Wirral University Teaching Hospital
NHS Foundation Trust

Council of Governors

20 February 2023

together we will

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Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Council of Governors
Date	Monday 20 February 2023
Time	16:30 – 18:00
Location	Board Room, Education Centre, Arrowe Park Hospital

	Agenda Item	Lead	Presenter/Exec Lead
1.	Welcome and Apologies for Absence	Sir David Henshaw	
2.	Declarations of Interest	Sir David Henshaw	
3.	Minutes of Previous Meeting	Sir David Henshaw	
4.	Action Log	Sir David Henshaw	
5.	Chair's Business and Strategic Issues – **Verbal**	Sir David Henshaw	
6.	Lead Governor Feedback – **Verbal**	Sheila Hillhouse	
	Items for Discussion		
7.	Quality and Performance Dashboard	All NEDs	Executive Directors
8.	Research and Innovation Committee Update	Sir David Henshaw	Ranjeev Mehra
9.	Quality Committee Update	Steve Ryan	Tracy Fennell/Ranjeev Mehra
10.	Finance Business Performance Committee Update	Sue Lorimer	Mark Chidgey
11.	Estates and Capital Committee Update	Sir David Henshaw	Paul Mason
12.	People Committee Update	Lesley Davies	Debs Smith
13.	Audit and Risk Committee Update	Steve Igoe	Mark Chidgey
14.	Charitable Funds Committee Update – **Verbal**	Sue Lorimer	Mark Chidgey
15.	WUTH Strategy 2021/26 Update	All NEDs	Mike Gibbs
	Wallet Items for Information		
16.	Board of Directors' Minutes	Sir David Henshaw	
	Closing Business		
17.	Any other Business	Sir David Henshaw	

Date and Time of Next Meeting

Monday 24 April, 14:30 – 16:30

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Council of Governors
Date	Monday 24 October 2022
Location	Board Room, Education Centre, Arrowe Park Hospital and Microsoft Teams

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SH	Sheila Hillhouse	Public Governor (Lead)
EH	Eileen Hume	Public Governor (Deputy)
SE	Steve Evans	Public Governor
RT	Robert Thompson	Public Governor
PP	Peter Peters	Public Governor
PI	Paul Ivan	Public Governor
SE	Sarah Evans	Public Governor
TC	Tony Cragg	Public Governor
AM	Alan Morris	Public Governor
AN	Anand Kamalanathan	Staff Governor
PD	Paul Dixon	Public Governor

In attendance:

HK	Hayley Kendall	Chief Operating Officer
DM	David McGovern	Director of Corporate Affairs
MC	Mark Chidgey	Chief Finance Officer
TF	Tracy Fennell	Chief Nurse
DS	Debs Smith	Chief People Officer
MS	Matthew Swanborough	Chief Strategy Officer
CC	Chris Clarkson	Non-Executive Director
SI	Steve Igoe	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
SR	Steve Ryan	Non-Executive Director
RM	Rajan Madhok	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer

Apologies:

JH	Janelle Holmes	Chief Executive Officer
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
CD	Chris Davies	Local Authority Governor
MC	Mike Collins	Local Authority Governor
PB	Philippa Boston	Public Governor
CH	Christine House	Public Governor
AT	Ann Taylor	Staff Governor
AT	Andrew Tallents	Public Governor

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed everyone to the meeting. Apologies are noted above.	
2	**Declarations of Interest** No 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 Council of Governors **NOTED** the action log.	
5	**Chair's Business and Strategic Issues** DH updated the Council of Governors on recent matters. The key points included an overview of the position regarding the new Integrated Care Board (ICB) and Place structure, as well as the continued high number of patients who had no criteria to reside at the hospital resulting in less bed capacity in the Trust. HK highlighted the domiciliary care available on the Wirral remained inadequate. HK added the Trust was being proactive and developing schemes such as Home First and virtual wards. RT queried what virtual wards were. HK stated virtual wards would be used to manage patients at home and out of hospital where necessary. HK agreed to provide feedback regarding virtual wards and Home First at the next meeting. SH noted the number of patients who had no criteria to reside was circa 200 and queried how discharge for those patients was prioritised. HK stated that generally it takes longer to discharge patients with more complex care needs in hospital and therefore those with less complex needs are often discharged first. AM queried what improvements were being made to the Trust's telephony. MS stated the improvements were ongoing and would span a number of years. MS added the Trust's directory had been revised,	Hayley Kendall

	resulting in fewer telephone numbers and one number for each ward. This meant calls were answered more promptly. MS agreed to provide an update regarding the Trust's telephony at the next meeting. The Council of Governors **NOTED** the update.	Matthew Swanborough
6	**Lead Governor Feedback** SH highlighted since the last meeting, she and the Deputy Lead Governor had been reviewed the membership database and had been involved in the formation of the Membership Strategy. Governors also observed a number of Committee meetings and were involved in two PLACE assessments recently undertaken at Arrowe Park and Clatterbridge. SH stated Governors were also invited to the Pre-Council of Governors meeting in advance to review and discuss the agenda and encouraged Governors to attend if available. The Council of Governors **NOTED** the update.	
7	**Quality and Performance Dashboard** TF reported C difficile remained a challenge for the Trust and there was a focus on reducing other gram-negative bacteraemia across the Trust. Enhanced cleaning was being undertaken and the team were strengthening assurance relating to cleaning processes and improving oversight to enable prompt action to be taken as necessary. TF explained the number of wards that were below the care hours per patient day threshold was 7 against a Trust target of 3. TF highlighted this was due to a rise in Clinical Support Worker (CSW) vacancies and sickness absence. A CSW event recently took place and resulted in 40 new CSW being recruited. TF highlighted the number of complaints remained high and emerging themes related to communication and access/delays to treatment. RT queried if a breakdown of complaints received by category could be shared with the Council of Governors. TF agreed to provide this. SH noted the Trust's staffing levels and queried due to the reduced staffing levels on certain wards if this resulted in any patient safety incidents. TF stated there was no correlation to impacts on patient safety, but the Trust was aware of the impacts on patient experience due to reduced staffing on certain wards.	Tracy Fennell

	SR stated the Quality Committee receive the Serious Incident Chairs Report and there were no emerging themes relating to patient safety incidents and reduced staffing. RT also queried if there were any challenges regarding medical staffing. DS stated medical and dental had 20% vacancy rate and agreed to provide the mitigating actions to reduce this to the Council of Governors. EH noted the recent NHS Blood and Transplant amber alert for low blood stocks and queried if the Trust had been impacted by this. TF stated there had been no cancelled operations or procedures because of low blood stock. DS stated sickness absence was 5.9% against the Trust target of 5% but that the overall improvement trend from the peak in January 2022 continued. There were emerging signs this would increase due to COVID related sickness in the coming months. Mandatory training compliance was above target at 90.5%. Appraisal compliance was 86.7% against the Trust target of 88% and the overall improvement trend from April 2022 continued. This continued to be a focus in Divisional Performance Reviews as well as improving the quality of appraisal discussions via the People Committee workstream. DS added staff turnover remained an area of concern and was 12% for permanent staff. SH queried if exit interviews were undertaken and what the main reason was for leaving the Trust. DS stated the exit interview process was being reviewed but data showed work/life balance and pay as the main reasons for leaving the Trust. PI queried which staff group had the highlighted level of turnover. DS stated the highlighted level of turnover was in the Clinical Support Worker staff group as well as Porters and Domestics. HK reported elective performance was 111.2% against a plan of 106.7% for outpatients. 106.5% of elective admissions activity was delivered against a target of 106.5%. No patients were waiting over 104 weeks for referral to treatment. HK added that unscheduled care performance against the four-hour standard for type 1 attendances has increased from 48.53% in July to 50.55% in August. The Trust reported 155 patients exceeding the 12-hour DTA target, the highest position year to date. PI queried how the Emergency Department performance compared to the Trusts in the area.	Debs Smith

	HK stated the 4-hour performance improving but ambulance handover remained challenging due to the Trust regularly exceeding 95% bed capacity. MC provided an update on the Trust's financial position and highlighted each month the Trust was in a deficit by circa £500k and if the position did not improve the Trust would end the year with a £6m deficit. MC added there were 4 areas driving the deficit and those included the cost of escalation beds, agency/bank staff, non-recurrent cost improvement programme (CIP) and elective recovery income. The Trust was closely monitoring the financial position and a range of mitigating controls had already been put into place. The Council of Governors **NOTED** the report.	
8	**Infection, Prevention and Control (IPC) Update** TF stated the COVID alert level had reduced to level 2 and explained the latest guidance implemented by the Trust including reduced swabbing and social distancing, with a greater emphasis on identifying symptomatic patients and protecting those who are immunosuppressed. TF added the Trust had commenced the Autumn Booster Vaccination Programme at the Clatterbridge Vaccination Centre from 12 September and there was an increased risk of flu this winter. RT queried how many staff had received a flu jab. DS stated so far 870 staff had received a flu jab and this equated to 15% of the total workforce. DS added the flu programme commenced later than last year due to the delayed issue of the vaccine, and therefore these numbers will improve. TC commented about the positive experience he received at the Clatterbridge Vaccination Centre and stated both staff and volunteers were doing a great job. The Council of Governors **NOTED** the update.	
9	**Feedback from Board Assurance Committees** **9.1) People Committee** LD reported on recent proceedings of the meeting held on 7 September. The Committee received a number of standing reports relating to Chief People Officer Report, People Strategy Report, Workforce Key Performance Report and Employee Relations Report. The Committee received a Flu Programme Update and approved the Terms of Reference and a number of a HR policies.	

The Council of Governors **NOTED** the report.

9.2) Audit and Risk Committee

SI reported on recent proceedings of the meeting held on 21 September. The Committee received a number of standing reports relating to Financial Assurance Report and Procurement Spend Controls Waivers Report. The Committee also discussed the latest internal audit reports and received an update on external audit. The Committee approved the Managing Conflicts of Interest Policy, Terms of Reference, and Standing Financial Instructions.

The Council of Governors **NOTED** the report.

9.3) Estates and Capital Committee

DH provided a verbal report on recent proceedings of the meeting held on 30 September. The Committee received an update on Urgent & Emergency Care Upgrade Programme (UECUP), 2022/23 Capital Programme Delivery Update and Arrowe Park Hospital Campus Master Planning. The Committee discussed the progress made with the Frontis Building Review and G4S Building Security Review. The Committee approved the Terms of Reference.

TC queried if the Trust had developed an asset register to monitor and track compliance of medical equipment etc.

MS stated the Trust was in the process of implementing a CAFM system to achieve this.

The Council of Governors **NOTED** the report.

9.4) Quality Committee

SR reported on recent proceedings of the meeting held on 30 September. The Committee received a number of standing reports including the Patient Safety Quality Board Key Issues Report, Quality and Patient Safety Intelligence Report and Serious Incident Panel Chair's Report. The Committee also received a Care Quality Commission Action Plan Update and the Clostridioides Difficile Q1 2022/23 Update and Improvement Plan

The Council of Governors **NOTED** the report.

9.5) Research and Innovation Committee

DH reported on recent proceedings of the first meeting held on 4 October. The Committee approved the Terms of Reference, received the Research Annual Report, and discussed the Research and Innovation Strategy and the upcoming priorities.

	The Council of Governors **NOTED** the report. **9.6) Charitable Funds Committee** SR reported on recent proceedings of the meeting held on 20 October. The Committee received the Head of Fundraising Report and Finance Report. The Committee approved the 2021-22 WUTH Charity Annual Report and Accounts, the Pennies from Heaven Scheme, and a Staff Well-being Charity Fund. AM queried how much income had been received for the recent abseil at Arrowe Park Hospital. SL stated so far £12k had been received and more income was anticipated. The Council of Governors **NOTED** the report.	
10	**Governance Update and Documents** CH provided an update on upcoming governor development opportunities for the remainder of the year including Committee attendance and welcomed expressions of interest for attending the Research & Innovation and Estates & Capital Committees. CH presented a role profile, outlining the responsibilities of a Governor, and a refreshed Code of Conduct for approval. TC volunteered to observe the Estates and Capital Committee. SH requested at the end of a Committee meeting if Chairs could invite feedback from Governors. The Council of Governors: • **NOTED** the development update • **APPROVED** the role profile • **APPROVED** the refreshed Code of Conduct	Cate Herbert
11	**Membership Strategy and Engagement** CH presented the Membership Strategy for approval. CH stated it was a three-year strategy and the Council of Governors would receive annual monitoring reports during the period. CH added a small working group of Governors would be established to put together and consult on an action plan for the strategy's objectives. The Council of Governors: • **APPROVED** the Membership Strategy • **ENDORSED** the next steps for implementing the strategy	
12	**Board of Directors' Minutes** The Council of Governors **NOTED** the Board of Directors' Minutes	

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

(The meeting closed at 17:45)

Action Log
Council of Governors
20 February 2023

No.	Date of Meeting	Minute Ref	Action	By Whom	Action Status	Due Date
1.	24 October 2022	5	To provide feedback regarding virtual wards and Home First at the next meeting	Hayley Kendall	Complete. There are good outcomes for Home First including high daily discharge rates and good staff and patient feedback. A proposal to expand Home First for pathway 1 discharges was presented to the Board of Directors on 25 January and the Trust would now progress with Wirral system partners to take forward.	February 2023
2.	24 October 2022	5	To provide an update regarding the Trusts telephony at the next meeting	Matthew Swanborough	Complete. Scheduled for February 2023 and included in the Estates and Capital Committee Update.	February 2023
3.	24 October 2022	7	To provide a breakdown of complaints received by category	Tracy Fennell	Complete. Circulated by email on 12 December. Further assurances provided in Quality Committee Update.	February 2023
4.	24 October 2022	7	To provide the mitigating actions to reduce the medical and dental vacancy rate	Debs Smith	Complete. Included in the People Committee Update under risk section.	February 2023
5.	24 October 2022	10	To invite Tony Cragg to observe Estates and Capital Committee meetings	Cate Herbert	Complete.	December 2022

Council of Governors
20 February 2023

Item 7

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 November 2022. It is recommended that the Council of Governors: • notes performance to the end of November 2022

Key Risks
This report relates to the key Risks of: • Quality and safety of care • Patient flow management during periods of high demand

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
25 January 2023	Board of Directors in Public	As above	Information

1	**Narrative**
1.1	Of the 49 indicators that are currently reported against thresholds (excluding Use of Resources): - 31 are off-target or failing to meet performance thresholds

	- 18 are on-target Following the 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.

Report Author	John Halliday - Assistant Director of Information
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Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

December 2022
Upated 12-01-23

	Indicator	Objective	Director	Threshold	Set by	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-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	0.19	0.18	0.18	0.22	0.04	0.22	0.09	0.09	0.33	0.17	0.13	0.04	0.09	0.14	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	97.2%	96.9%	96.7%	96.2%	96.4%	96.8%	96.9%	96.6%	96.5%	96.3%	96.5%	96.8%	97.1%	96.9%	
	Never Events	Safe, high quality care	CN	0	SOF	0	1	0	1	0	0	0	0	0	0	1	0	0	1	
	Clostridioides difficile (healthcare associated)	Safe, high quality care	CN	Maximum 72 for 2022-23. Max 6 cases per month	WUTH	5	3	18	12	13	7	8	16	17	15	13	12	12	110	
	Gram negative bacteraemia : e-coli	Safe, high quality care	CN	Maximum 56 for 2022-23. Max 4 cases per month	National	-	-	-	-	-	8	4	9	12	10	6	5	5	70	
	Gram negative bacteraemia : klebsiella	Safe, high quality care	CN	Maximum 19 for 2022-23. Max 1 case per month	National	-	-	-	-	-	0	4	1	3	6	3	2	4	28	
	Gram negative bacteraemia : pseudomonas	Safe, high quality care	CN	Maximum 9 for 2022-23. Max 0 cases per month	National	-	-	-	-	-	0	0	0	0	1	0	0	1	3	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	1	0	0	0	0	0	0	0	0	2	2	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	0	1	1	1	4	0	0	1	0	0	0	0	5	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	96%	96%	94%	95%	92%	89%	91%	96%	97%	95%	95%	95%	96%	94%	
	Safeguarding Audits	Safe, high quality care	CN	≥90%	WUTH	-	-	-	-	82.6%	71.6%	93.5%	89.6%	94.7%	85.0%	No audits completed	No audits completed	94.4%	89%	
	Mandatory Training compliance	Safe, high quality care	CPO	≥90%	WUTH	90.5%	90.4%	89.0%	87.2%	87.2%	87.17%	89.21%	90.39%	89.73%	90.59%	90.34%	89.78%	90.25%	91.0%	
	Sickness Absence % (12-month rolling average)	Safe, high quality care	CPO	≤5%	SOF	6.24%	6.40%	6.48%	6.53%	6.70%	6.79%	6.83%	6.89%	6.94%	6.90%	6.87%	6.87%	6.89%	14.5%	
	Sickness Absence % (in-month rate)	Safe, high quality care	CPO	≤5%	SOF	6.37%	7.86%	8.72%	7.05%	7.73%	6.84%	6.23%	6.50%	7.08%	5.98%	6.33%	6.81%	6.60%	6.64%	
	Staff turnover % (rolling 12 month rate)	Safe, high quality care	CPO	≤10%	WUTH	13.2%	13.4%	13.7%	13.9%	14.1%	14.1%	14.4%	14.4%	14.1%	13.9%	15.29%	14.01%	14.37%	14.5%	
	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	5	4	7	8	11	6	6	

	Indicator	Objective	Director	Threshold	Set by	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	2022/23	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	93.8%	92.6%	91.7%	96.7%	96.9%	94.6%	97.1%	97.9%	95.7%	96.5%	94.8%	95.6%	95.2%	95.7%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	95.5%	94.6%	95.2%	97.3%	96.3%	97.7%	98.2%	98.9%	98.5%	98.1%	97.7%	97.0%	98.7%	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	141	157	206	195	187	220	194	211	214	226	251	229	236	218	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	82.0%	77.9%	77.2%	77.9%	83.7%	79.3%	83.1%	80.9%	82.0%	84.7%	86.8%	85.3%	85.9%	81.5%	

	Indicator	Objective	Director	Threshold	Set by	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	2022/23	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	3	8	3	2	3	1	1	1	5	1	3	3	5	21	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	72.4%	77.7%	75.9%	77.3%	67.2%	74.0%	74.7%	77.4%	73.6%	78.2%	82.4%	76.2%	76.5%	76.7%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	95.1%	94.4%	95.4%	94.5%	92.3%	94.8%	94.1%	93.1%	95.6%	94.2%	95.1%	95.1%	95.9%	94.8%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	93.7%	94.3%	94.3%	94.1%	93.6%	93.5%	94.3%	93.5%	94.6%	94.1%	94.0%	94.0%	94.2%	94.1%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	94.7%	94.6%	96.6%	93.5%	97.7%	93.1%	98.0%	100.0%	96.9%	100.0%	100.0%	100.0%	100.0%	98.7%	

Quality Performance Dashboard

December 2022
Upated 12-01-23

	Indicator	Objective	Director	Threshold	Set by	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-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	59.5%	60.6%	59.1%	63.1%	61.5%	63.1%	63.4%	64.5%	62.3%	63.6%	66.4%	62.7%	63.9%	63.8%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	6	6	13	7	17	39	24	17	69	155	18	59	182	662	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	100%	National	49.8%	57.2%	57.3%	61.7%	54.0%	52.5%	53.5%	58.6%	53.6%	57.9%	60.9%	52.8%	55.8%	55.2%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	0%	National	9.4%	8.8%	11.0%	8.1%	11.6%	13.7%	10.7%	10.5%	14.6%	14.1%	10.8%	14.5%	13.6%	13.1%	
	Proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed	Safe, high quality care	COO	TBD	National	78.9%	74.6%	73.9%	82.4%	86.9%	91.2%	85.1%	86.1%	90.6%	90.2%	87.3%	90.7%	88.5%	89.1%	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	22.8%	19.2%	18.0%	15.5%	25.2%	23.9%	21.9%	18.5%	16.0%	12.5%	16.2%	24.3%	17.5%	19.1%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	≥92%	SOF	70.14%	67.84%	67.57%	65.89%	65.38%	64.08%	66.72%	65.46%	64.80%	64.77%	62.40%	61.85%	61.57%	57.75%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	27046	27406	28665	29445	30430	31504	32373	33306	34933	35742	37030	37157	37188	37460	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	510	557	475	525	582	730	811	1028	1119	1122	1245	1279	1219	1321	
	Referral to Treatment - cases waiting 78+ wks	Outstanding Patient Experience	COO	NHSEI Plan Trajectory 2022-23	National	70	72	59	65	60	70	73	82	91	62	60	55	47	71	
	Referral to Treatment - cases exceeding 104 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	5	5	4	5	1	0	0	0	8	0	0	0	0	0	
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥95% (from April 2022)	SOF	93.0%	89.8%	87.3%	86.4%	85.2%	82.8%	86.0%	87.2%	87.5%	85.3%	85.3%	86.8%	88.0%	86.2%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	87.9%	91.4%	76.2%	78.0%	76.2%	85.8%	96.6%	94.6%	94.4%	91.9%	78.7%	88.3%	92.0%	90.3%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	-	91.63%	-	-	76.7%	-	-	92.5%	-	-	88.4%	-	-	90.4%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	94.3%	94.8%	94.6%	95.1%	92.6%	91.2%	96.5%	96.4%	96.1%	94.7%	96.2%	97.3%	97.0%	95.7%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	-	94.85%	-	-	94.1%	-	-	94.9%	-	-	95.6%	-	-	95.3%	
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	79.7%	79.3%	79.6%	79.3%	75.9%	79.2%	79.6%	75.7%	79.9%	81.5%	73.8%	73.1%	74.4%	77.1%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	-	79.38	-	-	78.1%	-	-	78.2%	-	-	78.2%	-	-	78.2%	
	Cancer Waits - reduce number waiting 62 days +	Outstanding Patient Experience	COO	NHSEI 2022/23 plans trajectory - revised 07/10/22	National	n/a	n/a	n/a	n/a	81	97	118	152	167	158	200	200	173	177	
	Cancer - Faster Diagnosis Standard	Outstanding Patient Experience	COO	≥75% within 28 days	National	79.2%	80.5%	70.5%	78.9%	79.5%	76.7%	75.4%	78.3%	79.6%	76.6%	71.8%	75.2%	73.8%	75.9%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	177	149	180	187	211	170	185	174	207	191	234	187	178	184	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	3.27	3.26	2.34	4.87	3.05	4.50	3.96	2.88	4.13	5.02	3.57	3.54	3.17	3.56	
	Formal Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	61%	100%	100%	100%	100%	100%	86%	100%	91%	96%	100%	80%	100%	95%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	4	3	2	0	0	2	2	1	3	0	5	4	1	2	
	NEWS2 Compliance	Outstanding Patient Experience	MD/CN	≥90%	WUTH	-	-	-	-	85%	85.2%	88.3%	89.7%	89.1%	89.6%	90.3%	89.4%	89.2%	89%	

Quality Performance Dashboard

December 2022
Upated 12-01-23

	Indicator	Objective	Director	Threshold	Set by	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-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	0	0	0	0	0	0	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	958	1121	1445	1575	1666	21	59	85	110	147	213	255	326	354	
	% Appraisal compliance	Safe, high quality care	CPO	≥88%	WUTH	82.7%	82.3%	82.0%	78.0%	77.9%	77.2%	83.2%	85.2%	86.2%	86.7%	88.58%	88.25%	88.36%	88.4%	

	Indicator	Objective	Director	Threshold	Set by	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	2022/23	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	-0.7	-0.6	2.3	-0.1	0.1	-1.0	-0.4	-0.2	-0.4	-0.5	-0.6	-0.9	-0.7	-1.2	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	1.0	-0.9	1.9	-0.5	-0.3	-0.9	0.3	-1.2	-0.6	-0.7	-0.9	-0.8	-0.6	-1.1	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	2.0	2.0	2.0	2.0	2.0	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	
	CIP Performance (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	77.21%	48.24%	78.70%	78.61%	91.33%	7.26%	45.26%	47.60%	57.50%	51.00%	55.00%	45.00%	49.00%	21.77%	
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	-25.1%	-6.7%	-4.3%	-8.0%	-15.0%	-43.9%	-316.0%	-88.0%	-218.8%	-216.0%	-233.0%	-171.0%	-142.0%	-121.0%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-15.9	-18.0	-16.2	-18.6	-20.0	-21.4	-12.0	-16.6	-16.4	-21.4	-23.5	-26.0	-38.0	-37.9	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	36.3%	48.0%	59.0%	76.2%	100.0%	0.7%	1.4%	4.0%	8.7%	13.0%	17.9%	25.3%	31.5%	38.4%	

Metrics Added

Metrics Amended

Safe Domain

Clostridioides difficile (Healthcare Associated)

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:

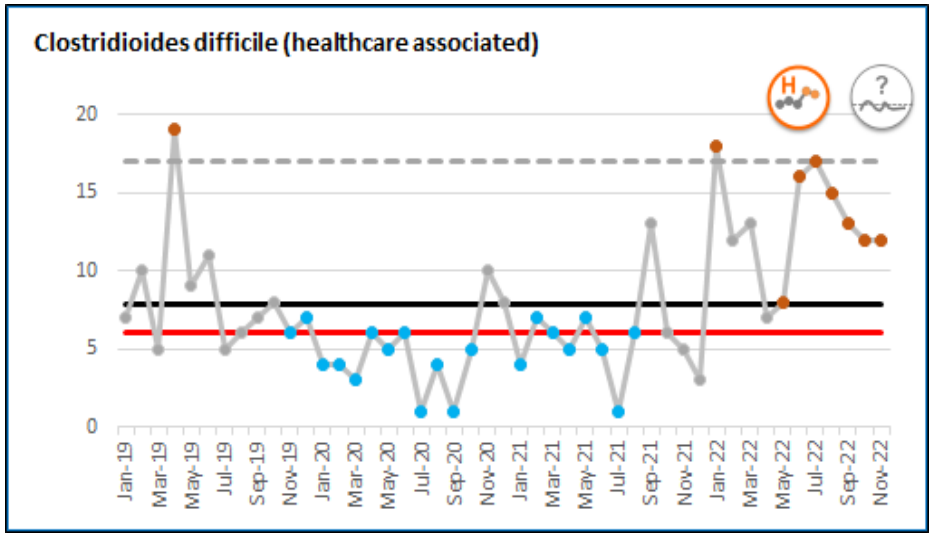
The *Clostridioides difficile* (CDI) threshold set for 2022-23 is 72 - equaling a monthly maximum threshold of 6 cases.

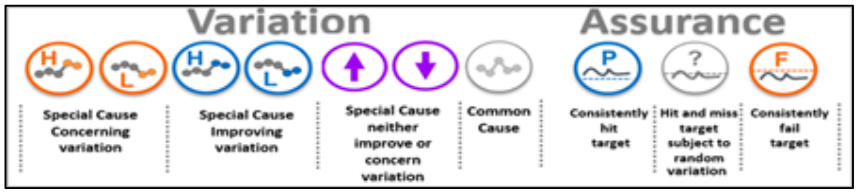
The monthly threshold of 6 has been exceeded each month since April, with 12 cases reported in November. A total of 100 cases since April 2022.

Action:
The CDI quarterly report and improvement plan is governed via the IPC group and directly overseen by the Chief Nurse / DIPC. The Q3 report has continued to evidence positive outcomes with a sustained reduction in the number of CDI's. Collaboration with healthcare partners continues with system wide challenges being addressed through the multi-agency Health Protection Board for Wirral.

Enhanced auditing of the cleaning standards has helped to drive improvements, resulting in a proactive approach and clearly defined roles and responsibilities of the cleaning teams and the ward staff. This has promoted immediate rectification and improvement in the effectiveness environmental cleaning process.

Review of IPC isolation priorities have strengthened clinical teams' decision making to enable a risk assessed approach to inform the order of patient isolation. This will ensure the transmission of infection between





patients is minimised during the current bed capacity challenges evident throughout the Trust.
Expected Impact: Sustained reduction in patients diagnosed with healthcare associated *Clostridioides difficile* by Q4.

Gram-Negative bloodstream infections - *E-coli* bacteraemia

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:
For 2022-23 the Gram-negative blood stream infection objective is separated into individual targets for *E-coli, klebsiella* and *pseudomonas*. Thresholds are derived from a baseline of the 12 months ending November 2021 (the most recent available data at the time of calculating the figures).

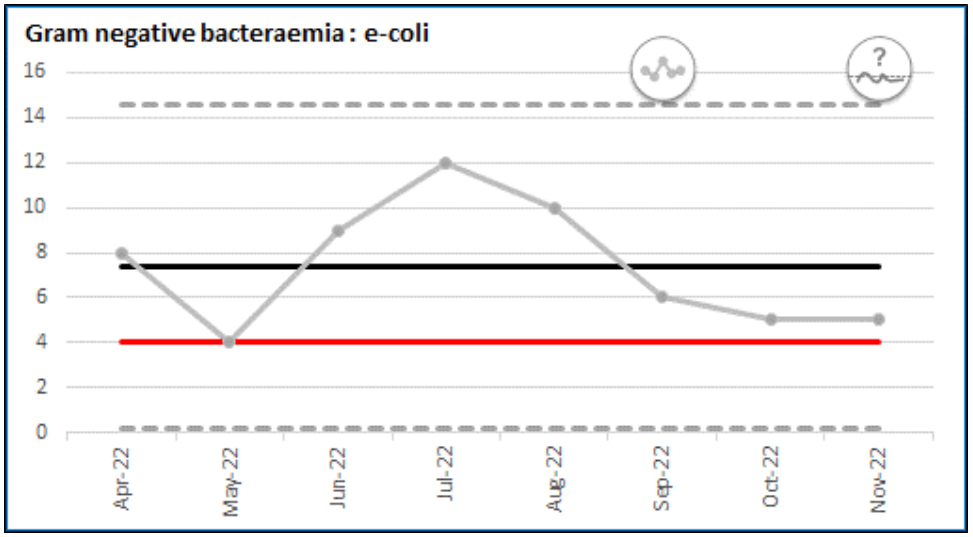
The threshold for *E-coli* bacteraemia is 56, which equates to a maximum 4 per month. From April-December 2022, 61 cases have been reported; 5 patients were diagnosed with an *E-coli* bacteraemia in November 2022.

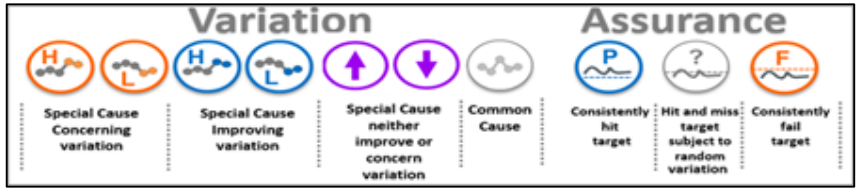
Action:
Individual case scrutiny continues that enables learning opportunities to be identified and remedial actions to be put into place where required.

Many blood stream infections are diagnosed in severely ill patients with no indication that there is a clinical omission in care. Review of the process to determine if a bacteraemia can be avoided is taking place. This will enable heightened focus on patients identified with infections that could be avoided and establish the cause that will inform effective action planning to avoid further cases.

Key priority areas of focus that may contribute to the reduction of E-*coli* bacteraemia are progressing within the Trust and as a Wirral wide system approach. This includes appropriate antibiotic prescribing, urinary catheter care and management, and aseptic non-touch technique.

Expected Impact:
The number of patients diagnosed with an *E-coli* bacteraemia is reduced to below the monthly threshold.





Gram-Negative bloodstream infections - klebsiella

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:
For 2022-23 the Gram-negative blood stream infection objective is separated into individual targets for *E-coli, klebsiella* and *pseudomonas*. Thresholds are derived from a baseline of the 12 months ending November 2021 (the most recent available data at the time of calculating the figures). The maximum threshold for *Klebsiella* is set at 19, with equates to an alternating threshold of 1 and 2 per month for monitoring purposes.

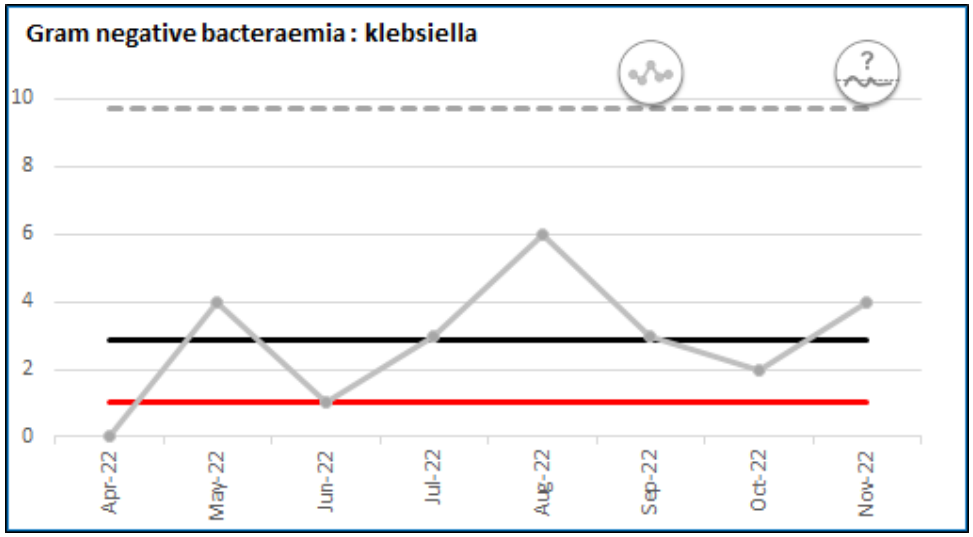
There were 4 cases reported in November 2022, against a threshold of 2. Since April 2022, 28 cases have been reported. Therefore the 2022-23 maximum threshold has been exceeded.

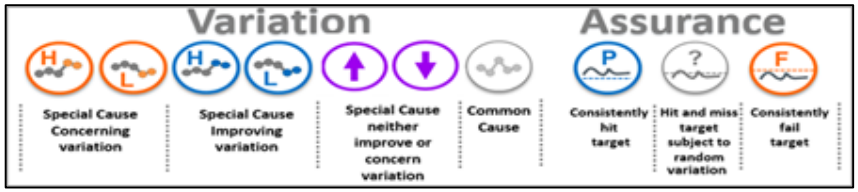
Action:
Klebsiella is a gut organism and common sources identified during the RCA process relate to the management of indwelling devices and intra-abdominal complexities.

Individual scrutiny of each case continues to enable learning opportunities to be identified and remedial actions to be put into place to avoid future harms. Recent reviews have not identified any specific causative factors that could have prevented the blood stream infection.

Effective infection prevention control measures by the multi-disciplinary team are essential. Therefore, the programme of work on aseptic non-touch technique (ANTT) and the 'Gloves off' campaign both have a focus on improved hand hygiene for all staff. ANTT competency framework ensures assessment for all staff undertaking clinical procedures to strengthen the prevention of device-associated infections.

Expected Impact:
The number of patients diagnosed with a *Klebsiella* blood stream infection is reduced to below the monthly threshold.





MRSA Bacteraemia – hospital acquired

Executive Lead: Chief Nurse

Performance Issue:
Healthcare providers have been set the challenge of demonstrating '*zero tolerance'* of MRSA Bloodstream Infections. All MRSA blood stream infections are subject to a Post Infection Review (PIR).

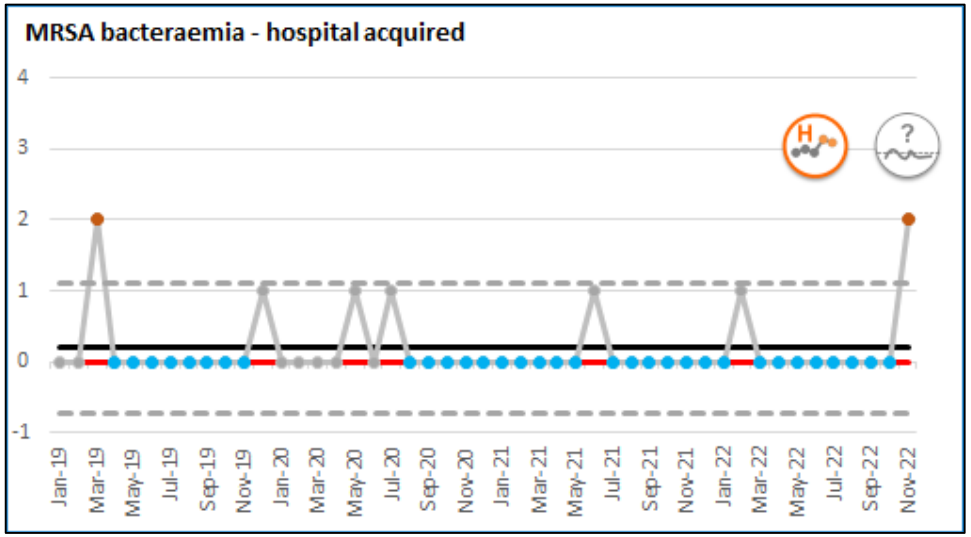
WUTH reported 2 MRSA bacteraemia cases in November 2022. The most recent case before that was in February 2022.

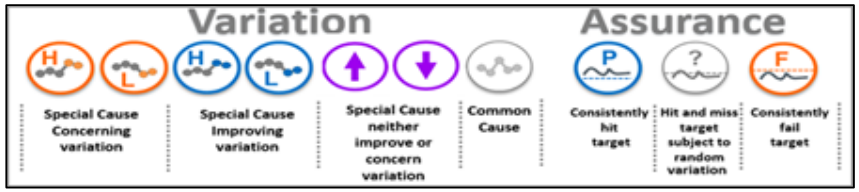
Action:
Review of both patients journey prior to diagnosis of the MRSA bacteraemia has been completed:

A source of infection was not determined in one case. However, aseptic non-touch technique and blood culture collection training for staff was highlighted as a recommendation.

The second case, the patient was diagnosed with a MRSA bacterium when known to be MRSA colonised. Determination of the source of infection is agreed to be most probably due to insertion of a urinary catheter or cannula. Urinary catheter care / management and aseptic non-touch technique are key priority areas of focus within the Trust and as a Wirral wide system.

Expected Impact:
Targeted interventions will help to reduce the risk of MRSA bacteraemia.





Sickness absence % (in-month rate)

Executive Lead: Deborah Smith, Chief People Officer

Performance Issue:

The Trust threshold for sickness absence is 5%. For November the indicator is 6.60% and demonstrates common cause variation.

Long term sickness absence accounts for 1.24%, whilst short term sickness absence is more of a challenge at 5.36% in November 2022.

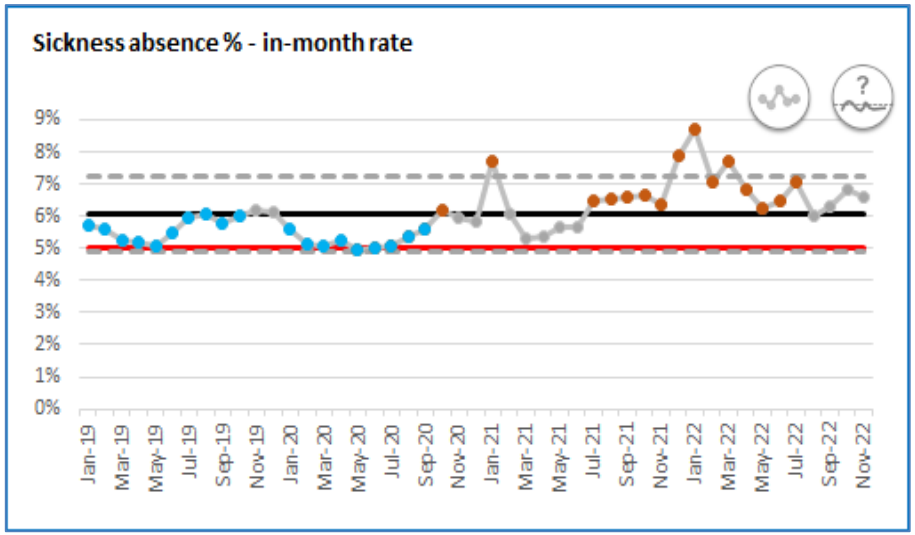
Estates and Ancillary are the staff group with the highest absence rate (10.41%) followed by Additional Clinical Services (9.17%) and this staff group are a particular area of focus.

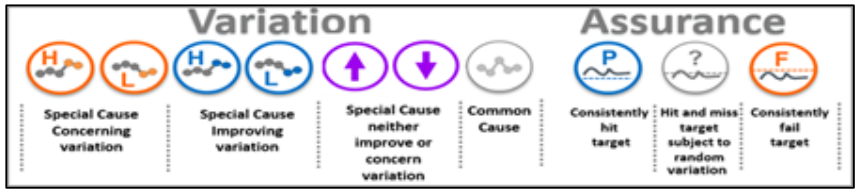
Anxiety, Stress and Depression remains the highest reason for long term sickness absence. The category 'Gastrointestinal problems' was the highest reported reason for short-term sickness, followed by 'Cold, Cough and Flu-Influenza' and 'Infectious Diseases'.

Action:

Monitoring of the Sickness Attendance KPI and associated actions is on-going via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews. Managers continue to be supported by HR.

Targeted Support
The highest sickness absence levels remain within Facilities, who are being supported by their HR Team. Facilities are undertaking an analysis of the drivers of the sickness absence and measures in place to address. It is also anticipated that new Attendance Management Policy triggers when implemented, will further support with the persistent short-term absence which is most disruptive to the service.





Managing Attendance Policy
The extensively revised Attendance Management Policy has now been agreed at Policy Pay Terms & Conditions and is progressing via the governance route. In parallel to this, work is progressing on the launch element.

Workforce Wellbeing
The newly appointed Wellbeing Specialist Practitioner will be focusing on reviewing the Trust Health and Wellbeing offer in the Trust, with an immediate focus on supporting staff during and following Industrial Action.

Development
As part of the Leadership for All approach a suite of stand-alone sessions development sessions have been designed. The next upcoming session in January is Building Personal Resilience.

Flu Vaccine
The Flu Vaccine Programme continues. Current uptake amongst frontline Healthcare Workers is 57%, compared to a Cheshire and Merseyside average of 49%.

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. We continue to appropriately prioritise workforce wellbeing and our commitment to mental health support.

Staff turnover %

Executive Lead: Deborah Smith, Chief People Officer

Performance Issue:

The Trust threshold for turnover is 0.83%. For November 2022 the indicator was 1.07% and demonstrates common cause variation.

The following staff groups have high turnover in November:

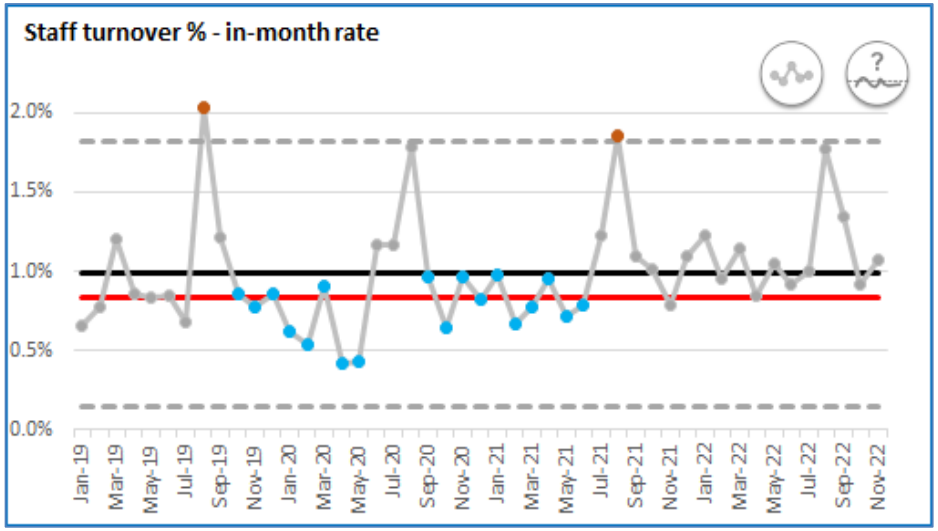
- Add Professional & Technical (2.08%)
- Admin & Clerical (1.56%)
- Allied Health Professionals (1.19%)

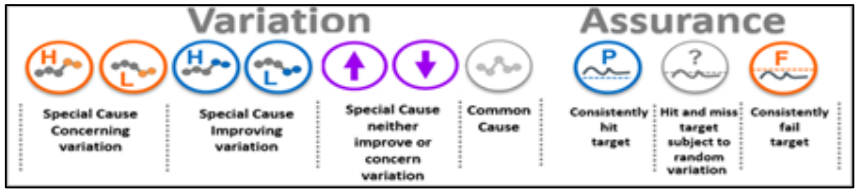
Actions:

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.

Current Interventions to support retention include:

- The Retention Delivery Plan was agreed with the Strategic Retention Group and priorities determined.
- Work has commenced with the HR Team and the National ESR Team to improve leaver reasons accuracy in ESR.
- The completed Nursing and Midwifery Retention Self-Assessment Tool has been submitted to the Northwest and ICB Retention Group. Feedback is currently awaited from the Northwest and ICB Retention Group.
- Expressions of interest are currently being sought for the new Leading Teams programme. This is a 6-month programme aimed at staff who have responsibility for leading others as part of their job.
- Use of apprenticeship for HCSW posts. At present there have been 6 cohort starts with a 6-month retention rate of 85%.





Staff Survey and the People Strategy

The Staff Survey closed in November 2022 with a response rate of 48%. Findings will be reported in early 2023 and will be used to inform retention strategies in 2023 and beyond.

There are also other programmes of activity within the People Strategy Delivery Plan that impact on staff experience including health and wellbeing initiatives, reward and recognition, flexible working and improvements in integration and diversity which will also help minimise turnover.

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: Tracy Fennell, Chief Nurse

Performance Issue:
The Trust monitors the number of wards that are below a care hours per patient day (CHPPD) threshold of 6.1. The metric for the Trust overall is set at a maximum of 3 wards to be below this threshold.

The number of wards for November 2022 were 6 as follows: Ward 37 - CHPPD 6, Ward 18 - CHPPD 5.9, Ward 22 - CHPPD 5.8, Ward 36 and 38 - CHPPD 5.7 and Ward M1 - CHPPD 5.6.

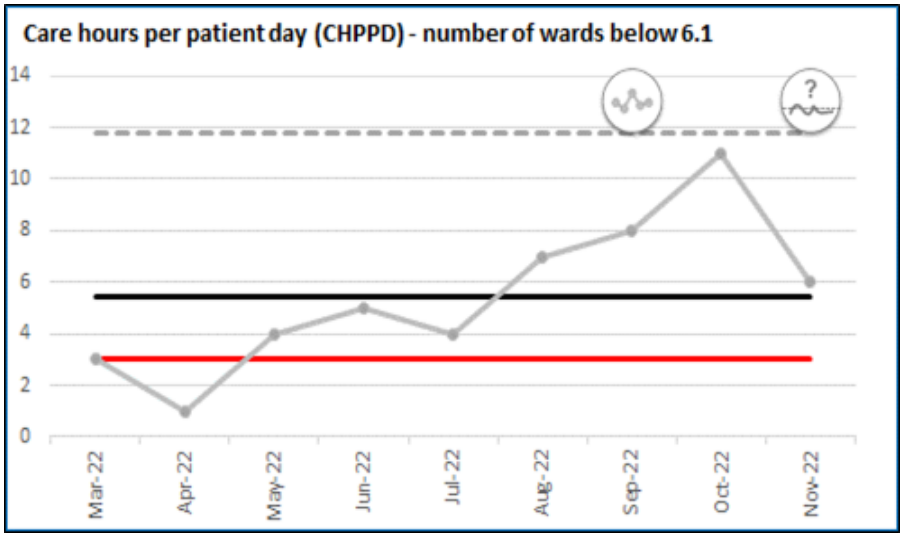
Action:
A CHPPD tracker is one of the safer staffing measures, which has been in place since May 2022, to monitor if any areas are consistently recording CHPPD <6.1. The CHPPD data is triangulated with further staffing metric data to monitor the impact on care. Impacts on care are being monitored and have remained minimal with the areas of lower than threshold CHPPD.

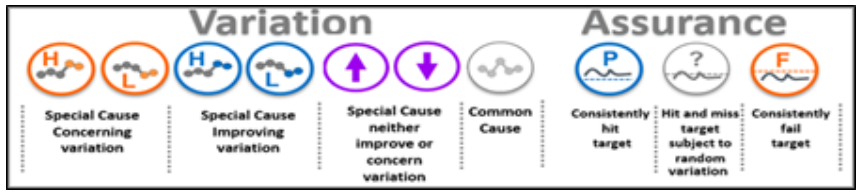
November, with 6 wards below the required threshold is the lowest number of wards below threshold each month since July 2022. Ward 18 has had 2 consecutive months below threshold with a variance of 0.1, equivalent to 6 minutes of nursing care, in November. Ward 22 and 36 have had consecutive months of a CHPPD of <6.1.

Ward M1 provides care to patients who do not have the criteria to reside. Healthcare professional input will not be required at the same level or frequency to that of an acute area. Ward 38 staffing levels had a CHPPD consistently <6.1 since November 2021, this is a result of clinical support worker (CSW) shortfalls created by staff moves to support higher risk staffing challenges across the Trust. Oversight has been provided by the Matron and professional judgement is that the ward has remained safe.

Successful system wide recruitment events have been led by the Trust. A focus on recruitment and retention for CSW and in-patient RN band 5's continues.

Expected Impact: A reduction in the number of wards with a consistent CHPPD of <6.1 by end of Q4.





Caring Domain

Same sex accommodation breaches

Executive Lead: Tracy Fennell, Chief Nurse

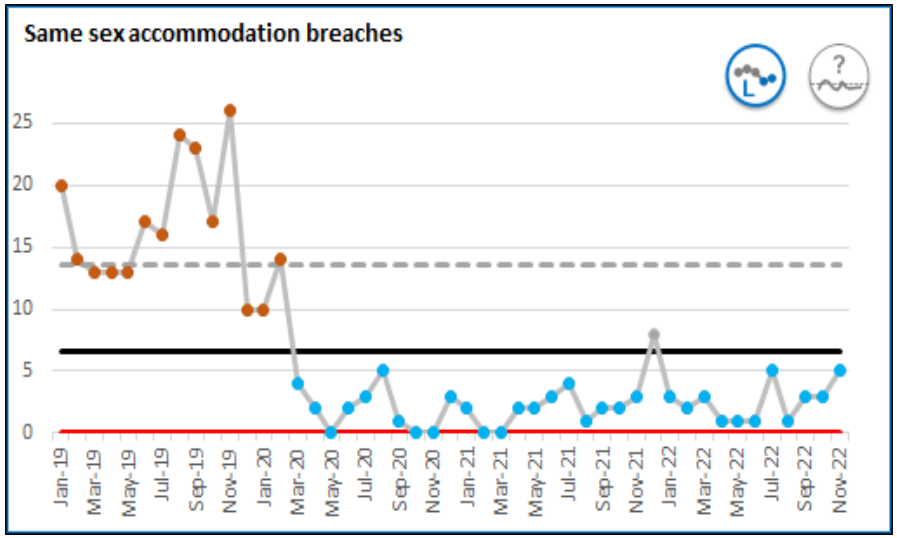
Performance Issue:
The national standard is set that providers should deliver same sex accommodation, except where it is considered in the overall best interests of the patient or reflects personal choice.

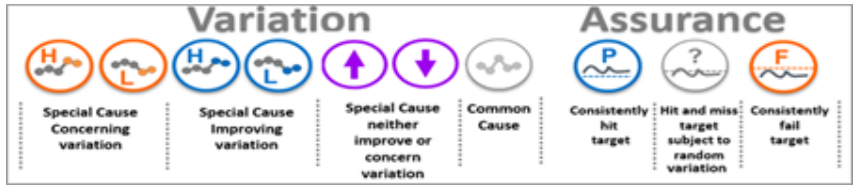
Breaches are often due to patients waiting more than 24 hours for transfer from critical care areas inclusive of Coronary Care Unit (CCU) to general wards; there were 5 such breaches in November 2022. (Intensive Care Unit (ICU) 2 and CCU 3). The breaches did not cause any delays or refused admissions to these areas as sufficient ICU and CCU capacity has been available. Patient's privacy and dignity needs are met whilst the person awaits transfer to the specialty areas and the teams ensure their specialty care is not compromised due to a lengthened critical care stay.

Action:
Delivering same sex accommodation is a high priority. It is recognised that system challenges resulting in high levels of activity and a high proportion of patients with no criteria to reside, which continued throughout November 2022, has an impact on the ability to deliver same sex accommodation.

Processes are in place that enable joint working with ICU, CCU, Patient Flow Team, and Divisional Directors and each breach is risk assessed and concerns are managed promptly via bed capacity and operational meetings. This enables daily oversight of individual patients requiring a stepdown and the length of time waiting.

Expected Impact:
Same sex accommodation breaches are minimised and all patients are transferred to their specialty bed within 24 hours of discharge.





Friends & Family Test – Overall Experience

Executive Lead: Tracy Fennell, Chief Nurse

Performance Issue:
A Trust standard of 95% 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 November 2022 was:

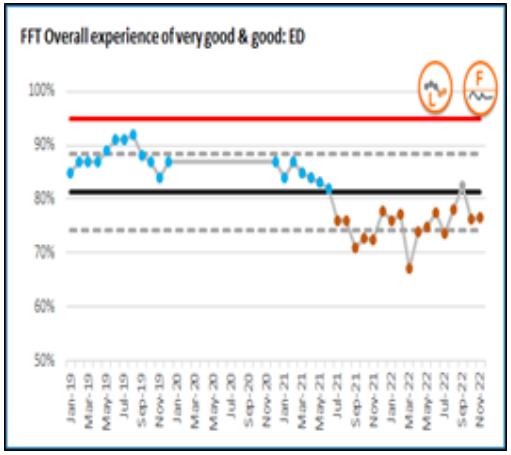
- Emergency Department (ED) – 76.5% (below threshold)
- Inpatients – 95.9% (above threshold)
- Outpatients – 94.2% (below threshold)
- Maternity 100% (above threshold)

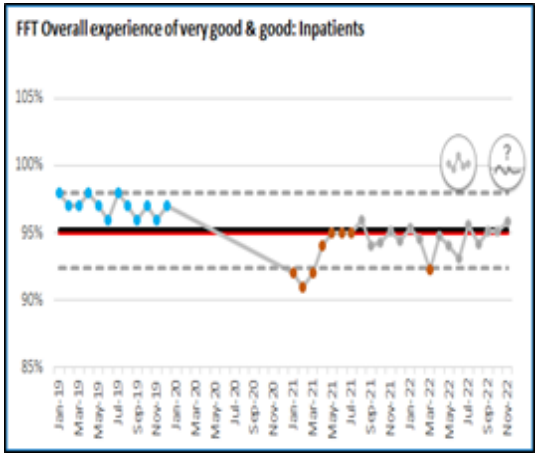
Action:
The Patient Experience Strategy has established 5 strategic promise groups; Welcome, Safe, Inclusive, Care, and Supported. Each promise group has a focus on identifying patients' experience improvement opportunities.

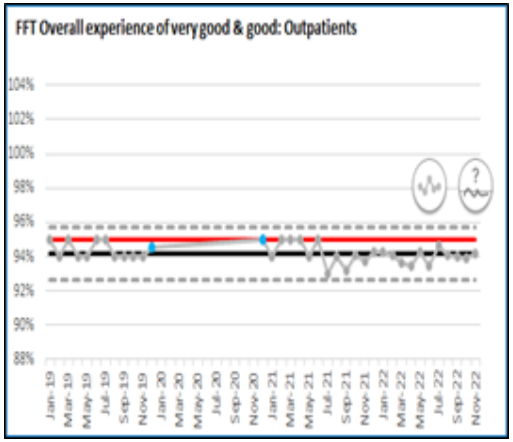
Operational pressures within the Emergency Department, consistent with the national position, is impacting on the FFT score. FFT score for ED remains below the Trust threshold of 95% however is in line with the national average scores for ED. Waiting times are consistently reported to be an area of challenge. Effective communication to patients remains a priority focus for the Divisional Triumvirate.

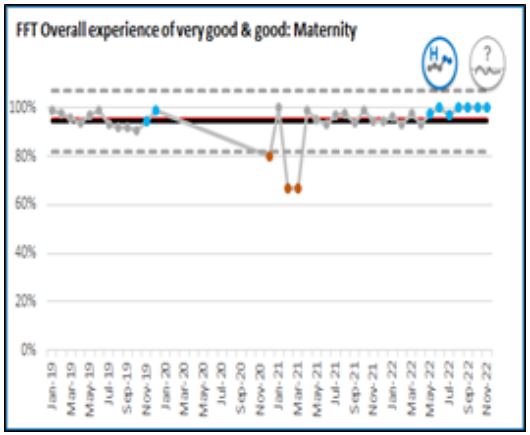
Out-patients FFT score of 94.2%, 0.8% below threshold, is consistent with previous months. Additional touch screen kiosks and feedback volunteers have been introduced to increase the opportunity for feedback in this area.

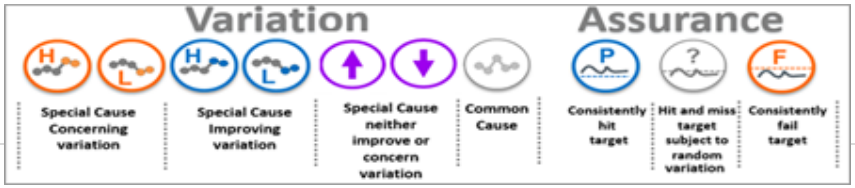
Expected Impact:
Improved FFT scores within the ED and an expectation to reach the Trust target for Outpatients in Q4.







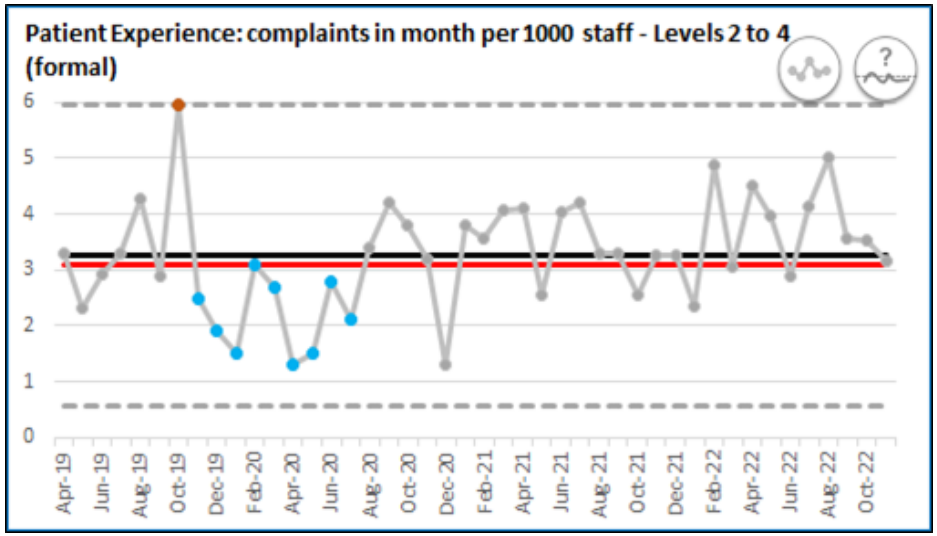


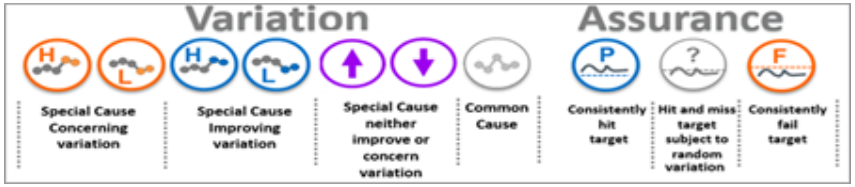


Responsive

Number of complaints received in month per 1000 staff

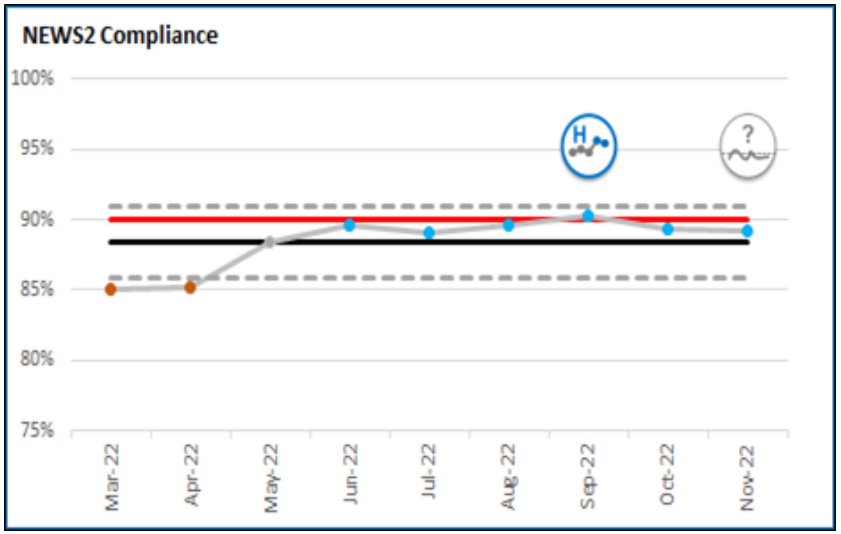
Executive Lead: Tracy Fennell, Chief Nurse
Performance Issue: The Trust has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per 1000 staff. The rate for November 2022 was marginally above this at 3.17.
Action: Complaints received continue to remain lower than the national average for 2020/21. During November 2022, 20 new formal complaints were registered: this was slightly above WUTH's expected/historical monthly average activity for 2021/22 (18). 32 complaints have been closed in November. Achieving a 39% increase over October, as a positive response to the current focus on reducing the number of active complaints being investigated and overall response times. Divisional plans are in place to address the concurrent causes of complaint (communication / staff attitude and capacity pressures) and the ways in which these can be addressed, as well as any seasonal surges in numbers. Weekly complaints management meetings with all divisions continue to take place. The purpose of these meetings is to support management of complaint responses and to identify and address barriers to completion as early as possible.
Expected Impact: Reduction in the response times and sustained improvement towards achieving the internal threshold by end of Q4.

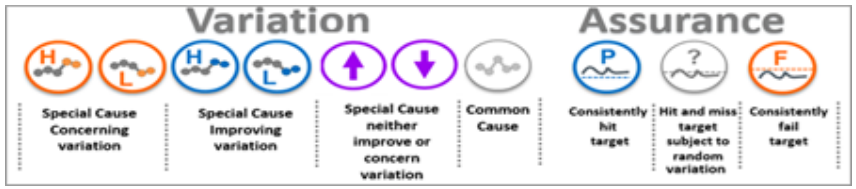




NEWS2 Compliance

Executive Lead: Tracy Fennell, Chief Nurse
Performance Issue: A threshold of greater than 90% compliance with NEWS2 patient observations conducted within national guidelines and Trust NEWS2 policy has been set. Compliance is measured by a rolling programme of monthly ward audits: with the standard achieved in September. Compliance for November 2022 was marginally below target by 0.8% at 89.2%.
Action: NEWS2 compliance with the recording NEWS2 observations is reported to the Executive Management Team fortnightly within nursing quality metrics. The Deteriorating Patient Quality Improvement Faculty, led by the Chief Nurse, has overseen quality improvement projects across several wards and an initiative resulting in trust wide change. In conjunction with a focused workstream the Trust has sustained improvement in compliance of recording NEWS2 since April 2022. As a response to the high proportion of patients with no criteria to reside the model of care for this patient population has been amended in accordance with their clinical requirements. One change is the reduction in observations being recorded for those with a NEWS2 score of 0 – 4 from 12 hourly to once daily. Compliance has reduced in the recording of NEWS2 score 0-4, this is most probably because of the clinically agreed change in care requirements for those with no criteria to reside. Further review is being undertaken to determine the impact of the change in model of care for no criteria to reside patients on the compliance rates and establish suitable solutions for resolve.
Expected Impact: The expectation is for all areas to achieve greater than 90% for completing NEWS2 observations by Q4.





Appendix 2 Quality Performance Dashboard - SPC Version - January 2023

Approach

The metrics from the existing WUTH Quality Performance Dashboard have been adopted into SPC format.
The template from the NHS England 'Making Data Count' (MDC) Team is the starting point.
The metrics have retained their CQC domain category, and grouped into 'themes'.

Issues / limitations

SPC charts should only be used for 15 data points or more. Some of the WUTH metrics only apply from 2022, so will take time to build up.
The national template does not support including a target where it is variable over time, eg a reducing trajectory for RTT long waiters
Larger scale adoption across the Trust, eg down to sub-Divisional level, is being explored with support from the MDC Team.

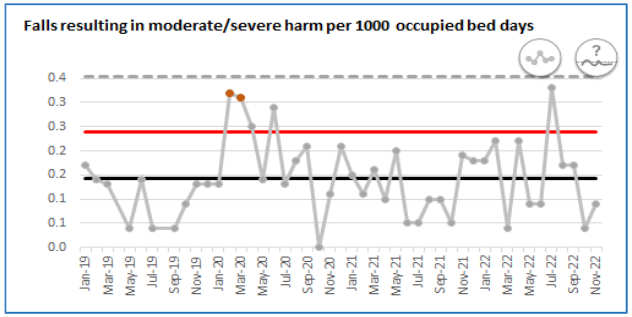
Next steps - following the December 2022 BoD

This iteration of the dashboard now includes summary tables against each metric on performance and variation type.
Not all metrics have been adopted into SPC format, as it is not always appropriate. The best chart format for these metrics are to be confirmed.
Supporting narrative is now included for many of the metrics classed as 'Red', using the commentary provided in the parallel IDA (exception) reports.
For the metrics covered by the separate COO report, narrative text has not been duplicated.
Further discussion on establishing the most beneficial narrative format for all metrics would be helpful.
As agreed with the Board, the existing performance dashboard will continue to be maintained until the replacement SPC format is considered acceptable.

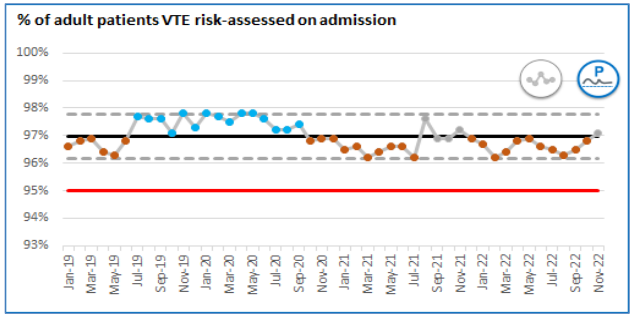
Note - Metrics not yet included:

CQC Domain	Indicator
Well-led	Duty of Candour compliance - breaches of the DoC standard for Serious Incidents
Well-led	Number of patients recruited to NIHR studies
Use of Resources	I&E Performance (monthly actual)
Use of Resources	I&E Performance Variance (monthly variance)
Use of Resources	NHSI Risk Rating
Use of Resources	CIP Performance (YTD Plan vs Actual)
Use of Resources	NHSI Agency Performance (YTD % variance)
Use of Resources	Cash - liquidity days
Use of Resources	Capital Programme (cumulative)

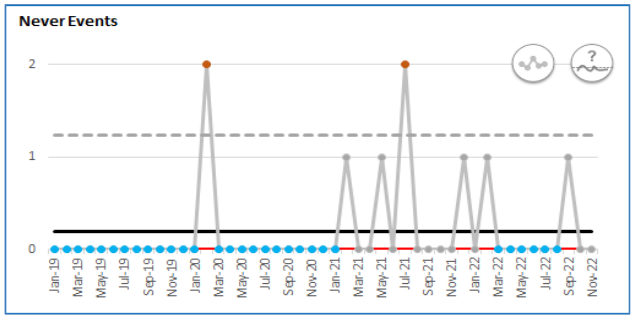
Safe - Avoiding Harm



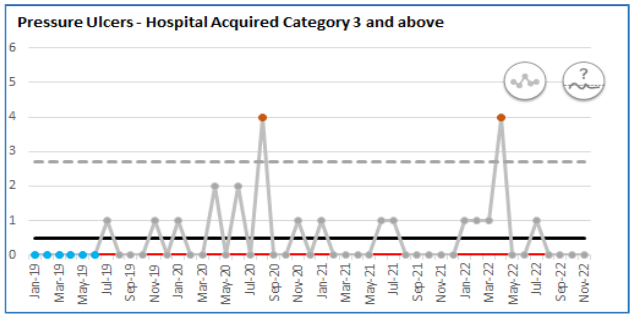
Nov-22
0.09
Variance Type
Common cause variation
Threshold
≤0.24
Assurance
Hit & miss target subject to random variation



Nov-22
97.10%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target



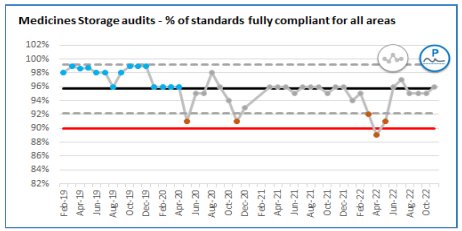
Nov-22
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation



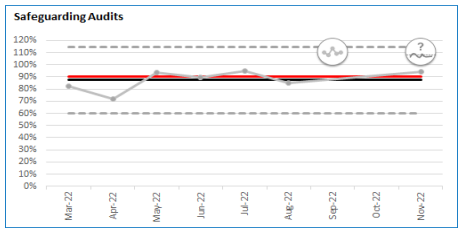
Nov-22
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Falls resulting in harm: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved**.**	No narrative on action as metric achieved
VTE risk-assessment on admission: Common cause variation. The target threshold is consistently achieved, including the most recent month.	No narrative on action as metric achieved
Never events: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved
Pressure ulcers HAI category 3: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved

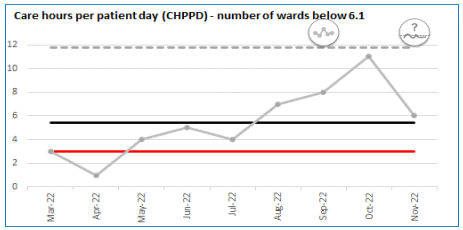
Safe - Assurance Audit



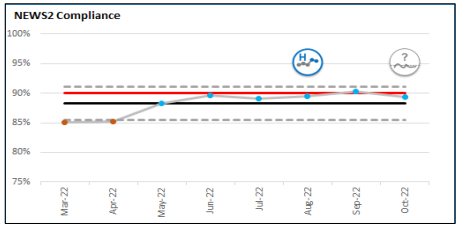
Nov-22
96%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target



Nov-22
94.4%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation



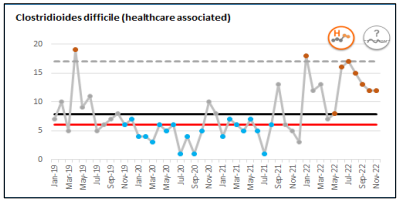
Nov-22
6
Variance Type
Common cause variation
Threshold
≤3
Assurance
Hit & miss target subject to random variation



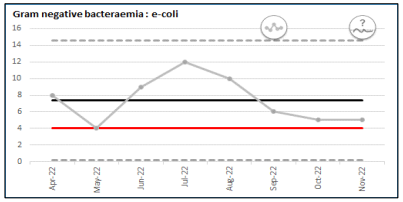
Nov-22
89.2%
Variance Type
Special cause variation - improving
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Medicines storage audits: Common cause variation. The target threshold is consistently achieved, including the most recent month.	No narrative on action as metric achieved
Safeguarding audits: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved
Care hours per patient day: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	A CHPPD tracker is one of the safer staffing measures, which has been in place since May 2022, to monitor if any areas are consistently recording CHPPD <6.1. The CHPPD data is triangulated with further staffing metric data to monitor the impact on care. Impacts on care are being monitored and have remained minimal with the areas of lower than threshold CHPPD. November, with 6 wards below the required threshold is the lowest number of wards below threshold each month since July 2022. Ward 18 has had 2 consecutive months below threshold with a variance of 0.1, equivalent to 6 minutes of nursing care, in November. Ward 22 and 36 have had consecutive months of a CHPPD of <6.1. Ward M1 provides care to patients who do not have the criteria to reside. Healthcare professional input will not be required at the same level or frequency to that of an acute area. Ward 38 staffing levels had a CHPPD consistently <6.1 since November 2021, this is a result of clinical support worker (CSW) shortfalls created by staff moves to support higher risk staffing challenges across the Trust. Oversight has been provided by the Matron and professional judgement is that the ward has remained safe. Successful system wide recruitment events have been led by the Trust. A focus on recruitment and retention for CSW and in-patient RN band 5's continues. Expected Impact: **a** reduction in the number of wards with a consistent CHPPD of <6.1 by Q4.
NEWS2 Compliance: Special cause variation - High improving. Achieving the threshold is hit & miss, with the most recent month not being achieved.	NEWS2 compliance with the recording NEWS2 observations is reported to the Executive Management Team fortnightly within nursing quality metrics. The Deteriorating Patient Quality Improvement Faculty, led by the Chief Nurse, has overseen quality improvement projects across several wards and an initiative resulting in trust wide change. In conjunction with a focused workstream the Trust has sustained improvement in compliance of recording NEWS2 since April 2022. As a response to the high proportion of patients with no criteria to reside the model of care for this patient population has been amended in accordance with their clinical requirements. One change is the reduction in observations being recorded for those with a NEWS2 score of 0 – 4 from 12 hourly to once daily. Compliance has reduced in the recording of NEWS2 score 0-4, this is most probably because of the clinically agreed change in care requirements for those with no criteria to reside. Further review is being undertaken to determine the impact of the change in model of care for no criteria to reside patients on the compliance rates and establish suitable solutions for resolve. Expected impact: the expectation is for all areas to achieve greater than 90% for completing NEWS2 observations by Q4.

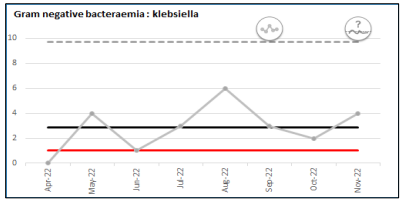
Safe - Infection Control



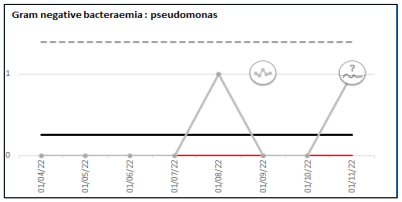
Nov-22
12
Variance Type
Special cause variation - concerning
Threshold
≤6
Assurance
Hit & miss target subject to random variation



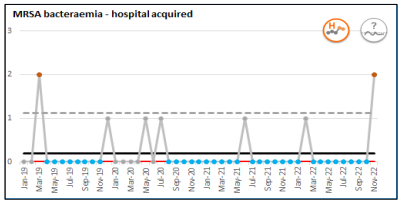
Nov-22
5
Variance Type
Common cause variation
Threshold
≤4
Assurance
Hit & miss target subject to random variation



Nov-22
4
Variance Type
Common cause variation
Threshold
≤1
Assurance
Hit & miss target subject to random variation



Nov-22
1
Variance Type
Common cause variation
Threshold
≤9 for 2022/23
Assurance
Hit & miss target subject to random variation



Nov-22
2
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

Issues:

Clostridioides difficile (healthcare associated): Special cause variation - High concerning. Performance consistently fails to achieve the target, including the most recent month.

Gram-negative bacteraemia e-coli: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

Gram-negative bacteraemia klebsiella: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

Gram-negative bacteraemia pseudonomas: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

MRSA bacteraemia: Special cause variation - High concerning. Achieving the threshold is hit & miss, with the most recent month being achieved.

Action & Expected Impact:

The CDI quarterly report and improvement plan is governed via the IPC group and directly overseen by the Chief Nurse / DIPC. The Q3 report has continued to evidence positive outcomes with a sustained reduction in the number of CDI's. Collaboration with healthcare partners continues with system wide challenges being addressed through the multi-agency Health Protection Board for Wirral.

Enhanced auditing of the cleaning standards has helped to drive improvements, resulting in a proactive approach and clearly defined roles and responsibilities of the cleaning teams and the ward staff. This has promoted immediate rectification and improvement in the effectiveness environmental cleaning process.

Review of IPC isolation priorities have strengthened clinical teams' decision making to enable a risk assessed approach to inform the order of patient isolation. This will ensure the transmission of infection between patients is minimised during the current bed capacity challenges evident throughout the Trust.

Expected impact: sustained reduction in patients diagnosed with healthcare associated Clostridioides difficile by Q4.

Individual case scrutiny continues that enables learning opportunities to be identified and remedial actions to be put into place where required.

Many blood stream infections are diagnosed in severely ill patients with no indication that there is a clinical omission in care. Review of the process to determine if a bacteraemia can be avoided is taking place. This will enable heightened focus on patients identified with infections that could be avoided and establish the cause that will inform effective action planning to avoid further cases.

Key priority areas of focus that may contribute to the reduction of E-coli bacteraemia are progressing within the Trust and as a Wirral wide system approach. This includes appropriate antibiotic prescribing, urinary catheter care and management, and aseptic non-touch technique.

Expected impact: the number of patients diagnosed with an E-coli bacteraemia is reduced to below the monthly threshold.
Klebsiella is a gut organism and common sources identified during the RCA process relate to the management of indwelling devices and intra-abdominal complexities.

Individual scrutiny of each case continues to enable learning opportunities to be identified and remedial actions to be put into place to avoid future harms. Recent reviews have not identified any specific causative factors that could have prevented the blood stream infection.

Effective infection prevention control measures by the multi-disciplinary team are essential. Therefore, the programme of work on aseptic non-touch technique (ANTT) and the 'Gloves off' campaign both have a focus on improved hand hygiene for all staff. ANTT competency framework ensures assessment for all staff undertaking clinical procedures to strengthen the prevention of device-associated infections.

Expected impact: the number of patients diagnosed with a Klebsiella blood stream infection is reduced to below the monthly threshold.

One case in case in November 2022, making a cumulative two for the year-to-date. This is well within the trajectory of a maximum nine for the full year 2022-23.

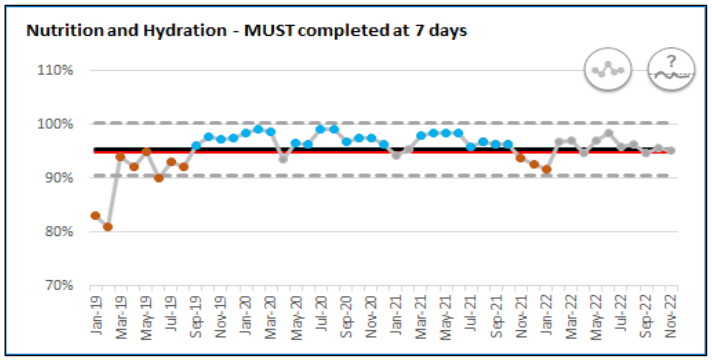
Review of both patients journey prior to diagnosis of the MRSA bacteraemia has been completed:

A source of infection was not determined in one case. However, aseptic non-touch technique and blood culture collection training for staff was highlighted as a recommendation.

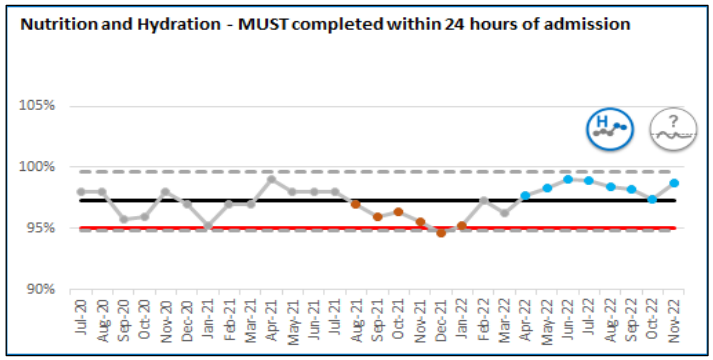
The second case, the patient was diagnosed with a MRSA bacterium when known to be MRSA colonized. Determination of the source of infection is agreed to be most probably due to a insertion of a urinary catheter or cannula. Urinary catheter care / management and aseptic non-touch technique are key priority areas of focus within the Trust and as a Wirral wide system.

Expected impact: targeted interventions will help to reduce the risk of MRSA bacteraemia.

Effective - Nutrition



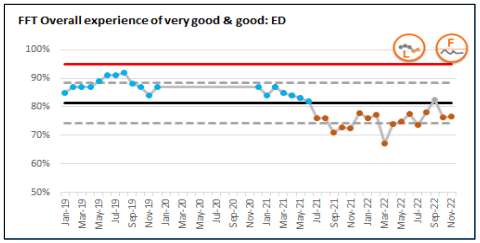
Nov-22
95.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



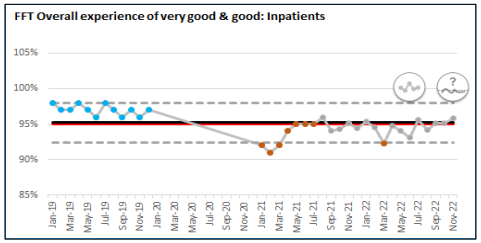
Nov-22
98.7%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Issues:	**Action & Expected Impact:**
MUST completed at 7 days: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved**.**	No narrative on action as metric achieved
MUST completed within 24 hours of admission: Special cause variation, High improving. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved

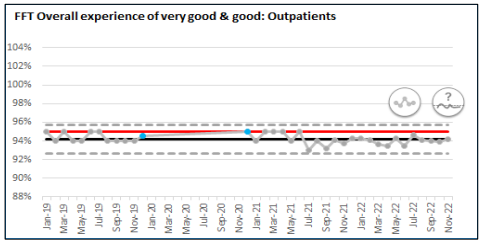
Caring - Patient Experience



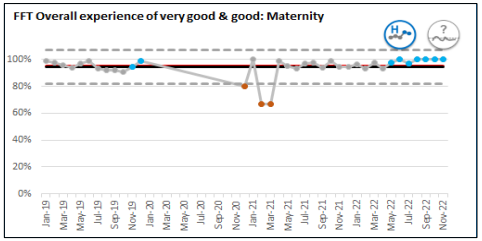
Nov-22
76.5%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target



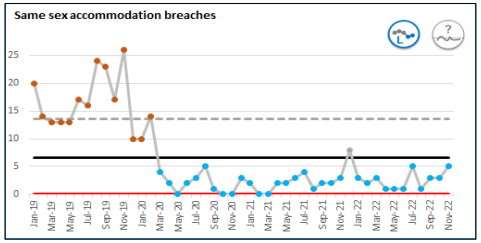
Nov-22
95.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Nov-22
94.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Nov-22
100.0%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation



Nov-22
5
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

Issues:

FFT Overall experience - ED: Special cause variation - Low concerning. Performance consistently fails to achieve the target, including the most recent month.

FFT Overall experience - Inpatients: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.

FFT Overall experience - Outpatients: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

FFT Overall experience - Maternity: Special cause variation - High improving. Achieving the threshold is hit & miss, with the most recent month being achieved.

Same sex accommodation breaches: Special cause variation - Low improving. Achieving the threshold is hit & miss, with the most recent month not being achieved.

Action & Expected Impact:

The Patient Experience Strategy has established 5 strategic promise groups; Welcome, Safe, Inclusive, Care, and Supported. Each promise group has a focus on identifying patients' experience improvement opportunities.

Operational pressures within the Emergency Department, consistent with the national position, is impacting on the FFT score. FFT score for ED remains below the Trust threshold of 95% however is in line with the national average scores for ED. Waiting times are consistently reported to be an area of challenge. Effective communication to patients remains a priority focus for the Divisional Triumvirate.

Out-patients FFT score of 94.2%, 0.8% below threshold, is consistent with previous months. Additional touch screen kiosks and feedback volunteers have been introduced to increase the opportunity for feedback in this area.

Expected impact: improved FFT scores within the ED and an expectation to reach the Trust target for Outpatients in Q4.

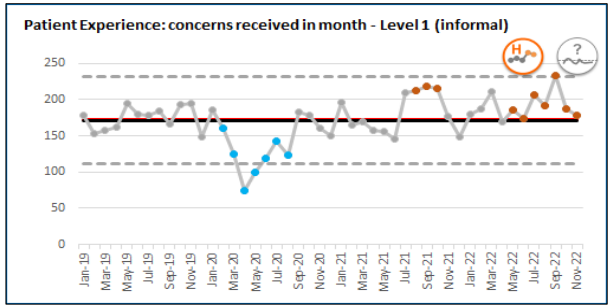
Breaches are often due to patients waiting more than 24 hours for transfer from critical care areas inclusive of Coronary Care Unit (CCU) to general wards; there were 5 such breaches in November 2022. (Intensive Care Unit (ICU) 2 and CCU 3). The breaches did not cause any delays or refused admissions to these areas as sufficient ICU and CCU capacity has been available. Patient's privacy and dignity needs are met whilst the person awaits transfer to the specialty areas and the teams ensure their specialty care is not compromised due to a lengthened critical care stay.

Delivering same sex accommodation is a high priority. It is recognised that system challenges resulting in high levels of activity and a high proportion of patients with no criteria to reside, which continued throughout November 2022, has an impact on the ability to deliver same sex accommodation.

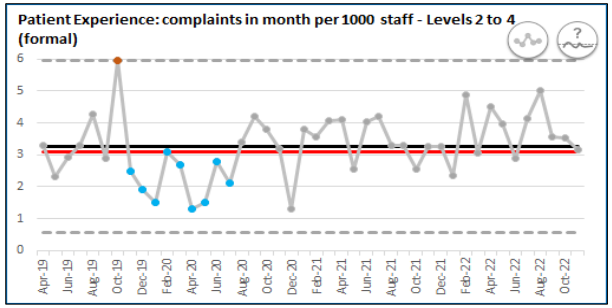
Processes are in place that enable joint working with ICU, CCU, Patient Flow Team, and Divisional Directors and each breach is risk assessed and concerns are managed promptly via bed capacity and operational meetings. This enables daily oversight of individual patients requiring a stepdown and the length of time waiting.

Expected impact: same sex accommodation breaches are minimised and all patients are transferred to their specialty bed within 24 hours of discharge.

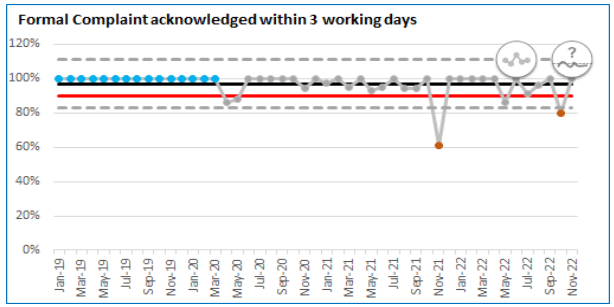
Responsive - Complaints



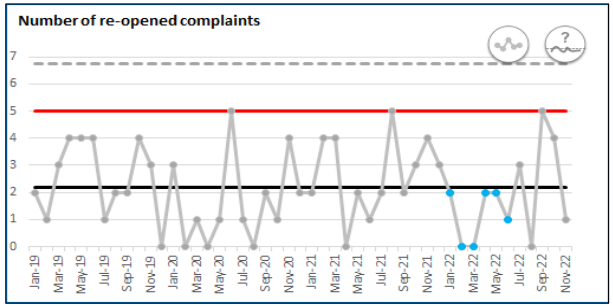
Nov-22
178
Variance Type
Special cause variation - concerning
Threshold
≤173
Assurance
Hit & miss target subject to random variation



Nov-22
3.17
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation



Nov-22
100%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation



Nov-22
1
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

Issues:

Concerns received in month (level 1): Special cause variation - High concerning. Achieving the threshold is hit & miss, with the most recent month not being achieved.

Complaints in-month per 1000 staff: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

Formal complaint acknowledged < 3 working days: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.

Number of reopened complaints: Common cause. Achieving the threshold is hit & miss, with the most recent month achieved.

Action & Expected Impact:

Complaints received continue to remain lower than the national average for 2020/21. During November 2022, 20 new formal complaints were registered: this was slightly above WUTH's expected/historical monthly average activity for 2021/22 (18).

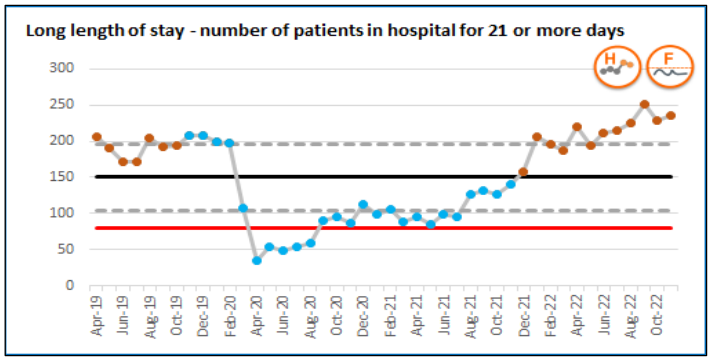
32 complaints have been closed in November. Achieving a 39% increase over October, as a positive response to the current focus on reducing the number of active complaints being investigated and overall response times.

Divisional plans are in place to address the concurrent causes of complaint (communication / staff attitude and capacity pressures) and the ways in which these can be addressed, as well as any seasonal surges in numbers.

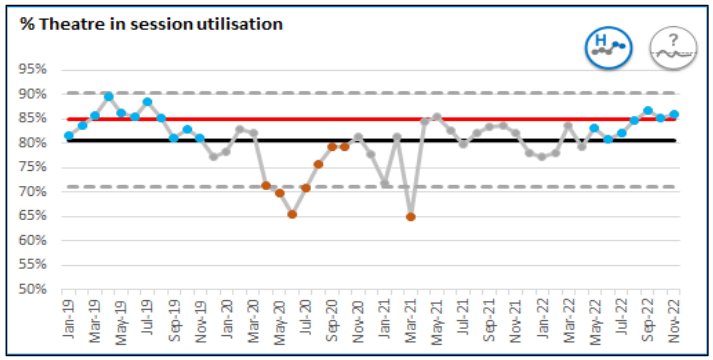
Weekly complaints management meetings with all divisions continue to take place. The purpose of these meetings is to support management of complaint responses and to identify and address barriers to completion as early as possible.

No narrative on action as metric achieved

Effective - Productivity



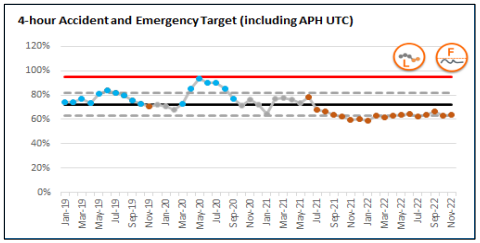
Nov-22
236
Variance Type
Special cause variation - concerning
Threshold
≤79
Assurance
Performance consistently fails to achieve the target



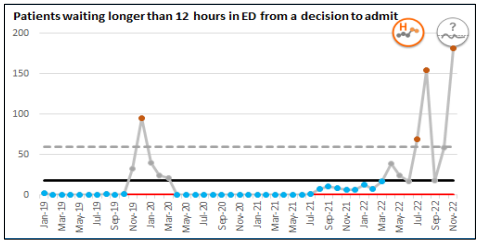
Nov-22
85.90%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Long Length of stay (21+): Special cause variation - High concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
% Theatre in-session utilisation: Special cause variation - High improving. Achieving the threshold is hit & miss, with the most recent month being achieved.	No narrative on action as metric achieved

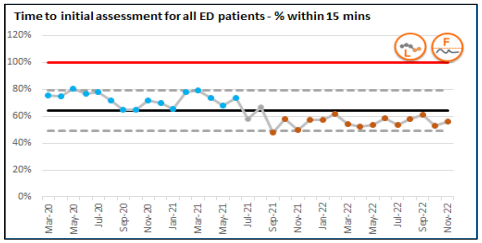
Responsive - Urgent Care



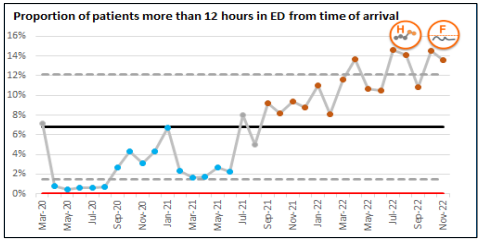
Nov-22
63.9%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target



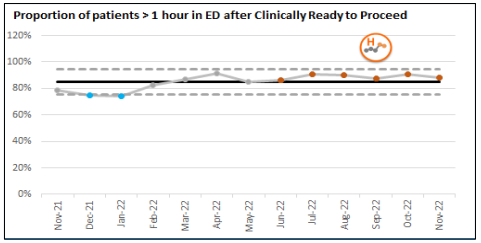
Nov-22
182
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation



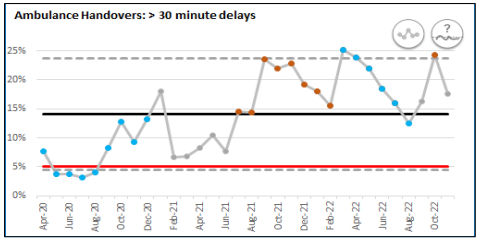
Nov-22
55.8%
Variance Type
Special cause variation - concerning
Threshold
100%
Assurance
Performance consistently fails to achieve the target



Nov-22
13.6%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target



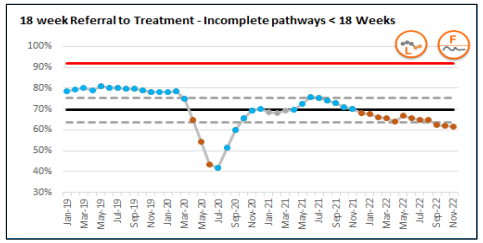
Nov-22
88.5%
Variance Type
Special cause variation - concerning
Threshold
TBC
Assurance



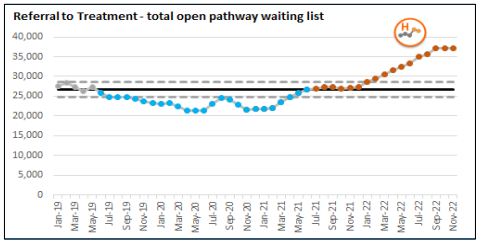
Nov-22
17.5%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
4-hour A&E Target : Special cause variation - Low concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
Patients waiting > 12 hours in ED: Special cause variation - High concerning. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board
Time to initial assessment - % < 15 mins: Special cause variation - Low concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
Proportion of ED patients in > 12 hours: Special cause variation - High concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
Proportion of ED patients > 1 hour in ED after CRtP: Special cause variation - High concerning. Performance threshold TBD.	Narrative provided in separate COO Report to the Board
Ambulance handovers > 30 mins delays: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	Narrative provided in separate COO Report to the Board

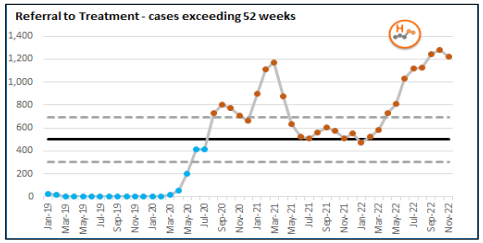
Responsive - Elective Care - RTT



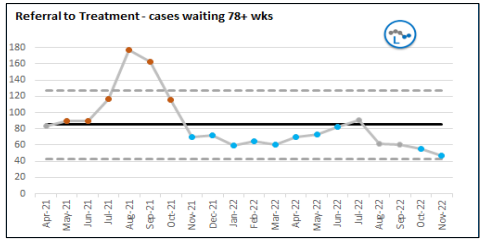
Nov-22
61.57%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target



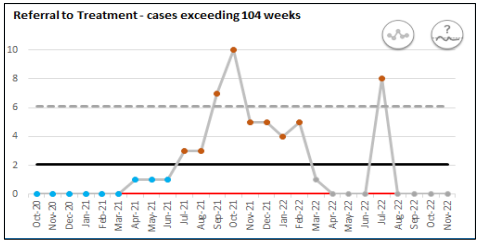
Nov-22
37188
Variance Type
Special cause variation - concerning
Threshold
≤31352
Assurance
Trajectory target not appropriate for SPC Assurance reporting



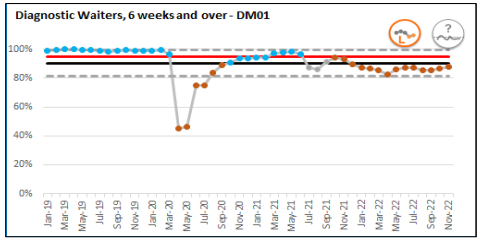
Nov-22
1219
Variance Type
Special cause variation - concerning
Threshold
520
Assurance
Trajectory target not appropriate for SPC Assurance reporting



Nov-22
47
Variance Type
Common cause variation
Threshold
≤55
Assurance
Hit & miss target subject to random variation



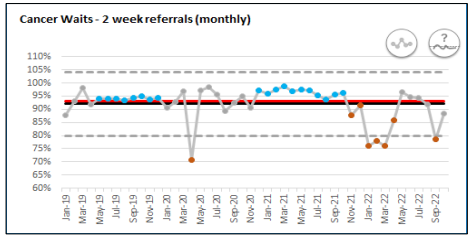
Nov-22
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation



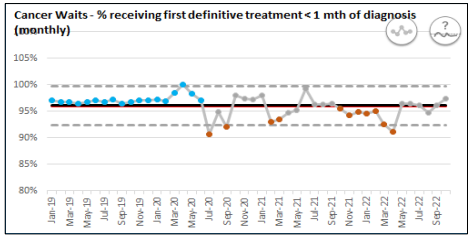
Nov-22
86.0%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
18 week RTT - % incomplete: Special cause variation - Low concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
RTT total open waiting list: Special cause variation - High concerning. Trajectory target not appropriate for SPC Assurance reporting. The target for the most recent month was not achieved.	Narrative provided in separate COO Report to the Board
RTT cases exceeding 52 weeks: Special cause variation - High concerning. Trajectory target not appropriate for SPC Assurance reporting. The target for the most recent month was not achieved.	Narrative provided in separate COO Report to the Board
RTT cases exceeding 78 weeks: Common cause variation - High concerning. Trajectory target not appropriate for SPC Assurance reporting. The target for the most recent month was not achieved.	Narrative provided in separate COO Report to the Board
RTT cases exceeding 104 weeks: Common cause variation - High concerning. Trajectory target not appropriate for SPC Assurance reporting. The target for the most recent month was achieved.	Narrative provided in separate COO Report to the Board
Diagnostic waiters 6 weeks and over: Special cause variation - Low concerning. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board

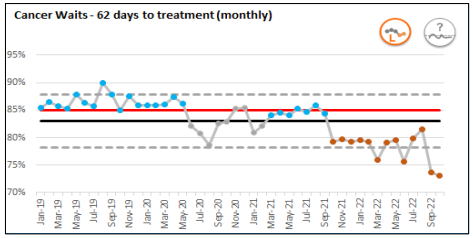
Responsive - Elective Care - Cancer (monthly - 1 mth in arrears)



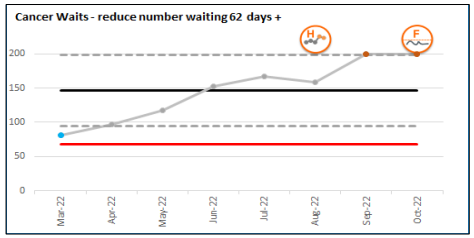
Oct-22
88.3%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation



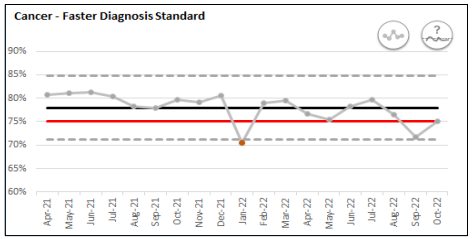
Oct-22
97.3%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation



Oct-22
73.1%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation



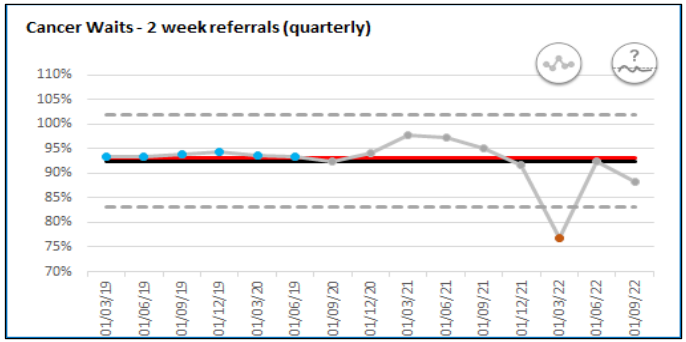
Oct-22
200
Variance Type
Special cause variation - concerning
Threshold
195
Assurance
Performance consistently fails to achieve the target



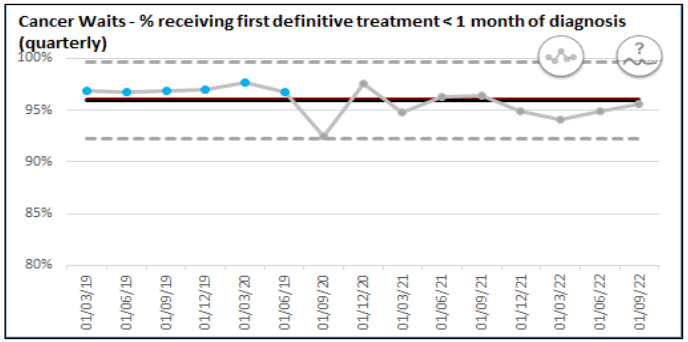
Oct-22
75.2%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Cancer waits - 2 wk refs (monthly): Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board
Cancer waits - % treated < 1 month of diagnosis (monthly): Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.	Narrative provided in separate COO Report to the Board
Cancer waits - 62 days to treatment (monthly): Special cause variation - Low concerning. Achieving the threshold is hit & miss, with the most recent month being achieved.	Narrative provided in separate COO Report to the Board
Cancer waits - reduce number waiting 62 days+ : Special cause variation - High concerning. Performance consistently fails to achieve the target, including the most recent month.	Narrative provided in separate COO Report to the Board
Cancer - Faster Diagnosis standard: Special cause variation - Low concerning. Achieving the threshold is hit & miss, with the most recent month being achieved.	Narrative provided in separate COO Report to the Board

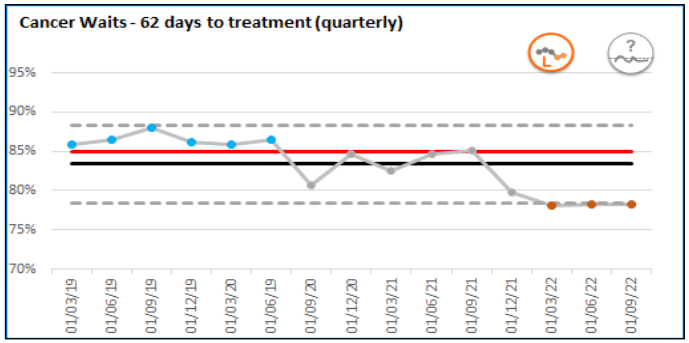
Responsive - Elective Care - Cancer (quarterly)



Sept-22
88.4%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation



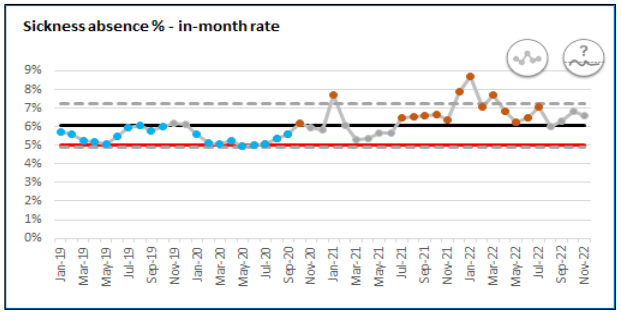
Sept-22
95.6%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation



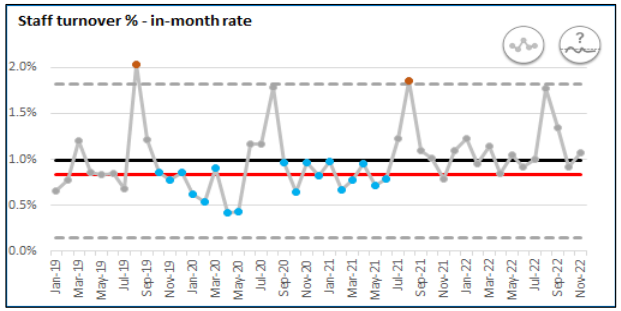
Sept-22
78.2%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation

Issues:	Action & Expected Impact:
Cancer waits - 2 wk refs (quarterly): Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board
Cancer waits - % treated < 1 month of diagnosis (quarterly): Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board
Cancer waits - 62 days to treatment (quarterly): Special cause variation - Low concerning. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Narrative provided in separate COO Report to the Board

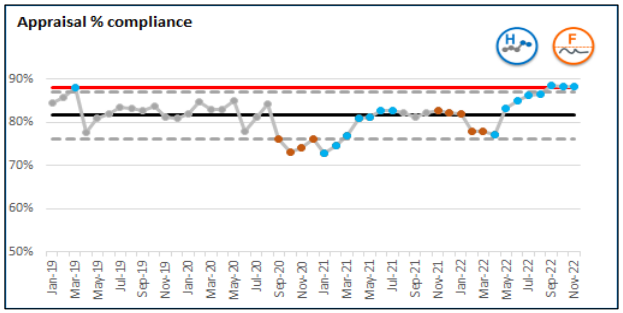
Safe - Workforce



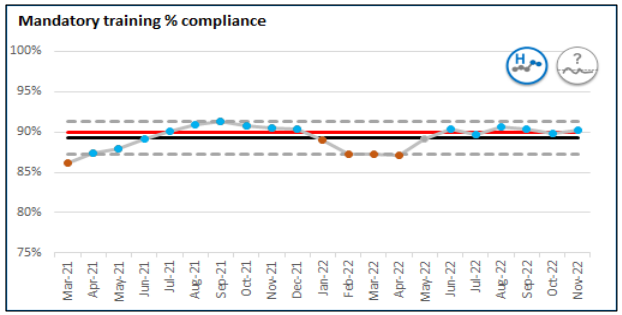
Nov-22
6.60%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Hit & miss target subject to random variation



Nov-22
1.07%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation



Nov-22
88.36%
Variance Type
Special cause variation - improving
Threshold
≥88%
Assurance
Performance consistently fails to achieve the target



Nov-22
90.25%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

Issues:	Actions:	Expected Impact:
Sickness absence % in-month rate: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.	Monitoring of the Sickness Attendance KPI and associated actions is on-going via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews. Managers continue to be supported by HR.	

Targeted Support
The highest sickness absence levels remain within Facilities, who are being supported by their HR Team. Facilities are undertaking an analysis of the drivers of the sickness absence and measures in place to address. It is also anticipated that new Attendance Management Policy triggers when implemented, will further support with the persistent short-term absence which is most disruptive to the service.

Managing Attendance Policy
The extensively revised Attendance Management Policy has now been agreed at Policy Pay Terms & Conditions and is progressing via the governance route. In parallel to this, work is progressing on the launch element.

Workforce Wellbeing
The newly appointed Wellbeing Specialist Practitioner will be focusing on reviewing the Trust Health and Wellbeing offer in the Trust, with an immediate focus on supporting staff during and following Industrial Action.

Development
As part of the Leadership for All approach a suite of stand-alone sessions development sessions have been designed. The next upcoming session in January is Building Personal Resilience.

Flu Vaccine
The Flu Vaccine Programme continues. Current uptake amongst frontline Healthcare Workers is 57%, compared to a Cheshire and Merseyside average of 49%.

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. We continue to appropriately prioritise workforce wellbeing and our commitment to mental health support.

Staff turnover % in-month rate: Common cause variation. Achieving the threshold is hit & miss, with the most recent month not being achieved.

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.

Current Interventions to support retention include:

- The Retention Delivery Plan was agreed with the Strategic Retention Group and priorities determined.
- Work has commenced with the HR Team and the National ESR Team to improve leaver reasons accuracy in ESR.
- The completed Nursing and Midwifery Retention Self-Assessment Tool has been submitted to the Northwest and ICB Retention Group. Feedback is currently awaited from the Northwest and ICB Retention Group.
- Expressions of interest are currently being sought for the new Leading Teams programme. This is a 6-month programme aimed at staff who have responsibility for leading others as part of their job.
- Use of apprenticeship for HCSW posts. At present there have been 6 cohort starts with a 6-month retention rate of 85%.

Staff Survey and the People Strategy
The Staff Survey closed in November 2022 with a response rate of 48%. Findings will be reported in early 2023 and will be used to inform retention strategies in 2023 and beyond.

There are also other programmes of activity within the People Strategy Delivery Plan that impact on staff experience including health and wellbeing initiatives, reward and recognition, flexible working and improvements in integration and diversity which will also help minimise turnover.

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.

Appraisal % compliance: Special cause variation - High improving. Performance consistently fails to achieve the target, though the most recent month was achieved.

No narrative on action as metric achieved

Mandatory training % compliance: Common cause variation. Achieving the threshold is hit & miss, with the most recent month being achieved.

No narrative on action as metric achieved

Council of Governors
20 February 2023

Item 8

Report Title	Research and Innovation Committee Update
Author	Sir David Henshaw, Chair of Research and Innovation Committee

Executive Summary/Current Position
The Trust launched its new Research and Innovation Strategy in May 2022, which set out its commitment to Research and Innovation transformation by 2026. This document summarises our position as of February 2023. In October 2022, a Research and Innovation sub-committee of the Trust Board was established. It will oversee the delivery of the strategy and sits at the top of a new governance structure for all research and innovation activity in the Trust.

Research and Innovation Delivery
The financial year 2022-23 has been a time to reset, review the research portfolio, and revitalise the research workforce, in combination with a new focus on innovation. To date, the 2022-23 Trust research portfolio includes 72 studies, 15 studies have closed, and 17 have opened. There are 5 studies in set-up, which should open before 31st March 2023. As anticipated, the closure of COVID-19 Urgent Public Health studies means recruitment is significantly lower this year than in the last two years. Recruitment is currently below the annual Trust target of 700 (n=406 as of 07/02/23). The end of year recruitment projection is 606. Attention is now focused on the 2023-24 pipeline, workforce efficiencies, and capabilities to accelerate recruitment early in the next financial year. A monthly schedule of meetings now exists to allow better reporting and oversite through the formation of the R&I operational meeting, Chaired by Dr Ranj Mehra, Deputy Medial Director. This meeting feeds into the quarterly meeting of the Trust R&I Sub-committee.

Research and Innovation Culture
The Strategic vision is *Tomorrow's outstanding care is built on today's best research.* The potential for health and social care research to benefit the population of Wirral is significant. The best example of this to date, is from the COVID-19 pandemic, when with its population disproportionately affected, the Wirral proved itself as a top-recruitment site for the RECOVERY Trial. This enabled our patients to access novel treatments at pace and our staff were proud to contribute to world-leading research. During 2022-23 work has begun to develop and embed the ethos that research and innovation is integral to everyone's role through the promotion of our vision. Research and Innovation is now integrated into the Trust induction programme. A communication workplan has been formulated with actions in progress. Research and innovation now feature regularly in Trust comms disseminating training opportunities, studies recruiting and study findings. When trial coordinating centres identify the Trust as a top recruiting site, this success is now shared publicly via social media. The number of nominations for the staff Research and Innovation award was in double figures. The R&I Team have scoped external support for innovation and the theme of innovation will be part of the trust wide R&I education morning on May 19th 2023. There will be two Trust wide events each year in the Spring and Autumn.

Partners and Place
To prioritise research at place, address local population health needs and reduce health inequalities through collaboration, in December 2022 the Research and Innovation Committee ratified portfolio consolidation in the following areas: Cancer, Respiratory, CVD/Stroke, Women's health. To enhance our reputational research offer through collaboration advantage in set-up and delivery the Trust is now working collaboratively with a primary care partner (Marine Lake Group

Practice). A new Wirral Research Forum has been created for Primary-Secondary-Tertiary collaboration going forward. It will hold its inaugural meeting in March 2023. Conversations have begun to drive innovation for Wirral involving partners already engaged in optimising digital platforms. Data sharing agreement discussions were expedited following an approach to develop a study with NWAS.

Capacity and Capability
A training workplan is in progress and a joint PI and RN Research Away-Day is scheduled for March 2023. Two applications aligned with regional and national programmes for research career pathways have been successful, which will bring reputational advantage and foster new Wirral-led research. An NIHR NWC ARC Internship to apply for an NIHR Advanced Research Fellowship and an NIHR Senior Research Leader (for public announcement April 2023).

Patient Experience
Work on consent to contact needs to be prioritised. Informing patients about ongoing studies is in the communication plan. Work is ongoing in maternity care to involve service users in the design and delivery of research.

Risks (New and ongoing)

Financial
There are financial advantages to participating in research, particularly commercial research. There are financial risks if research income is not invoiced or efficiently distributed for re-investment in research and innovation. The Trust has a Research Commercial Income Policy (278). It does not have a SoP for Research Income management. Work on this has begun in tandem with establishing if all income has been received and distributed to further future research and innovation advance.

Facilities
The limitations imposed by current research facilities was cited as one of the biggest barriers to research activity during the strategy engagement process. An architectural plan for relocation to the Education Centre was drawn in June 2022. In December 2022, a national NIHR infrastructure call was announced. An application was submitted to the NIHR in January 2023 (64,756). Also, in January 2023 an internal application to Capital Planning process was submitted (£864,674). The outcome of both these applications is expected in February 2022 for the financial year 2023-24.

Overview of Committee activity
- The Research and Innovation Committee has met twice since its establishment in October and December. Its first meeting was an introductory session and scene setting opportunity to set out the Strategy and the plan for achieving it.
- The December meeting was focussed around the communications strategy which will help to improve the recruitment of patients, and around how the team engage with staff and external opportunities to help increase the profile of our research department.
- The Committee also considered some initial proposals for a dashboard with KPIs which will assist the Committee with high level monitoring of key activity.

Other Comments from the Chair
- Sir David to update as required.

Statement of Assurance
- As a Committee, though new, we are assured that the activity being undertaken on this agenda is both correct and will push the research agenda at WUTH forward.

Council of Governors
20 February 2023

Item 9

Report Title	Quality Committee Update
Author	Steve Ryan, Chair of Quality Committee

Executive Summary/Current Position

- The Trust continues to implement oversight of quality through the existing governance structures including Quality Committee as the sub committee of the Trust Board and Patient Safety and Quality Board as the Executive Director led assurance group.
- Assurances have been received in relation to a range of quality indicators including; progress with WISE Ward Accreditation scheme, infection prevention and control particularly in line with reducing rates of Clostridioides difficile (CDI), improved oversight over the Emergency Department safety, falls reduction plans, completion of the Maternity Incentivisation Scheme and progress with the CQC action plans.
- In January, the Board of Directors received assurance and approved sign off in January, of the Maternity Incentive Scheme. Following this Trust has since been notified this achievement has now also been approved by the LMNS and ICB, as a result the Trust will now receive the full financial benefit of 0.559m.
- The quality dashboard discussed through these fora continues to note;
    - a CDI rate above trajectory, however improving through Q3,
    - a Gram-negative Bloodstream Infection (GNBSI) rate above trajectory
    - delays in operational delivery impacting on constitutional standards
    - staffing pressures
    - several areas failing to meet the Patient Experience thresholds
- Most of the above areas are impacted upon by the continued levels of operational pressure and the challenges to safely discharging patients where the Trust is no longer the right care environment for their needs.

Infection Prevention and Control

- The Trust has seen less infection control challenges throughout January with COVID and flu incidence being at the lowest point since the start of the pandemic (COVID cases 13, flu cases ,1 end January)
- Cases of norovirus and clostridioides difficile (CDT) do continue to be seen during the winter period, however the Trust has been able to prevent the spread of this to other areas using strict infection control practices. A steady continued reduction in the number of CDT cases continues as a result of the actions taken from Wirral wide CDT and Trust CDT improvement plan.
- The Trust had seen an increase in Gram Negative Blood Stream Infections (GNBSI) in 2022. In January, the board noted the Trust wide projects focusing on a “gloves off campaign” ANTT, blood culture competencies and the appointment of a Continence Specialist Nurse who is focusing on best practice around catheter care, were all noted to be having a positive impact on reducing the number of infections.

Patient Experience Strategy

- The Patient Experience Strategy has established 5 strategic promise groups; Welcome, Safe, Inclusive, Care, and Supported. Each promise group has a focus on identifying patients' experience improvement opportunities. These groups have several successful workstreams working in partnership with families and carers. These groups have already noted several improvements in areas such as signage, patient and family passports, department orientation videos, new FFT cards for children to name but a few.
- A recent assessment against the baseline position identifies considerable improvement on a number of the metrics that were agreed in line with the National Patient Experience Strategy to measure the outcomes of the strategy. The social media Patient Experience Links (Patient WUTH – Facebook) (WUTH Patient Experience - @patientWUTH – Twitter) now have just under 4000K active followers engaging and monitoring progress of the strategy across the two platforms.

Quality and Safety Strategy

- The implementation of the Quality and Safety Strategy seeks to continually improve the process of learning from sources of patient safety insight and driving targeted quality improvements in priority areas.
- The strategy will also see a significant increase in involvement both internally through making patient safety and quality everyone's responsibility but also externally through increasing the coproduction by utilising patient safety partners and enhancing opportunities for patients to lead on their own safety.

Sources of Learning

- The trust continues to seek learning from Patient Safety Events, Complaints and through a series of clinical governance processes including mortality review, clinical audit, and benchmarking. There has been learning identified in relation to;
    - Caring for patients who lack capacity and provision of support for agreed Deprivation of Liberty Safeguards (DoLS) plans.
    - Communication, both; failure to communicate and communication approaches.
    - Delays in treatment and diagnosis, including where appointment or procedures have required cancelation.
    - Safety stages particularly in relation to medicine safety and transfusion process.
- Incident rates are stable and provide a good source of intelligence. Rates have varied between 1045 and 1469 per month over the past 2 years.
- Complaint rates at the Trust have followed a similar pattern to the regional and national position and are now returning close to pre-pandemic levels, following a significant decrease in 2020/21 and 2021/22.
- The Trust complaint position is benchmarked per 1000 staff and is currently at 9.9 alongside the other general acute trusts in Cheshire and Merseyside ranging from 8.8 to 27.7.
- The locations of complaints have seen a shift over the previous months with an increase in those relating to Acute Division and often related to delays due to front door pressures.
- Appended is an overview of complaints trends, following the request at the last Council of Governors.

Risks (New and ongoing)

- The most recent learning has noted new and on-going risks;
- The challenges with care for patients who lack capacity and provision of support for agreed DoLS plans, relates to two main risks; the increasing number of patients no longer meeting the criteria to reside but specifically where the acute trust is not the right environment for ongoing health and care needs and the additional requirements this situation places on the workforce, specifically the Care Support Workers (CSWs). There are ongoing discussions across the ICB system and Wirral place to address this position and support more efficient

transfer from hospital. In addition, the trust has supported a significant recruitment drive for CSWs and will be repeating this drive moving forward.

- Communication has been most commonly seen within concerns and complaints, this has been a significant risks during restrictions in visiting but has continued as visiting restrictions have been lifted. The divisional clinical teams have implemented communication plans earlier in the year and these are currently being revised to ensure they are addressing the messages raised by patients and families.
- There are delays in the system as can been clearly see within the constitutional standards, this is a position the trust face alongside all health and care providers but are making progress. For most patients this is impacts experience but for some this does result in harm. We have robust harm review processes in place to prioritise patients where harm can be anticipated.
- The learning in relation to safety processes particularly around medicines administration have highlighted several elements for improvement. The Trust has revised training plans, reinforced the requirements for checked processes and is developing business cases for more robust models in managing blood components and pre-surgical anticoagulation management.

Overview of Committee activity

A meeting of the Quality Assurance Committee was held on 19th January 2023 and a Chair's report will be provided to the Board of Director's meeting on 1st March 2023. The Principle Board Assurance Framework Risk assigned to the Committee is "Risk 4: Catastrophic Failure in Standards of Care".

The Committee is provided with a series of regular "core" oversight reports, which provide triangulated and overlapping insights to give a rich picture of quality and safety across the organisation. This gives an opportunity to identify themes of concern to be addressed and areas where we have seen improvement and progress. They give assurance on how issues are identified (often by triangulating the information received) and how learning and improvement engendered. The relevant reports are:

- Patient Safety Quality Board Key Issues Report
- Serious Incident Panel Chair's Report
- Quality and Patient Safety Intelligence Report (Q2 2022/23)
- Complaints Report (Q2 2022/23)
- Quality and Performance Dashboard
- Learning from Deaths Report
- Board Assurance Framework

The reports to the Committee in January gave assurance that the Trust is developing its approach to quality and safety in line with the new national Patient Safety Incident Response Framework: In particular identifying themes for improvement work, without waiting for serious incidents to manifest themselves; whether this be from intelligence gained from low or no-harm incidents or complaints. A good example of this is in the improvement work on falls prevention where potential signals have been picked up, despite our comparative data not exceeding nationally set limits. A part of this issue relates to vacancies in clinical support workers (CSWs) The Chief Nurse who is working with colleagues from across Wirral has taken action to boost recruitment of CSWs.

Signals have also been picked up in relation to correct application of the Mental Capacity Act (MCA) in all cases and the Mental Health Strategy Group led by the Chief Nurse will provide oversight of improvements.

Mortality rates (Summary Hospital Mortality Indicator and Hospital Standardised Mortality Rate) lie within the accepted national reference rates. Except in one case outlier alerts for diagnostic groups have been examined and no care issues have been identified. The most recent alert - related to a

coded diagnosis of pneumonia is being reviewed using a case note clinical audit. Case reports reviewed by the Mortality Review Group had identified MCA compliance as a learning issue. One case report identified the risks of poor care as a result of care having to be delivered in one of our escalation corridors. This supports retaining the current high likelihood and impact for this risk in our Board Assurance Framework, which was reviewed by the Committee.

The Committee received a joint presentation from the Director of Midwifery and the Clinical Director for Maternity Services regarding the Trust's declaration with regard to the NHS Resolution Maternity Incentive Scheme (Year 4) This presentation outlined the process by which evidence was identified, reviewed and assured – including executive and non-0executive scrutiny of relevant information held on file – such as training records. to support a fully compliant declaration by the Chief Executive Officer following the Trust Board reviewing the submission at its January meeting-prior to submission toe NHS Resolution before 12:00 on 2nd February. The Committee judged that a fully-compliant declaration was supported by the evidence. A senior member of the Local Maternity and Neonatal System attended the item. The Committee recommended that the Trust Board should authorise the Chief Executive Officer to sign the submission to NHS Resolution.

The Committee received a Mersey Internal Audit Agency report – "Review of the Wirral Individual Safe Care Every Time (WISE) Ward Accreditation/Assurance Mechanisms." The review was to provide assurance on the effectiveness of the Ward Accreditation Framework, the validity of the results produced and reported, and the effectiveness of the organisational processes. The audit opinion was of *substantial assurance*. One medium and two minor areas for further improvement were identified which the Trust can readily address.

The Cancer Services Annual Report 2021/2022 contained some information from more than one year ago, but the key points made in this report remain pertinent. The impact of the Covid pandemic with delays to presentation for assessment and treatment has brought high pressure to these services. The data on access to cancer services is presented each month to the Trust Board who will be aware of the measures undertaken to increase capacity to meet the increased referral rate (of around 25% above pre-pandemic levels). A positive highlight of the report was the developments in personalized care and stratified follow-up, including cancer remote surveillance. These developments have been supported by innovations in digital pathways through our patient portal.

The Controlled Drug Accountable Officer (CDAO) Annual Report The Committee received from the Director of Pharmacy and Medicines Optimisation, outlined the systems, processes and outcomes for the oversight of the use of controlled drugs. The Committee felt the report gave good assurance on the controls in place but noted that there was the need for continuing vigilance and that societal factors acting on individuals could increase the potential risk of breaches. A proactive approach to communicating the need for compliance with controls was welcomed.

Other Comments from the Chair

The staff and leaders of the organisation are to be commended for the continued focus on the quality care despite the current unprecedented challenges. Citizens who cannot be discharged to the appropriate community setting which would best support their continued health (e.g. home and residential care) must therefore continue to reside in our wards, restricting timely access to other patients receiving unscheduled care. At the time of the meeting there had been no sustained large-scale out-of-hospital response, which could ease this situation. The Board Assurance Framework rating therefore accurately reflects the high level of likelihood and impact on quality of care.

Statement of Assurance

As Chair of the Committee and supported by my fellow Non-executive Directors on the Committee, I can confirm that we are assured on the processes and controls in place to manage the quality of care provided by the Trust.

Complaints

Formal Complaint (Level 2) Activity

Formal complaint numbers fell during the pandemic. There were 214 complaints formally registered in 2021/22. Although an 18% increase over the 181 registered in 2020/21, this was well below the pre-pandemic 279 received in 2018/19.

This increase was in line with national performance: NHS Digital's 2021/22 K041 data shows a 26% rise in complaints for acute trusts over 2020/21 (although 7% lower than pre-pandemic numbers). Complaints per 1000 staff averaged 10 per quarter. The national average (again, per NHS Digital KO41 data) for acute Trusts in England was 20.[1]

For context, these 214 2021/22 formal complaints comprised just 0.02% of patient contacts (974,355) for the year.

Up to the end of Q3 of 2022/23, WUTH had logged 180 formal complaints, compared with 163 during the same quarters of 2021/22. This suggests that complaints numbers are continuing to rise back to pre-pandemic levels.

Medicine, Surgery, and Acute Care have consistently been involved in the greatest numbers of complaints. However, whereas between 2018/19 and 2020/21 Acute Care received the lowest number of complaints of these top-three divisions, over the past two years it has consistently moved to first place. Formal complaints for Acute Care rose in 2021/22 by 20% from the number recorded in 20/18/19, and total figures up to the end of quarter 3 in 2022/23 are already equal to the whole of the previous year. This reflects current service pressures and their impact on waiting times in the ED and acute admissions areas.

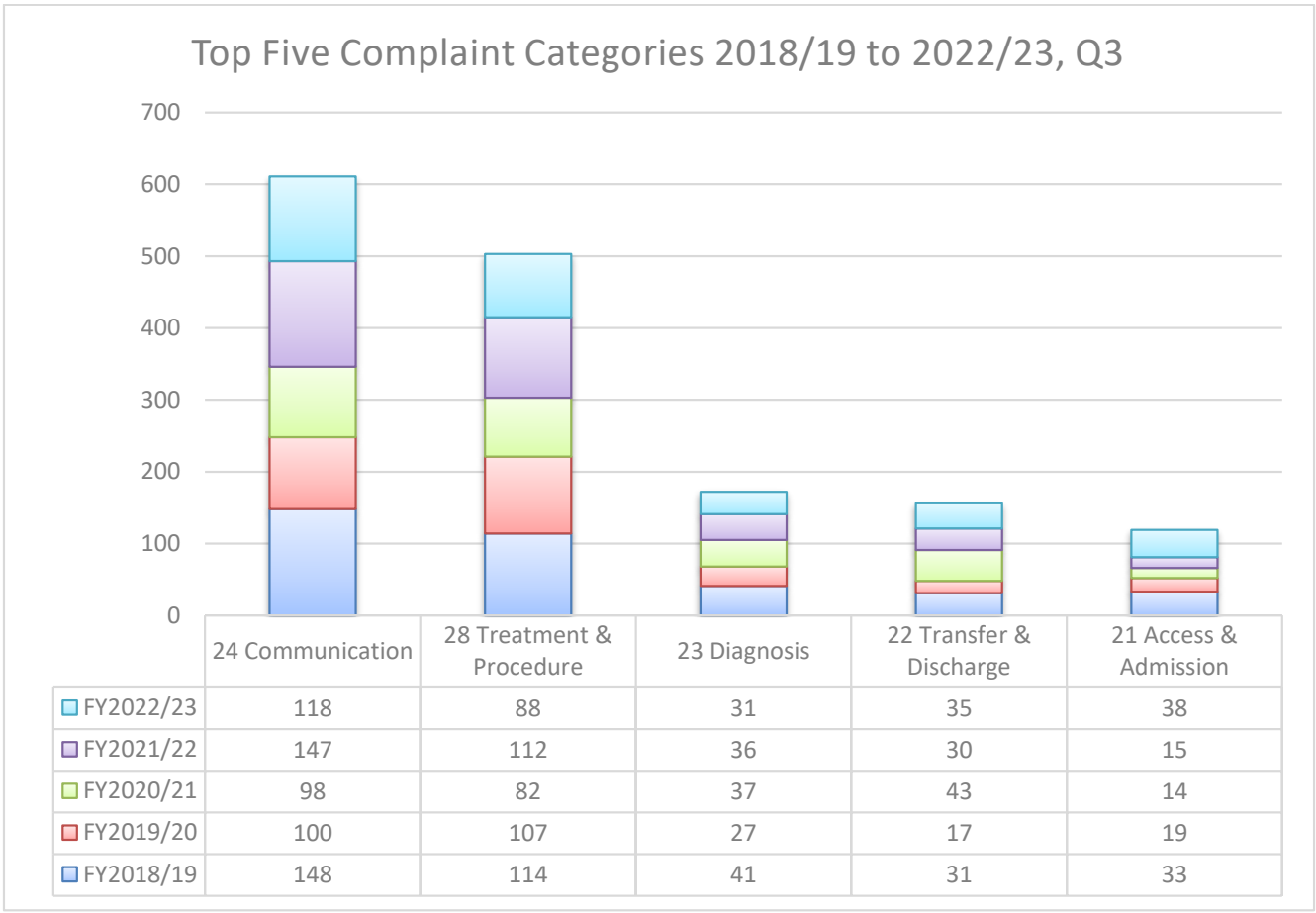
[1] [1] NHS Digital KO41 quarterly data for nearby acute trusts, per 1000 staff, in 2021/22 are as follows.

	Q1	Q2	Q3	Q4
Alder Hey Children's NHS Foundation Trust	**9.5**	**11.0**	**10.7**	**14.9**
Clatterbridge Cancer Centre NHS Foundation Trust	**10.1**	**7.1**	**7.6**	**6.1**
Countess of Chester Hospital NHS Foundation Trust	**14.1**	**14.6**	**16.5**	**13.0**
Liverpool Heart and Chest Hospital NHS Foundation Trust	**4.8**	**7.5**	**2.4**	**8.2**
Liverpool University Hospitals NHS Foundation Trust	**8.1**	**10.0**	**9.2**	**12.0**
Liverpool Women's NHS Foundation Trust	**9.3**	**9.5**	**10.7**	**9.2**
Mid Cheshire Hospitals NHS Foundation Trust	**16.3**	**16.0**	**18.4**	**12.5**
Southport and Ormskirk Hospital NHS Trust	**21.6**	**21.9**	**24.1**	**27.7**
St Helens and Knowsley Teaching Hospitals NHS Trust	**12.7**	**12.1**	**10.6**	**8.8**
Walton Centre NHS Foundation Trust	**15.0**	**12.9**	**16.3**	**16.2**
Wirral University Teaching Hospital NHS Foundation Trust	**10.7**	**10.7**	**8.6**	**9.9**

Complaint Themes

The top-five complaint categories are largely unchanged for the past five years. These are:

- **Communication** (an aspect of 611 complaints): This comprises subcategories such as staff attitude and failures of communication with service users).
- **Treatment and Procedure** (an aspect of 503 complaints): This comprises subcategories such as delayed or inappropriate treatment and surgical complications).
- **Diagnosis** (an aspect of 172 complaints): For example, delayed or inaccurate diagnosis.
- **Transfer and Discharge** (an aspect of 156 complaints): For example, inappropriate discharge or failings in discharge planning.
- **Access and Admission** (an aspect of 119 complaints): For example, appointment delays and cancellations.



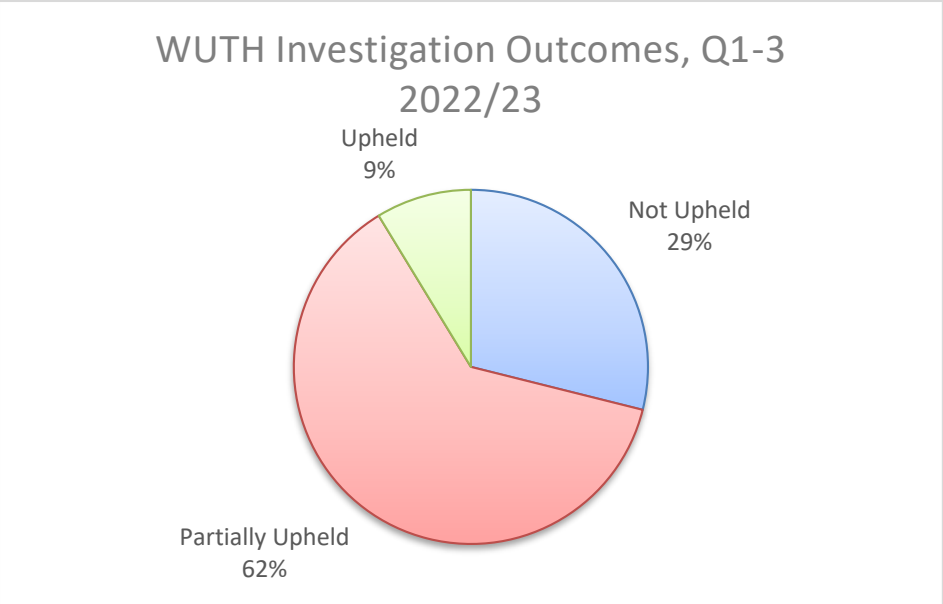
	24 Communication	28 Treatment & Procedure	23 Diagnosis	22 Transfer & Discharge	21 Access & Admission
FY2022/23	118	88	31	35	38
FY2021/22	147	112	36	30	15
FY2020/21	98	82	37	43	14
FY2019/20	100	107	27	17	19
FY2018/19	148	114	41	31	33

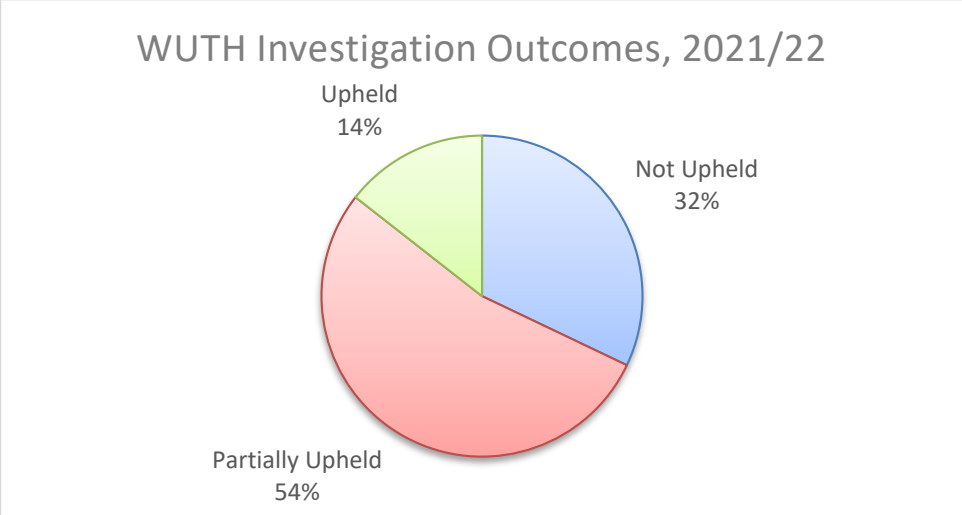
Despite the formation of the Family Support Team to mitigate the effects of restricted visiting during the pandemic, 'Communication' remained the highest reported category of complaint, featuring as a component in 32% of cases in 2021/22. However, despite the challenge of restricted visiting, a closer analysis of these complaints shows that the trend line has remained stable since 2018/19.

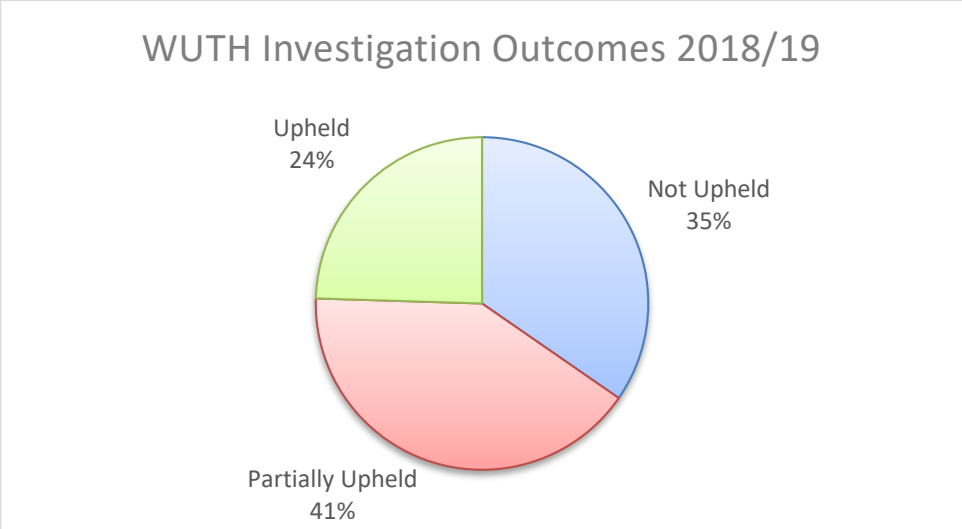
Learning

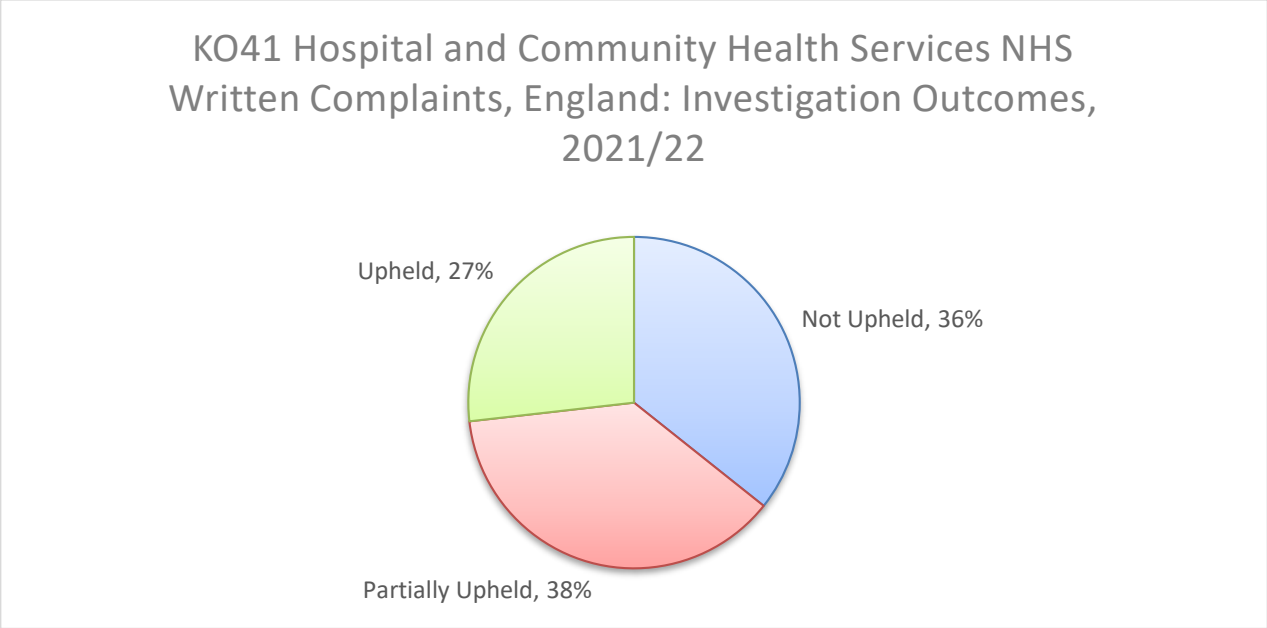
It should be appreciated that not all complaints will be upheld upon investigation. Per NHS Digital KO41 national data records, complaints are categorised as ‘Upheld, ‘Partially Upheld’ and ‘Not Upheld’. During 2021/22, 187 complainants received a first response to their concerns. Of these, 32% were not upheld, 54% were partially upheld, and 14% were upheld.

The percentage of complaints not upheld has not substantively changed from pre-pandemic and is also similar to recent NHS Digital KO41 data for all hospital and community services in England.









Where actions and learning are identified as part of a complaint investigation, these are set out in the complaint response.

Divisional clinical governance leads are asked to monitor the completion of their division's actions via daily automated reports from Ulysses Safeguard.

Council of Governors
20 February 2023

Item 10

Report Title	Finance Performance Assurance Committee Update
Author	Sue Lorimer, Chair of Finance Performance Assurance Committee

Present Position
At M8 the Trust reported a deficit of £4.670m. The forecast position is a deficit in the range £6.0m-£7.6m which is driven by:

- Escalation Capacity, which will cost c£6.4m.
- Bank & Agency Costs, which will exceed plan by £3.4m.
- Cost improvement plan (recurrent) , which will deliver by £8.2m below plan.

There is an offsetting benefit from non-recurrent mitigations which results in the forecast of £6.0m-£7.6m.

Risks (New and ongoing)
Trust delivery of statutory targets is summarised below:

Key Financial Targets	RAG	Target Measure
Financial Efficiency	🔴	Variance from efficiency plan
Financial Stability - Breakeven	🔴	Variance from breakeven
Agency spend	🔴	10% reduction vs 19/20
Capital	🟢	Capital spend on track and within CDEL limit
Cash	🟠	Trust cash balance

The risk to achievement of financial break-even for 2023/24 will increase as income levels are likely to reduce because of the national funding framework, specifically income relating to Covid-19 will be withdrawn. Consequentially, there is a risk that the Trust's cash resources will continue to reduce in 2023/24.

Overview of Committee activity

- The Committee held a shortened meeting in December due to the need for executives to prioritise operational pressures in the organisation. The Committee noted the deficit to the end of November 2022 as £4.7m, an adverse variance from plan of £5.4m. The adverse variance continued to be caused by underperformance on CIP, the cost of escalation wards staffed at premium rates, increases in energy prices and the national pay award exceeding funding available. The trust continues to forecast a yearend financial outturn of £6m deficit. The Committee received assurance that the forecast position has been discussed with the CFO of the ICB and there would be further discussion regarding the timing of formally changing the forecast. MC said he would also put this in writing to the CFO of the ICB.

- The Committee noted that the income and expenditure deficit had impacted the cash position and that cash balances were £8.2m behind plan. The cash impact is higher than the income and expenditure variance as there were non cash balance sheet items supporting the income and expenditure position. MC said that this had also been raised with the CFO of the ICB and it was likely the trust would need to seek cash support in 2023/24 in the form of loans or PDC.

- The CIP forecast for the year at M8 was £5.9m against a target of £13.9m. The Committee was assured that the organisation is still making best efforts to achieve an improved position and that service transformation and financial savings were now closely aligned.

- The Committee sought assurance on the level of premium rates being paid to locums and agency as this is a key issue affecting the workforce overspend. MC will be providing the details at the next meeting.

Other comments from the Chair
In the final quarter of the year review and endorsement of the Trust's 2023/24 plan will be a significant focus for the committee.

Statement of Assurance
The Committee is assured that the Trust that the Trust understands its financial risks and is working to mitigate them with all means within its control, and will deliver the 2022/23 financial position within the forecast range.

Council of Governors
20 February 2023

Item 11

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

Executive Summary/Current Position

Urgent and Emergency Care Upgrade Programme (UECUP) at Arrowe Park Hospital

- This £35m capital programme focusses on the construction and refurbishment of the accident and emergency department and Urgent Treatment Centre at Arrowe Park Hospital.
- The Committee received a presentation on and discussed the Programme, including capital envelope, construction and Phase 4 contract.
- Following the approval of the Full Business Case by the DHSC Joint Investment Sub-Committee (JISC) in July 2022, the Trust has been working with construction partners and cost advisers to finalise the Guaranteed Maximum Price (GMP) for the construction phases of the programme.
- This process identified a number of construction cost pressures, primarily due to inflation and supply, some of which the Trust were able to mitigate through two value engineering stages focussing on materiality and plant.
- Following these processes, the Trust requested draw down of additional funding, which was approved by the Cheshire and Merseyside ICS and DHSC JISC in November 2022, increasing the capital allocation for the project from £28m to £35m.
- In terms of UECUP construction, the Trust completed the Phase 1 enabling works on the site, including construction of a new road, installation of a new Ambulance canopy and new temporary entrance. Phase 2 construction commenced in late November 2022 and includes construction of the new structure, resuscitation unit, paediatric emergency department and staff wellbeing areas. This Phase is aiming to be completed by September 2023. At present the Trust is aiming to complete the project by late November 2024.

Modular Theatres and Theatre Complex Refurbishment – Phase 2 (Clatterbridge Hospital)

- The Committee received a presentation on and discussed the Programme, including capital envelope, construction and lessons learnt from Phase 1.
- The Phase 1 modular theatres included two new theatres, recovery areas and staff change rooms. This was completed in September 2022.
- The Phase 2 modular theatres increases the new development, adding two additional theatres (laminar flow), expansion of recovery areas, sterile stores, post-op recovery unit and training suite. Construction commenced in November 2022 and is aiming to be completed by late September 2023.

22/23 Capital Delivery Update

- The Committee was provided with a presentation of the capital projects for the 22/23 financial year. This included detail of the 26 approved projects, such as for the renal unit construction, hydrotherapy unit refurbishment, heating piped services works, window glazing, patient bathrooms, flooring and simulation suite.
- The committee were advised that 10 of the projects were complete, with 9 in design and procurement stage and 7 in construction stage. The committee were assured that these projects would be completed by year end.

Three-year capital programme process

- The committee was presented with the 23/24-25/26 capital programme approach, which includes the capital financial allocatiuons for the next three years, the approach to bbid development, role of the bid panel, review and selection of bids (against risk and condition assessments) and development of the three year capital programme.
- The timeframes were also highlighted with the finalised capital plan being received by FBPAC in April 2023.

Telephony

- Directory improvements are progressing, with a plan of work to end of Q3 2023/24 to support further development in improving telephony service, reducing calls hitting the Trust's switchboard, self-help support for all users and training for in house teams to then create process improvement and automation etc.
- An outline of in flight programmes is as below:
    - Working with BT to upgrade the Trust's telephony systems
    - Cisco / BT Workshop scheduled for late March/April which will take place with other Trusts who have discussed same issue with BT. They are hosting an initial workshop in Manchester to round table discussions with Cisco Account Teams / Other Trusts.
    - CISCO Telephony training has been planned for 2 engineers, with additional training awaiting FY approval.
    - ESR / Telephone Directory link in place with staged improvements planned.
    - Service Improvement roadmap developed with collaboration between Digital Healthcare Team (DHT) and Facilities & Support Services, (F&SS).
    - Telephony/Network cost centre to be setup to gain visualisation and cost improvements on billing
    - DHT Walk in service opened 1st Feb, also exploring how Switchboard & Security/Car Parking staff can support & enhance this service.
    - Resilience and automation processes to be written.
- There is a resource and capacity risk relating to the achievement of further improvements, and the team are progressing with proposals to mitigate this.

Risks (New and ongoing)

- UECUP- Deliver of programme to timeframes, whilst undertaking construction adjacent to a live clinical environment.
- Theatres - Deliver of programme to timeframes, whilst undertaking construction adjacent to a live clinical environment.
- Three year Capital Programme approach – the scale of capital bids and requests against the Trust's capital allocations for the next three financial years.

Overview of Committee activity

- As provided above.

Statement of Assurance

- The Committee are assured on the processes and controls in place to manage the Trust's estates and capital programme.

Appendix 1 – 2022/23 telephony performance

	Incoming Calls			Internal Calls		
Month	**Total Calls**	**Unanswered**	**% Unanswered**	**Total Calls**	**Unanswered**	**% Unanswered**
January 23	257,833	132,058	52%	506,241	293,671	59%
December 22	233,706	121,184	52%	523,793	309,882	60%
November 22	256,511	129,135	51%	524,254	306,172	59%
October 22	287,219	151,994	53%	559,039	336,906	61%
September 22	295,353	160,023	55%	553,986	336,397	61%
August 22	310,312	167,342	54%	578,408	351,412	61%
July 22	312,098	165,235	53%	579,206	350,483	61%
June 22	311,760	164,811	53%	588,903	360,238	62%
May 22	342,320	184,479	54%	616,614	376,985	62%
April 22	290,092	159,962	56%	539,278	324,508	61%

Council of Governors
20 February 2023

Item 12

Report Title	People Committee Update
Author	Lesley Davies, Chair of People Committee

Executive Summary/Current Position

- The Quality and Performance Dashboard continues to highlight:
  - Sickness Absence in December 2022 was 6.6% against a target of 5%. Short term absence is the key driver.
  - Turnover in December 2022 was 1.07% against a target of 0.83%. Work-life balance is an emerging theme from intelligence.
  - Mandatory Training was compliant with Trust target in December 2022.
  - Appraisal was compliant with Trust target in December 2022.
- Below is a summary of 'People' activity, which addresses the issues above and relates to the delivery of the People Strategy 2022-2026.

Workforce Wellbeing

- Health and Wellbeing Conversations have been implemented across the Trust. These provide an opportunity for line managers and staff to have a supportive, coaching style one to one conversation focused on wellbeing.
- A revised Attendance Management Policy has been drafted in partnership with staff side, providing greater structure around the management of reoccurring absence. This will be launched in Q4.
- Workforce Flu and COVID vaccine programmes continue. Uptake for the Trust remains above the Northwest average.
- Wellbeing Surgeries have been implemented within the Trust. These are workforce focused events run by the Occupational Health and Wellbeing Team, which provide face to face holistic support and advice to staff members on a range of wellbeing matters. A specific theme is selected for each surgery, based on intelligence gathering. Examples include financial wellbeing and work-life balance. Internal and external partners are invited to be part of our surgeries.
- A multi-year programme of work is in place to improve the flexible working offer across the Trust.

Education, Training and Development

- Following the launch of the Trust's Leadership Qualities Framework in June 2022, a range of leadership development programmes have been designed and implemented. Manager Essentials, Leading Self and Leading Teams development programmes have all been launched. They are supported by a series of leadership masterclasses. Leading Service and Leading Division programmes are in the final design phases.
- The Trust approach to Coaching has been reviewed and relaunched, offering coaching development opportunities across 3 levels.
- The review of the Trust's approach to supervision and appraisal which took place earlier in the year highlighted the need for a significant redesign. A proposal for a full transformation was developed and approved. This has been co-designed with staff and is now in pilot phase.

Equality and Inclusion

- The Trust remains compliant with all regulatory Equality and Inclusion reporting requirements.
- The experience of our staff members living with disability has emerged as a key theme through regulatory reporting and initial staff survey feedback. A new 'Action on Disability' working group has been established and this matter will be a key area of priority within the delivery of year 2 of the People Strategy.
- The Equality Delivery System (EDS) 2022 was launched in Autumn 2022, replacing EDS2. EDS 2022 is an equality improvement tool for NHS organisations. Trusts must self-assess, via stakeholder engagement, against 3 domains: Commissioned Services, Workforce Health and Wellbeing, and Inclusive Leadership. The assessment process is in the final stages, prior to publication by 28 February 2023.
- Excellent progress has been made on the strategic priority to develop our staff networks, as well as establishing the Menopause Staff Network and the Armed Forces Staff Network. All networks have Executive Partners in place.

Employee Engagement

- The Together Awards were held in November 2022. Over 230 entries were received, including strong local support for the Patient Choice award, nominated by the public. The evening was a tremendous success, celebrating the hard work of our colleagues and the WUTH values and behaviours in action.
- The Staff Survey 2022 ran through October and November 2022. The Trust achieved a response rate of 48%, a 2% increase since the previous year and higher than the average for Acute Trusts using the same service provider. Final results are expected in late February 2023 and will be embargoed until early March 2023.

Just and Learning Culture

- Good progress has been made across all four priorities identified by the Just and Learning Culture Group.
- Just and Learning Culture has been embedded into Manager Essentials development programme and will be included as a stand-alone workshop in Leading Teams programme.
- A new fairness at Work Policy is ratified and in place, and good progress has been made on the Respect at Work Policy.
- The new Freedom to Speak Up and Just Culture Lead role has now commenced.

Workforce Planning and Controls

- The Workforce Planning and Controls Programme has been established to focus on four key themes: Workforce Planning, Job Planning, Rostering and Temporary Staffing. The purpose of the programme is to both strengthen the current arrangements in place, providing immediate improvements, and to undertake a full review of each theme, revising the systems and processes to unsure optimum performance.

People Strategy

- A significant amount of work has been undertaken in year 1 delivery of the People Strategy. Much of the work described above has been driven by the principles within the Strategy.
- Work is now underway to review year 1 delivery and agree priority work streams for year 2.
- It is anticipated that Year 2 delivery will have an even greater focus on co-design and co-delivery with our workforce.

Risks (New and ongoing)

- Workforce retention and recruitment to certain posts remain a challenge. These are reflected on the Board Assurance Framework. Recruitment to certain medical specialties is challenge and a range of actions are in place to mitigate this including review of best practice in neighbouring Trusts, service changes where appropriate and refreshed attraction materials.

The recently announced Welsh pay deal may provide additional challenge in the areas of retention and recruitment.

- Workforce wellbeing remains a risk and sickness absence is above Trust target. Again, this is reflected in the Board Assurance Framework. A range of actions are in place to both proactively support the wellbeing of our workforce and to manage absence where it occurs, as described above.
- As highlighted above, the experience of our staff living with disabilities has emerged as an area which requires focused improvement. A new 'Action on Disability' working group has been established and this matter will be a key area of priority within the delivery of year 2 of the People Strategy.

Overview of Committee activity

A meeting of the People Committee was held on the 31st January 2023 and the Chair's report will be made available to the Board of Director's meeting on the 1st March 2023. The Committee received a number of detailed standing reports which enables the Committee to examine the progress the Trust is making against the People Strategy, which is a key strand in the delivery of the Trust's overarching strategic plan, as well as seek assurance that the Trust has robust systems and processes to deliver a positive working environment. Specifically, the committee is provided with the following reports:

- Chief People Officer Report
- People Strategy Update Report
- Workforce Key Performance Indicator Report
- Employee Relations Report
- Guardian of Safe Working Report
- Safe Staffing Report

At the January meeting the Committee was given assurance that there is ongoing oversight and focus on sickness absence and, although absence continues to be slightly above the Trust's target, action is being taken to support specific divisions and work is being undertaken aimed at reducing episodes of absence.

The recruitment of nurses from overseas has been a highly successful programme and it was encouraging to receive confirmation of the continued high level of retention of nurses and the success of the programme and which is having a positive impact on the safe care of patients.

Of particular note is the Trust's success in reducing the number of Care Support Worker (CSW) vacancies; this is particularly reassuring given the nationally picture. This success is a testament to the work by the staff and leaders who have worked diligently to ensure that all opportunities to engage with the community and encourage new entrants and returns to join the trust is explored. However, the Committee noted that a focus must remain on the retention of this staff group.

The Committee was also provided with a presentation and report on bank and agency staff usage which is being subject to a thorough deep dive by staff. The review was well structured and thorough and included information on the work being carried out to make sure patient care, always at the forefront of the work, is being reviewed alongside workforce planning issues, rostering, job planning and temporary staffing. The Committee was provided with good assurance on the efficacy of the work being carried out. A further update will be provided at the next Committee meeting.

At each People Committee information is provided on employee relation cases being dealt with by the Trust. The reports provided are of an extremely high standard and the work in the area is impressive. It was heartening to see the continued trend in a relatively low numbers of cases brought against the Trust and the thorough work undertaken throughout the process to deal fairly

and efficiently with each case. At the end of each case a through review and lessons learned is also conducted and the findings are shared with staff and the Committee.

An area where the Committee also received good assurance was from the Guardian of Safe Working who reported on the exception reporting regarding working hours of junior dentists and doctors. Again, good assurance was received on the management of exception reporting and the number of additional hours being worked by junior doctors and dentists in total and at an individual level with no major areas of concern identified across the Trust

An overview was also provided on the Trust's workforce education and training area of work; which is extensive and covers all education and training provided by the Trust. Whilst mandatory and specialist training is reviewed at each meeting other areas, including Leadership and Management programmes are covered as part of the People Strategy Update. The Committee recognised the extensive nature of the work and took good assurance from the work being undertaken.

The Committee was also furnished with up-to-date information on the on-going industrial action and its impact on the Trust. Extensive planning has been put in place by leaders and staff in order to maintain patient safety and the planning has had a clear focus on minimising the impact on patients. However, this is a difficult situation to manage and with an unknown end date the challenges are likely to continue for some months. The Committee will, of course, keep this situation on its agenda.

Other Comments from the Chair

Committee members thanked the staff and leaders for their work and their clear focus on delivering high quality care for patients and for the extensive arrangements that they have put in place to support our staff. Specifically, staff and leaders are to be applauded for their work and the progress they are making in delivering the Trust's People Strategy, particularly the emphasis on safe recruitment, retention and providing support for leaders and managers through the commencement of the leadership and management programmes. There is also extensive work being undertaken to ensure that the Trust is a welcoming and positive employer and that the Trust is regarded by our local and wider community as a 'good place to work'. The progress being made is particularly noteworthy given the national operating context.

Statement of Assurance

As Chair of the People Committee, along with my fellow Non-Executive Directors I confirm that we are assured on the processes and controls in place to manage the quality of care provided by the Trust.

Council of Governors
20 February 2023

Item 13

Report Title	Audit and Risk Committee Update
Author	Steve Igoe, Chair of Audit and Risk Committee

Overview of Committee Activity

Losses and special payments

The committee was provided with an update on Losses and special payments recorded up to 31 December 2022.

A number of "normal "losses were reported however the more significant issue related to a not insignificant loss arising from high-cost drugs. These were not physical losses but rather medications prepared that were unable to be used due to patients not attending for infusion. The Committee has requested a detailed deep dive in pharmacy as to ongoing stock losses which currently stand at £157,934.

Total debtor balances have reduced over recent months however the most significant debt relates to an amount owed by Wirral borough Council as a contribution to the cost of population health 21/22 data. The CFO confirmed that the Council now accept the validity of the debt but that there is a query over the calculation. A further update will be presented to the Committee at its next meeting.

Procurement spends control and waivers

The Trust continues to perform well in relation to Model Health System Targets for procurement. the use of national and regional frameworks has reduced the incidence of non-compliant spend. Further internal controls have been introduced to strengthen the reporting on procurement waivers. Two waivers were noted which with better planning should not have required a retrospective authorisation. The CFO was tasked with re-inforcing across the hospital the need for any waivers to be prospective and on an exceptional basis.

Internal audit and Anti-Fraud

Work continues through the Trust's Anti-Fraud service provided by MIAA**,** specifically focussing on; strategic governance, Counter fraud activities and holding to account. Overall, there were two referral queries outstanding at the end of the period comparted with one at the start.
A positive Internal Audit summary report was received and discussed in detail by the committee.

The following reviews were received:

- Wirral Individual Safe care every time (WISE) ward accreditation process – Substantial Assurance.
- Risk Management core controls – Substantial Assurance.
- HFMA improving financial sustainability checklist - non-standard report with positive outcome.
- Assurance Framework survey (BAF) - non-standard report with positive outcome.

Internal Audit tracker

The Committee tracks recommendations from previous audit work and resolution of those recommendations. A substantial number had been completed for this meeting however a similar

number had not been completed and of these some areas were requesting substantial delays to the implementation of agreed actions. The Committee whilst recognising operational challenges was not minded to agree to a number of these and instead asked for a revised completion date at the end of Q2 23/24.These will continue to be monitored independently by the Board secretary and reported to each Audit Committee meeting.

Internal Audit Plan
The Committee discussed the detailed internal audit plan for 23/24 which had been constructed based upon discussions with the Executive, Chair and Non-Executive directors and a thorough review of the Trusts BAF and Risk register. The plan was approved by the Committee subject to some realignment of the work programme to reflect activity being undertaken in the Trust.

External Audit Strategy for the financial statements year ended 31 March 2023
Azets, the external auditors introduced and set out in detail their audit strategy for the audit of the Trust's year-end account to 31 March 2023.
The external audit of every entity's account follows statutory requirements and is undertaken in according with International Financial Reporting standards and Auditing Standards.
Significant risks identified which are required to be rebutted by the Auditors were highlighted as:

- Management override of controls
- Fraud in revenue recognition
- Fraud in non-pay expenditure
- Valuation of land and buildings
- Implementation of IFRS 16 (lease accounting)

These are not unique to WUTH and will be highlighted in the audit strategy for all corporate entities regardless of operating sector.
The Committee also discussed the reporting timetable and value for money work to be done to underpin the year end reporting

Re-appointment of AZETS
The Committee discussed the option of re appointing Azets at the end of the current financial accounting period. Governors may well remember that they were appointed on a 3-year contract with the option of an extension based on performance. The Committee discussed the current market for audit services and concluded that the current climate was not conducive to re – entering the market to procure these services and that Azets had produced a good service performance over previous engagements .The Committee were therefore minded to recommend the re – appointment of Azets to the Council of Governors and to extend the contract in line with the original extension terms .The external Audit fee for 23/24 was also discussed .The Committee noted that despite accounting for cost inflation at 9.3% , by reducing the base fee by £15,000 Azets were seeking an audit fee of £124,800 for the year to 31 March 2023. This is an increase of £400 or 0.3%. Again, the Committee agreed to recommend the fee for approval to the Council of Governors.

Governors are asked to support the recommendation of the Audit Committee to extend the Azets Contract for the provision of external audit services as provided for in the initial contract and to accept the recommendation for a fee of £124,800 and annual increase of 0.3%.

Going concern assessment
The assessment of the Trust as a going concern is a fundamental principle in producing a set of accounts for the Trust at 31 March each year. In most organisations, this is implicit however the Audit Committee in this Trust has for a number of years required the rationale for this judgement to be specifically set out and approved by the Audit Committee on behalf of the Board. A detailed paper was prepared by the CFO and discussed in detail at the Committee. The Committee approved the paper and resolved to assure that Board that the use of the Going Concern judgement was appropriate in the construction of the year end accounts to 31 March 2023.

Review of accounting policies
The CFO confirmed to the Committee that there are no proposed changes to the accounting policies for the Trust for the year end accounts to 31 March 2023.

Review of Material Management Estimates
As noted in the External Audit strategy presentation the areas on valuation and estimate are considered high risk in all audits as they typically involve estimation of financial sums based upon experience and calculation. The Trust highlighted for the Committee the key valuations and estimates likely to have a bearing upon the construction of the accounts for the current year. They are:

- Annual leave provision
- Overtime and annual leave (flowers)
- Employee relations/ ET's
- Clinical support worker bandings

These will be reviewed in detail as part of the year end accounts process including by External Audit.

Bad Debt Policy
The Committee approved an updated policy on the management of Bad Debt by the trust.

Other Comments by the Chair
The Audit and Risk Committee is functioning as I would expect from a mature and self-aware organisation which is a significant improvement on where it was some years ago. The nature of the conversation is professional, and risk focussed and reflects the growing enhancements to the overall control environment. A tone set by the Board and implemented across the Trust through the various operating units.

The positive external and internal audit feedback provides substantive evidence to this effect.

Statement of Assurance

As Chair of the Committee and supported by my fellow Non-executive Directors on the Committee, I can confirm that we are assured on the processes and controls in place to understand and enhance the internal control and risk management activities within the trust. We are also assured as to the delivery of value for money through the activities of the Trust.

Council of Governors **Item 15**

20 February 2023

Title	WUTH 2022/23 Annual Priorities Update
Area Lead	Matthew Swanborough, Chief Strategy Officer
Author	Mike Gibbs, Associate Director of Integration and Partnerships
Report for	Information

Report Purpose and Recommendations

The purpose of this presentation is to provide an update on the organisations 2022/23 annual strategic priorities. In total 31 strategic priorities were developed for 2022/23, each having executive director ownership.

The 31 strategic annual priorities align to each of the 6 strategic objectives:

Outstanding Care
Compassionate Workforce
Continuous Improvement
Our Partners
Digital Future
Infrastructure

An away day was held, where the executive directors provided a six-month update to peers on each of their priorities. This presentation details the progress on each of these priorities, including next steps for Q3&4.

It is recommended that the Council of Governors:

- Note the report

Key Risks

This report relates to these key Risks:

- Ensuring the Trust has clear objectives and a mechanism for monitoring progress against these.

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**
08/11/22	Executive Team meeting	WUTH annual priorities update	Accepted
07/12/22	Board of Directors in Private	WUTH 2022/23 Annual Priorities update	Noted

Author	Michael Gibbs, Associate Director of Integration and Partnerships
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22-23 Annual Strategic Priorities

Q1&2 Progress Update

together we will

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Outstanding Care

WUTH Annual Priorities 2022/23

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Outstanding Care
Provide the best care and support

WUTH Strategic Objectives	WUTH Strategic Priorities	WUTH Annual Operational and Strategic Actions 2022/23	Key deliverables	Action Ownership
Outstanding Care Provide the best care and support	Empower patients through their care journey	1. Develop and deliver Urgent and Emergency Improvement Plan including a. ED Staffing b. Acute take model c. Staff and team development (OD)	1. - Improvement Plan approval - Bi-monthly tracking of delivery through Programme Board	1. COO
	Improve patient flow, ensuring the patient is in the right place at the right time	2. Deliver Year 1 of Infection Prevention and Control Strategy, including implementation of NHS England IPC guidance	2. - Year 1 IPC Strategy action plan developed, approved and tracked - Assessment and alignment of IPC to new NHSE guidance	2. CNO
	Strive to deliver intimate and personal patient experience	3. Deliver year 1 of 22-25 Patient Experience Strategy	3. - Develop and deliver year 1 Patient Experience Strategy annual priorities - Provide 6 monthly update	3. CNO
		4. Develop 22-25 Trust Quality and Safety Strategy	4. - Approval of Trust Quality and Safety Strategy by Board - Development of Year 1 priorities	4. Medical Director/CNO
	Provide services in the most appropriate and accessible setting	5. Develop and deliver plan for quality improvement across Trust, including establishing methodologies and delivery vehicle	5. - Approved QI plan - Embedded QI methodologies	5. CNO
		6. Develop Clinical Outcomes Group to monitor the quality of service delivery across the Trust	6. - Establishment of Group - Development of clinical outcomes methodology - 22/23 Work plan development and delivery	6. Medical Director
	Embed a culture of safety improvement that improves outcomes	7. Deliver national maternity improvement requirements and revisions to national policy	7. - Conduct review against revised requirements and policy - Develop and deliver action plan - Track through Board updates	7. CNO
		8. Understand the impact of covid and post covid recovery on health inequalities of patients across Wirral	8. - Undertake analysis and review	8. Medical Director

NHS Wirral University Teaching Hospital NHS Foundation Trust

Outstanding Care
Provide the best care and support

Action

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Action 22/23	Key deliverables:	Action Ownership
Outstanding Care Provide the best care and support	1. Develop and deliver Urgent and Emergency Improvement Plan including a. ED Staffing b. Acute take model c. Staff and team development (OD)	- ED Improvement Plan	COO

Outcome

Details of progress Q 1& 2	Next steps Q 3 & 4
• UEC Operational Improvement Plan developed outlining all of the areas that require improvement focus to deliver improved performance and patient experience. • Junior medical staff rotas not fit for purpose leading to significant gaps in rota cover – new rotas developed and currently finalising to ensure robust coverage over the week. • Acute take model has been reviewed and a workforce model developed to support the increasing demands to the acute take and options to cover this. Work ongoing with Medicine Division to develop a robust approach through winter pressures in times of escalation. • AMU capacity and demand modelling underway to design an optimal model for future service provision. • Development of the Full Capacity Protocol (FCP) to aid flow out of ED in times of escalation. • Development of a new ambulance receiving area to provide additional space to assess patients improving safety and privacy and dignity	• Implementation of a new junior medical staffing rota reducing risk and premium medical spend • Implementation of new ambulance receiving area, improving flow and reducing risk • UEC performance improvement metrics

WUTH Strategic Priorities 22/23

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Outstanding Care
Provide the best care and support

Action

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Action 22/23	Key deliverables:	Action Ownership
Outstanding Care Provide the best care and support	2. Deliver Year 2 of Infection Prevention and Control Strategy, including implementation of NHS England IPC guidance	- Improvement Plan approval - Bi-monthly tracking of delivery through Programme Board	CNO

Outcome

Details of progress Q 1& 2	Next steps Q 3 & 4
• 2022/2023 IPC work plan drafted – approved by IPCG . All actions remain on Track – reports through to PSQB .NHSE IPC manual mapped and aligned to all WUTH policies and protocols. • Link Nurses re established • Monthly newsletters active • Matrons Shared learning programme established bi monthly • IPC training TNA developed • Mandatory Surveillance processes strengthened , Sign off by DIPC monthly • Development of IPC BI portal to provide intelligent monitoring of risks • Development of SSI strategy commenced • Development of Wirral wide action plan to CDT • Review of IPC audit tools in Tendable to ensure they reflect the national standards • Wirral wide IPC group developed and active • Weekly meetings with Estates and Facilities • Strengthened Water safety and Ventilation governance • Commenced CDT QI collaborative • WUTH AMR Strategy / ASPIRE improvements noted	• Conclude remaining ongoing actions from work plan in line with Trust priorities / national guidance. • Consult and relaunch on remaining policies that are under review in line with the IPC manual. • Review of CPE policy • Further development of BI portal • Completion of SSI strategy • Strengthen assurances regarding Domestic cleaning across all sites • Review MRSA policy • Revise QI programme to include reduction in all gram negative bacteraemia • Launch of Gloves Off Hand Wash campaign

WUTH Strategic Priorities 22/23

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Outstanding Care
Provide the best care and support

Action

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Action 22/23	Key deliverables:	Action Ownership
Outstanding Care Provide the best care and support	3. Deliver year 1 of 22-25 Patient Experience Strategy	- Develop and deliver year 1 Patient Experience Strategy annual priorities - Provide 6 monthly update	CNO

Outcome

Details of progress Q 1& 2	Next steps Q 3 & 4
• Strategy Launched, all promise groups meeting actively with strong representation form partners / Patient Experience Faculty well established to oversee progress of project. • All promise groups completed baseline metrics to assess starting point . • Performance rating assessments aligned to CQC KLOES • Each group have projects ongoing to meet the requirements of their promise. • Designed focus months including baseline interactive workshop , staff pledges • High Social media activity particularly on Facebook (Facebook 2150 followers , twitter 750 followers) • Website for PE being drafted / Patient Story Library established • Way finding exercises completed with partners including MENCAP/ leading regional work on Patient and Carer passports	• Focus on Safe and Inclusive promise groups in Q4 • Interactive work sessions planned November • Focused surveys planned to seek further feedback • Launch of passport awareness phase 1 • Launch of patient experience newsletter

WUTH Strategic Priorities 22/23

NHS
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Outstanding Care
Provide the best care and support

Action

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Action 22/23	Key deliverables:	Action Ownership
Outstanding Care Provide the best care and support	4. Develop 22-26 Trust Quality and Safety Strategy	- Approval of Trust Quality and Safety Strategy by Board - Development of Year 1 priorities	Medical Director

Outcome

Details of progress Q 1& 2	Next steps Q 3 & 4
• Strategy in development. • Engagement meetings with key stakeholders completed	• Strategy on track for completion in Q3

WUTH Strategic Priorities 22/23

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Outstanding Care
Provide the best care and support

Action

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Action 22/23	Key deliverables:	Action Ownership
Outstanding Care Provide the best care and support	5. Develop and deliver plan for quality improvement across Trust, including establishing methodologies and delivery vehicle	- Approved QI plan - Embedded QI methodologies	CNO

Outcome

Details of progress Q 1& 2	Next steps Q 3 & 4
• Plan drafted to deliver QI across the Trust and approved by EMT • Operational QI appointed – starts November 2022 • Lead post in STT working across the STT / QI functions • In discussion with Aqua to progress stage 1 training plan • Recruitment of QI operational lead (starts December 22) • Observations live rolled out across the Trust • CDT QI project commenced • Deteriorating patient 2nd phase collaborative wards commenced tests of change	• Development of deterioration patient Change Package • Launch of change package Trust wide • Celebration event • Measurement of roll of change package to be incorporated into WISE accreditation / Tendable • Baseline data / scope to be agreed for Discharge QI from Q1 • Continue phase 2 of IPC QI project • Agree Board of Directors QI training package

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Outstanding Care
Provide the best care and support

Action

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Action 22/23	Key deliverables:	Action Ownership
Outstanding Care Provide the best care and support	6. Develop Clinical Outcomes Group to monitor the quality of service delivery across the Trust	- Establishment of Group - Development of clinical outcomes methodology - 22/23 Work plan development and delivery	Medical Director

Outcome

Details of progress Q 1& 2	Next steps Q 3 & 4
• Improving outcome group established and first meeting planned for Oct 19th 2022. Initial focus will be on audit and model hospital data • GSU have undertaken gap analysis into level 1 and 2 audits and work required to gather assurance around these.	• Develop roadmap for the Clinical Outcome group to develop over next 12 months to include work on clinical pathways • Develop forward audit plan for 23-22

WUTH Strategic Priorities 22/23

NHS Wirral University Teaching Hospital NHS Foundation Trust

Outstanding Care
Provide the best care and support

Action

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Action 22/23	Key deliverables:	Action Ownership
Outstanding Care Provide the best care and support **Outcome**	7. Deliver national maternity improvement requirements and revisions to national policy	- Conduct review against revised requirements and policy - Develop and deliver action plan - Track through Board updates	CNO

Details of progress Q 1& 2	Next steps Q 3 & 4
• Ockenden Gap analysis completed reported to BOD • CQC / NHSE/I assurance visits to assess compliance with Ockenden 1 EIAs overwhelmingly positive • Ockenden being reviewed regionally and nationally to define which EIAs will be required to take forward • Gap analysis undertaken re East Kent – Reported to EMT • MIS submission in draft for sign off (January 2023) • Safety Partner walkabouts completed regularly • Continuity of Carer risk assessment being undertaken	• Complete gap analysis on Ockenden Nottingham report following pending release • Complete MIS submission to LNMS • Devise action plan aligned to anticipated release of regional recommendations from Ockenden Final Report / East Kent / Nottingham • Continue to conclude ongoing actions in current WUTH Ockenden final action plan that do not require system direction • Agree plan for Continuity of Carer – proposed time scales and mitigations for any area of risk

WUTH Strategic Priorities 22/23

NHS
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NHS Foundation Trust

Outstanding Care
Provide the best care and support

Action

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Action 22/23	Key deliverables:	Action Ownership
Outstanding Care Provide the best care and support	8. Understand the impact of covid and post covid recovery on health inequalities of patients across Wirral	- Undertake analysis and review	Medical Director

Outcome

Details of progress Q 1& 2	Next steps Q 3 & 4
• ICB have established a " Core 20 action group" to look at health inequalities across the Wirral with representation from WUTH (DMD). The group is undertaking analysis into the 5 key areas of health inequalities (Maternity, mental health, chronic respiratory disease, early cancer diagnosis, hypertension	• Ongoing work through the Core 20 group. • Produce report on impact of covid and post covid recovery on health inequalities of patients across Wirral.

Compassionate Workforce

WUTH Annual Priorities 2022/23

NHS
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Compassionate Workforce
Be a great place to work

WUTH Strategic Objectives	WUTH Strategic Priorities	WUTH Annual Operational and Strategic Actions 2022/23	Key Deliverables	Action Ownership
Compassionate Workforce Be a great place to work	Develop and maintain a healthy organisational culture based on our values	1. Implement Year 1 of the People Strategy across 4 pillars: a. Looking after ourselves and each other b. Belonging at WUTH c. Transforming ways of working d. Shaping our future	1. - Development and delivery of Year 1 People Strategy priorities, examples include: • Implement holistic health checks • Deliver wellbeing surgeries • Implement leadership framework and development • Partnership with Wirral Met College to develop bespoke training opportunities	1. CPO
	Retain, attract and recruit high calibre and skilled staff	2. Development and delivery of People Inclusion Plan	2. - Development of People Inclusion Plan - Year 1 Implementation of Plan	2. CPO
	Support our staff to enjoy the best health and wellbeing	3. Deliver an improvement program relating to workforce planning and controls. Areas in scope: - workforce planning - rostering - job planning - temporary staffing	3. - Scope programme and develop specific projects - Agree outcomes - Align to Programme Board reporting	3. CPO
	Invest in our staff's continuous learning, education and innovation			

together we will

Wirral University Teaching Hospital NHS Foundation Trust

Compassionate Workforce
Be a great place to work

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Compassionate Workforce Be a great place to work **Outcome**	1. Implement Year 1 of the People Strategy across 4 pillars: a. Looking after ourselves and each other b. Belonging at WUTH c. Transforming ways of working d. Shaping our future	Development and delivery of Year 1 People Strategy priorities, examples include: • Implement holistic health checks • Deliver wellbeing surgeries • Implement leadership framework and development • Partnership with Wirral Met College to develop bespoke training opportunities	CPO

Details of progress	Next steps Q3 & 4
2022/23 delivery plan approved via Workforce Steering Board Deliverables achieved: • Wellbeing Surgeries • Health and Wellbeing Conversations and Health and Wellbeing Day • Winter Wellbeing Plan Evaluation Deliverables where significant progress has been made: • Enhance Staff Networks • Launch Leadership Qualities Framework and Programmes • Implement the CLIP Model • Advance levels of Attainment and Enhance Temporary Staffing Controls and Processes • Corporate Induction Review • Deliver a Programme of Work Relating to Retention • Education and Training Review • Appraisal and Supervision Review	• Present fully developed success measures for each principle. • Achieve year 1 outputs for each deliverable: • Holistic Health Checks • Flexible Working • Just and Learning Culture • Enhance FTSU Practices • Enhance Staff Networks • Engagement Framework • Leadership Qualities Framework and Programmes • Widening Participation • Number and Diversity of Volunteer Workforce • Coaching and Mentoring • Appraisal and Supervision • CLIP Model • Education and Training review • VR Training • On-Boarding • Induction • Retention • Levey Transfer • NHS Ambassador Programme

Compassionate Workforce
Be a great place to work

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Compassionate Workforce Be a great place to work	2. Development and delivery of People Inclusion Plan	- Development of People Inclusion Plan - Year 1 Implementation of Plan	CPO

Outcome

Details of progress	Next steps Q3 & 4
A new Workforce Inclusion Strategic Commitment 2022-26 is in draft. It will underpin the People Strategy and will set out our strategic commitment to the advancement of workforce inclusion through all four principles of the People Strategy. The People Strategy delivery plan will be further development following the publication of the Workforce Inclusion Strategic Commitment. Publication of this document forms part of the People Strategy deliverables for 2022/2023. Engagement and data analysis has been undertaken and a draft document will be complete in early October 2022. This will be presented to key stakeholders, including the Executive Team, ahead of approval in People Committee in November 2022.	• Presentation of draft to key stakeholders, October 2022 • Submission to People Committee, November 2022

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Wirral University Teaching Hospital
NHS Foundation Trust

Compassionate Workforce
Be a great place to work

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Compassionate Workforce Be a great place to work	3. Deliver an improvement program relating to workforce planning and controls. Areas in scope: - workforce planning - rostering - job planning - temporary staffing	- Scope programme and develop specific projects - Agree outcomes - Align to Programme Board reporting	CPO

Outcome

Details of progress	Next steps Q3 & 4
• Project initiation agreed via Programme Board. • Governance structure has been designed and agreed. • Funding for project lead identified with Workforce Directorate budget and recruitment has taken place. • Programme steering group meetings have commenced. • Prioritisation of Rostering and Temporary Staffing projects agreed. • Initial scoping of project plans has commenced and been set up in Smart Sheets. • Project groups established. • First full process mapping session has been held, focusing on medical temporary staffing. • Immediate improvement measures identified and enacted, including a focus on rostering in Acute Division and Medicine Division.	• Process mapping current state • Target operating model options and agreement • Implementation • KPIs finalised

Continuous Improvement

NHS Wirral University Teaching Hospital NHS Foundation Trust

Continuous Improvement

Maximise our potential to improve and deliver best value

WUTH Strategic Objectives	WUTH Strategic Priorities	WUTH Annual Operational and Strategic Actions 2022/23	Key deliverables	Action Ownership
Continuous Improvement Maximise our potential to improve and deliver best value	Embed a culture of improvement and transformation	1. Deliver Elective Recovery Programme to plan, including productivity reviews across: a. Gynaecology b. Urology c. Colo-rectal surgery	1. - Reduction in waiting list size - Reduction in 52+ week waiters - Development and delivery of Improvement plans following service reviews	1. COO
	Reduce variation in care pathways to improve outcomes	2. Achieve financial sustainability across 22/23	2. - Delivery to 22/23 financial plan - Development and delivery of CIP - Delivery of capital programme to budget	2. CFO
		3. Develop 22-26 Financial Strategy	3. - Board approval of 22-26 Financial strategy	3. CFO/DoS
		4. Develop and implement 22/23 Productivity and Efficiency plan, including transformation programme alignment	4. - Board approved Productivity and Efficiency Plan	4. DoS/CFO
	Use our resources effectively and sustainably, so we can improve our services	5. Review central corporate functions	5. - Completion of reviews and implementation of action plans	5. CEO
		6. Review clinical model and functions across hospital sites, aligning to clinical service strategies	6. - Establishment of review group - Approval of review report - Action plan to transfer functions and/or activity between hospital campuses	6. COO
	Create the conditions for clinical research to flourish	7. Development and delivery of Trust Accountability Framework	7. - Board approved Accountability Framework - Roll out programme for Accountability Framework	7. Director of Corporate Services
		8. Develop and deliver Year 1 of the Research and Innovation Strategy	8.. - Development and tracking of Y1 priorities	
		9. Continue to deliver CQC Action Plan to agreed timelines	9. - Update of CQC action plan - Monitoring of delivery of action plan	8. Medical Director 9. Medical Director

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WUTH Strategic Priorities 22/23

NHS
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Continuous Improvement
Maximise our potential to improve and deliver best value

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Continuous Improvement Maximise our potential to improve and deliver best value	1. Deliver Elective Recovery Programme to plan, including productivity reviews across: a. Gynaecology b. Urology c. Colo-rectal surgery	- Reduction in waiting list size - Reduction in 52+ week waiters - Development and delivery of Improvement plans following service reviews	COO

Outcome

Details of Progress	Next Steps Q3&4
• Significant challenges with delivering the elective programme due to the loss of six theatres for the first three months of the year. • Full governance structure put in place to ensure operational productivity is the focus across all points of deliver (Theatres, Endoscopy, Outpatients). Weekly tracking of the improvements required and changed to deliver our elective programme, through to Programme Board. • Full service review of Urology commenced to understand recurrent capacity and demand challenges. Operational plan to mitigate the gaps and improve performance heading into the next financial year. • Gynaecology outpatient re-modelling proposal developed with a change in service model to deliver an improved elective recovery position – now needs to be implemented • Delivered the target of having zero 104 week waits	• Deliver improved elective recovery position from quarter 3 with new governance that has been introduced • Deliver additional activity through the Surgical Centre from November • Implement new Gynaecology outpatient model • Deliver zero 78 week waits by year end • Deliver an improved 52 week non admitted position

NHS Wirral University Teaching Hospital NHS Foundation Trust

Continuous Improvement
Maximise our potential to improve and deliver best value

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Continuous Improvement Maximise our potential to improve and deliver best value	2. Achieve financial sustainability across 22/23	- Delivery to 22/23 financial plan - Development and delivery of CIP - Delivery of capital programme to budget	CFO

Outcome

Details of Progress	Next Steps Q3&4
- Financial reporting framed around 4 high level risks. - Forecasting processes reviewed and updated. - ICB provided with analysis pack (well received) - Forecast deficit non-recurrently mitigated to c£6m - CIP programme relaunched with link to strategic objectives. - CIP governance linked to Programme Board. - Financial controls to be strengthened across agency, substantive and non-pay. - Capital programme reprioritised and revised plan approved by Board.	- Programme Board to oversee CIP delivery. - DD comms session led by CFO. - 23/24 Planning initiated - Zero based budgeting initiated. - Finance strategy finalised and initiated. - LTFM (5 years) completed. - 3-5 year CIP and Capital programmes agreed.

NHS Wirral University Teaching Hospital NHS Foundation Trust

Continuous Improvement
Maximise our potential to improve and deliver best value

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Continuous Improvement Maximise our potential to improve and deliver best value	3. Develop 22-26 Financial Strategy	- Board approval of 22-26 Financial strategy	CFO

Outcome

Details of Progress	Next Steps Q3&4
- Development of LTFM initiated. - PLICS programme initiated and budgeting software incorporating costing information in final stages of development. Planning meetings undertaken with Strategy team, - High level strategic vision developed,	- Meet with ICB team - Test / socialise strategy with divisions - Test / socialise with NEDS through FBPAC - Finalise LTFM - Finalise strategy - Sign strategy off with Board - Incorporate within 23/24 Planning and budgeting.

WUTH Strategic Priorities 22/23

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Continuous Improvement
Maximise our potential to improve and deliver best value

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Continuous Improvement Maximise our potential to improve and deliver best value	4. Develop and implement 22/23 Productivity and Efficiency plan, including transformation programme alignment	- Board approved Productivity and Efficiency Plan	CSO

Outcome

Details of Progress	Next Steps Q3&4
Service Improvement Team • Aligned transformation programmes; Flow and Peri Operative with CIP • Re scoped Flow and Peri Operative Programmes with focus on delivery of benefits • Transferred Transformation Programmes & Projects to Smartsheets • Conducted Community Paediatric Service Review Productivity & Efficiency Team • Developed new CIP approach • Productivity and Efficiency plan established • Trust level diagnostic review completed • 10 Transformation Programmes introduced • Divisional plans to support Transformation programmes are in development • Financial benefits tracker established • Transformation Portfolio benefits tracker established • Programme board revised to focus on Transformation Programmes • 262 CIPs aligned to programmes • Digital Health Care projects aligned to programme	Service Improvement Team • Realisation of benefits from Flow & Peri-Op Programmes • Scope and build Diagnostic Programme • SIT Project Management training for new staff Productivity & Efficiency Team • Tracking and monitoring of benefits and removal of budget inline with savings • Accountability for delivery of programmes at divisional level • Tracking and monitoring of plans and deadlines • Delivery of CIP

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Continuous Improvement
Maximise our potential to improve and deliver best value

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Continuous Improvement Maximise our potential to improve and deliver best value	5. Review central corporate functions	- Completion of reviews and implementation of action plans	CEO

Outcome

Details of Progress	Next Steps Q3&4
	• Scope service reviews • Undertake analysis of corporate service opportunities with divisions

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Wirral University Teaching Hospital
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Continuous Improvement
Maximise our potential to improve and deliver best value

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Continuous Improvement Maximise our potential to improve and deliver best value	6. Review clinical model and functions across hospital sites, aligning to clinical service strategies	- Establishment of review group - Approval of review report - Action plan to transfer functions and/or activity between hospital campuses	COO

Outcome

Details of Progress	Next Steps Q3&4
• First draft of the site configuration work completed and presented across triumvirates • Clear vision for what specialities and services should be on which site • Significant progress made with the modelling to support the site configuration	• Complete the service vision for the site configuration with robust benchmarked data with a view to being best in class • Develop a case to access regional/national funding for the potential change to M1 to support the clinical vision for the Clatterbridge site • Finalise plans for the additional medical staff required to change the casemix of patients at the Clatterbridge site • Trust wide management of outpatient facilities to be commenced

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Continuous Improvement
Maximise our potential to improve and deliver best value

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Continuous Improvement Maximise our potential to improve and deliver best value	7. Development and delivery of Trust Accountability Framework	- Board approved Accountability Framework - Roll out programme for Accountability Framework	DCS

Outcome

Details of Progress	Next Steps Q3&4
• Framework has been created and shared with triumvirates. • A dashboard has been developed for use at TMB.	• Full Implementation of the framework in October 2022. • Organisation wide communication. • Board development session in December 2022.

NHS Wirral University Teaching Hospital NHS Foundation Trust

Continuous Improvement
Maximise our potential to improve and deliver best value

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Continuous Improvement Maximise our potential to improve and deliver best value	8. Develop and deliver Year 1 of the Research and Innovation Strategy	- Development and tracking of Y1 priorities	Medical Director

Outcome

Details of Progress	Next Steps Q3&4
• Research and Innovation strategy completed and approved by Board • New Research and Innovation Board subcommittee established • New Clinical lead for Research and Innovation in post • Estates plan for research hub completed	• Explore funding options to develop estates plan for R&I hub • Engagement with clinical staff to expand R&I capacity at WUTH

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Wirral University Teaching Hospital
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Continuous Improvement
Maximise our potential to improve and deliver best value

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Continuous Improvement Maximise our potential to improve and deliver best value	9. Continue to deliver CQC Action Plan to agreed timelines	- Update of CQC action plan - Monitoring of delivery of action plan	Medical Director

Outcome

Details of Progress	Next Steps Q3&4
• Regular CQC check and challenge meetings in place • CQC preparedness action plan developed • Use of Tendable as an audit platform for evidence of ongoing improvement work • External expert appointed to review current processes	• Commence mock inspection process • Review previous actions marked as completed to ensure ongoing assurance in place

Our Partners

WUTH Annual Priorities 2022/23

NHS
Wirral University Teaching Hospital
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Our Partners
Provide seamless care working with our partners

WUTH Strategic Objectives	WUTH Strategic Priorities	WUTH Annual Operational and Strategic Actions 2022/23	Key deliverables	Action Ownership
Our Partners Provide seamless care working with our partners	Integrate care to prevent ill-health, improve wellbeing and meet the needs of the Wirral population	1. Develop approach for Trust at ICB/CMAST and Place level	1. -Develop and implement representation plan and priorities across ICB/CMAST and Place - Support establishment of Place and TOM	1. DoS
	Deliver system partnerships which improve outcomes for our patients	2. Develop opportunities for clinical, clinical support and corporate service consolidation and integration with WCT and across C&M	2. - Map clinical services across two Trusts - Identify models for integration - Develop plan for integration	2. DoS
	Lever our clinical expertise to drive clinical quality and influence system working	3. Commence South Mersey Hub at Clatterbridge Hospital, aligning to new theatre complex	3. - Design and deliver clinical model for partner Trusts - Design and deliver financial and workforce model for partner Trusts	3. COO
	Build partnerships with academic institutions to develop research and education capability			

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Our Partners
Provide seamless care working with our partners

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Our Partners Provide seamless care working with our partners	1. Develop approach for Trust at ICB/CMAST and Place level	-Develop and implement representation plan and priorities across ICB/CMAST and Place - Support establishment of Place and TOM	CSO

Outcome

Details of progress	Next steps Q3&4
• Target Operating Model for Wirral Place-based Partnership completed and agreed by Place partners. • Development of a MoU and ToR for Wirral Provider Collaborative. • Representation from WUTH on all CMAST committees. • Agreed priorities for 22/23 CMAST	• Establishment of Wirral Provider Collaborative, with representation from WUTH on committee and sub-committees. • Agreement of Place priorities for Q3&4 and development of 23/24 CMAST & Place priorities

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Our Partners
Provide seamless care working with our partners

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Our Partners Provide seamless care working with our partners	2. Develop opportunities for clinical, clinical support and corporate service consolidation and integration with WCT and across C&M	- Map clinical services across two Trusts - Identify models for integration - Develop plan for integration	CSO

Outcome

Details of progress	Next steps Q3&4
• Tabletop review of clinical, clinical support and corporate services undertaken by CSOs and COOs of both WCT and WUTH. • Report produced with services considered as high opportunity for integration. • Draft development plan for integration produced.	• Agreement to develop strategic outline case and due diligence on services considered for integration

NHS Wirral University Teaching Hospital NHS Foundation Trust

Our Partners
Provide seamless care working with our partners

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Our Partners Provide seamless care working with our partners	3. Commence Cheshire and Merseyside Surgical Centre at Clatterbridge Hospital, aligning to new theatre complex	- Design and deliver clinical model for partner Trusts - Design and deliver financial and workforce model for partner Trusts	COO

Outcome

Details of progress	Next steps Q3&4
• Operational model developed for the Surgical Centre roll out • Workforce modelling completed and recruitment made to the majority of positions • Clear vision and scope of the Surgical Centre developed and supported by the clinical leadership team • Advanced discussions with local Trust regarding utilisation of the new asset • 40% of the capacity will be occupied by COCH • Full financial plan developed and discussed with COO, CFO and Deputy CFO to understand the full costs of the new development • WUTH clinical leads for the Orthopaedic development part of regional group reviewing Orthopaedic services across C&M – WUTH development recognised as a good model for system capacity and mutual aid	• Operationalise the new Centre with a go live date 31st October • Finalise plans for the phase two development • Further discussions with other local Trusts regarding the utilisation of capacity • Readiness for mutual aid requests over and after the winter period

Digital Future

WUTH Annual Priorities 2022/23

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Digital Future
Be a digital pioneer and centre for excellence

WUTH Strategic Objectives	WUTH Strategic Priorities	WUTH Annual Operational and Strategic Actions 2022/23	Key deliverables	Action Ownership
Digital Future Be a digital pioneer and centre for excellence	Use digital technology to reduce waste, automate processes and eliminate bottlenecks	1. Deliver Year 2 of Digital Strategy	1. - Develop Y2 Annual priorities and delivery plan - Track across financial year	1. CFO/CIO
	Empower patients with the data and tools to manage their own health and wellbeing	2. Optimise invested Cerner digital solution	2. - Stocktake of Cerner digital solution use and optimisation across Trust - Develop and deliver digital transformation projects - Track progress through Programme Board	2. CFO/CIO
	Allow business intelligence to drive clinical decision making	3. Complete review of analytical functions across Trust	3. - Complete review recommendations - Implement recommendations	3. CFO/CIO
	Use health information to enable population health management for the Wirral			

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WUTH Strategic Priorities 22/23

NHS
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Digital Future
Be a digital pioneer and centre for excellence

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key Deliverables:	Action Ownership
Digital Future Be a digital pioneer and centre for excellence	1. Deliver Year 2 of Digital Strategy	- Develop Y2 Annual priorities and delivery plan - Track across financial year	CFO

Details of progress	Next steps Q3&4
• Strategic priorities agreed and operational plan signed off accordingly by divisions. • Portfolio progress across the four programme pillars of the digital strategy overseen by DPSOC. • Change control process established to manage changing priorities. • All active projects migrated to the Trust Portfolio management system. • Board reporting established including delivery dashboard. • Delivery risks reported through RMC and Board report. • Project methodology refined to deliver greater levels assurance around prioritisation and delivery of projects in conjunction with PMO. • Millennium EPR upgrade delivered • Future project ideas identified and tracked for inclusion in future years operational plans.	. • Continue delivery with DPSOC oversight. • Board reporting established including delivery dashboard. • Delivery risks reported through RMC and Board report. • Work to mitigate current resourcing risks impacting both strategy delivery and business as usual functions. • Work with divisions to prioritise projects for 23/24 operational plan.

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Digital Future
Be a digital pioneer and centre for excellence

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key Deliverables:	Action Ownership
Digital Future Be a digital pioneer and centre for excellence	2. Optimise invested Cerner digital solution	- Stocktake of Cerner digital solution use and optimisation across Trust - Develop and deliver digital transformation projects - Track progress through Programme Board (DPSOC??)	CFO

Details of progress	Next steps Q3&4

• Identified 3 key priorities for the coming year those being:
  • Clinical alerts and supported decision making
  • Standardisation of Inpatient referrals
  • Management of clinical menu structure
• Recruitment of staffing structure to facilitate the above completed.
• Training of staff in core Millennium functionality complete.
• Associated project plans in place.
• "Smartzone" product procured from supplier, awaiting dates for supported implementation.
• Working group established for Inpatient referrals.
• Associated governance structure in place to support all projects.
• Future opportunities identified.
	• Establish working groups and governance to prioritise development and categorisation for alerts and menu structure.
	• Commence technical build of inpatient referrals
	• Agree design and complete build of clinical menu structure.
	• Prioritisation of future opportunities. Amongst those are:
	  • Nursing Documentation
	  • Care Pathways
	  • Management of OP referrals

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Digital Future
Be a digital pioneer and centre for excellence

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key Deliverables:	Action Ownership
Digital Future Be a digital pioneer and centre for excellence	3. Complete review of analytical functions across Trust	- Complete review recommendations - Implement recommendations - Track progress through DPSOC	CFO

Details of progress	Next steps Q3&4
• Review of information function completed and recommendations validated by exec team. • Stakeholders Identified and workforce related working group established. • Build of data models for clinical data sources commenced. • Migration of current clinical reports to new Data Warehouse • Training of existing information analysts in Power BI Tools. • Initial development of corporate data sources for identified areas.	• Agree scope of the hub and spoke future operating model. • Design future operating model. • Identification of corporate data sources for inclusion in data warehouse. • Completion of clinical reporting migration. • Transition to BI Portal for adhoc queries. • Design a governance framework to establish clear ownership and facilitate sign off of information submissions. • Design DQ Metrics to be presented on divisional dashboards.

Infrastructure

WUTH Annual Priorities 2022/23

NHS Wirral University Teaching Hospital NHS Foundation Trust

Infrastructure
Improve our infrastructure and how we use it

WUTH Strategic Objectives	WUTH Strategic Priorities	WUTH Annual Operational and Strategic Actions 2022/23	Key deliverables	Action Ownership
Infrastructure Improve our infrastructure and how we use it	Effectively use our estate to support the delivery of care	1. Design and deliver 22/23 Capital Programme and assets mapping and reviews	1. - Confirm Capital Programe projects - Monitor project delivery to plan - Complete asset surveys	1. DoS
	Delineate the role and functions of the hospital sites	2. Complete and close Capital Improvement Programme, aligning to Archus Review recommendations	2. - Monitor improvement project delivery - Track delivery through Programme Board - Complete projects and undertake improvement close out	2. DoS
	Develop the case for the upgrades of the hospital campuses	3. Deliver UECUP FBC and early construction phases	3. - Deliver FBC and gain approval by DHSC/NHSE - Gain planning approval from Council - Revise governance for construction phase - Monitor construction delivery to plan	3. DoS
	Improve travel and transport to our hospital campuses	4. Deliver Year 1 of Estates Strategy and Green Plan	4. - Development and delivery of Year 1 Estates Strategy priorities - Development and delivery of Green Plan	4. DoS
	Promote sustainability and social value	5. Develop master plan for the Arrowe Park Hospital campus	5. - Seek approval from NHSE - Appoint Architects - Undertake internal and external engagement - Design master plan	5. DoS

Wirral University Teaching Hospital NHS Foundation Trust

Infrastructure
Improve our infrastructure and how we use it

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Infrastructure Improve our infrastructure and how we use it	1. Design and deliver 22/23 Capital Programme and assets mapping and reviews	➢ Confirm Capital Programme projects ➢ Monitor project delivery to plan ➢ Complete asset surveys	CSO

Details of progress	Next steps Q3&4
Confirm Capital Programme Projects • Capital Programme developed for 22/23. **24 schemes** in Total.	• Prepare for 23/24 capital programme that supports 3-5 capital plan.
Monitor Project Delivery to Plan • Development of dashboard and Governance that determines delivery against plan with regular meetings to demonstrate delivery at operational, tactical and strategic levels.	• Finalise capital delivery manual, including design standards; and eek approval to implement. This will support and strengthen the interface between Capital delivery managers and Clinical operational teams. • Develop single governance methodology to capital delivery across all schemes.
Complete Asset Surveys • Developed specification and ITT • Undertook procurement exercise ready to award • Developed asset tagging methodology and integration with appropriate system • Developed mobilisation plan & RAMs • Awaiting financial approval to proceed	**Future Activities (Subject to funding)** • Seek approval and roll out asset tagging process • Develop risk based asset life cycle protocols • Develop E,F&C version control process • Load assets into Mainsaver & SFG20 Integration • Assess labour load • Develop appropriate TOM • Implement • Prepare for transition to CAFM

Infrastructure
Improve our infrastructure and how we use it

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Infrastructure Improve our infrastructure and how we use it	2. Complete and close Capital Improvement Programme, aligning to Archus Review recommendations	➢ Monitor improvement project delivery ➢ Track delivery through Programme Board ➢ Complete projects and undertake improvement close out	CSO

Details of progress	Next steps Q3&4
• Developed an improvement plan that targeted the actions from the Archus report. • Implemented a Task & Finish Group to create workstreams for delivery that directly responded to the reports recommendation. • Tracked, collated evidence that informed an appropriate governance mechanism for the closure of each action. • Provided sufficient update to appropriate Boards and Committees on the continued progression of the improvement plan. • Identified other areas of concern that were also addressed as a result of this improvement plan process. • Close the recommendations of the Archus report Q3 at Capital Committee 30.09.22.	**Future Activities (Subject to funding)** • Identify strategic aspirations for a CAFM & Helpdesk that integrates across E,F&C. • Develop options appraisal for investment. • Determine CAFM solution • Transition asset data from Mainsaver to CAFM system. • Realign the workforce in accordance with CAFM requirements.

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Infrastructure
Improve our infrastructure and how we use it

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Infrastructure Improve our infrastructure and how we use it	3. Deliver UECUP FBC and early construction phases	➢ Deliver FBC and gain approval by DHSC/NHSE ➢ Gain planning approval from Council ➢ Revise governance for construction phase ➢ Monitor construction delivery to plan	CSO

Details of progress	Next steps Q3&4
• FBC Submitted and Approved with conditions • Tracker developed for monitoring the conditions of the FBC • Planning approval gained, discharge conditions being executed • Governance revised agreed at Programme Committee and been implemented • Governance supports construction delivery plan • Design and Build meetings established to monitor delivery	• Conditions of FBC to closed out prior to the execution of the stage 4 contract • Delays in programme and costs and funding to be established • Monitor and track project budget throughout the life of the project

WUTH Strategic Priorities 22/23

NHS
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NHS Foundation Trust

Infrastructure
Improve our infrastructure and how we use it

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Infrastructure Improve our infrastructure and how we use it	4. Deliver Year 1 of Estates Strategy and Green Plan	➢ Development and delivery of Year 1 Estates Strategy priorities ➢ Development and delivery of Green Plan	CSO

Details of progress	Next steps Q3&4
Confirm Capital Programme Projects • Developed corporate Estates Strategy • Developed annual operational strategic priorities • Implemented mechanisms for reviewing progress (E,F&C Performance Meetings) • There are 13 priorities identified aligned with the Trust strategy pillars, with 56 corresponding activities that support the delivery of each objective. • Out of the 13 priorities the following performance levels can be attributed, the <70% objective is due to - Budget pressures - Delivery of CIP - Implementation of SLA's for Tenants	• Improve the position on the <70% priority • Continue to works towards priorities assigned in Q3/Q4
Development and delivery of Green Plan • Data collection has started to support WUTH Green Plan refresh ahead of 1-year anniversary; this will incorporate the priorities as set out in the C&M Green Plan *(WUTH Green Plan submitted to C&M ICS as mandated 14/01/22 – the C&M ICS Green Plan was shared 01/04/22)* • Workshops held for each Area of Focus and priority areas identified and workstreams established • Submitted applications for Healthier Futures funding for variety of small scale sustainability initiatives/ projects • Appointed a Trust Head of Sustainability and Net Zero Carbon Management (started 02/08/2022) • Further integrated within the C&M and the Council sustainability teams/groups • Appointed as Chair for Wirral Place Sustainability Group	• Refresh Green Plan and submit to Board for approval Q3/Q4 • Develop a high-level strategy for achieving operational Net Zero; specifically looking at building related energy use (direct emissions only) Q4 • Sign the Charter for WUTH to become Anchor Institution Q3 • Commence Climate Adaptation Risk Assessment National Pilot

	<70	70>	90>
Number of	1	7	5
%	8	54	38

NHS Wirral University Teaching Hospital NHS Foundation Trust

Infrastructure

Improve our infrastructure and how we use it

WUTH Strategic Objectives	WUTH Annual Operational and Strategic Actions 22/23	Key deliverables:	Action Ownership
Infrastructure Improve our infrastructure and how we use it	5. Develop master plan for the Arrowe Park Hospital campus	➢ Seek approval from NHSE ➢ Appoint Architects ➢ Undertake internal and external engagement ➢ Design master plan	CSO

Details of progress	Next steps Q3&4
• Developed ITT and specification • Undertook procurement exercise and identified a preferred provider • Not commissioned or awarded due to funding approval required from NHSE/I to commence • Developed and aligned local plan representations	• Award contract • Undertake internal and external engagement • Design master plan

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 5 October 2022
Location	Board Room, Education Centre, Arrowe Park Hospital

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Deputy Chair
SR	Steve Ryan	Non-Executive Director
CC	Chris Clarkson (joined at 9:30am)	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Nicola Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
DS	Debs Smith	Chief People Officer
MC	Mark Chidgey	Chief Finance Officer
MS	Matthew Swanborough	Chief Strategy Officer
SB	Stephen Baily	Deputy Chief Operating Officer
HK	Hayley Kendall (joined at 10am)	Chief Operating Officer

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
CM	Chris Mason	Chief Information Officer
SS	Sally Sykes	Director of Communications and Engagement
SH	Shelia Hillhouse	Lead Public Governor
PB	Phillipa Boston	Staff Governor
HKer	Helen Kerrs	Guardian of Safe Working (item 9.6)
RM	Ranjeev Mehra	Deputy Medical Director (item 9.7)
JS	Janice Smith	Good Governance Institute (observing)

Apologies:

RM	Rajan Madhok	Non-Executive Director

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed everyone to the meeting including JS from the Good Governance Institute who was observing the meeting for the purposes of Board development. Apologies were received from RM.	
2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** NS requested one amendment to section 9.2 to state there was a reduction in the number of quantitative research projects. Subject to the amendment, the minutes of the previous meeting held were **APPROVED** as an accurate record.	James Jackson-Ellis
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 presented at the Emergency Department (ED) with Quincy's and was subsequently admitted. The patient also had a severe phobia of needles, and the story described the challenges she encountered. TF commented that this was a complex story and learning had been identified. TF added learning from reviewing the case will be progressed through the Patient Experience Strategy Promise Group. SL noted the patient's parent was not able to accompany the patient when attending ED, the first time but could the second. SL enquired for the reason behind this. TF stated this was due to the COVID-19 restrictions at the hospital during the time. SR commented that this story echoed a previous patient story who had learning difficulties and it was important to ensure a personalised approach to each patient. The Board **NOTED** the patient story.	

6	**Chair's Business and Strategic Issues** DH updated the Board of Directors on recent matters and gave an overview of the position regarding the new Integrated Care Board (ICB) and Place structure. The Board discussed the challenges this created but acknowledged the Executive Team remained proactive in building relationships with Place and was continuing to influence colleagues and embed new arrangements. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH provided an Infection Prevention Control (IPC) update and explained the latest guidance implemented by the Trust. JH highlighted the Trust had commenced the Autumn Booster Vaccination Programme at the Clatterbridge Vaccination Hub from 12 September. JH stated the Trust was awarded £14.9m for the development of two additional modular operating theatres and the internal theatre complex refurbishment at Clatterbridge Hospital, as part of the NHS England Targeted Investment Fund (TIF) for 2022/23. JH added the Trust received notice from the Royal College of Paediatricians and Child health following the 2021 National Neonatal Audit Programme that Wirral University Teaching Hospitals have been identified as outstanding for the audit measure Antenatal Magnesium Sulphate. JH reported the Trust declared 5 serious incidents as well as four incidents in relation to RIDDORs. JH highlighted the electronic resolution approved by the Board between Board meetings in relation to an amendment to the Capital budget. Board was asked to ratify this approval. JH also mentioned other announcements made by system partners, such as the North West Ambulance Service (NWAS) Strategy 2022-25 and the Cheshire and Merseyside Acute and Specialist Trusts (CMAST) Briefing. LD queried the new North West Ambulance Service Strategy and if there were any implications for the Trust. MS stated there were no implications for the Trust. SR noted the positive news regarding the National Neonatal Audit Programme result.SI commented it would be beneficial for the	

	Board to understand the governance structure in regard to reporting, now the Integrated Care Board (ICB) was operational. DM stated the ICB, and the governance structure would be a focus for a future a Board Seminar. The Board • **NOTED** the report and • **RATIFED** the electronic approval taken during September in relation to Capital Expenditure.	David McGovern
8	**Chief Operating Officer's Report** SB provided an overview of the Trust's current performance against the elective recovery programme for planned care and standard reporting for unscheduled care. SB reported elective performance was 111.2% against a plan of 106.7% for outpatients. 106.5% of elective admissions activity was delivered against a target of 106.5%. No patients were waiting over 104 weeks for referral to treatment. SB stated unscheduled care performance against the four-hour standard for type 1 attendances has increased from 48.53% in July to 50.55 % in August. The Trust reported 155 patients exceeding the 12-hour DTA target, the highest position year to date. JH stated there was an upcoming meeting between both Trusts to discuss opportunities for collaboration in the Urgent Treatment Centre. CC noted there were circa 1100 patients waiting longer than 52 weeks for referral to treatment and queried how confident the Trust was in achieving this. HK stated the focus currently was on patients waiting 78 weeks for referral to treatment. A forecast for the 52-week waiters would be brought to the Board next year. HK added the Limited Liability Partnership would support the Trust to reduce the number of patients waiting 52 weeks. HK proposed that the internal performance trajectories be governed through FPBAC to provide the Board of Directors with further assurance. The Board **NOTED** the report.	Hayley Kendall
9	**Board Assurance Reports** **9.1 Quality and Performance Dashboard** The Executive Directors briefed the Board of Directors on metrics in the dashboard. It was noted that of the 49 indicators reported against thresholds (excluding Use of Resources) 34 were off-target or failing to meet performance thresholds and 15 are on-target.	

NS highlighted in line with the national trend, the number of complaints logged in August had risen from previous months and it was anticipated this trend would continue with a key theme being access to timely treatment.

TF reported C difficile remained a challenge for the Trust and highlighted that enhanced cleaning was being undertaken and the team were strengthening assurance relating to cleaning processes and improving oversight to enable prompt action to be taken as necessary. TF also reported there was a focus on reducing other gram-negative bacteraemia across the Trust.

TF added the number of wards that were below the care hours per patient day threshold was 7 against a Trust target of 3. TF highlighted this was due to a rise in Clinical Support Worker (CSW) vacancies and sickness absence. A CSW event was planned for 15 October.

DS stated sickness absence was 5.9% against the Trust target of 5% but that the overall improvement trend from the peak in January 2022 continued. There were emerging signs this would increase due to COVID related sickness in the coming months. Mandatory training compliance was above target at 90.5%. Appraisal compliance was 86.7% against the Trust target of 88% and the overall improvement trend from April 2022 continued. This continued to be a focus in Divisional Performance Reviews as well as improving the quality of appraisal discussions via the People Committee workstream.

DS added staff turnover remained an area of concern and was 12% for permanent staff. One area of focus was Additional Clinical Services who had a high turnover and sickness absence. A deep dive into this area would be presented to the People Committee in November.

The Board **NOTED** the report.

9.2 Month 5 Finance Report

MC highlighted the Trust was reporting a year-to-date deficit of £2.435m which is, an adverse variance against budget of £3.129m. The Trust continues to forecast a break-even position, but achievement of this should be considered as at risk. A revised annual forecast will be provided to the Board in November.

MC stated the year-to-date variance remained attributed to overspends on employee costs, driven by the under-delivery of recurrent CIP, the continued use of escalation wards, staffed at premium rates and the additional costs of employing consultants and junior doctors at agency rates of pay.

MC added the Trust has been able to partially mitigate these overspends by non-recurrent mitigations through the release of deferred income and underspends in non-pay resulting from reduced elective activity.

MC highlighted that, as agreed across the ICS, the financial position assumes that the Trust would retain 100% of the Elective Recovery Fund (ERF) income. This was a risk to the forecast because national policy on this may change and performance against the agreed elective plan was significantly below the target level of 104% of 2019/20 levels.

SL queried how the Trust compared to other Trusts financially.

MC stated that the Trust forecast position was similar to other acute Trusts but that we had one of the higher variances against plan. This was due to the Trust setting a balanced budget, whereas other Trusts set a budget with a deficit.

SL also queried if other Trusts had similar reasons for reporting a deficit.

MC stated that information had not been shared so as to establish this – but he was aware that for some other Trusts the phasing of CIP may make their position increasingly challenging.

JH highlighted she and MC met with the ICB recently to discuss the Trust's financial plan. The ICB had positive feedback for the Trusts approach and understood the issues and mitigation plans.

DH queried the variance relating to medical staffing.

MC stated additional financial controls were being established. The Finance Performance Group continued to scrutinise bank/agency staff placements and ensure Divisions had a clear exit plan in place to reduce the expenditure.

The Board **NOTED** the report.

9.3 Quarterly Maternity Report

TF highlighted the regional NHSE/I maternity insight visit with the Local Maternity and Neonatal System (LMNS) held on 16 August 2022 following the final Ockenden report. TF provided an update on Maternity Incentive Scheme (MIS), which would inform the Trust declaration to the MIS due for submission before 5 January 2023.

TF also provided an update on the implementation of the Continuity of Carer model of maternity care. A consultation with staff had taken place to support staff transitioning to work within a continuity of carer model.

TF reported despite the Trust having good progress moving towards Continuity of Carer before March 24. The Trust had received a letter advising the target date had now been reviewed. The Trust will continue to review plans to safely implement Continuity of Carer as far as possible.

SL queried the percentage increase in the number of babies born by caesarean section and if there was a reason for this.

TF stated the increase was due to personal preferences of mothers, multiple births, and an increase in obesity.

The Board

- **NOTED** the report including the NHSE/I maternity insight visit with the LMNS held on 16 August 2022;
- **NOTED** the Report of One to One published in September 2022;
- **NOTED** the Trust's position of Year 4 of the Maternity Incentive Scheme; and
- **NOTED** following the Ockenden 2 together with a workforce update with specific reference to the Continuity of Carer model of maternity care and the Trust's position to implement as a default model.

9.4 Digital Healthcare Update

CM provided a progress update on the development of operational plans to deliver the Digital Strategy strategic priorities of the Trust over the next 12 months. CM added of the 41 projects, 29 were currently green, 10 amber and 2 red.

CM stated there was a risk relating to resource within the innovation portfolio that involved integration work. There had been challenges recruiting to integration posts, which had been exacerbated with the unexpected and sad loss of a senior staff member within the team. CM added the operational plan was currently being reviewed with a revised schedule due to be determined in October.

DS queried if there was a plan in place to address the risk in terms of resource and if the Digital Healthcare Team had been provided with wellbeing support given the loss of the senior staff member.

CM stated the IT job market remained challenging and welcomed support from HR colleagues to address the risk. Staff were also aware of the wellbeing support and encouraged to use it.

DS agreed to ask HR colleagues to meet with CM to agree and enact a workforce plan.

The Board **NOTED** the report.

9.5 Cost Improvement Programme (CIP)

MS provided an update on the current CIP position for Trust, highlighting that the overall CIP target was £20.6m, of which £13.6m was required to be recurrent. MS added the Trust was altering the approach to CIP for the remainder of the year due to underperformance. MS also highlighted the revised governance, monitoring, and delivery process for CIP.

The Board **NOTED** the report.

9.6 Guardian of Safe Working Quarterly Report

HKer provided details of the number of doctors in training, details of the exception reports submitted for the reporting period by speciality and grade as well as details of breaches of safe working hours and fines incurred.

DH acknowledged the transformation in junior doctor relations and queried if this was also related to clinicians.

NS stated it was not related but noted it was positive junior doctors had confidence submitting exception reports.

DS commented that the Chair of the Joint Local Negotiating Committee noted an improvement in junior doctor engagement, and this was due to HKer's positive relationship with junior doctors.

The Board **NOTED** the report.

9.6 Learning from Deaths Report (Q1 2022-23)

RM provided a summary of the mortality review process, care issues, learning and current mortality comparator statistics for Q1 2022-2023. RM stated there were a total of 414 deaths in the period. 69 of these deaths were inpatients who died within 28 days of a positive COVID-19 swab. 11 of these patients were determined to have developed nosocomial COVID-19. RM added as per previous trends most recorded deaths are in the over 60 age group and the vast majority fall into the "White British" ethnicity.

SL noted deaths due to pancreatic cancer were trending upwards and these were seen in palliative care patients. SL queried where pancreatic cancer patients were managed.

RM stated pancreatic cancer patients were managed at Liverpool Hospital.

	SR noted the Trust's Summary Hospital Level Mortality Indicator (SHIMI) was impacted by high deprivation, resulting in higher-than-average deaths in the most deprived quintile. SR queried if it was worthwhile raising with the local Director of Public Health. NS stated she would raise health inequalities again at the next meeting. NS also highlighted that the overall data was not showing a continued upward trend. NS added she met regularly with the previous Director of Public Health and a new Director had recently been appointed. The Board **NOTED** the report, mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group	
10	**Safeguarding Annual Report** TF provided an overview of the national and local context of safeguarding and the current Trust position by providing assurance that the Trust was meeting its statutory obligations and national safeguarding standards. TF highlighted the number of improvements made to safeguarding in 2021-22 as well as the targeted areas requiring improvements during 2022/23. The Board **NOTED** the report and assurance provided, and the actions being taken to rectify the areas for improvement. Recognition was given to the hard work and commitment of the Safeguarding Team and all Trust staff.	
11	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards** HK highlighted the Department of Health and Social Care and NHSE/I require Trusts to undertake an annual assessment of their Core Standards for Emergency Preparedness, Resilience & Response. HK explained the Trust undertakes a self-assessment against each applicable core standard and requires an action plan for any standard that is not Fully Compliant. HK added for 2022/23 the Trust declared Partial Compliance. Areas which require improvement were largely as a result of national changes to the approach to EPRR as part of the response to COVID-19. The Trust was already putting in place robust plans to update the standards to ensure full compliance. HK stated regional Trusts will meet to discuss the core standards on 14 and 20 October prior to the Regional ICB submission deadline of the 28 October. The Board	

	• **NOTED** the scoring of the self-assessment and • **APPROVED** the submission to the Cheshire and Merseyside Integrated Care Board.	
12	**CQC Inspection Preparedness** DM informed the Board of work that had commenced in preparation for a CQC Inspection following the previous inspection in 2019, which resulted in an overall provider rating of 'Requires Improvement'. DM highlighted a full self-assessment against the CQC regulations and key lines of enquiry was being undertaken and led by the Governance Support Unit in conjunction with colleagues from across the Trust. DM explained an assessment against preparedness would be carried out by an independent advisor. DM provided an overview governance structure and the reporting mechanisms, highlighting the Board would receive regular progress reports from November to February. The Board **NOTED** the report.	
13	**ICB and Place Update - (CMAST) Joint Working Agreement and Committee in Common** DM highlighted as part of the introduction of the ICS/ICB the Cheshire and Merseyside Acute and Specialist Trust provider alliance brought Trusts together to establish joint priorities. DM added it had been determined that the arrangements for CMAST would be formalised through a joint working agreement and the establishment of a Committee in Common by each Trust. DM stated the Trust has a duty to collaborate. The approval of the Joint Working Agreement and Committee in Common Terms of Reference was an important step in formalising the governance arrangements to enable CMAST to operate effectively. SI commented about the feasibility of the agreement and the plan for when conflicts arise. SI also questioned the possible implications for the Trust as an autonomous Foundation Trust serving the community of Wirral. DH commented it was it was a voluntary agreement, and the Trust could exit should it wish to do so. The Board • **APPROVED** the CMAST Joint Working Agreement to be signed by the Chief Executive on behalf of the Board. • **APPROVED** the establishment of a Committee in Common with Terms of Reference as proposed.	

	• **ADOPTED** and **SPONSORED** the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals.	
14	**Policy Update Report (Managing Conflicts of Interest)** CH presented the Managing Conflicts of Interest for approval, following approval at the Audit and Risk Committee. SL queried the means of ensuring relevant staff were aware of the requirements and how this policy will be publicised. CH stated that a statement around the new policy will be included in a Communications bulletin and that all relevant documentation is included on the portal that the Trust uses to manage declarations. The portal also sends regular and frequent reminders to those who still need to submit a declaration. CH added that current position is around 75% compliance. The Board **APPROVED** the Managing Conflicts of Interest Policy.	
15	**Committee Terms of Reference** CH presented the Committee Terms of Reference for approval, following approval by each Committee. It was noted that Remuneration and Charitable Funds Committee Terms of Reference will come to November Board. The Board **APPROVED** the Committee Terms of References.	
16	**Standing Financial Instructions (SFIs)** MC presented the SFI's for approval, following approval at the Audit and Risk Committee. The Board **APPROVED** the revised SFIs.	
17	**Communications and Engagement Report** SS provided an update on Trust's communications and engagement activities in September and upcoming activity in October. The Board **NOTED** the report.	
18	**Committee Chairs Reports** **18.1 People Committee**	

LD provided a report on recent proceedings of the meeting held on 7 September. The Committee received a number of standing reports relating to Chief People Officer Report, People Strategy Report, Workforce Key Performance Report and Employee Relations Report. The Committee received a Flu Programme Update and approved the Terms of Reference and a number of a HR policies.

The Board **NOTED** the report.

18.2 Audit and Risk Committee

SI provided a report on recent proceedings of the meeting held on 21 September. The Committee received a number of standing reports relating to Financial Assurance Report and Procurement Spend Controls Waivers Report. The Committee also discussed the latest internal audit reports and received an update on external audit. The Committee approved the Managing Conflicts of Interest Policy, Terms of Reference, and Standing Financial Instructions.

The Board **NOTED** the report.

18.3 Estates and Capital Committee

DH provided a verbal report on recent proceedings of the meeting held on 30 September. The Committee received an update on Urgent & Emergency Care Upgrade Programme (UECUP), 2022/23 Capital Programme Delivery Update and Arrowe Park Hospital Campus Master Planning. The Committee discussed the progress made with the Frontis Building Review and G4S Building Security Review. The Committee approved the Terms of Reference.

The Board **NOTED** the report.

18.4 Quality Committee

SR provided a verbal report on recent proceedings of the meeting held on 30 September. The Committee received a number of standing reports including the Patient Safety Quality Board Key Issues Report, Quality and Patient Safety Intelligence Report and Serious Incident Panel Chair's Report. The Committee also received a Care Quality Commission Action Plan Update and the Clostridioides Difficile Q1 2022/23 Update and Improvement Plan

The Board **NOTED** the report.

18.5 Research and Innovation Committee

DH provided a verbal report on recent proceedings of the first meeting of the Committee held on 4 October. The Committee approved the Terms of Reference, received the Research Annual

	Report, and discussed the Research and Innovation Strategy and the upcoming priorities. The Board **NOTED** the report.	
19	**Questions from the Public** No questions from the public were raised.	
20	**Any other Business** No other business was raised.	

(The meeting closed at 11:45)

Meeting	Board of Directors in Public
Date	Wednesday 2nd November 2022
Location	Elm House, Clatterbridge Hospital

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Deputy Chair
SR	Steve Ryan	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
RM	Rajan Madhok	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
DS	Debs Smith	Chief People Officer
MC	Mark Chidgey	Chief Finance Officer
MS	Matthew Swanborough	Chief Strategy Officer
HK	Hayley Kendall	Chief Operating Officer

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
SS	Sally Sykes	Director of Communications and Engagement
PM	Paul Mason	Director of Estates, Facilities and Capital Planning
RC	Richard Crockford	Deputy Director of Quality Governance
SH	Sheila Hillhouse	Lead Public Governor
TC	Tony Cragg	Public Governor
PI	Paul Ivan	Public Governor

Apologies:

EH	Eileen Hume	Deputy Lead Public Governor
RT	Robert Thompson	Public Governor

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed all present to the meeting. Apologies were received as above.	

2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 5th October were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board viewed the story of a patient who required surgery and suffered anxiety relating to hospital visits. The patient explained how caring and accommodating all staff, including the surgeon, anaesthetist and ward staff, were during her time before, during, and after surgery, and outlined the challenges she encountered around discharge. The patient felt her experience was overwhelmingly positive, despite these challenges. TF noted that the staff mentioned in the patient story will be told of this positive feedback and added that the issues the patient raised are being addressed. DH enquired whether these stories are shared more widely. TF replied that they form part of the Chief Nurse check ins, and the workforce meetings. The Trust has a patient story library that is a repository of stories that are themed so that the Trust can easily access stories to use in other meetings. It was noted that patients would benefit from this as well, i.e. those patients with anxiety around hospital visits may benefit from hearing this patient's story. It was agreed some patients may benefit from seeing a video of what departments look like before attending the hospital, it was agreed this would be considered. The Board **NOTED** the patient story.	TF/HK
6	**Chair's Business and Strategic Issues** DH reported that work continues with strategic partners within Place and the ICS, and to improve access to social care.	

	Conversations continue with the ICB to ensure they remain sighted on our position and assured around the controls we have in place. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH gave an overview of the report, noting the position on COVID, the recent findings of the East Kent report, and the updated handover date of 4th November for the C&M Surgical Centre (delayed from 31st October). A second tranche of Targeted Investment Fund allocations totalling £14.95m was approved in September to expand the Surgical Centre's footprint. 1 RIDDOR and 4 Serious Incidents were reported in September, including 1 Never Event for which duty of candour has been commenced. JH also informed the Board that Michelle Beale (WUTH named safeguarding lead midwife) has won the NHS Safeguarding Award for outstanding midwifery safeguarding leadership pertaining to the implementation of the Maternity HOPE (Hold On Pain Eases) Box. The Board congratulated Michelle Beale on her award and suggested that she be invited to the next Board. Board were reminded of the two electronic approvals sent out between meetings relating to the cost increase on the UECUP project, and the contract award for the Clatterbridge Community Diagnostic Centre Modular Build Project. JH noted that these had both been approved successfully, and asked Board to ratify these electronic approvals. RM highlighted the section on the COVID inquiry and enquired if we can be proactive with this. NS replied that DM is working on this and that we have a proactive process to pull together our evidence. The Trust has kept logs of all decisions taken throughout the pandemic supported by relevant evidence, though we do not yet know how much detail will be required. RM enquired about means of considering the wider learning from the pandemic. NS stated that NHSE had visited a few months ago to review, and while no final report has yet been received, the informal feedback was positive and identified best practice that could be shared elsewhere. NS added that our learning response will be incorporated into the wider Place response.	CH/TF

	SR enquired about current flu figures. NS replied that there are very few patients in the hospital with flu, and we know this because we are using a new point of care testing which looks for both flu and COVID. The trend will be better established by December. The Board • **NOTED** the report and • **RATIFED** the two electronic resolutions taken between meetings.	
8	**Chief Operating Officer's Report** HK reported elective activity performance, stating that in September 2022, the Trust attained 108.6% against a plan of 104.7% for Outpatients. For elective admissions 100.7% of activity was delivered against a target of 105.5%. In terms of wait times, there are no 104+ week waiters, however there may be one potential breach in October for a patient awaiting a corneal graft. There is a national shortage of corneal grafts, and guidance around reporting these is still awaited. HK stated that in terms of cancer performance, the volume of two week wait referrals remains at its peak, and that 2 week breast referrals were non-compliant in August and September, mainly due to demand. Recovery was planned in October and compliance is forecast from November. HK noted a risk to recovery associated with the national position from the British Medical Association (BMA) on rates, and three specialties have confirmed they will not undertake additional sessions unless this is at the proposed BMA rate. HK is meeting with these specialties to understand mitigations and minimise impact on wait times. HK reported that for unscheduled care, performance against the 4 hour standard for Type 1 attendances increased from 50.55% in August to 54.70% for September. The new booking system for UMAC will help to further unscheduled care improvements. There have been minimal breaches in 12 hour waits and reduced corridor care as a result. HK highlighted the concerns on capacity going into winter and noted that the full capacity protocol has been implemented for use if required. There are particular concerns around the numbers of mental health patients and both their and staff safety while in our hospital.	

	Discussion took place around stranded patients. Current figures are 216 patients, with approximately 150 who should be out in the community. This is impacted by lack of access both to care homes and to packages for domiciliary care. There is a further risk around discharging patients who may end up readmitted if they don't have the correct care package. It was noted that being able to safely discharge even part of the stranded patient numbers would help significantly with patient flow. SL enquired how we care for the numbers of Section 136 patients we receive. TF replied that we undertake environmental assessments and are working closely with CWP to enhance pathways to keep these patients safe, but we only have three rooms equipped for these patients and have to consider how we keep the other waiting patients safe. It was acknowledged that we do not have the right environment for these patients, and they should be with CWP, but they are struggling with the same capacity issues that we are. It was also noted that the change in the Mental Health Act has meant that patients being sectioned cannot be detained in police cells and therefore more of these patients are presenting at hospital. JH commented that we are working with CWP around safety and risk assessments. SR noted that there will be further challenges with those patients who do not meeting the S136 criteria as we have no legal structure around these patients. SR enquired about boarding. NS replied that the full capacity protocol will allow for this in some wards where there is space. The Board **NOTED** the report.	
9	**Board Assurance Reports** **9.1 Quality and Performance Dashboard** It was noted that seeing both the RAG and SPC charts together was useful and that the SPC charts should be ready for December. DS highlighted the sickness and retention figures, noting that sickness in September was 6.3% which is above target. Work is ongoing with managers around managing sickness and attendance, and wellbeing initiatives are also undertaken.	

DS stated concerns remain around the Additional Clinical Services staff group and that a report will be taken to the next People Committee around managing this.

In terms of turnover, the figure was higher in August due to the expected annual turnover of junior doctors, though this does not account for the full figure. Work to mitigate turnover is in progress and a review will be needed at end of year to determine its effectiveness.

SR noted that the achievement of target on appraisals and mandatory training is to be commended and enquired about measuring appraisal quality.

DS stated that this achievement is due to the hard work of the divisions and that the workforce team are reviewing the appraisal process which will enhance both the forms and process to improve value and quality. This is expected to launch in the new financial year.

NS added that these appraisals are separate to the medical appraisals.

TF highlighted the C. difficile figures on the dashboard and stated that we can now identify community onset C. Difficile infections. Work with partners continues and some deliverables are being achieved already.

The Board **NOTED** the report.

9.2 Month 6 Finance Report

MC reported that at M6, the Trust is reporting a deficit of £3.053m, an adverse variance against budget of £4.018m. This variance is attributed to overspends on employee costs, driven largely by under performance 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 reduced elective activity compared to plan, and the release of deferred income.

MC noted that there will be no clawback of income on elective recovery work up to M6, though national guidance is yet to be confirmed for M7-M12. If the M1-M6 clawback had been transacted, then this is estimated as c£2m.

Total employee expenses represent an overspend against budget of £4.561m. This is primarily driven by the continued reliance on bank and agency staff as a result of staff sickness and use of escalation wards adverse together with the non-delivery of pay CIP.

The Capital programme is behind schedule by £9m, which is principally due to delays in the approvals of UECUP and Phase 2 of the Modular theatres project. This will be caught up in the second part of the year.

MC added that the CIP figures only include those delivered, and therefore there is potential to improve this once the forecast items are achieved.

A series of top down controls have been implemented to manage the financial position, including a vacancy control panel and controls on non-pay spend.

DH enquired about the controls on agency spend and whether we know yet if these are working.

MC replied that it is too early to know but that he has seen behaviours change in terms of ensuring forms are done proactively rather than retrospectively, etc.

DS added that this is why the transformation work is key as it will support behavioural change to make these process changes sustainable. DS noted that this is all being tracked through Programme Board.

SI noted that the underspend on capital is to be expected and enquired whether the cash position is a risk or opportunity based on the current economic situation.

MC stated that this is yet to be seen but noted that the capital programme will be moved to a 3 year programme rather than single year projections, to allow for better flow of funds and management of cash risks.

MS added that contingencies are in place as well to ensure some level of mitigation on spend.

The Board

- **NOTED** the report and
- **NOTED** that without further mitigation the forecast position remains a £6m deficit.

9.3 Monthly Maternity Report

TF noted there has been improvement in vacancies this month, and that risk assessments on the continuity of carer initiative are being undertaken to understand the impact of continuing or stopping this work. This will come back to the December Board.

	SR commended the maternity wards and stated that he had been on a walkabout of the maternity safety partners with Maternity Voices, and all feedback from that was positive. DH commented that in light of the East Kent review, the Board should note that we have undertaken a full review of maternity and that learning continues to be implemented. TF agreed with this and noted that the current action plan does contain a few points that are outside our control but everything else continues to be on track or already implemented. DH also asked about progress with developing a joint working model for Neonatal Services, with Liverpool Women's Hospital and Alder Hey Children's Hospital. MS replied that the Trust, in conjunction with partners, had completed a review and development of options for the future provision of neonatal services. MS added the next stage was to develop a Strategic Outline Case and Operating Model for neonatal services at Arrowe Park Hospital. The Trust was in discussion with NHS England Specialist Commissioners to support the funding of this next phase of work. NS confirmed that this is not impacting on staff morale, and that they understand that Exec are aware of this and are working on the issue. The Board • **NOTED** the report. **9.4 Estates, Facilities, and Capital Update** PM presented the revised dashboards for estates and facilities, to provide the Board with assurance in this area. PM highlighted the exceptions and noted that work continues to demonstrate compliance against statutory measures, including a re-inspection programme of fire risk assessments and fire door maintenance. LD enquired about the meals served figures. MS replied that the service is being reviewed to improve quality and that food wastage figures can be added for the next quarterly report to the Board. CC commented that it was good to see this level of reporting as it has not been available in the past and enquired about the reactive maintenance figures and whether this relates to safety issues. PM replied that reactive maintenance has been prioritised to focus on statutory compliance work first, and that the team are	PM

	considering whether to review the SLA time frames or to consider hiring more staff. MS added that anything that is patient safety related is categorised as urgent as well. SI commented that there are a number of CAFM technological solutions which can support these processes. MS agreed and noted that we are scoping a CAFM system and will aim to bid for internal capital funding as part of the 23/24 internal capital funding rounds. PM stated that getting the asset register completed will help determine our requirements for that system. SR enquired about the reactive maintenance increase and whether that is a real increase or a data quality improvement. PM replied that it is likely both as more people are reporting, and the team are doing walkarounds to pick up issues that need to be fixed. DH enquired about energy usage and how the Trust manages energy conservation. MS replied that a new sustainability manager has been appointed and that further reviews on this will take place. SI added that there are systems that can do this for the Trust, i.e. manage lights being turned on and off, though acknowledged the costs associated with this. The Board **NOTED** the report.	
10	**Patient Safety Incident Response Framework (PSIRF)** RC presented the report and stated that PSIRF is mean to replace the current serious incident reporting regime. Currently we are in stage one of implementation, and that work is progressing though there is an awareness of the requirements for training and development of staff, coupled with current clinical operating pressures. The full syllabus of this programme has not been released yet, and sections 3-5 are still expected. NS commented that while this initiative takes us in the right direction and links to the just and learning culture work, it represents a huge change and the amount of time needed to train staff should not be underestimated.	

	SR enquired if this has been evaluated or piloted anywhere. TF replied that it has been and, in our area, it was piloted at East Lancashire. Members noted that the timing of this is not ideal given the current and upcoming pressures, as well as having just come out of the pressures of the pandemic, though it was acknowledged that it is a step in the right direction. DH enquired if we know how much time will be required of staff to complete this training. RC stated that level 1 is a 15 minute e-learning requirement for all staff, and level 2 is an hour e-learning requirement. It is expected that levels 3-5 will require significantly more time and are likely to be required to be face to face. We are unable to determine the full impact on staff time until these are released. SR enquired if we are able to make the CQC aware of the risks around this. NS replied that we have a new lead from the CQC and that we will ensure we are proactive in informing him of the risks. The Board **NOTED** the report.	
11	**NHSE Operating Model** MS presented the report and stated that this has been released following the legislation passed in July. The Board **NOTED** the report	
12	**Committee Terms of Reference** The Board **APPROVED** the Terms of Reference.	
13	**Communications and Engagement Report** SS provided an update on Trust's communications and engagement activities in October and upcoming activity in November. The Board **NOTED** the report.	
14	**Committee Chairs Reports** **14.1 Quality Committee** The Board **NOTED** the report.	

	14.2 Charitable Funds Committee The Board **NOTED** the report. **14.3 Council of Governors** The Board **NOTED** the report. **14.4 Finance Business Performance Committee** The Board **NOTED** the report.	
15	**Questions from the Public** TC enquired if further information could be provided around statutory compliance on estates management. MS agreed to include further detail in the next report. No questions from the public were raised.	PM
16	**Any other Business** No other business was raised.	

(The meeting closed at 11:10)

Meeting	Board of Directors in Public
Date	Wednesday 7 December 2022
Location	Board Room, Education Centre, Arrowe Park Hospital

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Deputy Chair
SR	Steve Ryan	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
RM	Rajan Madhok	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
DS	Debs Smith	Chief People Officer
MC	Mark Chidgey	Chief Finance Officer
MS	Matthew Swanborough	Chief Strategy Officer
HK	Hayley Kendall	Chief Operating Officer

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
SS	Sally Sykes	Director of Communications and Engagement
CM	Chris Mason	Chief Information Officer
SH	Sheila Hillhouse	Lead Public Governor
TC	Tony Cragg	Public Governor
RT	Robert Thompson	Public Governor
AM	Alan Morris	Public Governor
PB	Phillipa Boston	Staff Governor
CD	Chris Davies	Local Authority Governor
SL	Sharon Landrum	Workforce Diversity and Inclusion Lead/ Freedom to Speak Up Guardian (item 13)

Apologies

LD	Lesley Davies	Non-Executive Director

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

2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 2 November were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story of the experience of a mother and son, who had been referred to A&E. The story described the son's experience at the hospital, as well as the excellent care and attention by staff. The Board **NOTED** the patient story.	
6	**Chair's Business and Strategic Issues** DH updated the Board of Directors on recent matters and highlighted the challenges, including the continuing high number of patients in hospital with no criteria to reside and the upcoming industrial action across the NHS. SL queried if the Trust would be impacted by the upcoming industrial action. DS stated the Royal College of Nursing ballot retuned a mandate for industrial action but there would be no industrial action at Wirral University Teaching Hospital on 15 or 20 December. DS highlighted that industrial action was likely to occur in January and the Royal College of Nursing was required to provide 14 days' notice. DS added the UNISON ballot did not return a mandate for industrial action. HK commented the industrial action at Liverpool may increase the number of ED attendances as well as ambulance diversions to the Trust. HK added the Trust would be prepared for this situation as well as the North West Ambulance Service industrial action. SR queried if industrial action would have an impact on any mental health Trusts. DS stated she was unsure but agreed to find out and provide an update by email.	Debs Smith

	DH commented due to the setting up of Wirral Place the CEO and Chair's meeting had been postponed and queried if it was possible to set up one. JH agreed to progress this. The Board **NOTED** the update.	Janelle Holmes
7	**Chief Executive Officer's Report** JH provided an Infection Prevention Control (IPC) update and explained COVID cases continue to reduce both across the community and in hospital. JH stated the Trust had developed surge plans to accommodate expected rises in respiratory viruses throughout the winter period. JH highlighted Victoria Smerdon, Consultant Orthoptist, part of the Orthoptic Clinical Placement Expansion Team received the award for Innovative Provision of Placements at the 2022 Chief Allied Health Professions Officer Awards. JH reported the Trust declared one serious incident in October and two RIDDORs. JH highlighted the Trust had an unannounced visit from Wirral Borough Council Environmental Health Services on the 15th November 2022 at Clatterbridge Hospital and the Trust was successful in maintaining its 5/5 food hygiene rating. JH stated the Department of Health and Social Care had confirmed details of the £500m Adult Social Care Discharge Fund. Wirral Metropolitan Borough Council had been allocated £1.5m and Cheshire & Merseyside ICB had been allocated £19.2m of which £2.1m was allocated to Wirral Place. JH also noted the COVID-19 public inquiry had commenced, and as part of this, the Trust will receive a questionnaire regarding the impact on healthcare systems and would respond accordingly. DH queried if there had been any progress regarding the Trust temporarily occupying an external venue to provide additional bed capacity. MS stated no appropriate venues including hotels were in a state to occupy. The Frontis Building at Arrowe Park was also not viable. JH explained NHSE acknowledged the issue was widespread across the UK and were keen to enable and support transformation. JH highlighted the Trust had recruited Clinical Support Workers (CSW) to provide domiciliary care through Home First and was considering establishing a CSW agency/bank team to scale up the scheme.	

	HK commented 20 patients were waiting for basic care packages and the Trust could deliver this through Home First. HK added a meeting with the Community Trust Chief Operating Officer was planned for w/c 12 December to discuss the proposal. The Board discussed the challenges around discharges and social care provision. RM queried if it was possible for local or voluntary organisations to support patients at home. HK stated those organisations were unable to provide scheduled planned care and whilst able to provide other services, the Trust cannot discharge patients without a scheduled care plan. CC commented he recently attended a CMAST meeting and heard a good example of St Helen's working together with a community provider to provide care in the community. The Board **NOTED** the report.	
8	**Chief Operating Officer's Report** HK provided an overview of the Trust's current performance against the elective recovery programme for planned care as well unscheduled care. HK highlighted in October 2022 the Trust attained 97.1% against a plan of 100.4% for outpatients. For elective admissions 91.0% of activity was delivered against a target of 105.8%. HK stated unscheduled care performance had ongoing challenges with long length of stay patients and reiterated the impact this has on urgent and emergency care performance. Performance against the 4-hour standard for type 1 attendances decreased from 54.70% in September to 49.36 % for October. HK explained the Trust continued to have high bed occupancy due to patients remaining in beds with no criteria to reside. HK added a Wirral Discharge Challenge, working with partners across the system to safely discharge patients who were medically fit to leave acute hospital care, was taking place w/c 5 December. SR noted the 2 week wait for cancer referrals continued to increase and queried if this resulted in any missed cancer diagnoses during COVID and if there was an impact on treatment. HK commented there had been no significant increase in cancer treatment being sought despite the increase in referrals.	

	SR was aware of plans to give GPs direct access to tests to speed up cancer diagnosis and queried how this was progressing. HK stated the relevant teams were involved in the process and design of tests for GPs. NS added feedback from the Cancer Alliance Group indicated there may be issues with capacity and the reporting of tests which need to be completed in a timely manner. JH commented challenges continue regarding unscheduled care, but improvement continues, however it was important to protect the improvement work as much as possible by ensuring elective activity continues. The Board **NOTED** the report.	
9	**Board Assurance Reports** **9.1 Quality and Performance Dashboard** TF highlighted a reduction in the number of C. difficile and other gram-negative bacteraemia cases, and this was due to a strong infection prevention and control focus by all staff. NS stated the number of patients recruited to NIHR studies continued to remain low and the Trust was unlikely to meet the 700 cumulative total for 2022/23. DS reported the people metrics, explaining sickness absence remained above the 5% target. Two staff groups had high sickness absence and assurance had been sought from the relevant Divisions. Appraisal and mandatory training compliance remained static. DS added all three metrics were likely to be a challenge throughout the winter. DS also reported staff turnover remained above the 10% target and data showed work/life balance was a reason for leaving. SR asked about short-term sickness and if any evidence pointed to repeat episodes. DS stated the Attendance Management Policy was in place to identify repeat episodes of short-term sickness and managers would have conversations with the staff member to determine any underlying concerns. DS added the policy was being revised to include an informal stage and more robust mechanisms. SR noted the care hours per patient day had continued to increase since May and enquired what the cause of this was. TF stated this was caused by a shortage of Clinical Support Worker (CSW) and highlighted two recruitment events had taken place and	

	100 CSW's had been appointed. TF added the increase in this metric had not caused any harm to patients. The Board **NOTED** the report. **9.2 Month 7 Finance Report** MC reported the Trust was reporting a deficit of £3.931m, an adverse variance against budget of £4.769m. The variance was attributed to overspends on employee costs, underperformance in respect of recurrent CIP, the unfunded element of the national pay award, the continued use of escalation wards staffed at premium rates, and by increases in energy prices. MC stated this was offset by reductions in non-pay spend, specifically clinical supplies, because of reduced elective activity compared to plan as well as the release of deferred income. MC highlighted the Trust had the potential to exceed the elective recovery target but, consistent with national guidance, no additional income had been assumed from the Elective Recovery Fund (ERF). SL queried why the forecast position remained a £6m deficit and not an £8m deficit. MC stated this was due to the Trust's current run rate, combined with the ongoing balance sheet release measures and non-recurrent CIP towards the end of the of the year. SL requested MC include an actual/variance position in future narratives to ensure this was clear. DH queried the structural deficit. MC stated in future the Trust would need to focus on reviewing the services provided, as well as integration and transformation. This would be reflected in the Trust's future Finance Strategy. JH commented the Executive Team had started to discuss the rationale that supports the Trust's potential future transformation, including the integration of services. SI queried if the Trust would be financially impacted by other Trusts who reported a deficit position. MC stated there would be no transfer of deficits between Trusts in Cheshire and Merseyside and the financial position reported at the end of the year would be the overall ICB position. SR noted recurrent CIP displayed a higher forecast from month 10 to 12 and queried if this was achievable.	Mark Chidgey

	MC stated each scheme had been scrutinised and appropriately RAG rated. Schemes rated green had been included in the forecast. The Board: • **NOTED** the report and; • **NOTED** that without further mitigation the forecast position remains a £6m deficit and; • **APPROVED** the reduction in the capital programme budget of £4.6m to reflect the rephasing of UECUP and other changes **9.3 Monthly Maternity Report** TF provided the key metrics reported to the Local Maternity and Neonatal System (LMNS) via the Maternity Dashboard, which were linked to the quality and safety of Maternity Services at the Trust. TF also provided the Perinatal Clinical Surveillance Quality Assurance report, providing an overview of the October key quality and safety metrics. TF stated there were no areas of concern to raise this month. The Board **NOTED** the report. **9.4 Digital Healthcare Update** CM provided a progress update on the development of operational plans to deliver the Digital Strategy strategic priorities of the Trust over the next 12 months. CM stated of the 37 projects within those programmes – 14 were currently green, 8 were amber, 8 were red and 7 were blue (complete). CM added resourcing shortages within the Integration and Development areas continue to cause issues for ongoing projects. However, processes were in place to alleviate pressure on teams by prioritising accordingly. The Board **NOTED** the report.	
10	**Governance and Regulation Update** DM provided an update regarding recently published governance and regulation documents, including the new Code of Governance, and on the upcoming review of the provider license and enforcement guidance, which were open for consultation. DM added a self-assessment and action plan against the new code was being undertaken to determine any gaps can be reviewed and amended as required prior to compliance from April 2023.	

	DM also added the Trust would respond to both consultations and report back to the Board once the licence and the enforcement guidance had been published. The Board **NOTED** the report.	
11	**CQC Adult In Patient Survey and National Cancer Patient Experience Survey Results** TF highlighted the adult in patient survey reviewed the experiences of patients aged 16 years and older who stayed at least 1 night in hospital as an inpatient, excluding people admitted to maternity or mental health units. TF stated the findings demonstrated a continued improvement in patient experience responses and the 2 lowest scoring responses were consistent with known operational pressures regarding waiting times and waiting lists. TF also highlighted the National Cancer Patient Experience Survey reviewed the experiences of patients aged 16 years and older with a primary diagnosis of cancer who were admitted as an inpatient or day case patient. TF stated the findings also demonstrated continued improvement in patient experience responses. The Trust had been identified as above or equal to the national average in most responses. There were 2 questions that were below the national average, and these have been shared with the specific groups and improvement plans devised. SL noted for nursing the Trust compared well with the other Trusts in the region and queried the typical questions from the survey. TF stated a range of questions were asked regarding nurses including if patients felt safe or cared for and it was positive the Trust was in the top 5 for the Cheshire and Merseyside. The Board **NOTED** the reports.	
12	**Equality, Diversity, and Inclusion (EDI) Annual Report** SL provided a summary of the annual EDI activity undertaken throughout 2021/22 as well as an annual summary of workforce data at the Trust in line with the annual and regulatory reporting cycle. DS provided an update on the Inclusion Strategy 2018-22 including an overview of achievement against the Trust's key priorities and outcomes during the period. DS added a new People Strategy had been developed with EDI embedded within it, along with a new Strategic Commitment for workforce EDI.	

	DS stated a future Board Seminar topic would be on the Strategic Commitment and what it meant for the Board. SR noted the 5.8% improvement of staff believing the Trust provides equal opportunities for career progression or promotion. DS commented this feedback was positive but further improvement was needed to improve the diversity of staff above band 7. The Board **NOTED** the report.	
13	**Fit and Proper Persons Update** DM presented a refreshed version of the Fit and Proper Persons Policy following approval at the Audit and Risk Committee on 16 November. The Policy was fully revised and adopted in October 2021 subject to an annual refresh. DM also stated the main addition to the Policy had been to provide a clearer definition of the roles that would be subject to the policy in future, which were listed in the appendix. DM added a process was now in place to complete annual checks and this would commence in December for all relevant Directors and Senior Leads. The Board: • **APPROVED** the annual refresh of the Policy; and • **NOTED** the process for annual renew of compliance with the policy	
14	**Risk Management Strategy** DM presented a refreshed version of the Risk Management Strategy following approval at the Audit and Risk Committee on 16 November. The Strategy was last refreshed and approved in October 2021. DM added MIAA carried out a review of the strategy and the accompanying processes in March 2022. The overall opinion was of substantial assurance and a small number of areas were highlighted to further enhance the Strategy. The Board **APPROVED** the annual refresh of the strategy.	
15	**Quality and Safety Strategy** NS presented the new enabling strategy, Quality and Safety Strategy for approval and explained the strategy formed one of eight enabling strategies, through which the 2021-2026 Strategy would be delivered.	

	NS added the Quality and Safety Strategy comprised three pillars, aligned to the 2021-2026 Strategy and was essential to build and embed a culture of improvement to continuously enhance the services and care the Trust provides to the Wirral population. NS stated the Quality & Safety Strategy had been developed through a series of engagement workshops with staff and external partners, in addition to engagement with over 230 patients, staff and external stakeholders. The approach enabled the Trust to gain a clear understanding of the current situation and priorities over the next four years. The Board **APPROVED** the strategy.	
16	**WUTH Charity Annual Report and Accounts 2021/22** The Board **NOTED** the report.	
17	**Communications and Engagement Report** The Board **NOTED** the report.	
18	**Committee Chairs Reports** **18.1 Audit and Risk Committee** The Board **NOTED** the report. **18.2 People Committee** The Board **NOTED** the report. **18.3 Quality Committee** The Board **NOTED** the report. **18.4 Estates and Capital Committee** The Board **NOTED** the report. **18.5 Research and Innovation Centre** The Board **NOTED** the report.	
19	**Questions from the Public** TC commented he observed the Estates and Capital Committee on 5 December and was assured regarding the UECUP programme and other capital projects. TC also commented the duration to see a GP was 3 weeks near his residence.	

	SH commented the duration to a see a GP was less than 3 weeks near her residence. SH also thanked the staff for their continued work. NS commented primary care network leads acknowledged the situation was difficult and there were challenges recruiting and retaining GP's, which was further exacerbating the delay seeing patients. No other questions from the public were raised.	
20	**Any other Business** No other business was raised.	

(The meeting closed at 11:15)