NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

4 May 2022

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Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Meeting of the Board of Directors in Public
Date	Wednesday 4 May 2022
Time	10:00 – 12:00
Location	Board Room, Education Centre, Arrowe Park Hospital

Agenda Item		Lead
1.	Welcome and Apologies for Absence	Sir David Henshaw
2.	Declarations of Interest	Sir David Henshaw
3.	Minutes of Previous Meeting	Sir David Henshaw
4.	Action Log	Sir David Henshaw
5.	Patient Story	Tracy Fennell
Operational Oversight and Assurance		
6.	Chair's Business and Strategic Issues	Sir David Henshaw
7.	Chief Executive Officer's Report	Janelle Holmes
8.	Chief Operating Officer's Report **– to follow**	Hayley Kendell
9.	Board Assurance Reporting	
	9.1 Quality and Performance Dashboard	Executive Directors
	9.2 M12 Finance Report	Robbie Chapman
	9.3 IPC Assurance Framework	Tracy Fennell
	9.4 Monthly Maternity Services Update Report	Tracy Fennell
Items for Decision and/or Discussion		
10	People Strategy - Presentation	Debs Smith
11	Ockenden 2 Gap Analysis and Discussion /Seminar	Tracy Fennell/Debbie Edwards
Wallet Items for Information		
12	Communications and Engagement	Sally Ann Sykes
13	Committee Chairs Reports	Committee Chairs
	13.1 Audit Committee	

13.2 Council of Governors **– verbal**
13.3 Finance Business and Performance Assurance **– verbal**

14	Cycle of Business	Cate Herbert

Closing Business

15	Questions from the Public	Sir David Henshaw
16	Any other business	Sir David Henshaw

Date and Time of Next Meeting

Wednesday, 1 June 2022

Meeting	Board of Directors in Public
Date	Wednesday 6 May 2022
Location	Microsoft Teams Meeting

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
JS	John Sullivan	Non-Executive Director & Vice Chair
SI	Steve Igoe	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
SR	Steve Ryan	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Nicola Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
HK	Hayley Kendal	Chief Operating Officer
DS	Debs Smith	Chief People Officer
RC	Robbie Chapman	Interim Chief Finance Officer
MG	Michael Gibbs	Associate Director of Integration and Partnerships (deputy for Matthew Swanborough)

In attendance:

TC	Tony Cragg	Public Governor
AM	Alan Morris	Public Governor
RT	Robert Thompson	Public Governor
SH	Sheila Hillhouse	Public Governor
DT	Diana Tyson	Public Governor
CM	Chris Mason	Chief Information Officer
DMcG	David McGovern	Director of Corporate Affairs
JN	Jonathan Lund	Associate Medical Director
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer (minutes)
DE	Debbie Edwards	Divisional Director of Nursing and Midwifery for Women's and Children's Division (item 11)

Apologies:

CC	Chris Clarkson	Non-Executive Director
MS	Matthew Swanborough	Director of Strategy and Partnerships
SS	Sally Sykes	Director of Communications and Engagement

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** The Chair welcomed everyone to the Board meeting. Apologies were received from Chris Clarkson, Matthew Swanborough and Sally Sykes.	
2	**Declarations of Interest** No new interests were declared and no interests in relation to the agenda items were declared.	
3	**Patient Story** The Board received a video story of the experiences of a patient and their partner. The story highlighted how staff at the Clatterbridge Vaccination Centre had responded positively with guidance and support, after the patient raised concerns about the risk of blood clots as a side effect from COVID vaccination. The team also assisted with advice and information in light of the patient's partner's severe allergies to allow both to have their COVID vaccines. The patient wished to thank the Clatterbridge team for their time, providing reassurance and a willingness to listen. The Board welcomed the positive feedback and recognised the dedication and hard work being carried out by the team at the Clatterbridge Vaccination Centre. The Chair agreed to sign a thank you note to staff on behalf of the Board, provided by TF.	TF, DH
4	**Minutes of the Previous Meeting** The minutes of the meeting held on 2 March 2022 were approved as an accurate record.	
5	**Action Log** The Board noted that all actions had been closed or completed.	
6	**Chair's Business and Strategic Issues** The Chair updated the Board on recent matters. The key points were: • Interviews for the Non-Executive Directors positions were held on 30 March, a recommendation will be made to the	

	Council of Governors at the April meeting and to seek approval to appoint two applicants. • Acknowledged and thanked the hard work being carried out by the Capital and Estate teams to improve the patient and staff experience at both Arrowe Park and Clatterbridge. • Good progress continued to be made with the Health Wirral Partnership Board.	
7	**Chief Executive Officer's Report** JH reported that the prevalence of COVID in the community continued to rise, therefore the Trust was experiencing an increase in the number of inpatients and the current bed occupancy due to COVID was 11.8%. The Trust was also experiencing an impact on sickness absence due to the number of staff testing positive, and this was creating challenging operational pressures. NHS England had provided an update on the testing guidance following the publication of the living with COVID plan on 30 March. Testing within the healthcare setting would not change, but from 1 April LAMP testing would no longer be available for NHS staff and instead advised continuing testing twice weekly with lateral flow tests. The Trust was also continuing to work with external advisers to scope and prepare for the COVID public inquiry. JH also reported that the Trust had declared four serious incidents in February 2022 and highlighted the Serious Incident Panel report and investigate under the Serious Incident Framework to identify any relevant learning. No common themes or areas were identified from the four serious incidents and had spanned multiple areas of the trust. JH reported one Never Event in the month of February and noted that there was no harm to the patient. One incident was reported to the Health and Safety Executive in accordance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). JH highlighted Simon Banks had been appointed as the Wirral Place Director. Simon was currently the Accountable Officer for Wirral Clinical Commissioning Group and will formally commence in post on 1 July 2022. JH also highlighted that the Arrowe Park theatre and ventilation system was experiencing operational challenges. Six theatres had to be shut with the remedial work due to be completed in the next 8 weeks. The clinical teams continued to prioritise the most urgent patients requiring surgery and were reviewing additional weekend sessions and day working.	

	SR queried if the Trust had forecasted when the current COVID wave would peak for the hospital. JH explained that forecasting had become more challenging due to the new guidance on testing, however the NHS expected the peak to occur towards the end of April. NS commented that the Trust was dealing with a high degree of uncertainty and the hospital continued to face increasingly difficult pressures. The Board **NOTED** the report.	
8	**Chief Operating Officer's Report** HK provided an overview to the Board of the Trust's current performance against the re-set and recovery programme for planned care and standard reporting for unscheduled care. During February the Trust delivered high levels of elective care and continued to be on track with 52 week and 104 week waiting targets. The Trust continued to be in a similar situation in January for the cancer backlog and the Board would hear more information in May about the recovery plans. Regarding unscheduled care, February and March had seen unprecedented levels of occupancy across the Trust with 98% occupancy during the week. This presented difficulties when responding to infection, prevention, and control outbreaks in the hospital due to the COVID. Due to the high bed occupancy ambulance turnaround times had been difficult to meet national targets. SL queried the endoscopy recovery plan. HK confirmed that a recovery plan would be presented on 18 April by the divisional team. The Board would be provided with the operational plan in May and would include further information about the endoscopy recovery plan. The Board **NOTED** the report and the performance and mitigations in place to support the Trust.	
9	**Board Assurance Reporting** **9.1) Quality and Performance Dashboard** The Executive Directors briefed the Board on metrics in the dashboard. It was noted that of the 47 indicators that were	

	reported, 28 were off plan or failing to meet performance thresholds and 19 were on-target. NS drew attention to the Trust declaring a Never Event and highlighted that such events had been increasing across all other NHS Trusts. Trusts had also seen a rise in the number of complaints received. DS drew attention to staff sickness absence. The percentage had improved in February following a peak in December and January of 7%. Appraisals had reduced to 78% compliance, and it was noted a lower percentage would impact on staff turnover and higher sickness absence. The Chair queried the balance between long term and short-term sickness absence. DS confirmed the biggest pressure remained short term sickness absence and this was mostly caused by COVID, colds and flu. SI queried given the recent theatre and ventilation failures does the Trust have the right critical maintenance and reliability strategies in place. HK reassured the Board that a planned maintenance programme was in place, however significant risks remain due to the aging estate and equipment across the Trust. RC drew attention to the recruitment and reliance on agency staff and it remained one of the Trust's largest financial risks. Work was ongoing to establish historic accruals and determine if any can be released and overall, the Trust's balance sheet was in a positive position. The Board **NOTED** the report. **9.2) M11 Finance Report** RC introduced Month 11 Finance Report. The Trust was reporting a deficit of £0.163m at M11, a positive variance against a budget of £0.039m. The Trust was forecasting a break-even position for the financial year. The Board **NOTED** the report. **9.3) Learning from Deaths Quarterly Report** NS introduced the Learning from Deaths Quarterly Report and highlighted the medical examiners continue to provide 100% scrutiny of adult deaths. The Summary Hospital Level Mortality Indicator (SHIMI) had remained stable when compared to the previous quarter. The latest available data (up to August 2021)	

	highlighted the SHIMI to be 107. Although the SHIMI is higher than the expected 100, it is still within acceptable range. The Mortality Review Group meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner. Learning from mortality reviews is fed back to clinical areas by the Divisional mortality leads. The Chair of the Quality Committee commented that he observes the Mortality Review Group and noted the high degree of information and thorough analysis of statistics. The Board **NOTED** the report, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group. **9.4) Maternity Quarterly Report** DE introduced the report and provided a specific update regarding the evidence submitted to NHS England and Improvement to support compliance with Ockenden recommendations (Part 1) and reported the Trust was in full compliance. The Board would receive an update at the May meeting regarding recommendations from Part 2 of the Ockenden report with an associated gap analysis of how the Trust compares. The Chair suggested the topic would be good to have in an open Board Seminar. The Board noted the Trust had full compliance with seven immediate and essential actions, however this wasn't the case for the region. The report noted Perinatal Clinical Surveillance Quality Assurance, Oversight of HSIB and SI reviews, and noted the Trust had met its requirements with year 3 of the Maternity Incentive Scheme. The Board also heard the Trust was progressing with continuity of carer although this would be risk assessed as per Ockenden 2 recommendations. DE confirmed some actions had been outstanding from a recommendation point of view. However due to the collaborative work during the previous months the local maternity system had now actioned all the recommendations in part 1. The Board **NOTED** the report and **DISCUSSED** the Trust's compliance with the Ockendon recommendations and the submission of compliance to NHSE/I.	TF TF/CH
10	**Children and Young People Patient Survey**	

	TF introduced the survey, highlighting in 2020 the Care Quality Commission commissioned a Children's and Young Person's Survey in line with the scheduled patient experience survey programme. The results would be used to support preliminary intelligence as part of the Care Quality Commission inspection process. The survey was undertaken between November 2020 and January 2021 during the second wave of COVID. Response rates were low at 16% compared with the national average of 24%. The Trust's overall results had been positive with seven indicators being recognised as "Better" when compared with other hospital trusts and no indicators being recognised as "Worse". An improvement plan had been developed to ensure that where possible children, young people and their families experience the best care and services delivered by the Trust. This improvement plan will be monitored at the Children's Clinical Governance meeting and via the Patient Experience and Family Group reporting to Patient Safety Quality Board. The Board **NOTED** the report.	
11	**Maternity Inpatient Survey** TF introduced the survey, highlighting it was an annual requirement and the results would be used to support preliminary intelligence as part of the Care Quality Commission inspection process. Due to the pandemic no survey was undertaken in 2020, therefore comparative data was made with 2019. The Trust's overall results had been positive with four indicators recognised by CQC as better, these and other areas where the Trust scored well in, centred on excellent communication and caring staff. No indicators had been recognised as worse. However, areas of suggested improvement had been identified and would form part of an improvement plan monitored via the Patient Experience and Family Group reporting to Patient Safety Quality Board. The Board **NOTED** the report.	
12	**Communications and Engagement** DS introduced the Communications and Engagement Report in absence of the Director of Communications and Engagement. The key points were: • On 4 May 2022 the Trust would celebrate 40 years of Arrowe Park Hospital	

	• The Communications team ran a campaign for International Women's Day • In March the Trust highlighted in the media the new investment in the £10.6 million funding for a new operating theatre – the new South Mersey Elective Hub • Additional media coverage included the 10,000 patients on Wirral who benefits from earlier access to diagnostics • WUTH Charity events had been planned in May and July The Board **NOTED** the report.	
13	**Committee Chairs Report** **13.1) Finance, Business, Performance and Assurance** The Board **NOTED** the report. **13.2) Quality** The Chair of the Quality Committee provided a report to the Board on recent proceedings of the Committee. It was noted that there had been temporary modification of infection control procedures to balance risks to patient safety and this resulted in a reduction in capacity of around 65 beds. Increased numbers of patients had been subjected to corridor care. There was an increasing number of ambulances experiencing delays in transferring patients into the emergency department, therefore increasing the NWAS response time to attend Category 2 patients. The Board **NOTED** the report. **13.3) Workforce Assurance** The Chair of the Workforce Assurance Committee provided a report to the Board on recent proceedings of the Committee. It was noted staff issues with attitudes and behaviours formed two thirds of recent Freedom to Speak Up reporting. The Monthly Nurse Safe Staffing Report provided assurance regarding patient safety but there was evidence the patient experience was deteriorating due to increased infections, demand pressures and high levels of staff absence. The 2021 NHS 2021 Staff Survey results demonstrated the Trust was at or close to the average of 126 comparator acute Trusts across all the survey themes. The Board **NOTED** the report.	
14	**Questions from the Public** Those members of the public in attendance were invited to ask questions relating to items on the agenda.	

	SH queried if the Board was aware when the Care Quality Commission (CQC) would carry out their inspection of the Trust. NS confirmed the CQC had already undertaken inspections locally in urgent care settings, however, was unaware when they would inspect the Trust.	
15	**Any other Business** No other business was raised.	

(The meeting closed at 11:33)

Action Log
Board of Directors – Public Meeting
4th May 2022

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	2nd March 2022	8	To provide further details in respect of the review of Governance structures and Committee Terms of Reference.	David McGovern	Included in Board workshop to discuss the action planning for the Well Led Review.	May 2022
2.	2nd March 2022	10	To constitute a Board workshop to consider the current and future approach to the Cost Improvement Programme (CIP)	Robbie Chapman	Included on the Board Seminar agenda.	May 2022
3.	2nd March 2022	11	To constitute a Board workshop to consider the future Estates Strategy and in particular the approach to the Arrowe Park Masterplan	Matthew Swanborough	Deferred to July 2022.	July 2022
4.	6th April 2022	3	Thank you note to be signed by the Chair and forwarded to the Clatterbridge Vaccination team.	Tracy Fennell/ Sir David Henshaw	Completed	April 2022
5.	6th April 2022	9.4	Update on Ockenden part 2 to be brought to the May meeting. Public Board "seminar" to allow time for discussion.	Tracy Fennell	Included at agenda item 11 with time allowed for presentation/discussion.	May 2022

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 7**
4 May 2022

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

Report Purpose and Recommendations
This is an overview of work undertaken and important recent announcements in April. It is recommended that the Board notes and receives the Chief Executive's report.

Key Risks
N/A

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
All Board Meetings in Public	Board in Public	Chief Executive's Report	For Information

1	Narrative
1.1	**COVID Update** There have been an increasing number of inpatients with Covid throughout the month, with in excess of 100 inpatients at the beginning of April. Numbers have now decreased to ~65 inpatients. Most of these patients (>75%) do not have respiratory Covid but have been identified during hospital screening after presenting for another reason. There have been no patients requiring critical care for a number of weeks. The Trust continues to follow infection prevention and control measures, but this has been amended following recent national guidance. However, due to high bed occupancy and the transmissibility of the current Covid variant, there have been a number of Covid outbreaks within the Trust. These have been managed with close supervision from the infection prevention and control team. Change in national guidance for testing means that the prevalence of Covid in the community is under-reported but hospital inpatients continue to be routinely screened on admission, and on day 3 and 6 of their admission. If there is clinical need, additional screening is undertaken. Other IPC measures are now also being relaxed in line with national guidance. Staff in office areas are no longer mandated to wear masks however this will still be supported with personal risk assessment and hierarchy of controls. In addition, some face-to-face meetings are now recommencing with appropriate risk assessment. The Trust also will be opening visiting across all wards from 3 May 2022 for patients to have 1 visitor for a period of 1 hour. This will be constantly reviewed and revised as necessary in balance with the prevalence of outbreaks and nosocomial infection.
1.2	**Serious Incidents** The Trust declared 6 serious incidents (SI) in the month of March 2022; this is an increase 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 Surgery (2), Women and Children’s (1) Medicine (1) and Acute (2). No Never Events were reported in the month of March. Duty of Candour has been commenced in line with legislation and national guidance. **RIDDOR** Since the last report there was a total of three events that were reported to the Health & Safety Executive (HSE) in accordance with RIDDOR. Two events were as a result of assaults by patients on our staff, resulting in staff absence. One event occurred when a member of staff was struck by a door which opened outward from a construction site onto a hospital corridor. All three events are subject to a local Review investigation to ensure appropriate action is taken to prevent a similar reoccurrence.

2	Implications
2.1	N/A

3	Conclusion
3.1	The Board are asked to Note and receive this report

Report Author	Janelle Holmes, Chief Executive
Contact Number	N/A
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Board of Directors in Public **Item No 8**
4 May 2022

Title	Chief Operating Officer's Report
Area Lead	Hayley Kendall, Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Nicola Cundle-Carr, Head of BI Planned Care
Report for	For information

Report Purpose and Recommendations

This paper provides an overview of the Trust's 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 03/04/22 and the current April performance (snapshot at 14/04/22) as well as providing the latest comparative data nationally, across Cheshire & Merseyside (C&M) and the Northwest.

For unscheduled care, the report details performance and highlights the ongoing challenges with long length of stay patients and the impact this has on Urgent and Emergency Care (UEC) performance. The report also highlights the number of patients who remain in the department for longer than 12 hours since arrival. This is in preparation for the proposed new clinical standards from 1st April 2022.

The report also provides 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.

The Board of Directors is asked to note the performance and mitigations outlined within the paper.

Key Risks

This report relates to these key risks:

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

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

1 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 and Response (EPRR) to the COVID 19 pandemic.

The last 2 years has seen elective activity being re-started, suspended, and disrupted due to ongoing COVID19 pressures, as has all hospitals in the region. During this period, focus has remained on treating the most clinically urgent patients first, followed by the long waiters.

The Trust has operated in line with the national categorisation of elective patients awaiting treatment and there is clear sight of the volumes of patients waiting across the clinical categories. This is reviewed on a weekly basis by the clinical divisions and reported via the weekly Performance Oversight Group.

2 Planned Care

2.1 Elective Activity

The national standard up to 31 March 2022 was to achieve 95% of 2019 comparable month's activity across all Points of Delivery (PODs). There are three things to note:

1. The actual is based on the value of the activity with activity numbers used as a proxy.
2. The threshold was revised for H2 2021/22 planning in that Trusts are required to close 89% of RTT pathways compared to the comparable month in 2019 to access to the Elective Recovery Fund (ERF).
3. To clear the backlog, systems need to be undertaking more than 100% of activity delivered in the comparable month of 2019.

The table below summarises the 4-week average activity delivered for weeks concluding 03/04/2022:

POD	National	North West	Cheshire & Mersey	WUTH
OP New	93%	98%	98%	99%
OP FU	98%	104%	105%	116%
Day Case	89%	87%	85%	81%
Elective IP	82%	90%	104%	87%

The number of closed RTT pathways as a percentage of those closed within the comparable month of 2019 is shown in the below table.

	Admitted	Non-Admitted
Cheshire & Merseyside	76%	74%
WUTH	73%	90%

It should be noted that due to the unavailability of 6 theatres on the APH site elective activity will be much lower than the planned target. This is being reviewed weekly and a full plan in place to recover those theatres currently available.

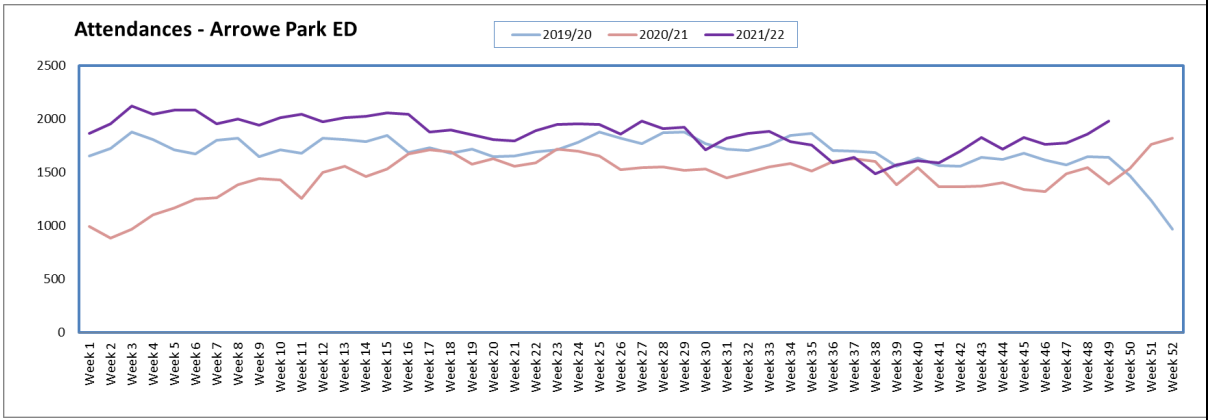
2.2	**Priority 2 Performance (P2)** The Trust continues to overachieve against the P2 month end trajectories with March's final position better than plan at 59 open pathways against a month end plan of 72 open pathways.
2.3	**Referral to Treatment** • 52 Week Wait Performance Currently there are 637 patients waiting longer than 52 weeks which is above the Trust's submitted trajectory of 550. The loss of 6 theatres has contributed to this position. Across C&M there are currently 16,695 patients waiting longer than 52 weeks for treatment. • 104 Week Wait Performance As at the end of March the Trust had no patients waiting longer than 104 weeks. This is ahead of the national plan to have zero 104-week waiters by end July 22. Across C&M there are currently 937 patients waiting over 104 weeks. • Waiting List Size There are 30,988 patients on an active RTT pathway under WUTH services whilst is currently lower than the Trust's submitted trajectory of 31,050 the position has deteriorated. This is mainly due to the significant decrease in elective activity due to the loss of 6 theatres, Covid and non-elective pressures along with the volume of patients that are currently inpatients that do not meet the criteria to reside. It is acknowledged nationally that the expectation is for all Trust's waiting list sizes continue to increase into 2024. For FY 22/23, the Trust has submitted its new activity and performance plans, and these will be detailed in next month's report.
2.4	**Cancer Backlog Performance** Full detail of the cancer performance is covered within the Trust Dashboard, but exceptions are covered within this section. • 2 week waits There continues to be a particular challenge with performance within Breast Surgery due to the significant increase in referrals from early in 2021. The position will not be recovered in this financial year; however, the service has submitted trajectories to recover by end June 22 with the aim being no patient waiting longer than 7 days for their first outpatient appointment. • 31- and 62-day treatment There are continued pressures in the achievement of both standards within Colorectal and Urology with the position unlikely to be achieved until FY 22/23 Q4. The Surgical Division have developed a recovery plan which is monitored through the weekly Performance Oversight Group. Cancer performance for Q4 will not achieved due to the number of Breast, Urology and Colorectal breaches. All activity plans for 2022/23 incorporate mitigating actions to ensure performance returns to previous levels.
2.5	**DM01 Performance – 99% Standard** The pre-submission position for March was 81.35%. The Divisional Teams are

	currently working through recovery trajectories for the modalities not achieving the standard with a particular focus on Endoscopy recovery. Specifically increasing the number of points per list and continued use of Insourcing during 22/23. These will be monitored via the Performance Oversight Group. The national target from April changes from 99% to 95% in recognition of the backlogs and challenges facings Trusts.

2.6	**Risks to recovery and mitigations**
	
	There are robust systems in place to monitor and review elective performance, but there remain significant risks in performance and activity delivery as the rise in COVID admissions continues to hinder elective operational activities coupled with the loss of several theatres due to breakdowns over the last month. In addition, workforce availability is a key challenge, balancing the requirement to deliver elective recovery, capacity for non-elective demand and continue to support the health and wellbeing of our people.
	
	The clinical divisions are well sighted on the risks to recovery and do have mitigations in place briefly summarised below:
	
	• Full participation in the C&M elective recovery programme which is supporting the coordination of:
	  ○ Use of the Independent Sector and Insourcing
	  ○ Regional/national capital, revenue, and 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 with the development on the Clatterbridge site
	• Divisional Director led cancer remedial action plans.
	• Appraisal of robot usage by non-cancer specialities/patients along with full service and staffing review.
	• Patient level tracking and active management in place monitored by the Divisional Directors via their weekly Access and Performance meetings and COO Performance Oversight Group.
	• Full participation in regional performance governance arrangements
	
	The Trust has also submitted ambitious but deliverable activity plans for the 2022/23 financial year to C&M that will further aid recovery and reduce waiting times across all points of delivery and modalities.

3.0	**Unscheduled Care**
3.1	**Performance** Performance the APH site type 1 performance in March was 61.5%. The key quality ED metrics which impact four-hour performance are the wait to be seen by an ED doctor after arriving in the Department and the 15-minute time to triage which in March was 54%. In March, 31.99% of ED patients were seen by a doctor within 60 minutes of arriving in the Department.

The Trust saw average daily attendances of 279 in March a substantial increase from the previous month. Total attendances for March were 8086 against 7316 for the same period in 2020/21, an increase of 10.5%. The graph below details the ED attendances over the last three years to demonstrate the increase demand:



There were 17 patients that breached the 12 hours in ED target in month, the highest figure year to date. The Trust experienced significant bed occupancy levels as well as one of the highest months of ED attendances; this was also at the same time of the most recent surge of Covid-19 affecting the Trust.

Ambulance handover performance was extremely challenged in month with 25% performance against the 30-minute handover.

The average number of super stranded patients (>21days LOS) decreased slightly in month to 187 from 195. Work is ongoing both internally and externally with system partners to improve the current position.

In conclusion performance was significantly challenged in February due to increasing demands and high bed occupancy across the organisation.

3.2 UEC and Winter Improvement

The Trust has embarked on a significant improvement plan focussed on urgent care and actions to mitigate operational pressures experienced during winter months in partnership with wider healthcare providers across the Wirral system. Progress against these plans are summarised as follows and the Programmes of work (UEC/Discharge) will now be managed through Programme Board and Performance Oversight Group.

- "Frailty at the Front Door" pilot on-going with significant success. 190+ patients have now been turned around / discharge supported since the trial began on 17/01/22 – an average of 22 per week saving a significant bed days
- Ambulance Handover Times improved significantly within January and February as a result of improvement work with NWAS and enhanced operational oversight although performance
- All paper-based trials of the Patient Safety Checklist now complete. Live trials due to start in April and NWAS are happy with the progress the Trust is making. Next live trial is due on the 5th May
- Clinical Review Standards developed and reportable pending next steps nationally
- Work has commenced on the delivery of a Discharge Hub led by the System Discharge Director to support improved discharge performance

	• Existing discharge pathways mapped, the focus is now on pathway redesign • Discharge Delivery Project has changed a Cerner workflow to improve accuracy of CTR recording, agreed a plan for Model Board Round rollout and commenced Daily Discharge Checks on medical wards • Trajectory to deliver a reduction in the number of patients on Pathway 1, 2 and 3 is monitored through daily COO and CEO meetings. Also submitted to the C&M ICB.
3.3	**Risks to improving performance** • Physical environment in ED is challenging during peaks in demand impacting on ability to delivered the timed pathways • Delivery of the LLOS recovery trajectory is at risk due to community capacity constraints for Pathway 1,2,3 patients • Risk to delivery of additional step-down capacity due to staff shortages and IPC guidance in both nursing homes and domiciliary care providers • Boarding time in department increased due to bed pressures • Increasing mental health activity and significant increases of attendances under S136 • Significant increase in the number of patients who do not meet the Criteria to Reside on Pathway 1,2 and 3 due to capacity constraints within the Wirral system • Availability of mental health inpatient beds resulting in 12-hour breaches for mental health patients and excessive LOS in the ED.

4.0	**Conclusion**
	The Trust had a significantly challenged month in relation to non-elective demands and rising rates of patients admitted with Covid. Recovery of the elective programme continues with some areas of performance over-achieving the trajectories set, but pressure from non-elective demand is increasingly challenging.

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Board of Directors in Public
4 May 2022

Item No 9.1

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

Report Purpose and Recommendations

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

It is recommended that the Board:

- Note performance to the end of March 2022

Key Risks

This report relates to the key Risks of:

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

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
6th April 2022	Board Seminar – Development Session	Proposed 2022/23 Quality and Performance Dashboard	Discussion on results of review and agreement on next steps

1	Narrative
1.1	Of the 35 indicators that are currently reported against thresholds (excluding Use of Resources): - 23 are off-target or failing to meet performance thresholds - 12 are on-target Following the recent discussions with the Executive Team and the Board as part of the Performance Management Framework Review, the metrics included in the Quality & Performance dashboard have been assessed for continued inclusion, alongside the relevant thresholds. The approved changes to metrics have been adopted for this version of the dashboard where possible. Some thresholds will only apply from performance in April 2022 onwards as they are components from the 2022/23 operational plans. Further development work is also continuing to clarify the precise definitions and thresholds on a small number of metrics. Amendments to previous metrics and/or thresholds are detailed below the dashboard.

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

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

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Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

April 2022
Upated 25-04-22

	Indicator	Objective	Director	Threshold	Set by	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	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	0.16	0.10	0.20	0.05	0.05	0.10	0.10	0.05	0.19	0.18	0.18	0.20	0.04	0.12	
	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	96.2%	96.4%	96.6%	96.6%	96.2%	97.6%	96.9%	96.9%	97.2%	96.9%	96.7%	96.2%	96.4%	96.7%	
	Never Events	Safe, high quality care	CN	0	SOF	0	0	1	0	2	0	0	0	0	0	0	1	0	4	
	Clostridium difficile (healthcare associated)	Safe, high quality care	CN	Maximum 79 cases for 2021-22, with a varying trajectory of a max 6 to 8 cases per month	WUTH	6	5	7	5	1	6	13	6	5	3	18	12	13	94	
	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	National	6	3	5	7	3	3	2	7	6	8	4	2	9	59	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	1	0	0	0	0	0	0	0	1	0	2	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	0	0	1	1	0	0	0	0	0	1	1	1	5	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	96%	96%	96%	95%	96%	96%	96%	95%	96%	96%	94%	95%	92%	95%	
	Safeguarding Audit scores	Safe, high quality care	CN	≥90%	WUTH	-	-	-	-	-	-	-	-	-	-	-	-	82.6%	-	
	Mandatory Training compliance	Safe, high quality care	CPO	≥90%	WUTH	86.2%	87.3%	87.9%	89.1%	90.1%	90.9%	91.3%	90.8%	90.5%	90.4%	89.0%	87.2%	87.2%	87.2%	
	Sickness Absence % (12-month rolling average)	Safe, high quality care	CPO	≤5%	SOF	6.52%	6.21%	6.10%	6.05%	6.12%	6.17%	6.21%	6.22%	6.24%	6.40%	6.48%	6.53%	6.70%	6.7%	
	Sickness Absence % (in-month rate)	Safe, high quality care	CPO	≤5%	SOF	5.29%	5.38%	5.68%	5.68%	6.48%	6.53%	6.62%	6.67%	6.37%	7.86%	8.72%	7.05%	7.7%	6.73%	
	Staff turnover % (rolling 12 month rate)	Safe, high quality care	CPO	≤10%	WUTH	13.0%	13.5%	13.2%	13.3%	13.0%	12.6%	12.9%	13.3%	13.2%	13.4%	13.7%	13.9%	14.1%	14.1%	
	Care hours per patient day (CHPPD) - number of wards below 6.1	Safe, high quality care	CN	No of wards ≤3	WUTH															

Quality Performance Dashboard

April 2022
Upated 25-04-22

	Indicator	Objective	Director	Threshold	Set by	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021/22	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	98.0%	98.4%	98.3%	98.3%	95.9%	96.7%	96.4%	96.2%	93.8%	92.6%	91.7%	96.7%	96.9%	96.0%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	97%	99.0%	98.0%	98.0%	98.0%	97.0%	96.0%	96.4%	95.5%	94.6%	95.2%	97.3%	96.3%	96.8%	
	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	88	96	85	99	95	126	132	126	141	157	206	195	187	187	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	84.9%	84.5%	85.5%	82.5%	79.8%	82.0%	83.4%	83.7%	82.0%	77.9%	77.2%	77.9%	83.7%	81.7%	

	Indicator	Objective	Director	Threshold	Set by	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021/22	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	0	2	2	3	4	1	2	2	3	8	3	2	3	35	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	85.0%	84.0%	83.0%	82.0%	76.0%	76.0%	71.1%	72.8%	72.4%	77.7%	75.9%	77.3%	67.2%	76.3%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	92.0%	94.0%	95.0%	95.0%	95.0%	96.0%	94.0%	94.3%	95.1%	94.4%	95.4%	94.5%	92.3%	94.6%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	95.0%	95.0%	94.0%	95.0%	93.0%	94.0%	93.2%	94.1%	93.7%	94.3%	94.3%	94.1%	93.6%	94.0%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	94.0%	99.0%	95.0%	93.0%	97.0%	98.0%	94.1%	98.8%	94.7%	94.6%	96.6%	93.5%	97.7%	96.0%	

Quality Performance Dashboard

April 2022
Upated 25-04-22

	Indicator	Objective	Director	Threshold	Set by	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	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	77.8%	76.1%	73.5%	78.0%	67.8%	66.2%	63.4%	62.6%	59.5%	60.6%	59.1%	63.1%	61.5%	65.9%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	0	0	1	7	11	8	6	6	13	7	17	76	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	TBD	National	78.8%	73.4%	68.1%	73.4%	57.7%	66.7%	48.1%	58.1%	49.8%	57.2%	57.3%	61.7%	54.0%	60.5%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	TBD	National	1.6%	1.7%	2.6%	2.3%	7.9%	4.9%	9.2%	8.0%	9.4%	8.8%	10.7%	8.0%	11.7%	7.1%	
	Proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed	Safe, high quality care	COO	TBD	National	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	78.9%	74.6%	73.9%	82.4%	86.9%	79.3%	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	6.8%	8.2%	10.4%	7.6%	14.5%	14.3%	23.5%	21.9%	22.8%	19.2%	18.0%	15.5%	25.2%	16.8%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	69.26%	69.61%	72.57%	75.64%	75.13%	74.14%	72.88%	70.84%	70.14%	67.84%	67.57%	65.89%	65.38%	65.38%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSEI H2 Plans Trajectory : Oct 21 to March 22	National	23444	24774	25873	26671	26979	27306	27424	26935	27046	27406	28665	29445	30430	30430	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSEI H2 Plans Trajectory : Oct 21 to March 22	National	1168	874	633	526	507	560	606	575	510	557	475	525	582	582	
	Referral to Treatment - cases waiting 78+ wks	Outstanding Patient Experience	COO	NHSEI 2022/23 plans trajectory	National	n/a	83	90	90	117	177	163	116	70	72	59	65	60	60	
	Referral to Treatment - cases exceeding 104 weeks	Safe, high quality care	COO	NHSEI H2 Plans Trajectory : Oct 21 to March 22	National	0	1	1	1	3	3	7	10	5	5	4	5	1	1	
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥99%	SOF	97.4%	97.7%	98.5%	96.8%	87.5%	86.0%	91.3%	94.3%	93.0%	89.8%	87.3%	86.4%	85.2%	91.2%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	98.8%	96.9%	97.6%	97.2%	95.4%	93.7%	95.7%	96.1%	87.9%	91.4%	76.2%	78.0%	76.1%	90.2%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	97.64%	-	-	97.21%	-	-	94.95%	-	-	91.63%	-	-		96.1%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	93.5%	94.7%	95.2%	99.2%	96.3%	96.4%	96.5%	95.4%	94.3%	94.8%	94.6%	95.1%	94.9%	95.6%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	94.73%	-	-	96.26%	-	-	96.41%	-	-	94.85%	-	-		96.3%	
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	84.1%	84.5%	84.1%	85.3%	84.7%	85.9%	84.4%	79.2%	79.7%	79.3%	79.6%	79.3%	76.7%	81.9%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	82.56%	-	-	84.66%	-	-	85.05%	-	-	79.38	-	-		84.9%	
	Cancer Waits - reduce number waiting 62 days +	Outstanding Patient Experience	COO	NHSEI 2022/23 plans trajectory - max 68	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	81	81	
	Cancer - Faster Diagnosis Standard	Outstanding Patient Experience	COO	NHSEI 2022/23 plans trajectory - min 78%	National	n/a	80.7%	81.0%	81.2%	80.4%	78.2%	77.9%	79.8%	79.2%	80.5%	70.5%	78.9%	80.1%	79.0%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	170	157	156	145	209	213	218	216	177	149	180	187	211	185	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	4.07	4.09	2.56	4.04	4.20	3.31	3.29	2.56	3.27	3.26	2.34	4.87	3.05	3.40	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	95%	100%	93%	95%	100%	94%	94%	100%	61%	100%	100%	100%	100%	95%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	4	0	2	1	2	5	2	3	4	3	2	0	0	2	
	% NEWS 2 Compliance	Outstanding Patient Experience	MD/CN																	

Quality Performance Dashboard

April 2022
Upated 25-04-22

	Indicator	Objective	Director	Threshold	Set by	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	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	87	22	38	107	279	457	613	774	958	1121	1445	1575	1666	1666	
	% Appraisal compliance	Safe, high quality care	CPO	≥88%	WUTH	77.0%	81.0%	81.3%	82.7%	82.7%	82.2%	81.2%	82.2%	82.7%	82.3%	82.0%	78.0%	77.9%	77.9%	

	Indicator	Objective	Director	Threshold	Set by	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021/22	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	3.5	0.8	-0.5	-0.2	0.0	0.2	-0.2		-0.7	-0.6	2.3	-0.1	0.1	-0.1	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	3.9	0.8	-0.4	-0.4	0.0	0.2	-0.1	0.0	1.0	-0.9	1.9	-0.5	-0.3	-0.3	
	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 (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.0	3.02%	6.03%	9.05%	14.50%	Not reported	77.21%	48.24%	78.70%	78.61%	91.33%	91.3%	
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	-21.9%	-50.5%	-27.7%	-32.4%	-40.5%	-11.7%	-5.2%	-50.0%	-25.1%	-6.7%	-4.3%	-8.0%	-15.0%	-23.1%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-16.9	-15.0	-15.5	-10.4	-15.7	-15.4	-15.2	-16.2	-15.9	-18.0	-16.2	-18.6	-20.0	-20.0	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	100.0%	2.0%	5.6%	12.5%	18.0%	22.6%	24.4%	30.7%	36.3%	48.0%	59.0%	76.2%	100.0%	100.0%	

Metrics Removed

		Change
Safe	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Removed
	Serious Incidents declared	Removed
	CAS Alerts not completed by deadline	Removed
	Hand Hygiene Compliance	Removed
	Protecting Vulnerable People Training - % compliant (Level 1)	Removed
	Protecting Vulnerable People Training - % compliant (Level 2)	Removed
	Protecting Vulnerable People Training - % compliant (Level 3)	Removed
	Staff turnover % (in-month rate)	Removed
Effective	SAFER BUNDLE: % of discharges taking place before noon	Removed
	SAFER BUNDLE: Ave number of stranded patients at 10am (in for 7 or more day)	Removed
	Length of stay - elective (actual in month - Patient Flow wards only)	Removed
	Length of stay - non elective (actual in month - Patient Flow wards only)	Removed
	Emergency readmissions within 28 days	Removed
Responsive	Referral to Treatment - cases waiting 0-18 wks	Removed
	Referral to Treatment - cases waiting 19-26 wks	Removed
	Referral to Treatment - cases waiting 27-40 wks	Removed
	Referral to Treatment - cases waiting 41-52 wks	Removed

Metrics Amended

Safe	Attendance % (12-month rolling average) - metric changed to % sickness absence	Amended
	Care hours per patient day (CHPPD) - change to wards below CHPPD of 6.1	Amended

Metrics Added

Safe	Safeguarding Audit scores	Added
	Mandatory Training compliance	Added
Responsive	Referral to Treatment - cases waiting 78+ wks	Added
	Cancer Waits - reduce number waiting 62 days +	Added
	Cancer - Faster Diagnosis Standard	Added
	% NEWS 2 Compliance	Added

WUTH Quality Dashboard Exception Report May 2022

Wirral University Teaching Hospital NHS Foundation Trust

Safe Domain

Clostridium difficile (Healthcare Associated)

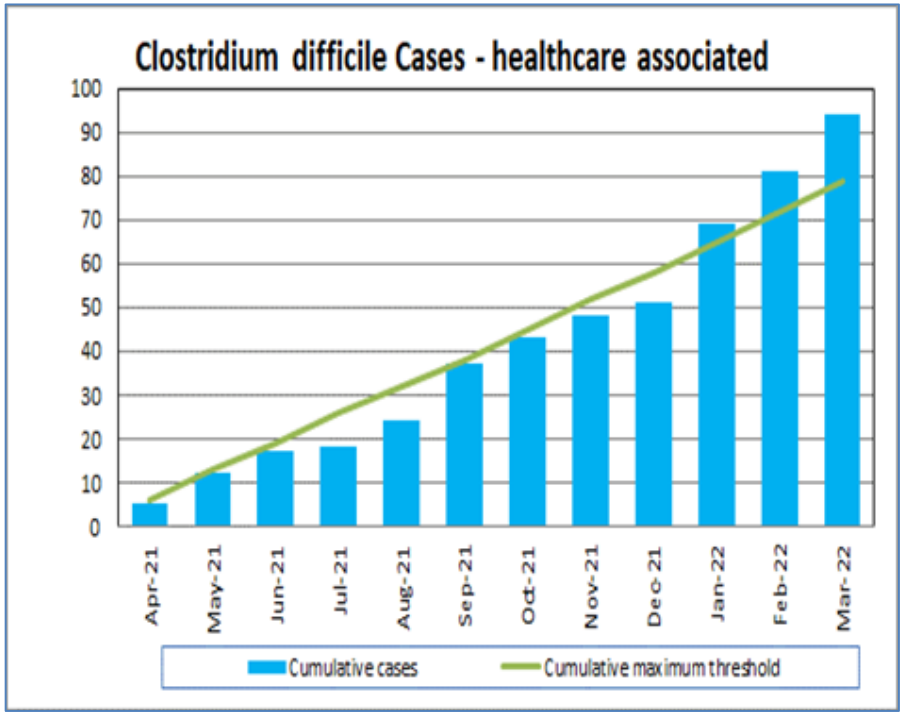
Executive Lead: Chief Nurse

Performance Issue:

In respect of the COVID pandemic the national objective set for WUTH for healthcare associated *Clostridium difficile* infections (CDI) this year is 115. This is an increase in the previous year and is not reflective of the achievements made in reducing CDI for the last 2 years. To promote continuous improvement an internal threshold has been agreed: a target of 79 healthcare associated CDI cases or less for 2021-2022. This a 10% reduction of last year's objective of 88.
The cumulative position for 2021-2022 at the end of March is reported at 94 cases, and higher than the cumulative threshold. The number of cases in the month of March 2022 was 13.

Action:

Following the circulation of the Trust wide CDI Improvement Plan in January we have seen a marked improvement with a reduction in numbers in February and March however this has not been enough to ensure that we have remained below our internal threshold. A rapid QI initiative focusing on CDT across four wards is in the development stage which is going to be launched this month which will provide further improvement initiatives for the coming year. The IPC team have continued its enhanced support to the wards with in an increased visible presence and additional administration support with completing RCAs.



The weekly Chief Nurse led CDT meeting continues which reviews each patient pathway, identifying causative factors and developing local action plans to focus on improvements. The Trust currently remains significantly below the PHE target of 115 cases.
Expected Impact: Reduction in patients diagnosed with healthcare associated *Clostridium difficile*

Gram-Negative Bacteremia

Executive Lead: Chief Nurse

Performance Issue:

The Trust has a maximum threshold set for 2021-22 of 63 cases, this allows a varying trajectory of 5 or 6 patients identified with a Gram-negative bloodstream infection per month. Whist there were 9 patients identified in March 2022, (6 E-coli, 2 klebsiella and 1 pseudomonas), an increase of 7 from the previous month, we remain under our cumulative objective at year end.

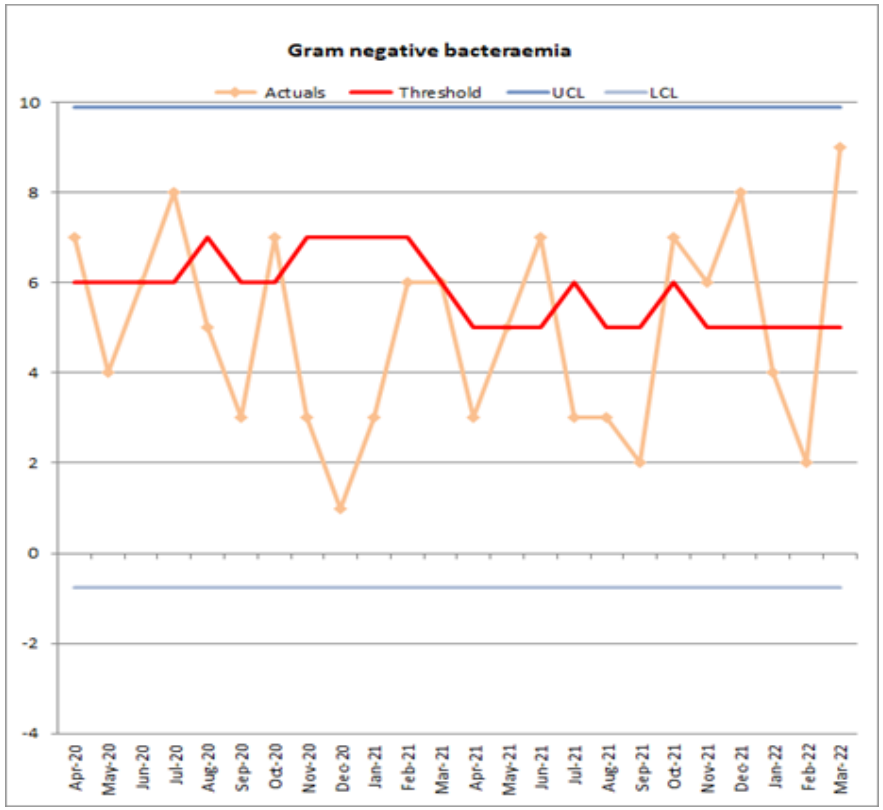
Action:

Senior representation continues at the weekly Patient Safety Learning Panel to enable in-depth scrutiny of the RCA investigations to ensure all learning areas are captured and action plans can be developed to promote improvements. Of the 6 E-coli bloodstream infections reported 4 are linked to UTI's, 3 of which are catheter related, 1 is post ERCP, 1 is biliary and 1 remains under investigation. The IPC team is working in collaboration with partner organisations looking at management of UTI's including catheter management.

Roles and responsibilities of the divisional teams in monitoring agreed action plans have been re-affirmed.

Expected Impact:

The number of patients diagnosed with a Gram-negative blood stream infection is reduced to below the monthly threshold and the annual objective for 2021 – 2022 is achieved.



Pressure Ulcers – hospital acquired category 3 and above

Executive Lead: Chief Nurse

Performance Issue:

WUTH has in an internal standard of zero hospital acquired pressure ulcers at category 3 or above.

Action:

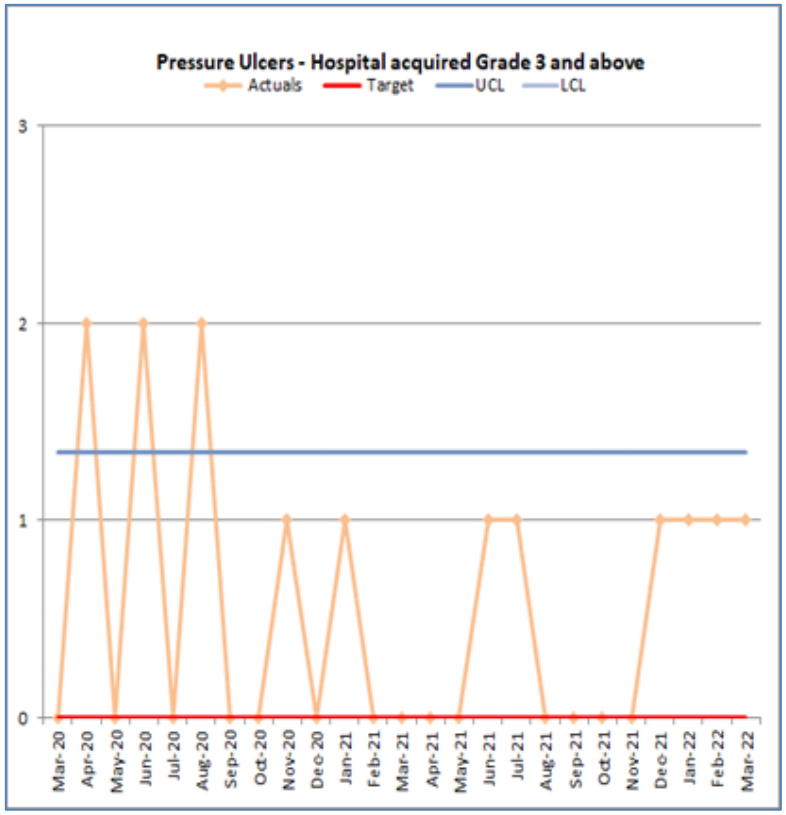
There was one Hospital Acquired (HA) Cat 3 reported in March. This incident has had a full review in the Patient Safety Learning Panel and full root cause analysis undertaken that identified some lessons to be learnt around effective documentation. Appropriate action has been taken as a result.

The Trust continues to have a sustained low prevalence of HA Pressure ulcers with a rate of ≤1 per thousand bed days. This low prevalence is supported by continuous improvement work streams, launch of the SSKIN bundle focusing on prevention and launch of the Tissue Viability Education E-learning Training.

The Pressure Ulcer Prevention and Management Policy replicative of the Cheshire and Merseyside Pressure Ulcer Steering Group standards has been submitted for consultation.

Expected Impact:

There will be a reduction in the number of patients with hospital acquired pressure damage.



Mandatory Training %

Executive Lead: Chief People Officer

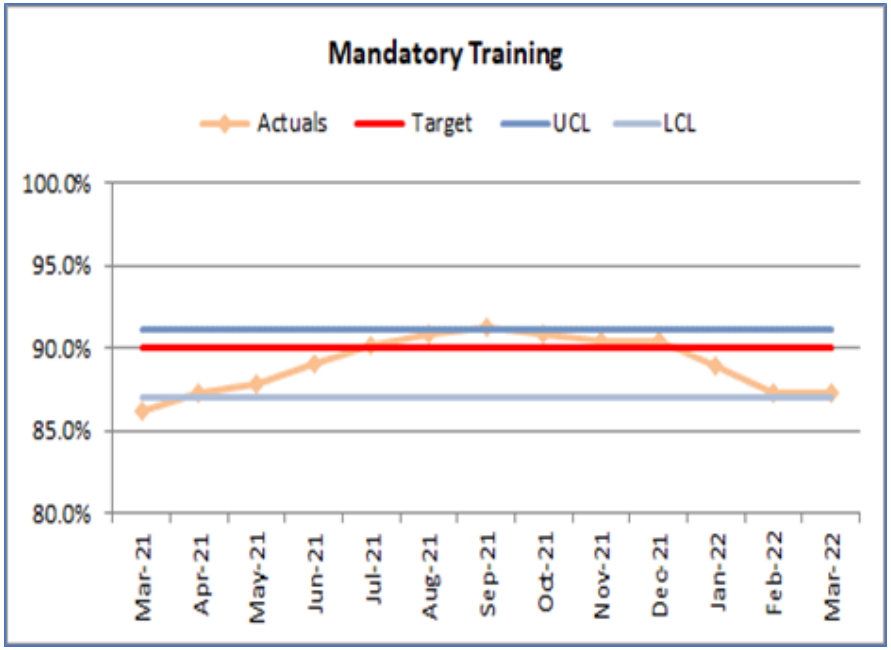
Performance Issue:

The Trust has an internal standard for 90% of staff to be compliant with applicable Mandatory Training. The rate for March 2022 was 87.2%

There were no Divisions in March 2022 that met the KPI. The highest compliance is Women & Children's at 88.77%, the lowest is Acute at 81.78%. Improvements this month were seen in Clinical Support, Estates & Hotel Services, Women & Children's.

There is a wide variance in compliance by staff group, with Add Prof, Scientific and Technical with the highest compliance rate at 84.5%, and Medical and Dental with the lowest compliance rate at 23.9%.

Of the 15 requirements for mandatory training, there are 5 subjects that are meeting the KPI of 90% compliance which are Conflict Resolution, Data Security Awareness (Level 1), Equality and Diversity (Level 1), Fire Safety (Level 1) and Infection Control (Level 1). All other subjects are below 90%, with the lowest compliance levels seen in PVP Levels 3 and 4 which stand at 74.2% and 77.7% respectively, and CPR which currently stands at 80.3%.



Action:

Workforce compliance data is available to Divisions and the HR Services team to enable them to manage non-compliance for their areas. HR Business Partners continue to support Divisional Management teams to identify and deliver actions to address low levels of compliance in specific areas.

Following a change in Trust covid restrictions there has been a return to face-to-face training at reduced social distancing requirements and so

capacity for subject leads to train staff has recently increased. There continue to be ongoing challenges in releasing staff to attend training when clinical demands are high and/or staffing levels are low.

Challenges with the national ESR system in recording Trust e-Learning completions have been reported and continue to be investigated. In the meantime, a process for manually inputting completions has been developed, and guidance on actions staff can take to help them have the best ESR user experience is currently being written.

A collaborative pilot project between Workforce and Women's and Children's Division is currently underway to create a mandatory and role specific training BI dashboard to help provide accessible and user-friendly data on mandatory training compliance to the division, its departments and managers. Should the pilot prove successful, there is the potential to offer easily accessible and visual data on training compliance across the organisation that will help support divisions to monitor and increase compliance.

Expected Impact:

The impact of covid on training provision has been significant and ongoing clinical pressures create challenges in sustaining compliance. The above actions mitigate against the full impact of this and, with divisions prioritising attendance at and completion of mandatory training, increases in compliance are achievable within the next reporting window.

Sickness absence % (in-month rate)

Executive Lead: Chief People Officer

Performance Issue:

The Trust compliance threshold for sickness absence is 5%, both for in-month sickness and over a rolling 12-month period. Sickness absence in March 2022 increased to 7.73%, from the 7.05% up to February, of this, 1.84% is related to COVID-19.

All Divisions in March 2022 have exceeded the 5% KPI, only Acute and Corporate showed an improvement in March 2022. Until this month it is noted that Estates and Hotel Services had steadily improved since September 21.

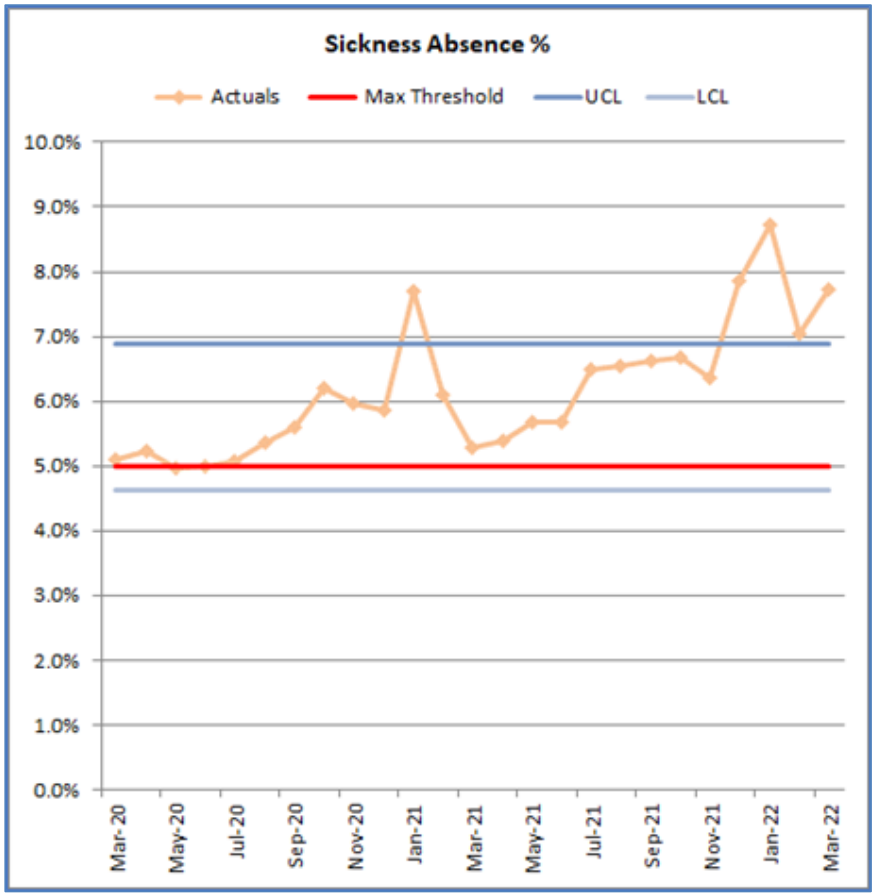
In March 2022, there was a decrease in long-term sickness absence as compared to February 2022. Proportionately, short term sickness absence continues to account for the majority (83%) of sickness absence.

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

Action:

Monitoring of the Sickness Attendance KPI and associated actions is on-going via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews (DPRs).

Work on the NHSE/i agreed HR Business Partner action plan continues against the Deep Dive Themes, in particular actions associated with the revised Managing Attendance Policy and newly proposed Managers Toolkit.



The HR Team are also embarking on the next round of sickness audits, using the revised sickness audit process (linked to the above NHSE/I work) and focusing on hotspot areas. Any audits where that identify low compliance are used by HR Managers to work with Matrons/managers to put appropriate measures/actions in place. Re-audits are undertaken the following month to assess improvements.

The new menopause staff support network has been launched to bring together those who are experiencing the menopause, along with colleagues who offer services or support that may help those experiencing the menopause.

The Health and Wellbeing Conversations have been launched from 1st April 2022.

The Workforce Wellbeing Winter Plan implementation has come to end and the evaluation analysis stage is almost complete. The aim of the analysis is to determine the provisions that staff have found useful and the way in which they would feed into the 'Looking After Our People' principle of the People Strategy to form part of 'business as usual'.

Following a return to face-to-face training, arrangements are being made for face-to-face Management Development sessions, including Attendance Management, to resume from May 2022. Additionally, a review of the Effective Managers Programme is underway which is anticipated to embed the foundations of good management practice, including supporting staff attendance and wellbeing, amongst new and existing leaders and managers in line with the Trust's newly developed Leadership Qualities Framework.

Expected Impact:

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

Risks to Trust financial management, quality, patient safety and operational performance due to cost of sickness absence, expense of bank and agency cover will reduce as the sickness absence is gradually improved over time

and as we emerge from the pandemic and transition into Living with Covid-19 response.

Staff turnover % (12-month rolling average)

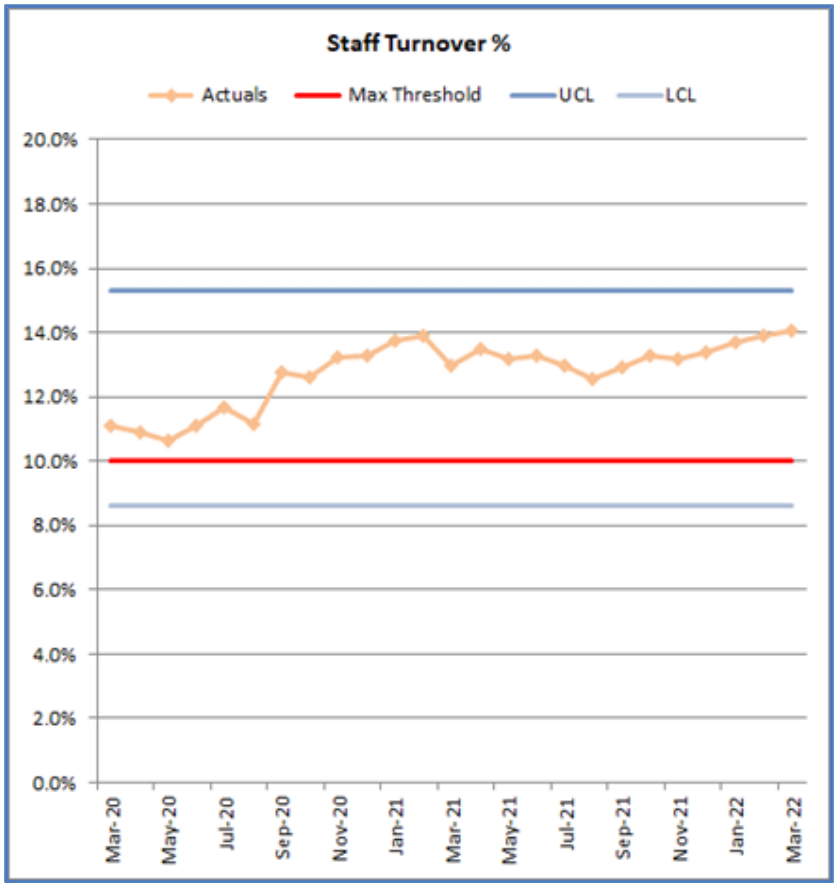
Executive Lead: Chief People Officer

Performance Issue:

The Trust target is set as a maximum rolling 12-month turnover threshold of 10%. Turnover has continued to increase and for the 12 months to March 2022 was 14.1%.

If turnover is calculated based on permanent assignments only, excluding fixed term employees, the In-Month figure for March 2022 is 1.08% which is an increase of 0.33% from February 2022.

The In-Month performance in Acute Care, Surgery and Women & Children's are all below the Trust Turnover KPI. All Divisions are over the 10% KPI for the rolling 12 months.



Actions:

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

<u>Current Interventions to support retention.</u>

A Nurse and CSW recruitment event is being held in May 2022 and recruitment leads are invited to showcase their areas and attract new candidates. 3rd year students have already expressed interest in joining WUTH and submitted applications.

Work to understand predicted student to staff nurse employment is underway with 4 local universities enabling the Trust to set recruitment targets for future cohorts.

International nurse recruitment continues and progress is on target.

The Facilitation in Practice programme is scheduled for May 2022.

Training dates for PARE and WEPP have been shared with preceptors. Recruitment have implemented a process for weekly reporting of new registrants to the Senior Nurse Lead for WEPP.
Expected Impact: The impact of high Turnover increases pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance, and safety. Risks to Trust financial management, quality, patient safety and operational performance due to the cost of high Turnover and the expense of bank and agency cover should reduce as Turnover improves over time with the interventions outlined above.

Effective Domain

Theatre in session utilisation %

Executive Lead: Chief Operating Officer

Performance Issue:

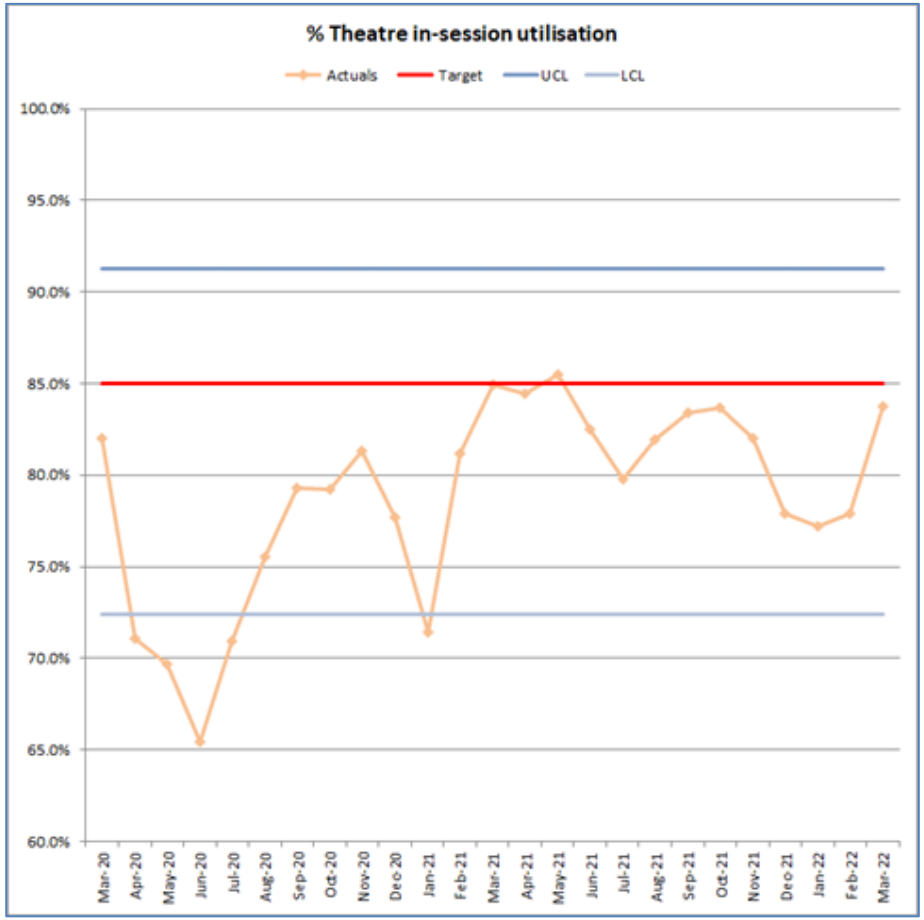
The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised.

Since September the Division has had a real focus on improving utilisation of sessions as part of reset and recovery. This initially had the desired result, however there have been further theatre ventilation failures resulting in theatres M1 – M5 and G1 being closed to maintain patient safety. M1 & M2 remedial works failed with further works due for completion w/c 18th April 25 2022 ahead of the ventilation system replacement.

As COVID prevalence continued to increase it had a direct impact on in-session utilisation due to patients being cancelled if their pre-op or pre-admission COVID swab was positive and lists are unable to be backfilled at such short notice due to clinical requirements/pathways. Proposals to change the process under "living with COVID" was approved at CAG with in-session performance showing an improvement.

COVID measures regarding PPE remain in place.

The number of patients not meeting the criteria to reside in hospital beds and COVID numbers remain high, though the loss in theatre estate has meant there have been minimal EL bed pressures. IPC measures have been revised in view of national guidance enabling access to closed beds and the restoration of the Elective wards.



Action: • Maintain the Theatre scheduling meeting to minimise the loss of activity through theatre ventilation failures • Maintain the daily TCI meeting to prevent cancellations on the day for inpatients and risk further reduction in in-session utilisation • Theatre ventilation repair works schedule remains on track • Heavier focus on CGH theatre to ensure >85% in-session delivery
Expected Impact: Increase in in session utilisation and increase in case throughput.

Caring Domain

Same sex accommodation breaches

Executive Lead: Chief Nurse

Performance Issue:

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

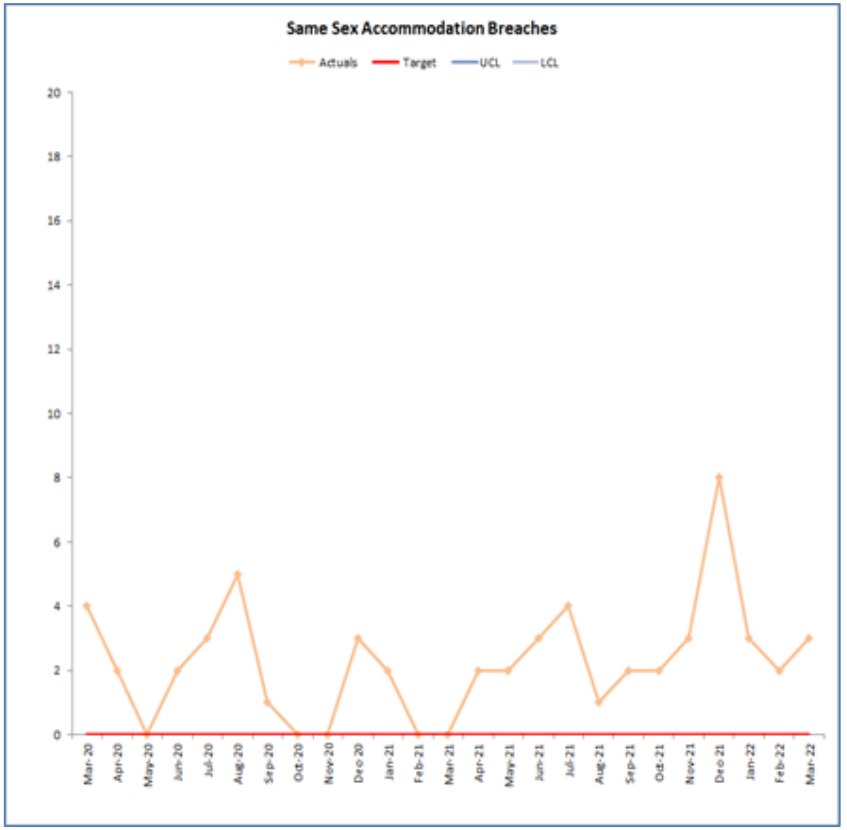
Same sex accommodation breaches are most often due to patients waiting more than 24 hours for transfer from critical care areas to general wards – there were 3 such breaches in March 2022. These reported breaches did not cause any delays or refused admissions to the Critical Care Unit as sufficient critical 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:
Increased pressure due to system challenges resulting in high levels of activity throughout the hospital and an increased proportion of patients with no criteria to reside continued in March 2022.

Joint working processes are in place, between critical care and the Patient Flow Team, to expedite discharges in response to an increase in acuity of patients.

Robust processes remain in place to ensure that delivering same sex accommodation continues to be a high priority and that breaches are managed promptly via bed capacity and operational meetings.

Expected Impact:
All patients are transferred to their specialty bed within 24 hours of discharge.



Well-led Domain

Appraisal compliance %

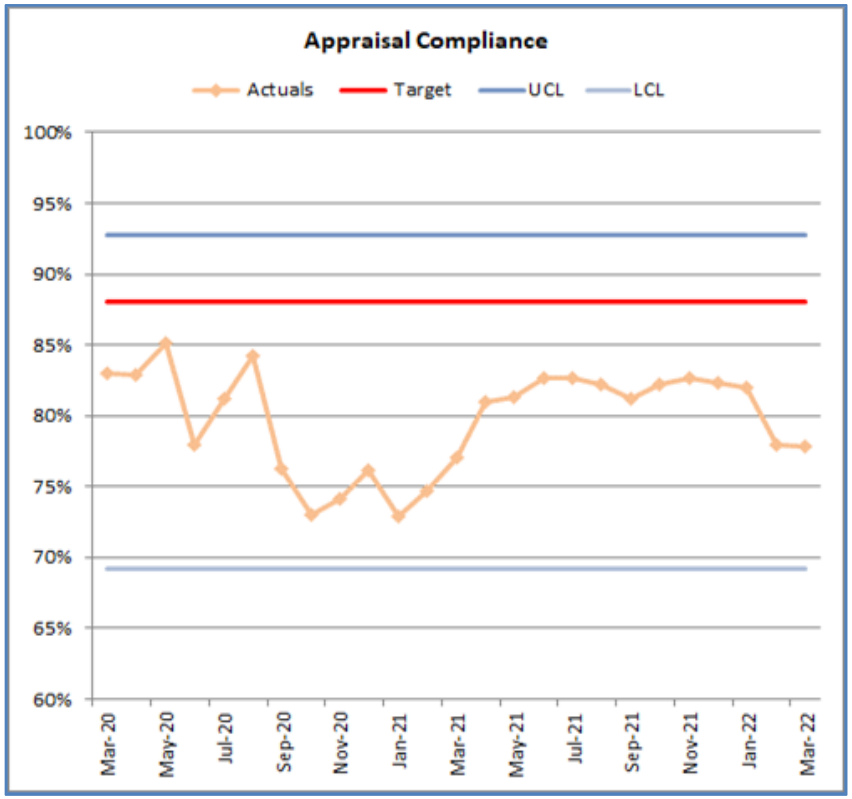
Executive Lead: Chief People Officer

Performance Issue:

The target for annual appraisal compliance is 88%. At the end of March 2022, 77.9% of the workforce had received an appraisal in the last 12 months. This is very similar to the 78% for February 2022.

From a divisional perspective, no divisions this month have achieved the Trust KPI of 88% appraisal and compliance is currently under 80% in all divisional areas. There have been small increases in compliance in comparison to the previous month in Clinical Support and Diagnostics, Estates and Hotel Facilities, and Medical Divisions with all other divisions seeing a decrease in compliance. The division with the highest compliance rate is Surgery at 79.6%, and the division with the lowest compliance rate is Acute at 67.3% and Medical at 76.5%.

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. HR Business Partners continue to support Divisional Management teams to identify and deliver actions to address low levels of compliance in specific areas. Increased focus upon appraisal compliance will be placed at divisional performance Review meetings this month and all divisions have been tasked with producing improvement trajectories.

As highlighted in previous reports, a review of appraisal has now commenced. This has been accelerated from a 6 month to a 4-month piece of work due to the

continued decline in compliance. To date, a quality audit and focus group have been conducted to gain greater insight into the issues relating to appraisal, and further feedback has been gathered through specific questions in the trust-wide wellbeing survey. Early indications are that there are a range of opportunities to strengthen the quality of the appraisal experience, enhancing its value across the Trust and subsequently driving improvements in both quality and compliance.
Expected Impact: Whilst actions will continue to increase compliance within the existing appraisal framework, the longer-term solution for maintaining compliance is to place a longer-term focus on quality improvement. It is acknowledged that ongoing clinical pressures may create some continuing challenges in maintaining appraisal completion rates across clinical areas over forthcoming months.

Board of Directors in Public
4 May 2022

Item No 9.2

Title	M12 Finance Report
Area Lead	Robbie Chapman, Interim CFO
Author	Robbie Chapman, Interim CFO
Report for	Information

Report Purpose and Recommendations

The Trust is reporting a surplus of £0.028m at M12, a negative variance against budget of £0.162m.

C&M have informed the Trust that we will receive £5.401m in respect of ERF for Q4 of 21/22 and this amount is recognised within these management accounts. However, the figures are based on estimates for M12 so the figure is subject to change.This gives total ERF for 21/22 of £17.688.

The improved income position is offset by significant increase in expenditure in M12, with variances of £0.390m in respect of pay (including COVID) and £3.784m in respect of non-pay.

It is recommended that the Board:

- Note the report.

Key Risks

This report relates to these key Risks:

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

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

Governance journey

This is a regular update provided to each Board meeting.

Month 12 Finance Report 2021/22

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2. Dashboard and risk

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   3.5. CIP Performance

4. Financial position

   4.1. Statement of Financial Position
   4.2. Capital expenditure
   4.3. Statement of Cash Flows
   4.4. Treasury
   4.5. Working capital
   4.6. Use of Resources

1 Executive Summary

1.1 Table 1: Financial position – M12

Month 12 Financial Position	Budget (Mth 12) £'000	Actual (Mth 12) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
NHS income - patient care	30,055	24,517	(5,537)	345,122	330,408	(14,714)
Income Guarantee	0	(198)	(198)	0	15,590	15,590
National Top-up	1,743	2,743	1,000	23,242	24,242	1,000
Elective Recovery Fund (ERF)	0	5,549	5,549	5,524	17,668	12,144
Covid 19 income	1,806	1,901	95	22,283	21,847	(436)
Non NHS income - patient care	392	471	79	4,723	4,796	73
Other income	3,014	6,147	3,133	30,979	36,072	5,093
Total Income	**37,009**	**41,129**	**4,120**	**431,873**	**450,623**	**18,749**
Employee expenses	(24,641)	(24,636)	5	(290,736)	(301,492)	(10,756)
Operating expenses	(11,615)	(15,794)	(4,179)	(136,602)	(144,058)	(7,456)
Total Expenditure	**(36,256)**	**(40,431)**	**(4,174)**	**(427,338)**	**(445,550)**	**(18,212)**
Non Operating Expenses	(391)	(365)	26	(4,695)	(5,038)	(343)
Actual Surplus / (deficit)	**362**	**333**	**(29)**	**(160)**	**35**	**195**
Control Total adjustment	29	(278)	(307)	350	(7)	(357)
Surplus/(deficit) - Control Total	**391**	**56**	**(336)**	**190**	**28**	**(162)**

1.2 The Trust is reporting a surplus of £0.028m at M12, a negative variance against plan of £0.162m.

1.3 Total income was £450.623m at M12, a positive variance of £18.749m. This reflects the 'block' contract arrangements with CCGs, confirmed values in respect of specialist and direct commissioning, Elective Recovery Fund (ERF) income received for the year.

1.4 C&M have informed the Trust that we will receive £5.401m in respect of ERF for Q4 of 21/22 and this amount is recognised within these management accounts. However, the figures are based on estimates for M12 so the figure is subject to change.This gives total ERF for 21/22 of £17.668m.

1.5 We have received £36.702m in other income, a positive variance of £5.093m. This is attributable to additional funding we received in respect of our telederm initiative, increased education and training funding, income in respect of Clatterbridge Diagnostic Centre and non-recurrent support for prolonged winter pressures and the elective recovery programme. All of this is offset by increased expenditure.

1.6 Total employee expenses including COVID-19 were £301.492m at M12, this represents an overspend against our budget of £10.756m. The overspend against plan is discussed at in more detail at 3.2.3 but is primarily driven by a £9.566m overspend in respect of M&A. Employee expenses excluding COVID, which were £297.743m, can be broken down as follows:

1. Executive summary

Table 2: Pay cost analysis excluding COVID

Pay analysis (exc Covid)	Budget (Mth 12 £'000	Actual (Mth 12) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Consultants	(4,285)	(4,418)	(133)	(44,546)	(48,867)	(4,321)
Other medical	(2,746)	(3,142)	(396)	(32,655)	(32,836)	(181)
Nursing and midwifery	(6,325)	(7,374)	(1,049)	(77,065)	(80,759)	(3,694)
Allied health professionals	(1,401)	(1,438)	(38)	(16,467)	(16,954)	(487)
Other scientific, therapeutic and technical	(582)	(571)	11	(6,960)	(6,480)	479
Health care scientists	(1,080)	(1,114)	(34)	(13,060)	(13,279)	(219)
Support to clinical staff	(4,808)	(3,003)	1,805	(56,487)	(57,306)	(819)
Non medical, non clinical staff	(2,953)	(3,168)	(215)	(37,848)	(40,154)	(2,306)
Apprenticeship Levy	(74)	(93)	(19)	(1,000)	(1,107)	(107)
Total	(24,254)	(24,320)	(66)	(286,088)	(297,743)	(11,655)

1.7 Operating expenses including COVID were £144.058m at M12, an overspend of £7.456m. This reflects increased expenditure on drugs, clinical supplies, premises and non-recurrent support in respect of reset and recovery partially offset by lower spend against purchase of healthcare from non-NHS bodies.

1.8 Cash balances at the end of M12 were £36.4m.

1.9 The Trust has recorded a capital spend of £29.031m at M12, which incorporates all spend including newly approved and PDC funded schemes.

2 M12 Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	2021/22
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	-0.5	-0.2	0.0	0.2	-0.2		-0.7	-0.6	2.3	-0.1	0.1	-0.1
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	0.0	-0.4	-0.4	0.0	0.2	-0.1	0.0	1.0	-0.9	1.9	-0.5	-0.3	-0.3
	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
	CIP Performance (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	3.02%	6.03%	9.05%	14.50%	Not reported	77.21%	48.24%	78.70%	78.61%	91.33%	91.3%
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	-50.5%	-27.7%	-32.4%	-40.5%	-11.7%	-5.2%	-50.0%	-25.1%	-6.7%	-4.3%	-8.0%	-15.0%	-23.1%
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-15.0	-15.5	-16.4	-15.7	-15.4	-15.2	-16.2	-15.9	-16.0	-16.2	-16.6	-20.0	-20.0
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	2.9%	5.6%	12.5%	18.0%	22.6%	24.4%	30.7%	36.3%	45.0%	59.0%	76.2%	100.0%	100.0%

2.1.1 Agency spend is above threshold. This is discussed in more detail at 3.2.3.

2.1.2 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. Despite continued progress with removing historic accruals this position is unlikely to improve prior to year end.

2.2 Risk summary (as per risks identified in risk register)

2.2.1 Risk 1 – Failure to manage financial position

- Our ability to operate within the financial envelope is dependent on effective cost management alongside the delivery of activity trajectories, the management of COVID activity and the centrally funded vaccination and testing programmes. Our financial results for M12 demonstrate that we have done so.

2.2.2 Risk 2 – Failure to deliver CIP

- The confirmed H2 CIP target was £5.588m and this was incorporated into our plans submitted to NHSE/I. At M12 we have underachieved against this plan by £1.530m. This was offset by non-recurrent reductions in spend but represents a pressure on the 22/23 budget. This is discussed in more detail at section 3.5.

2.2.3 Risk 3 – Failure to complete capital programme

- We achieved delivery of the full capital programme at the end of the financial year.

3. Financial Performance

3.1 Income

3.1.1 The Trust has received £450.623m at M12, a positive variance of £18.749m.

Table 4: Income analysis for M12

	Budget (Mth 12 £'000	Actual (Mth 12) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Elective & Daycase	4,267	3,945	(321)	49,261	44,038	(5,223)
Elective excess bed days	66	84	19	994	615	(380)
Non-elective	7,645	8,457	812	96,576	96,951	375
Non-elective Non Emergency	1,022	1,004	(18)	12,928	12,521	(407)
Non-elective excess bed days	556	280	(276)	4,564	2,762	(1,802)
A&E	1,074	1,380	306	15,352	16,369	1,017
Outpatients	3,527	3,683	156	38,292	40,108	1,816
Diagnostic imaging	290	210	(80)	3,285	2,518	(768)
Maternity	469	529	61	5,596	5,149	(447)
Non PbR	6,081	6,729	648	71,853	69,682	(2,170)
HCD	1,319	1,709	389	15,806	18,309	2,503
CQUINs	0	0	0	1,140	1,140	(0)
National Top up	1,743	2,743	1,000	23,242	24,242	1,000
Income Guarentee	0	(198)	(198)	0	15,590	15,590
Other	2,056	(524)	(2,581)	22,438	13,002	(9,436)
Sub-Total Board Clinical Income	30,114	30,030	(83)	361,328	362,996	1,667
Other patient care income	2,056	(2,564)	(4,620)	11,104	11,243	139
Elective Recovery Fund (ERF)	0	5,549	5,549	5,524	17,668	12,144
COVID-19 Income	1,806	1,901	95	22,283	21,847	(436)
Non-NHS: private patient & overseas	19	40	21	270	235	(35)
Injury cost recovery scheme	0	26	26	385	562	177
Total Patient Care Income	33,995	34,982	987	400,894	414,550	13,656
Other operating income	3,014	6,147	3,133	30,979	36,065	5,086
Other non operating income		0	0		7	7
Total income	37,009	41,129	4,120	431,873	450,623	18,749

3.1.2 Despite variations in respect of elective activity, clinical income was broadly in line with forecast.

3.1.3 In H2, ERF has been calculated on the basis of RTT "clock stops" and the threshold for additional payment has been set at 89% of equivalent performance in 19/20. The Trust's combined clock stops in respect of admitted and non admitted patients in M7-9 of 19/20 was 24,563. For M7-9 of 21/22 the equivalent figure was 23,849. This represented 97% of the baseline and had a notional value of over £15m for the period but translated into a payment of £4.706m.

3.1.4 In M10 we had combined clockstops of 6,671 compared with the 19/20 equivalent of 8,289, representing 80% of the threshold. However, once the number of working days in the comparable months are taken into account our adjusted performance is 89%. It has since been confirmed that this will result in a payment of £0.826m.

3.1.5 In M11 we had combined clockstops of 7,087 compared with the 1920 equivalent of 7,193, representing 99% of the threshold. There were no working day adjustments in

respect of M11. It has since been confirmed that this will result in a payment of £2.120m.

3.1.6 In M12 we had combined clockstops of 7,781. This is significantly higher than the equivalent figure for 19/20 but this is not being used as the basis for the comparison given March 2022 was affected by COVID. The provisional payment figure we have been received is £2.456m and is based on February's performance pro-rated. Given the issues we have had in respect of our elective programme in March, with surgical wards escalated as part of our COVID response and problems with ventilation in theatres, we think it is possible that this figure is overstated but initial indications are that the payment will be made in line with the figure shared.

3.1.7 Patient care income exceeded budget by £13.656m. This includes a positive variance of £12.144m in respect of ERF. We have actually received a further £1.6m for the elective recovery programme but have yet to incur costs associated with the programme so this has been deferred into 22/23.

3. Financial Performance

3.2 **Expenditure: Pay**

3.2.1 The Trust has spent £297.743m on pay costs at M12. Table 5 details pay costs by staff group, Table 6 details pay costs by pay category type and Table 7 details COVID pay costs.

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

Pay analysis (exc Covid)	Budget (Mth 12 £'000	Actual (Mth 12) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Consultants	(4,285)	(4,418)	(133)	(44,546)	(48,867)	(4,321)
Other medical	(2,746)	(3,142)	(396)	(32,655)	(32,836)	(181)
Nursing and midwifery	(6,325)	(7,374)	(1,049)	(77,065)	(80,759)	(3,694)
Allied health professionals	(1,401)	(1,438)	(38)	(16,467)	(16,954)	(487)
Other scientific, therapeutic and technical	(582)	(571)	11	(6,960)	(6,480)	479
Health care scientists	(1,080)	(1,114)	(34)	(13,060)	(13,279)	(219)
Support to clinical staff	(4,808)	(3,003)	1,805	(56,487)	(57,306)	(819)
Non medical, non clinical staff	(2,953)	(3,168)	(215)	(37,848)	(40,154)	(2,306)
Apprenticeship Levy	(74)	(93)	(19)	(1,000)	(1,107)	(107)
Total	(24,254)	(24,320)	(66)	(286,088)	(297,743)	(11,655)

Table 6: Pay analysis by pay type

Pay analysis (exc Covid)	Budget (Mth 12 £'000	Actual (Mth 12) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Substantive	(21,875)	(20,582)	1,293	(260,067)	(266,174)	(6,107)
Bank	(1,083)	(1,559)	(475)	(11,037)	(14,027)	(2,990)
Medical Bank	(498)	(617)	(119)	(5,689)	(6,293)	(604)
Agency	(723)	(1,470)	(747)	(8,295)	(10,141)	(1,847)
Apprenticeship Levy	(74)	(93)	(19)	(1,000)	(1,107)	(107)
Total	(24,254)	(24,320)	(66)	(286,088)	(297,743)	(11,655)

Table 7: COVID Pay costs

COVID-19 COSTS	Apr (M1) £'000	May (M2) £'000	Jun (M3) £'000	Jul (M4) £'000	Aug (M5) £'000	Sep (M6) £'000	Oct (M7) £'000	Nov (M8) £'000	Dec (M9) £'000	Jan (M10) £'000	Feb (M11) £'000	Mar (M12) £'000	Year to Date £'000
Medical Staff	(35)	(14)	(24)	(9)	(51)	(6)	(38)	(10)	(12)	(23)	(9)	(24)	(255)
Other Clinical Staff	(343)	(172)	(183)	(229)	(282)	(253)	(241)	(233)	(246)	(394)	(235)	(251)	(3,063)
Non Clinical Staff	(72)	(49)	(22)	(23)	(28)	(27)	(23)	(27)	(26)	(55)	(36)	(41)	(431)
Total Pay	(450)	(236)	(229)	(261)	(362)	(286)	(301)	(270)	(284)	(472)	(281)	(317)	(3,749)

3.2.2 Total pay costs at M12 excluding COVID were £297.743m, an overspend of £11.655m.

3.2.3 The main driver of this is the Medical & Acute Division, which has a £1.501m over-spend in month and £9.566m YTD. The pressure is being driven by the premium cost of using agency across all medical grades and increased demand for junior & middle grade doctors in ED to deal with increased demand.

3.2.4 At M12 M&A are carrying a high number of vacancies across the Division despite the previously reported appointments in long-standing vacancies. The Division continues

to employ additional consultants at premium cost to cover these vacancies and to assist with reset and recovery across specialities with the largest backlog, specifically Rheumatology and Gastroenterology.

3.2.5 There has also been a pressure of £0.643m against Nursing. This was driven by high spend in ED (£0.252m), the bonus element of the nurse incentive scheme (£0.131m) and high spend on bank and agency spend across the wards covering vacancies, escalation pressures and sickness. Demand for qualified NHSP shifts increased by 13% versus month 11 and the fil rate increased to 60% meaning total filled shifts were up 18%. This resulted in the highest number of filled shifts the Trust has seen all year.

3.2.6 Activity levels in ED rose by 21% from M11 and average 11.28% above 19/20 levels. The measures in place to address this remain in place, specifically 2 junior doctors per shift, which amount to 10 Whole Time Equivalents(WTE), and 1 additional nurse and Clinical Support Worker per shift (10 WTE). In addition, sickness has been high in the nursing workforce at around 10% average throughout the year compared to approximately 6% in 19/20.

3.2.7 The position also includes a provision for the potential rebanding costs in respect of our Clinical Support Workers (CSWs). Currently we have a strong push from Staff Side to reflect clinical care in our CSW AfC Bandings which would potentially see some roles / many roles moving from AfC 2 to an AfC 3 banding. There has been significant challenge in respect of the Outpatients CSW role and are now looking at the Trust wide implications – across all wards and departments – as per the new national profiles and match outcome. The financial risk of this move would be significant, not just for WUTH but for the entire NHS. We previously reported that under a worse case scenario this could result in costs of £3.993m. However, this was based on headcount, rather than WTE, and also included recently appointed staff who would not be eligible for backpay up to 2 years. Once these factors were applied the provision has now reduced to £2.191m.

3. Financial Performance

3.3 Expenditure: Non-Pay

3.3.1 The Trust has spent £140.276m on non-pay operating expenditure excluding COVID at M12, a variance of £6.415m YTD.

Table 8: Non-pay analysis (excluding COVID-19 costs)

Non Pay Analysis (exc Covid)	Budget (Mth 12 £'000	Actual (Mth 12) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Supplies and services - clinical	(2,674)	(3,882)	(1,208)	(35,005)	(36,469)	(1,463)
Supplies and services - general	(298)	(477)	(179)	(4,276)	(4,409)	(134)
Drugs	(2,256)	(2,517)	(261)	(25,386)	(27,777)	(2,391)
Purchase of HealthCare - Non NHS Bodies	(842)	(630)	213	(10,894)	(9,329)	1,565
CNST	(1,152)	(851)	301	(13,821)	(13,118)	703
Consultancy	(1)	(27)	(26)	(138)	(617)	(479)
Other	(3,244)	(6,251)	(3,007)	(32,960)	(37,718)	(4,758)
Sub-Total	(10,468)	(14,636)	(4,168)	(122,481)	(129,437)	(6,956)
Depreciation	(923)	(926)	(3)	(11,380)	(11,226)	154
Impairment	0	387	387		387	387
Total	(11,391)	(15,175)	(3,784)	(133,861)	(140,276)	(6,415)

3.3.2 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 offset by much lower than anticipated spend with the independent sector.

3.3.3 Increased expenditure on high cost drugs is an issue across all clinical divisions but particularly prevalent within M&A and Surgery. Our analysis, shared at the March meeting, demonstrated that the increase primarily relates to changes in prescribing practices, some of which are due to COVID. We have committed to undertake a detailed review of the financial controls in place in respect of drugs to be brought back to Committee in June.

3.3.4 The pressure on non-pay costs in respect of Estates and Hotel Services has continued in M12 with a £1.399m variance in month and £2.302m YTD. This is largely driven by non-capitalised costs in respect of Building & Engineering associated with minor repairs and the sharp rise in the cost of materials amounting to a £1.221m pressure YTD. The Trust has also seen higher inflation in respect of energy costs than we anticipated, with a total variance of £0.967m YTD.

3.3.5 Despite increases in respect of surgery, expenditure on healthcare from non-NHS bodies was again below plan in month and significantly below plan YTD. This cost, associated with the patient choice element of support, is budgeted to increase given longer wait times across a number of areas.

3. Financial Performance

3.4 Expenditure: COVID–19

3.4.1 The Trust spent £7.531m on COVID-19 costs at M12, with £3.749m on pay and £3.782m on non-pay.

Table 9: YTD COVID-19 revenue costs

COVID-19 I&E	Apr (M1) £'000	May (M2) £'000	Jun (M3) £'000	Jul (M4) £'000	Aug (M5) £'000	Sep (M6) £'000	Oct (M7) £'000	Nov (M8) £'000	Dec (M9) £'000	Jan (M10) £'000	Feb (M11) £'000	Mar (M12) £'000	Year to Date £'000
Total Income	2,313	2,129	1,118	1,796	1,641	2,118	1,486	2,177	1,745	1,768	1,655	1,901	21,847
Medical Staff	(35)	(14)	(24)	(9)	(51)	(6)	(38)	(10)	(12)	(23)	(9)	(24)	(255)
Other Clinical Staff	(343)	(172)	(183)	(229)	(282)	(253)	(241)	(233)	(246)	(394)	(235)	(251)	(3,063)
Non Clinical Staff	(72)	(49)	(22)	(23)	(28)	(27)	(23)	(27)	(26)	(55)	(36)	(41)	(431)
Total Pay	(450)	(236)	(229)	(261)	(362)	(286)	(301)	(270)	(284)	(472)	(281)	(317)	(3,749)
Clinical Supplies	(101)	(207)	(230)	(162)	(151)	(475)	47	(568)	(155)	(154)	(159)	(537)	(2,853)
Other Non-Pay	(106)	(129)	(39)	(24)	(15)	(54)	(22)	(5)	(300)	(47)	(106)	(82)	(929)
Total Non-Pay	(208)	(337)	(269)	(187)	(166)	(529)	25	(573)	(455)	(201)	(265)	(619)	(3,782)
Total Covid Expenditure	**1,655**	**1,557**	**620**	**1,349**	**1,113**	**1,303**	**1,209**	**1,334**	**1,006**	**1,095**	**1,109**	**965**	**14,316**

3.4.2 The vaccination costs were £1.469m at M12 which was in line with plan and is funded centrally so offset in income.

3.4.3 The testing costs were £2.687m at M12 and is funded centrally so offset in income.

3. Financial Performance

3.5 **CIP Performance**

3.5.1 The Trust's target for CIP was £1m for H1. The Trust achieved £1.202m of CIP in H1.

3.5.2 The target for H2 was set at 2.6% or £5.560m. The Trust has delivered £4.028m of recurrent CIP against this target, a shortfall of £1.532m.

Table 10: CIP performance breakdown by Division

	Target	H2 Actual YTD	Variance	FYE
M&A	1,398,140	784,000	614,140	1,362,000
Surg	1,065,751	425,392	640,359	640,235
DCS	1,015,509	1,023,248	-7,739	1,072,608
W&C	559,089	243,374	315,715	341,273
Corp	524,937	479,649	45,288	524,959
EHS	416,984	510,727	-93,743	510,727
Procurement	579,588	561,687	17,901	692,433
Total	**5,559,998**	**4,028,077**	**1,531,921**	**5,144,235**

3.5.3 This underperformance was offset by non-recurrent reductions in spend of £1.050m.

4. Financial Performance

4.1 Statement of Financial Position (SOFP)

4.1.1 The movement in total assets employed from M11 was £23.951m. PDC received in Month 12 and the annual revaluation of the estate has led to the increase in Total Taxpayers Equity. The equivalent increase can be seen in the increase in Tangible and Intangible assets.

4.1.2 Both current assets and liabilities have increased in Month 12. This is primarily driven by the Agreement of Balances process and the need to ensure that accrued income and expenditure are accurate.

Statement of Financial Position (SoFP)

Actual as at 31.03.21 £'000		Actual as at 28.02.22 £'000	Actual as at 31.03.22 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
163,560	Property, plant and equipment	166,175	187,631	21,456	↑
12,864	Intangibles	12,223	14,594	2,371	↑
869	Trade and other non-current receivables	967	968	1	↑
177,293		**179,365**	**203,193**	**23,828**	↑
	Current assets				
4,788	Inventories	3,940	4,924	984	↑
16,848	Trade and other receivables	14,680	21,286	6,606	↑
0	Assets held for sale	0	0	0	→
21,294	Cash and cash equivalents	32,717	36,435	3,718	↑
42,930		**51,337**	**62,645**	**11,308**	↑
220,223	**Total assets**	**230,702**	**265,838**	**35,136**	↑
	Current liabilities				
(44,124)	Trade and other payables	(50,082)	(56,577)	(6,495)	↑
(4,622)	Other liabilities	(6,886)	(10,702)	(3,816)	↑
(1,090)	Borrowings	(1,108)	(1,023)	85	↓
(7,256)	Provisions	(11,267)	(13,206)	(1,939)	↑
(57,092)		**(69,343)**	**(81,508)**	**(12,165)**	↑
(14,162)	**Net current assets/(liabilities)**	**(18,006)**	**(18,863)**	**(857)**	↑
163,131	**Total assets less current liabilities**	**161,359**	**184,330**	**22,971**	↑
	Non-current liabilities				
(2,479)	Other liabilities	(2,380)	(2,371)	9	↓
(5,193)	Borrowings	(4,685)	(4,177)	508	↓
(7,318)	Provisions	(6,451)	(6,348)	103	↓
(14,990)		**(13,516)**	**(12,896)**	**620**	↓
148,141	**Total assets employed**	**147,843**	**171,434**	**23,591**	↑
	Financed by Taxpayers' equity				
171,121	Public dividend capital	171,121	186,467	15,346	↑
(64,220)	Income and expenditure reserve	(64,518)	(64,185)	333	↑
41,240	Revaluation reserve	41,240	49,152	7,912	↑
148,141	**Total taxpayers' equity**	**147,843**	**171,434**	**23,591**	↑

4. Financial Performance

4.2 Capital Expenditure – M12

4.2.1 The Trust has recorded its highest ever capital spend of £29m. This includes spend of £15.3m on PDC funded assets including the modular theatre build. Notable non-PDC schemes completed in year include the ward refurbishment of £2m, the refurbishment of the staff changing rooms and restaurant at APH of £1.2m and the purchase and installation of two new CT scanners and three new X Ray machines totalling £1.6m.

Capital programme 2021/22 - Spend	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	TOTAL
Pre-commitments	297	375	396	437	409	97	454	105	146	628	1,387	505	**5,236**
Estates	0	0	0	112	94	34	226	59	32	305	222	2,195	**3,279**
Informatics	0	0	69	0	14	0	10	36	(9)	150	0	435	**705**
Equipment - Medicine and Acute	0	93	310	0	17	0	18	15	(13)	38	9	364	**851**
Equipment - Clinical Support and Diagnostics	0	0	0	118	8	62	20	207	670	1	361	720	**2,167**
Equipment - Surgery	0	0	101	102	10	58	153	15	182	12	86	5	**724**
Equipment - Women and Children's	0	0	99	0	0	0	0	0	7	47	22	77	**252**
Donated assets	0	7	0	8	95	(1)	0	0	0	84	0	300	**493**
UEC (PDC)	9	0	0	0	1	0	0	116	190	165	279	499	**1,259**
Other PDC funded schemes	0	0	0	0	0	0	0	14	0	1,143	1,533	11,375	**14,065**
TOTAL	**306**	**475**	**975**	**777**	**648**	**250**	**881**	**567**	**1,205**	**2,573**	**3,899**	**16,475**	**29,031**
NHSE/I PLAN	**562**	**678**	**511**	**889**	**983**	**2,295**	**953**	**875**	**3,363**	**2,115**	**2,398**	**13,409**	**29,031**
VARIANCE FROM PLAN	**(256)**	**(203)**	**464**	**(112)**	**(335)**	**(2,045)**	**(72)**	**(308)**	**(2,158)**	**458**	**1,501**	**3,066**	**0**

4.2.2 Spend in March 2022 totalled £16.475m which was more than half of the entire capital plan. Excluding the PDC funded schemes, spend totalled £5.1m which represents 40% of the original capital plan. Arguably the Trust has seen the largest level of investment in its infrastructure this year than it has for the last 7 years and whilst high spend in the last quarter of the financial year is inevitable, there are some lessons to be learned from the process. The Capital and Estates Team together with the Finance and Procurement Team will be holding a de-brieifng session in the coming weeks to identify improvements that can be made to processes and procedures.

4.2.3 The completed spend for the year is as follows:

4. Financial Performance

Capital Programme - 31 March 2022

	Full Year Budget			Full Year Outturn		Comments
	NHSI plan	Mvmnts	Trust Budget[1]	Actual Spend	Variance from budget	
	£'000	£'000	£'000	£'000	£'000	
Funding						
Total Internally Generated Funding	12,738	476	13,214	13,214	0	
PDC (Public Dividend Capital) - Various	1,300	14,024	15,324	15,324	0	
External Funding - donations/grants	450	43	493	493	0	
Total funding	**14,488**	**14,543**	**29,031**	**29,031**	**0**	
Expenditure						
Pre-commitments 21/22	5,007	348	5,355	5,236	119	There were some minor underspends on a small number of schemes which contributed to the underspend.
Estates	2,671	116	2,787	3,279	(492)	Theatre ventilation works were significantly more than anticipated.
Informatics	784	(135)	649	705	(56)	
Medicine and Acute	715	112	827	797	30	Kitchen refurbishment costs were less than anticipated.
Clinical Support and Diagnostics	1,914	345	2,259	2,167	92	Costs of installation of the X Ray equipment was less than anticipated.
Surgery	688	88	776	778	(2)	
Women and Children's	236	2	238	252	(14)	The planned office conversion cost more than anticipated.
Other	90	0	90	0	90	
Contingency[2]	633	(400)	233	0	233	
Donated assets	450	43	493	493	0	
PDC	1,300	14,024	15,324	15,324	0	
Total expenditure (accruals basis)	**14,488**	**14,543**	**29,031**	**29,031**	**0**	
Capital programme funding less expenditure	**0**	**0**	**0**	**0**	**0**	
Capital expenditure	14,038	14,500	28,538	28,538		
NBV asset disposals	0	0	0	0		
Donated assets	450	43	493	493		
CDEL impact	**14,488**	**14,543**	**29,031**	**29,031**		

[1] This is the NHSI plan, adjusted for approved business cases including additional donated, leased and PDC funded spend.

[2] Funding is transferred as business cases are approved.

4. Financial Performance

4.3 Statement of Cash Flows – M12

Statement of Cash Flows (SoCF) - March 2022

	Month Actual £'000	Year to date Actual £'000
Opening cash	**32,717**	**21,294**
Operating activities		
Surplus / (deficit)	333	35
Net interest accrued	(13)	165
PDC dividend expense	359	4,471
Unwinding of discount	(3)	(33)
(Gain) / loss on disposal	22	110
Operating surplus / (deficit)	698	4,748
Depreciation and amortisation	926	11,226
Impairments / (impairment reversals)	(387)	(387)
Donated asset income (cash and non-cash)	0	(193)
Changes in working capital	(2,536)	8,744
Investing activities		
Interest received	10	16
Purchase of non-current (capital) assets [1]	(7,713)	(19,605)
Sales of non-current (capital) assets	0	58
Receipt of cash donations to purchase capital assets	0	180
Financing activities		
Public dividend capital received	15,346	15,346
Net loan funding	(508)	(883)
Interest paid	(95)	(200)
PDC dividend paid	(2,016)	(3,846)
Finance lease rental payments	(6)	(62)
Total net cash inflow / (outflow)	**3,718**	**15,141**
Closing cash	**36,435**	**36,435**

[1] Outflows due to the purchase of non-current assets are not the same as capital expenditure due to movements in capital creditors.

4.3.1 Cash balances have increased by £3.7m and there is a corresponding increase in current liabilities.

4. Financial Performance

4.4 Treasury

4.4.1 Borrowings summary M12

Borrowings summary

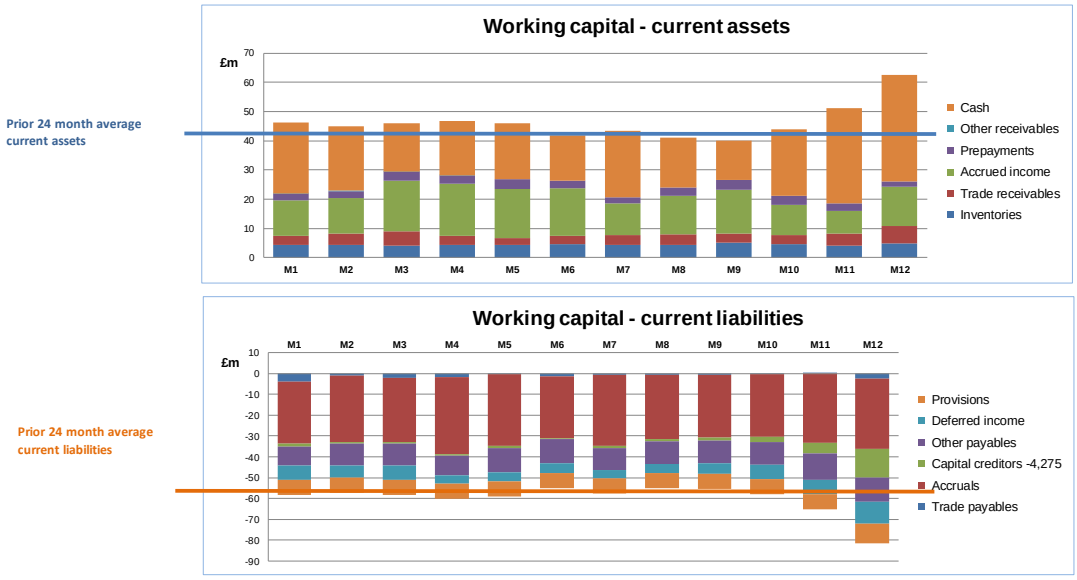
	Initial Loan Value	Loan Term	Interest rate (fixed)	Loan Balances Mar 21	Loan Repayment Sept 20	Loan Balances Dec 21	Loan Repayment Mar 22	Forecast Closing Balances Mar22
	£'000	Years	%	£'000	£'000	£'000	£'000	£'000
1. ITFF capital loan	7,500	10	1.96	2,625	(375)	2,250	(375)	1,875
2. ITFF capital loan	6,500	25	4.32	3,583	(133)	3,450	(133)	3,318
	14,000			6,208	(508)	5,700	(508)	5,193

This table does not include finance lease balances, which are included in Borrowings balances in the SoFP.
All listed borrowings are with the Department of Health and Social Care (DHSC).

4.4.2 The Trust's borrowings, comprising capital loans, will be repaid at a level of £1m per year.

4.5 Working capital profiles by month

4.5.1 2021/22 working capital profiles below show M12 working capital balances in the context of the previous 12 months, compared with an average of the previous 2 financial years. The credit risk associated with aged debt is monitored quarterly by the Audit Committee.



4. Financial Performance

4.6 Single oversight framework: Use of Resources (UoR) rating (financial) summary table

Use of Resources (UoR) Rating

Summary table

	Metric	Descriptor	Weight %	Year to Date Actual	
				Metric	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-20.0	4
Financial sustainability	**Capital service capacity (times)**	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	3.0	1
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	0.0%	2
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.3%	1
Financial controls	**Agency spend (%)**	Distance of agency spend from agency cap	20%	21.9%	2
	Overall NHSI UoR rating				**2**

4.6.1 The liquidity rating of 4 remains the same as M11 although liquidity days have reduced by 1. This is largely driven by the accrual levels which have increased at year end as expected. An exercise to review the level of accruals on the balance sheet, both income and expenditure will commence next month. Agency spend is £3.4m above the cap in M12 and is largely driven by the levels of staff sickness the Trust has experienced in the last three months. The overall UoR rating of 2 has been maintained throughout the financial year.

Board of Directors in Public **Item No 9.3**
4 May 2022

Title	Infection Prevention and Control Assurance Framework
Area Lead	Tracy Fennell Chief Nurse, Executive Director of Midwifery and AHPs and Director of Infection Prevention and Control
Author	Jay Turner Gardner, Assistant Director of Infection Prevention and Control/ Deputy DIPC Tracy Fennell Chief Nurse, Executive Director of Midwifery and AHPs and Director of Infection Prevention and Control
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide assurance against the NHSE/I IPC Assurance Framework V 1.8

The IPCG, PSQB and QAC have previously received the previous versions of the 'Infection Prevention and Control Board Assurance Framework' (IPC BAF NHS England, 2020). The framework is structured around the existing 10 quality standards set out in the 'Infection Prevention Control Code of Practice (2008)' which links directly to Regulation 12 of the 'Health and Social Care Act (2008)'. The IPC BAF is largely specific to COVID-19 but also includes IPC practices in general regarding other infections. This report contains the latest version 1.8 (Appendix 1)

It is recommended that the Board:

- Notes the contents of this report and acknowledges the controls in place to minimise the levels of risk associated with COVID-19 and acknowledges the hard work during challenging times to sustain safe standards of care.

Key Risks

This report relates to these key Risks:

- Risk 609 - Patients may acquire COVID-19 during inpatient stay. RATE 15
- Risk 799 - Outbreaks of COVID-19. RATE 15

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.	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
24/02/22	IPCG cancelled due to staff & capacity challenges		

1	Narrative
1.1	UK Health Security Agency (UKSA) formerly Public Health England (PHE) and NHSE/I have provided recommendations for COVID-19 management and screening throughout the pandemic. External to the Trust IPC and isolation restrictions have now been relaxed. In contrast COVID management healthcare policies have evolved over the last 18 months and remained in place until 14 April when the following documents were published • National Infection Prevention and Control Manual April 2022 • Regional IPC principles April 2022 • Northwest principles to support the delivery of "Living with COVID" using current IPC guidance and Hierarchy of controls April 22 The revised guidance has allowed Trusts to now undertake local risk assessment and relax IPC guidance to support operational pressures. In recent months variance in approaches has caused increased challenges in hospital settings due to the number of patients being admitted to hospital. These patients are predominantly being admitted due to other reasons and are screened as positive (whilst remaining "COVID well" and asymptomatic). The restrictions in recent IPC healthcare policy have been creating operational blockages in patient flow through the hospital. These challenges were creating greater risks to other patients resulted in a risk of patients being unable to receive timely specialist or acute care. When reviewing the IPC Board Assurance framework 1.8 four of the standards were downgraded and reported to Patient Safety Quality Board (March 22) as limited assurance rather than significant assurance. Requirement 5 has now been returned to significant assurance due to changes in regional guidance from 14 April 2022. The reduction in the remaining 3 areas reflects the current challenges the Trust is facing managing IPC best practice guidance against other operational risks.

2	Implications
2.1	As a result of operational pressures seen across the healthcare system providing assurance around best practice IPC guidelines has become more challenged. This has resulted in 3 areas of the IPC BAF that previously reported as significant assurance now being reported as limited assurance.

IPC BAF Standard	V1.0	V1.2	V1.4	V1.6	V 1.8 Current

	1 Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and risks posed by their environment and other service users.	Significant	Limited	Significant	Significant	Limited
	2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Limited	Limited	Limited	Significant	Significant
	3 The use of antimicrobials to optimise patient outcomes and manage adverse effect.	Significant	Significant	Significant	Significant	Significant
	4 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.	Limited	Significant	Significant	Significant	Significant
	5 Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Significant	Significant	Limited	Significant	Significant
	6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Limited	Significant	Significant	Significant	Significant
	7 Provide or secure adequate isolation facilities.	Limited	Significant	Limited	Significant	Limited
	8 Secure adequate access to laboratory support as appropriate.	Significant	Significant	Limited	Significant	Significant
	9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infection.	Limited	Significant	Significant	Significant	Limited

10 Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Significant	Limited	Significant	Significant	Significant
11 The Trust can demonstrate effective and knowledgeable leadership in relation to IPC at all levels, relevant to roles.	Limited	Limited	Significant	Significant	Significant

Rationale behind the current limited assurance

Standard 1. ***Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and risks posed by their environment and other service users.***
Systems are in place to monitor IPC and prevent risks of contracting a hospital acquired infection. However due to operational pressures across the health care system, there are risks of delaying isolation of infected patients due to no availability of side rooms. There also remains the risk of patients contracting COVID-19 due to an overcrowded Emergency Department and assessment areas.

Standard 5. ***Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.***

Following support from NHSE/I /PHE and in anticipation of updated IPC guidance 1 April 2022 it was agreed swabbing would be reduced to on admission and day 6 and for symptomatic patients. Day 3 and weekly swabbing would stop, this decreased assurance in relation to standard 5 to limited assurance. Following the release of revised guidance *Northwest principles to support the delivery of "Living with COVID" using current IPC guidance and Hierarchy of controls April 22.* This standard has now returned to substantive assurance as the Trust is supporting the latest seek and isolate guidance outlined in the publication above.

Standard 7. ***Provide or secure adequate isolation facilities.***
At times of increase pressure, it is not always possible to transfer COVID patients within 2 hours to a red ward due to lack of capacity of red beds. During these times the hierarchy of controls are closely monitored these are reported to Clinical Advisory Group (CAG) weekly.

Standard 9. ***Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infection.***
Whilst the IPC policies are in place, there is the requirement to undertake dynamic risk assessments daily to manage risks across the organisation. Operational pressures and limited capacity across the hospital means it is not always possible to adhere to best practice guidance, these decisions are tracked by the IPC team and reported along with impact to CAG weekly. The Trust risk register has been reviewed and the rating increased to reflect this.

3	Conclusion
3.1	Due to the significant risks identified, Interim IPC guidance has been agreed following a full risk assessment of several factors identified. To ensure operational effectiveness and safe care of patients in the Emergency Department and Acute Assessment Areas changes in local agreements were supported at CAG on the 16 /17 March 2022. These have been applied with monitoring and controls in place to ensure safety is not compromised. Further guidance has since been released by NHSE/I on the 14 April 2022. The Trusts now remains in line with current national protocols. However, did intermittently have to take decisions based on risk assessment to keep patients safe that impacted on the Trusts ability to assure the Board of Directors with the IPC BAF standards.

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Board of Directors in Public **Item 9.4**
4 May 2022

Title	Monthly Maternity Services Update Report providing an update on compliance with the Clinical Surveillance Quality Assurance Report
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and Director of Infection Prevention and Control (DIPC). Executive Director of Midwifery and Allied Health Professionals
Author	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and Director of Infection Prevention and Control (DIPC).
Report for	Information

Report Purpose and Recommendations

The last full quarterly update to Trust Board of Directors was presented in April 2022 featuring areas of assurance including but not exclusive to:

- Ockenden recommendations (Part 1)
- the outcome of the Maternity Incentive Scheme - MIS (Year 3)
- Maternity Equality and Equity plan
- Perinatal Clinical Surveillance Quality report
- Continuity of Carer
- Outcome of regional bids
- regional clinical outcome /outlier report

The Perinatal Clinical Surveillance Quality Assurance Report provides an overview of performance within Neonatal/Maternity Services. It is recommended this is presented monthly to the Board of Directors to ensure ongoing oversight of the quality of care in Maternity and Neonatal Services is maintained.

The Board is asked to:

- Note the contents of the Perinatal Clinical Surveillance Quality Assurance Report.

Key Risks

There are no risks to escalate presently regarding the Perinatal Clinical Surveillance Quality Assurance 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	Yes

Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it	No

Governance journey
This report is provided monthly.

1	Purpose
1.1	This paper provides a quarterly update to the Board of Directors with further oversight of the quality and safety of Maternity Services at Wirral University Teaching Hospital (WUTH). It is recommended the Perinatal Clinical Surveillance Quality Assurance Report is presented monthly to the Board of Directors to ensure ongoing oversight of the quality of care in Maternity and Neonatal Services.

2	The Perinatal Clinical Surveillance Quality (PCSQ) Assurance Report:
2.1	A Clinical Surveillance Quality Tool has recently been developed by the LMNS in the form of a dashboard on a page, however this tool does not provide the same level of assurance as the WUTH developed tool does. Therefore, reporting using the WUTH Perinatal Clinical Surveillance Quality Assurance report will continue pending the publication nationally of a PCSQ tool. An updated PCSQ report is included in Appendix 1 with no areas of concern for escalation. This report provides Board of Directors with an oversight of key themes relating to the quality and safety of the Maternity Service.

3	Conclusion
3.1	The Perinatal Clinical Surveillance Quality Assurance Report provides an overview of performance within Neonatal/Maternity Services, there are no areas for escalation or concern to highlight.

Report Author	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and Director of Infection Prevention and Control (DIPC).
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Perinatal Clinical Quality Surveillance Quality Assurance Report

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	
	Outlier for rates of neonatal deaths as a proportion of birth	yes	
	Rates of HIE where improvements in care may have made a difference to the outcome	no	
	Number of SI's	no	
	Progress on SBL care bundle V2	no	
	Outlier for rates of term admissions to the NNU	no	
Service user and staff feedback	MVP or Service User concerns/complaints not resolved at trust level	no	
	Trainee survey	no	
	Staff survey	no	
	CQC National survey		
	Feedback via Deanery, GMC, NMC	no	
	Poor staffing levels	no	
	Delivery Suite Coordinator not supernummary	no	
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	
	Concerns around the relationships between the Triumvirate and across perinatal services	no	
	False declaration of CNST MIS	no	
	Concerns raised about other services in the Trust e.g. A&E	no	
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	
Safety and learning culture	Lack of engagement in HSIB or ENS investigation	no	
	Lack of transparancy	no	
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	
	Learning from Trust level MBRRACE reports not actioned	no	
	Recommendations from national reports not implemented	no	
Incident reporting	Low patient safety or serious incdient reporting rates		
	Delays in reporting a SI where criteria have been met	no	
	Never Events which are not reported	no	
	Recurring Never Events indicating that learning is not taking place	no	
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	
Governance processes	Unclear governance processes - SAT		
	Business continuity plans not in place	no	
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	
	An overall CQC rationg of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	
	An overall CQC rating of Inadequate	no	
	Been issued with a CQC warning notice	no	
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	
	Been identified to the CQC with concerns by HSIB	no	

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	WUTH have the lowest rate of stillbirth in the North West Coast where TOPFA is excluded
	Outlier for rates of neonatal deaths as a proportion of birth	yes	C:\Users\alawrenc\Documents\PSQB Report NNU.docx brrace 2018 data however paper produced for board with mitigation as L3 unit. These babies were generally eaths - all deaths are reviewed using the Perinatal Mortality Review ToI and any deaths graded as a 2 are StEIS a the Trusts governance process.
	Rates of HIE where improvements in care may have made a difference to the outcome	no	Very low rates of cooling undertaken for inborns.
	Number of SI's	no	3 maternity SI's for 2020, one of which was stepped down as a no harm incident. Potentially 1 SI for neonates - awaiting update from external source.
	Progress on SBL care bundle V2	no	C:\Users\alawrenc\Documents\SBLV2 December the only provider in the North West to have implemented all elements of the care bundle.
	Outlier for rates of term admissions to the NNU	no	C:\Users\alawrenc\Documents\Term admission data FEB lowest rates in the region currently for term admissions to NNU.
Service user and staff feedback	MVP or Service User concerns/complaints not resolved at trust level	no	Great relationship with MVP Chair, new debrief clinic set up to enhance the service already provided by the Consultant Midwife debrief clinics which aim is to resolve any low level concerns quickly
	Trainee survey	no	Deanery TEF forms & the GMC survey were cancelled due to COVID
	Staff survey	no	Previous survey no concerns
	CQC National survey		
	Feedback via Deanery, GMC, NMC	no	No concerns, good feedback from trainees, continuation of services during pandemic.
	Poor staffing levels	no	Escalation process in place when staffing less than optimum, incentive to support pickup to maintain safe staffing levels.
	Delivery Suite Coordinator not supernummary	no	Coordinators are supernummary at all times to provide the helicopter view for Delivery Suite.
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Stable senior leadership team
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Strong, stable leadership from the Triumvirate who work collaboratively with operational teams to deliver safe services.
	False declaration of CNST MIS	no	Evidence available on request for all 10 maternity safety actions that make up CNST.
	Concerns raised about other services in the Trust e.g. A&E	no	Great progress made since the last Trust CQC inspection in all areas
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Well established pop-up MLU
Safety and learning culture	Lack of engagement in HSIB or ENS investigation	no	C:\Users\alawrenc\Documents\HSIB Case Updates
	Lack of transparancy	no	Teams can evidence a safety culture whereby incident reporting is encouraged and evidenced in weekly
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	No recurrent themes - actions from SI's are tracked and monitored via the CG team. Spot check audts are also undertaken and any harms will be added to the maternity harms prevention tool on Perfect Ward.
	Learning from Trust level MBRRACE reports not actioned	no	All MBRRACE reports undergo a GAP analysis and the action plans from any gaps are monitored via CG meetings.
	Recommendations from national reports not implemented	no	All National Reports undergo a GAP analysis and the action plans from any gaps are monitored via CG meetings.
cident reporting	Low patient safety or serious incdient reporting rates	no	Monitored via monthly Quality Assurance report - steady rates with increases predicted during peak activity months as expected during times of increased acuity, demonstrating a good risk aware unit.
	Delays in reporting a SI where criteria have been met	no	Robust SI process in place.
	Never Events which are not reported	no	Good open culture in terms of reporting of NE.
	Recurring Never Events indicating that learning is not taking place	no	Good open culture in terms of reporting of NE.

In	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent working relationships with the national teams.
Governance processes	Unclear governance processes - SAT	no	
	Business continuity plans not in place	no	Robust plans in place which can be evidenced by the successful continuation of our services throughout the Covid 19 pandemic.
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Robust plans in place which can be evidenced by the successful continuation of our services throughout the Covid 19 pandemic.
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Due CQC inspection early this year in respect of maternity services previous insepction rated as Good in 2018 - no concerns for next inspection.
	An overall CQC rationg of Requires Improvement with an Inadequate rating for either Saf	no	CQC inspection in main which was undertaken end of 2019 has overall rating of RI however previous Maternity Services inspection rated as 'Good' in 2018.
	An overall CQC rating of Inadequate	no	As above.
	Been issued with a CQC warning notice	no	
	CQC rating dropped from a previously Outstanding or Good rating to Requires improveme	no	
	Been identified to the CQC with concerns by HSIB	no	On track with HSIB quarterly review meetings. All HSIB reports have an action plan to address the safety recommentdations and these are tracked via the CG team and presented at Governance Board and via DMB QA report.

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	No funnel plot chart however no escalation from SCN / LMNS on outlier report
	Outlier for rates of neonatal deaths as a proportion of birth	no	No funnel plot chart however no escalation from SCN / LMNS on outlier report
	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	2021 Report submitted to BoD - WUTH were not an outlier for SI's in 2021.
	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	The rate of avoidable term admissions remains low. Atain action plan in place
Service user and staff feedback	MVP or Service User concerns/complaints not resolved at trust level	no	Current delays in responding to complaints but not an outlier regarding the number of complaints which are below most other providers each month
	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	Survey pubkished Feb 2022 and submitted to BoD for oversight
	Feedback via Deanery, GMC, NMC	no	Nil to report
	Poor staffing levels	no	Vacancy rate below 1% a- will increase due to staff promotion/retiring
	Delivery Suite Coordinator not supernummary	no	Supernummary status is maintained for all shifts.
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	HoM recruited into post and AND for Childrens Services commenced in post in Jan 2022.
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams.
	False declaration of CNST MIS	no	Externally audited by MIAA. Year 4 prepartion ongoing
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil of note, bi-monthly listening events in place.
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.
	Lack of transparancy	no	Being open conversations are regularly had and 100% DOC evident.
	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.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations.
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations.
Incident reporting	Low patient safety or serious incdient reporting rates	no	Consistent rates of reporting across the speciality groups. A
	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.
	Never Events which are not reported	no	No, no maternity or neonatal never events.
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales.
Governance processes	Unclear governance processes - SAT		Clear governance processes in place that follow the SI framework - Maternity specific Risk Management Strategy in draft for comments prior to ratification.
	Business continuity plans not in place	no	Business continuity plans in place.
	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.
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	LAst CQC core service review was undertaken in May 2021 which did not highlight any concerns.
	An overall CQC rationg of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	N/a
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	No escalation from SCN / LMNS on outlier report
	Outlier for rates of neonatal deaths as a proportion of birth	no	No escalation from SCN / LMNS on outlier report
	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	2021 Report submitted to BoD - WUTH were not an outlier for SI's in 2021. Currently one SI in progress
	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	The rate of avoidable term admissions remains low. Regular multi-disciplinary reviews of care take place
Service user and staff	MVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints which are below most other providers each month. Improvement this month with the number of complaint responses outstanding and with the division significant reduced.
	Trainee survey	no	Consistently high scoring year on year. No update this month
	Staff survey	no	Recent survey received and work on going as a division, however not maternity specific. Action plan in place to address areas for improvement.
	CQC National survey	no	Survey published Feb 2022 and submitted to BoD for oversight
	Feedback via Deanery, GMC, NMC	no	Nil to report
	Poor staffing levels	no	Current vacancy rate of 3% for midiwfes. Recruitment drive in progress.
	Delivery Suite Coordinator not supernummary	no	Supernummary status is maintained for all shifts.
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	New Quality and Safety Lead recruited into post, commenced March 2022. Director of Midwifery post is currently out to advert due to retirement of existing postholder
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams.
	False declaration of CNST MIS	no	Externally audited by MIAA. Year 4 preparation ongoing.
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil of note, bi-monthly listening events in place.
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. Quarterly regional meeting arranged
	Lack of transparancy	no	Being open conversations are regularly had and 100% compliance with duty of candour evident.
	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. Engagement with staff to assess and improve how learning is shared.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations.
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations.
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture.
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework.
	Never Events which are not reported	no	No maternity or neonatal never events. All Locssipps currently in review.
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales.
Governance processes	Unclear governance processes - SAT		Clear governance processes in place that follow the SI framework - Maternity specific Risk Management Strategy in draft for comments prior to ratification. Within division there is maternity and neonatal review of governance processes: 3 separate meetngs
	Business continuity plans not in place	no	Business continuity plans in place.
	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. Continued involvement of MVP throughout the pandemic.
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Last CQC core service review was undertaken in May 2021 which did not highlight any concerns. Insight meeting planned for 06/08/2022.
	An overall CQC rationg of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a th	no	N/a
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or W	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

People Strategy

2022 - 2026

Wirral University Teaching Hospital
NHS Foundation Trust

together we will

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Foreword

I am so pleased to welcome you to our People Strategy, one of seven enabling strategies that underpins the overall Trust Strategy. This is an ambitious and exciting strategy that sets out a four-year vision of how we will support our people (our staff members, temporary workers, volunteers and students) to be the best they can be and to provide the best possible care to our patients and communities.

Over the past two years, all of our people have worked incredibly hard to support the delivery of care to our patients during the COVID-19 pandemic. We know how challenging that has been and that is why every element of this strategy is focused on providing the best experience and support for our people, both now and for the future.

Ensuring that everyone's voice is represented is a key component of this strategy. It has been developed by talking to our people about what is important to them. I would like to thank everyone who has contributed to the development of this document.

As we move forward with the delivery of the strategy over the next four years, we will continue to talk with and listen to our people about how we best achieve our aims. We will also work hard to ensure that each element is delivered in line with our Trust values of Respect, Teamwork, Improvement and Caring, and that inclusion and wellbeing are at the heart of everything we do.

I am looking forward to working with you all to deliver this exciting and dynamic People Strategy.

Deborah Smith
Chief People Officer

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Wirral University Teaching Hospital NHS Foundation Trust

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Introduction

Our journey to be a great place to work

Wirral University Teaching Hospital NHS Foundation Trust

Our People Strategy forms one of seven enabling strategies, through which *Our 2021-2026 Strategy* will be delivered.

Our People Strategy consists of four principles, aligned to Our 2021-2026 Strategy Compassionate Workforce strategic objective, and the NHS People Plan: Looking after ourselves and each other, Belonging at WUTH, Transforming ways of working, and Shaping our future.

Our People Strategy has been developed through a series of engagement workshops with our people. This approach has enabled us to gain a clear understanding of our current situation and our priorities over the next few years.

This document assesses where we are now, outlines where we want to be through the development of priorities for each principle, and details how we are going to get there within the next steps section.

This strategy promises that we will lead with compassion and inclusivity, and put the health and wellbeing of our people at the heart of everything we do.

We will ensure that our people feel a sense of belonging, and that we will have the plans in place to attract and retain the best people. We will embrace new ways of working to deliver the best care for our patients.

Underpinned by existing national and regional priorities, this strategy was developed by listening to staff across the organisation and hearing what would make WUTH a great place to work and receive care.

Background

Developing Our 2021 – 2026 Strategy

Our previous strategic focus was upon our top three priorities: patient flow, outpatients and peri-operative medicine. Our Clinical Divisions aligned their operational plans to support improvements in each of these three areas. However, clear strategic objectives for all to work towards, aimed to ultimately deliver our vision were not defined. Therefore, our Trust Board decided further work was needed to create a new, clear and meaningful strategic direction.

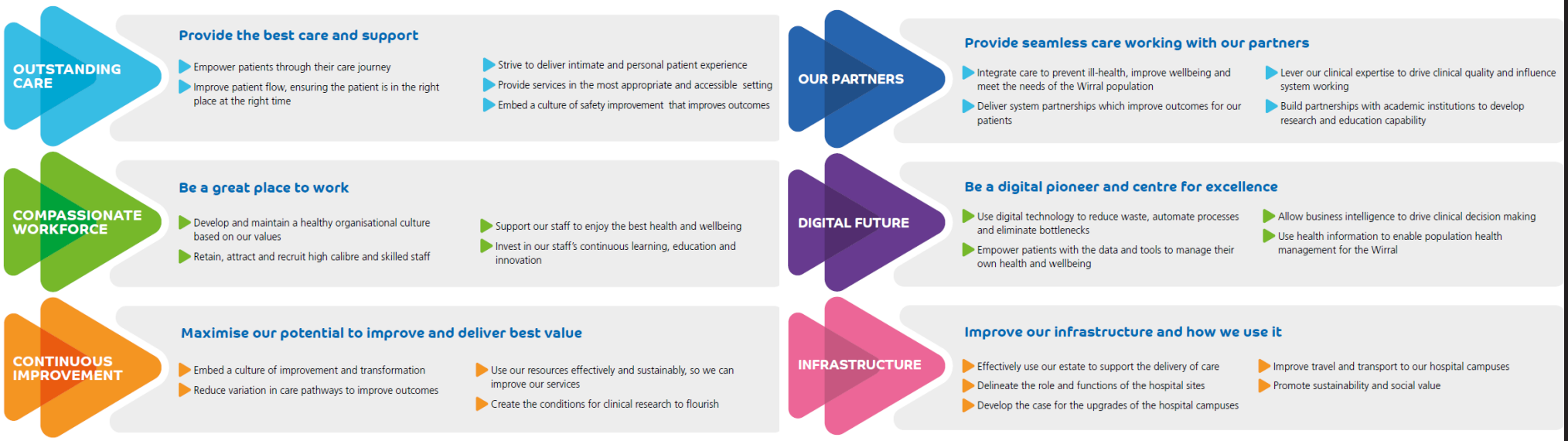
Our journey to develop our new strategic direction began early 2020, through a robust process of research and engagement as described.

Our 2021-2026 Strategy launched October 2020 outlining our intensions and setting out our specific strategic objectives to focus progress over the next five years.

Our 2021-2026 Objectives and Priorities

Wirral University Teaching Hospital NHS Foundation Trust

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



Strategic Framework

Our Enabling Strategies

Our 2021-2026 Strategy will be delivered through seven enabling strategies as shown. Our People strategy is one of the seven enabling strategies, it was originally titled 'Workforce and Education Strategy' and is referred to as this in previously developed enabling strategies. This strategy will set out our road map of people priorities for the next four years aligned to our People Strategy will be aligned to our Compassionate Workforce strategic objective and underpinning priorities to ensure we are all working towards the same goal in delivering *Our 2021-2026 Strategy*.

Collectively we, 'Our People' will determine whether we are successful in delivering this strategy. Our Workforce and Education Strategy will ensure we have the right number of staff with the required skills to be successful, through effective recruitment, retention, education, recognition and reward.

The People Strategy will be integrated with the other enabling strategies as an enabler to wider transformation, including our Research and Innovation Strategy, Finance Strategy and Estates Strategy. Compassionate Workforce objective priorities developed by our clinical teams will also be drawn out of our Clinical Service Strategy 2021-2026 to inform our People Strategy.

Developing our People Strategy

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

together we will

Our People Journey

Where we are now and where we want to be

In July 2020 the NHS published the NHS People Plan, alongside a People Promise for the NHS. People Plans for the North West and Cheshire & Merseyside were also produced. In addition, WUTH regularly carries out engagement activities such as the staff survey and the voice of our staff can be heard through staff networks and various other staff forums.

The core components of the national and regional documents, plus existing WUTH materials, were used to shape a series of draft visions and strategic priorities. These were then used in a series of workshops with members of WUTH staff to develop and refine them in to the principles, visions and priorities in this strategy.

The four principles of our People Strategy, which are introduced within this section of the document, encompass all required elements to enable us to progress from where we are now to where we want to be over the lifespan of this strategy, through alignment to our Compassionate Workforce objective and our Clinical Service Strategy 2021-2026 priorities.

Engagement with Our People

Wirral University Teaching Hospital NHS Foundation Trust

Our People Strategy is broken down into four principles aligned to the NHS People Plan: Looking after ourselves and each other, Belonging at WUTH, Transforming ways of working, and Shaping our future.

Over 100 people attended the workshops, with a wide variety of services and departments represented.

Our People Strategy will shape operational and strategic plans over the next four years and help our people to be the best they can be and to provide the best possible care to our patients and communities.

During the workshops a SWOT analysis was completed to assess our current position in terms of our people. Our strategic foundations model of getting the basics right, better and best was then used to help map out our priorities over the next four years.

Our executive and non-executive teams were taken through the engagement process, the background to the strategy and the principles and priorities within the strategy. There was then an opportunity for them to provide feedback.

January 2022 → **April 2022**

10

The Four Principles of Our People Strategy

Developing our People Strategy 2022- 2026

Wirral University Teaching Hospital NHS Foundation Trust

We have shaped our People Strategy around four key principles, each with a vision, strategic priorities and the actions required to realise change.

We will develop a wellbeing culture where supporting and enabling the holistic wellbeing of our people becomes the norm

We will develop an inclusive culture where everyone's voice is represented

We will embrace new ways of working and create opportunities to enable our people to achieve their potential

We will improve outcomes across Wirral for health, employment and wellbeing by working with our partners to be the best place to work

How This Strategy Will be Used

How we get to where we want to be: Setting visions and priorities

Wirral University Teaching Hospital NHS Foundation Trust

The visions and strategic priorities in this strategy set out a framework for us to achieve our 'Compassionate Workforce' strategic objective over the lifespan of this strategy.

In addition to the strategic priorities, a set of key actions have been drafted in order to ensure we achieve the outcomes we have set out for each component. These are set out in the appendix to this strategy.

An annual action planning process will take place based on these key actions.

Achieving Outcomes

Strategies, and the programmes of work mobilised to achieve them, are complex. There are many interacting elements, with some pieces of work already ongoing and others that will need to be started.

We don't know for certain that every project or initiative we commence will work, but all actions included in this strategy will be started with the belief that if we act, benefits will follow.

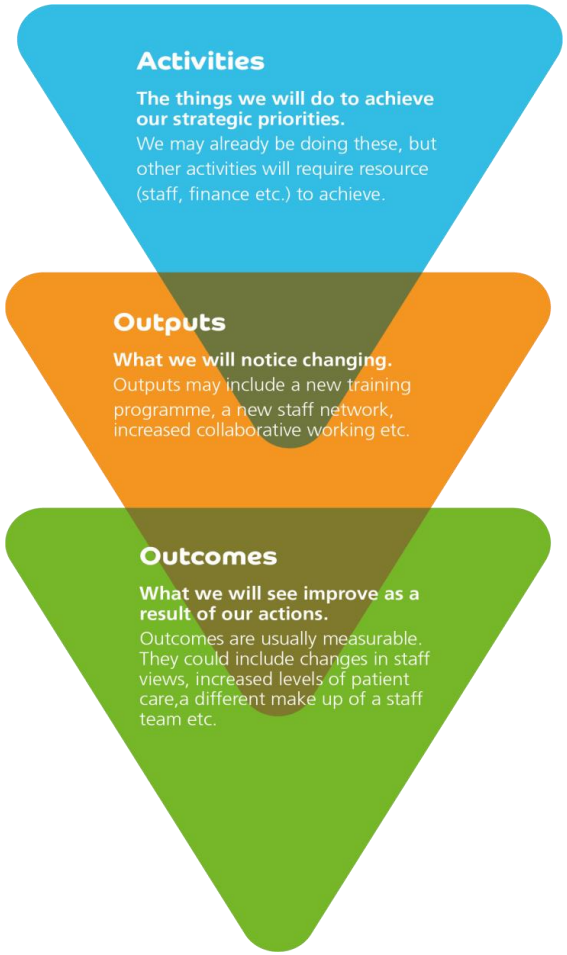
We have therefore developed a logical process which will:

- Help us be clear WHY we're doing something
- Help us think what the EVIDENCE is for acting
- Help us EVALUATE whether change has been beneficial

Each year of this strategy will see an annual planning session which will set out the activities for that year required to achieve the priorities set out.

From those activities we will see outputs and outcomes. We will measure these outcomes to assess whether we are achieving results.

On a yearly basis we will set specific outcome targets and measure success against these.



People Strategy
Key Priorities

NHS
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together we will

Looking after ourselves and each other

Wirral University Teaching Hospital NHS Foundation Trust

We strive to achieve outstanding levels of care for our patients, but the health and wellbeing of our people is just as important. We need to look after ourselves and each other in order to continue to deliver high quality and safe care.

We know that COVID-19 has had a physical and mental impact on our people. Many staff and volunteers have told us that they feel tired and in need of restoration and respite, and we recognise that having a wellbeing culture and proactive services to support our people is paramount.

Vision: ***We will develop a wellbeing culture where supporting and enabling the holistic wellbeing of our people becomes the norm***

To do this we will:

- Deliver first class, innovative Occupational Health and Wellbeing Services
- Equip our line managers and leaders with the knowledge, skills and tools to develop a wellbeing culture within their teams.
- Fully embrace flexible working across all roles.
- Create the conditions for civility and respect amongst our people.

Some key outcomes

- Increased staff satisfaction rates relating to positive action on health and wellbeing.
- Reduced levels of bullying and harassment
- Reduced sickness absence rates

Belonging at WUTH

Wirral University Teaching Hospital
NHS Foundation Trust

It has never been more urgent for us to take action to create an organisational culture where everyone feels like they belong.

This principle of our People Strategy is about making a commitment to ensuring that we are a understanding, kind and inclusive organisation where there is diversity amongst our people and they feel a strong sense of belonging.

Vision: ***We will develop an inclusive culture where everyone's voice is represented***

To do this we will:

- Proactively increase and celebrate diversity at all levels of the organisation.
- Enable a strong voice for our people throughout the Trust and recognise their contributions.
- Create the environment for compassionate and inclusive leadership.

Some key outcomes

- Increased diversity amongst our people
- An increased number of our people report that we act fairly with regard to career progression / promotion
- Organisational priorities and processes being shaped by our staff networks and increased numbers of people in our staff networks
- Increased numbers of staff participating in leadership development programmes

Transforming ways of working

Wirral University Teaching Hospital NHS Foundation Trust

COVID-19 compelled us to work in new and different ways to provide patient care. We want to build on this by transforming not only the way our teams work, but also how we work innovatively in partnership with other organisations across the system.

We will do this by embedding a continuous learning culture and ensuring all of our people have the opportunity to experience exciting and innovative development and learning opportunities.
We will work more collaboratively with or partners to create opportunities for in relation to our people, with more cross-sector working and development to transform how we provide patient care. We will embrace new technologies and the opportunities they bring.

Vision: ***We will embrace new ways of working and create opportunities to enable our people to achieve their potential***

To do this we will:

- Work with partners across Wirral and beyond to maximise people opportunities.
- Develop our people to equip them for both current and future challenges.
- Embrace technology to transform how we work.

Some key outcomes

- Highly developed, motivated people who continuously strive to improve their practice and enhance patient care
- An increased number of our people will work collaboratively with partner organisations to improve patient outcomes
- Impact evaluation results of collaborative development activity
- Achievement of NHS England levels of attainment

Shaping our future

Wirral University Teaching Hospital
NHS Foundation Trust

Vision: ***We will improve outcomes across Wirral for health, employment and wellbeing by working with our partners to be the best place to work***

To do this we will:

- Ensure we have a thorough understanding of our people requirements and use new roles and opportunities to deliver these.
- Become an employer of choice which attracts and retains the best people.
- Lead the way as an 'anchor institution' which is rooted in our community, including implementing the NHS Ambassadors Programme.

Some key outcomes

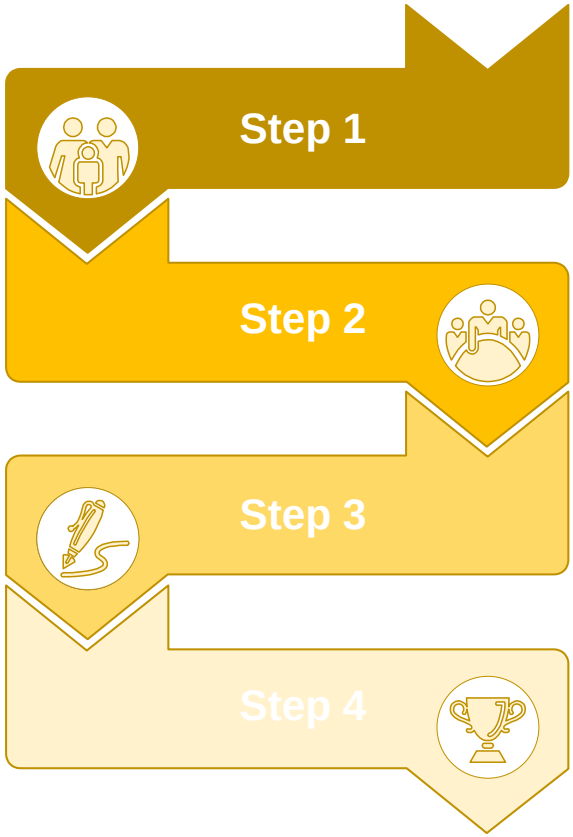
- Reduced vacancy rates
- Decrease in staff turnover
- Increased staff retention

We know that it's a continual challenge to address the gaps across various roles and professional groups. We will focus on ensuring that WUTH is an organisation where people want to stay to work and develop, and that we attract new people through innovative new roles and promoting WUTH as an employer of choice.

There is a strong link between work and health. We will develop our role as an 'anchor institution', ensuring that local people are engaged in our organisation from an employment perspective, with a view to decreasing health inequalities as a result.

Next Steps

How we Get to Where we Want to Be: Implementation, Monitoring and Review



Key to the success of this strategy is the continued involvement of our people. On an on-going basis our Workforce Directorate will use the outputs of a variety of engagement events, including the annual staff survey, to inform the delivery of this strategy.

Our Workforce Directorate will translate the People Strategy priorities into their annual operational and strategic priorities.

The People annual operational and strategic priorities will be reviewed and approved via Trust Board. Progress in delivering the priorities will be monitored via Workforce Assurance Committee.

People Strategy priorities will be reviewed as part of annual operational and strategic priority planning to ensure they remain relevant to our evolving needs and we maintain delivery momentum for the lifespan of this People Strategy.

Appendices

Glossary of Terms
Key Actions
Strategic Alignment

Glossary of Terms

Anchor Institution
A large, typically non-profit, public sector organisation whose long-term sustainability is tied to the wellbeing of the populations they serve.

Partners
Local and regional organisations we will work with to provide care to our patients.

People
A term to encompass anyone who is involved in supporting patient care. Staff, volunteers etc.

Place
Otherwise known as a ‘locality’ or ‘neighbourhood’. Areas of populations within a system.

Strategy
A plan of action that provides clear direction for all to work towards.

System
Cheshire & Merseyside Health and Care Partnership is a collection of NHS, local authority, voluntary, community, faith and social enterprise organisations from across the nine local authority areas that make up Cheshire and Merseyside.

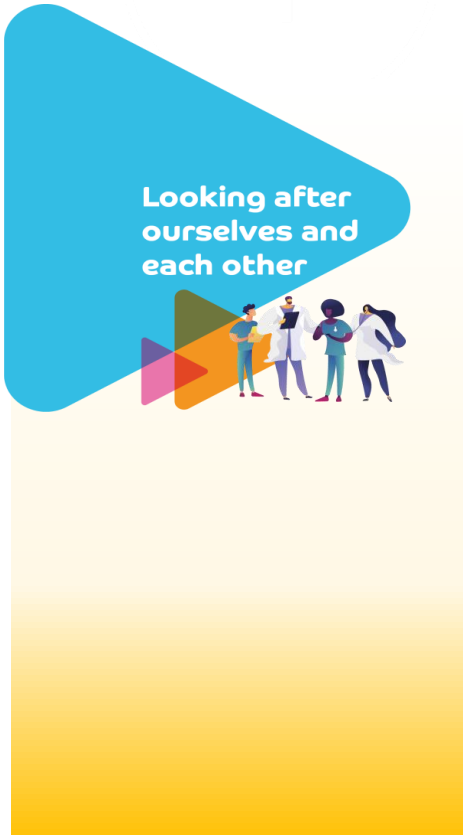
Key Actions: Looking after ourselves and each other

Wirral University Teaching Hospital NHS Foundation Trust

Vision: ***We will develop a wellbeing culture where supporting and enabling the holistic wellbeing of our people becomes the norm.***

To do this we will:

Deliver first class, innovative Occupational Health and Wellbeing Services	Equip our line managers and leaders with the knowledge, skills and tools to develop a wellbeing culture within their teams.	Fully embrace flexible working across all roles.	Create the conditions for civility and respect amongst our people.
• Recognising the impact of the pandemic, continue to invest in mental health and wellbeing support. • Enhance our physical wellbeing offers. • Take action to expand the focus of Occupational Health and Wellbeing Service towards a holistic approach to Wellbeing, including financial, social, cultural wellbeing. • Introduce new ways of working which support the development of a wellbeing culture, in line with the refreshed NHS Health and Wellbeing Framework.	• Ensure that there is a wellbeing focus throughout all manager development and training. • Roll out annual Wellbeing Conversations, supporting line managers to fully embrace the opportunities they present. • Introduce a training package to enable line managers to hold effective and meaningful Wellbeing Conversations. • Develop managers to proactively support staff when they go off sick and support their return to work.	• Board members and senior leaders will proactively support and embrace flexible working. • The opportunity to explore flexible working should be open to all and included in induction, Wellbeing Conversations and personal development reviews. • Acknowledge the current pressure our people face and allow staff to manage their annual leave flexibility, with opportunities to carry over leave or buy back unused leave. • Roll out the new working carers passport to support people with caring responsibilities, as well as working passports across other areas.	• Continue the programme of work to embed Trust values and behaviours across the organisation. • Utilise the NHS England and NHS Improvement Civility and Respect toolkit. • Introduce a restorative approach to addressing conflict in the workplace, in line with the principles of Just and Learning Culture. • Take action to prevent and tackle bullying and harassment.



Key Actions: Belonging at WUTH

Wirral University Teaching Hospital NHS Foundation Trust

Vision: ***We will develop an inclusive culture where everyone's voice is represented***

To do this we will:

Proactively increase and celebrate diversity at all levels of the organisation.	Enable a strong voice for our people throughout the Trust and recognise their contributions.	Create the environment for compassionate and inclusive leadership.
• Ensure that we collect and analyse data on the diversity and characteristics of our people to enable a deep understanding of lived experiences. • Proactively use data to identify and build a culture of continuous improvement. • Examine recruitment processes to remove barriers and to create opportunities to proactively increase diversity. • Refresh recruiting managers training to increase inclusivity of selection processes and increase diversity • Implement an annual calendar of events to celebrate diversity across our organisation.	• Continue to strengthen our staff networks to ensure they are embedded in our governance arrangements and able to influence our decision-making processes. • Support our staff networks to look beyond the boundaries of WUTH and work with colleagues across the system and in our communities. • Create a programme of work to enhance reward and recognition for our people. • Continue to promote and enhance the range of opportunities for our people to raise concerns, including the development of Freedom to Speak Up Champions. • Refresh our recruitment and selection training to look at proactive and innovative ways of promoting greater diversity and inclusion	• Introduce a refreshed approach to leadership development, talent management and succession planning, with an emphasis on the leadership qualities, multidisciplinary development, and leadership at all levels. • Create and deliver plans to proactively target leadership development in under-represented groups, identifying and removing barriers to progression. • Ensure that our leaders understand that they have explicit responsibility to continuously improve equality, diversity, and inclusion for our people. Proactively support and develop our leaders to deliver on this responsibility. • Continue to create a culture where all leaders are visible, accessible, and open to listening to the lived experience of our people

Key Actions: Transforming ways of working

Wirral University Teaching Hospital NHS Foundation Trust

Vision: ***We will embrace new ways of working and create opportunities to enable our people to achieve their potential.***

To do this we will:

Work with partners across Wirral and beyond to maximise people opportunities	Develop our people to equip them for both the current challenges and the future.	Embrace technology to transform how we work.
• Establish collaborative learning and development opportunities via partnership working. • Create a culture where our teams are empowered to work across sector boundaries, with greater collaborative working with colleagues in social care and other partner organisations. • Create the systems and processes to enable our people to easily work across organisational boundaries	• Continued focus on developing skills and expanding capabilities to boost morale and create career progression pathways for our people. • Create exciting and agile volunteer roles, supporting our volunteers to move in to paid employment should they wish to do so. • Work with training and education partners to anticipate, design and commission a portfolio of learning opportunities that enhances workforce capability, clinical practice and supports the professional development of our people. • Embed a Just and Learning culture that facilitates continuous learning, creates psychological safety to raise and address concerns, and focuses upon good practice that is shared and replicated within and beyond organisational boundaries.	• Make effective use of the valuable contribution made by our temporary staff by having robust systems and processes for planning and control. • Embrace the opportunities presented by workforce deployment systems, advancing our levels of attainment for e-rostering and e-job planning. • Ensure that we have a modern and exciting approach to education and learning, empowering our people to learn in a way that best fits for them wherever possible through innovative and immersive technologies.

Key Actions: Shaping our future

Wirral University Teaching Hospital NHS Foundation Trust

Vision: ***We will improve outcomes across Wirral for health, employment and wellbeing by working with our partners to be the best place to work.***

To do this we will:

Ensure we have a thorough understanding of our people requirements and utilise new roles and opportunities to deliver those requirements.	Become an employer of choice which attracts and retains the best people.	Lead the way as an 'anchor institution' which is rooted in our community
• Develop and deliver a flexible and agile people plan that's fit for the future and that is aligned to the national expansion of clinical roles and enables new care delivery models to become possible. • Accelerate, grow and develop innovative new roles to maximise skill mix, broaden staff autonomy and improve patient care. • Work with partners in Wirral and beyond to introduce new ways of working that tackle the workforce supply challenge end enable us to deliver the best quality care to our communities. • Make effective use of the valuable contribution made by our temporary workforce by having robust systems and processes for planning and control.	• Develop a 'brand' for WUTH so that those outside of our organisation understand that we are a modern, flexible and innovative employer and a great place to work. • Focus on new approaches to marketing WUTH as the best place to work, targeting people from all backgrounds and under-represented groups. • Focus on retaining our people by creating opportunities for engagement prior to leaving and, where staff do choose to leave, using our exit interview process to learn and improve. • Continue and expand our international recruitment programme and focus on attracting, recruiting, and retaining high-quality nurses, midwifes, allied health professionals and other high-skilled people.	• Build on work already underway by participating in the Health Anchors Learning Network. • Explore new entry routes and continue to expand our volunteering and apprenticeship programme. • Work with local partners to explore the implementation of integrated health and social care apprenticeships. • Promote the NHS Health Ambassadors programme across our workforce.

Strategic Alignment of Our Four Principles

Wirral University Teaching Hospital NHS Foundation Trust

	Compassionate Workforce Be a great place to work			
People Strategy Principles	Support our staff to enjoy the best health and wellbeing	Develop and maintain a healthy organisational culture based on our values	Retain, attract and recruit high calibre and skilled staff	Invest in our staff's continuous learning, education and innovation
Looking After Ourselves and Each Other	✔	✔		
Belonging at WUTH	✔	✔		✔
Transforming Ways of Working			✔	✔
Shaping Our Future			✔	✔

The People Strategy principles are aligned to delivering the Compassionate Workforce priorities specifically, but it will also support the delivery of all trust strategic objectives.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
4 May 2022

Item No 11

Title	Ockenden 2 Gap Analysis
Area Lead	Tracy Fennell, Chief Nurse
Author	Debbie Edwards – Director of Midwifery /Divisional Director of Nursing - Women and Children's Division
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide an update to the Board of Directors on an initial gap analysis undertaken by the W&C Division, which reviewed Trust compliance against all 15 Immediate and Essential Actions that were outlined in Part 2 of the Ockenden report. The report provides an overview of current compliance and brief actions identified with time frame/s to fully implement the recommendations.

The last quarterly update to Trust Board of Directors was presented in April 2022, where it was agreed to present an update on the findings from Part 2 of the Ockenden report. Part 2 of the Ockenden report was published on the 30 March 2022 and outlined 15 specific key Immediate and Essential Actions (IEA's) that each maternity provider should implement.

This paper includes an update on initial compliance with the 15 IEA's that relate to both the Maternity and Neonatal Service at Wirral University Teaching Hospitals (WUTH). A presentation to the Board of Directors will follow, which will further outline the ongoing work within Maternity and Neonatal services to further improve the quality and safety of these services at WUTH.

Previous Maternity updates have provided oversight to the Board of Directors on Trust compliance with the 7 IEA's outlined in Ockenden (Part 1), and previous reports have also confirmed compliance with all recommendations published in the Kirkup report from 2015.

It is recommended that the Board:

- Note the contents of the report specifically, the current compliance status with all 15 IEAs from Part 2 of the Ockenden report recommendations.

Key Risks

This report relates to these key Risks:

- Board Assurance Framework references 1, 2 and 4

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

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

1	Ockenden Review of Maternity Services – Part 2 (Final Report) update
1.1	The final report of the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, led by Donna Ockenden, was published on 30 March 2022. The review examined cases involving nearly 1500 families looking at the care provided at the Trust from 2000 to 2019. The review found significant failures in the quality of care and governance at the Trust during this time, with evidence that the Trust failed to undertake appropriate serious incident, identify areas for improvement and learn from each incident leading to repeated failings. The reasons for these failings are outlined fully within the report but centre on inadequate staffing levels, a lack of training, ineffective investigation and governance at the Trust and a culture of not listening to the families involved often blaming women and the families for the poor outcomes experienced. The final report outlines 60 Local Learning actions for Shrewsbury and Telford NHS Trust, which is separate to the 15 Immediate and Essential Actions identified for each Trust to implement and evidence. These IEA's cover ten key areas including: • Financing a safe maternity workforce • Essential action on training • Maintaining a clear escalation and mitigation policy when agreed staffing levels are not met • Essential roles for Trust Boards in oversight of their maternity services • Meaningful incident investigations with family and staff engagement and practice changes introduced in a timely manner • There must be joint learning across all care settings when a mother dies • Care of mothers with complex and multiple pregnancies • Ensuring the recommendations from the 2019 Neonatal Critical Care Review are introduced at pace • Improving postnatal care for the unwell mother • Care of bereaved families

	In response to the findings and recommendations from the independent review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust in December 2020 (Part 1 Ockenden Report) significant improvement work has been supported nationally to improve the quality and safety of Maternity Services. A paper outlining an update in maternity services that was presented to the Board of Directors in April 2022 outlined the Trust compliance against 7 Immediate and Essential Actions that were recommendations from the report. Significant quality improvement work has been undertaken in the Maternity Service within the Trust over the last 18 months which meets full compliance against all of the recommendations. Appendix 1 includes each of the 15 Immediate and Essential actions detailing a brief update regarding progress / compliance with each. Predicted completion dates have been included against those IEA's that require further action and each action has been RAG rated according to the compliance status. In reference to the IEA's there are some recommendations that are being reviewed from a risk perspective by NHSE. These relate to the recommendation of Band 5 (newly qualified midwives-NQM) working in a hospital setting and the workforce review relating to the roll out of Continuity of Carer. It is important that the midwifery staffing establishment in each provider provides safe staffing levels to support this model of care. An update from the last BR+ staffing review was included in the Maternity update presented to Board on the 6 October 2021. The current establishment supports this model of care and there is currently an organisational change process being managed within the maternity service with a plan to continue to roll out the Continuity of Carer model of care model. This paper in particular Appendix 1 will further inform discussion with the Maternity / Neonatal leads presenting an update and providing overview of maternity and neonatal services at WUTH.

3	**Conclusion**
3.1	Part 2 of the Ockenden report has outlined further actions in an attempt to further improve Maternity Services nationally. Each maternity provider must evidence its quality improvement work to further improve both Maternity and Neonatal Services, which also relies on the significant collaborative working with both the LMNS, Regional Network and the Regional NHSE Maternity team. The quality improvement agenda continues to incorporate the Neonatal Service as well as Maternity Service at WUTH with the next quarterly update to the Board of Directors due to be presented in July 2022. The July Maternity update will include an update on compliance with the 15 IEA's, detailed update on the implementation of the 10 Safety Actions outlined in the Maternity Incentive Scheme and will also provide a specific update on midwifery staffing in conjunction with the Continuity of Carer Implementation Plan.

Report Author	Debbie Edwards – Director of Midwifery /Divisional Director of Nursing - Women and Children's Division
Contact Number	0151 678 5111
Email	debbie.edwards4@nhs.net

Appendix 1
Ockenden
Essential Actions -

			1: WORKFORCE PLANNING AND SUSTAINABILITY	RAG Rating e	Comments / Lead Progress
1: WORKFORCE PLANNING AND SUSTAINABILITY	The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	**1**	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.		Neonatal service Staffing Review undertaken and bid for national monies successful.: Adam Brown with Angela MacDonald. Anaesthetic staffing review to be undertaken :Medical & Anaesthetic staffing review to be undertaken: Alice Arch. Libby Shaw and Mustafa Sadiq. Midwifery Staffing review undertaken but same to be reviewed and updated pending CoC model: Debbie Edwards and Jo Lavery. Deadline - July 2022.
		2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.		As above with addition of Sarah Weston, Rachel Hutton, Karen Cullen and Jo Allen Work to complete TNA compliance to be agreed with LMNS. Completion date - June 2022
		3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		Local uplift to be calculated and compared to BR+ staffing requirements. To be included in staffing review. Completion date - June 2022.
		4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.		National review awaited of BR+ Tool. Completion date TBC
			Essential Action : Training		
	We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	**5**	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		National programme being developed however robust preceptorship in place currently. For review once national work completed. Completion date TBC
		6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.		NQM are included in community roles - This IEA is under review / being discussed nationally as risk is greater keeping NQM in the hospital setting.
		7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.		Shift Coordinators have attended development Programmes including Hiuman Factors training however National Programme awaited. Completion date TBC.
		8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		Orientation pack currently in use but same to be reviewed and to include study time for profrssional development. Completion date of review - September.
		9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.		EMC Team based on DS and all midwives have undergone recognised specific HDU training.
		10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience		Workforce strategy in place however this will be reviewed and include reference to leadership roles. Compl;eltion date - September 2022.
		11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.		Regional work re MMN ongoing with training available. National update awaited. Completion date TBC.

2: SAFE STAFFING					
2: SAFE STAFFING	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	**1**	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.		Escalation processes in place and the number of diverts is included on the maternity dashboard. Staffing related incident forms reviewed and reported monthly. Staffing reviewed and reported monthly with Chief Nurse oversight. Review of need for SOP to compliment policy by LMNS. Completion date TBC
		2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.		Escalation in-house at present therefore review whether SOP to be developed and agreed at Board to formalise process.Leads: Mustafa Sadiq and Libby Shaw. Completion date - July 2022.
		3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.		Specific job description in place with personal specification. JD has been through matching process.
		4	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.		Debbie Edwards and Jo Lavery to review staffing establishments as detailed above - staffing previously has supported CoC - withold complete roll out but continue with partial roll out pending staffing review. Completion date - June 2022.
		5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction		Final position statement on this to be formalised nationally - completion date awaited.
		6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.		Park, Jon Lund, Mustafa Sadiq and Libby Shaw.to finalise. Completion date - June 2022.
		7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.		Facilitators in post to support - guidance awaited re what should be included. Date TBCSarah Weston, Ali Campion, Jo Allen and Karen Cullen
		8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		Process to be reviewed and agreed with L&D Team within the Trust. Also include specific requirements for appraisals and support for leadership training eg Top Leaders; 4 C's
		9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.		CoC - Engagement, listening events, one-to-one meetings, Block C update, Senior midwife meeting joint with all leads.
		10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.		Locum pack developed and shared across C&M- Libby Shaw and Mustafa Sadiq to check RCOG guidance for locum guidance to further support current process. Date TBC
3: ESCALATION AND ACCOUNTABILITY					
3: ESCALATION AND ACCOUNTABILITY	Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines	**1**	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals		policy with flowcharts required. Libby Shaw developing SOP as per EBC Guidance. Completion date July 2022.
		2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role		Mustafa Sadiq and Libby Shaw
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable		Ward round take place at weekend, twice daily however resident consultant presence not in place 24/7.
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit		Guidance in place / in policy

	for when a consultant obstetrician should attend.	5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.		Partial guidance in place and currently no dedicated maternity on call rota in place - same being reviewed - Debbie Edwards and Jo Lavery to look at midwifery manager on-call. Completion date June 2022
4. Clinical governance and leadership					
4 : CLINICAL GOVERNANCE-LEADERSHIP	Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	1	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans		Mat Neo agenda is in place and other QI work is reported in Governance meetings but there is limited Board oversight - same to be reviewed. Date TBC.
		2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board		actons in place and presented to Board. However same to be reviewed following Ockenden and an updated self assessment to go to Board in July.
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services		In place. Structure organogram required
		4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. Completion date - July 2022.
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		Staff currently trained however review of staff group required and additional training to be identified.Completion date - July 2022.
		6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.		Multi-discipinary leads - include Angela Kerrigan
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		Audit plan in place - same to be strengthened for Maternity and Neonates.Obstetric leads in place but midwifery leads for the audit plan to be agreed with Mustafa Sadiq Completion date - June 2022.
5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS					
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.		In place and evidenced. Robust process for reviewing documents before they are sent to families.
		2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.		In place in various forums both internal and external to the Trust
		3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.		Implementation of actions recorded and monitored however audit of same to be reviewed.Link with audit plan
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		Learning put in place immediately. - evidenced on individual reports.
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such		Clear MDT process in place - SI Panel
		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent		Complaint response processes in place however MVP to review and to identify improvements to further strengthen the process
		7	Complaints themes and trends must be monitored by the maternity governance team.		Processes currently in place to incorportae all patient feedback - LEAP to include Feedback Friday - positive and negative feedback and trends to be communicated to all staff.
6: LEARNING FROM MATERNAL DEATHS					

6: LEARNING FROM MATERNAL DEATHS	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	**1**	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		Guidance awaited nationally
		2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.		Guidance awaited nationally
		3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.		Guidance awaited nationally and regionally
7: MULTIDISCIPLANRY TRAINING					
7: MULTIDISCIPLINARY TRAINING	Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	**1**	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		Midwifery and middle grades involved in audit - need to expand to neonatal evidence of same and allocated time to be evidenced.
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.		SBAR in all training including neonates. Audit of same to be further improved.
		3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.		For all staff attend human factors training however guidance re content awaited from LMNS
		4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		PROMPT includes all of these topics however all staff groups including neonatal staff to be included in PROMPT Completion date - July 2022.
		5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.		Jo Allen support for NQM. PMAs. NWAS has toolkit for staff Contact Steph Heyes. Discussed psychological support that was available in ITUs during Covid pandemic - that there was psychological support present at work.This helped staff to attend work becuase they knew the support would be there.
		6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.		Physiology in addition to Ali Campion and Libby Shaw.
		7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory		PROMPT, K2, fetal physiology, CIF meetings, Pass mark for CTG assessment is mandated and reviewed monthly.
8: COMPLEX ANTENATAL CARE					
8: COMPLEX ANTENATAL CARE	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	**1**	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.		Do not currently offer routine pre conception care. Will discuss regionally at what can be offered - will look at what high risk team could provide. Completion date - July 2022.
		2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019		Twins Trust coming in multi-pregnacy clinic - Mustafa Sadiq is lead.
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		Guidance in place - to link wth Rachel Tildesley and Lauren Evertts
		4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.		In place but could be subject to audit to demonstrate compliance

		5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).		Guidance in place to support this practice - specific clinic to be reviewed. Completion date - July 2022.
9: PRETERM BIRTH					Link with Kellie Weaver
9: PRETERM BIRTH	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.		Policy in place with clear guidance.
		2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.		Guidance discussed at time dependant on individual situation. Guidance in place re type of monitoring as per gestation of pregnancy.
		3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.		Regional policy - link in with Angela MacDonald and Sanjeev Rath re any further update
		4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.		Current review of Level 3 neonatal services however as WUTH Level 3 currently this is not applicable.
10: LABOUR AND BIRTH					
10: LABOUR AND BIRTH	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made		Practice in place - Demonstrated in care metrics
		2	Midwifery-led units must complete yearly operational risk assessments.		In place however Discuss with Emma Rohmann, Katherine Wilkinson and Kate McCabe re review content of risk assessment
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		All staff included in PROMPT training however schedule of drills to be recorded
		4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust		Transfer policy in place regionally and adopted locally - same under review currently. Completion date - July 2022
		5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.		Pathways in place - same being reviewed regionally.
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		Purchase of system currently being undertaken. Procurement In progress. Completion date - July 2022.
11: OBSTETRIC ANAESTHESIA					
	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	1	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia		Alice Arch overview: If a post-operative debrief would be useful these can be arranged to be purely or involve a Consultant Anaesthetist and we do this for lots of patients already - we usually offer this at 6-8 weeks post event unless the patient requests it to be earlier or later - and these patients can be referred to the Obstetric Anaesthetic Assessment clinic if they present in subsequent pregnancies
		2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		Currently being undertaken but need to review guidance to ensure all criteria included with audit of same. Completion date - July 2022
		3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		Documentation is recorded in maternity record hwoever need to review audit process. Completion date - July 2022.

11: OBSTETRIC ANAESTHESIA		**4**	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.		National guidance awaited.
	Obstetric anaesthesia staffing guidance to include:	**5**	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.		Staff who do not do regular Obstetric Anaesthesia sessions want to do a Consultant Accompanied CPD session in Obstetric Anaesthesia to keep skills up to date we are more than happy to facilitate this - and several people have already taken up this opportunity. Process to be reviewed. Completion date - July 2022.
		6	• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		Staffing of same to be reviewed. Completion date - July 2022.
		7	• The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments.		As point 5
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		All anaesthetists attend PROMPT MDT training.
12: POSTNATAL CARE					
12: POSTNATAL CARE	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.Postnatal wards must be adequately staffed at all times	**1**	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward		Check if this is in written policy
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		To be checked
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		To be checked
		4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.		Acuity tool
13: BEREAVEMENT CARE					
13. BEREAVEMENT CARE	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	**1**	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.		Bereavement midwife in post but works Monday to Friday. EMC team upskilled and shift coordinators. With development of bereavement champions in teams. Cover available 24/7
		2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.		EMC staff and coordinators - can be inlcuded in development package for coordinators
		3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome		In place - dual with obstetrics and neonates
		4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway		Pathway in place and in use.
14: NEONATAL CARE					
14: NEONATAL CARE	There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers,	**1**	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.		Guidance in place
		2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.		Guidance re report content awaited from LMNS
		3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.		This is a unit with onsite Level 3 NICU
		4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.		Regional meetings in place re sharing of best practice however work to be developed on identifying secondment/s and shadowing. Completion date - July 2022.
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.		ODN leading on this regionally. Completion date TBC

	develop the workforce and enhance the experience of families. This work must now progress at pace.	6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required		Evidence of this happening in practice to be confirmed and to be followed up with Angela McDonald, Adam Brown and Sanjeev Rath
		7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		NLS Guidance followed - action to be followed up with neonatal team
		8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.		Staffing review to be undertaken as above -Adam Brown and Anand to lead staffing review.
15: SUPPORTING FAMILIES					
15: SUPPORTING FAMILIES	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provisionMaternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.		Perinatal mental health team in post. GIRFT identified need for neonatal support. This is in place regionally
		2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.		Perinatal mental health team in post with further support from Psychiatric Liason team..
		3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care		Psychiatric liaison team and dedicated psychologist to support. WUTH also involved in regional project to further enhance PMH support.

National/Regional Action required
Fully Compliant
Partially Compliant
Non Compliant
NOTE: Completion dates are provisional pending detailed improvement plan.

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Board of Directors in Public **Item No 12**
4 May 2022

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

Report Purpose and Recommendations

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

Key Risks

This report relates to these key Risks:

- Risk 1.1 – Unscheduled care demand (communications interventions to support addressing this risk and Trust initiatives like addressing winter pressures and patient flow)
- Risk 2.1 – Failure to fill vacancies (communications support on recruitment, retention and reputation)
- Risk 3.4 – Failure of Transformation programmes (communications and engagement, including stakeholders and patients for WUTH Improvement activities for service transformation, patient flow and Winter Plan)
- Risk 6.1 – Estates related risks (Communications, stakeholder and staff engagement to support delivery of Estates Strategy, Masterplans and capital programme developments. Including in month communications for the South Mersey Elective Hub and Clatterbridge Diagnostics)

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
Standing report to Board			

1	Narrative
	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 communications and stakeholder relations** **Campaigns** **Celebrating 40 years of Arrowe Park Hospital** – on May 4th, 2022, it will be 40 years since Her Majesty, The Queen opened Arrowe Park Hospital and we have a number of commemorative events planned or underway to mark the occasion with staff, stakeholders and the local community. These are being finalised throughout April and May and will carry on throughout the year. Commissioned activities to date include staff pin badge, promotional items, tea and cakes, a set of murals from a prominent local street artist, a supplement in the Wirral Globe, a charity prize draw, a special issue of the Trust 'In Touch' magazine, videos with patients, leaders and staff, social media and news releases, a staff photography competition, a flag for Arrowe Park, roadside adverts with Wirral Council and celebratory content using memories of patients, staff and retired executives who were present at the opening or have 40 years' service. We have received congratulatory messages from Her Majesty and from Lord Ken Clarke of Nottingham, who attended the opening as Health Minister in 1982. **The Vaccination Hubs** continued to require campaign and communications support – especially stepping up of the booster programme, the changes to cohort eligibility and the roll out of the fourth booster dose to over 75s and the further roll out to children aged 5-11 years. There are some lovely examples of patient and family feedback for staff care and kindness towards our youngsters having their first vaccinations. **In month campaigns**, included World Health Day 2022 where the climate change theme enabled us to highlight our Green Plan and we also took part in Bowel Cancer Awareness Month We shared new 'When am I going home?' campaign materials to support patient flow. We support recruitment to a major new clinical trial in early detection of cancer NHS-Galleri Trial | Detecting cancer early. We shared content and information about Ramadan and the Trust repeated its wellbeing initiatives to provide Iftar meal boxes to staff breaking their fast at the end of their shift. We also commenced the roll out of our Patient Experience Strategy including new ward boards for 57 Trust locations, social media and staff communications. As part of this, we've been sharing more patient feedback internally including audio clips from

satisfied patients experiencing care in our Emergency Department.

Media

In month media relations were more subdued owing to being in the 6-week pre-election period ahead of the local elections on May 5th, 2022.

Our press release about the Clatterbridge site's 10,000th patient 10,000 patients on Wirral have benefited from earlier access to diagnostics for our diagnostics hub, which is jointly operated with Clatterbridge Cancer Centre, was referenced in a national NHS news release about elective recovery and innovations to cut waiting times.

CEO Janelle Holmes was interviewed by the Health Care Technology Network on sustainability and the Trust's Green Plan Leading healthcare--exploring-the-future-of-sustainability-within-the-nhs/

HSJ Partnership award win

Ann Taylor from WUTH Substance Misuse team was part of a winning team at the recent Health Service Journal (HSJ) Partnership Awards, in the category 'HSJ Best Educational Programme'.

Working in collaboration with Kyowa Kirin, a pharmaceutical company and other colleagues from a number of other NHS Trusts, they developed 'Drink Talking' resources developing new education programmes, raising awareness of alcohol services.

The judging comments were: "This excellent initiative harnesses shared collaboration and partnership working. The ability to adapt and respond quickly and effectively at such a challenging time has made a real difference to this vulnerable group of service users. The programme utilised digital platforms and was cost effective. The presenters of this were very passionate and humble about this achievement and thoroughly deserved winners."

Accessing Services over Easter

Together with system partners we made the public aware of the pressures in the Emergency Department and of the range of options to access care during the Easter Bank Holiday.

Employee Communications

We communicated WUTH's outcomes from **the NHS Staff Survey**, working with colleagues in Employee Engagement and a programme of action planning and sharing the Divisional results is now taking place.

We submitted staff and team entries to the **NHS Parliamentary Awards** for staff who have demonstrated extraordinary commitment.

In support of our Digital Strategy, we assisted our IT colleagues to create a new identity as the Digital Healthcare Team.

Employee health and wellbeing continued to be an important focus for communications, including the launch of staff and manager wellbeing conversations

and sharing resources for seminars on financial wellbeing.

The Arrowe Park Hospital 40th anniversary will have a strong element of celebrating staff contribution to the hospital and commemorations will include a number of staff facing activities.

Stakeholders

Plans are in hand to create a place-based network of communications leads to support integrated working and prepare for the transition to the Integrated Care System in July.

WUTH Charity

The Charity team focus for April has been continuing to plan this year's event calendar in line with the agreed fundraising strategy approved by the Charitable Funds Committee.

The Easter raffle raised over £1,800 for the Tiny Stars Neonatal appeal.

In the Tri4life Everest Summit Challenge. Dr Martin Pritchard Howarth and friends are half way through their trip before their summit attempt at the end of the month. If you would like to know more about the Everest Summit challenge or support Martin, please visit Tri4Life fundraising for Wirral University Teaching Hospital NHS Foundation Trust Charitable Fund on JustGiving

Spring Lunch. April 26th - This reception and 3 course lunch for 80 guests has been kindly donated by the Red Fox Thornton Hall following our successful charity ball with Thornton Hall last November. The event is sold out. Local author Gina Kirkham will be attending and talking about her latest book The event is being organised in partnership with Tiny Stars Charity supporter Mandy Molby and is in aid of Tiny Stars.

The Mayor of Wirral Charity Golf Day is on13th May at Caldy Golf Club. This is the last event of Mayor Councillor George Davies term. It is hoped the appeal will receive £10,000 donation form the Mayor's Charity, which is also supporting the RNLI, following this final event.

Wirral Coastal Walk 22nd May. The Charity team will be supporting a team of walkers completing the 12.5mile route in support of Tiny Stars

Heswall Hall Party Night. July 9th -Tickets cost £10 and are available from the Charity Office.

'It's a Knock Out' July 2nd Arrowe County Park Up to 24 teams of 12 will take part in this classic 'fun day'.

Arrowe Park Hospital Abseil 23rd/24th September. This popular event will return for a third year. Booking for this event will open in June.

Virtual London Marathon 2nd October. WUTH Charity has 25 places available for this year's virtual event. The ballot for this event will open in June.

The Charity is also supporting the 40th anniversary event programme.

2	Implications
2.1	The Board is asked to note the progress and the 40th anniversary commemorations.

3	Conclusion
3.1	The Board is asked to note the developments and progress outlined in the report.

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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 13.1**
4 May 2022

Title	Chair's Report – Audit Committee 20th April 2022
Area Lead	Robbie Chapman, Interim Chief Finance Officer
Author	Steve Igoe, NED
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide assurance on the detailed activity and Internal controls Environment operating at the Trust. It updates on Internal Control and Risk Management, Internal Audit outcomes including the Head of Internal Audit opinion, External Audit preparations in relation to VFM planning and Annual report and Governance matters.

It is recommended that the Board:

- Note that positive discussion and approval of key estimates took place likely to have an impact in terms of the Year end accounts
- Note the positive progress on Internal Audit outcomes from Audit work and the large number of substantial assurance outcomes.
- Note the Positive Internal Audit Report and Head of Audit opinion resulting in Substantial Assurance for the Trust and a recognition that the Trust has a good system of Internal Control. In the previous years this has only been moderate Assurance.

Key Risks

This report relates to these key Risks:

- Fundamental Failure of the Internal Control system resulting in Regulatory intervention and damage to Brand and Reputation.

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

Governance journey

This is a standing report to the Board.

1	Narrative
1.1	This report updates on the work of the Audit Committee at its meeting on 21st April 2022.The work of the Audit Committee as well as being documented in its terms of reference is prescribed by Accounting /Auditing Standards and Regulatory requirements. The Committee considered:
1.2	**Internal Control and Risk Management** Regular reports were received relating to Financial Assurance and procurement spend controls. The Committee was assured on this latter item of the positive oversight of procurement, particularly in relation to Capital Expenditure. Work will continue to be undertaken to manage the number of waiver requests received although many of these relate to OEM suppliers where alternative provision is not available.
1.3	**Policies** The Trust's policies in relation to Bad Debts and accounting policies used in the formulation of the year end accounts for the Trust were discussed and approved. The Anti-Fraud policy was also approved whilst the Committee received updates on ongoing work in relation to the strengthening of the Control Environment relation to Overpayments (typically salary) and standing financial instructions (particularly in relation to levels of delegated authority). These latter two items will return to the Committee for further discussion and ultimately, if appropriate, approval in due course.
1.4	**Year-end matters** The Committee discussed the use of the Going concern basis to produce this year's year end accounts and confirmed it was applicable. This will be further discussed and ultimately agreed by the Board of Directors when the Accounts are submitted post Audit for approval. The Committee also discussed and endorsed managements position in relation to significant management accruals which will be subject to detailed scrutiny by External Audit as all matters of valuation and judgement are. They will report their views on the same as part of their end Audit ISA 260 report.
1.5	**Internal Audit** The Committee received its usual update in relation to the outcomes from Internal Audit work over the preceding period. The Committee was encouraged to see the significant number of Reports with an outcome of Substantial Assurance and only two with Limited Assurance. In relation to these latter two reports the Committee agreed that going forward where it received a report offering Limited assurance, the relevant Executive Director would be invited to present their responses to the report and provide assurance as to the timely and satisfactory resolution of any issues noted.
1.6	**Head of Internal Audit Opinion and Internal Audit Annual Report** MIAA presented a positive end of year report on the basis of the work undertaken in accordance with the Annual Audit plan approved by the Committee. The Overall opinion being: "*The overall opinion for the period 1st April 2021 to 31st March 2022 provides Substantial Assurance that there is a good system of Internal Control designed to meet the Organisation's objectives, and that controls are generally being applied consistently.*

1.7	**Audit Plan** The Committee discussed and approved the Internal Audit Plan for 2022/23 and the accompanying fee.
1.8	**Anti-Fraud** The Committee approved the Anti-Fraud work plan for 2022/23 and positively received and approved the Annual Report for 2021/22.
1.9	**External Audit** Azets updated the Committee on their likely work requirements to support their Value for Money opinion on the Year end Accounts.Their report was noted.
1.10	**Governance matters** The Committee discussed the draft Annual Governance Statement for inclusion in the year end report and accounts noting that this was from the CEO and would be further discussed by the Committee and the Board at subsequent meetings.

2	**Implications**
2.1	The positive Audit opinion and Strong Audit outcomes further re-inforce the trajectory of the Trust in terms of control environment and well led position.

3	**Conclusion**
3.1	The positive opinions as to control environment and robust reports on Internal Control are significant in underpinning the trust and confidence regulators and the public can have in the safe ,effective and efficient operation of the Trust

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Public Board of Directors Work Plan 2022/23

Item	Lead	6 Apr	4 May	1 Jun	8 June (ARA)	6 Jul	7 Sep	5 Oct	2 Nov	7 Dec	25 Jan	1 Mar
Welcome and apologies for absence	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting and matters arising	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Action log	Chair	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Patient story	Chief Nurse	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Chair's Business and key strategic issues	Chair	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Chief Executive Officer's Report	Chief Executive	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Chief Operating Officer's Report	Chief Operating Officer	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Quality and Performance Dashboard	Chief Operating Officer	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Month X Finance Report	Chief Finance Officer	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Monthly Maternity Perinatal Update	Chief Nurse	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Reports from Committees by Chair's	Committee Chairs	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Communications and Engagement Report	Director of Communications and Engagement	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Board Assurance Framework	Director of Corporate Affairs	✓		✓		✓		✓		✓		✓
Charitable Funds Annual Report	Chief Finance Officer										✓	
Diversity and Inclusion Annual Report	Diversity and Inclusion Lead									✓		
Emergency Preparedness, Resilience and Response (EPRR) Annual Report	Chief Operating Officer											✓

Item	Lead	6 Apr	4 May	1 Jun	8 June (ARA)	6 Jul	7 Sep	5 Oct	2 Nov	7 Dec	25 Jan	1 Mar
Annual Appraisal and Revalidation: Annual Board Report and Statement of Compliance	Medical Director									✓		
Annual Board of Directors Fit and Proper Persons Checks Report	Director of Corporate Affairs								✓			
Financial and Operational Plan 2022/23	Chief Finance Officer	✓										
Chief Nurse Six Monthly Nursing Establishment Review Staffing Report	Chief Nurse			✓						✓		
Guardian of Safe Working Quarterly Report	Medical Director			✓			✓			✓		
Freedom to Speak Up Quarterly Report	FTSU Lead Guardian			✓			✓			✓		
Quality and Safety on Maternity Services Quarterly Report	Chief Nurse	✓				✓		✓			✓	
Learning from Death's: Quarterly Update (Mortality Dashboard & Report)	Deputy Medical Director – Surgery	✓				✓		✓			✓	
Audit Findings Report	Azets				✓							
2021/22 Annual Accounts	Chief Finance Officer				✓							
Draft Annual Report 2021/22	Director of Corporate Affairs				✓							
Provider Licence: Self – Certification Declarations	Director of Corporate Affairs				✓							
Draft Quality Account	Chief Nurse				✓							
Questions from the public	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Any other business	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓