Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

6th October 2021

together we will

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Meeting of the Board of Directors in Public
Wednesday 06.10.2021
10.00 a.m. - 12 noon
Via Teams
AGENDA

Item	Item Description	Presenter	Verbal or Paper
21/22-125	Apologies for Absence	Chair	Verbal
21/22-126	Declaration of Interests	Chair	Verbal
21/22-127	Patient Story	Deputy Chief Nurse	Video
21/22-128	Minutes of Previous Meeting – 01 September 2021	Chair	Paper
21/22-129	Board Action Log	Chair	Paper
21/22-130	Chair's Business	Chair	Verbal
21/22-131	Key Strategic Issues	Chair	Verbal
21/22-132	Chief Executive's Report	Chief Executive	Paper
21/22-133	Chief Operating Officer's report	Chief Executive	Paper
21/22-134	Quality and Performance Dashboards & Exception Reports	Chief Operating Officer, Medical Director, Director of Workforce & OD and Chief Nurse	Paper
21/22-135	Learning from Death's : Quarterly Update (Mortality Dashboard & Report)	Deputy Medical Director – Surgery	Paper
21/22-136	Quarterly Maternity Update	Deputy Chief Nurse	Paper
21/22-137	Finance Report for Month 5 incl. CIP	Chief Finance Officer	Paper
21/22-138	Risk Management Strategy	Interim Director of Corporate Affairs	Paper
21/22-139	Monthly Safe Nurse Staffing Report	Deputy Chief Nurse	Paper
21/22-140	EPRR Statement of Compliance and Action Plan	Chief Operating Officer	Paper
21/22-141	Fit and Proper Persons Policy	Interim Director of Corporate Affairs	Paper
21/22-142	Chair's Report – Workforce Assurance Committee	Committee Chair	Paper

21/22-143	Chair's Report – Finance, Business Performance & Assurance Committee	Committee Chair	Paper
21/22-144	Chair's Report – Quality Assurance Committee	Committee Chair	Paper
21/22-145	Chair's Report – Audit Committee	Committee Chair	Paper
21/22-146	Chair's Report – Safety Management Assurance Committee	Committee Chair	Paper
21/22-147	Chair's Report - Trust Management Board	Chief Executive	Paper
21/22-148	Communications and Engagement Report	Director of Communications and Engagement	Paper
21/22-149	Questions from the Public	Chair	Verbal
21/22-150	Any Other Business	All	Verbal
21/22-151	Date of Next Meeting – 03 November 2021	Chair	Verbal
21/22-152	**Exclusion of the Press and Public** To resolve that under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, the public and press be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.		

BOARD OF DIRECTORS

DRAFTMINUTES OF MEETING HELD IN PUBLIC

01 SEPTEMBER 2021

VIRTUAL MEETING VIA MICROSOFT TEAMS

Commencing at 10.00 am
Concluding at 12 noon

Present

John Sullivan	Non-Executive Director/Vice Chair
Chris Clarkson	Non-Executive Director
Steve Igoe	Non-Executive Director
Steve Ryan	Non-Executive Director
Claire Wilson	Chief Finance Officer
Janelle Holmes	Chief Executive
Nicola Stevenson	Medical Director / Deputy CEO
Mags Barnaby	Interim Chief Operating Officer
Debs Smith	Interim Director of Workforce

In attendance

Chris Mason	Interim Chief Information Officer
Jonathan Lund	Associate Medical Director
Molly Marcu	Interim Director of Corporate Affairs
Sally Sykes	Director of Communications & Engagement
Philippa Boston	Staff Governor
Eileen Hume	Public Governor
Allen Peters	Public Governor
Angela Tindall	Public Governor
Charlotte Williams	Digital Multi-media manager

Apologies

Jayne Coulson	Non-Executive Director
Sue Lorimer	Non-Executive Director
Matthew Swanborough	Director of Strategy and Partnerships

*Denotes attendance for part of the meeting

Reference	Minute	Action
21/22-125	**Apologies for Absence**	
	Apologies for absence were noted as reported above. The Chair acknowledged the presence of governors in attendance. The Chair also informed the meeting that Allen Peters, Public Governor was unwell and attendees wished him a quick and complete recovery.	
21/22 -126	**Declarations of Interest**	
	No interests were declared at the meeting.	
21/22- 127	**Patient Story**	
	The Board viewed a version of the Patient Story video, featuring Mr F. Mr F's general experience was positive, and he highlighted a number of areas where improvements could be made. He reported that rapidly ended up in	

Reference	Minute	Action
	ward 32 with a heart issue after having a diagnostic ultrasound after a referral from his GP. He reported the treatment at WUTH and Broad Green could not have been better with a comprehensive range of diagnostic investigations. He reported that he recognised that there had been enormous expenditure on his care as well as consistent tender loving care. On the positive side, he said that he could not have had better treatment anywhere else in the world. He reported that he had observed a friendly culture, that he felt listened to and received personalised care attention from non-medical staff which was heart-warming. All of this resulted in a good outcome from the patient's perspective and he was delighted with his treatment. The Chair reported that he was pleased with the feedback. *Action : Deputy Chief Executive to communicate thanks to the patient* **The Board NOTED the patient story**	
21/221-128	**Minutes**	
	The minutes of the meeting held on 04 August 2021 were approved as an accurate record subject to a minor amendment. The Chair agreed that Item 104 in Chair's business was to be amended to refer to the Chair of the meeting.	
21/22-129	**Board Action Log** The Board reviewed the actions log noting that items had either been actioned or were on the agenda.	
21/22-130	**Chair's Business**	
	The Chair reported that work for the ICP in Wirral was progressing well with good relationship building with partners. The Chair reported that there would be a rotation of Chairs in relation to forthcoming work on the ICP. He considered that progress was being made by the Trust which has to take into account the prevailing circumstances of the Covid pandemic as well as the post Covid environment. He reported that the Trust was in a better place and should keep moving forward with the established vision. He reported that there was Board Development work and a well led review being undertaken by Deloitte. The Chair thanked staff and colleagues for their work. **RESOLVED:** **That the Board NOTED the Chair's Business**	
21/22- 131	**Key Strategic Issues**	
	There were no additional strategic issues to report.	

Reference	Minute	Action
21/22 - 132	**Chief Executive's Report**	
	The Chief Executive presented her report which gave an overview of work undertaken and important announcements for the month of September 2021. The Chief Executive presented her report and highlighted that the community prevalence of COVID-19 currently remained static with an incidence of 293 per 100,000 over 7 days at the time of writing. The number of Covid inpatients had remained static at 40 inpatients. The Trust is not anticipating any drop in inpatient numbers as the national forecast is for a lower but prolonged peak compared to the January/ February peak. It was reported that all Cancer standards were achieved in July 2021.The number of 52 week waits breaches remains below trajectory. The forecast is zero 52 week non-admitted breaches by the end of November 30 (excluding Priority 5/6 patients. From a reset and recovery perspective, the Trust was aware that it was behind plan. The Chief Executive then referenced the ongoing support for the vaccination programme, citing that as at 20 July 2021, 417,630 vaccinations had been given across the Wirral in GP practices, PCN local vaccination sites, the WUTH vaccination centre in pop up clinics and using the vaccination bus. Interim guidance had been issued in relation to the autumn booster programme, and it was expected that the hospital centre would play a role in system delivery for staff and patients in relation to the flu and Covid programme. The Board were informed that there had been five serious incidents in July which was a decrease from the previous month. There were two incidents reported to the HSE in July 2021 in accordance with RIDDOR. Both events were slips, trips or falls. In relation to the 2021 Governor Elections it was reported that the Trust had received nominations for 12 out of 13 constituencies where vacancies existed prior to this election. It was reported that voting would commence in early September 2021, with an outcome announced at our Annual Members Meeting on 30 September 2021, where staff, patients as well as the public can attend. The governors who were elected unopposed were congratulated. In the meantime all staff and public members were encouraged to vote for their preferred candidates from the 3 September to 28 September 2021. It was reported that the Deloitte would be commencing a well led review of the Trust Board, as well as the associated governance and operational infrastructure. The Trust had committed to an extensive engagement process a wide range of stakeholders such as governors who would be contributing through focus groups. A short survey to staff would be issued as part of an engagement process. The review is anticipated to be completed by November and the Board will receive updates on progress as appropriate. The report also incorporated an update on the new quarterly staff survey, which would be undertaken in quarter two of the financial year. The Chief Executive stated that the quarter 3 survey would not be carried out due to the timing of the national staff survey taking place in the same period.	

Reference	Minute	Action
	The Chief Executive highlighted some leadership changes at the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative, with the recent appointment of Linda Buckley as their Managing Director. **RESOLVED:** **That the Board RECEIVED and NOTED the report.**	
21/22-133	**Quality and Performance Dashboard and Exception Reports**	
	The Executive Directors briefed the Board on the content of the Quality & Performance Dashboard up to end of July 2021 for their respective areas. The Medical Director reported that following the outgoing Chief Nurse's recent retirement that she was now responsible for governance. The Medical Director further reported that two never events had occurred in July involving invasive procedures which had happened outside of a theatre environment. Appropriate action had been taken operationally, and duty of candour procedures were also followed. The never events had given the Trust to ensure that safe standards are applied both inside and outside theatre environments. There was no complacency but there had been an increase in never events elsewhere in other Trusts. The COO reported that from March 8 the Trust has restarted its non-urgent elective programme in a phased manner and that monthly theatre activity had increased to typical pre-pandemic levels. Improvement in trajectory was expected as the Trust returned to normal activity. It was expected that there will be an ongoing improvement in ED using an improvement programme from the current position. From a system and integration perspective the Trust had strengthened its approach. The CEO identified that the Board should be made aware that increases in cases of Covid was higher overall in the North West as a region. The COO reported that ED attendances had continued to exceed pre-Covid levels since March 2021 and the Trust was forecasting that it would get back on revised trajectory by September 2021. The CEO reported that work was being performed on the rota system for staffing arrangements. Emma Danton and the COO were to be invited to the next Board Meeting specifically around the issue of system improvements work. This was led being by the Trust with system partners to provide assurance that there would be an improvement in the reduction number of patients visiting ED as well as improving arrangements in relation to discharge for managing flow during times of escalation and pressure. The Chair commented that the key drivers were discharge arrangements and partners in the health system helping with the strain. Improvements had been dramatic in the last two years with the Trust being in a better position with the way it functioned with system partners. In terms of ease of working with partners, the CEO evaluated the position at 8 out of 10 (on a scale with zero being the lowest score and 10 the highest). The CEO by way of illustration identified that system partners had in conjunction with the Trust conducted a quality questionnaire of 100 patients who had attended ED and who were classified as minor categories. A number of key questions were asked: what services had they contacted previously, what was the outcome from their	

Reference	Minute	Action
	contacts with other services and why they had attended ED with issues which probably could have been delivered or supported elsewhere. The questionnaire produced meaningful information and from that there was a workshop held with senior representatives from community trusts, and GP's to come up with a plan to utilise the derived information to support the delivery of some changes. The changes proposed are then to be tracked and performance managed through the ED delivery board. Five actions came out of the meeting one of which was for the Trust which was to manage around how the Trust deals with re-directing patients. The remainder are principally for primary care around communications strategy, as well as for mental health and transport which have an impact on flow. The CEO reported that this area was a major BAF risk and so it would be useful to bring it to Board the following month as a development piece. ACTION: CEO to bring to next board details of plans to improve performance in ED. The COO was asked whether the Trust was confident whether it would be able to cope with a twenty per cent step change in attendance at ED. The COO offered the view that it was difficult to predict whether the numbers attending would remain the same or decrease or go up. The difficulty in estimating was associated with Winter demand since there was a predicted influenza outbreak which may impact attendances. The COO confirmed that she could not predict whether the Trust would see a reduction back to the way it was unless the work around the A&E transformation and the pillars around "front door" re-direction of patients begins to gain some further traction. The CEO identified that the increases in attendance experienced by the Trust was also being seen elsewhere in the region of the North West as a whole. The modelling which had been provided centrally indicated that admissions would remain broadly flat but there had been an increase in patients which could possibly have been attended to elsewhere – some of which was driven by the national programme linked to 111, and their management and call handling, so it is a 57 per cent abandonment rate which lead people to voting with their feet. It was identified that this was no excuse for performance but this was a national problem and not uniquely a Wirral issue - with Wirral fitting into the middle of the pack whereas 2 years ago the Trust would have been a statistical outlier. The Chair offered the views that with the schools reopening in September he expected to see more problems and that Covid was not going to go away. He wanted to forward plan for a possible future scenario where the Trust was struggling with admissions in ED. The question for the Trust was to determine what mitigations would be put in place in such a scenario. ACTION: CEO to bring to next board details of a back-up plan to deal with a scenario where the Trust found itself in a future position where it was struggling with admissions in ED. The COO also reported that the ongoing inclusion of overdue planned diagnostic cases is expected to further deteriorate the Trust position in July, with subsequent improvement through the reset and recovery programme. The Deputy Chief Nurse presented the report which provided information regarding safe nurse staffing and the actions to improve the vacancy rates. It	

Reference	Minute	Action
	was highlighted that there had unfortunately been one case of a category 4 pressure ulcer reported in July. It was reported that there had been a full review of that case and all elements of care were completed. The patient had mental capacity and had declined care (which was fully documented) and so the case was deemed unavoidable. The Deputy Chief Nurse drew the attention in respect of Protecting Vunerable People ("PVP"). Hazel Richards who had been Chief Nurse had previously reported monthly challenges around PVP training due to the pressures and staffing issues. For level one the Trust was just below trajectory of 90 per cent and the two highest risk divisions which were Women's and Children as well as Medicine had attained the trajectory of 90 per cent. For PVP2 and PVP3 it was confirmed that all actions were in place to meet compliance by the end of Quarter 3. . The Deputy Chief Nurse reported that there were measures in place for regular checks on compliance relating to mandatory safeguarding training. The interim Director of Workforce presented the highlights of her report, by drawing the Board's attention to two areas. Sickness absence performance had increased in July, at 6.48%, with the drivers typically being short term sickness as a result of stress, anxiety and depression as well as other factors previously reported. Mitigations included focussed programmes for managing sickness absence as well as supporting and promoting wellbeing. Appraisal compliance target was 88% but was 82.7 % as at the end of July (still below target) however the improvement in trajectory was expected as the Trust returned to normal. In terms of context sickness absence in the NHS across the entire North West region was higher than the national average. It was observed that there had been a ratio increase in the extent of short term sickness absence when compared to long term sickness absence. It was also reported that there had been an increase in turnover in July and that there would be a further review of staff turnover data in August to identify whether this was an ongoing trend which needed additional attention. The review of staff turnover in August alongside July's would provide more meaningful and statistically reliable data. If appropriate following the outcome of the review of August data there would begin a deep dive to look at root causes for staff turnover with the aim of addressing it by putting in place appropriate remedial actions. **RESOLVED:** **That the Board of Directors RECEIVED and NOTED the Quality and Performance Dashboard and the Exception Reports for the period to 31 July 2021.**	
21/22-134	**Month 4 Finance Report**	
	The Chief Finance Officer presented the report as previously circulated. The Trust reported a small surplus of £0.094m at M4, an adverse variance against plan of £0.005m. In addition to £0.780m of income from the Elective Recovery Fund (ERF) in respect of M4, NHSEI confirmed that we would receive £2.589m for M1, £1.194m more than was originally reported. There was no expectation of receiving significant income from ERF in Q2 due	

Reference	Minute	Action
	to way that eligibility thresholds had increased to 95 % but in months 2 and 3 there was an expectation to see income from ERF. Total employee expenses excluding COVID-19 were £94.171m at M4, this represents an overspend against budget of £0.646m. However, this figure includes a significant overspend of £2.817m in respect of Medicine and Acute services, specifically relating to pressures in A&E, this is offset by underspends in other parts of the Trust. It was reported that good progress was being made on the cost improvement plan (CIP) identification which was expected to be implemented in H2. It was also reported that the Capital Programme was going well and materially on plan. The only associated risks which needed to be highlighted were that there were industry wide limitations on the supply of materials and availability of contractors which could lead to cost increases from those originally forecast. It was reported that the Trust resubmitted its financial plan to NHSE/I on the 22nd June 2021. As anticipated this did not result in any material movement in the plan and the Trust is still expected to break even in H1 in line with its plan. The funding arrangements for H2 have yet to be confirmed but it is likely that the Trust will have to undertake a second planning process ahead of the 2nd half of the year. Action: CFO to investigate the risk of a new cost base-line in excess of 20 % as well as a cost base-line review for the Board. Action: CEO to explore the top five management actions which would occur and could be implemented quickly in such a situation. Action: Interim Director of Corporate Affairs to we could look at the risks aligned with these areas of demand and finance at the October meeting and then update them for a seminar session in November. **RESOLVED:** **That the Board NOTED the report.**	
21/22-135	**Guardian of Safe Working (Quarterly Report)**	
	The Guardian of Safe Working presented the report as previously circulated. She reported that this was her fourth report and that she had been in her role for over a year. Her report highlighted the concerns raised by doctors and dentists in training to the Guardian of Safe Working, locum shift cover and fines incurred by the trust. It was reported that surgical teams were now working within their agreed shift time hours, there being a breach which had been due to excess hours which as a result of a teaching session; this was	

Reference	Minute	Action
	swiftly remedied. It was reported that the junior doctors had raised a concern based on equity and a sense of fairness that they seemed to be on call more often. This may have been linked to training issues in relation to making sure they got relevant training. It was considered a good sign that that they felt that they could raise such a concern and that it was looked at by the hospital management. It was reported that the surgical juniors have highlighted that they would prefer to work in a team, prepared a report with the right evidence and that their request was granted. The Medical Director reported that she was pleased to see the exception reports that staff felt comfortable making exception reports which in itself were evidence of valid and appropriate practice. **Key points:** • 42 exceptions raised in Q1 in relation to working hours. All exceptions are now closed. • There were 9 exception reports in relation to training. All are now closed. • Most exceptions raised related to working hours on F1 rotas in both medicine and surgery (66.6%). • There were 2 fines issued to surgery in relation to a breach in contract due to length of shift. The shifts are now compliant as a result of moving the handover on Friday AMs ahead of departmental teaching. • Medical registrars have raised an issue about potential disparity between the two medical registrar rotas. Medical staffing are reviewing the master rota with the Director of Medical Education. • Surgical F1s are moving to a team based system following feedback from the last cohort. It will be reviewed for assurance of benefit in October prior to rotational changes in December. **Action: GOSW to look at engaging junior doctors to facilitate communications via different media that would support recruitment of the future workforce** **RESOLVED:** • **That the Board NOTED the report**	
21/22-136	**Monthly Safe Nurse Staffing Report**	
	It was reported that Care Support Vacancies ("CSW") vacancies have reduced significantly to 0.49% in July. The apprenticeship programme had facilitated, supported and enabled a significant part of this achievement. There is a talent pool of around 30 CSW's who are waiting to work for the Trust and who wish to work at the Trust. In terms of international recruitment that remains on track so the target was to recruit 160 nurses from overseas into the Trust and 105 have been recruited and shall be on the wards and fully working by the end of September and the remaining 55 are recruited and are in process to be on board prior to December. The Trust launched the local Registered Nurse (RN) recruitment utilising the	

Reference	Minute	Action
	"We are WUTH" branding across a number of channels to further reduce RN vacancies. The Chair thanked the Deputy Chief Nurse for the work that was done on recruitment and asked the Deputy Chief Nurse to thank all those that had been involved. Month 4 was a challenging month for safe staffing in the month as had previously been identified there had been pressures caused by levels of sickness amongst registered nurse; no serious harm has been reported as a result. During this period 11 wards reported shifts with a professional judgement of red (risk of care standards falling below expected levels) despite additional mitigations being put in place. This was the highest seen since the second wave of the pandemic which signalled that there were significant pressures. It was reported that in Month 4 there was as increase in the number of incidents reported that related to nursing and midwifery staff shortages. All incidents have been reviewed and actions are place to address the issues raised. It was highlighted that there were regional pressures which had been seen in maternity services so there had been a gold command structure set up as well as a daily situation representative to manage the situation across the region. The Trust had remained safe utilising community maternity services during this experience of regional pressures in maternity services. It was reported that agency spend had increased in July by 6 % in order to address any gaps in staffing. This level of agency spend was not forecast to continue but had simply arisen due to the pressures experienced that month. **RESOLVED:** **That the Board NOTED the report.**	
21/22-137	**Legacy Board Assurance Framework**	
	Following the completion of an intensive review of the legacy Board Assurance Framework (BAF) by the Board in seminars, this report was presented by the Interim Director of Corporate Affairs to the Board for approval as part of the process of transitioning to the new BAF, which is presented to this Board meeting as a separate item on the agenda. The process was to review what was in the BAF before, making sure the risks before were either relevant or obsolete, then the outcome of the detailed assessment was considered individually and collectively by the non-executive directors and executive directors at a seminar in August. As part of this review, it was agreed that risks that are either considered	

Reference	Minute	Action
	complete or deemed no longer relevant/ applicable (based on the new objectives/priorities) will be closed. The legacy BAF was attached in Appendix A of the presentation. The outcome of the detailed assessment of each risk previously incorporated within the legacy Board Assurance Framework (BAF) report was identified as summarised in this report which outlined the status and actions taken in relation to the risk, which were incorporated with her report in section 3 of this report. The Interim Director of Corporate Affairs then highlighted to the Board what key modifications were made with each area of the previous BAF. The Board were informed that the first section of the legacy BAF which previously incorporated three risks now was now revised to reflect unscheduled and scheduled demand risks which had been carried forward onto the new BAF. The legacy workforce risks in section PR2 which had previously focussed on general workforce issues such as national shortages been consolidated and refined to reflect gaps in staffing in section 2.1 of the new BAF. There was another risk on continuity of staffing and care as a result of those gaps. There also had been a specific focus on regulatory compliance and this was one risk that could be clearly linked to regulatory standards. Legacy risk 2.2 (relating to workforce productivity) had been reassessed as being more of a gap in control rather than risk. Following a review of section PR3 (financial sustainability) with the CFO there were now two new risks which had transitioned onto the new BAF: one for cost improvement plans and the other on financial plan delivery. Section PR4 (catastrophic failure in standards) was described as the most revised section. It was reported that the section had been written at an earlier specific point in time when risks were either prevalent or not assured that quality of care was in place. The position at the Trust had since moved in since the time the legacy BAF had been put in place. Assurances to support this shift in position included the Trust's removal from the system improvement board oversight earlier in the year, as well as improved CQC reviews. On this basis risks in this section had been archived Section PR5 was connected to disruption and disruptive events, w There had been a move to connect these links with business continuity. Section 6 had been written at an earlier time when the Trust was experiencing issues with licence conditions as well as the systems improvement board. This did not now reflect the progress the Trust had subsequently made and assurance given to stakeholders (including but not limited to regulators). **RESOLVED:**	

Reference	Minute	Action
	• **That the Board NOTED and approved the revisions to the BAF where deletions are proposed** • **That the Board NOTED and endorsed the incorporation of revised legacy risks onto the 2021/22 BAF**	
21/22-138	**2021/22 Board Assurance Framework**	
	The Interim Director of Corporate Affairs presented the first version of the new BAF to the Board for their consideration and to enable the Board to review, approve and adopt the attached 2021/22 Board Assurance Framework (BAF), which is also aligned with the 2021/26 Trust Strategy objectives. It was reported that the format of the 2021/21 BAF report was based on best practice arising from publications such as the Audit Committee's Taking it On Trust Study and the Integrated Governance Handbook, most recently updated in 2016. It was highlighted that this was the first version of the newly adopted BAF, will be subject on ongoing amendments. Therefore the risks and controls will be updated over the next few months as identified there will be a seminar session in October to discuss demand and finance which will further inform BAF content. It was reported in undertaking this review the Board had also considered the output of the Risk appetite workshop in July which was facilitated by Merseyside Internal Audit. In August the Board held a seminar session focussing on risks deemed significant to the delivery of the strategic objectives. Following this, the BAF has been refined further to reflect the output of the Board seminar, and is attached as appendix A. It was reported that MIAA had reviewed the document and they had confirmed that it meets their requirements and were keen as a minimum on a bi-monthly review of the BAF. Action: Interim Director of Corporate Affairs With effect from November 2021 it will be highlighted any new risks since the last meeting, any changes in risk ratings, any updates on the delivery of actions, any updates on external assurances and triangulation with items elsewhere on the agenda. Action: Interim Director of Corporate Affairs All BAF risks to be either aligned with specific papers on BAF or to come back with an update if there are any issues and what action will be taken. The interim Director of Corporate Affairs highlighted that the report incorporated recommendations for monitoring BAF risks at Board and Committee level, in line with the discussions held at the Board seminar in August 2021. This approach was also due to be set out in the draft Risk Management	

Reference	Minute	Action
	Strategy was due to be submitted to the Board in October 2021. It was reported that the BAF provides a structure for the evidence to support the Annual Governance Statement disclosure which simplifies Board reporting and the prioritisation of action plans which, in turn, allow for more effective performance management. It was also reported that the main aim of the BAF refresh is to provide the Board with a mechanism of identifying and assessing risks significant to the delivery of Trust strategy, whilst evaluating the effectiveness of controls, and monitoring the action plans. It was further reported that the purpose of the report was to enable the Board to review the refreshed BAF and if deemed appropriate, adopt its use with effect from September 2021. **RESOLVED:** **That the Board NOTED, APPROVED** and **ADOPTED** the revised BAF **with** effect from September 2021 **That the Board NOTED** and **APPROVED**, the process and frequency for monitoring the BAF at Board and Committee level **That the Board NOTED, APPROVED** and **ADOPTED** the recommended process for further refining the BAF, in advance of the next BAF update to the Board in November 2021 **That the Board NOTED**, **APPROVED** and **ADOPTED** the annual process aligned to refreshing the BAF	
21/22-139	**Chair's Report – Finance, Business Performance & Assurance Committee**	
	Chris Clarkson briefed the Board on the report of the Committee. He reported that the Committee was well attended. There were four main areas highlighted: • There was a review of the M4 Finance Report. Most of debate was on overspend in Medicine and Acute which was currently off-set by underspend in other areas; • The CIP planning good progress on identifying new projects was noted; • The Committee received a briefing on the A&E patient flow improvement programme; and • Review of Quality and Performance Dashboards and it was noted that the metrics had been adversely impacted by Covid. **RESOLVED:** **That the Board NOTED the report.**	
21/22-140	**Chair's Report – Workforce Assurance Committee**	

Reference	Minute	Action
	John Sullivan reported that the full Committee had met the previous month and was pleased that the Committee meetings had resumed. He highlighted to the Board that the workforce directorate had experienced a number of challenges and it was important that the Board supported the workforce directorate generally as well as specifically in the delivery of workforce strategy. It was also highlighted that there are now people plans in place which were top down so there were people plans cascading at various levels, emanating nationally, regionally and then downwards and one key task to be to inter-weave all the various people plans together coherently so that they can be applied to the Trust. **RESOLVED:** **That the Board NOTED the report.**	
21/22-141	**Communications and Engagement Monthly Report**	
	The Board received the report on the Trust's communications and engagement activities since the last Board meeting, including media relations, campaigns, marketing, social media, employee communications and staff engagement. The Director of Communications and Engagement highlighted campaigns supported by her team including : • Band 5 nurses campaign • Pressures in A&E • NHS Procurement award nomination for the team • The approval of the £140,000 grant from NHS Charities which would support the wellbeing of Trust staff. **RESOLVED:** **That the Board NOTED the report.**	
21/22-122	**Any other business**	
	There was no other business conducted during the meeting. The Chair announced that it was the last meeting of Angela Tindall as governor and the Chair thanked her for her support and service to the Trust. Angela Tindall thanked the Chair and the Board for their support. She observed that compared to 6 years ago the Trust was in a much healthier position and that she appreciated the fact that there had been good teamwork and that the governors felt more confident about speaking up and being more proactive.	
21/22-123	**Date of Next Meeting** 06 October 2021 via MS Teams	
21/22-124	**Exclusion of the Press and Public**	
	RESOLVED: That under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, the public and press is excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.	

Chair

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Date

PUBLIC Board of Directors Action Log
1 September 2021
Action Log

No.	Minute Ref	Action	By Whom	Action status	Due Date
1	**21/22106** Chief Executives Report August 2021	To submit a lessons learnt report as a result of the Millennium critical incident	Chief Information Officer	Completed, a summary of the downtime debrief is included in the CEO report	October 21
2	**21/22-107** Quality and Performance Dashboard August 2021	Information Team to undertake a review of the upper and control limits, on the graphs within the Quality and Performance dashboard	Chief Information Officer	Completed, John Sullivan have met offline to close off the action.	October 2021
3	**21/22-109** Digital Strategy August 2021	To provide the Board with projected costings associated with the strategy after an assessment of divisional requirements has been undertaken	Chief Information Officer	Open	December 2021
4	**21/22-109** Digital Strategy August 2021	To amend the strategy to incorporate more narrative around research	Chief Information Officer	Completed. Research and Innovation strategy narrative incorporated on page 8	October 2021

5	**21/22-127 Patient Story September 2021**	Communication of thanks to patient who provided his patient story to the Board	Deputy CEO	Completed	September 2021
6	**21/22-133 Quality and Performance September 2021**	To bring to the board details of plans to improve performance in ED	CEO	Open, incorporated within Chief Operating Officer's report on board agenda	October 2021
7	**21/22-134 M4 Finance Report September 2021**	Investigate the risk of a new cost base-line in excess of 20% as well as a cost base-line review for the Board	CFO	Open	October 2021
8	**21/22-134 M4 Finance Report September 2021**	Consideration of the risks aligned with these areas of demand and finance at the October meeting and then update them for a seminar session in November	Interim Director of Corporate Affairs	Completed, this action is incorporated within the Board seminar agenda	November 2021
9	**21/22-135 Guardian of Safe Working Report**	GOSW to look at engaging junior doctors to facilitate communications via different media that would support recruitment of the future workforce	GOSW	Open	December 2021
10	**21/22-138 Board assurance Framework September 2021**	With effect from November 2021 any new risks since the last meeting, any changes in risk ratings, any updates on the delivery of actions, any updates on external assurances and triangulation with items elsewhere on the agenda	Interim Director of Corporate Affairs	Open	November 2021
11	**21/22-138 Board assurance Framework September 2021**	To ensure a process is in place for all BAF risks to be either aligned with specific papers on annual board cycle or as exception reports to the Board	Interim Director of Corporate Affairs	Completed, this action is incorporated within the Board seminar agenda	October 2021

Agenda Item: 21/22-132

BOARD OF DIRECTORS

6 October 2021

Title:	Chief Executive's Report
Responsible Director:	Janelle Holmes, Chief Executive
Presented by:	Janelle Holmes, Chief Executive

Executive Summary
This is an overview of work undertaken and important announcements for the month of October 2021.

Recommendation: (e.g. to note, approve, endorse)
The Board is asked to note and receive the Chief Executive's report.

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	No
Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
N/A
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
N/A
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
N/A
Specific communications and stakeholder /staff engagement implications
N/A
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
N/A
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)
This report incorporates narrative on an update on the governors' elections as well as the Annual Members Meeting

FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No

Previous considerations by the Board / Board sub-committees	Trust Board
Background papers / supporting information	N/A

BOARD OF DIRECTORS

October 2021

Chief Executive's Report

Purpose

This report provides an overview of work undertaken and any important announcements in September 2021.

Introduction / Background

1. COVID-19 Update

The Covid inpatient position remains largely stable; at the time of writing there are 40 Covid positive inpatients. Of these 23 were not admitted due to Covid symptoms but were found to be positive on screening. There has been a reduction in the number of Covid positive patients requiring critical care support (n=4). The community prevalence is increasing with a weekly rate of 309.9 per 100,000 population. The largest proportion of cases remain in children and young adults (32% aged 10-19). The vaccination programme has now been extended to cover this population.

The Trust has also been closely monitoring the rates of Respiratory Syncytial Virus (RSV) in children due to an anticipated spike in cases. This has not yet impacted on hospitalisation but there are robust escalation plans in place if this does occur

2. Reset and Recovery, Planned Care

The Trust has delivered above plan on its internal trajectory for Outpatients and Day cases during September with Outpatient combined activity exceeding the 100% National Target. It is behind plan for Inpatients primarily because of staffing due to sickness and supporting the Emergency Department. There is also a reduced amount of Waiting List Initiatives (WLIs) additional sessions being picked up and an increase in patients testing positive at their 3 day TCI COVID swab or on the day meaning there is no time for the patient to be backfilled on operating lists due to the isolation period.

For patients prioritised as a priority 2 (P2) status, the Trust has exceeded its September plan, reporting 31 against a target of 39.

All activity continues to be prioritised by clinical urgency and then time waiting from referral.

Activty Type	National Target	Trust Trajectory	September Actual to Date
Outpatient New	100	97	99
Outpatient Follow Up	100	102	106
Total Outpatients	**100**	**101**	**104**
Daycase	100	88	92
Inpatients	100	87	78
Total Electives	**100**	**88**	**90**

3. Serious Incidents

The Trust declared 6 serious incidents (SI) in the month of August 2021; this is an increase of one on the previous month. The Serious Incident panel report and investigate under the "Serious Incident Framework" so that learning can be identified.

There were no common themes or areas identified from the 6 reported incidents, which spanned areas of the trust, including the Women's and Children's (1), Diagnostics and Clinical Support (1) Surgical Services (3) and Medicines and Acute (1).

Duty of Candour has been commenced in line with legislation and national guidance.

4. Covid -19 Vaccination programme

The Covid-19 vaccination programme continues across the local health economy. To 28th September 2021, 453,593 vaccinations (234,717 1st dose and 218,876 2nd dose) have been given across Wirral place in GP practices, PCN local vaccination sites, the WUTH vaccination centre, in pop up clinics and using the vaccination bus. The national data states this currently equates to 84% and 78% of the local eligible population respectively.

As of 26th September 2021, the Trust service had delivered 90,866 vaccinations to patients and staff. This includes 5,598 (84.8% of WUTH employees (those on ESR) who have had their first vaccine and 5,406 (81.9%) who have had both doses. This is a small rise since the previous month..

JCVI guidance has been issued for both a third primary dose for patients who are immunosuppressed either as a result of a clinical condition or due to medication regimes. WUTH is working with system partners to identify and vaccinate this population group.

The Joint Committee on Vaccination and Immunisation (JCVI) final guidance regarding the Autumn Booster programme has been issued in September and the Trust site commenced vaccinating staff and patients in accordance with this direction on 22nd September. Appointments have been issued on the National Booking Service and these were rapidly taken up by our local population. As a Trust our priority must be staff vaccination and our partners have also asked that the Trust initially prioritise local health and social care staff and to this end local booking systems will be re-activated to free and protect capacity for these cohorts.

All 16 and 17 year olds, alongside clinically vulnerable 12 to 15 year olds, and those age 12 to 15 years who are household contacts of clinically extremely vulnerable family members continue to be vaccinated at the Clatterbridge Vaccination Centre. The guidance remains that this group are only eligible for one dose. The centre remains part the National Grab a Jab scheme for this cohort where vaccination candidates are permitted to arrive without an appointment.

The Trust Pharmacy Team are currently supporting our Community Trust with the school's immunisation programme and the Trust Chief Pharmacist continues to provide pharmaceutical support to the Cheshire and Mersey Vaccine Silver Command and Control structure.

The first allocation of flu vaccines has also been received in the Trust and are being administered in an Arrowe Park pop up clinic, via roaming vaccinators and co vaccination of Covid-19 and flu vaccination at our Clatterbridge Centre. Vaccine supply will be intermittent between now and November. As of 22nd September, 729 flu vaccinations had been delivered which equates to 10.94% of Trust staff.

5. Millennium downtime incident

The Board will recall previous reports pertaining to a decision to switch off the Millennium (the Trust Patient Administration System) move to Downtime on 22nd July, with restoration taking place on 23rd July 2021.

At this stage the Trust entered the recovery phase to transpose downtime paper based information onto Millennium. The Business Continuity Incident was closed when recovery was completed on 24th July 2021.

This was an unprecedented event which did not lead to patient harm. Incidents identified as a result of the downtime were reported as no harm incidents. One incident was CQC reportable under Ionising Radiation (Medical Exposure) Regulations IRMER requirements. This related to 4 patients receiving unnecessary exposure to radiation/ imaging. All individual incidents were assessed as low dose /low risk incidents. This was reported to CQC on 13th August 2021 and is being managed through the Risk Management process.

An Improvement Plan based on the debrief recommendations is in development and will be reviewed by the Risk Management Committee on 5th October 2021.

6. 2021 Governor Elections results

The contested governor elections were completed on the 29th of September and the results for the contested seats are below:

Governors elected to public constituencies:

Constituency	Successful candidate
Bebington & Clatterbridge	Tony Cragg
West Wirral	Andrew Tallents
Bidston and Claughton	Alan Morris
Greasby, Frankby, Irby & Upton	Eileen Hume
Leasowe, Moreton & Saughall Massie	Paul Ivan

In addition, we also had one seat successfully filled in the medical and dental seat by Anand Kalanathan.

These governors will be inaugurated at the next Annual Members Meeting on the 18th of October 2021.

7. Deloitte Well led review

The Deloitte Well Led review continues at pace, and to date significant progress has been made with board member interviews, staff surveys, governor focus groups and Board Committee observations. In addition, Deloitte are also observing the October Board meeting, and will be commencing the external stakeholder engagement aspect of the review in the same period.

8. Integrated Care System

The Trust has continued to work with system partners to support the development of the Integrated Care System for Cheshire and Merseyside, aligning with the recent NHSE guidance for integrated care development and the emerging legislation.

This has included the development of 'Place' governance and functions for Wirral, working with Wirral Council, Wirral Community Health and Care NHS Trust and the Wirral Primary Care Networks. These arrangements at 'Place' are expected to be finalised and operational by April 2022, following approval by the receptive NHS organisation boards across Wirral.

9. Clatterbridge Hospital Campus Master Planning

The Trust has continued to work with Campus partners, including Clatterbridge Cancer Centre NHS Foundation Trust (CCC), to develop the master plan for the Clatterbridge Hospital Campus.

This planning has been coordinated by BDP Architects and Archus Ltd and focussed on options to integrate and co-locate clinical services across WUTH and CCC along with the redevelopment of hospital facilities across the campus. The planning also examines options for surplus land across the campus.

This master planning exercise is expected to be finalised in October and presented to WUTH and CCC Boards in November 2021.

10. Recommendation

The Board is asked to note and receive the Chief Executive's report.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 21/22-133

BOARD OF DIRECTORS
6 October 2021

Title:	Trust Performance – Planned & Unscheduled Care
Responsible Director:	Chief Operating Officer
Author:	Director of Operations Planned Care Director of Operations Unscheduled Care
Presented by:	Chief Executive Officer

Executive Summary

This report provides the current Organisational performance data for Planned (Elective) and Unscheduled (Non Elective) Care.

The report covers the performance against the reset & recovery planned trajectories which includes:

- Outpatient New & Follow Up
- Day case & Elective Inpatients
- Diagnostics (Planned and Unplanned)
- Priority 1(P1) & Priority 2 (P2) Elective patients
- 52 & 104 week waiters
- Cancer

The report also provides performance against the following Unscheduled Care standards:

- Emergency Department (ED) Performance
- Ambulance Conveyances
- Long Length of Stay

Recommendation:
(e.g. to note, approve, endorse)

To note performance, risks and mitigations.

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)		
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)		
Essential Standards: NHSI CQC		
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)		
-		
Specific communications and stakeholder /staff engagement implications		
-		
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)		
-		
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)		
-		
FOI status	Document may be disclosed in full	
	Document includes FOI exempt information	
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees		
Background papers / supporting information		

BOARD OF DIRECTORS MEETING IN PUBLIC
6 October 2021

Chief Operations Officer Report to Trust Board

1.0 Purpose

This paper provides an overview of the Trusts current performance against the Re-set and Recovery Programme for Planned Care and standard reporting for Unscheduled Care.

For Planned Care activity volumes, it highlights the Trust's 4 week average for weeks concluding 12/09/21 and the current September performance (snapshot at 29.9.21) as well as providing comparative data nationally, across Cheshire & Merseyside (C&M) and the North West.

For Unscheduled Care, the report details performance and highlights the ongoing challenges around increase in attendances and long length of stay patients and the impact this has on 4 hour performance. The report also highlights the percentage number of patients who remain in the department for longer than 12 hours since arrival. This is in preparation for the proposed new National standards.

The report also highlights current risks in the Trust's ability to return to pre-Pandemic activity levels and general Emergency Department (ED) performance overall on a sustainable level together with associated mitigations underway to manage these.

2.0 Introduction / Background

March 2020 saw the first large scale cancellation of all but the most urgent elective activities aligned to the National Emergency Preparedness Resilience & Response (EPRR) to the COVID 19 pandemic. Over the last 18 months elective activity has been re-started and suspended during the 2nd and 3rd COVID19 waves alongside general disruption due to ongoing COVID19 pressures during this period. This has impacted negatively on both waiting list numbers and waiting times for treatment.

From an unscheduled care perspective at the start of the pandemic & during subsequent lockdowns non COVID19 emergency attendance & admission numbers declined significantly. However since the summer these numbers have continued to increase and have surpassed 19/20 pre pandemic activity by around 20%.

The delivery of reset & recovery elective activity commenced in earnest in 2021 with the main focus areas being on treating the most clinically urgent patients first followed by the long waiters. To do this all Trusts were asked to:

- Clinically prioritise their waiting list into 6 categories (P1 – P6) based on how long it was deemed clinically safe to wait for treatment. P1 being the most urgent e.g. cancer through to P6 least urgent. National focus has been on P2 performance with these patients requiring to be treated within 1 month.
- Increase elective activity to an agreed proportion of the 19/20 rates (taking into account the productivity impact of the COVID environment on managing electives) as a sliding trajectory back to 95%
- Work as a system of providers within their Integrated Care System (ICS) establishing mutual aid, green site working and shared waiting lists.
- Reduce cancer waits to pre pandemic levels
- Minimise / Eradicate 104+ week waiters by the end of March 2022

In terms of unscheduled care once the lockdown was fully released the numbers of attendances to ED have continued to increase far surpassing the 19/20 levels. In addition the numbers of patients who occupy a hospital bed but no longer meet the criteria to reside (deemed fit for discharge) continues to increase with acute bed occupancy over 95%. This is a national picture and is recognised as such, being driven in part by changes in patient behaviour, access to face to face GP appointments, increasing levels of acuity in the population based on previous ability to access services during the pandemic, COVID restrictions & a fragile out of hospital care market. The level of demand experienced is putting increased pressure into the system across all points of delivery. This is further compounded by a number of workforce issues which include:

- Higher than average sickness absence rates & continued COVID isolation.
- Fatigued staff who are reluctant to work additional shifts
- Recruitment to domiciliary care to support the out of hospital care sector

3.0 Elective Performance

The elective performance to date is outlined below

Activity

The National Standard was to achieve 95% of 2019 comparable month's activity across all Points of Delivery (PODs). However 3 things to note

1. The actual is based on the value of the activity with activity numbers used as a proxy
2. The threshold has been revised for H2 21/22 to 89% of closed RTT pathways not activity value for access to the Elective Recovery Fund (ERF)
3. To clear backlog systems need to be undertaking in excess of 100%

The table below summarises the 4-week average for weeks concluding 12/09/21

POD	National	North West	Cheshire & Mersey	WUTH
OP New	90%	102%	104%	99%
OP FU	94%	100%	105%	103%
Day Case	85%	82%	77%	82%
Elective IP	82%	86%	91%	98%

Diagnostic Activity

Planned activity levels continue to be over achieved. Unplanned activities are dependent upon referrals from Unscheduled Care so lower performance is based on demand not activity.

Diagnostics			
Planned		UnPlanned	
Actual	Div Trajectory	Actual	Div Trajectory
117	100	**90**	100

Priority 2 Performance (P2)

The Trust continues to achieve P2 month end trajectories with September's position better than planned at 31 open pathways against a month end plan of 39 open pathways. There are currently 276 patients at WUTH that have an assigned P2 category of which 72% having date scheduled for their procedure (TCI). This compares to 2780 P2 patients across the Cheshire & Mersey ICS with 66% having a TCI in place.

52 Week Wait Performance

The 52 week wait number is 697. Whilst this position has deteriorated over the last 2 months it still remains below the 873 trajectory. This deterioration is due to the requirement to prioritise patients with higher priority P code. This is in line with the national priority of managing patients based on clinical urgency. Across C&M there are currently 12,953 and the North West 29,632 52 + week waiters.

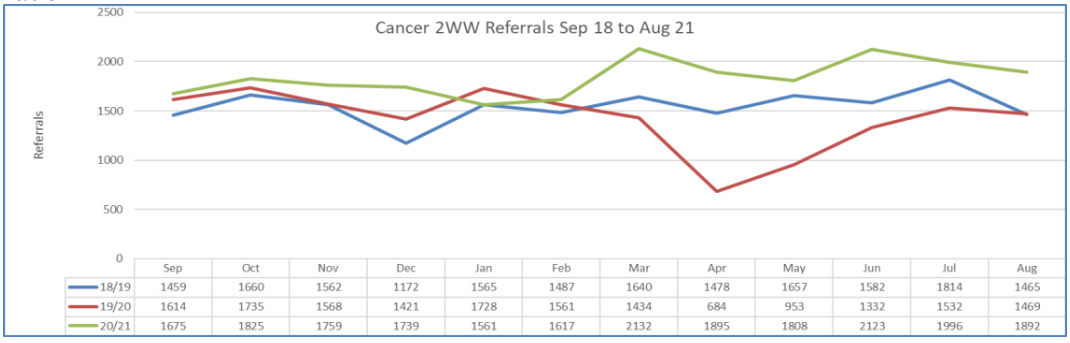
104+ Week Wait Performance

As of 12.9.21, the Trust had a total of 6 104+ week patients, of which 1 remains untreated but has a TCI of 15.10.21. This compares to 169 across C&M.

Cancer Backlog Performance

The 62 and 104 day cancer backlogs have returned to pre-Pandemic levels, despite an increase in TWW referrals as demonstrated in the table A below. Cancer performance for Q1 and Q2 has been achieved as illustrated in table B. However Q3 performance is at risk due to the number of Urology patients requiring access to the robot, along with the general increase in Urology and Colorectal urgent P2 patients. Actions are underway to reduce this risk in Q3.

Table A



	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
18/19	1459	1660	1562	1172	1565	1487	1640	1478	1657	1582	1814	1465
19/20	1614	1735	1568	1421	1728	1561	1434	684	953	1332	1532	1469
20/21	1675	1825	1759	1739	1561	1617	2132	1895	1808	2123	1996	1892

Table B

2WW performance	Q2 (21/22)	
2WW performance	Q3 (21/22)	
28 day performance	Q2 (21/22)	
28 day performance	Q3 (21/22)	
31 day performance	Q2 (21/22)	
31 day performance	Q3 (21/22)	
62 day performance	Q2 (21/22)	
62 day performance	Q3 (21/22)	
Long waiting patients (maintaining pre-pandemic levels)	Ongoing	
Third wave recovery projection	Ongoing	
Outstanding harm reviews	Ongoing	

Risks to Recovery

There remain significant risks to elective recovery which include:

- Staff shortages & fatigue impacting on uptake of additional sessions
- Movement of theatre and anaesthetic staff to support critical care
- Balancing clinical priority against long waiters
- Winter non elective surge
- Increased cancer referrals

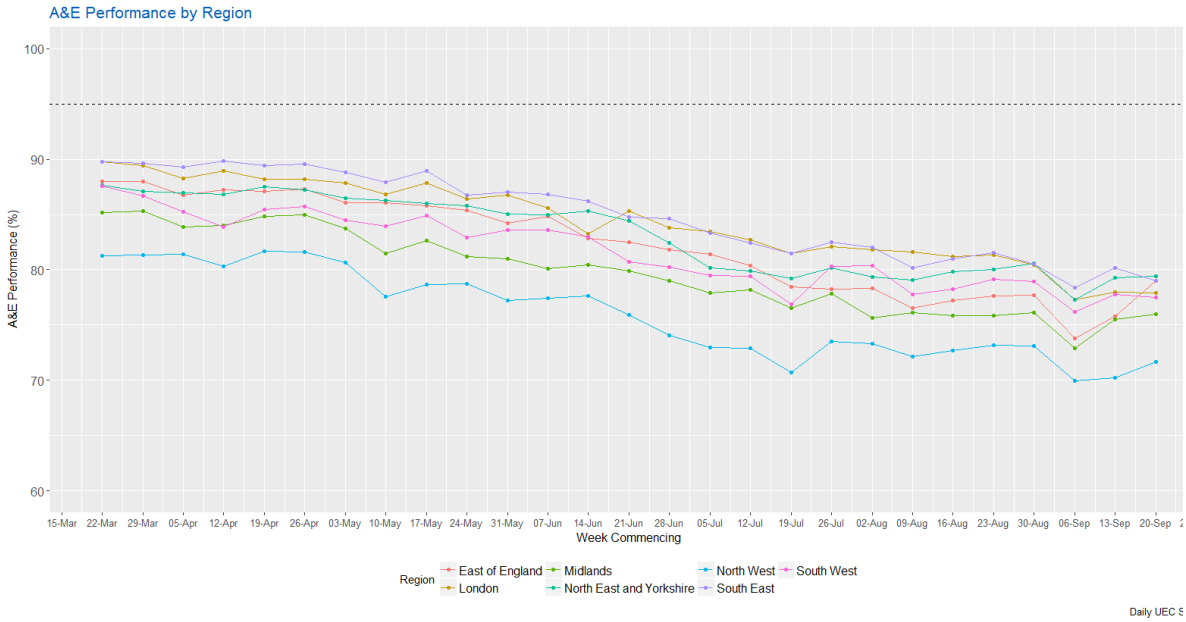
Mitigations

Recognising these risks there are a number of mitigations in place which include:

- Full participation in the C&M elective recovery programme which is supporting the coordination of
  - Use of the independent sector
  - Regional/National capital, revenue & technology bids to increase capacity and throughput.
  - Regional review and agreement around staffing requirements to maximise qualified staff utilisation, particularly in critical care
  - Introduction of HVLC (High Volume Low Complexity) surgical pathways including theatre lite alongside organisational bench marking.
  - Green site working
- Divisional Director deep-dive of planned Cancer treatments during Q3.
- Appraisal of robot usage by non-CA specialities/patients along with full service and staffing review.
- Patient level tracking & active management in place monitored by the Divisional Directors via the weekly operation delivery group (ODG)
- Full participation in regional performance governance arrangements

4.0 Unscheduled Care

Performance against the 4 hour standard remains challenged in Wirral, across C&M and the North West as can be seen below



Performance for APH site type 1 for August was 55.92%, for the APH site; including UTC this was 66.2% and YTD 72.8%. The All type Wirral Performance for August was 76.1%.

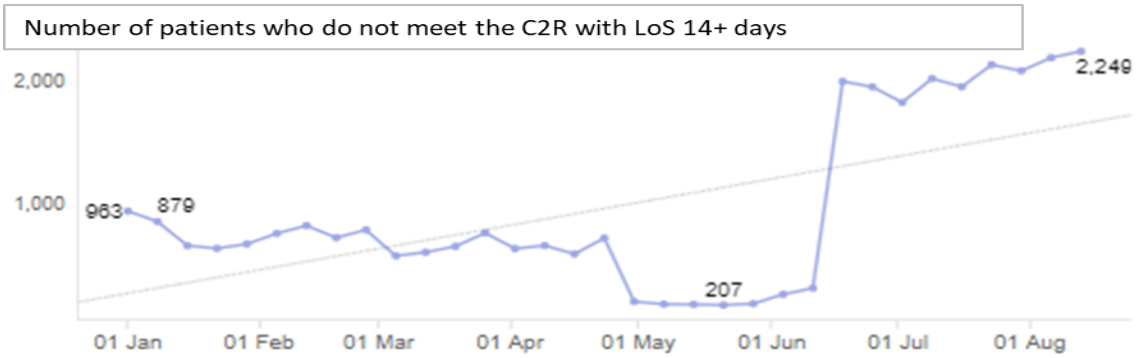
The Trust saw average daily attendances of 254 which is an increase compared to the average of 244 for the same period in 19/20. Total attendances for August 2021 was 8206 against 7407 for 19/20 and 7074 for 20/21

The proportion of patients waiting more than 12 hours in the department from time of arrival was 4.9% in August compared to 7.9% in July with YTD average of 3.9%. This compares favourably both within C&M & North West where the range is from 1% to 15%.

Total ambulance turnaround time was achieved in August 2021 with a mean time of 28.77 mins. There were a total of 1833 ambulance conveyances in August, accounting for 25% of ED attendances. There were 105 ambulances that had a greater than 60mins handover in August compared to 139 in July

The average number of super stranded patients (>14days LOS) in August was 117 compared to 91 in July. Work is ongoing both internally and externally with system partners to improve the current position.

This is mirrored in the Cheshire & Mersey position outlined in the graph below



Risks to Unscheduled Care Performance

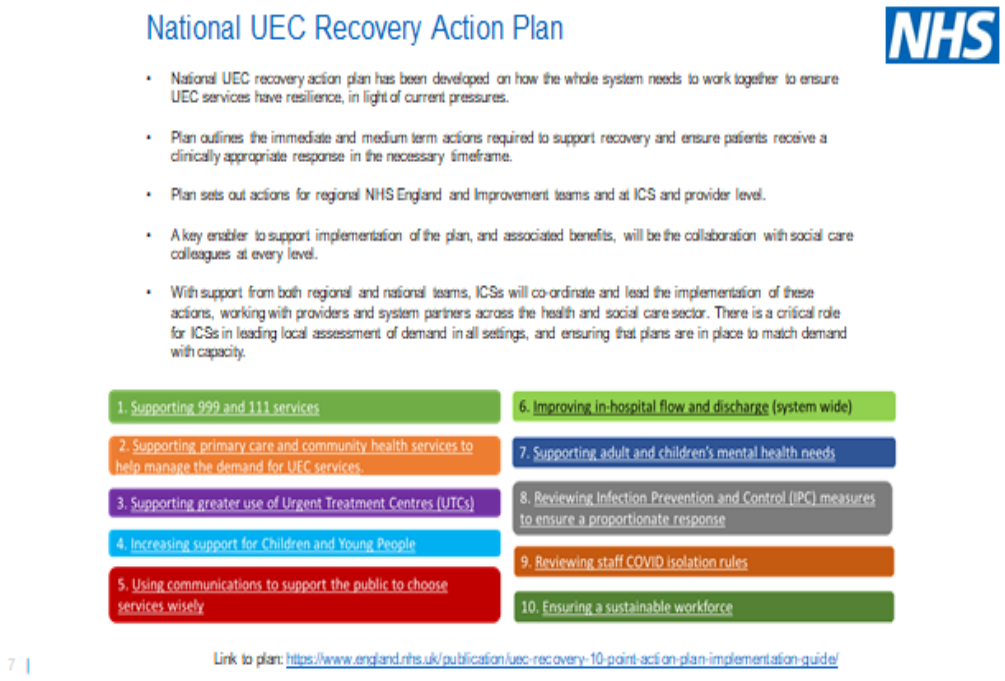
There are a number of risks to improving performance as outlined below:

- Increased attendances at ED is significantly compromising capacity in ED
- Physical environment is compromised during periods of overcrowding
- The fluctuation in Covid attendances and admissions, alongside nosocomial infections compromises flow as a result of closed hospital beds
- Staff shortages across the Trust impacting on patient flow and reduces the ability to open additional escalation areas
- Increase in delayed transfers of care resulting in patients staying in hospital longer than required.
- The lack of domiciliary care provision in the community is impacting on overall hospital occupancy and resulting in reduced patient flow through the Trust.
- T2A (Transfer to Assess) beds availability in the Wirral system as new providers have not been able to come on line within agreed time frames due to staffing challenges in the community.
- Availability of Mental health inpatient beds

Mitigations

There are a number of mitigations in place which include

- System wide Winter plan in line with the National UEC Recovery Action Plan



- Full participation in the unscheduled Care transformation programme which includes Working with Wirral Community Trust to improve streaming and reduce the numbers of patients attending the ED department who can have their care needs met away from ED.
- Trust level winter resilience director in place from November 2021 until April 2022
- Monitoring of ED improvement plan and Wirral system urgent care plan by

systems Chief Operating Officers including Director of Adult Social care 3 times weekly.

- Health Economy CEO Oversight of discharge cell.
- Additional spot purchase care home beds in place
- Participation in C&M winter room including mutual aid arrangements
- NWAS Divert Deflection policy

4.0 Conclusions

Whilst progress against elective plans remains strong, achievement of the 95% ED 4 hour performance remains significantly challenged especially as we move into the winter period. The impact of non-elective demand will compromise elective recovery if Trust & system capacity is not actively managed over the next half of the year.

Improved performance is heavily reliant on the Trust working with the Wirral system to achieve the trajectory submitted as part of the overall Wirral Urgent Care Improvement Programme. The Trust winter plans are being finalised to support achievement of the trajectory and to meet the increased demand the Trust will be challenged with this winter.

5.0 Recommendations to the Board

To note performance, risks and mitigations.

Agenda Item: 21/22–134

Meeting of the Board of Directors
6 October 2021

Title:	Quality & Performance Dashboard
Author:	J Halliday Assistant Director of Information
Responsible Director:	COO, MD, CN, DoW, DoF
Presented by:	COO, MD, CN, DoW, DoF

Executive Summary
Contextual and background information pertinent to the situation / purpose of the report.

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note performance to the end of August 2021.

Of the 46 indicators that are reported (excluding Use of Resources):

- 22 are currently off-target or failing to meet performance thresholds
- 24 of the indicators are on-target

Please note during the current Covid-19 pandemic some metrics have been suspended from national reporting, and departments within the Trust have been focused on operational priorities over some internal reporting. Where the information is still available and reported within the Trust it has been included.

The metrics included are under continual review with the Directors to consider the appropriateness and value of inclusion and the performance thresholds being applied. Amendments to previous metrics and/or thresholds are detailed below the dashboard.

Recommendation:
(e.g. to note, approve, endorse)

For noting.

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)		
Quality and Safety of Care. Patient flow management during periods of high demand.		
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)		
The dashboard Includes NHSI Oversight Framework metrics, considered as part of provider segmentation.		
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)		
N/a		
Specific communications and stakeholder /staff engagement implications		
N/a		
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)		
N/a		
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)		
N/a		
FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees	N/a	
Background papers / supporting information	N/a	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021/22	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	CN	≤0.24 per 1000 Bed Days	WUTH	0.18	0.21	0.00	0.11	0.21	0.15	0.11	0.16	0.10	0.20	0.05	0.05	0.10	0.10	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	95.3%	95.4%	95.1%	95.3%	94.7%	94.2%	94.9%	94.0%	94.4%	94.5%	94.7%	93.3%	95.2%	94.42%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	97.2%	97.4%	96.8%	96.9%	96.9%	96.5%	96.6%	96.2%	96.4%	96.6%	96.6%	96.2%	97.6%	96.7%	
	Serious Incidents declared	Safe, high quality care	CN	≤48 per annum (max 4 per month)	WUTH	4	2	3	2	4	4	5	4	5	4	8	7	4	28	
	Never Events	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	1	0	0	1	0	2	0	3	
	CAS Alerts not completed by deadline	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	0	0	0	1	0	0	0	1	
	Clostridium difficile (healthcare associated)	Safe, high quality care	CN	≤88 WUTH maximum from 2019-20 retained, with a varying trajectory of a max 6 to 8 cases per month	SOF	4	1	5	10	8	4	7	6	5	7	5	1	6	24	
	Gram negative bacteraemia	Safe, high quality care	CN	Maximum 63 for financial year 2021-22, with a varying trajectory of a maximum 5 or 6 cases per month	WUTH	5	3	7	3	1	3	6	6	3	5	7	3	3	21	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	0	0	0	0	0	0	0	1	0	0	1	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	99.0%	99.6%	100.0%	100.0%	100.0%	99.3%	98.9%	100.0%	99.2%	99.2%	99.0%	99.3%	99.0%	99.1%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	4	0	0	1	0	1	0	0	0	0	1	1	0	2	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	98%	96%	94%	91%	93%	Not avail	Not avail	96%	96%	96%	95%	96%	96%	96%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	75.9%	72.9%	73.2%	75.1%	76.6%	77.9%	79.1%	79.9%	84.3%	85.9%	87.5%	89.1%	91.0%	87.6%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	72.1%	73.9%	74.5%	77.6%	81.3%	82.9%	84.1%	82.3%	83.0%	83.6%	83.9%	86.1%	85.9%	84.5%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	48.3%	53.2%	54.7%	60.9%	77.8%	79.0%	80.1%	67.0%	69.5%	70.8%	72.3%	74.3%	75.5%	72.5%	
	Attendance % (12-month rolling average)	Safe, high quality care	DoW	≥95%	SOF	94.41%	94.40%	93.58%	93.61%	93.66%	93.48%	93.42%	93.48%	93.79%	93.90%	93.95%	93.88%	93.83%	93.83%	
	Attendance % (in-month rate)	Safe, high quality care	DoW	≥95%	SOF	94.63%	94.41%	93.81%	94.04%	94.14%	92.30%	93.91%	94.71%	94.62%	94.32%	94.32%	93.52%	93.47%	94.05%	
	Staff turnover % (in-month rate)	Safe, high quality care	DoW	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	1.79%	0.97%	0.64%	0.97%	0.82%	0.98%	0.67%	0.77%	0.95%	0.72%	0.79%	1.22%	1.86%	1.11%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DoW	≤10%	WUTH	11.1%	12.7%	12.6%	13.2%	13.3%	13.7%	13.9%	13.0%	13.5%	13.2%	13.3%	13.0%	12.6%	12.6%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	9.9	8.0	8.5	10.1	9.5	8.1	8.9	9.0	8.7	8.3	8.8	8.5	8.4	8.5	

Quality Performance Dashboard

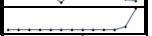
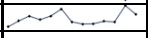
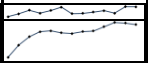
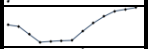
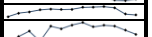
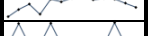
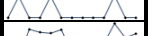
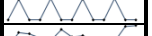
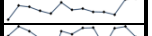
	Indicator	Objective	Director	Threshold	Set by	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021/22	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	99.0%	96.8%	97.4%	97.5%	96.2%	94.1%	95.3%	98.0%	98.4%	98.3%	98.3%	95.9%	96.7%	97.5%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	98%	96%	96%	98%	97%	95%	97%	97%	99%	98%	98%	98%	97%	98.0%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	18.6%	17.8%	17.7%	18.5%	17.9%	18.4%	18.9%	18.0%	18.0%	17.7%	18.4%	18.5%	18.1%	18.2%	
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	MD / COO	≤156 (WUTH Total)	WUTH	239	309	305	279	319	371	354	341	323	329	318	319	367	367	
	Long length of stay - number of patients in hospital for 21 or more days	Safe, high quality care	MD / COO	Maintain at a maximum 52 (revised Sept 2020)	WUTH	59	92	95	86	112	98	106	88	96	85	99	95	126	126	
	Length of stay - elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤5.3 days average	WUTH	3.8	4.8	3.9	4.1	3.4	2.8	3.2	3.1	3.6	3.3	3.5	3.8	3.8	3.6	
	Length of stay - non elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤7.3 days average	WUTH	4.5	5.4	5.8	5.4	4.3	4.7	4.4	4.2	3.8	4.0	4.0	4.1	4.2	4.0	
	Emergency readmissions within 28 days	Safe, high quality care	COO	≤1,110 per month	WUTH	1012	1014	1007	992	1020	1027	938	1097	1149	1131	1084	1115	1018	1099	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	75.6%	79.3%	79.2%	81.3%	77.7%	71.9%	81.3%	84.9%	84.5%	85.5%	82.5%	79.8%	82.0%	82.8%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021/22	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	5	1	0	0	3	2	0	0	2	2	3	4	1	12	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	87.0%	84.0%	87.0%	85.0%	84.0%	83.0%	82.0%	76.0%	76.0%	80.2%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	TBC	92.0%	91.0%	92.0%	94.0%	95.0%	95.0%	95.0%	96.0%	95.0%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	95.0%	94.0%	95.0%	95.0%	95.0%	94.0%	95.0%	93.0%	94.0%	94.2%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	80.0%	100.0%	67.0%	94.0%	99.0%	95.0%	93.0%	97.0%	98.0%	96.4%	

Quality Performance Dashboard

September 2021
Upated 22-09-21

	Indicator	Objective	Director	Threshold	Set by	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021/22	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	NHSI Trajectory 2020-21, and Q2 21-22	SOF	85.0%	76.9%	71.6%	76.2%	71.8%	64.6%	76.8%	77.8%	76.1%	73.5%	78.0%	67.8%	66.2%	72.3%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	0	0	0	0	0	0	0	0	0	1	7	8	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	TBD	National	71.4%	64.8%	64.9%	71.4%	69.6%	65.3%	77.8%	78.8%	73.4%	68.1%	73.4%	57.7%	66.7%	67.9%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	TBD	National	0.7%	2.7%	4.3%	3.1%	4.3%	6.7%	2.3%	1.6%	1.7%	2.6%	2.3%	7.9%	4.9%	3.9%	
	Proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed	Safe, high quality care	COO	TBD	National	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	4.2%	8.3%	13.8%	9.2%	13.2%	18.0%	8.7%	9.1%	11.0%	13.0%	9.3%	18.9%	18.6%	14.2%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	51.30%	59.76%	65.66%	69.16%	69.81%	68.40%	67.89%	69.26%	69.61%	72.57%	75.64%	75.13%	74.14%	74.14%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 22,980 for WUTH by March 2021	National	24486	24212	22945	21633	21792	21880	21955	23444	24774	25873	26671	26979	27306	27306	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2020-21	National	733	806	777	704	666	899	1108	1168	874	633	526	507	560	560	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	83.5%	88.8%	90.5%	93.7%	94.9%	94.0%	94.3%	97.4%	97.7%	98.5%	96.8%	87.5%	86.0%	93.3%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	89.3%	92.6%	94.9%	90.5%	97.2%	96.0%	97.6%	98.8%	96.9%	97.6%	97.2%	95.4%	93.6%	96.1%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	–	92.48%	-	-	94.20%	-	-	97.64%	-	-	97.21%	-	-	97.2%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	94.8%	92.1%	98.0%	97.4%	97.2%	98.0%	93.0%	93.5%	94.7%	95.2%	99.2%	96.3%	97.1%	96.5%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	–	92.44%	-	-	97.55%	-	-	94.73%	-	-	96.26%	-	-	96.3%	
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	78.6%	82.6%	82.9%	85.3%	85.4%	80.9%	82.1%	84.1%	84.5%	84.1%	85.3%	84.7%	85.6%	84.8%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	–	80.68%	–	–	84.60%	-	-	82.56%	-	-	84.66%	-	-	84.7%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	124	183	178	161	150	196	165	170	157	156	145	209	213	176	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	3.40	4.20	3.80	3.20	1.32	3.80	3.56	4.07	4.09	2.56	4.04	4.20	3.31	3.64	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	100%	100%	94%	100%	97%	100%	95%	100%	93%	95%	100%	94%	96%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	0	2	1	4	2	2	4	4	0	2	1	2	5	2	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021/22	Trend
Well-led	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	CN	100%	National	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	700 for FY 21/22 (cumulative 59 per month until year total achieved)	National	31	126	329	215	163	599	206	87	19	37	109	281	455	455	
	% Appraisal compliance	Safe, high quality care	DoW	≥88%	WUTH	84.3%	76.3%	73.0%	74.1%	76.2%	72.9%	74.7%	77.0%	81.0%	81.3%	82.7%	82.7%	82.2%	82.2%	

	Indicator	Objective	Director	Threshold	Set by	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021/22	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.8	0.7	0.5	-0.2	-5.4	3.5	0.8	-0.5	-0.2	0.0	0.2	0.2	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.4	0.5	0.3	-0.1	-5.4	3.9	0.8	-0.4	-0.4	0.0	0.2	0.2	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2	
	CIP Performance	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.02%	6.03%	9.05%	9.0%	
	NHSI Agency Performance (monthly % variance)	Effective use of Resources	CFO	On Plan	NHSI	34.5%	22.3%	12.1%	0.5%	10.2%	18.5%	-22.5%	-21.9%	-50.5%	-27.7%	-32.4%	-40.5%	-11.7%	-32.5%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-97.9	-16.3	-15.0	-15.6	-17.4	-28.0	-17.8	-16.9	-15.0	-15.5	-10.4	-15.7	-15.4	-15.4	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	44.6%	42.1%	41.8%	46.2%	66.3%	67.5%	-74.8%	100.0%	2.0%	5.0%	12.0%	17.4%	21.8%	21.8%	

(*) Updated Metrics

(**) Updated Thresholds

Safe Domain

Protecting Vulnerable People Training - % Compliant Level 2

Executive Lead: Chief Nurse

Performance Issue:

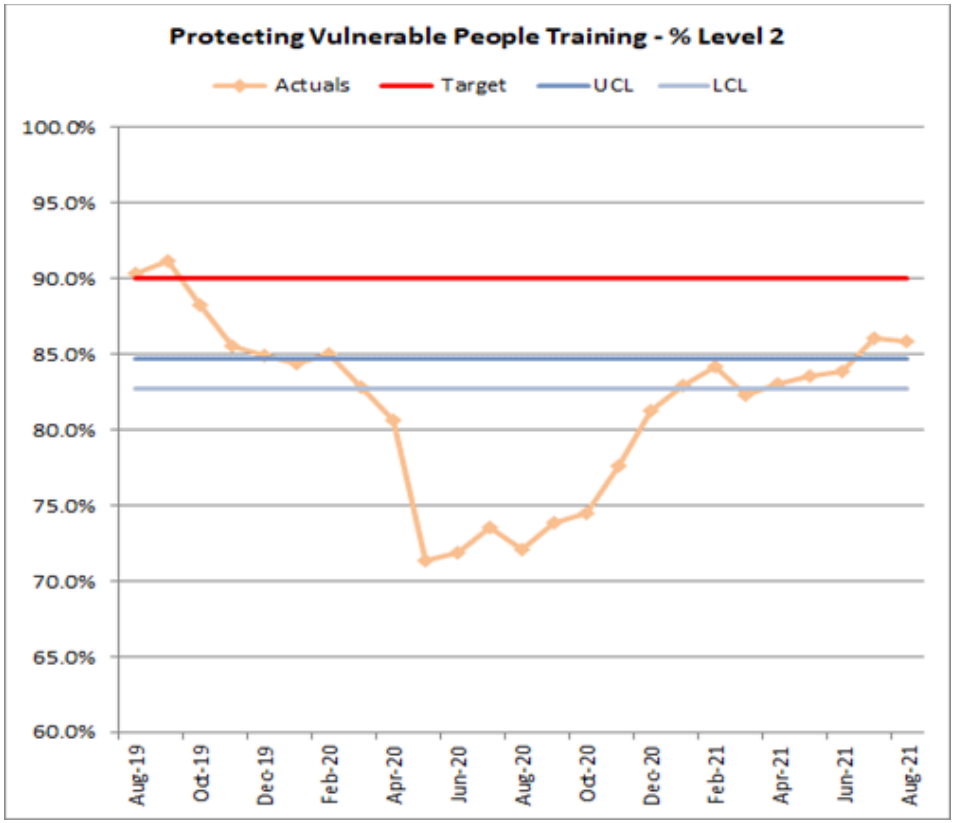
Compliance target for level 2 training is set at a minimum of 90%. Performance against this standard had been improving since February 2021, however August 2021 shows a slight deterioration with current compliance at 85.9%.

Action:
A slight deterioration was noted this month for PVP Level 2 due to the focus on ensuring level 1 compliance was achieved. Divisional triumvirates are asked to provide a trajectory to achieve compliance for level 2 PVP training for all relevant staff; this is monitored at Safeguarding Assurance Committee. Training is available as eLearning via ESR, therefore there are no capacity challenges for delivery of the training.

Associate Director of Nursing for Safeguarding will continue to provide detailed monthly breakdown of compliance to the Divisions to enable key areas to be focused upon.

Expected Impact:

Level 2 PVP training is expected to increase to the mandatory 90% compliance and above mark by end of Q3.



Protecting Vulnerable People Training - % Compliant Level 3

Executive Lead: Chief Nurse

Performance Issue:

Compliance target is set at a minimum of 90% of relevant staff have undertaken training every 3 years (available via eLearning). Performance against this standard has made a steady progression, with August 2021 compliance increasing to 75.5%.

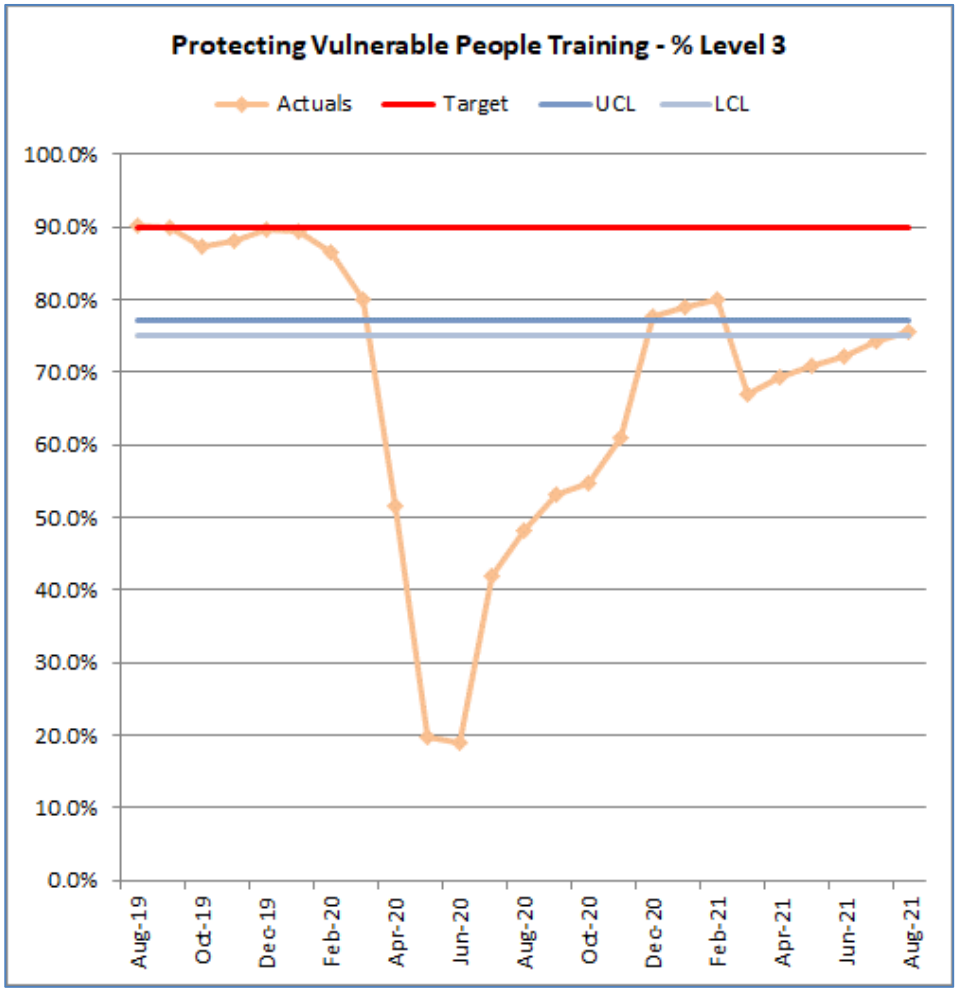
Identified staff need an additional face to face element of level 3 to comply with Working Together Intercollegiate requirements: This is set at a minimum of 90%. Performance has improved from 70.4% July 2021 to 71.8% for August 2021.

Action:

Divisional triumvirates have developed trajectories determining when compliance of each aspect of level 3 will be achieved. These are monitored via Safeguarding Assurance Group. The Associate Director of Nursing for Safeguarding continues to provide monthly reports to enable triumvirates to target areas on non-compliance. Adequate training capacity is available across the year to enable the Trust to meet its requirements.

Expected Impact:

Level 3 safeguarding training is expected to continue to increase to the mandatory 90% and above mark during Q2.



Staff attendance % (in-month rate)

Executive Lead: Director of Workforce

Performance Issue:

The Trust compliance threshold for sickness absence is 5%, both for in-month sickness and over a rolling 12-month period. The increase in sickness absence levels continue to be above the Trust's 5% target, both for in-month sickness and over a rolling 12-month period.

The in-month sickness absence for August 2021 has increased to 6.53% which is a 0.05% increase from July 2021 and is the highest since January 2021 (7.70%).

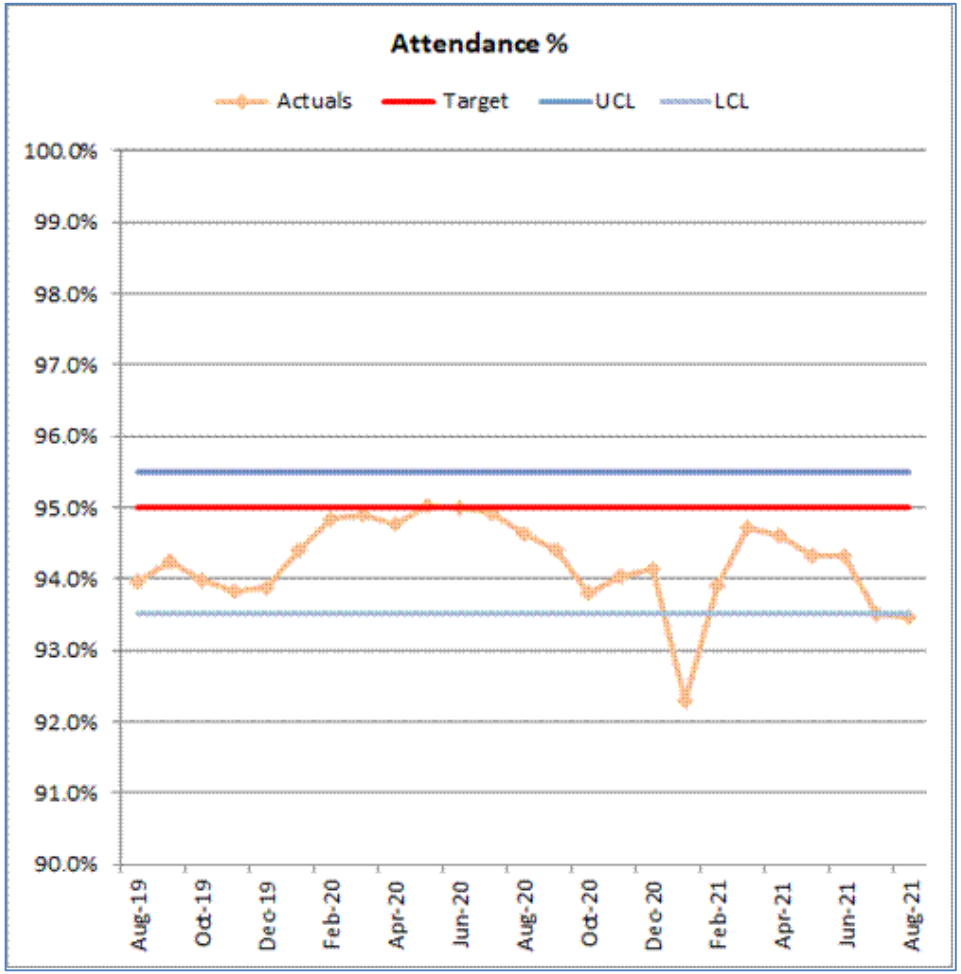
6 Divisions have exceeded the 5% KPI in August 2021:

- Diagnostics & Clinical Support (5.59%)
- Corporate Support (5.25%)
- Estates and Hotel Services (10.68%)
- Medical & Acute (6.5%)
- Surgery (6.05%)
- Women & Children's (6.74%)

There was an increase in long-term sickness absence in August although the position is mostly impacted by short term sickness absence, which accounted for 67% of all absence.

Anxiety, Stress and Depression remains the highest reason for long term sickness absence at 33.82% (116 episodes) in August, followed by Musculoskeletal Health at 11.37% (39 episodes).

Gastro problems were the highest reported reason for short term sickness absence at 23.41% (177 episodes) followed by Cough, Cold & Flu at 15.48% (117 episodes).



Action:

Work is being undertaken strategically, operationally, and locally. The following are updates on initiatives in place to improve workforce wellbeing and address sickness absence, over and above the information previously provided to Trust Board.

Managing Sickness Absence

A review is taking place on the Trust Attendance Management Policy, as part of the NHS England and NHS Improvement Deep Dive. There has been increased engagement with Staff Side and discussions have taken place regarding more fundamental changes to the Attendance Management Policy that have been learnt from benchmarking against low sickness absence Trusts.

North West Wellbeing Workshop

A North West Wellbeing Workshop was held on 21 September 2021, which aimed to begin discussions around different ways of working to address the long-standing high levels of sickness absence in the NHS across the North West. Trust Boards will be asked to make a commitment to taking a new approach to workforce wellbeing by shifting the focus from absence management to holistic wellbeing support. Further information is awaited following the workshop and this will be provided to Board members for discussion and consideration.

Mental Health and Wellbeing Support

Following investment into the Occupational Health and Wellbeing Department to enable to appointment of a substantive Psychological Wellbeing Practitioner, a review of the provision mental health and wellbeing support to the workforce has been instigated. The impact of the current Employee Assistance Programme is also within the scope of this review.

Workforce Wellbeing Winter Plan

The Workforce Directorate is in the process of producing a Workforce Wellbeing Winter Plan. The plan will be based on evidence around wellbeing across the NHS workforce and on the specific needs of the Trust workforce. The plan will articulate the support available to our staff

throughout winter, over and above that which is already in place. The plan will be published in early November 2021 and will be evaluated in April 2021, to inform the Trust approach to wellbeing going forward.
Expected Impact: The impact of high sickness is increased pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance, and safety. Risks to Trust financial management, quality, patient safety and operational performance due to cost of sickness absence, expense of bank and agency cover will reduce as the sickness absence is gradually improved over the next quarter.

Staff turnover % (in month rate)

Executive Lead: Director of Workforce

Performance Issue:

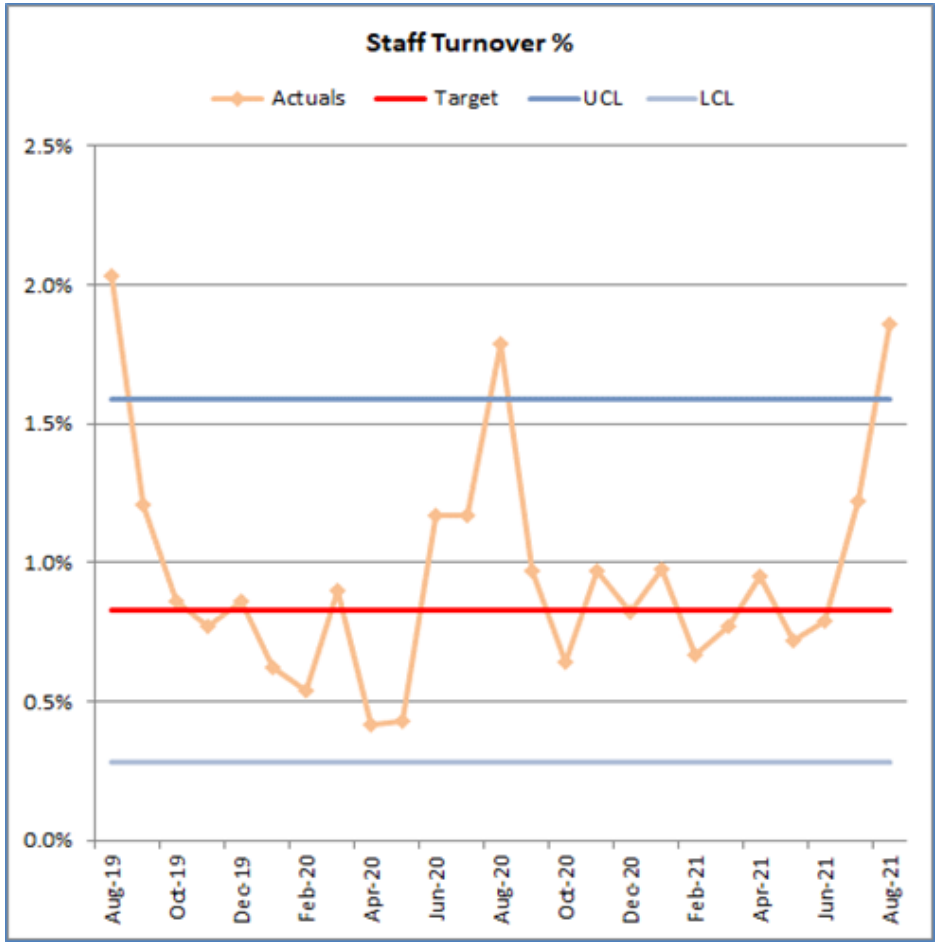
The Trust target is set as a maximum rolling 12-month turnover threshold of 10%. Turnover in August 2021 spiked significantly however this was due to the planned turnover of foundation year doctors and students. This increase does not therefore represent unplanned turnover, although the number of leavers within the Additional Clinical Services staff group was an outlier in month and will be reviewed in September 2021.

Actions:

Operational, clinical and HR staff continue to ensure that attention is focused on retention by reviewing the preceptorship programme, responding at pace to staff feedback via staff side colleagues, the freedom to speak up guardian, and guardian of safe working, and maximising access to wellbeing and staff support initiatives. An additional focus for 2021/22 is planned on development and support for line managers on key skills following feedback from the national NHS Staff Survey. Divisional level staff survey action plans have been produced.

Expected Impact:

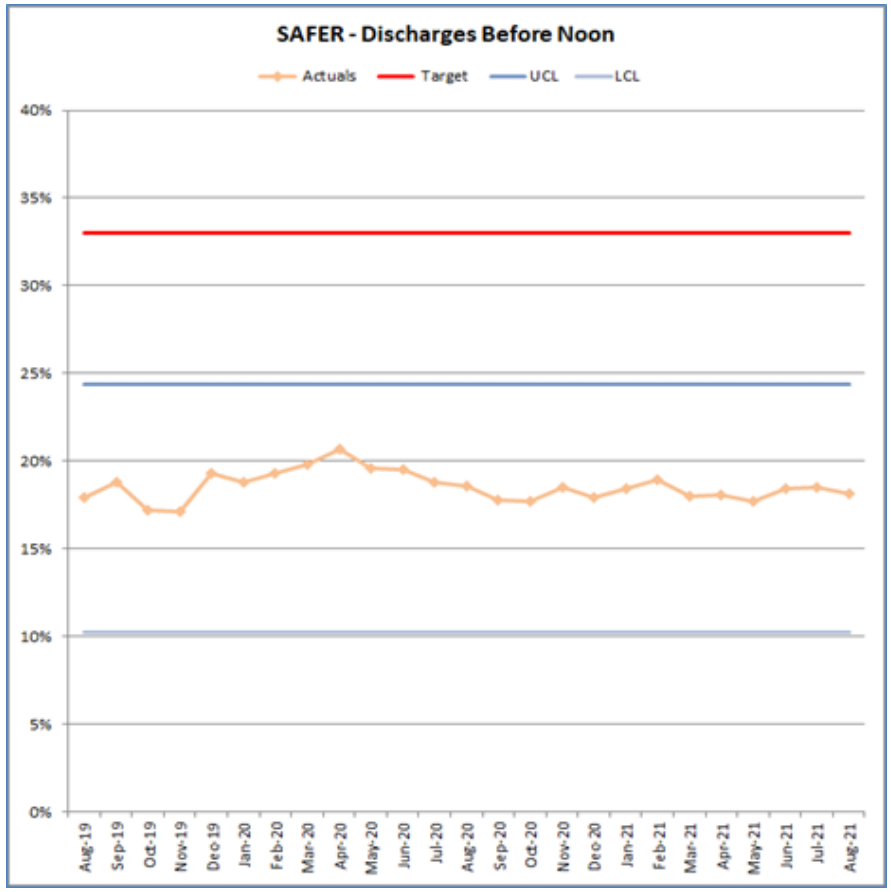
Embedding and benefit realisation from Recruitment & Retention Strategy and benefit from September 2021 following cohorts of managers receiving additional L&OD intervention to support them in their leadership roles.



Effective Domain

SAFER bundle: % of discharges taking place before noon

Executive Lead: Medical Director / Chief Operating Officer
Performance Issue: A WUTH target has been set that at a minimum 33% of inpatients are to be discharged before noon. The pattern of delivery has improved over the long term but is short of the optimum figure of 33%.
Action: The patient flow improvement programme has a dedicated workstream working on improving ward-based discharge processes. It is specifically focusing on: 1. the roll out of SAFER principles on board rounds 2. the improvement of discharge processes via the development of PDSAs. Controls have been put in place to ensure ward rounds have commenced as planned and is comprehensively staffed by senior decision makers.
Expected Impact: August data shows we are currently at 18.1% for patients discharged before midday.



Theatre in session utilisation %

Executive Lead: Chief Operating Officer

Performance Issue:

The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. During COVID prevalence increases there is a direct correlation to reduced in session utilisation.

Key reasons for this are patients are now being COVID swabbed on the day of surgery, as well as the established 3 days prior to admission, which is identifying asymptomatic COVID positive patients resulting in cancellations on the day.

Patients COVID swabbed 3 days prior to surgery who test positive means there is insufficient time to “backfill” as the patient wouldn’t be able to isolate for the required 3 days.

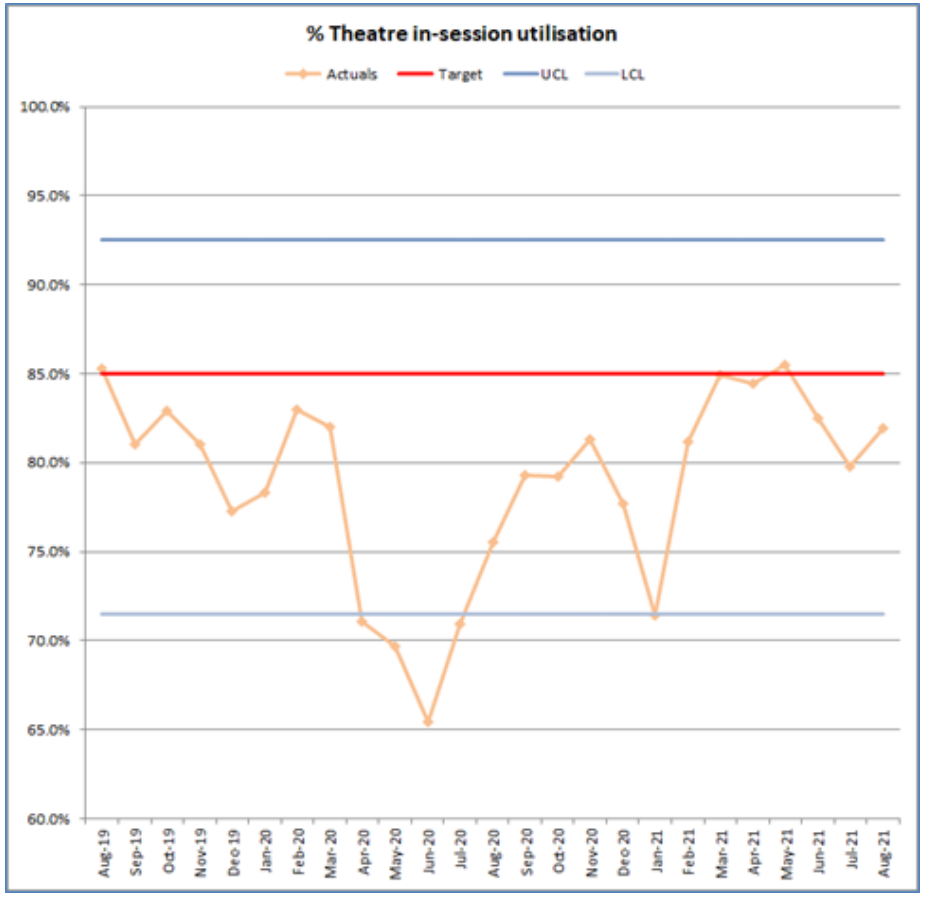
August has seen improved performance back up to 82.0%, with September on track to be at 85%

Staffing issues across the Trust in August remain a concern and have potential impact on theatre utilisation with theatre sessions cancelled to move theatre staff into ED and Critical Care.

COVID measures regarding PPE remain in place.

Action:

From March 8th the Trust has restarted its non-urgent elective programme in a phased manner. Monthly theatre activity has largely increased to typical pre-pandemic levels, though still impacted when a Surgeon or



Anesthetist, including household member shows COVID symptoms on the day.
Expected Impact: The increase in utilisation rates is expected to continue as activity returns to pre-pandemic levels on a consistent basis.

Same sex accommodation breaches

Executive Lead: Chief Nurse

Performance Issue:

The national standard is set that providers should not have mixed-sex accommodation, except where it is considered in the overall best interests of the patient or reflects personal choice.

Mixed sex breaches are largely due to patients waiting more than 24 hours for transfer from critical care areas to general wards – there was 1 such breach in August 2021. These reported breaches did not cause any delays or refused admissions to the Critical Care Unit as sufficient critical care bed capacity was available at this time. Patient's privacy and dignity needs are met whilst in critical care and the team ensures their specialty care is not compromised due to a lengthened critical care stay.

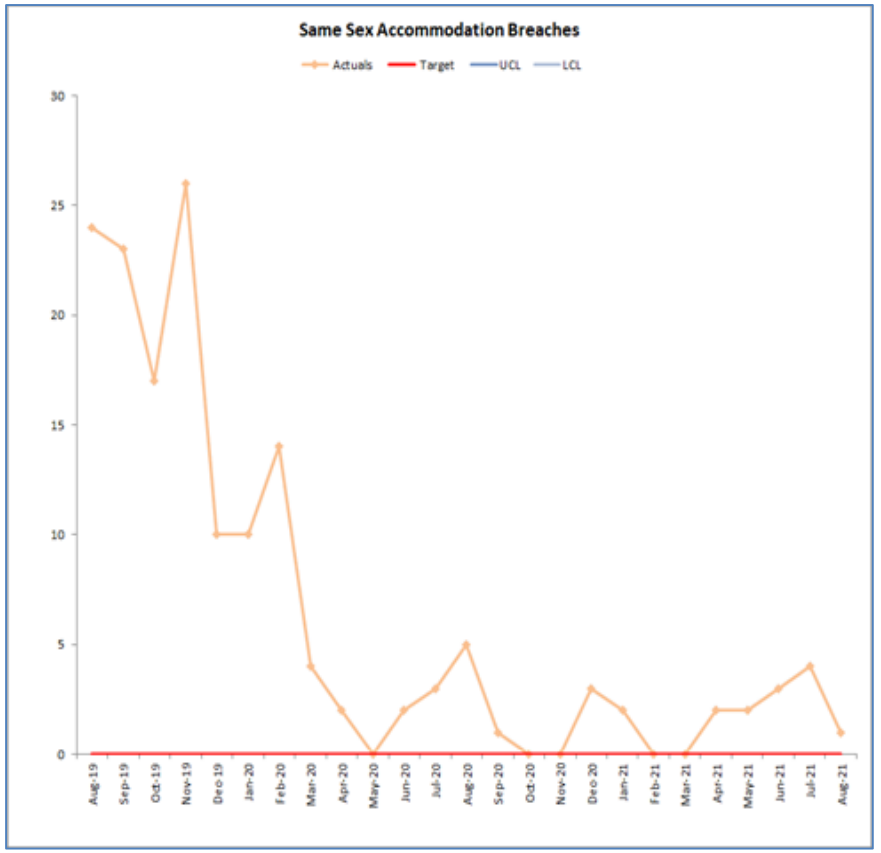
Action:

Joint working continues between Critical Care and Patient flow teams to expedite discharges in response to an increase in acuity of patients and extremely poorly Covid-19 positive patients.

The management of mixed sex breaches is considered as high priority and will continue to be managed via Bed Capacity and Bronze Command Meetings to ensure actions are taken to address these promptly. Critical Care Matron continues to attend the bed meetings to ensure focus remains high on any patients that are at risk or reported as mixed sex breaches.

Expected Impact:

All patients are transferred to their specialty bed within 24 hours of discharge



Responsive Domain

4-hour Accident and Emergency Target (including Arrowe Park Walk in Centre)

Executive Lead: Chief Operating Officer

Performance Issue:

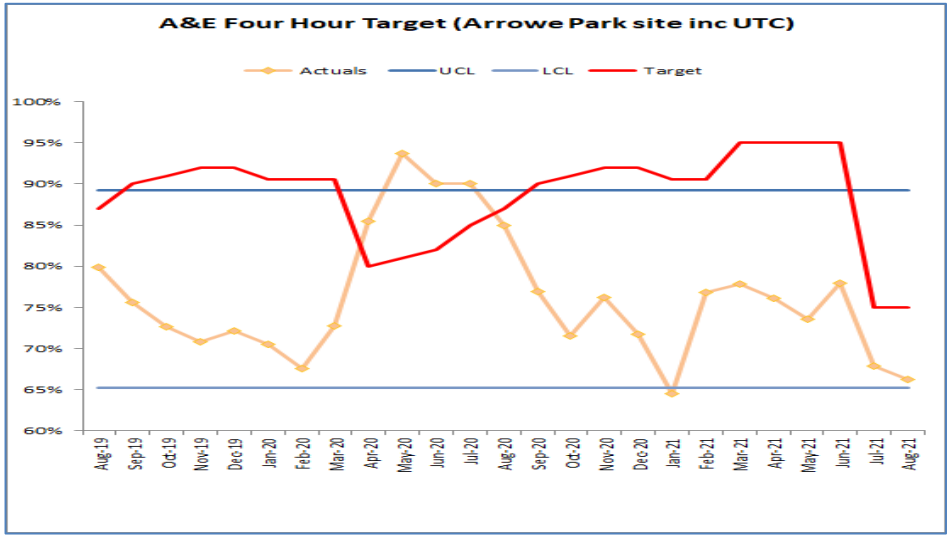
ED attendances have continued to exceed pre-covid levels since March 2021, hitting a peak during May-July of >300 attendances. July had started to see a reduction, but activity has started to increase again and is consistently >15% higher than 2019 levels. Hospital occupancy has remained consistently over 90% and has peaked at 99% in September. This compromises patient flow.

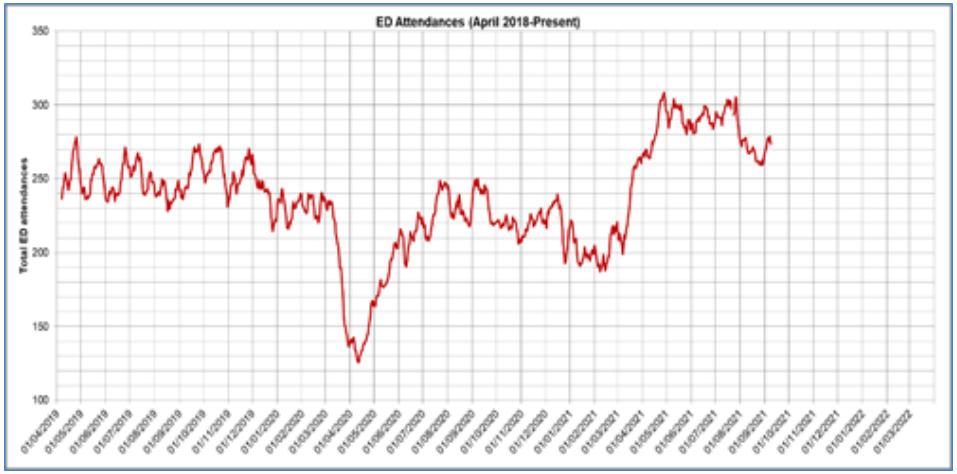
Bed capacity has been further compromised with the 3rd wave of covid with two designated covid wards and in September this has been compounded by an increase in nosocomial infections resulting in a number of beds being closed as part of the Trusts outbreak policy. The impact has resulted in performance of around 66.2% against the 4-hour standard. The challenges across mental health services have resulted in further 12-hour breaches in the Trust in August due to capacity of mental health beds.

Action:

The improvements in bed breaches have been maintained and accounts for only 5% of breaches in ED, however the delays have been challenged with the high number of attendances which is impacting on available capacity to see patients. Triage times and the time taken for initial assessment is the focus of the improvement plan and is tracked through the transformation agenda.

A new nursing leadership model has been implemented at the end of September with the focus on triage, diagnostics, rounding and quality. This is expected to improve triage times, diagnostics times and support wait to be seen by medic.





The workforce transformation plan will be presented to TMB in October following the work done with ECIST, this is an addition of the mobilisation of the winter plan.
Expected Impact: The Trust winter plan and the ED workforce plan is expected to bring the Trust back in line with its ED performance trajectory from October.

Referral to Treatment – incomplete pathways < 18 weeks

Executive Lead: Chief Operating Officer

Performance Issue:

The Trust had a trajectory agreed with NHSI for 2020-21 to maintain at 80% of patients waiting on incomplete Referral to Treatment pathways to be under 18 weeks.

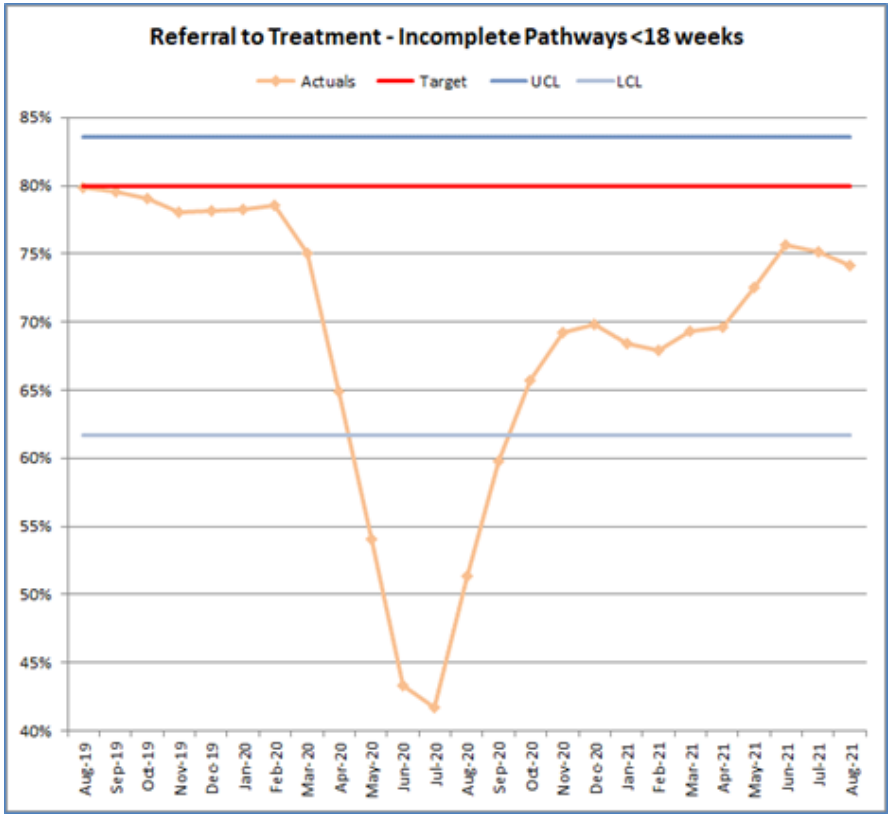
Following the directive to cease all non-urgent elective activities as part of the COVID response this metric sharply declined. The subsequent resumption of elective activity from July 2020 saw performance improve, until the onset of the Covid third wave from January 2021.

Referral to Treatment (RTT) performance for the Surgical Division in August 2021 was 65.98% against the agreed NHSI trajectory of 80%. September 2021 is currently at 65.13% as a result of staff taking higher amounts of leave (carried over from 20/21) and increase in COVID related sickness.

Underperformance of Divisional activity in August 2021 had an impact on RTT performance, increasing waiting times and list sizes. August activity performance when compared to August 19: New % (97) FUP % (106) DC % (79) IP % (82) against a target of 100% delivery across all four PODs.

Factors impacting activity delivery:

- Inability to staff extra lists (WLIs)
- Anaesthesia – On the day sickness, though do flex non-DCC sessions
- Oral Surgery – 1 consultant down and 1.5 SAS doctors down
- Vascular – theatre staff pulled to backfill lists with higher P status
- Cancellation of patients testing positive at day 3 swab and too short notice to backfill list due to isolation requirements



- Staff moved to support ED demands
- Higher A/L than in August 2019

Activity delivery will continue to be an issue largely due to nursing staff shortages within ED/Critical Care for which theatre lists have been taken down to enable theatre staff to support in those areas

National focus is moving to delivery of P2 patients (WUTH is ahead of trajectory) and having zero 104+ week waits from 31/3/22, which WUTH is on trajectory for.

Risks linked to medical admissions and challenges in Domiciliary care is restricting discharges, putting at risk the elective program. Winter plans are in place to minimize the impact which may mean only Cancer Elective surgery takes place.

Action:

From March 8th the Trust has restarted non urgent activities and has developed activity and performance trajectories.

To address Divisional activity underperformance the Division will:

- Offer consultants WLIs where possible (however reliant on consultant uptake)
- Use the independent sector, Insourcing & Outsourcing where possible
- Establishing High Volume Low Complexity lists at CGH

Expected Impact:

It is expected that the performance will improve moderately month on month but scenarios around referral growth will be monitored closely.

Activity levels in September are anticipated to increase as lower levels of A/L which will support improved Referral to Treatment performance.

Diagnostic Waiters, 6 weeks and over

Executive Lead: Chief Operating Officer

Performance Issue:

There is a national standard that patients awaiting diagnostic investigations should wait a maximum of six weeks. This is measured based on a specific subset of investigations, and with an expected tolerance that 99% or more patients waiting will be under six weeks. The position at the end of August 2021 was 86.0%. The main area of underperformance lies with endoscopy diagnostics (gastroscopy and colonoscopy). Whilst Endoscopy backlog and waiting times have steadily improved post-COVID, as of July 2021 overdue surveillance patients are now placed on the inpatient waiting list (as per national best practice) and counted within the DM01 denominator. This has negatively impacted on DM01 performance.

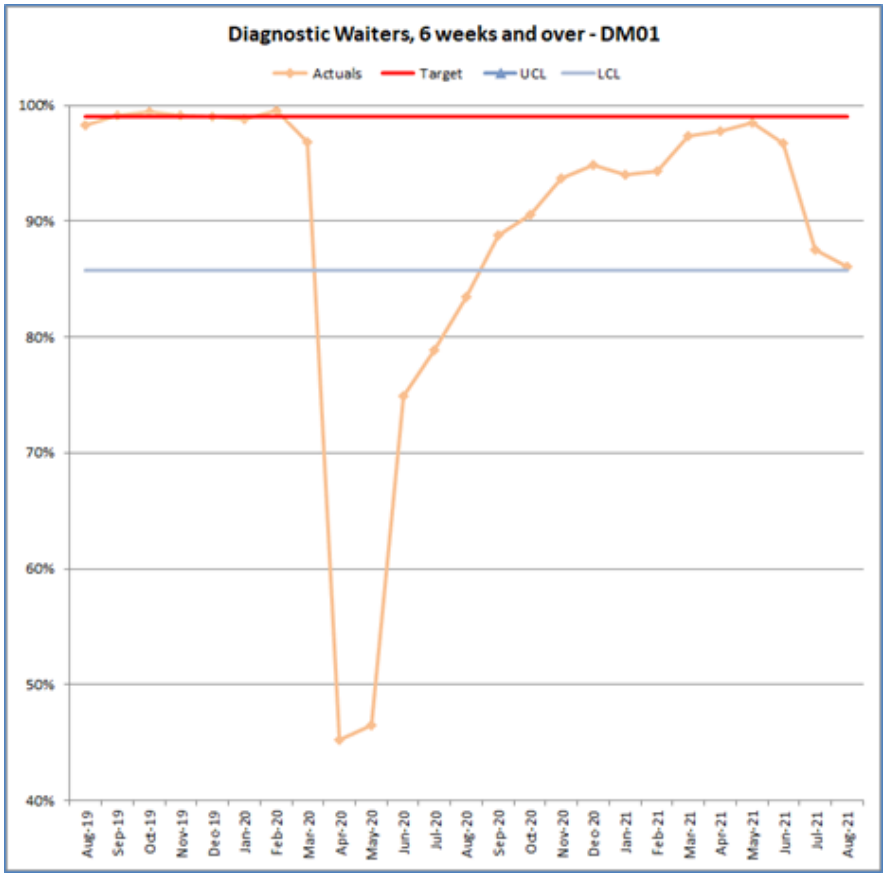
Under national waiting time rules, patients waiting for medically planned investigations are excluded. However, if they wait beyond their expected waiting time, they should become active waiters and included.

WUTH have a number of planned pathways where patients are now waiting beyond the time to be seen, and those waiters are now being included in the total position – hence the deterioration since the end of May.

Action:

The recovery of diagnostic backlogs is part of the overall reset and recovery programme and trajectories, including the clinical validation of priority.

Endoscopy have submitted an improved activity trajectory for October-December that takes into account the additional activity that can be performed as a result of two recent improvements: 1) successfully sourced a second insourcing provider to delivery additional activity, 2) decontamination washer replacement programme now full complete.



Expected Impact:

The ongoing inclusion of ‘overdue’ planned cases is expected to further deteriorate the Trust position, with subsequent improvement through the reset and recovery programme

Number of complaints received in month per 1000 staff

Executive Lead: Chief Nurse

Performance Issue:

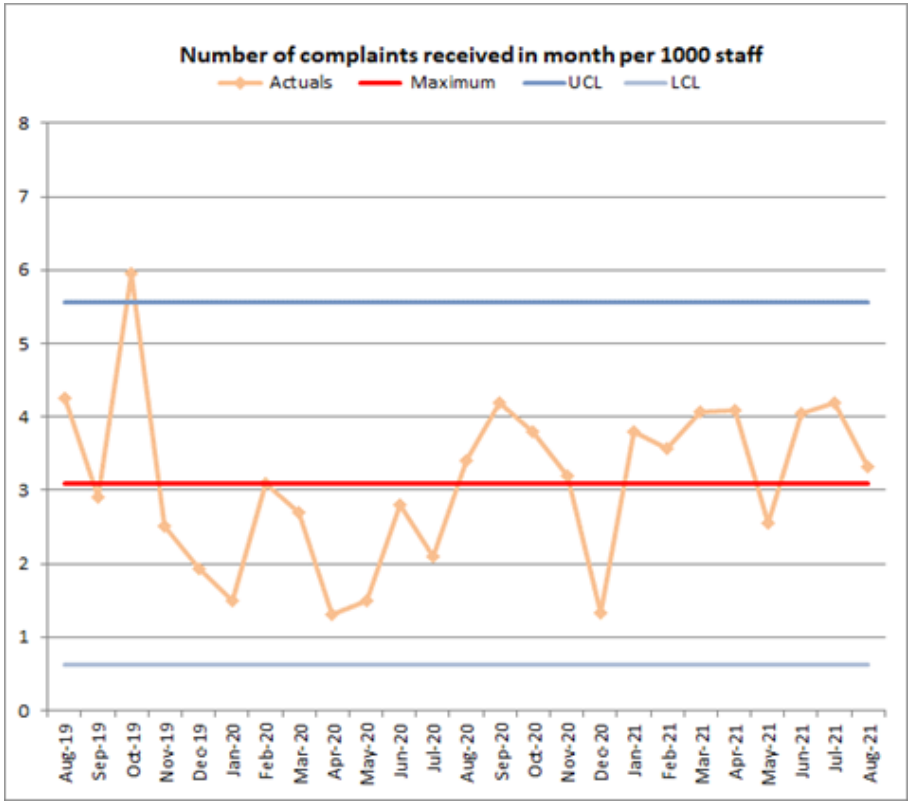
WUTH has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per 1000 staff. The rate for August 2021 was 3.31

Action:

In August 2018 we registered 18 formal complaints. The average for this year, 2021/22 has been 19. In 2020/21, the average was 15, in 2019/20 it was 16, and in 2018/19 it was 23.
The largest thematic category for complaints in August 2021 was 'Treatment and Procedure' (50%) – most frequently delay in emergency care treatment / waiting times. The other significant category was 'Communication' (28%) – usually a perceived lack of communication with patient or family. During the past 18 months, with visiting restricted, this has been a consistent theme, with relatives and patients encountering difficulties in contacting wards and departments respectively.
Targeted work to improve communication has been led via the Clinical Advisory Group, the Trust continues with the Family Support Team also to support communication with families.

Expected Impact:

It is not practicable to suggest actions to reduce the number of complaints received in month, given that they are still under investigation and actions – if any – are yet to be established. Work is, however, already ongoing to review ED care, while 'Communication' and current divisional strategies to address this was discussed at a recent CAG meeting, as it was acknowledged that this problem had been amplified by the restriction on visiting.



Well-led Domain

Appraisal compliance %

Executive Lead: Director of HR / OD

Performance Issue:

The target for annual appraisal compliance is 88%. Compliance at the end of August 2021 was 82.23%.

Although this standard has not been achieved, the previous month's compliance has been sustained despite an increase in sickness absence in month.

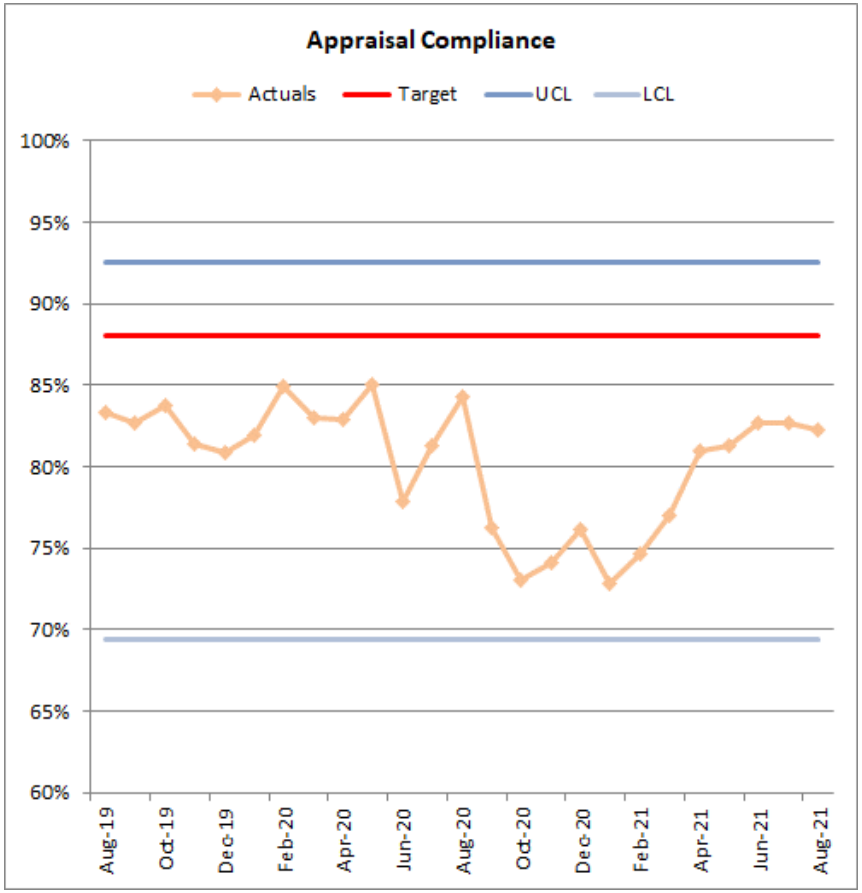
From a divisional perspective, Corporate, Medicine and Acute, Surgery, and Women's and Children's, have all continued to increase compliance since February 2021. Women's and Children's and the COVID-19 Vaccination Hub met the 88% compliance target at the end of August 2021.

Corporate Division continues to have the lowest compliance rate at 73.70%.

Please note that Medical appraisal is currently excluded from the above figures.

Action:
Workforce compliance data is available to Divisions and the HR Services team to enable them to manage non-compliance for their areas and alerts of appraisals due are generated via the ESR system.

Detailed compliance reports are received by the Education Governance Group and the OD Team and HR Business Partners continue to support Divisional Management teams to identify and deliver actions to address low levels of compliance in specific areas. Targeted action will be undertaken to alert Corporate



Leads of outstanding appraisals in their area to support improvements in compliance across this Division. Check and challenge discussions take place at a divisional triumvirate levels and recommencement of divisional performance review meetings will see this challenged further.
Expected Impact: Improvement in trajectory as the Trust returns to business as usual.

Agenda Item: 21/22-135

BOARD OF DIRECTORS
30 September 2021

Title:	Learning from Deaths Report
Responsible Director:	Dr Nikki Stevenson, Executive Medical Director
Presented by:	Dr Ranjeev Mehra, Deputy Medical Director

Executive Summary
Contextual and background information pertinent to the situation / purpose of the report.

This paper represents the Wirral University Teaching Hospitals (WUTH) *Learning from Deaths* report and reports on deaths observed in Q1 2021-2022

Key points:

- The medical examiners continue to provide 100% scrutiny of adult deaths
- SHMI remains within expected range on the latest available data
- HSMR remains within expected range on the latest available data
- Analysis of Dr Foster data has led to focused work in areas with potential for improvement
- Mortality review process has been reviewed to align it with the SI process.
- This report has been presented at Patient Safety and Quality Board (Aug 21) and at Quality Committee (Sept 21)

Recommendation:
(e.g. to note, approve, endorse)
What action / recommendation is needed, what needs to happen and by when?

To note the ongoing workstreams around mortality and the reduction in mortality indicators that are currently within acceptable limits.

Which strategic objectives this report provides information about:	
Outstanding Care	**Yes** / no
Compassionate Workforce	**Yes** / no
Continuous Improvement	**Yes /** no
Our Partners	**Yes** / no
Infrastructure	Yes / **no**

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
None
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
CQC essential standards

Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)	
None	
Specific communications and stakeholder /staff engagement implications	
Local and system learning issues	
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
None	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
None	
Previous considerations by the Board / Board sub-committees	
Background papers / supporting information	

PATIENT SAFETY AND QUALITY BOARD
4th August 2021

LEARNING FORM DEATHS REPORT (Q1)

Purpose

To provide a summary of the mortality review process, care issues, learning and current mortality comparator statistics.

Introduction / Background

The Learning from Deaths Guidance published in March 2017 by the National Quality Board for NHS Trusts and Commissioners in England identified the requirement for Trusts to report on the numbers and outcomes of deaths. To support Trusts the National Quality Board generated a Mortality Reporting Dashboard as a suggested tool to aid the systematic recording of deaths and learning. The Learning from Deaths Report has been adapted in line with this National Guidance and incorporates the required National Reporting Criteria.

The Medical Examiner role was to be introduced by April 2020 in acute trusts and its' introduction was delayed till August 2020 due to the COVID pandemic. The role of the medical examiners is to;

- agree the proposed cause of death and the overall accuracy of the medical certificate cause of death
- discuss the cause of death with the next of kin/informant and establishing if they have any concerns with care that could have impacted/led to death
- act as a medical advice resource for the local coroner
- inform the selection of cases for further review under local mortality arrangements and contributing to other clinical governance procedures

Patient demographics

There were a total of 390 deaths in Q1 (Apr21- Jun 21). Of these only 3 were registered as Covid-19 on the death certificate.

Category	Female	Male
Covid *	1	2
Not Covid	174	213
Total	**175**	**215**

** Defined as a death within 28 days of a Covid-19 positive result*

Age Band	Total
0-9	3
10-19	2
20-29	2
30-39	4
40-49	13
50-59	29
60-69	45
70-79	113
80-89	116
90-99	62
100+	1

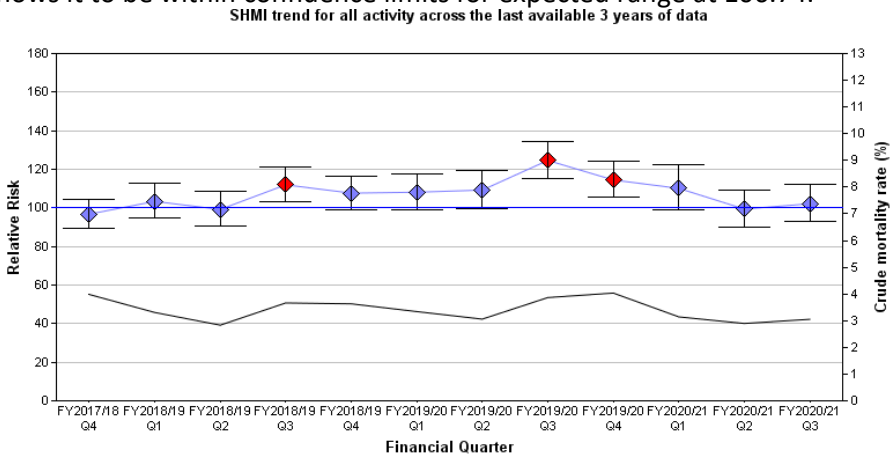
Ethnic Category	Deaths
White - British	345
White - Irish	3
White - Any other White background	5
Mixed - Any other mixed background	1
Asian or Asian British - Indian	1
Asian or Asian British - Pakistani	1
Asian or Asian British - Any other Asian background	1
Other Ethnic Groups - Any other ethnic group	1
Not stated	27
Not known	5
Total	**390**

Mortality Comparators

Due to delays in data analysis at a national level the latest figures on mortality comparators are from Dec 2020.

Summary Hospital Level Mortality Indicator (SHIMI)

The SHIMI has fallen consistently over the past 12 months and the latest available data shows it to be within confidence limits for expected range at 106.74.

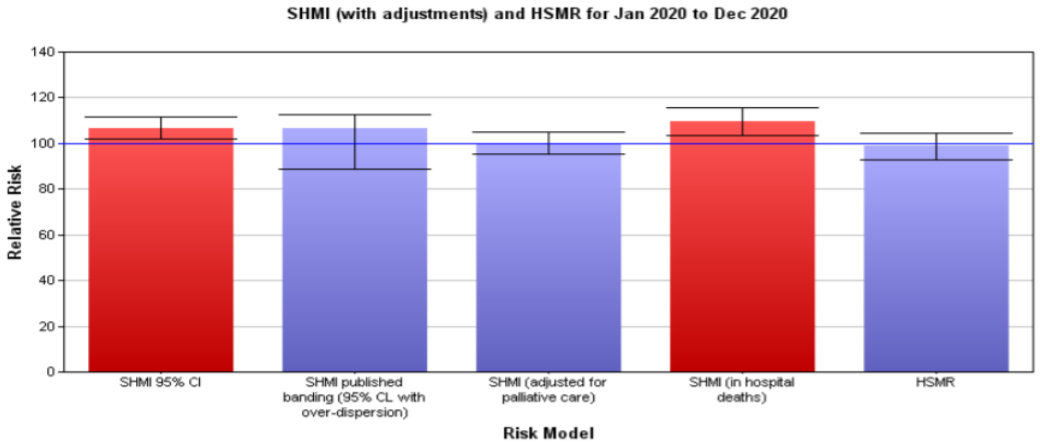


Hospital Standardised Mortality Ratio (HSMR)

The HSMR remains with in expected range at 98.71.

One of the main drivers for the difference between SHIMI and HSMR is palliative care coding as SHIMI does not account for this while HSMR does. Once we adjust for palliative care coding te SHIMI falls to 100.14.

SHMI (with adjustments) and HSMR for Jan 2020 to Dec 2020



Model	SHMI Spells	SHMI
SHMI 95% CI	55127	106.74
SHMI published banding (95% CL with over-dispersion)	55125	106.76
SHMI (adjusted for palliative care)	55127	100.14
SHMI (in hospital deaths)	55127	109.34
HSMR	27614	98.71

The Trust Mortality review Group is coordinating a review of our palliative care coding and how this impacts our mortality indicators.

Medical Examiner Scrutiny

Summary of all Adult in patient deaths					
	Total Adult In-patients Deaths (ME review)	Total Reviewed by Med Examiner	Total No of PMRs (concerns)	Total No of SJR and SI deaths	Total reviewed
Q1 (20-21)	533	0	27	20	47
Q2 (20-21)	383	331	79 (0)	8	87
Q3 (20-21)	572	572	76 (4)	8	84
Q4 (20-21)	588	588	57 (1)	5	62
Q1 (21-22)	390	394	21 (0)	5	26

Learning Disability Mortality Reviews				
20/21	Total No. of LD Deaths	No. reviewed using SJR	Problems in Health care	Referred to LeDeR
Q1 (20-21)	4	4	1	4
Q2 (20-21)	2	2	0	2
Q3 (20-21)	0	0	0	0
Q4 (20-21)	0	0	0	0
Q1 (21-22)	0	0	0	0

Grading of Adult Care and avoidability (Following SJR review)				
	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
Q1	2	2	1	0

Perinatal Deaths and Stillbirths				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome for mother or baby	Care issues, may have affected outcome for mother or baby	Care issues, definitely affected outcome for mother or baby
Q1	1	2	0	0

The medical examiners (MEs) continue to maintain 100% scrutiny of all WUTH adult deaths. The process for escalation of cases from the ME has been reviewed to avoid duplication of work with the SI process, and to allow better triangulation of data from mortality reviews. An updated flow diagram is included in appendix A.

26 (6.5%) cases have been escalated by the ME to the mortality review group during Q1. All cases requiring review have been escalated for PMR or SJR through the Mortality Review Group. The review of process has led to delays in allocation of case reviews, and outcomes from these cases will be reported in Q2. During Q1 there was 1 death associated with nosocomial Covid-19, and this accounts for the lower number of PMR's undertaken during this quarter when compared to previous quarters.

Following the compilation of this report a further review of Learning Disability deaths for this calendar year was undertaken to give assurance. During this review it was discovered that we have had a total of 3 deaths in Learning Disability patients from January 2021- June 2021.
The delay in reporting was partially due to changes in the national LeDeR programme (Learning Disability Mortality Review) and delays in internal escalation of learning disability deaths.
Internal process has now been strengthened to ensure any death occurring in a learning disability patient is highlighted to the Lead Nurse for Learning disabilities in real time. All these cases are currently undergoing a Structured Mortality Review as per the agreed process.

Learning identified through review of mortality reviews during Q1

1. Withhold ACE inhibitors on day of surgery to prevent hypotension
2. Inability to acess fast track palliative care discharge home
3. Requirement for a guideline to aid management of Acute Pancreatitis
4. Importance of following local and national IPC guidance when isolating patients.
5. Identifying patients requiring palliative care at an earlier stage of their hospital stay.

Learning identified from mortality reviews and from the Medical Examiner scrutiny is discussed and logged at the Mortality Review Group. This is then feedback to the clinical divisions by the divisional mortality leads.

Dr Foster Data

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

Review of the latest Dr Foster data has highlighted two areas for further work;

1) Malignant neoplasm without specification of site

Dr Foster data shows WUTH to be an outlier for this diagnostic group. There seems to be a direct correlation between the start of the pandemic and the increase in relative risk for this group of patients. Although there were only 8 patients in this group the mortality review group has asked for a case note review of all 8 patients to identify learning and themes and will feedback in due course.

2) Pneumonia

Although SHIMI for pneumonia patients overall is within expected range, when we look at pneumonia deaths in hospital it is above expected range. Further analysis of the data has shown that;

- For Pneumonia, the Trust had a higher percentage of patients who received specialist palliative care, at 13.4% compared to a NW peer average of 9.3%. This will not be taken into account in the SHMI model and subsequent expected risk, for these patients.

- Only 74% of deaths were attributed to pneumonia, by the end of the patients pathway of care. The remaining 26% of deaths were attributed to other diagnoses including: Covid-19, cancer of bronchus/lung, septicaemia, aspiration pneumonitis.

Improving care for pneumonia patients is one of the Trusts quality improvement projects facilitated through AQUA, and this work will be monitored through the Trust Clinical Effectiveness Group and the Patient Safety and Quality Board

Conclusions

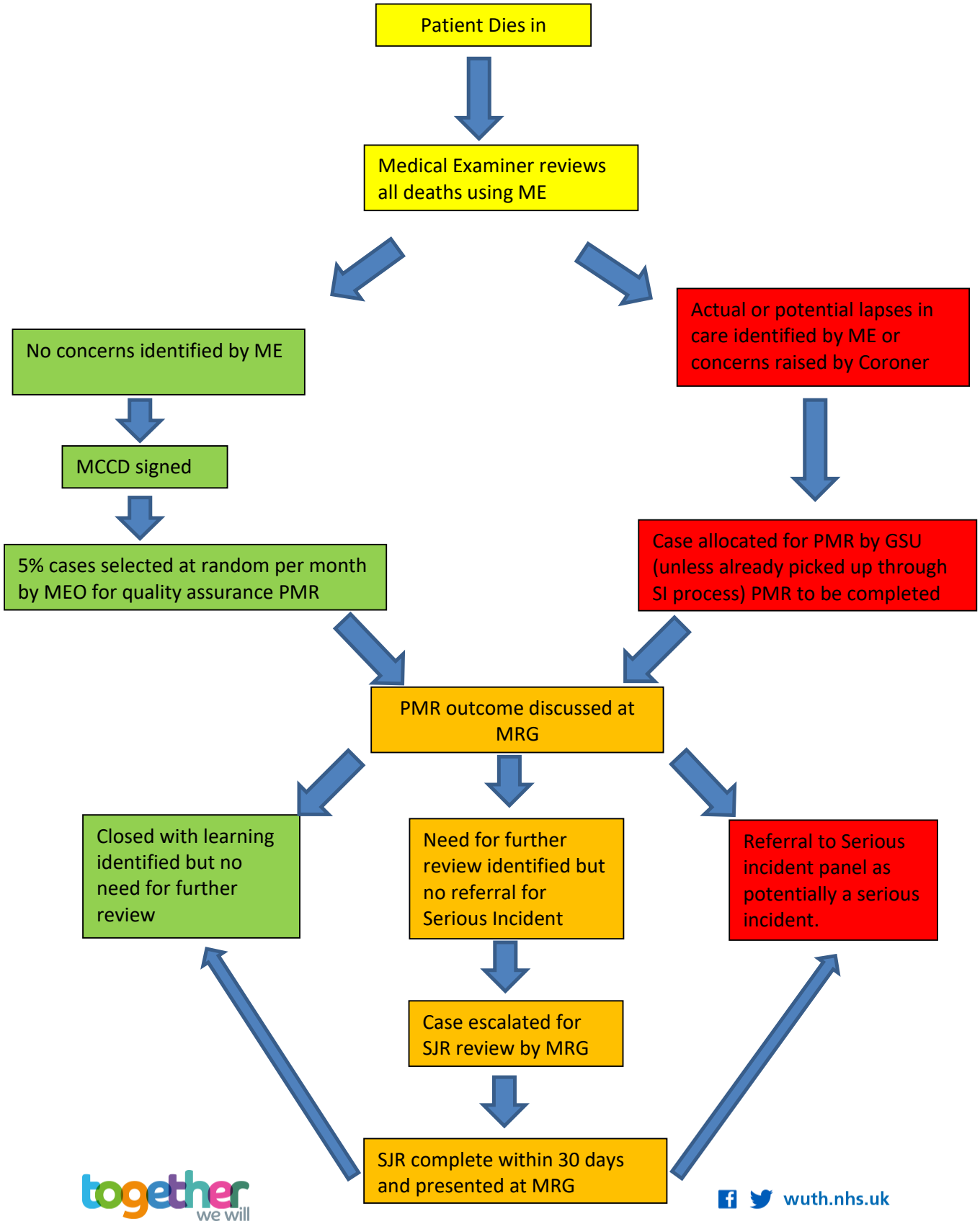
The Trust mortality indicators remain with the expected range, and the number of total deaths for Q1 has decreased as the number of Covid-19 patients has decreased. There were 3 deaths attributed to Covid-19 for Q1.

The medical examiner continues to provide 100% scrutiny for all adult deaths, and escalates concerns to the Mortality Review Group for further review. Learning from these reviews is disseminated through the Trust Divisional structures.

Dr Foster data as highlighted 2 areas for further focus (malignant neoplasm without site and pneumonia) and this work will be coordinated through the mortality review group and clinical effectiveness group.

Appendix A

Mortality Review Process



Cases referred for mortality review outside of the medical examiner framework.

The following cases will automatically be escalated for mortality review.

- Any death where to patient was an elective surgical admission to undergo a SJR (Highlighted to MRG by the MEO)

- Any death where families have raised concerns through the ME office to undergo a SJR. Concerns raised through the formal complaint process will be picked up through the SI process.

- Any death escalated to the MRG by departmental mortality process to undergo a SJR (Escalated to MRG by the departmental mortality lead)

- All deaths where the deceased was identified as having Learning Disabilities referred for LeDeR reviews (referred by the Learning Disabilities lead nurse). LeDeR reviews to be presented at MRG to highlight learning.

Agenda Item:
2122-136

Board of Directors
6th October
2021

Title:	Quarterly Update - Maternity Services including an overview of the Continuity of Carer Model of Midwifery Care & Birthrate+ review findings.
Responsible Director:	Tracey Fennell, Deputy Chief Nurse
Presented by:	Debbie Edwards Director of Nursing & Midwifery, Women & Children's Division

Executive Summary

The last quarterly update to Trust Board was presented in July 2021 which provided an update on Trust compliance with the Maternity Incentive Scheme (MIS) 10 Safety Actions, this included a summary of the evidence supporting the declaration with Year 3 requirements.

This paper provides an update and further oversight of the quality and safety of maternity services at Wirral University Teaching Hospital NHSF Trust (WUTH) and focuses on a staffing review undertaken by Birthrate+ (a specific midwifery staffing tool used nationally to assess midwifery staffing requirements within maternity services). In addition a further update on the Continuity of Carer model of care and the proposal for WUTH to implement this model of care for all women. The report also includes reference to the challenges recently experienced in maternity services given the extreme pressures with maternity staffing regionally and nationally.

Recommendation: (e.g. to note, approve, endorse)
To note

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	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

Please provide details of the risks associated with the subject of this paper,

including new risks (x-reference to the Board Assurance Framework and significant risk register)
BAF references 1,2,4. **Positives:** Full compliance with the Perinatal Clinical Surveillance Quality Assurance Report Compliance with the Gap analysis – Maternity and Neonatal 8 Point Plan. **Gaps:** • Midwifery staffing deficit for implementation of a Continuity of Carer model
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
NHSI – Planning Guidance , CQC Essential Standards
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Maternity Incentive Scheme; Staffing expenditure
Specific communications and stakeholder /staff engagement implications
Stakeholder confidence
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
NMC Code , NHS Constitution, NHS People Plan; NHSE Transformation Programme
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)
NA

Previous considerations by the Board / Board sub-committees	Quarterly Maternity updates to Board – March 2021; July 2021.
Background papers / supporting information	

Purpose

This report provides a quarterly update and further oversight of the quality and safety of maternity services at Wirral University Teaching Hospital NHSF Trust (WUTH)

1. Maternity Staffing including an update on the findings following the Birthrate+ review

During the last maternity update presented to Board, it was noted that a bid had been submitted (as part of NHSE Service Development Funding) for additional obstetric and midwifery posts. Whilst the current staffing establishment meets the needs of the service it was identified that additional staffing was required to introduce continuity of carer to all women, to meet the recommendations from Ockenden and to deliver the increased training requirements of maternity staff from 2021-22.

WUTH was successful in its bid for additional funding with an additional 0.6wte Consultant Obstetrician funded and a total of 10.1wte Band 6 Midwives totalling almost £400,000.

Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

Current processes within the maternity service ensure that on a daily basis staff are deployed effectively within the service including the flexing of staff across both the acute and community

care settings. Delivery Suite use a daily acuity tool that formally assesses acuity every 4 hours as a minimum. This at times of high acuity is assessed more frequently and there are plans regionally to further progress the acuity reporting to a regional platform.

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwife units through to regional referral centres, and from units that undertake 10 births annually through to those that have in excess of 8000 births. In addition, it caters for the various models of providing care, such as traditional, community based teams and continuity caseload teams. It is responsive to local factors such as demographics of the population; socio-economic needs; rurality issues; complexity of associated neo-natal services, etc. The methodology remains responsive to changes in government policies on maternity services and clinical practices. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care.

Summary of Results

The BR+ Report is based on a 24% uplift to reflect the additional training requirements included in Year 4 of the MIS which equates to an additional 40hours per week per midwife and is also based on the following:

2020 activity and delivering 36% Continuity of Carer the clinical total recommended for Wirral University Teaching Hospitals NHSFT is 137.61wte, of this 123.85wte are Registered Midwives bands 5 -7 and 13.76wte MSWs providing postnatal care (on the ward/community).

Table 1 Summarises the staffing requirements identified by Birthrate Plus (wte) whilst considering the current funded establishment and that required to meet 100% Continuity of Carer model of care.

	BIRTHRATE PLUS WTE Bands 3 to 8	**CURRENT FUNDED WTE** Bands 3 to 8	**VARIANCE with current wte**
Core Services and with Continuity Teams at 100%	158.79	141.23	-17.56

The NHSE bid outlined the need for a total of 18wte midwives to deliver 100% continuity of carer with 10.1wte funding secured. The proposed establishment with the Continuity of Carer model of midwifery care following BR+ establishment review is 158.79wte which when offset by the current establishment (including 10.1wte from NHSE) leaves a deficit of 7.46wte

The additional posts have all been filled with newly qualified midwives following student expansion regionally. There is progression of International recruitment of midwives regionally but at present this is not required at WUTH due to effective recruitment and retention of midwives. A business case will be developed to support meeting the 7.46wte deficit identified in midwifery staffing, to further improve and fully implement the continuity of carer model of care.

2. Continuity of Carer:

The benefits of women being cared for within Continuity of carer model of care cannot be underestimated. Care provided by the same team of midwives throughout pregnancy including the delivery and into the postnatal period demonstrates improved. clinical outcomes with women reporting improved birth experiences and less likely to experience postnatal illness.

WUTH has partially implemented Continuity of carer and currently month on month delivers a continuity of carer rate of above 35%. In the 2021-22 NHSE/I Planning Guidance it states a target of 51% (of all women) receiving this model of care by March 2022, with 100% of women receiving this model of care by the end of March 2023.

As highlighted above there is a need for additional staff to deliver this model of care, and to prevent a two tier system being delivered in maternity services where care with the continuity of carer team is favored by women and their families with improved experiences. Progression to a continuity of carer rate of 100% is the preferred option and an additional 7.46wte midwifery posts are required to deliver this with an uplift of 24%. Whilst it is recognised that the NHS Planning Guidance sets out a trajectory of 100% by March 2023 it is proposed that WUTH look at this being introduced before June 2022 (subject to the timeliness of the organisational change requirements) given the inequity in care currently being delivered through two separate models of care.

It is important to mention that there is pressure from the Royal College of Midwives to pause the introduction of this model due to the increasing demands of the service however, NHSE have confirmed that providing the midwifery establishment meets the requirements outlined in the BR+ review, engagement takes place with staff regarding the changes to the model of midwifery care and that staff are supported from a training perspective that the roll out of the Continuity of Carer model of care should continue.

3. Maternity Incentive Scheme (MIS) – Year 4

NHS Resolution has published the Year 4 Maternity Incentive Scheme (MIS) with updated Safety Actions requiring Trusts to further improve and deliver enhanced and safer maternity care. Feedback has been given to NHSR regarding the expectation of some safety actions and a revision of these is currently being considered by NHSR.

Compliance with all of the Safety Actions outlined in Year 4 of the scheme will be a challenge however a progress update will be presented to Board in December 2021.

4. The Perinatal Clinical Surveillance Quality Assurance Report

The Perinatal Clinical Surveillance Quality Assurance Report provides oversight to the Board against key metrics and is included in Appendix 1. The Perinatal Clinical Surveillance Quality Assurance Report continues to report against the following themes:

Clinical care

Service user and staff feedback

Leadership and relationships

Safety and learning culture

Incident reporting

Governance processes

CQC Inspections & DHSC / NHSE/I request for support.

The regional template for reporting Perinatal Clinical Surveillance Quality is yet to be published therefore the WUTH developed template continues to be used for assurance reporting.

5. The C&M Clinical Outcome / Outlier Report

The latest outlier report for clinical outcomes is included in Appendix 2. Discussion has taken place regionally regarding the management of timely submission of data by some providers and its impact when data is missing. A revised process of escalation is being developed to alert the Director of Midwifery and Chief Nurse of non-compliance with submission to improve the reporting of data with the regional Quality and Safety Surveillance Group (QSSG) and the LMS having oversight of this.

6. Serious Incidents (SI's) & Health Care Safety Investigation Branch (HSIB):

The number of serious incidents (SI's) are reported on the regional dashboard and to the LMS by all maternity providers. The newly formed Quality and Safety Surveillance Group (QSSG) will have further oversight of all SI's across the region and are currently developing an SI overview panel with a view to integrating this into the requirements of the Integrated Care System/Board.

HSIB undertake independent investigation into incidents within maternity services that fall under defined criteria that include maternal deaths, stillbirths and babies that require cooling**.** All cases have external representation working with HSIB when reviewing cases, and if it is evident that harm has been caused then involvement from NHS Resolution is progressed at an early stage.

All HSIB case reviews and SI's involve input from the woman and the family and once concluded are shared with the woman and her family. An update regarding current ongoing SI's is included in Appendix 3. The detail of these SI's will be included in the next quarterly Board report.

7. Safety Champion Report

The Maternity Safety Champions continue to meet on a bimonthly basis with an action log capturing work to date (Appendix 4). A verbal update from the Non Executive Safety Champion at each Board meeting further supports update on the ongoing work.

With the retirement of Hazel Richards as Chief Nurse, the role of the Executive Safety Champion will be filled on an interim basis by Tracey Fennell (Interim Chief Nurse). Update through social media regarding the work of the safety champion has been undertaken with the Trust Communications team to celebrate World Patient Safety Day on the 17th September 2021.

8. NHS Digital / Funding to develop IT provision in Maternity Services:

NHSE/I recently contacted all Trusts to outline an opportunity for providers to bid for monies to further support IT systems within maternity services. Prior to any submission NHSE has undertaken a mapping exercise to determine the maturity of digitalisation within each Trust. The W&C Division has worked closely with WUTH IT team to complete a Digital Maturity assessment which will inform the bid proposal.

It is anticipated that work to develop digitalisation will be in collaboration with the LMS and ICS but further detail is awaited.

9. Gap Analysis – NHSE Maternity & Neonatal Services Action Plan (8 Point Plan)

This updated NHSE document published in July 2021 outlines immediate and medium term actions to ensure the safe care of pregnant women who have tested positive for COVID19 and includes reference to the management of current pressures on maternity and neonatal services.

These have been reviewed with an update on compliance is included in Appendix 5, whilst there are areas of non-compliance these include the Health Visitor and Community Trust 0-19 team who have been approached to implement these actions. The Pharmacy department are

also working closely with Primary Care to further improve compliance with the Covid vaccination Programme.

Work is ongoing with the Trust to support unvaccinated staff and pregnant women having a COVID vaccine, however identification of staff who haven't been vaccinated has proved difficult.

10. Maternity Escalation and Divert

Maternity services both regionally and nationally have experienced an increase in acuity and demand. Within Cheshire & Merseyside extreme pressure has been experienced by several maternity providers resulting in escalation and the divert of women in labour to other providers. This has been extremely challenging given the closure / divert of women from Liverpool Women's Hospital on several occasions. WUTH has experienced an increase in the frequency of internal escalation due to reduced staffing and high acuity and this is further detailed in the 6 monthly staffing report.

A weekly Gold Command meeting has been set up and takes place at least weekly with a view to identifying any particular hotspots in a timely manner. This has been beneficial however providers have been challenged resulting in the divert of services.

The Cheshire & Merseyside Escalation and Divert policy has been revised and operationalised and adopted by Trusts on the 1st September 2021 which further supports the management of escalation and divert.

One aspect of clinical practice contributing to the increasing acuity across the maternity system is the increase seen in women undergoing induction of labour. It is envisaged that numbers will further increase given the imminent publication of revised guidance from NICE. A separate piece of work is being undertaken to see how this can be best managed given its impact at times on patient flow.

WUTH has experienced episodes of delayed patient care (namely Induction of labour) and an increase in the frequency of internal escalation – staff have voiced concern at this and weekly engagement sessions have been introduced to ensure staff are updated on actions being taken to support. This has also included support from staff side and also support from the FTSU Champion. Senior Midwifery managers are also providing an out of hours support to the maternity bleepholder. The number of women choosing to birth at WUTH has also been steadily increasing from May 2021.

9. Conclusion:

In summary the focus on the delivery of high quality, safe maternity care continues with the publication of Year 4 of the MIS, development of the regional QSSG and the alignment of the LMS to the ICS across C&M.

The last few months have provided significant challenge at timesto the service with increased staff absence, higher acuity of women and the divert of maternity services including several diverts from Liverpool Women's Hospital/other providers which has impacted on the demand in services at WUTH. In an attempt to maintain safe maternity services at WUTH it has been necessary to initiate the escalation policy on a regular basis which has impacted on staff having to work additional hours. The daily sitrep reported to NHSE looks retrospectively at acuity and escalation and the weekly Maternity Gold Command meeting looks at demand and capacity in real time and prospectively. The LMS are working with the HOMs to implement an acuity tool in all providers to report acuity on a 4hourly basis to further support NWAS and providers at time of high acuity leading to requests for divert of services.

The C&M Divert Policy has been reviewed and in collaboration with NHSE, NWAS and the LMS a revised policy is being introduced 1st September 2021. This will be reviewed in 3 months time with a proposal for the policy to then extend to cover the whole of the North West.

10. Recommendations to the Board

The Board of Directors are requested to note the contents of report specifically,

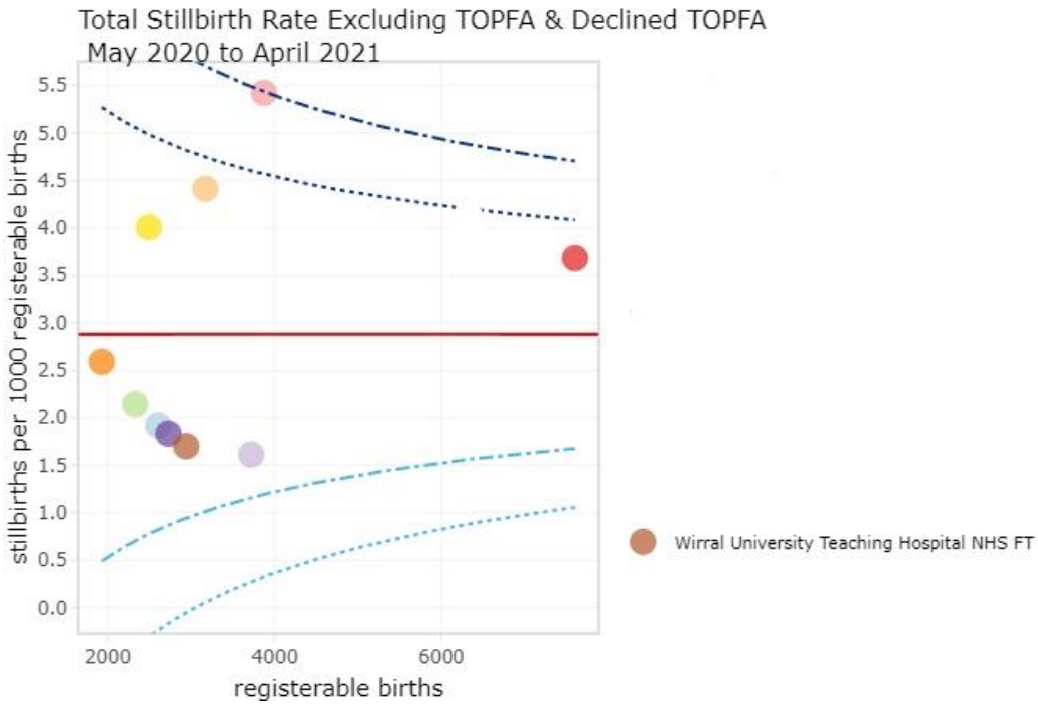
- The content of the Perinatal Clinical Surveillance Quality Assurance Report and the Outlier report.
- Trust compliance with the findings of Birthrate+ staffing review and the identified shortfall in midwifery staffing given the need to implement Continuity of Carer model of midwifery care.

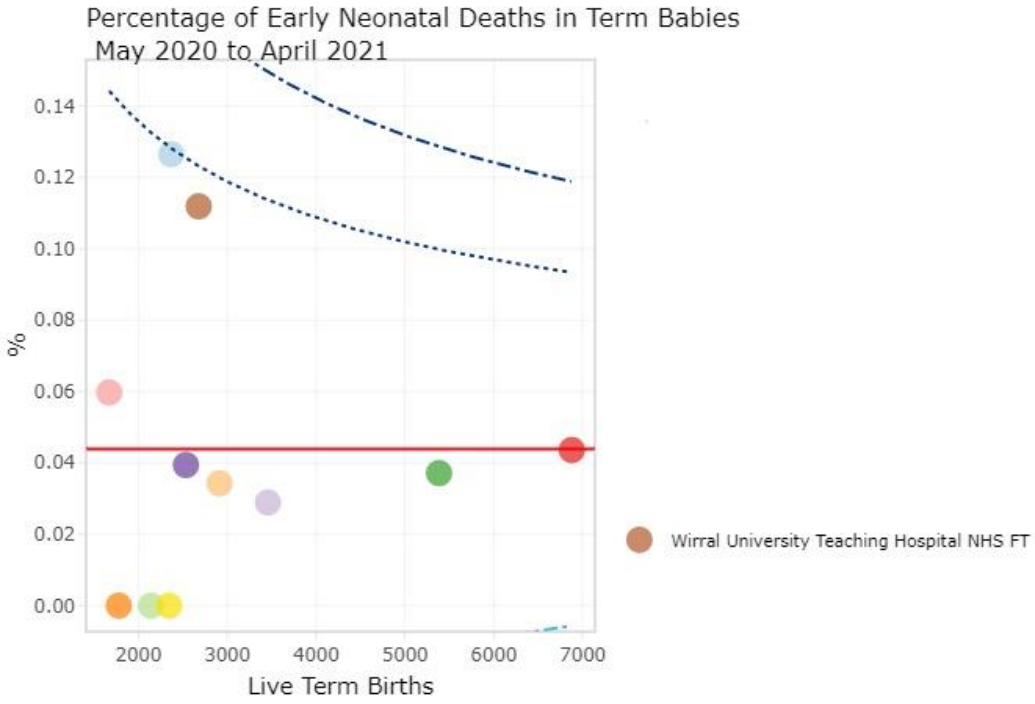
APPENDIX 1: Perinatal Clinical Surveillance Quality Assurance Report

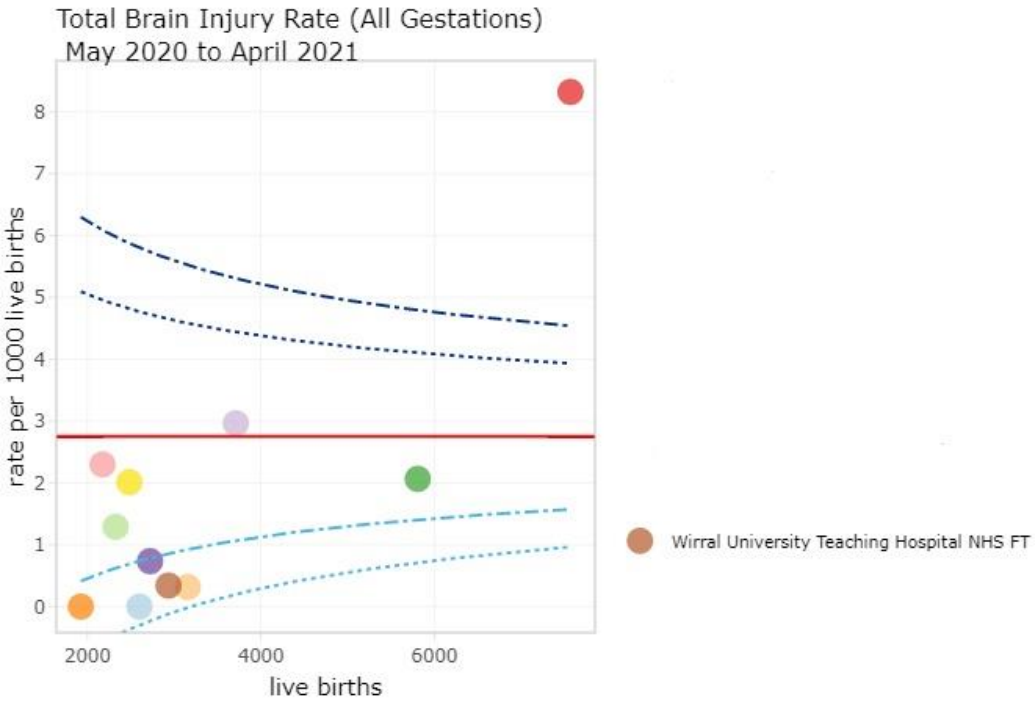
	A	B	C	D
	Themi	Area requiring further enquiry or shared intelligence	Outlier	Evidence
	Clinical Care	Outlier for rates of stillbirth as a proportion of births	No	Currently sitting well below the regional mean for total stillbirths, with the lowest rate in the region based upon total stillbirth rate excluding TOPFA and declined TOPFA.
		Outlier for rates of neonatal deaths as a proportion of birth	No	Mortality rates for Q1 2021/22 are reported as 0% for all gestations in comparison to a Cheshire and Merseyside rate of between 2%-5% and a NWCODN rate of 15%.
		Rates of HIE where improvements in care may have made a difference to the outcome	No	Very low rates of HIE, sitting way below the lower control limit for the region.
		Number of SI's	No	X3 SI's reported for maternity in 2020. During 2021, there have been 2 SI's so far, one in maternity and one in neonates.
		Progress on SBL care bundle V2	No	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP.
		Outlier for rates of term admissions to the NNU	No	WUTH are way below the lower control limit for term admission to NNU - all admissions are reviewed at a weekly term admission meeting and any cases wherby admission was felt to have been avoidable are incident reported.
	Service user and staff feedback	MVP or Service User concerns/complaints not resolved at trust level	No	Very good position in terms of complaints, sitting with the lowest within the region which is comparable to our outcome data.
		Trainee survey	No	Consistently high scoring year on year.
		Staff survey	No	As a Division, we have maintained or improved in all domains, scoring higher than the Trust average for the majority of domains. Action plan in place to address areas for improvement.
		CQC National survey	No	
		Feedback via Deanery, GMC, NMC	No	
				All vacanices have been recruited to with a number of newly qualified midwives due to start in post using the funding allocated from NHSE/I following the National monies made available as a result of Ockenden. Although there have been times of increased patient
17	Leadership and relationships	New leadership within or across maternity and/or neonatal services	No	Some interim arrangements have been in place within the leadership team since September 2020 however these have created stability and imporoved quality and safety.
18		Concerns around the relationships between the Triumvirate and across perinatal services	No	Good working relationship between the teams.
19		False declaration of CNST MIS	No	Externally audited by MIAA in preparation for the submission.
20		Concerns raised about other services in the Trust e.g. A&E	No	Not aware of any issues, good working relationships in place.
21		In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	No	Not aware of any issues, bi-monthly listening events in place.
22				
23	Safety and learning culture	Lack of engagement in HSIB or ENS investigation	No	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead.
24		Lack of transparancy	No	Being open conversations are regularly had and 100% DOC evident.
25		Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	No	Robust processes following lessons learned from all SI's, local reviews, rapid reviews, complaints and compliments.
26		Learning from Trust level MBRRACE reports not actioned	No	All reports receive a gap analysis to benchmark against the recommendations.
27		Recommendations from national reports not implemented	No	All reports receive a gap analysis to benchmark against the recommendations.
28				
29	Incident reporting	Low patient safety or serious incdient reporting rates	No	Consistent rates of reporting across the speciality groups. Any months were lows numbers were reported are usually associated with a reduction in clinical acitivity or low birth rate figures/ low NNU admissions.
30		Delays in reporting a SI where criteria have been met	No	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework.
31		Never Events which are not reported	No	No, no maternity or neonatal never events.
32		Recurring Never Events indicating that learning is not taking place	No	N/a
33		Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	No	Excellent reporting within the required timescales.
34				
35	Governance processes	Unclear governance processes - SAT	No	Clear governance processes in place that follow the SI framework - Task and finish group in place which will address the ask for the new PSIRF to be launched later this year which will ensure the Division is ready to implement the new guidance once released.
36		Business continuity plans not in place	No	Business continuity plans in place.
37		Ability to respond to unforeseen events e.g. pandemic, local emergency	No	The service was able to continue to provide an acute service from the start of the pandemic due to the robust contingency plans in place. Business as usual was operated following changes necessary to safegaurd staff and service user well being.
38				
39	CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	No	Recent CQC core service review was undertaken in May 2021 which did not highlight any concerns.
40		An overall CQC rationg of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third d	No	N/a
41		An overall CQC rating of Inadequate	No	N/a
42		Been issued with a CQC warning notice	No	N/a
43		CQC rating dropped from a previously Outstanding or Good rating to Requires Improvement in the safety or Well-Le	No	N/a
44		Been identified to the CQC with concerns by HSIB	No	N/a
45				
46				

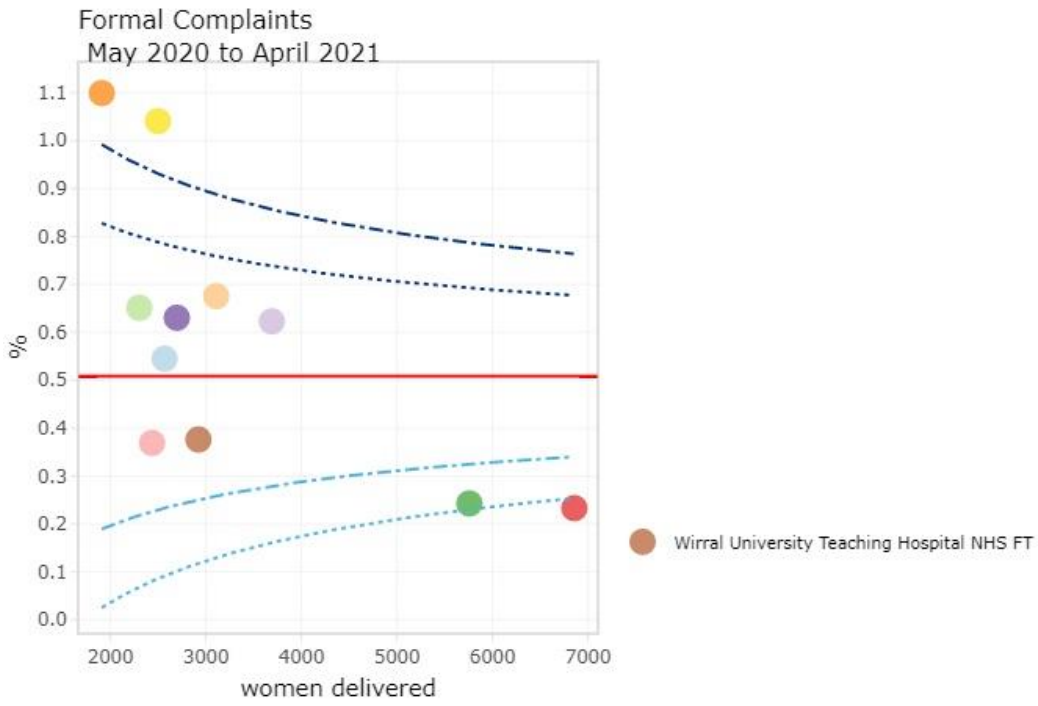
Standards Summary | March 2021 | June 2021 | Septmeber 2021 | Drop Downs

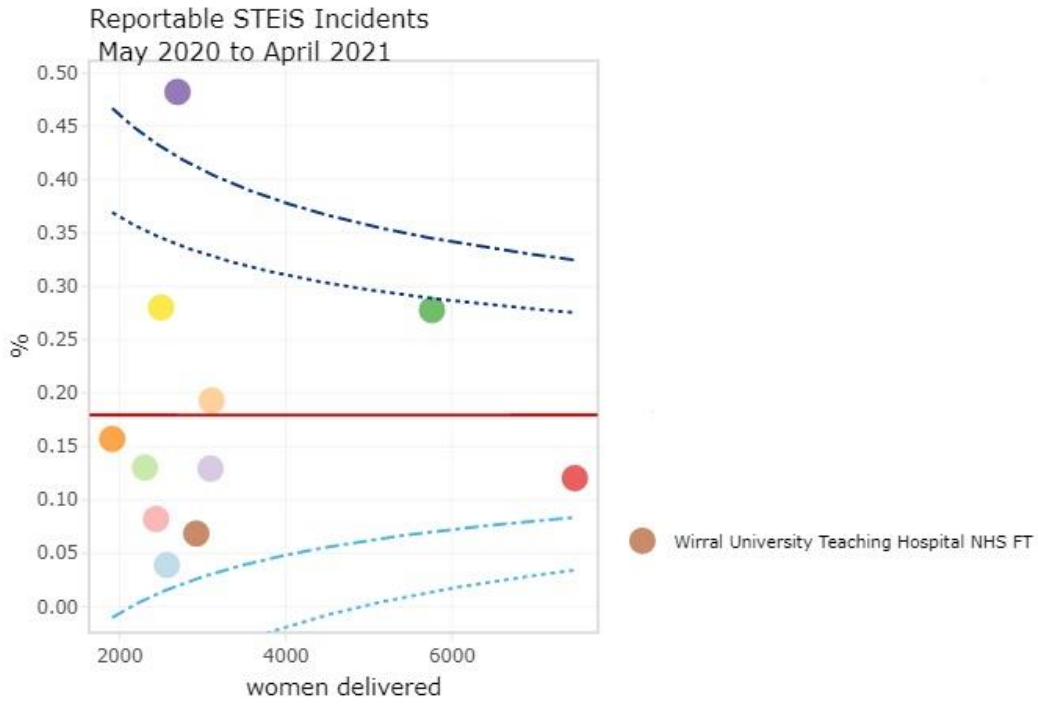
APPENDIX 2: Cheshire & Merseyside Outlier Report




Percentage of Early Neonatal Deaths in Term Babies
May 2020 to April 2021
0.14
0.12
0.10
0.08
%
0.06
0.04
0.02
0.00
2000
3000
4000
5000
6000
7000
Live Term Births
Wirral University Teaching Hospital NHS FT


Total Brain Injury Rate (All Gestations)
May 2020 to April 2021
8
7
6
5
4
3
2
1
0
rate per 1000 live births
2000
4000
6000
live births
Wirral University Teaching Hospital NHS FT





Appendix 3: SI and HSIB Summary

Executive Summary

Cases to date	
Current active cases	3
Exception reporting	2011-2701 – delays due to police involvement. Investigation currently on hold.

SI cases

Executive Summary

Incident No.	StEIS No.	Details	Date Due	Lead Investigation Officer
67940	2021/13974	40+4 Stillbirth	02/09/2021	J.Lavery
49883	2020/13454	SUDI – iatrogenic airway injury	20/09/2021	A.Kamalanathan
68818	2021/14994	Cooled Baby (rejected by HSIB) – locum, decision for trial of twins in room	17/09/2021	A.Kerrigan
70581	2021/17356	Cooled Baby – CTG concerns	22/10/2021	A.Lawrence

Appendix 4: Safety Champion Action Log

Safety Champion Walkabout Log for Women's & Neonatal 2020 - 2021

Maternity safety champions work at every level – trust, regional and national – and across regional, organisational and service boundaries. They develop strong partnerships, can promote the professional cultures needed to deliver better care, and play a central role in ensuring that mothers and babies continue to receive the safest care possible by adopting best practice.

The document provides a record of the safety champion walkabouts that have taken place and the key feedback points as a log.

No.	Date Carried Out	Safety Champion's Responsible	Feedback
1	18th August 2020	Hazel Richards, Chief Nurse Annemarie Lawrence, Divisional Quality & Safety Specialist for W&C	Compliance with PPE was re-iterated to staff on duty There was a focus on the Trusts well-being initiatives and raising awareness to staff groups Staff were open and welcomed a visit from the Chief Nurse valuing the visibility
2	11th May 2021	Hazel Richards, Chief Nurse Steve Ryan, Non-Executive Board Member (Accompanied by Jo Lavery, Deputy Head of Midwifery, Angela Kerrigan, Consultant Midwife)	Walkabout of all areas within maternity to include ANC, A/N & P/N ward and Delivery suite There was a focus on the Trusts well-being initiatives and raising awareness to staff groups Locality Lead feedback at length on the feedback from women on continuity of carer teams and the benefits of the positive outcomes Discussion on labour ward was safe staffing; IOL prioritisation, birth rate plus and professional midwife which feedback from staff was for an additional midwife for IOL suite and a second on triage; touched on COVID experiences with pregnant women; MDT handover and importance within maternity; safety huddles implementation in all areas re-iterated Staff were open and welcomed a visit from the Chief Nurse valuing the visibility.

Appendix 5: Gap Analysis – Maternity & Neonatal 8 Point Plan.

	Provider Maternity and neonatal services action plan GAP Analysis		Immediate and medium-term actions to ensure the safe care of pregnant women who have tested positive for COVID-19, and the management of current pressures on maternity and neonatal services		
	10th August 2021 V1	Starting Position	Narrative to support Implementation	Date of full Implementation	Completion RAG
	Local Response				
1	Care of pregnant women who test positive for COVID-19	Providers should continue to follow infection prevention and control (IPC) guidance and undertake a full quality impact risk assessment to ensure safe delivery of care for all women and families.	YES		Implemented and sustained throughout the Covid-19 pandemic	YES
1	Care of pregnant women who test positive for COVID-19	Providers to continue to allow partners access to all maternity services.	YES	Encourage support person to all antenatal appointments and during birth for the whole journey; support persons accommodated to stay overnight; x 2 birth partners considered for individual circumstances	As per guidance dated December 2020	YES
1	Care of pregnant women who test positive for COVID-19	When a woman is identified as being critically ill with COVID-19, continue to follow local guidance on the timing of transfer to intensive care unit (ICU) and delivery. This is a multidisciplinary team (MDT) decision, and systems should continue to work towards deliveries at less than 27 weeks gestation taking place at a maternity unit with an onsite neonatal ICU (NICU).	YES	WUTH Level III unit	Ongoing	YES
1	Care of pregnant women who test positive for COVID-19	Continue repatriation of baby as soon as clinically safe to do so when appropriate cot capacity, safe staffing and transport are available	YES	WUTH Level III unit and guided by condition of mum and baby	Ongoing	YES
1	Care of pregnant women who test positive for COVID-19	Medical directors are asked to ensure that care meets the standards set out in the guidance of the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Midwives (RCM), including early senior involvement of the maternal medicine team for any pregnant or postpartum woman admitted with COVID-19.	YES	All WUTH SoP's refer to the RCOG/RCM guidance	Ongoing and SoP's updated as new guidance released	YES

	Local response					
2	**COVID-19 vaccination for pregnant women**	All healthcare professionals have a responsibility to proactively encourage pregnant women to get vaccinated against COVID-19. Since 16 April, the Joint Committee on Vaccination and Immunisation (JCVI) has recommended that pregnant women should be offered the Pfizer or Moderna COVID-19 vaccines alongside the general population. The RCOG and RCM recommend vaccination as one of the best	YES	Further education and communications to midwifery staff in support of aiding their knowledge to be able to proactively encourage pregnant women to take up the vaccine	Aug-21	YES
2	**COVID-19 vaccination for pregnant women**	Ensure availability of up-to-date information on vaccination in pregnancy, including information on the safety of the woman and baby.	YES	Live sessions implemented; working collaboratively with MVP; internet site updated; social media activity; supported information leaflets in all WUTH A/N outpatients areas and GP's; community midwives and A/N core staff provided with leaflets to distribute (PHE, RCOG, RCM)	Aug-21	YES
2	**COVID-19 vaccination for pregnant women**	Vaccination leads to consider providing vaccination clinics within antenatal clinics and engagement of the most vulnerable populations about vaccination to encourage uptake.	PARTIAL	Being supported via the WUTH Clinical Advisory Group (CAG) to implement vaccination clinics in ANC with effect from September 2021	Planned for September 2021	PARTIAL
2	**COVID-19 vaccination for pregnant women**	Vaccination programme and primary care to cascade key messages from the letter of 30 July from the Chief Midwifery Officer and National Clinical Director for Women's Health and Maternity to: – vaccination settings as a reminder that pregnant women should receive the vaccination if they choose. – primary care to have proactive discussions with women and partners about vaccination as part of routine preconceptual care.	YES	Actioned	Aug-21	YES
2	**COVID-19 vaccination for pregnant women**	Increase the involvement of maternity voices partnerships (MVPs) and other networks in the cascade of information on vaccination in pregnancy, and ensure concerns raised by women and their families are addressed.	YES	Strong collaboratively working with MVP chair; supportive of live sessions ongoing and regular cascading of information re: vaccinations and interactional feedback to maternity staff (named) with questions and concerns from women that are addressed individually	Ongoing	YES
2	**COVID-19 vaccination for pregnant women**	Provide information at every contact with pregnant women, including to children's centres.	YES	Midwives are advised to address at every contact; PHE guidance distributed to community midwives to initiate discussions;	Aug-21	YES
2	**COVID-19 vaccination for pregnant women**	Local engagement with pharmacy colleagues encouraging them to take the opportunity to have proactive discussions on vaccination when pre/antenatal women are purchasing pregnancy tests/folic acid.	NO	Advice and action plan to be implemented to achieve		NO
2	**COVID-19 vaccination for pregnant women**	Health visitors should use the 28-week health check to provide information and support women on vaccine choice.	NO	To discuss with Lindsey Costello via email to re-iterate		NO
2	**COVID-19 vaccination for pregnant women**	Health visitors use their five universal health reviews (particularly new-born visits) to support mother and infant health and wellbeing, and use this as an opportunity to support women in their vaccine choice	PARTIAL	To discuss with Lindsey Costello via email to re-iterate; midwifery staff discuss as part of discharge summary home from ward		PARTIAL
	Local response					
3	**COVID-19 vaccination – to increase uptake among the maternity workforce**	Every provider to ensure a supportive conversation has taken place with any member of the maternity team who has not had a vaccine.	PARTIAL	Staff lists being reviewed by the Trust for each division		PARTIAL

	Local response					
2	**COVID-19 vaccination for pregnant women**	All healthcare professionals have a responsibility to proactively encourage pregnant women to get vaccinated against COVID-19. Since 16 April, the Joint Committee on Vaccination and Immunisation (JCVI) has recommended that pregnant women should be offered the Pfizer or Moderna COVID-19 vaccines alongside the general population. The RCOG and RCM recommend vaccination as one of the best	YES	Further education and communications to midwifery staff in support of aiding their knowledge to be able to proactively encourage pregnant women to take up the vaccine	Aug-21	YES
2	**COVID-19 vaccination for pregnant women**	Ensure availability of up-to-date information on vaccination in pregnancy, including information on the safety of the woman and baby.	YES	Live sessions implemented; working collaboratively with MVP; internet site updated; social media activity; supported information leaflets in all WUTH A/N outpatients areas and GP's; community midwives and A/N core staff provided with leaflets to distribute (PHE, RCOG, RCM)	Aug-21	YES
2	**COVID-19 vaccination for pregnant women**	Vaccination leads to consider providing vaccination clinics within antenatal clinics and engagement of the most vulnerable populations about vaccination to encourage uptake.	PARTIAL	Being supported via the WUTH Clinical Advisory Group (CAG) to implement vaccination clinics in ANC with effect from September 2021	Planned for September 2021	PARTIAL
2	**COVID-19 vaccination for pregnant women**	Vaccination programme and primary care to cascade key messages from the letter of 30 July from the Chief Midwifery Officer and National Clinical Director for Women's Health and Maternity to: – vaccination settings as a reminder that pregnant women should receive the vaccination if they choose. – primary care to have proactive discussions with women and partners about vaccination as part of routine preconceptual care.	YES	Actioned	Aug-21	YES
2	**COVID-19 vaccination for pregnant women**	Increase the involvement of maternity voices partnerships (MVPs) and other networks in the cascade of information on vaccination in pregnancy, and ensure concerns raised by women and their families are addressed.	YES	Strong collaboratively working with MVP chair; supportive of live sessions ongoing and regular cascading of information re: vaccinations and interactional feedback to maternity staff (named) with questions and concerns from women that are addressed individually	Ongoing	YES
2	**COVID-19 vaccination for pregnant women**	Provide information at every contact with pregnant women, including to children's centres.	YES	Midwives are advised to address at every contact; PHE guidance distributed to community midwives to initiate discussions;	Aug-21	YES
2	**COVID-19 vaccination for pregnant women**	Local engagement with pharmacy colleagues encouraging them to take the opportunity to have proactive discussions on vaccination when pre/antenatal women are purchasing pregnancy tests/folic acid.	NO	Advice and action plan to be implemented to achieve		NO
2	**COVID-19 vaccination for pregnant women**	Health visitors should use the 28-week health check to provide information and support women on vaccine choice.	NO	To discuss with Lindsey Costello via email to re-iterate		NO
2	**COVID-19 vaccination for pregnant women**	Health visitors use their five universal health reviews (particularly new-born visits) to support mother and infant health and wellbeing, and use this as an opportunity to support women in their vaccine choice	PARTIAL	To discuss with Lindsey Costello via email to re-iterate; midwifery staff discuss as part of discharge summary home from ward		PARTIAL
	Local response					
3	**COVID-19 vaccination – to increase uptake among the maternity workforce**	Every provider to ensure a supportive conversation has taken place with any member of the maternity team who has not had a vaccine.	PARTIAL	Staff lists being reviewed by the Trust for each division		PARTIAL

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 2122-137

Board of Directors

Title:	Finance Report for the period ending 31st August 2021
Responsible Director:	Claire Wilson, Chief Finance Officer
Author:	Robbie Chapman, Deputy Chief Finance Officer
Presented by:	Claire Wilson, Chief Finance Officer

Executive Summary

The Trust is reporting a surplus of £0.218m for the period ending 31st August 2021 (M5), a positive variance against plan of £0.125m.

No income in was generated through the Elective Recovery Fund in M5, where the value of activity was below 95% of the value of activity against the reference period (19/20). However, NHSEI have confirmed a net £1.120m of additional ERF funding in respect of previous periods after the regional position improved significantly from initial estimates in M2.

Total employee expenses excluding COVID-19 were £117.614m at M5, this represents an overspend against our budget of £0.818m. However, this figure includes a significant overspend of £3.401m in respect of Medicine and Acute offset by underspends in other parts of the Trust.

The Trust is forecast to break-even at the close of H1 and awaits detailed guidance on the finance regime for H2.

A detailed Finance report has been received and reviewed by the Finance and Business Assurance Committee (FPBAC). The attached report provides an overview of the key areas for Board focus. The report of the FBPAC is reported separately on the agenda.

Recommendation:
(e.g. to note, approve, endorse)

The Finance, Business & Performance Assurance Committee have received a detailed report on the financial position fo the period.
Board of Directors are asked to note the contents of this summary report and raise any questions in the meeting.

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

Infrastructure: improve our infrastructure and how we use it.	Yes

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
PR3: failure to achieve and/or maintain financial sustainability.
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
N/A
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Summary of financial performance at M5 with implications for year-end forecast.
Specific communications and stakeholder /staff engagement implications
N/A
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
N/A
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)
N/A

FOI status	Document may be disclosed in full	✓
	Document includes FOI exempt information	
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees	Finance and Business Performance Assurance Committee (FPBAC) received a detailed report on the financial position each month.	
Background papers / supporting information	N/A	

Contents

1. Executive summary

Wirral University Teaching Hospital NHS Foundation Trust

1.1 **Table 1: Financial position**

Month 5 Financial Position	Budget (Mth 5) £'000	Actual (Mth 5) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
NHS income - patient care	27,374	25,463	(1,911)	136,953	133,733	(3,220)
Income Guarantee	0	2,461	2,461	0	5,561	5,561
National Top-up	2,131	2,131	0	10,655	10,655	0
Elective Recovery Fund (ERF)	790	1,126	336	4,582	5,988	1,406
Covid 19 income	1,914	1,641	(273)	9,536	8,997	(539)
Non NHS income - patient care	409	378	(31)	2,047	1,946	(101)
Other income	2,524	2,489	(36)	12,539	11,824	(715)
Total Income	**35,142**	**35,690**	**547**	**176,312**	**178,704**	**2,392**
Employee expenses	(23,271)	(23,443)	(172)	(116,796)	(117,614)	(818)
Operating expenses	(10,912)	(11,162)	(251)	(54,552)	(56,375)	(1,823)
Covid 19 costs	(612)	(528)	84	(3,109)	(2,703)	406
Total Expenditure	**(34,795)**	**(35,133)**	**(339)**	**(174,457)**	**(176,692)**	**(2,234)**
Non Operating Expenses	(382)	(366)	16	(1,907)	(1,829)	78
Actual Surplus / (deficit)	**(34)**	**190**	**224**	**(52)**	**184**	**236**
Control Total adjustment	29	(66)	(95)	145	34	(111)
Surplus/(deficit) - Control Total	**(6)**	**124**	**130**	**93**	**218**	**125**

1.2 The Trust is reporting a surplus of £0.218m for the period ending 31st August 2021 (M5), a positive variance against plan of £0.125m. The Trust is forecast to break-even at the close of H1.

1.3 Total income was £178.704m at M5. This reflects the revised 'block' contract arrangements with CCGs with the reduced income compared to draft plans, confirmed values in respect of specialist and direct commissioning and ERF income of £5.988m.

1.4 No income in was generated through the Elective Recovery Fund in M5, where the value of activity was below 95% of the value of activity of M5 19/20. However, NHSEI have confirmed a net £1.120m of additional ERF funding in respect of previous periods after the regional position improved significantly from initial estimates in M2. We do not expect to receive significant ERF income in the remainder of H1.

1.5 We have received £11.824m in other income, an adverse variance of £0.715m. This is attributable to reduced income in respect of car parking, catering and other non-clinical income.

1.6 Total employee expenses excluding COVID-19 were £117.614m at M5, this represents an overspend against our budget of £0.818m. However, this figure includes a significant over-spend of £3.401m in respect of Medicine and Acute offset by underspends in other parts of the Trust and an over-recovery on Elective Recovery Fund (ERF) income. Employee expenses can be broken down as follows:

Table 2: Pay cost analysis

Pay analysis (exc Covid)	Budget (Mth 5) £'000	Actual (Mth 5) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Substantive	(21,409)	(21,144)	265	(107,393)	(105,041)	2,352
Bank	(719)	(915)	(196)	(3,630)	(5,023)	(1,393)
Medical Bank	(444)	(618)	(174)	(2,219)	(3,044)	(825)
Agency	(617)	(681)	(65)	(3,138)	(4,063)	(925)
Apprenticeship Levy	(83)	(85)	(2)	(417)	(443)	(26)
Total	(23,271)	(23,443)	(172)	(116,796)	(117,614)	(818)

1.7 Operating expenses were £56.375m at M5, an overspend of £1.823m. This reflects lower spend against clinical supplies and services than budget offset by increased expenditure on drugs, premises and non-recurrent support in respect of reset and recovery.

1.8 Cash balances at the end of M5 were £19.2m.

1.9 The Trust has recorded capital spend of £3.181m at M5, which is £0.442m behind plan.

1.10 A detailed Finance report has been received and reviewed by the Finance and Business Assurance Committee (FPBAC). This report provides an overview of the key areas for Board focus. The report of the FBPAC is reported separately on the agenda.

2. Background

2.1 The Trust resubmitted our financial plan to NHSE/I on the 22nd June. As anticipated this did not result in any material movement in the plan, albeit the Trust is now forecast to achieve a surplus of £0.2m in H1.

2.2 The funding arrangements for H2 are due to be confirmed in M6 but it is unlikely that the financial settlement will be confirmed until M7.

2.3 We are required to submit our plans for H2 to NHSEI on 11th November.

3. Dashboard and risks

3.1 **Table 3: Performance Dashboard**

	Indicator	Objective	Threshold	Set by	Apr-21	May-21	Jun-21	Jul-21	Aug-21	2021/22
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	On Plan	WUTH	0.8	-0.5	-0.2	0.0	0.2	0.2
	I&E Performance Variance (monthly variance)	Effective use of Resources	On Plan	WUTH	0.8	-0.4	-0.4	0.0	0.2	0.2
	NHSI Risk Rating	Effective use of Resources	On Plan	NHSI	2.0	2.0	2.0	2.0	2.0	2
	CIP Performance	Effective use of Resources	On Plan	WUTH	0.0	0.0	3.02%	6.03%	9.05%	9.0%
	NHSI Agency Performance (monthly % variance)	Effective use of Resources	On Plan	NHSI	-50.5%	-27.7%	-32.4%	-40.5%	-11.7%	-32.5%
	Cash - liquidity days	Effective use of Resources	NHSI metric	WUTH	-15.0	-15.5	-10.4	-15.7	-15.4	-15.4
	Capital Programme (cumulative)	Effective use of Resources	On Plan	WUTH	2.0%	5.0%	12.0%	17.4%	21.8%	21.8%

3.1.1 Agency spend is above threshold. This is discussed in more detail at 4.2.3.

3.1.2 Despite significant improvement over the last year, the Trust's liquidity days measure is below threshold. This is based on net current liabilities compared against operating expenses. Steps are being taken to reduce historic accruals which will serve to improve this measure.

3.2 **Risk summary (as per risks identified in risk register)**

3.2.1 Risk 1 – Failure to manage financial position

- Our ability to operate within the H1 financial envelope will be dependent on effective cost management alongside the delivery of activity trajectories, the management of COVID activity and the centrally funded vaccination and testing programmes. This report demonstrates that, as of M5, we are managing this position within envelope.

3.2.2 Risk 2 – Failure to deliver CIP

- The confirmed H1 CIP target is £1m and this has been incorporated into our plans submitted to NHSE/I. This figure will likely increase in H2 and work has already begun to identify schemes for the period.

3.2.3 Risk 3 – Failure to complete capital programme

- Our capital programme target for 21/22 is £14m which contains work carried forward from the previous financial year and significant work throughout the Trust. M5 performance is behind plan but we do not expect this to be an issue.

4.1 **Income**

4.1.1 The Trust has received £178.704m at M5.

Table 4: Income analysis for M5

	Budget (Mth 5) £'000	Actual (Mth 5) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Elective & Daycase	4,087	3,164	(924)	20,230	18,345	(1,885)
Elective excess bed days	62	44	(18)	422	251	(172)
Non-elective	7,642	7,886	244	40,079	41,471	1,391
Non-elective Non Emergency	1,159	1,122	(37)	5,459	5,340	(119)
Non-elective excess bed days	482	138	(344)	1,894	801	(1,092)
A&E	1,301	1,354	53	6,594	7,010	416
Outpatients	2,876	3,110	234	15,426	16,400	975
Diagnostic imaging	242	44	(198)	1,306	1,090	(217)
Maternity	462	368	(94)	2,303	2,050	(254)
Non PbR	5,781	5,451	(330)	29,692	27,947	(1,745)
HCD	1,274	1,696	421	6,645	7,622	978
CQUINs	190	190	(0)	950	950	(0)
National Top up	2,131	2,131	0	10,655	10,655	0
Income Guarentee	0	2,461	2,461	0	5,561	5,561
Other	2,408	1,085	(1,323)	8,883	5,148	(3,735)
Sub-Total Board Clinical Income	30,097	30,244	147	150,538	150,640	102
Other patient care income	82	151	69	408	931	523
Elective Recovery Fund (ERF)	790	1,126	336	4,582	5,988	1,406
COVID-19 Income	1,914	1,641	(273)	9,536	8,997	(539)
Non-NHS: private patient & overseas	29	14	(15)	146	90	(55)
Injury cost recovery scheme	64	25	(39)	320	234	(87)
Total Patient Care Income	32,976	33,201	225	165,530	166,880	1,350
Other operating income	2,166	2,489	322	10,782	11,824	1,042
Other non operating income		0	0		0	0
Total income	35,142	35,690	547	176,312	178,704	2,392

4.1.2 Clinical income in M5 was in line with forecast. The lower elective & daycase and non-elective excess bed days income offset by strong performance in respect of out-patients and non-elective care.

4.1.3 Patient care income exceeded budget by £1.350m. This includes a positive variance of £1.406m in respect of ERF despite not generating any funding in month. This increase is partly attributed to better performance across Cheshire and Merseyside in M1 and M2, with income in excess of plans shared according to an agreed mechanism but can also be explained through the prudent expectation of income when originally reported.

4.1.4 Other Operating income was £11.824m at M3, a positive variance of £1.072m. This is attributable to additional funding we received in respect of our telederm initiative and larger than expected income from Clatterbridge Cancer Centre for SLAs due to their continued use of the site. Both of these are offset by increased expenditure.

4.2 **Expenditure: Pay**

4.2.1 The Trust has spent £117.614m on pay costs at M5. Table 5 details pay costs by staff group and Table 6 details pay costs by pay category type.

Table 5 Pay costs by staff type (excluding COVID-19)

Pay analysis (exc Covid)	Budget (Mth 5) £'000	Actual (Mth 5) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Consultants	(3,877)	(3,637)	240	(19,377)	(18,787)	590
Other medical	(2,645)	(2,845)	(200)	(13,220)	(13,672)	(453)
Nursing and midwifery	(6,184)	(6,285)	(101)	(31,064)	(31,734)	(671)
Allied health professionals	(1,349)	(1,351)	(2)	(6,729)	(6,829)	(100)
Other scientific, therapeutic and technical	(570)	(576)	(6)	(2,851)	(2,566)	285
Health care scientists	(1,057)	(1,066)	(9)	(5,289)	(5,376)	(87)
Support to clinical staff	(4,401)	(4,335)	66	(22,081)	(21,775)	307
Non medical, non clinical staff	(3,105)	(3,263)	(158)	(15,769)	(16,432)	(663)
Apprenticeship Levy	(83)	(85)	(2)	(417)	(443)	(26)
Total	(23,271)	(23,443)	(172)	(116,796)	(117,614)	(818)

Table 6: Pay analysis by pay type

Pay analysis (exc Covid)	Budget (Mth 5) £'000	Actual (Mth 5) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Substantive	(21,409)	(21,144)	265	(107,393)	(105,041)	2,352
Bank	(719)	(915)	(196)	(3,630)	(5,023)	(1,393)
Medical Bank	(444)	(618)	(174)	(2,219)	(3,044)	(825)
Agency	(617)	(681)	(65)	(3,138)	(4,063)	(925)
Apprenticeship Levy	(83)	(85)	(2)	(417)	(443)	(26)
Total	(23,271)	(23,443)	(172)	(116,796)	(117,614)	(818)

4.2.2 Total pay costs at M5 were £117.614m, an overspend of £0.818m. This hides under-spends on staff across most of the Trust, with an overspend of £3.401m in Medicine & Acute as a result of significant pressures in A&E due to increased levels of activity.

4.2.3 The main driver of this is medical staffing (£3.3m) both in Acute Care (£1.9m) & Medical Specialties (£1.3m). Medical bank and agency are being used to cover consultant vacancies within the Medical Specialties and support non-recurrent costs of recovery in Haematology & Rheumatology which, along with other costs, is offset by £2.201m income in respect of medical specialities from ERF.

4.2.4 Vacancies, increased activity levels and sickness are driving the pressure within ED and Acute Medicine and Surgery, with escalated rates being paid to increase uptake of shifts and ensure safe staffing levels. Nursing expenditure is (£0.259m) overspent due to the extension of the nurse incentive scheme through Q1.

4.3 **Expenditure: Non-Pay**

4.3.1 The Trust has spent £56.375m on non-pay operating expenditure at M5.

Table 6: Non-pay analysis (excluding COVID-19 costs)

Non Pay Analysis (exc Covid)	Budget (Mth 5) £'000	Actual (Mth 5) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000
Supplies and services - clinical	(2,999)	(3,169)	(170)	(15,304)	(14,387)
Supplies and services - general	(407)	(352)	54	(2,090)	(1,877)
Drugs	(2,136)	(2,345)	(209)	(9,888)	(11,305)
Purchase of HealthCare - Non NHS Bodies	(1,061)	(859)	201	(4,848)	(4,165)
CNST	(1,152)	(1,152)	(0)	(5,758)	(5,758)
Consultancy	(11)	(45)	(34)	(55)	(236)
Other	(2,217)	(2,323)	(106)	(11,875)	(13,954)
Sub-Total	(9,982)	(10,246)	(264)	(49,817)	(51,682)
Depreciation	(930)	(916)	13	(4,735)	(4,693)
Impairment	0	0	0		0
Total	(10,912)	(11,162)	(251)	(54,552)	(56,375)

4.3.2 The overspend in respect of non-pay is being driven by pressure in respect of higher than expected costs for high cost drugs, non-capital estates works and increased, non-recurrent costs associated with the elective recovery programme.

4.3.3 Expenditure on high cost drugs was historicaly offset by additional funding from commissioners but this is not the case in this financial year given the block funding arrnagements. Increased expenditure on high cost drugs is an issue across all clinical divisions and is under regular review, however, this pressure is currently affordable within our overall funding envelope for 2021/22.

4.3.4 The Trust has seen increased costs in respect of estates most notably in respect of support from architects, project management consultants and maintenance costs. It is possible that some of these costs will be capitalised in due course.

4.3.5 Non-pay costs include non-recurrent support from a number of insourcing suppliers supporting additional capacity for elective recovery. This includes, insourcing in Surgery (£0.119m), Radiology services in DCS (£0.219m), Spire in Women's & Children's (£0.291m) and Totally Healthcare Limited in Medicine and Acute (£0.025m). All of these non-recurrent costs contributed to our elective performance being above trajectory in M1-3 and are fully offset by ERF income .

4.3.6 NHS Improvement are no longer directly funding independent sector spend through the nationally agreed contract. This is currently below budget but we expect this to increase in H2.

4.4 **CIP Performance**

4.4.1 The Trust's YTD target for CIP was £0.5m with £1m for the whole of H1. As at M5 the Trust has achieved £0.992m of CIP.

4.4.2 Plans are in place for to achieve a further £0.606m in CIP in H1 of which £0.318m is recurrent and £0.288m is non-recurrent.

4.4.3 The target for the remainder of the year (H1 and H2) has yet to be confirmed but, as at the 14th Sepember, 290 opportunities have been identified with a recurrent value of £6.483m IYE and £7.797m FYE, this is an increase of £0.732m in month. A break-down by division can be seen in Table 10 below:

Table 10: Breakdown by Division

Division	IYE Identified £m	FYE Identified £m
DCS	1.928	2.009
M&A	1.649	2.392
Surgery	1.388	1.757
W&C	0.344	0.546
Corp	1.174	1.093
Total	**6.483**	**7.797**

4.4.4 74 projects with a value of £1.047m have currently been identified as areas of opportunity and are awaiting sign off from the divisional directors to progress to gateway 2.

4.4.5 183 projects with a value of £1.556m have progressed to design & plan (gateway 2), meaning documentation is now being completed on PM3 with indicative costings..

4.4.6 33 projects with a value of £3.880m have now moved into governance and assurance (gateway 3), meaning the QIA/EA has been completed and is awaiting panel review in September.

4.5 Capital Expenditure

4.5.1 At month 5 capital spend is behind plan by £442k as set out in the table below.

Capital programme 2021/22 - Spend	M1	M2	M3	M4	M5	TOTAL
Pre-commitments	297	375	396	437	409	**1,914**
Estates	0	0	0	112	94	**206**
Informatics	0	0	69	0	14	**83**
Equipment - Medicine and Acute	0	93	310	0	17	**420**
Equipment - Clinical Support and Diagnostics	0	0	0	118	8	**126**
Equipment - Surgery	0	0	101	102	10	**213**
Equipment - Women and Children's	0	0	99	0	0	**99**
Other	0	0	0	0	0	**0**
Donated assets	0	7	0	8	95	**110**
UEC	9	0	0	0	1	**10**
TOTAL	**306**	**475**	**975**	**777**	**648**	**3,181**
NHSE/I PLAN	**562**	**678**	**511**	**889**	**983**	**3,623**
VARIANCE FROM PLAN	**(256)**	**(203)**	**464**	**(112)**	**(335)**	**(442)**

4.5.2 Planned spend Clinical Support equipment is behind plan as the procurement of the CT scanner, X Ray machines and enabling works has taken longer than anticipated. Requisitions for all equipment have now been made with expected delivery dates in the latter part of Q2. This means slippage on equipment purchases will continue over the next three months but spend should be back in line with plan by M9.

4.5.3 Over the last few weeks detailed discussions have taken place with the Estates Team, the Procurement Team and Divisions to determine a more accurate forecast level of spend both on a monthly basis and by the end of the financial year. This forecast have been reviewed by FPBAC.

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting of the Board of Directors

Draft Risk Management Strategy
6th October 2021

Title:	Draft Risk Management Strategy
Responsible Director:	Chief Executive Officer
Author:	Molly Marcu, Interim Director of Corporate Affairs
Presented by:	Molly Marcu, Interim Director of Corporate Affairs

Executive Summary

The draft risk management strategy is submitted to the Board of Directors for approval following consultation with the following forums:

- Risk Management Committee
- Trust Management Board
- Audit Committee
- Executive Directors Group

As part of this strategy it is proposed that the Risk Management Committee maintains oversight of the significant risks with a trust wide impact, as well as the BAF, whilst the other Board Committees review risks within their remit. The implications of this proposal is that the Risk Management Committee will now be formally be incorporated within the Board structure, and chaired by the Senior Independent Director.
Terms of reference of this committee and the rest of the Board committees will be reviewed at the November Board.

Recommendation:

The Board of Directors is asked to :

- Note and approve the draft risk management strategy
- Note and approve the implementation of the strategy, including the delegation of authority of the Risk Management Committee to take on the role of Risk Committee of the Board, with effect from November 2021.

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)

Weak arrangements for monitoring the delivery of strategy and associated risks expose the organisation to gaps in internal control, which may adversely impact on quality of care and reputation		
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)		
The Foundation Trust Code of Governance places specific responsibilities on NHS Board to monitor delivery of strategy ,associated risks and corresponding mitigations		
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)		
There will be a requirement to provide risk management training to board members and managers on an annual basis in order to embed the risk maturity arrangements. This will be explored as part of the implementation plan		
Specific communications and stakeholder /staff engagement implications		
Not applicable		
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)		
Not applicable		
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)		
not applicable		
FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No
Previous considerations by the Board / Board sub-committees	This document has been previously shared with the Chief Executive, Deputy Chief Executive ,Non Executive Directors, Executive Directors Group ,Risk Management Committee, Audit Committee, Trust Management Board	
Background papers / supporting information	Integrated Assurance proposal and Board Assurance Framework papers	

Wirral University Teaching Hospital
NHS Foundation Trust

Wiirral University Hospital Trust

Risk Management Strategy

2021 - 2024

Document Reference No.	V.1
Target audience	Trust Wide
Author	Interim Director of Corporate Affairs
Group responsible for developing document	Trust Board
Status	Draft
Authorised/Ratified By	Trust Board
Authorised/Ratified On	TBC
Review Date	TBC
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
Distribution date	TBC

Contents

1. INTRODUCTION

1.1. The Wirral University Hospital Trust NHS Foundation Trust is committed to providing high quality patient services in an environment where patient and safety is paramount. However healthcare provision has an inherent level of risk that cannot always be eliminated.

1.2. The Trust Risk Management Strategy provides a framework for the robust identification, assessment and management of risks to the delivery of strategy and of high quality healthcare by enabling staff to:

- Identify actual or potential risks
- determine how best to treat them
- apply the treatment
- monitor the effectiveness of that treatment while supporting the safe development of clinical care and maintaining continuity of service delivery.

1.3. Every member of staff is responsible for effective risk management.

1.4. The Trust promotes a just, responsible culture that fosters learning, improvement, and accountability. It intends all staff to be able to raise issues of concern and be listened to.

1.5. The Trust Board recognises that complete risk control/avoidance is impossible, but risks can be minimised by making sound judgements from a range of fully identified options.

1.6. The Trust Board is fully committed to ensuring a robust process is in place to ensure risks are identified, evaluated and mitigated to an acceptable level in a timely manner wherever possible.

2. PURPOSE

2.1. The Risk Management Strategy is a framework for the continued development of the risk management process, building on principles and plans linked to the Board Assurance Framework, the Risk Register and meeting requirements of Regulators such as CQC, along with national priorities.

2.2. The Risk Management Strategy aims to deliver a pragmatic, effective multidisciplinary approach to Risk Management, underpinned by the “Ward to Board” accountability and devolved governance structure.

3. STRATEGIC OBJECTIVES

3.1. This strategy supports the delivery of the Trust’s Strategic objectives from the 2021-2025/26 period.

3.2. The Trust Strategic objectives will be delivered through the following enabling strategies:

- Clinical Service Strategy
- Workforce Strategy
- Estates Strategy
- Digital Strategy
- Patient Experience Strategy
- Risk Management Strategy
- Patient Safety Strategy

3.3. The delivery of this Risk Management Strategy will enable the embedding of an infrastructure that enables robust identification and management of risks that may prevent the achievement of Trust objectives.

3.4. The Board will approve and monitor the delivery of these strategies and mitigations of associated risks through its Board Committees.

3.5. The work plan of each Board committee will incorporate agenda items which will ensure risks to the delivery of our strategies are identified and managed as appropriate.

3.6. Section 8 provides more detail on Board Committees and their specific responsibilities.

4. OBJECTIVES OF THE RISK MANAGEMENT STRATEGY

4.1. The objectives of the Risk management strategy are:

*4.1.1. To **proactively identify**, manage and monitor significant risks that the Trust is exposed to during the delivery of its objectives*

4.1.2. To ensure that risks that can materially impact on the Trust's key statutory objectives and terms of authorisation as a Foundation Trust are identified, assessed and managed

4.1.3. To enhance the risk maturity of the Trust from Risk Aware to Risk Enabled

4.2. The Strategic Objectives of the Trust evidence the Board prioritising patient safety, quality of care, staff wellbeing and development, and achievement of national standards.

4.3. The Trust Performance and Risk Management Frameworks will be integrated, to ensure risks related to performance indicators are identified, treated and monitored to minimise the impact on quality. Performance indicators will be integrated with the Board Assurance Framework.

4.4. At an operational level, the Trust will apply a proactive risk management approach to identify risk through analysis of performance data and an Early Warning Trigger Tool, described in detail in section 11.10.

4.5. A quality impact assessment tool will be used to identify possible risks to quality and safety arising from service re-design savings initiatives or variations in service delivery, such as bed pressures.

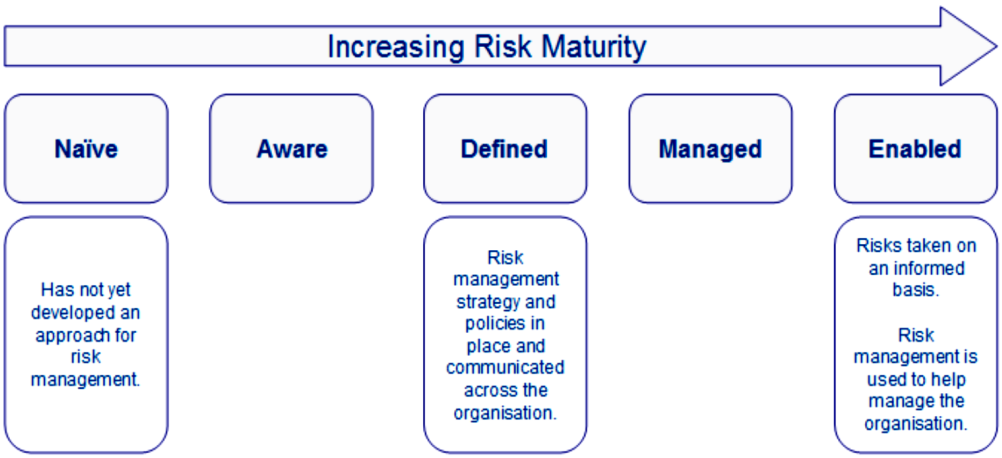
4.6. Themes from a number of quality and safety indicators including patient safety incidents, mortality reviews, complaints, and claims will be used to identify risks to quality, and trends used to assess whether previously identified risks are managed appropriately.

4.7. The Trust will also use learning from experience as a risk mitigation approach.

4.8. This is covered in more detail in section 12.5.

Objective 3: *To increase the risk maturity of the Trust from Risk Aware to Risk Enabled*

Figure 2: Risk Maturity scale



4.10. Figure 2 above shows the different levels of risk maturity that the Trust can achieve as risk managements becomes embedded in the organisation.

4.11. The Trust Board intends to improve the risk maturity of the organisation to 'Risk Defined by March 2023, and achieve 'Risk Enabled' status by 2024.

4.12. The Board will review its risk maturity, appetite and Board Assurance Framework annually at the end of each financial year.

4.13. The Annual internal audit of risk management will include an assessment of the risk maturity of the organisation. The Audit Committee will monitor the implementation of any recommendations arising from this audit.

5. RISK APPETITE

5.1. Risk appetite is the total level of risk exposure, or potential adverse impact, that the Trust is willing to accept in pursuit of its objectives.

5.2. The pursuit of one objective may hinder the achievement of another and this will impact upon the associated risk appetite. Similarly, the relative importance of one objective against another may be influenced by external factors, such as changes in national policy.

5.3. The Board recognises the importance of a robust and consistent approach to determining risk appetite to ensure:

5.3.1. The organisation's collective appetite for risk and the reasons for it are widely known to avoid erratic risk taking, or an overly cautious approach which may stifle growth and innovation.

5.3.2. Trust Managers know the levels of risk that are legitimate for them to take, and opportunities appropriate to pursue, to ensure service improvements and patient outcomes are not adversely affected.

5.4. To value and compare the relative merits and weaknesses of different risks, the Trust Board will determine the level of risk the organisation is willing to tolerate in different areas.

5.5. This will include deciding whether the Trust will treat, tolerate, transfer or terminate a risk and what the organisation's 'target risk score' should be. Operating within risk tolerances gives the Board assurance that the trust will remain within its risk appetite and, as a result, achieve its objectives.

5.6. The Trust Board will put systems in place to manage risk to an acceptable level within its agreed risk appetite levels. In setting such levels, the Trust Board will take account of the degree of both and opportunity.

5.7. When risks are identified, the Executive Directors will recommend to the Board whether to tolerate or accept them. Executive Directors will provide on-going assurance to the Board that existing controls are sufficient to mitigate risks to within the agreed tolerance levels, and

will highlight where the cost of treating the risk is more expensive than the potential benefits to be realised.

5.8. Target risk ratings shall be set for all risks on the Ulysses Risk Management System. A target risk rating is the estimated residual risk following the application of reasonable mitigating controls.

5.9. The target risk rating is the lowest level of risk acceptable or tolerable for particular risks.

5.10. Some risks tolerance levels will require the approval of the Board, particularly where the application of controls is restricted by external factors. Where this is the case, it will be outlined clearly in the BAF cover report, which is expanded on in section 6.

5.11. Risks that have reached the agreed target rating will also be treated as tolerated risks.

5.12. Risks should be accepted as tolerable only when the mitigation plan has been implemented as far as reasonably practical and there is assurance that controls are effective.

5.13. The Trust regards risks that fall into the red 'high' category as significant and actions to control the risk must be taken immediately.

5.14. RISK APPETITE STATEMENT

5.15. 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.

5.16. 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.

5.17. 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.

5.18. 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.

5.19. 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.	OPEN	The Trust Board recognises that in order to provide outstanding care and patient experience there may be a need to accept a short-term impact on quality outcomes to achieve longer term rewards and innovations for our patients.
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.

6. THE BOARD ASSURANCE FRAMEWORK (BAF)

6.1. An effective Board Assurance Framework gives the Board a simple comprehensive tool for effective and focused management of the principal risks to meeting its objectives.

6.2. It provides a structure for the evidence to support the Annual Governance Statement disclosure. It simplifies Board reporting and the prioritisation of action plans which, in turn, allow for more effective performance management.

6.3. The Board Assurance Framework provides the Board with a mechanism of identifying and assessing risks significant to the delivery of Trust strategy, whilst evaluating the effectiveness of controls, and the monitoring of action plans.

6.4. The Board Assurance Framework (BAF) is be based on six key elements:

6.4.1. Clearly defined principal objectives aligned to clear lines of responsibility and accountability.

6.4.2. Clearly defined principal risks with an assessment of potential impact and likelihood.

6.4.3. Key controls by which these risks are being and can be managed.

6.4.4. Quantification of the strengths and weaknesses of potential and actual assurances that the risks are being properly managed.

6.4.5. Reports identifying those risks are being reasonably managed and objectives being met, together with the identification of any gaps in assurances and in control?

6.4.6. Action plans which ensure the delivery of objectives control of risk and improvements in assurances.

6.5. The BAF cover reports will be aligned to support assurances to support the Chief Executive's Annual Governance Statement Disclosure.

6.6. Specifically, BAF assurance reports to the Board will reflect:

- New risks added since the last meeting
- Changes in risk ratings
- Updates on delivery of action plans, at points in which they fall due
- Updates on external assurances, as a result of enhancing the visibility of evidence to support risk mitigations.
- Triangulation with any other items on the agenda, such as performance reports
- Recommendations for remedial actions that require detailed board review

Lastly, the BAF reports will flag risks that require escalation to the Board in a timely manner.

6.7. The BAF will be refreshed annually considering :

6.7.1. Risks which may prevent the Trust from achieving the Strategic Objectives will be set out in the Board Assurance Framework, and assessed annually.

6.7.2. At the end of each financial year, the Board will collectively review the BAF, to identify the risks significant to the delivery of the organisation's strategic objectives.

6.8. The Executive Directors will jointly approve risks proposed for inclusion on the BAF, on the basis of strategic impact, prior to inclusion on the BAF

6.9. Further new risks proposed for inclusion on the Board Assurance Framework will be added following the agreement of the Board as they arise.

6.10. Each risk in the BAF will be scored using the Trust's Risk Scoring Matrix , and monitored in accordance with the frequency set out

6.11. The Board Assurance Framework will be reviewed bi-monthly by the Trust Board

7. RISK MANAGEMENT DUTIES

7.1. **Chief Executive**

7.1.1. As Accounting Officer of the Trust, the Chief Executive Officer has overall responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's objectives, whilst safeguarding public funds and assets

7.1.2. The Chief Executive will ensure that executives have appropriate access to annual training and education for risk management in healthcare to enable them to undertake their roles effectively.

7.1.3. The Chief Executive will ensure that there are robust arrangements for business continuity planning.

7.1.4. The Chief Executive is responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively, in accordance with the Accounting Officer Memorandum.

7.2. **Executive Directors**

7.2.1. The Executive Directors are accountable to the Chief Executive for all areas of risk and assurance in respect of areas in their remit, including the maintenance of live risk registers which are monitored regularly

7.2.2. Executive Directors are collectively accountable for risk management and ensuring risk management arrangements are embedded in their areas of responsibility.

7.3. **Medical Director**

7.3.1. The Medical Director has delegated overall strategic responsibility from the Chief Executive for the management of risk in the Trust and is the Executive Lead Director for devising, implementing and embedding all risk processes throughout the organisation.

7.3.2. The Medical Director will provide advice on risk management to the Executive Directors and Board, and will recommend the inclusion of risks on the Board Assurance Framework.

7.3.3. The Medical Director will ensure the risk register is reviewed monthly at the Risk Management Committee, with remedial actions put in place to address non-compliance.

7.3.4. As Executive lead for Health and Safety, the Medical Director is responsible for ensuring the timely identification and mitigation of risks to Health and Safety

7.4. **Director of Corporate Affairs**

7.4.1 The Director of Corporate Affairs is responsible for:

- Drafting and refreshing the risk management strategy
- Overseeing the process of implementing the strategy
- Maintaining and updating the BAF, whilst ensuring timely submissions are made to the Board and Assurance Committees as appropriate

- Ensuring the Annual Governance Statement requirements pertaining to risk management are met on an annual basis

7.5. **Chief Nurse**

7.5.1. The Chief Nurse will ensure nursing and allied healthcare staff comply with all safety and risk management procedures, providing assurance on the management of risks related to their professional practice, liaising with professional bodies as required.

7.6. **Chief Finance Officer**

7.6.1. The Chief Finance Officer is also the Senior Information Risk Owner (SIRO) and has executive responsibility for the identification, scoping definition and implementation of an information security risk programme.

7.6.2. The SIRO oversees the development of an Information Risk Management Strategy and related policies and procedures; ensures that the Trust's approach to information risk is effectively resourced and executed and provides a focal point for resolution of information risk issues.

7.6.3. The SIRO will act as an advocate for information risk on the Board and in internal discussions, and will provide written advice to the Accounting Officer on the content of the annual Governance Statement in regard to information risk.

7.6.4. The Chief Finance Officer has responsibility for ensuring that the Trust operates within financial constraints and balances competing financial demands and overseeing the delivery of the internal audit plan and associated internal audit recommendations.

7.6.5. The Chief Finance Officer is accountable to the Board for the delivery of the financial plan and digital strategies, and for managing associated risk.

7.7. **Director of Strategy and Partnerships**

7.6.1 The Director of Strategy and Partnerships is jointly responsible (with the Director of Corporate Affairs) for putting in place an infrastructure of ensuring risks deemed significant to the delivery of the Trust Strategies are identified and mitigated as part of the drafting of the Strategy.

7.6.2 In the role of Security Management Director, the Director of Strategy and Partnerships will oversee delivery of the Local Security Management Specialist Services (LSMS), receiving assurance on the management of security risks and reporting to Audit Committee as appropriate

7.8. **Director of Workforce**

7.8.1 The Director of Workforce is responsible for ensuring risks deemed significant to the delivery of workforce objectives are met, with assurance reports feeding into the Workforce Assurance Committee, Board, and elsewhere as appropriate.

7.9. **Chief Operating Officer**

7.9.1 The Chief Operating Officer is responsible for ensuring the delivery of the Trust ' Outstanding Care' objectives whilst mitigating associated risks, such as risks to delivery of targets being achieved. In discharging this duty the Chief Operating Officer will ensure a robust divisional accountability infrastructure is in place in order to provide assurance that risks are being appropriately mitigated

7.10. **All Staff**

7.10.1. All staff have a responsibility to:

7.10.1.1. Familiarise themselves with and comply with Trust Risk Management Policy and processes

7.10.1.2. Attend appropriate risk management training deemed necessary to enable them to undertake their duties

7.10.1.3. Mitigate risks over which they have control in their daily work

7.10.1.4. Proactively escalate concerns in instances where gaps in risk management training are identified, as soon as reasonably possible to their line manager.

7.10.1.5. Report breaches of compliance as outlined within the risks management strategy, whether by others or by themselves

8. GOVERNANCE ARRANGEMENTS FOR RISK MANAGEMENT

8.1. **Trust Board**

8.1.1. The role of the Board includes the identification, treatment and monitoring of risks signification to the delivery of the organisation's strategic objectives, which is aided by the use of a Board Assurance Framework (BAF).

8.1.2. The BAF document has been established by the Board and is reviewed Bi-Monthly.

8.1.3. The Executive Directors retain operational ownership and maintenance of the BAF. Its key elements include:

8.1.3.1. Identification of the principal risks that may threaten the achievement of Board identified strategic objectives

8.1.3.2. Identifying the design of controls to manage these principal risks

8.1.3.3. Setting out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk

8.1.3.4. Identifying assurances and are gaps in controls and / or assurances

8.1.3.5. Instigating corrective plans where gaps in control have been identified

8.1.3.6. Dynamic risk management including a well-founded risk register

8.1.4. The Board is responsible for monitoring the internal control arrangements in each financial year to support the Annual Governance Statement Disclosure declaration.

8.1.5. As part of the delivery of this strategy, the Board will:

8.1.5.1. Ensure significant strategic risks are mitigated sufficiently within the risk tolerance levels in a timely manner and monitored through the BAF and the Board agenda

8.1.5.2. Assess and evaluate the appropriateness of risk tolerance levels set out in the risk tolerance matrix and formally agree any amendments.

8.1.5.3. Monitor significant risks via the BAF, whilst receiving assurance from Board committees, on the implementation of mitigating actions

8.2. **Board Committees**

8.2.1. Each Committee of the Board has specific responsibility for seeking on going assurance on the effectiveness of the arrangements for managing key risks.

8.3. The Board will review the effectiveness of each Committee annually to support the review of the system of internal control.

8.4. Board Committees all have responsibility for elements of the risk management system, with the Audit Committee providing assurance on its effectiveness

8.5. **Audit Committee**

8.5.1. The Audit Committee supports the Board in reviewing the effectiveness of the system of internal control, through a structured annual work plan. The Committee will seek assurance that the Trust's governance and risk management systems are fit for purpose, adequately resourced and effectively deployed.

8.5.2. Non-Executive Committee members of the Audit Committee will play a key role in the internal control assurance processes, by scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the Trust risk register.

8.5.3. To aid this assurance, the Committee's work plan incorporates a review of the organisation's risk management processes, and associated risk registers, from divisional to corporate level on a cyclical basis, to gain assurance that systems in place are effective.

8.5.4. The Committee will monitor action plans associated with the delivery of this strategy.

8.5.5. The Audit Committee will provide assurance to the Board on the effectiveness of the system of internal control through:

8.5.5.1. Regular monitoring of significant corporate and strategic risks on behalf of the Board

8.5.5.2. Monitoring of the implementation of the internal audit plan, and of associated internal audit recommendations, requesting further assurance on internal audits with limited assurance opinion

8.5.5.3. Monitoring the effectiveness of the information risk management arrangements through the Senior Information Risk Owner (SIRO) reports and chair assurance reports from the Information Governance Group

8.5.5.4. Receiving assurance on the management of security risks via updates on the delivery of the Local Security Management Specialist services action plan, and annual reports

8.5.5.5. Formally reviewing the system of internal control annually taking assurances from Board Committees on management of detailed risks.

8.6. **Risk Management Committee**

8.6.1. The Risk Management Committee will maintain oversight of the operational arrangements to ensure the BAF and risk register are robustly maintained. In addition the Committee will scrutinise and challenge the delivery of mitigations against specific risks, whilst holding to account risk owners for non-delivery of action plans or variation from the provisions of this strategy

8.6.2. As the Risk Committee of the Board, the Risk Management Committee will meet six times a year and will review significant risks with a Trust wide impact and the BAF at each meeting

8.6.3. As part of its role the Risk Management Committee will seek detailed assurance reports on significant risk areas identified through the aggregation of incidents, complaints, never events and claims

8.6.4. The Committee will report to the Board via a Chair's assurance report, with specific assurance given on the action plans to mitigate risks, as well as independent sources of assurance where possible.

8.6.5. The Risk Management Committee will review all risks with a residual rating of 15-25

8.6.6. Risks that fall below this threshold will be monitored by the Groups of the Committee, with assurance updates provide via a Chair's report. These groups will review and monitor progress against mitigation of key risks at each meeting on a bi-monthly basis.

8.6.7. As part of the implementation of this strategy the Risk Management Committee will:

8.6.7.1. Review assurances on learning and how it is embedded in divisions to manage risks. The Committee will consider the EWTT indicator relating to recurring themes from incidents, complaints and SIs

8.6.7.2. Request detailed reports on the top strategic risks as highlighted on the BAF, assuring to the Board via Committee Chair assurance reports

8.7. **Quality Assurance Committee**

8.7.1. As part of its remit, the Committee has a responsibility to monitor the delivery of the Clinical Strategy and associated risks. The Quality Assurance Committee meets six times a year and will review significant quality and patient safety risks and the BAF at each meeting

8.7.2. The Quality Assurance Committee will review current and future risks to quality and safety, which extend to risks identified by Divisions and corporate departments of the Trust.

8.7.3. The Quality Assurance Committee will review quality and patient safety risks with a residual rating of 15-25

8.7.4. Risks that fall below this threshold will be monitored by the Groups of the Committee, with assurance updates provide via a Chair's report. These groups will discuss risks at each meeting on a bi-monthly basis.

8.7.5. As part of the implementation of this strategy the Quality Assurance Committee will:

8.7.5.1. Review assurances on learning and how it is embedded in divisions to manage risks. The Committee will consider the EWTT indicator relating to recurring themes from incidents, complaints and SIs

8.7.5.2. Request detailed reports on the top strategic risks to quality as highlighted on the BAF, assuring to the Board via Committee Chair assurance reports

8.8. **Finance, Business Performance Assurance Committee**

8.8.1. As part of the delivery of this strategy the Committee will:

8.8.1.1. Review significant corporate and strategic risks that fall in its remit as a standing agenda item

8.8.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

8.8.1.3. Monitor the implementation of the financial plan and the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

8.9. **Safety Management Assurance Committee**

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8.9.1. As part of the delivery of this strategy the Committee will:

8.9.1.1. Review significant patient and staff safety risks that fall in its remit as a standing agenda item

8.9.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

8.9.1.3. Monitor the implementation of key action plans and the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

Workforce Assurance Committee

8.9.2. .

8.9.3. As part of the delivery of this strategy the Committee will:

8.9.3.1. Review significant workforce and education risks that fall in its remit as a standing agenda item

8.9.3.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

8.9.3.3. Monitor the implementation of key action plans and the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

9. APPROACH TO RISK

9.1. **Risk Identification**

9.1.1 The risk management process is outlined in detail within the Risk Management Policy.

9.1.2 As part of the implementation of this strategy, the Trust will put in place proactive and reactive approaches to the identification of risks, primarily through the risk assessment processes which assess the potential to cause any of the following:

- Injury
- Complaint
- Litigation
- Damage to the environment or property
- Failure to maintain services and/or the quality of services provided by the Trust,
- Failure to meet national and organisational targets loss of reputation and financial loss etc.

9.2 Sources of risk identification

9.2.1 There are internal and external sources of risk:

Internal risks are identified, in the course of strategic and business planning, adverse incidents, complaints, claims, noncompliance with statutory duties and guidance, enquiries and clinical/nonclinical hazards identified for any Trust activities.

- External sources of risk are identified in the course of risk alerts, hazard warnings and recommendations received by the Trust from a recognised external source – e.g. information from the Medicines & Healthcare Products Regulatory Agency (MHRA), National Patient Safety Agency (NPSA), Care Quality Commission, National Institute for Clinical Excellence (NICE), Health and Safety Executive (HSE), inquiries and other bodies. These will be communicated immediately and applied as appropriate in the Trust.

In implementing this strategy, the Trust's goal is to ensure that the effect of any risk is reduced to an acceptable level or negated completely. In practice, this will be executed by using internal and/ or external advice to decide on the most appropriate options to treat risk and by sharing best practice and learning from other organisations.
Sources of advice include the CQC, NHS Resolution, NHSR, National reporting & Learning System (NRLS), Health and Safety Executive, Internal Auditors.

Risk treatment (means of addressing risks) can be broken down into the following:

- Avoid - some risks may only be managed by terminating the activity (i.e. avoiding the risk by not undertaking the activity that could lead to the risk occurring)

- Control - preventative controls are measures currently in place when a risk is identified to control the risk i.e. directive controls or policies and processes, clear labelling of packages, checking a patient's identity before a procedure. If existing controls are shown not to be adequate, e.g. gaps are identified, an action plan should be produced to ensure the risk is mitigated with additional controls. Action plans will be approved initially by a division as per the risk reporting arrangements

- Transfer - for some risks, the best method of control is to transfer them to a third party to reduce the exposure to the Trust or because another organisation will manage the risks more effectively e.g. financial risks can sometimes be transferred by effecting insurance (NHSLA). However, this process needs to be carefully managed and audited to ensure the Trust's exposure is minimised.

- Tolerate - the exposure to the risk may be tolerable/accepted without any further controls

In assessing any mitigating actions associated with a risk there should also be an assessment of the impact of such actions.

All managers have authority for risks in their areas of responsibility in line with their resources available to them to eliminate or control the risk. Where the manager does not have suitable or sufficient resources they should refer the issue to their line manager.

10. RISK MANAGEMENT PROCESS

The Risk Management process is summarised in figure 4 below, and incorporates a proactive and reactive approach.

10.1. Risk assessment is an iterative process and all risks will be periodically reviewed and re-assessed in view of contextual changes.

10.2. Re-assessment is undertaken proactively at intervals proportionate to the risk magnitude and risk appetite as well as reactively in response to anticipated or known changes.

10.3. The trust will explore its risk appetite for significant risks through a review of the Board Assurance Framework, Trust risk register and evidence considered as to whether residual risks are acceptable or not.

10.5 All strategic risks will be reviewed on a monthly basis by the Executive Directors who confirm their management through the content of the BAF in preparation for presentation to the Board.

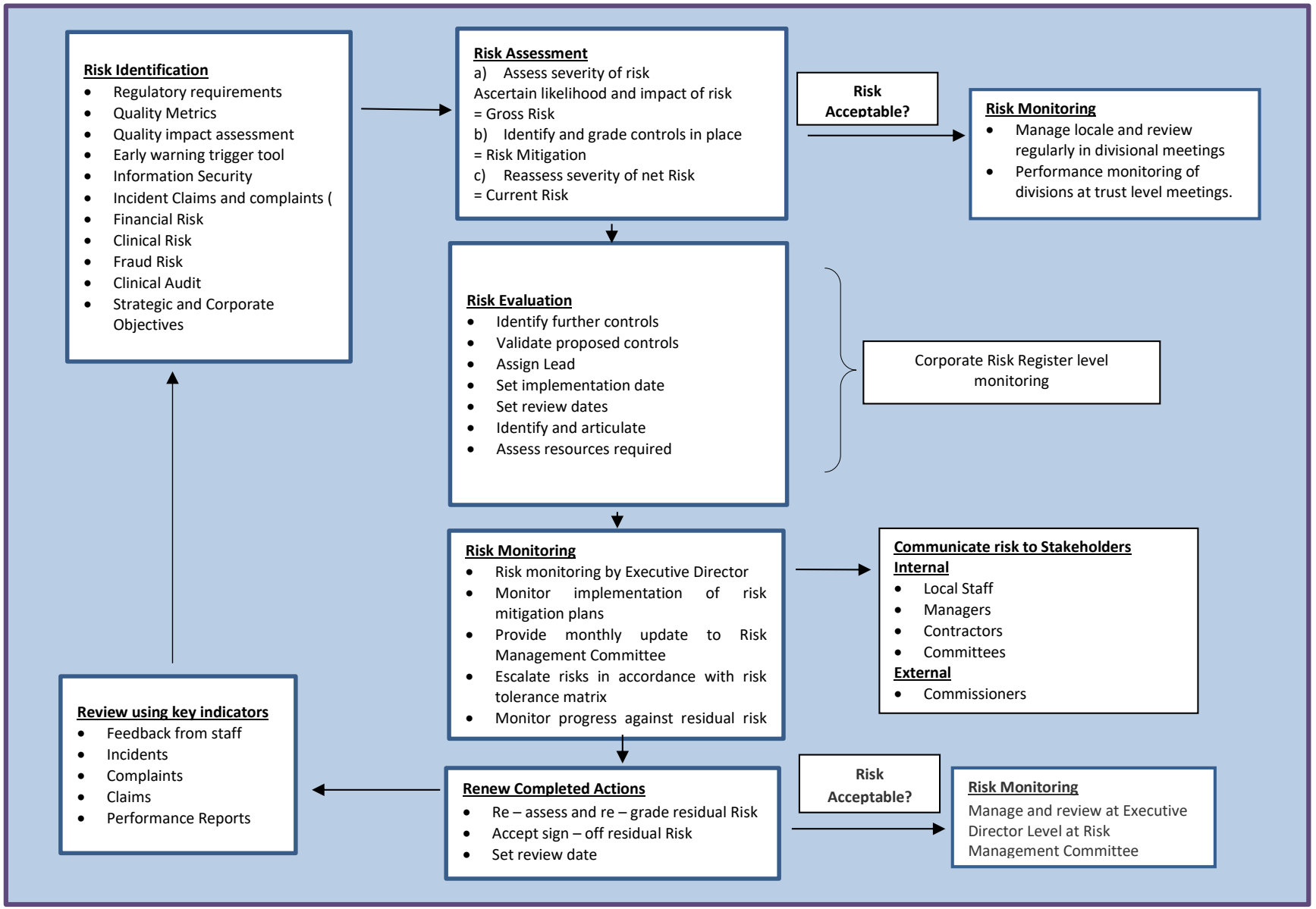
10.6 All moderate and significant risks (current risk score 9-25) will be reviewed by the Executive Directors who will confirm their approach to mitigation through the content of the Trust risks register operationally at Trust Management Board, and also the Risk Management Committee on an alternate basis in preparation to the Board for their consideration

10.4. All lower level risks (with a current risk score less than 9) are reviewed and managed locally by the Divisional management in their Governance meetings.

10.5. Risks which are not considered acceptable at a local level will be escalated as appropriate, and managed through strategic and operational change or transferred (e.g. by contracting out) leaving acceptable (and opportunity) risks.

10.7 Such risks are managed and mitigated through the Risk Management processes and retained risks are recorded and reviewed through the Trust's risk registers.

Figure 4: Risk Management process


Risk Identification
Regulatory requirements
Quality Metrics
Quality impact assessment
Early warning trigger tool
Information Security
Incident Claims and complaints (
Financial Risk
Clinical Risk
Fraud Risk
Clinical Audit
Strategic and Corporate Objectives
Risk Assessment
a) Assess severity of risk
Ascertain likelihood and impact of risk
= Gross Risk
b) Identify and grade controls in place
= Risk Mitigation
c) Reassess severity of net Risk
= Current Risk
Risk Acceptable?
Risk Monitoring
Manage locale and review regularly in divisional meetings
Performance monitoring of divisions at trust level meetings.
Risk Evaluation
Identify further controls
Validate proposed controls
Assign Lead
Set implementation date
Set review dates
Identify and articulate
Assess resources required
Corporate Risk Register level monitoring
Risk Monitoring
Risk monitoring by Executive Director
Monitor implementation of risk mitigation plans
Provide monthly update to Risk Management Committee
Escalate risks in accordance with risk tolerance matrix
Monitor progress against residual risk
Communicate risk to Stakeholders
Internal
Local Staff
Managers
Contractors
Committees
External
Commissioners
Review using key indicators
Feedback from staff
Incidents
Complaints
Claims
Performance Reports
Renew Completed Actions
Re – assess and re – grade residual Risk
Accept sign – off residual Risk
Set review date
Risk Acceptable?
Risk Monitoring
Manage and review at Executive Director Level at Risk Management Committee

11 PROACTIVE RISK MANAGEMENT APPROACH

11.5 Internal inspections/reviews and assessments

11.6 Risks will be identified, assessed and mitigated through internal inspections or reviews, e.g.:

- 11.6.1 CQC internal self-assessment
- 11.6.2 Delivery of clinical audit plan
- 11.6.3 Health, safety and fire inspections
- 11.6.4 Internal infection control visits
- 11.6.5 CQC Peer reviews
- 11.6.6 Internal audit reviews
- 11.6.7 Internal assessment of risks

11.7 Risks identified will be escalated in accordance with the thresholds set out in the Risk Tolerance Matrix.

11.8 Quality impact assessment tool

- 11.8.1 A Quality Impact Assessment Tool provides a consistent approach to ascertaining the impact on quality associated with service changes.
- 11.8.2 It is intended to support quality governance by assessing the impact of CIPs and service change on quality.
- 11.8.3 It involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.
- 11.8.4 Where a negative impact score of 9 and above is identified a detailed quality impact assessment is required, with associated mitigations.
- 11.8.5 The Quality Assurance Committee will monitor action plans associated with a negative impact score of 15 and above, and also action plans resulting in a positive impact. Quality impact assessments with an adverse impact will be generated onto the Trust risk register and monitored in line with other quality risks
- 11.8.6 Risks will be escalated in accordance with levels set out in the *risk tolerance matrix*.

11.9 **Learning from external sources**

- 11.9.1 The Trust Board will put in place a Development Programme that incorporates learning from various sources, such as coroner interventions and inspections by the Care Quality Commission for example.
- 11.9.2 Where appropriate and relevant, the Board will delegate the monitoring of action plans to specific Committees, receiving assurance through Chair Assurance reports.
- 11.9.3 The Trust ensures that there is a systematic approach to the analysis of incidents, complaints and claims to enable learning and improvement as part of the implementation of this strategy.

11.9.4 The Executive Directors will instigate a robust process to ensure that risks identified from learning are added to the corporate risk register, where appropriate, with associated action plans which are reviewed regularly by the Risk management Committee.

11.10 **Early Warning Trigger Tool**

11.10.1 The Trust will develop an Early Warning Trigger Tool (EWTT) with a set of automatically weighted indicators (with a possible maximum score of 50) which taken together indicate how well a ward is functioning, and provide an early warning, pre-empting more serious concerns and enabling action *before* things go wrong.

11.10.2 The output of the EWTT enables ward managers and Divisional directors to benchmark the overall risk on their wards with others, resulting in the rapid identification of remedial action

11.10.3 The EWTT provides robust and reliable information from 'Ward to Board' offering the Trust Board further assurance of the quality of care specifically at an individual clinical team level.

11.10.4 The EWTT will also be adapted for use in non-clinical areas applying 'early warning' metrics such as sickness absence, freedom to speak up issues, never events, near misses

11.10.5 The table summarises the risk escalation process based on ranges of EWTT scores:

Score Analysis Guide	Early Warning Trigger Tool score
Executive Committee monitoring and Trust Board escalation and assurance	**40-50**
Trust-wide Performance monitoring , Executive Director monitoring and Quality Assurance Committee escalation and assurance	**30-40**
Divisional Director and Trust-wide Performance Executive Committee escalation	**20-30**
General Manager escalation	**10-20**
Service /Ward Manager escalation	**0-10**

12 REACTIVE RISK MANAGEMENT APPROACH

12.5 As part of delivering this strategy, the Trust will identify risks arising from serious incidents, claims, complaints and incidents and form action plans to reduce risks to a tolerable level.

12.6 The Trust operates a fair, Just culture to ensure staff feel able and confident to report events or concerns.

12.7 Risks arising from complaints, Incidents and near misses rated 9 or above ('amber' or 'red') using the Risk Scoring Matrix will be entered on the Trust Risk Register and escalated in accordance with the Trust's risk escalation process as articulated in the risk tolerance matrix

12.8 Claims scored using the Trust's Risk Scoring Matrix and those rated 9) or above) will be entered on the Trust Risk Register and are escalated in accordance with the Trust's risk escalation process.

12.9 The Deputy Director of Patient Safety and Governance will review reports produced by Internal and External Audit with an audit opinion of limited assurance ensuring risks are identified and placed on the risk register as appropriate.

13 REGULATORY COMPONENTS OF RISK MANAGEMENT

13.5 In delivering this strategy the Trust will consider the following aspects of statutory compliance, and the management of associated risks.

13.5.1 Health and Safety Legislation

13.5.1.1 The Trust will discharge its statutory responsibilities under the EC framework directive (89/91/EEC) and the Management of Health & Safety Regulations 1992 (Amended 1999) to 'evaluate the risk to the safety and health of workers and anyone else who may be affected by its activity but not in its employment'.

13.5.2 Care Quality Commission

13.5.2.1 In undertaking its statutory obligations under the Health and Social Care Act 2008, the Trust will maintain compliance with the regulation within the Act that governs its activity.

13.5.2.2 In delivering this strategy the Trust will identify and mitigate associated risks relating to CQC compliance.

13.5.3 Statutory Annual Governance Statement Disclosure

13.5.3.1 The Trust will put in place robust arrangements to comply with requirements from the Annual Reporting Manual in relation to the production of an annual Governance statement disclosure which is assured by an effective risk management system.

13.6 **Monitoring the Implementation of this Strategy**

13.6.1 The implementation of this strategy will be monitored by:

- Routine monitoring of the risks by the Quality Assurance Committee, and independent assurance updates to the Audit Committee
- The Trust's progress against its strategic and corporate objectives;
- Assurance from internal and external audit reports that the Trust's risk management systems are being implemented
- Annual updates to the Board as part of the year-end review
- An external review of governance and leadership every three years.

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 2122-139

Board of Directors
6 October 2021

Title:	Monthly Safe Nurse Staffing Report
Author :	Tracy Fennell – Deputy Chief Nurse Johanna Ashworth Jones – Programme Developer, Corporate Nursing Team
Responsible Director:	Tracy Fennell Deputy Chief Nurse
Presented by:	Tracy Fennell Deputy Chief Nurse

Executive Summary

Workforce Assurance Committee has approved the approach to overcoming the challenges of safe staffing and highlights:

- M5 continued to be a challenging month for safe staffing across the Trust; some improvement on M4 with no serious harm reported as a result.
- Reduced RN staffing was considered a possible contributing factor for two falls in M5 neither of these falls resulted in any patient injuries.
- CSW vacancies have reduced for the second month to 0.21%.
- 6 wards reported shifts with a professional judgement of red in M5 (risk of care standards falling below expected levels) despite additional mitigations being put in place.
- Maternity completed their pilot and evaluation of the Birth Rate Plus (BR+) app which will be adapted for use regionally to provide staffing and acuity data.

Recommendation: (e.g. to note, approve, endorse)
To note the contents of the report.

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
BAF references 1,2,4,6. Positives. • CSW vacancies have reduced to 0.21% • Establishment reviews have been completed in line with Developing Workforce Safeguards (2018) NHSE guidance. • No known serious harm occurred as an impact of reduced staffing • There have been no formal complaints in relation to patient or stakeholder's perception of reduced staffing received for three consecutive months. • Funding has been identified to recruit a further 10 international nurses (total 170) Gaps. • Reduced staffing may be a contributing factor for 2 falls within DME but did not result in harm. • Staff isolating due to increasing COVID community prevalence continues to impact staffing during M5 • 6 shifts had a professional judgement of red in M5
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
NHSI – developing Workforce Safeguards , CQC Essential Standards
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Nursing expenditure
Specific communications and stakeholder /staff engagement implications
Stakeholder confidence
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
NMC Code , NHS Constitution, NHS People Plan
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)
NA

Previous considerations by the Board / Board sub-committees	Monthly safe nurse staffing report to Board since October 2020
Background papers / supporting information	

Board of Directors
6 October 2021

Monthly Safe Nurse Staffing Report.

Purpose

This report provides the Board of Directors with information regarding safe nurse staffing and the actions to improve the vacancy rates.

1 Current position: areas to note

1.1 Vacancies

The RN band 5 vacancy rate has increased by 1.63% to 13.94% (M5) from 12.31% (M4).

There are currently 30 international nurses (IR) working in band 4 posts that are awaiting NMC registration that will be deducted from the vacancy figure in the forthcoming months. RN vacancy projection figures based on the scheduled arrival of the remaining IR nurses and other recruitment initiatives forecasts that by M9 the Trust should be fully established.

As detailed in M4 the cohesive partnership working between Human Resources, Corporate Nursing Department and Divisions has streamlined recruitment processes thus reducing delays in CSW recruitment times this has resulted in a further reduction on CSW vacancies to 0.21% (M5) from 0.49% (M4).

Weekly corporate RN and CSW recruitment continues along with commencement of CSW apprenticeships and on-going recruitment into the Care Support Worker Development (CSWD) Programme.

1.2 Sickness

RN sickness has reduced by 0.52% to 6.01% (M5) from 6.79 % (M4). However, staff isolating due to the COVID pandemic continues to provide a pressure on staffing.

CSW sickness has increased by 0.52% to 9.68% (M5) from 9.16% (M4). Despite high levels of CSW sickness the Trust has been able to maintain fill rates for CSW at 98% days and 103% for nights due to the improvements in CSW vacancies and improved NHSP CSW fill rates to 85.06% (M5) from 84% (M4).

1.3 Safe Staffing Oversight Tracker (SSOT) review

During M5 the SSOT reported the number of shifts that fell below minimum RN staffing levels as 545 which is a decrease from 614 (M4).

To reduce the risks in areas with reduced staffing levels 301 staff were relocated from other areas (M5), which is a significant reduction from 407 (M4).

In M5, 6 shifts were assessed by the Senior Nursing Team as a professional judgement of red (high risk of care standards falling below expected levels) which is a reduction on (M4) 11. All 6 shifts were within the Medical Division across 3 wards, with 4 shifts being a night shift, 1 late and 1 early shift. Details are listed below:

CCU (1 shift)
At the start of the shift the ward was deemed safe as there were only two patients, however overnight a further two patients were admitted. Patient acuity increased with patients recording high MEWS scores.

Ward 21 (1 shift)
Staffing was reduced due to short notice sickness, the Ward Manager worked clinically on this shift and an RN from a neighbouring ward supported during the medication round to maintain patient safety.

Ward 26 (4 red shifts)
Ward 26 was highlighted in (M4) for a number of red professional judgement shifts, in M5 this has reduced to 4 from 8 in (M4). Staffing had been reduced due to a number of vacancies and increased sickness levels. All RN vacancies have now all been filled however staff are concluding recruitment checks and therefore have not yet commenced in post. Sickness is being managed proactively in line with policy. Vacant NHSP gaps were covered clinically by the Ward Manager who covered the night shifts as there was reduced staffing across the division. Grade changes of additional CSW were also put in place to support the ward.

During the recent establishment reviews Ward 26 was highlighted as having an increased acuity and in light of this a 3 month temporary uplift to the ward's establishment has been agreed.

A full report on the outcome of the ward establishment reviews will be presented to Board of Directors in December 2021.

1.4 Impact on Care

17 falls occurred in M5 where staffing levels were less than expected which is a significant decrease on 29 (M4). A review of these falls indicated that reduced staffing may have been a contributing factor to two of these falls.

There was a significant reduction in the number of red flags for the following indicators recorded in the SSOT:

- Staff Missed break, 50 (M5) compared with 100 (M4)
- Delayed / Missed observations, 129 (M5) compared with 198 (M4)

- Delayed / Missed pressure care, 64 (M5) compared with 82 (M4)
- Delayed / Missed MNews, 222 (M5) compared with 367 (M4)
- Delayed Medications, 248 (M5) compared with 263 (M4)
- Number of 1:1 specials not covered, 4 (M5) compared with 12 (M4)

2 Actions to mitigate risks

The number of hours covered by nursing agencies increased by 1% in (M5) to 7% compared with 6% (M4). WUTH requested 28042 registered nursing hours to be covered during M5 with 61.3% of these filled by NHSP.

The number of CSW shifts requiring cover in (M5) decreased by 145 hours compared with (M4), the NHSP fill rate however increased by 1.6% to 85.6%.

The Trust remains on track with the International Recruitment Programme in line with agreed plans. Funding has been sourced to support recruitment of a further 10 International nurses bringing the total to 170 that will be in the Trust before the end of Q3.

3 Children's and Maternity Staffing.

3.1 Maternity

Maternity staffing continues to be extremely challenging in M5 with several providers across C&M going on divert. Daily and weekly sitreps continue to be submitted to NHSE. There have been no local diverts however the Maternity Unit has been in escalation on a daily /ongoing basis with support required from the Community Midwifery Service. Weekly staff engagement sessions are held due to some concerns raised by community staff with an improvement plan supporting additional work being undertaken.

M5 is the fifth consecutive month that the Delivery Suite has been noted as an area submitting higher numbers of staffing incidents with 15 reported. These incidents included the requirement to utilise the escalation policy, inability to accommodate in-utero transfers from other hospitals due to staffing shortages and short notice sickness and already high patient acuity and numbers.

The close monitoring of acuity and senior support in and out of hours continues to be provided. The Birth Rate Plus (BR+) Acuity Tool is in use – an example report for August is detailed in table 1 below. It is anticipated that this will be adapted for use regionally with real time RAG rated acuity submitted by each provider. Maternity Staffing has been added to the risk register given the current national demands on maternity services and the lack of available midwives regionally. NHSE/I are currently scoping international recruitment to support Liverpool Women's Hospital and St Mary's in Manchester due to the excessive vacancy numbers/difficulty in recruiting midwives across the system.

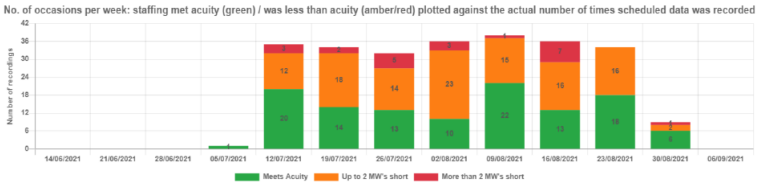
A revised Maternity Escalation and Divert Policy was approved and operationalised on 1 September 2021 supporting a system wide approach to relieving pressures.

There are currently no vacancies within the Maternity Service. Workforce Steering Board and Workforce Assurance Committee are receiving regular updates on the recent staffing review by BR+ and associated recommendations.

Table 1

birthrateplus® | Safe Staffing for Maternity Services

Wirral University Teaching Hospital NHS Foundation Trust - Delivery Suite Archive



Overall during the data period for weeks commencing 14/06/2021

% of recordings where staffing level more than 2 MW's short	2.4%
% of recordings where staffing level is up to 2 MW's short	12.7%
% of recordings where staffing level meets acuity	12.9%
Data collected for the period covered by this summary provides	28% compliance

3.2 Children's

There is currently 1 WTE vacancy in Children's Ward which is currently out to advert, with additional staffing being sourced through NHSP and agency. Further recruitment is underway to increase the availability of additional staffing as and when required.

All newly qualified students have been recruited are being supported with a period of supernumerary status followed by preceptorship.

Short term absence in M5 has at times been a challenge; this has resulted in 1 child being diverted from Paediatric Assessment Unit to the Paediatric Ward on one occasion.

Weekly review meetings regarding anticipated Respiratory Syncytial Virus (RSV) surges are held with input from the Wirral Healthcare system partners and plans are in place for the anticipated surge in RSV. Currently to date RSV numbers have remained relatively low. RSV is being monitored closely with a C&M Command structure in place.

There have been no incidences of diverting children out of the organisation. The Trust Escalation and Divert Policy for Children's Services is currently being revised expecting to be ratified in Q3.

3.3 Neonates

In Neonates 1 WTE Band 5 vacancy is out to advert but all other vacancies have been recruited to, any vacant hours have been covered in the short term with NHSP and staff working additional hours. The Neonatal Unit continues to be extremely busy with babies being transferred in from outside the region due to a lack of capacity regionally. Several in-utero transfers (IUT) have been declined in M5 due to midwifery staffing or no cot availability but each IUT declined has been subject to senior clinical review. Priority is given to those babies requiring ITU / Level 3 support.

4. Conclusions

M5 has demonstrated some improved staffing levels. There has been a reduction in the impact on care compared with M4. However, this was still a challenging month for staffing both in adult and maternity services due to increased patient acuity, sickness, and staff absence due to staff isolating because of the increase in COVID community prevalence.

All areas have mitigations in place using enhanced monitoring, escalation processes, NHSP, agency staffing and sickness monitoring processes. Due to this, wards have remained safe in M5.

Despite mitigations M5 is expected to continue provide increased staffing challenges due to the rising community COVID prevalence. There is expected to be a further increase in staff absence and an increase in acuity due to increased births, increased positive COVID cases and a rise in RSV cases.

Workforce Assurance Committee has been assured that resilience planning is in place locally, linking into regional workstreams, to ensure plans are in place ahead of the predicted pressures over the forthcoming months.

4. Recommendations to the Board

The Board of Directors are requested to note the contents of report.

Appendix 1 – Safe staffing dashboard Aug 2020- Aug 2021

	Safe Staffing Board Assurance Dashboard 2020 /21 - 2021/2022													
Data Source	Indicator	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Spark line
Corporate Nursing	Care Hours Per Patient Day - Total	9.6	8	8.5	10.1	9.5	8.1	8.9	9	8.7	8.3	8.8	8.5	8.4	
Corporate Nursing	Care Hours Per Patient Day - Registered Nurses	4.8	3.8	4.1	5.2	4.8	4	4.3	4.4	4.1	4.1	4.4	4.1	4.2	
Corporate Nursing	Care Hours Per Patient Day - CSW's	4.2	3.5	3.7	4.1	3.8	3.4	3.7	3.8	3.5	3.5	3.6	3.6	3.6	
Corporate Nursing	Number of ward below 6.1 CHPPD	0	2	0	0	0	1	1	0	1	4	1	3	2	
Corporate Nursing	National Fill rates RN Day	79%	76%	83%	84%	85%	79%	81%	83%	84%	83%	84%	82%	83%	
Corporate Nursing	National Fill rates CSW Day	76%	86%	89%	94%	88%	86%	91%	91%	92%	93%	100%	97%	98%	
Corporate Nursing	National Fill rates RN Nights	94%	72%	79%	81%	82%	77%	84%	78%	84%	80%	82%	78%	81%	
Corporate Nursing	National Fill rates CSW Nights	97%	90%	104%	100%	99%	95%	71%	101%	98%	99%	98%	96%	103%	
Informatics	Trust Occupancy Rate	66.90%	79.50%	79.50%	76.10%	79.30%	83.50%	80.20%	80.80%	81.40%	83.90%	82.30%	81.50%	84.10%	
Informatics	Occupancy Rate - APH	72.10%	81.50%	79.10%	76.00%	80.30%	82.30%	80.30%	83.50%	83.90%	86.70%	85.00%	84.80%	87.30%	
Informatics	Occupancy Rate - CBH	24.90%	51.90%	46.10%	39.00%	37.90%	50%	50%	52%	55%	55%	53%	51%	54%	
Workforce	Vacancy Rate (Band 5 RN's)	18.05%	16.94%	16.61%	17.66%	18.10%	19.42%	18.81%	18.57%	15.92%	13.97%	13.10%	13.44%	14.56%	
Workforce	Vacancy rate (Band 5 inpatient wards)	20.16%	18.73%	17.11%	17.72%	18.49%	19.89%	19.01%	17.92%	15.35%	12.59%	11.47%	12.31%	13.94%	
Workforce	Vacancy Rate - All RN (All grades)	9.90%	9.40%	8.67%	9.79%	9.57%	10.79%	10.03%	9.69%	8.26%	7.47%	7.15%	6.97%	7.69%	
Workforce	Vacancy Rate (CSW's)	5.86%	7.86%	7.77%	8.11%	6.28%	6.79%	5.94%	5.97%	5.82%	2.99%	3.08%	0.49%	0.21%	
Workforce	Sickness Rate - RN	6.12%	6.38%	6.80%	6.95%	6.49%	9.17%	7.14%	6.01%	5.96%	5.92%	5.51%	6.79%	6.01%	
Workforce	Sickness Rate - CSW	9.58%	10.09%	8.82%	7.59%	8.18%	12.34%	9.47%	8.11%	8.46%	10.04%	9.89%	9.16%	9.68%	
Workforce	Absences Rate - RN	2.36%	2.60%	1.55%	1.76%	1.50%	2.39%	1.78%	2.24%	0.07%	0.03%	0.30%	1.12%	0.40%	
Workforce	Absences Rate- CSW	3.33%	3.17%	1.55%	2.17%	1.56%	2.64%	2.71%	2.47%	0.05%	0.14%	0.50%	1.88%	0.67%	
Corporate Nursing	Number of Professional Judgment Red Shifts	1	0	0	0	0	0	0	0	0	0	2	11	6	
Corporate Nursing	Number of RN Red Shifts *	359	445	454	243	499	689	330	383	323	427	446	614	545	
Corporate Nursing	RN Red Shift Impact : Number of Falls	7	9	17	4	19	26	36	16	16	21	19	29	17	
Corporate Nursing	RN Red Shift Impact : Number of Falls with Harm	0	1	1	0	0	0	1	1	0	0	3	1	1	
Corporate Nursing	RN Red Impact : Meds Errors / Misses	3	0	7	1	27	2	1	27	2	2	1	2	2	
Corporate Nursing	RN Red Impact : Patient relative complaints	2	0	3	0	0	1	2	0	0	1	2	2	0	
Corporate Nursing	RN Red Impact : Staffing incident submitted	6	16	18	7	23	33	6	14	14	9	4	7	15	
Corporate Nursing	RN Red Impact : Special 1:1 (uncovered)	3	7	9	0	26	38	2	3	1	10	2	12	4	
Corporate Nursing	RN Red Impact: Missed Breaks	14	26	26	10	107	119	34	41	42	71	57	100	50	
Corporate Nursing	RN Red Impact: Delayed / Missed Obs	10	19	122	1	287	278	31	126	75	248	74	198	129	
Corporate Nursing	RN Red Impact: Delayed / Missed nMEWS	12	33	12	31	239	237	72	286	90	226	120	367	222	
Corporate Nursing	RN Red Impact: Delayed / Missed Pressure Care	3	14	24	23	145	46	23	58	15	43	44	82	64	
Corporate Nursing	RN Red Impact : Delayed Meds	8	20	127	6	582	299	88	193	55	199	79	263	248	
Governance support	Number of SI's where staffing has been a contributing factor	0	0	0	0	1	1	0	1	0	0	0	0	0	
Corporate Nursing	Total Number of staffing incidents	53	80	75	25	90	102	42	57	48	93	80	105	92	
Complaints team	Formal complaints in relation to staffing issues	0	0	0	1	0	0	1	0	0	1	0	0	0	
Complaints team	Informal Concerns raising staffing levels as an issue	0	0	1	0	0	1	0	1	0	0	1	0	0	
Corporate Nursing	Patient Experience feedback raising staffing levels as a concern	0	0	0	0	0	0	0	0	0	1	1	1	0	
Corporate Nursing	Staff Moves	232	329	140	164	172	606	337	337	288	341	302	407	301	
NHS Professional	Number of RN hours requested	22878	24734	28432	31103	28638	43952	35299	34182	24465	24192	24382	27501	28042	
NHS Professional	Number of CSW hours requested	25196	25007	32505	28386	30651	42759	33056	30218	24122	24171	23421	25435	25286	
NHS Professionals	% of requested filled RN's	62.80%	61.70%	60.20%	72.70%	58.90%	57.50%	54.60%	62.80%	64.50%	68.22%	65.90%	59.00%	61.30%	
NHS Professionals	% of requested CSW filled	80.20%	76.50%	71.10%	85.30%	68.10%	62.80%	68.00%	75.00%	77.60%	84.20%	86.20%	84.00%	85.60%	
NHS Professionals	% of Agency staff used RN	3%	3%	2%	6%	1%	2.30%	7.00%	7.00%	5.00%	1.70%	4.80%	6.00%	7.00%	
NHS Professionals	% of Agency staff used CSW	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	

** The National Safe Staffing submission reports the total actual hours filled against the agreed funded establishment. RN Red shifts are defined as shifts that are below both the agreed funded establishment and below the agreed minimum staffing model.*

*Blue text denotes where an amendment to the previous figures has been made following a review of establishment figures. These figures are correct at the time of the divisional sign off process at the beginning of each month for the retrospective month

Agenda Item: 21/22-140

BOARD OF DIRECTORS
6th October 2021

Title:	Emergency Preparedness Resilience and Response (EPRR) Core Standards
Responsible Director:	Mags Barnaby
Author:	Jane Hayes-Green
Presented by:	Mags Barnaby

Executive Summary
The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet and are included in the NHS standard contract. The director level Accountable Emergency Officer and/or governing body in each organisation are responsible for making sure these standards are met. This report is to assure the Board of the process and the self-assessed compliance with the core standards for EPRR and to approve the actions identified.

Recommendation:
To note.

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
None
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
None
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
None
Specific communications and stakeholder /staff engagement implications
None
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
None
Council of Governors implications / impact (e.g. links to Governors' statutory role,

significant transactions)		
None		
FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees		
Background papers / supporting information		

1. Executive Summary

Under the Civil Contingencies Act (2004) NHS organisations and providers of NHS funded care must show that they can effectively respond to emergencies and business continuity incidents while maintaining services to patients. This work is referred to in the health service as 'Emergency Preparedness, Resilience and Response' (EPRR).

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet and are included in the NHS standard contract and, through this, the NHS Commissioning Board Emergency Planning Framework (2013). The director level accountable emergency officer and/or governing body in each organisation are responsible for making sure these standards are met.

The EPRR assurance process usually uses the NHS England Core Standards for EPRR. However, as a result of the events of 2020, these standards did not receive their tri-annual review and, as a consequence, not all standards reflect current best practice. NHS England has therefore removed a small number of standards to accommodate this year's assurance process, until they undertake a full review.

This report is to assure the board of the process and the self-assessed compliance with the revised core standards for EPRR and to approve the actions identified.

The Trust has assessed itself as:

Substantially Compliant.

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
46	0	2	44
Substantial	**Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.**		

The self-assessment compliance level and actions have been discussed and agreed with the Head of EPRR at NHS England (Cheshire & Merseyside).

2. Background

The 2021/22 EPRR Assurance Process is based on the revised Core Standards. To comply with the national requirements NHS England requested that each organisation:

- Undertake a self-assessment against the revised core standards identifying the level of compliance for each standard (red, amber, green)
- Submit an improvement plan addressing any areas of improvement required
- Complete the statement of compliance (attached) identifying the organisation's overall level of compliance - full, substantial, partial or non-compliance
- Present the above outcomes to the Public Board

3. Key Issues/Gaps in Assurance

The self-assessment compliance level and actions have been discussed and agreed with the Head of EPRR at NHS England (Cheshire & Merseyside). The areas identified as requiring improvement to achieve compliance are:

Core Standards Ref.	Action required	Action Lead	Due Date
67	Identify additional staff to be trained as Decontamination trainers in ED. Access 'train the trainer' decontamination training from NWAS.	Acting Corporate Directorate Manager Operations Jane Hayes-Green	1 April 2022
59	ED Decontamination trainers to train new ED staff & update existing staff including Reception team. In addition train Hospital Co-ordinators.		1 August 2022

4. Next Steps

The Statement of Compliance and the Improvement Plan have been submitted to EPRR NHS England and the Wirral Clinical Commissioning Group by the 1st October deadline.

The Improvement Plan will be added to the Trust Risk Register and monitored in line with the Risk Management Strategy.

5. Conclusion

The Trust has self-assessed against the NHS England's revised Core Standards for Emergency Preparedness, Resilience and Response and is declaring Substantial Compliance. An action plan is in place that will be completed within the next 12 months.

6. Recommendations

The Board is asked to note the content of this report.

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

Wirral University Teaching Hospital Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Wirral University Teaching Hospital Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
46	0	2	44
Acute providers: **46** Specialist providers: **38** Community providers: **37** Mental health providers:**37** CCGs: **29**			

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Margaret Barnaby

Signed by the organisation's Accountable Emergency Officer

24/09/2021

Date signed

05/10/2021	06/10/2021	01/04/2022
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Agenda item: 2122 -141

BOARD OF DIRECTORS MEETING
Fit and Proper Persons Policy
6th October 2021

Title:	Fit and Proper Persons Policy
Responsible Director:	Sir David Henshaw, Trust Chairman
Author:	Molly Marcu, Interim Director of Corporate Affairs
Presented by:	Molly Marcu, Interim Director of Corporate Affairs

Executive Summary
The attached paper provides an overview of the changes made to the Fit and Proper persons policy and process, as a result an assessment undertaken to aid continuous improvements of the Trust's well led arrangements. This paper therefore incorporates the revised proposed Fit and Proper Persons Policy for approval, and implementation with effect from the 1st of October 2021.

Recommendation:
The Board is asked to: • Note and approve the Fit and Proper Persons Policy. • Approve the adoption of the Fit and Proper Policy, with effect from 1st October 2021.

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Not applicable.
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Not applicable
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Not applicable at this current stage
Specific communications and stakeholder /staff engagement implications
Not applicable
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Not applicable
Council of Governors implications / impact (e.g. links to Governors' statutory role,

significant transactions)		
Not applicable		
FOI status	Document may be disclosed in full	No
	Document includes FOI exempt information	Yes
	Entire document is exempt under FOI	Yes
Previous considerations by the Board / Board sub-committees	Not applicable	
Background papers / supporting information	Not applicable	

BOARD OF DIRECTORS MEETING
6 October 2021

Fit and Proper Persons Policy

1.0 Background and purpose

Under Regulation 5 and 19 of the Fit and Proper Person Regulations (FPPR) the Trust is required as an NHS Trust to ensure and carry out fit and proper checks on senior managers on employment, and on an annual basis thereafter.

The Care Quality Commission (CQC) may intervene where there is evidence that proper processes have not been followed, or are not in place for FPPR, as part of a targeted review or a well led inspection.

It is also important to note that the Trust bears responsibility for compliance, not an individual director potentially or actively in breach of the regulation.
For this reason, this report is focused on proposals to address gaps identified in the processes in order to ensure remedial actions are in place as soon as possible within the Trust

This report is aligned to the 3 lines of defence model approach to ensuring robust mitigations and assurances in relation to :

- Scope and content of the Fit and Proper Persons Policy
- Gaps in processes set out in Fit and Proper Persons Policy
- Completeness of employment and annual Fit and Proper Persons Checks

2. Scope and content of the Fit and Proper Person Policy

An assessment has been undertaken in relation to clarifying the number of individuals that are required to comply with the checks, taking into account the requirement to include senior managers responsible and accountable for delivering care (including associate and deputy directors), in line with the CQC definitions of the scope.

It is also worth noting that there are some very specialist roles that would naturally involve a level of autonomy, decision making and advice (that is heavily relied upon) that would also fall within the scope, without necessarily having the title of director. This includes roles such as the Chief Pharmacist, and Company Secretary, for example.
These roles will be included as part of the assessment.

In addition, the current policy was silent on whether the policy applied to interims, whether employed directly or indirectly by the Trust.
There is variability on practice in relation to this particular area.
Some Trusts require employment agencies or Executive Search agencies to carry out the checks, with evidence or confirmation that this process has been completed.
This presents a significant risk to the Trust, as the regulations do not apply to third parties acting on behalf of providers.
These changes have therefore been incorporated within this policy

3. Enhancement of definitions and guidance in Fit and Proper Persons Policy

During the review it was identified that there were a range of gaps or omissions in the policy which then expose the Trust to a risk of breaches, either due to the ambiguity of the policy, or the lack of knowledge of individuals falling within the scope.
One example of this is the definition of mismanagement and misconduct, which was not previously included in the Policy, but it was incorporated as a line in the associated declaration in **Appendix A**, which states:

I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider

It is very possible that individuals can sign their declaration in good faith whilst not being aware that they may have potentially been in breach of this policy.
In addition, the lack of comprehensive and guidance to staff that fall within the scope of this policy exposes the Trust to a risk of non-compliance.
For this reason, the definitions have been included in the revised policy in section 4.5
It is also worth noting that the CQC updated their guidance in 2018 to further expand on their regulation approach as well as comprehensively define misconduct and mismanagement. This previous policy was not updated accordingly; therefore this is also an area of focus going forward.
The previous policy applied a blanket approach to disclosures. Furthermore, it did not align the possibility of conflicts of interests existing, which may affect the eligibility of the individual to be appointed. Alternatively, whilst an individual was appointed, conflicts may have arisen which then require processes to mitigate any risk to the Trust or that individual.

The previous process did not allow for a segregation of duties to exist between the individual carrying out the checks and the authorised signatory signing them off.
Furthermore, it is important to note that the definition of good character is quite broad. Therefore there may be instances where it is necessary to triangulate all available information relating to a concern in order to ensure it is dealt with robustly.
In undertaking FPP checks it is proposed that a tighter , documented verification process is applied, with a segregation of duties in relation to ensuring :

- Checks are applied in line with the policy with documentary evidence of each check
- An independent check is undertaken by an individual confirming that the checks have been completed.

This is currently incorporated within the revised policy on as Appendix C: *Pre-Employment Fit and Proper Persons File Check List.*

4. Annual Fit and Proper Persons Check on Board members

At the time of writing, the FPP annual checks were being carried out on the members of the Board, in line with the provisions of the policy. The outcome of the checks will be reported to the Board in November 2021.

5. Recommendation to the Board

The Board is asked to:

- Note and approve the Fit and Proper Persons Policy
- Approve the adoption of the Fit and Proper Policy, with effect from 1st October 2021

Wirral University Teaching Hospital NHS Foundation Trust

Policy Reference: 282

FIT AND PROPER PERSONS TEST POLICY

Version: Draft New

Name and Designation of Policy Author(s)	Interim Director of Corporate Affairs
Ratified By (Committee / Group)	Trust Board
Date Ratified	TBC
Date Published	(To be updated once published)
Review Date	(To be updated once published)
Target Audience	All directors
Other Associated Strategies, Policies, Procedures, etc	Disciplinary Policy Conflicts of interest guidance and policy Professional Codes of Conduct relevant to registered nurses, allied health professionals, medical staff and others

1 Introduction

1.1 All Executive and Non-Executive Director appointments are subject to the Fit and Proper Persons Test ("FPPT") as laid out in Regulation 5 of the Health and Social Care Act 2008 (Regulations of Regulated Activities) (Amendment) (Regulated Activities) Regulations 2014 (the "Regulations") which came into force on 27th November 2014.

1.2 Individuals in these roles must meet the requirements on appointment and continue to meet these requirements whilst holding office as a Director.

1.3 The Trust will regularly review the ongoing continuing fitness of a Director to hold a Directorship with the Trust. In the event that the Trust determines on reasonable grounds that the Director has ceased to be a "fit and proper person" within the meaning of the Regulations then the appointment may be terminated with immediate effect. (Subject to Trust HR processes for executive directors)

1.4 This policy applies to permanent and interim positions, whether the individual is employed directly or via a third party, or anyone performing similar or equivalent functions, including those in permanent, interim or associate roles, irrespective of their voting rights at board meetings. The Trust will retain responsibility for carrying out checks on all interim staff, as well as maintaining the relevant evidence.

1.5 The word "Director" is used throughout this policy to include all individuals within this wider definition with autonomy & authority to act in the capacity of a director when required in a manner comparable to a director.

2 Purpose

The purpose of this policy is to inform those outlined in the scope of their responsibilities in relation to the Fit and Proper Persons Test and to outline the processes that will ensure the test is correctly applied and regularly monitored.

The policy is to set out the required standards based on the guidance issued by the Care Quality Commission (CQC) which emphasises the importance of the Fit and Proper Persons Test in ensuring the accountability of directors of NHS providers.

To ensure the Trust meets its statutory and regulatory requirements, this policy defines the way in which areas of responsibility have been determined, together with processes for assessment checking and compliance monitoring.

The policy for Fit and Proper Persons Tests is based upon the following key principles:

a) The Trust complies with its statutory and regulatory obligations when appointing directors to the Trust Board.
b) The Trust meets the requirements of its Governance framework.
c) The Trust has in place a robust process for the assessment of directors in meeting the requirements of the Fit & Proper Persons Test at the point of recruitment and on an on-going basis.
d) The Trust is prepared for external monitoring and assessment undertaken by regulatory bodies.

3 Scope

3.1 This policy and procedure applies to all Board level appointments and those senior managers acting in an associate or deputy director role, whether on an interim or permanent basis.

The Trust regards the following posts as subject to the 2014 regulations:

a) The Chairman, Non-Executive Directors and Associate Non-Executive Directors
b) The Chief Executive and Executive Directors
c) Associate and Deputy Directors
d) Senior management in autonomous and specialist positions
e) Any other senior position designated by the Chair or Chief Executive as being a role that performs a function of, or functions equivalent or similar to those of a Director.

4 Meeting the Requirements of Regulation 5

4.1 The Regulations places the ultimate responsibility on the Chair to discharge the requirement placed on the Trust, to ensure that all relevant post holders meet the FPPT and do not meet Chief Executive's letter to Executive Directors should include a paragraph to confirm this responsibility. Further detail is provided in the CQC Guidance for NHS Bodies: Fit and Proper Persons: Directors, November, 2014 & NHS Provider Fit and Proper Persons Regulations in the NHS February 2018:

4.2 Web links

Fit and proper person requirements: adult social care services | Care Quality Commission (cqc.org.uk)

http://nhsproviders.org/fit-and-proper-persons-regulations-in-the-nhs

4.3 The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about board directors available to CQC on request.

All Directors falling within the scope of the policy as set out in sections (3.1 and 1.4) must provide evidence that they:

- are of good character
- hold the required qualifications and have the competence, skills and experience required for the relevant office for which they are employed
- are capable, by reason of their physical and mental health, after any necessary reasonable adjustments, of properly performing their work
- can supply relevant information as required by schedule 3 of the Regulations
- Have not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

Regulations a person is deemed "unfit" if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.

- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

4.4 While there is no statutory guidance on what constitutes "good character", CQC guidance names the following features that are "normally associated" with good character that trusts should take into account when assessing an individual under FPPR, in addition to the matters specified in Part 2 of Schedule 4:

- honesty
- trustworthiness
- integrity
- openness
- ability to comply with the law
- a person in whom the public can have confidence
- prior employment history, including reasons for leaving
- if the individual has been subject to any investigations or proceedings by a professional or regulatory body
- any breaches of the Nolan Principles of Public Life
- any breaches of the duties imposed on directors under the Companies Act
- the extent to which the director has been open and honest with the trust
- any other information which may be relevant, such as disciplinary action taken by an employer.

4.5 In accordance with part 2 of the Regulations a person will fail the good character test if they:

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence.
- Have been erased, removed, struck off a register of professionals maintained by a regulator of health care or social work professionals

4.5 **Serious misconduct or mismanagement**

Serious misconduct:

- Misconduct is defined by CQC as a breach of "a legal or contractual obligation imposed on the director", for example an employment contract, regulatory requirements, criminal law or engaging in activities which are morally reprehensible or likely to undermine public confidence. Examples of serious misconduct include assault, fraud and theft.

Mismanagement:

- Mismanagement is defined by CQC as "being involved in the management of an organisation in such a way that the quality of decision-making and actions of the managers falls below any reasonable standard of competent management". Examples of serious mismanagement include any dishonest conduct, continued failure to develop and manage business, financial or clinical plans, and having no regard to appropriate standards of governance.
- While serious misconduct tends to be a single incident, serious mismanagement is likely to refer to actions over a period of time.

Privy to" - misconduct or mismanagement

- "Privy to" means that there is evidence that the director was aware
- Of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed. This action could include making a formal complaint or drawing the matter to the attention of the appropriate senior member of staff or a suitable person outside the organisation.
- "Responsible for, contributed to or facilitated" means that there is evidence that a person has intentionally or through neglect behaved in a manner, through action or omission, which would have led to, assisted or enabled serious misconduct or mismanagement.

5 Process for New Appointments

5.1 The Trust's comprehensive pre-employment checking processes are determined by the NHS employment standards and include the following:

- Employment history and reference checks, one of which must be the most recent employer (including validation of a minimum period of three consecutive years of continuous employment or training and details of any gap) and including reasons for leaving, . If self-employed, the Trust will accept references from the director's accountant or similar professional;

- Qualification and professional registration checks (as relevant to post);
- Right to work checks;
- Proof of identity checks;
- Occupational Health Assessment;
- Different types of criminal record check, including the Disclosure and Barring Service (DBS), where relevant to the post and where eligibility criteria are met.

5.2 In addition, the following checks shall be carried out for Director appointments:

- Search of the insolvency and bankruptcy register by individual's name
- Search of the insolvency and bankruptcy register by individual's company name, where appropriate
- Search of the disqualified directors register and the removed trustee register;

5.3 The Regulations introduce the requirement to complete a FPP Declaration form for new employees. This form and a copy of this policy will be included within the application pack and form part of the application process, regardless of whether the Trust is employing the individual on a temporary or permanent basis, directly or indirectly.

5.4 While the Trust will have regard to information on when convictions, bankruptcies or similar matters are considered 'spent', there is no time limit for considering serious misconduct or responsibility for failure in a previous role.

5.5 The Chair of the appointments panel will be responsible for ensuring compliance supported by the relevant recruitment support, with input from the Director of Corporate Affairs. No offers of employment shall be met until this process has been complied with and evidenced. A detailed checklist will be completed and will be retained on the post holder's personal file for the purposes of audit. The Senior Independent Director or Vice Chair will carry out an independent assessment of the checklists completed by the Director of Corporate Affairs.

5.6 Any executive or non-executive appointment will take into account the Trust's obligations under the Regulations. Where the Trust makes a decision on the suitability of an individual, the reasons will be appropriately documented.

5.7 Where the Trust deems that the individual who is to be appointed is suitable, despite not meeting the characteristics outlined in Schedule 4, Part 2 of the Regulations (Good Character), and the reasons will be recorded in the minutes of the relevant meeting and the information about the decision will be made available to those that need to be aware. The appointment process will include an evaluation against the Trust's values, and any relevant external guidance. External advice will be sought as necessary.

5.8 Where specific qualifications are deemed by the Trust as necessary for a role, the Trust will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional Regulator.

5.9 The Trust will carry out employment checks (so far as reasonably practicable) on a candidate's qualifications and employment records. The recruitment process will necessarily include a qualitative assessment and values based assessment.

5.10 If the Director has a physical or mental health disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to.

6 Process for Existing Staff and Ongoing Fitness

6.1 Every year there will be a requirement for directors to complete a further form of declaration confirming that they continue to be a fit and proper person.

6.2 Individuals will be required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person, and provide details of the issue, so that this can be considered by the Trust.

6.3 If concerns are raised at the pre-employment stage, then the matter will be raised with the Director of Corporate Affairs who undertakes the Fit and Proper Persons checks. The Director of Corporate Affairs will then inform the Chairman who will decide whether the candidate is to be appointed or rejected.

6.8 Should the Director fail the Insolvency, Bankruptcy, and Disqualified Directors checks or any other necessary check under the Regulations (post-employment/appointment), or if concerns about the Directors "fitness" are raised by a member of the public or otherwise, the Director of Workforce will notify the Director of Corporate Affairs, who in turn will then take appropriate action. In light of the evidence that is obtained following an investigation, the Chairman will decide whether the individual has ceased to be a "fit and proper person" within the meaning of the Regulations. Any investigation should be undertaken as soon as reasonably practicable.

6.9 The Trust reserves the right to suspend a Director or restrict them from duties on full pay / emoluments (as applicable) to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the interests of service users or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

6.10 Should there be sufficient evidence to support the allegation(s), then the Trust will consider terminating the appointment of the Director with immediate effect (in line with the Trust's Disciplinary policy).

6.11 When a Director no longer meets the requirements of Paragraph 3 of the Regulation and is a health care professional, or other professional registered with a health or social care regulator, then the Trust will inform the regulator in question.

7. Concerns regarding an individual have continued FPP compliance

7.1 If, either at the time of appointment or later, it becomes apparent that circumstances exist or have arisen whereby an Executive Director may not be considered to meet all the requirements of a 'fit and proper person', the Director of Corporate Affairs shall inform the Chair.

7.2 The Chair will lead on addressing these concerns on a case by case basis and will need to consider whether an investigation is necessary or appropriate given the allegation. Where it is necessary to investigate or take action, the Trust's current processes will apply using the Trust's Capability Policy and Procedure or the Attendance Management Policy (managing

performance or sickness absence), Trust's Disciplinary procedure or afforded a similar process to this if the potential discontinuation could be due to 'some other substantial reason'.

7.3 The Trust reserves the right to suspend a Director or restrict them from duties to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the interests of patients or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

7.4 Should the Chair consider the individual to be suitable, despite existence of information relevant to issues identified in Schedule 4, Part 2, the Chair's reasons should be recorded for future reference and made available to those that need to be aware.

7.5 If an investigation concludes that an individual carrying out an identified position under this policy may no longer meet the requirements of the "fit and proper person test" the following two-stage procedure will be applied:

7.6 **Fit & Proper Person Hearing** - If there is sufficient evidence that an individual carrying out one of the identified positions under this policy may no longer be a fit and proper person, and the evidence is such that formal action may be required, then that person will be invited to a hearing to give them the opportunity to test the evidence and/or offer an explanation for consideration.

7.7 **Fit & Proper Person Appeal Hearing** - If an individual carrying out one of the identified positions under this policy has been determined to no longer be a fit and proper person, then that person may appeal that decision in writing within 14 calendar days of receipt of notification of the Trust's decision.

7.8 Should there be sufficient evidence to support the allegation(s), then the Trust may terminate the appointment of the Director with immediate effect, in line with the Trust's Disciplinary policy. Where an individual who is registered with a professional regulator (General Medical Council (GMC), Nursing & Midwifery Council (NMC) etc.) is deemed as no longer meets the fit and proper person's requirement the Trust must inform the regulator, and take action to ensure the position is held by a person meeting the requirements.

7.9 The criteria and process around the removal of Non-Executive Directors, including the Chair, is outlined in NHS Improvement's "Arrangements for the Removal or Suspension of NHS Trust Chair and Non-Executive Directors and NHS Charity Trustees" (or for a Foundation Trust within the Trust's Constitution)

8 Annual Review Process

8.1 The Trust is responsible for ensuring the continued "fitness" of those persons who the requirements apply. The Trust will therefore undertake the following on an annual basis:

a) The completion of an annual self-declaration form by all those named within the Scope of this policy, the process for this will be managed and co-ordinated by the Director of Corporate Affairs after the end of each financial year, 31st March. A copy of the signed self-declaration form should be returned to the Director of Corporate Affairs and subsequently placed on the director's personal file. It is the responsibility of the Director of Corporate Affairs to escalate any non-compliance to the Chair.

b) The Director of Corporate Affairs will undertake annual checks of the insolvency, bankruptcy and disqualified directors register after the end of the financial year, 31st March. It is the responsibility of the Director of Corporate Affairs to escalate any non-compliance to the Chair.

c) The formal appraisal process, enhanced to address the Fit & Proper Persons requirements, will be undertaken by the appropriate person with line management responsibility.

11 Duties & Responsibilities

Individual Roles

Chair	The Chair is ultimately responsible to discharge the requirement placed upon the Trust to ensure that all directors meet the requirements of the Fit and Proper Persons Test and do not meet any of the 'unfit' criteria. The Chair is also subject to the requirements of the test. The Chair is responsible for taking the necessary action to ensure existing directors who no longer meet the regulations of the FPPR (i.e. are deemed 'unfit') do not continue in their role
Senior Independent Director/Vice Chair	The Senior Independent Director or Vice Chair is responsible for undertaking independent verification on Fit and Proper Persons checks. The SID will verify the accuracy of the Vice Chair's Fit and Proper Persons checks and vice versa
Chief Executive	The Chief Executive although subject to the requirements of the test is also accountable to the Board for the Trust's compliance with statute and regulation.
Director of Workforce	The Director of Workforce is responsible for ensuring that all employment checks are undertaken in accordance with Trust policy and procedures for new appointments and that the annual checking process is adhered to for all those directors in post.
Director of Corporate Affairs	The Director of Corporate Affairs is responsible for ensuring that all checks are undertaken in accordance with the Fit and Proper Persons policy and that the Trust complies with its statutory and regulatory requirements.
Executive and Non-Executive Directors	All Executive and Non-Executive Directors as outline in the scope of this policy are accountable for ensuring they meet the requirements of the Fit and Proper Persons Test on appointment and complete annual self-declarations. They are also responsible for informing the Chair if during the course of employment or term of office they no longer meet the requirements of the Fit and Proper Persons Test and therefore are deemed "unfit".

Committee Roles

Workforce Assurance Committee	The Workforce Assurance Committee (WAC) is responsible for the performance management of this policy.

12 References

Acts of Parliament

Health & Social Care Act 2008 (Regulated Activity) Regulations 2014: Regulation 19.

Regulations

Care Quality Commission (CQC) Guidance for NHS bodies November 2014 - Regulation 5: Fit and proper persons: Directors.

Websites

Care Quality Commission - www.cqc.org.uk

NHS Sources

NHS Employers - www.nhsemployers.org

NHS Improvement
Trust Licence No. 130142 section G4 – Fit and Proper Persons

Regulatory Bodies

Care Quality Commission (CQC)

Appendix A – Fit and Proper Persons Declaration – Non Executive Director

1. Non-executive roles in the NHS are positions of significant public responsibility and it is important that those appointed can maintain the confidence of the public, patients and NHS staff. NHS Improvement has a duty to ensure that those we appoint to NHS boards are of good character, will ensure an open and honest culture across all levels of the organisation. The "Fit and Proper Person" requirements are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2. By signing the declaration below, you are confirming that you are a "fit and proper person" outlined at (2), that you do not fall within any of the categories outlined at (4) or (5) below and that you are not aware of any pending proceedings or matters which may call such a declaration into question in the future.

3. The regulations require you are:

   (a) of good character;
   (b) have the necessary qualifications, competence, skills and experience; and
   (c) are able by reason of your health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position.

4. Do any of the following conditions apply to you? You are asked to confirm that you are not:

   (a) a person who has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence;
   (b) a person who has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals;
   (c) an undischarged bankrupt, or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;
   (d) the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
   (e) a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40);
   (f) a person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
   (g) included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern

Ireland;

(h) a person who has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

5. In addition, the following conditions disqualify you from appointment as a chair or non-executive director of an NHS Trust. You are asked to confirm that you are not:

(a) an employee of the NHS Trust with the vacancy;
(b) a chair or member of the governing body of a clinical commissioning group, or employees of such group;
(c) a serving MP nor MEP or a candidate for election as MP or MEP;
(d) a person who has been dismissed (except by redundancy) by any NHS body;
(e) a person whose earlier appointment as chair or chair or non-executive director of an NHS trust was terminated;
(f) under a disqualification order under the Company Directors Disqualification Act 1986; and / or
(g) a person who has been removed from trusteeship of a charity.

DECLARATION

☐ I confirm that I do not fit within any of the categories listed at (4) or (5) and that there are no other grounds under which I would be ineligible for appointment. If appointed, I undertake to notify NHS Improvement immediately of any change of circumstances that may affect my eligibility to remain in post.

☐ I wish to declare the following information which may be relevant to my eligibility for this role:

Signature: **Name:** **Date:**

Disclosure of wider interests

Role:	Organisation:	Detail:	Paid/Unpaid:

Appendix B – Fit and Proper Persons Declaration (Executive Director)

1. Executive roles in the NHS are positions of significant public responsibility and it is important that those appointed can maintain the confidence of the public, patients and NHS staff. The Trust has a duty to ensure that those we appoint to the board are of good character, will ensure an open and honest culture across all levels of the organisation. The "Fit and Proper Person" requirements are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2. By signing the declaration below, you are confirming that you are a "fit and proper person" outlined at (2), that you do not fall within any of the categories outlined at (4) or (5) below and that you are not aware of any pending proceedings or matters which may call such a declaration into question in the future.

3. The regulations require you are:

   (a) of good character;
   (b) have the necessary qualifications, competence, skills and experience; and
   (c) are able by reason of your health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position.

4. Do any of the following conditions apply to you? You are asked to confirm - Yes or No:

	Questions	**Y**	**N**
4a	a person who has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if omitted in any part of the United Kingdom, would constitute an offence		
4b	a person who has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals		
4c	an undischarged bankrupt, or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged		
4d	the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland		
	Questions	**Y**	**N**
4e	a person to whom a moratorium period under a debt relief order		

	applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40)		
4f	a person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it		
4g	included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland		
4h	a person who has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.		

5. In addition, the following conditions may disqualify you from being an Executive Director of an NHS Trust.

You are asked to confirm - Yes or No:

	Questions	**Y**	**N**
5a	a person who has been dismissed (except by redundancy) by any NHS body		
5b	under a disqualification order under the Company Directors Disqualification Act 1986; and/or		
5c	a person who has been removed from trusteeship of a charity		

You are asked to confirm that you have - Yes or No:

	Questions	**Y**	**N**
5d	the qualifications, skills and experience necessary for the relevant position		

You are asked to confirm that you are - Yes or No:

	Questions	**Y**	**N**
5e	capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010		

DECLARATION

☐ I confirm that I do not fit within any of the categories listed at (4) or (5) and that there are no other grounds under which I would be ineligible for appointment. If appointed, I undertake to notify the Trust immediately of any change of circumstances that may affect my eligibility to remain in post.

☐ I wish to declare the following information which may be relevant to my eligibility for this role:

Signature: **Name:** **Date:**

Disclosure of wider interests

Role:	Organisation:	Detail:	Paid/Unpaid:

Appendix C - Pre-Employment Fit and Proper Persons File Check List

Name:	
Position:	
Date of Commencement:	

Criteria for checking:	**Evident on file:**
Disclosure and Barring Service (DBS) disclosure	Yes/No If no state reason:
2 Satisfactory References (3 for Medical Director)	Yes/No If no state reason:
Employment History – application form or CV	Yes/No If no state reason:
Occupational Health Clearance	Yes/No If no state reason:
Relevant qualification(s) e.g.; Professional Body (if applicable)	Yes/No/NA If no state reason:
Fit & Proper Persons Test – Self Declaration Form	Yes/No If no state reason:

Has the insolvency, bankruptcy and disqualified directors register been checked by the Director of Corporate Affairs?	Yes, no concerns □	Yes, concerns escalated □	Register not checked: □
			Reason for not checking:

Authorising Signatory:

Signed:
Name:
Position: Senior Independent Director/Vice Chairman
Date:

A copy of this form should be retained on the individual's personnel file.

Agenda Item: BM21/22 – 142

BOARD OF DIRECTORS
6 October 2021

Title:	Workforce Assurance Committee Chair's Report
Author:	John Sullivan, Vice Chairman
Responsible Director:	Debs Smith, Interim Director of Workforce
Presented by:	John Sullivan, Vice Chairman

Executive Summary
The Workforce Assurance Committee met on 22 September 2021. Positive progress was reported in a number of areas. However, higher than target sickness absence levels remain significant Trust and NW Region risks.

Recommendation:
• To note the progress made in a number of Workforce Assurance areas. • To continue to support the proposed reorganisation of the Workforce Directorate

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Risks 2.1, 2.2, 2.3 and 2.4 from July 2021 BAF
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Specific communications and stakeholder /staff engagement implications
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Compliance with Disability Equality Standards and Race Equality Standards
Council of Governors implications / impact (e.g. links to Governors statutory role,

significant transactions)	
Previous considerations by the Board / Board sub-committees	
Background papers / supporting information	

BOARD OF DIRECTORS
6 October 2021

Workforce Assurance Committee Meeting held 22 September 2021 -- Chair's report

Purpose

To provide the Trust Board with assurance on Workforce matters including:

- Workforce performance metrics
- Recruitment
- Diversity and Inclusion annual report approval
- Monthly Safe Nurse Staffing reports (July & August 2021)
- Staff Flu Vaccination Programme 2021
- Workforce Well Being Winter Plan
- Communications and Engagement activities and outcomes
- Contractors and DBS
- Midwifery Staffing -- Use of the Birthrate+ Staffing Tool
- Fit & Proper Persons Policy approval
- Workforce Assurance Committee Cycle of Business approval

Introduction / Background

The Workforce Assurance Committee met on 22 September 2021.

Conclusions

- The analysis of organisational issues in Estates remains in the Diagnostic stage and external help facilitation and support will be sought to define the 'Lessons Learned'. The lessons will be shared at a future Private Board meeting rather than at Workforce Assurance Committee. The committee were assured that detailed work on sickness absence rates was continuing in Estates.
- The Trust's Workforce & Education Strategy process will begin October 4 with a progress report back to this committee at its November meeting.
- There appears to be an annual seasonal peak in short term (< 30 days) sickness absence during July and August. This coincides with summer school holidays.
- The North West region has also experienced higher than average sickness absence rates for some years and the region is promoting more holistic management of individual well being rather than only micro management of short term absence.
- Some excellent results reported for Care Support Worker (CSW) recruitment and subsequent reduction in vacancy rates. 10% to 0.2%.
- Extensive Diversity & Inclusion work at the Trust has enhanced the Trust's reputation.
- 105 of 160 external Registered Nurse (RN) recruitments are complete.

100% OSCE accreditations of overseas RNs have been achieved after no more than 2 attempts. This recruitment work is forecasted to reduce RN vacancy rates from 20% to the current 12% to 0% by November 2021.

- The Committee welcomed the proactive and flexible nature of the Winter Well Being Plan.
- The Committee supported the proposed update of the Trust's Recruitment Policy to improve DBS Checks compliance amongst contractors working in Trust premises.
- The Committee supported the proposed business case for Midwifery which would allow a move from 35% compliance with the Continuity of Carer model of care to 100% by increases in net staffing of 7.46 FTE. (Note the Trust is 1 of only 2 Maternity units to currently achieve 35% compliance).
- The Fit & Proper Person Policy is part of the Workforce Assurance Committee remit. The Committee supported the update of the 2018 policy, which will also include Interim appointments.
- The refresh of the Cycle of Business for period ending March 2022 and proposal for year 2022 / 2023 were approved
- Substantial assurance was received on Trust recruitment processes.

Recommendations to the Board

- To note the progress made in a number of Workforce Assurance areas.
- To continue to support the proposed reorganisation of the Workforce Directorate

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 2021-143

Board of Directors

6 October 2021

Title:	Finance & Business Performance Assurance Committee Update
Responsible Director:	Claire Wilson, Chief Finance Officer
Presented by:	Sue Lorimer, Non-Executive Director

Executive Summary

Recommendation: (e.g. to note, approve, endorse)
To note the contents of the report

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.	Yes

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Specific communications and stakeholder /staff engagement implications
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)

Previous considerations by the Board / Board sub-committees	
Background papers / supporting information	

Board of Directors

6th October 2021

Finance & Business Performance Assurance Committee Update

Purpose

To update the Board of Directors on the work carried out by the Finance & Business Performance Assurance Committee in its meeting on 23rd September 2021.

The report highlights the key issues considered at the meeting, risks for the board to be aware of and makes recommendations as appropriate.

Update

The Committee received several reports from the Executive team with the key points being as follows:

Financial position and Cost Improvement Plan (CIP)

- The Trust continues to deliver a strong financial performance in the current financial year, but it is recognised that strong Elective Recovery Funding (ERF) was supporting this position non-recurrently.
- Committee reviewed divisional financial performance in detail, with a particular focus on Medicine and Acute division who are reflecting a £3.3m overspend in pay costs at month 5.
- The committed received assurances on the progress of the Capital programme and reviewed the forecast for the year to satisfy itself that this could be delivered.
- The CIP programme continues to make steady progress through each stage of scheme maturity. In response to Committee questions, members were assured that several schemes would move to the final gateway at the next meeting as a number of QIAs were ready to be approved this month.
- We noted need to keep focussed on maturing and embedding the Trusts Cost Improvement Plan (CIP) to support longer term sustainability

Operational Performance

- The Committee received an update on all key areas of operational performance with A&E being the biggest area of concern.
- In response to a request at a previous meeting, the committee received a presentation from the Chief Operating Officer which specifically focussed on progress of the A&E improvement project. Concerns were raised that the work was not as embedded and delivering the outcomes as expected and so this needs to be a key focus for the Trust.
- The Committee also asked for assurance that the Quality Committee reviewed the quality impact of increased waiting times for our patients.

Recommendations to the Board

The Board is asked to note the contents of the report with two key points of escalation.

- Further assurances needed on the impact and pace of A&E improvement work.
- The Committee asked for assurance that the Quality Committee reviewed the quality impact of increased waiting times for our patients

Agenda Item: BM21/22 – 144

BOARD OF DIRECTORS
06 OCTOBER 2021

Title:	Report of the Quality Assurance Committee
Author:	Steve Ryan, Non-Executive Director
Responsible Director:	Dr Nikki Stevenson, Executive Medical Director/Deputy CEO
Presented by:	Steve Ryan, Non-Executive Director

Executive Summary
This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 30th September 2021.

Recommendation:
For noting

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Principle BAF Risk 4: Catastrophic Failure in Standards of Care
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
CQC standards on safety and effectiveness
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
N/A
Specific communications and stakeholder /staff engagement implications
N/A
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
N/A
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)
N/A

Previous considerations by the Board / Board sub-committees	Quality Assurance Committee
Background papers / supporting information	

BOARD OF DIRECTORS
6th October 2021

Report of the Quality Assurance Committee
Held on 30th September 2021

Purpose

This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 30th September 2021.

Introduction / Background

1. Maternity service

The quarterly update report noted that the Trust was successful in its bid for additional funding for a 0.6wte Consultant Obstetrician funded and a total of 10.1wte Band 6 Midwives (c. £400,000). This takes us to within 7.46 wte to meet our target to deliver our commitment 100% continuity of carer by March 2023. A bid for the necessary resources will be developed. A variety of internal and external reports and metrics were reviewed to provide assurance on the quality of care.

2. Emergency Department

A detailed report was presented to provide assurance of the Delivery of Reliable Safe Care within the Emergency Department. As background the committee noted the extreme patient workload pressures the service was currently dealing with as well as workforce shortages. Key quality and safety metrics were outlined along with proposed approaches to support their delivery. More detailed analysis and planning will be discussed at the next Patient Quality and Safety Board after which the Committee will be updated.

3. Complaints

The Committee received the Annual Complaints Report for 2020-21 and the Quarterly complaints report for Q1 2021-22. Key areas of patient complaint included communication, which had been exacerbated by the visiting restrictions required during the pandemic. Action has been taken in response, with all divisions having an action plan and access to a toolkit to promote effective communication. The visiting policy is reviewed weekly and when appropriate a pilot of more accessible visiting will be recommenced. The Trust's internal target of a response within 40 days was not met during the pandemic falling to as low as 23% in Q1 of 2020-21 but was 46% by Q2. A newly established complaints and claims management group now oversees a recovery trajectory and also supports cross specialty responses to complaints.

4. Patient safety

Two key areas for focus and improvement were: the Identification and response to patient deterioration: and the prevention of never events.

It was acknowledged that the burden of the Covid pandemic, through high workload and the need to adapt new ways of working at great pace had contributed significantly to both these issue. As an example to ensure that patients can continue to get procedures undertaken in a timely way, many procedures are now taking place away from their previous locations – e.g. not in operating theatre but in outpatients or radiology. Established and embedded ways of working in operating theatres (such as the WHO surgical checklist) are less familiar in other department and present a higher risk of untoward occurrences such as never events. Intelligence suggests that this issue has been seen in other hospitals.

Assurance has been sought from all divisions that the relevant procedures have been identified in all areas and controls have been put in place and audit and cross-checking are undertaken to validate assurance.

Work underway about patient deterioration (Quality Improvement Collaborative across 4 inpatient wards and in the Emergency Department) was being bolstered with a rapid task and finish group.

The Committee received an update on the modified harm review process. The process, based on national guidance, appears to be well calibrated. 3 episodes of moderate harm were detected in 176 patients reviewed, 2 within orthopaedics As a result sampling rates in orthopaedic patients in priority group 3 will be increased from 20% to 50%.

5. Infection Prevention and Control

The Committee received a report on the Infection Prevention and Control Board Assurance Framework version 1.6 (2nd edition) and was able to acknowledge the controls in place to minimize all infections and specifically Covid-19. It was noted that the Trust had set itself an ambitious target for *Clostridioides difficile* that exceeded the externally mandated trajectory.

6. Learning from Deaths

The Board will receive an update report at its meeting on 6th October. The Committee noted the continued improvement in the processes for the appropriate scrutiny of all deaths in the Trust and the sharing of learning. The Mortality review group is able to identify potential outliers for mortality by diagnosis or procedure & working with Dr. Foster and to determine any systematic issues that require addressing.

7. The Committee complemented the new Quality and Patient Safety Intelligence Report that replaces the CLIPPE report. Thematic analysis is much clearer so that key issues can be identified and interrogated.

Conclusions

The Committee received appropriate and detailed documentation in relation to the items it considered on 30th September and was able to scrutinise this and note areas of progress,

areas for development and areas of risk, receiving relevant assurance on actions to meet the objective of providing outstanding care

Recommendations to the Board

The Board is requested to note this report.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: BM21/22 – 145

BOARD OF DIRECTORS
6th October 2021

Title:	Audit Committee Update
Author:	Steve Igoe
Responsible Director:	Claire Wilson
Presented by:	Steve Igoe

Executive Summary
To update the Board on the Audit Committee meeting held on 13th September 2021

Recommendation:
To note

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Specific communications and stakeholder /staff engagement implications
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)

Previous considerations by the Board / Board sub-committees	
Background papers / supporting information	

BOARD OF DIRECTORS
6th October 2021

Report to the Board on the Audit Committee meeting held on 13th September 2021

1.Introduction

This report updates the Board on the details considered at the Audit Committee meeting on 13th September 2021. Of note is the final piece of work from Azets our external auditors in relation to their value for money statement which was delayed when we signed the Trust accounts earlier this year. Their report as detailed below was positive confirming that their work uncovered no significant weaknesses in the trust's arrangements for securing value for money

2.Internal control and risk Management

The Committee received reports on losses and special payments and a summary of outstanding debts. It also received the most recent quarterly report on procurement spend controls and waivers.

Some minor amendments to the trust's Governance manual including the standing financial instructions were considered and approved.

A detailed risk management strategy was presented and discussed .NED's had already had a chance to comment on the detail included therein .Members were asked to feedback any further comments in advance of the document coming to the Board in due course .Colleagu7es will recollect that this is part of a suite of items which we have been considering recently as a Board including the BAF and specific risks, mitigations and risk appetite.

3.Internal Audit

Audit reports were reported on as follows:

Data Quality (Limited Assurance) – Recognised as a risk by management hence its inclusion in the workplan. A detailed response plan was presented, and actions will continue to be monitored by the Committee

Recruitment (Substantial Assurance) – The committee welcomed this positive report given the previous issues with the area. As reported elsewhere I'm hopeful that by the end of the next meeting of the Extraordinary Audit Committee overseeing the HR and payroll related control weaknesses we will have made sufficient progress to lay that special committee down.

Clinical Negligence Scheme for Trusts /CNST (No opinion) – Positive report overall although some improvements in control required.

COVID-19 Expenditure claim review (Substantial Assurance).

The Committee considered a report following up previous recommendations made by Internal Audit which in the main was positive with most actions recommendations accepted being followed up and resolved satisfactorily.

The Anti-Fraud progress report was received, and the work and activity noted given the increasing threats from cyber related risks given the substantial levels of on line activity

4.External Audit

The final piece of work on the Trust's annual financial statements from Azets regarding value for money was discussed and their report considered.

In summary as a result of all of their work they confirmed:

1.The Financial statements give a true and fair view of the financial performance and position of the Trust.

2.They confirmed that the Governance statement had been prepared in line with DHSC requirements

3.They were required to identify if they found any matters indicating significant weaknesses in the Trust's arrangements for achieving value for money. They confirmed that they had nothing to report in this regard.

5.NED's meeting with Internal and External Auditors

NED's met in private session with both External and Internal Audit. There is nothing specific to report from that meeting.

Steve Igoe
Chair of Audit Committee
17th September 2021

BOARD OF DIRECTORS	
Agenda Item	
Title of Report	Report of the Safety Management Assurance Committee
Date of Meeting	17th September 2021
Author	Steve Igoe, Non-Executive Director
Accountable Executive	Nikki Stevenson, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Safety Management Assurance Committee

This report provides a summary of business conducted during a meeting of the Safety Management Assurance Committee on 17th September 2021

1.Fire Safety Update

The Committee were provided with a detailed update on Fire Safety issues across the Trust as a result of works done in relation to risks identified and reported by Merseyside Fire and Rescue Service (MFRS) .It is fair to say that a substantial number of significant issues were identified which had previously not been visible to the Trust Board .Having sight of these has now enabled the newly appointed Estates team to start to address the historic failings in management in the area. A detailed review has been commissioned by Capita which will report towards the end of the year however in the meantime the Trust has developed a fire safety programme which includes:

- Appointed an authorized Fire engineer and drafted a programme of works
- Conducted a detailed Asset survey
- Is developing a comprehensive fire strategy for all sites and buildings
- Developing a detailed maintenance fire safety PPM schedule
- Developing training on vertical evacuation and escape strategies
- Developing a 5-year strategy to ensure full fire safety compliance by the trust.

A further progress report will be discussed by SMAC at its next meeting.

2.GAP analysis following HSE spot inspections of 17 acute trusts (Not WUTH)

The HSE inspected 17 acute hospitals as part of the national HSE COVID-19 spot check inspection programme. The inspections were led by an HSE Occupational Health Inspector and focused on 7 key areas:

- Risk Assessments
- Management Arrangements
- Social Distancing
- Cleaning and hygiene measures
- Ventilation
- PE
- Dealing with suspected cases

As a result of the gap analysis 9 detailed recommendations were identified. These will be discussed and agreed with key stakeholders and an improvement plan developed to address the gaps identified. Delivery of the plan and the resolution of these issues will be monitored by the Health and Safety Management Committee.

3.Health and Safety Trust Dashboard

The Committee received an update on Health and safety performance and activity alongside relevant data actions taken in connection with previous recommendations.

6 RIDDOR incidents were reported which is lower on a monthly basis than the previous year.

The top 6 non-clinical incidents continue to be:

- Violence and Aggression
- Unsafe environment (a substantial increase in number of issues reported this time as a result of the newly appointed Estates team getting under the skin of issues within the area)
- Sharps
- Collision with an object
- Slips, trips and falls
- Manual Handling

These continue to be managed within the trust.

Divisional Exception reports were received from:

- Diagnostics and clinical support
- Medicine and acute
- Surgery
- Women's and children's

There is good evidence of risk management and engagement with risk in these clinical areas which is a major improvement from the position a few years ago.

Corporate divisional reports were received from:

- Estates and Facilities (It's fair to say that the newly appointed team are still establishing a baseline in terms of activity and compliance for this are. This is reflected in the fire issues reported earlier but also in previous reports discussed by the Board on the challenges in this area). This will remain an area of scrutiny for some time to come.
- Finance and performance
- HR and OD
- IT

4.Annual Health and Safety work plan progress update

A detailed report on the above was received and discussed.
As of 8th September 2021, of the 73 remaining actions at the start of the period, 58 have been completed ,9 are underway and 6 are yet to be started.
It is envisaged that these actions will all have been resolved by the end of the calendar year and a further update will be provided to SMAC in January 2022 to confirm this.

5. Health and Safety Committee (HSMC) Chairs' report

The Committee received and discussed the reports from the HSMC meetings on 21st July 2021 and 18th August 2021. These included update reports from sub-committee chairs for; Water safety, violence prevention and aggression (VAP) group, Needle-stick injuries and trends of sharps (NITS) group, PPE group, Ventilation group and Environmental group.

8.Summary

The above and attached serve to update the Board of Directors on the work and discussions of the Safety management assurance committee at its meeting on 17th September 2021

S J Igoe

Chair of Safety Management Assurance Committee

28th September 2021

Agenda Item: 21/22-120

BOARD OF DIRECTORS
6 October 2021

Title:	Report of the Trust Management Board
Responsible Director:	Chief Executive
Author:	Molly Marcu, Interim Director of Corporate Affairs
Presented by:	Janelle Holmes, Chief Executive

Executive Summary
The purpose of this report is to provide the Board with an assurance summary of the Trust Management Board meeting held in September 2021

Recommendation: (e.g. to note, approve, endorse)
The Board is asked to note and receive the September Trust Management Board.

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Across all BAF priorities.
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
N/A
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Specific communications and stakeholder /staff engagement implications
N/A
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)

N/A		
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)		
N/A		
FOI status	Document may be disclosed in full	✓
	Document includes FOI exempt information	
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees	NA	
Background papers / supporting information	NA	

BOARD OF DIRECTORS MEETING IN PUBLIC
6 October 2021 2021

REPORT OF THE TRUST MANAGEMENT BOARD

Purpose

The purpose of this report is to provide the Board with an assurance summary of the Trust Management Board meeting held in September 2021

Overview of main

A summary of the topics covered is provided below:

1. Approval of Severe Asthma Business case

The trust management board met on the 27th of September and below is an overview of the key decisions and assurance reports that we received.
The severe asthma business case was received and approved in this meeting, following its prior endorsement by the operational performance committee in the same month.

This business case was approved on the basis that it's demonstrated an increase in capacity to support projected increase of severe asthma patients particularly during the winter period. The need and requirement for additional capacity was also evident following review in November 2019 which highlighted a lack of a respiratory CNS to support the respiratory service.
In addition this approval of this business case enables the trust to comply with the national asthma and COPD audit program requirements with regards to participation

2. Trust Escalation Policy

The Trust Management Board reviewed and approved the Trust Escalation Policy, which will enable the Trust to deal effectively with variation in demand and adjustments to bed capacity, as well as the management of associated clinical risk within acceptable limits.

The policy is designed to help mitigate the risk of further escalation and ensure that an appropriate response from the local systems is enacted to contribute to the safe management of patient flow.

3. Millennium downtime incident

TMB reviewed the Millennium downtime incident de-brief which had also been discussed in detail by the Risk Management Committee on the 7th of September 2021.

The report highlighted valuable learning from the business continuity incident which took place in July 2021. The committee was assured that the management and handling of the incident was positive and that learning had been captured with appropriate actions agreed.

The downtime was managed appropriately as a business continuity incident and the overall learning was that the Trust hadn't anticipated the incident would last 4 days and this had proved to be challenging. It was agreed that moving forward a more sustained period should be included in business continuity planning. From feedback received, communication from the leadership team had been considered as good, with staff reporting they felt informed.

The incident has identified that training of loggists may need to be formalised and that some of the ward paper packs needed updating.

The findings and recommendations of the report will be used to develop a delivery plan which will be shared with the Risk Management Committee meeting of the 5th of October 2021.

4. Risk Management Committee Key Issues Report

The Trust Management Board reviewed the report of the Risk Management Committee held on 7th September 2021.It was acknowledged that the committee has been overseeing some key improvements in the visibility of risk assurance reporting, particularly in relation to risks with a residual rating of 15 and above.

Members were assured by the outcome of the MIAA review of the Security and Protection Toolkit which was undertaken in June 2021 with substantial assurance being achieved.

Members took into consideration the detailed review of the Risk Management Strategy by the Risk Management Committee.

5. PSQB Report

TMB reviewed the report of the Patient Safety and Quality Board (PSQB) held in August 2021 which gave assurance updates on a number of key areas such as the receipt of the annual research report, which highlighted that the Trust has performed well in progressing the research agenda.
The annual report provided assurance that, despite the pandemic, the Trust continued to participate in a range of research studies and exceeded its target for the number of participants recruited onto NIHR portfolio studies.

For the study *Randomised Evaluation of COVID-19 Therapy,* the Trust was the 7th highest performing Trust in the country for the percentage of COVID patients

recruited.

7. Safeguarding Annual Report

The annual report provided assurance that the Trust has arrangements in place to meet its statutory obligations and national safeguarding standards for children and adults. The report provided an in-depth breakdown of activity to progress each of the key safeguarding areas, alongside progress against the objectives set in the 2019/20 annual safeguarding report; the report also highlighted key priority areas and challenges for 2021/22. Improvements have been noted in compliance with PVP training, timeliness of the Initial Health Assessments (LAC) and the compliance with Child Protection Information Sharing system.

8.Sepsis & Deteriorating Patient Quarterly Report

The report provided an update to PSQB on performance against the key AQ and CCG Sepsis indicators, progress of the Trust's deteriorating patient quality improvement initiative and areas for improvement. It was agreed that future reports will include targets for each of the key indicators and performance against these. Sepsis will be a regularly scheduled agenda item on the Clinical Effectiveness Committee.

9.Risk Management Strategy

The draft Risk Management Strategy was reviewed and discussed in advance of its submission to the October Board meeting. In undertaking its review, the Trust Management Board took into account the feedback from the Risk Management Committee and the Audit Committee.
The Trust Management Board endorsed the strategy.

10.Fit and Proper Persons Policy

The Trust Management Board reviewed the draft Fit and Proper Persons Policy , noting that associate and deputy directors are now incorporated within the scope of the requirement to undertake Fit and Proper Persons checks.

11.Deloitte Well Led Review

The Trust Management Board received updates on the Deloitte Well Led review project plan which is currently underway, with a particular focus on progress made to date.

12.Divisional Updates

The TMB reviewed and noted the key issues in the previously circulated updates from each operational division. There were no issues to escalate.

13. Recommendations to the Board

The Board is asked to note and receive the report of the Trust Management Board

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 2122 148

Public Board of Directors

6 October 2021

Title:	Communications and Engagement Report
Responsible Director:	Debs Smith, Interim Director of Workforce
Presented by:	Sally Sykes, Director of Communications and Engagement

Executive Summary
The report covers the Trust's communications and engagement activities in August and September 2021 to date, including media relations, campaigns, marketing, social media, employee communications and engagement, WUTH Charity and staff engagement.

Recommendation
To note the progress in communications and engagement.

Which strategic objectives this report provides information about:	
Providing the best care and support	Yes
Be a great place to work	Yes
Maximise improvement and deliver best value	Yes
Digital pioneer and centre for excellence	Yes
Work seamlessly with partners to deliver care	Yes

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Previous Board Assurance Framework risks PR2 (staff engagement) and PR 6 (stakeholder confidence).
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Workforce Risk 133 – reputation and loss of stakeholder confidence
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
None
Specific communications and stakeholder /staff engagement implications
Fundamental purpose of the team's activity is to ensure positive relations are maintained with staff and stakeholders.

Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Patient confidence and staff engagement are influenced by communications, media relations, campaigns, issues management and positive engagement. Staff engagement supports providing the best patient care.
Council of Governors' implications / impact (e.g. links to Governors' statutory role, significant transactions)
None, unless reputation risks manifest in an unforeseen way

FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No

Previous considerations by the Board / Board sub-committees	Monthly reports to Board, Workforce Steering Group, WUTH Charity Committee and Workforce Assurance Committee.
Background papers / supporting information	Report attached with appropriate links embedded.

Public Board of Directors

6 October 2021

Communications and Engagement Report

Purpose

To advise the Board of significant progress in communications, marketing, media relations, employee communications, patient communications, awareness campaigns and stakeholder and staff engagement.

Introduction / Background

This is the report of the Director of Communications and Engagement, providing an update on the team's work to generate proactive media and social media coverage of WUTH, to keep staff informed of critical matters to help them work safely and to keep patients safe.

Campaigns, media, social media, internal communications, staff engagement and stakeholder relations

Campaigns

- The Vaccination Hubs continued to require campaign and communications support whether for changes to advice and guidance or to communicate to staff and the public the availability of booking slots and the opening up of vaccine for new eligible cohorts – including younger age groups and the ability to book into Clatterbridge directly from the national booking system. We provided media support to making local people aware of the Wirral Vaccination Bus touring the community and also to the availability of walk-in clinics at our Clatterbridge site

- We have further promoted the changes to booster availability in line with national guidance and we have commenced our seasonal flu campaign

- We put significant campaign efforts into World Patient Safety Day (WPSD) on September 17th - an official WHO campaign for all stakeholders in the health care system to work together to improve patient safety. The theme for 2021 is safe maternal and new born care

- At WUTH and with The Wirral Women and Children's Hospital, we took part in a number of activities to mark the day and get involved, including a major focus on COVID-19 and vaccinations

- We opened a new vaccination hub in our ante-natal clinic making it even easier for pregnant mums to get their jab while attending another appointment. We staffed a pop up vaccination clinic at the Seacombe Children's Centre Centre. WUTH Consultant Midwife Dr Angela Kerrigan also took to the airwaves with this **video** for NHSE/I regionally and also took part in a maternity Q&A on Facebook with Wirral Maternity Voices Partnership

- Our Maternity Safety Champions and colleagues from partner organisations, WUTH Non-Executive Director Dr Steve Ryan MB ChB, MD, Richard Crockford, Deputy Director of Quality and Safety, NHS Wirral Clinical Commissioning Group and Victoria Walsh, chair of Wirral Maternity Voices Partnership provided videos for social media outlining their support for World Patient Safety Day

- **Fetal Physiology** -on 15th September, we promoted an online learning session from one of our obstetricians, Dr Libby Shaw, who led a Physiological CTG training event with the aim of improving understanding of how the Fetal Heart Rate may change in labour.

- **Women and Children's new website launched -** we also marked World Patient Safety Day by launching the new Women and Children's Hospital website and Twitter account. The website is full of helpful materials to guide pregnant women and their partners through maternity and new born care. It also includes our popular WUTH resources on parent craft and highlights lots of support available from our partners like Wirral Maternity Voices. It also addresses recommendations set out in the Ockenden report that have previously been discussed at the Board. Wirral Women and Children's Hospital

- As our Emergency Department, along with others in the region, continued to experience significantly increased demand, we sustained our messaging to 'Keep A&E free for emergencies'. While the key message is to contact NHS 111 in the first instance, face-to-face appointments with GPs have resumed and Walk-in Centres on the Wirral are now fully open, including the Urgent Treatment Centre at Arrowe Park, if it is not an emergency. There's an example of the campaign **here**

- On 13 September 2021, we publicised World Sepsis Day and marked the 10th anniversary of this event. The theme this year was 'Stop Sepsis – Save Lives'

Media

In addition to the above campaign-related media coverage, the team has continued to produce proactive news stories from the wealth of positive work being done by staff, volunteers, clinicians and fundraisers. We also seek to inform the public about key developments at the hospitals. The following were covered in the month:

- For the first time ever our Trust has flown the Pride Progress rainbow flag and it was raised as part of Pride in the NHS Week. Thank you to everyone who showed their support last week. We have had some great support on social media after the flag was raised. You can see the **social post here**

- The theme for 2021 was Elevate, Educate, Celebrate. 'Pride in the NHS Week' was a week-long focus at the end of Pride Season 2021 (June – September) to provide rest, relaxation and recovery for NHS colleagues from our LGBT+ communities

- The work of the Communications Team and IPC with our 'Keep it SIMPLE' campaign was highly commended for a national Forward Communications award by the publication 'Leading Healthcare'

- Our clinicians were highlighted in the media when we publicised that Wirral University Teaching Hospital (WUTH) is the first Trust in the UK to use an innovative system to aid the diagnosis for patients with potential prostate cancer. Mr Nigel Parr, Consultant Urologist at Wirral University Teaching Hospital, said:

"We are pleased to be the first hospital in the UK to have the ExactVu imaging system which aids in the diagnosis of prostate cancer. With 300 times greater resolution than the current generation of scanners, we can now precisely target small areas of tissue, so only 3 or 4 core samples are needed to identify whether the patient has a tumour and to determine if it is relatively slow growing or a more aggressive type. Without this technology, around 1 in 5 biopsies need repeating to confirm the correct diagnosis. The Wirral Globe reported this story. You can read more **here**

- There was also coverage of innovative shoulder surgery when patient Barry Rowlands needed shoulder surgery- but wanted to stay awake. Consultant Orthopaedic Surgeon, Simon Robinson carried out the five hour procedure at Clatterbridge while Mr Rowlands watched his surgery and chatted to the theatre team. You can read this from the Liverpool Echo **here**

- We shared a collaboration with Chester Zoo whereby neonatal equipment that was no longer going to be used in hospital was donated to support animal care Keeping the smallest patients warm

Internal Communications and staff engagement

We maintained a schedule of two or more staff 'In Touch' Bulletins a week with important information on PPE, patient feedback and thanks, clinical guidance, staff wellbeing and support; thank yous to staff and charity updates

- There was an increased need to communicate self-isolation rules following increases in staff absences arising from contact tracing in the community and in schools. The Government's new guidance on how healthcare professionals could return to work if double-vaccinated and taking regular tests required communications support to help explain the guidance to staff and managers

- We continued to promote the Quarterly People Pulse Staff Survey, which now replaces the Staff Friends and Family test and going forward will be the main measure of ongoing staff feedback (with the exception of Q3 when the main Staff Survey takes place)

- We are preparing to communicate the annual NHS Staff Survey, which will start on October 4th.

- The operational pressures continued unabated in September and we worked with our Operations colleagues to support messaging and calls to action on patient discharges and patient flow, in challenging circumstances and increased hospital attendances

- There have been a number of media reports relating to a shortage of blood bottles from Becton Dickenson. The supply of blood bottles at WUTH is from Greiner. However supply shortage at Becton Dickenson is starting to affect other supply chains and subsequently hospital trusts. The Trust is starting to see a reduction in the supply of larger orders. The supply issue remains constrained nationally and it is anticipated that the situation will start to improve from mid-September. The overall supply will remain challenging for a significant longer period. We supported our colleagues with communications to conserve supplies and limit usage

- COVID-19 case rates continued to be in the news and the hospital and local community saw a rise in cases, as reported by the Globe- Link

- We responded to Liverpool Echo enquiries from a patient who had had cancer surgery deferred pending further tests and a patient death from 2015, which will be the subject of an Inquest in December of this year.

WUTH Charity

The team continues to plan future events and deliver some activity safely and in line with restrictions.

- NHS Charities Together (NHSCT) grant - The application for £143,000 for the Bowman's refurbishment was successful. Further funding is expected to be released by NH CT, the themes and timeframes for these grants have yet to be confirmed

- Wirral Mayor's Charity of the Year – The first event for the Mayor's Charity is the Mayor's Ball, which will take place on 15th October 2021 at Thornton Hall Hotel. The ball will have COVOD-19 safeguards in place and be thoroughly risk assessed.

- Arrowe Park Abseil 10th/11th September. The event, in aid of our Tiny Stars Neonatal Appeal went very well and £24,000 has been raised so far, exceeding last year's total by 25%.Tiny Stars are twinkling again

- WUTH's first Charity Golf Day took place on15th September 2021- with PGA Golfer John Singleton's support. The event was a great success and our supporters would like to see it become an annual event. Carden Park to host Wirral neonatal unit charity golf day | Wirral Globe Tranmere Rovers midfielder Jay Spearing and former WBC Cruiserweight Champion Tony Bellew also took part.

Stakeholders

- We continued to work with system partners to promote different ways to access healthcare in the light of substantially increased pressures on A&E. We met with system partners in a workshop facilitated by the CCG to look at how, as a system, we can signpost the right pathways for patients to access services, although all parts of the system are reporting higher demand, greater acuity and delayed patient presentations

- We held a stakeholder communications planning workshop with the system communicators who are going to be supporting the communications work stream for the Urgent and Emergency Care Upgrade (UECUP) project

- We are also working with partners to develop a Community Diagnostics hub at Clatterbridge, working with Clatterbridge Cancer Centre to optimise use of facilities.

Conclusions

The Board is asked to note the report.

Recommendations to the Board

To note the NHS National Staff Survey will commence on October 4th and be open for 2 months.