Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

6 July 2022

0.0 Cover Sheet

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Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 6 July 2022
Time	09:00 – 11:00
Location	Boardroom, Education Centre, Arrowe Park Hospital

Agenda Item		**Lead**
1.	Welcome and Apologies for Absence	Chair
2.	Declarations of Interest	Chair
3.	Minutes of Previous Meeting	Chair
4.	Action Log	Chair
5.	Patient Story	Tracy Fennell
Operational Oversight and Assurance		
6.	Chair's Business and Strategic Issues – **Verbal**	Chair
7.	Chief Executive Officer's Report	Janelle Holmes
8.	Chief Operating Officer's Report	Hayley Kendall
9.	Board Assurance Reports	
	9.1 Quality and Performance Dashboard	Executive Directors
	9.2 Month 2 Finance Report	Mark Chidgey
	9.3 Maternity Quarterly Report, including Ockenden Final Report Update	Tracy Fennell/Jo Lavery
	9.4 Learning from Deaths Quarterly Report	Ranjeev Mehra
	9.5 Freedom to Speak Up Annual Report	Sharon Landrum
	9.6 Guardian of Safe Working Quarterly Report	Nikki Stevenson
	9.7 Estates, Facilities & Capital Update	Paul Mason
	9.8 Digital Healthcare Update	Chris Mason
Wallet Items for Information		
10.	Communications and Engagement	Sally Ann Sykes
11.	Committee Chairs Reports 11.1) Capital Committee 11.2) Finance Business Performance and Assurance Committee - **verbal**	Committee Chairs

Closing Business

12.	Questions from the Public	Chair
13.	Any other Business	Chair

Date and Time of Next Meeting

Wednesday 7 September 2022, 10:00 – 12:00

Meeting	Board of Directors in Public
Date	Wednesday 1 June 2022
Location	Boardroom, Education Centre, Arrowe Park Hospital

Members present:

DH	Sir David Henshaw	Chair
JS	John Sullivan	Non-Executive Director & Vice Chair
SR	Steve Ryan	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
SI	Steve Igoe	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Nicola Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
HK	Hayley Kendall	Chief Operating Officer
DS	Debs Smith	Chief People Officer
RC	Robbie Chapman	Interim Chief Finance Officer
MS	Matthew Swanborough	Director of Strategy & Partnerships

In attendance:

RM	Rajan Madhok	Non-Executive Director (observing)
SS	Sally Sykes	Director of Communications and Engagement
CM	Chris Mason	Chief Information Officer
DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
AM	Alan Morris	Public Governor
EH	Eileen Hume	Public Governor
TC	Tony Cragg	Public Governor
DT	Diana Tyson	Public Governor
PI	Paul Ivan	Public Governor

Apologies:

SL	Sue Lorimer	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
SH	Shelia Hillhouse	Public Governor

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

	The Chair welcomed everyone to the Board of Directors in Public Meeting. Apologies were received as noted above. DH thanked JS for his contributions as a Non-Executive Director and Vice Chair, who would step down from the Board at the end of June.	
2	**Declarations of Interest** No new interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting were approved as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story of the experience of a patient who had motor neurone disease. The video described his and his carers experience of the Trust's emergency department (ED), ward setting and discharge. The Board acknowledged the patient and family experience was poor. TF agreed that it was disappointing to see this incident and highlighted the learning that it presented and the changes that can be made because of it. HK commented that she had discussed with the clinical teams about disaggregating minor illness/injury from majors and resuscitation in ED to support improved patient flow, response and waiting times. More discussions were planned to take place in June with a testing phase in July and HK agreed to provide an update at the July Board meeting. The Board enquired if this was an isolated incident and whether there is a systematic issue with dealing with vulnerable patients and patients with disabilities. JH added there is a general issue with community provision, which often means that those with long term conditions who become unwell are sent to A&E rather than put through a specialty specific referral. JH noted that solutions that have been explored are a passport for patients with long term conditions that describes the best place to go to seek treatment when they were unwell, and a carer's passport	Hayley Kendall

	SR suggested a carers corner in the ED to provide any necessary support to patients while they wait. It was also noted that staff in ED should have access to wellbeing and compassionate support given the difficult nature of their role. This is being reviewed with the People team. The Board **NOTED** the Patient Story.	
6	**Chair's Business and Strategic Issues** The Chair updated the Board on recent matters and highlighted that continued engagement at Wirral Place and Integrated Care System (ICS) level is required to ensure the ICS has a fresh perspective and provides strong leadership and positive outcomes. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH highlighted the prevalence of COVID in the community was reducing and this was reflected in the number of COVID inpatients within the hospital – currently 10. NHSE/I had reclassified the COVID incident from a Level 4 (National) to a Level 3 (Regional) Incident due to community cases and hospital inpatient numbers now seeing a sustained decline. JH highlighted the full business case had been submitted to NHS for the redevelopment of the urgent and emergency care unit at Arrowe Park Hospital. The new modular theatres had been delivered to Clatterbridge Hospital in April. The theatres were currently being fitted out and equipped, with commissioning and handover to the Trust scheduled for August 2022. JH reported that in April the Trust declared 8 serious incidents (SI), an increase of 3 on the previous month. Two incidents were reported to the Health & Safety Executive in accordance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). JH highlighted the Trust's Endoscopy Service had achieved the Joint Advisory Group (JAG) accreditation certificate from the Royal College of Physicians, demonstrating the Service meets the best practice quality standards. CC commented on the positivity from staff regarding Clatterbridge being refurbished. SR commented that the JAG accreditation was a great achievement. SR also queried if the Trust had received any monkeypox cases.	

	NS confirmed the Trust's Clinical Advisory Group had a process in place for identifying and treating any patients who display monkeypox symptoms; in addition to staff safety measures Arrowe Park Hospital had no inpatients at present but any presenting requiring admission would be referred to Royal Liverpool University Hospital where there was a specialist Tropical and Infectious Diseases Unit. DH requested a joint letter be drafted with Wirral Community Health and Care regarding the contract tenders and awards. The Board **NOTED** the report.	Janelle Holmes
8	**Chief Operating Officer's Report** HK highlighted in April 101.9% of outpatient activity was delivered against a performance target of 104.3%. For elective admissions 86.2% of activity was delivered against a target of 109.5%. Due to unplanned ventilation works, 6 theatres on the Arrowe Park Hospital were unavailable throughout April resulting in a reduction of elective admissions. The Trust did not meet the priority 2 performance (P2) month end trajectories for April. The month end final position was over reporting 81 P2 breaches against a month end plan of 66, due to the prioritisation that had to take place due to the lack of operating theatres. In April 730 patients waited longer than 52 weeks, which was higher than the Trust's trajectory of 550. The loss of 6 theatres led to this position with an 300 procedures lost as a direct result. No patient was waiting longer than 104 weeks. Cancer backlog performance against 31- and 62-day treatment continue to face pressures within colorectal and urology, with the position unlikely to be achieved until quarter 4 2022/23. The breast surgery 2-week wait was expected to recover by June 2022 with no patient waiting more than 7 days for an appointment. Ambulance handover delays were challenged within April with 23.9% of ambulances experiencing a 30-minute delay or more. Daily ED attendances averaged 257 in month, 1% higher than in the same period of the previous financial year. There were 39 patients that breached the 12 hours in ED target in month, the highest figure year to date. SI queried what was driving the total volume of daily ED attendances. HK confirmed there had been a general increase in minor injuries, and that behaviours had also changed as patients want to be seen in person.	

	JS commented that Wirral had an aging population, and it was possible that those on the waiting list would present in ED. JS queried if the there was a risk to staff wellbeing and morale for those working in ED. HK confirmed it was difficult to give assurance, given the challenges with demand and space but was confident that the new leadership team along with HR were engaging with the staff and providing support. The Board **NOTED** the report.	
9	**Board Assurance Reports** **9.1 Quality and Performance Dashboard** The Executive Directors briefed the Board on metrics in the dashboard. It was noted that of the 46 indicators that were reported 33 were off off-target or failing to meet performance thresholds and 13 are on-target. TF drew attention to the 4 pressure ulcers declared in April that were patients admitted with skin damage that had deteriorated during admission. DS reported that mandatory training remained static at 87% against a target of 90%. DS confirmed that improvement trajectories for Divisions had been set and was being monitored through the Divisional Performance Reviews. Sickness absence had reduced to 6.74% and short-term sickness absence had improved. Staff turnover for April remained the same as March at 14.1%. JS queried if there was a correlation between individuals who had a high sickness absence rate and no history of an appraisal. DS confirmed there is correlation with areas with low compliance on appraisal, high sickness absence and high turnover. SI queried if the Trust's mandatory training list had been reviewed recently and if the list remained current. DS confirmed a review of education governance was ongoing. JS commented on the dashboard itself and noted the Trust was achieving less than 1/3 of the indicators and queried if the dashboard reflected the Trust accurately given the level of senior leadership presence and assurance in place.	

HK confirmed the dashboard needed to include certain statutory indicators but there were opportunities to include other indicators on specific focus areas.

DM confirmed a date was to be arranged for statistical process control training in July for the Board.

DH commented that he had called the hospital switchboard recently and found it difficult to reach the operators. It was confirmed that this was being looked into and telephony technology being reviewed.

The Board **NOTED** the report.

9.2 Board Assurance Framework

DM highlighted that the annual review of the BAF was currently taking place to align current strategic risks with the Trust to annual objectives. DM confirmed a fully refreshed BAF would be presented to the Board in September.

SI commented that good progress had been made to understand the nature of the risks and noted the Trust would be unable to mitigate all risks as some risks would inevitably be system owned.

SR suggested the risk likelihood for the risk number 1.4 *(Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints)* was too high.

DH requested SR raise this at the next Quality Committee meeting to discuss in more detail.

The Board

- **NOTED** the current BAF;
- **APPROVED** the proposed amendments to the BAF; and
- **NOTED** the proposals for the annual refreshment and updating of the BAF.

9.3 Month 1 Finance Report

RC introduced the Month 1 Finance Report, noting the Board has approved a deficit budget of £6.197m for the year. However, the budget has not yet been approved by NHSE/I and further operational planning is ongoing with NHSE/I

RC highlighted about the importance of a achieving a break-even balance and outlined the options and self-imposed stretch targets the Trust was taking to deliver this. RC confirmed the ICB had explained there would be consequences for Trusts who did not receive a break-even balance.

The Trust was reporting a deficit of £0.956m at month 1, an adverse variance against budget of £0.886m. This variance was attributed to our overspend on employee costs, driven largely by the continued use of escalation wards staffed at premium rates and underperformance in respect of Cost Improvement Programme. This was offset by reductions in non-pay spend, specifically clinical supplies, because of the unavailability of theatres due to ventilation issues.

RCE confirmed that the full balance of Elective Recovery Fund (ERF) income included within the plan would be received and would not be dependent upon activity. However, the introduction of the Aligned Incentive Payment (AIP) scheme represented a risk of financial penalties in respect of underperformance associated with the elective programme.

The Board **NOTED** the report.

9.4 Monthly Maternity Update (including Ockenden 2 Progress)

TF reported to the Board the monthly Perinatal Clinical Surveillance Quality Assurance Report to ensure ongoing oversight of the quality of care in Maternity and Neonatal Services. TF confirmed there were no areas of concern to raise this month.

TF highlighted that Ockenden 2 progress continues and confirmed the Board would be provided with a full review of actions at the July Board meeting, following an initial assessment of the 15 Immediate and Essential Actions at May's Board meeting.

SR commented that good progress continued to be made against Ockenden 2 and the Maternity Unit was safe and effective. No issues had been reflected by the Local Maternity and Neonatal System (LMNS). The Trust had also appointed a new Director of Midwifery following the retirement of the previous post holder.

The Board **NOTED** the report.

9.5 Digital Healthcare Update

CM provided the Board with a progress update on the development and agreement of operational plans to deliver the Digital Strategy strategic priorities of the Trust over the next 12 months.

CM also indicated future plans for reporting to Board to provide assurance at this level.

SI queried if the Trust had still been experiencing a delay in receiving IT equipment due supply chain issues.

	CM confirmed the duration had improved but some IT equipment such as servers and laptops were typically taking 2-3 months to be received. The Board **NOTED** the update. **9.6 Estates and Facilities Update** MS provided to the Board an overview of the report, including the proposed assurance dashboard for strategic priorities for the Estates Strategy which would be provided on an ongoing basis to the Board. SR queried if the asset management and maintenance survey had been completed yet. MS confirmed the survey was taking place and would be discussed further at a future Capital Committee meeting. The Trust would likely secure a managed service contract option instead of a replacement programme, with a provider recommendation being presented to the Board next April. The Board **NOTED** the update.	
10	**Operational Plan for 2022/23** HK commented that the report provides the Annual Operational Plan that incorporates all elements of activity and operational performance, workforce plans to deliver the annual activity plans, quality plans that outline the key priorities and a financial plan that ensures the Trust remains financially sustainable. The Board **NOTED and APPROVED** the report.	
11	**NHS Staff Survey 2021** DS noted that the results of the survey have been shared with the Workforce Assurance Committee since the embargo was lifted, and highlighted the next steps for disseminating both the results and our plans following those results. The Board **NOTED** the report.	
12	**Modern Slavery Statement** CH noted that this report provides the annual statement that the Board must approve in line with the Modern Slavery and Human Trafficking Act 2015. The Board **APPROVED** the updated statement for 2022/23.	
13	**Communications and Engagement**	

	SS gave an overview of the report and highlighted some of the key activity, including the upcoming leadership conference and the return to in person awards for staff side. The Board **NOTED** the report.	
14	**Committee Chairs Reports** **14.1 Audit Committee** The Chair of the Audit Committee provided a verbal report to the Board on recent proceedings of the meeting held on 23 May. The Committee had received the draft 2021/22 Quality Accounts as well as the draft 2021/22 Annual Report and Accounts and an external audit progress report. The Committee had approved each ahead of the Board of Directors meeting on 8 June whereby the Board would sign off each. The Board **NOTED** the report. **14.2 Quality Committee** The Chair of the Quality Committee provided a report to the Board on recent proceedings of the meeting held on 25 May. The Committee subsequent to the Audit Committee approved the draft 2021/22 Quality Accounts. The Committee received the Q4 2021/22 Learning from Deaths Report and the Serious Incident Review Panel's Chair's Report. The Committee also received an update on the Care Quality Commission Action Plan. The Board **NOTED** the report. **14.3 Workforce Assurance Committee** The Chair of the Workforce Assurance Committee provided a verbal report to the Board on recent proceedings of the meeting held on 26 May. The Committee received a staff story which highlighted the value of the Trust's Equality, Diversity, and Inclusion work. The Freedom to Speak Up processes continue to work well and there had been zero anonymous reports, which provided assurance that the reporting culture was changing positively. The Trust's People Strategy was moving to detailed implementation planning and success measures were being defined. The 2021 Staff Survey results was now with Divisions for detailed improvement planning.	

	The Board **NOTED** the report.	
15	**Questions from the Public** No questions from the public were raised.	
16	**Any other Business** No other business was raised.	

(The meeting closed at 12:15)

Action Log
Board of Directors – Public Meeting
6 July 2022

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	2 March 2022	8	To provide further details in respect of the review of Governance structures and Committee Terms of Reference.	David McGovern	In progress. Included in Board workshop to discuss the action planning for the Well Led Review.	July 2022
2.	2 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	In progress. Deferred to October 2022.	October 2022
3.	4 May 2022	7	To ensure the Audit Committee are provided with assurance that actions following a RIDDOR were completed.	Cate Herbert	In progress. This will be completed in time for the next Audit Committee in September.	September 2022
4.	4 May 2022	8	To provide a presentation to the Capital Committee on theatre ventilation once work is completed.	Matthew Swanborough	Complete. Include on the Capital Committee cycle of business for the October meeting.	October 2022
5.	4 May 2022	11	To provide an updated report to Board with the Ockenden 2 Gap Analysis, and to include a timescale for any items that are not fully compliant.	Tracy Fennell	Complete. A progress update on the gap analysis be brought back to July.	July 2022
6.	1 June 2022	5	To provide an update to the Board regarding progress about improvements in ED required to improve performance and safety.	Hayley Kendall	Complete. Scheduled on the agenda for July.	July 2022
7.	1 June 2022	7	Consider a joint letter with Wirral Community Health and Care be sent to the Wirral Place Director regarding contract tenders and awards.	Janelle Holmes	Complete. Having had further constructive conversations with the Place Director, it has been agreed a letter is not required at this point in time.	July 2022

Board of Directors in Public **Item No 7**
6 July 2022

Title	Chief Executive Officers' 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 June. It is recommended that the Board notes 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 IPC Update** Nationally IPC measures have continued to reduce and these changes are now being seen through IPC policy for Acute Trusts. In response the Trust has eased some of its IPC measures throughout June 2022. As a result, some face-to-face meetings have been reintroduced and the capacity of the education centre has been increased to support recovery of mandatory training and education requirements. In early June following updated national guidance the Clinical Advisory Group approved removal of routine use of surgical face masks in all areas except for high-risk

	areas (e.g. neonates, Haematology, Dialysis). It was agreed staff could continue to wear masks if they had a preference to do so. FFP3 masks remained in use for all staff spending prolonged periods in high-risk areas where the patients are known COVID positive. The Trust also revised the visiting policy in line with national recommendations permitting 2 visitors per patient for one hour per day. Due to an increase in number of patients identifying with positive cases of COVID in the latter end of the month, the Trust took a risk-based decision to reintroduce surgical face masks in clinical areas for both staff, patients, and visitors in a bid to protect individuals from the risk of nosocomial infections and reduce transmission. The Trust continues to risk assess its IPC measures weekly via the Clinical Advisory Group and amend local guidance based on prevalence, risk, and latest guidance.
1.2	**Chief Midwifery Officer visits WUTH** Professor Jacqueline Dunkley-Bent, England's Chief Midwifery Officer visited the Trust on 9th June 2022, along with Sascha Wells-Munro, Deputy Chief Midwifery Officer and Susan Stansfield, Regional Chief Midwife, NHS England The national team are visiting all Midwifery Services across England. The Safety of Maternity Services Visit focuses on setting the shared vision "*Maternity services in England to be the safest place to be pregnant, give birth and transition into parenthood and for staff to feel value, respected and invested in".* On the day there was a strong focus on maternity services at WUTH and a positive celebration of the Trusts success in delivering high standards of quality maternity care. The visiting team felt this was evidenced by the strengthened clinical governance structure, leadership structure & investment innovation and positive psychological safety culture and strong board oversight that had been achieved, it was emphasised by the Chief Midwifery Officer for England the future challenge and importance of sustainability. The national team also took time to share the consistent themes that had been found during their review of other maternity services on safety support programmes and noted they were sharing these learning themes across the country. During the visit Debbie Edwards (Director of Nursing and Midwifery – Women's and children's Division) was awarded the National Chief Nursing and Midwifery Silver Award for her outstanding contribution to developing maternity practice and her commitment to leading safe maternity Services at WUTH and across the region.
1.3	**Serious Incidents** The Trust declared 5 serious incidents (SI) in the month of May 2022; this is a decrease of 3 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 5 reported incidents, which spanned areas of the trust, including the Surgical Services (1) Acute (1) and Women and Children's (3). The Trust reported 0 Never Events in the month of May. Duty of Candour has been commenced in line with legislation and national guidance. **RIDDOR** There have been four incidents that were reported to the Health & Safety Executive (HSE) in accordance with RIDDOR in May 2022. One event was reported as a specified injury to a member of the public who tripped in the hospital grounds and sustained a fracture.

	The other three were staff incidents, two due to moving and handling and one following an assault by a patient.
1.4	**Senior leadership appointments** Following a competitive selection process, Ged Murphy, Acting Chief Executive, has been appointed to the substantive role of Chief Executive for East Cheshire NHS Trust. Two appointments have been made to the NHS North West regional leadership team in the roles of Regional Chief Nurse and Regional Medical Director. Dr Michael Gregory has been appointed to the post of Medical Director, and Jackie Hanson to the Chief Nurse post as a part-time job share with Hayley Citrine.
1.5	**Key documents for consultation** As part of the development of ICSs, NHSE/I have issued three documents for consultation: a draft Code of Governance, a draft Addendum to Governor duties, and draft Guidance on Good Governance and Collaboration. The Draft Code of Governance is a revision of the 2014 document issued by (then) Monitor, and sets out a common overarching framework for corporate governance. Unlike the 2014 code, this will have provisions for and apply to provider trusts as well as foundation trusts. The Code also draws from best practice and the recent revisions to the UK Code of Governance. Draft Code of Governance (england.nhs.uk) The draft Addendum to Governors' Duties supplements the existing guide, and aims to clarify the role of the Council of Governors in the ICS. The document details additional considerations for the core duties of the governors, and widens the engagement role of the governor to ensure they are not restricted to representing small section of the population i.e. just their electorate or those within the vicinity of the Trust. Draft Addendum to Your statutory duties – reference guide for NHS foundation trust governors (england.nhs.uk) The draft Guidance on Good Governance and Collaboration aims to set an expectation on how providers should be working and collaborating with partners through system and place-based partnership, along with the governance that must be in place to support this. The document encourages collaboration and requires collective responsibility for tackling issues. Draft Guidance on good governance and collaboration (england.nhs.uk) All three documents are out for consultation until the 8th July, and are available via the links above for review.
1.6	**Urgent and Emergency Upgrade Programme (UECUP) at Arrowe Park Hospital** Following the submission of the full business case (FBC) to NHS England, in May 2022, for the redevelopment of the urgent and emergency care precinct at Arrowe Park Hospital, the Trust has undertaken an FBC Gateway 3 Review with support from the Department of Health and Social Care. The aim of the Government Gateway 3 Review is to confirm that the FBC has the relevant information including that the project has the necessary funds and authority to proceed, confirmation that the objectives and desired outputs of the project are still aligned with the programme and that management controls are in place to manage the project through to completion.

	The Gateway 3 Review was undertaken by representatives from the Department of Health and Social Care between 27th June and 1st July 2022, with a range of interviews held with stakeholders from across WUTH, Wirral Community Health and Care NHS FT and Wirral CCG, along with key document reviews. The Gateway 3 Review report is due to be finalised and presented to the Trust in July 2022, and will support the Trust's submission of the FBC to the Department of Health and Social Care Joint Investment Committee meeting in late July 2022.
1.7	**Community Diagnostic Centre expansion bid** In conjunction with Clatterbridge Cancer Centre NHS FT, the Trust has submitted a capital bid to Cheshire and Merseyside ICS for the expansion of the Community Diagnostic Centre on the Clatterbridge Hospital campus. The bid includes a new modular building, with CT and MRI facilities, consultation rooms and patient change areas and would allow the Trust to continue to improve patient access to rapid diagnostics and align with the expansion of operating theatres on the hospital campus. A decision on the bid is expected to be made by Cheshire and Merseyside ICS and NHS England in August 2022.
1.8	**'Leadership for all' – Trust Leadership Conference - 22 June** We were delighted to be able to bring together our leaders from all levels in the Trust on June 22 for a conference for 220 people. We invited senior leaders and staff who self-nominated to attend, so that we would have a genuinely representative cross section of colleagues in leadership roles at all levels, fulfilling our intention that we want to grow the leadership potential in all our staff and continuously improve as a well-led organisation. It was the first face to face training and development event for a group of leaders in over two and a half years, due to the COVID-19 pandemic. It was a great opportunity to share in plenary sessions with a guest speaker on trust in leadership, Professor Veronica Hope-Hailey and also to hear from our Director of Strategy and Partnerships, Matthew Swanborough on progress with our strategy. The Trust Chair, Sir David Henshaw and I welcomed delegates and took the opportunity to speak about the strategic changes in the Cheshire and Merseyside NHS provider and integrated care landscape, plus we also took time to thank our staff and leaders for all their hard work and dedication to patients, in what the chairman described as 'the most challenging time in the NHS' recent history'. In the afternoon, delegates were able to select from a range of workshops on quality improvement, digital healthcare, leadership awareness and skills to have great conversations, compassionate and inclusive leadership and leading high performing teams. We also hosted a 'marketplace' featuring exhibitions and stalls from suppliers and trust teams showcasing wellbeing initiatives like yoga and our Employee Assist provider of employee support, the plans for our new Urgent and Emergency Care Upgrade Project (UECUP), our clinical research team, WUTH Charity, the volunteering and apprenticeships team and our Library, plus our Digital Healthcare Team and Cerner, who demonstrated amazing advances in virtual reality headset technology and how it can be used in healthcare.

	We used the conference to launch the new 'Leadership for all' Leadership Qualities Framework, which is a document and a structured approach to supporting our people to progress on their personal and professional leadership journey. The value and benefits of investing in an important opportunity to work together as a leadership team – with patients and service excellence as our goals- were clear to see on the day and will bring lasting benefits to our work as a team.

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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Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 8**
06 July 2022

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

Report Purpose and Recommendations

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

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

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 and the key performance metrics for the Emergency Department (ED).

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key risks:

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

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

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

1	Introduction / Background
	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the National Emergency Preparedness Resilience and Response (EPRR) to the COVID-19 pandemic, WUTH continues to progress elective care recovery plans to reduce the waits for elective care. Patients are prioritised in line with the nationally mandated clinical prioritisation of patients, with a focus on those prioritised as clinically urgent. 2022/23 will see this work expand to outpatients and non-admitted patients. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. Through the pandemic unscheduled care performance was extremely challenged and this continues with the high bed occupancy levels within the Trust.

2	Planned Care
2.1	**Elective Activity** For FY 2022/23 the elective activity has been profiled against the corresponding periods in FY2019/20. In May 2022, the Trust over-performed on outpatient activity, achieving 111.08% against a performance target of 105.80%. For elective admissions 92.55% of activity was delivered against a target of 107.40% which is an improvement on the previous month's performance. **Outpatient activity by POD** **Elective activity by POD** Due to unplanned ventilation works, 6 theatres on the APH site continued to be unavailable throughout May, further impacting elective admission activity. The planned re-introduction of the theatres on 1st June 2022 successfully went ahead. A decision on Gynaecology theatre 1 will be made in early July 2022.
2.2	**Priority 2 Performance (P2)** The Trust did not meet the P2 month end trajectories for May the month end final position over reporting 93 P2 breaches against a month end plan of 60, due to the prioritisation that had to take place due to limited operating theatres.

	Target	Actual
New	105.00%	108.57%
F/UP	106.20%	112.05%
Combined	105.80%	111.08%

	Target	Actual
Day Case	109.00%	94.25%
Inpatients	98.30%	82.15%
Combined	107.40%	92.55%

2.3	**Referral to Treatment**
	
	• 52 Week Wait Performance
	  ○ In May 2022, 814 patients waited longer than 52 weeks, which is higher than the Trust's trajectory of 545. The loss of 6 theatres has led to this position with an indicative 300 procedures a month lost as a direct result. There is a clear need to recover this position into quarter 2.
	• 104 Week Wait Performance
	  ○ As at the end of May the Trust continued to have no patients waiting longer than 104 weeks. This is ahead of the national plan to have zero 104-week waiters by end July 2022.
	• Waiting List Size
	  ○ In May 2022 there were 32,373 patients on an active RTT pathway which is higher that the Trust's trajectory of 31,100. Again, the loss of the theatres has significantly impacted on the position losing approximately 300 cases each month the theatres were unavailable.

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
	  ○ The Trust achieved the TWW standard in May and this is expected to continue in June. However, the 2 week wait standard will be slightly behind target for Q1 due to April's performance where the Breast Service were recovering a backlog position.
	
	• 31 and 62 day treatment
	  ○ Both standards for Urology and Colorectal are not expected to be achieved until the end of Q4 2022/23. Recovery plans have received executive oversight and are being monitored via the Performance Oversight Group.

2.5	**DM01 Performance – 95% Standard** In May 86.15% (pre-submission) of patients waited 6 weeks or less for their diagnostic procedure for those modalities included within the DM01 submission. This is against the new national standard of 95%. Excellent performance should be noted across Echocardiogram, Dexa and Sleep Studies along with Radiology and MR modalities all achieving the 95% compliance target. The main area of challenge is endoscopy, and a full recovery plan has been submitted to the executives and will be monitored weekly. Divisional action plans and recovery trajectories are being monitored via Performance Oversight Group for those modalities below the required standard.
2.6	**Risks to recovery and mitigations** The Trust does have robust systems in place to monitor and review elective performance, with performance for May continuing to be impacted because of the loss of the 6 theatres on the APH site, with workforce availability continuing to be a challenge with the effects of covid still felt within the operational teams. The Trust's activity plans are being monitored at executive level weekly and this will support the ongoing delivery of the national standards, reducing waiting times across all points of delivery and ultimately providing treatment for our patients.

	The clinical divisions are progressing through their plans outlined in the previous update including insourcing, outsourcing and the exciting progress made with the South Mersey Surgical Hub providing much needed additional theatre capacity, due in September 2022. Governance structures are in place across all divisional teams, feeding into the executive led Performance Oversight Group weekly with full participation in regional recovery initiatives.

3.0 Unscheduled Care

3.1 Performance

Type 1 performance: Performance against the **four-hour standard** for type 1 attendances has increased from 50.42% in April to 51.06% in May.

Type 1 ED attendances:

- 7,707 in April
- 8,407 in May
- 9.1% increase

Type 3 ED attendances:

- 2,750 in April
- 2,901 in May
- 5.5% increase

Despite an increase of 700 patients attending ED in May 2022, the overall ED performance position has improved. One reason for this is that medical staffing levels were improved in May compared with April.

There were 28 patients that breached the 12 hour DTA target in May, this is not unexpected with the level of occupancy that the Trust is running at and the restart of the full elective programme. Adding an additional challenge to this is the level of patients that we have in an acute bed that do not have a criteria to reside. The criteria to reside position remains a significant concern for the Trust with over 200 patients in the acute bed base. The Trust's concern has been escalated to system partners for a response due to the level of risk that the Trust is holding in this area.

The main challenge for the department is physical space with attendances some days reaching 350 compared to the average of 270 attendances per day. The table below details the APH ED attendances compared to the levels of 2019/20 (deemed our base year prior to Covid-19):

Arrowe Park Site ED Type 1 Attendances vs 2019					
Month	2022/23	2019/20	YoY Varia	% Var	% of 19/20
April	7,707	7,585	122	1.6%	101.6%
May	8,407	7,696	711	9.2%	109.2%

3.2 Risks to improving performance

- Physical environment in ED is challenging during peaks in demand impacting on ability to delivered the timed pathways and there is regular overcrowding
- There are significant increases in walk in attendances to ED

	• Delivery of the LLOS recovery trajectory is at risk due to community capacity constraints for complex discharge pathways 1,2,3 • Boarding time in department increased due to bed pressures and the risk of increasing 12 hour DTAs • Increasing mental health activity and significant increases of attendances under S136 leading to the Mental Health Unit being regularly over 100% and patients being cared for in the ED Initial Assessment Area • 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 impacting bed occupancy and the ability to deliver the full elective programme • 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 demand and ED performance and bed occupancy levels. Recovery of the elective programme has been impacted by the lack of operating theatres during April and May however with the 6 theatres now back online from 1st June 2022 this will significantly support the admitted recovery position.

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Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
06 July 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 May 2022.

It is recommended that the Board:

- Note the report and performance to the end of May 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

1	Narrative
1.1	Of the 49 indicators that are currently reported against thresholds (excluding Use of Resources): - 34 are off-target or failing to meet performance thresholds - 15 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.

	Some thresholds only apply from April 2022 onwards as they are components from the 2022/23 operational plans. Further development work is 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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Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	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	0.20	0.05	0.05	0.10	0.10	0.05	0.19	0.18	0.18	0.22	0.04	0.22	0.09	0.15	
	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	96.6%	96.6%	96.2%	97.6%	96.9%	96.9%	97.2%	96.9%	96.7%	96.2%	96.4%	96.8%	96.9%	96.9%	
	Never Events	Safe, high quality care	CN	0	SOF	1	0	2	0	0	0	0	1	0	1	0	0	0	0	
	Clostridioides difficile (healthcare associated)	Safe, high quality care	CN	Maximum 72 for 2022-23. Max 6 cases per month	WUTH	7	5	1	6	13	6	5	3	18	12	13	7	8	15	
	Gram negative bacteraemia : e-coli	Safe, high quality care	CN	Maximum 56 for 2022-23. Max 4 cases per month	National	-	-	-	-	-	-	-	-	-	-	-	8	4	12	
	Gram negative bacteraemia : klebsiella	Safe, high quality care	CN	Maximum 19 for 2022-23. Max 1 case per month	National	-	-	-	-	-	-	-	-	-	-	-	0	4	4	
	Gram negative bacteraemia : pseudomonas	Safe, high quality care	CN	Maximum 9 for 2022-23. Max 0 cases per month	National	-	-	-	-	-	-	-	-	-	-	-	0	0	0	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	1	0	0	0	0	0	0	0	1	0	0	0	0	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	1	1	0	0	0	0	0	1	1	1	4	0	4	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	96%	95%	96%	96%	96%	95%	96%	96%	94%	95%	92%	89%	91%	90%	
	Safeguarding Audits	Safe, high quality care	CN	≥90%	WUTH	-	-	-	-	-	-	-	-	-	-	82.6%	71.6%	93.5%	83%	
	Mandatory Training compliance	Safe, high quality care	CPO	≥90%	WUTH	87.9%	89.1%	90.1%	90.9%	91.3%	90.8%	90.5%	90.4%	89.0%	87.2%	87.2%	87.17%	89.21%	89.2%	
	Sickness Absence % (12-month rolling average)	Safe, high quality care	CPO	≤5%	SOF	6.10%	6.05%	6.12%	6.17%	6.21%	6.22%	6.24%	6.40%	6.48%	6.53%	6.70%	6.79%	6.83%	6.8%	
	Sickness Absence % (in-month rate)	Safe, high quality care	CPO	≤5%	SOF	5.68%	5.68%	6.48%	6.53%	6.62%	6.67%	6.37%	7.86%	8.72%	7.05%	7.73%	6.84%	6.23%	6.54%	
	Staff turnover % (rolling 12 month rate)	Safe, high quality care	CPO	≤10%	WUTH	13.2%	13.3%	13.0%	12.6%	12.9%	13.3%	13.2%	13.4%	13.7%	13.9%	14.1%	14.1%	14.4%	14.4%	
	Care hours per patient day (CHPPD) - number of wards below 6.1	Safe, high quality care	CN	No of wards ≤3	WUTH	-	-	-	-	-	-	-	-	-	-	3	1	4	2.5	

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	98.3%	98.3%	95.9%	96.7%	96.4%	96.2%	93.8%	92.6%	91.7%	96.7%	96.9%	94.6%	97.1%	95.9%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	98.0%	98.0%	98.0%	97.0%	96.0%	96.4%	95.5%	94.6%	95.2%	97.3%	96.3%	97.7%	98.3%	98.0%	
	Long length of stay - number of patients in hospital for 21 or more days	Safe, high quality care	MD / COO	Maintain at a maximum 79 (Revised April 2022)	WUTH	85	99	95	126	132	126	141	157	206	195	187	220	194	194	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	85.5%	82.5%	79.8%	82.0%	83.4%	83.7%	82.0%	77.9%	77.2%	77.9%	83.7%	79.3%	83.1%	81.5%	

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	2	3	4	1	2	2	3	8	3	2	3	1	1	2	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	83.0%	82.0%	76.0%	76.0%	71.1%	72.8%	72.4%	77.7%	75.9%	77.3%	67.2%	74.0%	74.7%	74.3%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	95.0%	95.0%	95.0%	96.0%	94.0%	94.3%	95.1%	94.4%	95.4%	94.5%	92.3%	94.8%	94.1%	94.5%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	94.0%	95.0%	93.0%	94.0%	93.2%	94.1%	93.7%	94.3%	94.3%	94.1%	93.6%	93.5%	94.3%	93.9%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	95.0%	93.0%	97.0%	98.0%	94.1%	98.8%	94.7%	94.6%	96.6%	93.5%	97.7%	93.1%	98.0%	95.5%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	≥95%	National	73.5%	78.0%	67.8%	66.2%	63.4%	62.6%	59.5%	60.6%	59.1%	63.1%	61.5%	63.1%	63.4%	63.2%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	1	7	11	8	6	6	13	7	17	39	24	63	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	100%	National	68.1%	73.4%	57.7%	66.7%	48.1%	58.1%	49.8%	57.2%	57.3%	61.7%	54.0%	52.5%	53.5%	53.0%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	0%	National	2.7%	2.2%	8.0%	5.0%	9.2%	8.2%	9.4%	8.8%	11.0%	8.1%	11.6%	13.7%	10.7%	12.2%	
	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	78.9%	74.6%	73.9%	82.4%	86.9%	91.2%	85.0%	88.1%	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	10.4%	7.6%	14.5%	14.3%	23.5%	21.9%	22.8%	19.2%	18.0%	15.5%	25.2%	23.9%	21.9%	22.9%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	≥92%	SOF	72.57%	75.64%	75.13%	74.14%	72.88%	70.84%	70.14%	67.84%	67.57%	65.89%	65.38%	64.08%	66.72%	66.72%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	25873	26671	26979	27306	27424	26935	27046	27406	28665	29445	30430	31504	32373	32373	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	633	526	507	560	606	575	510	557	475	525	582	730	811	811	
	Referral to Treatment - cases waiting 78+ wks	Outstanding Patient Experience	COO	NHSEI Plan Trajectory 2022-23	National	90	90	117	177	163	116	70	72	59	65	60	70	71	71	
	Referral to Treatment - cases exceeding 104 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	1	1	3	3	7	10	5	5	4	5	1	0	0	0	
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥99%	SOF	98.5%	96.8%	87.5%	86.0%	91.3%	94.3%	93.0%	89.8%	87.3%	86.4%	85.2%	82.8%	86.0%	84.4%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	97.6%	97.2%	95.4%	93.7%	95.7%	96.1%	87.9%	91.4%	76.2%	78.0%	76.2%	85.8%	96.6%	91.2%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	-	97.21%	-	-	94.95%	-	-	91.63%	-	-	76.7%	-	-		
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	95.2%	99.2%	96.3%	96.4%	96.5%	95.4%	94.3%	94.8%	94.6%	95.1%	92.6%	91.2%	93.3%	92.3%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	-	96.26%	-	-	96.41%	-	-	94.85%	-	-	94.1%	-	-		
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	84.1%	85.3%	84.7%	85.9%	84.4%	79.2%	79.7%	79.3%	79.6%	79.3%	75.9%	79.2%	79.2%	79.2%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	-	84.66%	-	-	85.05%	-	-	79.38	-	-	78.1%	-	-		
	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	81	97	118	118.00	
	Cancer - Faster Diagnosis Standard	Outstanding Patient Experience	COO	≥75% within 28 days	National	81.0%	81.2%	80.4%	78.2%	77.9%	79.8%	79.2%	80.5%	70.5%	78.9%	79.5%	76.7%	75.8%	76.2%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	156	145	209	213	218	216	177	149	180	187	211	170	185	178	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	2.56	4.04	4.20	3.31	3.29	2.56	3.27	3.26	2.34	4.87	3.05	4.50	3.96	4.23	
	Formal Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	93%	95%	100%	94%	94%	100%	61%	100%	100%	100%	100%	100%	86%	93%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	2	1	2	5	2	3	4	3	2	0	0	2	2	2	
	NEWS2 Compliance	Outstanding Patient Experience	MD/CN	≥90%	WUTH	-	-	-	-	-	-	-	-	-	-	85%	85.2%	88.3%	87%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	Trend
Well-led	Duty of Candour compliance - breaches of the DoC standard for Serious Incidents	Outstanding Patient Experience	CN	0	WUTH	-	-	-	-	-	-	-	-	-	-	-	0	1	1	
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	700 for FY 22/23 (cumulative 59 per month until year total achieved)	National	38	107	279	457	613	774	958	1121	1445	1575	1666	20	53	53	
	% Appraisal compliance	Safe, high quality care	CPO	≥88%	WUTH	81.3%	82.7%	82.7%	82.2%	81.2%	82.2%	82.7%	82.3%	82.0%	78.0%	77.9%	77.16%	83.24%	83.2%	

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	-0.5	-0.2	0.0	0.2	-0.2		-0.7	-0.6	2.3	-0.1	0.1	-956.0	-421.0	-421.0	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	-0.4	-0.4	0.0	0.2	-0.1	0.0	1.0	-0.9	1.9	-0.5	-0.3	-886.0	319.0	319.0	
	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	Not reported	Not reported	Not reported	
	CIP Performance (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	3.02%	6.03%	9.05%	14.50%	Not reported	77.21%	48.24%	78.70%	78.61%	91.33%	7.26%	45.26%	45.26%	
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	-27.7%	-32.4%	-40.5%	-11.7%	-5.2%	-50.0%	-25.1%	-6.7%	-4.3%	-8.0%	-15.0%	-43.9%	-315.0%	-315.0%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-15.5	-10.4	-15.7	-15.4	-15.2	-16.2	-15.9	-18.0	-16.2	-18.6	-20.0	-21.4	-12.0	-12.0	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	5.6%	12.5%	18.0%	22.6%	24.4%	30.7%	36.3%	48.0%	59.0%	76.2%	100.0%	0.7%	6.0%	6.0%	

Metrics Added

Metrics Amended

Responsive : Threshold added for 'Time to initial assessment for all patients presenting to A&E - % within 15 minutes'
Responsive : Threshold added for 'Proportion of patients spending more than 12 hours in A&E from time of arrival'

Safe Domain

Clostridioides difficile (Healthcare Associated)

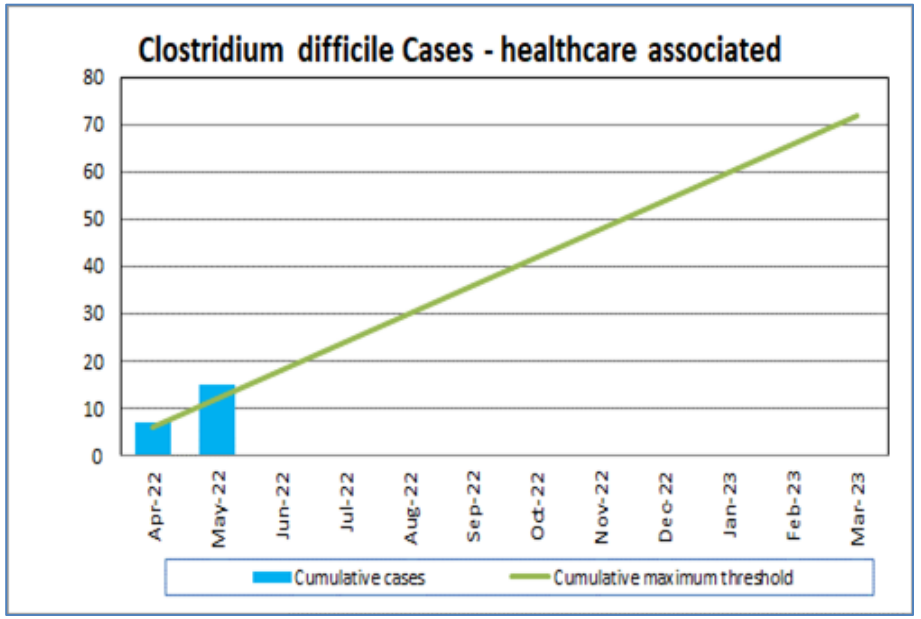
Executive Lead: Chief Nurse

Performance Issue:
The National objective set for WUTH for healthcare associated *Clostridium difficile* infections (CDI) for this year 2022-23 is 72, this is derived from a base line of the 12 months ending November 2021, as this was the data available to NHSE/I at time of calculating the figures. The figures were calculated as below

- If a trust had fewer than or equal to 10 cases during the 12 months ending November 2021, the threshold will be equal to that count. If a trust had more than ten cases, the threshold will be one less than the count.
- All thresholds were rounded down to the nearest whole number and pertain to healthcare-associated cases i.e., Hospital onset, hospital associated (HOHA) and Community onset, Hospital associated (COHA)cases.

The monthly trajectory has been calculated by dividing the objective by 12, so a maximum 6 cases per month.

There were 8 cases in May, making a cumulative 15 cases for the year-to-date. This is 3 higher than the cumulative threshold.



Action:

The weekly Chief Nurse led CDT meeting continues which reviews each patient pathway, identifies the causative factors which inform the local

action plans to focus on improvements. The common themes are being addressed by the QI initiative. Focus is being made on early sampling in assessment areas. A system-wide action plan is being developed that will be presented to the first ICB quality meeting. A regular report is also now being provided to wards listing patients who are having diarrhoea, but a sample has not been collected to ensure samples are collected at the earliest opportunity. A new daily digital sit rep has also been created to improve overview of side rooms to ensure patients are isolated promptly.
Expected Impact: Reduction in patients diagnosed with healthcare associated *Clostridioides difficile*

Gram-Negative bloodstream infections - klebsiella

Executive Lead: Chief Nurse

Performance Issue:

For 2022-23 the maximum threshold for Gram-negative blood stream infections has been separated into the component elements of *E-coli, klebsiella* and *pseudomonas*. All thresholds are derived from a baseline of the 12 months ending November 2021, as this is the most recent available data at the time of calculating the figures.

For each of the three Gram-negative bloodstream infection types specified, if a trust had fewer than or equal to 10 cases during the 12 months ending November 2021, the threshold will be equal to that count. If a trust had more than 10 cases, the threshold will be 5% less than the count. All thresholds were rounded down to the nearest whole number and pertain to healthcare-associated cases i.e., Hospital onset, Healthcare associated (HOHA) Community Onset, Hospital associated (COHA)

The threshold for Gram-negative klebsiella is set at a maximum nineteen cases, with a monthly threshold of a maximum one per month for monitoring purposes.
There were four cases reported in May 2022.

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. Only one case was considered to have a lapse in care actions have been enacted to address the identified issue.

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.

Mandatory Training %

Executive Lead: Chief People Officer

Performance Issue:

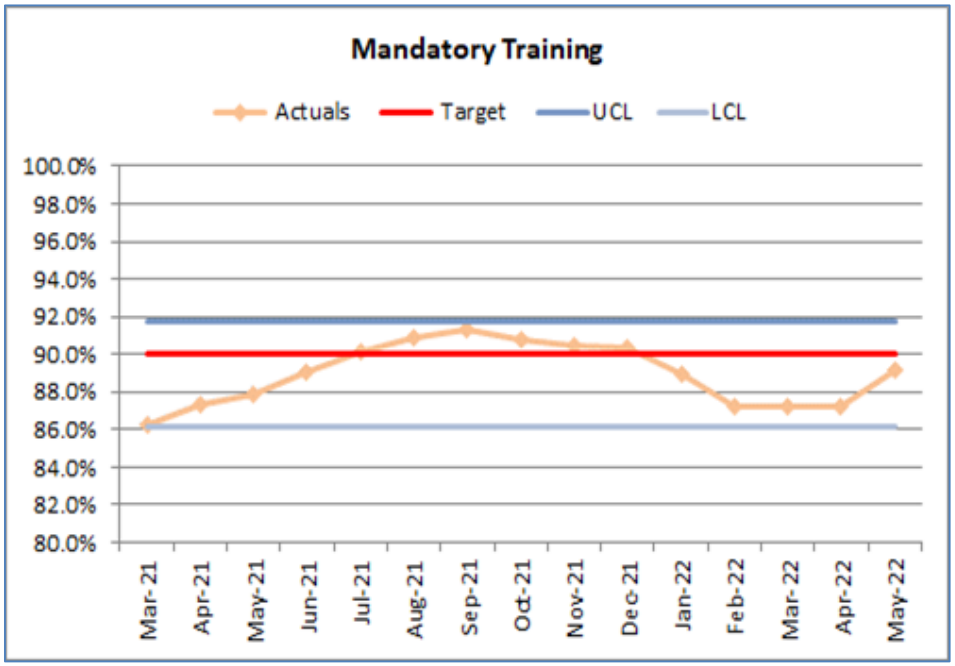
The Trust has an internal standard for 90% of staff to be compliant with applicable Mandatory Training. The rate for May 2022 was 89%

In May 2022, Clinical Support and Surgery both met the KPI. The highest compliance is Clinical Support at 91%, the lowest is Acute at 84.01%. Improvements this month were seen in all Divisions.

There is a wide variance in compliance by staff group, with Add Prof, Scientific and Technical with the highest compliance rate at 98%, and Medical and Dental with the lowest compliance rate at 74%.

Of the 15 requirements for mandatory training, there are 7 subjects that are meeting the KPI of 90% compliance which are Conflict Resolution, Data Security, Equality and Diversity (Level 1), Fire Safety (Level 1), Infection Control (Level 1), Moving & Handling (Inanimate Load) and Moving & Handling (People Handling).

All other subjects are below 90%, with the lowest compliance levels seen in CPR and PVP Level 3 which stand at 82.39% and 82.73% respectively.



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. Increased focus upon appraisal compliance is being placed at Divisional performance review (DPR) meetings. All Divisions have produced

improvement trajectories and have confirmed expected date of compliance to Trust Management Board.

Steps have been taken by the Learning and Development Team to improve access to mandatory training. This includes significant efforts to target non-compliance by subject. There has been particular focus over the last two months on increasing Health and Safety training which has successfully resulted in an increase in compliance for this subject, and this approach will be implemented for other subject areas of below 90% compliance moving forward.

Arrangements for the re-establishment of the SME Network have commenced as planned, with the first meeting due to take place in July. The aim of the network is to increase engagement and collaboration with SMEs across the Trust, as well as provide a channel for two-way feedback through the Trust's Education Governance Group.

Plans for a phased re-introduction of face-to-face Induction from mid-July 2022 have also now been agreed by the Education Governance Group. From August, this will also see the inclusion of some mandatory training subjects to ensure that staff are able to gain compliance prior to starting in the workplace. Plans are also underway to re-introduce face-to-face e-Learning drop-in sessions which will provide hands on support to people accessing online mandatory training modules.

Expected Impact:

The impact of covid on training provision has been significant and there are a number of challenges in sustaining compliance. It is anticipated that continued focus on targeting completion will continue a trajectory of improvement that enables the Trust to achieve its KPI. However, it must be recognised that a strategic and long-term approach is required, particularly in relation to the provision of face-to-face provision, to achieve sustained increases in compliance.

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 May 2022 has improved to 6.23%, from 6.84% in April. Of this 0.67% is related to COVID-19.

All Divisions, with the exception of Women and Children's, in May 2022 have exceeded the 5% KPI, although all Divisions, except Corporate Support, showed an improvement in May 2022.

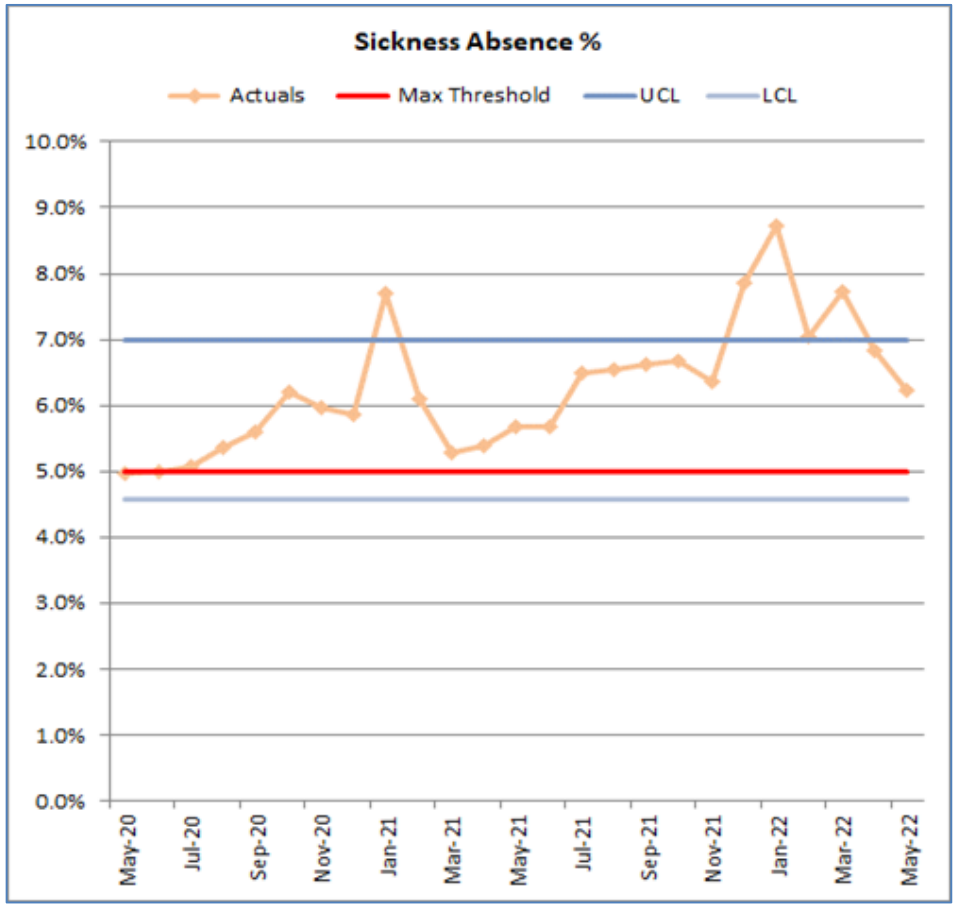
Anxiety, Stress and Depression remains the highest reason for long term sickness absence. The 'Gastro Problems' category was the highest reported reason for short-term sickness, followed by 'Cough, Cold & Flu'.

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). All Divisions have reintroduced Sickness Auditing to ensure the Attendance Management Policy is being consistently applied at departmental level.

The HR Services Team is now fully established and in turn there is now a greater level of oversight and focus on short term sickness. Additionally, on average long term sickness case length, which has reduced with a number of key cases being concluded utilising support from Occupational Health, as appropriate.

NHS E/I have now shared the evaluation report from the Supporting People to Manage Attendance Programme that ran at the end of 2021. The pilot included three Trusts – WUTH, Liverpool Women's and the Walton Centre,



with WUTH staff taking 47.4% of available places. The evaluation found staff are now more willing to discuss sensitive issues that may affect attendance at work, and an increase in participant confidence to manage attendance was reported. The evaluation clearly highlighted that the programme had positive benefits for the individuals who took part. Following evaluation of the pilot, NHS North-West Leadership Academy will now develop a product with an accompanying training package and resources so that this can be cascaded across the Trust.

Health and Wellbeing Conversations and Day continue to be promoted and uptake will be monitored following the recording function going live on ESR so we can capture the data.

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 was 14.38% for the rolling 12 months to May 2022, which is a similar position to that reported in April 2022 (14.1%). Rolling 12-month turnover to May 2022, calculated on permanent assignments only, is 12.18%.

The in-month performance in Estates, Facilities & Capital are below the Trust Turnover KPI. All other Divisions are above.

All Divisions are over the 10% KPI for the rolling 12 months.

Actions:

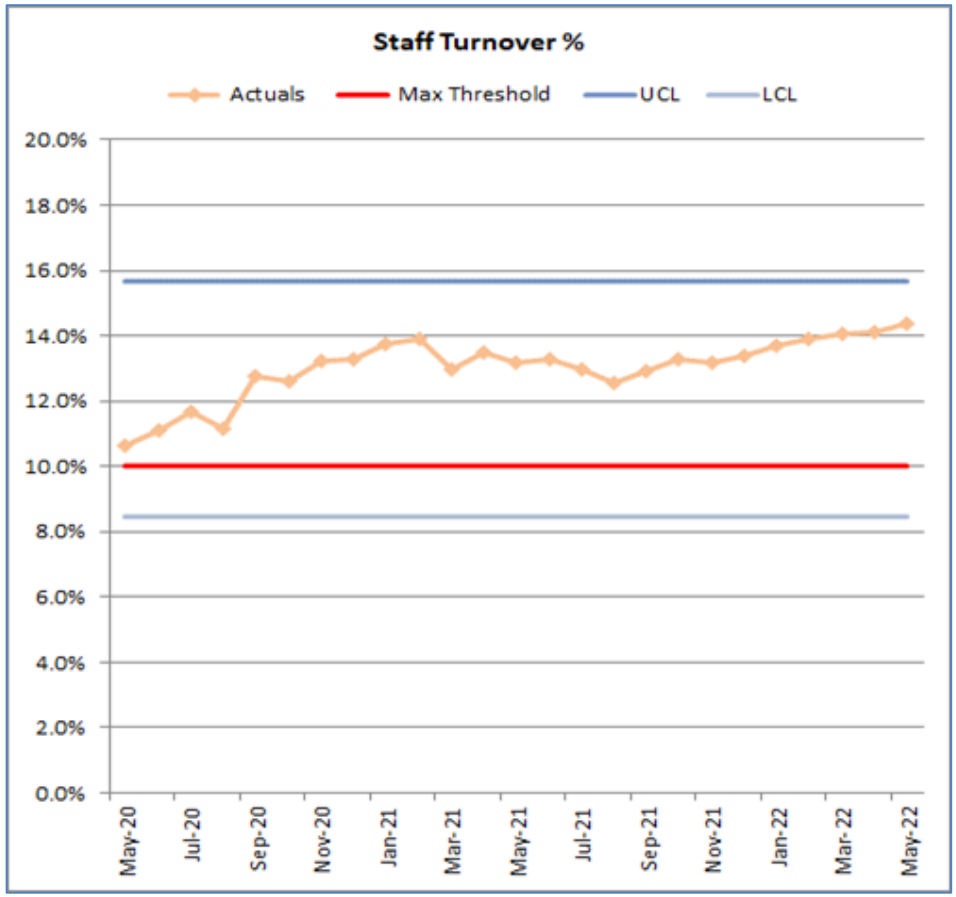
Monitoring of the Turnover KPI is on-going via Divisional Management, Divisional governance infrastructure, and via Divisional Performance Reviews (DPRs), with specific actions in place according to the local feedback. A specific focus on Registered Nurse and CSW turnover is also discussed at the Recruitment and Retention Working Group which meets monthly.

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

A Retention workstream has been included as part of the People Strategy 2022-2026 Delivery Plan and an HRBP project lead identified with key quarterly deliverables to aid the improvement of retention across all staffing groups.

Q1 Activity includes National, Regional and Local activities:

- Utilise into NHS England and NHS National Retentions programme resource to review and implement evidence based best practice.
- Review retention plans from across the Cheshire Mersey network and understand success to date.



- Identify existing retention workstreams and development of a Trust Retention Group which incorporates all staffing groups.
- Commence a gap analysis to understand stand still position and to identify key deliverables to aid in the improvement of retention within WUTH.
- Scope out Q2 activities to understand current position with data mining with reference to source accuracy, time frames of completion and are they fit for purpose.
- Identified Data Sources: ESR, Exit Surveys and Staff Survey

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.

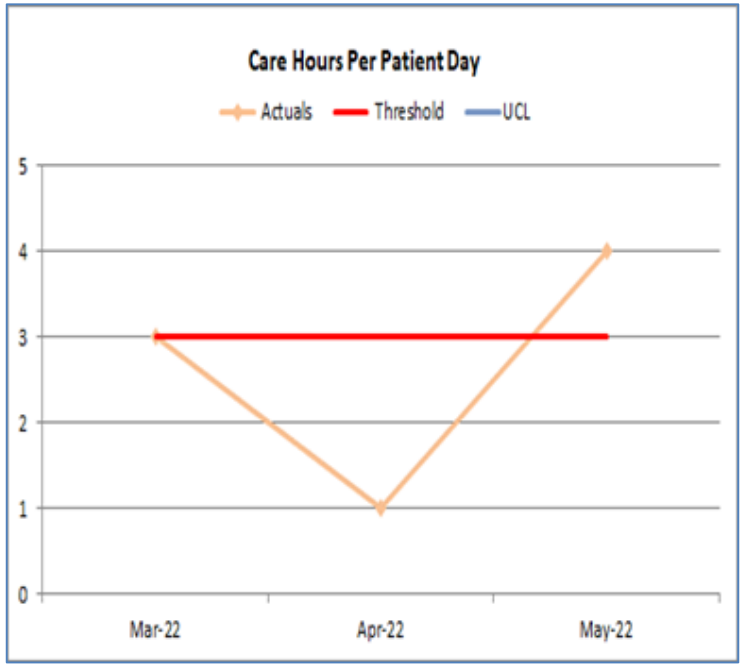
Care Hours Per Patient Day – number of wards below 6.1

Executive Lead: Chief Nurse

Performance Issue:

WUTH monitors the number of wards that are below a Care Hours Per Patient Day threshold of 6.1. The metric for the Trust overall is set at a maximum of three wards to be below this threshold.
The number of wards for May 2022 was four.

The wards that had a CHPPD of <6.1:
Ward 27 = CHPPD 6
Ward 36 = CHPPD 6
Colorectal Unit = CHPPD 6
Ward 38 = CHPPD 5.7



Action:

Three of the wards who had a CHPPD of <6.1 had a variance of 0.1, this is equivalent to 6 minutes of care.

The wards identified will be monitored to see if this is a continuous occurrence using a CHPPD tracker. This tracker will be shared monthly as part of the safe staffing oversight tool data report provided to Divisional Senior Nurse Management Teams. CHPPD is monitored as part of the six-monthly Establishment review process. The Trust is currently in the review process period and will be consider as part of the establishment setting process.

Expected Impact:

A reduction in the number of wards with a consistent CHPPD of <6.1

Effective Domain

Theatre in session utilisation %

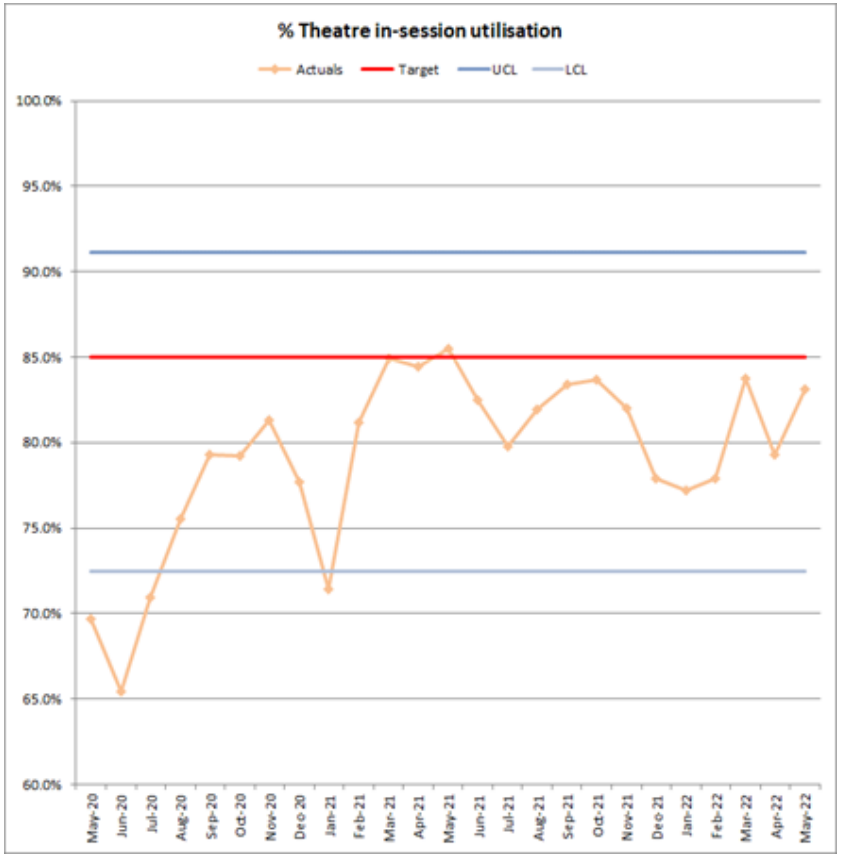
Executive Lead: Chief Operating Officer

Performance Issue:
The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. Overall, May's performance was 83.1%, up from April's 79.3%.

Focus remains on improving utilisation of core sessions as part of reset and recovery. This has been critical given the loss of 6 theatres due ventilation failures resulting in theatres M1 – M5 and G1 being closed to maintain patient safety. Works have been completed in M3-5 and the second fix remedial work of M1 & M2 are holding. G1 remains out of action. Core session utilisation is currently above the target at 98.7%.

Proposals to change the process under "living with COVID" was approved at CAG with in session performance showing an improvement. This was expected to have greater impact however, during June we saw an increased in cancelations on the day for non-clinical reasons due to lack of a bed and lack of operating time though we did see an increase in the number of cases performed.

Recent Peri-op GIRFT measures have been released which WUTH benchmarks favorably against for theatre optimisation. Following the change in COVID pathways the application of the 4-week lockdown of theatres has been achieved.
COVID measures regarding PPE remain in place.



Action:

- Maintain the daily TCI meeting to prevent cancellations on the day for inpatients and risk further reduction in in-session utilisation

• Heavier focus on CGH theatre to ensure >85% in-session delivery, recognizing 4+ patients per list loses circa 8% of capacity • Through TRG focus on the case mix to ensure theatre time maximised
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 was 1 such breach in May 2022. This 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:

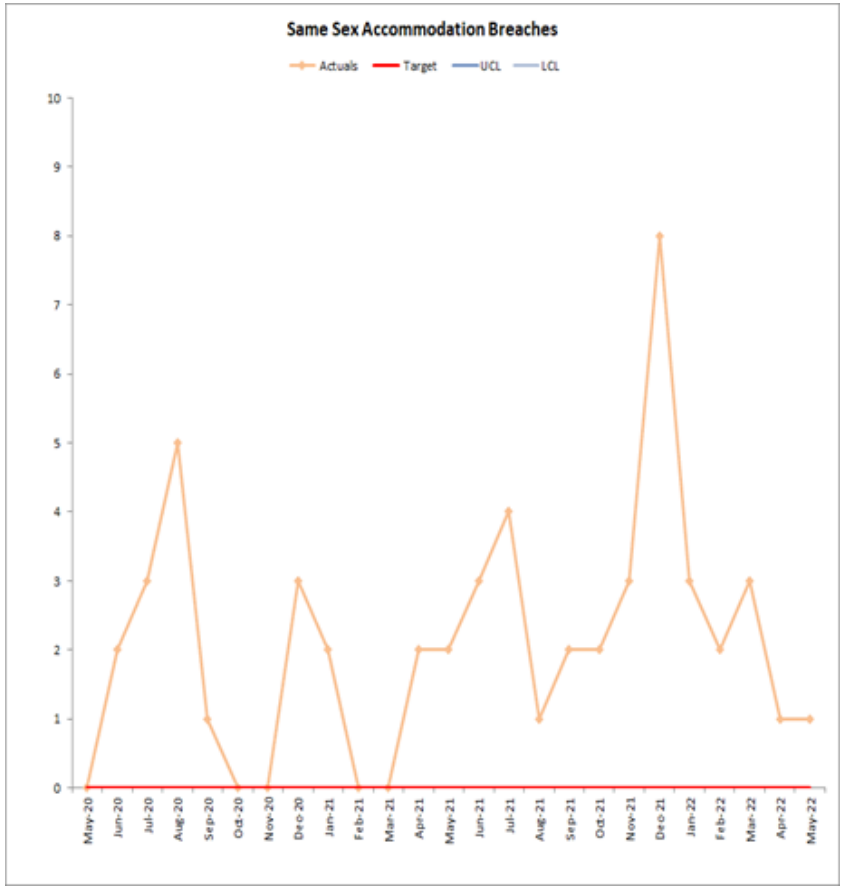
Increased pressure due to system challenges resulting in high levels of activity throughout the hospital and an increased proportion of patients with no criteria to reside continued in May 2022.

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.



Friends & Family Test – Overall Experience

Executive Lead: Chief Nurse

Performance Issue:

A WUTH standard is set for achieving an overall experience rating of very good or good for each of the main care settings.

Performance against the 95% threshold for May 2022 was:

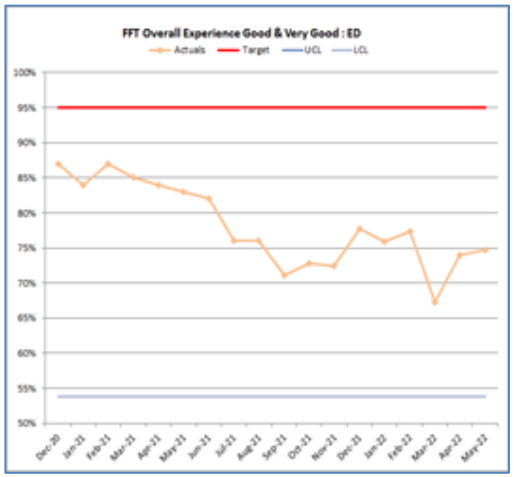
- ED - 74.7%
- Inpatients – 94.1%
- Outpatients – 94.3%
- Maternity 98.0%

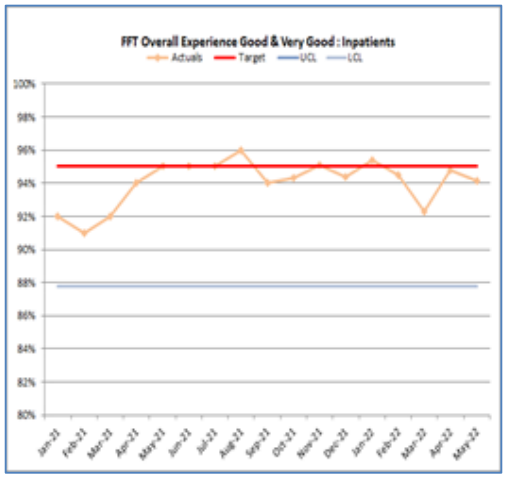
Action:
The Trust formally launched its Patient Experience Strategy on the 4th April 2022 with five strategy promises: Welcome, Safe, Inclusive, Care and Supported. Promise action groups will focus on identifying improvement opportunities to improve the patients' experience.

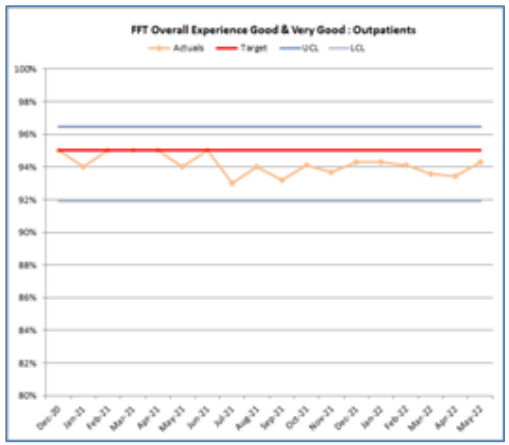
Operational pressures continue within the Emergency Department as they do nationally, whilst FFT scores are low they are in line with other regional organisations and negative feedback focuses on waiting times. ED has a newly appointed Divisional Nurse Director and a meeting to review patient experience feedback has been arranged for August 2022.

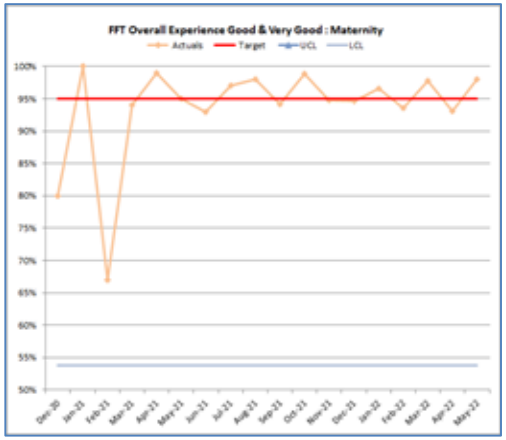
There were fourteen wards that did not meet the target of 95%, of these three wards have now developed a responding to feedback action plan in place. The eleven wards without will be expected to have agreed their action plans by the end of July 22.

Themes from feedback are being coded against the patient experience strategy promise group to support trust wide improvement workstreams.







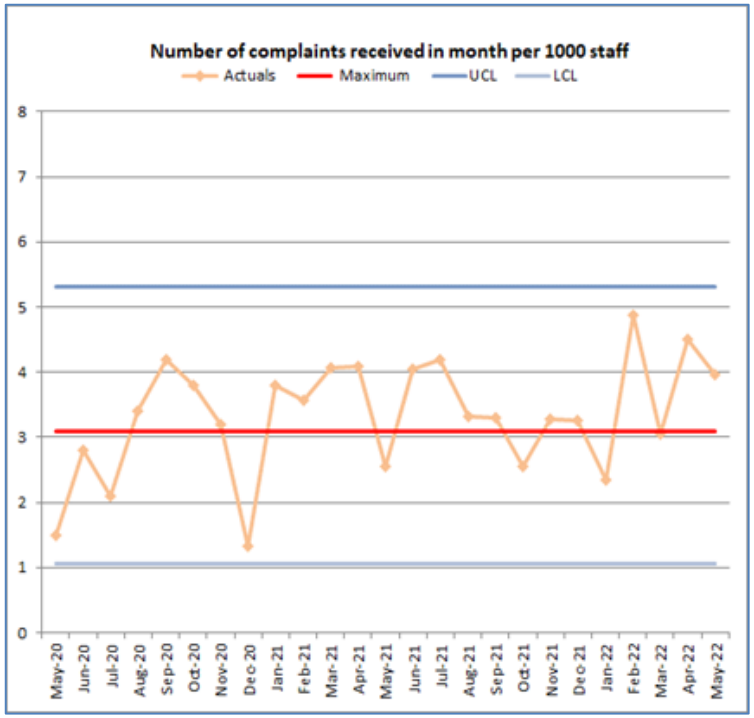


All areas receive regular patient experience feedback and areas are monitored for themes and trends.
Expected Impact: Improved FFT scores with an expectation to reach the Trust target for Inpatients, Maternity Services, and Outpatients.

Responsive

Number of complaints received in month per 1000 staff

Executive Lead: Chief Nurse
Performance Issue: WUTH has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per one thousand staff. The rate for May 2022 was 3.96.
Action: Complaint numbers remain broadly in line with historical performance. Over time, the numbers of complaints received each month have consistently increased in line with the trend seen nationally. Divisions have localised plans to address the main continuing causes of complaint (communication / staff attitude and capacity pressures) and the ways in which these might be addressed.
Expected Impact: Actions being taken will strengthen the approach to complaint management within the Trust.



NEWS2 Compliance

Executive Lead: Chief Nurse

Performance Issue:

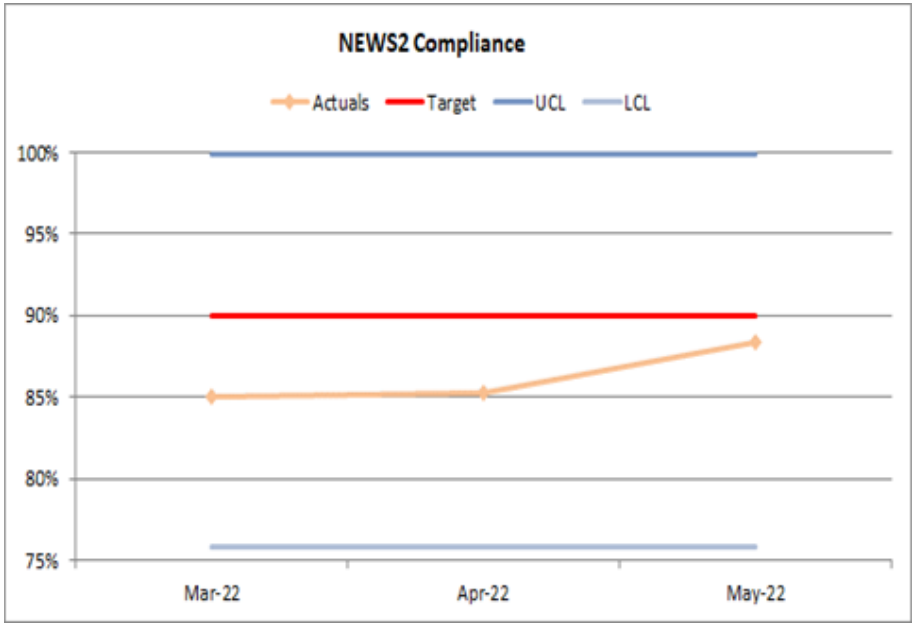
WUTH has set a threshold of greater than 90% compliance with NEWS2 patient observations conducted within timeframes agreed within national guidelines and Trust NEWS2 policy. Compliance is measured by a rolling programme of monthly ward audits - for May compliance was at 88.34%.

Action:

The Trust has progressed two workstreams to support an increase in compliance with the timeliness of recording NEWS2 observations.

Fast-Track Improvement Work

A fast-track improvement plan led by the Trust Medical Director has developed advanced communications in the form of a 'Deteriorating Patient Take 5' poster and a created a live report from the Trust's electronic patient record that identifies each ward / department NEWS2 compliance status. The 'Deteriorating Patient Take 5' communication poster has been presented at Chief Nurse Check-in and has been provided to all areas via Ward Managers as part of their Safety Huddles. To support staff accessing the new live NEWS2 compliance report a "Knowing How You are Doing" presentation has been delivered to all Ward and Department Managers. NEWS2 compliance is reported to the executive Management Team fortnightly as part of a series of Nursing Quality Metrics.
The fast-track improvement plan also includes the planned introduction of integrated systems. This will allow observations recorded on modified observations machines to instantly migrate into patient medical records, increasing compliance with the timeliness of observations.



Quality Improvement Focused Work

The Trust has also established a Deteriorating Patient Faculty, led by the Chief Nurse, to oversee Deteriorating Patient Quality Improvement (QI) work on eight wards across the Trust.
Wards have participated in workshops to identify issues and potential solutions by using QI tools such as Fishbone and Driver Diagrams. Solutions are then assessed on wards using 'Plan, Do, Study, Act' cycles. The solutions are refined on the wards and presented at the executive-led Deteriorating Patient Faculty. Solutions considered successful and sustainable are to be compiled into a Deteriorating Patient Bundle for Trust-wide use

Expected Impact:

The expectation is for all areas to achieve greater than 90% for completing NEWS2 observations within national and locally agreed timeframes.

Well-led Domain

Appraisal compliance %

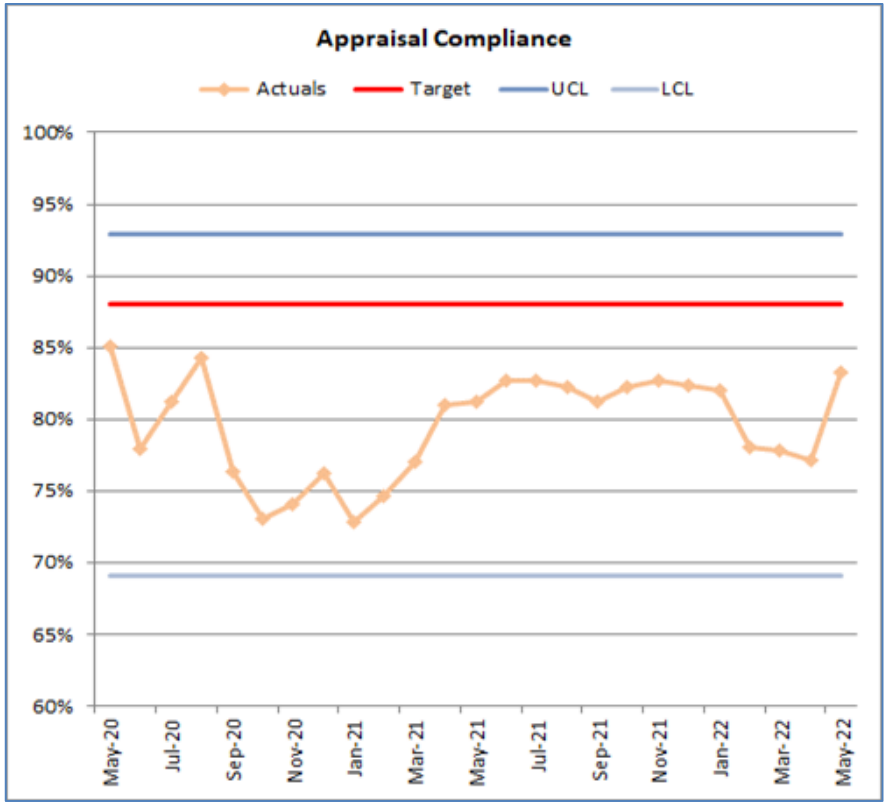
Executive Lead: Chief People Officer

Performance Issue:

The target for annual appraisal compliance is 88%. At the end of May 2022 83% of the workforce had received an appraisal in the last 12 months. This is an improvement of 6% on April's position.

From a Divisional perspective, Clinical Support (88.14%) and Women & Children's (89.44%) have achieved the Trust KPI of 88% appraisal and compliance is currently under 80% in Acute and Surgery. All Divisions, with the exception of Corporate Division, have seen an increase in compliance this month.

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 with alerts of appraisals due 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 is being placed at Divisional performance review (DPR) meetings. All Divisions have produced improvement trajectories and have confirmed expected date of compliance to Trust Management Board.

All outstanding appraisals have been reviewed by the Learning and Development Team, who have directly targeted areas of low compliance in each Division to provide staff with support. This includes prompts of an over-due appraisal with supportive guidance that includes advice on how to record their appraisal onto ESR. Given that this action appears to have had a positive impact on compliance

levels, the Team will maintain this targeted approach with further correspondence being issues by the end of June 2022. As highlighted in previous reports, a review of appraisal has now commenced. Feedback to further inform our future approach has been gathered this month from Trust leaders through a Leadership Conference workshop and recommendations from the review to strengthen the quality of the appraisal experience, enhance its value across the Trust and subsequently drive improvements in both quality and compliance are expected in July 2022.
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 any increase in clinical pressures may create continuing challenges in maintaining appraisal completion rates over forthcoming months.

Board of Directors
6th July 2022

Item No 9.2

Title	M2 Finance Report
Area Lead	Mark Chidgey, CFO
Author	Robbie Chapman, Deputy CFO
Report for	Information

Report Purpose and Recommendations

In April the Board approved a deficit budget of £6.197m for the year 2022/23. This was submitted to NHS England (NHSE) as part of the Cheshire & Merseyside ICS (C&M) 2022/23 initial plan. NHSE required improvements in this position and following subsequent discussion with the ICS and partner organisations, the Trust submitted a revised balanced plan on 20th June 2022. The revised balanced plan includes additional income from NHSE and C&M and is proposed to the Board for approval (see section 2). All monitoring information and variance analysis within this report is in comparison to the the original (deficit) budget.

At M2 the Trust is reporting a deficit of £1.377m, an adverse variance against the original budget of £0.567m. This variance is attributed to overspends on employee costs, driven largely by underperformance in respect of recurrent CIP and the continued use of escalation wards staffed at premium rates. This is offset by:

- reductions in non-pay spend, specifically clinical supplies, as a result of the unavailability of theatres due to ventilation issues.
- release of deferred income.

The introduction of the Aligned Incentive Payment (AIP) scheme has yet to be formally implemented but does represent a risk of financial penalties should current activity underperformance associated with the elective programme continue.

It is recommended that the Board:

- Approves the revised balanced plan for 2022/23; and
- Notes the report.

Key Risks

This report relates to the following key risk:

- 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. A more detailed version of the report was presented to FBPAC on 29/06.

Month 2 Finance Report 2022/23

Contents

1. Executive Summary

1.1 **Table 1: Financial position – M2**

M2 Financial Position	In Month (£'000)			Year to Date (£'000)		
TRUST	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Income from Patient Care Activities	£32,770	£32,863	£93	£65,541	£65,545	£5
Other Income	£3,411	£4,362	£951	£6,820	£7,845	£1,025
Total Income	**£36,181**	**£37,225**	**£1,044**	**£72,360**	**£73,390**	**£1,030**
Employee Expenses	-£24,646	-£25,983	-£1,336	-£48,224	-£51,556	-£3,332
Operating Expenses	-£10,831	-£10,222	£610	-£22,059	-£20,495	£1,564
Total Operating Expenditure	**-£35,478**	**-£36,204**	**-£727**	**-£70,283**	**-£72,051**	**-£1,768**
Non Operating Expenses	-£1,443	-£1,441	£2	-£2,887	-£2,716	£171
Surplus/(Deficit)	**-£740**	**-£421**	**£319**	**-£810**	**-£1,377**	**-£567**

1.2 The Trust is reporting a deficit of £1.377m at M2, an adverse variance against plan of £0.567m.

1.3 Total income was £73.390m at M2, a positive variance of £1.030m. This relates to the release of deferred income in respect of international nurse recruitment and telederma-tology and the recharge of energy costs to Clatterbridge Cancer Centre. All of these costs are offset by increases in expenditure. Income is discussed in more detail in 4.1.1.

1.4 The introduction of the Aligned Incentive Payment (AIP) scheme has yet to be formally approved within Cheshire & Merseyside (C&M) but it is expected to be implemented this financial year. Therefore, the Trust is at risk of financial penalties for any underperfor-mance in respect of the elective programme. We estimate the potential risk at M2 to be penalties of £1.513m. This is not reflected within the position and is discussed in more detail from 4.1.3.

1.5 Total employee expenses including COVID-19 were £51.556m at M2, this represents an overspend against our budget of £3.332m. The overspend against plan is explained at 3.2.3 but is primarily driven by the continued reliance on bank and agency staff as a result of staff sickness and use of escalation wards together with the non-delivery of pay CIP.

Table 2: Pay cost analysis excluding COVID

Pay analysis by Division	IN MONTH			YEAR TO DATE		
	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Consultants	-£4,025	-£4,669	-£644	-£8,281	-£8,511	-£230
Other medical	-£2,678	-£2,964	-£286	-£5,404	-£5,767	-£363
Nursing and midwifery	-£7,112	-£8,352	-£1,240	-£14,408	-£15,577	-£1,169
Allied health professionals	-£1,397	-£1,417	-£20	-£2,791	-£2,838	-£47
Other scientific, therapeutic and technical	-£586	-£558	£28	-£1,175	-£1,134	£41
Health care scientists	-£1,142	-£1,090	£52	-£2,280	-£2,172	£108
Support to clinical staff	-£5,427	-£4,760	£667	-£9,251	-£9,593	-£342
Non medical, non clinical staff	-£2,186	-£2,064	£122	-£4,446	-£5,770	-£1,323
Apprenticeship Levy	-£94	-£92	£1	-£188	-£194	-£6
Total	**-£24,646**	**-£25,965**	**-£1,319**	**-£48,224**	**-£51,556**	**-£3,332**

1. Executive Summary

1.6 Operating expenses including COVID were £19.940m at M2, an underspend of £1.560m. This is reflective of reduced activity levels but is offset by the non-delivery of non-pay CIP. This is discussed in more detail from 4.3.1.

1.7 Cash balances at the end of M2 were £34.053m.

1.8 The Trust has recorded a capital spend of £0.592m at M2 compared to an expected spend of £3.431m.

2. Revised Plan 2022/23

2.1 The Trust submitted a deficit plan of £6.197m to NHSE on the 28/04 and this was approved by the Board on 4th May 2022. However, given the scale of the deficit at national and regional level, we were required to submit a revised plan by 20th June 2022.

2.2 The plan submitted by C&M on 28th April 2022 included a "stretch" target of £40m that was not allocated to individual organisations. A methodology for the allocation of this target for providers was agreed based on existing share of deficit and expenditure growth during the period. This resulted in the Trust assuming a 2.75% share of the stretch amounting to £1.103m.

2.3 It has now also been confirmed that NHS England has further uplifted tariff by 0.7% to reflect higher than planned rates of inflation. This funding, which is recurrent, results in an increase in income across local and specialised commissioning contracts of £2.682m.

2.4 NHS England has also allocated additional, non-recurrent funding to the regions. NHS England North West has transferred this to ICBs on a fair share basis for allocation at their discretion. Whilst the allocation has yet to be confirmed, C&M have provided initial indications that this will result in additional funding for 2022/23 for the Trust of £2.437m.

2.5 Now that the stretch target and additional funding described from 2.2 to 2.4 has been confirmed by C&M, the Trust submitted a plan with a surplus of £0.024m on 20/06. However, due to timing of reporting these amounts are not reflected within this report but will be incorporated for M2 reporting.

2.6 On the basis of the revised plan, as summarised below, C&M has indicated that the Trust will not be required to participate in the peer review process.

Table 3: Revised Plan 2022/23

	Board Approved Plan	Revisions	Revised Plan for Approval
Operating Income	£407.0m	£2.7m	**£409.7m**
Income (C&M)	£27.5m	£2.4m	**£29.9m**
Pay	-£297.0m		**-£297.0m**
Non Pay	-£164.5m		**-£164.5m**
CIP (Recurrent)	£13.8m		**£13.8m**
CIP (Non Recurrent)	£7.0m	£1.1m	**£8.1m**
Financial Position	**-£6.2m**	**£6.2m**	**£0.0m**

3. Risk

3.1 The revised Oversight Framework does not require us to report our Use of Resources rating. We do, however, believe that there are two indicators (cash liquidity and agency spend) that we have previously reported on that warrant inclusion in this report.

3.2 Cash liquidity at 31 May 2022 is -12 days which is a significant improvement on M1 (-21.4). Work is progressing well on a review of the historical accruals on the balance sheet so we are expecting a further improved position moving forward.

3.3 The agency spend cap has not yet been set for 2022/23 but we continue to report against expenditure. Agency spend at M2 is £1.798m which is £1.228m above budget. This is explained in more detail at 3.4.3.

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

3.4.1 Risk 1 – Failure to manage financial position

Our ability to deliver the planned deficit is dependent on effective cost management, CIP delivery and the delivery of activity trajectories. Our financial performance in M2, our failure to deliver CIP to plan (see below) and potential penalties in respect of AIP indicates that this risk has increased. However, the anticipated increase in funding from C&M discussed at 2.2-2.4 does mitigate this position.

3.4.2 Risk 2 – Failure to deliver CIP

The 22/23 plan includes an assumed 2022/23 CIP target of 4.5% (£20.838m). Of this target, 3% (£13.849m) was planned to be delivered recurrently and 1.5% (£6.989m) was to be delivered non-recurrently. So far we have identified plans of £6.697m in respect of recurrent CIP, a shortfall against plan of £7.152m. At M2 only £0.406m CIP has been transacted recurrently and £1.187m has been transacted non-recurrently. Whilst underperformance was expected given the planning and year end process, this does indicate that the risk has increased. This is discussed in more detail at 4.5.

3.4.3 Risk 3 – Failure to complete capital programme

Our capital expenditure envelope for 22/23 totals £44.628m which is the largest capital programme the Trust has ever delivered in one financial year. The internally generated capital plan for 22/23 totals £9.765m and is described in more detail at 5.2.

3.5 **Risk summary (as per risks identified in budget report)**

3.5.1 CIP

Failure to deliver CIP remains our most significant risk and our performance so far this year indicates this risk has increased. Please see 3.3.2 and from 4.5 for more detail.

3.5.2 Shortfall in funding

All funding included within our planned deficit has now been confirmed. This includes ERF of £10.069m which will be received irrespective of activity levels. As discussed at 2.3 and 2.4, we will receive £5.119m in addition to the income specified within our original plan.

3.5.3 Activity below plan

As at M2, the Trust has delivered £2.017m less elective activity than plan, resulting in potential penalties under AIP of £1.513m. However, all but one theatre is now back in use and with the new modular theatres due for completion in August, the opportunity to meet and exceed the elective plan remains. The risks and opportunities associated with AIP are discussed from 4.1.4.

3.5.4 Reliance on agency staff

Workforce information indicates that the reliance upon high cost agency staff has reduced in M2 but remains higher than plan, principally due to the continued use of escalation wards. Please see 4.2 for more detail.

3.5.5 Inflation

Whilst inflation continues to run significantly higher than forecast we have received confirmation from NHSE that they will fund equivalent of 0.7% increase in tariff to adjust for higher than expected inflation. This amounts to additional, recurrent funding of £2.682m. This additional income is yet to be included within our contracts so is not reflected in this report.

3.5.6 COVID-19

The Trust has spent £0.006m more than it received in respect of COVID-19 at M2. Whilst the variance has reduced from M1 (£0.160m deficit) this does remain a risk. Please see 4.4 for more detail.

4.1 Income

4.1.1 The Trust has received £73.390m at M2, a positive variance of £1.030m.

Table 4: Income analysis for M2

	IN MONTH			YEAR TO DATE		
Point of Delivery	**Budget (£'000)**	**Actual (£'000)**	**Variance (£'000)**	**Budget (£'000)**	**Actual (£'000)**	**Variance (£'000)**
Elective & Daycase	£5,152	£4,227	-£925	£9,917	£7,599	-£2,318
Elective excess bed days	£100	£130	£31	£196	£184	-£12
Non-elective	£8,547	£8,544	-£3	£16,621	£16,789	£168
Non-elective Non Emergency	£1,202	£1,155	-£47	£2,347	£2,126	-£221
Non-elective excess bed days	£568	£440	-£128	£1,114	£902	-£213
A&E	£1,471	£1,424	-£48	£2,922	£2,734	-£188
Outpatients	£3,690	£3,841	£151	£7,284	£6,995	-£290
Diagnostic imaging	£282	£253	-£29	£558	£411	-£147
Maternity	£418	£440	£22	£800	£826	£25
Non PbR	£6,638	£5,636	-£1,002	£13,237	£11,071	-£2,166
HCD	£1,582	£1,822	£241	£3,164	£3,026	-£138
National Top up	£2,328	£2,328	£0	£4,656	£4,656	£0
Other	-£108	£1,723	£1,831	£927	£6,430	£5,504
Sub-Total Clinical Income	**£31,872**	**£31,964**	**£93**	**£63,744**	**£63,748**	**£5**
Other patient care income	£140	£534	£393	£383	£737	£354
Elective Recovery Fund	£899	£899	£0	£1,797	£1,797	£0
COVID-19 Income	£362	£658	£296	£723	£980	£257
Non-NHS: private patient & overseas	£25	£21	-£4	£49	£30	-£18
Injury cost recovery scheme	£43	£36	-£7	£86	£93	£6
Total Patient Care Income	**£1,469**	**£2,147**	**£678**	**£3,038**	**£3,637**	**£599**
Other operating income	£2,841	£3,225	£384	£5,579	£6,005	£426
Other non operating income	£0	£0	£0	£0	£0	£0
Total Other income	**£2,841**	**£3,225**	**£384**	**£5,579**	**£6,005**	**£426**
Total income	**£36,181**	**£37,336**	**£1,154**	**£72,360**	**£73,390**	**£1,030**

4.1.2 Clinical income at M2 was £63.748m, a positive variance against budget of £0.005m. However, as shown in the table, income is lower than budget across a large number of activity categories and this is offset by back to block and system top up monies (under "National Top Up"). Whilst this does not represent the same risk that would be the case under full Payment by Results, the introduction of AIP does mean that underperformance against activity will again have an impact on the Trust's financial position.

4.1.3 Income includes 2/12ths of the Trust's allocation of Elective Recovery Funding (ERF) to support delivery of 104% of 2019/20 elective activity in order to reduce the length of time patients are waiting for treatment. As previously reported, providers in C&M will receive this income irrespective of their level of activity and that the mechanism for recovery of income will be through AIP and not through ERF.

4.1.4 During 2022/23 the Trust will be monitoring its elective performance against an agreed NHSE/I baseline. Included in the scope of the baseline are elective, day case, outpatient attendances and procedures. For NHS England specialised commissioning, chemotherapy and radiotherapy delivery will also be included. The baseline is calculated using the 104% of 19-20 trust activity valued at 22-23 tariffs as per the national guidance. Actual activity will be monitored each month on a cumulative basis and the Trust's funding will be adjusted up or down by 75% of tariff if actual activity delivered is above or below the 104% baseline value.

4.1.5 At M2 the elective baseline is £17.754m and the actual M2 activity valued at national and local tariffs is £15.738m, this includes capping the outpatient follow ups at 85% of the baseline as per the published guidance. Therefore, at M2 the Trust is £2.016m below the baseline, however only 75% of this is at risk of being recouped by the ICB (as a commissioner) which equates to £1.512m. Table 5 below demonstrates the position at M2.

Table 5 Comparison of actual performance against 19/20 baseline

	Cumulative Position at M2			
	Plan	Actuals (inc FUPs)	Variance	75% up or down
Day Case	£5,184,089	£4,687,019	(£497,070)	(£372,802)
Elective	£4,180,469	£3,458,830	(£721,639)	(£541,229)
OP Procedures	£862,404	£590,937	(£271,467)	(£203,600)
OP First Attendances	£3,684,560	£3,860,130	£175,570	£131,678
OP Follow Ups	£3,843,389	£3,141,231	(£702,158)	(£526,618)
	£17,754,911	**£15,738,148**	**(£2,016,763)**	**(£1,512,572)**

4.1.6 The elective calculation is a cumulative calculation, so the Trust is able to increase activity in future months to cover any prior months under-performance against the baseline. However, the baseline value for M1 and M2 was relatively low when compared to other months so this will be a challenge for the Trust especially given the issues with theatre ventilation and the continued use of escalation wards that have been experienced in M1 and M2 and have continued into June.

4.1.7 Given the AIP scheme has not yet been finalised, that performance is considered on a cumulative basis and the opportunity to achieve the elective plan, the potential penalty has not been included within these accounts.

4.1.8 In line with national guidance, the financial plan assumes Car Parking income will revert back to pre COVID-19 level (i.e. patient and staff charges will come back into force). The Trust remains in discussions around the implications locally for its staff and as yet charges have not been reinstated. This creates an adverse variance of £0.088m.

4.2 Expenditure: Pay

4.2.1 The Trust has spent £51.556m on pay costs at M2, an overspend of £3.332m. Table 6 details pay costs by staff group, Table 7 details WTE by staff group and Table 8 details pay costs by pay category type.

Table 6: Pay costs by staff type

Pay analysis by Division	IN MONTH			YEAR TO DATE		
	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Consultants	-£4,025	-£4,669	-£644	-£8,281	-£8,511	-£230
Other medical	-£2,678	-£2,964	-£286	-£5,404	-£5,767	-£363
Nursing and midwifery	-£7,112	-£8,352	-£1,240	-£14,408	-£15,577	-£1,169
Allied health professionals	-£1,397	-£1,417	-£20	-£2,791	-£2,838	-£47
Other scientific, therapeutic and technical	-£586	-£558	£28	-£1,175	-£1,134	£41
Health care scientists	-£1,142	-£1,090	£52	-£2,280	-£2,172	£108
Support to clinical staff	-£5,427	-£4,760	£667	-£9,251	-£9,593	-£342
Non medical, non clinical staff	-£2,186	-£2,064	£122	-£4,446	-£5,770	-£1,323
Apprenticeship Levy	-£94	-£92	£1	-£188	-£194	-£6
Total	**-£24,646**	**-£25,965**	**-£1,319**	**-£48,224**	**-£51,556**	**-£3,332**

* Note that the significant overspend on non-medical/non-clinical staff reflects CIP yet to be allocated to specific schemes and coded within this pay category.

Table 7: WTE by staff type

Pay analysis by Division	WTE		
	Budget	Contracted	Actual
Consultants	288.31	274.80	286.71
Other medical	371.37	371.10	418.80
Nursing and midwifery	1,687.18	1,596.66	1,716.51
Allied health professionals	335.12	321.35	331.43
Other scientific, therapeutic and technical	113.82	112.82	111.91
Health care scientists	282.85	270.84	270.25
Support to clinical staff	1,813.31	1,762.21	1,906.50
Non medical, non clinical staff	1,136.02	1,041.23	1,103.69
Apprenticeship Levy	-	-	-
Total	**6,027.98**	**5,751.01**	**6,145.80**

Table 8: Pay costs by pay category (excluding COVID)

Pay analysis (exc Covid)	Budget (Mth 2) £'000	Actual (Mth 2) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Substantive	-£23,624	-£23,321	£303	-£46,152	-£45,836	£316
Bank	-£81	-£1,223	-£1,142	-£161	-£2,602	-£2,440
Medical Bank	-£294	-£602	-£308	-£587	-£1,154	-£566
Agency	-£285	-£959	-£674	-£569	-£1,760	-£1,190
Apprenticeship Levy	-£94	£4	£97	-£188	-£98	£90
Total	**-£24,376**	**-£26,101**	**-£1,724**	**-£47,658**	**-£51,449**	**-£3,791**

4.2.2 This overspend includes £0.559m of non-achieved pay CIP in month and £1.729m YTD. This is discussed in more detail from 4.5.1.

4.2.3 The biggest overspends in month related to Medicine (£0.543m in month, £1.083m) and Surgery (£0.716m in month, £1.198m YTD).

4.2.4 Medicine pay is £0.543m overspent in month and £1.083m overspent YTD. The pressure is mainly attributable to unachieved CIP of £0.155m in month (£0.310m YTD) and escalation (i.e. unfunded) ward costs of £0.293m (£0.600m YTD) for additional beds on W26 and M3 and medical cover for these areas. Plans for de-escalation of the unfunded ward areas are currently being worked up, however, this is being impacted by the non-achievement of criteria to reside reductions across the system. There are currently 2 additional agency consultants in post in Haematology and Gastroenterology to deliver additional activity. The cost of these posts was £0.050m in month. This is reflected in the over achievement of activity in these areas. Haematology OP achieved 33% activity above plan and DC/EL 4.83% The FUP backlog in Haematology has now been cleared. Gastroenterology OP delivered activity 26% above plan and DC/ EL 7.77%. The remaining pay pressure has been driven by an agency Consultant in Dermatology (£0.024m) who is covering a substantive vacancy. It also includes (£0.090m) relating to the bonus element of the nurse incentive scheme, which ended in April.

4.2.5 Surgery pay is £0.716m overspent in month and £1.198m YTD. The main drivers of this overspend are agency spend of £0.260m in month and £0.368m YTD, this is associated with gaps on the Junior Doctor rota and agency consultants within Pain and ENT. The pain consultants are offset within substantive underspends and are due to cease once the pain re-design being led by AHPs is in place by the end of July. There is currently an agency consultant in ENT covering a maternity leave, there was an NHS locum in place prior to the maternity leave commencing, however the locum subsequently withdrew from the recruitment process. The YTD pay position includes £0.356m of costs associated with staffing the additional beds open within the Division in the main on Ward 1 which closed on the 10th June. The position includes £0.043m of costs for the nurse incentive scheme which has now ended. Within the Nursing Bank spend there is also year to date expenditure of £0.175m covering sickness on the wards and within theatres (£0.115m of this is in M2). Unachieved YTD CIP of £0.310m is also included in the pay position.

4.3 Expenditure: Non-Pay

4.3.1 The Trust has spent £19.940m on non-pay operating expenditure excluding COVID at M2, a positive variance of £1.560m.

Table 9: Non-pay analysis (excluding COVID-19 costs)

Trust	IN MONTH			YEAR TO DATE		
Month 2 Financial Position	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Actual (£'000)	Variance (£'000)
Supplies and services - clinical	-£3,244	-£2,507	£737	-£6,720	-£5,446	£1,274
Supplies and services - general	-£409	-£451	-£42	-£829	-£853	-£24
Drugs	-£2,392	-£2,646	-£255	-£4,779	-£4,683	£95
Purchase of HealthCare - Non NHS Bodies	-£877	-£822	£55	-£1,994	-£1,651	£343
CNST	-£1,070	-£1,070	£0	-£2,143	-£2,140	£3
Consultancy	-£28	£10	£38	-£56	£7	£63
Other Operating	-£2,985	-£2,963	£23	-£5,952	-£5,590	£362
CIP - Non-pay	£453	£416	-£37	£973	£416	-£557
Total Operating Exenses excl Covid 19	**-£10,551**	**-£10,034**	**£517**	**-£21,499**	**-£19,940**	**£1,560**

4.3.2 Elective activity in M2 represented 88.6% of the plan submitted to NHSEI. This was attributable to issues around theatre ventilation and the continued use of escalation wards. This has resulted in significant underspends in respect of clinical supplies and services and drugs, most notably in surgery.

4.3.3 The underspend in respect of purchase of healthcare from non-NHS bodies relates to the Community Diagnostic Centre and our reduced reliance on insourcing and outsourcing compared to plan, with more activity being delivered by our own staff. This is offset by reductions in income.

4.3.4 The underspend was offset by the non-achievement of non-pay CIP of £0.557m.

4.4 **Expenditure: COVID–19**

4.4.1 The Trust has spent £0.986m on COVID-19 costs at M2, with £0.430m on pay and £0.555m on non-pay. This is set against income of only £0.980m.

Table 10: COVID-19 costs

COVID-19 I&E	Apr (M1) £'000	May (M2) £'000
Total Income	£322	£658
Medical Staff	£3	-£4
Other Clinical Staff	-£222	-£120
Non Clinical Staff	-£24	-£63
Total Pay	-£243	-£188
Clinical Supplies	-£204	-£584
Other Non-Pay	-£35	£268
Total Non-Pay	-£239	-£316
Total Covid Expenditure	**-£160**	**£154**

4.4.2 The vaccination costs were £0.200m at M2 which was in line with plan and is funded centrally so offset in income.

4.4.3 The testing costs were £0.788m at M2 and is funded centrally so offset in income.

4.5 CIP Performance

4.5.1 The 22/23 plan includes an assumed 2022/23 CIP target of 4.5% (£20.838m). Of this target, 3% (£13.849m) was planned to be delivered recurrently and 1.5% (£6.989m) was to be delivered non-recurrently. Given the importance of recurrent CIP, non-recurrent CIP has not been assigned to divisions and will be managed centrally by Finance. This report will focus on delivery of recurrent CIP only.

4.5.2 As at the 13th June, 219 opportunities have been submitted by divisional teams with a recurrent value of £6.636m against a target of £13.849m.

Table 11 Identified savings by Division

Division	Annual Target	Forecast	FYE Variance	% Variance
DCS	£2,400,897	£601,207	-£1,799,690	-75%
Corporate	£1,260,526	£533,795	-£726,731	-58%
Medicine	£2,698,861	£1,824,947	-£873,914	-32%
Acute	£879,014	£102,684	-£776,330	-88%
Surgery	£2,617,788	£953,209	-£1,664,579	-64%
Estates	£1,131,379	£857,356	-£274,023	-24%
W&C	£1,136,000	£88,097	-£1,047,903	-92%
Trust Central	£1,724,535	£1,385,076	-£339,459	-20%
Total	**£13,849,000**	**£6,346,371**	**-£7,502,629**	**-54%**

4.5.3 £0.406m has been delivered in M2 against targets assigned of £2.270m and validated plans of £0.889m.

Table 12 YTD performance by Division

Division	YTD Target	YTD Plan	YTD Actual	YTD Variance to plan	YTD Variance to target
DCS	£400,150	£46,723	£51,518	£4,795	-£348,632
Corporate	£210,088	£58,490	£64,598	£6,108	-£145,490
Medicine	£449,810	£293,799	£116,840	-£176,959	-£332,970
Acute	£146,502	£4,248	£7,114	£2,866	-£139,388
Surgery	£436,298	£70,249	£24,164	-£46,085	-£412,134
Estates	£188,564	£164,967	£142,046	-£22,921	-£46,518
W&C	£189,332	£872	£0	-£872	-£189,332
Trust Central	£250,000	£250,000	£0	-£250,000	-£250,000
Total	**£2,270,744**	**£889,348**	**£406,280**	**-£483,068**	**-£1,864,464**

Table 13 Breakdown of underperforming schemes

Division	Project Name	YTD Plan	YTD Actual	Reason for under delivery
DCS	DCS miscellaneous schemes	£21,262	£14,622	Not started, expected to recoup savings

Corporate	Corp miscellaneous schemes	£2,167	£0	Not started, expected to recoup savings
Medicine	Medicine miscellaneous schemes	£6,591	£0	Not started, expected to recoup savings
W&C	W&C miscellaneous schemes	£872	£0	Not started, expected to recoup savings
Surgery	Insides Company	£18,545	£0	No suitable patients identified during M2
DCS	Lab MSC - Roche - Yr. 1	£13,787	£0	Not started, expected to recoup savings in M3
Corporate	BlueChip contract removal (Pathology System)	£5,130	£0	Contract now ended, expected to recoup savings in M3
Medicine	Review of maintenance Contracts	£9,500	£0	Review underway, no savings identified at M2
Medicine	Medical Bed Closure M1. Seasonal closure 20 beds April - Sept.	£58,332	£0	Escalation areas still open, expected to delivery in M3
Trust Central	Trust central RECURRENT	£251,832	£0	See 4.5.7
Medicine	3% reduction of drug spend	£87,500	£0	No reduction in drug spend at M2
Surgery	3% Reduction of Drug Spend-Surg`	£27,541	£0	No reduction in drug spend at M2
DCS	MSK sub contract tariff reduction	£1,444	£0	Not started, expected to recoup savings
Medicine	Bowel Cancer Screening Programme	£19,166	£0	Delivered planned activity, however did not over deliver in M2 to release CIP

4.5.4 The most significant underperformance is within Trust Central and relates primarily to costs associated with COVID. In the context of a 53% reduction in COVID funding and the expectation that funding will reduce further, the Trust is committed to reviewing all aspects of COVID expenditure and set itself the target of reducing costs by £1.724m in 22/23. However, due to the residually high number of COVID patients at the start of the year and increasing community prevalence, this review has been delayed. We remain confident that the CIP in respect of COVID will be delivered.

4.5.5 35 projects with no value have currently been identified as areas of opportunity and are awaiting sign off from the divisional directors to progress to gateway 2.

4.5.6 86 projects with a value of £2.064m have progressed to design & plan (gateway 2), meaning documentation is now being completed on Smartsheets with the support of the PMO. All schemes in gateway 2 are awaiting QIA completion by project leads.

4.5.7 2 projects with a value of £0.045m are in the governance and assurance (gateway 3), awaiting QIA panel 14th June.

4.5.8 54 projects with a value of £2.514m have been approved at QIA panel and are now in the implementation gateway.

5. Financial Position

5.1 Statement of Financial Position (SOFP)

5.1.1 The movement in total assets employed from M2 was £0.468m.

Statement of Financial Position (SoFP)					
Actual as at 31.03.22 £'000		Actual as at 30.04.2022 £'000	Actual as at 31.05.2022 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
187,353	Property, plant and equipment	187,731	185,830	(1,902)	
14,871	Intangibles	15,909	14,800	(1,109)	
968	Trade and other non-current receivables	397	397	0	
203,192	**Total non-current assets**	**204,037**	**201,027**	**(3,011)**	
	Current assets				
4,924	Inventories	4,679	4,302	(377)	
21,288	Trade and other receivables	18,556	17,733	(823)	
36,435	Cash and cash equivalents	39,917	34,053	(5,864)	
62,647	**Total current assets**	**63,151**	**56,088**	**(7,064)**	
£265,839	**Total assets**	**£267,189**	**£257,115**	**-£10,074**	
	Current liabilities				
(60,592)	Trade and other payables	(60,746)	(54,353)	6,393	
(10,702)	Other liabilities	(12,902)	(10,351)	2,551	
(1,023)	Borrowings	(1,038)	(1,053)	(15)	
(9,213)	Provisions	(9,215)	(8,645)	570	
(81,530)	**Total current liabilities**	**(83,901)**	**(74,402)**	**9,499**	
-£18,883	**Net current assets/(liabilities)**	**-£20,749**	**-£18,314**	**£2,435**	
£184,309	**Total assets less current liabilities**	**£183,288**	**£182,712**	**-£576**	
	Non-current liabilities				
(2,371)	Other liabilities	(2,371)	(2,371)	0	
(4,177)	Borrowings	(4,177)	(4,177)	0	
(6,348)	Provisions	(6,237)	(6,129)	108	
(12,896)	**Total non-current liabilities**	**(12,785)**	**(12,677)**	**108**	
£171,412	**Total assets employed**	**£170,503**	**£170,036**	**-£468**	
	Financed by				
	Taxpayers' equity				
186,445	Public dividend capital	186,467	186,445	(22)	
(64,185)	Income and expenditure reserve	(65,116)	(64,874)	241	
49,152	Revaluation reserve	49,152	48,464	(687)	
£171,412	**Total taxpayers' equity**	**£170,503**	**£170,036**	**-£468**	

5. Financial Position

5.2 Capital Expenditure – M2

5.2.1 The Trust's core programme for 22/23 is £9.765m and is made up as follows:

Capital plan 2022/23	
IT - various schemes	1,976
Medical equipment	737
Facilities equipment	93
Bathroom refurbishment	137
Simulation suite refurbishment	98
Doctors mess refurbishment	72
Ventilation works	400
Flooring	80
Fire compartmentation	400
Ward 1 - Renal Unit refurbishment	2,800
Modular theatre build completion	2,972
Total CDEL	**9,765**

5.2.2 At M2 spend was £0.592m against a plan of £3.431m. The key areas of underspend were UECUP (£1m), clinical equipment (£0.220m), car parking (£0.250m) and backlog maintenance (£0.8m). UECUP is delayed as formal approval has yet to be received for the business case. Both car parking and backlog maintenance have been delayed as a result of the issues encountered in respect of theatre ventilation and pipework.

5.2.3 In addition to the internally generated capital spend, the Trust will be drawing down £18m of PDC funding for UECUP in 22/23. The Trust is also submitting a TIF funding bid of 14.594m for the second phase of the South Mersey Elective Hub theatre development.

5. Financial Position

5.3 **Statement of Cash Flows – M2**

Statement of Cash Flow (SoCF)	
	Actual as at 31.05.2022 £'000s
Opening cash	**36,435**
Operating activities	
Surplus / (deficit)	(1,377)
Net interest accrued	5
PDC dividend expense	598
Unwinding of discount	(5)
(Gain) / loss on disposal	0
Operating surplus / (deficit)	**(779)**
Depreciation and amortisation	2,115
Impairments / (impairment reversals)	0
Donated asset income (cash and non-cash)	0
Changes in working capital	5,163
Other movements in operating cash flows	
Investing activities	
Interest received	45
Purchase of non-current (capital) assets	(8,927)
Sales of non-current (capital) assets	0
Receipt of cash donations to purchase capital assets	0
Financing activities	
Public dividend capital received	0
ITFF loan principal drawdown	
Support funding 2 principal drawdown	
ITFF loan principal repaid	0
Support funding 2 principal repaid	
Interest payable	(0)
PDC dividend paid	
Total net cash inflow / (outflow)	**(2,382)**
Closing cash	**£34,053**

5.3.1 Cash balances have reduced by £2.382m, adjusting for our variance from budget documented within plan this is in line with our expectations.

Wirral University Teaching Hospital
NHS Foundation Trust

Item 9.3

Board of Directors in Public

06 July 2022

Title	Quarterly Maternity Services Update Report
Area Lead	Tracy Fennell, Chief Nurse
Author	Debbie Edwards, Director of Midwifery & Nursing
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide 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).

The paper also provides an update regarding the compliance with the Immediate and Essential Actions (IEA's) / Recommendations from the Final Ockenden Report and the Continuity of Carer Assurance Plan – both being submitted to the Local Maternity and Neonatal System (LMNS) and NHSE/I.

An update on current compliance with the Year 4 of the Maternity Incentive Scheme is also included in the paper.

It is recommended that the Board note the contents of the report specifically:

- The content of the Perinatal Clinical Surveillance Quality Assurance Report
- The compliance report detailing progress with the 15 IEAs from the Ockenden final report
- The Continuity of Carer Assurance plan

Key Risks

This report relates to these key Risks:

- BAF references 1,2,4.

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: Final Report – Update on Trust compliance with the Immediate and Essential Actions/Recommendations**
1.1	An initial gap analysis outlining compliance against these recommendations detailed within the 15 Immediate and Essential Actions (IEA's) was reported to the Board of Directors in April 2022. Further work has been ongoing within Maternity/Neonatal Services to support and further evidence compliance against all 92 recommendations outlined in the 15 IEA's. A gap analysis against the Ockenden recommendations was included in the last Quarterly Maternity Services Update to the Board of Directors meeting in April 2022. Discussion took place regarding Trust compliance at that time, further supporting the Board of Directors having oversight of the Trust's position. All recommendations have since been reviewed with the Chief Nurse, with Appendix 1 outlining the Trust's current position. Progress against the recommendations/IEAs across Cheshire & Merseyside is being collated by the Local Maternity and Neonatal System (LMNS) prior to their submission to NHSE/I later this month. Further funding has been identified from the LMNS that further supports the implementation of the 92 recommendations outlined in the 15 IEA's.

2	**Maternity Incentive Scheme (MIS) – Year 4 update**
2.1	Now in its fourth year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. NHS Resolution in conjunction with NHSE/I confirmed the relaunch of the Year 4 MIS in May 2022 following its pause in 2021-22. The W&C Division has continued with its work to progress the 10 safety actions (Appendix 2) and whilst it is currently on track to meet the requirements of each safety action there is one particular action that requires support from IT. This relates to the reporting of CO monitoring in pregnancy (at 36 weeks gestation) and the urgent need for a mandated question being added to the maternity records. It is anticipated that this work will be completed before September 2022 (deferred due to a Cerner upgrade) to ensure the submission of data four months prior to the Trust's compliance declaration in January 2023. A detailed MIS update will be included in the October 2022 Board of Directors Quarterly Maternity Services Update, which will further inform Trust declaration with the MIS due for submission before a deadline of 5 January 2023.

	Provider compliance with the ten Safety Action Standards across C&M has been closely monitored by the LMNS and NHSE/I with WUTH having previously gone through a process of audit by Mersey Internal Audit Agency (MIAA). A further compliance update will be included in the October Maternity Update prior to sign off and declaration on 5 January 2023.

3	The Perinatal Clinical Surveillance Quality (PCSQ) Assurance Report
3.1	A Clinical Surveillance Quality Tool has recently been developed by the Strategic Clinical Network (SCN) in the form of a dashboard on a page (see Appendix 3). The dashboard on a page from each provider was presented at the last C&M Quality Surveillance Safety Group and these will provide assurance to the LMNS regarding the quality and safety of maternity services. WUTH developed its own PCSQ Tool, and this is also included in Appendix 3. This tool is used to provide a monthly update to the Board of Directors on maternity/neonatal performance/outcomes and provides a more detailed oversight, at a glance on the following: • Clinical care • Service user and staff feedback • Leadership and relationships • Safety and learning culture • Incident reporting • Governance processes • CQC Inspections & DHSC / NHSE/I request for support. Monthly reporting using the WUTH Perinatal Clinical Surveillance Quality Assurance tool will continue pending the publication nationally of a PCSQ tool. There is no indication to escalate any of the metrics from this month's report.

4	The Northwest Coast Outlier Report
4.1	A summary from the Northwest Coast Outlier Report for the period May 2021 – April 2022 is included in Appendix 4 and refers to data from the regional (Northwest Coast). The full report is 100 pages in total and is available for review, however for the purposes of this paper there is a summary of specific key metrics, that indicate how WUTH maternity/neonatal services are performing. The key metrics include: • Stillbirth rate • Stillbirth rate over 37 weeks • Intrapartum stillbirth • % Babies below the 3rd centile • % Live born babies below the 3rd centile • % Haemorrhage above 1500ml • Caesarean section rate • Induction of labour rate • % Instrumental deliveries • % Preterm deliveries below 34 gestations

	• Home deliveries with no midwife present • Term babies with an Apgar score of below 7 after 5 minutes • Term admissions to the Neonatal unit • HIE (Brain injury) A narrative is included against each of the metrics included in the summary report.

5	**Serious Incidents (SI's) & Health Care Safety Investigation Branch (HSIB):**
5.1	An overview and the detail of all Serious Incidents (SIs) from 2021 was presented to Board in January 2022. When compared to other maternity providers across C&M, WUTH is below the regional average in serious incidents and HSIB cases. SIs continue to be reported monthly on the regional dashboard by all maternity providers in C&M and in Lancashire and South Cumbria (Northwest Coast). SIs are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity SI's across the region. There are no maternity SIs reported in May 2022 and no new cases referred to HSIB. Quarterly engagement meetings continue to be held with HSIB, with good engagement with all cases.

6	**Workforce Update – Implementing a Continuity of Carer Model of Maternity Care.**
6.1	The Maternity Service continues to deliver care via two models of maternity care – one that is traditional in its approach, and the other a Continuity of Carer Model of care. Women being cared for by a team of midwives under the Continuity of Carer model appreciate the benefits of improved outcomes and experience compared to those cared for by a traditional model. A consultation with staff has taken place to support staff transitioning to work within a continuity of carer model. This consultation was positively received with plans finalised for the implementation of 100% Continuity of Carer (CoC). The roll out of this model of care within the Trust was initially planned for June 2022, however there were recommendations included in the Ockenden report that have delayed its implementation, this included the need for a further review of the midwifery workforce. NHSE/I continue to support the implementation of CoC and each provider has finalised and submitted an assurance plan for its roll out to the LMNS and NHSE/I. It is anticipated that with further upskilling of staff, a further CoC team will be introduced at the end of this year with the upskilling of the four remaining teams before October 2023. NHSE/I have stated that the CoC model of care will be the default model of care that each maternity provider should offer by March 2024. A workforce review using the Birthrate+ tool was undertaken in 2021 and a paper presented to the Workforce Assurance Committee outlining midwifery staffing requirements to deliver 100% CoC. Funding from NHSE/I supported the recruitment of an additional Obstetrician and additional midwifery staff to support the roll out of this model of care. Midwifery staffing levels are reviewed every four hours as a minimum in conjunction with the acuity on the Delivery Suite with staff being moved accordingly to the area of

	greatest need. Processes in place support the effective deployment of staff across all areas including the community staff. Following the publication of the Ockenden Report a further review of the midwifery workforce has been undertaken as summarised below. The workforce review has looked at skill mix and the uplift in the establishment needed given the additional training each midwife needs to complete. This uplift considered sick leave, maternity leave, training and annual leave and was calculated over a 3 Year period as outlined in the Ockenden recommendations. The uplift was calculated as 24% and the workforce establishment was reviewed, outlining the additional staffing requirements as detailed below in Table 1: ***Table 1 Summarises the staffing requirements identified initially by Birthrate Plus (wte)/ as per workforce review; whilst considering the current funded establishment and requirements to meet 100% Continuity of Carer model of care.***

	BIRTHRATE PLUS WTE Bands 3 to 8	**CURRENT FUNDED WTE** Bands 3 to 8	**VARIANCE with current wte**
Core Services and with Continuity Teams at 100%	158.79 required.	152.69	-6.10

Table 1 outlines midwifery staffing but a proportion of the wte identified can be that of a Maternity Support Worker (MSW). Further funding to support staffing and the implementation of the Ockenden IEA's is anticipated from the LMNS within the next month.

WUTH has submitted the Continuity of Carer Assurance plan to the LMNS (see **Appendix 5**) which was signed off by the Trust Safety Champions. This outlines an implementation plan of when the Trust will meet the 100% Continuity of carer requirement.

7	**Maternity Escalation and Divert**
7.1	The weekly C&M Gold Command meetings continue to identify any particular hotspots in a timely manner and have improved collaborative working within C&M. This has undoubtedly reduced the need for maternity providers to formally divert services to another provider. There have been no diverts from WUTH during 2022 / to date and mutual aid from WUTH has supported other providers within the region. The C&M Escalation and Divert policy was revised, operationalised and adopted by Trusts on 1 September 2021 which further supports the management of escalation and divert. This policy has been further updated and ratified in May 2022 and its circulation to Trusts is anticipated shortly.

8	**Regional Equity & Equality Plan**
8.1	At the Board of Directors meeting in January 2022, the Trust Equality and Equity plan (specific to Maternity Services) was discussed. This has since been forwarded to the LMNS who have submitted a regional Equality and Equity plan to NHSE/I (see Appendix 6).

	Whilst Wirral does not have a high population of women and families from a black and ethnic minority / non-English-speaking background, work continues with the MVP Chair (supported by the Midwifery Team) engaging with the Wirral Multicultural Society to further improve the experiences of women from these backgrounds. Work is ongoing to further support women from areas of high deprivation and to improve access to care and social prescribing through the Midwifery Teams. Three teams currently support women and their families from those areas with the highest rate of deprivation.

9	Regional Equity & Equality Plan
9.1	At the Board of Directors meeting in January 2022, the Trust Equality and Equity plan (specific to Maternity Services) was discussed. This has since been forwarded to the LMNS who have submitted a regional Equality and Equity plan to NHSE/I (see Appendix 6). Whilst Wirral does not have a high population of women and families from a black and ethnic minority / non-English-speaking background, work continues with the MVP Chair (supported by the Midwifery Team) engaging with the Wirral Multicultural Society to further improve the experiences of women from these backgrounds. Work is ongoing to further support women from areas of high deprivation and to improve access to care and social prescribing through the Midwifery Teams. Three teams currently support women and their families from those areas with the highest rate of deprivation.

10	Neonatal Service update
10.1	**Family Integrated Care (Fi Care)** An accreditation visit took place on 25 May 22 with independent assessors looking at how care on the Neonatal unit supports family orientated care. The Neonatal Service was accredited as amber with some excellent feedback received on the day regarding current practices. An improvement plan is currently being developed to further improve care with a view to being re-accredited in 6 months' time.
10.2	**Neonatal Operational Delivery Network (NODN)** The annual NODN visit took place on 27 May 2022 led by the NODN Lead – Louise Weaver Lowe. Feedback was positive with the neonatal team being commended for their performance in terms of patient outcomes. The NODN confirmed that they have no concerns with regards to neonatal clinical outcomes at WUTH. Ongoing improvement to services was discussed including work in integrating the Hospital at Home team (traditionally paediatrics) and the Neonatal Critical Care Outreach team to deliver an enhanced service 7 days a week until 10pm. This was very well received, and discussion took place with regards to the adoption of a similar services being set up in other Trusts. The potential for increased funding for Consultants and AHPs as part of the Neonatal Critical Care Review was also discussed and will be taken forward by the team. In summary both visits were positive with the team appreciative of the excellent feedback. Some key points included:

	• Excellent performance in reducing term birth admissions to the Neonatal unit. • The use and benefits of transitional care were discussed including the Neonatal Support Worker role. • Discussed a concern with babies requiring surgery being delivered at WUTH when they should be delivered at LWH. Further update being provided to the NODN. • The team were advised of the need to supply robust data regarding the Hospital @ Home/Outreach team re number of babies visited, length of visit, distance travelled). The need to quantify the reduction in length of stay and readmission rates as a result of the enhanced service was also discussed. • The ODN have no concerns with regards to clinical outcomes and praised WUTH for its performance. • Intensive Care Day activity was discussed as WUTH do not meet the requirements of a Level 3 Neonatal service. • A Neonatal Safety Champion is part of the Maternity Safety Champion Team. • A planned workforce review was discussed and how it is part of our Divisional Strategy for 2022/23. The NODN will support this review. • Discussed intention to apply for increased funding from NHSE via NODN for nursing quality roles and the opportunity of additional increased funding for medical staff if not BAPM compliant. • The importance of reporting Paediatric HDU activity, especially in view of proposed HDU hubs was discussed. Finally, progress with ongoing discussion with Neonatal Service reconfiguration was discussed, with the outcome of the current regional review (incorporating the Critical Care review) concluding in the Autumn.

11	**Regional and National visits to WUTH**
11.1	Maternity/Neonatal visits to the Trust by both the regional NHSE Maternity team/LMNS and the National team are being finalised. The National NHSE/I Team visit with Jacqui Dunkley Bent (Chief Midwife) is taking place on the 16 June 2022 with the regional NHSE/I Maternity team undertaking an Insight visit with the LMNS on 16 August 2022.

12	**Conclusion**
12.1	The quality improvement work with the W&C Division continues to incorporate both the Neonatal and Maternity Service with the next quarterly update to the Board of Directors in October 2022. The October paper will include a detailed update on the MIS and will focus on the publication of the East Kent Maternity Service review (if published). An update will also be provided on the Continuity of Carer Implementation Plan.

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			1: WORKFORCE PLANNING AND SUSTAINABILITY	RAG Rating e	Lead	When	Comments / Lead Progress
			Full workforce review required in 2022 - Priority to Neonatal and Obstetric Workforce with focus on additional governance related work and training. Neonatal nursing workforce reviewed and additional funding via NODN secured. Midwifery staffing reviewed with BR+ however as per ask re increased uplift for additional training PER HEAD COUNT not wte sme to be reviewed as a priority.				
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.		DE	31/7/22	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. On target to achieve by 31/7/22
		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.		DE	31/7/22	On target and within timeframes to achieve target date
		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.		DE	31/7/22	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.				Recommendation reviewed - WUTH ready however awaiting Regional / National review
			Essential Action : Training				
			Work to update orientation packages for |Band 7 staff with process to allocate a mentor. Decision re NQM with NHSE as moreof a risk. Additional work re support for senior leaders.				
	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.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		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; awaiting national
		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.		DE	30/9/22	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		DE	31/12/22	Workforce strategy in place however this will be reviewed and include reference to leadership roles. Compl;eltion date - September 2022; leadership programmes and initiiatves in place
		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.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
			2: SAFE STAFFING				
			Escalation policy to be further reviewed re risk assessment specifically for medical Process re assessing staffing in place but review will provide further assurance. This includes review of rotas for Obs and Gynae. RCOG tool to be used once introduced to assess medical staffing. Progress with the roll out of the				
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.		DE	31/10/22	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; SoP to be devised
		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.		DE,MS & LS	31/8/22	Escalation in-house at present therefore formal process - SOP to be developed and agreed at Board to formalise process.Leads: Mustafa Sadiq and Libby Shaw. Completion date - August 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.		DE, JL	31/8/22	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	N/A			Final position statement on this to be formalised nationally - completion date awaited. No code as MCofC not withheld
		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.		DE	31/8/22	Job plans review in progress Natalie 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.		DE	31/12/22	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.		DE	31/1/23	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. Locum pack and Gapa analysis required with assurance mechanisms
			3: ESCALATION AND ACCOUNTABILITY				
			Processes in place - same to be auditted with clear SOPs.				
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		DE	31/12/22	Guidance in place but standalone 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		DE	31/12/22	Mustafa Sadiq and Libby Shaw to lead on embedding the Locum package being embedded and evidence of assurance
		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; Added to Risk Register inview of non-compliance but review completed by WUTH therefore no further action required.
		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.		DE	31/4/23		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								
			Review of additional resource as detailed above to support. Training in place but to be formalised/auditted.					
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		DE	31/12/22		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. Maternty safety champions and regular board meetings
		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					Self-assessment tool completed with 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		DE	31/12/22		In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. Completion date - July 2022; reviwing additional PA's and funding to achieve
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		DE	31/12/22		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		DE	31/12/22		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								
			Robust governance processes in place - same to be reviewed with MVP Chair					
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.		DE	31/12/22		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.		DE	31/12/22		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		DE	31/12/22		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.			TBC		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		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.			TBC		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		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.			TBC		Recommendation reviewed - WUTH ready however awaiting Regional / National review
7: MULTIDISCIPLANRY TRAINING								
			MDT in place - same to be extended and recorded (ad hoc drills)					
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.		DE	31/12/222		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.		DE	31/12/22		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.					Karen Cullen in post for CTG / Fetal 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								
			Review of High Risk team and support to implement MMN links. Review of preconceptual care and further progress in secondary 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.		DE	31/3/23		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; Plan to be developed
		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		DE	31/3/23		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).		DE	31/1/23		Guidance in place to support this practice - specific clinic to be reviewed. Completion date - July 2022.
9: PRETERM BIRTH								Link with Kellie Weaver
			Both 9 + 10 are in place - audit of processes needed					
	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high	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.

9: PRETERM BIRTH	risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	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		DE	31/12/22	All staff included in PROMPT training however schedule of drills to be recorded and ad-hoc taken forward
		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		DE	31/12/22	Transfer policy in place regionally and adopted locally - same under review currently. Completion date - July 2022; Community transfer document and leaflet to be provided
		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		DE	31/12/22	Purchase of system currently being undertaken. Procurement in progress. Completion date - July 2022.
11: OBSTETRIC ANAESTHESIA							
			Close links with Anaesthetic leads with compliance to standards - same to be auditted				
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		DE	31/3/23	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; Assurance process developing
		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.		DE	31/3/23	Currently being undertaken but need to review guidance to ensure all criteria included with audit of same. Completion date - July 2022; part of assurance process 11.1
		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		DE	31/3/23	Documentation is recorded in maternity record hwoever need to review audit process. Completion date - July 2022; part of assurance process 11.1; part of assurance process 11.1
		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.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
	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.		DE	31/3/23	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; assurance process to be developed
		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.		DE	31/3/23	Staffing of same to be reviewed. Completion date - July 2022; assurance process to be developed
		7	• The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments.		DE	31/3/23	As point 5; assurance process to be developed
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		DE	31/3/23	All anaesthetists attend PROMPT MDT training; assurance process to be developed
12: POSTNATAL CARE							
			Audit and review of processes / policies re 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		DE	31/1/23	Check if this is in written policy; document to support process
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		DE	31/1/23	Document to be produced to support process
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		DE	31/1/23	Document to be produced to support process
		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							
			Close links with NODN to progress - this links in with the regional transformational work with Exec input to support				
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, develop the workforce and enhance the experience of families. This work must now progress at pace.	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.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		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.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		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		DE	31/12/22	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.		DE	31/12/22	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.		DE	31/12/22	Staffing review to be undertaken as above -Adam Brown and Anand to lead staffing review.
15: SUPPORTING FAMILIES							

			Ensure support covers maternity and neonatal care/services				
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.		AK	31/12/22	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.		AK	31/12/22	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		AK	31/12/22	Psychiatric liaison team and dedicated psychologist to support. WUTH also involved in regional project to further enhance PMH support.

Recommendation reviewed - WUTH ready however awaiting Regional / National Guidance
Fully Embedded
On target to achieve; no risks
Partially Compliant
Non Compliant/risk identified on risk register
NOTE: Completion dates are provisional pending detailed improvement plan.

Appendix 2 – Maternity Incentive Scheme Safety Actions

Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard? STATUS: Green	Confirmation will be required from the Clinical Network that all cases meeting the PMRT criteria have been reviewed using the PMRT tool. To date all such cases have been reported to MBRRACE and have external clinical input to provide an independent professional opinion. WUTH continues to support 100% external representation at the PMRT case reviews.
Safety Action 2: Are you submitting data to the Maternity Service Data Set (MSDS) to the required standard? STATUS: Green	The Trust submits data to MSDS with NHS Digital sending a monthly scorecard confirming Trust compliance with the dataset submission. It is anticipated that the September 2022 submission will be the dataset that informs compliance with MIS safety action.
Safety Action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions into Neonatal units Programme? STATUS : Green	Whilst the revised action does not require an agreed clinical pathway for transitional care, nor does this require auditing. Activity does need to be captured through HRG XAA04 coding. does need to continue. The number of avoidable term admissions into the neonatal unit at WUTH is one of the lowest across C&M and is monitored monthly. The Atain action plan was complete but to further improve transitional care it has been agreed that an Atain action plan will include all learning/developments identified from the Reducing Term Admissions meeting.
Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?	Whilst this action no longer includes feedback from the survey, formal minuting of the O&G trainee gaps nor Trust sign off for a workforce strategy /action plan workforce planning has taken place within both the maternity and neonatal services. The Neonatal workforce has been reviewed with support from the Cheshire and Merseyside Neonatal Operational Delivery Network (NODN). Additional

STATUS: Green	nurse staffing has been funded from NHSE/I monies. The anaesthetic medical workforce currently meet the Anaesthesia Clinical Services Accreditation (ACSA) standards The Obstetric workforce has been reviewed using the RCOG guidance and there is a requirement for additional consultant hours to support the recommendations from Ockenden (due to the increase in governance, training and audit). All reviews to outline the clinical workforce have been completed.
Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	The revised action has stated that a staffing oversight report to Board is required at least annually and has not specified every 6 months, however maternity staffing will be included in the 6 monthly nurse staffing paper that goes to Board. A detailed midwifery workforce review was undertaken by Birthrate+ (which specifically looks at acuity and demand within the Maternity service to determine safe staffing levels). This report was presented at Workforce Steering Board in August 2021 outlining the midwifery staffing requirements. However, following the recommendations in the Ockenden report the uplift for the midwifery establishment has been reviewed and in delivering the continuity of carer model there is a requirement for an additional 4wte midwives and 1.4wte Maternity Support workers (or 5wte midwives and reduced MSW's). The workforce planning has been completed and the funding has been identified from additional recurring monies to implement and give assurance

STATUS: Green	Maternity Continuity of Carer (MCoC) model will be delivered by March 2024.
Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle v2? STATUS: Green	All 5 elements of the Saving Babies Lives care bundle (SBL) v2 have been implemented with compliance monitored by the LMNS. . Evidence includes training delivered by the Fetal Surveillance Midwife/ Obstetrician; development of policies and audit undertaken. Such audits are included in the Divisional (FAAP) with further audit due in September 2022 . CO2 monitoring which is an element of the bundle was paused during the pandemic but has since been recommenced with audit of compliance monitored at booking and at 36 weeks of pregnancy. WUTH is working towards with a robust action plan to e give assurance of compliance at 36 weeks along with IT supporting works to add a mandated question into the maternity records. Work is planned for week beginning 13 August 2022 to ensure compliance in data submitted to NHSE in September 2022. Element 5 – reducing the risk of pre-term birth requires a policy update to be completed in July 2022 and has been included on the SBL2 to give assurance of compliance.
Safety Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to co-produce local maternity services? STATUS : Green	The Wirral MVP Chair meets at least weekly with the maternity team and the consultant midwife and MVP Chair do a joint live 'open session' for service users to update on service provision and to answer any queries service users may have. The consultant midwife has recently been interviewed on national news promoting a project that has been rolled out to support service users who experience hardship or who need legal / financial advice.

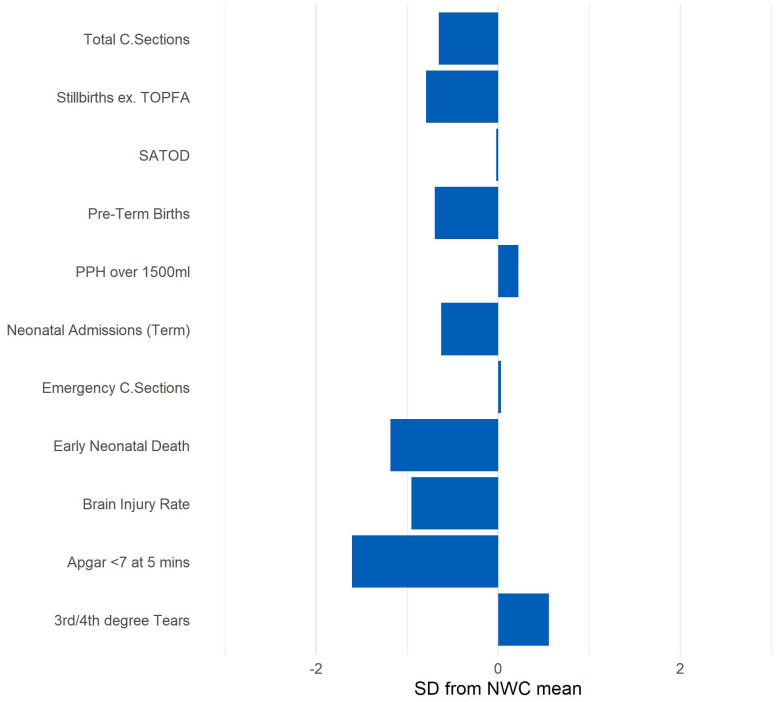
Safety Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year? STATUS : Green	The multidisciplinary staff training - PROMPT training is delivered in different ways with on online learning and 1:1 drills. The Midwifery staff have to date met the 90% compliance rate but obstetric and anaesthetic staff are 66%. There is a trajectory for full compliance and robust plan to provide assurance all staff working in maternity services from across the W&C and the Surgical Division will have attended. Additional training requirements are outlined in Ockenden which the Division are also working through.
Safety Action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues? STATUS : Green	Regular meetings/walkabouts of the Trust Safety Champion continue. The (NED) Safety Champion updates Board with the escalation of any concerns. Oversight of Maternity services at Board level is crucial in the safe delivery of maternity services and must not be underestimated. The ongoing improvement / action log capture improvements in both the Maternity and Neonatal services.
Safety Action 10: Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme(ENS) STATUS : Green	This safety action no longer applies in its entirety, but HSIB regularly review the cases to evidence compliance. The Director of N&M and the Q&S Lead for the W&C Division meet with HSIB on a quarterly basis. A monthly update report is received from HSIB to support timely progress of each case review with discussion of actions agreed.

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	Stillbirth rate as a proportion of all births remains below the average rate in C&M however, the rate is above average within C&M for those babies born at 37 weeks and over. All are reviewed as part of PRMT and are taken to SI panel with all identified as unavoidable and no
	Outlier for rates of neonatal deaths as a proportion of birth	no	Rate of both early and late neonatal deaths are not outliers within the rgeion.
	Rates of HIE where improvements in care may have made a difference to the outcome	no	Low rates of HIE, sitting below the lower control limit for C&M.
	Number of SI's	no	No SI's declared in May 2022
	Progress on SBL care bundle V2	no	Annual audits being undertaken in September to evidence compliance with SBL Care Bundle..
	Outlier for rates of term admissions to the NNU	no	Transitional Care activity is consistent and WUTH has a relatively low rate of avoidable term admissions in month. The Atain improvement plan is up to date with no actions outstanding.
Service user and staff feedback	MVP or Service User concerns/complaints not resolved at trust level	no	Relatively low number of maternity complaints but work ongoing to adopt Trust Patient Strategy in W&C Division
	Trainee survey	no	Generally positive feedback although reference some limited training in part due to Pandemic.
	Staff survey	no	Divisional response rate increased and results demonstrated high scores - work ongoing to support the Trust action plan.
	CQC National survey	no	Maternity survey published 10/02/2022 - separate paper went to Board in April 2022
	Feedback via Deanery, GMC, NMC	no	Nil of note
	Poor staffing levels	no	Vacancy rate has increased during May to 5% - all vacancies filled at recent interviews.
	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	of Midwifery therefore vacancy for HoM currently. New DoM is being supported by the retiring DoM reducing any risk/s to the service.
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams.
	False declaration of CNST MIS	no	Year 4 MIS has been relaunched with a separate update in the Maternity update to the Board of Directors.
	Concerns raised about other services in the Trust e.g. A&E	no	Nil
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	No concerns
Safety and learning culture	Lack of engagement in HSIB or ENS investigation	no	Good engagement processes in place. Monthly reports received of ongoing cases.. Recent survey completed - results of same awaited.
	Lack of transparancy	no	100% DOC evident.
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes in place supporting lessons learned from all SI's, local reviews, rapid reviews, complaints and compliments. Patient strategy being adopted to further support.
	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		Consistent rates of reporting across the speciality.
	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 reported in May 2022.
	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. Review of governance meetings undertaken with focus on establishing a joint maternity/neonatal meeting. Same to commence in March.
	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 continues to provide an acute service (since the start of the pandemic) due to the robust contingency plans in place.
CQC inspection and DHSC or	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	NHSE Visit to the Trust on 16 June 2022 with a regional Insight visit by the LMNS/NHSE North West team on 16 August 2022.
	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

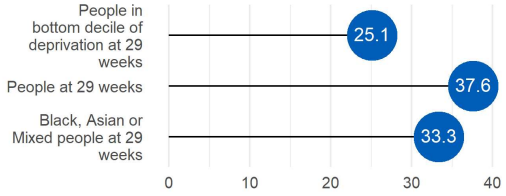
Wirral University Teaching Hospital NHS FT

April 2021 - March 2022



Number of STEIS reportable incidents

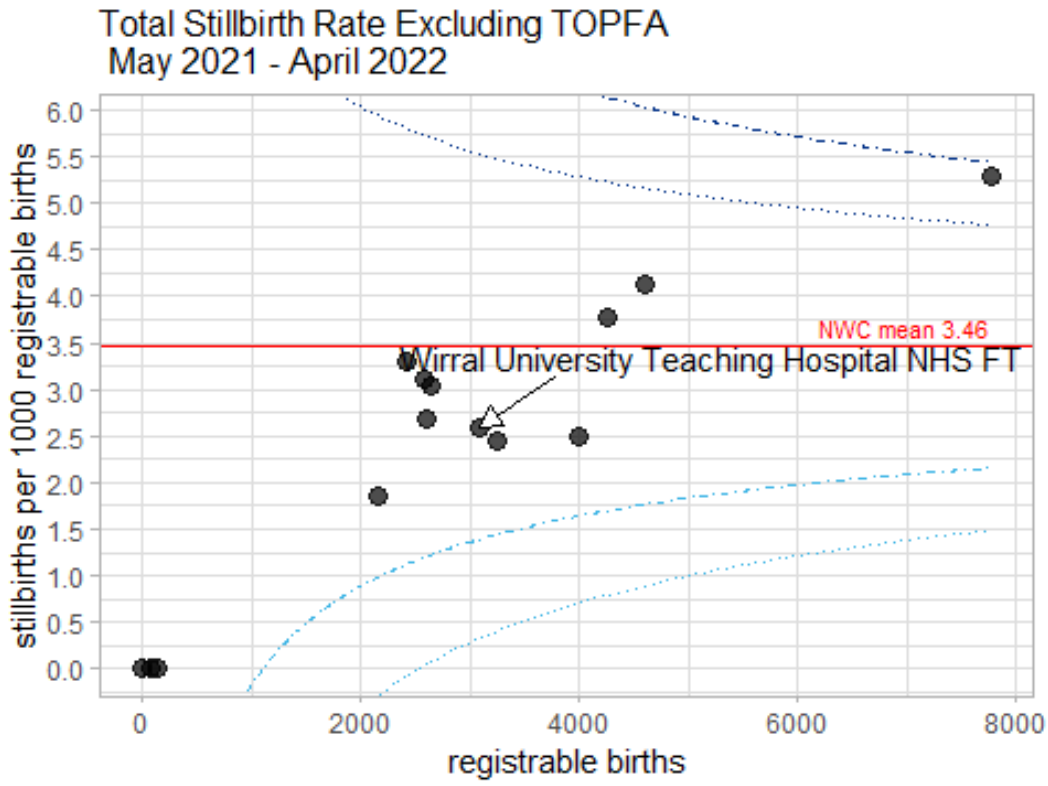
% Receiving Continuity of Carer



Element 1	Element 2	Element 3	Element 4	Element 5
All met	All met	All met	All met	All met

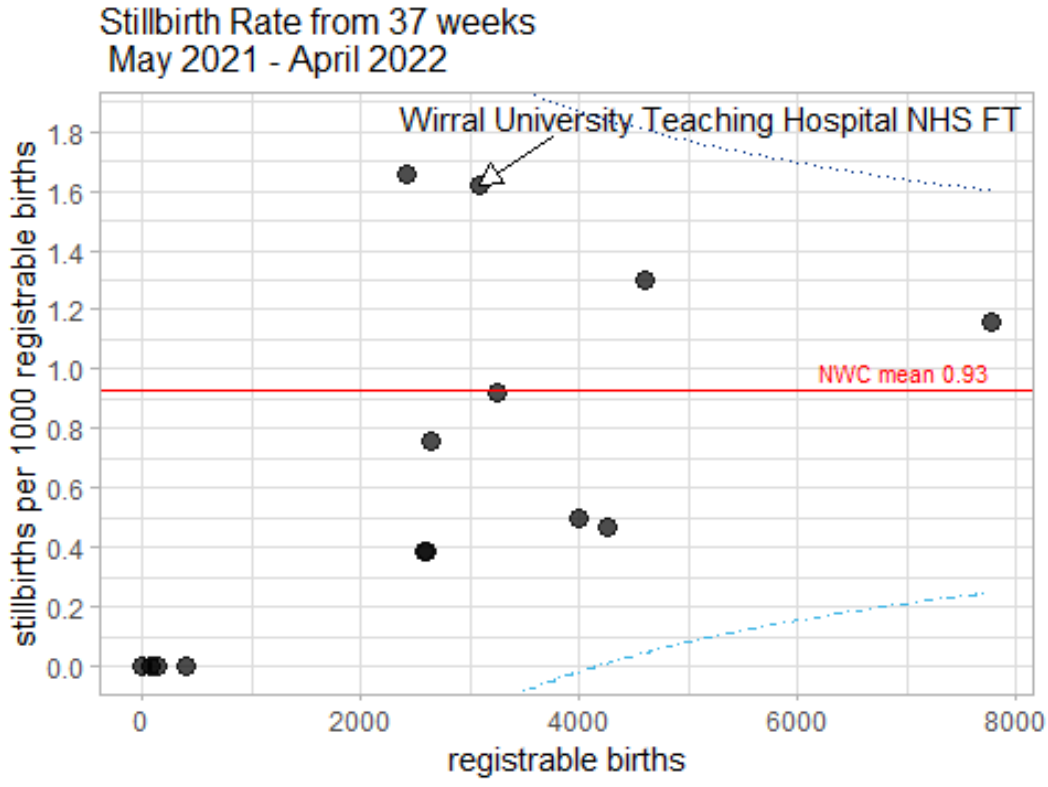
The CQC rating for maternity services in this trust is good.

Appendix 4 – North West Coast Outlier Summary



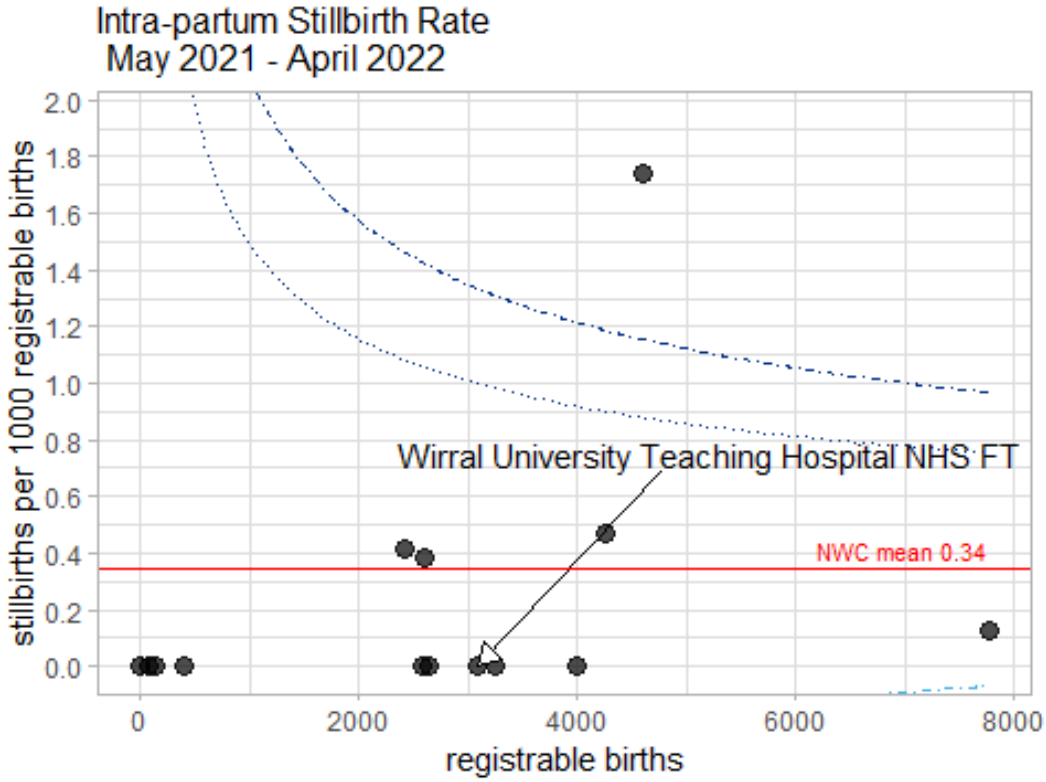
Data Source: NWC CN Maternity Dashboard

Looking at the overall stillbirth rate WUTH is not an outlier despite observing a spike in stillbirths in October 2021.



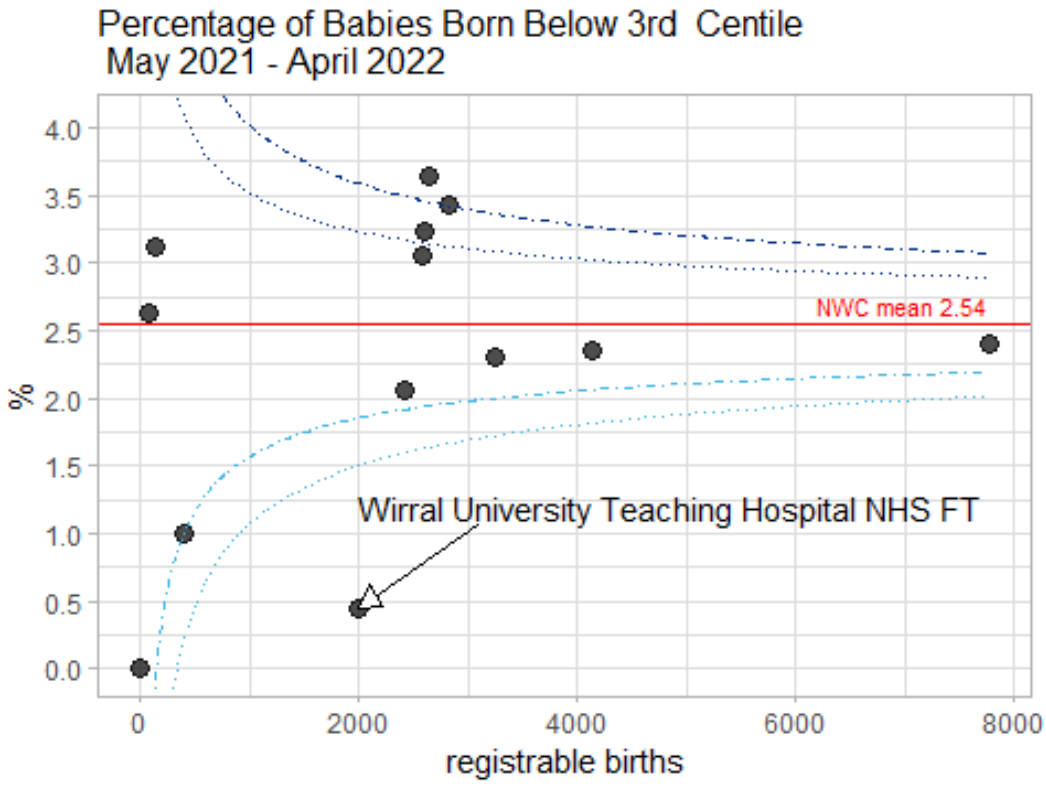
Data Source: NWC CN Maternity Dashboard

A thematic review was undertaken with all 'term' stillbirths confirmed as not meeting the criteria for an SI – although lessons were learnt and shared from each stillbirth.



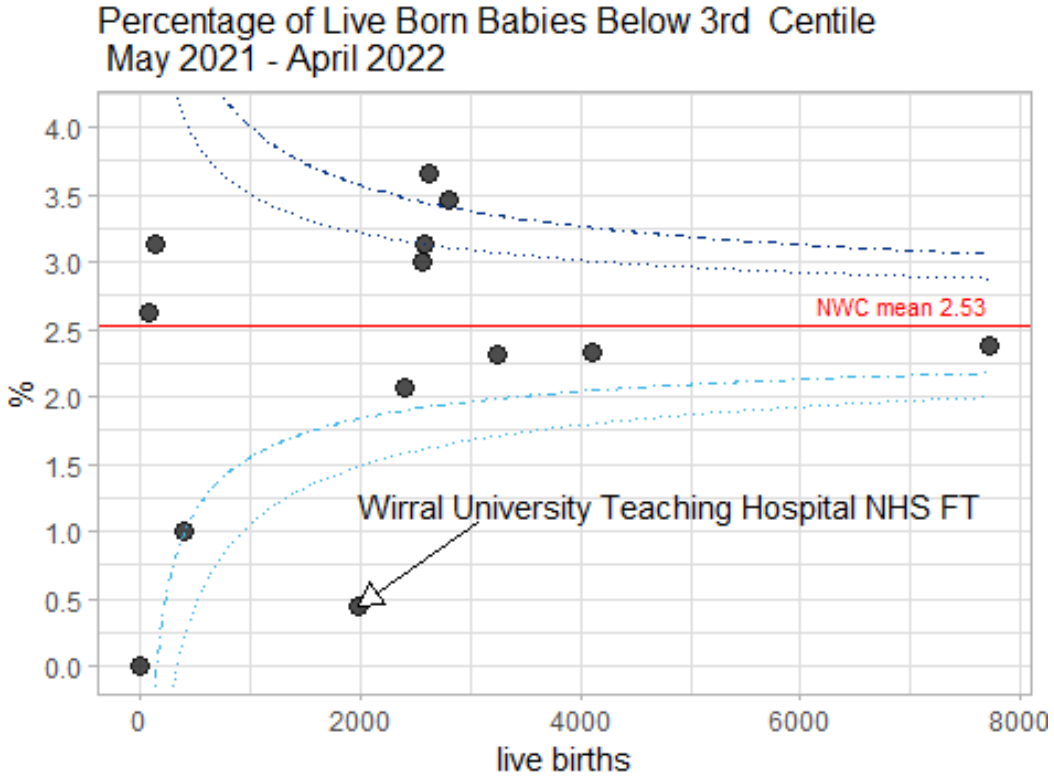
Data Source: NWC CN Maternity Dashboard

There were no intrapartum stillbirths at WUTH during this timeframe.



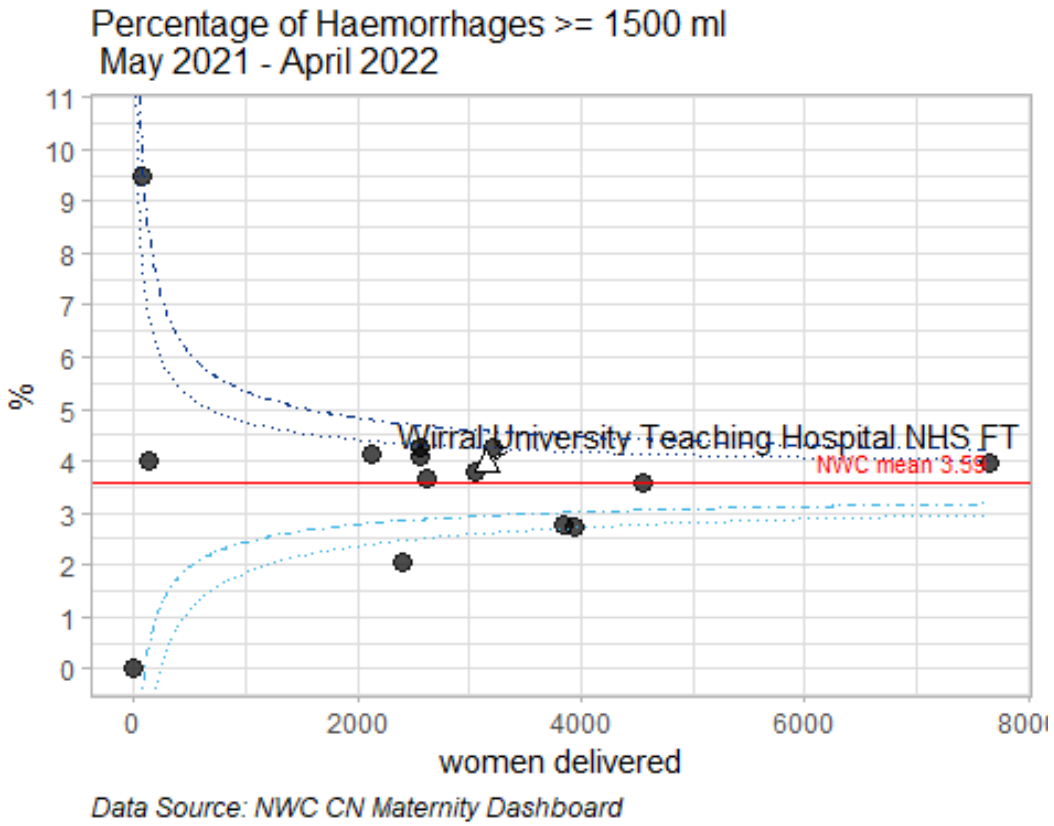
Data Source: NWC CN Maternity Dashboard

WUTH has the lowest % of babies born below the 3rd centile which positively is a result of the effective detection of growth restricted babies.



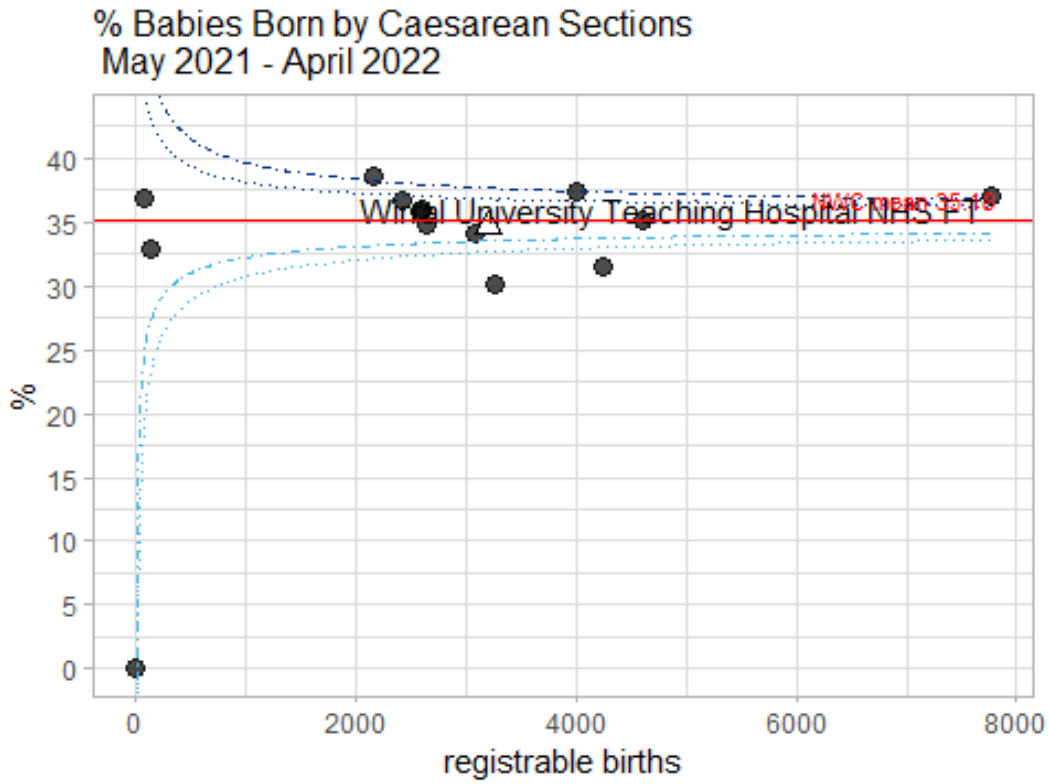
Data Source: NWC CN Maternity Dashboard

WUTHs % of live babies born below the 3rd centile further supports the detection of growth restricted babies improving the overall outcome of pregnancies.



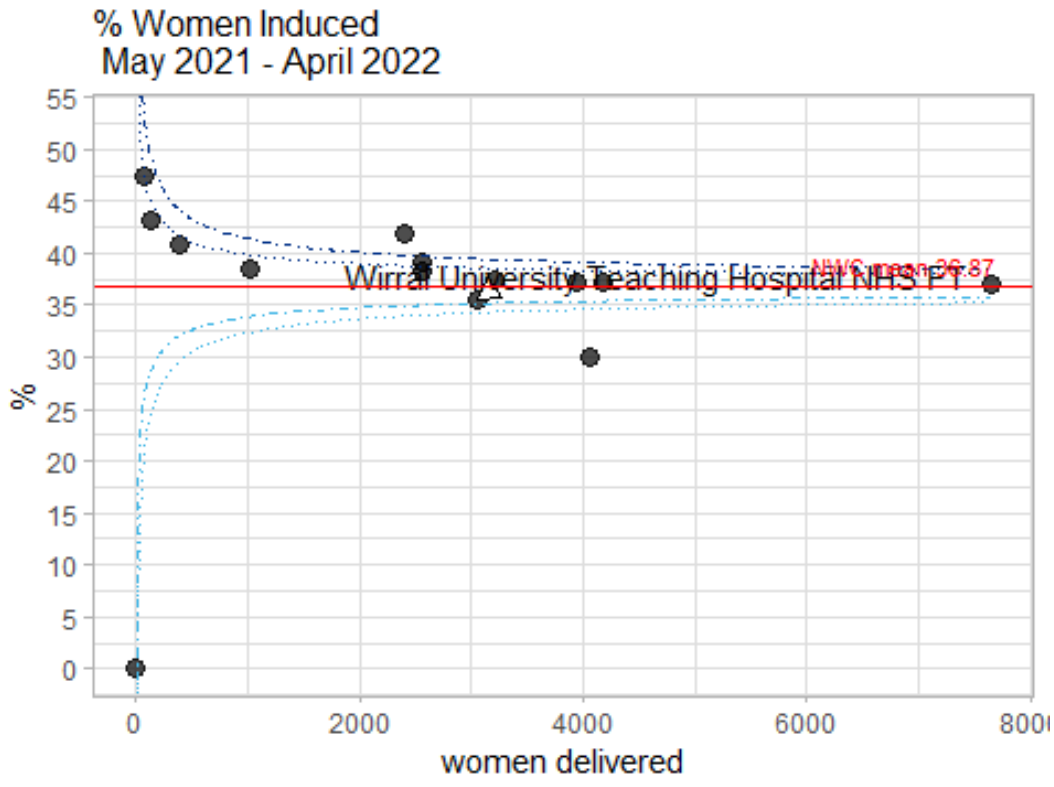
Data Source: NWC CN Maternity Dashboard

WUTH % of haemorrhages is consistent with other providers of a similar size.



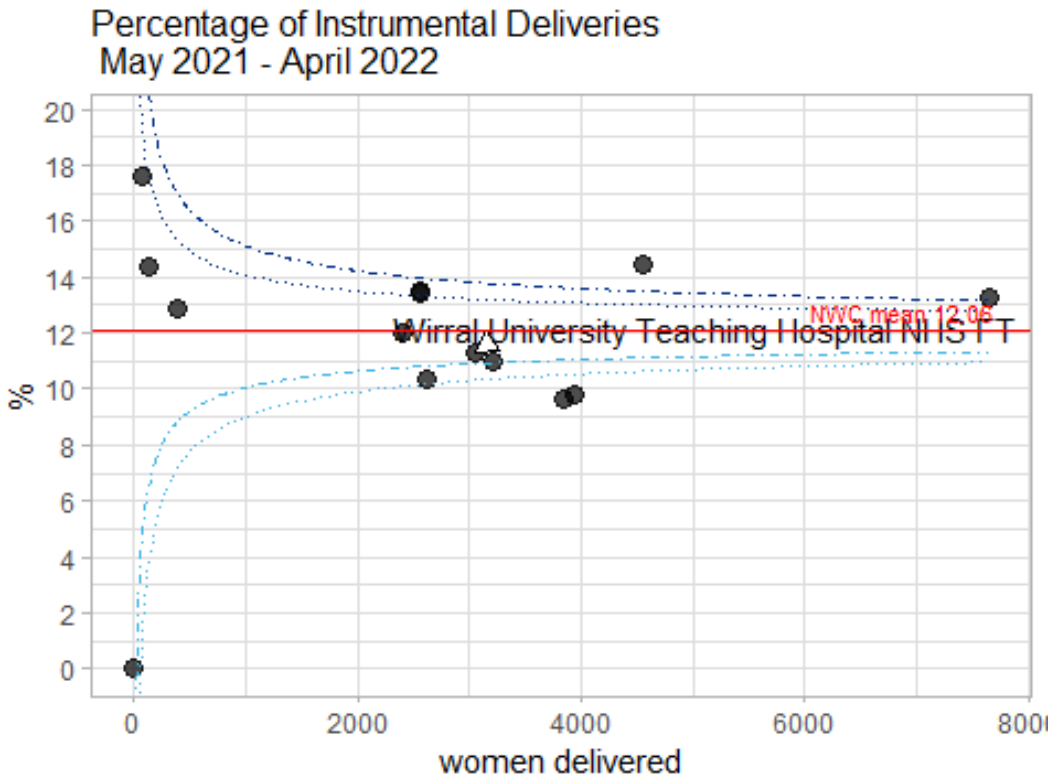
Data Source: NWC CN Maternity Dashboard

This includes both elective and emergency caesarean sections and is consistent with other providers.



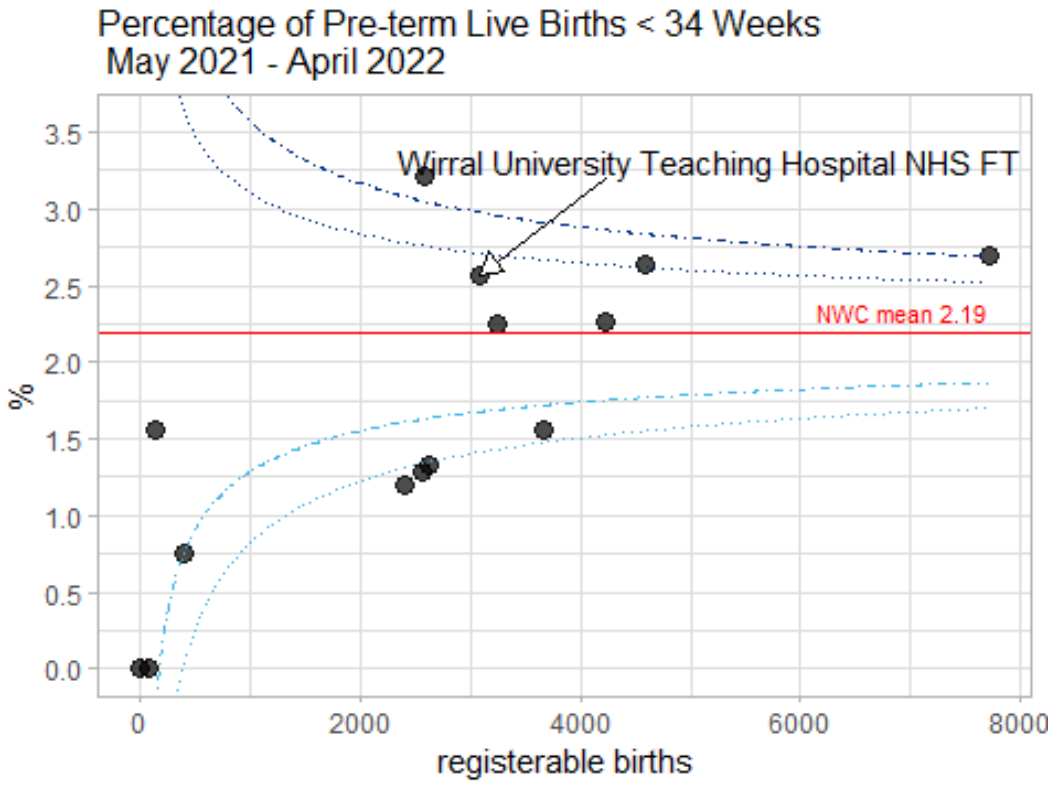
Data Source: NWC CN Maternity Dashboard

The % of women undergoing induction of labour is consistent with other providers.



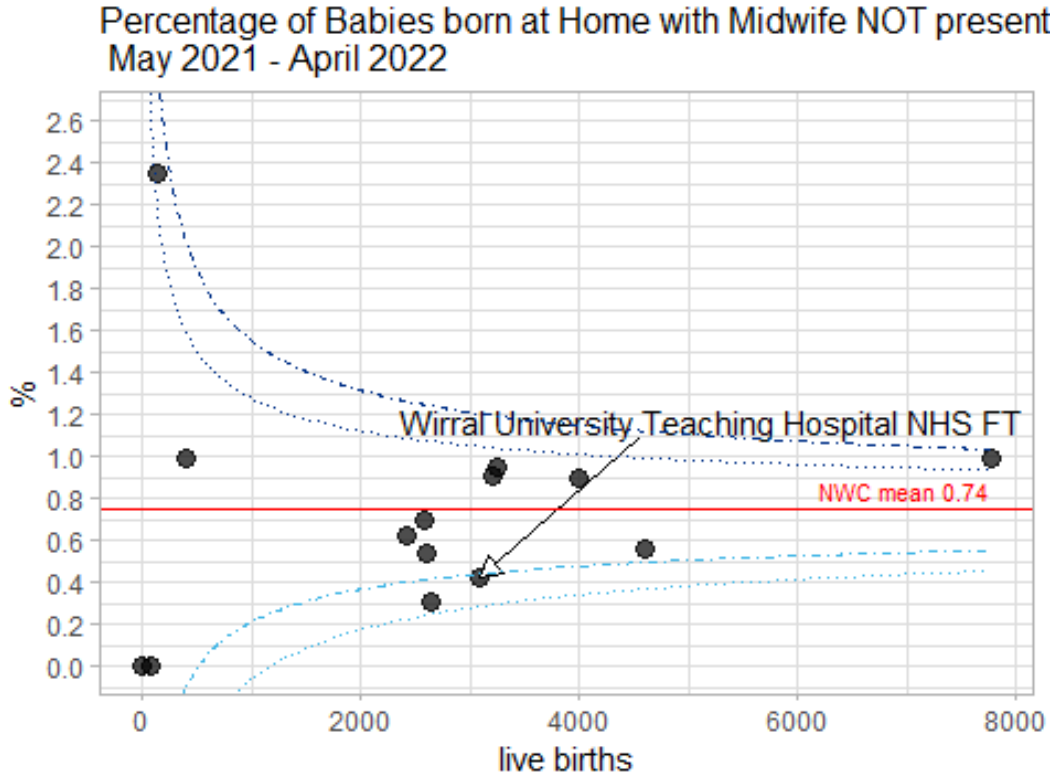
Data Source: NWC CN Maternity Dashboard

WUTH is consistent with other maternity providers



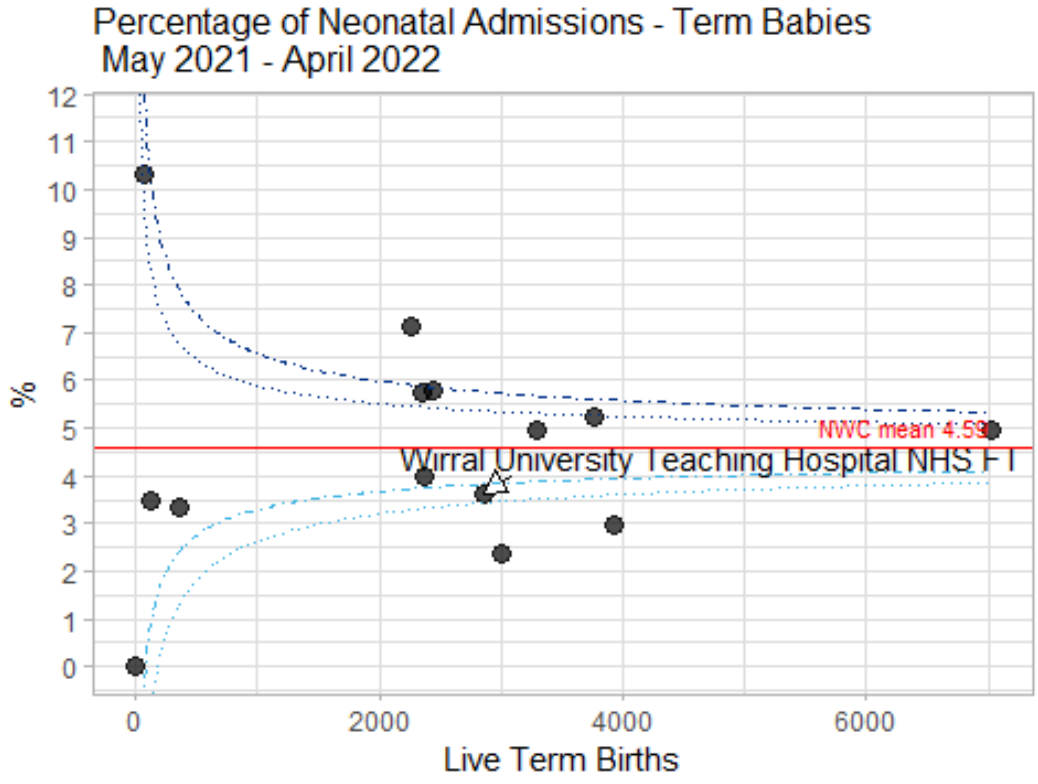
Data Source: NWC CN Maternity Dashboard

WUTH is above the NWC mean of 2.19 which is consistent with the level of Neonatal care available.



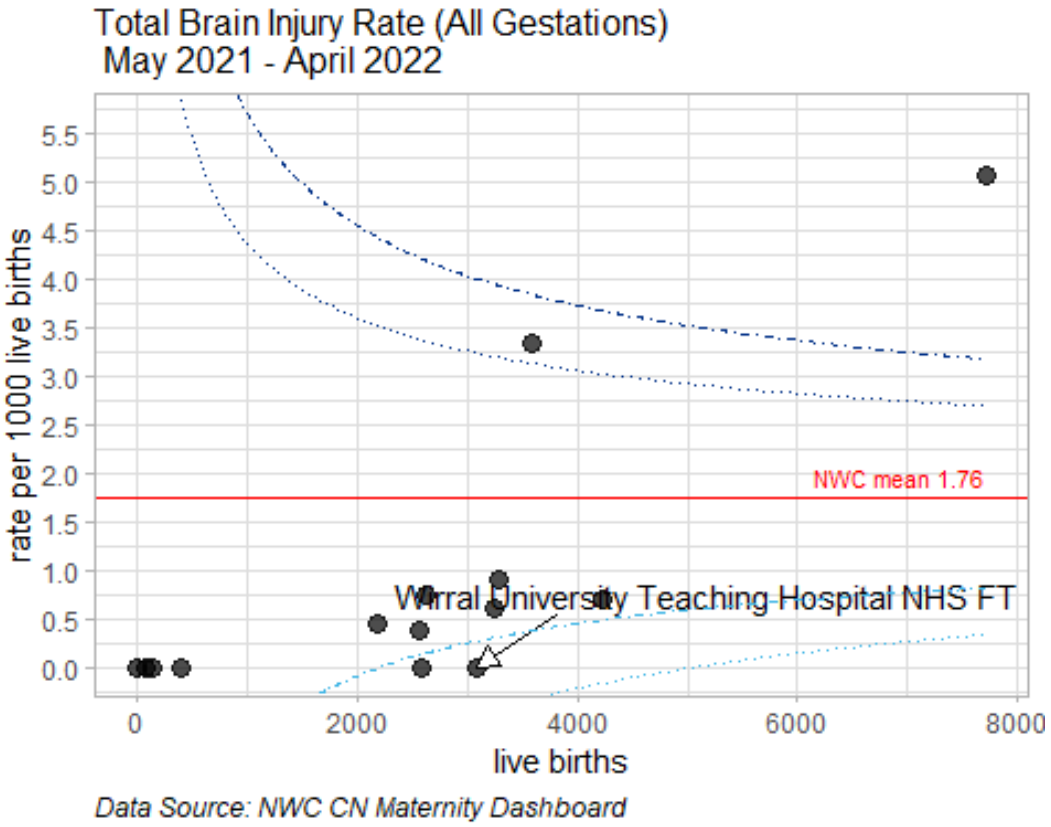
Data Source: NWC CN Maternity Dashboard

This % positively supports the benefit of a dedicated home birth team.



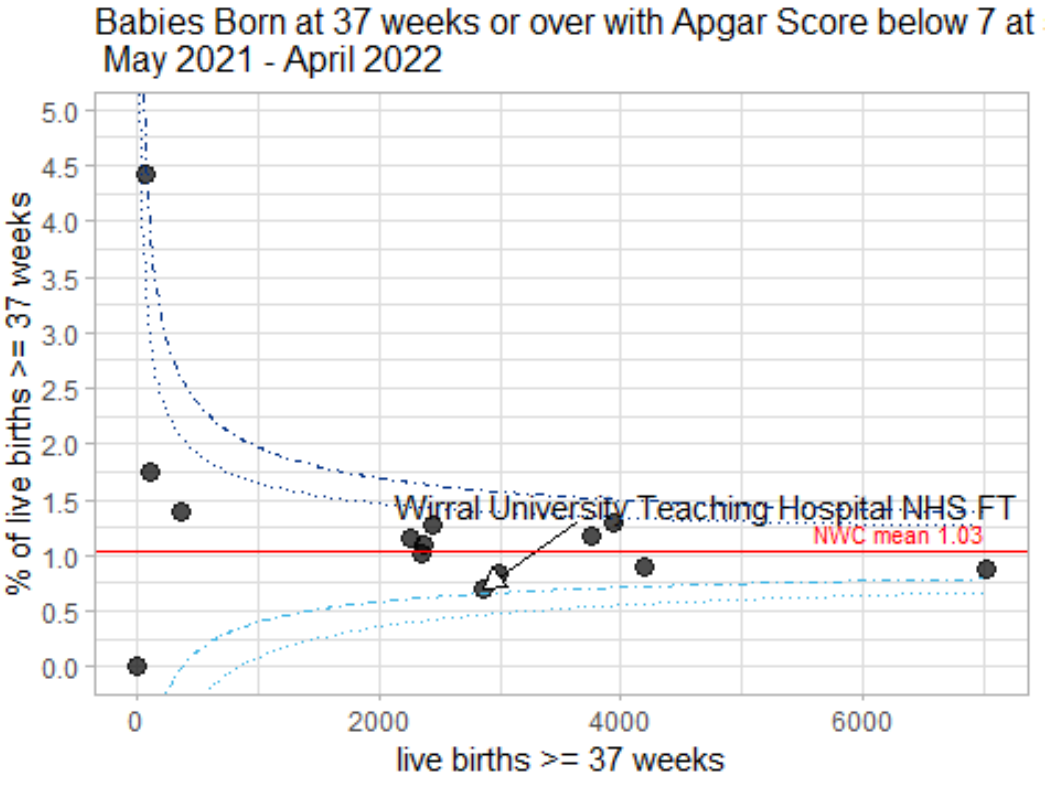
Data Source: NWC CN Maternity Dashboard

WUTH is plotted as being below the NWC mean of 4.59 – this is supported by transitional care facilities and these admissions are generally unavoidable.



Data Source: NWC CN Maternity Dashboard

WUTH has no reported HIE cases which links in with the low incidence of low Apgar scores.



Data Source: NWC CN Maternity Dashboard

WUTH has the lowest rate which links in to the HIE incidence/rates.

Description of all MCoC teams and enhanced status

Please complete the below table for every active, planned and, if relevant, suspended MCoC team in your LMS. Information provided in this table will form the Expression of Interest for teams in your LMS to be enhanced MCoC pilots for 2022/23.

Team name	Trust	Trust code	Planned annual caseload of team	Number of midwives in team	WTE of team	Please select the status of the team i.e. whether it is active, planned, or if it was previously active but has been suspended for any reason	If suspended or planned, what is the planned date to (re)launch?	Will this team be covering one of the most deprived areas as defined by the IMD?	Does this team cover an area with a high proportion of Black, Asian and Mixed ethnicity women?	If the team is in one of the most deprived 10% of areas, do you propose that this is an enhanced team?	If this will be an enhanced team, what postcodes will it cover?	If this will be an enhanced team, what additional staffing establishment is proposed e.g. MSW or other holistic support, please see the implementation guidance for details	Estimated annual salary add-on costs for proposal Up to £46,102 (the equivalent of a Band 4 community MSW) will be provided
Highfield	Wirral University Teaching Hospital NHS Foundation Trust	RBL	200	7	6.6	Active		Yes in the most deprived 10%	No	Yes	CH41, 42, 43, 44, 45, 46, 47, 48, 49, 60, 61, 62		
Willow	Wirral University Teaching Hospital NHS Foundation Trust	RBL	280	8	7.8	Active		No	No	No	CH61, CH62		
Bluebell	Wirral University Teaching Hospital NHS Foundation Trust	RBL	280	8	7.7	Active		No	No	No	CH42, CH62		
Lotus	Wirral University Teaching Hospital NHS Foundation Trust	RBL	320	7	6.6	Active		Yes in the most deprived 10%	No	Yes	CH41, 42, 43, 44, 45, 46, 47, 48, 49, 60, 61, 62		
Queensway	Wirral University Teaching Hospital NHS Foundation Trust	RBL	280	8	7.84	Active		Yes in the most deprived 20%	No	Yes	CH41, CH44, CH45, CH63	MSW x 1.0 wte	£46,000
Team 6 - Name to be decided (Wallasey)	Wirral University Teaching Hospital NHS Foundation Trust	RBL	310	9	9	Planned	Jan-23	Yes in the most deprived 20%	No	Yes	CH44, CH45		
Team 7 - Name to be decided (Birkenhead)	Wirral University Teaching Hospital NHS Foundation Trust	RBL	280	8	8	Planned	Jun-23	Yes in the most deprived 20%	No	Yes	CH41, CH44, CH45, CH63	MSW x 1.0 wte	£46,000
Team 8 - Name to be decided (West Wirral)	Wirral University Teaching Hospital NHS Foundation Trust	RBL	280	8	8	Planned	Jun-23	No	No	No	CH46, CH47, CH48, CH49, CH62		
Team 9 - Name to be decided (West Wirral)	Wirral University Teaching Hospital NHS Foundation Trust	RBL	280	8	8	Planned	Jun-23	No	No	No	CH49, CH60, CH63		
Team 10 - Team to be decided (Birkenhead)	Wirral University Teaching Hospital NHS Foundation Trust	RBL	280	8	8	Planned	Jun-23	Yes in the most deprived 20%	No	No	CH42, CH43, CH63		

Appendix 6 - Cheshire & Merseyside Local Maternity & Neonatal Systems (LMNS) Five Priority Areas to Improve Equity & Equality for Women

Source: The 2021/22 priorities and operational planning guidance: Implementation guidance

By 30 November 2021: The C&M LMNS are asked to submit an equity and equality analysis *(covering health outcomes, community assets and staff experience)* and a co-production plan as set out in sub-priority 4a, interventions 1 to 4
By 31 May 2022: The C&M LMNS are asked to submit a refresh of the original equity and equality analysis to include missing data

By 28 February 2022: The C&M LMNS are asked to co-produce equity and equality action plans - **Date amended to 30 September 2022**

Complete	
In Progress	
Not Yet Started	

		Interventions	Process indicators	LMNS Position - What will the equity plan do to address this?	Outcome indicators	Timeline achieved/to be achieved	Source	Groups who will benefit most	Brief LMNS notes
Priority 1: Restore NHS services inclusively	**1**	Continue to implement the COVID-19 four actions.	Implementation of the COVID-19 four actions	Ensure Maternity Providers continue to collate and share the data with the LMNS	% of maternity records where ethnicity is recorded % of women with up to date risk assessments % of women taking vitamin D & folic acid	May-22	Regional Measures Report	Women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities	
Priority 2: Mitigate against digital exclusion	**2a**	Ensure personalised care and support plans (PCSPs) are available in a range of languages and formats, including hard copy PCSPs for those experiencing digital exclusion	The number of women with a Personalised Care and Support Plan which covers:	Ensure Maternity Providers continue to collate and share the data with the LMNS. Conduct a baseline audit of the quality of PCSPs from all maternity providers in line with The Long Term Plan (LTP) guidance, ensuring the 5 technical criteria are met. Baseline will be used to review the PCSP offer for the LMNS ensuring they are available in a wide range of languages and alternative formats. Review providers Training offer and resources for delivery of PCSP training as part of Core Competency Framework . Conduct a survey of women's experiences of delivery and quality of PCSP.	% of Trusts with PCSPs in different languages and formats % of Trusts reporting compliance via MSDS **MCoC** Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion	by March 2023	Maternity Services Data Set (MSDS)	Women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities including disabilities e.g. Autism/LD/Deaf/Blind	June 2022 LMNS Assurance Board paper will include recommended actions, required budgets to support programme deliverables and next steps
	2b		o antennal care by 17 weeks gestation			by March 2023			
	2c		o intrapartum care by 35 weeks gestation			by March 2023			
	2d		o postnatal care by 37 weeks gestation			by March 2023			
	2e		The numbers of women who had all three of the above in place by the gestational dates			by March 2023			
Priority 3: Ensure datasets are complete and timely	**3a**	On maternity information systems continuously improve the data quality of ethnic coding and the mother's postcode.	Safety action 2, category 9: data submitted to Maternity Services Data Set (MSDS) contains valid postcode for mother at booking in 95% of women booked in the month.		MSDS - 95% of women booked in the month contains valid postcode	Mar-22	All Trusts able to submit through to MSDS.	Women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities	
	3b		Ethnicity data quality		MSDS- 80% of women booked in the month includes a valid ethnicity category and postcode	Mar-22	Regional Measures Report		
	3c		Safety action 2, category 10: data submitted to MSDS includes a valid ethnic category for at least 80% of the women booked in the month. Not stated, missing and not known are not valid records			Mar-22	All Trusts able to submit through to MSDS.		
	4a. Understand your population & co-produce interventions	4a.1 Understand the local population's maternal and perinatal health needs (including the social determinants of health).	Review strategic documents across C&M LMNS/PHE/LA/VSCE and available data.	Understanding the population will support the LMNS to prioritise communities who need additional support to access Women's Maternity & Health Services	Outcome indicators included within detailed action plan **tab 4a.1 - 4**	Nov-21	Within the C&M LMNS Equity & Equality Analysis & Board Report submitted to NHSEI 30/11/2021	Women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities including disabilities e.g. Autism/LD/Deaf/Blind	
		4a. 2 Map the community assets which help address the social determinants of health.	Review all available assets identifying any gaps	Utilise the community asset register to support engagement with women who are representative of the C&M population and ensure their views are heard/included to support better health within their communities	C&M LMS Community Asset Register	Nov-21	Within the C&M LMNS Equity & Equality Analysis & Board Report submitted to NHSEI 30/11/2022	Women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities including disabilities e.g. Autism/LD/Deaf/Blind	
		4a. 3 Conduct a baseline assessment of the experience of maternity and neonatal staff by ethnicity using WRES indicators 1 to 8.	Develop a Maternity Staff Survey with HEE	Provide a baseline survey which will be used to support improvements in the Maternity & Neonatal workplaces. Work in partnership with Health Education England (HEE)/Key Stakeholders to support maternity staff in areas identified following the survey	C&M LMS Maternity Staff Survey	Jun-22	C&M LMNS Maternity Service Provider Staff Survey	Staff from ethnic minority. Protected characteristic groups or living in socially deprived neighbourhoods	
		4a. 4 Set out a plan to co-produce interventions to improve equity for mothers, babies and race equality for staff.	Hold engagement events to obtain views from all women across C&M LMNS. Specific focus on communities and socially deprived areas highlighted within the Equality Analysis	CO -PRODUCTION Advisory Group (CAG) - to obtain views from women regarding perinatal trauma/loss. Focus groups to be arranged in Granby joint working with Community Engagement and Merseycare to obtain views .	Engagement Register of feedback activities undertaken for women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities including disabilities e.g. Autism/LD/Deaf/Blind Feedback collated to support co-production of the action plan	Mar-22	C&M LMNS Equality & Equity Action Plan - submission deadline to NHSEI amended from **28/02/2022 to 30/09/2022**	Women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities including disabilities e.g. Autism/LD/Deaf/Blind	
		Implement maternal medicine networks to help achieve equity	The Maternal Medicine Network is implementing the KPIs in the non-mandatory national service specification. They are broken down by level of deprivation of the mother's postcode and ethnicity			Mar-22		Women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities including disabilities e.g. Autism/LD/Deaf/Blind	
		Offer referral to the NHS Diabetes Prevention Programme to women with a past diagnosis of gestational diabetes mellitus (GDM) who are not currently pregnant and do not currently have diabetes.	Booking at <70 days gestation		Number of referrals into NHS Diabetes Prevention Programme Number of women previously identified with gestational diabetes % of pregnancies with diabetes compared to England average 5%	Mar-22	Regional Measures Report	Women from Black, Asian & Mixed Ethnicity Groups	

Priority 4: Accelerate preventative programmes that engage those at greatest risk of poor health outcomes	**4.b Action on maternal mortality, morbidity and experience**	Implement NICE CG110 antenatal care for pregnant women with complex social factors.	Proportion of women with complex social factors who attend booking by 10 weeks Proportion of women with complex social factors who attend booking by 12+6 weeks and 20 weeks Proportion of women with complex social factors who attend booking by 20 weeks Proportion of women who attend the recommended number of antenatal appointments		% of women identified with complex social factors who attend booking appointments by gestation (10/12+6/20)	May-22 May-22 May-22 May-22		Pregnant women with complex social factors	
		Implement maternal mental health services with a focus on access by ethnicity and deprivation	Proportion of women who access maternal mental health by ethnicity, deprivation and protected characteristic groups	Working in partnership with Merseycare to include the recording of ethnicity, deprivation, seldom heard groups and protected characteristics information on the RIO Merseycare for MMHS will improve early identification of women who will require additional support to access appropriate support or services.		Apr-22	PMH dashboard provides access data by ethnicity and deprivation. Personalised	Black African, Asian & Ethnic Minority groups; those living in the most deprived areas.	
		Ensure personalised care and support plans are available to everyone.	% of women attending the booking appointment who are from ethnic minority groups	Maternity Provider Trust baseline audit of PCSPs for ethnicity codes being recorded	% of PCSPs where ethnicity is recorded	Mar-22	Regional Measures Report	Women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities including disabilities e.g. Autism/LD/Deaf/Blind	
			Ethnicity data quality		None	Mar-22		Black African, Asian & Ethnic Minority groups	
		Ensure the MVPs in your LMS reflect the ethnic diversity of the local population, in line with NICE QS167.	% of parent members of the MVP who are from ethnic minority groups	Working with MVPs to improve community engagement and collaboration with women from Women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities. All of the C&M MVP's plans for 2022-23 include actions to improve membership from women representative of ethnic minority and socially deprived groups. Awaiting guidance from NHSEI on the review of funding streams for MVPs (dependant on DOH/ICS funding structure) and development/support for Chairs including job descriptions and key deliverables of the role.	% of parent, peer and lay members chairs who are from ethnic minority groups	Jul-22	Audit of current membership C&M MVPs annual plans for 2022-23 include improving membership/representation from women from Black, Asian, Minority, Socially Deprived & Protected Characteristic Groups	Women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities	
	4.c Action on perinatal mortality and morbidity	Implement targeted and enhanced continuity of carer (75% of women in these groups receiving continuity of carer by 2024)	Placement on a continuity of carer pathway – Black/Asian women Placement on a continuity of carer pathway – women living in the most deprived areas	Ensure providers continue to submit monthly data . Report and escalate any concerns in data reporting to risk register. Ensure all Trusts have submitted action plans to LMNS by March 2022 which outlines their plans to achieve MCOC as default model of care by 2023 prioritising Black /Asian women and those living in the lowest decile of deprivation. Audit of Trusts local plans and monthly monitoring of readiness to implement CofC - awaiting National and Regional guidance to proceed. Collaborate with CoC leads/providers to establish models of care for Black/Asian women and those from the most deprived areas. Explore wider determinants of health and social needs for women and families. I.e. asylum seekers, young mums and women with learning disabilities.	Breast milk at first feed Low birth weight (<2,500g for term births) Deliveries under 27 weeks Deliveries under 37 weeks Breast milk at first feed Low birth weight (<2,500g for term births) Deliveries under 27 weeks Deliveries under 37 weeks	Apr-22 Apr-22 Apr-22 Apr-22 Apr-22 Apr-22 Apr-22 Apr-22	Audit of Trust local action plans	Women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic communities including disabilities e.g. Autism/LD/Deaf/Blind	
		Implement a smoke-free pregnancy pathway for mothers and their partners.	40% of women on a smoke free pathway	C&M LMNS & Cancer Alliance SiP programme key deliverables	Reduction in women SATOD (LTP/National aspiration 6%)	by March 2023	NHS Digital Quarterly SATOD data C&M LMNS SiP Joint Programme Cancer Alliance	Women living in the most deprived areas	12 month dedicated SiP programme to support a reduction - targeting socially deprived areas
		Implement an LMNS breastfeeding strategy and continuously improve breastfeeding rates for women living in the most deprived areas	Baby Friendly accreditation - UNICEF Accreditation for all Maternity Providers across C&M (7)	Source: https://www.unicef.org.uk/babyfriendly/about/accreditation-statistics-and-awards-table-2/	All Maternity Providers across C&M Baby Friendly Accredited 2021 position: Countess of Chester - **Full accreditation** Liverpool Women's - **Re-assessment due** Mid Cheshire Hospitals - **No accreditation listed** Southport & Ormskirk Hospital - **2nd stage accreditation** St Helens & Knowsley Teaching Hospitals - **No accreditation listed** Warrington & Halton Hospitals - **Accreditation suspended** Wirral University Teaching Hospital - **No accreditation listed**	by March 2023	UNICEF Baby Friendly	Women living in the most deprived areas	Across England **28.1%** of Maternity Providers are listed as achieving 'Full accreditation' or 'Gold Award'. **25%** of Maternity Providers across C&M met this standard which is the highest % within the NW region. Increase in overall % of Maternity Providers across C&M obtaining Baby Friendly Accreditation
		Culturally-sensitive genetics services for consanguineous couples C&M LMNS		Scoping exercise of current clinical genetic provision across C&M	Service provision across C&M LMNS	Jan-22		Pakistani and Bangladeshi babies	The Liverpool Centre for Genomic Medicine is based at Liverpool Women's Hospital and provides a regional genetics service known as the Merseyside and Cheshire Genetics Service covering a population of 2.8 million people across Merseyside, Cheshire and the Isle of Man
	4.d Support for maternity and	Roll out multidisciplinary training about cultural competence in maternity and neonatal services.	% of maternity and neonatal staff who attended training about cultural competence in the last two years	Liaising with Maternity Provider HR Directors to mandate CC training for staff who have advised they are awaiting National Guidance	% of maternity & neonatal staff who have undertaken multidisciplinary training about cultural componence	by March 2023		Black, Asian and Minority Ethnicity groups	C&M LMNS scoping CCT for all team staff
		When investigating serious incidents, consider the impact of culture, ethnicity and language	% of maternity and neonatal Serious Incidents relating to patient care with a valid ethnicity code	SI reports are anonymised - review of report template to now include if ethnicity/language barriers contributed to the SI	Scope the numbers of women experiencing a near misses between different ethnic groups and locally agree action plan to investigate, assess local variation and identify/share best practice	Mar-22	SI reports		

	neonatal staff	culture, ethnicity and language.	% of Perinatal Mortality Review Tool cases with a valid ethnicity code	Identify themes and trends from PMRT and effectively communicate these through comms and engagement to at risk groups of women	The stillbirth and neonatal mortality rate per 1,000 births for Black and Asian babies divided by the rate for White babies in the UK, expressed as a ratio (baseline 2017 - 1.7).	Apr-22			
		Implement the Workforce Race Equality Standard (WRES) in maternity and neonatal services.		Survey will provide baseline of maternity and neo-natal staff experiences using the WRES indicators 1-8		Jun-22	WRES indicators 1 to 8 for midwives, nurses & medical staff in maternity and neonatal services	Black, Asian and Minority Ethnicity Groups	
	4.e Enablers	Establish community hubs in the areas with the greatest maternal and perinatal health needs.		Pilot Hubs set up at Granby C Centre/ KOALA Wirral/Lowes House-St Helens. Joint working with Specialist Perinatal Psychologist to attend CAG meetings and work with community engagement team. Launching CE CW Warrington Halton & Out of Area e.g. Sefton & Ormskirk August 2022		by March 2023		Women from Black, Asian, Minority Ethnicity and Socially Deprived groups	
		Work with system partners and the Voluntary Sector & Community Enterprise (VSCE) organisations to address the social determinants of health.	Engagement register of activity (past/present) and forward plan 2022-23	Engagement Register of feedback activities undertaken with women from Black, Asian & Mixed Ethnicity, Socially Deprived & Protected Characteristic Groups including disabilities e.g. Autism/LD/Deaf/Blind, Key Stakeholders & VSCE to address the social determinants of health		Sep-22			
Priority 5: Strengthen leadership and accountability									

Board of Directors in Public **Item 9.4**
6 July 2022

Title	Learning from Deaths Report (Q4 2021-22)
Area Lead	Dr Nikki Stevenson, Medical Director
Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q4 2021-2022.

Key points:

- The Medical Examiner service continues to provide independent scrutiny of all deaths
- The Trust SHMI remains stable at 107.04, within acceptable range.
- HSMR has decreased from 95 in the last quarter to 93.5 in this quarter, significantly lower than expected
- Dr Foster benchmark data has highlight one area that requires more work to understand a raised SHIMI (Stroke). This work will be coordinated through the Mortality Review Group
- 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 form mortality reviews is fed back to clinical areas by the Divisional Morality leads.

It is recommended that the Board:

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

Key Risks

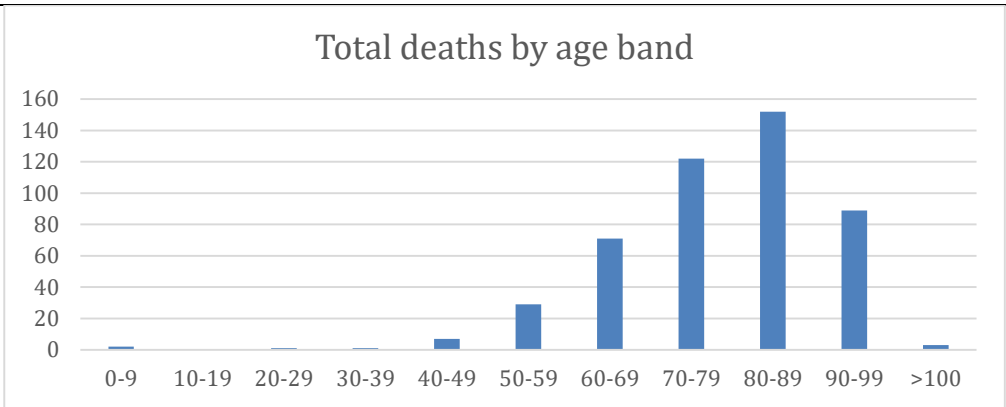
BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

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

Governance journey
This is a standing quarterly report.

1	Narrative
1.1	To provide a summary of the mortality review process, care issues, learning and current mortality comparator statistics. Wirral University Teaching Hospital is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework: • Preventing people from dying prematurely. • Treating and caring for people in a safe environment and protecting them from avoidable harm. Wirral University Teaching Hospital uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a 'warning' of potential problems and help identify areas for investigation. The Medical Examiner service provides independent scrutiny for all deaths that occur within WUTH, and escalates any concerns for a mortality review, coordinated through the Trust Mortality Group. Additionally, a random 5% of non-escalated deaths are selected for a "quality assurance" mortality review. Lessons learnt from mortality reviews are fed back to each clinical Division via the Divisional Mortality leads who attend the Mortality Review Group. **Patient demographics** There were a total of 477 deaths in Q4 (Jan-Mar 2022) . 62 of these deaths are in patients who died within 28 days of a positive COVID-19 swab (compared to 58 for Q3). As per previous trends most recorded deaths are in the over 60 age group and the vast majority fall into the "White British" Ethnic band.

Category	Female	Male	Total
COVID	35	33	68
Not COVID	206	203	408
Total			**477**



Ethnicity	Number of deaths
White - British	439
White - Irish	0
White - Any other White background	0
Mixed - Any other mixed background	1
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	0
Other Ethnic Groups - Chinese	6
Not stated	31
Total	477

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The SHIMI has remained stable when compared to the previous quarter. The latest available data shows the SHIMI to be 107.04
Although the SHMI is higher than the expected 100, it is still within acceptable range.

SHIMI can be broken down into specific disease groups, and for Q4 there was one disease group (Stroke) that had a significantly raised SHIMI. This will be picked in more detail under the Dr Foster section of the paper.

Hospital Standardised Mortality Ratio (HSMR)

The HSMR has fallen this quarter to 93.5 having previously been 95. This is significantly below the expected level of 100.

As discussed in previous Learning from Deaths papers the difference in HSMR and SHMI can be explained by the fact that SHMI does not exclude deaths with a palliative care code, whereas HSMR does. Palliative care coding for WUTH is higher than peers, reflecting the proactive nature of our palliative care team.

Additionally SHIMI countts deaths occuring 30 days post discharge, whereas HSMR focuses on hospital deaths only.

MRG has been given assurance that processes around palliatve care coding are robust, and that this doees not represent a potential patient safety risk, but is a reflecton of good palliatve care.

COVID-19

National Mortality comparators are not calibrated to predict mortality due to COVID-19, so it is difficult to compare different organisations in terms of COVID-19 mortality if using SHIMI or HSMR.

In terms of raw mortality (total number of deaths as a percentage of admissions) WUTH has a mortality rate of 14.7%. This is lower than the national average of 15.6%.

Six (6) deaths were determined to have been probable or definite nosomial COVID-19 which is the same number as for Q3.
All nosocomial deaths have been reviewed or are currently being reviewed via a mortality review and then scrutiny at the Serious Incident Review panel.
During Q4 one (1) nosocomial Covid-19 death was declared as a serious incident after review at the Serious Incident Review Panel.

Mortality Dashboard

The Medical Examiners (MEs) and Medical Examiners Officers (MEO's) continue to maintain 100% scrutiny of all WUTH adult deaths and escalate cases where potential concerns are identified.

33 cases that were escalated by the ME to the mortality review group have undergone a review during Q4. These cases have been reviewed using a revised PMR template (26 cases) or via the Royal College of Physicians Structured Judgement review tool (7 cases). One case was escalated to the Serious Incident Review panel and has been subsequently declared a serious incident as per the National Patient Safety Framework.

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 21 deaths were reviewed in Q4 (approx. 5%) using the PMR template. 2 of these deaths were further reviewed in the Serious Incident Review Panel but did not meet the threshold to be declared as serious incidents.

Summary of all Adult in patient deaths and case reviews

	Total Adult In-patients Deaths	Total Reviewed by Med Examiner or MEO	Total No of cases escalated from Medical Examiner	Total No of SJR's opened from cases escalated	Serious Incidents opened following MRG review	Quality assurance PMR's undertaken	Total number of case reviews by MRG
Q1 (21-22)	390	394	21	5			21
Q2 (21-22)	415	415	26	9	3	20	46
Q3 (21-22)	485	485	27	9	1	24	51
Q4 (21-22)	477	477	33	7	1	21	54

Grading of Adult Care and avoidability (For SJR's completed in Q4)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
Q3	0	4	0	0

During Q4, 4 deaths were reported in patients identified as having a Learning disability. All 4 of these deaths have been (or are currently being) reviewed using the SJR template and have also been referred for external review through the national LeDeR programme. Completed SJR reviews for this group of patients identified have not identified any care issues within WUTH during Q4.

Learning Disability Mortality Reviews				
	Total No. of LD Deaths	No. reviewed using SJR	Problems in Health care Identified in this Quarter	Referred to National LeDeR Programme
Q1 (21-22)	3	3	0	3
Q2 (21-22)	4	4	0	4
Q3 (21-22)	6	6	3	6
Q4 (21-22)	4	4	0	4

Perinatal and Neonatal deaths

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

During Q4 there were 2 stillbirths and 1 neonatal death. The 3 deaths are still undergoing review as per the process above and learning will be feedback in due course.

There were no paediatric deaths during Q4, and no completed reviews from previous quarters to feedback.

Learning identified through review of mortality reviews during Q4

Learning for mortality is derived from 3 main sources

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

Specific learning and themes identified during Q4 as well as actions taken are listed in the table below.

Learning theme	Source	Action taken
Antibiotic usage not in line with Trust Formulary	Mortality reviews	Discussed with Antibiotic Stewardship lead pharmacist. Plan to introduce automatic stop date after 72hrs (May 2022). Antibiotic audits to be strengthened to highlight areas of poor compliance
Delays in fast-track discharge home due to lack of availability in community	Mortality reviews	Fed back to End-of-Life lead, to be discussed at a system level.
Poor documentation	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads
Communication issues	Medical Examiner feedback	Although still a theme the number of incidents where families have raised communication issues is reducing. With the reintroduction of a more open visiting policy from May it is anticipated this will reduce further. All cases where families have raised concerns around communication are fed back to the clinical team so they can contact the family and resolve issues.
Lack of recognition of deteriorating patients	Mortality reviews and SI process	Overall reduction in cases where this is highlighted. Ongoing QI project around deteriorating patient. New Deteriorating patient steering group to be set up (May 2022)

Additionally, several reviews have identified areas of good practice, and these have been feedback to the teams looking after patients.

Dr Foster Data

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

During Q4 one disease group (Stroke) was highlighted as having a significantly raised SHMI. Further analysis of this suggests this is due to deaths in patients after discharge from hospital. However, MRG has agreed to undertake a case note review of 12 relevant cases and will report back in due course with any learning or future actions required.

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

Diagnostic Group	Quarter Highlighted	Alert type	Work undertaken	Outcome/ Learning
Non-Specific Gastroenteritis	Q2 21-22	CUSM alert	Case note review	Closed. High alert triggered by inaccurate coding from clinical teams
Malignancy of unspecified site	Q2 21-22	CUSM alert	Case note review	Closed. Case not review (8 cases) did not show any concerns with care at WUTH. However, the majority of cases were late cancer presentation, and this raised questions around screening and GP acess during the pandemic. This review has ben shared with the Trust Cancer Lead and the MD of the CCG to discuss any further actions required from a system point of view.
COPD	Q3 21-22	High SHIMI	Review by Clinical Lead	Ongoing
Cerebral vascular Disease	Q3 21-22, Q4 21-2	High SHIMI	Review By Clinical Lead	Ongoing, case note review added to original review in Q4

2 Conclusion

2.1 Mortality indicators do not show cause for concern and remain relatively stable. The difference between SHIMI and HSMR can be explained by the relatively high palliative care coding at WUTH.

Deaths attributable to COVID-19 are comparable to Q3. WUTH is not an outlier in terms of crude mortality for Covid-19.
Nosocomial Covid-19 and Clostridium Difficile deaths are investigated through the SI process.

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

Perinatal and Neonatal mortality does not show any cause for concern, with all deaths subject to investigation through the Perinatal Mortality Review Tool (PMRT).

Dr Foster data has highlight deaths due to Stroke as an area for further focus due to a higher-than-expected SHIMI. This work will be coordinated though MRG and findings feedback in due course.

Report Author	Dr Ranjeev Mehra, Deputy Medical Director
Email	ranjeevmehra@nhs.net

Board of Directors in Public **Item No 9.5**
6 July 2022

Title	Freedom to Speak Up (FTSU) Annual Report
Area Lead	Debs Smith, Chief People Officer
Author	Sharon Landrum, Lead FTSU Guardian
Report for	Information

Report Purpose and Recommendations
The purpose of this report is to provide the Board with an update of Freedom to Speak Up (FTSU) matters for 2021/22, including specific data for Q4 2021/22. It is recommended that the Board note the report.

Key Risks
Concerns raised may identify potential or actual risks, however these are managed on an individual basis and escalated to appropriate management representatives as necessary.

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
26 May 2022	Workforce Assurance Committee	Freedom to Speak Up Annual Report	Information
21 June 2022	Trust Management Board	Freedom to Speak Up Annual Report	Information

1	**Narrative**
1.1	**Introduction/Background** Guidance issued by the National Guardians Office (NGO) in July 2019 (“Guidance for Boards on Freedom to Speak Up in NHS Trusts and NHS Foundation Trusts”) states that regular updates, should be provided regarding the Freedom to Speak Up (FTSU) agenda and should be presented by the FTSU Guardian. Updates have been presented through the workforce governance structure, Trust Management Board and the Board of Directors on a regular basis and therefore this report provides an annual update and includes Q4 data 22.

Data is presented in a way that maintains the confidentiality of individuals who speak up.

1.2 **Number of People Speaking Up**

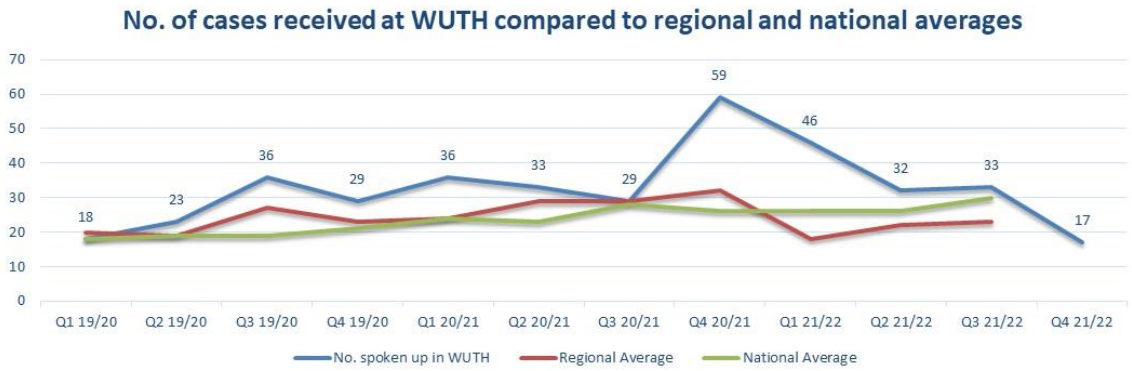
The number of people speaking up to FTSU Guardians has reduced significantly this quarter with 17 people speaking up in Q4 21/22 as opposed to 33 last quarter. Data for Q4 21/22 is also significantly lower than the same time period last year, with 59 people speaking up in Q4 20/21. The number of people speaking up in Q4 20/21 was unusually high.

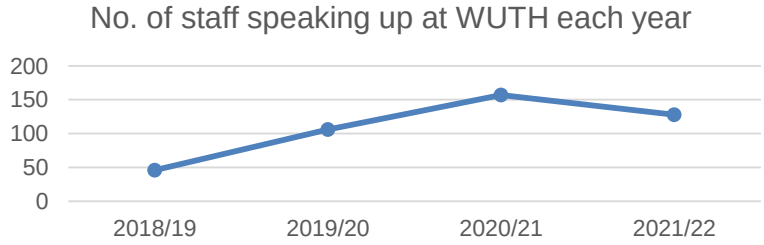
The Trust has also seen a reduction in the number of people speaking up for the year, with 128 people speaking up in 2021/22 as opposed to 157 people in 2020/21. 2020/21 did however see a significant increase in people speaking up, particularly in Q4 2020/21 and so data does now fall more in line with regional and national averages.

Data is submitted to the National Guardians Office (NGO) on a quarterly basis and the charts below allow comparison between the overall number of people speaking up against regional and national Trusts of similar size.

National and regional reporting data is not currently available for Q4, however based on previous data and trends, numbers of people speaking up within the Trust are expected to fall more in line with national and regional averages. Whilst this may be a positive indication that there are a lower number of concerns being raised to FTSU Guardians this reduction is a noticeable difference and not consistent with previous data and should therefore be monitored closely.

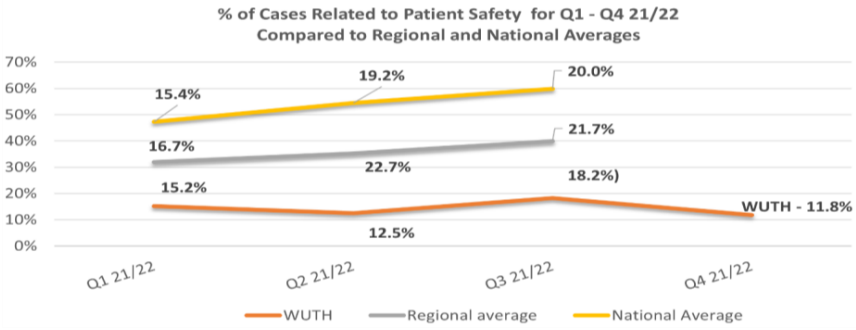
The Lead FTSU Guardian has a split role and this role was reassigned in Q4 to support additional Trust pressures and priorities. It is felt this has impacted on the availability and effectiveness of the Lead FTSU Guardian this quarter.





1.3 **FTSU Patient and Staff Safety Data**

The following chart highlights the % of cases concerning patient safety for Q4 21/22, compared with quarterly data from Q1 21/22. 11.8% (2) of the concerns raised in Q4 highlighted areas of patient safety as opposed to 18% in Q3.



The Trust remains considerably lower than regional and national reporting data for patient safety, and numbers have dropped within Q4. This is still seen as a positive as the number of staff speaking up within Wirral University Teaching Hospital are usually significantly higher.

2 concerns were raised this quarter linked to staff safety, which was 11.86% of concerns raised, which is an increase from 3% last quarter.

The following chart highlights the number of cases concerning patient and staff safety for Q4 21/22, compared with quarterly data from Q1 – Q4 2021/22 and compared to regional and national comparator Trusts.

	Q1 21/22					Q2 21/22					Q3 21/22					Q4 21/22				
	No. spoken up	No. concerning patient safety	%	No. concerning staff safety	%	No. spoken up	No. concerning patient safety	%	No. concerning staff safety	%	No. spoken up	No. concerning patient safety	%	No. concerning staff safety	%	No. spoken up	No. concerning patient safety	%	No. concerning staff safety	%
In WUTH	46	7	15.2%	0	0.0%	32	4	12.5%	3	9.4%	33	6	18.2%	1	3.0%	17	2	11.8%	2	11.8%
Regional Average	18	3	16.7%	2	11.1%	22	5	22.7%	3	13.6%	23	5	21.7%	3	13.0%	Awaiting Data				
National Average	26	4	15.4%	4	15.4%	26	5	19.2%	4	15.4%	30	6	20.0%	4	13.3%					

All cases were referred to senior management and steps taken to address.

1.4 **Speaking Up Data by Division for Q1 – Q4 2021/22**

The chart to follow highlights comparative data for the number of people speaking up, broken down by Division:

Division	**Total 20/21**	**Q1 21/22**	**Q2 21/22**	**Q3 21/22**	**Q4 21/22**	**Total 21/22**	**% of Division for Q4 21/22**	**% of Division for Q1 - Q4 21/22**
Surgery	**39**	12	7	2	**5**	**26**	0.4%	2.0%
Clinical Support & Diagnostics	**16**	9	12	5	**0**	**26**	0.0%	1.9%
Medical & Acute	**33**	10	2	11	**3**	**26**	0.2%	1.6%
Corporate Services	**37**	9	4	7	**3**	**23**	0.6%	4.5%

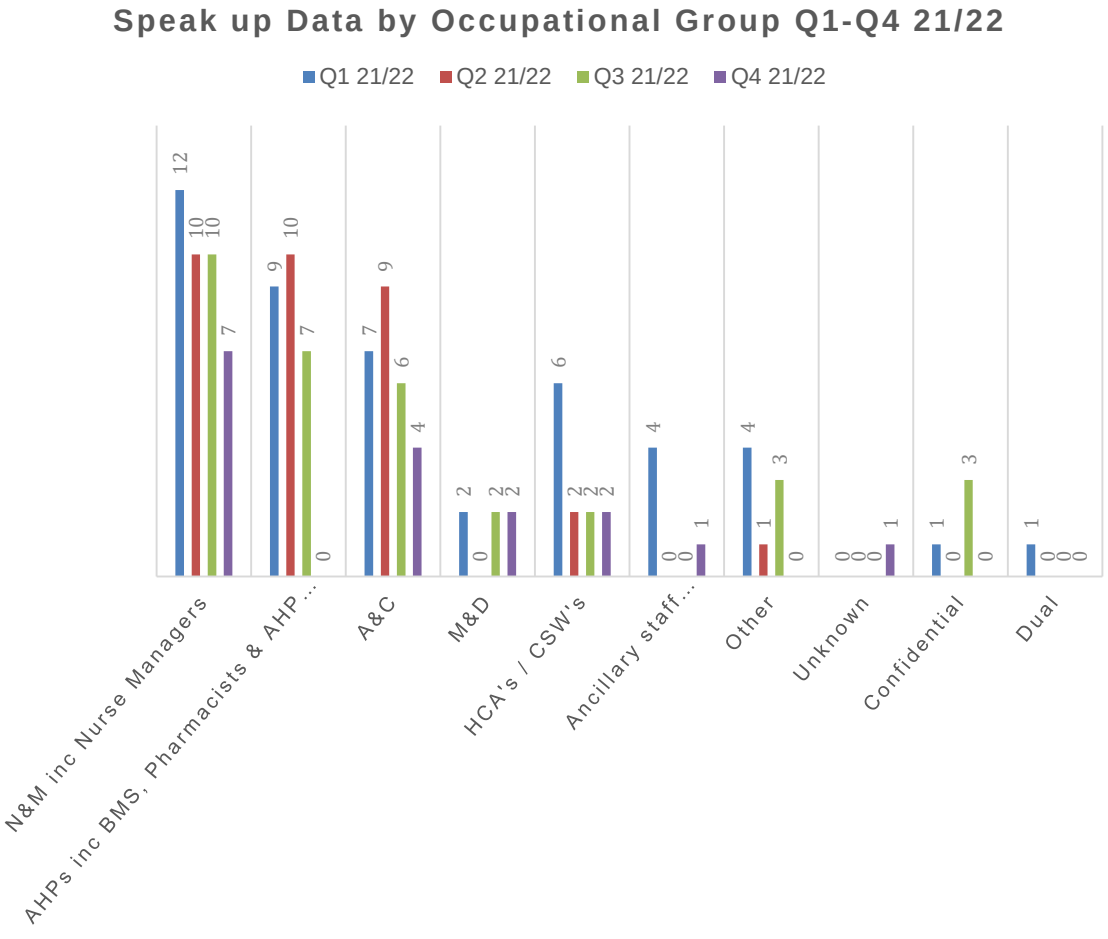
Women & Childrens	**12**	1	2	5	**5**	**13**	0.7%	1.9%
Estates & Facilities	**13**	2	2	1	**1**	**6**	0.1%	0.7%
Unspecified	**3**	0	0	0	**0**	**0**	0.0%	0.0%
Multiple	**1**	2	0	0	**0**	**2**	N/A	N/A
External	**3**	1	3	2	**0**	**6**	N/A	N/A
Total	**157**	46	32	33	**17**	**128**		

Corporate Services were the highest reporters for 2021/22 however these numbers have reduced within Q4. Corporate Services incorporates a number of different functions, including volunteers and students, however data reporting is inaccurate for this area as total numbers of volunteers and students are not included within parameters. This will be reviewed for 2022/23 to ensure effective monitoring and comparisons can be drawn.

Women and Childrens have seen an increase in reporting for Q4 and became the highest reporters this quarter. People speaking up within Women and Childrens have largely been linked to processes taking place e.g. service changes. Links have been made to the wellbeing team following walkabouts undertaken within the area and additional proactive wellbeing support has been offered to support staff in these areas.

1.5 **Speak Up Data by Occupational Group**

The chart to follow highlights the number of people speaking up from Q1 to Q4, broken down by occupational group. Nursing and midwifery (N&M) continue to be the highest reporters.



1.6 **Anonymous Reporting**

0 anonymous concerns were received during Q4 with only 3 received for the year. This is significantly better than regional and national averages of 4 per quarter and is a positive sign that staff feel comfortable raising concerns and sharing their information with FTSU Guardians.

1.7 **Themes**

Q4 continues to see attitudes and behaviours as the highest reported theme, with 7 (41.2%) of the overall 17 concerns raised. Whilst still the highest reported theme, there has been a significant drop this quarter from 63.6% in Q3.

Q4 21/22 Themes	Total
Attitudes and behaviours	7
Bullying	1
Equipment and maintena	0
Staffing	2
Policies, procedures and	1
Patient Safety	0
Patient Experience	0
Performance Capability	0
Service Changes	4
Other	2
COVID-19	1
Staff Safety	2
Health & well being	0
Inequality / Discriminatory	2

"Bullying" was reported in only 1 concern in Q4 (0.6% of the total raised), which is a further significant reduction from 33.3% in Q3.

This is really pleasing to see and now falls below the regional peer median of 17% and national peer median of 25% (comparative data for Q3 only as Q4 data is still unavailable).

The chart above highlights the full breakdown of each category for Q3.

Note: Many concerns have more than one theme so the numbers in the chart will not correlate with the number of cases raised

It is important to note that "bullying" is recorded where cases may indicate a risk or incident of bullying or harassment or where the person raising the case believes there is an element of bullying or harassment. The National Guardians Office (NGO) requires the term to be interpreted broadly and to be focussed on the perceptions of the person bringing the case.

1.8 **Action Taken**

All concerns raised to the FTSU Guardians are referred to the appropriate level of management for action, along with Human Resources, staff side colleagues and any additional support services as appropriate and agreed with the individual speaking up.

All cases relating to patient and staff safety are escalated to management and necessary Trust wide colleagues as soon as possible.

Board level contact has been involved in a number of concerns this quarter, particularly linked to escalation of unresolved concerns and plans to roll out of Vaccinations as a Condition of Deployment (VCOD).

1.9 **Time Taken to Close Cases**

The average time taken to close cases in Q4 was 5.8 weeks and has increased from 3.2 weeks in Q3.

A number of longer-term cases closed within Q4 which account for some of the lengthier closure time, and also demands on capacity in Q4 have impacted on the ability of FTSU Guardians to pursue cases and close as quickly as they have previously.

1.10	**Case Examples for Q4** 1**. Concerns raised regarding the introduction of vaccinations as a condition of deployment (VCOD).** A number of concerns were raised regarding the introduction of VCOD and whilst staff understood the national driving forces, wanted to ensure their voices were heard and to express concern that they felt this was being forced upon staff. FTSU Guardians linked concerned staff to Trust bulletins for information and to ensure they were linked with the most up to date information. The Lead FTSU Guardian was also included as part of the VCOD task and finish group for the Trust. Feedback was captured regarding the continued impact that VCOD was having on staff and how staff felt and that staff wanted to ensure that Trust management were aware of how they felt when developing their future plans. Feelings included staff feeling discriminated against; like they were being "outed" as their vaccination status was being shared with others and intelligence was shared that resentment was building amongst staff who were starting to consider leaving, even if national decisions were reversed. Staff suggestions for listening events to be held, were taken on board and a number of options offered to staff. This was positively received and has resulted in positive feedback and staff feeling heard. **2. Concerns regarding an apprenticeship placement.** A number of concerns were raised including basic placement information e.g. clarification of working times, role expectations and boundaries and also lack of effective development and support whilst new in to role. Concerns were also raised regarding patient care. Concerns were reviewed and meetings held with the appropriate management and corporate nursing teams and feedback offered to the reporter. A new post has been developed to offer enhanced support to Clinical Support Workers and a review of the apprenticeship process has been undertaken. 3) **Attitudes and behaviours** The FTSU Guardians provide an opportunity for staff to talk through their concerns and offer advice and signposting to help to resolve matters. Staff are always encouraged to share their concerns with those involved where possible or indeed to raise to management teams, which also happened in this case. In this case, concerns were shared regarding the individual's line manager. The individual did not want to raise matters directly at this stage, however agreed for support to help build confidence and resilience and build coping strategies to be able to express how they felt when faced with future challenges and feel more able to speak up directly to the person concerned.
1.11	**Disadvantageous and/or Demeaning Treatment for Speaking Up** The National Guardians Office (NGO) requires organisations to report data on the number of staff who feel they have suffered disadvantageous and/or demeaning

treatment for speaking up (often referred to as 'detriment'). This may include actions such as being ostracised, given unfavourable shifts, being overlooked for promotion or moved from a team.

No staff reported examples of experiencing disadvantageous treatment as a result of speaking up in Q4.

The Trust is currently reviewing its response to staff that may have suffered disadvantageous and/or demeaning treatment as a result of speaking up and a statement regarding this, will be included within the Trust's revised speak up policy.

1.12 **Staff Survey Feedback**

Results from the 2021 National staff survey, identify some improvements with regards to raising concerns.

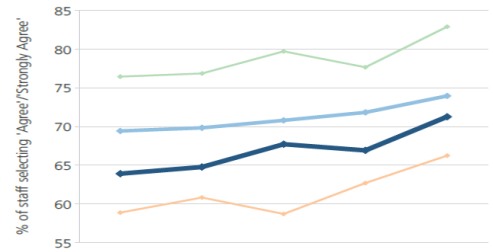
The charts below highlight comparative data for the last five years and whilst the overall "rising concerns" theme is 6.3 and slightly below the national average of 6.4, improvements can be seen in both staff feeling secure raising concerns about unsafe clinical practice and confident that the organisation would address their concern.

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > Detailed information > **We each have a voice that counts** – Raising concerns

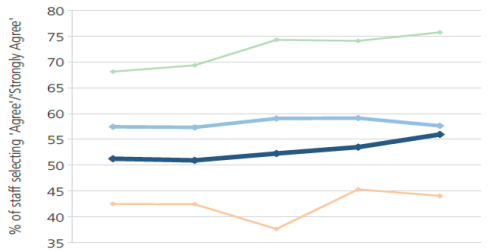
NHS

Q17a
I would feel secure raising concerns about unsafe clinical practice



	2017	2018	2019	2020	2021
Best	76.4%	76.9%	79.7%	77.7%	82.9%
Your org	63.9%	64.8%	67.7%	66.9%	71.3%
Average	69.4%	69.8%	70.8%	71.8%	73.9%
Worst	58.9%	60.8%	58.7%	62.7%	66.2%
Responses	368	2,602	2,219	2,443	2,878

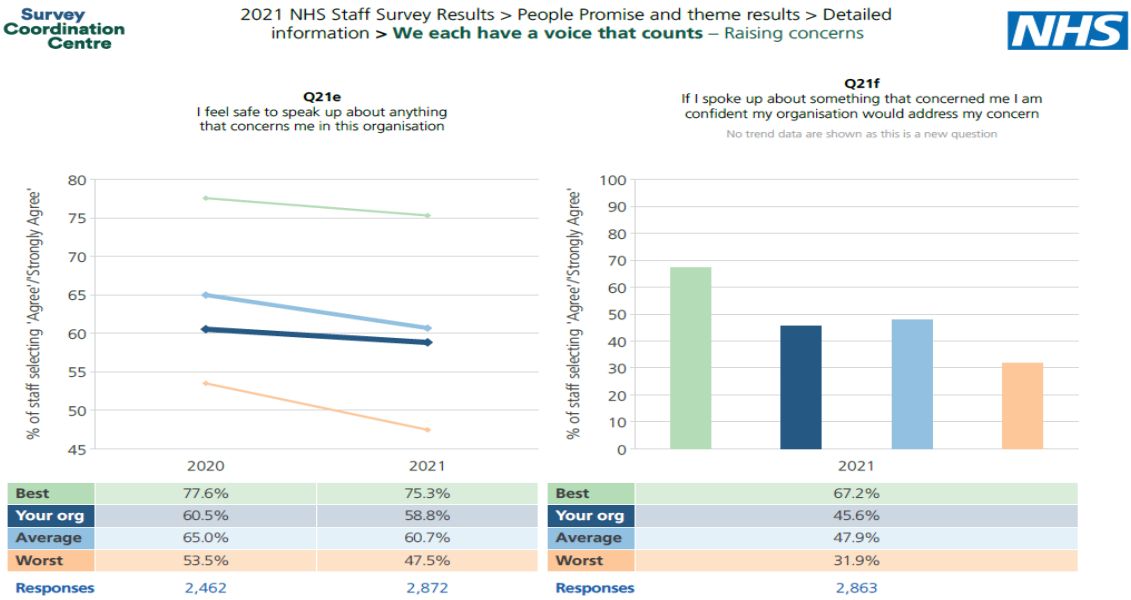
Q17b
I am confident that my organisation would address my concern



	2017	2018	2019	2020	2021
Best	68.1%	69.4%	74.3%	74.1%	75.7%
Your org	51.3%	50.9%	52.3%	53.5%	56.0%
Average	57.4%	57.3%	59.1%	59.1%	57.6%
Worst	42.5%	42.4%	37.6%	45.3%	44.1%
Responses	370	2,602	2,212	2,444	2,870

Staff were also asked a further two questions (as shown below) and whilst the Trust's response has reduced this year for in the number of staff who feel safe to speak up about anything that concerns them in the organisation (Q21e), there is a reduction across all comparators. The reduction at Wirral University Teaching Hospital however, is less than other areas.

A new question was also asked this year (Q21f). The Trust is unfortunately lower than the national average for this response, however no comparative data is available.



1.13 **FTSU Forward View**

The FTSU team are currently reviewing their processes in line with national guidance, best practice following an NGO case review at Blackpool Teaching Hospital, staff survey and internal feedback.

A new NGO Board level review toolkit is expected to be launch shortly and will be utilised to review current processes and ensure effective speak up arrangements are in place.

We have also integrated the importance of speaking up and ensuring everyone voice is represented within our new People Strategy 2022 – 2026; with four overarching key principles:

Principle 1 – Looking after ourselves and each other – developing a wellbeing culture where supporting and enabling the holistic wellbeing of our people becomes the norm
Principle 2 – Belonging at WUTH - developing an inclusive culture where everyone's voice is represented
Principle 3 – Transforming ways of working - embracing new ways of working and create opportunities to enable our people to achieve their potential
Principle 4 – Shaping our future - improving outcomes across Wirral for health, employment and wellbeing by working with our partners to be the best place to work

A FTSU action plan will be developed to ensure effective progression of key priorities. This will be shared with the Q1 FTSU update report.

1.14 **Additional Updates**

FTSU Training

Level 1 and 2 e-learning programmes, developed by the National Guardians office – Speak up and Listen Up are all fully functional and accessible via staff ESR records, relevant to staff roles.

Compliance or level 1 training has remained static this quarter at 81.17% (as at 31/03/22). However, level 2 for managers and team leaders continues to increase again this quarter from 76% to 78.32% (as at 31/03/22).

	The Trust is still at the forefront with the inclusion of FTSU training and therefore any progress made to date is seen as positive by the National Guardians Office and colleagues across the region, with some Trusts still awaiting launch and integration within role specific / mandatory training offerings. Level 3 has recently been released for senior leaders; however regional feedback has highlighted concerns regarding the effectiveness of this as a standalone session. Further review of this is therefore underway before final release and an update will be provided in the next report.
1.15	**FTSU Guardians and FTSU Champions** System pressures and current capacity of FTSU Guardians has resulted in delays within the service, however following a successful business case, plans are underway to establish a dedicated Lead FTSU Guardian role combined with lead for implementation of a Just and Learning Culture approach within the Trust. Recruitment to this post will commence as soon as possible. 22 FTSU Champions are currently in place across the organisation with FTSU Champions identified from Trust staff multicultural, LGBT+ and disability support networks Thanks are passed to all FTSU Guardians and FTSU Champions for continuing to strive for improvements in our speak up culture and supporting our staff across the Trust, often during difficult circumstances.
1.16	**National Guardians Office (NGO), National and Regional Updates** The Trust continues to be part of the regional FTSU network and meets regularly with regional FTSU Guardians and NGO representatives. This ensures support is in place for FTSU Guardians and that best practice and national guidance are adhered to.
1.17	**New Reporting Guidelines** New reporting guidelines come into effect with effect from 01/04/22, with new categories that the Trust must commence national reporting on. These changes will be reflected within subsequent 2022/23 reports

2	Implications
2.1	Whilst some progress can be seen with improvements within our staff survey data, the service is under review so as to ensure that adequate and effective support and processes are in place so that FTSU Guardians are also supported and that further improvements and progress can be made. The Trust is looking to identify proactive steps that can be taken to address key issues arising from concerns raised e.g. those suffering disadvantageous treatment and to support the Trust in achieving a just and learning culture approach.

3	Conclusion
3.1	The Trust has seen a reduction in the number of people speaking up this year with 128 people speaking up in 2021/22 as opposed to 157 people in 2020/21. 2020/21 did however see a significant increase in people speaking up, particularly in Q4 2020/21 and so data does now fall more in line with regional and national averages.

	Our 2021/22 data shows that people across all Divisions and a range of occupational groups are accessing the speak up service. Attitudes and behaviours continue to be the most reported theme with 17 concerns linked with patient safety, compared to 25 last year. The number of people speaking up at WUTH has increased significantly over the last couple of years, which has been as a result of promotional activities, engagement with staff across the Trust and staff building up trust and confidence to use the service. That said, this increase adds additional pressures on the FTSU team to ensure effective and adequate support and responses and so WUTH have reviewed its provision and are working to increase resource available. Current pressures and competing demands for FTSU Guardians, may also have negatively impacted on results this quarter and therefore additional support for the FTSU team and a review of FTSU processes is underway and a development plan will be established and shared with the next update report.

Report Author	Sharon Landrum, Lead FTSU Guardian/Workforce Diversity & Inclusion Lead
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Board of Directors in Public **Item No 9.6**
6 July 2022

Title	Guardian of Safe Working Quarterly Report
Area Lead	Nikki Stevenson, Medical Director and Deputy CEO
Author	Helen Kerss, Guardian of Safe Working
Report for	Information

Report Purpose and Recommendations

The Guardian of Safe Working is a senior person, independent of the management structure within the organisation by whom the doctor in training is employed. The Guardian is responsible for protecting the safeguards outlined in the 2016 TCS for doctors and dentists in training.

Appendix 1 provides:

- Details of the actual number of doctors in training
- Details of the exception reports submitted for the reporting period by speciality and grade
- Details of breaches of safe working hours and fines incurred.

It is recommended that the Board:

- Note the report

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
26 May 2022	Workforce Assurance Committee	Guardian of Safe Working Quarterly Report	Information

1	Narrative
1.1	The information for the report is gathered from exception reports and feedback from the junior doctors at their forum which happens bimonthly. Where themes are identified we work in a proactive manner to resolve concerns. The Trust has worked incredibly hard over the last 18 months to engaged with the junior doctors and the positive impact of this is being seen with the engagement in exception reporting and attendance at JDF. The junior doctors are keen to not only highlight concerns but also to provide solutions. This was seen with the self-development time, which is now rostered.

2	Conclusion
2.1	Doctors and dentists in training continue to submit exception reports as appropriate. Exception reports are dealt with in a timely manner. No fines have been issued this quarter. Most of the exception reports this quarter have been from foundation doctors. I will continue to proactively encourage all training grades of doctors to engage with the exception reporting system, to maintain both their and patient safety.

Report Author	Helen Kerss
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QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING January to March 2022

High level data for Wirral University Teaching Hospital NHS Foundation Trust

Number of doctors / dentists in training (total):	289 (277.2WTE)
Number of doctors / dentists in training on 2016 TCS (total):	289 (277.2WTE)
Amount of time available in job plan for guardian to do the role:	1 PA / 4 hours per week
Admin support provided to the guardian (if any):	0.6 WTE
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

A) Exception reports (with regards to working hours)

Exception reporting is the mechanism to ensure that training can be safeguarded, workloads kept manageable and safeguards for both the doctor and the patients. Exception reports are for when actual hours worked differs from the agreed hours on their work schedule or rota.

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E	0	1	1	0
General Medicine	0	38	38	0
General Surgery	0	54	54	0
T&O	0	5	5	0
Total	0	98	98	0

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	83	83	0
F3/CMT	0	13	13	0
SPR	0	2	2	0
Total	0	98	98	0

	Addressed within 48 hours	Addressed within 7 days	Addressed in 7-14 days	Addressed in 15-28 days	Still open
F1	42	30	8	3	0
F3/CMT	4	5	4	0	0
SPR	1	1	0	0	0
Total	47	36	12	3	0

a) Exception reports (regarding training/academic issues)

Exception reports also monitor when doctors in training miss key educational opportunities. For example, teaching or clinics. These reports are monitored by the director of medical education.

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
General Medicine	0	19	18	1
General Surgery	0	7	7	0
T&O	0	1	1	0
Total	0	27	26	1

Exception reports by grade				
Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	25	24	0
F3/CMT	0	1	1	0
SPR	0	1	1	0
Total	0	27	26	0

	Addressed within 48 hours	Addressed within 7 days	Addressed within 7-14days	Addressed within 15-28 days	Still open
F1	5	13	4	2	1
F3/CMT	1	0	0	0	0
SPR	0	0	1	0	0
Total	6	13	5	2	1

b) Work schedule reviews

Work schedule reviews are carried out by the medical staffing department. This is to ensure that rotas are compliant with both the training needs of the doctors and the junior doctors' contract. There has been no work reschedule reviews this quarter.

c) Vacancies

Staff vacancies are managed by medical staffing in a proactive manner. It is important for them to be noted as it will have an impact on both doctor and patient safety. Reasons behind the vacant posts include less than full time doctors, sickness, and parental leave.

Vacancies by month						
Specialty	Grade	Jan	Feb	Mar	Total gaps (average)	Number of shifts uncovered
Medicine	F1	0	0	42	14	0*
Surgery	ST3-5	1	1	0	0.66	0*
Total		1	1	42	14.66	0*

d) **Fines**

Fines are issues against the department if there has been a consistent breach in the terms and conditions in accordance with the 2016 contract.

There have been no fines issued this month.

Board of Directors in Public **Item 9.7**

06 July 2022

Title	Estates, Facilities and Capital Assurance Report
Area Lead	Paul Mason, Director of Estates, Facilities and Capital planning
Author	Clare Jefferson, Associate Director of Estates, Facilities and Capital Governance and Sustainability
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide an update and some initial data that will form part of the proposed Estates, Facilities and Capital (E, F & C) Board Assurance dashboard, that will be provided on an ongoing basis to the Board from September 2022 onwards.

It is recommended that the Board:

- Reviews the information and data submitted and advises on any additional areas for which assurance is to be provided and any metrics that should be removed

Key Risks

This report relates to these key Risks:

- BAF Risk 3.3: Delays/restrictions in accessing capital resources to support the delivery of the Trust's Estates Strategy
- BAF Risk 6.1: Adverse impact on delivery of clinical care and application of infection control measures due to the quality of the Trust's estate, and substantial maintenance backlog

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
24.06.2022	Estates, Facilities and Capital SMT meeting	Estates, Facilities and Capital Assurance reporting	Review and Sign Off
16.05.2022	Estates, Facilities and Capital Senior Leadership Review	Workshop to identify KPIs	To highlight what we can measure now and future goals

1	Narrative
1.1	**Background** For the June Board of Directors meeting Estates, Facilities and Capital (E, F & C) provided a report outlining proposed measures, aligned to the strategic priorities, defining our assurance reporting intent. This report provides some initial data, where available, building upon the information provided in June. It is hoped that a full E, F & C Board Assurance Dashboard will be available for the September meeting.
1.2	**Scope** We have linked our assurance reporting to the CQC five questions as follows: • Safe – technical standards • Effective – performance of our services • Caring – patient experience • Responsive – response times • Well-led – people performance The Capital Programme and the Infrastructure Improvement Programme have been excluded from the Assurance reporting as these have a direct reporting structure into the Board through the Capital Committee and Programme Board.
1.3	**Measure: Safe** (technical standards & audit) For each Technical Standard we are developing an underlying set of criteria to demonstrate a self-assed level of compliance against the standard in relation to People, Processes and Tools. These scores will be aggregated into a single performance metric reported to the Board. Proposed compliance Targets as a percentage: • Compliant **95% to 100%.** • Controlled Compliancy **80% to 94%.** **Low Risk** • Deficient Compliancy **70% to 79%.** **Moderate Risk** • Fail Compliance **0% to 69%.** **High Risk** The 22/23 Authorising Engineer Audit plan is illustrated below. Monthly tracking against the Audit plan will be reported to the Board along with any escalations of 'Reportable findings to an external body' identified through the Audits.

	An exception report will be provided for any audit which identifies areas of non-compliance with an associated Improvement Plan which will be tracked and monitored. {Note HTM-06-02 LV & HTM-06-03 HV AE Audits were for APH only; CGH will be conducted in August 2022}
1.4	**Measure: Effective** (performance of our services) The New National Standards of Healthcare Cleanliness 2021 are now being implemented across the Trust. The average cleanliness audit scores for April and May are provided in the Dashboard.
1.5	**Measure: Caring** (patient experience) Patient and staff experience is incorporated into the weekly senior leadership meetings where Incidents, Complaints and RIDDORs are reviewed. Estates, Facilities and Capital Formal complaints and RIDDORs for April and May have been incorporated into the dashboard and will be presented monthly.
1.6	**Measure: Responsive** (response times) This KPI provides an indication of our response time with regards to switchboard call handing, Portering requests, and reactive maintenance calls.
1.7	**Measure: Well-led** (people performance) This KPI provides date on our performance in relation to our Sickness levels, Mandatory Training and Appraisal compliance. Data for April and May has been incorporated into the dashboard and will be presented monthly.

Confirmed / Expected	AE	Freq. (M)	Last Audit	2022 Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 Jan	Feb	Mar	Apr	May	Jun
HTM-01-01 - Decon	Jonathan Tucker	12	Sep-21					Confirmed								
HTM-02-01 - Med Gases	Rob McCrea	12	Apr-22											Expected		
HTM-03-01 - Ventilation	Ray Hughes	Periodic (12)	Feb-22									Expected				
HTM-04-01 - Water	Sean Rimmer	Periodic (12)	Jun-21	Confirmed												
HTM-05-01 - Fire	Darren Kirk	Periodic (12)	Sep-21				Expected									
HTM-06-02 - LV Elec	Rick Seymour	12	May-22												Expected	
HTM-06-03 - HV Elec	Rick Seymour	12	May-22												Expected	
HTM-08-02 - Lifts	Andrew Hicks	12	Aug-21			Confirmed										

1.8	**Dashboard**

Estates, Facilities and Capital interim Board Assurance Dashboard 22/23

Measure	Metric		Target	Apr-22	May-22
Safe	Technical Standards & Audit	TBC			
Effective	Trust average cleanliness score	%	**95%**	97.70%	97.90%
	Efficacy overall score*	%	**80%**	90%	88%
Caring	Formal Complaints	Number reported	n/a	0	0
	RIDDOR	Number reported	n/a	1	0
Responsive	Switchboard call handing	TBC			
	Portering response times	Number Patient Moves	n/a	13,987	14,877
		average "transport request to transport complete"	TBC	16 Mins 57 Secs	17 Mins 24 Sec
	Reactive Maintenance calls completed within required timeframes	Priority 1: Emergency 4 Hours	**100%**	100%	100%
		Priority 2: Urgent 3 Days	**95%**	88.42%	91.07%
		Priority 3: Essential 7 Days	**90%**	83.65%	84.98%
		Priority 4: Non Urgent 21 Days	**90%**	76.09%	75.41%
Well-Led	Sickness Absence	% (in Month)	**5%**	8.27%	8.05%
	Core Mandatory Training	%	**90%**	87.82%	89.06%
	Appraisal	%	**88%**	81.38%	85.56%

*Please note that the Efficacy audit score is based on the average score of 8 different areas audited each month.

{Note thresholds for Amber and Red Flags are currently being established}

2	**Implications**
2.1	**Data instability** The Technical Standards metrics are currently heavily weighted on subjective self-assessment reviews. As the recording and reporting matures over time, more quantitative metrics will be added which will increase the validity of the indicator. It is expected that over the next 12-months there will be artificial fluctuations in this indicator as more robust metrics are introduced.
2.2	**Discovery** Whilst great advances have been made over the past 12-months, the aging infrastructure and lack of maintenance and investments in some areas of the Estate is resulting in critical audit findings requiring significant investment to resolve. Areas of performance improvement or progression is highly likely to be subject to revenue or capital investment which, if not made available, may impeded developments and this will be reported on as matters arise.

3	**Conclusion**
3.1	The proposed approach is our baseline assurance reporting with the information that is currently captured across the departments, our aspiration is to produce a high-level PowerBI Dashboard which will visualise the key Board Assurance metrics to be accompanied by an exception report, as required.

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NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 9.8**
6th July 2022

Title	Digital Healthcare Update
Area Lead	Chris Mason, Chief Information Officer
Author	Chris Mason, Chief Information Officer
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide an update and an initial draft of the proposed Digital Healthcare Board Assurance dashboard, that will be provided on an ongoing basis to the Board from September 2022 onwards.

It is recommended that the Board:

- Reviews the information and data submitted and advises on any additional areas for which assurance is to be provided and any metrics that should be removed.

Key Risks

This report relates to these key Risks:

- BAF Risk 5.2 Loss of clinical systems due to a cyber-attack, resulting in an adverse impact on the delivery of care.
- BAF Risk 5.3 Failure to successfully implement the digital strategy, resulting in an adverse impact on patient care.

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
20.05.2022	Digital Healthcare Team Senior Management Forum	Departmental Performance Management Review	To clarify measures for reporting to Board in the immediate future and identify areas for further development

1	Narrative
1.1	**Delivering our Digital strategy:** ***22/23 Operational plan:*** The schedule satisfies the required strategic deliverables of the Trust in financial year 22/23. Key projects due for implementation in the next financial year include: • Extensive digital provision for the South Mersey Elective Hub • Replacement of the wired network infrastructure across the estate • Robotic Process Automation for streamlining of back-office processes • Substantial roll out of Patient Portal offering including patient self-booking • Development of an in-house data warehouse to initially deliver clinical reporting • Completion of migration to the regional PACS solution • Introduction of a Learning Management System to baseline staff educational needs. • Digital consent – continuing our journey to one patient record. ***Monitoring delivery:*** Each project within the plan is RAG rated on delivery status. This is then rolled up into a high-level dashboard that gives a status summary for each of the sections within the Digital Healthcare Portfolio, those being: - Digital Foundations: Provision of a safe and secure digital infrastructure, protecting the Trust data and it's assets. - Digital Innovation: Using Digital Innovation to streamline processes, increase efficiency & improve quality across Clinical & supporting functions within WUTH and as part of the wider health economy - Digital Education: Enabling staff and patients with the digital skills to utilise our digital tools to their full potential, delivering the highest levels of safe & effective care. - Digital Intelligence: Embedding Business Intelligence to drive clinical decision making at WUTH & across the wider health economy through collaboration with our healthcare partners. This view will give the board assurance on general health on the delivery of strategic objectives for the year. ***Changes to plan:*** If there have been any approved changes to the overall operational plan, this will be documented accordingly. ***High Level Risks*** Any high-level risks impacting on the delivery of the operational plan will be documented accordingly. An initial illustrative dashboard view of Strategy delivery KPIs is shown in Appendix B.

1.2	**Business Continuity & Service Delivery** In addition to delivery of strategic elements of the service, we also have a responsibility to ensure that our digital infrastructure, including networks, servers, desktop and all of our applications continue to function on a daily basis to ensure effective, efficient and safe clinical care whilst minimizing the threat from Cyber-attack. Our information governance function ensures effective management and sharing of information or data appropriately, providing a framework for employees to handle data through our information governance policies and procedures. From a customer facing perspective our Service desk aims to deliver a highly responsive fault fixing service, supplemented by self-serve functionality. ***Monitoring Delivery*** In order to monitor delivery in this instance we will be proposing monthly KPI's in relation to network / application availability and Cyber security as well as giving indications as to the responsiveness of our service through information gathered from our service desk system. It will also give an overview of our HR related metrics – focusing on the ability and capacity of our workforce to deliver these critical functions. Some typical examples would be those illustrated below: Network availability: EPR availability: Foreign System Interface availability: Service Desk calls received: Service Desk faults fixed: Current Digital risks recorded on the Trust Risk register rated "High" and above. Data Breaches reported to Information Commissioners Office. Freedom of Information requests received. Appraisal Compliance Mandatory Training Compliance For the above measures we would look to report on a monthly basis, showing trends over time. An initial illustrative dashboard view of Service delivery KPIs is shown in Appendix B.

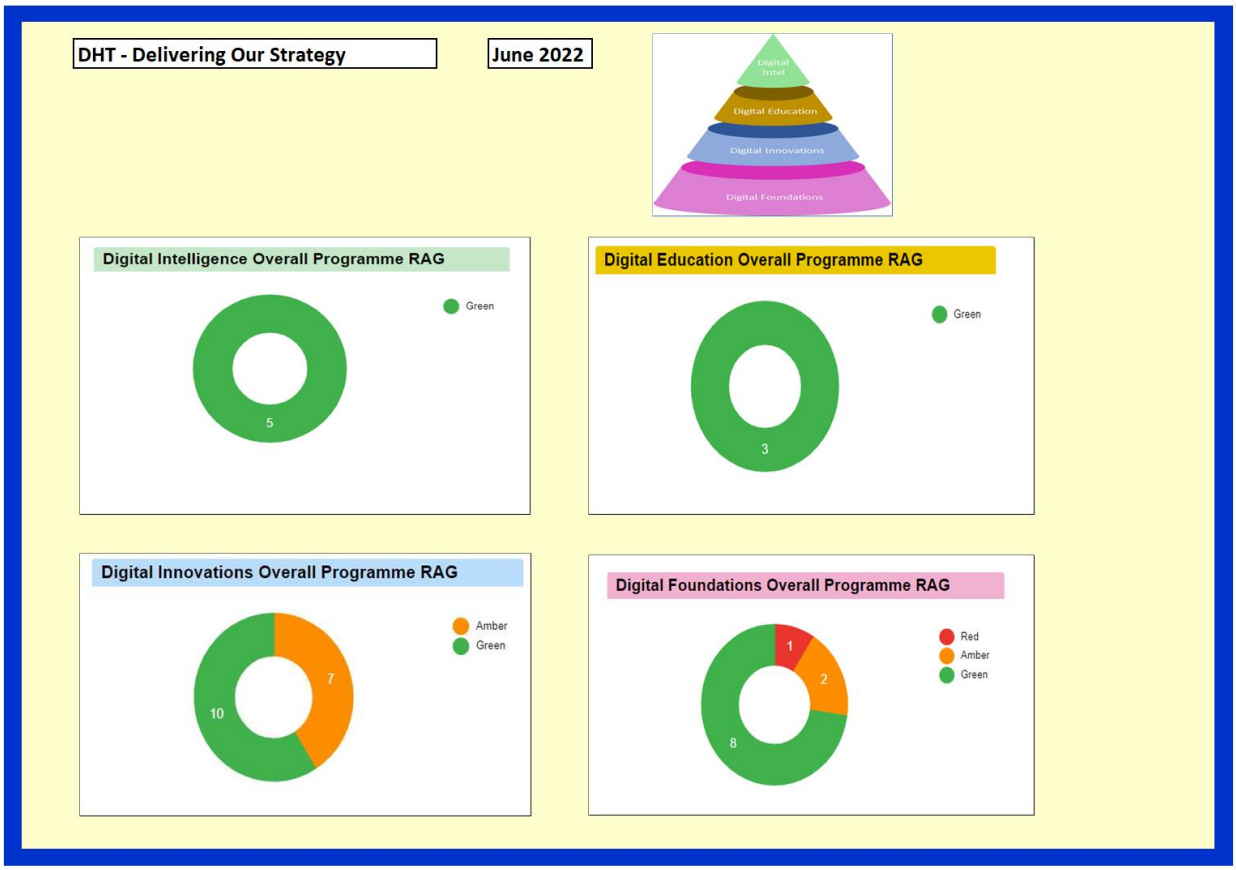
2	**Implications**
2.1	**Strategy Delivery** Delivery of the proposed 22/23 Digital Healthcare operational plan will ensure achievement of the strategic priorities outlined in the Digital Strategy. Namely: - Using technology to reduce waste, automate processes and eliminate bottlenecks. - Empowering patients with the data and tools to manage their own health and wellbeing. - Allow business Intelligence to drive clinical decision making - Use health information to enable population health management for Wirral.

	The proposed dashboard will increase visibility for the board around delivery and provide assurances in relation to both the project and technical infrastructure in place to deliver the objectives above.
2.2	**Business Continuity** Continual uninterrupted provision of our existing infrastructure and healthcare applications is critical to ensuring that the highest levels of patient care can be delivered on a daily basis. The proposed dashboard will increase visibility for the board around the availability of the critical healthcare applications for the organisation and the safety of its data assets.

3	**Conclusion**
3.1	We are positive about working with board members to further refine the measures within the dashboard and would encourage regular feedback to ensure continual improvement in this area.

Report Author	Chris Mason, Chief Information Officer
Contact Number	Ext 5475
Email	chrismason@nhs.net

Appendix A: Digital Healthcare Team - Delivering Our Strategy

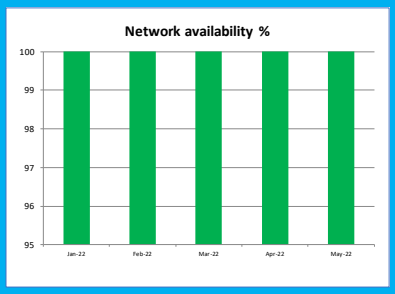


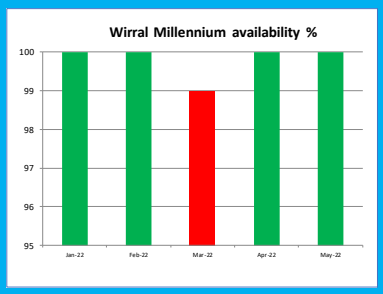
Figures shown within the dashboard are for illustrative purposes only.

Appendix B: Digital Healthcare Team - Business Continuity and Service Delivery Dashboard

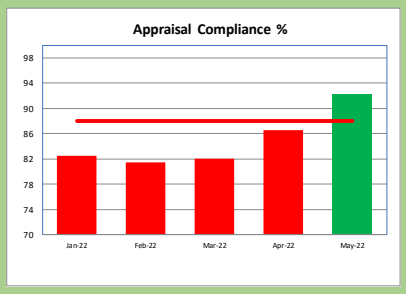
DHT - Business Continuity and Service Delivery | **June 2022**

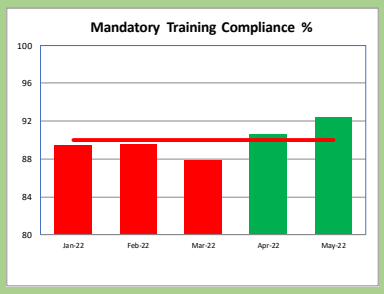
Outstanding Care

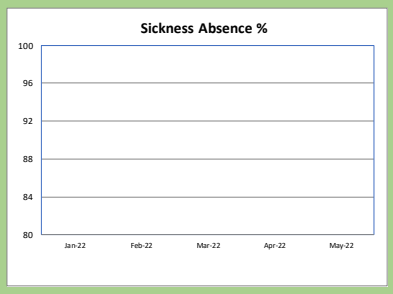




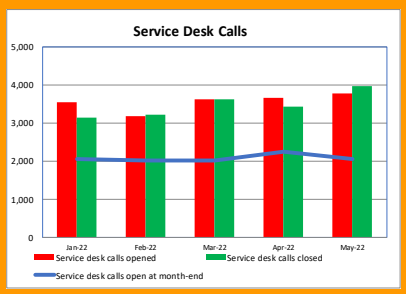
Compassionate Workforce

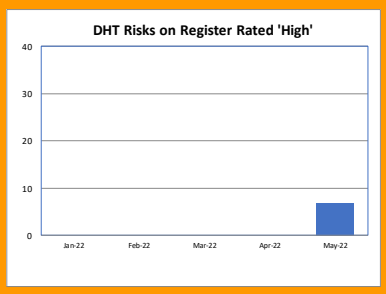




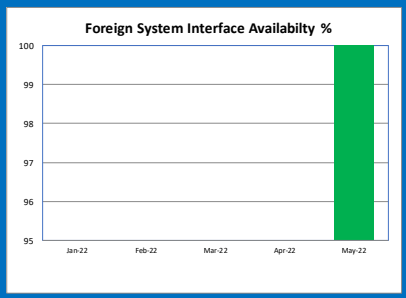


Continuous Improvement

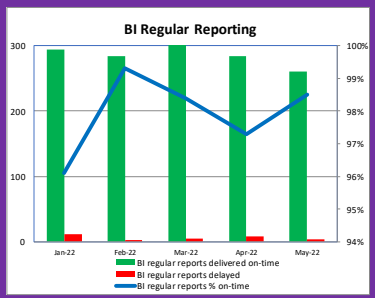




Our Partners



Digital Future



Figures shown within the dashboard are for illustrative purposes only.

Board of Directors in Public **Item No 11**
6 July 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 June 2022, including media relations, campaigns, marketing, social media, employee communications and stakeholder engagement, WUTH Charity and staff communications to support engagement.

It is recommended that the Board:

- Note the report

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 discharges 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 and elective recovery)
- 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 Urgent and Emergency Care Upgrade Programme)

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 and the Queen's Platinum Jubilee** – in May we celebrated the 40th Anniversary of the day Her Majesty the Queen, accompanied by the Duke of Edinburgh, officially opened Wirral's new hospital at Arrowe Park. Following immediately on from the 40th anniversary celebrations for Arrowe Park, we commemorated the Queen's Platinum Jubilee with great staff engagement getting into the spirit of marking the occasion, especially supporting patients in hospital over the Bank Holidays and staff working on shift. The Sunday of the 4-day Bank Holiday was designated as a national 'Thank you day' and so we also used this to thank our staff for their support to patient and families. **National Volunteers' Week**- in early June we celebrated the work of our volunteers in a social media campaign highlighting the diversity of our volunteers support and featuring profiles of the vital work they do to support our hospitals. Wirral University Teaching Hospital (@wuthnhs) / Twitter Other in month campaigns have included Learning Disability Awareness Week 20-26 June where we highlighted our partnership with Mencap who are also working with us as part of the Patient Experience Strategy delivery plans. We are also supporting Armed Forces Week and PRIDE month in June. In addition, we took part in national campaigns for Diabetes awareness, breastfeeding and cervical cancer, plus commemorating Biomedical Sciences Day and the work of our laboratory colleagues. **Media** We achieved national media coverage with an ITV news interview with Consultant Midwife Dr Angela Kerrigan for a pilot scheme for midwives to support women by signposting advice to sources of support around maternity rights and pay. Maternity Action is the UK's maternity rights charity dedicated to promoting, protecting and enhancing the rights of all pregnant women, new mothers and their families to employment, social security and health care. Our Neonatal Unit Deputy Ward Sister Helen Ewbank-Smith was also featured in the

national women's magazine 'Women and Home' talking about how fulfilling her job is and highlighting our Tiny Stars appeal.

Our Women and Children's Hospital also featured in social media posts when we hosted a visit from NHSE's Chief Midwife Jacqueline Dunkley- Bent and her team. During the visit they also presented a special award, on her retirement, to the Director of our Women and Children's Hospital, Debbie Edwards.

Debbie's outstanding contribution to midwifery and maternity services was recognised with a special silver award from NHS national Chief Nurse Dame Ruth May and Chief Midwifery Officer Jacqueline Dunkley-Bent. This was presented to Debbie as a surprise on 16th June during a visit by Jacqueline and her deputy, Sascha Wells-Munro, accompanied by North West Regional Chief Midwife, Sue Stansfield. The regional and national colleagues were visiting WUTH as part of an England-wide best initiative to visit all maternity units.

They heard about the improvements made to our services and both CEO Janelle Holmes, and Non-Exec Director and Maternity Safety Champion, Dr Steve Ryan emphasised the culture of learning and improvement – and a commitment to sustainably embedding changes

Jacqueline commented after the visit that it was ' A privilege to share and learn. Thank you for supporting safe and personal maternity care,' she added that the NHS team were 'keen to share a few of your innovations that will make a difference to all who use maternity services.'

Awards

Pharmacy Technician Abbie Stirling was awarded the 'Rising star award' at the annual Primary Care Pharmacy Awards (PCPA) in June.

Employee Communications

In month we focused on the careful and risk-based removal of some of the COVID-19 restrictions for staff and visitors. We also highlighted the changes necessary to facilitate the Urgent and Emergency Care Upgrade project enabling works.

Returning to in-person training enabled us to host a leadership conference – '**Leadership for all,'** which enabled us to meet as a leadership group across all levels for the first time in over 2 years.

We also planning our staff awards as an in-person event on 25th November 2022 at Thornton Hall Hotel.

Staff networks communications included the launch of a forces families support group and a group focusing on the menopause.

Patient communications

As part of the continuing focus on our vision and values, we rolled out 57 new ward boards featuring the Patient Experience Vision and photographs of ward staff.

	WUTH Charity The Charity team's main focus is now our events calendar. Wirral Coastal Walk Sunday 22nd May -over 40 people took part in the event and raised £ 3,440 for the Tiny Stars appeal It's a Knock Out July 2nd Arrowe Country Park 11am – 4pm. Teams of 12 will take part in this classic 'funday'. Over 100 people are expected to take part on the day with friends and family attending to lend their support. A special offer of £20 per person for NHS staff is available. Additional fun activities and stalls are also planned for others who are not participating in the main event. Red Fox Thornton Hough has nominated WUTH Charity to benefit from Brunning and Prices Charity Giving for 2022. They have also pledged to support the appeal with a second spring lunch in 2023 following the success of this year's event, which raised over £6000. Heswall Hall 70's, 80's & 90's Party Night. July 9th 7pm – Midnight. 110 out of 160 tickets have been sold to date. Tickets cost £10 and are available from the Charity Office. Dave J Critchley, Executive Head Chef at Lu Ban has offered to support Tiny Stars appeal. The BBC's Great British Menu Chef will be hosting a three-course cooking demonstration followed by banquet lunch for guests at Thornton Hall Hotel on the 7th of September. Tickets are £55 and guests will also receive a copy of Dave's new book featuring his BBC Great British Menu recipes (worth £35). The Tiny Stars appeal will benefit from all fundraising activity at the event. Arrowe Park Abseil, planned for 23rd September- this popular event will return for a third year. Registration for this event will open in July. Santander Bank will be supporting the event. Virtual London Marathon 2nd October. WUTH Charity has 25 places available for this year's virtual event. The ballot for this event will open Monday 27th June.

2	Implications
2.1	The Board is asked to note the progress in communications, media, campaigns, employee support, patient communications and the WUTH Charity.

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

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Board of Directors in Public **Item No 12.1**
June 2022

Title	Chair's Report – Capital Committee 13 June 2022
Area Lead	Matthew Swanborough, Director of Strategy
Author	Steve Igoe, Non-Executive Director
Report for	Information

Report Purpose and Recommendations
The purpose of this report is to provide an update to the Board on the discussions at the Capital Committee on 13 June 2022.

Key Risks
This report relates to these key Risks: • Failure to deliver the capital programme • Failure to effectively plan the capital development of the Arrowe Park Site • Management of the Frontis building and its associated legal and financial liabilities • Management of the security requirements for the Trust

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

1	**Narrative**
1.1	This report updates on the work of the Capital Committee at its meeting on 13 June 2022. The Committee considered the following areas.
1.2	**Arrowe Park Master Planning** The Committee received an oral update relating to the ongoing challenges in support of the Master planning of the Arrowe Park Site. It was noted that funding was a challenge, but the strategic importance of the work noted. It was agreed that the Exec would continue to seek funding for the works and continue the planning in the meantime.

1.3	**Urgent and emergency upgrade programme** An update was received on the progress of the Trust's Urgent Emergency care upgrade Programme (UECUP). The Trust is well on with this project. The Trust submitted its FBC to NHSI/E on 6th May 2022. Prior to submission the case was subjected to rigorous review through the Trust's own Governance processes. The FBC will now go through a detailed review in June after which it will be subject to evaluation by the Joint Investment Sub Committee (JISC) leading to final sign off on 15th August. Funds will flow within 4 weeks of JISC approval. Enabling works are progressing to allow a prompt start on site following approval with areas due for demolition works to be completed by September 2022.
1.4	**Frontis Building** Due to the commercially sensitive nature of these discussions and the associated documentation, the chair concluded that this information whilst able to be discussed at capital committee should not be available for general circulation and any discussion at Board level to be within the Private section.
1.5	**Capital Programme Delivery 2022/23** A detailed report was introduced highlighting the substantial amount of capital works undertaken at the Trust during 2021/22 .This was arguably the busiest year ever for such investment .Delivery and spend covered 43 specific projects which included planned , contingency and specially funded schemes such as the CGH Theatres phase1.Four of the 43 projects above have been carried forward into 22/23 and are part of a further 17 projects with a projected spend of £22m to be completed in year.
1.6	**Capital Risk and Backlog Maintenance** The Committee received a detailed report and presentation providing an overview of backlog maintenance risk across the Trust Estate. This included an examination of historic capital expenditure and allocations, levels of backlog maintenance and estimated costs and equipment maintenance. The discussion also covered the approach and progress with assessing and recording all assets across the Trust along with a timeline for the development and implementation of a CAFM system to manage trust assets and backlog maintenance.
1.7	**Estates Improvement Plan** The Committee received and oral update and presentation on the ongoing works to develop the Estates area and enhance its effectiveness and control. Work was continuing on multiple projects and in multiple areas and positive results were already becoming evident
1.8	**G4S Building Security review** The Committee received a detailed presentation on the current state of affairs relating to the Trust's effectiveness and vulnerabilities associated with current security threats in particular focusing on those key threats and vulnerabilities across the WUTH property portfolio. The Committee were pleased to see the outcomes from this important piece of work. Noted the risk assessment outcomes from the report, the priority recommendations identified, and the next steps recommended in the plan. The Committee also noted that

	following the implementation of the improvement plan there may be a need for further investment or changes to operating models. These will be considered in appropriate for a in due course.

2	Implications
2.1	The Board can use the report from the Capital Committee to update more generally on Capital issues and challenges

3	Conclusion
3.1	The Capital Committee is effectively managing and providing oversight of major capital issues and associated processes and systems for the benefit of the Board.

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