2024-25	Dr Ranj Mehra	
	Strategic Objective: Compassionate Workforce			

94	15.	Freedom to Speak Up Biannual Report	Debs Smith	Tracey Nolan
104	16.	Guardian of Safe Working Report Q2 2024/25	Dr Ranj Mehra	Dr Alice Arch
109	17.	Equality Diversity and Inclusion Bi-Annual Report	Debs Smith	Sharon Landrum
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123	18.	Chief Finance Officer Report	Mark Chidgey	
130	19.	Chief Operating Officer Report	Hayley Kendall	
	Governance and Assurance			
138	20.	Quality Committee Terms of Reference	David McGovern	
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	Closing Business			
	22.	Questions from Governors and Public	Sir David Henshaw	
	23.	Meeting Review	Sir David Henshaw	
	24.	Any other Business	Sir David Henshaw	
	Date and Time of Next Meeting			
	Wednesday 5 March 2025, 09:00 – 11:00			

Meeting	Board of Directors in Public
Date	Wednesday 4 December 2024
Location	Hybrid

Members present:

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

In attendance:

DM	David McGovern	Director of Corporate Affairs
JC	Jo Chwalko	Director of Integration and Delivery
CM	Chris Mason	Chief Information Officer
JJE	James Jackson-Ellis	Corporate Governance Officer
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.4
RM	Dr Ranj Mehra	Deputy Medical Director – item 8.5
JTG	Jay Turner-Gardner	Interim Director - Infection Prevention and Control – item 9
CG	Dr Chris Green	Director of Pharmacy and Medicines Optimisation – item 10
SH	Sheila Hillhouse	Lead Public Governor
TC	Tony Cragg	Public Governor

Apologies:

SW	Sam Westwell	Chief Nurse
SL	Sue Lorimer	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 November were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story from a husband, who was the carer to his wife. The video story described their experience of attending ED following his wife suffering from a fall at home. Members acknowledged the patient and her husband had received good care and a positive experience in ED. Members thanked the staff for their continued hard work in ED. The Board **NOTED** the video story.	
6	**Chairs Business and Strategic Issues** DH provided an update on recent matters and highlighted he had joined a WUTH and WCHC Governor meet and greet in November following his appointment as Joint Chair of both Trusts. DH added Governors had fed back it was a good opportunity and a positive meeting. DH stated the integration between WUTH and WCHC was progressing well and engagement with primary care was a key focus. DH added the support provided by WCHC during the recent cyber security incident had been positively received and thanked the relevant teams for their help. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH reported in October there was one Patient Safety Incident Investigation opened under the Patient Safety Incident Response Framework and one Reporting of Injuries, Diseases and Dangerous Occurrences were reported to the Health and Safety Executive. JH stated on Tuesday 26 November the Trust declared a major incident following a targeted cyber security issue, following suspicious activity on the Trust's systems. JH added the Trust	

	continued to respond to the incident and was working closely with the relevant organisations to resolve the incident. JH referenced the Care Quality Commission (CQC) Report of Urgent and Emergency Care Services had been published following the inspection in March 2024. JH indicated the Trust had been rated as 'Good' in three out of five domains. JH updated on the implementation of Martha's Rule, indicating the Trust was already a pilot site and from 1 October wards 14 and 38 had been testing component 2, which ensures patients, their relatives or staff members can contact the critical care outreach team 24/7 if they have concerns that a patient is clinically deteriorating or getting worse. JH explained the Trust had been re-accredited with the Navajo Charter Mark, which recognises the efforts the Trust has made in trying to improve services and support for LGBTIQA+ staff and patients. JH highlighted Joe Clarkson, a Junior Doctor at the Trust, had been awarded the first CEO Star Award. Joe was presented with the award by the CEO and Medical Director for his efforts in saving a life while off duty. JH summarised the recent meetings of the Cheshire and Merseyside Acute and Specialist Trust Board (CMAST) on 1 November and the Wirral Place Based Partnership Board on 21 November. The Board **NOTED** the report.	
8	**Board Assurance Reports** **8.1) Chief Finance Officer Report** MC reported during October the Trust received a non-recurrent deficit support allocation of £9.7m and as a result of this the Trust's plan was resubmitted as a £6.7m deficit. MC stated at the end of October, month 7 the Trust was reporting a deficit of £13.2m, an adverse variance against plan of £7.4m. MC set out the key drivers of this forecasted variance, noting these were full delivery of elective activity, CIP, maintaining expenditure on urgent care within planned levels and delivering planned integration benefits. MC explained the Trust's unmitigated forecast was a deficit of £6.4m, an adverse variance to plan of £19.8 and the Trust was continuing to reduce expenditure to mitigate against these risks. MC added full implementation of the actions would reduce the	

	unmitigated forecast deficit to £13.6m, an adverse variance to plan of £7.0m MC indicated the deficit position continued to place significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP). MC provided an update on the statutory key financial risks for month 7, noting the RAG rating for each, highlighting that financial stability and financial sustainability were red, financial efficiency and cash were amber, agency spend and capital was green. MC highlighted this position was prior to the recent cyber security incident and it was anticipated there would be a further deterioration to plan due to lost income from activity. Members discussed the financial position and challenges, including the decisions made to remain committed to provide robust patient safety and quality of care. SI noted CIP was behind plan and queried about the non-recurrent CIP risk for 2025/26. MC stated any gap would become a cost pressure for 2025/26 and indicated over the last 2 years the Trust had delivered recurrent savings of circa £50m. SR queried about the planning for the elective activity case mix for 2025/26. HK reported the case mix was being reviewed to understand the variance for this year and this would also inform the plan for 2025/26. Members discussed the underperformance in respect of the Cheshire and Merseyside Surgical Centre, noting the original business was unlikely to be achieved due to lower than planned referrals from Trusts in the region, despite the available capacity and because of this the business case had been reset. The Board: • **NOTED** the report; • **NOTED** that full implementation of agreed mitigations will significantly but not fully mitigate financial risk; • **NOTED** that the Trust has submitted a cash support request in Q3 and will be submitting an additional request in Q4 (January to March 2025); and • **NOTED** that this report pre-dates the current cyber-incident and therefore the financial impact will be included within future reports.	

	8.2) Chief Operating Officer Report HK highlighted in October the Trust attained an overall performance of 96.6% against plan for outpatients and an overall performance of 91.5% against plan for elective admissions. HK added the Trust underachieved plan for both outpatient new appointments and elective inpatients/day cases and set out the reasons for this. HK summarised the referral to treatment standard and the requirement to have no patients waiting over 65 weeks by September. HK indicated 1 patient had been waiting 104+ weeks and this had been resolved, 11 patients had been waiting 78+ weeks and 135 patients had been waiting 65+ weeks. HK explained the key drivers for each of the breaches, noting the majority had been due to patient choice or reduced capacity within gynaecology. HK explained the cancer performance against the trajectory, noting the Trust did meet the faster diagnosis standard for September with performance at 76.58%. HK reported the DM01 performance standard was 95.9% at the end of October, achieving above the 95% standard by March 2025. HK highlighted in October type 1 unscheduled care performance was 44.69% and continues to remain below the planned improvement trajectory. HK added this was due to high walk in and ambulance conveyances, however several pilots to reduce this had already started to improve the position. HK stated the number of patients not meeting the criteria to reside remained above the trajectory and the demand for patients attending the ED with mental health conditions was high and experienced delays. HK added work with Wirral system partners remained ongoing to reduce these pressures on the hospital. SR queried about the increase in outpatient procedures and if this was driven by better recording of appointments or transformation. HK stated this was due to better reporting facilitated by transformation. The Board **NOTED** the report. **8.3) Integrated Performance Report** JR highlighted C Diff remains above the target of 6 per month with 15 incidences in October and there was 1 category 3 hospital acquired pressure ulcer in October against a target of 0.	

	JR stated the Friends and Family Test for ED and outpatients was below target with maternity and inpatients exceeding the target threshold. JR added the number of level 1 concerns raised exceeded the target threshold as well as the number of level 2 formal complaints. JR explained RN and CSW fill rates had now been added to the report with RN and CSW days below the threshold and nights exceed the threshold for both RN and CSWs. SR referenced the 4 pillar Wirral C Diff strategic plan and queried if data was available in relation to the level of C Diff in the community. JR stated this was a challenge for Wirral Place partners to record, but work was ongoing to improve this as part of the strategic plan. DS highlighted mandatory training compliance continues to be achieved and turnover has reduced by 0.41% following the spike in August and seasonal trend. DS explained appraisal has dipped below compliance by 0.29% and there was a trajectory in place for Corporate teams to achieve target. DS reported sickness absence continues to remain above target at 6.61% and is an ongoing area of concern. DS set out the main drivers of sickness absence, noting this remains driven by short term and common cold/flu. DH queried about sickness absence and what other mechanisms could be put in place to reduce this. DS stated there were sufficient preventive measures in place, however further work was required to manage sickness absence when it occurred including triggers and return to work interviews. DS added the 6 month review of the new Attendance Management Policy would be carried out this month following a delay last month. DH requested an update be provided at the next meeting following the review of the Attendance Management Policy. CM reported the staff vacancy as a percentage of the workforce remained at 12.5% and this continued to impact on service delivery. CM added a case had been approved to recruit a position in business intelligence as this had been identified as a key area of risk for Trust. CM explained the subject access request waiting list continued to increase and a new database was being implemented to track	

	these more easily. CM added the Service Improvement Team would carry out a review of processes once the new database was installed. DH queried about the use of apprenticeships within the Digital Healthcare Team as mechanism for providing additional resource. CM stated there were a number of apprenticeships already within the team, explaining apprentices generally started in the help desk team and progressed into other IT specialities within the team. The Board **NOTED** the report. **8.4) Quarterly Maternity and Neonatal Services Report** JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were no areas of concern to raise for October. JL stated there were no Patient Safety Investigation Incidents (PSIIs) declared for Maternity Services or Neonatal Services in October. JL added to date there were four Maternity and Newborn Safety Investigations (MNSI). JL gave an update on Maternity Incentive Scheme (MIS) Year 6 and summarised the progress to date in regard to delivering the 10 safety action standards. JL noted this would be presented to Quality Committee and Board in January with LNMS colleagues present. JL explained the position in relation to Saving Babies Lives, noting the Trust achieved 96% compliance against the 6 elements based on evidence submitted in June 2024. JL added Q2 evidence had been submitted and was under review by the LMNS. JL referenced the Ockenden gap analysis and the 15 immediate and essential actions, noting the Trust remained in the same RAG rated position as fully compliant. JL reported progress against the recommendations of the three year delivery plan for maternity and neonatal services and the CQC national review of maternity services in England, noting the Trust was in a strong position in relation to these. JL updated on progress regarding implementing a Continuity of Carer Model, indicating the preferred option ensures the Trust continues with the current maternity continuity of carer model with teams supporting women with enhanced needs as the national directive.	

	JL highlighted the NHSE visit on 23 October by the North West Chief Midwifery Officer, who had provided positive feedback on the Trust's Maternity and Neonatal Services. SR stated as Maternity Safety Champion he regularly attended Maternity Services meetings and was assured of the rigor of reporting. SR added he recently visited the Seacombe Birthing Centre which had been a positive visit with visible signs of strong leadership. Members thanked JL and the team for their continued hard work. The Board: • **NOTED** the report; • **NOTED** the Perinatal Clinical Surveillance Assurance report; • **NOTED** the position of Patient Safety Incident Investigations (PSSI's) & Maternity and Newborn Safety Incidents (MNSI); • **NOTED** the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3; • **NOTED** the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals"; • **ENDORSED** option 2 of the Maternity Continuity of Carer Model options appraisal, which continues with current maternity continuity of carer teams supporting women/birthing people with enhanced needs as the national directive; • **NOTED** the CQC national report and WUTH's response to include a review via a gap analysis; • **NOTED** the outcome of the NHSE annual review **8.5) Learning from Deaths Report Q1 2024/25** RM summarised the report, highlighting the Trust's Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) continued to be within the expected range of mortality data for the reporting period. RM explained from early 2025 HSMR will be changing to HSMR+ and it was anticipated this new model would increase the ratio by 8 points but will remain within expected range. RM added the main driver of this was the removal of palliative care coding. RM explained from September the Medical Examiner began examining deaths in the community as well and there had been changes to the death certificate process implemented across England and Wales. SR stated the report had been discussed at the Quality Committee in November which provided good assurance and commented	

	there was also a strong amount of external scrutiny by the medical examiner and Telstra Health. NS stated she and RM met quarterly with the Coroner who continued to remain satisfied with the Trust's processes. The Board **NOTED** the mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group.	
9	**Infection Prevention and Control 2023/24 Annual Report** JTG provided an overview of the report summarising the activity undertaken during the year, noting the number of COVID, C Diff and Norovirus outbreaks. JTG added the Trust was one of the 21 Trusts out of the 24 in the North West who had breached their annual objective for C Diff. JTG explained the various cleaning services, training activities and audits undertaken. JTG added an infection prevention and control plan had been developed for 2024/25 to focus on priority areas in the Trust and Wirral system partners. SR stated the report had been discussed at the Quality Committee in November and commented the Board were aware of the contributory factors to the level of C Diff cases, including the lack of isolation facilities and high bed occupancy. SR also commented the integration with WCHC should further support the reduction of community and healthcare associated C Diff cases. NS agreed and added the Trust had an action plan to reduce C Diff cases within the hospital and this remained a priority to embed actions as part of business as usual. DH suggested both the WUTH and WCHC infection prevention and control teams present the 4 pillar Wirral C Diff strategic plan at a future Board Seminar. The Board **NOTED** the report.	Sam Westwell
10	**Accountable Officer Controlled Drugs 2023/24 Annual Report** CG gave an overview of the report, highlighting there were 298 incidents involving controlled drugs during 2023/24 compared to 211 reported the previous year. CG stated 279 incidents were reported as no harm or near miss with 19 incidents classified as low harm.	

	CG highlighted the Trust is noted by the regional Controlled Drug Local Intelligence Network (CDLIN) to be a high number, low harm reporter indicative of an open reporting culture. CG set out the four recommendations for 2024/25 to continue to support improvements in compliance with legislation, patient experience and safety, and monitoring of usage trends to highlight potential diversion. SR stated the Annual Report had been discussed in detail at the Quality Committee in November and Committee was pleased to hear the Trust was a high number, low harm reporter, indicating a transparent reporting culture. SI agreed and added CG presented at the Audit and Risk Committee in November and provided good assurance on the processes in place to reduce pharmacy stock losses. The Board **NOTED** the report and **APPROVED** the recommendations.	
11	**WUTH Charity Annual Report and Accounts 2023/24** MC provided an overview of the Annual Report and Accounts, highlighting the various fundraising activity undertaken in year for the Tiny Stars appeal, noting this included the Arrowe Park Abseil, Wirral Winter Ball and other fundraising events. MC added the Charity relies upon donations and legacies as its main source of income and the total income for 2023/24 was £383k, compared to £303k in 2022/23. MC stated the accounts had been subject to external audit and no material issues had been identified. The Board **NOTED** the Annual Report and Accounts 2023/24.	
12	**Annual Review of Standing Financial Instructions (SFIs)** MC presented the SFIs for approval, noting key changes related to the removal of the retrospective requisitions process, the inclusion of a breaches process and changes to threshold values including delegation limits. MC added any requisition that was now raised after receipt of goods and services was now deemed to be a breach of SFIs. SI stated the review of SFIs had been discussed at the Audit and Risk Committee in November and the proposed changes were recommended to the Board for approval. The Board **APPROVED** the Standing Financial Instructions.	

13	**Annual Review of Committee Terms of References** DM presented the Board Assurance Committee Terms of Reference for approval, noting in line with good governance practice an annual refresh had been undertaken and any changes were highlighted in the appended documents. NS commented about the Quality Committee Terms of Reference, specifically the attendance of all Executive Directors and suggested this be reviewed due to the competing pressures of Directors. DM agreed to consider the Executive Directors' attendance at Quality Committee and how this can be achieved, with the updated Terms of Reference provided to the next meeting for approval. The Board **APPROVED** the Terms of References with the exception of Quality Committee.	David McGovern
14	**Committee Chairs Reports** **14.1) Estates and Capital Committee** SI indicated the Committee were provided with good assurance in relation to the delivery of statutory estates compliance, reactive maintenance, and cleaning standards. SI added the Committee also received a standalone Health and Safety update which explained the highest number of non-clinical incidents related to violence and aggression against staff. SI highlighted the Committee received a presentation on the NHSE Premises Assurance Model (PAM) submission for 2024 and this demonstrated significant improvement across the Estates and Facilities functions over the past 3 years. SI explained the Committee also received a series of standing reports on capital programme delivery progress and the UEUCP programme. **14.2) Quality Committee** SR reported the Committee were provided with an update on the C Diff and acknowledged a strategic plan consisting of 4 pillars of action had been agreed between the Trust and Wirral Place partners which would be overseen by the Wirral Health Protection Board. SR stated children with special education needs and difficulties continued to experience delays due to pathway issues and work was ongoing with Wirral Place partners to improve this pathway. SR highlighted a high number of children and young people had been admitted to the paediatric ward and it remained a challenge	

	due to the bult environment on the ward to provide a good patient experience and safe care. **14.3) Audit and Risk Committee** SI stated Committee had received a presentation from the Director of Pharmacy & Medicines Optimisation following a request to provide assurance in relation to pharmacy stock losses. SI added the Committee were provided with good assurance that sufficient processes were in place to reduce this. SI added the Committee received a deep dive into the Trust's EPRR processes as well as an update from the Chief Information Officer in regard to the annual Digital Maturity Assessment. SI highlighted the Committee received a range of standing reports on procurement, financial assurance which provided good assurance on the financial controls in place. SI added the internal audits also provided three internal audit reports and good progress continued to be made in embedded audit recommendations. **14.4) Charitable Funds Committee** SR highlighted the Committee received an update on the plans for the redevelopment of the Neonatal Unit and were pleased to see a preferred option had been selected following engagement from clinical teams. SR stated the Committee also received an update on a range of potential fundraising opportunities and options to engage with fund-holders. SR explained the Committee had been made aware that the League of Friends for Arrowe Park had given a donation to the Charity following the closure of their shop on the ground floor. The Board **NOTED** the reports.	
15	**Questions from Governors and Public** TC commented that the Governor get together in November with WCHC Governors had been positive and looked forward to building relationships further. SH queried about the publication of the CQC report of Urgent and Emergency Care Services and how ED staff felt about the findings. NS stated ED staff were pleased with the good ratings and feedback had been provided to the Divisional Directors with areas for improvement and an action plan was being developed to address any recommendations. NS added the Trust had held robust discussions with the CQC on the narrative of the report,	

	specifically in relation to corridor care, recognising this was a national issue. SH also queried about the integration with WCHC and how staff also felt about this. JH highlighted she and the WCHC Executives had been undertaking walkabouts at WCHC and feedback from clinical teams had been positive. JH added corporate teams had voiced some concerns and these were being addressed proactively.	
16	**Meeting Review** No comments were made.	
17	**Any other Business** No other business was raised.	

(The meeting closed at 10:45)

Action Log
Board of Directors in Public
29 January 2025

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	4 December 2024	8.3	To update on the outcome of the review of the Attendance Management Policy	Debs Smith	Complete.	January 2025
2.	4 December 2024	9	To provide at a future Board Seminar the 4 pillar Wirral C Diff strategic plan, with WUTH and WCHC IPC teams presenting	Sam Westwell	In progress. Due April 2025.	April 2025
3.	4 December 2024	13	To consider the Executive Directors attendance at Quality Committee and how this can be achieved, with the updated Terms of Reference provided to the next meeting for approval	David McGovern	Complete. Presented and approved at Quality Committee in January, also included on the agenda for approval at this meeting.	January 2025

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
29 January 2025

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

Executive Summary and Report Recommendations
The purpose of this report is to provide Board with an update on activity undertaken since the last meeting and draws the Board's attention to any local and national developments. 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	**Health and Safety** There were two Patient Safety Incident Investigations (PSII) opened in November 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 completed. There was one Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in November. All RIDDORs 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.
1.2	**News and Developments** **Cyber Security Update** The major incident that was called on Tuesday 26th November, as required by the Network and Information Systems Regulations 2018, has been notified to the Information Commissioner and the Department for Health and Social Care. Included within this notification is confirmation that the security of patient records and other sensitive information was maintained throughout the incident. For the period from 26th November until 3rd December business continuity processes were enacted and enabled the continuation of urgent care services however, it was necessary to significantly reduce elective services, including out-patient appointments. All systems and services were reinstated from Wednesday 4th December and cancelled activity either has been or is in the process of being rescheduled. **100 Day Plan** Following completion and publication of the Wirral System Review Report in October 2024, Wirral Community Health and Care NHS FT and Wirral University Teaching Hospital NHS FT have commenced the initial phases of integration, through the development and delivery of a 100 Day Integration Plan. The Plan commenced in November 2024 and will conclude in April 2025, with a focus on a number of key areas for integration between the two Trusts. This includes: • Governance • Clinical Services • Corporate Functions • Finance • Workforce and Culture • Communication and Engagement • Estates The 100 Day Plan has been initially overseen by the Integration Management Group, which includes membership from WCHC and WUTH Executive Teams, and will be governed through the Integration Management Board from April 2025. **Trust Declaration of Critical Incidents** The Trust has experienced unprecedented demand to its urgent and emergency services in early January which culminated in significant volumes of patients requiring admission and longer than desired waiting times for patients.

On Saturday the 5 January these demands were the highest experienced and at the levels of which required the Trust to declare a critical incident to maintain patient safety between Saturday 4 January and Monday 6 January. Command and control arrangements were in place during this period.

On Monday 7 January the Trust site position was reviewed and the critical incident stood down given the capacity available. On Wednesday 8 January the level of demand for patients requiring admission, including large numbers for flu, again to maintain patient safety a further critical incident was declared with specific actions to reduce the level of demand and create further capacity.

This included many more clinicians covering inpatient wards and expediting discharges as well as in reach into ED to avoid admission. In addition, Same Day Emergency Care (SDEC) was stood up in frailty and provided alternatives to admission for this patient group.

On Friday the 10 January the Trust assessed the actions undertaken and demand to urgent and emergency services and deemed it reasonable for the critical incident to be stood down. For the weekend of the 11-12 January the situation had improved but the Trust maintained the critical incident status along with two other Trusts at the request of NHS England.

The Trust has robust plans in place to maintain safety of our patients and we acknowledge the fantastic response from staff in maintaining patient safety during the two incidents.

Professor Simon Rogers receives prestigious lifetime achievement award for services to maxillofacial surgery

Professor Simon Rogers has received the lifetime achievement award for 2024 from the British Association of Oral and Maxillofacial Surgeons (BAOMS).

The prize is awarded annually and is considered a high honour awarded to individuals who are judged to have made a major contribution to oral and maxillofacial surgery in the widest sense. The award is made in recognition of the significant contribution Simon has made to the specialty of oral and maxillofacial surgery, and to the association, over his 35-year career as a consultant.

Simon will formally receive the prize and medal at the BAOMS awards ceremony in June 2025.

WUTH named in new national commercial research delivery centre initiative

WUTH has been named as one of 10 ‘spoke’ sites for a new NIHR Commercial Research Delivery Centre (CRDC) which will bring cutting-edge clinical research to communities in Cheshire and Merseyside.

The new CRDC has been announced as part of the NHS 10-year health plan, the Department of Health and Social Care (DHSC) has announced plans to establish 20 CRDCs, giving patients access to pioneering clinical trials and treatments in record time.

	The Wirral Research and Innovation Centre has brand new facilities for delivering research studies which ensure the experience of research participants is smooth, pleasant and safe.
1.3	**System Working** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** The CMAST Leadership Board met on 6 December discussing a number of system issues as follows: The Leadership Board were joined by Trust Chairs for a quarterly update on programme deliverables through the first half of the financial year. A summary of progress to date was both widely noted and celebrated by those present. The Board also received an update on recent system discussions and was asked to feedback, outside of the meeting, on the suggestion that there could be one provider collaborative within Cheshire and Merseyside. Board feedback was particularly sought on anticipated benefits and any areas which should be subject to wider exploration. Update papers were also provided on the following areas: • System financial report • System performance update **Wirral Place Based Partnership Board (PBPB)** The PBPB met on 19 December discussing a number of Place issues as follows: PBPB received the regular Quality and Performance Report which gave an overview of the Place aggregate position. The Board acknowledged patients waiting more than 6 weeks for a diagnostic test remained within the national and local target, however performance against relevant cancer targets remains a challenge. Healthcare-associated infections (HCAIs) also remain a focus within Wirral and governance has been strengthened through the Health Protection Board to focus on the C Diff plan. PBPB discussed the Unscheduled Care Improvement Programme update and the progress to date across the 4 workstreams with the aim of improving urgent and emergency care services in Wirral. PBPB received the Place Finance Report and noted the actual reported deficit of £31.4m compared with a planned year-to-date deficit of £16.9m, which represents an adverse variance of £14.4m.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework Quarter 3 (To December) 2024

Item 8

Contents

1. Introduction

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

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

Baker Tilly 2021

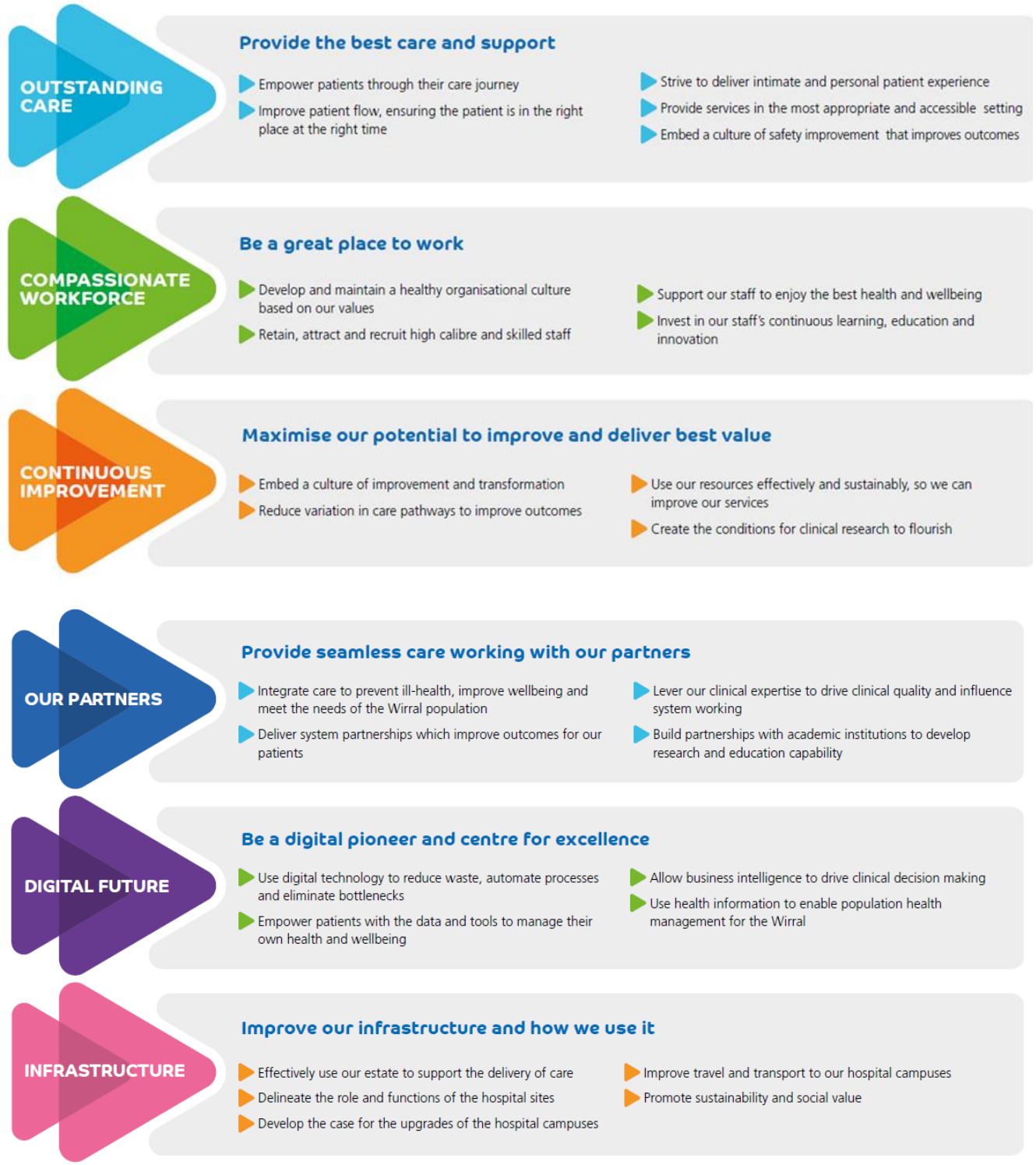
2. Vison, Strategy and Objectives

2.1 Our Vision

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

2.2 Our Strategic Objectives

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



3. Our Risk Appetite

3.1 Risk Appetite Statement

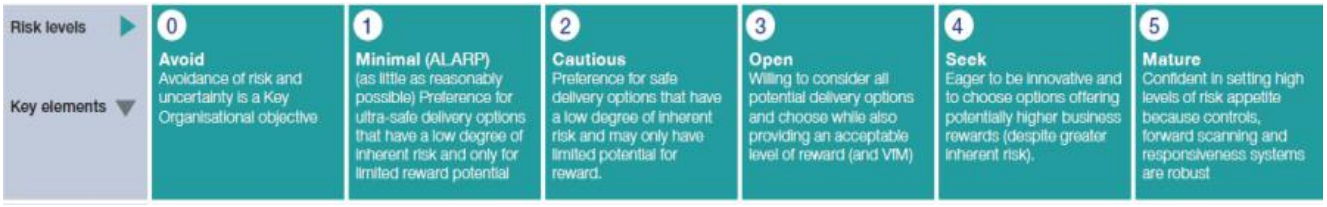
The Trust endeavours to establish a positive risk culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

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

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

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

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



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

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

4. Operational Risk Management

4.1 Operational Risk Management

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

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

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

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

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

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

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

The Trust shall achieve this by:

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

In order to support the Risk Management Process the Trust (via the Risk Management Committee) gives consideration to the latest set of significant risks at each meeting.

In order to further align this process the current list of significant risks is now included as an appendix to this BAF.

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 Quarterly 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 subject to regular monitoring, it was noted that the schedule had been designed to help highlight the BAF and its content and widen engagement across the Trust. Having achieved this aim it is now proposed that the schedule will revert to that originally in place and in line with sector norms as follows:

- Is Updated on a quarterly basis.
- Reports to the Board at every other meeting.
- Reports to every other meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy.
- Reporting to every other meeting of relevant Board Committees.
- Reporting to every meeting of the Executive Assurance and Risk Committee (EARC).
- Cyclical (at least yearly) circulation to Divisional Boards for information and to raise awareness.

6. Update Report

6.1 Purpose

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 most of the current strategic risks have been, or are being, reviewed with Executive Team members and further iterations will be reflected in future reports to Board.

6.2 Changes to the previous version

Following the annual review of the BAF the Board has approved the strategic level risk that will be monitored for the year 2024/25. Work is continuous to update previous risks and populate newer risks.

Including in the key changes for this report are as follows:

- Risk 1 (Failure to effectively manage unreasonable unscheduled care demand, adversely impacting on quality of care and patient experience) – This risk has been increased from 12 to 16.
- Risk 3 (Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints) – This risk has been increased from 12 to 16.
- Risk 6 (Failure to embed the Trust's approach to planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans) – This risk has been increased to 20 from 16.
- Risk 12 (Failure to reduce health inequalities for the Wirral population due to the absence of effective partnership working) – this risk has been decreased from 12 to 9.

6.3 Risk Appetite and Risk Maturity

The report includes the current position of the Trust in relation to Risk Appetite and Maturity.

6.4 Recommendations

Board is asked to:

- Note and comment on the current version of the BAF.

Board Assurance Framework Dashboard								
Strategic Priority	**Risk No**	**Risk Description**	**Lead**	**Committee**	**Original Score (I and L)**	**Current (I and L)**	**Direction of Travel**	**Target (I and L)**
Outstanding Care **R, O, C, F**	1	Failure to effectively manage unreasonable unscheduled care demand, adversely impacting on quality of care and patient experience.	Chief Operating Officer	Finance and Board	20 (4 x 5)	16 (4 x 4)	↑	12 (4 x 3)
Outstanding Care **R, O, C, F**	2	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	Chief Operating Officer	Finance and Board	16 (4 x 4)	12 (4 x 3)	↔	12 (4 x 3)
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 and Chief Nurse	Quality and Board	16 (4 x 4)	16 (4 x 4)	↑	12 (4 x 3)
Compassionate Workforce **O, C, F**	4	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	↓	6 (3 x 2)
Compassionate Workforce **R, O, C, F**	5	Failure of the Trust to have the right culture, staff experience and organisational conditions to deliver our priorities for our patients and service users.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	↓	6 (3 x 2)
Continuous Improvement **R, O, F**	6	Failure to embed the Trust's approach to planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans.	Chief Finance Officer	Finance	16 (4 x 4)	20 (5 x 4)	↑	8 (4 x 2)
Digital Future **R, O, F**	7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.	Chief Finance Officer	Finance	12 (4 x 3)	12 (4 x 3)	↔	8 (4 x 2)
Continuous Improvement **R, F**	8	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.	Chief Strategy Officer	Board	16 (4 x 4)	9 (3 x 3)	↓	6 (3 x 2)
Our Partners **R, S, F**	9	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 Wirral review as a long term threat or opportunity to service sustainability.	Chief Executive Officer	Board	12 (4 x 3)	9 (3 x 3)	↓	6 (3 x 2)
Infrastructure **R, O, C, F**	10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.	Chief Strategy Officer	Capital and Board	16 (4 x 4)	12 (4 x 3)	↓	9 (3 x 3)
Infrastructure **R, O, C**	11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.	Chief Operating Officer	Board	20 (5x4)	15 (5x3)	↓	10 (5x2)
Our Partners **R, O, C, F**	12	Failure to work with local partners to address and reduce health inequalities across the Wirral population.	All Directors	Board	16 (4 x 4)	9 (3 x 3)	↓	9 (3 x 3)

12 Month – Quarterly Trend

Risk No	Risk Description	Initial Score	Target	Jan 24	Feb 24	Mar 24	Apr 24	June 24	Sept 24		Dec 24 Current
1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	20 (4 x 5)	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)	↑	16 (4 x 4)
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)	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)	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)	↑	16 (4 x 4)
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.	16 (4 x 4)	6 (3 x 2)	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, staff experience and organisational conditions to deliver our priorities for our patients and service users.	16 (4 x 4)	6 (3 x 2)	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	Failure to embed the Trust's approach to planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans.	16 (4 x 4)	8 (4 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	16 (4 x 4)	↑	20 (5 x 4)
7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.	12 (4 x 3)	8 (4 x 2)	N/A	N/A	N/A	N/A	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
8	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.	16 (4 x 4)	6 (3 x 2)	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 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 Wirral review as a long term threat or opportunity to service sustainability.	12 (4 x 3)	6 (3 x 2)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.	20 (5x4)	10 (5x2)	N/A	N/A	N/A	N/A	15 (5x3)	15 (5x3)	↔	15 (5 x 3)
12	Failure to reduce health inequalities for the Wirral population due to the absence of effective partnership working.	16 (4 x 4)	9 (3 x 3)	N/A	N/A	N/A	N/A	N/A	12 (4 x 3)	↓	9 (3 x 3)

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

Strategic Priority	Outstanding Care				
Review Date	31/12/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (4 x 5)	12 (4 x 3)	16 (4 x 4)	12 (4 x 3)

Controls	Assurance
• Annual preparation and presentation of a system wide Winter plan in line with the National UEC Recovery Action. • Full participation in the Unscheduled Care transformation programme which includes working with Wirral Community Trust to reduce the numbers of patients attending the ED department who can have their care needs met away from ED. • Onsite support from Wirral Community Trust with the Chief Operating Officer focusing on admission avoidance and supporting early and timely discharge. • Monitoring of ED improvement plan and Wirral system urgent care plan by system Chief Operating Officers including Director of Adult Social care. • Health Economy CEO oversight of Executive Discharge Cell. • Additional spot purchase care home beds in place. • Participation in C&M winter room including mutual aid arrangements. • NWAS Divert Deflection policy in place and followed. • Rapid reset programme launched with a focus on hospital flow and discharge. • Continued communications out to primary care and to Wirral residents around only use A+E for urgent care requirements. • Regular meetings with the divisional leadership teams to ensure actions for improvement are delivered. • 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. • **System 4 hour performance response to deliver 76% in March.** • **External support into ED from Aqua reviewing 4 hour and 12 hour performance – recommendation report received and local action plan in development with urgent actions.** • **Full engagement with the national Rapid Improvement Offer (RIO) from the national ECIST.**

Progress
Key Changes to Note • Additions in red.

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

Strategic Priority	Outstanding Care				
Review Date	31/12/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	16 (4 x 4)	12 (3 x 4)	12 (3 x 4)	12 (4 x 3)

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 • N/A.

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

Strategic Priority	Outstanding Care				
Review Date	31/12/24	Initial Score	Last Quarter	Current	Target
Lead	Medical Director and Chief Nurse	16 (4 x 4)	12 (4 x 3)	16 (4 x 4)	12 (4 x 3)

Controls	Assurance
• Patient Safety Governance Process. • CQC compliance focus on ensuring standards of care are met. • Embedding of safety and just culture. • Implementation of learning from PSIRF. • Patient safety, quality and research and innovation strategies. • Monitoring and review of quality and safety indicators at monthly divisional performance reviews and bi-annual Corporate Service Performance Reviews. • Trust safety huddle. • **Patient safety Learning Partners.** • **R and I Strategy.**	• Executive 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 • Mortality Review Group Oversight Regular board review of Quality Performance Report, highlighting exceptions and mitigations • 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 • Maternity self-assessment • Board focus on R and I • Clinical Outcomes Group • Trust led CQC mock inspections • Daily Safety Huddle • JAG accreditation • C and M Surgical Centre • LLP Assurance. • GIRFT. • AXA accreditation. • National SNAPP Audits. • Nursing and Maternity Champions. • **Monthly Maternity report.** • **CEO Complaints sign-off.** • **Digital – Incident dashboard.** • **Programme Board.**

Gaps in Control or Assurance	Actions
• Fully complete and embedded patient safety and quality strategies. • **Current operational impacts and organisational pressure.** • **Capital availability for medical equipment.** • **Medical workforce gaps.** • **Impact of unscheduled care demand.** • **Significant financial controls in place.** • **Update required to WISE accreditation programme.**	• 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 – SIT Review. • CQC preparedness programme and mock inspections. • **Delivery of Mental Health key priorities.** • **Unscheduled Care Board action plan.** • **Trust and C and M elective recovery programme.** • **Wirral system strategy for CDiff.**

Progress
Key Changes to Note • Additions in red.

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

Strategic Priority	Compassionate Workforce				
Review Date	31/12/24	Initial Score	Last Quarter	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives, including apprenticeship recruitment. • Vacancy management and recruitment systems and processes, including TRAC system for recruitment and the Established and Pay Control (EPC) Panel. • Achievement of Armed Forces Employer Silver Accreditation • E-rostering and job planning plans to support staff deployment. • Strategic retention closed down as consistent achievement of the Turnover KPI; appropriate targeted work will continue via the task and finish groups. • Facilitation in Practice programme. • Training and development activity, including leadership development programmes aligned to the Trust LQF. • Utilisation of NHS England and NHS National Retention 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 and on-site presence at the Wellbeing Surgeries. • Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy. • Career clinics have recommenced within Divisions • New Flexible working policy, toolkit and training embedded. New FW brochure, intranet page, electronic application process launched and FW Ambassadors in place • New Engagement Framework launched, and all Divisions now have agreed objectives with key lines of enquiry now included withing Divisional Performance Reviews (DPRs) • New monthly recognition scheme has launched, with monthly Employee or Team of the month winners identified for Patient Care and Support Services and new CEO Star Award launched. • Chief Executive and Executive Team breakfast engagement sessions • Understanding staff experience Listening Event with Black, Asian and Minority Ethnic staff • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • EAP app (Wisdom) launched • Restorative supervision provided trust wide following significant events • SEQOHS annual reaccreditation approved • Representation of OH at Induction, Preceptorship Programme and Managers Essentials • Phase 1 upgrade of Cohort to Cority successfully implemented. • Targeted psychological support for Divisions, as issues arise • Health Surveillance programme successfully relaunched • OH & Wellbeing intranet page updated • Quarterly People Pulse Survey and associated actions to address concerns • Leadership Qualities Framework and associated development programmes and masterclasses. • Bi-annual divisional engagement workshops • Staff led Disability Action Group. • Staff drop in sessions. • Retention group annual plan approved at Workforce Steering Board • New Attendance Management Policy • Buddy system for new CSWs introduced & evaluated • Staff career stories linked to EDI on intranet • Promotion of CPD development opportunities • Increased senior nurse visibility – walkabouts led by Chief Nurse & Deputy • Succession planning launched as part of the new Talent Management Approach • Trust wide communications sent out re Covid-19 outbreak and precautionary measures to prevent further transmission including the wearing of face masks and adherence to IPC protocols in outbreak areas. • The return-to-work guidance for staff with respiratory illness including COVID-19 result has been reviewed and updated for monthly review at CAG, and recirculated across the Trust • Signed up to the NHSE Sexual safety Charter and met all objectives required. Trust comms delivered and Intranet page updates e.g. how to make and respond to disclosures • Questions PSS survey added to reflect sexual safety at WUTH • Trust Wide legal awareness session delivered • Completed action plan set against NHSE Sexual Safety Charter & core principles, and updates provided via Workforce Steering Board • Achieved Bronze status in June 2024 as set within the Anti-Racism Charter and was identified as one of four Trust in the region to achieve this.	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy. • Monthly Workforce monitoring.

Gaps in Control or Assurance	Actions
14 Board Assurance Framework David McGovern Director of Corporate Affairs	

• 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. • Increases in illness related to stress and anxiety.	• Focus remains on supporting the health and wellbeing of our workforce, as well as close management of absences in line with the revised Attendance Management Policy. • The staff winter vaccination programme and associated 'It starts with you' campaign. • Wellbeing Surgeries across sites • OH Capacity and Demand Review • Targeted retention work via the task and finish groups - focusing on Nurses, Midwifery & HCSWs and AHP's Clinical Scientists & Pharmacy led by Corporate Nursing • Talent mapping exercise for senior leaders • Task and finish Sexual Safety Working group to set out phase 2 priorities for next 12 months. • The electronic resignation and exit interviews are being built in Smartsheet; now the new FW one has been completed and rolled out.

Progress
Key Changes to Note • Changes in red

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

Strategic Priority	Compassionate Workforce				
Review Date	31/09/24	Initial Score	Last Quarter	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• Just and Learning Culture work delivered and embedded as 'business as usual'. • 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. • Just and Learning Plan implemented. • Provision for mediation and facilitated conversations as part of new Fairness in Work Policy • New approach to coaching and mentoring • New supervision and appraisal process • Talent Management approach launched • Targeted promotion of FTSU to groups where there may be barriers to speaking up. • Completion of national FTSU Reflection and Planning Tool • Business as usual support continues to be in place such as FTSU. OH&WB, HR and line manager support • CPO working with local networks	• 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
• Full understanding of the experience of Multi-Cultural staff across the Trust	• Debriefing tools (hot and cold) and guidance on the intranet for supporting staff affected by unplanned events. • Develop and implement the WUTH Perfect Start • Listening event with Black, Asian and Minority Ethnic staff • Work ongoing to resolve dispute in theatres • Working in progress to progress the settlement for CSWs – led by DCN • Q1 project planned for Q3 to address team working – led by CN

Progress
Key Changes to Note • Changes in red

BAF RISK 6	Failure to embed the Trust's approach to planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans.

Strategic Priority	Continuous Improvement				
Review Date	31/12/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Finance Officer	16 (4 x 4)	9 (3 x 3)	20 (5 x 4)	8 (4 x 2)

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document. • **Finance Gold Command implemented.** • **Weekly submission to and attendance at ICB FICC.** • **H2 control totals set for each division.** • **Fortnightly finance group implemented.**	• 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. • CFO presents quarterly forecasts to FBPAC and Trust Board. • Approval of 24/25 plan. • **FBPAC meeting more frequently.** • **Finance Gold Command implemented.** • **Weekly submission to and attendance at ICB FICC.** • **Fortnightly finance group implemented.**

Gaps in Control or Assurance	Actions
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Approval of deficit plan. • **Mitigated forecast of 7m variance to plan.** • **Unmitigated forecast of 29m variance to plan.**	• 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. • **Expand current mitigation plan to measure risk.** • **Continue full engagement with the FICC.** • **Negotiate required support from PWC.**

Progress
Key Changes to Note • **Additions in red.**

BAF RISK 7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.

Strategic Priority	Digital Future				
Review Date	31/12/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Finance Officer	12 (4x3)	12 (4 x 3)	12 (4x3)	8 (4x2)

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. • FBPAC Oversight. • Audit Committee oversight. • Integration of PMO and Digital Project Teams. • DIPSOC Oversight.	• Scale of projects versus resources. • FBPAC Committee. • Governance structures for key projects. • Capital Process Audit with significant assurance. • DSPT Audit with significant assurance. • MIAA Audit. • Digital Maturity Assessment.

Gaps in Control or Assurance	Actions
• Resources to remain up to date with emerging technology.	• Delivery of DHT annual plan.

Progress
Key Changes to Note • N/A.

BAF RISK 8	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.

Strategic Priority	Continuous Improvement				
Review Date	31/12/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• Programme Board oversight. • 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. • Developed and embedded improvement methodology.	• Quarterly Board assurance reports, Monthly Programme Board chaired by CEO to track progress and delivery of improvements. • Monthly tracking of individual projects with scrutiny at programme board meetings. • Rotational presentations by divisions to FBPAC meetings • Improvement presentations at Board Seminar on a twice yearly basis • CIP Assurance Group tracks all schemes and actions fortnightly, and mitigations requested where required. • Annual review and approval of improvement team supported projects, aligning to Trust priorities and risks • Project completion reviews

Gaps in Control or Assurance	Actions
• Lack of protected time due to conflicting priorities in service delivery, particularly in relation to clinical staff. • Ability to deliver system wide change across Wirral NHS organisations and wider partners.	• Delivery of 24/25 improvement projects to plan • Strong Governance through PMO working of all schemes, risk and outputs. • Detail improvement staff training approach and programme • **Review of PMO and PDU in line with the Wirral Review**

Progress
Key Changes to Note • **Highlighted in red**

BAF RISK 9	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 Wirral review as a long term threat or opportunity to service sustainability.

Strategic Priority	Continuous Improvement				
Review Date	31/12/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Executive Officer	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• WUTH senior leadership engagement in ICB and Wirral Place • WUTH Strategic intentions are aligned with the ICB. • ICB design framework. • NHS Oversight and Assessment Framework • Input of Trust CEO and Chief Strategy Officer into Outline of the Wirral Place governance. • Creation of IMB to oversee the outcomes of the Wirral Review. • Joint Chair and CEO now in place with WCHC.	• CEO and Chief Strategy Officer updates to Board and Executive Director meetings. • CEO attendance at Wirral Place Partnership Board • Executive participation in CMAST professional network groups • Chief Strategy Officer attendance at Wirral Health and wellbeing Board • Monthly reporting to Board of Wirral System Review progress • Recommendations of the Wirral Review

Gaps in Control or Assurance	Actions
• Formal mechanisms to ensure delivery of partnership working with Wirral Place partners	• Continue identification of partnership opportunities with Wirral Community Health and Care NHS Trust • Implement actions of the Wirral Review. • Refresh Governance processes at Place. • Stand up the WPP and IMB.

Progress
Key Changes to Note • N/A

BAF RISK 10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.

Strategic Priority	Infrastructure				
Review Date	31/12/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	9 (3 x 3)

Controls	Assurance
• Implementation of 3 year capital programme • Delivery of 2021-2026 Estates Strategy. • Business Continuity Plans. • Procurement and contract management. • Assigned 3 year capital budgets, with Executive Director accountability • Assessment of current backlog maintenance risk and future potential risk	• 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 and completion of business continuity plans for critical infrastructure • Independent review of risks carried out. • Appointment of authorised engineers.

Gaps in Control or Assurance	Actions
• Delays in backlog maintenance and funding of backlog maintenance • Timely reporting of maintenance requests.	• Develop Arrowe Park development control plan and Prioritisation of estates improvements • Heating and ventilation programme completion • Replacement of generators and ventilation systems • Delivery of 2024/25 Capital Programme to plan and budget allocation. • **Development of bids in preparation for potential NHSE Capital Grants.**

Progress
Key Changes to Note • **Highlighted in red**

BAF RISK 11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.

Strategic Priority	Infrastructure				
Review Date	31/12/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (5x4)	15 (5 x 3)	15 (5x3)	10 (5x2)

Controls	Assurance
• Implementation of the national Business Continuity Toolkit with a process underway to re-write all Business Continuity Plans (BCP) in the Trust. • Full risk assessment undertaken on critical infrastructure and mitigations for major failure in these areas. • Full engagement and adaptation of regional and national EPRR guidance and alerts. • Submission of Data Security and Protection Toolkit (DSPT) Annual assessment and associated audit. • Privileged Access Management (PAM) for external providers accessing systems.	• Trust command and control framework in place and tested thoroughly the Covid pandemic and industrial action over the last 12 months. • Regional core standards self-assessment process and central peer review. • Planned exercise programme in place to test BCPs. • Quarterly updates provided to the Risk Management Committee. • Annual report to the Board of Directors and updates in between as required. • Estates and Capital Committee sighted on the risk relating to the critical infrastructure • Trust received substantial assurance received from the MIAA DSPT audit. • Trust policy is to follow Privileged Access Management – preventing unauthorised access to 3rd parties.

Gaps in Control or Assurance	Actions
• System BCPs raised as a gap in the core standards self-assessment and a Wirral wide discussion on this is lacking. • Internal resource limited to cover the large spectrum of EPRR assurance - 1 WTE working to the Accountable Emergency Officer (AEO) • Issues identified as part of Dionach, Penetration testing conducted on Trust Network. • Some 3rd parties and national providers have not adopted PAM	• Continue with the actions highlighted in the core standards peer review assessment. • Engage with the regional Local Health Resilience Forum (LHRP) ensuring the Trust is up to date with the latest guidance and central notifications. • Operational Cyber programme addressing the risks raised within the Dionach, Penetration test. • Working with suppliers to irradicate legacy connections, expressing importance of the standards.

Progress
Key Changes to Note • N/A

BAF RISK 12	Failure to reduce health inequalities for the Wirral population due to the absence of effective partnership working.

Strategic Priority	Our Partners				
Review Date	31/12/24	Initial Score	Last Quarter	Current	Target
Lead	All Executive Directors	16 (4x4)	N/A	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Wirral Place Based Partnership Board Governance Manual. • Wirral Place Target Operating Model. • ICB. • Wirral Review Terms of Reference. • Joint Chair and CEO in place across WCHC and WUTH.	• Wirral Place Based Partnership Board. • Health and wellbeing Board. • Wirral Review Steering Committee. • CORE 20+5 Board. • Unscheduled Care Board. • Wirral Place Partnership Committees and fora. • IMB for Integration.

Gaps in Control or Assurance	Actions
• Lack of strategic alignment between partner bodies.	• Board discussion on Phase 1 of Wirral Review. • Consider outcomes of full review. • Implement outcomes of the full review. • Board to Board sessions. • Council of Governors Joint session. • Standing up of the IMB. • Standing up of the WPP. • Refreshment of Wirral Place Governance.

Progress
Key Changes to Note • Changes in red.

Appendix – Risk Scoring Matrix

Table 1 – Consequence scores.

Consequence scores can be used to assess actual and potential consequences: -

- The actual consequence of an adverse event e.g. incidents, claims and complaints.
- The potential consequence of what might occur because of the risk in question e.g. risk assessments, and near misses.

Choose the most appropriate domain for the identified risk from the left-hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

Consequence					
	Patient	Reputational	Financial	Workforce	Legal / Regulatory*
5 Catastrophic	**Prolonged failure or severe disruption** of **multiple** services Multiple deaths caused by an event**; major impact** on patient experience	**Widespread permanent loss of patient trust and public confidence** threatening the Trust's independence / sustainability. Hospital closure	**>£5m** directly attributable loss / unplanned cost / reduction in change related benefits	Workforce experience / engagement is **fundamentally undermined** and the Trust's reputation as an employer damaged	Breach of regulation Trust put into Special Administration / Suspension of CQC registration. Civil/Criminal **Liability > £10m**
4 Severe	**Prolonged failure or severe disruption** of a **single** patient service Severe permanent harm or death caused by an event. **Significant impact** on patient experience	**Prolonged** adverse social / local / national media coverage with **serious impact** on patient trust and public confidence	**£1m - £5m** directly attributable loss / unplanned cost / reduction in change related benefits	**Widespread material impact** on workforce experience / engagement	Breach of regulation likely to result in enforcement action. Civil/Criminal **Liability < £10m**
3 Moderate	**Operation of a number** of patient facing services is disrupted Moderate harm where medical treatment is required up to 1 year. Temporary disruption to one or more CSUs Resulting in a poor patient experience	**Sustained** adverse social / local / national media coverage with **temporary impact** on patient trust and public confidence	**£100k - £1m** directly attributable loss / unplanned cost / reduction in change related benefits	**Site material impact** on workforce experience / engagement	Breach of regulation or other circumstances likely to affect our standing with our regulators. Civil/Criminal **Liability < £5m**
2 Minor	**Operation of a single** patient facing service is disrupted. Minor harm where first aid required up to 1 month. **Temporary service restriction Minor impact** on patient experience	**Short lived** adverse social / local / national media coverage which **may impact** on patient trust and public confidence in the short term	**£50k - £100k** directly attributable loss / unplanned cost / reduction in change related benefits	**Department / CSU material impact** on workforce experience / engagement	Breach of regulation or other circumstances that may affect our standing with our regulators, with minor impact on patient outcomes. Civil/Criminal **Liability < £2.5m**.
1 Limited	**Service continues with limited/no patient impact**	**Short lived** adverse social / local / traditional national media coverage with **no impact** on patient trust and public confidence	**£Nil - £50k** directly attributable loss / unplanned cost / reduction in change related benefits	**Material impact** on workforce experience / engagement for a **small number of colleagues**	Breach of regulation or other circumstances with limited impact on patient outcomes. Civil/Criminal **Liability < £1m**.

Table 2 – Likelihood

The likelihood score is a reflection of how likely it is that the adverse consequence described will occur.

In considering the likelihood, the following supports the conversations and assessment from British Standards Institution (BSI) (2011) Risk management – Code of practice and guidance for the implementation of BS ISO 31000:

In risk management terminology, the word "likelihood" is used to refer to the chance of something happening, whether defined, measured or determined objectively or subjectively, qualitatively or quantitatively and described using general terms or mathematically [such as a probability or a frequency over a given time period].

Appendix – Risk Appetite

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.

Appendix – Significant Operational Risks

Highest Scoring Risks

1547	Corp	Cash Management	(5 x 5) 25	↑
1179	D+CS	Risk to patient treatment pathways due to the delay in supply of aseptically made medicinal products if the Aseptic Unit fails	(4 x 5) 20	⇔
1251	Corp	3rd Parties	(4 x 5) 20	↑
1728	Surg	SSD Washers/disinfector breakdown	(4 x 5) 20	⇔
1849	Surg	Failure to deliver Surgical Division Elective activity plan for 2024/25	(5 x 4) 20	⇔

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9**

29 January 2025

Title	Integrated Performance Report
Area Lead	Executive Team
Author	Executive Team
Report for	Information

Executive Summary and Report Recommendations
This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of December 2024. It is recommended that the Board: • Note performance to the end of December 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:** Further metrics are shown under the Chief Information Officer (CIO) relating to the Digital Healthcare Team.

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	5	2	7
Effective	0	1	1
Caring	2	2	4
Responsive	6	17	23
Well-led	1	2	3
Use of Resources	2	3	5
All Domains	16	27	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.

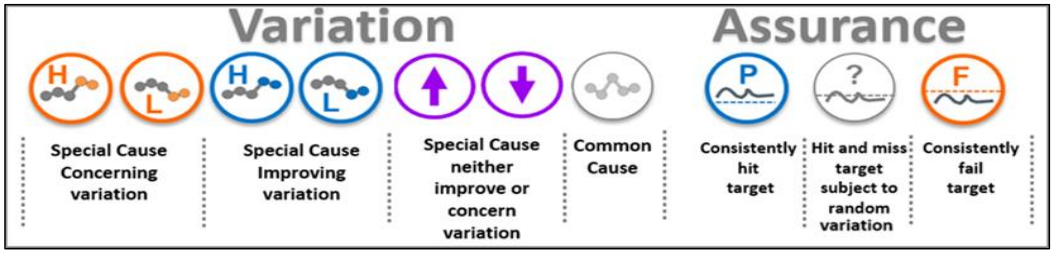
3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Integrated Performance Report, and at the regular operational meetings with the Clinical Divisions.

Integrated Performance Report - January 2025

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.

Key to SPC Charts:



Summary of latest performance by CQC Domain:

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Responsive	6	17	23
Well-led	1	2	3
Use of Resources	2	3	5
All Domains	16	27	43

Issues / limitations

SPC charts should only be used for 15 data points or more.
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.

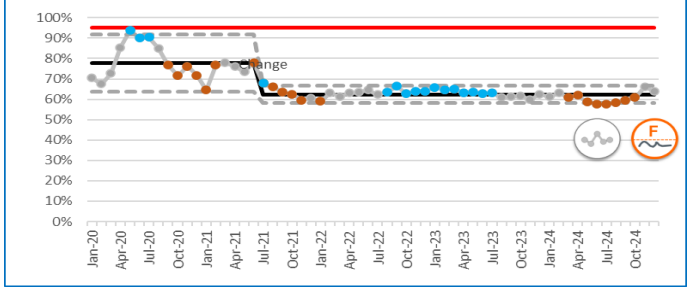
Changes to Existing Metrics:

Metric	Amendment
Clostridioides difficile (healthcare associated)	National threshold target for 2024/25 is not yet confirmed - internal maximum set at 108 cases for the year.

Chief Operating Officer (1)

CQC Domain : Responsive

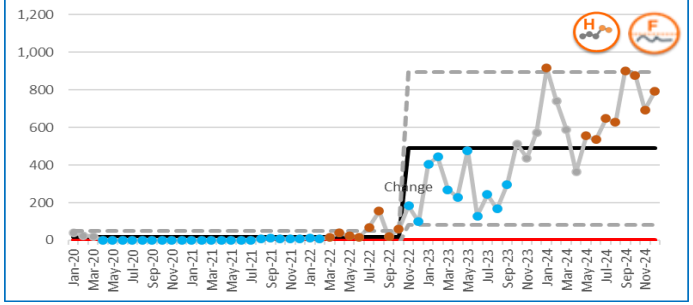
4-hour Accident and Emergency Target (including APH UTC)



Dec-24
64.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

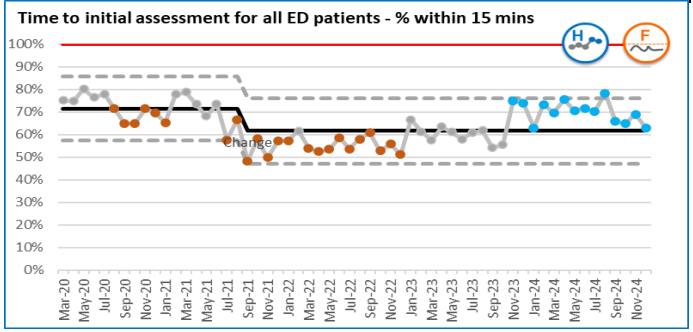
Patients waiting longer than 12 hours in ED from a decision to admit



Dec-24
794
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

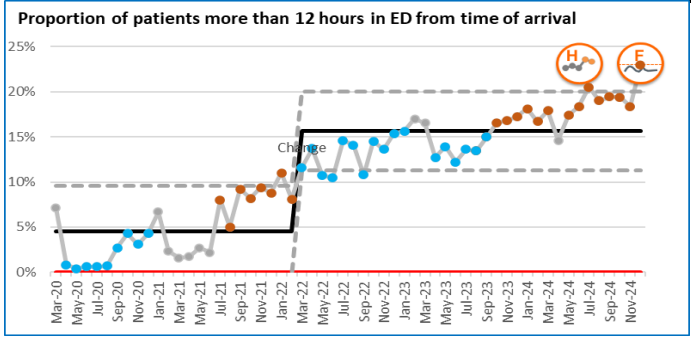
Time to initial assessment for all ED patients - % within 15 mins



Dec-24
63.0%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

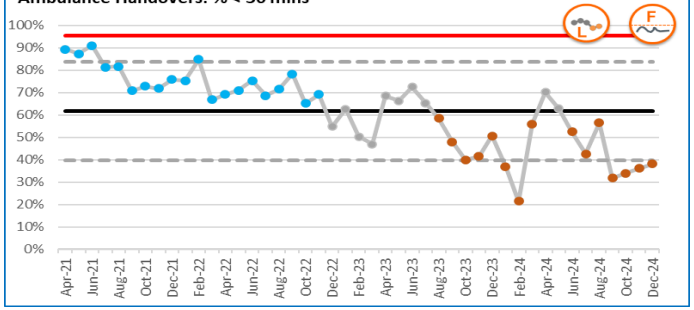
Proportion of patients more than 12 hours in ED from time of arrival



Dec-24
23.0%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

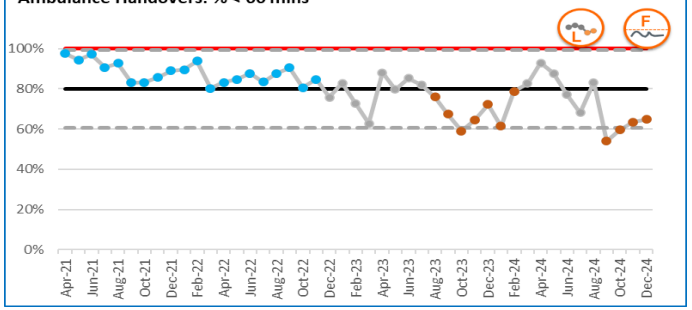
Ambulance Handovers: % < 30 mins



Dec-24
37.9%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Ambulance Handovers: % < 60 mins

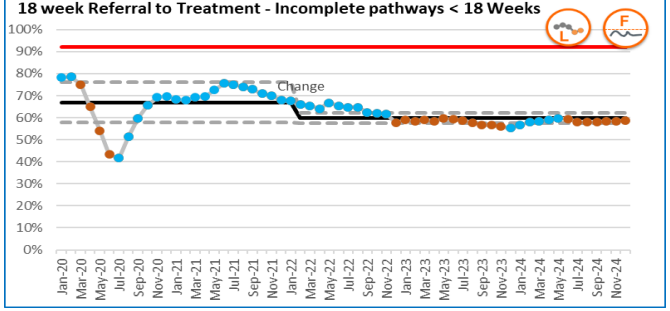


Dec-24
64.9%
Variance Type
Special cause variation - concerning
Threshold
100%
Assurance
Performance consistently fails to achieve the target

Chief Operating Officer (2)

CQC Domain : Responsive

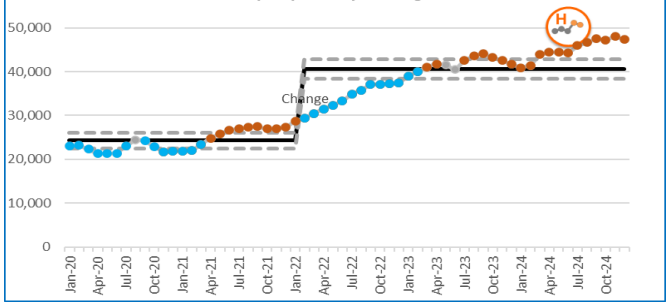
18 week Referral to Treatment - Incomplete pathways < 18 Weeks



Dec-24
58.70%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

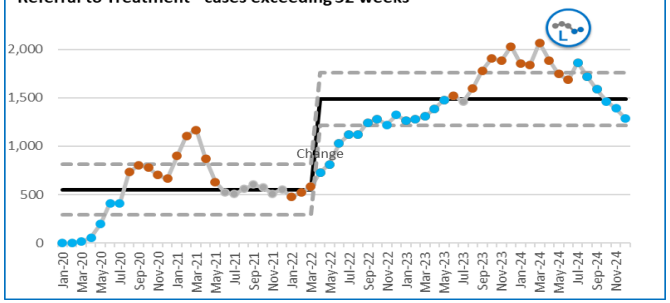
Referral to Treatment - total open pathway waiting list



Dec-24
47379
Variance Type
Special cause variation - concerning
Threshold
≤ 40511
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

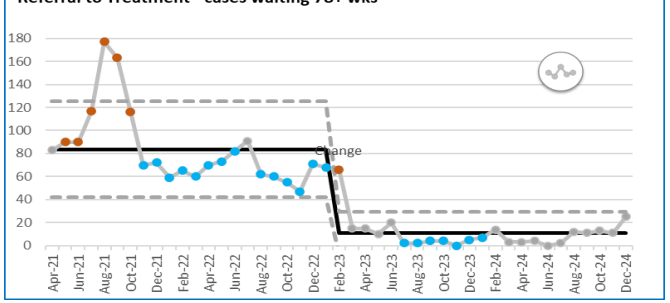
Referral to Treatment - cases exceeding 52 weeks



Dec-24
1286
Variance Type
Special cause variation - improving
Threshold
≤ 1795
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

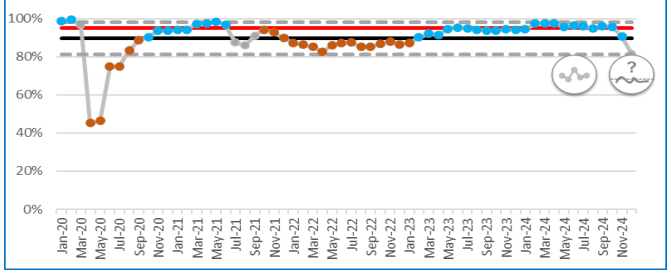
Referral to Treatment - cases waiting 78+ wks



Dec-24
25
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

Diagnostic Waiters, 6 weeks and over - DM01

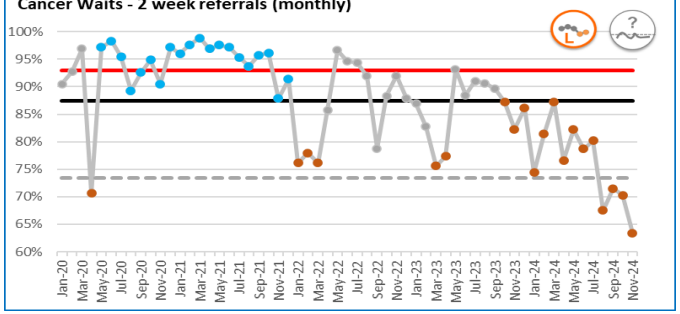


Dec-24
81.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

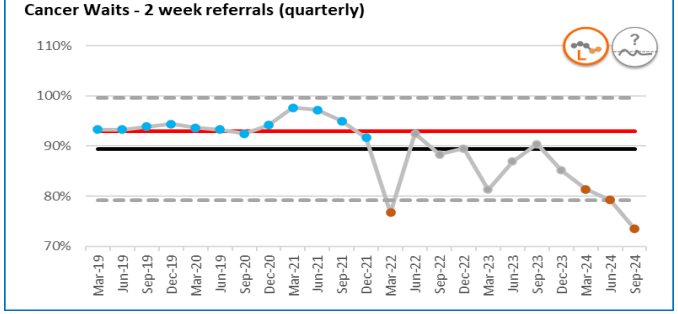
Cancer Waits - 2 week referrals (monthly)



Nov-24
63.4%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

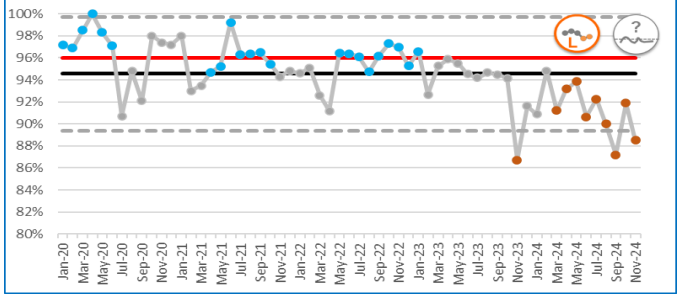
Cancer Waits - 2 week referrals (quarterly)



Sep-24
73.5%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

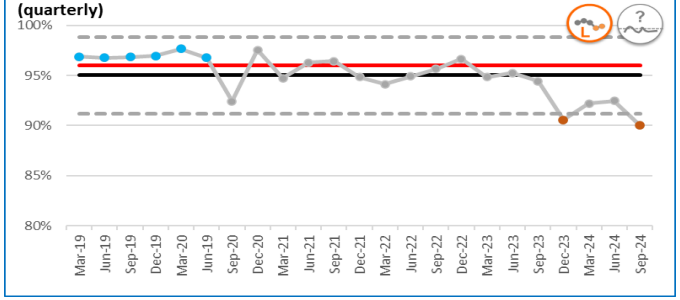
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



Nov-24
88.5%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

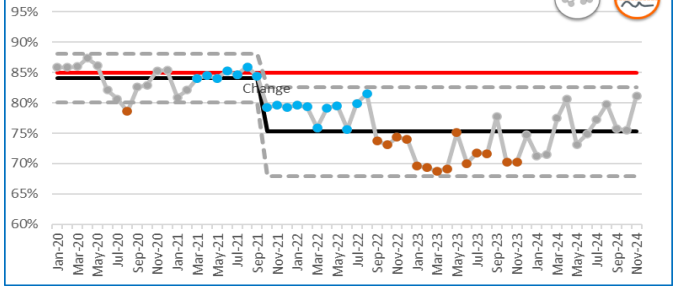
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



Sep-24
90.0%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

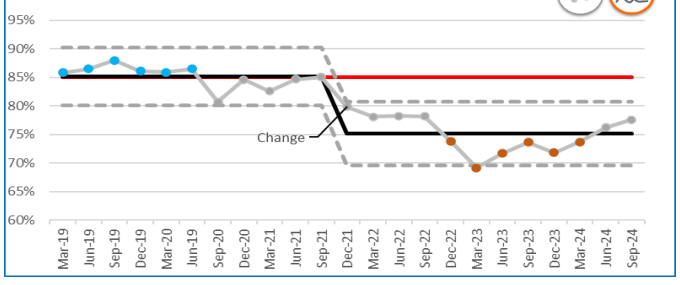
Cancer Waits - 62 days to treatment (monthly)



Nov-24
81.2%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Cancer Waits - 62 days to treatment (quarterly)

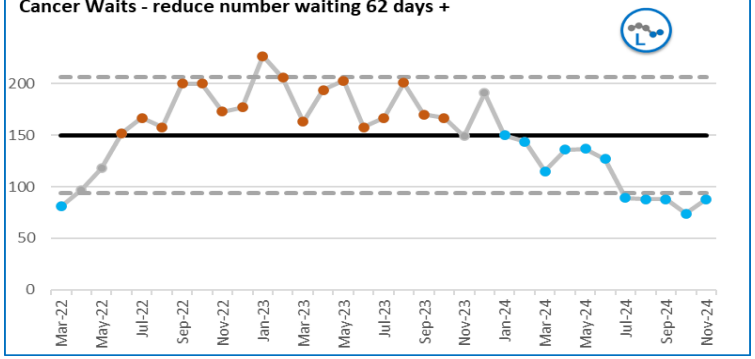


Sep-24
77.6%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

Chief Operating Officer (4)

CQC Domain : Responsive

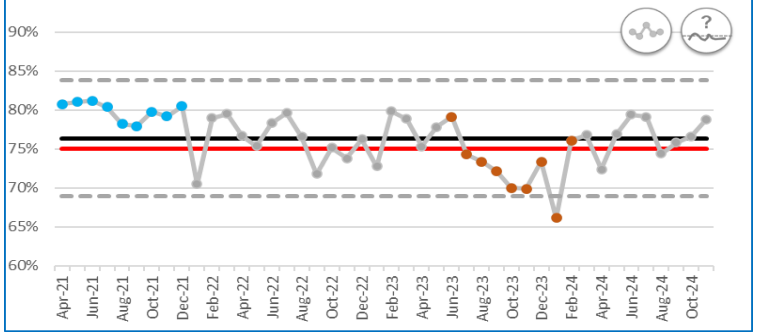
Cancer Waits - reduce number waiting 62 days +



Nov-24
88
Variance Type
Special cause variation - improving
Threshold
83
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

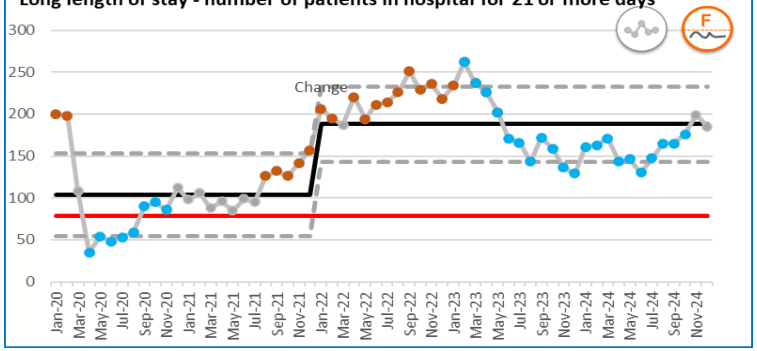
Cancer - Faster Diagnosis Standard



Nov-24
78.8%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

CQC Domain : Effective

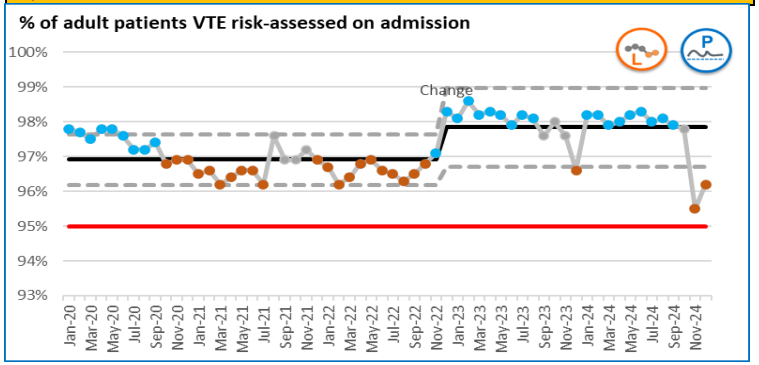
Long length of stay - number of patients in hospital for 21 or more days



Dec-24
185
Variance Type
Common cause variation
Threshold
≤79
Assurance
Performance consistently fails to achieve the target

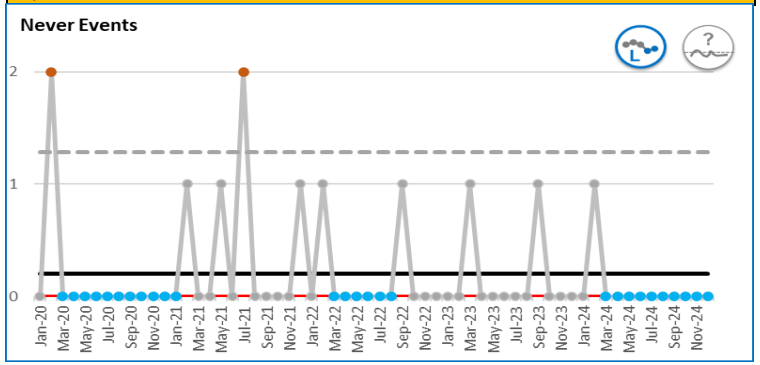
Medical Director

CQC Domain : Safe



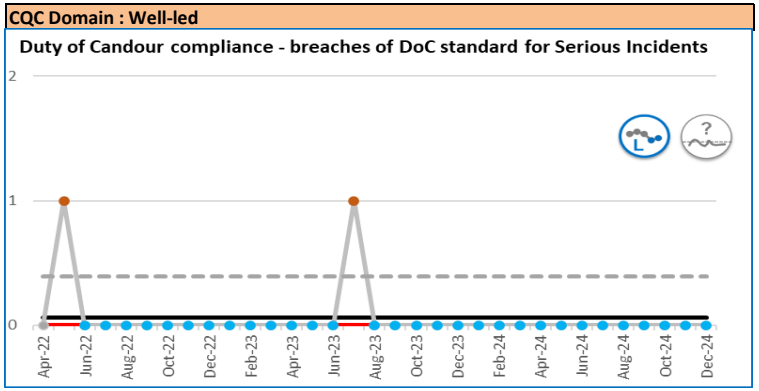
Dec-24
96.2%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



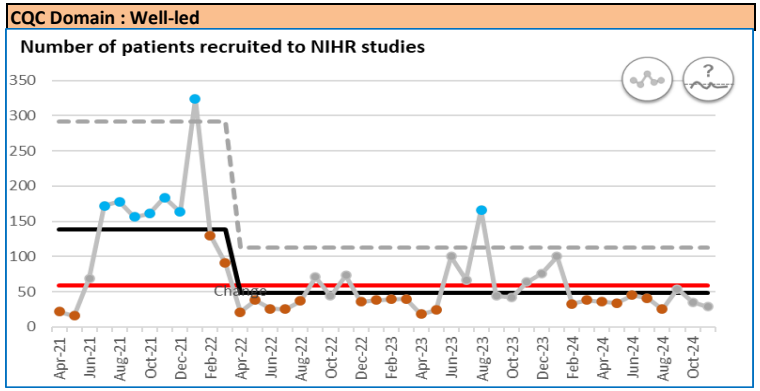
Dec-24
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led



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

CQC Domain : Well-led

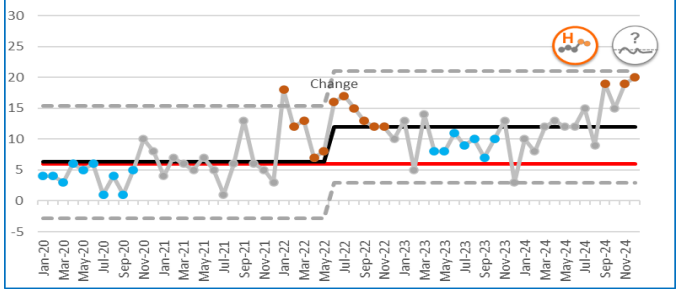


Nov-24
29
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse (1)

CQC Domain : Safe

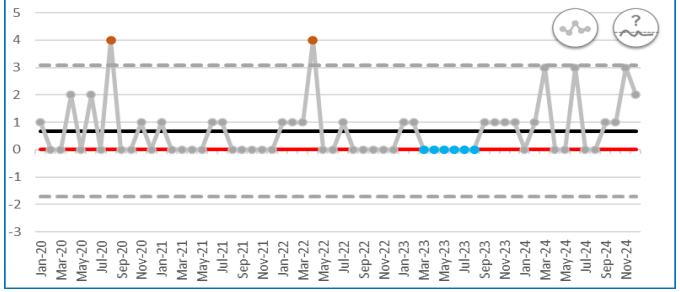
Clostridioides difficile (healthcare associated)



Dec-24
20
Variance Type
Special cause variation - concerning
Threshold
≤9
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

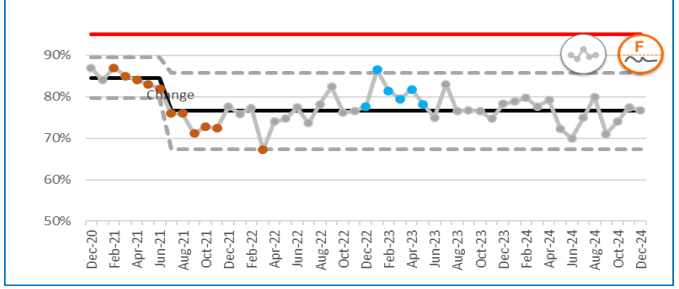
Pressure Ulcers - Hospital Acquired Category 3 and above



Dec-24
2
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

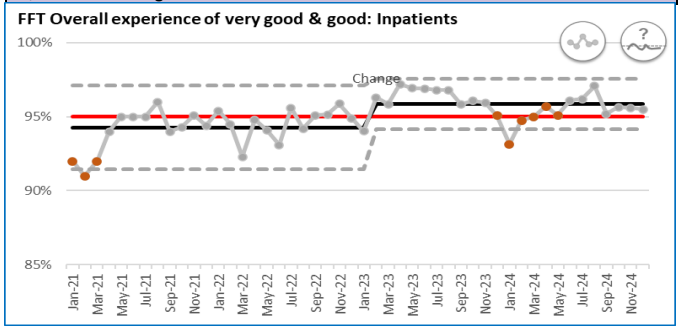
FFT Overall experience of very good & good: ED



Dec-24
76.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

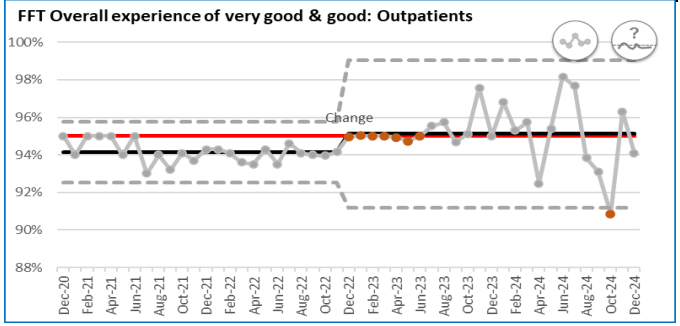
FFT Overall experience of very good & good: Inpatients



Dec-24
95.5%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

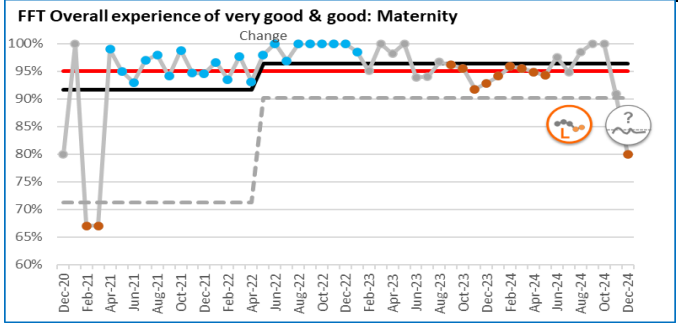
FFT Overall experience of very good & good: Outpatients



Dec-24
94.1%
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

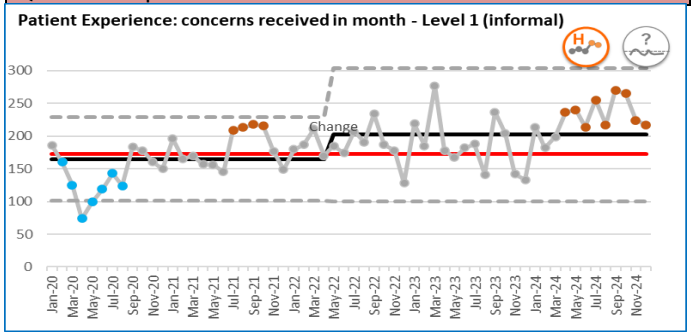


Dec-24
80.0%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse (2)

CQC Domain : Responsive

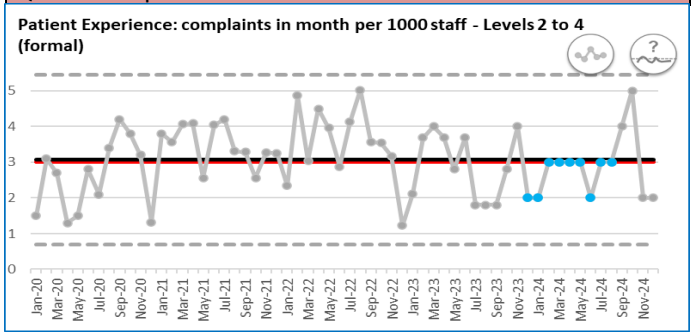
Patient Experience: concerns received in month - Level 1 (informal)



Dec-24
217
Variance Type
Special cause variation - concerning
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

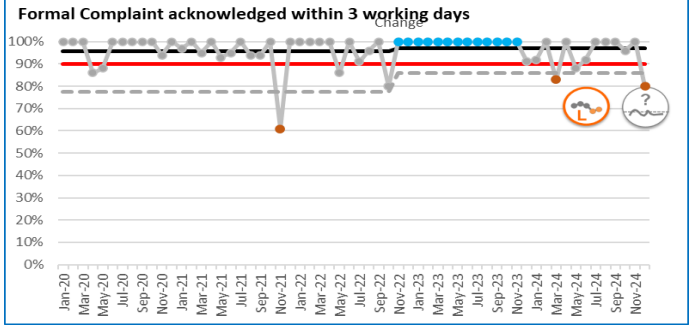
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)



Dec-24
2
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

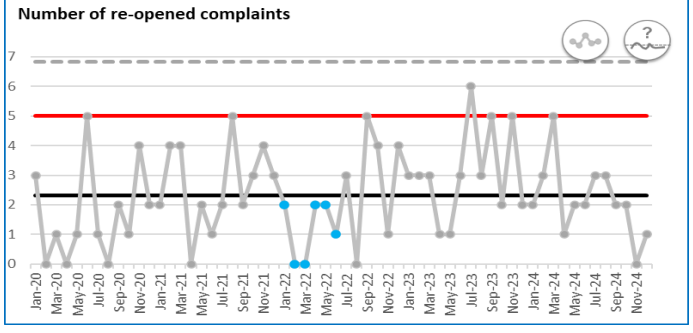
Formal Complaint acknowledged within 3 working days



Dec-24
80.0%
Variance Type
Special cause variation - concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

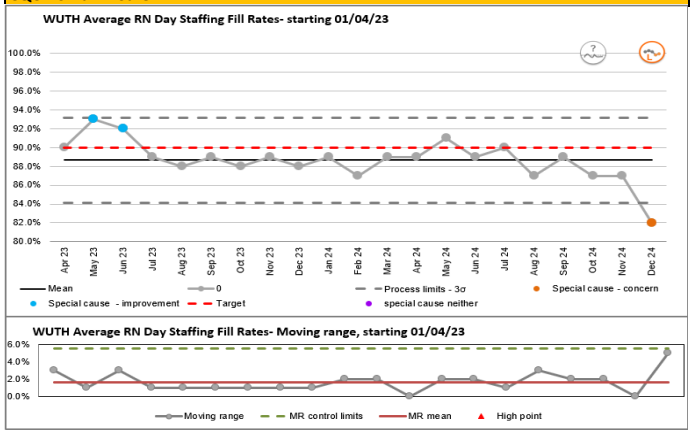
Number of re-opened complaints



Dec-24
1
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

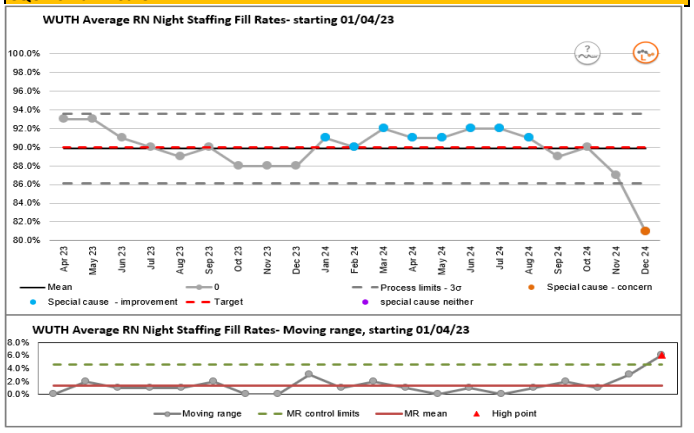
Chief Nurse (3)

CQC Domain : Safe



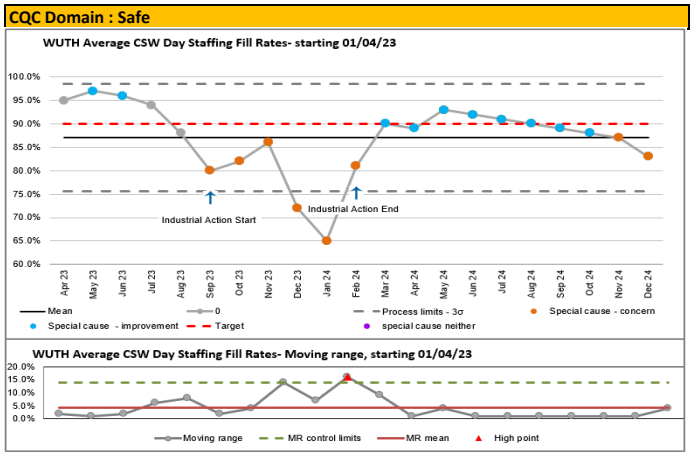
Dec-24
82.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



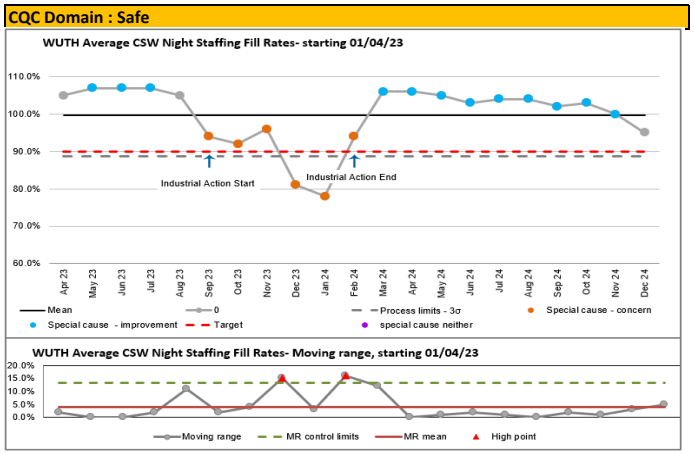
Dec-24
81.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe



Dec-24
83.0%
Variance Type
Actual below threshold
Threshold
≥90%
Assurance

CQC Domain : Safe



Dec-24
95.0%
Variance Type
Actual above threshold
Threshold
≥90%
Assurance

Chief Nurse

Overall position commentary

Clostridioides difficile remains above the target of 6 per month with 19 infections reported in November 24, (14 HOHA / 5 COHA) resulting in a cumulative total of 115 (76 HOHA / 38 COHA).

There was 1 category 3 hospital acquired pressure ulcer in December against a target of 0.

Friends and family test for ED 76.7%, outpatients increased to 94.1%. Inpatients exceeded the 95% of those that responded were either satisfied or very satisfied with the service. Maternity decreased in December to 80%.

During December 2024, WUTH logged 11 formal complaints (level 2) and 219 informal concerns (level 1). As with November, this represented a decrease in formal complaints from the previous month.

RN and CSW fill rates are now added to the integrated performance report. In a threshold of 90% fill rate is set in November RN Days was below the threshold at 82% and CSW day fill rate was 83%. Nights exceed the threshold for CSW's but was below the threshold for RNs at 81%.

Infection Prevention and Control

Narrative:
To achieve the annual threshold of ≤ 103 patients diagnosed with CDT in 24/25. The wards in the CDI improvement project continue to meet bi-weekly to share their local improvement initiatives that each area has developed (Wards 36, 26, 18, AMU, ED). In November the wards in the improvement project held a showcase event and presented their achievements to other ward managers/matrons across the Trust to enable the sharing of good practice. The wards within the CDI improvement project reported 5 incidences of CDT in November, Ward 36 reported x 2 HOHA and 1 COHA, Ward 18 reported 1 HOHA and ED 1 COHA. Wards 26 and AMU reported none which is an improvement from last month.

The improvement project continues to focus on but not limited to:

- Education with staff regarding side room prioritization with a written guideline for support
- Collaborative nursing & medical review if patients experience loose stools.
- During huddles discuss stool chart compliance and documentation.

- Ward 36 in collaboration with E&F and IPC continue to pilot new cleaning equipment and cleaning solutions, these include microfiber flat head mops, which effectively pick up and trap 99.54% of dirt, dust and bacteria at microscopic level using water alone, and hypochlorous acid for hard surface cleaning and hand sanitization. This is a natural microbial agent, which will help to reduce the amount of chemicals we use thus promoting improved sustainability...
- Increased scrutiny re: taking samples in a timely manner when symptoms start and isolating the patient within 2 hrs (as per CDT policy)

Actions:
Completed or in place.

- Ongoing daily use of ward 44 as a decant facility to allow for reactive HPV to take place in a bay once a patient diagnosed with CDT has been isolated.
- Ongoing IPC visibility to wards and department offering expert advice and guidance.
- Robust process embedded to pick up weekend results.
- Weekly CDT MDT in place involving, Pharmacy, Microbiology, IPC, and a clinician with an interest in CDT.
- A place wide 'working draft' improvement plan developed in partnership with WCT, the ICB and public health.
- Collaborative monthly meeting with WUTH IPC and the Community IPC team
- C&M IPC collaboration group focusing on CDT

Planned

- Draft 4 pillar system plan developed. Workstreams include, public health, Primary care, Community (inc care home/nursing homes) and acute. To progress though organisational governance for approval, with public health board overseeing delivery.
- Support the wards in identifying additional QI projects with a reduction in CDT as a theme.
- Review sampling protocol anticipated that approval to complete a sample will come from a senior clinician.
- Review of the number of patients who have been reported as having more than 1 episode of CDT since April 2024.
- Review of different types of HPV to meet improved delivery times and future sustainability.
- Review of the reasons available in Cerner for staff to highlight why they haven't sampled stool type 5.6.7.

Risks to position and/or actions

- Hospital occupancy- The daily demand for beds exceeds the availability.
- Continuous flow increases the demand for cleaning and the time allowed to complete.
- Competing staff priorities impacting engagement in the QI project.
- Low numbers of side rooms and/or side rooms with en-suites across the Estate does not support isolating all patients when needed. Risk assessment approach adopted.
- Old estate requiring ongoing maintenance and repairs to facilitate effective cleaning.
- Not always able to decant in a timely manner due to challenges with staffing, equipment and competing pressures with patient flow

FFT Overall experience of very good and good.

Narrative:
The NHS Friends and Family Test (FFT) was created to help service providers, and commissioners understand if patients are satisfied with the service provided, or where improvements are needed. It's a quick anonymous way for patients to provide their views. The trust monitors FFT across a range of care settings, with a target rating of a minimum 95% for good or very good.

Rating for maternity in November was 90% and in December 80% below the minimum target.
Monitored improvement and December 2024 remained a cause of concern at 80%.
Analysis of the patient comments for Maternity identifies Poor food quality and choice, inadequate pain and staff attitude.

Actions:

- Continued focus on providing people with access to provide feedback via FFT.
- Feedback analysed and patterns have been identified relating to the areas of improvement.
- Engagement with stakeholders and MNVP to share feedback.
- Action plan developed to address the main concerns raised in both the FFT and MNVP service user feedback and improvement initiatives to include clear goals.
- Implement short term actions immediately such as inadequate pain relief.
- Plan broader changes such as staff attitude via training.
- Monitor progress tracking FFT results to measure the impact of implemented changes.
- Collected qualitative feedback via MNVP to supplement FFT data
- Generic communications to all staff promoting FFT.

Risks to position and/or actions:

- Continue monitoring FFT data and patient feedback monthly.
- Expand patient engagement efforts to improve response rates in underrepresented areas.
- Delivery suite requires an improvement to response rates, although many comments relating to birth are received during the postnatal period they should be separated.
- Evaluate effectiveness of actions taken and adjust strategies accordingly
- Educate staff in the importance of FFT feedback and their role in encouraging participation.
- Educate staff via communication platforms including social media, safety huddles, meetings, and a specific direct email on the importance of ensuring the credibility of FFT and guidelines which should be adhered to including staff not completing or influencing the vital tool.

- Provide staff with an anonymous staff comments box to provide feedback and encourage/promote an open and honest culture if staff have suggestions.
- Continue to co-produce with MNVP to seek feedback via other mechanisms as well as FFT
- Encourage staff engagement and QI projects/involvement.

Complaints

Narrative:
During December 2024, WUTH logged 11 formal complaints (level 2) and 219 informal concerns (level 1). As with November, this represented a decrease in formal complaints from the previous month, and from the significant increase received in October (monthly averages over the previous two years are 17 for level 2 and 201 for level 1, so 35% lower and 9% higher respectively).

Medicine was involved in the greatest number of complaints (4), followed by Emergency Care (3), Women's and Children's (3), Diagnostics and Clinical Support (2), and Surgery (2).

For level 1 concerns, Medicine received the most (74), followed by Surgery (62), Women's and Childrens (35), Diagnostics and Clinical Support (30), Emergency Care (23) Corporate Departments (17), and Estates, Facilities and Capital (4).

Combining level 1 and level 2, the top five themes for the organisation were:

- Access and Admission (27%): These mostly reflect delays and cancellations.
- Communication (19%): These mostly reflect communication failure with patients and relatives, including staff attitude.
- Treatment and Procedure (17%): These most reflect delays in treatment.
- Infrastructure (12%): These mostly reflect lost property and difficulties contacting departments.
- Tests and Results (9%): Again, these most reflect forms of delay.

The top five departments were ED (3 formal and 21 informal, with the largest categories being lost property and treatment), followed by Community Child Health (16 informal, reflecting the known access problems with waiting times for assessment by that service), then Gastroenterology (10 informal, with the largest category being Access and Admission), Ward 14 (9 informal, with the largest category being delayed treatment), then MSK Service (9 informal, with the largest categories being delays and difficulties in contacting).

24% of responses to formal complaints were completed within WUTH's local standard of 40 working days, with an average response time of 60 working days. At the end of December, there were 32 formal complaints in progress, of which 20 had already breached 40 working days with the divisions. This active caseload represented a considerable improvement from November (51 and 25), with the decrease being due to the fewer new complaints registered during the previous two months (meaning more responses were sent than new cases opened).

Of the 219 level 1 concerns opened, 49% had been resolved within three working days and 71% within 10 working days. Of those cases taking longer than 10 working days, these lay with Medicine (19), Emergency Care (17), Women's and Children's (12), Surgery (12), Corporate Departments (9), Diagnostics and Clinical Support (5), and Estates, Facilities and Capital (3).

Actions:
Average complaint response time during the fiscal year to date remains at 60 working days (compared with 70 working days in 2022/23, 58 working days in 2021/22, and 45 working days 2020/21).

As noted previously, discussions have taken place with the divisional triumvirates to emphasise the role of a single divisional investigator to coordinate a unified response with all stakeholders, answering all complaint issues and with appropriate actions set out. The absence of this remains the biggest delaying factor in the investigation and response process. Performance oversight continues to be provided to the divisional triumvirates via daily reports and weekly meetings with the central Complaints Team, which also continues to provide monthly training sessions for staff.

Risks to position and/or actions:

- Operational pressure
- Lack of individual ownership
- Variable skillsets

Nurse Staffing Fill Rates

Narrative:
Registered nurse and care support working fill rates should be reported to the board on a monthly basis to ensure compliance with NHSE developing workforce safeguards 2018 and the national quality board safe sustainable and productive staffing 2017. A ward level dashboard should also be available to demonstrate safe effective care is being delivered. Fill rate threshold is currently set at 90% day and night CSW and RN. In December the RN fill rate on days was 82% and the CSW fill rate was 83%, on nights RN fill rate was 81%, CSW fill rate 95%.
Staffing challenges increased during increased UEC demand with associated staffing demand in escalation areas including ED corridors.

Actions:
Review of vacancies across the organisation, to fully understand the risk and impacts and determine the most effective recruitment process ie; speciality based recruitment events.

Acuity review completed with new safer nursing care tool, data currently being analysed. Divisional establishment reviews underway in January. Report to Board in March 25.

Assurance re effectiveness of absence management.

Weekly roster oversight review meetings undertaken by DCN/CN to review use of bank and agency, and roster KPI's

Roster/establishment/ESR alignment project under way.

Proposal regarding the approach to maternity leave backfill in development.

ED recruitment to new establishment underway, staff being temporarily redeployed to ED from wards to maintain safety, impacting on the wards.

Retention group reinitiated.

Risks to position and/or actions:

- High sickness absence rates.
- Staffing escalation areas and temporary escalation areas ie; ED corridor and escalation wards

Pressure ulcers Hospital Acquired Category 3 and above

Narrative:
WUTH has a zero tolerance on Hospital Acquired Pressure Ulcers (HAPU) category 3 and above. During December there was 1 x Hospital Acquired Pressure Ulcer (HAPU) Category 3. This was due to a hearing aid, 1cm x 1cm.

Actions:

- 1ST Link Nurse study day 8th January 2025. Good attendance mixture of RNs & CSWs all interested in improving care in relation to Tissue Viability. Programme of education being developed 4 times a year.
- Development of CSW training days.
- Development of Student Nurses training days.
- Wound Care formulary launched.
- Pressure Ulcer Policy Ratified and available.
- Working with Emergency Department - undertaking pressure ulcer risk assessment, categorisation of pressure ulcers, provision of dressing supplies and review of trolley mattresses.
- Reviewing documentation and care plans within Cerner.

- Development of further Tissue Viability policies – TNP, Maggots, Wound care, lower limb and wound swabbing.
- Collaboration with Community Tissue Viability Team.

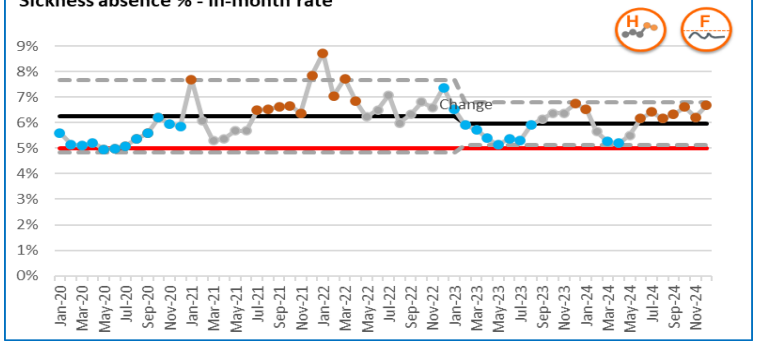
Risks to position and/or actions:

- Part time (temporary) leadership within the tissue viability team.

Chief People Officer

CQC Domain : Safe

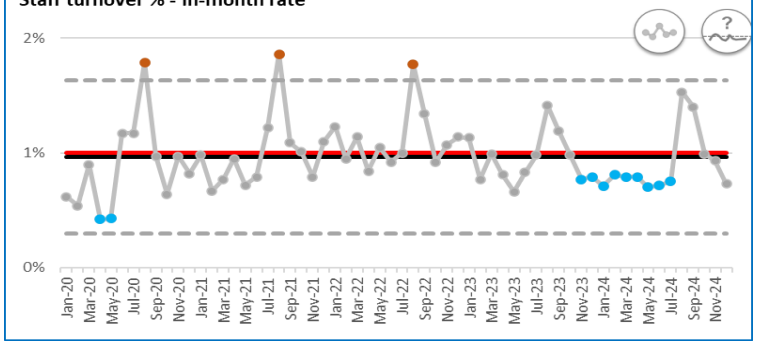
Sickness absence % - in-month rate



Dec-24
6.68%
Variance Type
Special cause variation - concerning
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe

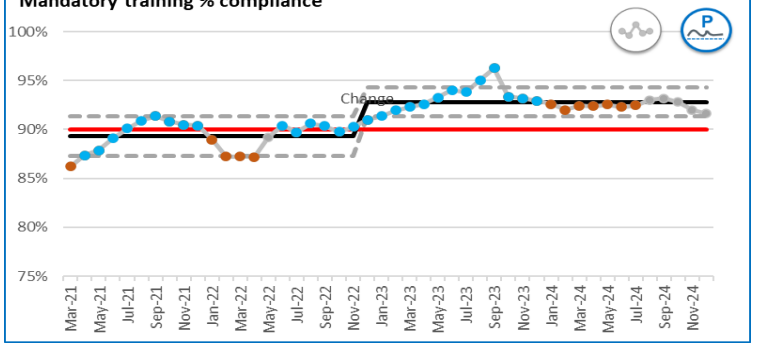
Staff turnover % - in-month rate



Dec-24
0.73%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

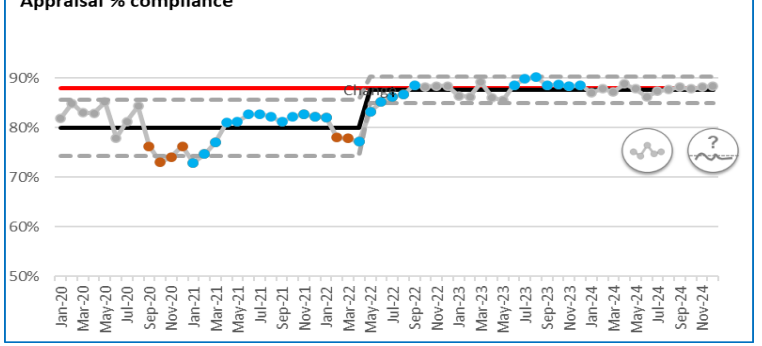
Mandatory training % compliance



Dec-24
91.62%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led

Appraisal % compliance



Dec-24
88.42%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer

Overall position commentary

Despite operational pressures and unprecedented demand for our urgent and emergency services the Trust's People KPIs for mandatory training, appraisal compliance and turnover are on target.

Sickness absence remains above target at 6.68% and an area of concern.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is ≤5%. For December 2024 the indicator was 6.68% and demonstrates special cause variation - concerning.

The majority of absences relate to short term sickness (under 28 days). The top three reasons for absence in December are, Cold/Flu, Gastrointestinal problems and Chest/Respiratory problems.

Absence relating to Stress / Anxiety / Depression is not currently within the top three reasons, although this remains a key area of focus.

Focus remains on supporting the health and wellbeing of our workforce, as well as close management of absences in line with the revised Attendance Management Policy.

The local risk (397) score has been reviewed and increased from 12 to 15 and BAF risk increased from 3 to 4 (moving the overall risk to 12).

Actions:

Proactively Supporting Wellbeing

- Divisional identification of local actions to support the health and wellbeing of staff.
- Occupational Health December Winter Wellness: Promotion focused on maintaining a safe and healthy environment to reduce infectious illnesses.
- Winter Vaccination Programme continues via drop-in clinics, roaming vaccinators and dial-a -jab.
- Social Media push campaign promotion of self-referral to Occupational Health and Workforce Wellbeing Service.
- Social Media push campaign promotion of support available to staff regarding any work-related musculoskeletal issues.
- Safe Effective Quality Occupational Health Service (SEQOHS) Accreditation annual re-accreditation achieved for Occupational Health Department.

- Onsite presence and ongoing promotion of the Trust's EAP.
- Planning the February Wellbeing Surgery which will focus on reducing alcohol consumption.

Managing Absence

- Monitoring of the sickness absence KPI and associated actions are ongoing via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews. Managers continue to be supported by HR.
- Return to Work Guidance updated for staff with respiratory infections (including Covid 19) approved at Clinical Advisory Group and published.
- Part-year review undertaken of the new Attendance Management Policy published 1 March 2024.
- Revised approach to local attendance management audits.
- Increased reporting on outcome of local attendance management audits both divisionally and to Workforce Steering Board.

Risks to position and/or actions:

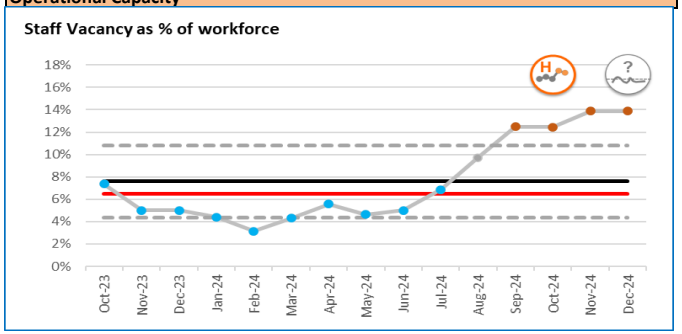
The management of sickness absence is primarily management led as they are responsible for monitoring employee attendance addressing sickness absence and ensuring that the policy is applied consistently, supported by the HR team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels, financial controls 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. Benchmarking data shows that the Northwest has the highest sickness rate with sickness rising since May 2024. Similar challenges are being experienced at System Level.

Managing attendance can also help control costs related to overtime, absenteeism and temporary staffing.

Work continues on the deliverables within the People Strategy with a number of workstreams that will support attendance across the Trust, this includes promotion of flexible working, which is available to all staff, transforming and modernising Occupational Health and Wellbeing Service in line with the Growing OH and Wellbeing together 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. This is part of our proactive culture of wellbeing across the trust.

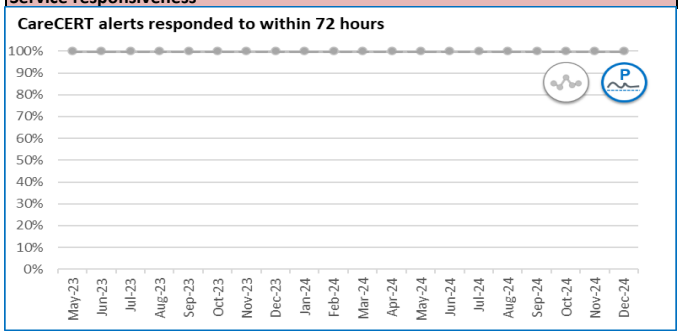
Chief Information Officer

Operational Capacity



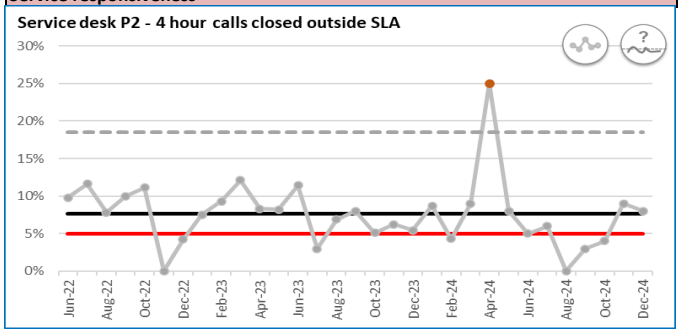
Dec-24
13.9%
Variance Type
Special cause variation - concerning
Threshold
<=6.5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



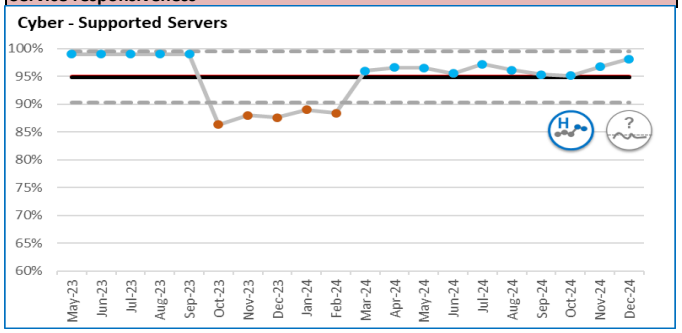
Dec-24
100%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently achieves the target

Service responsiveness



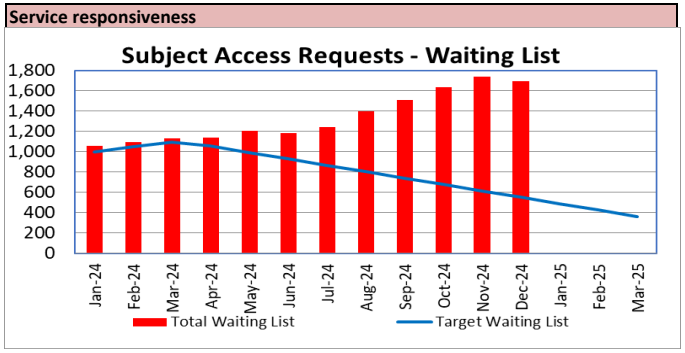
Dec-24
8.0%
Variance Type
Common cause variation
Threshold
<=5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



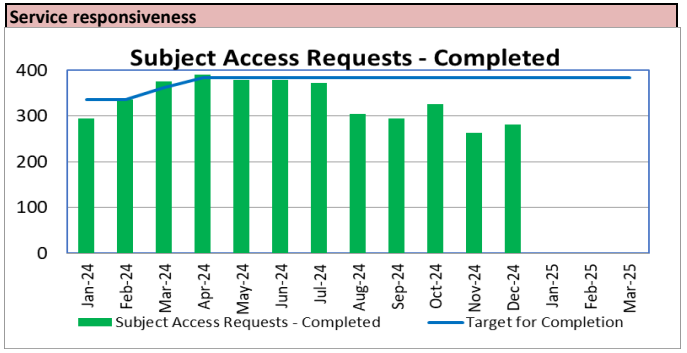
Dec-24
98.1%
Variance Type
Special cause variation - improving
Threshold
>=95%
Assurance
Hit & miss target subject to random variation

Service responsiveness



Dec-24
1695
Variance
Total requests waiting worse than target
Threshold
738

Service responsiveness



Dec-24
282
Variance
Completed requests worse than target
Target
384

Chief Information Officer

Overall position commentary

Strong performance is maintained in:

- CareCERT alerts at 100% - a key control for cyber-security.
- Cyber supported servers continue above the 95% threshold figure.
- P2 calls closed outside SLA – achieved target for December

Key areas for improvement are:

- Subject Access Requests (SARs) – completed requests were significantly below the trajectory, however numbers received in December were exceptionally low which resulted in a slight decrease in the overall backlog.
- Staff vacancies are currently at 13.9% of the workforce, which continues to impact the services provided. Prioritisation is key to maintaining confidence in the service and the morale of staff.

As part of the Cyber plan for 2025/26 the full suite of Cyber KPIs for board are being reviewed.

Service Responsiveness – Subject Access Requests

Narrative:

The organisation has experienced a year-on-year increase in volume and complexity of Subject Access Requests (SARs) totaling 41% since 2016. Change in legislation, increase in request numbers, the complexity of the requests and the evolving attitudes towards information rights have had a significant impact on the demand. This combination has led to a significant backlog of requests within the Access to Information department. As at January 2024 there was a backlog of circa 1,000 requests, with approximately 650 of those requests being outside of the regulatory 1 month response target.

The improvement trajectory for completing requests was 102 behind target in December with 282 being processed against a target of 384
Total requests waiting decreased slightly from 1736 in November to 1695 in December 2024. This was due to a decrease in requests for the month which is the usual trend around the period. We would expect figures to return to levels over and above the targeted trajectory within the recovery plan again during January and vacancies remaining in the department means that backlog figures are also likely to increase.

Actions:

- Implementation plan for new tracking software to help manage and streamline the process shows a go live date of early February 2025.
- Service Improvement team review will commence following introduction of the new database.
- Technical platform to be implemented allowing digital transfer of information to requestors which will improve productivity within the team.

Risks to position and/or actions:

- Risk posed by any further increase in demand
- Risk of further trajectory slippage depending on any personnel issues such as sickness, staff turnover
- Risk of not being able to appoint to established posts

Operational Capacity – Staff vacancy as a % of workforce.

Narrative:

The last reporting period has seen a further increase in staff vacancies as a percentage of the workforce, rising to 13.9%. The increase is due to a number of staff departing to accept opportunities at a higher banding at other C&M organisations and the retirement of several long serving senior managers, particularly within the BI & Information department. There are some key areas of risk for the Trust in the areas of BI & Information, Development & Integration, Coding, Cyber Security, Access to Information, and more recently Clinical Analysis (with specialist knowledge of Laboratories)

The team continues to assess its workforce risks together with executive colleagues. Prioritisation of work is ongoing across the teams to ensure the reduced capacity we do have is focusing on the correct areas. Vacancies have been approved for the Business Intelligence Team and are currently being recruited to.

Actions:

- All departments across DHT have been risk assessed and proposals are being prioritised to address the high risk areas.
- Technical Cyber work is being managed by the Technical Infrastructure Team. The job description for the vacant Cyber Manager's post is being finalised and will be submitted to vacancy panel.
- Chief Technology Officer providing backup cover for Integration Team.
- Scoping work ongoing to understand the opportunity of collaboration with Community Trust in problem areas.
- Investigating Artificial Intelligence opportunities within the coding arena.

Risks to position and/or actions:

- Difficulties in recruiting the desired skill sets for vacated positions due to national skills shortages in those areas.
- Chief Technology Officer providing expert cover for Development & Integration is not sustainable.
- Prioritised vacancies are not approved at the exception process.
- Performance impacts across the department.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 10**
29 January 2025

Report Title	Committee Chairs Reports – Finance Business Performance Committee
Date of Meeting	12 December 2024
Author	Sue Lorimer, Chair of Finance Business Performance Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Trust's cash position is significantly lower than that required for effective operation. The Trust has requested cash support from the centre, and this has been declined. Another request for £23.1m is in progress. This comprises £6.7m deficit support and £16.4m working capital. Payment of invoices is being delayed as the payroll is the main priority. This represents reputational risk for the Trust. The ICB is supporting by rephasing contract payments, but it is critical the situation is resolved by the end of March 2025. ○ The Trust reported a financial position to the end of November of a £17m deficit which is £11.2m adverse to plan. The forecast after mitigations of £8.4m is a deficit of £14.7m. This is significantly higher that the mitigated forecast of £7m submitted to the ICB and includes the cost of the cyber-attack and unfunded pay award. There is scope to improve the forecast position, but this is dependent on receipt of capital funding connected to the Frontis building. ○ Performance on CIP is forecast at £20.1m against a target of £28.9m. The amount transacted to month 8 was £17.9m. The full year effect of the CIP is £26m.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The Committee agreed to extend the LLP contract from 30th September 2024 to 31st March 2025. This is due to unforeseen circumstances regarding the Most Suitable Provider Selection regime which has resulted in the procurement process being halted and restarted. The Committee requested assurance that core activity was being delivered before premium spend activity is commissioned.

	○ The Committee considered a business case for 3 locum consultants for the Stroke service and after due consideration of the financial cost versus the sustainability of the service, agreed to fund 2 posts only. ○ The Committee considered the Integrated Performance Report noting that Type 1 A&E performance for w/c 2/12/24 was the highest in 12 months at 50%. ○ Ambulance handover times remained a key concern. The Committee noted that there was a meeting planned for that day with NHSE and Place partners to discuss urgent care pressures. ○ The Committee received feedback on the response to the cyber security incident noting the learning from this and acknowledging the excellent response from all team members. ○ The Committee discussed the BAF and agreed the risk scores applicable to the Committee, in particular the risk score of 20 assigned to risk 6.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ Despite best efforts to achieve an improved financial position there is no assurance that the forecast will be in line either with plan or with the mitigated plan. The Committee agreed that no action should be considered which puts patient care at risk.
Review of Risks	• The Committee agreed that the risk of not approving the appointment of a third locum consultant to the Stroke service be discussed with the Medical Director. • The cash risk is significant and delaying payment of creditors creates a reputational risk for the Trust.
Other comments from the Chair	• The extension of the LLP contract requires approval from the Board of Directors due to the contract value. • The CFO continues to engage with the ICB regarding the financial position and cash requirements.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
29 January 2025

Item No 10

Report Title	Committee Chairs Reports – Finance Business Performance Committee
Date of Meeting	13 January 2025
Author	Sue Lorimer, Chair of Finance Business Performance Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Trust has received confirmation that the central Revenue Support Team has approved £3.5m cash support for January. This, combined with the £4m agreed with the ICB will cover the Trust's cash requirements for January and February. The central approval sends a positive signal regarding the further £13m which the Trust has requested for March. ○ The Trust reported a financial position to the end of December of a £17.2m deficit which is £11.3m adverse to plan. This shows that the position has broadly held steady during December. However, the position is off trajectory by £4.4m due to cyber (£3m), slippage in integration (£0.9m) and unfunded pay award (£0.5m). ○ The Committee were informed that NHSE is prioritising £6m capital funding for the trust to cover a £2m capital to revenue transfer and £4m relating to the Frontis building. This would reduce the forecast deficit to £10m which (with the exception of the cyber incident) would take the Trust to a position in line with the revised plan of £7m.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The Committee approved a business case for the provision of bleeps at a cost of £387k over 5 years. The current system will no longer be supported after March 2025. The Committee wished to be assured that the benefits of the new system would be utilised, and that sufficient training would be made available to users.
Assure	○ The Committee wish to assure members of the Board of Directors that: ○ CIP planning for 2025/26 is advanced and a report was provided setting out a plan for a CIP of £31.1m. The CIP is based largely on transformational rather than divisional schemes though the divisions are involved in the delivery of the schemes. Each transformational

	scheme has been assigned a target based on previous work. ○ The year end forecast for 2025/26 while not in line with original plan is now much closer to the mitigated forecast approved by the Board, the difference of £3m relating to the Cyber attack which was an unforeseen incident.
Review of Risks	• The benefit to the financial position relating to the Frontis building is subject to successful negotiations with Your Housing Group for the transfer of the building.
Other comments from the Chair	• The Committee wished to understand the position for 2025/26 and how the non-recurrent benefits in the current year will be covered in the new year. A report on the financial plan for 2025/26 will be brought to the February meeting of the Committee.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
29 January 2025

Item No 11

Report Title	Committee Chairs Reports – People Committee
Date of Meeting	13 December 2024
Author	Lesley Davies, Chair of People Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ There has been a month on month decrease for fire safety level 2 mandatory training – driven by a high did not attend rate and staffing pressures. Committee understood overall fire safety was a high risk on the significant risk register and requested the Deputy Chief People Officer raise this at the next Executive Assurance and Risk Committee regarding the compliance rate. ○ Sickness absence continued to not meet Trust target and remained an area of concern. Committee acknowledged the main driver remained short-term absence and related to gastro problems and anxiety, stress and depression. Committee noted the work commissioned via Workforce Steering Board to identify specific Divisional interventions and also to review the newly implemented Attendance Management Policy.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The Chief People Officer remained the SRO for the Wirral Workforce Group – which was leading on the creation of the Wirral Place People Strategy. Committee understood due to the governance implications following the Wirral System Review this work had been paused whilst the impact of other changes is reviewed. ○ Committee noted a number of employee relations cases related to bullying/behaviour which, when triangulated with the FTSU themes around attitudes, behaviours and bullying, highlights a concern. Committee requested a deep dive for the March meeting to further understand this. ○ Committee noted the data on bank and agency spend, and provided some scrutiny around the controls in place, noting the MIAA Medical Staffing Review. The Committee were satisfied with the update provided on

	current controls, opportunities to strengthen controls and work in place to do so. Committee noted that PWC are supporting the Trust on delivering some elements of this work include e-rostering and medical job planning.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ A staff story was played featuring a selection of Black, Asian and Minority Ethnic staff who described their positive experience of working at the Trust, noting the good sense of community and belonging. The Chief People Officer advised a series of listening events were held to further understand the employee experience of this staff group following concerns through the 2023 NHS Staff Survey. Committee were assured 2 actions had been agreed for implementation which would be reviewed in 6 months' time. ○ The average employee relations case length continued to reduce and overall cases was comparable to 1.3% of the workforce and not a cause for concern. ○ The number of staff speaking up through the Freedom to Speak Up mechanism was 37 during Q1 and this was a significant increase compared to previous years. Committee were pleased to see the increase as an indicator of open culture, noting that this number remained in line with regional and national averages. ○ A higher number of exception reports had been submitted during Q2, noting this had been driven by a greater number from non-Foundation doctors who had been supporting junior doctors with their workload and facilitating them leaving on time. Committee were pleased to hear from the Guardian of Safe Working that strong interventions were in place to support junior doctors combined with help from Educational Supervisors.
Review of Risks	• No risks require escalating.
Other comments from the Chair	• Committee agreed the executive summary sections of reports had improved further following previous feedback.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
29 January 2025

Item No 12

Report Title	Committee Chairs Reports – Quality Committee
Date of Meeting	16 January 2025
Author	Dr Steve Ryan, Chair of Quality Committee

Alert	• The Committee wish to alert members of the Board of Directors that: ○ Agreed improvement trajectories for Gram negative blood stream infections such as *Escherichia coli* have not been met and alongside the trajectory for *Clostridioides difficile* not being met, this indicated gaps in control of healthcare associated infections. There are opportunities for collaborative quality improvement working with the Community Trust to help address this challenge and the Committee asked for an update at its next meeting. ○ Although the position is stable, a number of policies still remain overdue to updating. The Committee, whilst recognising the challenge (given the number of policies and the high pressure on staff) emphasised the need to have the policies up to date and discussed mechanisms that could assist in this. ○ A high number of complaints have been received about waiting times to access community paediatric services, particularly around support for children accessing SEND pathways. Collaborative improvement work is underway and an OFSTED/CQC inspection of SEND service on the Wirral is currently underway. ○ The executive team are sighted on the high risk to the continued provision of a full range medicinal products in the pharmacy Aseptic Unit.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ There is clear action on improving gaps in application of the Mental Capacity Act, especially around the induction and support for locum doctors and ensuring learning from patient safety incidents is widely shared. ○ Due to a high number of delays in treatment for Acute Macular Degeneration in the ophthalmology service, early mitigations have stabilised the issue, but further work is needed (around workforce and estates) to ensure the service is in the best position to meet a high and rising demand. ○ A paediatric audiology action plan has been developed in response to a national report. Risk assessments around estates, hardware and procedures have been updated and collaborative improvement work is

	ongoing. There is no evidence of patient harm arising in this service. ○ It considered how the Trust was progressing with its use of the Patient Safety Incident Response Framework and noted that it will soon have 3 patient safety partners in place. It has also seen evidence of thoughtful and engaging investigations capable of highlighting causal issues such as human factors and of identifying actions that can be taken.
Assure	• The Committee wish to assure members of the Board of Directors that: ○ There is a high level of confidence and support in the evidence provided to support the Trust's declaration that it is fully compliant with the 10 safety actions required in its application to the 6th year of the CNST Maternity Incentive Scheme. A detailed presentation was provided and members of the Committee including maternity safety champions were able to provide supportive insights. A large amount of external assurance has been provided by the Local Maternity and Neonatal System. It is important to note that outside the specific parameters of the scheme, improvement work continues in other areas around patient experience on the maternity ward and in our triage function for example. ○ The Committee were impressed by the conduct of and results from the Equality Delivery System annual assessment of domain 1 (commissioned/provided services). A deep dive into endoscopy services, developed in collaboration of people with additional needs, resulted in findings of "achieving" in 3 domains and "excelling" in the 4th. There had been excellent clinical engagement and a strong appetite to build on this work. ○ There was evidence of effective quality improvement and learning. Following previous concerns about gaps in response to deteriorating patients, interventions had achieved an improvement trajectory for early warning (NEWS) scores to > 90% and concomitant decrease of out of hours calls needed to the medical emergency team (MET). ○ The Quarter 2 Learning from Deaths Report demonstrated that the Trust's mortality rates lie within expected reference rates and that there is no trend to increased mortality in the emergency department despite high level of delays and occupancy. ○ In addition to work to reduce all cancer waiting times to acceptable levels, quality improvement work is active and supporting patient journeys and experience. Of particular note were the success of the Non-specific

	rapid diagnostic service (in detecting not only cancers but other rare medical conditions) and the feedback received from those on the Student Nurses Cancer Nursing Programme.
Review of Risks	• The rating for the Board Assurance Framework risk of failure to ensure adequate quality of care has been increased as a result of high levels of unscheduled care demand, workforce gaps and the financial pressures. An example impact is seen in delays to the WISE (ward quality) accreditation programme. The committee requested an update on a catch-up and review programme at its May meeting.
Other comments from the Chair	• The Committee had a broad discussion on the elements of the risks in the Board Assurance Framework that were in it control and those that within its control and those that were driven by external factors such as unscheduled care demand and how these should be represented and treated in future iterations of the BAF.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 13**

29 January 2025

Title	Monthly Maternity and Neonatal Services Report (including Maternity Incentive Scheme Year 6 Annual Declaration)
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Approval

Executive Summary and Report Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in December 2024 and extended monthly reports in in October and November 2024.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).

In addition to the paper a presentation is provided to give assurance to the Board of Directors compliance with the 10 Maternity Safety Actions (MIS) Year 6 that is due for submission before 3 March 2025.

Also included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (November and December 2024) key quality and safety metrics.

It is recommended the Board of Directors

- Note the report; and
- Approve the compliance document for the submission of the declaration form to NHSR

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**
10th January 2025	Maternity & NNU Assurance Meeting	Maternity and Neonatal Services Report	For approval
16th January 2025	Patient Safety and Quality Board	Quarterly Maternity and Neonatal Services Report	For approval
16th January 2025	Quality Committee	Monthly Maternity and Neonatal Services Report	For approval

1	Maternity Incentive Scheme (MIS) Year 6
	A detailed MIS update is included to Board of Directors Monthly Maternity Services update, which will further inform Trust declaration with the MIS due for submission before a deadline of 12 noon on 3 March 2025. Now in its sixth year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. The compliance has been monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. A detailed Maternity Incentive Scheme (MIS) update utilising the audit tool is included in the paper which will support the Trusts declaration at Appendix **1.** Provider compliance with the 10 Safety Action Standards across Cheshire &Merseyside has been monitored closely by both the LMNS and NHSE/I, with the Integrated Care Board (ICB) also having oversight of compliance. The supporting evidence includes a Presentation **(Appendix 2).**

2	Perinatal Clinical Surveillance Quality Assurance Report
	The Perinatal Clinical Surveillance Quality Tool revised dashboard is included in **Appendix 3** and provides an overview of the latest (December 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 January 2025 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.

3	**Patient Safety Incident Investigations (PSII's) & Maternity and Newborn Safety Incidents (MNSI)**
	Patient Safety Incident Investigations (PSII'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 November and December 2024 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date four cases will undergo the independent safety investigation. There were no Patient Safety Investigation Incidents (PSII's) declared in November and December 2024 for Neonatal services.

4	**Conclusion**
	The Board of Directors are requested to approve Trust compliance with Year 6 of the Maternity Incentive Scheme and to note the supporting evidence prior to the Chief Executive sign off of the Trust declaration form and submission to NHSR by noon on 3 March 2025. The next BOD paper will continue to update on the delivery of safe maternity and neonatal services.

5	**Implications**
5.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
5.2	**People** • Compliance and confirmation via the LMNS/ICB WUTH 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.
5.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) there is a requirement to meet all 10 safety actions.
5.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
29 January 2025

Item 14

Title	Learning from Deaths Report (Q2 2024-2025)
Area Lead	Dr Ranjeev Mehra, Interim Medical Director
Author	Dr Ranjeev Mehra, Interim Medical Director
Report for	Information

Executive Summary and Report 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 2024-2025.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths.
- The Trust SHMI for the 12 months to Jan 2024 is 1.04 (within expected range)
- HSMR on the latest available data is 98 (within expected range)
- HSMR methodology will change in 2025 and this will likely result in a rise in the HSMR for WUTH
- The Mortality review group (MRG) is a multidisciplinary group that 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 Telstra Health data to benchmark nationally and highlight areas of concern.
- Learning form mortality reviews is fed back to clinical areas by the Divisional Mortality leads and via the Divisional Quality Boards. Specific learning points are also fed back to relevant Trust wide steering groups.

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

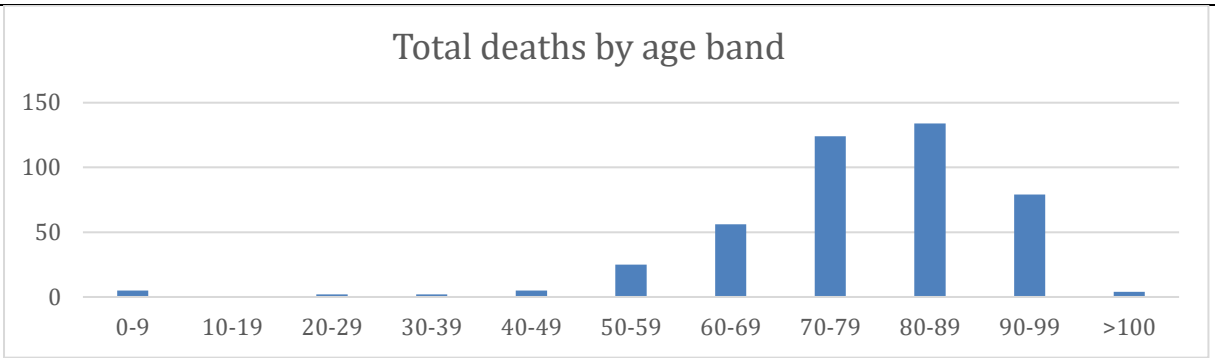
Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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

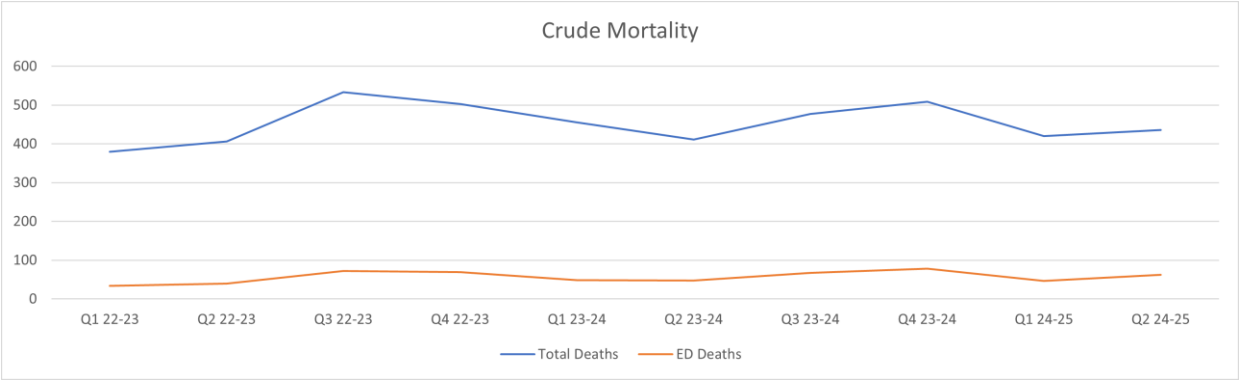
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
January 2025	Quality Committee	As above	As above
December 2024	Patient Safety Quality Board	As above	As above

1	Narrative
1.1	This report provides a summary of all deaths that occurred within Wirral University Teaching Hospitals NHS Foundation Trust over Quarter 2 (Apr 24- Jun 24). It aims to identify key learning points, trends, and areas for improvement to enhance patient safety and care quality. 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 Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare and benchmark against 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 an indication 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 sample of non-escalated deaths (approx. 5% per quarter) 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, and by the circulation of this report through Divisional Quality Boards **<u>Patient demographics</u>** There was a total of 436 deaths in Q2 24-25. Most recorded deaths are in the over 70 age group and the vast majority fall into the “White British” Ethnic band.



Ethnicity	Number of deaths
White - British	375
White - Irish	0
White - Any other White background	6
Mixed - Any other mixed background	0
Asian or Asian British - Indian	1
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	1
Other Ethnic Groups -	1
Black/ Black British	1
Not stated/ Not known	51
Total	436



Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The overall SHIMI for WUTH on the latest available data (12 months to January 2024) is 1.04 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.

- Specific diagnostic groups

There were no specific SHIMI diagnostic groups that were flagged as outliers during Q2 (using NHSE over dispersal method)

- Deprivation

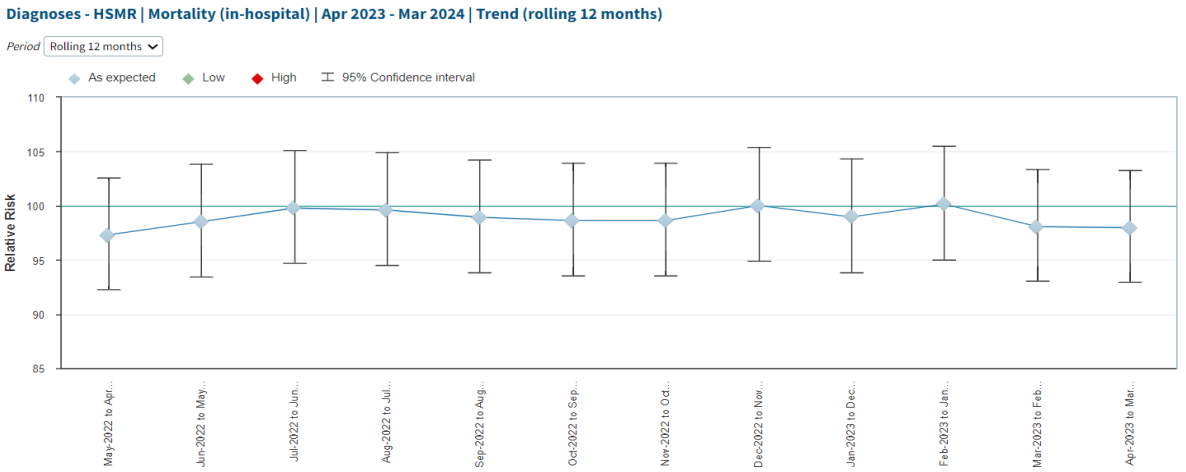
The Trusts continues to have a higher-than-average percentage of provider spells from the most deprived areas. Potential additional risks/complexities associated with these patients, is not factored into the SHMI calculation unlike HSMR, and can lead to a higher SHIMI.

- 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). Review of practice has shown that palliative care coding remains appropriate and is a reflection of a proactive palliative care service. This is also suported by ongoing natoinal audits for palliative care (NACEL).

<u>Hospital Standardised Mortality Ratio (HSMR)</u>

The HSMR on the latest 12 months rolling trend is at 98 This is in the expected range.



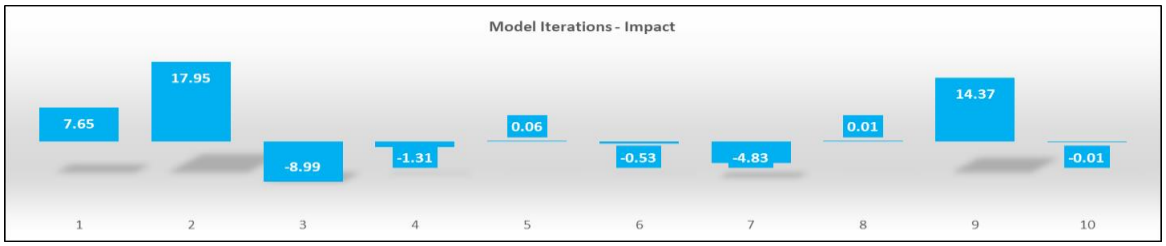
HSMR+

From early 2025 Telstra Health will be switiching to HSMR+. Analysis has shown that although the relative risk will rise as a result the overall risk will still be within the " as expected" range.

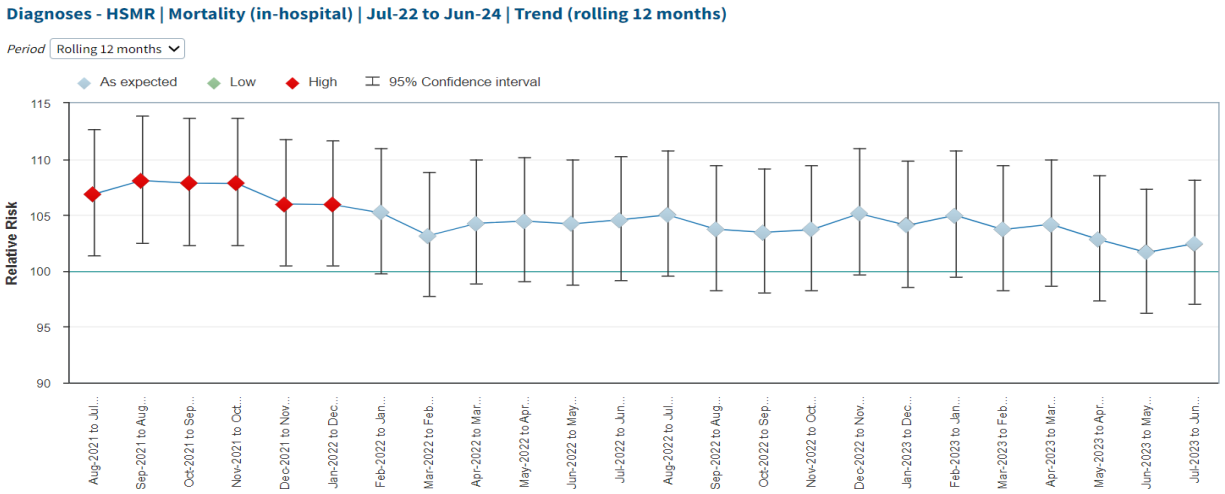
This rise in relative risk is alomost entirely explaind by removal of palliative care coding from the new model.

HSMR vs HSMR+ (The original HSMR vs HSMR+)	Relative Risk	Banding
HSMR	95.38 (90.43 - 100.53)	Within
HSMR+	103.03 (97.63 - 108.66)	Within

Key	Model Iterations	Relative Risk Difference
1	HSMR vs HSMR+	7.65
2	HSMR vs HSMR without palliative	17.95
3	HSMR without palliative vs. HSMR+	-8.99
4	Cohort Update	-1.31
5	COVID subgroup	0.06
6	Deprivation	-0.53
7	Comorbidity	-4.83
8	Frailty	0.01
9	Palliative care	14.37
10	Modelling	-0.01



Analysis of the data up to the period to June 2024 shows the projected figure for HSMR+ to be 102.4



Mortality Dashboard

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

16 cases escalated by the ME service during Q2 have been allocated for review using our Mortality Review form.

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 32 deaths were allocated for review in Q2 (7%) using the PMR template.

During Q2 42 mortality reports were discussed at MRG with the grading as below.

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	Quality assurance PMR's opened	Total number of case reviews opened by MRG
Q3 (23-24)	477	100%	18	16	34
Q4 (23-24)	509	100 %	25	24	49
Q1 (24-25)	420	100%	9	12	21
Q2 (24-25)	436	100%	16	32	48

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	27	14	0	1

During Q2 there were 5 deaths reported for patients with a recognised learning disability

Learning Disability Mortality Reviews				
	Total No. of LD Deaths	No. reviewed	Problems in Health care Identified in this Quarter	Referred to National LeDeR Programme
Q2(23-24)	2	2	0	2
Q4 (23-24)	3	3	0	3
Q1 (24-25)	0	0	0	0
Q2 (24-25)	5	5	0	0

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 (23-24)	0	3	1	3
Q4 (23-24)	1	2	0	3
Q1 (24-25)	1	2	1	3
Q2 (24-25)	0	3	3	3

During Q2 there were 3 neonatal deaths and 0 stillbirths.

There were 3 paediatric deaths during Q2 which is unusually high. Analysis of the deaths has shown that 2 were due to known terminal malignancies and one due to a house fire (this will be further investigated under the SUDIC 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	1	0	0

Learning Identified from PMRT reviews

There were 2 PMRT case reports finalised during Q2.
One was graded as Grade A and one as Grade B

Learning from the Grade B report identified lessons around better thermal management of babies during the first 24hrs of life. This has been picked up by the department and a new process is in place.

Learning identified through review of mortality reviews during Q2.

Learning for mortality is derived from 3 main sources.

- Mortality reviews (collated into a learning log)
- Themes and trends escalated from the Medical Examiner
- Learning identified through the PSIRF 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 (not affecting patient outcome)	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads. The EPR template has been adjusted to remind staff not to copy and paste notes as routine.
Medication errors (not causing harm)	Mortality reviews	All medication errors are feedback to relevant clinician. If a medication error has resulted in possible harm this is picked up under the PSIRF process
Poor thermoregulation during 1st day of life	PMRT	New process in place to reflect national guidance

Nosocomial Infections prolonging length of stay	Mortality reviews	SOP for side room allocation reviewed. Proactive HPV cleaning programme initiated for C Diff cleans

External Benchmarking Data

Telstra Health Data

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

During Q 2 an alert around “procedures of the mouth” was highlighted, but further analysis showed this only consisted of 2 patients and in both cases there were no concerns around the care provided.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 15**

29 January 2025

Title	Freedom to Speak Up Report – Biannual report
Area Lead	Debs Smith, Chief People Officer / Executive Lead for FTSU
Author	Sharon Landrum, Head of People Experience & Tracey Nolan, FTSU Guardian/ People Experience Lead
Report for	Information

Executive Summary and Report Recommendations

National Guardians Office (NGO) guidance ("Freedom to Speak Up: A Guide for Leaders in the NHS and Organisations delivering NHS Services" 2022) highlights that reporting activity should be on a bi-annual basis.

The purpose of this report is to therefore provide a biannual update on Freedom to Speak Up (FTSU) activity in line with the NGO guidance. The report includes data for Q1 and Q2 2024/25 reporting periods.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to key Board Assurance Framework (BAF) Risks:

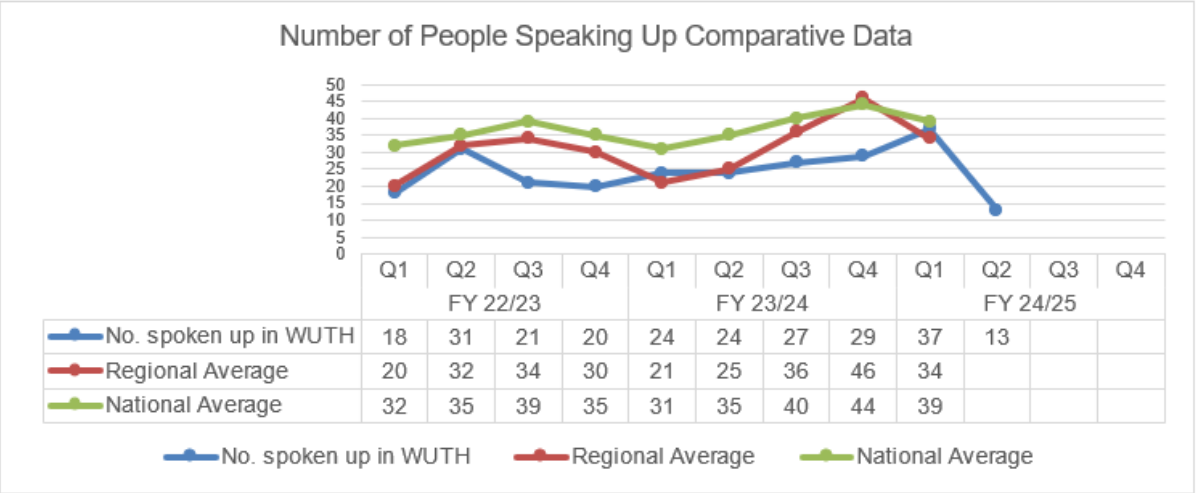
- BAF 5: Failure to have the right culture, staff experience, and organisational conditions to delivery our priorities for our patients and service users.
- NOTE: Concerns raised via FTSU process may identify potential or actual risks, however these are managed on an individual basis and escalated to appropriate management representatives as necessary.

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
December 2024	People Committee	As above	As above

1	Introduction
1.1	This report provides an overview of activity data for Q1 and Q2 2024/25 and activities to support improvements in the speak up culture at WUTH. Data is presented in a way that maintains the confidentiality of individuals who speak up. The chart below highlights speak up data for Q1 and Q2 compared with previous quarters.



The data shows that 37 people have spoken up in WUTH for Q1, which is an increase from 29 people in Q4 23/24 and an increase in numbers for the same quarter since 2022/23. Numbers of people speaking up in WUTH for Q1 is however in line with the regional and national averages.

Q2 2024/25 saw a significant reduction in the number of people speaking up, with only 13 people recorded. This is the lowest number of people speaking up for a number of years. Regional and national averages are currently unknown however will be shared as soon as available.

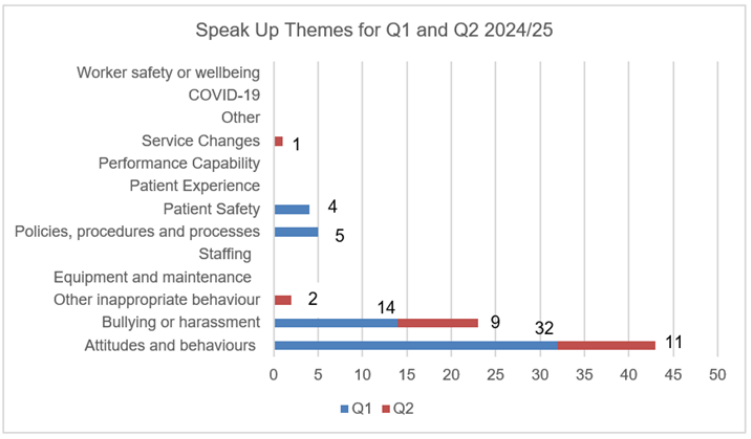
Numbers of people speaking up combined however equate to 50 staff for the first half of the year (Q1 and Q2) and is similar to 2023/24 with 48 people speaking up in the same time frame.

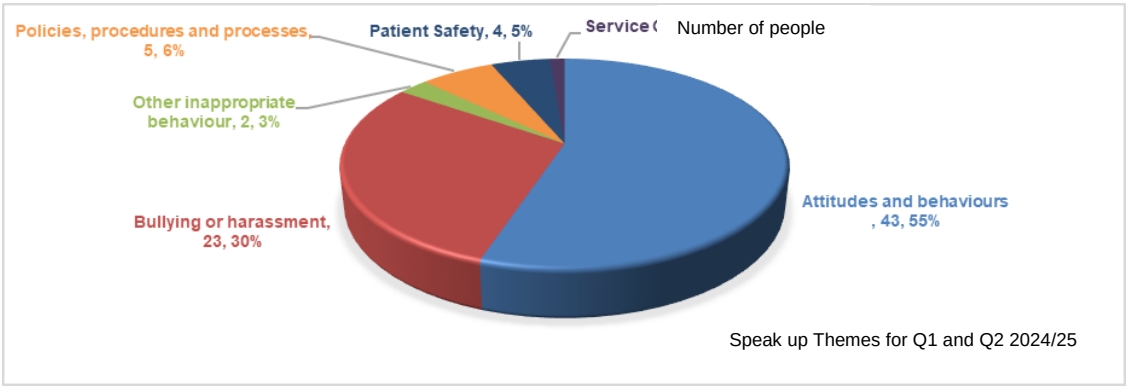
Numbers of staff speaking up at WUTH continues to be lower than the national and regional averages, however this is not necessarily an indication of concern, however due to the decrease in Q2, a review of staff experience will be undertaken with the 2024 staff survey feedback results relating to staff feeling able and confident to speak up.

1.2	**Anonymous Reports** Two anonymous concerns were received in Q1 2024/25 with one raised regarding a bullying allegation against a colleague, the other concern was raised in relation to inappropriate behavior that the individual had witnessed taking place. Anonymous reporting continues to remain low, with no anonymous concerns raised in Q2. This may suggest that the FTSU process at WUTH is considered a psychologically safe process. Staff are encouraged in the first instance to discuss their concerns with

	their line manager where possible and support is offered by the FTSU guardian to assist them in doing this where required
1.3	**Disadvantageous or Demeaning Treatment as Result of Speaking Up** There was no reports of disadvantage or demeaning treatment reported across the last 6-month period.
1.4	**Time Taken to Close Cases** The average time taken to close cases across the year was 2 weeks– most cases are resolved quickly resulting in staff feeling satisfied with an outcome. It is the experience of the FTSU Guardian that WUTH managers are responsive and receptive to the concern being raised, working swiftly to resolve. The length of time taken to close cases has increased due to the follow up element of speaking up being undertaken by the FTSU Guardian.

2	**Concerns Raised by Theme**
2.1	The chart below highlights the themes of the concerns raised for Q1 and Q2 2024/25.





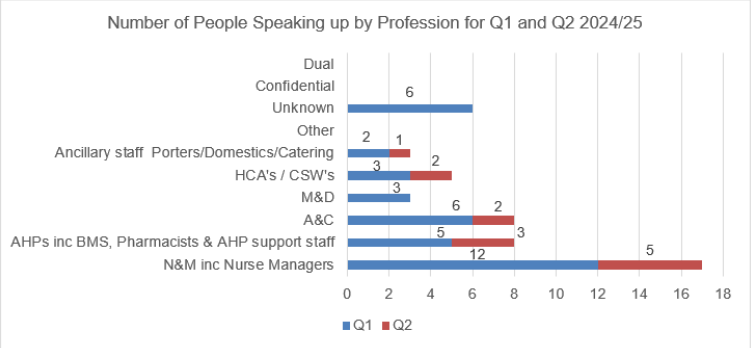
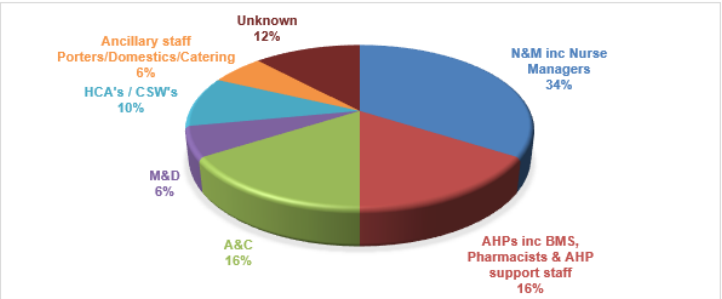
It is important to note that concerns can often span numerous themes and numbers may therefore not equate alongside number of concerns raised.

Attitudes and behaviours continue to be the highest reported theme. There is a reduction in the number of “other inappropriate behaviours” themed concerns and also those relating to policies, procedures and processes.

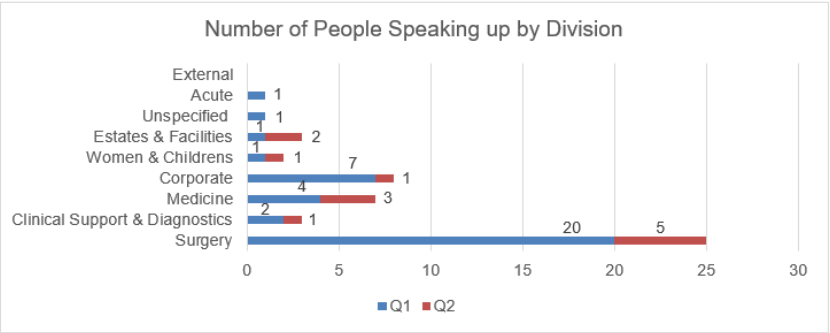
Other inappropriate behaviour is defined by the NGO as:

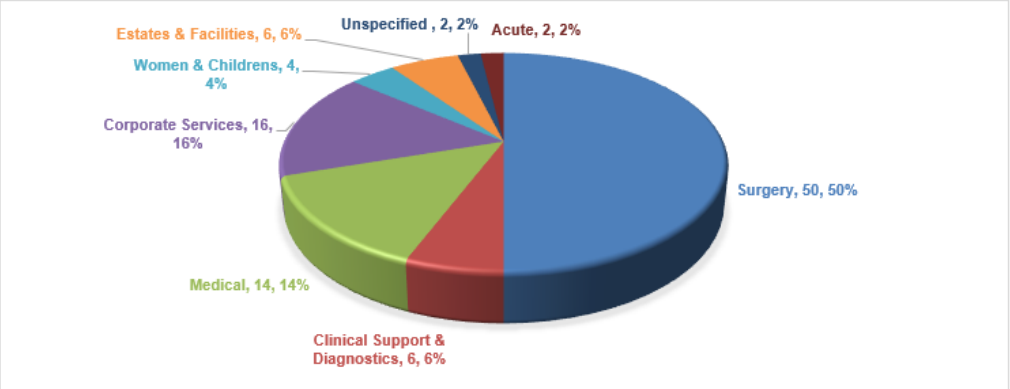
- Any case that includes an element that may indicate a risk of other inappropriate attitudes or behaviours that do not constitute bullying or harassment. This can be a current or past matter and may identify risks or be about actual events.
- where the person raising the case believes there is an element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

	• The focus should be on the perceptions of the person bringing the case.
2.2	**Patient Safety Related Concerns** Q1 data shows an increase in concerns raised regarding patient safety, with 4 staff speaking up regarding this theme. There were no concerns raised in Q2 with a theme of patient safety. The number of people speaking up about patient safety at WUTH is lower than both the Regional average (5 people) and National Average (6 people) for Q1. Data for Q2 is unavailable at the time of reporting. The FTSU Lead and Patient Safety Lead continue to monitor concerns raised regarding patient safety, through a quarterly triangulation of data and escalation process, involving management teams as appropriate.

3.0	**Concerns Raised by Professional Group**
3.1	The following charts highlight the number of people speaking up by professional group for Q1 and Q2 2024/25.  % of people speaking up by Professional Group for Q1 and Q2 2024/25  The highest group of staff raising concerns for Q1 and Q2 are from Nurses and Midwives along with Allied Health professionals and admin, CSWs have consistently remained a low staff group for raising concerns however this has increased by 40% over the last 6 months.

4	**Divisional Data**
4.1	**Concerns Raised by Division** The charts below show the concerns raised in Q1 and Q2 by Division.





Surgery had the most people speaking up with 20 people speaking up in Q1. This is a significant increase from only 10 in total for 2023/24.

Theatres have seen a significant increase in staff speaking up this last quarter. Theatres concerns make up 50% of all total concerns raised. Concerns raised from theatres in the last 6 months have increased by 170% in comparison to the previous 6 months.

This increase has prompted further investigation and OD are working closely with the division. Survey monkey along with audit days have also been undertaken to gain a clearer understanding of the concerns.

A number of steps have been undertaken within the Surgical Division, to promote the speak up service, with regular walkabouts and drop-in sessions held within areas, particularly as part of Theatre audit days.

5.0	**Advancing the FTSU Agenda**
5.1	**FTSU Training** Compliance with FTSU training as at 30 September 2024 is: • Freedom to speak up level 1 – 86.57%, increasing from 84.99% in April 2024. • Freedom to speak up level 2 - 91.33%, increasing from 90.18% in April 2024 Compliance is increasing in all areas, with reminders being sent out to non-compliant staff and plans in development to provide additional learning opportunities for areas of high levels of non-compliance and for those who with additional challenges accessing e-learning modules. Level 3 was introduced for Executives in March 24 and compliance is currently 87.5%. This has been a significant improvement since commencement and full compliance is expected in Q3 2024/25.

The importance of speaking up and the FTSU service is included within the Trust welcome event for new starters along with managing teams and leading teams, with the FTSU Guardian promoting key messages and holding a stall as part of the World Café event.

The FTSU Guardian has delivered numerous bespoke Speak Up sessions to various staff to promote the importance of speaking up and the support available. Regular walk abouts are undertaken in both Arrowe Park as well as Clatterbridge to promote the importance of speaking up and being visible to staff. The Bromborough laboratory is also included in walk about calendars.

FTSU sessions also include key messages focussing on supporting staff safety, with the FTSU team supporting the Trust's sign up to the sexual safety charter and Anti-Racism Framework.

Agreement has also been reached for WUTH to support a new approach to improving staff safety and the FTSU team will be pivotal to its development and launch.

5.2 **Respect at Work Training Compliance**

These locally developed e-learning training packages are included as part of the Trusts role essential training and therefore compliance is monitored accordingly. Compliance at 30 September 2024 is as follows:

- Level 1 (for all staff) - 86.04%, increasing from 84.86% in April 2024
- Level 2 (for managers / supervisors) - 96.45%, reducing slightly increasing from 96.59% in April 2024.

Further to the previous annual report, completed gap analysis, NGO guidance and best practice and feedback from a recent MIAA audit, an action plan has now been developed and is attached at appendix 1. Updates on progress made against each of the areas is also included for review and noting.

5.3 **FTSU Champions**

There have been **39 champions recruited** over the past 12 months, all have completed their champions training. Regular meetings are held with guest speakers. We are proud to have recruited four Junior Doctors and two Consultants as our champions also.

Division	Number of Champions
Acute	4
Corporate	5
Estates & Facilities	1
Medicine	11
Surgery	6
Women & Childrens	8

More FTSU Champions are encouraged by Estates, Facilities and Capital Planning and there are currently none within Clinical Support and Diagnostics.

This year we included a **review of the FTSU Champion and Guardian roles** to ensure they were operating within the updated guidance launched. This has been completed and WUTH is in line with recommendations made.

	Raise awareness of FTSU Guardians, Champions, and Speak Up Agenda across the organisation – We will continue to recruit champions within the divisions to ensure that the spread of champions is equal. We are also looking to ensure that all staff networks have a FTSU champion.
5.4	**Reducing Barriers to Speaking Up** **Identify groups potentially facing barriers to speaking up and work towards addressing those barriers** This objective seeks to engage staff from minority groups who are potentially less likely to speak up. The work of the FTSU champions is particularly important to promote the FTSU agenda and to further champion the agenda amongst staff with protected characteristics. In addition, work is ongoing to review data from other sources such as staff survey to identify staff groups that may be facing barriers to speaking up. The FTSU Guardian has worked with the Head of People Experience and Head of HR to triangulate staff experience data (including FTSU data) and findings have been reported in staff experience and equality, diversity and inclusion update papers through the workforce governance structure and as part of a Board Seminar in October. Listening events have also taken place in relation to our Black Asian and Minority Ethic staff to understand their experiences of working at WUTH. High Impact Actions have been agreed with the multicultural staff network members and progress will be monitored through the Workforce Steering Board. The FTSU Guardian is also now leading on building capacity and capability of Trust staff networks and is working with co-chairs to ensure regular meetings and contact with network members to further understand experiences.
5.5	**Lessons Learnt** **Mental Health** Staff continue to struggle with their mental health and continue to, at times feel unable to communicate their concerns directly with line management. Cases have been received whereby staff have felt that they have not been sufficiently supported.

6	**Implications**
6.1	**Patients** When people speak up, everyone benefits. Building a more open culture, in which leadership encourages learning and improvement, leads to safer care and treatment and improved patient experience. Our staff are the eyes and ears of an organisation; their views and concerns can act as a valuable early warning system that a policy, process or decision is not playing out as anticipated or could be improved. A speaking-up culture benefits staff satisfaction and performance, too which in turns impacts on the care our patients receive.
6.2	**People** This report aims to provide assurance and indications for future priorities to provide a psychologically safe environment in which all staff are able to raise concerns.
6.3	**Finance**

	A speaking-up culture benefits staff satisfaction and performance, too. When people feel that their opinions matter and are valued and acted on, they become more committed, and performance and retention improve.
6.4	**Compliance -** This report is in line with National Guardians Office reporting requirements.

Speak Up @ WUTH Action Plan 2024 - 2025

Overview –This action plan takes into consideration National Guardian's Office (NGO) Guidance, Care Quality Commission Requirements, internal review findings and recommendations and learning from NGO case reviews.

	Objective	Action	Ownership	Deadline RAG	Progress
1	Raise Awareness of FTSU Guardians, Champions and the Speak Up agenda across the organisation	1.1 Review the role of the Champions	Lead FTSU Guardian	Nov 24	Reviewed WUTH FTSU Champion role in line with NGO guidance. – completed Champions are allowed to thank and signpost any staff who want to raise concerns Champion network increased with 35 trained Champions now in place. Plans in place to continue to increase and ensure spread across Divisions. The FTSU Lead is now also leading on staff networks and is supporting the refresh and relaunch of staff networks at WUTH. A network activity steps back up, the champion role is being promoted and staff supported to facilitate a more diverse representation of champions. The Trust Intranet is refreshed to better advertise the FTSU Network
		1.2 Regular meetings established with Champions.	Lead FTSU Guardian	Dec 24	Network meetings in place, with speakers booked for future meetings in line with champion needs. Next session is with HRBP. A 12-month schedule of quarterly meetings is to be fully established.
		1.3 Involve Champions with walk abouts and campaigns	Lead FTSU Guardian	Dec 24	Champions are updated as part of network meetings and as and when news / information is applicable.
		1.4 Ensure Communications Plan in place to promote speaking up and the FTSU Guardian role	Lead FTSU Guardian	Feb 25	Regular FTSU Guardian walk-abouts Promote positive staff stories of speaking up, sharing at key events and forums
2	Ensure the Trust is up to date with national and local guidance, policy and best practice	2.1 Ensure executive team has completed level 3 training	Lead FTSU Guardian	Feb 25	Level 3 compliance is currently 87.5%. so is on track for completion.
		2.2 All relevant policies to reference FTSU Guardians / Champions as part of the support options available, including suspension letters	Lead FTSU Guardian	Ongoing	Programme in place to review all policies as they are due for renewal.
		2.3 Review NGO recording and reporting guidance and ensure WUTH is compliant	FTSU Lead	Completed and ongoing	All policies and process reviewed and positive feedback received from recent MIAA audit.
		2.4 Guardians to attend regional and national events/meetings	FTSU Lead	Ongoing	FTSU Lead a member of the regional network - BAU

		2.5 Quarterly thematic review to be re established	FTSU Lead and HOSE	Jan 25	FTSU linked as part of Trust lessons learnt forum.
3	Identify groups potentially facing barriers to speaking up and work towards addressing those barriers.	3.1 Trust compliance with NGO levels 1,2 & 3 eLearning programmes	FTSU Lead	April 25	Level 1 and 3 are currently below compliance. A plan is being developed to support levels of low compliance.
		3.2 Ensure FTSU Champions from "vulnerable" staff groups / those who share protected characteristics or have cultural/socio-economic barriers	FTSU Lead	April 25	See also 1.1 F1 and F2 Doctors now have champions, along with the majority of staff networks.
		3.3 Promote the role of FTSU Guardian and the process for raising concerns in the Volunteer newsletter quarterly	FTSU Lead	Completed	Completed and to be shared on an ongoing basis. FTSU Lead attended Volunteer annual event.
		3.4 Promote the role of FTSU Guardian and the process for raising concerns in the student newsletter -	FTSU Lead	Completed	Completed and ongoing
		3.5 Focus on the role of "Listening Up" – ensuring key points are built into leadership for all programmes and highlighted as part of Trust comms.	FTSU Lead	April 25	New slides will be incorporated into managers training as well as induction on listening up. Listening Up was the theme for 2024 Speak UP month, with regular comms messages shared and a video from the CPO.
		3.6 Support the development of a new campaign that seeks to ensure safety of staff at work. This includes anti-racism, sexual safety and violence and aggression.	FTSU Lead	Mar 25	Key messages already included within presentations and training sessions. Supported a review of data and sexual safety training programmes and working with key stakeholders to develop a new campaign and key messages.
	Objective	**Action**	**Ownership**	**Deadline**	**Progress**
4	Review effectiveness of FTSU processes	4.1 Review of staff survey data and deep to identify areas for improvement.	FTSU Lead	Mar 25	Completed for 2023 and just awaiting 2024 data.
		4.2 Further develop comms plan using staff survey data to inform areas for increased targeting with communications and engagement.	FTSU Lead	Mar 25	
		4.3 Review feedback received from staff who have spoken up and share key learning	FTSU Lead	Mar 25	
		4.4 Undertake review of process for ensuring staff do not suffer detriment as a result of speaking up and ensure it is fit for purpose.	FTSU Lead	Mar 25	

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 16**

29 January 2025

Title	Guardian of Safe Working Report Q2 2024/25
Area Lead	Dr Ranj Mehra, Interim Medical Director
Author	Dr Alice Arch, Guardian of Safe Working
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide an update on compliance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

The number of gaps present in the trainee medical workforce continues to be a focus for the Trust to ensure compliance with the safe working directive and to reduce overall locum and agency spend. There are currently a total of 294 doctors/dentists in training in the Trust.

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. This report details a summary, exception reports and locum bookings submitted for the Q2 2024/2025 (July-September).

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**
December 2024	People Committee	As above	As above

1	Narrative

Dr Alice Arch is the Trust Guardian of Safe Working. The contents of this report contain details regarding exception reports submitted by Doctors/Dentists in Training (DiT) 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)	294 (278.3 WTE)
Number of doctors/dentists in training on 2016 TCS (total)	294 (278.3 WTE)
Amount of time available in job plan for guardian to do the role	1 PAs/4 hours per week
Admin support provided to the guardian (if any)	1.0 WTE
Amount of job-planned time for educational supervisors	0.25 PAs per trainee

Exception reports (regarding working hours)

Exception reports by Department				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E	0	11	11	0
General Medicine	0	25	20	5
General Surgery	0	7	4	3
O&G	0	2	2	0
Otolaryngology (ENT)	0	1	1	0
General Practice	0	1	1	0
Total	0	47	39	8

Exception reports by Grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	15	12	3
F2	0	1	1	0

SHO	0	15	10	5
SPR	0	16	16	0
Total	0	47	39	8

Exception reports by Rota				
Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E F2 20 per cent Fellow 2024	0	1	1	0
A and E SpR and ST3 2024	0	9	9	0
A&E SHO 2024	0	1	1	0
O and G T1 2024 LTFT 0.8 Flexi	0	2	2	0
ENT General Full Time	0	1	1	0
GP F2 2023	0	1	1	0
Medicine IMY2 2024 LTFT 0.8 Flexi	0	2	1	1
Medicine IMY2 2024	0	4	0	4
Medicine F1 2024	0	4	4	0
Medicine SHO 2024 LTFT 0.8 Flexi	0	3	3	0
Medicine SHO 2024	0	2	2	0
Medicine SpR 2024 LTFT 0.8 Flexi	0	6	6	0
Medicine F1 2023	0	4	4	0
Surgical F1 2022	0	5	2	3
Surgical F1 2022 LIFT MT	0	2	2	0
Total	0	47	39	8

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	3	4	4	1	0	3
F2	1	0	0	0	0	0
SHO	1	3	3	3	0	5
SPR	0	2	8	6	0	0
Total	5	9	15	10	0	8

Exception Reports

During this quarter there have been a relatively higher number of Exception Reports from non-Foundation doctors. For some of these the more senior Doctor in Training (DiT) have been supporting their more junior colleagues with their workload and facilitating them leaving on time.

There have also been a number of reports where a specific intervention from Educational Supervisors were advantageous in clearly defining what was expected and

	the mechanisms for handover of work and ensuring that they knew that there would be the opportunity to meet their learning requirements within their scheduled working hours, particularly in A&E. **Work Schedule Reviews** There have been no work schedule reviews this quarter. **Vacancies** There are several 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.

Vacancies by Month						
Specialty	Grade	April	May	June	Total Vacant Shifts (Average)	Number of Shifts Uncovered
A&E	F2-ST8	303	371	178	284	396
Medicine	F1-ST8	282	177	102	187	272
Surgery	F1-ST8	82	56	52	63	46
W&C	F2-ST8	76	15	40	44	46
Total		743	619	372	145	760

Fines

There have been no fines issued this quarter.

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.

Board of Directors in Public **Item 17**

29 January 2025

Title	Equality, Diversity and Inclusion (EDI) Bi-Annual Report including Equality Delivery System (EDS) 2024 Assessment
Area Lead	Deb Smith, Chief People Officer
Author	Sharon Landrum, Head of People Experience
Report for	Approval

Executive Summary and Report Recommendations

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

This report seeks to provide assurance that WUTH is fulfilling the requirements of the Public Sector Equality Duty (PSED) and in addition, sets out how WUTH is advancing the EDI agenda and principles and objectives of the Trust's People Strategy and underpinning EDI Strategic Commitment (2022 – 2026):

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

This report is the second bi-annual report for 2024/25 reporting cycle and includes the following:

- Summary of activities that demonstrate we are advancing the EDI agenda at WUTH in line with the Trust's People Strategy and EDI Strategic commitment – summarised in appendix 1.
- Equality Delivery System (EDS) 2024 Self-Assessment – section 3.2 highlights recommended ratings for review, which are recommended to remain the same as 2023.
- Updates on regulatory and statutory requirements – WUTH is currently compliant with requirements.

Whilst the agreed governance cycle for EDI reporting includes gender pay gap reporting within EDI Biannual report two – the gender pay gap report is **not** included within this paper. To ensure due consideration of agenda items, the gender pay gap report will be submitted as a separate report to Workforce Steering Board in January 2025, for subsequent ratification at People Committee in February 2025.

This still falls within the national reporting requirements for gender pay gap reporting as organisations are not required to report 2024 data until 30 March 2025.

It is recommended that Board of Directors:

- Note the report; and
- Approve the EDS assessment rating

Key Risks
This report relates to these key risks: • 397 – Increased Sickness Absence • BAF Risk – Failure of the Trust to have the right organisational culture, staff experience and organisational conditions to deliver our priorities for our patients and service users

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
19/12/2025	Workforce Steering Board	Equality, Diversity and Inclusion (EDI) Bi-Annual Report including Equality Delivery System (EDS) 2024 Assessment	Approval

1	Background and Introduction to EDI Requirements
1.1	Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the ***general duty*** and all public authorities must adhere to the following obligations: • To eliminate unlawful harassment and victimisation. • To foster good relations between people who share a protected characteristic and those who do not. • To advance equality of opportunity between people who share a protected characteristic and those who do not. In addition to these general duties, there are specific duties which require public bodies to publish relevant, proportionate information showing compliance with the Equality Duty and to set equality objectives. The information that is contained within this report meets the requirement of the specific duties of the PSED. The Trust also takes into consideration national guidance e.g. Model Employer recommendations and has integrated these within action planning and review processes as appropriate.

	As detailed in the Executive Summary, this is the second EDI specific bi-annual report and in line with the Trust's EDI reporting schedule, contains the following: • Trust led EDI projects and progress towards EDI Strategic Commitment and activities to underpin our PSED commitment and advance the EDI agenda • Equality Delivery System (EDS). • Updates on regulatory and statutory requirements This report was initially intended to include gender pay gap reporting however this is **not** included in this report and will be submitted separately at a subsequent meeting.
2	**Statutory / Regulatory Reporting Requirements Update**
2.1	Updates are as follows: **1) Workforce Race Equality Standards (WRES) Reporting** Part one - National data upload required by 31 May – **Completed** Part two – Narrative report required by 31 October – **Completed** **2) Workforce Disability Equality Standards (WDES) Reporting** Part one - National data upload required by 31 May – **Completed** Part two – Narrative report required by 31 October – **Completed** **3) Public Sector Equality Duty (PSED)** Activities detailed within both EDI biannual reports highlight the work WUTH is doing to uphold the principles of the Public Sector Equality Duty. This includes publication of Trust workforce demographics. **4) Gender Pay Gap Reporting (GPG)** WUTH is currently compliant with GPG reporting requirements, with 2024 data not required for submission until 30 March 25. The report is now scheduled for submission to Workforce Steering Board in January 2025 and ratification by People Committee in February 2025. **5) Equality Delivery System (EDS) 2024** Trusts are required to self-assess how it feels it is performing against a series of national indicators. Details pertaining to this assessment are included within this report and detailed in section 3. **6) NHS EDI Improvement Plan** Trusts are required to implement six high impact actions. These were outlined in biannual report one with an update on progress provided at that stage. Progress updates will be provided to Workforce Steering Board on an annual basis. All regulatory and statutory reporting requirements are therefore complete or online to meet the requirements listed above.
3	**Equality Delivery System (EDS) 2024**
3.1	**Background** EDS was introduced by NHS Equality Council in 2010 and part of the NHS standard contract since 2015 *(SC13.5 Equity of Access, Equality and Non-Discrimination).* A new framework was launched in 2022 with a requirement for all NHS organisations to

measure EDI performance. The framework is based on 11 outcomes grouped under 3 domains:

- **Domain 1:** Commissioned or Provided Services
- **Domain 2:** Workforce health and wellbeing
- **Domain 3:** Inclusive leadership

Aim

The EDS is a regulatory requirement that forms part of the Trust standard contract. It is designed to support identification of equality and diversity gaps and to provide the Trust with a tool to gain a greater understanding of priorities for both staff and service users. It is monitored by commissioners and used by Integrated Care Boards / Integrated Care Systems to identify health inequalities and support system wide improvement approach.

A short overview video is available here.

Process

The process includes:

- Evidence collection and understanding of experiences to support understanding of what extent the Trust meets nationally set criteria.
- Self-assessment against the national criteria.
- Identification of gaps in performance and potential actions needed to improve
- Ratification and publication of Trust rating.
- Peer review / collaboration.

Domain 1 was led by Corporate Nursing working in close collaboration with Wirral Community Health and Care Trust. A joint review and assessment was undertaken of the selected service areas; with Endoscopy identified for Wirral University Teaching Hospital and Dental Care for Wirral Community Health and Care Trust. Endoscopy was selected in conjunction with Healthwatch, key stakeholders and as a result of initial community feedback.

Domains 2 and 3 were led by the People Experience Team, with a peer review process implemented with Wirral Community Health and Care Trust.

Assessment and Scoring

Evidence is collected and collated in advance of assessment dates, for all Domains.

Two assessment sessions were held; one for Domain 1 (14 Jan 25) and one for Domains 2 and 3 (10 December 2024), with evidence shared with key stakeholders in advance.

Assessment sessions included a wide representation of key stakeholders including clinical and non-clinical staff; management and frontline staff; staff side and staff network colleagues and Healthwatch for Domain 1.

Stakeholders were presented with information in advance of the assessment and during the assessment session, were asked to score what level they felt the Trust was performing at against the national indicators. Levels of performance that could be selected were:

- Undeveloped
- Developing
- Achieving
- Excelling

Scoring was on an individual basis via electronic voting systems and majority votes were recorded.

Additional Stakeholder Review

For Domains 2 and 3, assessment recommendations were then shared with Workforce Steering Board and Executive Management Team members for review and consideration, as key stakeholders in the process.

It was important that key stakeholders had an opportunity to review and consider ratings and provide additional areas of contribution or challenge as appropriate. Ratings for Domains 2 and 3 have remained the same throughout these additional stakeholder reviews.

Scores are assigned to each rating as detailed below and then added together to form a combined Trust total score.

Ratings for outcomes and Domains as follows:

Undeveloped Activity = 0
Developing activity = 1
Achieving activity = 2
Excelling activity = 3

Trust rating scoring:

<8	Undeveloped
8-21	Developing
22-32	Achieving
33	Excelling

Section 3.2 summarises the current and proposed ratings for 2024. It is important to note that for Domain 1, ratings are not directly comparable as the service selected for review in 2023 was Cancer Services.

3.2 Outcome

Following the process outlined in section 3.1, recommended ratings are detailed below. The majority of respondents agreed with the same ratings as last year and therefore no changes to levels are proposed this year.

Domain 1: Commissioned or Provided Services – Endoscopy	**2023 Rating (Cancer Services)**	**Recommended rating for 2024**
1A: Patients (Service Users) have required levels of access to the service	Achieving Activity	Achieving Activity
1B: Individual patients (service users) health needs are met	Achieving Activity	Achieving Activity
1C: When patients (service users) use the service, they are free from harm	Achieving Activity	Achieving Activity
1D: Patients (service users) report positive experiences of the service	Achieving Activity	Excelling Activity
Domain 2: Workforce Health & Wellbeing	**2023 Rating**	**Recommended rating for 2024**
2A: When at work staff are provided with support to manage obesity, diabetes, asthma, COPD & mental health conditions	Achieving Activity	Achieving Activity
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Achieving Activity	Achieving Activity

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying, harassment and physical violence from any source	Excelling Activity	Excelling Activity
	2D: Staff recommend the organisation as a place to work and receive treatment	Developing activity	Developing activity
	Domain 3: Inclusive Leadership	**2023 Rating**	**Recommended rating for 2024**
	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Achieving Activity	Achieving Activity
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	Excelling Activity	Excelling Activity
	3C: Board members, system & senior leaders (Band 9 & Very Senior Managers) ensure levers are in place to manage performance & monitor progress with staff & patients	Achieving Activity	Achieving Activity
	Total Score	**22 = Achieving**	**24 = Achieving**

Key Points for Consideration

1) It is pleasing to see excelling activity within Domain one for the first time.
2) Domains 2 and 3 have been maintained at the same level as 2023.
3) Improvements can be seen in scoring this year in the following way:
   - ❖ No areas showed “undeveloped” this year, compared to three in 2023
   - ❖ With the exception of 2A, all “achieving” areas saw an increase in the number of respondents believing that the Trust was “excelling” in those areas. 2A did however still see more respondents belieiving the Trust was achieving.
4) Whilst 2D remains at “developing”, the rating was close this year, with 52.1% of members thinking it should remain at “developing” and 47.9% of repondents feeling WUTH was “achieving”, despite the rigid criteria.

Criteria for 2D requires Trusts to have 70% of staff recommending the organisation as a place to work and receive treatment. Whilst WUTH increased advocacy scores in the 2023 staff survey, the national target was ot achieved and remains difficult to achieve. This is also acknowledged regionally. 2023 staff survey results highlight that:

- More staff would recommend the Trust as a place to work this year, increasing from 55.4% to 56.26%.
- More staff would also recommend the Trust as a place to receive treatment this year, increasing from 62.09% to 64.63%.
- Quarterly pulse surveys continue to be promoted, with more staff now advocating for WUTH as a place to work or receive treatment, with Q2 24/25 at the highest level since commencement in Q1 2022/23.

5) Working in collaboration with Wirral Community Health and Care Trust was felt to be extremely beneficial, with a range of shared learning opportunities, shared contacts and areas of best practice identified.

3.4 **Next Steps**

Board members are asked to note and approve the Trust ratings for 2024.

Final ratings will also be reviewed by Patient Safety and Quality Board and People Committee before national upload and public display by 28 February 2025.

	Actions arising from the assessment, will be included in overarching EDI and patient experience plans. Results will also be shared with the ICB and regional partners as part of a regional benchmark and review process and uploaded to the Trust's public facing webpage.

4	Advancing the EDI Agenda
4.1	**People Strategy and EDI Strategic Commitment** Since the launch of the new People Strategy and underpinning EDI Strategic Commitment, the Trust is striving to ensure EDI is embedded within all of our people processes and practices. This has resulted in a shift of areas and individuals seeking support to understand how they can advance EDI within their sphere of influence and progressing actions to commence improvements.  The annual objectives set out in the People Strategy delivery plan have also been mapped to the EDI Strategic Commitment to ensure EDI is reflected in all strategic people projects. A recent detailed review has been undertaken on People Strategy deliverables to ensure EDI is integrated and impact is measured. Regular updates are reported to WSB and People Committee as part of People Strategy Updates. It is therefore hoped that this will have a positive impact on staff experiences moving forwards. Demographic monitoring is now included of flexible working applications and request outcomes along with Occupational Health experience survey results. Data has been reviewed and revised to support more effective data monitoring and updates to be included within service area updates. A summary of key activities undertaken along with key next steps are attached at appendix 1.
4.2	**Trust Accreditations** WUTH has been reaccredited with the following Accreditations: **1) Merseyside In-Touch Navajo LGBTIQA+ Chartermark** Navajo Merseyside Cheshire Manchester Regional Chartermark Award for Equality Diversity Inclusion Intersectionality Equity for all people especially Gay and Gender Variant individuals. They have demonstrated their commitment to developing the principles of EDIIE for all their staff stakeholders and service users WUTH has successfully been reaccredited with this local prestigious Chartermark, in recognition of support and commitment to our LGBTIQA+ staff and community and to the wider equality agenda. **2) Disability Confident Employer** WUTH continues to remain a Disability Confident Employer, showing commitment to recruiting and supporting disabled employees. This is the second level of the Government Initiative and is valid for three years. WUTH will continue to identify actions to support improvements in experiences for staff with disabilities and long-term conditions, with future EDI plans to incorporate actions to progress to the highest level of Disability Confident Leader.

4.3	**Staff Network Update** The Trust continues to support staff networks at WUTH with six networks established, including our newest Volunteer network. Matthew Swanborough has been identified as the Executive Partner for this new network, with an inaugural meeting held and have already identified a number of initial key actions. The Rainbow Alliance continues to need new co-chairs, however will continue to be supported until such time as one is identified. The First "One Network" meeting took place on 17 December, with network members joining together to hear more about what's happening with staff networks and to hear updates from the Trust's Employee Assistance Programme. Capacity to support network activities has been added to the Trust's risk register, with staff struggling to be released to undertake network activities. Eight new network co-chairs are now in place, with network meetings and activities stepping back up. Network updates are now included in monthly Leaders InTouch meetings. Work has commenced to improve data capture of network membership and a review of mailing lists. Divisional data is being sought and captured to provide enhanced feedback to Divisions where possible and appropriate, on levels of representation across networks.
4.4	**Equality Analysis** Equality Analysis is required in the following circumstances: • When policies are being developed or renewed. • Development of business cases impacting on service users or staff. • Service redesign/reviews impacting on service users or staff – organisational change. • Changes that may impact on service users or staff. Completed analysis should also be shared publicly as appropriate. Equality analysis is currently integrated within the workforce policy approval process, however further work is required to enhance the quality of completed assessments, ensure equality analysis is completed in all of the above circumstances, and that a process is developed to ensure closer monitoring of assessments moving forwards. NHS England have also developed a Health Equities Assessment Tool (HEAT) that should also be completed where changes affect patients and service users. Consideration of potential impacting factors for staff and / or patients was included this year as part of Board and Committee papers, with a review required of the Trust's Equality Analysis policy. The Equality Analysis policy has now been reviewed and is progressing through the policy governance structure. The revised policy seeks to provide an enhanced process of analysis as follows: **Part One – Initial analysis** – to be completed in all of the circumstances listed earlier, to support identification of any potential equality related impacting factors: **Part Two** – Full Analysis to be completed when:

	• Negative or unknown impacting factors have been identified in Part One. • A large number of people will be affected by the proposal / activity. • There is a high-moderate financial or reputational risk. Full analysis will include details of: • Consultation and engagement with key stakeholders • Completion of NHS England Health Equities Assessment Tool (HEAT) for use with activities / proposals impacting on patients and service users • Action planning, to minimise or eliminate risks. Copies of completed analysis will be requested, logged and audited on a biannual basis, with copies shared with key stakeholders as required e.g. EDI Steering Group, Patient and Family Experience Group and staff networks. Development sessions will be offered to underpin policy changes and copies of completed analysis will be publicly promoted as appropriate.
4.5	**Education and Training** Biannual report one outlined the range of education and training opportunities currently available for staff to building further understanding of the EDI agenda and support knowledge gaps. Compliance with Level 1 EDI mandatory training is 95.27% at 31 December 2024. A review of EDI training is currently underway, with a plan to be shared at a future meeting. WUTH has signed up to the NHS Employers Diversity in Healthcare Partners Programme for 2024/25, with staff representatives invited to attend sessions and seminars on key topics and link with other organisations to share best practice and support knowledge building across a range of diverse areas.
4.6	**Additional Actions to Support PSED Responsibilities** **Calendar of Events** All of the details shared in appendix 1 seek to advance the EDI agenda and continue to support the achievement of our EDI Strategic Commitment and Public Sector Equality Duties as detailed in the background of this report. EDI Steering group meetings continue to ask members what they have done to advance the EDI agenda, with members asked to feedback and discuss locally too. Divisions now have EDI objectives which are monitored at Divisional Performance Reviews. A number of Divisional EDI Leads have been identified and linked to the EDI Steering Group and staff networks. In addition to Executive Directors, Non-Executive Directors now have EDI objectives. A Board seminar was held with a focus on understanding experiences of non-white staff, with opportunity provided for personal reflection and identification of actions that could be taken to ensure inclusion at WUTH.

	In addition to those highlighted in biannual report one, further promotional activities have included: • Trust participation in local **PRIDE parades,** parading at Liverpool and Chester on behalf of WUTH. • **Red Card for Racism Day** – photographs shared of staff showing racism the red card and messages of Trust commitment to being positively anti-racist. • First **Multicultural celebration** event – held with over 100+ staff in attendance. This was the first of its kind and saw staff coming together from all different cultures and backgrounds, sharing different foods, showcasing traditional dances and dress and sharing information and songs important to them and their culture. • **Remembrance** – a service was held on site in remembrance of those that have fallen. New Armed Forces co-chairs laid a wreath at Birkenhead Cenotaph again this year as part of local proceedings. • **National Inclusion Week** – with information and support promoted to support advancement of the EDI agenda. • **International Mens Day –** was celebrated in Trust communications • **Menopause Month and Day –** was celebrated with network meetings and a promotional stall on site and sessions scheduled with Consultant Gynaecologist. A new process has also been developed by Corporate Nursing to support lightweight uniforms for staff. • **Diwali** celebrations – with sweet treats on site, ecards for sharing and signposting to local celebrations • Departmental **culture days** and lunches held for staff in local wards / departments to come together, celebrate and share traditional food. • A **guest speaker** was arranged to promote and encourage "Harnessing Talent" on International Day of Persons with a Disability. Unfortunately this was cancelled due to the major incident however will be rearranged. • **Information stalls** held within the library at APH for national and international awareness events, with links to events and activities on site, books, articles and journals. • **Drop Everything and Read (DEAR)** Sessions on a range of topics including Black History month, Inclusion Week and South Asian Heritage Month. A range of activities have also been undertaken as part of the Patient Experience Inclusive Promise pillar that whilst supporting improvements in patient care, also improve experiences for staff too. **Forthcoming Events** Appendix 2 highlights the events agreed as part of EDI steering group for focus this year. Members are encouraged to review the events and share locally with consideration of how you will specifically uphold the following EDI priorities: ❖ Seek to Understand ❖ Support ❖ Develop and Educate ❖ Celebrate and Promote

5	Summary and Next Steps
	A range of actions and activities continue to be undertaken to ensure WUTH is an inclusive place to work and receive treatment. Members are asked to:

	1) Review and note the contents of the report 2) Approve EDS recommended rating 3) Acknowledge and share forthcoming EDI calendar of events and consider ways to support / observe locally.

6	Implications
6.1	**Patients** The work undertaken to advance the EDI agenda aims to improve awareness of a range of aspects and celebrate diversity for all. Whilst this should be a positive experience for all, there is also recognition of the diverse nature of our workforce and community and promotion and celebration of some areas, may not be in line with individual values, beliefs and behaviors. Whilst we strive to ensure appropriate values and behaviours are upheld for our workforce, this can be more challenging for our patients.
6.2	**People** As also detailed in section 2.1.
6.3	**Finance** No implications.
6.4	**Compliance** This report seeks to provide assurance that WUTH is currently in line with EDI reporting requirements for 2023/24 and outlines key areas of priority for 2024/25.

Appendix 1 - Workforce Equality, Diversity and Inclusion (EDI) Update Summary – Dec' 2024

Setting Direction

- EDI Strategic Commitment (including objectives) 2022-2026 underpins WUTH's People Strategy (2022-2026)
- Staff networks involved in decision making processes and shaping future improvements at WUTH
- Member of regional network to support collaborative working across the ICB.
- EDI Objectives set for all Exec and Non-Exec Directors
- Divisional EDI objectives in place
- New Anti-racist Framework adopted and actions implemented. One of four regional Trusts to achieve Bronze status
- New Engagement Framework launched
- NHSE EDI Improvement actions integrated with existing EDI action plan
- Disability co-creation group concluded with a number of supportive actions completed
- New Menopause policy and revised disability and Reservist policies.
- Listening events held for non-white staff

What's next… EDS 2024 assessment & Gender Pay

Development, Education and Awareness

- 97.28% compliance with EDI mandatory training (Oct)
- EDI embedded within all leadership and management programmes - Inclusive Recruitment and Inclusive Leadership sessions delivered.
- Dedicated EDI Board seminars
- Mini manager sessions on supporting disabilities and advancing EDI and supporting trainers and facilitators
- Monthly deaf awareness programme in place
- Neurodiversity sessions delivered by the Brain Charity
- Development plan agreed for network co-chairs
- Staff stories integrated within key meetings and development offerings and website page launched
- Range of national e-learning programmes promoted
- Range of "Drop Everything and Read" sessions held
- Guest speakers at conference and as part of leadership masterclasses

What's next…

- Neurodiversity, LGBT+ and Gender Inclusion sessions

Monitoring and Assurance

- Annual monitoring of workforce demographics
- Workforce Race and Disability (WRES and WDES) and gender pay gap reporting completed
- New reporting cycle implemented and working well, with EDI Bi-Annual reporting commenced
- Revised EDS framework implemented
- Enhanced review and monitoring of staff survey data and HR KPI's to support Trust's Strategic Retention and flexible working projects
- Demographic monitoring of volunteers, widening participation and leadership for all programmes
- Quarterly pulse surveys launched
- Board and Divisional EDI objectives in place
- Revised staff survey campaign approach to increase staff voice
- Staff experience triangulation methodology developed to further understand experiences of non-white staff

What's next…

- 2024 EDS and gender pay gap reporting

Communications

- Regular Trust communications to promote key events and information
- Staff networks included in Leaders in Touch briefs
- EDI webpages updated with key reports
- Reachdeck software in place to support web accessibility
- Deaf awareness development opportunities
- Launch of #Hellomynameis campaign linked to Race Equality Matters initiative and use of titles and pronouns
- Comms campaigns to promote Race equality, Sexual Safety and inclusion at WUTH

What's next… Enhanced promotion of staff networks

Events

- Flag raising for PRIDE month and armed forces week
- Trust involvement in PRIDE parades
- Range of events that support awareness raising for patient and staff support
- Support of various national and international awareness days/weeks and months e.g. International Women and Mens Day, Race Equality Week and menopause month
- Range of activities to support religious festivals
- Departmental events e.g. Culture Days
- Remembrance Day events, including service on site and at local Cenotaph
- New EDI category in staff awards and inclusion embedded across recognition schemes. Staff networks included in judging panels.
- Multicultural network celebration event

What's next… "One Network" events

Staff Support

- Six staff networks in place – with new volunteer network launched November 2024. 8 new co-chairs recruited
- Staff networks refreshed
- Network members "buddying" with colleagues
- Staff sharing experiences to help others
- New staff menopause policy launched, menopause clinic continues established with dedicated website, including guidance and support
- OH service, including 24/7 employee assistance programme
- Provision of Iftar boxes for staff during Ramadan
- Disability Co-creation group developed key priorities and actions based on feedback from engagement events.
- New process and support pathway for disabled staff
- Listening events held for non-white staff

What's next…

- Demographic monitoring of Occupational Health and wellbeing services

Accreditations

- Achieved Veteran Aware Accreditation
- Re-Accredited with Merseyside In-Touch Navajo LGBTIQA+ Chartermark
- Defence Employer Recognition Scheme (DERS) Silver Level Achieved
- Re-accredited as a Disability Confident Employer
- Achieved anti-racism framework bronze level

What's next…

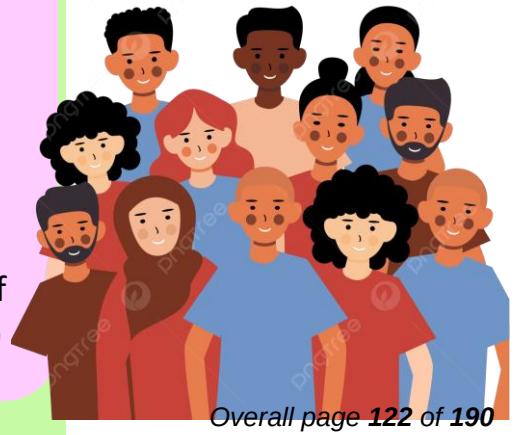
- Maintaining and advancing accreditation status

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Equality, Diversity and Inclusion Events Calendar for 2024/25

APR	MAY	JUN	JUL	AUG	SEP
18th – 21st Easter **21st/22nd** Eid	**6th** Deaf Awareness Week **8th** National Day of Staff Networks **13th** Mental Health Awareness week	**Pride Month** **10th** Carers Week **10th** Mens Health Week **17th** Learning Disability week **17th** Eid-Al-Adha **24th** Armed Forces Week	**18th Jul – 17th Aug** South Asian Heritage Month **27th** Liverpool Pride	**17th** Chester Pride **24th** Manchester Pride	**23rd** National Inclusion Week

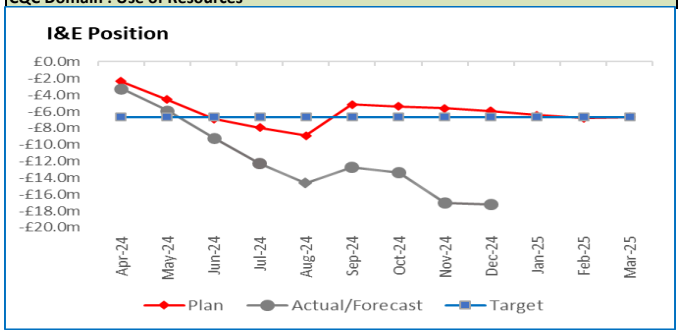
OCT	NOV	DEC	JAN	FEB	MAR
Black History Month **Speak up month** **Menopause month** **18th** World Menopause Day **16th** Pronouns Day **18th** Red Card to Racism	**1st** Diwali **11th** Armistice Day **13th** Trans Awareness Week **16th** Disability History month **19th** International Mens Day **20th** Trans Day of Remembrance	**1st** World Aids Day **3rd** International Day of Persons with Disabilities	**19th** World Religion Day **29th** Chinese New Year	**LGBTQ+ History Month** **3rd** Race Equality Week **4th** World Cancer Day **6th** Time to Talk Day	**1st** Ramadan commences **8th** International Womens Day **31st** Eid-al-Fitr **31st** Trans Day of Visibility (TDOV)



together we will

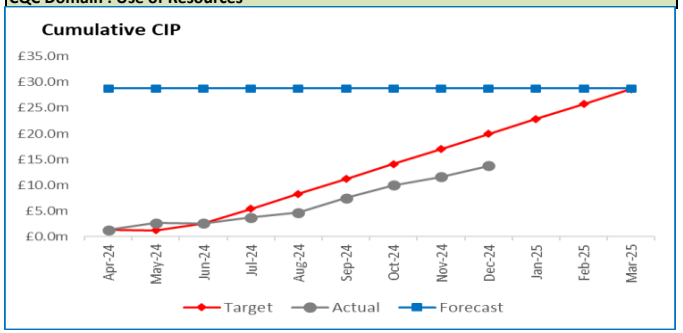
Chief Finance Officer

CQC Domain : Use of Resources



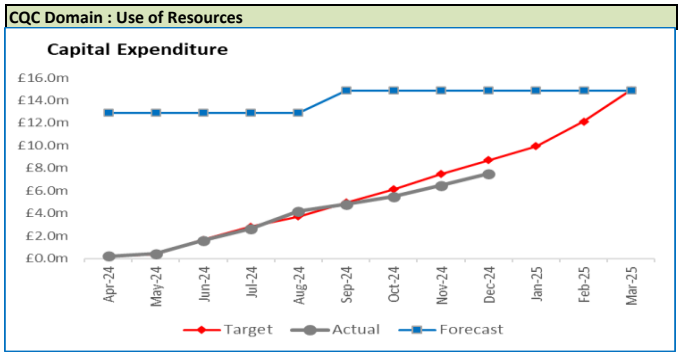
Dec-24
-£17.2m
Variance
Position worse than plan
Target
-£5.9m

CQC Domain : Use of Resources



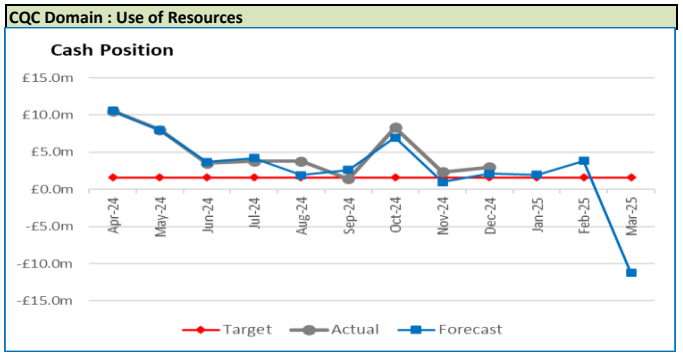
Dec-24
£13.8m
Variance
Position worse than plan
Target
£19.9m

CQC Domain : Use of Resources



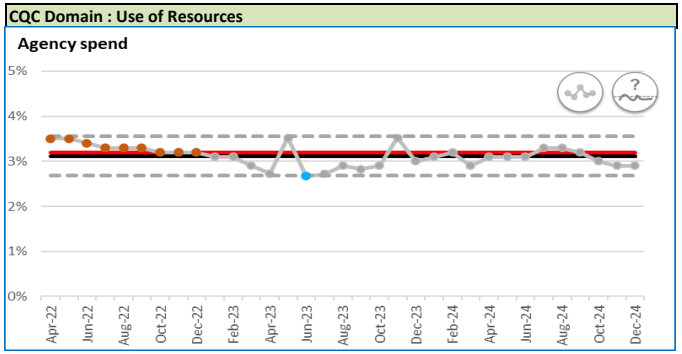
Dec-24
£7.5m
Variance
Position better than plan
Target
£8.7m

CQC Domain : Use of Resources



Dec-24
£3.0m
Variance
Position better than plan
Target
£1.6m

CQC Domain : Use of Resources



Dec-24
2.90%
Variance
Position better than threshold
Threshold
3.2%

Executive Summary

At the end of December, M9, the Trust is reporting a deficit of £17.2m, an adverse variance against plan of £11.3m.

The key drivers of this forecast variance and the internal risks to achievement of plan are:

- reduced income and additional expenditure associated with the Cyber Incident.
- the full delivery of the elective activity plan.
- the Cost Improvement Programme (CIP).
- maintaining expenditure on urgent care within planned levels.
- delivering planned integration benefits.

As a result, the Trust's unmitigated forecast is a deficit of £25.6m, an adverse variance to plan of £19.0m. The Trust has fully engaged with NHSE and C&M ICB to plan actions to reduce expenditure to mitigate against these risks. Full implementation of these agreed actions will reduce the unmitigated forecast deficit to £16.7m, an adverse variance to plan of £10.0m. This variance is consistent with the finance trajectory submitted by the Trust to NHSE, adjusted for the financial impact of the cyber incident.

The Trust continues to work with the ICB to identify the additional mitigation options necessary to achieve the plan.

The deficit is placing significant pressure on both the Trust's cash position and compliance with the Better Payment Practice Code (BPPC). NHSE has confirmed £3.5m of cash support in January 2025 and the Trust will apply for the remainder of the projected 24/25 cash requirement as part of the process for March 2025.

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. Quarterly updates are provided to the Board on progression of the strategy and the underlying financial position.

The risk ratings for delivery of statutory targets in 2024/25 are:

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

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

The Board is asked to:

- Note the report.
- Note that full implementation of agreed mitigations will significantly but not fully mitigate financial risk.
- Note the significant cash risk and that the Trust will be submitting an additional cash support request in M12 and that the NHSE approval criteria require full delivery of finance and workforce plans.
- Approve the revision of the capital budget to £19.707m.

I&E Position

Narrative:

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

	Year to Date			Unmitigated Forecast		
Cost Type	Plan	Actual	Variance	Plan	Forecast	Variance
Clinical Income from Patient Care Activities	£359.6m	£355.4m	-£4.2m	£478.4m	£468.0m	-£10.4m
Other Operating Income	£25.2m	£26.2m	£1.0m	£33.5m	£39.7m	£6.2m
Total Income	**£384.8m**	**£381.6m**	**-£3.2m**	**£511.9m**	**£507.6m**	**-£4.2m**
Employee Expenses	-£275.6m	-£277.9m	-£2.4m	-£367.9m	-£369.8m	-£1.8m
Operating Expenses	-£116.8m	-£117.3m	-£0.5m	-£154.4m	-£160.4m	-£6.0m
Non Operating Expenses	-£4.5m	-£3.6m	£0.9m	-£6.0m	-£5.1m	£0.9m
CIP	£6.1m	£0.0m	-£6.1m	£9.9m	£2.1m	-£7.8m
Total Expenditure	**-£390.7m**	**-£398.8m**	**-£8.1m**	**-£518.5m**	**-£533.2m**	**-£14.7m**
Unmitigated Forecast	**-£5.9m**	**-£17.2m**	**-£11.3m**	**-£6.7m**	**-£25.6m**	**-£19.0m**

The unmitigated forecast position is before Board approved actions which are intended to reduce the forecast deficit to £16.7m.

Key variances within the YTD position are:

Clinical Income – £4.2m adverse variance relates to underperformance against the value of the elective plan in Surgery and the impact of the Cyber Incident. This variance is net of the benefit realised by release of historic deferred income balances.
Employee Expenses - £2.4m adverse variance relates to the approved increase in nursing staff and the continued pressure on medical bank in ED.
Non-operating expenses – £0.9m favourable variance relates to PDC payments lower than plan.
Cost Improvement Programme – £6.1m adverse variance for recurrent CIP across clinical divisions. This is offset by non-recurrent underspends.

The Trust's agency costs were 1.5% of total pay costs in M7 and are 2.8% YTD. This is below the 2024/25 target of 3.2%.

Risks to position

The main risks to the I&E position are:

- The impact of the cyber incident.
- The Trust fails to fully deliver the Elective Activity plan.
- The Trust fails to fully deliver the recurrent Cost Improvement Programme.
- The Trust fails to manage urgent care expenditure within planned levels.

Actions:
- Maximising elective capacity and recovery.
- Full delivery of recurrent CIP schemes and identification of non-recurrent underspends.
- Urgent care improvement plan.
- Full delivery of agreed mitigation plan.

Cumulative CIP

Narrative:

The Trust has transacted £18.6m of recurrent CIP at M9 which is £6.1m behind plan. The Trust has risk adjusted the CIP forecast to £20.6m, a shortfall against target of £8.2m.

The Trust does not classify non-recurrent underspends as CIP but the forecast under-delivery of CIP is fully mitigated by non-recurrent underspends.

Risks to position:
- That the gap between target and identified schemes is not reduced.
- 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.
- Implementation of the Board approved mitigation plan which includes acceleration of enhanced controls over variable expenditure.

Elective Activity

Narrative:

The Trust delivered elective activity to the value of £7m in M9 and £92.3m YTD, an adverse variance of £16.7m for the year. This is primarily driven by the impact of the Cyber Incident, underperformance in respect of the Cheshire and Merseyside Surgical Centre (CMSC), a shortfall of elective and day cases in Surgery and a lower case mix within the Surgery Division.

Risks to position:
- That the Trust fails to utilise the elective capacity in place.
- That the current case mix of cases continues.

Actions:
- Implementation of the Board approved mitigation plan which includes increased productivity of core elective capacity and reduced reliance on non-core support.

Capital Expenditure

Narrative:

Description	Approved Budget at M1	Revision to Budget M2	Revision to Budget M6	Revision to Budget M7	Revised Budget
CDEL					
Internally Generated	£12.870m				**£12.870m**
ICB/PDC/WCT	£6.284m	-£1.400m	£1.953m		**£6.837m**
Charity	£1.000m			-£1.000m	**£0.000m**
Confirmed CDEL	**£20.154m**	**-£1.400m**	**£1.953m**	**-£1.000m**	**£19.707m**
Total Funding for Capital	**£20.154m**	**-£1.400m**	**£1.953m**	**-£1.000m**	**£19.707m**
Capital Programme					
Estates, facilities and EBME	£5.000m				£5.000m
Heating and chilled water pipework replacement	£2.100m				£2.100m
Operational delivery	£2.750m				£2.750m
Medical Education	£0.080m				£0.080m
Transformation	£1.000m				£1.000m
Digital	£0.750m				£0.750m
UECUP	£6.010m				£6.010m
Charity	£1.000m			-£1.000m	£0.000m
Approved Capital Expenditure Budget	**£18.690m**			**-£1.000m**	**£17.690m**
Diagnostics Digital	£0.064m				£0.064m
LIMS - PDC	£1.400m	-£1.400m			£0.000m
RAAC	£0.000m		£1.953m		£1.953m
Confirmed PDC	**£1.464m**	**-£1.400m**	**£1.953m**	**£0.000m**	**£2.017m**
Total Anticipated Expenditure on Capital	**£20.154m**	**-£1.400m**	**£1.953m**	**-£1.000m**	**£19.707m**
Under/(Over) Commitment	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**

Spend at M9 totals £7.5m which is £1.2m behind plan. The delays primarily relate to the Central Sterile Services Department (CSSD) and Interventional Radiology business cases that have now been approved. We do not anticipate any underspend 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:

- Estates and Capital Committee to continue to monitor progress and risks from capital projects.

Cash Position

Narrative:

The cash balance at the end of M9 was £3m. Applications for cash support in November and December were both rejected and the Trust was only able to maintain a positive cash balance by delaying expenditure through BPPC performance (see below) and increasing income by rephasing contract payments.

The reduction in the cash balance is presenting challenges on a daily basis with a direct impact on the BPPC target by volume and value. The year-to-date position of bills paid within target stands at 73.6% which is 21.4% lower than the national target of 95%. In M9 the Trust was only able to pay 54.8% of invoices received within the timeframe required to achieve BPPC. This reduced performance is a direct consequence of the Trust managing its cash position.

The Trust need for deficit and working capital support continues and, following Board approval, applied for cash support from NHSE in advance of Q4. Whilst this initial request was rejected, we have received confirmation that partial support of £3.5m will be provided for January. This will enable the Trust to service creditors until March when further cash support will be required. The Trust continues to review options and impact should the request for support in March not be approved in full. This is the principal risk in respect of our financial position.

Risks to position:

- Management of the cash trajectory is impacting significantly on BPPC performance.
- 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.
- Discussions with ICB around mitigations for cash position and process for applying for cash support.
- Submission of request for additional cash support in March 2025.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 19**
29 January 2024

Title	Chief Operating Officer's Report
Area Lead	Hayley Kendall, Chief Operating Officer & Deputy CEO
Authors	Hayley Kendall, Chief Operating Officer & Deputy CEO Steve Baily, Deputy Chief Operating Officer Alistair Leinster, Divisional Director – Performance and Planning
Report for	Information

Executive Summary and Report Recommendations

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

For planned care activity, it highlights the Trust's performance against the targets set for this financial year. The Board should note the ongoing positive performance with recovering elective waiting times, following the cyber incident, but the continued challenge in achieving reduced waiting times in gynaecology services.

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 improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the UEC Improvement Plan to ensure that the increase in demand can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED along with system partners.

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	In line with the national position, Trusts continue to recover elective waiting times post the impact of Covid. The Trust has been in a strong position with improving waiting times for elective, diagnostic and cancer pathways but this performance has been significantly impacted by the cyber attack that was experienced late November and into early December. 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. The Trust has been supported by AQuA on improving the 4 hour performance standards and is in receipt of support from the Emergency Care Intensive Support Team (ECIST).

2	Planned Care
2.1	**Elective Activity** In December 2024, the Trust attained an overall performance of 73.98% against plan for outpatients (81.81% for new outpatients) and an overall performance of 81.93% against the plan for elective admissions, as shown in the table below:

Activity Type	Target for December	Actual for December	Performance
Out pt New	11069	9056	81.81%
Out pt Follow up	23191	15268	65.84%
Out pt procedures	2686	3008	111.99%
Total Out pts	36946	27332	73.98%
Day case	4162	3568	85.73%
Inpatients	674	394	58.46%
Total	4836	3962	81.93%

The Trust underachieved plan for both outpatient new appointments and elective inpatients / daycase, with the delivery and capture of activity impacted by the cyber incident, which saw the cancellation of clinic appointments, elective activity and interruption of recording of activity onto Cerner. Under delivery of outpatients and elective admitted care was seen across all clinical divisions. Divisional teams are currently working on ensuring all activity that took place is captured as part of the focus of restoration following the cyber incident.

2.2 Referral to Treatment (RTT)

The national standard is to have no patients waiting over 65 week waits by September 2024. The Trust's performance at end of December against these indicators was as follows:

- 104+ Week Wait Performance – 1
- 78+ Week Wait Performance – 20
- 65+ Week Wait Performance - 151
- 52+ Week Wait Performance – 1,286
- Waiting List Size - there were 47,374 patients on an active RTT pathway which is an decrease on the previously month of 48,018.

Referral to treatment reported position was impacted by the cyber incident, both in terms of the loss of activity that would have provided treatment and stopped waiting times for patients, and on the ability to validate the waiting times position.

The 1 x 104+ week waiter was a patient (where onward referrals from one service to another was not picked up), this patient has now been treated. Two of the 78-week waiters were Ophthalmology graft patients (limited tissue available managed nationally), three of the 78-week waiters are Trauma and Orthopaedic mutual aid patients.

The Trust achieved 151 x 65 week waiters at the end of December. In line with other Trusts in Cheshire and Mersey, the Trust has continued to reduce the number of patients waiting 65 weeks or more and this will be the continued area of focus for the end of February (timescales for the recovery from the cyber attack).

Gynaecology is the largest contributor to the Trust's 65- and 52-week waiters but has seen notable improvements in both metrics. Gynaecology 65-week waiters reduced from 188 in June 2024 to 73 in December 2024.

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	01/10/2024 - 31/12/2024

National Standards:

Standard	Indicator	Threshold	October-24	November-24	December-24	Quarter 3
28 Day Wait	GP USC Referral or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	75.00%	76.57%	78.76%	N/A	77.55%
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	91.92%	88.46%	N/A	90.38%
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	75.50%	81.18%	N/A	77.97%

Sub Standards:

Standard	Indicator	Threshold	October-24	November-24	December-24
28 Day Wait	Individual Trust Provider Trajectory	Per Month	76.57%	78.76%	N/A
28 Day Wait	Breast >=90%	90.00%	95.45%	91.80%	N/A
28 Day Wait	Skin >=90%	90.00%	92.52%	92.36%	N/A
62 Day Wait	Individual Trust Provider Trajectory	Per Month	75.50%	81.18%	N/A

Removed Standards (Not National Standards):

Standard	Indicator	Threshold	October-24	November-24	December-24
14 Day Wait	GP USC Referral to First Appointment	93.00%	70.31%	63.38%	N/A

- *Faster Diagnostic Standard (FDS)* – The Trust met the FDS standard for November 2024, with current performance of 77.55% for the quarter.
- *62 day treatment* - For 2024/25, the 62 day treatment standard sees a previous national target of 85%, a national requirement to achieve 70% and a local trajectory to achieve 77% performance by March 2025. The Trust achieved the local trajectory in November 2024 (see '62 Day Wait' in Sub Standards section of the table above).
- *62 day waiters* – the number of waiters increased in December 2024, moving above trajectory which decreased in November and December (174 patients against a trajectory of 40).

	01/04	08/04	15/04	22/04	29/04	06/05	13/05	20/05	27/05	03/06	10/06	17/06	24/06	01/07	08/07	15/07	22/07	29/07	05/08	12/08	19/08	26/08	02/09	09/09	16/09	23/09	30/09	07/10	14/10	21/10	28/10	04/11	11/11	18/11	25/11	02/12	09/12	16/12	23/12	30/12
Actual 24/25	135	132	119	131	136	141	140	148	137	127	122	129	127	106	91	92	103	89	82	90	92	93	88	76	74	79	88	88	81	80	74	83	88	88	88	116	137	146	146	174
Trajectory	120	120	120	120	120	112	112	112	112	103	103	103	103	93	93	93	93	93	83	83	83	83	72	72	72	72	72	60	60	60	60	50	50	50	50	40	40	40	40	40
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

- *104 day long waiters* – performance is ahead of trajectory for December, at 29 against a plan of 14.

	01/04	08/04	15/04	22/04	29/04	06/05	13/05	20/05	27/05	03/06	10/06	17/06	24/06	01/07	08/07	15/07	22/07	29/07	05/08	12/08	19/08	26/08	02/09	09/09	16/09	23/09	30/09	07/10	14/10	21/10	28/10	04/11	11/11	18/11	25/11	02/12	09/12	16/12	23/12	30/12
Actual 24/25	45	36	33	32	29	38	38	35	36	34	35	40	42	42	37	36	40	37	26	23	22	19	24	22	21	17	19	15	16	12	12	18	20	20	20	25	21	24	24	29
Trajectory	50	50	50	50	50	47	47	47	47	42	42	42	42	39	39	39	39	39	33	33	33	33	30	30	30	30	30	23	23	23	23	20	20	20	20	14	14	14	14	14
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

Whilst performance for October and November was positive for both the 28 day and 62 day treatment standards, the forecasts for December and January predict a deterioration in performance. Performance over December is seen to dip seasonally with reduced capacity, but the cyber incident has impacted cancer performance and will take a number of months to recover from.

2.4 DM01 Performance – 95% Standard

At the end of December 81.64% of patients had been waiting 6 weeks or less for their diagnostic procedure for those modalities included within the DM01, seeing performance fall below the revised national standard of 95%.

Prior to the cyber incident DM01 performance was being achieved and has been significantly impacted across modalities following the incident. Non-obstetric ultrasound, as a high-volume modality, was notably impacted with a significant number of cancellations. Breaches rose from an average of 102 per month (year to date) to 958 in December. This saw performance for non-obstetric ultrasound drop from an average of 97% (monthly average April to November) to 79% in December. A recovery plan is in place to restore non-obstetric ultrasound performance but at present due to the shortage of ultrasonographers this is a high risk area.

Endoscopy remains an area of pressure. Improvements are noted in Dexa despite the cyber incident, as a result of the improvement work in that modality.

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.

The cyber incident was seen to impact elective performance both in terms of the loss of activity that would have provided treatment / diagnostic and stopped waiting times for patients, and on the ability to validate the waiting times position. Performance across RTT, cancer and diagnostics was affected. Operational teams are working through plans to recover lost activity.

	The main area of concern has been delivering 0 x 65 weeks and 0 x 78 weeks. Mutual aid for Gynaecology has commenced with a number of patients transferring to a local hospital.

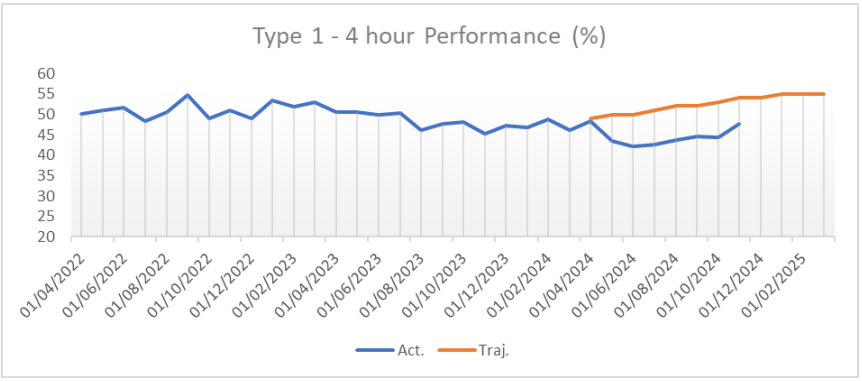
3.0 Unscheduled Care

3.1 Performance

December Type 1 performance was reported at 45.56%, with the combined performance for all Wirral sites at 61.56%:

Type 1 ED attendances:	Type 3 ED attendances:
• 7,348 in November (avg. 245/day) • 7,393 in December (avg. 239/day) • 0.6% increase from previous month	• 2,712 in November (avg. 90/day) • 2,879 in December (avg. 93/day) • 6.16% increase from previous month

The performance of emergency care (UEC) in December is below the planned target but has improved in comparison to previous months, demonstrating the sustained impact of the improvement areas being focussed on. The increasing complexity of cases and seasonal pressures including the increase in flu, COVID and norovirus outbreaks, is contributing to the pressure on resources. Due to these pressures, it remains difficult to meet the 4-hour standard, despite efforts to improve efficiency and patient flow however improvement projects remain in place and are progressing to address the non-admitted performance.

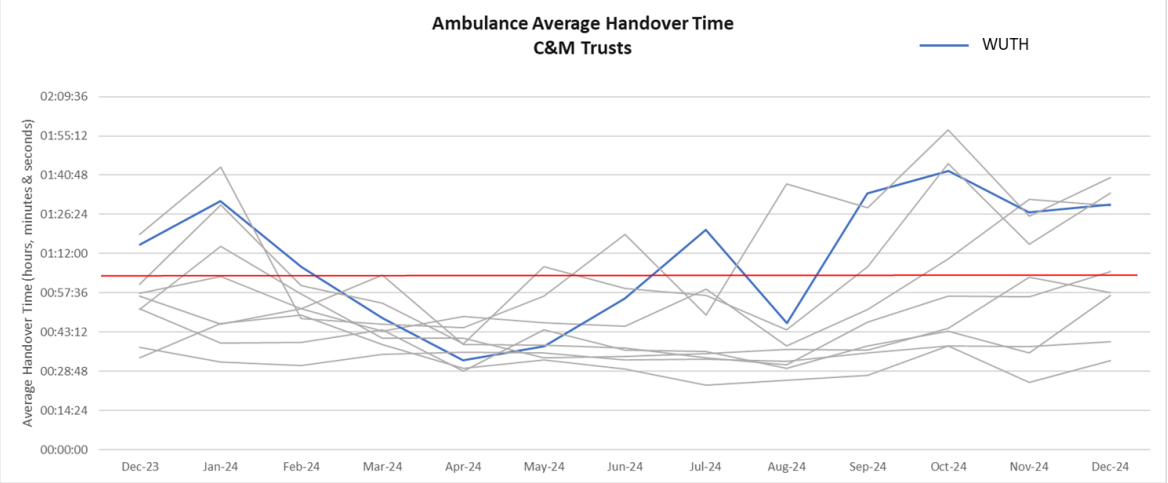


Urgent care improvement initiatives include expanding the Trusts same day emergency care (SDEC) offer, introducing front door triage by the nursing team from the Urgent Treatment Centre, implementing the call before convey offer to NWAS and working more closely with primary care and social services to provide more effective alternatives to attending A&E. The integration of urgent care services across Wirral are continuing the development with a focus on improving the referral pathways ensuring patients receive the right treatment at the right time, reducing waiting times and improving overall patient outcomes.

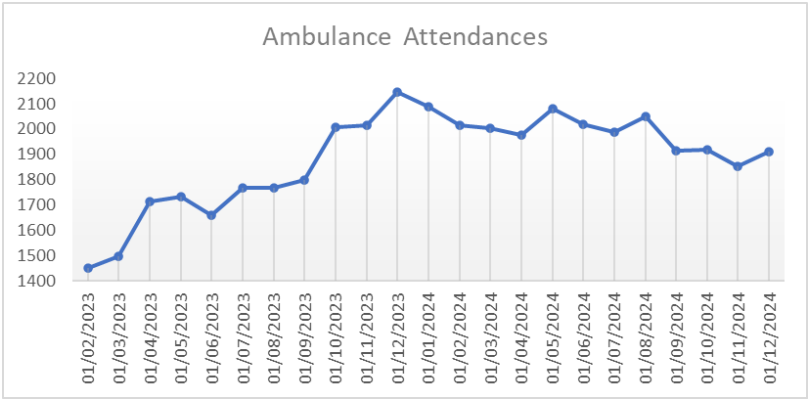
The Frailty Same Day Emergency Care (SDEC) pilot has successfully improved care for older patients with frailty by enabling rapid assessment and treatment without the need for hospital admission. The pilot focused on providing personalised, holistic care through multidisciplinary teams in a faster and more efficient manner. This enabled patients to receive appropriate care on the same day, reducing unnecessary hospital admissions and improving patient satisfaction. The success of the pilot has demonstrated the

benefits of early intervention and better management of frailty, contributing to better outcomes and more efficient use of urgent care resources. The patients that accessed the service, had a low admission rate of an average of 23%. The Divisional leadership team are working on a plan to implement the service long term within the existing workforce.

Due to increased patient demand and capacity constraints, ambulance turnaround at Arrowe Park Hospital has remained a challenge. Contributing factors include overcrowding in A&E, staffing pressures and high patient volumes, particularly at peak times of the day. The Trust is working to address the delays. This includes substantively recruiting additional nursing staff and clinical support workers for A&E to staff several corridor spaces. The system is focusing on reducing the number of conveyances to A&E by utilising alternative services identified by the daily point prevalence in A&E.

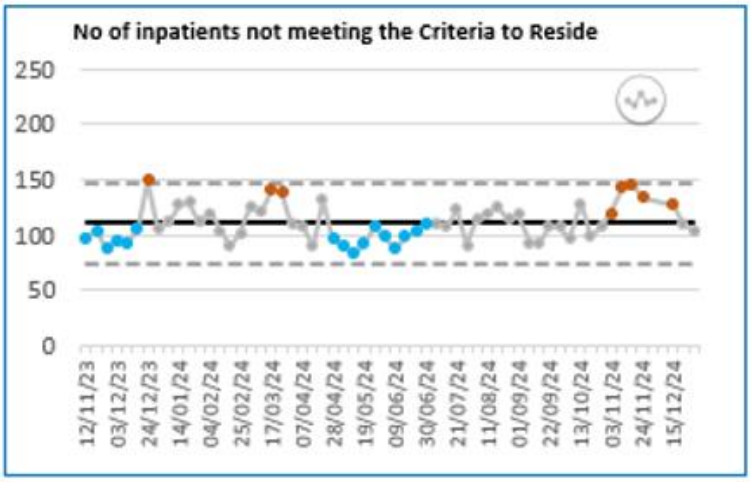


Ambulance attendances remained similar to previous months but continued to track significantly above 2022/23.



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

The number of NCTRs decreased in December compared to previous months with an average of 105 patients. The Trust ran a MADE event in December ahead of the Christmas period focusing on our NCTR patients with a length of stay of more than 7 days and those still on complex discharge pathways to see if we could remove barriers and discharge patients before the Christmas bank holiday period.



With the introduction of the new screening tool, the number of patients has also shifted from pathway 3 to pathway 2 and from pathway 2 to pathway 1. The process is challenging the potential overprescribing of care outside of the hospital. The new process has only been in place for a few weeks and will therefore continue to be monitored.

3.3 Mental Health

The demand for patients presenting to the emergency department with mental health needs fell in December, this included overall number of patients presenting with mental health needs and the reduction in the length of stay of patients waiting to be admitted to a mental health bed.

The Trust continues to work with the local mental health provider to develop a workforce model that includes RMNs for the new mental health area which is due to be completed in Q2 2025/26. The proposal for the model is due to be shared with executives at both Trusts for the end of January 2025.

With the next phase of Right Care Right Person due to go live in mid-March, the Trust is working with partners to ensure plans are in place to enable the police to handover patients to A&E within the target of 1 hour. Cheshire and Merseyside are aware that this will be a challenge due to limited resources but are working closely with Merseyside Police to ensure that no patients or staff are put at risk during the implementation of the next phase.

3.4 Risks and mitigations to improving urgent care performance

The Trust continues to make progress in implementing actions from the improvement plans for urgent care quality standards and the 4-hour performance target. Performance and progress will be monitored through the UEC Improvement Group, with the Sentinel metrics being overseen by Place leads and the ICB.

However, there remains a risk that the consistently high levels of attendances and acuity could pose challenges to these improvement plans. Additionally, the need to increase nursing staff in the ED to facilitate the prompt release of ambulance crews (including staffing corridors as necessary) and the growing vacancies among junior medical staff are adding further pressure to the department.

Implementation of pilots including triage by UTC nursing and call before convey are working towards reducing the volume of patients in the department and will hopefully deliver in the coming months. Whilst nursing recruitment is ongoing, the nursing support

	for corridors is achieved from reallocating nursing staff from other areas reducing the risk of crews being held.

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. The paper also details the extra actions introduced recently 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** • Recovering elective waiting times, post pandemic, remains a significant pressure within the Trust.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets relating mainly to 65 weeks by the end of March 2024 and 76% 4 hour performance.

5	Conclusion
	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 UEC Improvement Plan to ensure that the increase in demand 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 it is noted that there has been a significant impact on elective recovery from the cyber attack.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 20**

29 January 2025

Title	Quality Committee Terms of Reference Review
Area Lead	David McGovern, Director of Corporate Affairs
Author	James Jackson-Elis, Corporate Governance Manager
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is to provide the final Terms of References for approval for Quality Committee following the annual review and feedback from Board members in December. All major amends are highlighted on the appended document.

It is recommended that the Board:

- Approve the Terms of Reference

Key Risks

This report relates to these key Risks:

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

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

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
November 2024	Quality Committee	As above	Approval

December 2024	Board of Directors	As above	Approval
January 2025	Quality Committee	As above	Approval

1	Narrative
1.1	An annual refresh has been undertaken on the Terms of References for Board Assurance Committees. These were provided to each Committee for feedback and all the requested amendments have been made. The Terms of Reference had been presented to the Committee in November and included amends to section 5 (attendance), relating to the inclusion of all Executive Directors as part of a Deloitte well-led review carried out during 2024. Following feedback at the Board of Directors in December this has been amended to reflect other members of the Executive Team will attend on a rotational basis only. The Board are asked to approve the appended Terms of Reference. As with all other Terms of Reference, these will continue to be live documents and will be reviewed annually in line with good governance practice. The Terms of References will also be uploaded the website.

2	Implications
2.1	**Patients** • No implications
2.2	**People** • No implications
2.3	**Finance** • No implications
2.4	**Compliance** • Clear terms of reference support effective decision making and good governance

Wirral University Teaching Hospital NHS Foundation Trust

Quality Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: November 2025
Issue Date: April 2013
Version: 4.0
Authorisation Date: December 2024

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to provide assurance in relation to clinical quality and effectiveness, patient safety and patient experience (including complaints and serious incident learning); the effectiveness of the quality governance framework; and learning and quality improvement. The Committee shall also provide assurance concerning clinical Health and Safety arrangements which ensure a safe environment for patients.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

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

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1.1 To review the policies and practices that relate to patient safety and experience, clinical health and safety, and quality governance.
3.1.2 To review and approve the Trust's Quality Strategy and Patient Experience Strategy, recommending them to the Board for final approval, and to seek assurance that the associated actions are being implemented.
3.1.3 To provide scrutiny of the Trust's patient safety record, clinical outcomes, patient experience ratings, compliance with fundamental standards of care, and learning effectiveness.
3.1.4 To provide scrutiny of the frameworks and processes in place for managing patient safety and quality governance. This may include reviewing operational challenges, resourcing, clinical audit programmes, and other key areas of quality control.
3.1.5 To consider and seek further assurance regarding any potential quality impact arising from Trust activities, as referred by other Committees.
3.1.6 To receive relevant reports as required by guidance or regulation and any other matters referred by the Patient Safety Quality Board, including Divisional quality performance.
3.1.7 To provide review and recommend the Quality Account/Report to the Board for approval on an annual basis.
3.1.8 To provide to the Board such assurances as it may reasonably require regarding compliance by the Trust with all CQC and other quality regulations or legal obligations to which they are subject. This will include assurance on the outcomes of CQC and other quality related inspections.
3.1.9 To monitor and review the BAF in accordance with the Risk Management Strategy, in particular the risks associated with patient safety, quality governance.
3.1.10 To consider any findings of major investigations of internal control over safety critical matters, clinical effectiveness, patient concerns, or clinical health and safety matters and agree subsequent actions required to keep residual risk under prudent control.
3.1.11 To consider and review the Trust's compliance with the statutory duty of candour, and to be satisfied that the Trust is being open, honest, and effectively engaging and supporting with patient's and relatives who have been victims of moderate or serious harm.

3. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

4. Membership

The Committee shall consist of:

- Three Non-Executive Directors, one of whom shall be appointed the Chair
- Medical Director (Nominated Deputy – Deputy Medical Director)
- Chief Nurse (Nominated Deputy – Deputy Chief Nurse)

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend, they should send a designated nominated deputy.

5. Attendance

Meetings of the Committee will generally be attended by:

- Deputy Director of Quality Governance
- Director of Corporate Affairs
- A Governor to observe
- A representative from Healthwatch Wirral
- Other members of the Executive Team on a rotational basis

The Committee may invite other persons to attend a meeting as required, and the Chair will be informed of these additions where possible prior to the meeting.

No officer shall be present for discussions about his/her own remuneration.

6. Conflicts of Interest

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

7. Quorum and Frequency

A quorum shall be at least 2 Non-Executive Directors and either the Medical Director or Chief Nurse (or their deputy).

Meetings shall be held as necessary and at least 4 times annually. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

There will be a scheduled meeting each year to approve the Quality Account.

8. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

The Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

The Committee will report annually on its work in support of the Annual Governance Statement and Quality Account/Report, as laid out in the reporting guidance for the creation of those documents.

9. Conduct of Meetings

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

Authors of papers should use the standard template.

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

10. Performance Evaluation

As part of the Board's annual performance review process, the Committee shall review its collective performance each year.

11. Review

The terms of reference of the Committee shall be reviewed as required and at least annually.

Draft

Integrated Performance Report

January 2025

NHS
Wirral University Teaching Hospital
NHS Foundation Trust


together
we will
...deliver the best quality and safest care to the communities we serve
caring for everyone
respect for all
embracing teamwork
committed to improvement


OUTSTANDING CARE
Provide the best care and support
Empower patients through their care journey
Improve patient flow, ensuring the patient is in the right place at the right time
Strive to deliver intimate and personal patient experience
Provide services in the most appropriate and accessible setting
Embed a culture of safety improvement that improves outcomes
COMPASSIONATE WORKFORCE
Be a great place to work
Develop and maintain a healthy organisational culture based on our values
Retain, attract and recruit high calibre and skilled staff
Support our staff to enjoy the best health and wellbeing
Invest in our staff's continuous learning, education and innovation
CONTINUOUS IMPROVEMENT
Maximise our potential to improve and deliver best value
Embed a culture of improvement and transformation
Reduce variation in care pathways to improve outcomes
Use our resources effectively and sustainably, so we can improve our services
Create the conditions for clinical research to flourish


OUR PARTNERS
Provide seamless care working with our partners
Integrate care to prevent ill-health, improve wellbeing and meet the needs of the Wirral population
Deliver system partnerships which improve outcomes for our patients
Lever our clinical expertise to drive clinical quality and influence system working
Build partnerships with academic institutions to develop research and education capability
DIGITAL FUTURE
Be a digital pioneer and centre for excellence
Use digital technology to reduce waste, automate processes and eliminate bottlenecks
Empower patients with the data and tools to manage their own health and wellbeing
Allow business intelligence to drive clinical decision making
Use health information to enable population health management for the Wirral
INFRASTRUCTURE
Improve our infrastructure and how we use it
Effectively use our estate to support the delivery of care
Delineate the role and functions of the hospital sites
Develop the case for the upgrades of the hospital campuses
Improve travel and transport to our hospital campuses
Promote sustainability and social value

Board of Directors in Public **Item ?**

Date

Title	Integrated Performance Report (Draft)
Area Leads	Executive Team
Author	David McGovern, Director of Corporate Affairs
Report for	Information

Executive Summary and Report Recommendations

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

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 each domain identified in this report. Commentary is provided at a general level and by exception on metrics not achieving the standards set.

Grouping the metrics by report domains shows the following breakdown for the most recently reported performance:

Summary of latest performance by Domain

Domain	Number achieving	Number not achieving	Total
Health Inequalities and Place			
Workforce			
Operations			
Quality and Safety			
Finance			
Digital			
Estates			

To the end of December 2024, X metrics were achieving the agreed target and X were not achieving target.

It is recommended that the Board:

- Note performance to the end of December 2024.

Key Risks

This report relates to the key risks of:

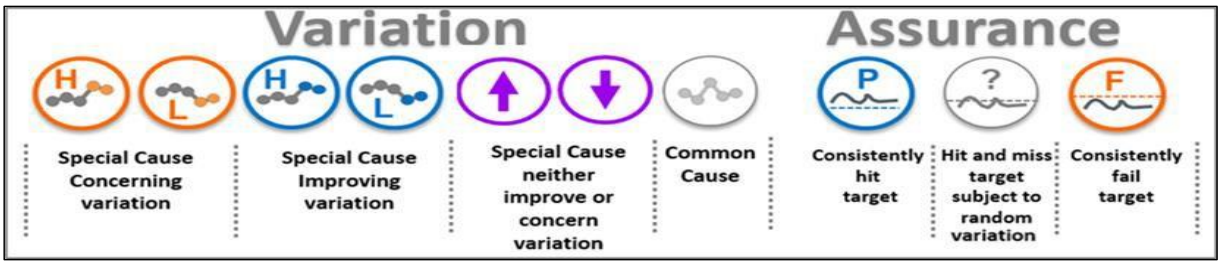
-

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

1	Narrative
1.1	**Health Inequalities and Place** Executive summary of commentary **Workforce** Executive summary of commentary **Operations** Executive summary of commentary **Quality and Safety** Executive summary of commentary **Finance** Executive summary of commentary **Digital** Executive summary of commentary **Estates** Executive summary of commentary

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 report by each Executive Director.

3	General guidance and Statistical Process Charts (SPC)
3.1	 **Orange dots signify a statistical cause for concern. A data point will highlight orange if it:** • Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance. • Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance. • Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend. **Blue dots signify a statistical improvement. A data point will highlight blue if it:** • Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance. • Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance. • Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend. Special cause variation is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated, and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots.

Dashboard	All Indicators
Lead	All Execs

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Data Quality

Dashboard	Health Inequalities and Place
Lead	All Execs

Health Inequalities and Place Domain Matrix

Health Inequalities and Place Summary

Highlights	Areas of Concern	Forward Look (Actions)

Wirral Measure of Deprivation	Inequality Comparison with other ICB areas
Available from April 2025	Available from April 2025

Commentary	Commentary
What does the data tell us? **What are the main risks impacting performance?** **What actions are being taken to improve performance?**	**What does the data tell us?** **What are the main risks impacting performance?** **What actions are being taken to improve performance?**

Wirral Top 10 Conditions for Inequality	Population Makeup by Protected Characteristics
Available from April 2025	Available from April 2025

Commentary	Commentary
What does the data tell us? **What are the main risks impacting performance?** **What actions are being taken to improve performance?**	**What does the data tell us?** **What are the main risks impacting performance?** **What actions are being taken to improve performance?**

Wirral Life Expectancy - Men	Wirral Life Expectancy - Women
Available from April 2025	Available from April 2025

Commentary	Commentary
What does the data tell us?	**What does the data tell us?**
What are the main risks impacting performance?	**What are the main risks impacting performance?**
What actions are being taken to improve performance?	**What actions are being taken to improve performance?**

Children in Low income Families	Employment
Available from April 2025	Available from April 2025
Commentary	**Commentary**
What does the data tell us? **What are the main risks impacting performance?** **What actions are being taken to improve performance?**	**What does the data tell us?** **What are the main risks impacting performance?** **What actions are being taken to improve performance?**

Behaviours and Lifestyle – Smoking/Weight/activity and Alcohol	Referral Rates by Diagnosis
Available from April 2025	Available from April 2025
Commentary	**Commentary**
What does the data tell us? **What are the main risks impacting performance?** **What actions are being taken to improve performance?**	**What does the data tell us?** **What are the main risks impacting performance?** **What actions are being taken to improve performance?**

Benchmarking GIRFT and Model Health

Available from April 2025

Commentary

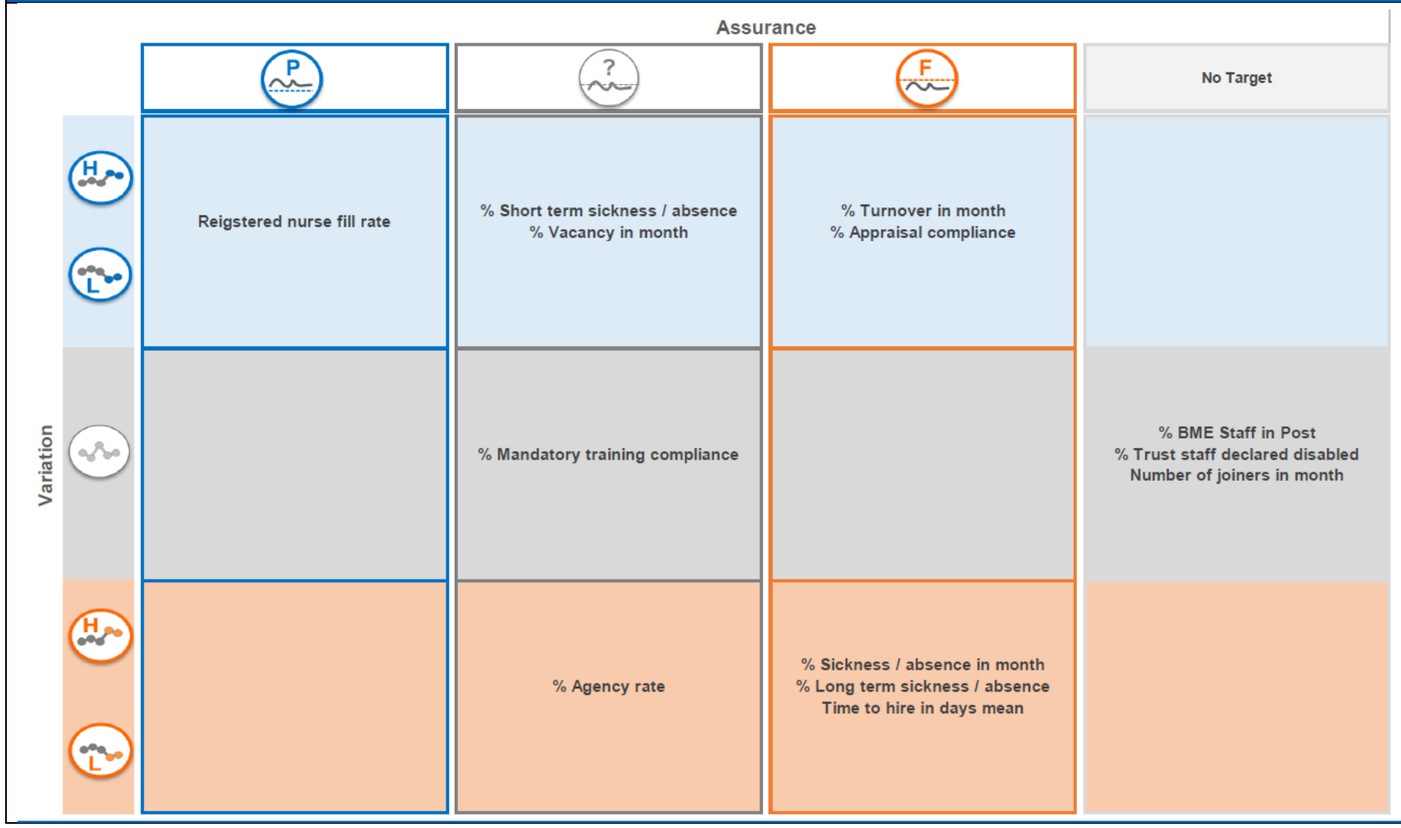
What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Dashboard	Workforce
Lead	Chief People Officer

Workforce Domain Matrix



Dashboard Example

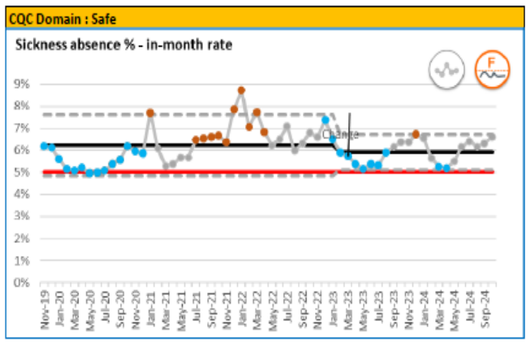
Workforce Summary

Highlights

Metric	Latest month	Measure	Target	Variation	Assurance	Mean	Data Quality Indicators
% Vacancy In-month	Sep 23	10.7%	12.0%			10.9%	S T P
% Registered nurse fill rate	Sep 23	95.1%	85.0%			93.4%	S T P
% Agency rate	Sep 23	5.3%	3.7%			4.3%	S T P
% BME Staff in Post	Sep 23	7.3%	-			7.7%	S T P
% Trust staff declared disabled	Sep 23	4.7%	-			4.6%	S T P

Areas of Concern

Forward Look (Actions)

Sickness absence % in month rate	Long term sickness absence – in month rate	Short term sickness absence – in month rate
	Data reported to People Comm/WSB but not SPC	Data reported to People Comm/WSB but not SPC

Oct-24
6.61%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

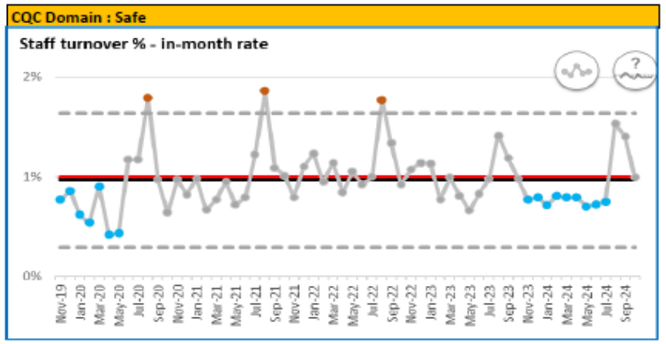
Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Staff turnover % in month rate



Oct-24
0.99%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

Staff turnover % by staff group

Data reported to People Comm/WSB but not SPC

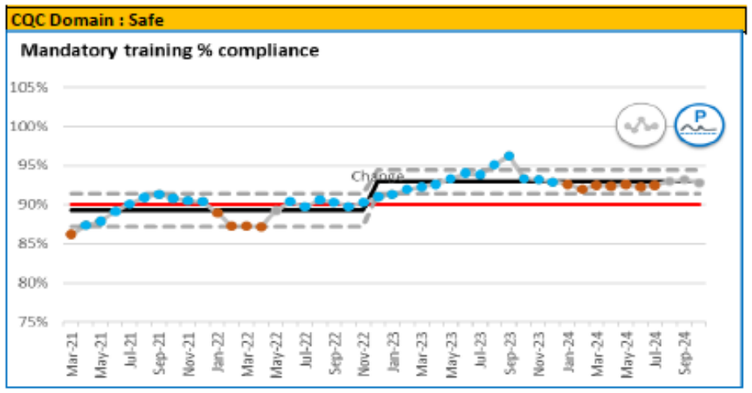
Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Mandatory training % compliance



Oct-24
92.80%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

Mandatory training % compliance by staff group

Data reported to People Comm/WSB but not SPC

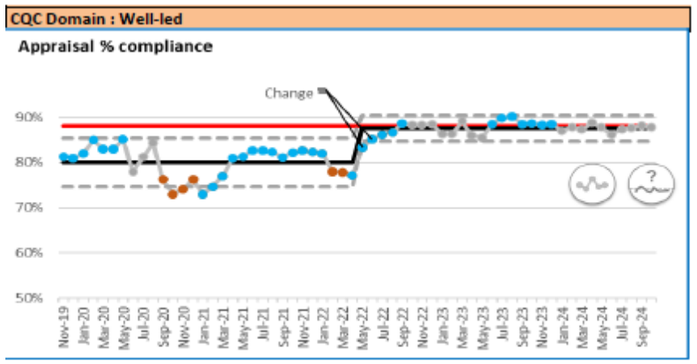
Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Appraisal % compliance



Oct-24
87.83%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Appraisal % compliance by staff group

Data reported to People Comm/WSB but not SPC

Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Staff Experience	Staff Experience
To Be Considered	To Be Considered

Commentary	
What does the data tell us? **What are the main risks impacting performance?** **What actions are being taken to improve performance?**	**What does the data tell us?** **What are the main risks impacting performance?** **What actions are being taken to improve performance?**

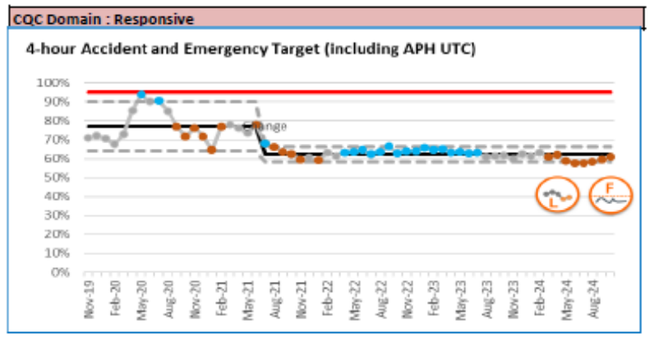
Dashboard	Operations
Lead	Chief Operating Officer

Operations Domain Matrix

Operations Summary

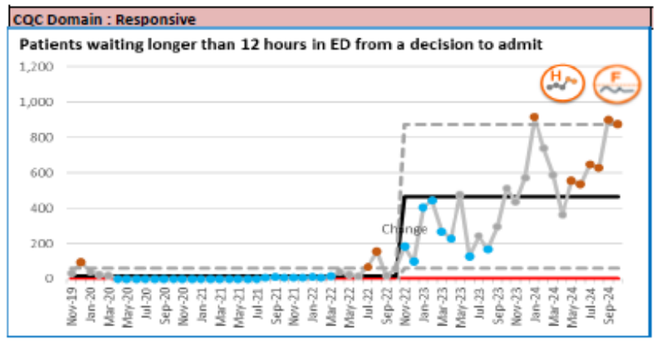
Highlights	Areas of Concern	Forward Look (Actions)

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



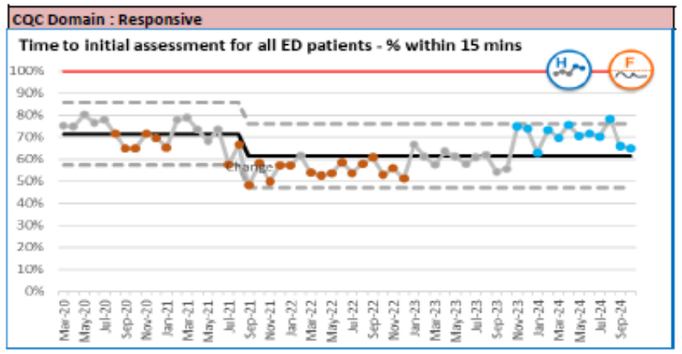
Oct-24
60.8%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

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



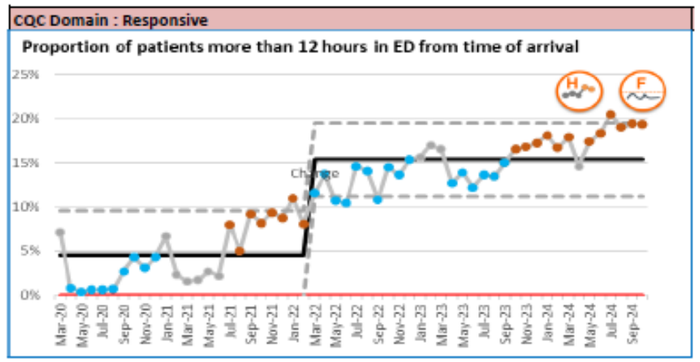
Oct-24
878
Variance Type
Common cause variation
Threshold
0
Assurance
Performance consistently fails to achieve the target

Time to initial assessment for all ED patients – within 15 minutes



Oct-24
64.9%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

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



Oct-24
19.4%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

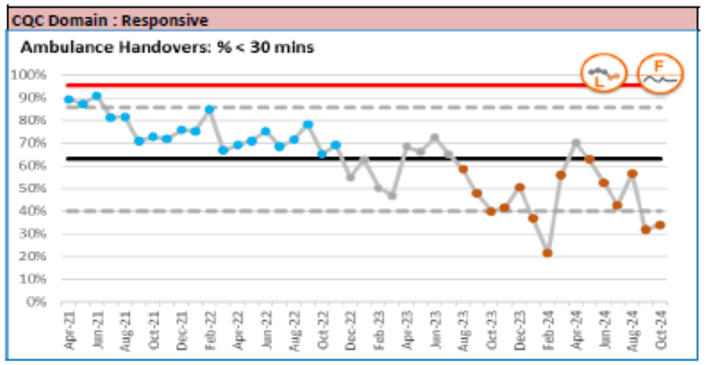
Commentary

What does the data tell us?

What are the main risks impacting performance?

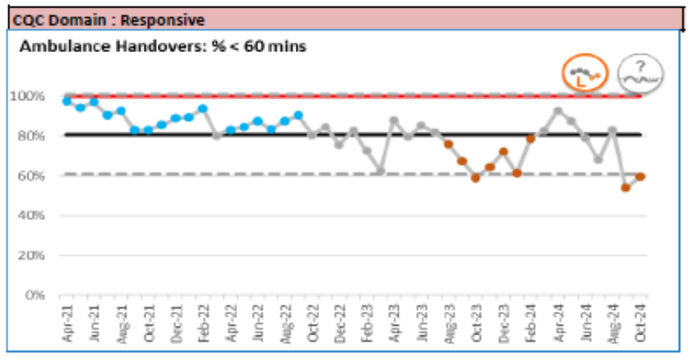
What actions are being taken to improve performance?

Ambulance handover % < 30 minutes



Oct-24
33.8%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

Ambulance handover % < 60 minutes



Oct-24
59.7%
Variance Type
Special cause variation - concerning
Threshold
100%
Assurance
Hit & miss target subject to random variation

Commentary

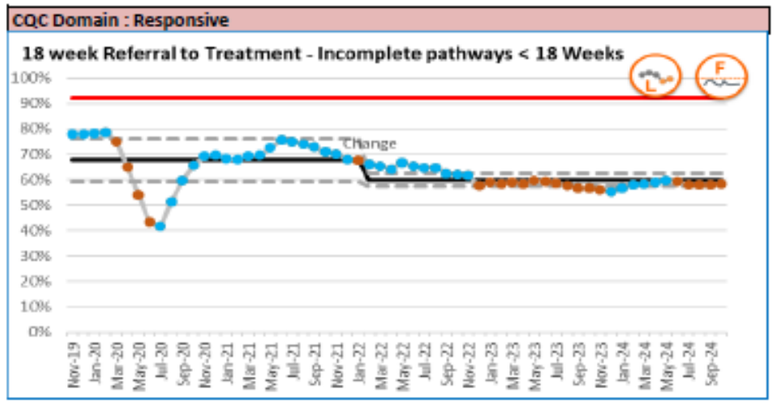
What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

18 week Referral to Treatment – incomplete pathways < 18 weeks

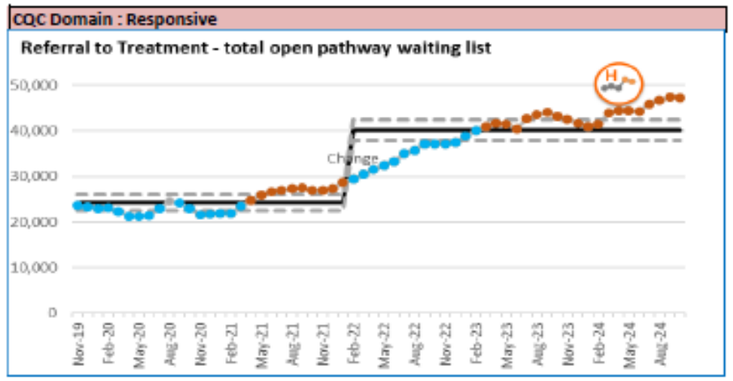
CQC Domain : Responsive



Oct-24
58.41%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

Referral to Treatment – total open pathway waiting list

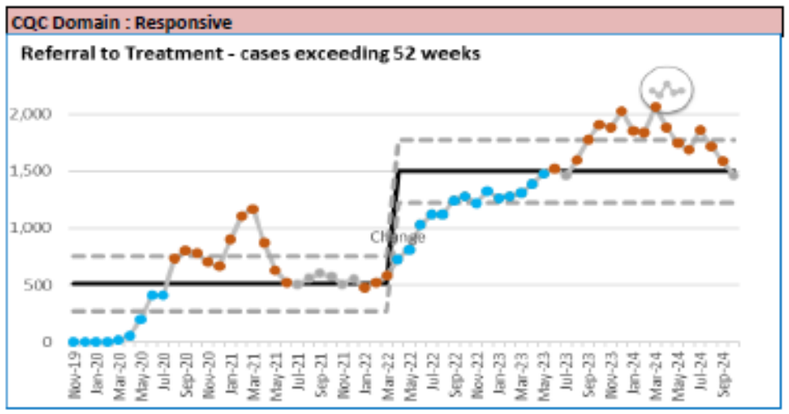
CQC Domain : Responsive



Oct-24
47262
Variance Type
Special cause variation - concerning
Threshold
≤ 40511
Assurance
Trajectory target not appropriate for SPC Assurance reporting

Referral to Treatment – cases exceeding 52 weeks

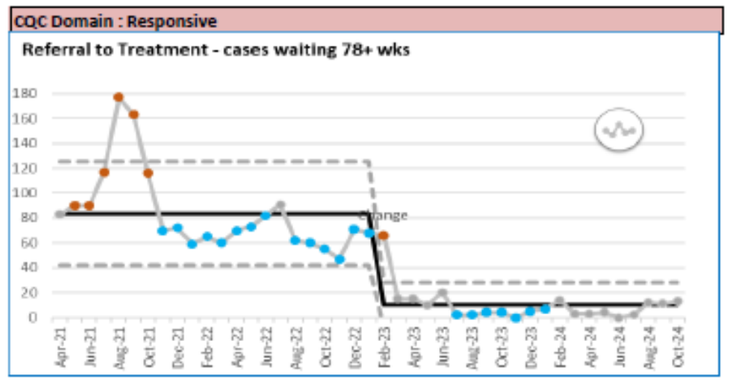
CQC Domain : Responsive



Oct-24
1461
Variance Type
Common cause variation
Threshold
≤ 1795
Assurance
Trajectory target not appropriate for SPC Assurance reporting

Referral to Treatment – cases waiting 78+ weeks

CQC Domain : Responsive



Oct-24
13
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

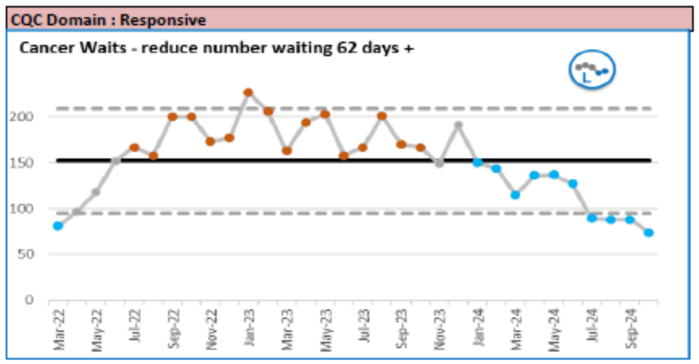
Commentary

What does the data tell us?

What are the main risks impacting performance?

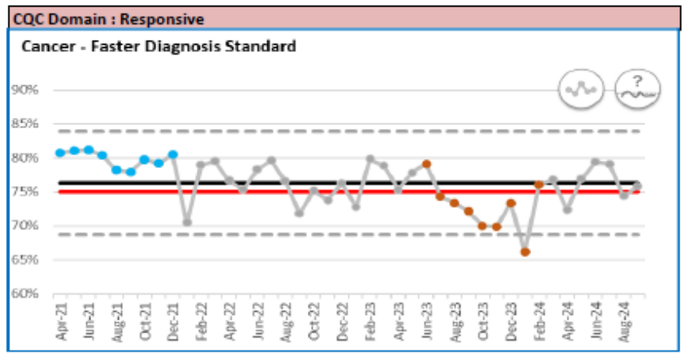
What actions are being taken to improve performance?

Cancer Waits – reduce number waiting 62 days +



Oct-24
74
Variance Type
Special cause variation - improving
Threshold
83
Assurance
Trajectory target not appropriate for SPC Assurance reporting

Cancer – Faster Diagnostic Standard



Sep-24
75.8%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

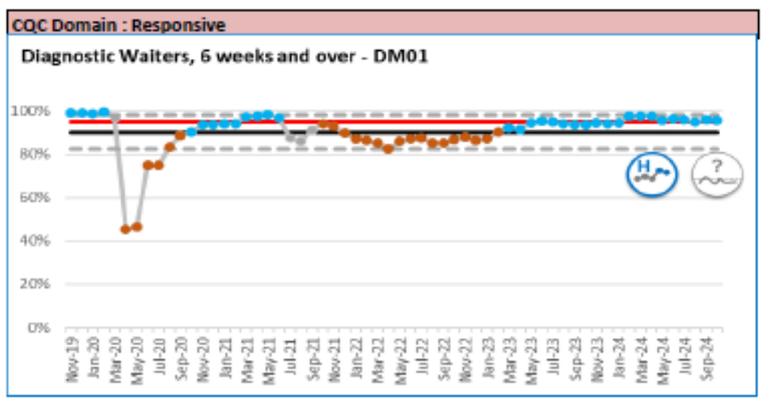
Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Diagnostic Waiters – 6 weeks and over – DM01



Oct-24
95.9%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

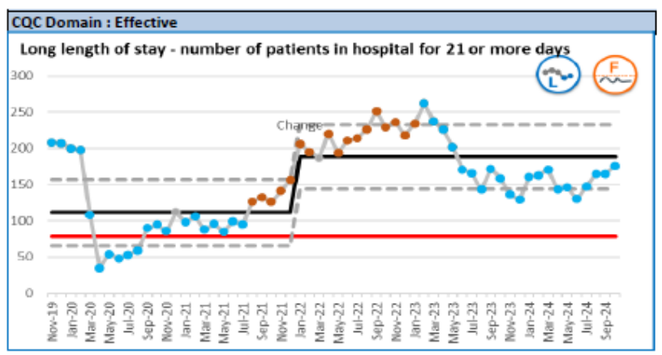
Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Long length of stay – numbers of patients in hospital for 21 or more days



Oct-24
176
Variance Type
Special cause variation - improving
Threshold
≤79
Assurance
Performance consistently fails to achieve the target

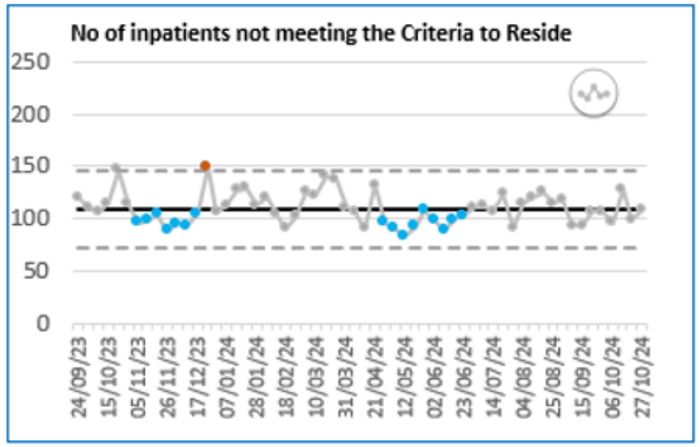
Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Number of inpatients not meeting the Criteria to Reside



Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Dashboard	Quality and Safety
Lead	Chief Nurse

Quality and Safety Domain Matrix

Quality and Safety Care Summary

Highlights	Areas of Concern	Forward Look (Actions)

Patient safety Incidents

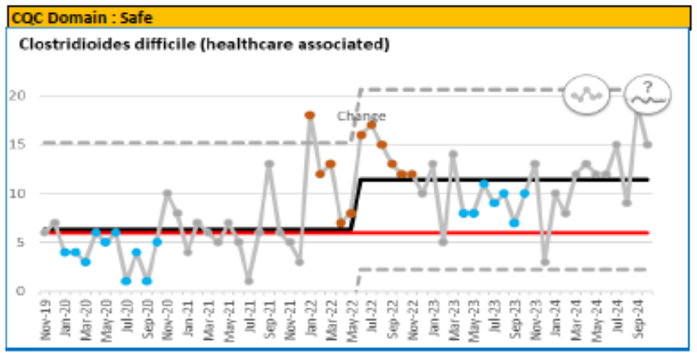
Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Clostridioides difficile (healthcare associated)



Oct-24
15
Variance Type
Common cause variation
Threshold
≤9
Assurance
Hit & miss target subject to random variation

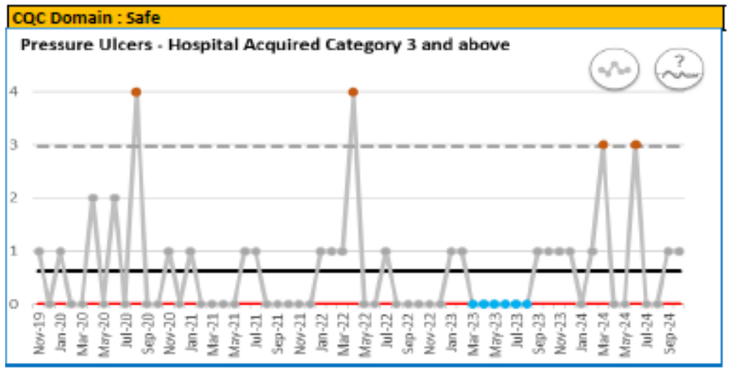
Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Pressure Ulcers – Hospital Acquired Category 3 and above



Oct-24
1
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

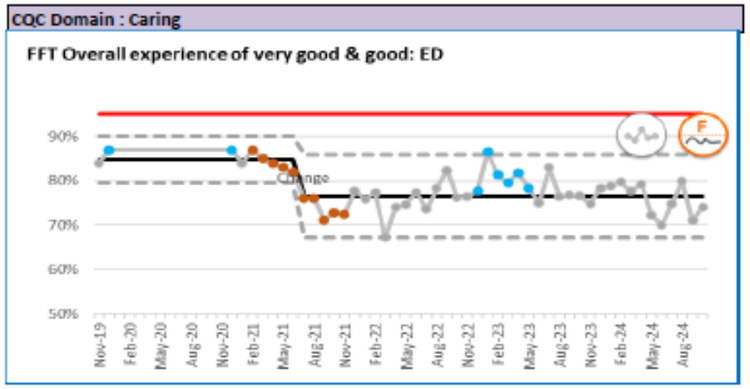
Commentary

What does the data tell us?

What are the main risks impacting performance?

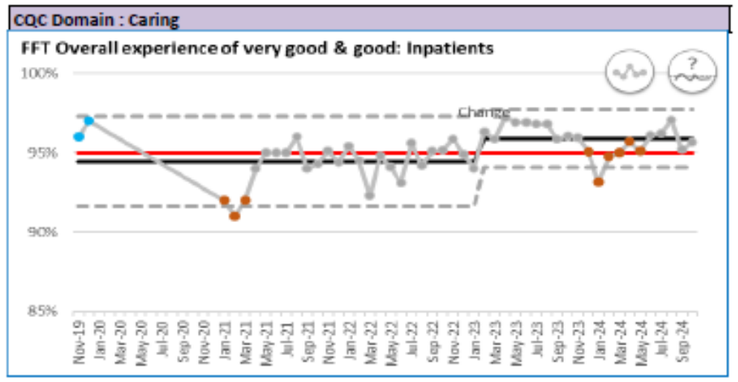
What actions are being taken to improve performance?

FFT Overall experience of very good & good – ED



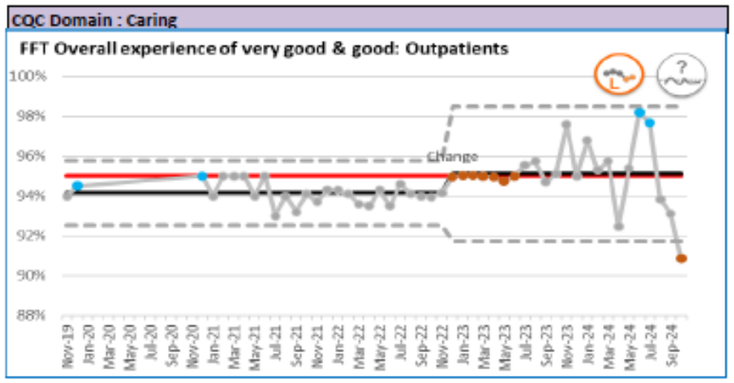
Oct-24
74.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

FFT Overall experience of very good & good – Inpatients



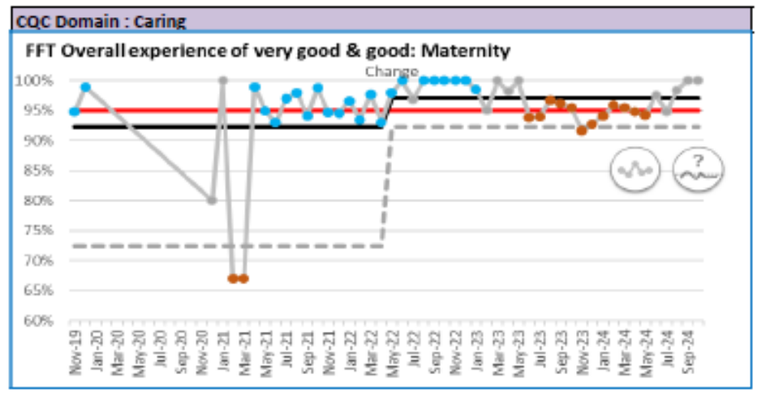
Oct-24
95.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

FFT Overall experience of very good & good – Outpatients



Oct-24
90.9%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

FFT Overall experience of very good & good – Maternity



Oct-24
100.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

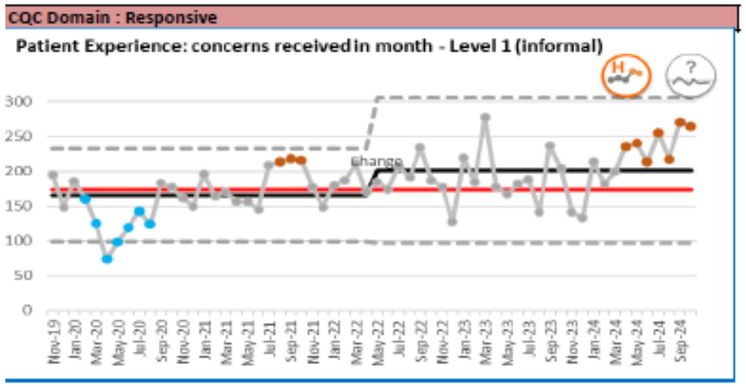
Commentary

What does the data tell us?

What are the main risks impacting performance?

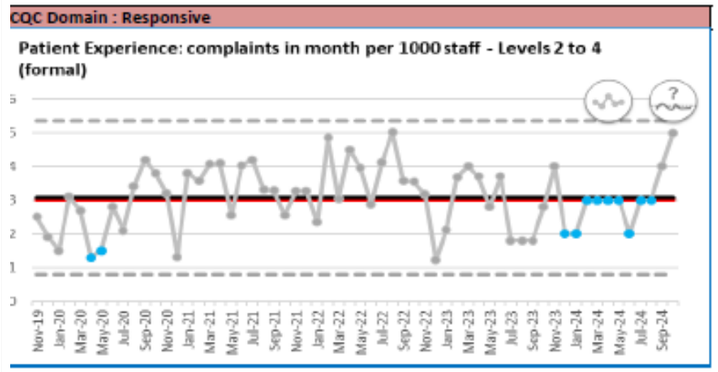
What actions are being taken to improve performance?

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



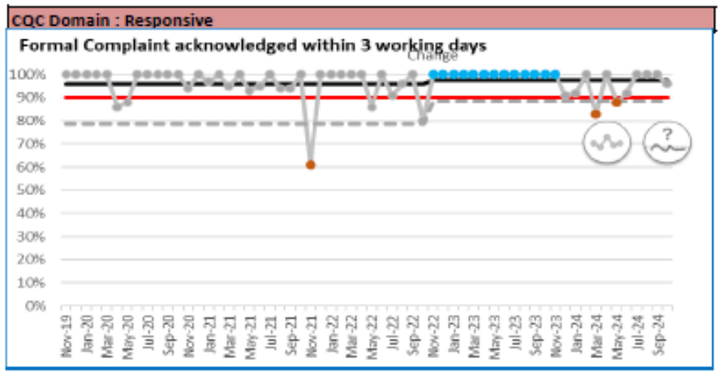
Oct-24
265
Variance Type
Special cause variation - concerning
Threshold
≤173
Assurance
Hit & miss target subject to random variation

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



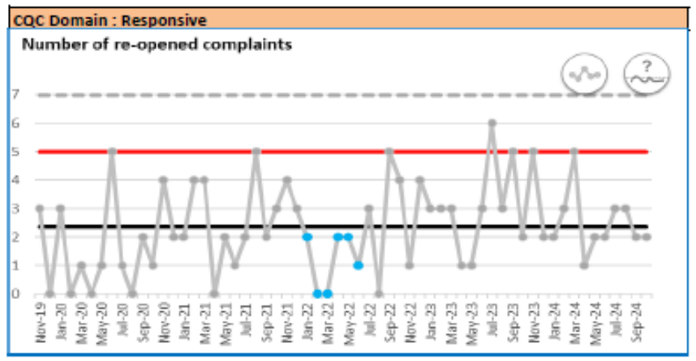
Oct-24
5.0
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

Formal complaints acknowledged within 3 working days



Oct-24
96.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Number of re-opened complaints



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

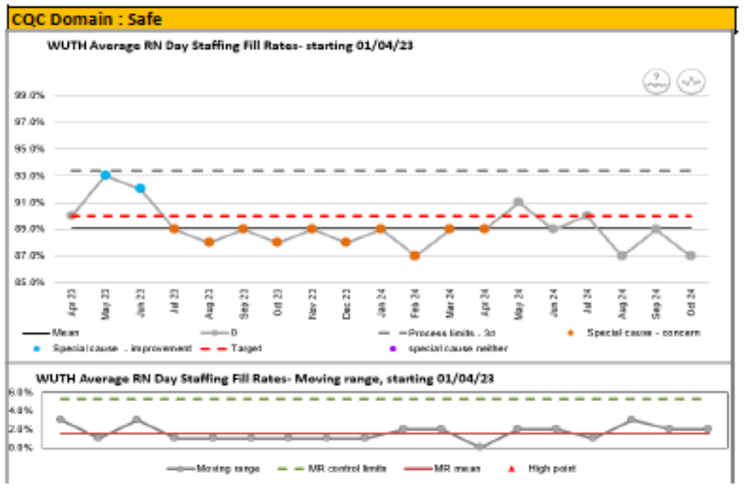
Commentary

What does the data tell us?

What are the main risks impacting performance?

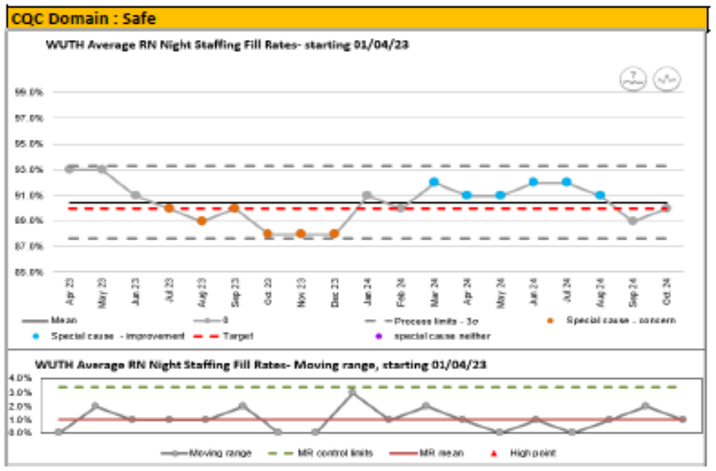
What actions are being taken to improve performance?

Average Registered Nurse Day Staffing Fill Rates



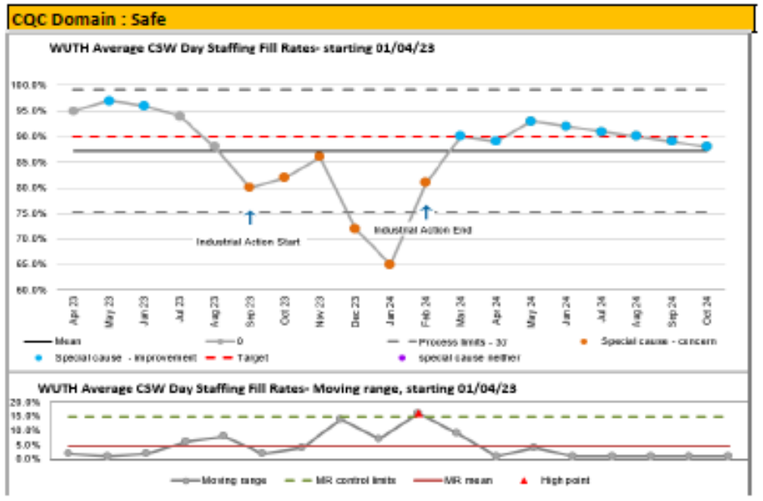
Oct-24
87.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Average Registered Nurse Night Staffing Fill Nurse



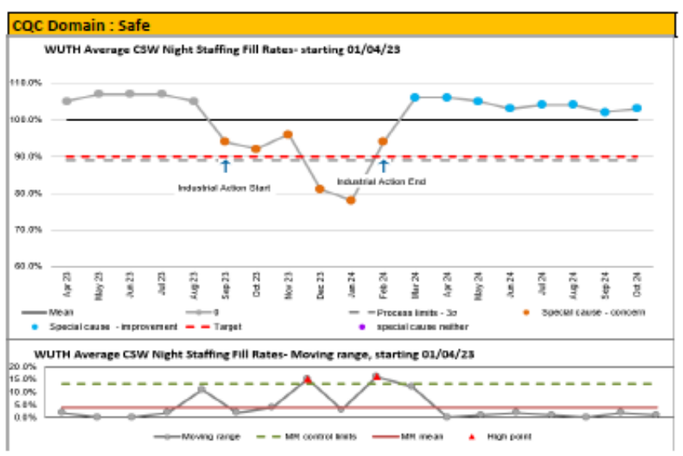
Oct-24
90.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Average Clinical Support Worker Day Staffing Fill Rates



Oct-24
88.0%
Variance Type
Actual below threshold
Threshold
≥90%
Assurance

Average Clinical Support Worker Night Staffing Fill Rates



Oct-24
103.0%
Variance Type
Actual above threshold
Threshold
≥90%
Assurance

Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

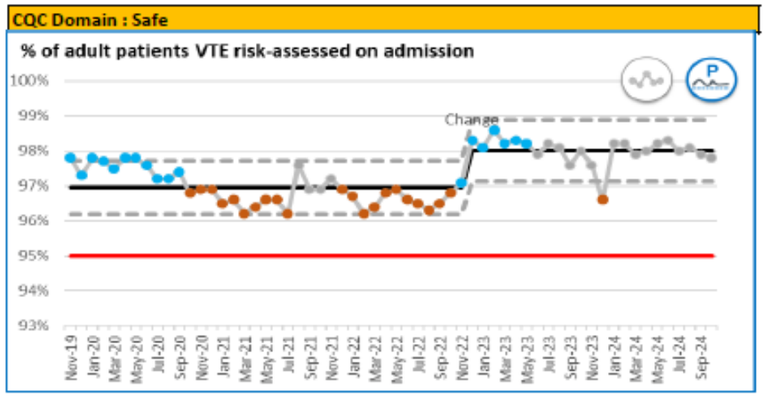
Dashboard	Quality and Safety
Lead	Medical Director

Quality and Safety Domain Matrix

Quality and Safety Summary

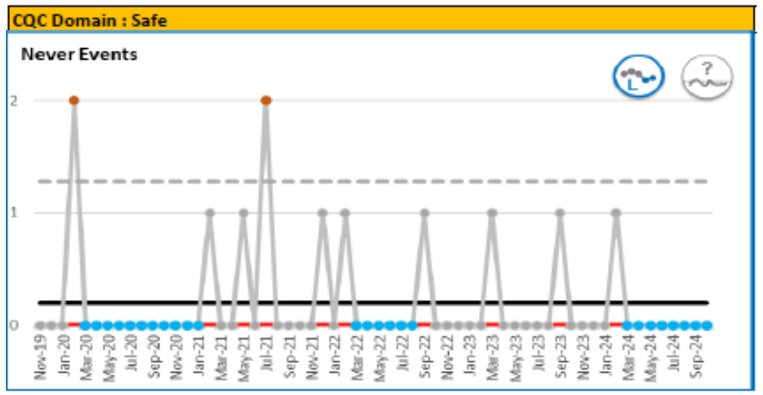
Highlights	Areas of Concern	Forward Look (Actions)

% of adult patients VTE risk assessed on admission



Oct-24
97.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

Never Events



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

Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

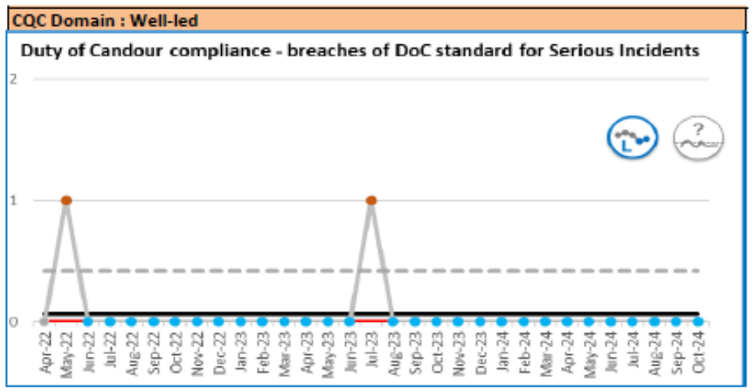
Commentary

What does the data tell us?

What are the main risks impacting performance?

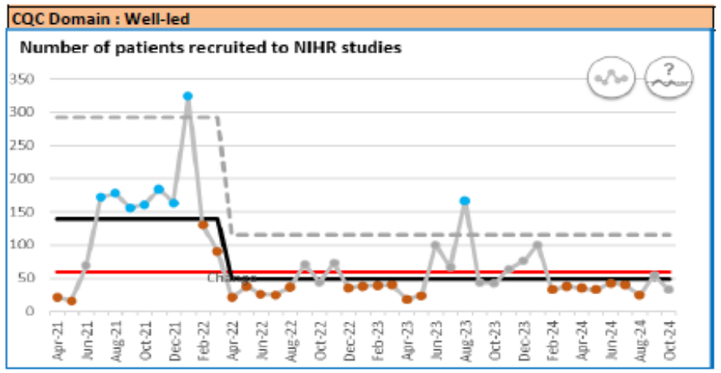
What actions are being taken to improve performance?

Duty of Candour Compliance



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

Number of patients recruited to NIHR studies



Oct-24
33
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

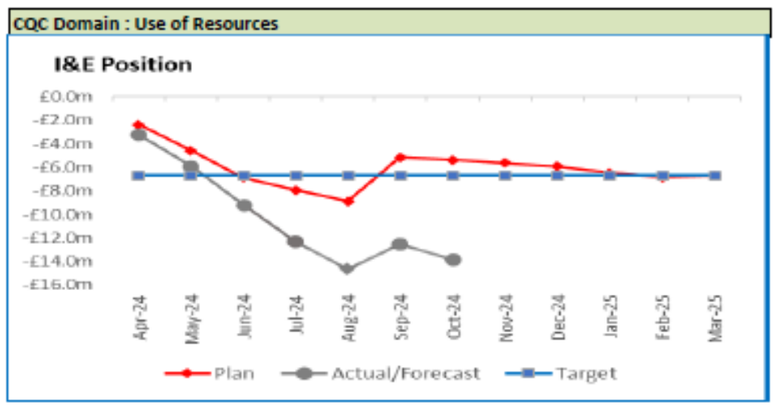
Dashboard	Finance
Lead	Chief Finance Officer

Finance Domain Matrix

Finance Summary

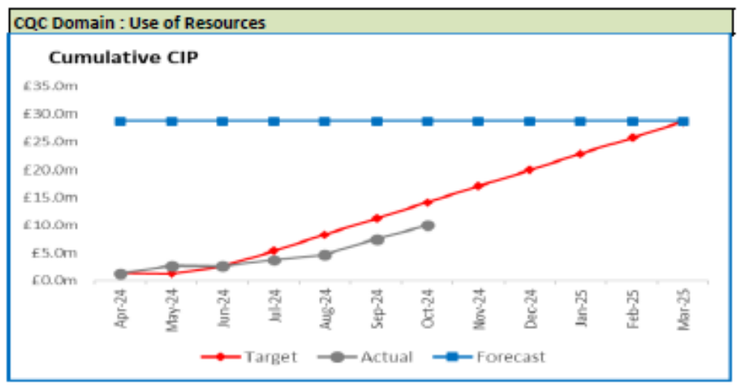
Highlights	Areas of Concern	Forward Look (Actions)

I&E Position



Oct-24
-£13.8m
Variance
Position worse
than plan
Target
-£5.4m

Cumulative CIP



Oct-24
£10.0m
Variance
Position worse
than plan
Target
£14.1m

Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

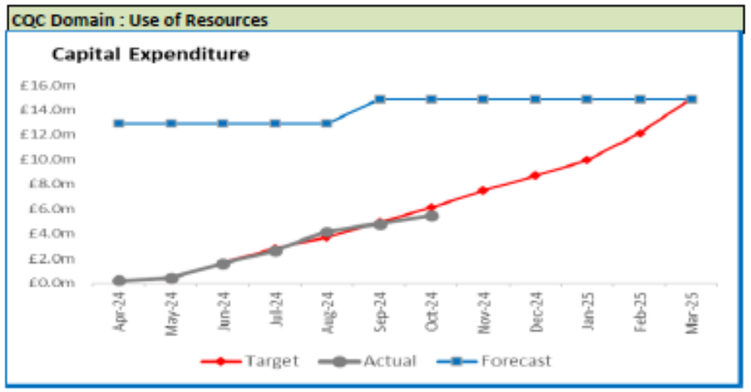
Commentary

What does the data tell us?

What are the main risks impacting performance?

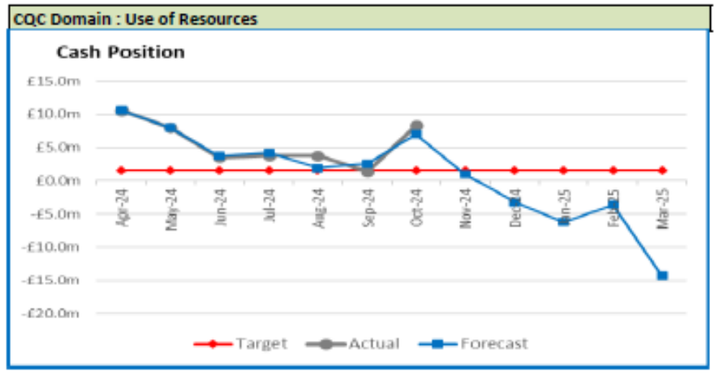
What actions are being taken to improve performance?

Capital Position



Oct-24
£5.5m
Variance
Position better than plan
Target
£6.1m

Cash position



Oct-24
£8.3m
Variance
Position better than plan
Target
£1.6m

Commentary

What does the data tell us?

What are the main risks impacting performance?

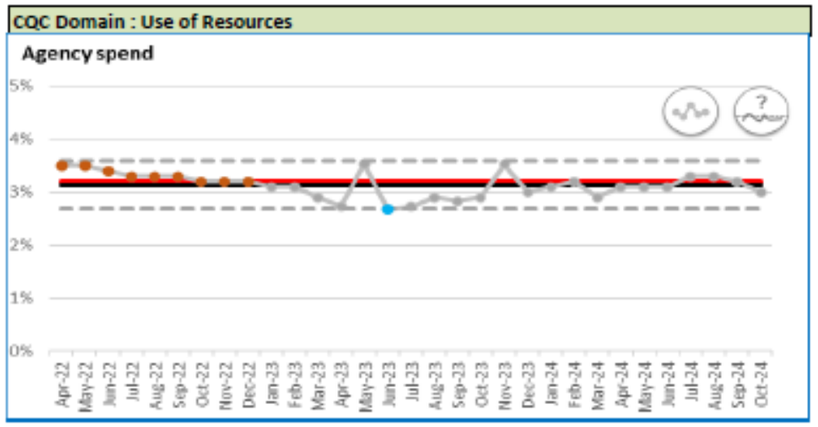
What actions are being taken to improve performance?

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Agency spend



Oct-24
3.00%
Variance
Position better than threshold
Threshold
3.2%

Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

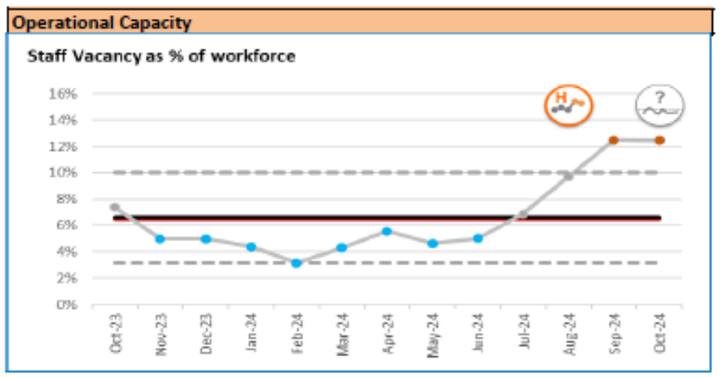
Dashboard	Digital
Lead	Chief Information Officer

Digital Domain Matrix

Digital Summary

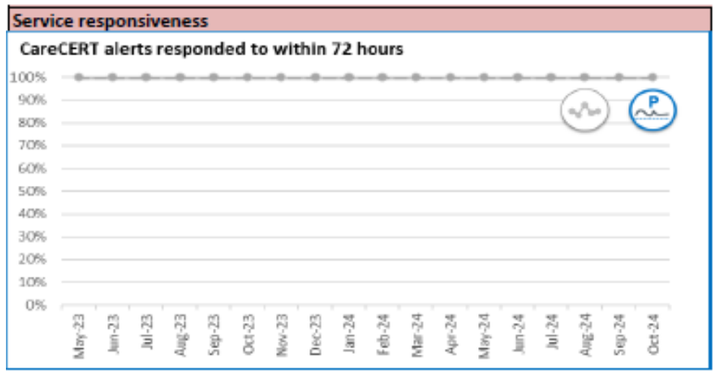
Highlights	Areas of Concern	Forward Look (Actions)

DHT Staff vacancy as % of workforce



Oct-24
12.5%
Variance Type
Special cause variation - concerning
Threshold
<=6.5%
Assurance
Hit & miss target subject to random variation

CareCERT alerts responded to within 72 hours



Oct-24
100%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently achieves the target

Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

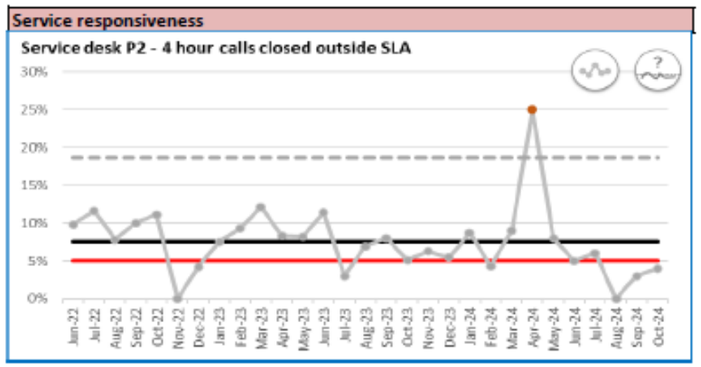
Commentary

What does the data tell us?

What are the main risks impacting performance?

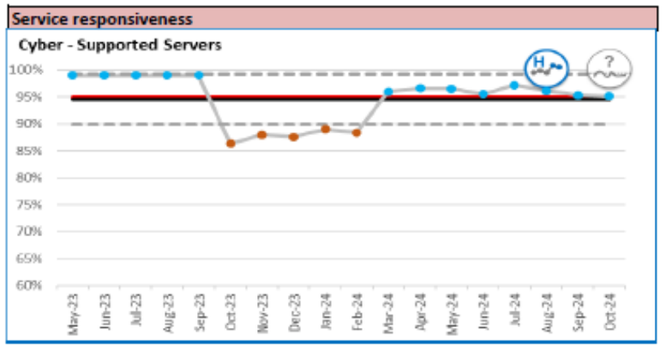
What actions are being taken to improve performance?

Service desk P2 – 4 hour calls closed outside SLA



Oct-24
4.0%
Variance Type
Common cause variation
Threshold
<=5%
Assurance
Hit & miss target subject to random variation

Cyber – supported servers



Oct-24
95.1%
Variance Type
Special cause variation - improving
Threshold
>=95%
Assurance
Hit & miss target subject to random variation

Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

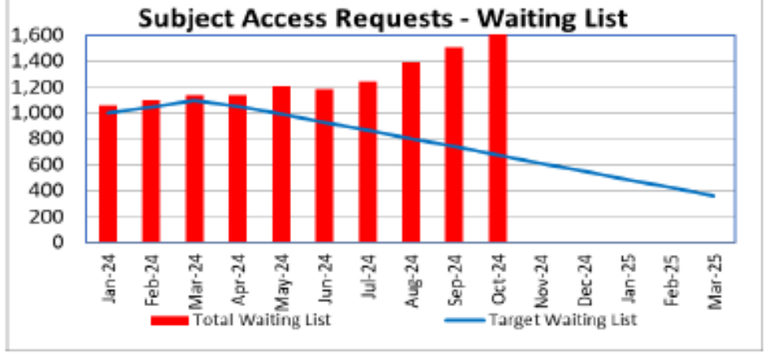
What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Subject access requests – waiting list

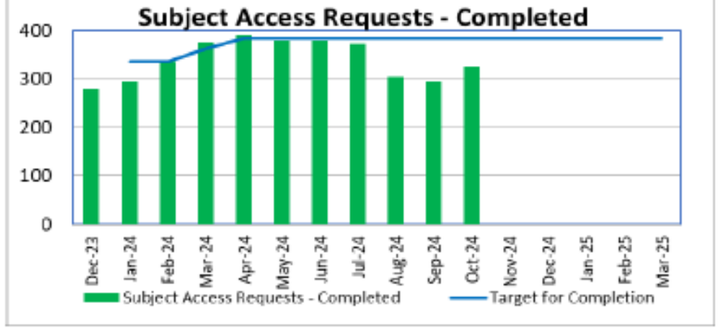
Service responsiveness



Oct-24
1635
Variance
Total requests waiting worse than target
Threshold
738

Subject access requests – completed

Service responsiveness



Oct-24
326
Variance
Completed requests worse than target
Target
384

Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Dashboard	Estates
Lead	Chief Strategy Officer

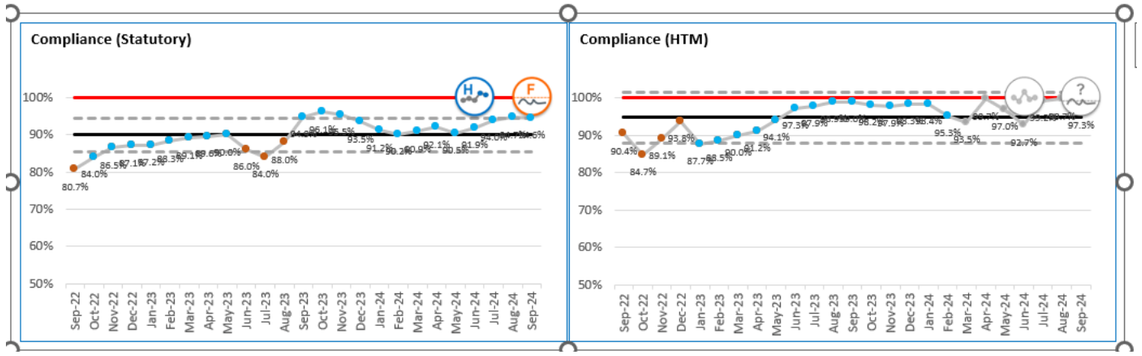
Estates Domain Matrix

Estates Summary

Highlights	Areas of Concern	Forward Look (Actions)

Carbon Footprint

Estates – Statutory Compliance



Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

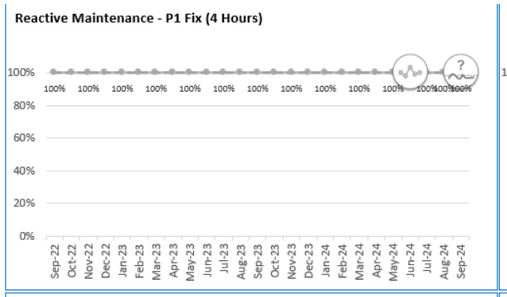
Commentary

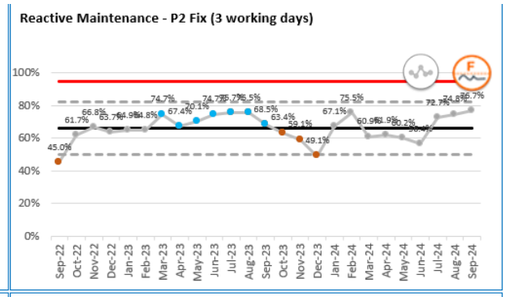
What does the data tell us?

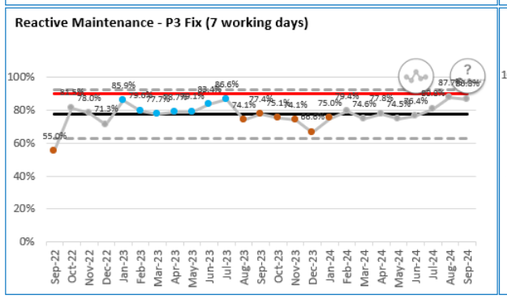
What are the main risks impacting performance?

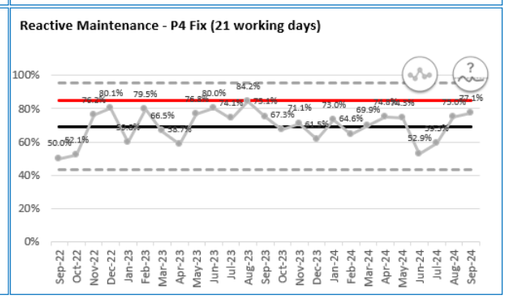
What actions are being taken to improve performance?

Reactive Maintenance









Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?

Reportable RIDDORs

Commentary

What does the data tell us?

What are the main risks impacting performance?

What actions are being taken to improve performance?