NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

4 September 2024

10:00 GMT+1 Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

Only PDFs are attached

- 0 Board of Directors in Public Agenda.pdf
- 3 Board of Directors in Public Minutes - 3 Jul.pdf
- 4 Action Log - Public Board.pdf
- 7 Chief Executive Officer Report.pdf
- 8.1 WUTH IPR SPC Dashboard - August 2024 - 5 CFO.pdf
- 8.1.1 CFO Commentary M4 24-25.pdf
- 8.2 COO.pdf
- 8.3.1 IPR - Sept 2024.pdf
- 8.3.2 WUTH IPR SPC Dashboard - August 2024 - Intro.pdf
- 8.3.3 WUTH IPR SPC Dashboard - August 2024 - 1 COO.pdf
- 8.3.4 WUTH IPR SPC Dashboard - August 2024 - 2 MD.pdf
- 8.3.5 WUTH IPR SPC Dashboard - August 2024 - 3 CN.pdf
- 8.3.6 CN Commentary - July 2024 data.pdf
- 8.3.7 WUTH IPR SPC Dashboard - August 2024 - 4 CPO.pdf
- 8.3.8 CPO Commentary - for Sept BoD.pdf
- 8.3.9 WUTH IPR SPC Dashboard - August 2024 - CIO.pdf
- 8.3.10 CIO Commentary - for August 2024.pdf
- 8.4 Productivity Efficiency Update August.pdf
- 8.5 Quarterley Maternity & Neonatal Report Sept 2024 Final V2.pdf

- 8.6 Learning from Deaths Report Q4 2023-24.pdf
- 8.7 Guardian of Safe Working Report.pdf
- 8.8 BAF Sept 2024.pdf
- 9 EDI Bi-Annual Report.pdf
- 9.1 Appendix 3 Workforce Race Equality Standard Report (WRES).pdf
- 9.2 Appendix 4 Workforce Disability Equality Standard (WDES) Report and Action Plan 2024.pdf
- 10 NHS England North West Appraisal and Revalidation.pdf
- 10.1 Appendix 1 Annual Submission Template WUTH.pdf
- 11 BoD TOR.pdf
- 11.1 Board of Directors Terms of Reference.pdf
- 12.1 People.pdf
- 12.3 Quality.pdf

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 4 September 2024
Time	10:00 – 12:00
Location	Hybrid

Page	Agenda Item			Lead	Presenter
	1.		Welcome and Apologies for Absence	Steve Igoe	
	2.		Declarations of Interest	Steve Igoe	
5	3.		Minutes of Previous Meeting	Steve Igoe	
15	4.		Action Log	Steve Igoe	
	Items for Decision and Discussion				
	5.		Patient Story	Sam Westwell	
	6.		Chair's Business and Strategic Issues – **Verbal**	Steve Igoe	
16	7.		Chief Executive Officer Report	Janelle Holmes	
	8.		Board Assurance Reports		
20		8.1)	Chief Finance Officer Report	Mark Chidgey	
26		8.2)	Chief Operating Officer Report	Hayley Kendall	
33		8.3)	Integrated Performance Report	Executive Directors	
53		8.4)	Productivity and Efficiency Update	Hayley Kendall	
68		8.5)	Quarterly Maternity and Neonatal Services Report	Sam Westwell	Jo Lavery
74		8.6)	Learning from Deaths Report	Dr Nikki Stevenson	Dr Ranj Mehra
84		8.7)	Guardian of Safe Working Report	Dr Nikki Stevenson	Dr Alice Arch
89		8.8)	Board Assurance Framework	David McGovern	
118	9.		Equality Diversity and Inclusion Bi-Annual Report	Debs Smith	Sharon Landrum
169	10.		2023/24 Annual Submission to NHS England North West: Appraisal and Revalidation	Dr Nikki Stevenson	
207	11.		Board of Directors' Terms of Reference	David McGovern	
	Committee Chairs Reports				
213	12.	12.1)	People Committee	Lesley Davies	

	12.2)	Charitable Funds Committee – **Verbal**	Sue Lorimer
215	12.3)	Quality Committee	Dr Steve Ryan
	12.4)	Finance Business Performance Committee – **Verbal**	Sue Lorimer

Closing Business

13.	Questions from Governors and Public	Steve Igoe
14.	Meeting Review	Steve Igoe
15.	Any other Business	Steve Igoe

Date and Time of Next Meeting

Wednesday 2 October, 09:00 – 11:00

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 3 July 2024
Location	Hybrid

Members present:

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

In attendance:

DM	David McGovern	Director of Corporate Affairs
JJE	James Jackson-Ellis	Corporate Governance Officer
CM	Chris Mason	Chief Information Officer
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.4
TN	Tracey Nolan	Freedom to Speak Up Lead – item 8.6
TC	Tony Cragg	Public Governor
EH	Eileen Hume	Public Governor

Apologies:

LD	Lesley Davies	Non-Executive Director
RM	Dr Rajan Madhok	Non-Executive Director
HK	Hayley Kendall	Chief Operating Officer

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed everyone to the meeting. Apologies are noted above.	
2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	

3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 5 June were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** The Board received a video story from a member of staff who identified herself as a gay woman. The video story described her previous experience in another workplace and how this compared to the welcoming and supportive culture at the Trust. DS commented about the importance of proactively raising awareness of minority groups. DS added one of the ways to do this was by encouraging staff to use their pronouns because this creates a more inclusive environment, particularly for those colleagues who use they/them pronouns. NS highlighted she was the Executive Lead for the Rainbow Alliance Staff Network, which celebrated Pride last month and raised the flag at the hospital. NS added it was important to raise awareness of this for staff and members of the public. DH suggested the staff story presenter be invited to a future Board Seminar on the wider Equality, Diversity and Inclusion progress. DS agreed to include this as part of a future Equality, Diversity and Inclusion Annual Board Seminar. The Board **NOTED** the video story.	Debs Smith
6	**Chairs Business and Strategic Issues** DH provided an update on recent matters and commented about the challenging financial position for Cheshire and Merseyside. DH commented the Wirral system review was progressing as planned. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH reported junior doctors undertook strike action between 27 June and 2 July and the dispute with Unite in relation to Theatre Recovery regrading remains ongoing. JH highlighted in May there was one Patient Safety Incident Investigation opened under the Patient Safety Incident Response Framework and two Reporting of Injuries, Diseases and Dangerous Occurrences reported to the Health and Safety Executive.	

	JH explained the Trust achieved the Silver award of the Armed Forces Covenant Defence Employer Recognition Scheme and achieved a Gold Award from the Royal Society for the Prevention of Accidents (RoSPA) for the fifth year running. JH highlighted Ward 21 achieving its third level 3 WISE accreditation. JH referenced the annual Fit and Proper Person submission which was due at the end of June, noting this had been completed and submitted on time. JH summarised the recent meetings of the Cheshire and Merseyside Acute and Specialist Trust Board (CMAST) on 7 June, noting a key area of discussion was the Virtual Ward proposal and the need to maximise the use of elective hubs to reduce 65 week waiters. JH updated members on the Wirral system review, highlighting a workshop between WUTH and Wirral Community and Social Care NHS FT would take place on Thursday 4 July to explore the available opportunities. JH added a discussion between Trust Chairs would also take place in coming weeks. SL commented she undertook a walkabout of the Cheshire and Merseyside Surgical Centre recently and understood a greater number of patents were now being referred to the Hub. JH highlighted patients from across Cheshire and Merseyside were now being transferred from other providers and this was primarily patients who had not already received a first appointment. DH queried if lower waiting time for the Hub had now been publicised more widely. JH confirmed that the Hub was on the Choose and Book system and was available for patients to select the Hub as a place of treatment directly with their GP. DH commented about the importance of delivering the £5m integration benefits promptly. JH agreed, and stated the Chief Operating Officer from Wirral Community and Social Care NHS FT would join the Trust in July as Director of Integration and Delivery to focus on improving pre and post hospital unscheduled care. The Board **NOTED** the report.	
8	**Board Assurance Reports**	

	8.1) Chief Finance Officer Report MC reported at the end of May, month 2 the Trust was reporting a deficit of £5.9m against a plan of £4.6m. This £1.3m adverse variance primarily relates to lower than planned levels of elective activity. MC provided an update on the statutory responsibilities and key financial risks for month 2, noting the RAG rating for each, highlighting that agency spend, financial efficiency and capital were green, cash was amber, financial stability and financial sustainability were both red. MC summarised the risks to each position and the actions in place across the I&E position, CIP, elective activity, capital, and cash. MC sought approval for a £1.40m reduction in the capital plan. MC explained this reflects a variation to the original ICS Pathology plan whereby expenditure originally planned for WUTH will now be met by other Trusts. DH queried the achievability of the plan. MC summarised the 3 risks to financial position and the mitigation in place to address these. MC added there was a 2 month window available to bring the position back in line with plan. SL commented the position was challenging and noted CIP was now considered a lower risk in comparison to the other risks identified. MC agreed, and stated the remaining risks were external and difficult for the Trust to mitigate. SI commented about the importance of understanding the longer-term financial implications, where possible, to plan accordingly. DH commented the Trust was in a good position financially in a regional context and agreed about the importance of longer-term financial planning. MC agreed, and stated the Trust only had recurrent CIP which was an important factor and was focussed on delivering a break-even position in 2026/27. SL commented the Finance Business Performance Committee received a presentation on digital transformation. SL added it was noted the Trust had a good IT system and the digital strategic developments were aligned with overall direction of the Trust. JH highlighted a number of productivity and efficiency workstreams were multi-year and would continue to deliver financial savings	

	throughout. JH added financial and operational opportunities identified through the Wirral system review would be tracked closely through the Trust Programme Board. The Board: • **NOTED** the report; and • **APPROVED** a reduction in the capital plan of £1.40m **8.2) Chief Operating Officer Report** SB highlighted in May the Trust attained an overall performance of 101.6% against plan for outpatients and an overall performance of 100.2% against plan for elective admissions. SB summarised referral to treatment, cancer performance and DM01 performance against the relevant trajectories. SB reported in May type 1 unscheduled care performance was 48.86% and remains the greatest challenge. SB stated the Trust was working with Place to reduce attendances in A&E and has recently commissioned Aqua to review the pathway of non-admitted patients through A&E. SB stated the Trust continues to be in an improving position with ambulance handover times, ranking fourth out of the nine Acute Trusts in Cheshire and Merseyside. SB reported in May, the average wait for a mental health bed increased from 38 hours in April to 47 hours. SW stated as the new Chief Nurse she was in the process of relaunching the mental health improvement groups, which include partners from the local mental health provider, and will focus on improving mental health provision. SR queried how many patients attending ED with mental health needs specifically required a mental health bed. SB stated 30 patients were referred to a mental health bed in May, but this varied in each. SB added there was work to do with primary care, specifically to raise awareness of the available mental health pathways other than sending patients to the ED. DH noted the good work that continued in relation to the Transfer of Care Hub, commenting this was a good example of partnership working to improve patient care. The Board **NOTED** the report. **8.3) Integrated Performance Report**	

	NS stated the number of complaints acknowledged within 3 working days had decreased due to capacity issues within the Governance Support Unit. SW highlighted the number of C Diff cases was above trajectory and the Deputy Director for Infection Prevention and Control was working with the Quality Improvement Team to embed specific actions to reduce the prevalence of C Diff. SW added the FFT for ED and Maternity remained below threshold and there was 1 category 3 pressure ulcer. JH explained a pilot of the cleaning system was being undertaken to ensure these enabled the domestic teams to maximise the efficiency and robustness of cleaning methods. JH added work was also being undertaken with Divisions to convert non-clinical space back into clinical space for the purposes of increasing side room capacity and the productivity and efficiency of ward staffing establishments. SR queried if there had been any cross infection or C Diff outbreaks across the hospital. NS stated there had been low cross infection and, if there had been, there would be enhanced infection prevention controls implemented. DS stated sickness absence remained above Trust target. An analysis had been reviewed by the Workforce Steering Board in May regarding stress related absences and the Board was satisfied appropriate measures were in place for Occupational Health to provide robust support to staff experiencing stress, anxiety and depression. CM stated demand for subject access requests remained high. The cyber position in relation to servers was positive and would be providing an update to the next Audit and Risk Committee on cyber assurance and controls. DH suggested it would be helpful to receive an update on the digital transformation as part of a future Board Seminar. The Board **NOTED** the report. **8.4) Monthly Maternity Report** JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were no areas of concern to raise this month.	

	JL referenced the recently published notification for Maternity and Neonatal Services – listening to women and families' letters that had been published by NHSE. SR commented there had been good feedback received at the neonatal maternity assurance meeting regarding the low separation of babies from mothers and this was positive. SR queried about the national review of the neonatal estate and if there would be any funding available. MS stated the Trust took part in the national submission to understand the size and age of buildings. MS added it was unlikely additional funding would be available. The Board **NOTED** the report. **8.5) Board Assurance Framework (BAF)** DM provided the latest version of the BAF, highlighting following the annual review of the BAF earlier in the year, work has commenced to update previous risks and populate newer risks. SR noted the significant operational risks had been appended at the end of the BAF and commented this was helpful to see to triangulate risks. DM agreed, and stated this was a recommendation from the recent Deloitte well-led review. SL queried the significant operational risk relating to condemning the G1 theatre. MS stated this related to historical issues because of particles in the ventilation system which meant the theatre could not be used fully. NS added the likelihood of this risk materialising had increased due to time sensitive caesarean sections needing to be carried out. NS added there was a standard operating procedure in place for managing this. SI commented there would remain a level of residual risk and risks that were unknown that could arise unexpectedly. SR queried where the unknown risks may arise from. SI stated the robust risk management systems in place would aim to identify risks but commented not all risks were identifiable. The Board: • **APPROVED** the proposed update to the BAF; and	

	• **NOTED** the current position in regard to Risk Appetite and Risk Maturity. **8.6) Freedom to Speak Up Annual Report** TN highlighted that data from the 2023 NHS Staff Survey indicated 46% of staff feel the organisation would address any concerns raised – which was 2% below the national average. TN summarised the most common themes of concerns raised, noting the highest was policies, procedures and process followed by attitudes and behaviours and bullying/harassment. TF added highest number of concerns raised were in the Corporate Division (39%) followed jointly by Medicine and Surgery (19%). TN explained some of the upcoming priorities for the year, including increasing the number of Champions and improve the triangulation of data trends between FTSU, HR, Safeguarding, Staff-side. DS stated it was positive to hear the number of Freedom to Speak Up champions from medical staffing had increased as well as the recent internal audit into Freedom to Speak Up. DS commented service change made up 10% of concerns raised and stated the importance of beginning these conversations earlier to assure staff impacted by service change. DS added HR Business Partners would support this. SL queried if the individuals who raised a concern confidentially were all in the same Division. TN stated this was correct and was being actively addressed by an Executive Director. The Board **NOTED** the report.	
9	**Employee Experience Update** DS gave an overview of the revised results of the 2023 NHS Staff Survey, recapping in March a problem had been identified with questions 13 and 14. DS reported the initial score for 'we are safe and healthy' was 5.90 and the revised data indicated the score had improved to 6.01. DS added there was now a statistically significant change for this People Promise element to 'significantly higher' – which was positive. DS indicated bullying and harassment experienced from patients or other members of the public was 24.09% and this was similar to 2022. DS also indicated bullying, and harassment experienced	

	from colleagues at work was 19.09%, an increase of 2% compared to 2022. DS stated Black, Asian and Minority Ethnic staff experienced a higher amount of bullying and harassment. DS added targeted work to promote healthy relationships, civility and respect amongst staff would be undertaken. Listening events would also be held to further understand the experience of this staff group. DH queried when a further update could be provided to consider the feedback from the listening events. DS stated September would be appropriate.	Debs Smith
10	**2024/25 Financial and Operational Plan** MC provided a summary of the 2024/25 plan which had been approved at the Private Board meeting in June and submitted to NHSE. MC highlighted the Trust's position in relation to the 2024/25 NHSE national planning guidance, noting the Trust met all objectives except for two, which related to the financial position and outpatient first attendance rates. MC set out the financial position for 2024/25, noting this was a deficit position of £16.3m, which was the lowest deficit for an Acute Trust in Cheshire and Merseyside. The Board **NOTED** the Plan as that approved at the Private Board meeting in June.	
11	**Committee Chairs Reports** **11.1) Audit and Risk Committee** SI commented there had been two Audit and Risk Committee meetings in June to focus on scrutinising the 2023/24 Annual Report and Accounts, which Committee recommended to the Board for approval and had subsequently approved. SI added the Committee also approved the 2023/24 Quality Account and a new Procurement Strategy. **11.2) Research and Innovation Committee** DH highlighted at the last meeting there was good discussion around the new Research and Innovation target operating model which would provide a framework for delivery of the Research and Innovation Strategy. DH added there was a strong focus on recruiting to research studies to demonstrate the Trust's commitment to research.	

	NS explained the Research and Innovation Hub on the Clatterbridge site would open in September and there were a number of research studies planned to start there. NS added there was a focus on increasing the number of commercial studies, particularly related to critical care and women's health. **11.3) Finance Business Performance Committee** SL provided a verbal update on the most recent meeting and highlighted the majority of business had already been discussed in this meeting. SL added the Committee received a presentation form the Surgery Division on their Cost Improvement Programme progress as well as presentation from the Chief Information Officer on digital transformation. The Board **NOTED** the reports.	
12	**Questions from Governors and Public** SH stated it had been a good meeting and looked forward to hearing the outcome of the workshop on Thursday in relation to the Wirral system review.	
13	**Meeting Review** Members commented there had been detailed discussions and an appropriate level of challenge. Members also commented the overall mood across the team was enthusiastic and positive.	
14	**Any other Business** No other business was raised.	

Action Log
Board of Directors in Public
4 September 2024

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	3 July 2024	5	To invite members of the staff network to a future Board meeting	Debs Smith	Complete. Scheduled for 4 September.	September 2024
2.	3 July 2024	9	To provide an update on the feedback following the staff listening events	Debs Smith	Complete. Scheduled as part of the Equality, Diversity and Inclusion Annual Board Seminar.	September 2024

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
4 September 2024

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

Executive Summary and Report Recommendations
The purpose of this report is to provide Board with an update on strategic activity undertaken since the last meeting and draws the Board's attention to any local and national developments. It is recommended that the Board of Directors: • Note the report

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

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

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

1	**Narrative**
1.1	**Health and Safety** There were no Patient Safety Incident Investigations (PSII) opened in July under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety Response

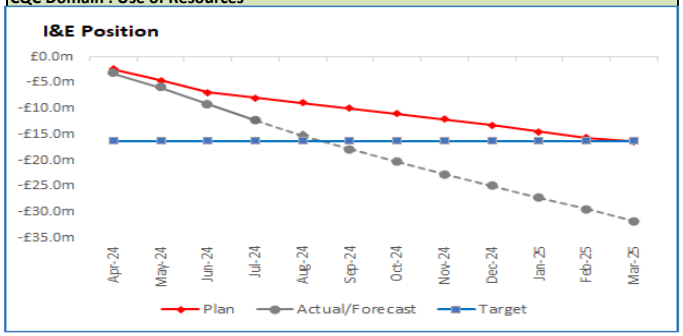
	Meeting report and investigate under the PSIRF to identify learning and improve patient safety. There were two Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in July. All RIDDORs reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring.
1.2	**News and Developments** **Wirral System Review** In April 2024, The Value Circle LLP commenced the independent Wirral System Review, on behalf of Cheshire and Merseyside Integrated Care Board (C&M ICB). The Review initially focuses on collaboration and integration opportunities across NHS provider services on Wirral, including identifying priorities for clinical, operational and financial integration between Wirral University Teaching Hospital NHS FT (WUTH) and Wirral Community Health and Care NHS FT (WCHC). The review also will set out the integration delivery mechanisms and implementation roadmap for WUTH and WCHC, as part of the second phase. Following a range of interviews, analysis and workshops with key stakeholders, The Value Circle LLP recently completed the first phase of the Wirral System Review and presented the report to the C&M ICB as well as the key stakeholder organisations participating in the Review. This first phase report highlighted that the Wirral system had a good understanding of opportunities for improving service delivery and productivity, with some significant delivery across Urgent and Emergency Care. The report also indicated that there was consensus on the opportunities for integration between WUTH and WCHC and detailed some of the benefits, particularly to patients and the Wirral population. The Report also highlighted the historic barriers to effective collaboration and integration across NHS providers on Wirral and recommendations to address, going forward. The Value Circle LLP will be working with C&M ICB, along with WUTH and WCHC, to now examine and detail the integration delivery mechanisms, future integration governance arrangements and the implementation roadmap. This report is expected to be finalised and presented to C&M ICB by October 2024. **Cheshire and Merseyside Surgical Centre treats over 5,000 patients** The new Cheshire and Merseyside Surgical Centre at Clatterbridge has treated over 5,000 patients – cutting waiting times for those requiring planned surgery. The multi-million pound Centre first opened in November 2022 as a regional surgical hub with two new state-of-the-art theatres as part of phase one. It opened phase two last year and now has four brand new theatres.

	Patients in Wirral and across the region who require planned surgery are advised that they have the option to choose to have their procedure at the Centre. At the point when they are being referred for surgery, patients simply need to speak to their GP and ask if they can have their elective surgery at the Centre. Last year the Centre was accredited by NHS England's Getting It Right First Time (GIRFT) programme, in collaboration with the Royal College of Surgeons of England. **Phase 1 UECUP Update** The first phase the Urgent and Emergency Care Upgrade Programme (UECUP) has officially opened. **WUTH are finalists in the HSJ Awards for Trust of the Year** WUTH have been announced as shortlisted finalists in the Health Service Journal (HSJ) Awards for Trust of the Year. This is a real testament to all the hard work and tireless dedication of everyone as the Trust has undergone an unprecedented transformation programme in recent years. The winners will be announced at the HSJ Awards on 21 November. **WISE Accreditation** Ward 20, 54, 26, 14 and 17 achieved green level 3 WISE accreditation.
1.3	**System Working** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** CMAST Leadership Board met on 2 August and discussed three substantive items as follows: • Carnall Farrar presented on the opportunities the Federated Data Platform present to C&M trusts as early adopter sites. The population health management data product is already under discussion via the Data Into Action Board, and there is now the opportunity to explore a suite of products that would enable a shared elective patient waiting list. Carnall Farrar will link with CMAST to facilitate a demo of the products and will also contact individual trusts to discuss next steps, and time frames. • A discussion took place on the system financial position and the national meeting, which was postponed as a result of the tragic incident in Southport. National colleagues will be seeking assurance from trust leaders on the ability to deliver the organisation's financial plan. PWC work is ongoing with meetings underway with each of the trusts identified. • Liverpool's University Teaching Hospital NHS FT provided an update on the Liverpool Services Review next steps and progress to date. **Place Based Partnership Board (PBPB) Update** The PBPB met on the 25 July and discussed several standing reports on Place Quality and Performance and programme delivery reports related to capacity and demand planning as well as unscheduled care.

	The Board heard about the progress made by the Wirral Place Workforce Group towards establishing a strong baseline and the steps being taken to develop a Wirral People Strategy to support the delivery of the Wirral Health and Care Plan. A project team have already initiated the establishment of a Wirral Workforce Dashboard to synthesise key workforce data across health and care providers to understand the wider workforce profile, strengths, and challenges.

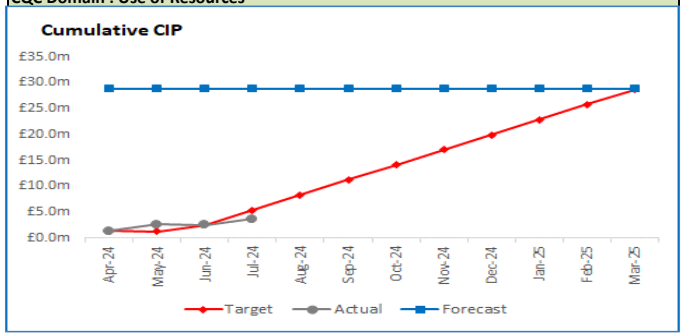
Chief Finance Officer

CQC Domain : Use of Resources



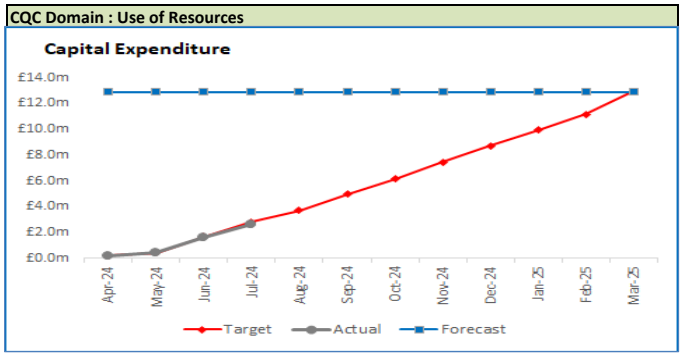
Jul-24
-£12.3m
Variance
Position worse than plan
Target
-£7.9m

CQC Domain : Use of Resources



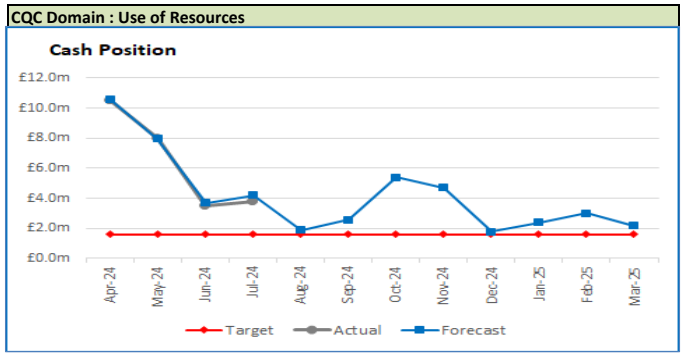
Jul-24
£3.7m
Variance
Position worse than plan
Target
£5.4m

CQC Domain : Use of Resources



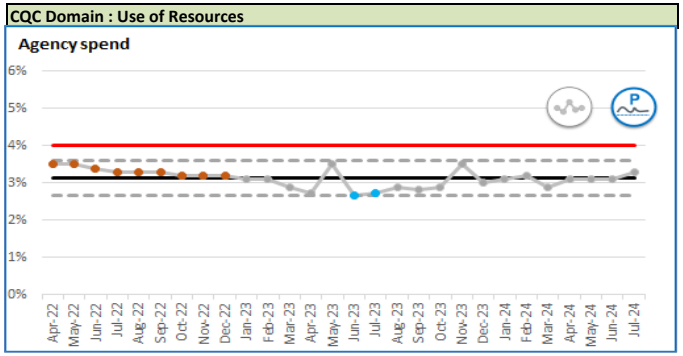
Jul-24
£2.6m
Variance
Position not worse than plan
Target
£2.8m

CQC Domain : Use of Resources



Jul-24
£3.8m
Variance
Position better than plan
Target
£1.6m

CQC Domain : Use of Resources



Jul-24
3.3%
Variance
Position worse than plan
Threshold
3.2%

Chief Finance Officer

Executive Summary

At the end of July, M4, the Trust is reporting a deficit of £12.3m, an adverse variance against plan of £3.4m. The Trust is forecasting a risk adjusted deficit of £31.7m, a potential variance to plan of £15.4m.

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

- the full delivery of the elective activity plan and
- the Cost Improvement Programme (CIP) and
- maintaining expenditure on urgent care within planned levels.
- delivering planned integration benefits.

The Trust has fully engaged with NHSE and C&M ICB to plan actions to reduce expenditure to mitigate against these risks.

Failure to achieve the financial plan would place additional significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP).

Management of risks against this plan alone do not deliver long-term financial sustainability. The significant financial improvement required for sustainability will be delivered through the medium-term finance strategy. Quarterly updates are provided to the Board on progression of the strategy and the underlying financial position.

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

Statutory Financial Targets	RAG (M4)	RAG (Forecast)	Section within this report / associated chart
Financial Stability	🔴	🔴	I&E Position
Agency Spend	🟡	🟡	I&E Position
Financial Sustainability	🔴	🔴	N/A (quarterly update)
Financial Efficiency	🟡	🟢	Cumulative CIP
Capital	🟢	🟢	Capital Expenditure
Cash	🟡	🔴	Cash Position

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

The Board is asked to:

- Note the report including engagement with NHSE and the ICB on the management of financial risk.
- Note that the Trust will be submitting a request for additional cash support in Q3 (October to December 2024).

I&E Position

Narrative:

The table below summarises this I&E position at M4:

	Year to Date			Forecast		
Cost Type	**Plan**	**Actual**	**Variance**	**Plan**	**Forecast**	**Variance**
Clinical Income from Patient Care Activities	£152.1m	£148.4m	-£3.8m	£454.1m	£445.7m	-£8.4m
Other Operating Income	£10.7m	£11.8m	£1.0m	£32.1m	£33.4m	£1.3m
Total Income	**£162.9m**	**£160.1m**	**-£2.7m**	**£486.2m**	**£479.1m**	**-£7.2m**
Employee Expenses	-£118.3m	-£118.9m	-£0.6m	-£356.2m	-£357.3m	-£1.1m
Operating Expenses	-£53.4m	-£52.0m	£1.4m	-£158.2m	-£158.3m	-£0.1m
Non Operating Expenses	-£2.0m	-£1.5m	£0.5m	-£6.0m	-£4.7m	£1.4m
CIP	£1.9m	£0.0m	-£1.9m	£17.8m	£9.4m	-£8.4m
Total Expenditure	**-£171.8m**	**-£172.4m**	**-£0.6m**	**-£502.6m**	**-£510.8m**	**-£8.2m**
Total	**-£8.9m**	**-£12.3m**	**-£3.4m**	**-£16.3m**	**-£31.7m**	**-£15.4m**

Key variances within the position are:

Clinical Income – £3.8m adverse variance relates to underperformance against the value of the elective plan in Surgery.
Operating Expenses - £1.4m positive variance largely relates to the under delivery of elective activity in Surgery.
Non-operating expenses – £0.5m favourable variance relates to PDC payments lower than plan.
Cost Improvement Programme – £1.9m adverse variance for CIP across clinical divisions.

The Trust's agency costs were 3.3% of total pay costs in M4. This is above the 2024/25 target of 3.2%.

Risks to position

The main risks to the I&E position are:

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

Actions:

- Full identification and delivery of CIP schemes.
- Maximising elective capacity and recovery.
- Urgent care improvement plan.

Cumulative CIP

Narrative:

The Trust has transacted £11.274m of CIP at M4 which is £1.895m behind plan at M4. The Trust has now identified CIP with a part year effect of £20.120m, a shortfall against target of £8.736m. However, we are forecasting that this will be mitigated by non-recurrent underspends. The CIP identified has a full year effect of £24.961m.

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

Risks to position:

- That the gap between target and identified schemes is not reduced.
- That the momentum on delivery of schemes is not sustained.
- That the capacity of the Trust is not sufficient to deliver across all improvement agendas.

Actions:

- Continuation of the Productivity and Improvement Programme.

Elective Activity

Narrative:

The Trust delivered elective activity to the value of £8.5m in M4 and £34.4m YTD, an adverse variance of £5.6m for the year. This is primarily driven by underperformance in respect of the Cheshire and Merseyside Surgical Centre (CMSC), a shortfall of elective and day cases in Surgery and by a lower case mix within the Division.

Risks to position:

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

Actions:

- The Chief Operating Officer and Chief Finance Officer are jointly undertaking a review into the full drivers of the adverse income position on income for surgery with a mitigation plan to address any remaining underlying issues impacting the Trust's delivery of elective activity in surgery. This will be presented to the next meeting of FBPAC.

Capital Expenditure

Narrative:

Description	Approved Budget at M1	Revisions to Budget	Revised Budget
CDEL			
Internally Generated	£12.870m		**£12.870m**
ICB/PDC/WCT	£6.284m	-£1.400m	**£4.884m**
Charity	£1.000m		**£1.000m**
Confirmed CDEL	**£20.154m**	**-£1.400m**	**£18.754m**
Total Funding for Capital	**£20.154m**	**-£1.400m**	**£18.754m**
Capital Programme			
Estates, facilities and EBME	£5.000m		£5.000m
Heating and chilled water pipework replacement	£2.100m		£2.100m
Operational delivery	£2.750m		£2.750m
Medical Education	£0.080m		£0.080m
Transformation	£1.000m		£1.000m
Digital	£0.750m		£0.750m
UECUP	£6.010m		£6.010m
Charity	£1.000m		£1.000m
Approved Capital Expenditure Budget	**£18.690m**	**£0.000m**	**£18.690m**
Diagnostics Digital	£0.064m		£0.064m
LIMS - PDC	£1.400m	-£1.400m	£0.000m
Confirmed PDC	**£1.464m**	**-£1.400m**	**£0.064m**
Total Anticipated Expenditure on Capital	**£20.154m**	**-£1.400m**	**£18.754m**
Under/(Over) Commitment	**£0.000m**	**£0.000m**	**£0.000m**

The capital programme expenditure of £2.6m at M4 is behind plan by £0.3m but no underspend is anticipated against plan at year end.

The level of capital available for equipment replacement and infrastructure update is very limited and could be committed many times over. As a consequence there is continued review of both schemes and prioritisation decisions. Monitoring of risks associated with delivery of capital schemes and the overall programme will continue to be reported through the Estates and Capital Committee.

Risks to position:

- That delays and increased costs of significant schemes, such as UECUP, result in the diversion of funding from equipment replacement and the update of infrastructure with a consequential impact on quality of care.

Actions:

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

Cash Position

Narrative:

The underlying deficit position places increasing pressure on the Trust's ability to maintain a positive cash balance. At the end of M4 the cash balance was £3.8m. The Trust's capital programme and a planned deficit means that a positive cash balance is only possible by active daily management of the level of debtors and creditors. This arrangement is not sustainable and the Trust will need to request additional borrowing from NHSE by Q3 of 24/25.

Risks to position:

- Management of the cash trajectory is impacting significantly on Public Sector Payment Policy performance.
- Failure to achieve the full recurrent CIP plan would mean that the cash trajectory cannot be achieved.
- The low level of cash headroom that the Trust is working within increases the impact of any delayed payment of income due to the Trust.

Actions:

- Continued daily monitoring and forecasting of the Trust cash position and PSPP performance.
- Monitoring and escalation of any aged debt delays.
- Discussions with ICB around mitigations for cash position and process for applying for cash support.
- Plan to submit a request for additional cash support from October 2024 (Q3)

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 8.2**
4 September 2024

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

Executive Summary and Report Recommendations

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

For planned care activity volumes, it highlights the Trust's performance against the targets set for this financial year. The Board should note the ongoing positive performance with recovering elective waiting times and the achievement of the diagnostic 6 week waiting time.

For unscheduled care, the report details performance and highlights the ongoing challenges with achievement of the national waiting time standards in the Emergency Department (ED).

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

Elective recovery remains a strong point and improvements continue, but medical industrial action remains the highest risk to the elective recovery programme.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

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

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

Infrastructure: improve our infrastructure and how we use it.	No

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

1	Introduction / Background
1.1	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the national Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny to ensure delivery of timely ambulance handover. The Trust has also been supported by AQuA on improving the 4 hour performance standards.

2	Planned Care
2.1	**Elective Activity** In July 2024, the Trust attained an overall performance of 98.03% against plan for outpatients and an overall performance of 97.56% against the plan for elective admissions, as shown in the table below:

Activity Type	Target for July	Actual for July	Performance
Outpatient - New	**14,110**	**13,265**	**94.01%**
Outpatient - Follow up	**34,133**	**34,030**	**99.70%**
Outpatients - Total	**48,243**	**47,295**	**98.03%**
Elective - Day case	**4,764**	**4,834**	**101.47%**
Elective - Inpatients	**803**	**597**	**74.35%**
Elective - Total	**5,567**	**5,431**	**97.56%**

The Trust underachieved plan for both outpatient new appointments and elective inpatients, with an overachievement on daycases.

2.2	**Referral to Treatment (RTT)** The national standard is to eliminate routine elective waits of over 78 weeks by April 2023, and to have no 65 week waits by September 2024. The timescale for elimination of 65 week waiters has moved nationally to September 2024, due to the impact of

industrial action. The Trust's performance at end of July against these indicators was as follows:

- 78+ Week Wait Performance – 1 (complex pathway)
- 65+ Week Wait Performance - 310
- 52+ Week Wait Performance – 1,863
- Waiting List Size - there were 45,909 patients on an active RTT pathway which is an increase on the previously report Trust position of 44,224.

The Trust has a delivery plan to achieve 65 weeks by the end of September in all specialities excluding Gynaecology, whereby the significant backlog has been more difficult to recover, mutual aid has been requested in the region but no Trust is able to support.

WUTH have continued to support Trusts across the North West by offering mutual aid to treat very long waiting patients through the Cheshire and Merseyside Surgical Centre, although this demand

2.3 Cancer Performance

Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 1 to date:

Quarter	1
Period	01/04/2024 - 30/06/2024

National Standards:

Standard	Indicator	Threshold	April-24	May-24	June-24	Quarter 1
28 Day Wait	GP USC Referral or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	75.00%	72.38%	76.90%	79.39%	76.19%
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	93.16%	93.86%	90.64%	92.46%
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	80.60%	73.17%	74.86%	76.20%

Sub Standards:

Standard	Indicator	Threshold	April-24	May-24	June-24
28 Day Wait	Individual Trust Provider Trajectory	Per Month	72.38%	76.90%	79.39%
28 Day Wait	Breast >=90%	90.00%	97.72%	95.37%	97.88%
28 Day Wait	Skin >=90%	90.00%	97.32%	93.44%	94.86%
62 Day Wait	Individual Trust Provider Trajectory	Per Month	80.60%	73.17%	74.86%

Removed Standards (Not National Standards):

Standard	Indicator	Threshold	April-24	May-24	June-24
14 Day Wait	GP USC Referral to First Appointment	93.00%	76.63%	82.20%	78.71%

- *FDS* – The Trust met the FDS standard for Quarter 1 2024, with performance of 76.2% (above the standard of 75%). As predicted, performance improved through May and June.
- *62 day treatment* - For 2024/25, the 62 day treatment standard sees a previous national target of 85%, a national requirement to achieve 70% and a local trajectory to achieve 77% performance by March 2025. The Trust is achieving the local trajectory each month of April - June 2024 (see '62 Day Wait' in Sub Standards section of the table above).
- *62 day waiters* – the number of waiters continued to decrease in July 2024, seeing performance ahead of plan by month end (89 patients against a plan of 93).

	01/04	08/04	15/04	22/04	29/04	06/05	13/05	20/05	27/05	03/06	10/06	17/06	24/06	01/07	08/07	15/07	22/07	29/07
Actual 24/25	135	132	119	131	136	141	140	148	137	127	122	129	127	106	91	92	103	89
Trajectory	120	120	120	120	120	112	112	112	112	103	103	103	103	93	93	93	93	93
Pre-COVID Average	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51

- *104 day long waiters* – performance is ahead of trajectory for July, at 23 against a plan of 33.

	01/04	08/04	15/04	22/04	29/04	06/05	13/05	20/05	27/05	03/06	10/06	17/06	24/06	01/07	08/07	15/07	22/07	29/07
Actual 24/25	45	36	33	32	29	38	38	35	36	34	35	40	42	42	37	36	40	37
Trajectory	50	50	50	50	50	47	47	47	47	42	42	42	42	39	39	39	39	39
Pre-COVID Average	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12

The continued multi-disciplinary approach to improving the efficiency of cancer pathways is working well and is being rolled out across the most challenged tumour groups.

2.4 DM01 Performance – 95% Standard

At the end of July 96.1% of patients had been waiting 6 weeks or less for their diagnostic procedure for those modalities included within the DM01, maintaining the achievement of target. There is a real challenge with maintaining this given demand to Lower GI endoscopy has increased by 125% and Dexa scanning increases, and August and September performance is likely to be under 95%.

2.5 Risks to recovery and mitigations

The clinical divisions are continuously working through options to reduce the backlogs of patients awaiting elective treatment and progress is being made to improve waiting times for patients. These include the recruitment of new staff, with a focus on consultants, additional activity outside of core capacity to ensure reductions in elective waiting times continue.

The main area of concern in delivering 65 weeks by the end of September 2024 is Gynaecology which is the specialty that has taken the longest to recover from the pandemic. This has been flagged to the ICB as an area of concern. In addition to Gynaecology, delivery plans for Colorectal and Upper Gastrointestinal Surgery are currently subject to further review and tracked on a weekly basis but are currently forecasting to be compliant by the end of September.

3.0 Unscheduled Care

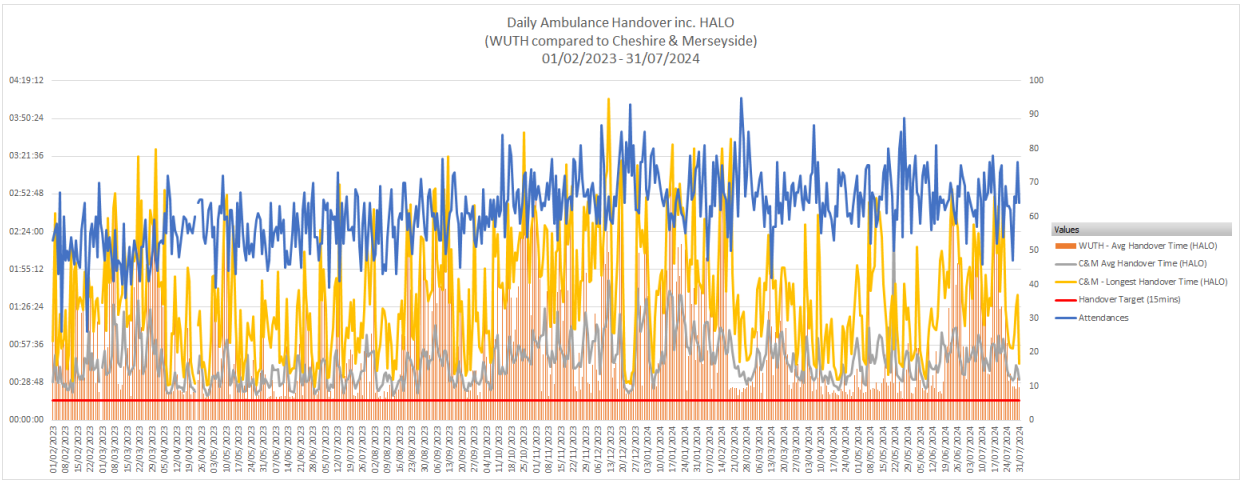
3.1 Performance

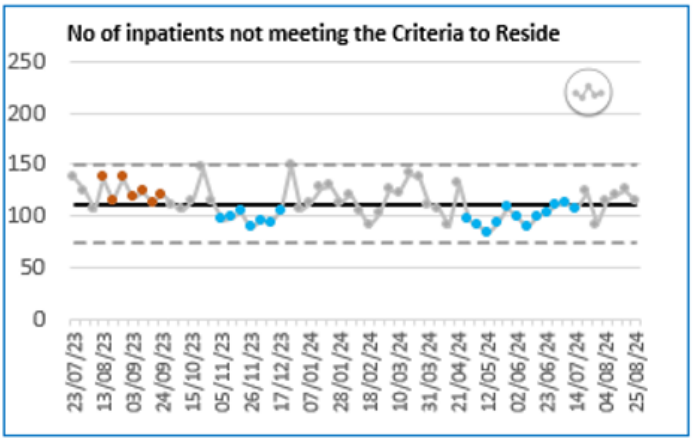
July Type 1 performance was reported at 42.68%, with the combined performance for all Wirral sites at 72.52%

Type 1 ED attendances:	Type 3 ED attendances:
• 7,965 in June (avg. 266/day) • 7,935 in July (avg. 256/day) • 0.4% decrease from previous month	• 2,947 in June • 2,784 in July • 5.5% decrease from previous month

Type 1 performance remains the most significant challenge, however as part of 2024-25 planning, the Trust is working with system colleagues to agree the out of hospital response to support the improvement to achieve the recovery trajectory.

4 hour performance is an increasing risk and is currently behind the internal improvement trajectory. At the request of the Trust, AQuA were asked to undertake a targeted review of 4 hours and spent time in the department reviewing pathways and processes. The final report has now been received and is being discussed with the clinical team and is

	based around several themes. This will be shared with the Board and the Finance, Business Assurance Committee. Ambulance handover performance has been a priority for improvement and this can be seen month on month following several interventions implemented during February, including the continuous flow policy and increasing the staffing for ED corridors. In July the department experienced challenges due to acuity and the level of ambulance attendances. In quarter one the Trust experienced a 20% increase in ambulance conveyances supporting the increases in acuity that the medical staff have reported.  There is a broad workstream that is being prioritised relating to Same Day Emergency Care (SDEC) given the level of attendances at ED and the ability to be able to manage patients via an SDEC service. 12 hour DTAs remain a challenge with out of hours being a particular area of focus to reduce the number of patients waiting longer than 12 hours in the department. The divisions of Medicine and Acute have developed a pilot of a new take model for new emergency admissions to the hospital that is being piloted from 9th September with the aim of improving assessment and flow of patients to the assessment areas and general wards.
3.2	**Transfer of Care Hub development and no criteria to reside.** The Trust continues to be in a much-improved position as the number of patients not meeting the criteria for transfer has reduced. The Transfer of Care Hub is now identifying more complex reasons for delays, some of which are due to out of area placements, specialist step down beds and challenging social issues. The Super MaDE held in August identified key themes for delays in patients with no criteria to reside which there will be a Trust and system response to this. Despite there being peaks to 140 the position remains between 100-120.

	 Working with system partners the aim is to consistently deliver a position of less than one hundred patients prior to the winter period.
3.3	**Mental Health** The demand for patients attending the ED with mental health conditions remains high. The refresh of mental health working groups for 2024/25 annual planning is underway. The Trust's mental health groups have been re-established and the meetings with the local mental health provider continue. Demand through July remained high and continues to provide challenges with managing patients with mental health challenges in the main ED.
3.4	**Risks and mitigations to improving urgent care performance** The Trust continues to make progress in implementing the actions from the improvement plans for each of the urgent care quality standards although this is not improving the delivery of the 4 hour standard. There remains a risk that the continued high level of attendances and acuity will challenge the improvement plans and actions. Added to this is the need to increase the number of nurses in the ED to support the requirement to release ambulance crews as soon as possible (which includes staffing corridors as required) and vacancies in junior medical staff is increasing the pressure in the department.

4	**Implications**
4.1	**Patients** • The paper outlines good progress with elective recovery but still waiting times for elective treatment are longer than what the Trust would want to offer but given the backlog from the Covid pandemic the Trust is in a strong position regionally in delivering reduced waiting times for patients. The paper also details the extra actions introduced recently to improve UEC performance.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • Cost of recovering activity from medical industrial action to ensure the Trust delivers against the national waiting time targets. The paper details additional

	resource agreed as part of the winter plan that has been introduced. The cost of providing corridor care is above the Trust's financial plan.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets in the main due to the impact of medical industrial action, relating mainly to 65 weeks by the end of March 2024 and 76% 4 hour performance.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 8.3**

04 September 2024

Title	Integrated Performance Report
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 July 2024.

It is recommended that the Board:

- notes performance to the end of July 2024.

Key Risks

This report relates to the key risks of:

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

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

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

1	Narrative
1.1	Following further discussion with the Executive Team and the Board, the performance metrics for inclusion, format and title of the report have been amended. The metrics are grouped under the responsible Executive Director, with the relevant CQC domain noted against each metric.

	Grouping the metrics by CQC domain shows the following breakdown for the most recently reported performance: **Summary of latest performance by CQC Domain:** Further metrics are shown under the Chief Information Officer (CIO) relating to the Digital Healthcare Team.

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	5	2	7
Effective	0	1	1
Caring	2	2	4
Responsive	7	16	23
Well-led	1	2	3
Use of Resources	1	4	5
All Domains	16	27	43

2	Implications
2.1	Implications for patients, people, finance, and compliance, including issues and actions undertaken for those metrics that are not meeting the required standards, are included in additional commentaries and reports.

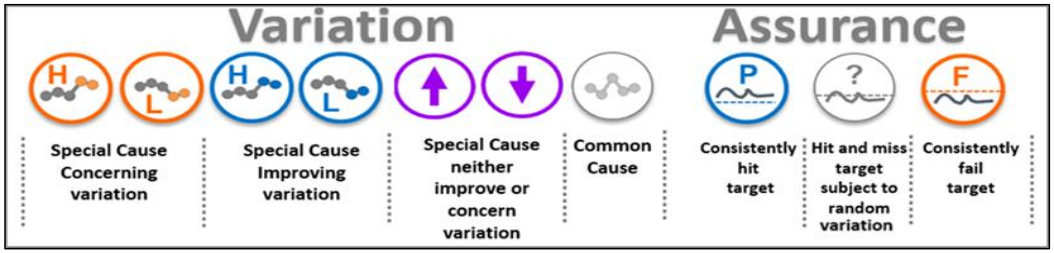
3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Integrated Performance Report, and at the regular operational meetings with the Clinical Divisions.

Integrated Performance Report - August 2024

Approach

The metrics for inclusion have been reviewed with the Executive Director team.
Performance is represented in SPC chart format to understand variation, and a summary table indicating performance against standards.
The metrics are grouped into Executive Director portfolios, with individual metrics showing under their CQC Domain.
Commentary is provided at a general level and by exception on metrics not achieving the standards set.

Key to SPC Charts:



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Well-led	1	2	3
Use of Resources	1	4	5
All Domains	16	27	43

Issues / limitations

SPC charts should only be used for 15 data points or more.
SPC format does not support including a target where it is variable over time, eg a reducing trajectory for long waiters.
Alternative formats of charts are included where they are more appropriate.

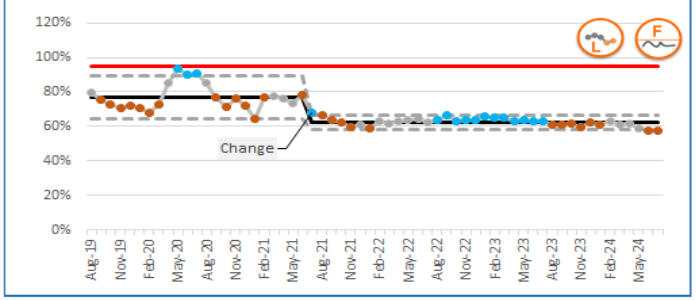
Changes to Existing Metrics:

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

Chief Operating Officer (1)

CQC Domain : Responsive

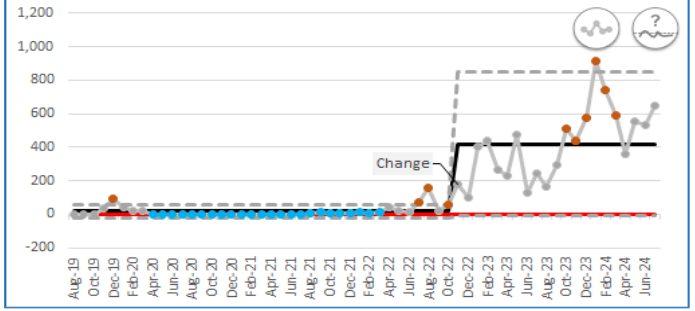
4-hour Accident and Emergency Target (including APH UTC)



Jul-24
57.5%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

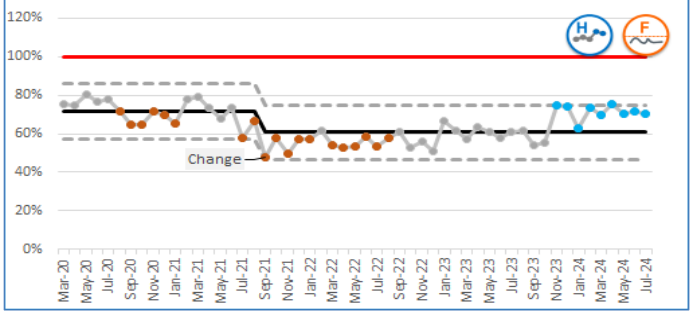
Patients waiting longer than 12 hours in ED from a decision to admit



Jul-24
648
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

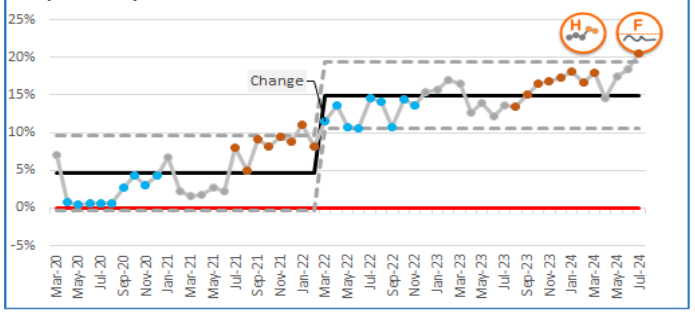
Time to initial assessment for all ED patients - % within 15 mins



Jul-24
70.3%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

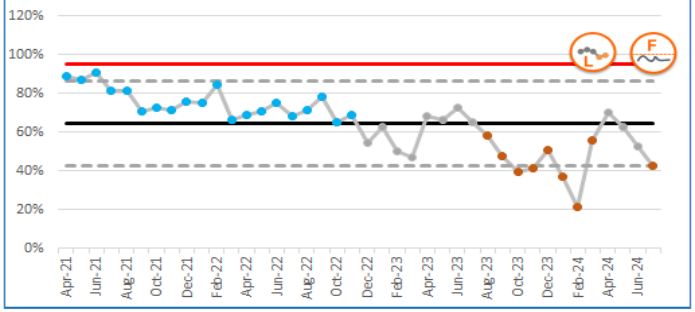
Proportion of patients more than 12 hours in ED from time of arrival



Jul-24
20.5%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

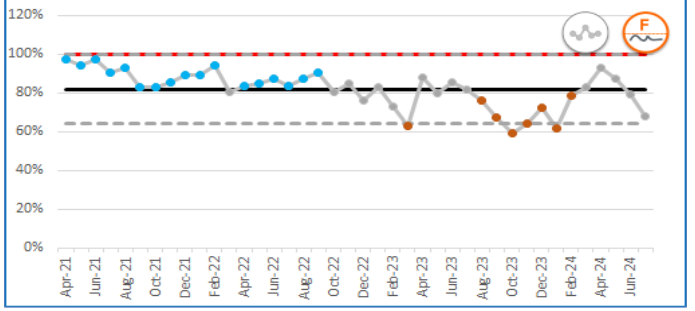
Ambulance Handovers: % < 30 mins



Jul-24
42.4%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

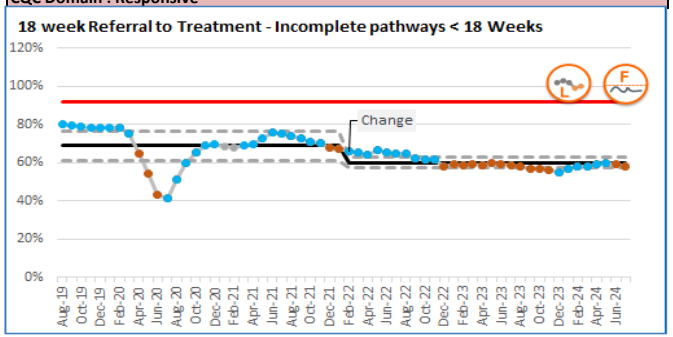
Ambulance Handovers: % < 60 mins



Jul-24
68.2%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

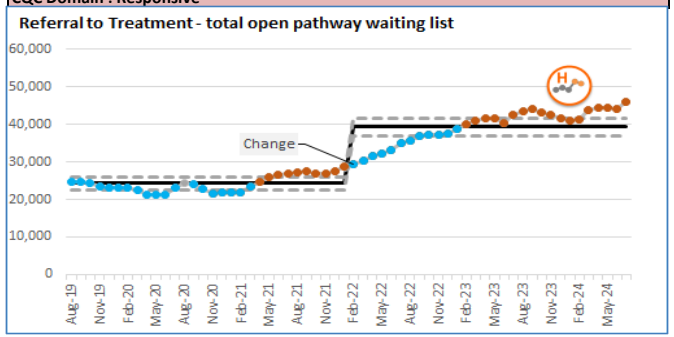
Chief Operating Officer (2)

CQC Domain : Responsive



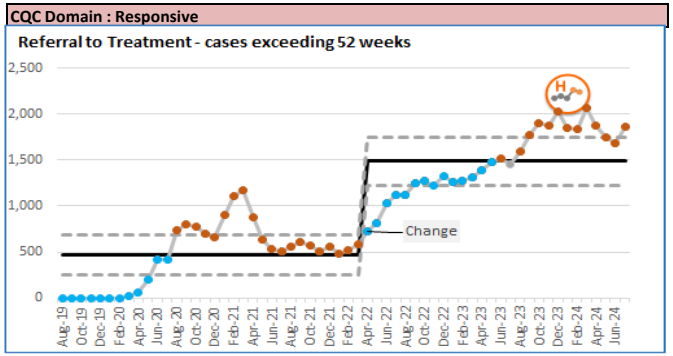
Jul-24
58.17%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



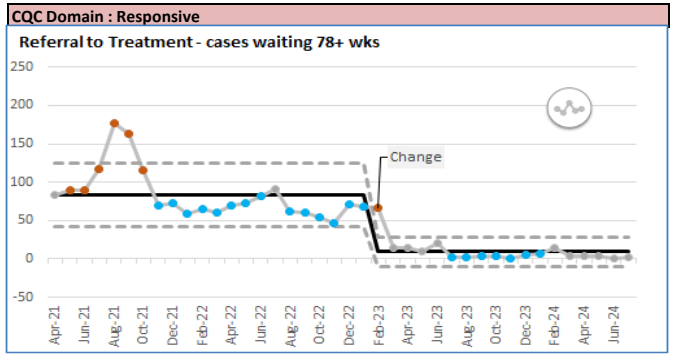
Jul-24
45909
Variance Type
Special cause variation - concerning
Threshold
≤ 39648
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



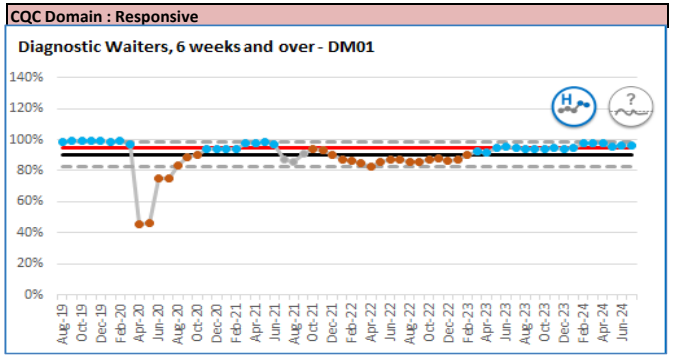
Jul-24
1863
Variance Type
Special cause variation - concerning
Threshold
≤ 1875
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



Jul-24
2
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

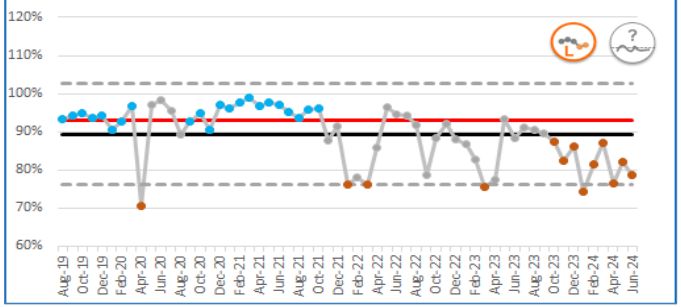


Jul-24
96.1%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

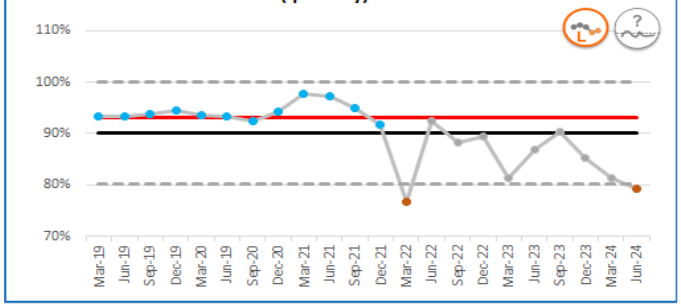
Cancer Waits - 2 week referrals (monthly)



Jun-24
78.7%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

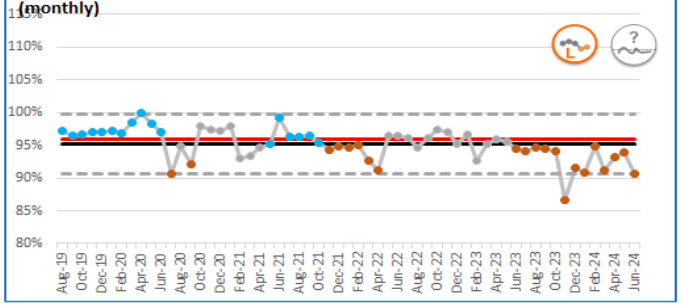
Cancer Waits - 2 week referrals (quarterly)



Jun-24
79.2%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

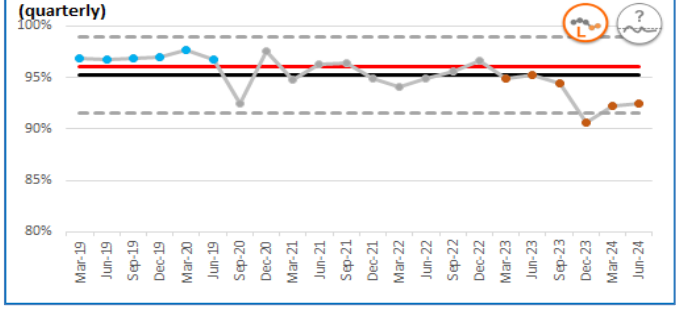
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



Jun-24
90.6%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

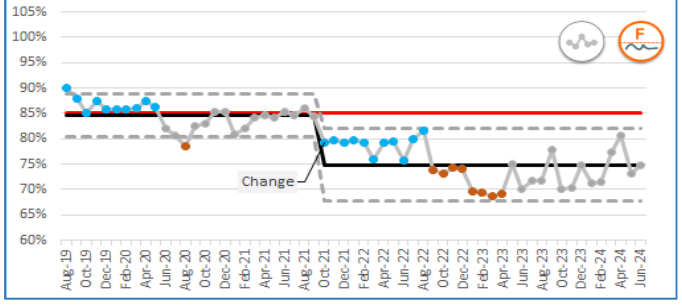
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



Jun-24
92.2%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

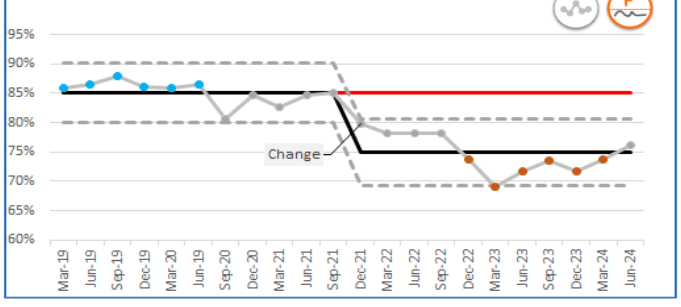
Cancer Waits - 62 days to treatment (monthly)



Jun-24
74.9%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

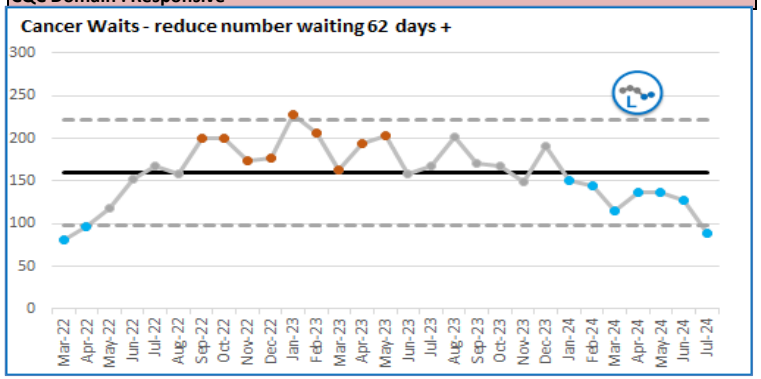
Cancer Waits - 62 days to treatment (quarterly)



Jun-24
76.2%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

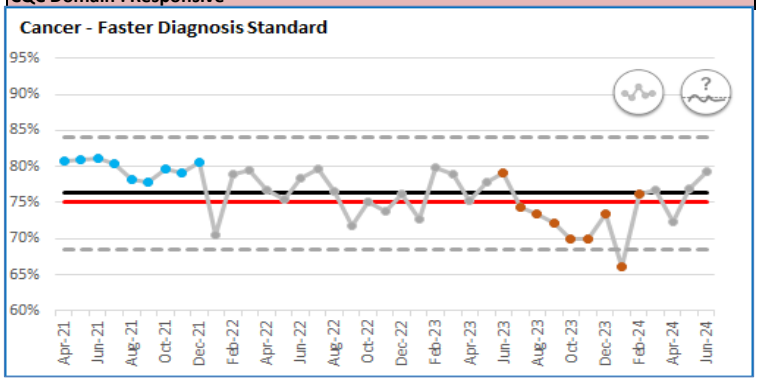
Chief Operating Officer (4)

CQC Domain : Responsive



Jul-24
89
Variance Type
Special cause variation - improving
Threshold
120
Assurance
Trajectory target not appropriate for SPC Assurance reporting

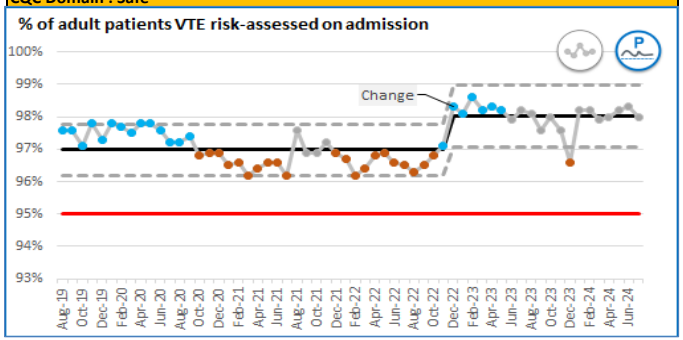
CQC Domain : Responsive



Jun-24
79.4%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

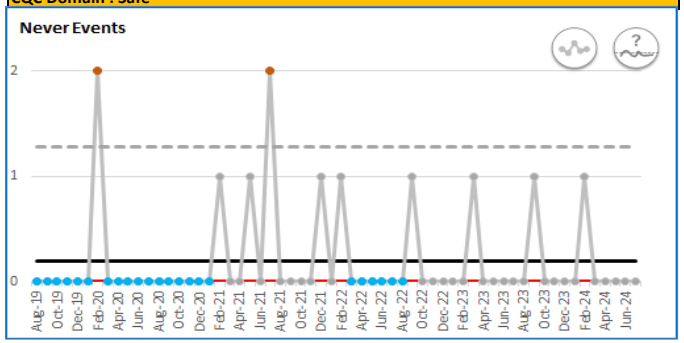
Medical Director (1)

CQC Domain : Safe



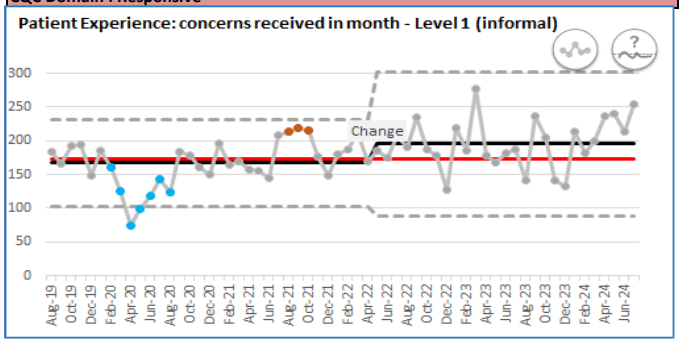
Jul-24
98.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



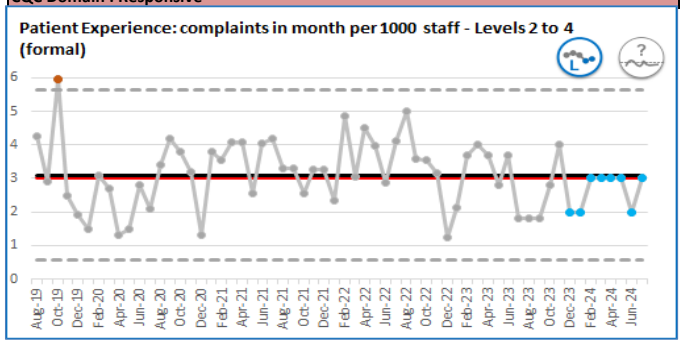
Jul-24
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



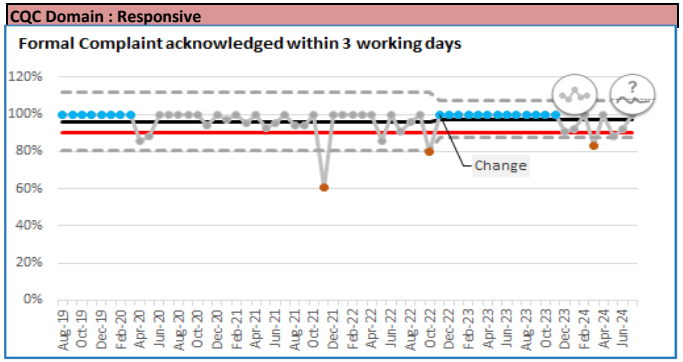
Jul-24
255
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



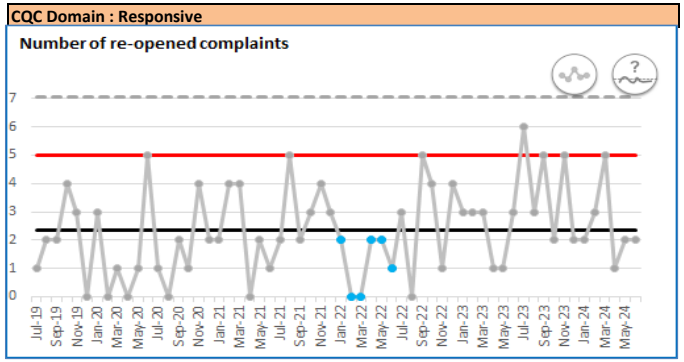
Jul-24
3.0
Variance Type
Special cause variation - improving
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Jul-24
100.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

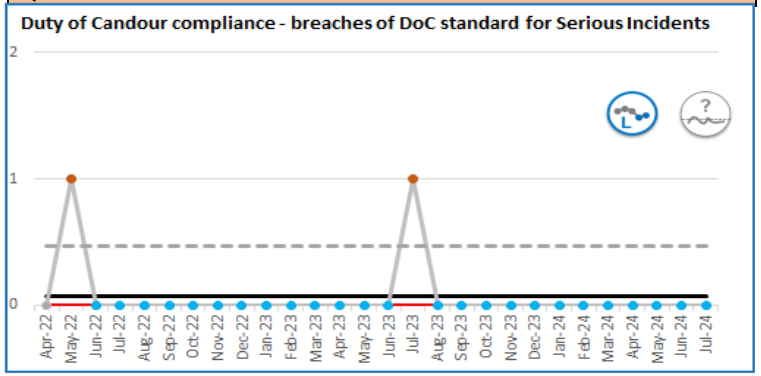
CQC Domain : Responsive



Jul-24
3
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

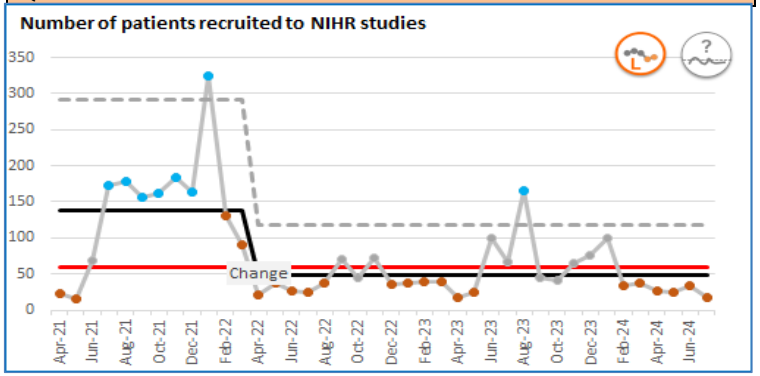
Medical Director (2)

CQC Domain : Well-led



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

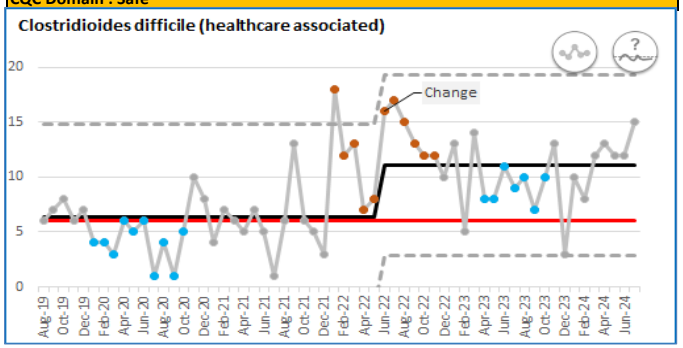
CQC Domain : Well-led



Jul-24
17
Variance Type
Special cause variation - concerning
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

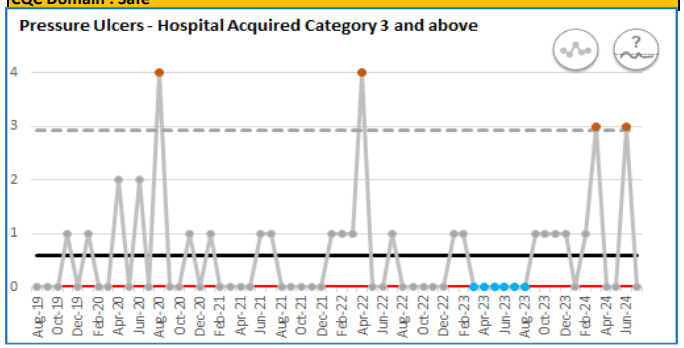
Chief Nurse

CQC Domain : Safe



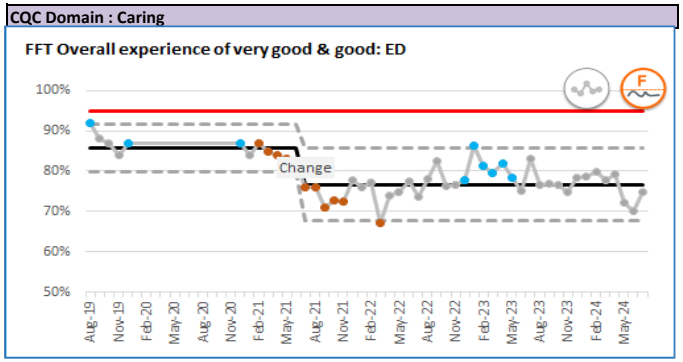
Jul-24
15
Variance Type
Common cause variation
Threshold
≤9
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



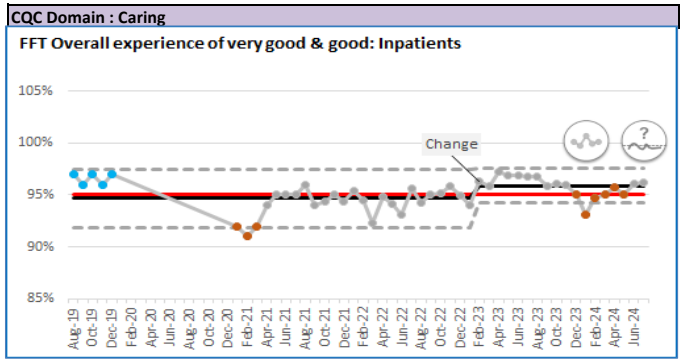
Jul-24
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



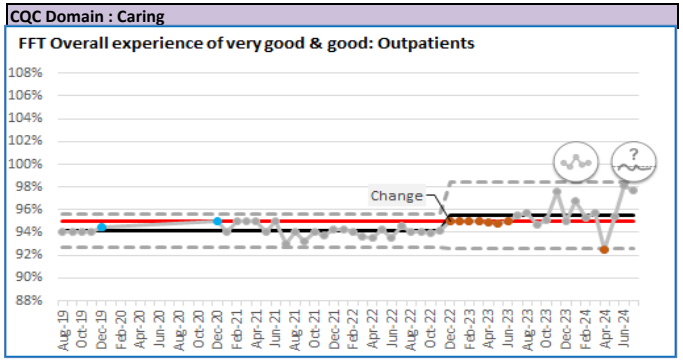
Jul-24
74.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring



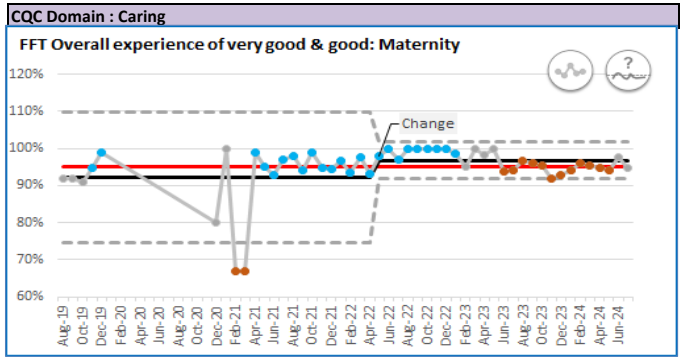
Jul-24
96.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



Jul-24
97.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



Jul-24
94.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse

Overall position commentary

The Trust quality KPIs all demonstrate no significant variation;

C Difficile remains above the target of 6 per month, peaking at 15 in July 24.

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

Friends and family test for ED had increase to 74.9%, maternity 94.9%, with inpatients and outpatients maintaining the target.

Infection Prevention and Control

Narrative:

Clostridium difficile infections remain above the target of 6 per month with an average of 9 per month. From the thematic review undertaken by the Associate Director of Infection prevention and control an improvement plan has been developed in collaboration with the high incidence areas, 36, 26, 18, AMU, ED, each area has developed individualised plans and test of change. Including but not limited to:

- Re-focus on education with staff regarding prioritisation / use of side rooms.
- Focus at huddles on stool chart compliance and documentation. Educating team about requesting early medical review if there are loose stools.
- Tracking side room occupancy and which patients would be the least risk to step out should one be required.
- Ward 36 and facilities are piloting a change to cleaning products and processes, including macrofibre plat head mobs, to avoid the need to store traditional mop heads and moving to a non chloring based cleaning product.

Actions:

- Use of a decant area, ward 44, to allow a proactive and reactive decant and HPV program.
- Mattress review, and exchange planned September 24.
- Enhanced IPC visibility to wards and department offering expert advice and guidance.
- Improved time to receive results to facilitate isolation, with a robust process to cover the weekend.
- Newly commenced senior nurse walkrounds have focused on IPC basics, including cleanliness, hand hygiene bare below the elbows, estates issues.
- A place wide improvement plan is in development in partnership with WCT, the ICB and public health.

Risks to position and/or actions

- Hospital occupancy
- Engagement in the QI project.

FFT Overall experience of very good and good.

Narrative:

The Trust monitors FFT experience across a range of care settings, with a target rating of a minimum 95% for good or very good.

In July ED scored 74.9% analysis of the patient comments for ED identifies waiting times, delays and communication, as the main reasons for attributing a negative ED response.

Actions:

- Monitor FFT performance against national average: we perform similar or above the national average since December 2022.
- Proactively respond to feedback, making immediate rectifications when able to and encourage patient and carer participation through Patient Experience Promise groups.
- Continue coproduction with patients via patient experience strategy.
- Continued focus on providing people with access to provide feedback via FFT:
- Feedback to local teams themes from FFT.

Risks to position and/or actions:

- Bed occupancy impacting on the length of time patients remain within ED: Processes are in place operationally to prevent this where possible and flow improvement program.

Pressure ulcers Hospital Acquired Category 3 and above

Narrative:

WUTH has a zero tolerance on Hospital Acquired HA Pressure Ulcers category 3 and above. From the 1st April WUTH implemented the national wound management classifications replacing previously classified PU of unstageable to a Cat 3, this has been socialised within the organisation and based on historical data will result in an increase of Trust HA cat 3 and above Pressure ulcers prevalence.

During July there were 0 HAPU Category 3 pressure ulcer reported, any learning will be included as part of the Pressure ulcer pressure improvement plans.

Actions:

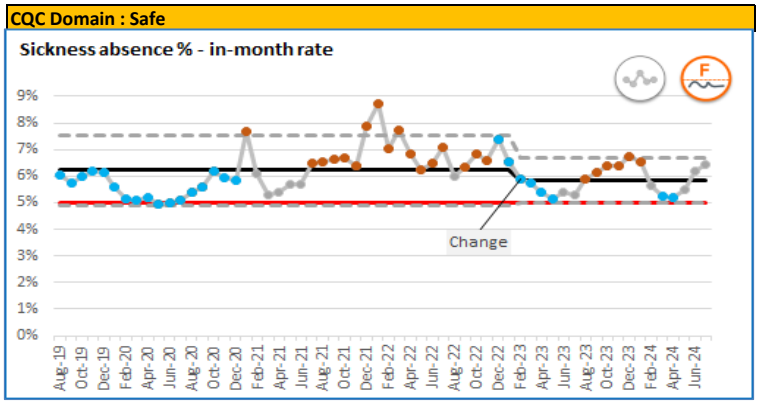
- Trust wide implementation of Purpose T as its Pressure ulcer risk assessment has replaced Braden from the 1st April 2024.
- The Trust has an overarching Trust Pressure Ulcer improvement plan with Divisional specific improvement plans identifying divisional themes and trends.
- Review underway in relation to documentation provisions with Cerner system to streamline documentation.
- Increase awareness on the importance of timely skin inspections to be shared at the safety huddle.
- Trust wide static mattress review planned September 24.
- Dynamic mattresses require a review.
- Validation processes require review.
- Opportunities being explored with WCT to collaborate on an integrated team.

Risks to position and/or actions:

- Changes to national reporting for wound classification will be implemented from 1st April 2024 which will remove the classification of Unstageable. These historical unstageable will automatically be classified as a Cat 3 which will result in an increased prevalence for the Trust.

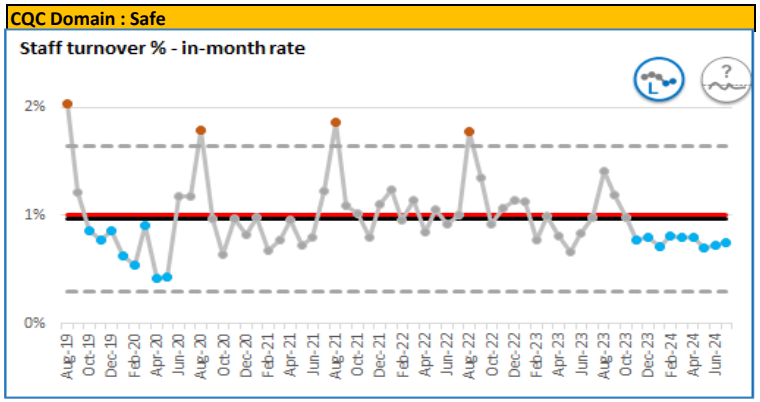
Chief People Officer

CQC Domain : Safe



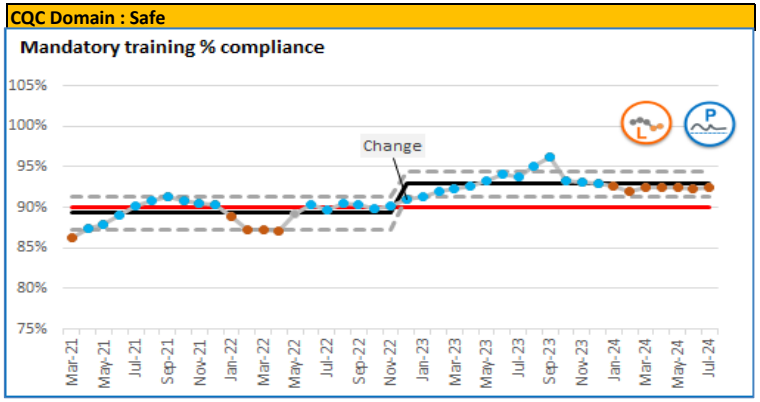
Jul-24
6.42%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe



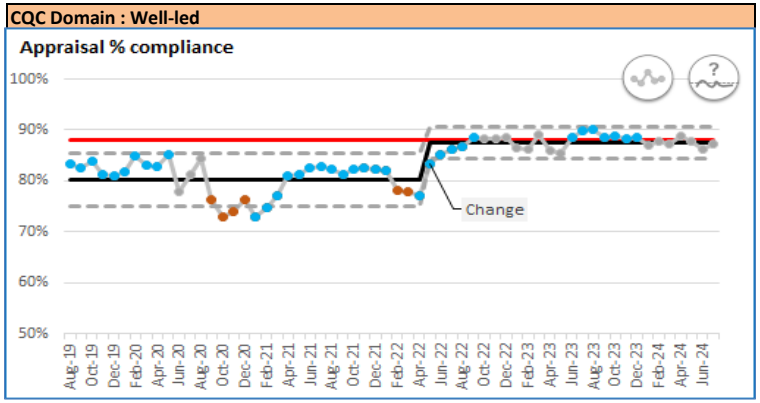
Jul-24
0.75%
Variance Type
Special cause variation - improving
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



Jul-24
92.48%
Variance Type
Special cause variation - concerning
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led



Jul-24
87.31%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – for Sept 2024 BoD

Overall position commentary

The Trust's People KPIs for mandatory training and turnover remain on target and continue to be achieved.

Appraisal completion remains below compliance by 0.69%, with Divisional trajectories in place to achieve target.

Sickness absence remains above target at 6.42% and is an area of concern; it has increased from the previous month.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For July 2024 the indicator was 6.42% and demonstrates common cause variation.

The majority of absences relate to short term sickness. The top three reasons for absence have remained the same for the past four months, Gastrointestinal problems, Stress/Anxiety/Depression and Cough, Cold & Flu however, there has been an increase in absences relating to Infectious Diseases within the past two months.

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

Actions:

- Trust wide communications issued on Covid-19 outbreak and precautionary measures.
- The return-to-work guidance for staff with respiratory illness, including COVID-19, has been reviewed and reissued.
- Pertussis staff drop-in vaccination clinics held.
- Ongoing effective contact tracing.
- Preparation has commenced for the staff winter vaccination programme.
- Annual patterns of absence during the winter period are being identified to be shared with line managers, to facilitate proactive conversations with individuals and offer support to those who may need it.
- Wellbeing Surgeries held across Trust sites.
- Proactive support from Occupational Health to issues raised at the Trust Safety Huddle.
- Additional on-site promotion of our Employee Assistance Programme

Risks to position and/or actions:

The management of sickness absence is primarily management led as they are responsible for monitoring employee attendance addressing sickness absence and ensuring that the policy is applied consistently, supported by the HR team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels and staff morale / engagement. Effective attendance management is critical and contributes to productivity and patient care. The Trust continues to promote a positive attendance culture by investing in, and focusing on, employee health and wellbeing initiatives to help mitigate this risk by preventing ill-health and supporting people to balance work whilst minimising the impact of any ill-health symptoms, where possible.

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

Work continues on the deliverables within the People Strategy with a number of workstreams that will support attendance across the Trust, this includes promotion of flexible working, which is available to all staff, transforming and modernising Occupational Health and Wellbeing Service in line with the Growing OH and Wellbeing together strategy as set out in the NHS People Plan to improve the health and wellbeing services for our people, to keep them safe and healthy and able to provide good care to our patients. This is part of our proactive culture of wellbeing across the trust.

Appraisal % compliance

Narrative:

The threshold for Appraisal compliance is 88% and for the month of July 2024 compliance remains slightly below the threshold at 87.31%, demonstrating common cause variation. Acute Division, Corporate Support, Medicine Division and Surgery Division are all below target.

Actions:

- Divisional improvement plans were agreed at July Workforce Steering Board These will continue to be monitored by the Steering Board.
- Divisional leaders and HR business partners continue to identify areas of lower performance and work with service leads to address compliance gaps.
- The Learning and Development Team contacts all individuals that are out of compliance and due to become out of compliance with details about the appraisal process.
- Contact is also made with all line managers each month to actively highlight gaps in compliance and provide information and guidance on the process, note this is in addition to ESR automatic messages which are also issued.
- Development for managers continues with online resources and guidance made available together with formal management training.
- The intranet has a comprehensive suite of guidance and ‘on-demand’ learning resources that brief staff and managers on the new process.
- A new appraisal ‘portlet’ has been developed in collaboration with the national ESR Team. This makes recording appraisal easier for managers with a short step by step video to assist them in recording appraisals.

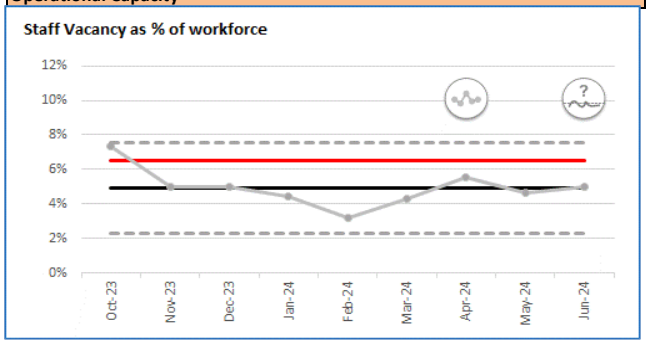
- The Learning and Development Team have offered short-term interim support to divisions to support with recording of appraisals during periods of significant system pressures and ongoing industrial action.

Risks to position and/or actions:

- Ongoing system pressures continue to be a risk to capacity for managers and staff to have quality appraisal discussions. To help mitigate this, the OD Team will work in collaboration with HR to provide targeted awareness sessions for teams / services that are particularly lower in compliance.

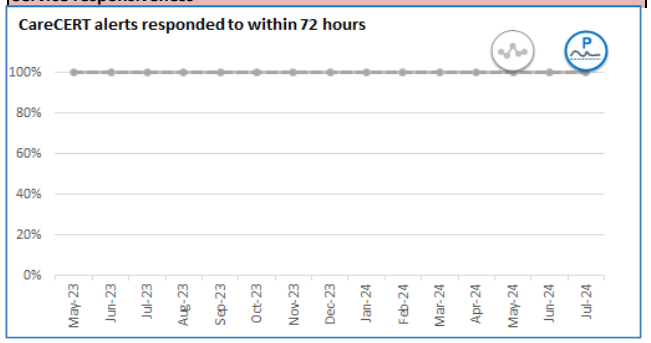
Chief Information Officer

Operational Capacity



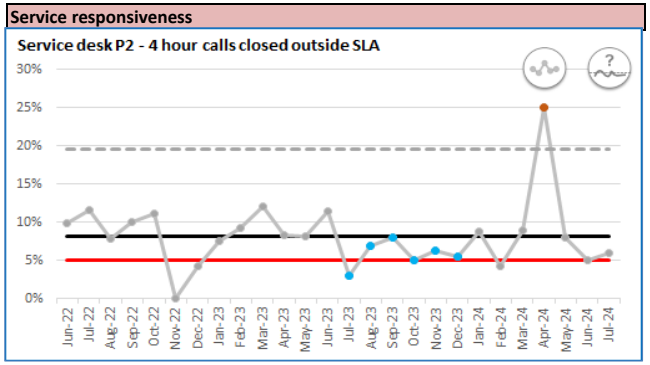
Jul-24
6.9%
Variance Type
Not enough data points yet
Threshold
<=6.5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



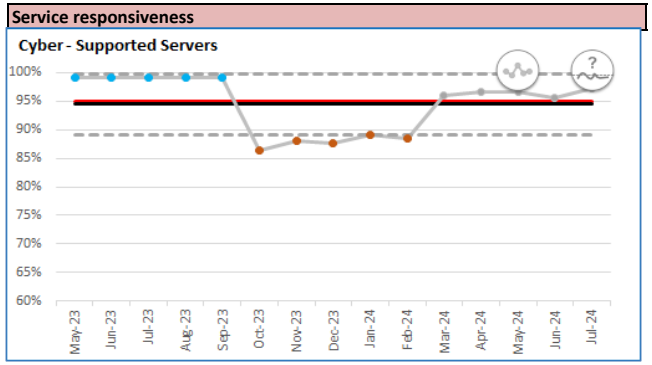
Jul-24
100%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently achieves the target

Service responsiveness



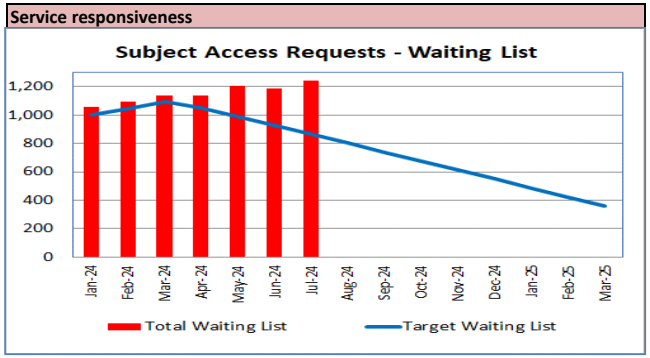
Jul-24
6.0%
Variance Type
Common cause variation
Threshold
<=5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



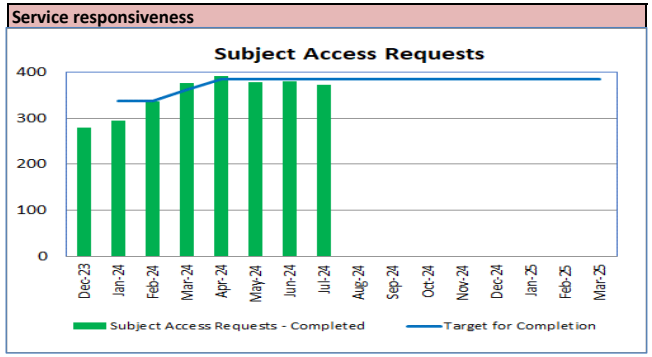
Jul-24
97.2%
Variance Type
Common cause variation
Threshold
>=95%
Assurance
Hit & miss target subject to random variation

Service responsiveness



Jul-24
1244
Variance
Total requests waiting worse than target
Threshold
864

Service responsiveness



Jul-24
373
Variance
Completed requests worse than target
Target
384

Chief Information Officer

Overall position commentary

Strong performance is maintained in:

- CareCERT alerts at 100% - a key control for cyber-security
- Cyber supported servers, again a key control for cyber-security

Key areas for improvement are:

- Service desk response times for Priority 2 incidents which have improved significantly but still remain slightly below target
- Subject Access Requests – completed requests were slightly below the improvement trajectory, however the total backlog has increased further due to continuing high levels of requests.

Service Responsiveness – Priority 2 calls closed outside of SLA

Narrative:

All calls raised with the Digital Healthcare Team Service Desk are assigned a priority, based upon the perceived level of impact that a particular technical issue will have upon the continuity of operations and/or clinical care of our patients. Priority 2 (P2) calls are classified as clinical issue impacting patient care that needs direct action within 4 hours. The associated performance threshold in place is that no more than 5% of P2 calls should breach their SLA of 4 hours.

Since a spike in calls exceeding the 4 hour SLA in April of 2024 performance has stabilised somewhat although is still slightly over and above the 5% target set, which sits at 6% for July.

Actions:

- Work is ongoing to ensure that all support teams are compliant with Helpdesk system call closure procedures
- Together with our stakeholders we will be assessing and agreeing the qualifying criteria for call priority categorisation to ensure it reflects the needs of the organisation.

Risks to position and/or actions:

- Risk around embedding process into the teams concerned, which we are continually monitoring and addressing gaps in compliance.

Service Responsiveness – Subject Access Requests

Narrative:

The organisation has experienced a year-on-year increase in volume and complexity of Subject Access Requests (SARs) totalling 41% since 2016. Change in legislation, increase in request numbers, the complexity of the requests and the evolving attitudes towards information rights have had a

significant impact on the standard of service delivery. This combination has led to a significant backlog of requests within the Access to Information department. As at January 2024 there was a backlog of circa 1000 requests, with approximately 650 of those requests being outside of the regulatory 30 day response target.

The improvement trajectory for completing requests was just 11 behind in July: 373 completed against a target of 384.
Total requests waiting had an increase to 1,244.

The number of new requests received every month remains higher than in 2023 and above the average anticipated. In July 433 requests were received, this is an increase on June 2024 and is the highest number received in the last 12 months.

Actions:

- Ongoing demand in 2024 will be discussed and assessed against 2023 levels and against the trajectory assumptions.
- Recruitment to team leader vacancy.

Risks to position and/or actions:

- Risk posed by any further increase in demand that is unaccounted for.
- Risk of trajectory slippage depending on any personnel issues such as sickness, staff turnover, recruitment etc.
- A further post is due to become vacant in August.

Productivity and Efficiency Update

Board of Directors – September 2024

Hayley Kendall, Chief Operating Officer

Divisional Performance

24-25 M4 CIP - Workstream

Wirral University Teaching Hospital NHS Foundation Trust

In Year				
Workstream	FY Target	FOT	Variance	Transacted
Division	£14,356	£10,300	-£4,057	£5,413
Productivity	£4,000	£1,530	-£2,470	£110
Site Capacity	£2,000	£689	-£1,311	£321
Workforce	£2,000	£945	-£1,055	£541
Meds Optimisation	£1,000	£1,137	£137	£179
Diagnostics	£1,000	£644	-£356	£548
Non Pay	£1,000	£2,873	£1,873	£2,442
Digital Innovation	£1,500	£479	-£1,021	£336
Estates	£1,000	£978	-£22	£741
Admin & Clerical	£1,000	£545	-£455	£401
Trust	**£28,856**	**£20,120**	**-£8,736**	**£11,032**

IDENTIFIED FYE					
Workstream	Red	Amber	Green	Blue	Total
Division	£2,486	£1,494	£485	£5,306	£9,771
Productivity	£812	£2,265	£86	£109	£3,272
Site Capacity	£322	£590		£321	£1,233
Workforce	£0	£1,088	£249	£522	£1,859
Meds Optimisation	£50	£150	£851	£180	£1,231
Diagnostics		£374		£550	£924
Non Pay	£200	£533	£67	£2,473	£3,273
Digital Innovation	£680	£218	£4	£648	£1,550
Estates	£0		£237	£741	£978
Admin & Clerical	£143	£305		£423	£870
Trust	**£4,693**	**£7,016**	**£1,979**	**£11,274**	**£24,961**

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24-25 M4 CIP – Division

Wirral University Teaching Hospital NHS Foundation Trust

In Year				
Division	FY Target	FOT	Variance	Transacted
Medicine	£5,253	£1,842	-£3,411	£585
Acute	£1,533	£607	-£927	£156
Surgery	£6,345	£3,931	-£2,415	£1,110
DCS	£4,960	£3,511	-£1,450	£2,006
W&C	£3,073	£1,378	-£1,694	£1,015
Corporate	£2,560	£2,237	-£323	£2,202
Estates	£3,455	£2,599	-£856	£2,196
Central	£1,676	£4,016	£2,340	£1,761
Trust	**£28,856**	**£20,120**	**-£8,736**	**£11,032**

- Target £28.8m
- FYE identified £24.9m
- Forecast delivery £20.1m in year
- Gap to target £8.7m in year
- Transacted as at M4 £11m

Full Year Effect					
Division	Red	Amber	Green	Blue	Total
Medicine	£522	£1,444	£738	£605	£3,309
Acute	£0	£1,091	£491	£156	£1,738
Surgery	£2,218	£2,634	£50	£975	£5,877
DCS	£1,294	£1,110	£326	£2,013	£4,744
W&C	£50	£419	£117	£1,019	£1,605
Corporate	£38	£13	£0	£2,222	£2,273
Trust Central	£570	£72	£0	£1,761	£2,403
Estates	£0	£233	£257	£2,523	£3,013
Total	**£4,693**	**£7,016**	**£1,979**	**£11,274**	**£24,961**

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Transformation Workstreams

Productivity & Efficiency Workstreams 2024/25

Wirral University Teaching Hospital
NHS Foundation Trust

R Chapman	H Kendall	D Smith	N Stevenson	N Stevenson	M Chidgey	M Chidgey	M Swanborough	H Kendall
								
Productivity £4m	Site Capacity £2m	Workforce £2m	Diagnostics & Reporting £1m	Medicines Optimisation £1m	Non-Pay Spend £1m	Digital Innovation £1.5m	Estates & Facilities £1m	Admin & Clerical £1.0m

Workstreams

Wirral University Teaching Hospital
NHS Foundation Trust

RAG Delivery Status

Productivity: £4m

- Improve efficiency in theatres, outpatients and endoscopy to utilise core sessions and reduce non-core costs.
- Optimise ward calibration and agree a target model of care to reflect national standards with robust e-rostering modelling and controls.
- Develop robust job planning policy to ensure alignment between demand and capacity and the delivery of annual activity targets.

Site Capacity: £2m

- Free up beds across the Trust by ensuring we treat patients in the right beds at the right time and closing escalation beds
- Improving discharges and delivering best in class Length of Stay (LOS) including assessment model
- Establishment of virtual wards and front door consultant delivered services to reduce G&A bed admissions

Workforce: £2m

- Utilising our existing workforce to address challenges of capacity and reducing the reliance on temporary staffing
- Reduction of medical bank and agency spend and embedding a sustainable workforce models
- Review of junior doctors rotas to ensure alignment between demand and resource requirements delivering fit for purpose rosters that do not rely on additional non-core spend

Workstreams

Wirral University Teaching Hospital NHS Foundation Trust

RAG Delivery Status

Medicines Optimisation: £1m

- Safely reduce our drug and prescribing spend
- Identify product switches in line with best practice and regional benchmarking
- Reducing spend on high-cost drugs in line with national guidance

Non-Pay Spend: £1m

- Reduce non-pay spend by standardising products across the Trust and improving quality at a lower cost.
- Increased use of data analytics to identify cost improvement opportunities.
- Collaborate with system partners to increase purchasing power and achieve greater economies of scale.
- Reduce waste identified by staff and patients.

Diagnostics & Reporting: £1m

- Ensure efficient use of our diagnostic service
- Reduce the reliance on outsourced support delivering improved value for money and quality
- Ensuring our capacity for internal services is maximised
- Maximise opportunities brought about by the Community Diagnostic Centre

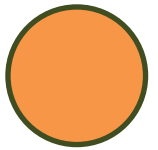
Workstreams

Wirral University Teaching Hospital NHS Foundation Trust

RAG Delivery Status

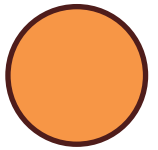
Digital Innovation: £1.5m

- Complete One Patient Record initiative to ensure clinicians are able to access all medical records digitally.
- Utilise digital technology to improve services and minimise manual processes and reduce cost.
- Improve data quality and reporting to enable better decision making.



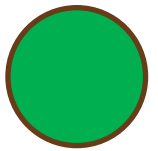
Estates & Facilities: £1m

- Ensuring our footprint is fully utilised and reduce the reliance on off site space and temporary accommodation



Admin & Clerical: £1.0m

- Implementation of digital dictation and voice recognition
- Implementation of Robotic Process Automation
- Develop the optimal workforce model that embraces skill mix and delivers quality patient administration
- Deliver an outpatient scheduling solution that delivers maximum efficiency and use of staff



Fast tracking of the productivity workstream

Background

- Productivity workstream expedited in line with the C&M financial recovery request
- Productivity workstream developed to focus on improving rostering, productivity and job planning
- Work has progressed with project plans to support the desired outputs
- I&I process has driven the need to deliver the productivity elements of WAVE faster than originally planned
- Engagement with executive and divisional leads to agree next steps to expedite the work and deliver within the next 3 months
- Agreement that a dedicated team is developed to work solely on this workstream and deliver the actions over the next 4-8 weeks

Dedicated team

Wirral University Teaching Hospital NHS Foundation Trust

Confirmed

- Associate Director of Productivity and PMO
- Project Manager - PMO
- Senior Improvement Lead
- Divisional Director for Planning and Performance
- Financial analyst
- BI analyst
- Workforce team experienced in e-roster

Executive Sponsor – Hayley Kendall
SRO – Robbie Chapman

Initially a 3-month period with clear project plans to deliver the desired outputs

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Rostering

Wirral University Teaching Hospital NHS Foundation Trust

Progress

- ✓ Budgeted Ledger and ESR Reconciliation Complete
- ✓ Emergency Department Budget and Actual Reconciliation Complete
- ✓ Nursing KPI Dashboard built and published on the BI Portal for review
- ✓ Nursing KPI Dashboard to run weekly
- ✓ Flexible working arrangement review in ED complete with ADN-53/142 WTE on informal/formal working arrangements
- ✓ ED ESR matched to the Ledger
- ✓ ED establishment being updated into Health Roster
- ✓ ED Flexible working impact reviewed with workforce team and next steps confirmed

Immediate Next Steps

- ✓ Bank and agency spend to be added to KPI dashboard
- ✓ HR BP for Acute to work with ADN post leave to validate flexible working arrangements
- ✓ Confirmed flexible working arrangements to be loaded into health roster
- ✓ Auto Roster to run to show % gap to be filled with remaining substantive staff
- ✓ Review of Safer Care Implementation plan with Corporate Nursing and feasibility of test build for the 6 above wards with DDN post leave

Medical Productivity

Wirral University Teaching Hospital NHS Foundation Trust

Progress

- ✓ Triangulation of Budget, L2P and ESR completed
- ✓ Draft Job Planning timetable for 25/26 developed
- ✓ Population of base sheet of 24/25 job plans underway to feed performance reports, matching scheduled and delivered sessions against job planned sessions for theatres, outpatients and endoscopy
- ✓ L2P job plans in the process of being loaded into costing model, to link PA'd sessions to forecasted income and costs
- ✓ Capacity and demand analysis meetings arranged led by the Divisional Director-Performance & Planning in August, to develop clear and robust activity forecasts for 25/26 to inform job planning
- ✓ BI investigating reporting capabilities
- ✓ PMO developing temporary reporting solution, mapping Theatre and Outpatient Sessions to Job Plans
- ✓ Opportunities identified for automated solutions to pre-operative process

Immediate Next Steps

- ✓ Deputy Medical Director and Head of Workforce to confirm proposed changes to draft Job Planning Policy
- ✓ Completion of Job Planning base sheet re activity
- ✓ Finalisation of temporary reports for Divisional Directors

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Junior Doctors

Wirral University Teaching Hospital NHS Foundation Trust

Progress

- ✓ Review of ED rota pattern with medical staffing lead
- ✓ Review of the Junior Doctor mandatory rules
- ✓ Confirmation of 48 hours off post 4 consecutive days worked and opportunities to review rota designs
- ✓ Meeting with medical staffing team w/c 19th to review rota design process
- ✓ Review of highest spend days and areas-Monday, Tuesdays and Thursdays
- ✓ Confirmation that Education Schedule is a driver in rota gaps

Immediate Next Steps

- ✓ Confirmation of Education schedule for the year
- ✓ Confirmation of how the education schedule is developed
- ✓ Mapping of Education schedule to Education PA's
- ✓ Confirmation of education schedule re juniors, eg F2's Wed's pm. F1's and GP's Thurs PM

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Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.5**

04 September 2024

Title	Quarterly Maternity and Neonatal Services Report
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Information

Executive Summary and Report Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in June 2024 and a monthly report in July 2024.The following paper provides a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

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

This paper provides a specific update regarding MIS Year 6, Saving Babies Lives (SBLv3), Ockenden, the Three-Year Delivery plan, Ockenden, Midwifery staffing update, Maternity Continuity of Carer (MCoC) together with an update on the 24/25 Maternity and Neonatal Voices Partnership (MNVP) annual plan.

It is recommended that the Board:

- Note the report.
- Note the Perinatal Clinical Surveillance Assurance report.
- Note the position of Patient Safety Incident Investigations (PSSI's) & Maternity and Newborn Safety Incidents (MNSI)
- Note the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3.
- Note the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals".
- Note the position of the neonatal medical and nursing workforce.
- Note the position of the maternity workforce.
- Note the updates within the maternity self-assessment tool.
- Note the PMRT reports.

Key Risks

This report relates to these key Risks:

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

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
September 2024	Maternity & NNU Assurance Board	Quarterly Maternity and Neonatal Services Report	For information
September 2024	Patient Safety and Quality Board	Quarterly Maternity and Neonatal Services Report	For information

1	Perinatal Clinical Surveillance Quality Assurance Report
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (July 2024) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services. The dashboard is provided for information and whilst there is no indication to escalate any of the metrics to the Board of Directors, it should be noted since there is no longer a Northwest coast regional report being produced WUTH is no longer able to report on the benchmarking against other providers for rates such as stillbirth and neonatal deaths. Assurance has previously been provided to the Board of Directors this was escalated via the Local Maternity and Neonatal System (LMNS) for a resolution. However, a Northwest Regional Dashboard Tool for use by Regional Maternity and Neonatal Teams is available to provide bespoke reports for Regional Operational Performance reporting. The Maternity Services Data Set publications have a lag of circa three months and at the time of the report December 2023 data was unavailable to access. On review of the dashboard the Board of Directors should be aware concerns regarding the accuracy of the data sources have been raised regionally, further escalating regionally it remains WUTH is still unable to benchmark against other providers.

2	Patient Safety Incident Investigations (PSII's) & Maternity and Newborn Safety Incidents (MNSI)
	Patient Safety Incident Investigations (PSII's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSSI's across the region. There were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in June and July 2024 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date two cases will undergo the independent safety investigation. There were no Patient Safety Investigation Incidents (PSII's) declared in June and July 2024 for Neonatal services.

3	Maternity Incentive Scheme (MIS) Year 6
	A detailed MIS update is included to Board of Directors Monthly Maternity Services update, which will further inform Trust declaration with the MIS due for submission before a deadline of 12 noon on 3 March 2025. Now in its sixth year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. The compliance is being monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. An updated gap analysis is provided at **Appendix 2** in line with the revised updates to the scheme published in July 2024 at **Appendix 3, 4 and 5**. Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS and the declaration will also be required to be signed off by the ICB. The compliance will be monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. A further compliance update will be included in the next maternity quarterly update report utilising the audit tool. Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS/ICB.

4	National Perinatal Mortality Maternity Incentive Scheme (MIS) Year 5
	The Perinatal Mortality Reviews Summary Report (PMRT) is included in **Appendix 6**. The report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool for WUTH which occurred in the Quarter 2 and 2 24/25 period.

5	Saving Babies Lives v Three (SBLv3) Safety Action 6 of the MIS year 5 Scheme

	The Saving Babies' Lives Care Bundle (SBLCB) launched in July 2023 provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle (SBLCBv3) was redeveloped to include a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. On final review of all the evidence as of 30th June 2024 the Trust achieved 96% compliance against the 6 elements included at **Appendix 7**. The Trust continues to work towards full implementation and a further update will be in the next Board of Directors quarterly paper.

6	**Ockenden Review of Maternity Services: Final Report – Update on Trust compliance with the Immediate and Essential Actions / Recommendations**
	An initial gap analysis outlining compliance against these recommendations detailed within the 15 Immediate and Essential Actions (IEA's) was reported to the Board of Directors in December and updates have been provided quarterly. The gap analysis is included at **Appendix 8** and remains in the same RAG rated position as fully compliant.

7	**Three Year Delivery Plan – Maternity and Neonatal**
	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 9** and is RAG rated accordingly. The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion • Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support • Standards and structures that underpin safer, more personalised, and more equitable care. Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress is monitored via the Maternity and Neonatal Quality assurance board and WUTH continues to implement within the timescales. The Equity and equality guidance for local maternity services is the pathway followed to address health equalities and is also part of the three-year delivery plan.

8	**Midwifery Workforce and update on Maternity Continuity of Carer Model (MCoC)**
	The Maternity Service continues to deliver care via two models of maternity care – one that is traditional in its approach, and the other a Continuity of Carer (CoC) Model of care. Women being cared for by a team of midwives under the Continuity of Carer

	model appreciate the benefits of improved outcomes and experience compared to those cared for by a traditional model. As a provider WUTH has six maternity continuity of carer teams and in line with upskilling programs and safe staffing levels. A further team was launched in February 2024 and further teams were anticipated in 2024, subject to identifying additional funding. A comprehensive review of MCoC is being undertaken that will be presented to the Board of Directors on completion and data is being collated on the outcomes for women. There is a delay to this piece of work as there has been a regional request to broaden and publish the findings as research. An options appraisal is being developed with support of the regional team to consider recommendations for WUTH's future model of maternity care considering safe staffing levels and meeting the enhanced element of continuity which evidences better outcomes for women/birthing people. As previously presented to Board of Directors a full workforce review was last undertaken using the Birthrate+ tool in 2021, a repeat of this as recommended every 3 years in line with Ockenden is being undertake and a report is expected in Autumn 2024. The midwifery oversight report that covers staffing and safety was included on the People Committee and is included at **Appendix 10.**

9	**NNU Medical and Nursing Workforce**
	Included at **Appendix 11** is the neonatal medical and nursing workforce paper reported in line with British Association of Perinatal Medicine (BAPM) providing an update on the Trusts position.

10	**Maternity Self-Assessment Tool**
	There is a requirement by NHSE and the Care Quality Commission (CQC) to report the Maternity Self-Assessment tool 6 monthly to the Board of Directors included at **Appendix 12**.

11	**Conclusion**
	The Board of Directors are requested to note the content within the report and progress made within maternity and neonatal services. The next BOD paper will continue to update on the delivery of safe maternity and neonatal services.

12	**Implications**
12.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
12.2	**People** • Compliance and confirmation via the LMNS/ICB WUTH have that meet all 10 safety standards provides assurance of the improvements to high quality, safe care and the delivery of best practice in both Maternity and Neonatal services. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement.

	• Progress with the three-year delivery plan supports birthing people and their families with quality improvements to deliver safer, more personalised, and more equitable care. • Progress with sustainability of Ockenden • Progress with Saving Babies Lives v3 supporting better outcomes for women/birthing people and babies.
12.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) and continue to deliver Maternity Continuity of Care as for women/birthing people with enhanced care needs, investment into the maternity and neonatal workforce is required and funding options continue to be explored. • To achieve compliance of MIS Year 6 the Statement of case for an additional Neonatal Consultant has been approved to cover Monday to Sunday, currently out to advert.
12.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.6**

4 September 2024

Title	Learning from Deaths Report (Q4 2023-24)
Area Lead	Dr Nikki Stevenson, Executive Medical Director & Deputy CEO
Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide the Board with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q4 23-24.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths within the Trust and escalates and deaths where there are potential concerns.
- The Trust SHMI for the latest available 12-month period (to Oct 23) is 1.07 (within expected range)
- HSMR on the latest available 12-month period (to Nov 23) is 97.5 (within expected range)
- The Mortality review group (MRG) meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner.
- MRG continues to review Telstra Health data to benchmark nationally and highlight areas of concern.
- Learning form mortality reviews is fed back to clinical areas by the Divisional Mortality leads and to relevant steering groups.

It is recommended that the Board:

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

Key Risks

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

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

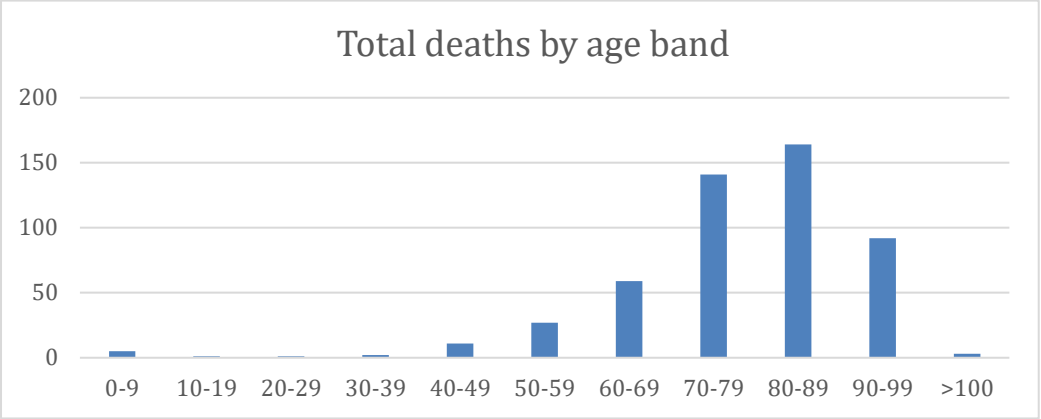
Which strategic objectives this report provides information about:

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
31 July 2024	Quality Committee	As above	As above
20 June 2024	Patient Safety Quality Board	As above	As above

1	**Narrative**
1.1	To provide a quarterly summary of the mortality review process, care issues, learning and current mortality comparator statistics. This paper is for Adult and perinatal mortality. Wirral University Teaching Hospital is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework: • Preventing people from dying prematurely. • Treating and caring for people in a safe environment and protecting them from avoidable harm. Wirral University Teaching Hospital uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a 'warning' of potential problems and help identify areas for investigation. The Medical Examiner service provides independent scrutiny for all deaths that occur within WUTH, and escalates any concerns for a mortality review, coordinated through the Trust Mortality Group. Additionally, a random 5% of non-escalated deaths are selected for a "quality assurance" mortality review. Lessons learnt from mortality reviews are fed back to each clinical Division via the Divisional Mortality leads who attend the Mortality Review Group. **Patient demographics** There was a total of 509 deaths in Q4 23-24.

Most recorded deaths are in the over 70 age group and the vast majority fall into the "White British" Ethnic band.



Ethnicity	Number of deaths
White - British	457
White - Irish	1
White - Any other White background	5
Mixed - Any other mixed background	0
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	1
Asian or Asian British - Any other Asian background	1
Other Ethnic Groups -	3
Black/ Black British	0
Not stated/ Not known	42
Total	477

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The overall SHIMI for WUTH on the latest available data (12 months to October 23) is 1.07 which is within the "as expected" range. SHIMI for WUTH has been relatively stable in the "expected" range for several quarters now.

Factors impacting SHIMI.

- Specific diagnostic groups

SHIMI can be broken down into specific diagnostic groups to highlight any areas of concern.

On the latest SHIMI data one group (Cancer of Bronchus Lung) has been highlighted as an outlier with a SHIMI of 1.63.

MRG agreed to look at 20 highlighted deaths to gain better understanding around the cause of this increase. The main learning points from this review are;

- 12 of the 20 deaths were known cancer cases on a palliative care pathway (SHIMI does not exclude palliative care patients). In several of these cases there was a delay in fast track discharge home for palliative care that resulted in patients dying in hospital.

- 6 patients presented as an emergency admission and were not fit for treatment due to advanced disease.

- 2 patients had a known diagnosis of stable lung cancer and died from pneumonia. Review of these 2 deaths has graded their inpatient care as appropriate.

Based on the above findings MRG have agree not to undertake further analysis on this diagnostic group but to review in the next quarter.

- Impact of deprivation on SHIMI

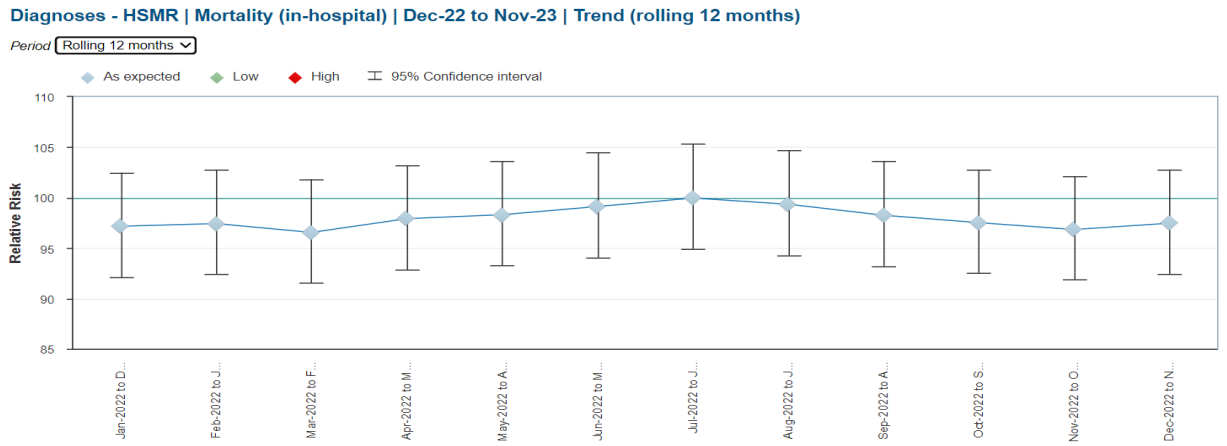
The Trusts continues to have a higher-than-average percentage of provider spells from the most deprived areas. Potential additional risks/complexities associated with these patients, is not factored into the SHMI calculation unlike HSMR, and can lead to a higher SHIMI.

- Palliative care coding

As discussed in previous reports WUTH continues to have a higher than average number of patients who have a palliative care code (after being reviewed by palliative care). A large number of patients with this code will impact on SHIMI as the SHIMI model does not exclude these patients (unlike HSMR). Recent reviews have shown that palliative care coding remains appropriate and is a reflection of a proactive palliative care service.

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

The HSMR on the latest 12 months rolling trend is at 97.5 This is in the expected range.



Telstar Health is changing the HSMR model from 2025, with the main change being around inclusion of patients with a palliative care code. This group of patients have previously been excluded from HSMR and it is likely that including these patients will increase the Trust HSMR. There are other changes that may lower HSMR (eg, using deprivation index and expanding comorbidity groups). MRG have asked Telstart Health to undertake an impact analysis into this change and present findings at MRG in Q4 2024.

Mortality Dashboard

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

25 cases escalated by the ME to the mortality review group have undergone a review during Q4. These cases have been reviewed using a revised PMR template, or via the Royal College of Physicians Structured Judgement review tool.

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 24 deaths were reviewed in Q4 (5%) using the PMR template. 2 of these cases were subsequently escalated for further review.

During Q4 41 mortality reports were discussed at MRG with the grading as below.

Summary of all Adult in patient deaths and case reviews						
	Total Adult In-patients Deaths	Deaths reviewed by ME service (%)	Total No of cases escalated for review by Medical Examiner	Total No of SJR's opened from cases escalated	Quality assurance PMR's opened	Total number of case reviews opened by MRG
Q1 (23-24)	456	100%	24	10	26	50
Q2 (23-24)	411	100%	16	7	13	29
Q3 (23-24)	477	100%	18	3	16	34
Q4 (23-24)	509	100 %	25	3	24	49

Grading of Adult Care and avoidability following review in Q4 (Includes reviews opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
Number of cases	20	13	8	0

During Q4 four (3) deaths were reported in patients identified as having a Learning disability. All of these deaths will be reviewed using the SJR template and have also been referred for external review through the national LeDeR programme.

Learning Disability Mortality Reviews				
	Total No. of LD Deaths	No. reviewed	Problems in Health care Identified in this Quarter	Referred to National LeDeR Programme
Q1 (23-24)	10	10	0	10
Q2 (23-24)	4	4	0	4
Q3(23-24)	2	2	0	2
Q4 (23-24)	3	3	0	3

Perinatal and Neonatal deaths

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

	Stillbirths	Neonatal Deaths	Paediatric deaths	Cases sent for PMRT review
Q1 (23-24)	0	2	1	3
Q2 (23-24)	3	2	0	5
Q3 (23-24)	0	3	1	3
Q4 (23-24)	1	2	0	3

During Q4 there were 2 neonatal deaths and 1 stillbirth. There were no paediatric deaths during Q4.

During Q4 we have seen a rise in sudden infant deaths from the community, with a total of 4 deaths between January and March 2024. All 4 cases were brought into the Emergency Department in cardiac arrest with resuscitation ongoing. Sadly all 4 of these babies were pronounced dead in the ED.

The Trust has undertaken a themed analysis of these deaths to look for any concerns or trends around care. The review has identified the following themes.

- The common theme from the cases was unintentional co-sleeping. Despite all cases receiving documented advice surrounding co-sleeping the reviewing group have generated a number of ideas and suggestions how we may strengthen this advice in future, and this requires improved standardisation. Actions suggested to enhance safer sleeping advice have been captured within the actions log of this report.
- There is potential that austerity may be an issue and it is important that there is an assessment of home conditions documented in the antenatal and postnatal periods.
- Visual assessment of the sleeping conditions for babies should be recommended when confirming and advising upon safe sleeping practices.
- There appears to be differences in discharge processes and information given to parents between Transitional Care/NNU and maternity ward. This needs clarification going forward to ensure that all parents receive safer sleeping advice prior to discharge from hospital.

The review did not identify any specific gaps in the care that may have contributed to death. An action plan has been developed to pick up the learning points identified above.

Outcome of PMRT reviews reported in Q4				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, likely affected outcome
	0	2	0	1

Learning Identified from PMRT reviews.

There were 3 PMRT case reports finalised during Q4. All but one of the cases were adjudged to have good care, or minor care issues that would not have affected the outcome.

One case was graded as “D”, where it was felt care issues have likely affected the outcome. This was a case where an appropriate risk assessment had not taken place at the onset of labour that led to inappropriate management of labour. Actions have been put in place to address the issues identified.

Learning identified through review of mortality reviews during Q4.

Learning for mortality is derived from 3 main sources.

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

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

Learning theme	Source	Action taken
Poor documentation/ copying and pasting of medical documentation (not affecting patient outcome)	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads. The EPR template has been adjusted to remind staff not to copy and paste notes as routine. A working group is being set up to look at documentation across all professions.
Issues around maternity risk assessment, not following correct process.	PMRT	Learning fed back to relevant clinicians. Process have changed to ensure this can not happen again in the future
Lack of assessment of nutrition and hydration status	Mortality Reviews	Examples have been fed into the nutrition and hydration steering group for action.
Medication errors (not causing harm)	Mortality reviews	All medication errors are feedback to relevant clinician. If a medication error has resulted in possible harm this is picked up under the PSIRF process
Delay in fast track discharge (palliative care)	Case note review	Work ongoing to improve this by the community team. A new electronic form is being implemented over next few months that will speed up the process

External Benchmarking Data

Dr Telstar Health (Dr Foster) Data

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

For Q4 Cancer of Bronchus Lung has been highlighted as an outlier with a SHIMI of 1.63.

MRG agreed to look at 20 highlighted deaths to gain better understanding around the cause of this increase as detailed below.

Based on the review findings MRG have agreed not to undertake further analysis on this diagnostic group but to review in the next quarter.

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

Diagnostic Group	Quarter Highlighted	Alert type	Work undertaken	Outcome/ Learning
Ovarian Malignancy	Q2 23-24	CUSM alert	Case note review	Small numbers of deaths (6). 2 cases were out of region patients who deteriorated while on holiday in Wirral. No care issues or themes found in other cases. This diagnostic group is no longer an outlier
Complication of device implant	Q3 23-24	CUSM alert	Case note review	16 cases to be reviewed
Carcinoma of Bronchus	Q4 23-24	CUSM alert	Case review by Trust Cancer lead	No specific cause for concern found. Most of the cases were known to palliative care team and received appropriate care. Delay in fast track discharge

2	Implications
2.1	**Patients** • This report provides assurance around mortality statistics and shows that WUTH is not an outlier in terms of SHMI or HSMR when benchmarked against other Trusts.
2.2	**People**

	• Currently there is sufficient capacity in the Medical Examiner service to continue scrutiny of all inpatient deaths. From September 2024 the ME service will be required to scrutinse deaths in the community and plans are in place to ensure sufficient capacity to undertake this work.
2.3	**Finance** • Effective patient care will have a positive impact on the financial position of the Trust
2.4	**Compliance** • This report supports the Trusts requirements to provide safe and effective care as set out in the CQC framework

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.7**

04 September 2024

Title	Guardian of Safe Working Report Q1 2024/25
Area Lead	Dr Nikki Stevenson, Executive Medical Director and Deputy CEO
Author	Dr Alice Arch, Guardian of Safe Working
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to give assurance to the board that doctors and dentists in training are safely rostered and that their working hours are compliant with the terms and conditions of service (TCS).

To monitor compliance with the working hours directive, Doctors / Dentists in Training (DiT) continue to submit exception reports via the appropriate process and in accordance with the 2016 Terms and Conditions of Service. This report details a summary, exception reports and locum bookings submitted for Q4 2023/2024 (April to June) with data to 3rd July 2024.

The number of gaps present in the junior medical workforce continues to be a focus for the Trust to ensure compliance with the safe working directive and to reduce overall locum and agency spend.

There are a small number of exception reports outstanding which will be closed with the support of the Guardian of Safe Working. The Trust continues to support Junior Doctors to complete exception reports as it gives a greater understanding of workforce and training issue.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

- BAF Risk 3: Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

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

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

Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

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

1 Narrative

Dr Alice Arch is the Trust Guardian of Safe Working. The contents of this report contain details regarding exception reports submitted by Doctors/Dentists in Training (DiT) via the appropriate process and in accordance with the 2016 Terms and Conditions of Service.

High level data for Wirral University Teaching Hospital NHS Foundation Trust

Number of doctors / dentists in training (total): 281 (255.6 WTE)
Number of doctors / dentists in training on 2016 TCS (total): 281 (255.6 WTE)
Amount of time available in job plan for guardian to do the role: 1 PA/4 hrs per wk
Admin support provided to the guardian (if any): Access to 1.0 WTE
Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

Exception reports (regarding working hours)

Exception reports by Department

Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E	2	5	5	2
General Medicine	5	14	15	4
General Surgery	1	5	4	2
O&G	0	4	3	1
Paediatrics	2	1	2	1
General Practice	1	0	1	0
Total	11	29	30	10

Exception reports by Grade

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	5	10	14	1
F2	1	1	2	0
SHO	5	17	13	9
SPR	0	1	1	0
Total	11	29	30	10

Exception reports by Rota

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E 20% Fellow	1	0	1	0
A&E F2 LIFT WF 2023 24	0	1	1	0
A&E SHO 2023-2024	1	4	3	2
O and G SpR 2020	0	1	1	0

Medicine IMY2 2024	0	2	2	0
Medicine IMY2 2023	0	1	1	0
Medicine F1 2023	5	7	12	0
Surgical F1 2022 LIFT MT	0	1	1	0
O and G T1 2023 8w	0	3	2	1
General Paediatrics T1 2024 LTFT 0.8 MTWT	0	1	0	1
Gen Paediatrics T1	2	0	2	0
Surgical T1 1:10 2020	1	4	1	4
Renal LIFT 0.8TWTF 2023	0	2	1	1
Surgical F1 2022	0	2	1	1
GP F2 2023	1	0	1	0
Total	11	29	30	10

Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
F1	1	3	3	1	1	1
F2	0	0	1	0	0	0
SHO	0	1	4	2	1	9
SPR	0	1	0	0	0	0
Total	1	5	8	3	2	10

Exception reports (time claimed)					
	30-60 mins	1 – 2 hours	2 -3 hours	3 hours +	Zero Time Based Exceptions
F1	0	5	3	0	2
F2	0	0	1	0	0
SHO	0	17	0	0	0
SPR	0	1	0	0	0
Total	0	23	4	0	2

Exception reports (regarding training/academic issues)

Exception reports by department, grade or rota				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Total	0	0	N/A	0

Exception Reports

In this Quarter the pattern of majority reporting by foundation doctors which was seen in previously recent reports is not reported. Reporting, particularly from this group, might be expected to reduce through the academic year as our more junior medical staff gain the time management and essential non-clinical skills to complete their roles. The effect of interventions as a hospital might therefore only be expected to be seen in year-on-year data, which will be provided with the year-end report to the board.

Work Schedule Reviews

There have been two work schedule reviews this quarter, both in Obstetrics and Gynaecology. These will be implemented in quarter 2.

Vacancies

There are several vacant shifts which occur, for example, due to sickness or parental leave gaps on rotas which can contribute to exception reports.

The majority of these vacant shifts were within the Emergency Department. Vacancies are covered by doctors on flexible contracts and via the collaborative bank to minimise risks to patients or doctors in training. Medical staffing reviews are underway in several specialities.

Vacancies by Month						
Specialty	Grade	April	May	June	Total Vacant Shifts (Average)	Number of Shifts Uncovered
A&E	F2-ST8	448	393	403	415	550
Medicine	F2-ST8	176	183	157	172	438
Surgery	F2-ST8	59	63	88	70	82
W&C	F2-ST8	64	59	56	60	64
Total		747	698	704	717	1134

Fines

There have been no fines issued this quarter.

Doctors Mess

Dr Nikki Stevenson, Medical Director in conjunction with our Estates Team, Junior Doctors, Director of Medical Education and Guardian of Safe Working have worked collaboratively to refurbish and expand our Junior Doctors Mess.

Paul Scragg, Associate Director of Estates, and his team have worked closely with Junior Doctor representatives to design the refurbishment, enabling the delivery of a fully functioning space with enhanced rest facilities and a new study / administration work area.

The renovation will contribute to the delivery of safe and effective care by providing appropriate rest facilities for doctors who have long working weeks and will enhance the education and development of our doctors, supporting the Trust's aim of becoming an employer of choice.

Summary

The Trust continues to support Junior Doctors to complete exception reports as it gives the Trust a greater understanding of what is happening on the ground within the workforce. Additional work to improve and enhance our Junior Doctors working lives continues.

2	Implications
2.1	**Patients** • The role of the safe working hours is designed to reassure junior doctors and the Trust that rotas and working conditions are safe for doctors and patients.

2.2	**People** • The Guardian ensures that issues of compliance with safe working hours are addressed by the doctor and the Trust as appropriate. It provides assurance to the board of the employing organization that doctors' hours are safe. • The guardian works in collaboration with the Director of Medical Education and Local Negotiating Committee to ensure that the identified issues within exception reports, concerning both working hours and training hours, are properly addressed by the Trust.
2.3	**Finance** • The Guardian distributes monies received as a consequence of financial penalties to improve the training and working experience of all doctors. There have been no financial penalties this quarter.
2.4	**Compliance** • This report provides assurance and compliance as per contractual obligations with NHSE and the NHS employers.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework
September 2024

Item 8.8

Contents

1. Introduction

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

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

Baker Tilly 2021

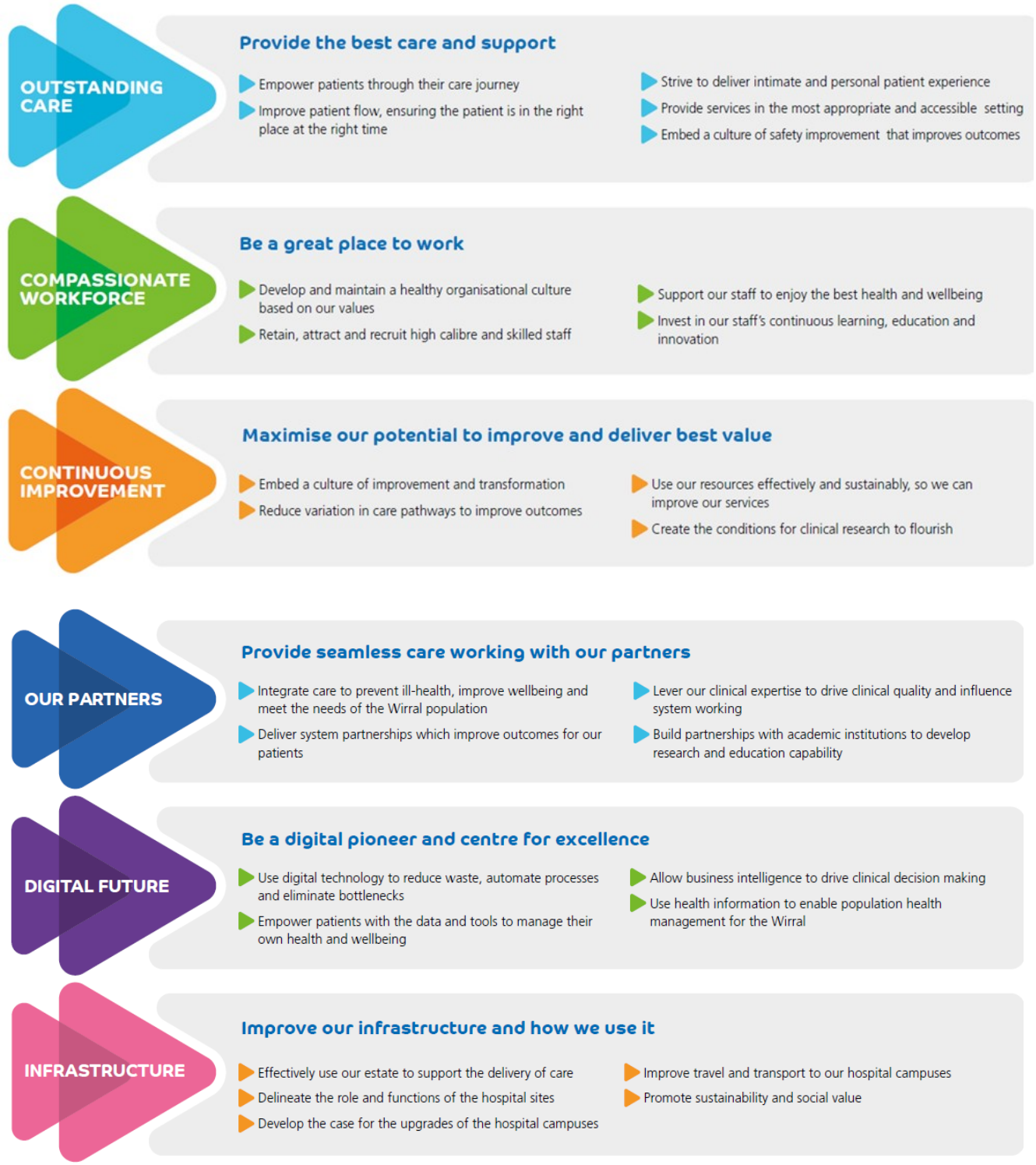
2. Vison, Strategy and Objectives

2.1 Our Vision

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

2.2 Our Strategic Objectives

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



3. Our Risk Appetite

3.1 Risk Appetite Statement

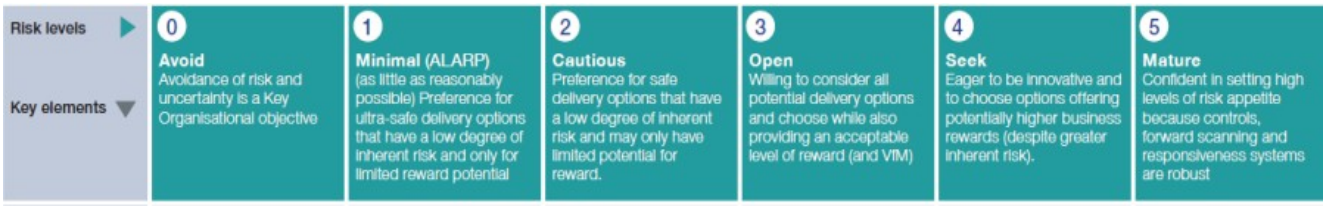
The Trust endeavours to establish a positive risk culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

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

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

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

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



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

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

4. Operational Risk Management

4.1 Operational Risk Management

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

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

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

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

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

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

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

The Trust shall achieve this by:

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

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

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

4.2 Risk Categorisation

All BAF Risk are further identified by the following risk categories:

- Reputational risk. **R**
- Operational risk. **O**
- Strategic risk. **S**
- Compliance risk. **C**
- Financial risk. **F**

5. Creating and Monitoring the BAF

5.1 Creation of the BAF

The original refreshed version of the BAF was created and approved in September 2021 following discussions and workshops with all Board members. The BAF is updated on a bi-monthly basis and subject to a full refresh on an annual basis.

5.2 Monitoring the BAF

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

- Is Updated on a quarterly basis.
- Reports to the Board at every other meeting.
- Reports to every other meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy.

- Reporting to every other meeting of relevant Board Committees.
- Reporting to every other meeting of the Executive Assurance and Risk Committee (EARC).
- Cyclical (at least yearly) circulation to Divisional Boards for information and to raise awareness.

6. Update Report

6.1 Purpose

The purpose of this report is to provide the Board with information and assurance as it relates to the Board Assurance Framework (BAF) and the current high level and strategic risks within the Trust.

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

6.2 Changes to the previous version

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

6.3 Risk Appetite and Risk Maturity

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

6.4 Recommendations

Board is asked to:

- Note and comment of the update to the BAF.
- Note and comment on the current position in regard to Risk Appetite and Risk Maturity.

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

12 Month – Quarterly Trend

Risk No	Risk Description	Initial Score	Target	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	June 24		Sept 24 Current
1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
2	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
4	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
5	Failure of the Trust to have the right culture, staff experience and organisational conditions to deliver our priorities for our patients and service users.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
6	Failure to embed the Trust's approach to planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans.	16 (4 x 4)	8 (4 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↑	16 (4 x 4)
7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.	12 (4 x 3)	8 (4 x 2)	N/A	N/A	N/A	N/A	N/A	12 (4 x 3)	↔	12 (4 x 3)
8	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
9	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and Wirral review as a long term threat or opportunity to service sustainability.	12 (4 x 3)	6 (3 x 2)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.	20 (5x4)	10 (5x2)	N/A	N/A	N/A	N/A	N/A	15 (5x3)	↔	15 (5x3)
12	Failure to reduce health inequalities for the Wirral population due to the absence of effective partnership working.	16 (4 x 4)	9 (3 x 3)	N/A	N/A	N/A	N/A	N/A	N/A	↓	12 (4 x 3)

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

Strategic Priority	Outstanding Care				
Review Date	01/09/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

Controls	Assurance
• Annual preparation and presentation of a system wide Winter plan in line with the National UEC Recovery Action. • Full participation in the Unscheduled Care transformation programme which includes working with Wirral Community Trust to reduce the numbers of patients attending the ED department who can have their care needs met away from ED. • Onsite support from Wirral Community Trust with the Chief Operating Officer focusing on admission avoidance and supporting early and timely discharge. • Monitoring of ED improvement plan and Wirral system urgent care plan by system Chief Operating Officers including Director of Adult Social care. • Health Economy CEO oversight of Executive Discharge Cell. • Additional spot purchase care home beds in place. • Participation in C&M winter room including mutual aid arrangements. • NWAS Divert Deflection policy in place and followed. • Rapid reset programme launched with a focus on hospital flow and discharge. • Continued communications out to primary care and to Wirral residents around only use A+E for urgent care requirements. • Regular meetings with the divisional leadership teams to ensure actions for improvement are delivered. • Business Continuity and Emergency Preparation planning and processes in place • Winter plan initiated that includes additional resource and capacity to aid strong UEC flows and performance • Full review of post take model to ensure sufficient resource is allocated to manage volumes • Implementation of continuous flow model to improve egress from ED.	• Trust Management Board (TMB) Assurance • Divisional Performance Review (DPR) • Executive Committee • Wirral Unscheduled Care Board • Weekly Wirral COO • Board of Directors • Finance Business and Performance Committee • Full unscheduled care programme chaired by CEO • Trust wide response to safe staffing of ED when providing corridor care

Gaps in Control or Assurance	Actions
• The Trust continues to be challenged delivering the national 4 hour standard for ED performance. • The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criterion to reside means the Trust occupancy is consistently above 95%, making the delivery of the four target very challenging.	• There is one overall Emergency Department Improvement Plan in place which focusses on ambulance turnaround times, time patients spend in the department and all other national indicators. Following the completion of several service improvements the operational plan for ED will be revised to include new areas of focus as the new leadership team for that area commence in post. • Develop with Wirral system partners a response to the Improving Urgent and Emergency Care Services released in January 2023. • Response to the national 10 high impact actions in preparation for winter • Design of a more streamlined UEC pathway • System 4 hour performance response to deliver 76% in March. • External support into ED from Aqua reviewing 4 hour and 12 hour performance – recommendation report received and local action plan in development with urgent actions.

Progress
Key Changes to Note • Additional action added relating to a system wide response required on delivering against the new national measures for improving urgent and emergency care, released in January 2023.

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

Strategic Priority	**Outstanding Care**				
Review Date	**01/09/24**	**Initial Score**	**Last Quarter**	**Current**	**Target**
Lead	**Chief Operating Officer**	**16** **(4 x 4)**	**12** **(3 x 4)**	**12** **(3 x 4)**	**12** **(4 x 3)**

Controls	Assurance
• Clinical harm reviews in place for long waiting patients, full divisional and trust oversight of the overdue follow-up appointments by specialty, the specialities utilise the national clinical prioritisation process which is monitored weekly in divisions. • Utilising of insourcing and LLP to provide capacity to achieve the new national targets. • Access/choice policy in place. Detailed operational plans agreed annually. • Weekly review via the performance meeting, chaired by the COO, on key targets and indicators with agreed actions and mitigations. • Full engagement in the Cheshire and Merseyside Elective Recovery Programme	• Performance Oversight Group (Weekly) • Divisional Access & performance Meetings (weekly) • Think big programme • Monthly Divisional Board meetings • Divisional Performance Reviews • Trust Management Board (TMB) • NHSI/E oversight of Trust improvement plan • There are several specialities whereby recovery plans do not achieve reasonable waiting times in year. These are subject to a full service review with the COO and action plans as required.

Gaps in Control or Assurance	Actions
• National challenge relating to medical staff rates of pay creating uncertainty with regards to additional capacity. • Industrial Action is creating a significant gap in plans to achieve the 2023/24 access targets • Impact of industrial action • 2 specialities are challenged in delivery of 65 and 75 weeks.	• Continue with delivery of mitigation plans for scheduled care, managing the risk with the utilisation of the national policy on clinical prioritisation. • Explore alternative avenues of providing additional core surgical capacity to reduce the backlog of long waiting patients. • Utilisation of the LLP to deliver the gap in recurrent capacity.

Progress
Key Changes to Note • Further gaps in controls identified relating to the impact of Industrial Action • Additional action added.

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

Strategic Priority	Outstanding Care				
Review Date	01/09/24	Initial Score	Last Quarter	Current	Target
Lead	Medical Director	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

Controls	Assurance
• Patient Safety Governance Process. • CQC compliance focus on ensuring standards of care are met. • Embedding of safety and just culture. • Implementation of learning from PSIRF. • Development and implementation of Patient safety, quality and research and innovation strategies. • Monitoring and review of quality and safety indicators at monthly divisional performance reviews and bi-annual Corporate Service Performance Reviews. • WISE Accreditation Programme. • Trust safety huddle. • Just and Learning Culture. • Patient Safety Learning Partners.	• Patient Safety and Quality Board oversight and monitoring of quality and clinical governance themes and trends through the Quality and Patient Safety Intelligence Report at Quality Assurance Committee • Mortality Review Group Oversight Regular board review of Quality Performance Report, highlighting exceptions and mitigations • IPCG and PFEG • CQC engagement meetings • Cheshire and Merseyside ICB oversight of Trust clinical governance, including Sis, never events action plans. • Internal Audit – MIAA • PSIRF • Maternity self-assessment • Board focus on R and I • Clinical Outcomes Group • Trust led CQC mock inspections • Daily Safety Huddle • JAG accreditation • C and M Surgical Centre • LLP Assurance. • GIRFT. • AXA accreditation. • National SNAPP Audits. • Nursing and Maternity Champions.

Gaps in Control or Assurance	Actions
• Fully complete and embedded patient safety and quality strategies • Industrial action impacts • Current operational impacts • Capital availability for medical equipment • Medical workforce gaps.	• Complete implementation, monitoring and delivery of the patient safety and quality strategies. • Monitoring Mental Health key priorities • Complete delivery of the Maternity Safety action plan • Ongoing review of IPC arrangements – SIT Review. • CQC preparedness programme and mock inspections. • Delivery of Mental Health key priorities.

Progress
Key Changes to Note • Additional actions added.

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

Strategic Priority	**Compassionate Workforce**				
Review Date	**01/09/24**	**Initial Score**	**Last Quarter**	**Current**	**Target**
Lead	**Chief People Officer**	**16 (4 x 4)**	**9 (3 x 3)**	**9 (3 x 3)**	**6 (3 x 2)**

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives, including apprenticeship recruitment. • Vacancy management and recruitment systems and processes, including TRAC system for recruitment and the Established and Pay Control (EPC) Panel. • Achievement of Armed Forces Employer Silver Accreditation • E-rostering and job planning plans to support staff deployment. • Strategic retention closed down as consistent achievement of the Turnover KPI; appropriate targeted work will continue via the task and finish groups. • Facilitation in Practice programme. • Training and development activity, including leadership development programmes aligned to the Trust LQF. • Utilisation of NHS England and NHS National Retention programme resource to review and implement evidence based best practice. • Effective utilisation of the Trust's EAP has increased uptake across the organisation and is enabling staff to access support more quickly and on-site presence at the Wellbeing Surgeries. • Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy. • Career clinics have recommenced within Divisions • New Flexible working policy, toolkit and training embedded. New FW brochure, intranet page, electronic application process launched and FW Ambassadors in place • New Engagement Framework launched and all Divisions now have agreed objectives with key lines of enquiry now included withing Divisional Performance Reviews (DPRs) • New monthly recognition scheme have launched, with monthly Employee or Team of the month winners identified for Patient Care and Support Services and new CEO Star Award launched. • Chief Executive and Executive Team breakfast engagement sessions • Understanding staff experience Listening Event with Black, Asian and Minority Ethnic staff	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy.

- Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy.
- EAP app (Wisdom) launched
- Restorative supervision provided trust wide following significant events
- SEQOHS annual reaccreditation approved
- Representation of OH at Induction, Preceptorship Programme and Managers Essentials
- Phase 1 upgrade of Cohort to Cority successfully implemented.
- Targeted psychological support for Divisions, as issues arise
- Health Surveillance programme successfully relaunched
- OH & Wellbeing intranet page updated
- Quarterly People Pulse Survey and associated actions to address concerns
- Leadership Qualities Framework and associated development programmes and masterclasses.
- Bi-annual divisional engagement workshops
- Staff led Disability Action Group.
- Staff drop in sessions.
- Retention group annual plan approved at Workforce Steering Board
- New Attendance Management Policy
- Buddy system for new CSWs introduced & evaluated
- Staff career stories linked to EDI on intranet
- Promotion of CPD development opportunities
- Increased senior nurse visibility – walkabouts led by Chief Nurse & Deputy
- Succession planning launched as part of the new Talent Management Approach
- Trust wide communications sent out re Covid-19 outbreak and precautionary measures to prevent further transmission including the wearing of face masks and adherence to IPC protocols in outbreak areas.
- The return-to-work guidance for staff with respiratory illness including COVID-19 result has been reviewed and updated for monthly review at CAG, and recirculated across the Trust
- Signed up to the NHSE Sexual safety Charter and met all objectives required. Trust comms delivered and Intranet page updates e.g. how to make and respond to disclosures
- Questions PSS survey added to reflect sexual safety at WUTH
- Trust Wide legal awareness session delivered
- Completed action plan set against NHSE Sexual Safety Charter & core principles, and updates provided via Workforce Steering Board
- Achieved Bronze status in June 2024 as set within the Anti-Racism Charter and was identified as one of four Trust in the region to achieve this.

Gaps in Control or Assurance	Actions
• National shortages in certain roles and full rollout of clinical job planning are pending workforce planning processes. • Availability of required capabilities and national shortage of staff in key Trust roles. • Talent management and succession planning framework is yet to be implemented. • Increases in illness related to stress and anxiety.	• Focus remains on supporting the health and wellbeing of our workforce, as well as close management of absences in line with the revised Attendance Management Policy. • The staff winter vaccination programme and associated 'It starts with you' campaign. • Annual patterns of absence during the winter period to be shared with line managers, to facilitate proactive conversations with individuals and offer support to those who may need it. • Wellbeing Surgeries across sites • Phase 2 of the Cority upgrade – new portal for staff and manager to improve communication, oversight and reduce DNAs • OH Capacity and Demand Review • Targeted retention work via the task and finish groups - focusing on Nurses, Midwifery & HCSWs and AHP's Clinical Scientists & Pharmacy led by Corporate Nursing • Talent mapping exercise for senior leaders • Task and finish Sexual Safety Working group to set out phase 2 priorities for next 12 months. • The electronic resignation and exit interviews are being built in Smartsheet; now the new FW one has been completed and rolled out.

Progress
Key Changes to Note • Additional Controls.

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

Priority					
Review Date	01/09/24	Initial Score	Last Quarter	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• Just and Learning Culture work delivered and embedded as 'business as usual'. • Leadership Qualities Framework and associated development programmes and masterclasses. • Just and Learning culture associated policies. • Revised FTSU Policy. • Triangulation of FTSU cases, employee relations and patient incidents. • Lessons Learnt forum. • Just and Learning Plan implemented. • Provision for mediation and facilitated conversations as part of new Fairness in Work Policy • New approach to coaching and mentoring • New supervision and appraisal process • Talent Management approach launched • Targeted promotion of FTSU to groups where there may be barriers to speaking up. • Completion of national FTSU Reflection and Planning Tool • Business as usual support continues to be in place such as FTSU. OH&WB, HR and line manager support	• Workforce Steering board and People Committee oversight. • Internal Audit. • PSIRF Implementation Group. • Lessons Leant Forums. • Increased staff satisfaction rates relating to positive action on health and wellbeing.

Gaps in Control or Assurance	Actions
• The actual impact of national and local industrial action	• Debriefing tools (hot and cold) and guidance on the intranet for supporting staff affected by unplanned events. • Develop and implement the WUTH Perfect Start • Listening event with Black, Asian and Minority Ethnic staff • Work ongoing to resolve dispute in theatres • Working in progress to progress the settlement for CSWs – led by DCN • Q1 project planned for Q3 to address team working – led by CN

Progress
Key Changes to Note • **Addition of controls.** • **N/A**

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

Strategic Priority	**Continuous Improvement**				
Review Date	**01/09/24**	**Initial Score**	**Last Quarter**	**Current**	**Target**
Lead	**Chief Finance Officer**	**16 (4 x 4)**	**9 (3 x 3)**	**16 (4 x 4)**	**8 (4 x 2)**

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document.	• Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • Monthly COO checks and monitoring. • Recovery plan to achieve 23/24 financial plan implemented in full. • Mitigations and Risk Plan Completed. • CFO presents quarterly forecasts to FBPAC and Trust Board. • H2 plans submitted and approved by Board. • Approval of 24/25 plan.

Gaps in Control or Assurance	Actions
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery.	• Continue delivery of CIP programme and maintain oversight of divisional progress. Ongoing. • Complete benchmarking and productivity opportunities review pack.

• Uncertainty of impact of industrial action • Approval of deficit plan.	• Develop 3 year CIP Plan to include all trust wide strategic and transformational plans. • Completion of submission of H2 plan to ICB.

Progress
Key Changes to Note • Addition of controls.

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

Strategic Priority	**Digital Future**				
Review Date	**01/09/24**	**Initial Score**	**Last Quarter**	**Current**	**Target**
Lead	**Chief Finance Officer**	**12 (4x3)**	**12 (4 x 3)**	**12 (4x3)**	**8 (4x2)**

Controls	Assurance
• Programme Board oversight. • Service improvement team and Quality Improvement team resource and oversight. • QIA guidance document implemented as part of transformation process. • Implementation of a programme management process and software to track delivery. • FBPAC Oversight. • Audit Committee oversight. • Integration of PMO and Digital Project Teams. • DIPSOC Oversight.	• Scale of projects versus resources. • FBPAC Committee. • Governance structures for key projects. • Capital Process Audit with significant assurance. • DSPT Audit with significant assurance. • MIAA Audit. • Digital Maturity Assessment.
Gaps in Control or Assurance	**Actions**
• Resources to remain up to date with emerging technology.	• Delivery of DHT annual plan.

Progress
Key Changes to Note • Creation of Risk.

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

Strategic Priority	Continuous Improvement				
Review Date	01/09/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• Programme Board oversight. • Improvement team resource and oversight. • QIA guidance document implemented as part of transformation process. • Implementation of a programme management process and software to track delivery. • Quality impact assessment undertaken prior to projects being undertaken. • Developed and embedded improvement methodology.	• Quarterly Board assurance reports, Monthly Programme Board chaired by CEO to track progress and delivery of improvements. • Monthly tracking of individual projects with scrutiny at programme board meetings. • Rotational presentations by divisions to FBPAC meetings • Improvement presentations at Board Seminar on a twice yearly basis • CIP Assurance Group tracks all schemes and actions fortnightly, and mitigations requested where required. • Annual review and approval of improvement team supported projects, aligning to Trust priorities and risks • Project completion reviews

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

Progress
Key Changes to Note • N/A

BAF RISK 9	**Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and Wirral review as a long term threat or opportunity to service sustainability.**

Strategic Priority	**Continuous Improvement**				
Review Date	**01/09/24**	**Initial Score**	**Last Quarter**	**Current**	**Target**
Lead	**Chief Executive Officer**	**12 (4 x 3)**	**9 (3 x 3)**	**12 (4 x 3)**	**6 (3 x 2)**

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

Gaps in Control or Assurance	Actions
• Formal mechanisms to ensure delivery of partnership working with Wirral Place partners	• • Support Wirral System Review from May to September 2024 • Continue identification of partnership opportunities with Wirral Community Health and Care NHS Trust

Progress
Key Changes to Note • N/A

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

Strategic Priority	Infrastructure				
Review Date	01/09/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	9 (3 x 3)

Controls	Assurance
• Implementation of 3 year capital programme • Delivery of 2021-2026 Estates Strategy. • Business Continuity Plans. • Procurement and contract management. • Assigned 3 year capital budgets, with Executive Director accountability • Assessment of current backlog maintenance risk and future potential risk	• Capital Committee oversight. • FBP oversight of capital programme implementation and funding. • Board reporting. • Internal Audit Plan. • Capital and Audit and Risk Committee Deep Dives. • Assessment of business continuity to address increasing critical infrastructure risks and completion of business continuity plans for critical infrastructure • Independent review of risks carried out. • Appointment of authorised engineers.

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

Progress
Key Changes to Note • N/A

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

Strategic Priority	Infrastructure				
Review Date	01/09/24	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (5x4)	15 (5 x 3)	15 (5x3)	10 (5x2)

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

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

Progress
Key Changes to Note • EPRR core standards update to Risk Management Committee scheduled for July 2024 following recommendations from the last peer review process.

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

Strategic Priority	**Our Partners**				
Review Date	**01/09/24**	**Initial Score**	**Last Quarter**	**Current**	**Target**
Lead	**All Executive Directors**	**16 (4x4)**	**N/A**	**12 (4 x 3)**	**9 (3 x 3)**

Controls	**Assurance**
• Wirral Place Based Partnership Board Governance Manual. • Wirral Place Target Operating Model. • ICB. • Wirral Review Terms of Reference.	• Wirral Place Based Partnership Board. • Health and wellbeing Board. • Wirral Review Steering Committee. • CORE 20+5 Board. • Unscheduled Care Board. • Wirral Place Partnership Committees and fora.

Gaps in Control or Assurance	**Actions**
• Clarity on outcome of the Wirral Review. • Lack of strategic alignment between partner bodies.	• Board discussion on Phase 1 of Wirral Review. • Consider outcomes of full review. • Implement outcomes of the full review. • Board to Board sessions.

Progress
Key Changes to Note • N/A new Risk.

Appendix – Risk Scoring Matrix

Table 1 – Consequence scores.

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

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

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

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

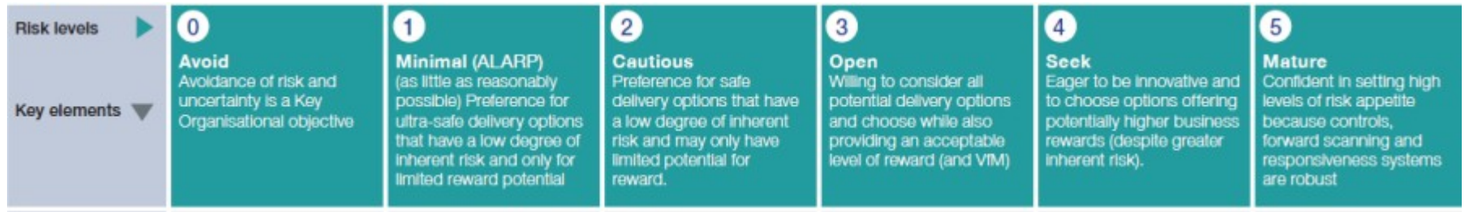
Table 2 – Likelihood

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

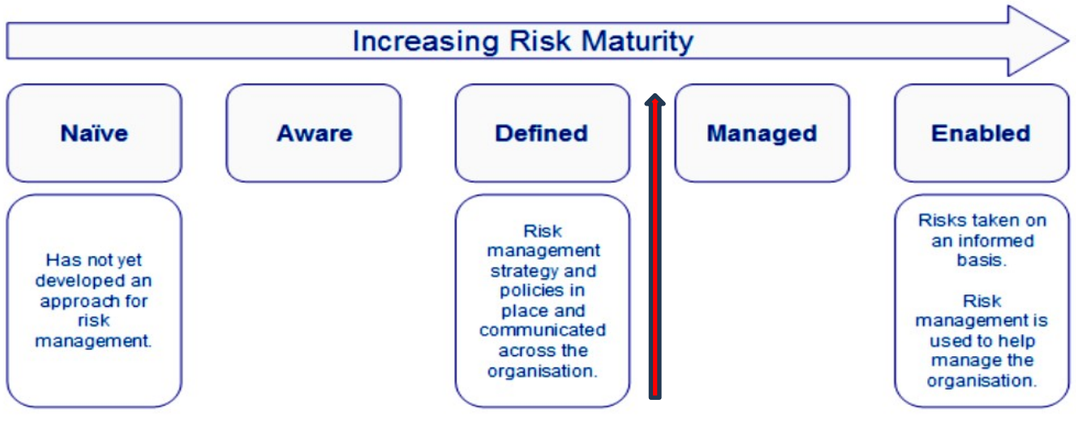
In considering the likelihood, the following supports the conversations and assessment from British Standards Institution (BSI) (2011) Risk management – Code of practice and guidance for the implementation of BS ISO 31000:

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

Appendix – Risk Appetite



Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Outstanding Care – Provide the best care and support.	**Various**	The Trust has an **OPEN** risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation. The Trust has **MINIMAL** risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed. We have a **SEEK** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.
SO2: Compassionate Workforce – Be a great place to work.	**OPEN**	The Trust Board has an open risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Trust is an employer of choice.
SO3: Continuous improvement – Maximise our potential to improve and deliver best value.	**OPEN**	The Trust Board is prepared to accept risk in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and ensuring we deliver our goals and targets.
SO4: Our partners – Provide seamless care working with our partners.	**SEEK**	The Trust Board recognises there may be an increased inherent risk faced with collaboration and partnerships, but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.
SO5: Digital Future – Be a digital pioneer and centre for excellence.	**SEEK**	The Trust Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: Infrastructure - Improve our infrastructure and how we use it	**OPEN**	The Trust Board has an open risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.



Appendix – Significant Operational Risks

1199	D+CS	Ageing Aseptic Services Unit (ASU) and Aseptic Air Handling Unit (AHU) - Financial risk of failure	(5 x 5) 25	ó
877	Acute	Pressure on the emergency department with increasing numbers of patients experiencing a mental health crisis	(4 x 5) 20	ó
1849	Surg	Failure to deliver Surgical Division Elective activity plan for 2024/25	(4 x 5) 20	é
1179	D+CS	Risk to patient treatment pathways due to the delay in supply of aseptically made medicinal products if the Aseptic Unit fails	(4 x 5) 20	ó
1730	Surg	Sterilisers and Washers in SSD are over 13yrs and fail regularly which will impact service delivery due to the ability to reprocess surgical instruments.	(4 x 5) 20	ó
1728	Surg	SSD Washers/disinfector breakdown	(4 x 5) 20	ó
1860	Corp	Inappropriate Accessing of Patient Records	(4 x 5) 20	ó
87	W+C	Increasing numbers of children and young people with mental health disorders	(4 x 4) 16	ó
447	Med	Stroke consultant vacancies	(4 x 4) 16	ó
1201	Acute	Management of the ED PTWR	(4 x 4) 16	é
1213	W+C	Insufficient Capacity and within Community Paediatrics	(4 x 4) 16	ó
1320	W+C	Risk related to the long-term proposal to condemn Theatre (G1) and not proceed with the recommended works	(4 x 4) 16	ó
1434	Surg	Aging Anaesthetic Machines - Gynaecology Theatres	(4 x 4) 16	ó
1435	W+C	Risk that patients at risk of breast cancer due to family history, are not reviewed following referral from their GP/breast clinic caused by inadequate process in obtaining 1st and 2nd degree family history (high rate of poor compliance in completing questionnaires and no follow up), resulting in potential delay for review and preventative treatment.	(4 x 4) 16	ó
1898	W+C	There is currently a risk of missed or delayed aspirin within maternity services as we are reliant upon letters to GP to prescribe.	(4 x 4) 16	«
1900	W+C	There is a risk of missed maternity discharges that can result in poor outcome	(4 x 4) 16	«
1901	W+C	There is a risk of poor clinical outcome for mothers and babies due to lack of theatre slots for elective caesarean sections.	(4 x 4) 16	«
1004	D+CS	Risk of Transfusion service disruption	(4 x 4) 16	ó
1142	Surg	MAX FAX Equipment	(4 x 4) 16	ó
1166	EF+C	Risk of the ventilation system which serves ITU at APH failing	(4 x 4) 16	ó
1502	Surg	Fisch type handpiece for ENT Surgery - lack of available equipment	(4 x 4) 16	ó
1505	Surg	Flexible Cystoscopes availability	(4 x 4) 16	ó
1572	EF+C	Risk of failure to Pharmacy Aseptic Suite, Vent Plant 33 Theatre 10 and Vent Plant 33A Theatre 11 due to the age and condition of these units.	(4 x 4) 16	ó
1635	D+CS	MRI Service unable to deliver timely care to emergency / urgent patients	(4 x 4) 16	ó
1726	W+C	Olympus Stacker System Broken for 2nd time this year	(4 x 4) 16	ó
1789	Corp	Limitations to capital funding	(4 x 4) 16	ó
516	Acute	There is an increased risk of harm to patients caused by slow egress from the department	(4 x 4) 16	é
1724	Surg	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care in the Surgical Division.	(4 x 4) 16	ó
1287	W+C	Risk of delays in reviews and poor patient experience caused by gaps in gynaecology middle grade doctors	(4 x 4) 16	ó
1529	Med	Lack of junior doctor cover and sufficient oversight of when gaps are occurring	(4 x 4) 16	ó

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors
4 September 2024

Item 9

Title	Equality, Diversity and Inclusion (EDI) Bi-Annual Report including Gender Workforce Race and Disability Equality Standards (WRES and WDES) Reporting
Area Lead	Deb Smith, Chief People Officer
Author	Sharon Landrum, Head of People Experience
Report for	Information

Executive Summary and Report Recommendations

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

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

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

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

- Summary of activities that demonstrate we are advancing the EDI agenda at WUTH in line with the Trust's People Strategy and EDI Strategic commitment (appendix 1).
- Workforce demographic data in line with PSED requirements (appendix 2).
- WRES full narrative report* (Appendix 3)
- WDES full narrative report* (Appendix 4)

It is recommended that the Board:

- Note the content of the report

Key Risks

This report relates to these key risks:

- 397 – Increased Sickness Absence
- BAF Risk – Failure of the Trust to have the right organisational culture, staff experience and organisational conditions to deliver our priorities for our patients and service users

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
27 June 2024	WSB	Equality, Diversity and Inclusion (EDI) Bi-Annual Report including Gender Workforce Race and Disability Equality Standards (WRES and WDES) Reporting	Approval
19July 2024	People Committee	Equality, Diversity and Inclusion (EDI) Bi-Annual Report including Gender Workforce Race and Disability Equality Standards (WRES and WDES) Reporting	Ratification

1	Background and Introduction to EDI Requirements
1.1	Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the ***general duty*** and all public authorities must adhere to the following obligations: • To eliminate unlawful harassment and victimisation. • To foster good relations between people who share a protected characteristic and those who do not. • To advance equality of opportunity between people who share a protected characteristic and those who do not. In addition to these general duties, there are specific duties which require public bodies to publish relevant, proportionate information showing compliance with the Equality Duty and to set equality objectives. The information that is contained within this report meets the requirement of the specific duties of the PSED. The Trust also takes into consideration national guidance e.g. Model Employer recommendations and has integrated these within action planning and review processes as appropriate. This report is one of two EDI specific bi-annual report. We report as follows: **Biannual report one** – Submission in Q1 and will include updates on: • Trust led EDI projects and progress towards EDI strategic commitment and activities to underpin our PSED commitment. • Annual WRES data and summary for noting. • Annual WDES data and summary for noting. • Workforce demographics **Biannual report two** – Submission in Q3 and will include updates on: • Trust led EDI projects and progress towards EDI Strategic Commitment and activities to underpin our PSED commitment. • Gender Pay Gap reporting. • Equality Delivery System (EDS).

	Reports seek to provide updates on regulatory and statutory requirements and work undertaken to advance the EDI agenda.

2	**Statutory / Regulatory Reporting Requirements Update**
2.1	Updates are as follows: **1) Workforce Race Equality Standards (WRES) Reporting** Part one - National data upload required by 31 May – **Completed** Part two – Narrative report required by 31 October – **Completed as part of this report** **2) Workforce Disability Equality Standards (WDES) Reporting** Part one - National data upload required by 31 May – **Completed** Part two – Narrative report required by 31 October – **Completed as part of this report** **3) Public Sector Equality Duty (PSED)** Activities detailed within both EDI biannual reports highlight the work WUTH is doing to uphold the principles of the Public Sector Equality Duty. This includes publication of Trust workforce demographics. All regulatory and statutory reporting requirements are therefore complete or online to meet the requirements listed above.
2.2	**Workforce Race Equality Standards (WRES)** The aim of the WRES is to improve the experience of Black, Asian and Minority Ethnic (BAME) staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes. It also applies to BAME people who want to work in the NHS. The full narrative report is attached at Appendix 3 and includes full details of the national indicators that the Trust is required to submit along with progress updates for each area and actions identified to improve. Findings this year have identified a mixture of results. There are improvements in: • Workforce demographics - with increased representation of non-white staff (from 12.3% to 13.66%) across clinical, and non-clinical roles. • The likelihood of non-white staff entering the formal disciplinary process – non-white staff are less likely to enter the disciplinary process this year with a similar likelihood to white staff. • Equality of access to non-mandatory development opportunities. • Non-white staff believing that the Trust provides equal opportunities for career progression or promotion. However all other areas have unfortunately declined this year. For example, Black, Asian and Minority Ethnic applicants are less likely to be appointed this year when compared to white applicants and indicators relating to staff experiences, appear less positive this year with more Black, Asian and Minority Ethnic staff reporting a poorer experience than white colleagues. The Trust has therefore identified race equality as one of its key priorities for 2024/25 with key actions identified to ensure improvements. Action plan contained within the WRES report attached at appendix 3. Whilst WRES specific staff survey related indicators have also declined for white staff, the decline for Black, Asian and Minority Ethnic colleagues has been significant in some areas (*refer to the WRES report for more details, attached at appendix 3).*

	Despite the disappointing deterioration this year there still remains an improving trend for the majority of staff experience related indicators since 2018. The Trust has therefore identified race equality as a focus this year and following discussion of initial data at WSB in May 2024 WSB, actions will be undertaken to ensure improvements in experiences for non-white staff. This will include a series of listening events led by the Trust's Chief People Officer in collaboration with the multicultural staff network co-chair and Staff Side Lead for EDI to better understand experiences of our non-white staff. WUTH must ensure that steps are taken to eliminate harassment, victimisation and discrimination along with ensuring staff feel they belong at WUTH in line with the Trust's People Strategy and EDI Strategic Commitment. The Trust has also signed up to the NHS North-West Anti-Racist framework and has publicly declared its commitment to being an anti-racist organisation. A gap analysis has been undertaken against the bronze level criteria of the framework and an application was submitted. The Trust has recently received news that it has also been successful in achieving Bronze status, one of only two Trusts in the North West to have achieved. This is a fantastic achievement for WUTH, with feedback received on outstanding areas that include the Red Card Campaign and promotional newsletters and with guidance on areas to focus on as we move forwards which includes work to support reducing health inequalities.
2.3	**Workforce Disability Equality Standards (WDES)** WDES allows an enhanced insight into how disabled staff feel they are treated compared with non-disabled staff and whether any bias conscious or unconscious is shown during key Trust processes such as recruitment. The full WDES narrative report is attached at appendix 4, with details of the Trust's performance against the required indicators, compared to national averages. There are a number of pleasing results this year, with improvements seen in: • Self-reporting on ESR – with more disabled staff declaring they have a disability. • Likelihood of being appointed – disabled applicant now as likely to be appointed as non-disabled applicants. • Experiences of bullying, harassment or abuse (BHA) by managers in the last 12 months – with less staff experiencing this compared to last year and results now above the national average. • Reporting of the last experience of bullying, harassment or abuse – with more staff reporting this year and results are now above the national average. • Pressure coming to work, despite not feeling well enough to perform their duties – disabled staff are feeling less pressure this year, with results now above the national average. However, it is concerning to see a deterioration in experiences of our disabled staff, with disabled staff declaring they have experienced more bullying, harassment or abuse patients, relatives or the public and particularly concerning is that it has also increased from colleagues too. Results highlight increases from 21.87% of disabled staff in 2022 staff survey to 24.72% in the 2023 staff survey experiencing BHA from colleagues in the last 12 months. Staff survey data also highlights a lower staff engagement score this year, with disabled staff feeling less valued by the organisation this year, with less provision of opportunities for career progression or promotion and less satisfaction with provision of adequate reasonable adjustments.

Whilst a deterioration can be seen this year in a number of the staff experience related metrics (metrics 4-8), it is still pleasing to see an improved position from commencement of the WDES metrics in 2018 with all except one metric (4b) seeing improvements.

Additional WDES Reporting Data

Unique to WDES, WUTH has to provide confirmation that it is taking action to facilitate the voices of disabled staff (Indicator 9b), with qualitative data also required.

Activities have included:

- Engagement event with staff with disabilities and long-term conditions to understand experiences and suggestions for improvement.
- Establishment of a co-creation group in addition to our existing staff network, with a number of actions completed and include:
  - Support options reviewed and repository of information developed for easy access for all who need it.
  - Processes reviewed and flowcharts developed to support staff and managers understanding how to support and signpost staff accordingly.
  - Staff passport launched and integrated within revised disability policy.
  - New disability brochure under development to highlight all of the above and more.

In addition, focussed communications and education sessions to commence from July 2024 which is hoped will support improvements in experiences.

It is hoped that efforts undertaken this year and new actions, together with the reconvening of the staff network, will support improvements of staff experiences.

2.4 **NHS EDI Improvement Plan**

Achieving equality of health outcomes requires identification of barriers and biases, and targeted action to overcome specific inequalities, discrimination and marginalisation experienced by certain groups and individuals. This includes, but is not limited to, those with protected characteristics under the Equality Act 2010.

The aim of the NHS EDI Improvement Plan is to improve equality, diversity and inclusion, and to enhance the sense of belonging for NHS staff to improve their experience.

This plan sets out six high impact actions to address the prejudice and discrimination – direct and indirect that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.
The six high impact actions are detailed below with a summary update provided on current progress against each. Details of key areas of improvement are contained within an overarching EDI plan.

Trusts are required to provide regular detailed progress updates against the six high impact actions and key success metrics as part of our wider Cheshire and Merseyside ICB collaboration.

No.	High Impact Actions	Progress	Summary Update
1	Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable	Green	Objectives in place.

	2	Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.	Amber	An audit of recruitment processes is being developed for 2024/25 due to an increase in inequality identified as part of WRES data. Inclusive recruitment session is being delivered and monitoring of the likelihood of appointment by ethnicity and disability are in operation as part of WRES and WDES reporting. Trust widening participation agenda in place to support entry into employment. Trust Strategic retention project in place with EDI integrated within it. Focus on talent management for 2024/25 with a workshop included within the Trust's 2024 Leadership conference on harnessing diverse talent.
	3	Develop and implement an improvement plan to eliminate pay gaps	Amber	WUTH's gender pay gap continues to reduce, with monitoring now in place for those who share protected characteristics (PCs). However, further work is still needed to ensure implementation of the "mend the gap" review and to monitor improvements by PCs since commencement of new reporting data in 2023.
	4	Develop and implement an improvement plan to address health inequalities within the workforce	Amber	A new model has been developed and launched with task and finish groups being established to drive actions forwards.
	5	Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.	Green	Pastoral award received for the support and processes provided for our international recruited nurses. Listening events scheduled for July to understand experiences of all multicultural staff further. Perfect start co-creation group underway to support improvements in experiences for new recruits and key actions identified and progressing. Welcome event for all staff.
		Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur	Amber	A number of steps have been taken to support improvements in this area as detailed within this report however, staff experiences from the 2023 staff survey identify a number of areas of concern and reducing experiences for some staff. This will be explored further in 2024/25. Triangulation of data by ethnicity and for sexual safety is underway, with processes to be developed further and to be embedded within business as usual.
2.5	**Workforce and Patient Demographics** In line with specific duties under the Equality Act 2010, the Trust is required to publish information relating to employees who share protected characteristics. A summary of these is attached at appendix 2.			

Comparison data is also provided for our patients, based on the annual date of 31 March 2024. It must however be noted that whilst 31 March is the comparator date used, this was a Sunday and as such, data captured identified limited data for Outpatient attendance.

Sex / Gender

78.3% of the WUTH workforce is female and 21.7% is male. The number of male staff have increased from 21% in 2023 to 21.7% in 2024. The numbers therefore reflect that the largest staff group is nursing, and that this group is predominately female. This is reflective of most NHS Acute Trusts.

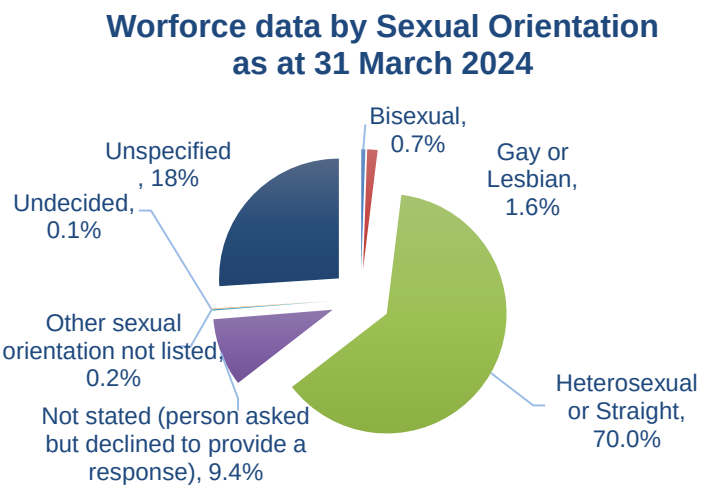
The chart below highlights the breakdown of staff and patients compared with community demographics.

	Workforce	Patients	LA: Wirral	Region: North West
Male	21.7%	42.62%	48.11%	49.13%
Female	78.3%	57.38%	51.89%	50.87%

Sexual Orientation

Charts below highlight the workforce sexual orientation data on 31 March 2024, along with comparative data for community members within the North West. Data this year has seen an increase in the % of LGB staff at WUTH with more staff specifying their sexual orientation on ESR. The number of LGB staff is also higher than those declared within the Northwest region.

Sexual Orientation	% of Workforce
Bisexual	0.7%
Gay or Lesbian	1.6%
Heterosexual or straight	70.0%
Not stated (person asked but declined to provide a response)	9.4%
Other sexual orientation not listed	0.2%
Undecided	0.1%
Unspecified	18%
Grand Total	**100.00%**



Sexual Orientation Data Comparison with Community Demographics		
	Workforce	**Region: North West**
Gay / Lesbian / Bisexual	2.3%	1.66%
Heterosexual / straight	70.0%	94.89%
Unknown	27.5%	3.45%

Gender Reassignment / Identity

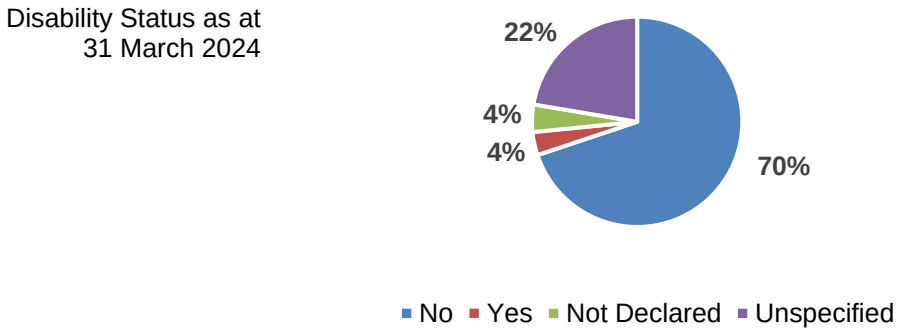
ESR currently only has the functionality to record male, female or unspecified. The Trust has been working hard to further understand the needs of its staff and patients and as such, understand that more accurate recording options are needed.

A number of staff may not identify with a specific gender or have a variation of gender identities and therefore national updates are being awaited that will allow greater options for staff and accurate data in this area.

The Trust can only therefore report against the number of staff recorded as male or female. This has been raised at a national level and updates awaited.

Disability

As of 31st March 2024, the self-reporting rate for those staff with a disability within WUTH is 3.6%, 244 people (as entered on staff ESR records). This has continued to improve from last year, whereby only 2.8% of staff (186 people) had declared. Whilst it is positive to see continued improvements in declaration rates, rates continue to still be low, with 22% of staff ESR records still remining unspecified. Work will therefore continue to support improvements.



2024 data sees improvements in both clinical and non-clinical representation with 3.2% (150) staff in a clinical role, increasing from 2.7%, (121 staff) in 2022/23 and 4.2% (94 staff) in a non-clinical role, increasing from 3% (65 staff) in 2022/23.

Breakdown of workforce data by disability status as of 31 March 2024 and compared to 2022/23 data.

Chart 2 - Breakdown of disability declaration categories, clinical and non-clinical of 31 March 2024

	Total Clinical Staff	% of clinical	Total non-clinical	% of non-clinical	Combined 2024	% overall 2024	% overall 2023
Disabled	150	3.2%	94	4.2%	244	3.6%	2.8%
Non-disabled	3363	72.7%	1414	63.9%	4777	69.9%	67.1%
Not declared	197	4.3%	94	4.2%	291	4.3%	4.7%
Unspecified	915	19.8%	610	27.6%	1525	22.3%	25.4%
Total	4625	100.0%	2212	100.0%	6837	100.0%	100.0%

Further work is still required to ensure staff are encouraged and supported to be able to update their disability status within ESR. This would then ensure that data can be truly representative of the disabled staff within the Trust and thus contribute to actions for improvement.

Religion or Belief

The chart below highlights the religious beliefs of our workforce and patients compared with the community demographics as of 31 March 2024. The categories are grouped together so as to aid ease of comparison; however it is important to recognise some of the heading below subgroup heading e.g. Christianity include Catholicism, Anglican etc.

Workforce ***Patients*** ***LA: Wirral*** ***Region:***

				North West
Atheism / Not religious	12.3%	2.34%	21.33%	19.82%
Buddhism	0.4%	0%	0.28%	0.29%
Christianity	43.8%	45.43%	70.41%	67.25%
Hinduism	1.8%	0.7%	0.23%	0.54%
Islam	1.4%	1.41%	0.57%	5.05%
Judaism	0.1%	0.0%	0.08%	0.43%
Other	7.7%	0.47%	0.26%	0.27%
Sikhism	0.1%	0.47%	0.07%	0.13%
Jainism	0.0%	0.0%	Unknown	unknown
Unknown	32.3%*	8.43%	6.77%	6.20%

*Includes 14.3% of staff who do not wish to disclose

Ethnicity

84.6% of WUTH staff are white, 13.7% of staff are Black, Asian, or other Ethnic Group and 1.8% of staff have not stated their ethnic group on ESR. The following chart shows the breakdown of the workforce by ethnicity and compared to community demographics as of 31 March 2024.

Ethnicity Group	WTE	Headcount	% in Trust 2024	% in Trust 2023
BAME	873.57	935	13.7%	12.3%
Not Stated	103.04	121	1.8%	1.9%
White	4729.97	5788	84.6%	85.9%
Grand Total	**5706.58**	**6844**	100.0%	**100.0%**

It is pleasing to see an increase in the representation of Black, Asian and Minority Ethnic staff at WUTH, with increases identified throughout clinical and non-clinical roles.

To follow is a full breakdown of staff compared with community demographics.

	Workforce	Patients	LA: Wirral	Region: North West
White - British (inc English, Scottish & Cornish)	**82.3%**	87.35%	94.97%	87.08%
White - Irish	**0.76%**	0.94%	0.83%	0.92%
White Traveller / Gypsy / Irish Traveller	**0.01%**	0.0%	0.02%	0.06%
White - other	**1.57%**	1.87%	1.17%	2.15%
Mixed - White & Black Caribbean	**0.16%**	0.23%	0.30%	0.56%
Mixed - White & Black African	**0.19%**	0.0%	0.17%	0.26%
Mixed - White & Asian	**0.26%**	0.23%	0.30%	0.43%
Mixed - Any other mixed background	**0.37%**	1.17%	0.25%	0.32%
Asian or Asian British - Indian	**7.19%**	0.94%	0.42%	1.52%
Asian or Asian British - Pakistani	**0.45%**	0.0%	0.07%	2.69%
Asian or Asian British - Bangladeshi	**0.34%**	0.23%	0.27%	0.65%
Asian / Asian British: Chinese	**0.37%**	0.23%	0.52%	0.68%
Asian or Asian British - Any other Asian background	**1.33%**	1.64%	0.33%	0.66%
Black/African/Caribbean/Black British: African/Black British: Caribbean or Black British - Caribbean	**1.54%**	0.0%	0.18%	1.17%
Any other Black African / Caribbean	**0.20%**	0.0%	0.04%	0.22%

Arab	**0.00%**	0.0%	0.07%	0.35%
Any Other	**1.27%**	0.0%	0.10%	0.28%

Age
The following chart highlights the age profile within WUTH as of 31 March 2024.

Age Band	% workforce	% patients
<=20 Years	1.5%	20.37%
21-25	6.3%	3.98%
26-30	10.8%	8.43%
31-35	12.2%	5.85%
36-40	12.9%	8.43%
41-45	11.7%	3.51%
46-50	10.7%	4.22%
51-55	11.6%	5.85%
56-60	10.9%	5.15%
61-65	8.6%	8.20%
66-70	2.2%	6.56%
>=71 Years	0.7%	19.44%

For ease of cascade, a summary of the demographics of WUTH staff is attached at appendix 2 (based on data as of 31 March 2024).

Key Findings
The Trust has seen improvements in workforce demographics in a number of areas that have been a priority. This includes increased representation of Black, Asian and Minority Ethnic staff, disabled staff and LGB staff. It is pleasing to see more staff are specifying their demographic data and thus allowing more accurate monitoring information. Workforce demographics are broadly aligned to those of the local community.

3 Advancing the EDI Agenda

3.1 **People Strategy and EDI Strategic Commitment**

Since the launch of the new People Strategy and underpinning EDI Strategic Commitment, the Trust is striving to ensure EDI is embedded within all of our people processes and practices. This has resulted in a shift of areas and individuals seeking support to understand how they can advance EDI within their sphere of influence and progressing actions to commence improvements.

The annual objectives set out in the People Strategy delivery plan have also been mapped to the EDI Strategic Commitment to ensure EDI is reflected in all strategic people projects. This is reported to WSB and People Committee as part of People Strategy Updates. It is therefore hoped that this will have a positive impact on staff experiences moving forwards.

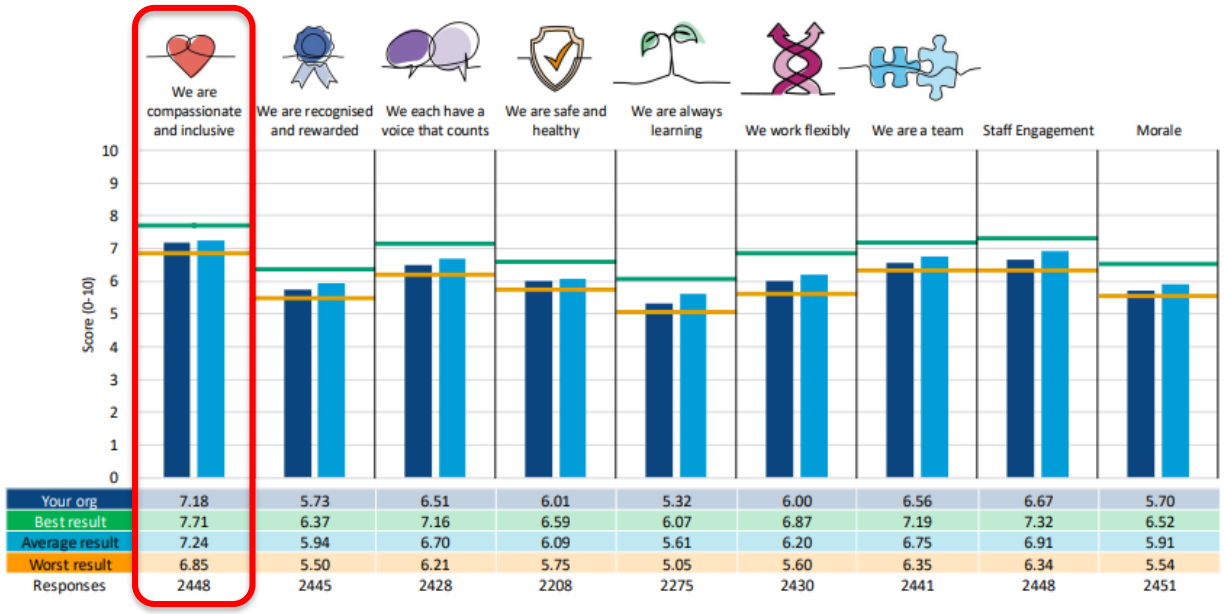
A summary of key activities undertaken along with key next steps are attached at appendix 1.

3.2 **Staff Experience**

Whilst the Trust has previously reported continuous improvements with staff experience data contained within the national staff survey, the 2023 staff survey results highlighted a reduction in experiences of WUTH staff with regards to equality, diversity and inclusion.

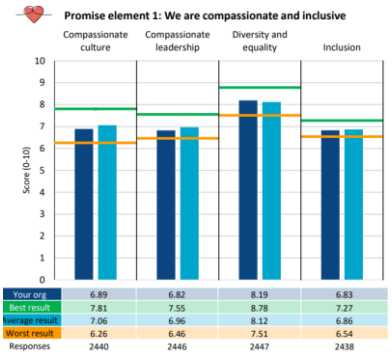
The chart below highlights a summary overview of Trustwide staff survey results for each of the People Promise themes. We are compassionate and inclusive is the highest scoring theme

again this year, however whilst previously scoring above the national average, results have deteriorated this year and now fall below the national average for comparative Trusts.

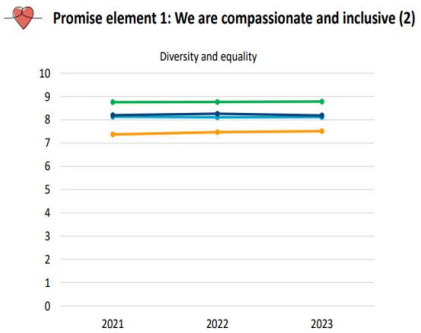


	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.18	5.73	6.51	6.01	5.32	6.00	6.56	6.67	5.70
Best result	7.71	6.37	7.16	6.59	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.09	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	2448	2445	2428	2208	2275	2430	2441	2448	2451

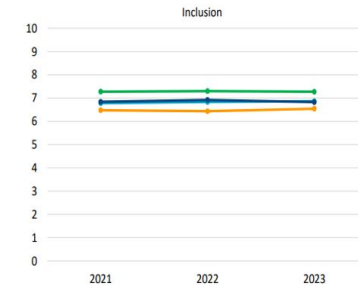
The following charts provide a summary of each of the compassionate and inclusive people promise theme sub scores, followed by annual comparative data for diversity and equality and inclusion subscores. Diversity, equality and inclusion have all unfortunately declined.



	Compassionate culture	Compassionate leadership	Diversity and equality	Inclusion
Your org	6.89	6.82	8.19	6.83
Best result	7.81	7.55	8.78	7.27
Average result	7.06	6.96	8.12	6.86
Worst result	6.26	6.46	7.51	6.54
Responses	2440	2446	2447	2438



	2021	2022	2023
Your org	8.20	8.26	8.19
Best result	8.76	8.77	8.78
Average result	8.13	8.11	8.12
Worst result	7.37	7.47	7.51
Responses	2887	3123	2447



	2021	2022	2023
Your org	6.84	6.92	6.83
Best result	7.28	7.30	7.27
Average result	6.78	6.83	6.86
Worst result	6.48	6.44	6.54
Responses	2871	3116	2438

In addition, the “We are safe and healthy” people promise theme has been identified as an area of statistically significant improvement from last year. Elements included in this theme relate to violence and aggression, bullying, harassment and abuse and also health, wellbeing and burnout.

A summary of findings from the 2023 staff survey for those who share protected characteristics is summarised below :

- **Male staff** are generally more satisfied than females, however staff who “**prefer not to say**” are significantly less satisfied in all people promise elements.

- Staff who “**prefer not to say”** whether their gender is the same as assigned at birth are also significantly less satisfied across all people promise elements.

	• Staff who identify as **Lesbian, Gay, Bisexual** and "other" (LGB+) are more satisfied in a number of areas this year, including with equality and diversity, feeling more recognised and rewarded, more satisfied with line management and teamwork and less burnt out. • However, experiences of **LGB+ staff** are less favourable than heterosexual / straight colleagues with staff less motivated and considering leaving. • Staff aged **16-20** are the most satisfied age group. • **Hindu staff** are the most engaged and motivated and most likely to recommend the organisation as a place to work or receive treatment. Staff who "**prefer not to say**" their religion or belief are the least satisfied, significantly so, across all areas. • **Disabled staff** feel more rewarded, less burnt out and more satisfied with line management, flexible working, development and appraisals. However, disabled staff feel less motivated, engaged and included or involved and less satisfied in raising concerns. • Experiences of our **non-white staff** have reduced this year across a number of people promise elements however are more satisfied with appraisals and learning and more satisfied than white colleagues in the majority of people promise sub themes. • **Non-white staff** are more likely to experience violence, harassment, bullying or abuse from both patients and other staff however are more likely to recommend the organisation as a place to work or receive treatment. • Staff who identify as **"White Other background"** are the least satisfied. As a result of staff experiences within the 2023 staff survey, WUTH has identified equality, diversity and inclusion as a key priority for 2024/25 and has integrated questions relating advancement of the EDI agenda, within divisional performance review processes.
3.3	**Trust Accreditations** **Defence Employer Recognition Scheme** Following a recent application, Wirral University Teaching Hospital are proud to have been successful in achieving Defence Employer Recognition Scheme (DERS) Silver Status. This is a fantastic achievement and confirms the commitment and support to our armed forces community working here at WUTH. The armed forces staff network have been pivotal in shaping and delivering plans and activities across the Trust. The Trust's accreditation will be celebrated as part of Armed Forces Week commencing 24 June 2024. **Merseyside In-Touch Navajo LGBTIQA+ Chartermark** WUTH is currently accredited with this local prestigious Chartermark, however is due for re-accreditation this year. It is hoped that re-assessment will be undertaken this summer. **Anti-Racist Framework**

	NHS England North West and the Northern Care Alliance Inclusion Centre of Excellence have developed a new framework for organisations across the North West to adopt and together and work towards the ambition of becoming actively anti-racist organisations. The framework aims to embrace both the spirit of our commitments and provide NHS organisations with guidance on actions to put in place and reduce inequalities and eliminate racism. A gap analysis was undertaken and actions identified to support the Trust in commencing the first step towards an intentionally anti-racist organisation (as defined within the framework) and attainment of the frameworks "Bronze" status. An application was submitted for bronze status in May 2024 and as mentioned earlier, The Trust has now been identified as one of only four Trusts in the region to be successful in achieving Bronze accreditation.  **Sexual Safety Charter** The NHS is committed to supporting the working lives of all its staff and to ensure that staff are safe in work, unfortunately staff continue to report unwanted behaviour and the national profile regarding sexual harassment and assault within the NHS continues to grow. This is particularly highlighted by reports such as *'Breaking the silence: Addressing Sexual misconduct in Healthcare' (2023)* which provides a summary of the experiences of female trainee doctors working within surgical specialties.  NHS England has now launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. It is expected that signatories will implement all ten commitments by July 2024. NHS England are also asking every organisation to implement the actions it sets out to improve safety at work. The Trust Executive team have made the commitment on behalf of the Trust to sign up to the Charter. The Trust are now listed as a signatory to the Charter as detailed on the website. (NHS England » Sexual safety in healthcare – organisational charter). Trust staff experience data has been reviewed including experiences by those who share a protected characteristic. Triangulation of data has also taken place with processes in place to embed these moving forwards.
3.4	**Staff Network Update** The Trust continues to support five employee networks, with members continuing to be active within WUTH shaping a variety of policies, plans and processes and supporting the EDI steering group and calendar of events. A recruitment campaign has commenced to replace gaps in co-chair positions. The Trust continues to confirm its commitment to staff networks and has agreed to support ringfenced time for network co-chairs with two days per month identified per network. A staff network toolkit has been developed along with a development plan for co-chairs and funding has been ringfenced to support network activities. New network logos have been drafted and will support enhanced communications on appointment of new co-chairs.

	Network Executive Partners are linked with networks, with personal objectives agreed for 2024/25 to support closer working and support of new network co-chairs and development of capacity and capability of networks.
3.5	**Equality Analysis** Equality analysis / impact assessments continue to be embedded within our policy approval process. A review of the process is currently underway as further improvements are needed to support improved quality of completion and facilitate integration of a new national health equity assessment tool (HEAT). A task and finish group has been identified with feedback received from local Trusts to determine a revised approach for 2024/25.
3.6	**Education and Training** The Trust has delivered a variety of training opportunities to support achievement of an inclusive environment for both staff and patients. Some of the sessions delivered / offered in 2023/24 have included: • Deaf awareness – face to face and e-learning opportunities • Inclusive recruitment • Inclusive leadership • LGBTQ+ awareness • Neurodiversity awareness for staff and managers • Leadership masterclass and workshop at our annual leadership conference • A range of Drop everything and Read sessions (DEAR) – linked to the inclusion agenda. • Cultural competency e-learning modules promoted • Armed Forces e-learning modules promoted • How to deliver inclusive sessions (for trainers and facilitators) • Inclusive coaching • Sharing of staff stories • Mini manager essentials sessions to support managers supporting staff with disabilities and long-term conditions **Priorities for 2024/25** • Further disability related sessions e.g. deaf awareness, neurodiversity and support for managers • Anti-racism • Gender inclusion • Inclusive Recruitment • Harnessing Diverse Talent - with a workshop integrated on the 2024 leadership conference • Integration of new Inclusive Leadership in Health and Social Care e-learning programme
3.7	**Additional Actions to Support PSED Responsibilities** **Calendar of Events** All of the details shared in appendix 1 seek to advance the EDI agenda and continue to support the achievement of our EDI Strategic Commitment and Public Sector Equality Duties as detailed in the background of this report.

EDI Steering group meetings continue to ask members what they have done to advance the EDI agenda, with members asked to feedback and discuss locally too. This is also now integrated within Divisional Performance Review meetings, with advancing EDI across our Divisional areas, identified as a priority for 2024/25.

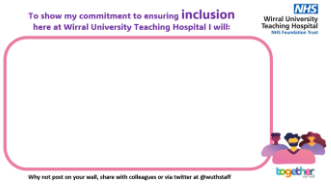
Executive Directors now all have EDI objectives and EDI development sessions are scheduled in for Board colleagues throughout the year to ensure our most senior leaders remain updated on key EDI matters and are able to guide policy and decision making within the context of EDI. As also previously mentioned in section 3.2, Executive Partners have specific objectives to proactively support the attraction and recruitment of staff network co-chairs. To provide mentorship to co-chairs, to support and enable them to set and deliver objectives. To proactively support network co-chair development and taking a lead role in amplifying the voices of network members.

EDI is embedded within the Trusts Leadership Qualities Framework and forms a golden thread across all leadership and management development programmes, with dedicated **"**Inclusive Recruitment" and "Inclusive leadership" sessions held.

Demographic monitoring of key programmes – In order to ensure inclusive access and diverse representation at Trust development programmes, demographic monitoring is being implemented across a number of leadership development programmes.

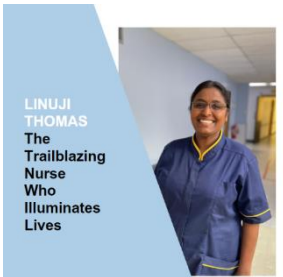
The EDI pledge form was developed to share the EDI commitment with staff and encourage people to identify one thing they would do differently to advance inclusion at WUTH.

This is promoted and shared at a variety of opportunities including management and leadership development programmes and linked with EDI calendar of events and awareness campaigns.



In order to advance the EDI agenda at WUTH we take a holistic approach and celebrate the diversity of our staff and reinforce key messages regarding our commitment to Inclusion. Promotions / activities include:

- Chinese New Year celebrations with Chinese themed menus in our onsite restaurants.
- Race Equality week – with an Electronic newsletter, Press releases e.g. Liverpool Echo and various linked in articles / stories.
- Iftar boxes provided for staff during Ramadan and sweet treats to celebrate Eid.
- Easter celebrations with a new Good Egg initiative launched by the kindness and civility group.
- Trust communications to celebrate LGBT+ history month with education sessions held by former Rainbow Alliance Chair and newly appointed Staff Side Chair.
- Dedicated International Womens Day flipbook and communications with staff stories featured and individuals celebrated.



- Variety of information shared as part of deaf awareness week including staff and patient stories; signs of the day, deaf awareness training and a stall held by the Audiology Team on site, to offer advice, support and check inside of your ear!
- Pride progress flag raising event to celebrate the commencement of PRIDE month and PRIDE parades promoted with staff encouraged to attend.
- Preparations underway for Armed Forces Week with a flag raising event scheduled for Monday 24 June with involvement of the local Reservist Centre.
- Inclusion integrated within wider celebrations e.g. international nurses day with network members celebrated.
- Carers week event held within 30+ community organisations involved and a range of support, information and even a local choir!

- Information stalls held within the library at APH for all national awareness weeks and months, with links to events and activities on site, books, articles and journals.
- New Inclusion category introduced for our annual Together Awards nominations, with inclusion integrated across criterion for all categories.
- Mental health awareness regularly promoted and support options provided.
- Inclusion integrated within new monthly employee and team of the month criterion.

- Pleased to meet you initiative launched by our library and knowledge service to support staff getting to know each other
- Public declarations of the Trusts commitment to being anti-racist.
- Promotion of staff networks and support available.
- Promotional video developed for our Estates, Facilities and Capital Planning staf to support belonging at WUTH and raise the profile of staff in an areas that feel unseen.

New menopause policy developed in collaboration with the menopause staff network. A revised approach has been taken for the staff menopause clinic due to increasing demands. Staff awaiting appointments have been reviewed and offered Specialist Nurse support or group review opportunities.

The Trusts Reservists Policy has also been reviewed against Ministry of Defence standard template policy and criteria for the Defence Employer Recognition Scheme and updates made to ensure inclusion of support for armed forces families and encouragement and support for staff to undertake duties as Cadet Force Adult Volunteers (CFAV).

A range of activities have also been undertaken as part of the Patient Experience Inclusive Promise pillar that whilst supporting improvements in patient care, also improve experiences for our staff too. Further details of patient experience related activities are included within a merged EDI report to Board.

4	**Next Steps**
4	**Next Steps** A range of activities and steps are being taken across the Trust to advance the EDI agenda at WUTH, with increased responsibility now being taken by Divisions, departments, networks and service areas who are empowered to develop new and exciting ways to value and celebrate diversity and support staff to belong here at WUTH. The following methodology will be used whereby we will: Key priorities for the Trust aligned to these areas are:

	• **Seek to understand**
	  • Working with the Trust's multicultural staff network to undertake a series of listening events to understand experiences of working at WUTH and identify potential reasons for areas of deterioration and actions needed to ensure improvements.
	  • Develop process of regular recruitment audits of processes for under-represented areas / roles to understand challenges / barriers or areas of potential bias
	  • Undertake equality analysis impact assessment for policy and service development, seeking to understand potential impacting factors from the changes proposed.
	  • Develop a process to identify and triangulate data relating to incidents/concerns and employee relations case linked to protected characteristics
	
	• **Support**
	  • Launch and embedding of actions developed by the disability co-creation group, with support offered to managers on how to best support their staff.
	  • Build capacity and capability of Trust staff networks, with appointment of new co-chairs and re-establishment of regular meetings.
	  • Supporting Divisions to advance EDI across their areas and identifying actions to support staff belonging at WUTH
	  • Continue to encourage staff to enter/update personal information via ESR self-service, with guidance documents and support offered to complete.
	  • Increase the number of non-white FTSU Champions to promote and encourage staff to speak up
	
	• **Develop and educate**
	  • Progression of key actions to support achievement of the sexual safety charter and embed key activities and principles within business as usual.
	  • Increase inclusion training offering with a focus on Gender Inclusion, disability and anti-racism
	  • Visible Respect at Work campaign to promote zero tolerance to bullying, harassment or abuse within the workplace
	  • EDI training to support leaders in understanding how to ensure WUTH is an anti-racist organisation and upholds the principles of the sexual safety charter.
	
	• **Celebrate and promote**
	  • Application submitted for NHS Northwest Anti-Racist Framework Bronze Status with outcome reviewed and further areas of priority to be identified.
	  • Achievement of the Merseyside in Touch Navajo LGBTIQA+ Chartermark
	  • Develop of campaign to increase staff survey responses and encourage staff to complete the 2024 staff survey.
	  • Annual calendar of events to ensure proactive celebration of diversity and raising awareness of key EDI events / festivals/ awareness days sharing staff experiences and linking external / internal support mechanisms to aid and enhance understanding and support
	  • Promoting WUTH as an inclusive employer that celebrates diversity and harnesses individuality
	  • Develop a series of staff stories to share experiences of non-white staff

2	Implications
2.1	**Patients** The work undertaken to advance the EDI agenda aims to improve awareness of a range of aspects and celebrate diversity for all. Whilst this should be a positive experience for all, there is also recognition of the diverse nature of our workforce and community and promotion and celebration of some areas, may not be in line with individual values, beliefs and behaviors.

	Whilst we strive to ensure appropriate values and behaviours are upheld for our workforce, this can be more challenging for our patients.
2.2	**People** As also detailed in section 2.1.
2.3	**Finance** • **N/A**
2.4	**Compliance** This report seeks to provide assurance that WUTH is currently in line with EDI reporting requirements for 2023/24 and outlines key areas of priority for 2024/25.

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

Setting Direction

- EDI Strategic Commitment (including objectives) 2022-2026 underpins WUTH's People Strategy (2022-2026)
- Staff networks involved in decision making processes and shaping future improvements at WUTH
- Member of regional network to support collaborative working across the ICB.
- EDI Objectives set for all Exec and Non-Exec Directors
- New Anti-racist Framework adopted and gap analysis undertaken and application submitted for Bronze status
- Launch of new Engagement Framework
- NHSE EDI Improvement actions integrated with existing EDI action plan
- Disability co-creation group task and finish group established and completed.
- New Menopause policy and revised disability and Reservists policies.

What's next…

- Promotion and education of actions and support developed by the disability co-creation group
- Listening events for non-white staff

Development, Education and Awareness

- 97.91% compliance with EDI mandatory training (May)
- EDI embedded within all leadership and management programmes - Inclusive Recruitment and Inclusive Leadership sessions delivered.
- Dedicated EDI Board seminars
- Mini manager sessions on supporting disabilities
- Monthly deaf awareness programme launched
- Neurodiversity sessions delivered by the Brain Charity
- Development plan agreed for network co-chairs
- Staff stories integrated within key meetings and development offerings and website page launched
- Range of national e-learning programmes promoted
- Range of "Drop Everything and Read" sessions held
- Inclusion guest speakers booked for leadership masterclasses and conference

What's next…

- Gender inclusion and LGBTQ+ awareness sessions
- New process and support pathway for disabled staff

Monitoring and Assurance

- Annual monitoring of workforce demograhics
- Workforce Race and Disability (WRES and WDES) and gender pay gap reporting completed
- New reporting cycle implemented and working well, with EDI Bi-Annual reporting commenced
- Revised EDS22 framework implemented and 2023 assessment completed
- Enhanced review and monitoring of staff survey data and HR KPI's to support Trust's Strategic Retention and flexible working projects
- Demographic monitoring of volunteers, widening participation and leadership for all programmes
- Re-launch of people pulse survey one of the highest regional response rates in Q2
- EDI related question now included within Divisional Performance Reviews

What's next…

- Focus on improving staff demographics on ESR
- Focus on improving staff survey response rates

Communications

- Regular Trust communications to promote key events and information
- EDI webpages updated with key reports
- Reachdeck software in place to support web accessibility
- Deaf awareness development opportunities
- Launch of #Hellomynameis campaign linked to Race Equality Matters initiative and use of titles and pronouns

What's next…

- Exploration of assistive technology to support communications
- Greater use of social media

Events

- Flag raising for PRIDE month and armed forces week
- Trust involvement in PRIDE parades
- Range of events that support awareness raising for patient and staff support e.g. MENCAP Treating me well events, deaf awareness and menopause
- Support of various national and international awareness days/weeks and months e.g. International Women and Mens day promotional communications and LGBTQ+ history month
- Range of activities to support religious festivals
- Departmental events e.g. Culture Days
- Remembrance Day events, including laying wreaths on site and at local Cenotaph for the first time
- New EDI category in staff awards, with inclusion embedded across wider categories

What's next…

- Relaunch and refresh of staff networks
- Listening events for non-white staff

Staff Support

- Five Staff networks in place
- EDI team & networks meet new staff at induction
- Network members "buddying" with colleagues
- Staff sharing experiences to help others
- Networks hosting themed meetings & guest speaker sessions held including "Let's Talk Menopause" and "Disordered Eating"
- New staff menopause clinic established with dedicated website, including guidance and support
- Wellbeing Week focused on supporting staff with disabilities
- Provision of Iftar boxes for staff during Ramadan
- Disability Co-creation group developed key priorities and actions based on feedback from engagement events.

What's next…

- Embedding of disability co-creation group actions
- Refresh and relaunch of staff networks
- Listening events for non-white staff.

Accreditations

- Veteran Aware Accreditation
- Merseyside In Touch Navajo LGBTIQA+ Accredited
- Defence Employer Recognition Scheme (DERS)Silver Level Achieved
- Disability Confident Employer

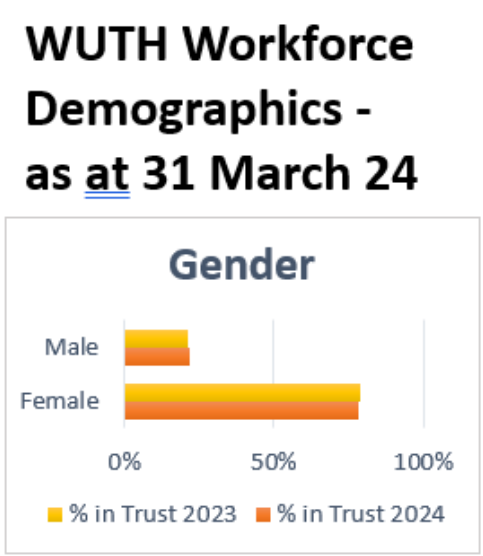
What's next…

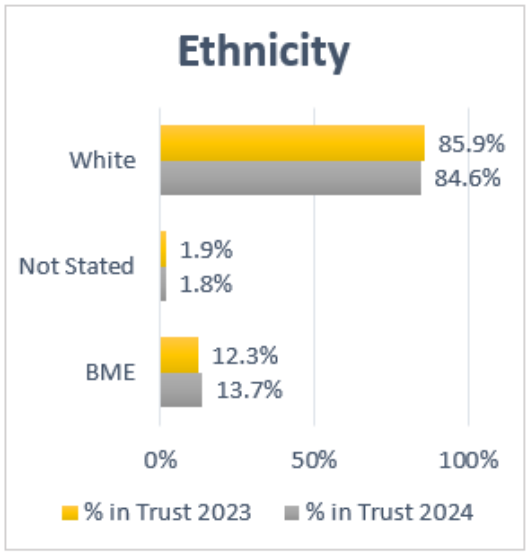
- Attainment of anti-racism framework bronze level
- Re-accreditation of Navajo LGBTIQA Chartermark

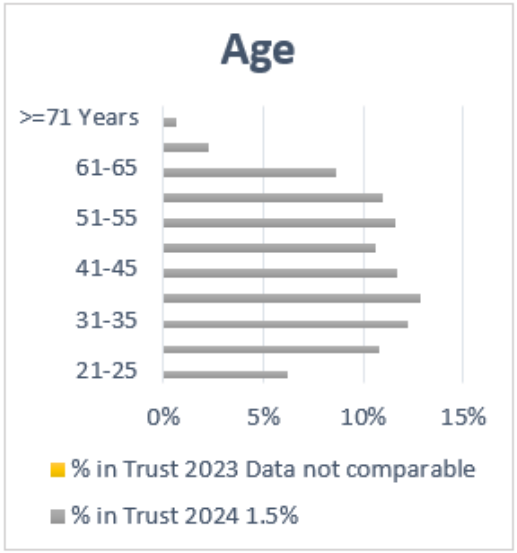
Appendix 2

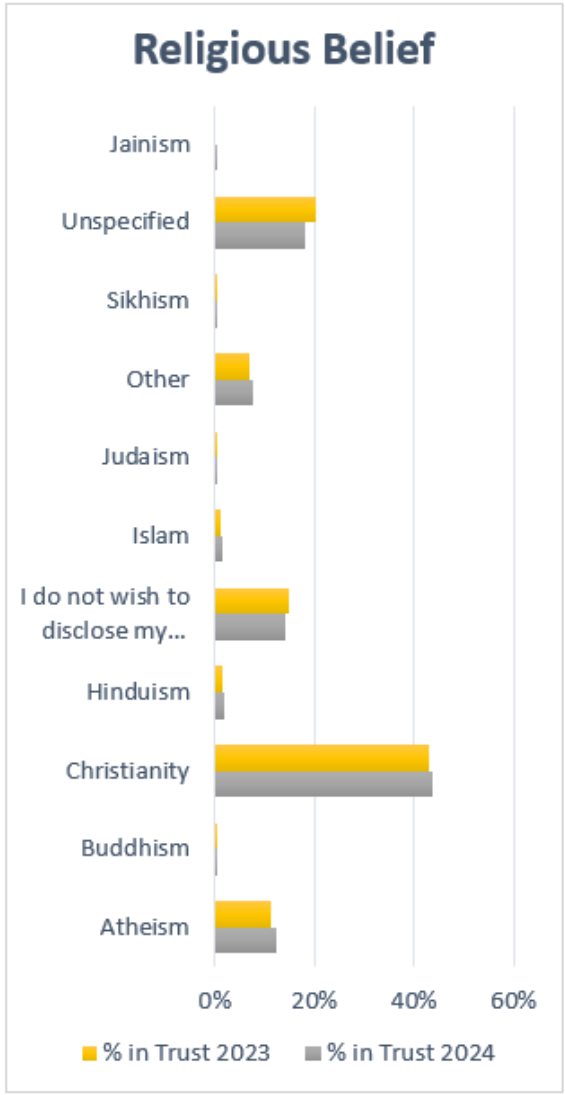
Summary of WUTH Workforce Demographics as at 31 March 2024

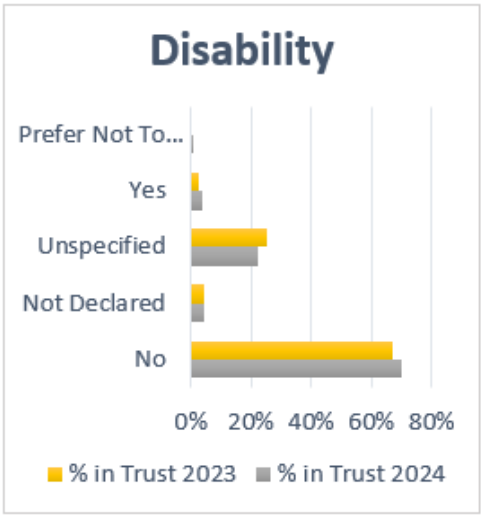
Understanding the workforce composition by equality and diversity demographics is important in order to ensure that we are a fair and open organisation and to monitor the effectiveness of our policies and procedures. There has been an increase in the workforce numbers from 6753 staff last year to 6837 this year. The graphics below summarise the Trust position compared to last year where possible

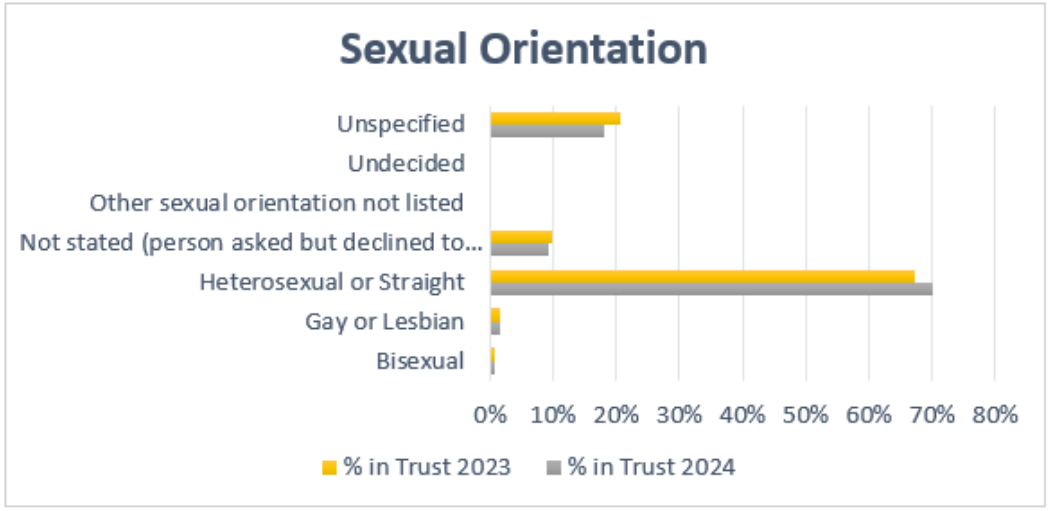












Wirral University Teaching Hospital
NHS Foundation Trust

Workforce Race Equality Standards (WRES) Report

June 2024

Sharon Landrum, Workforce Engagement and Inclusion Lead

together we will

wuth.nhs.uk

Contents

Background

All the available evidence shows that Black, Asian and Ethnic Minority (BAME) staff have a significantly inferior experience of the NHS as employees when compared to white staff. This report details the background to and the content of the Workforce Race Equality Standard (WRES) report that is required annually of all NHS organisations in order to help ensure the fulfilment of the public sector equality duty as set out in the Equality Act 2010.

The aim of the WRES is to improve the experience of Black, Asian and Ethnic Minority (BAME) staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes. It also applies to BAME people who want to work in the NHS.

WUTH has declared its commitment to supporting staff to feel they belong in our organisation as outlined in our People Strategy 2022 – 2026 and to address areas of inequality. This is delivered through our equality, diversity and inclusion strategic commitment:

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

WUTH is also committed to ensuring that it upholds the principles of the Public Sector Equality Duty to:

- To eliminate unlawful harassment and victimisation.
- To foster good relations between people who share a protected characteristic and those who do not.
- To advance equality of opportunity between people who share a protected characteristic and those who do not.

WRES data provides an invaluable opportunity to annually review staff experiences and Trust performance against a series of nationally agreed indicators and support identification of key areas of progress and areas requiring additional attention.

In the context of the WRES, "white staff" comprises of white British, white Irish and white other, whereas "BAME staff" comprise all other categories with the exception of "not stated".

Executive Summary

The aim of the Workforce Race Equality Standard is to improve the experience of Black, Asian and Minority Ethnic (BAME) staff in the workplace. This includes employment, promotion and training opportunities as well as the experience of employment relations processes. It also applies to BAME people who want to work in the NHS.

Appendix A provides a summary overview of the Trust's results, compared to national and regional data where available.

Trust has seen a mixture of results this year with some improvements however a number of areas of decline.

2023/24 data highlights improvements in:

- Trust demographics – with increased representation of non-white staff across clinical and non-clinical roles.
- The likelihood of non-white staff entering the formal disciplinary process –non-white staff are less likely to enter the disciplinary process this year with a similar likelihood to white staff.
- Staff feeling that the Trust provides equality opportunities for career progression or promotion.

However, all other areas have unfortunately declined this year.

Non-white applicants are less likely to be appointed this year when compared to white applicants and indicators relating to staff experiences, appear less positive this year.

The Trust has now signed up to the North-West Anti-Racist framework and has publicly declared its commitment to being an anti-racist organisation. It is working towards achievement of bronze status as the first step in our journey towards achieving Gold and to ensure we support improvements in staff experiences.

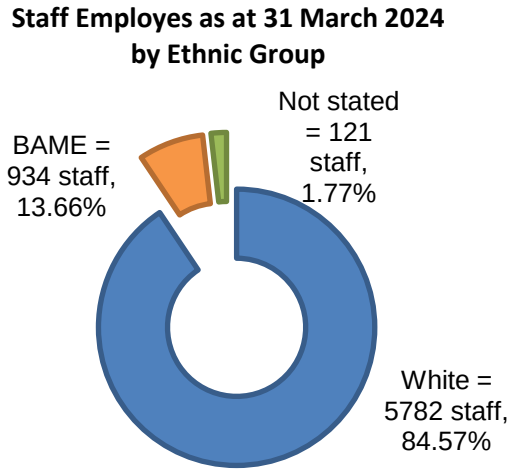
As part of the Trust's People Strategy, race equality has been identified as a key priority for 2024/25. The action plan detailed in appendix B outlines key areas of focus this year to ensure improvements.

The WDES has been mandated by the NHS Standard Contract and all NHS Trusts and Foundation Trusts will be required to publish their results and develop action plans to address the differences highlighted by the Indicators with the aim of improving workforce race equality.

Total Staff by Ethnicity 31 March 2024

As of 31 March 2024, a total of 6837 staff were employed by WUTH. Of these, 934 (13.66%) were BAME and 5782 (84.57%) were white. 121 staff however, (1.77%) were unstated for their ethnicity (as per our electronic staff record (ESR). Work will continue to take place to support and encourage staff to update personal information within ESR.

The results highlight therefore that there continues to be a significant increase in the number of BAME staff within the Trust, with numbers remaining higher than that within the local population (95.2% of residents identified as "white" in the 2021 census). That said, there is a significant disparity between the levels of BAME staff within clinical and non-clinical roles, however increases can be seen in both areas, including very senior managers.



The definitions of "Black, Asian and Minority Ethnic" and "White" used have followed the national reporting requirements of Ethnic Category in the NHS Data Model and Dictionary, and as used in Health and Social Care Information Centre data. "White" staff includes White British, Irish and Any Other White. The "Black, Asian and Minority Ethnic" staff category includes all other staff except "unknown" and "not stated."

Section One

The WRES Standard Indicators

Table 1. The Workforce Race Equality Standard Indicators	
Workforce Indicators For each of these four workforce indicators, compare the data for White and BAME staff.	

1	Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM (*including executive Board members*) compared with the percentage of staff in the overall workforce disaggregated by:
	• Non-clinical staff
	• Clinical staff – of which
	  • Non-medical staff
	  • Medical and Dental staff

2	Relative likelihood of staff being appointed from shortlisting across all posts.
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation* **Note:** *this indicator will be based on data at 31 March.*
4	Relative likelihood of BAME staff accessing non-mandatory training and CPD.
National NHS Staff Survey findings (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for White and BAME staff.	
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
6	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.
7	Percentage believing that trust provides equal opportunities for career progression or promotion.
8	In the last 12 months have you personally experienced discrimination at work from any of the following? b) manager/team leader or other colleagues
Boards representation indicator For this indicator, compare the difference for White and BAME staff	
9	Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board

Indicator 1

This indicator relates to the relative numbers of staff in each of the Agenda for Change Bands and VSM compared with the percentage of staff in the overall workforce. The tables below show this data for WUTH as a whole workforce as of 31 March 2024.

Staff breakdown for clinical and non-clinical combined

Payband	White	BAME	Not Stated	Grand Total	% in Band 2024	% in band 2023	% in band 2022
Band 1	105	0	2	107	**0.00%**	0%	0%
Band 2	1698	155	20	1873	**8.28%**	6.30%	4.20%
Band 3	677	31	3	711	**4.36%**	2.90%	2.10%
Band 4	411	10	10	431	**2.32%**	4.20%	13.30%
Band 5	913	376	37	1326	**28.36%**	26.90%	19.10%
Band 6	801	79	13	893	**8.85%**	7.80%	8.20%
Band 7	490	29	10	529	**5.48%**	5.30%	4.10%
Band 8A	206	19	2	227	**8.37%**	5.90%	6.80%
Band 8B	90	5	2	97	**5.15%**	5.50%	7.90%
Band 8C	29	2	0	31	**6.45%**	3.10%	0.00%
Band 8D	14	0	0	14	**0.00%**	9.10%	14.30%
Band 9	4	0	0	4	**0.00%**	0%	0%
M&D - Career Grade	31	30	2	63	**47.62%**	49.10%	45.20%
M&D - Consultant	196	106	11	313	**33.87%**	33.60%	34.60%
M&D - Trainee	108	92	9	209	**44.02%**	37.80%	26.20%
Other Incl VSM	9	0	0	9	**0.00%**	5.30%	0.00%
Grand Total	**5782**	**934**	**121**	**6837**	**13.66%**	12.30%	10.40%

Staff breakdown by clinical and non-clinical staff group

Clinical/Non Clinical	Staff Group	White	BAME	Not Stated	Grand Total	2023/24	2022/23
Clinical - Medical	Medical and Dental	335	228	22	585	38.97%	35.40%
Clinical - Non Medical	Add Prof Scientific and Technic	188	17	1	206	8.25%	7.10%
	Additional Clinical Services	1164	143	14	1321	10.83%	8.56%
	Allied Health Professionals	413	46	7	466	9.87%	7.60%
	Healthcare Scientists	136	14	1	151	9.27%	8.20%
	Nursing and Midwifery Registered	1430	419	47	1896	22.10%	21.40%
Non Clinical	Administrative and Clerical	1123	42	14	1179	3.56%	2.80%
	Estates and Ancillary	993	25	15	1033	2.42%	2.10%
Grand Total		**5782**	**934**	**121**	**6837**	**13.66%**	**12.30%**

Clinical staff breakdown by pay band

Pay Band	White	BAME	Not Stated	Grand Total	% BAME staff in band 2023/24	% BAME staff in band 2022/23
Band 2	719	121	8	848	**18.34%**	10.4%
Band 3	290	17	1	308	**6.66%**	3.5%
Band 4	144	5	5	154	**3.33%**	7.3%
Band 5	798	372	35	1205	**26.05%**	29.4%
Band 6	731	77	8	816	**17.64%**	8.1%
Band 7	419	24	10	453	**9.79%**	6.0%
Band 8A	155	16	2	173	**3.74%**	6.0%
Band 8B	54	5	1	60	**1.30%**	10.0%
Band 8C	15	2	0	17	**0.37%**	6.3%
Band 8D	4	0	0	4	**0.09%**	33.3%
Band 9	2	0	0	2	**0.04%**	0.0%
M&D – Career Grade	31	30	2	63	**1.36%**	49.1%
M&D – Consultant	196	106	11	313	**6.77%**	33.6%
M&D – Trainee	108	92	9	209	**4.52%**	37.8%
Other Incl VSM	1	0	0	1	**0.0%**	0.0%
Grand Total	3672	774	98	4544	**100%**	**100%**
% of clinical staff	**79.26%**	**18.75%**	**1.99%**	**100%**		

Non-clinical staff breakdown by pay band

Pay Band	White	BAME	Not Stated	Grand Total	% BAME staff in band 2023/24	% BAME staff in band 2022/23
Band 1	105	0	2	107	**4.84%**	0.0%
Band 2	979	34	12	1025	**46.34%**	2.7%
Band 3	387	14	2	403	**18.22%**	2.5%
Band 4	267	5	5	277	**12.52%**	2.5%
Band 5	115	4	2	121	**5.47%**	1.6%
Band 6	70	2	5	77	**3.48%**	5.2%
Band 7	71	5	0	76	**3.44%**	1.3%
Band 8A	51	3	0	54	**2.44%**	5.5%
Band 8B	36	0	1	37	**1.67%**	0.0%
Band 8C	14	0	0	14	**0.63%**	0.0%
Band 8D	10	0	0	10	**0.45%**	0.0%
Band 9	2	0	0	2	**0.09%**	0.0%
Other Incl VSM	9	0	0	9	**0.41%**	5.6%
Grand Total	**2116**	**67**	**29**	**2212**	**100.00%**	2.5%
% of non-clinical	**95.66%**	**3.03%**	**1.31%**	**100.00%**		

Key Findings:-

- The percentage of non-white staff employed at WUTH has increased from 12.3% last year to 13.66% this year with increases seen across clinical and non-clinical roles. Representation continues to be significantly higher within clinical roles.
- The majority of bands have increased, with the exception of bands 4, 8B, 8D, Career Grade Doctors and Other including VSM and band 9 has remained the same at 0%.
- Medical Trainees have seen a significant increase, rising from 37.8% to 44.02%
- The percentage of non-white staff employed at WUTH (13.66%) is greater than the population of Wirral as a whole (4.8%, 2021 Census).
- The number of non-white clinical staff is significantly higher than non-clinical BAME staff with 18.75% (17.0% last year) of non-white staff being clinical and only 3.03% non-clinical (2.5% last year).

Indicator 2

This indicator relates to the relative likelihood of BAME staff being appointed from shortlisting compared to that of white staff being appointed from shortlisting across all posts.

Key Findings
Whilst a significant improvement was identified in the 2022/23 data, results have unfortunately declined this year. BAME applicants are less likely to be appointed from shortlisting than white applicants this year, with a relative likelihood of 2.02 (1.28 last year).

As part of the Trust's focus on race equality this year, a recruitment audit process will be established this year along with listening events with staff to understand any potential reasons for the deterioration in results.

Indicator 3

This indicator relates to the relative likelihood of BAME staff entering the formal disciplinary process, compared with that of non-BAME staff.

Key Findings:
Within 2023/24, 73 people (1.07%) entered the disciplinary process. 2 staff were BAME (0.03% of workforce numbers), 64 were white (including any "white ethnic group") (0.94% of workforce numbers) and 6 people have an undefined / unknown ethnicity (0.09%).

This data therefore highlights that BAME staff are less likely to enter the disciplinary process than white staff, with a relative likelihood of 0.6.

Indicator 4

Relative likelihood of BAME staff accessing non-mandatory training and CPD.

Key Findings
Data highlights that BAME staff have an equal likelihood of accessing non-mandatory training and CPD as with white colleagues.

National NHS Staff Survey Findings

The next 4 indicators are taken directly from the 2023 staff survey report and relate to relative staff experience of bullying and harassment, career progression opportunities and personally experienced discrimination.

Indicator 5

30.03% of our staff have indicated that they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. To follow is a chart to highlight annual data comparisons.

Chart 1 - Annual Data Comparison

	2018	2019	2020	2021	2022	2023	National Average 2023
non-white staff	32.0%	30.1%	22.3%	27.8%	25.6%	**30.03%**	27.34%
white staff	25.2%	25.4%	21.4%	23.4%	22.8%	**21.25%**	24.05%

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months		2015	2016	2017	2018
	BAME Staff	30.7%	6.7%	20.0%	32.0%
	Non BAME colleagues	24.5%	21.8%	21.0%	25.2%

Chart 2 - Annual Comparison

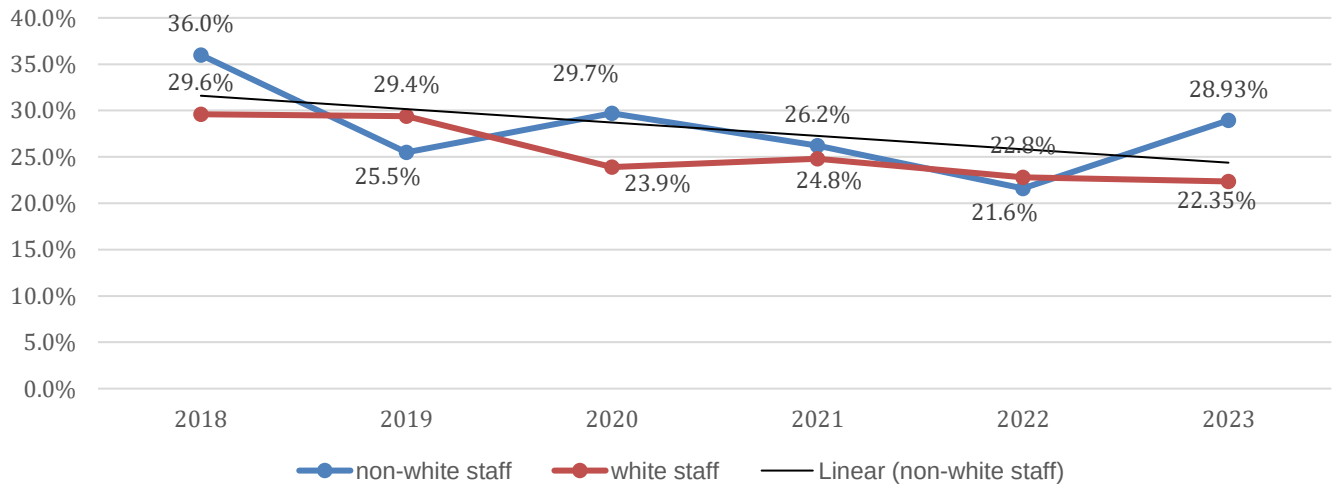
Indicator 6

The chart below highlights the percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

Chart 3 - Annual Data Comparison

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months		**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**National Average 2022**
	BAME Staff	30.7%	20.0%	25.0%	36.0%	**25.5%**	29.7%	26.2%	21.6%	28.8%
	Non BAME **colleagues**	18.8%	24.5%	23.0%	29.6%	**29.4%**	23.9%	24.8%	22.8%	23.3%

Chart 4 – Annual Comparison



Indicator 7

The chart below shows the percentage believing that the Trust provides equal opportunities for career progression or promotion.

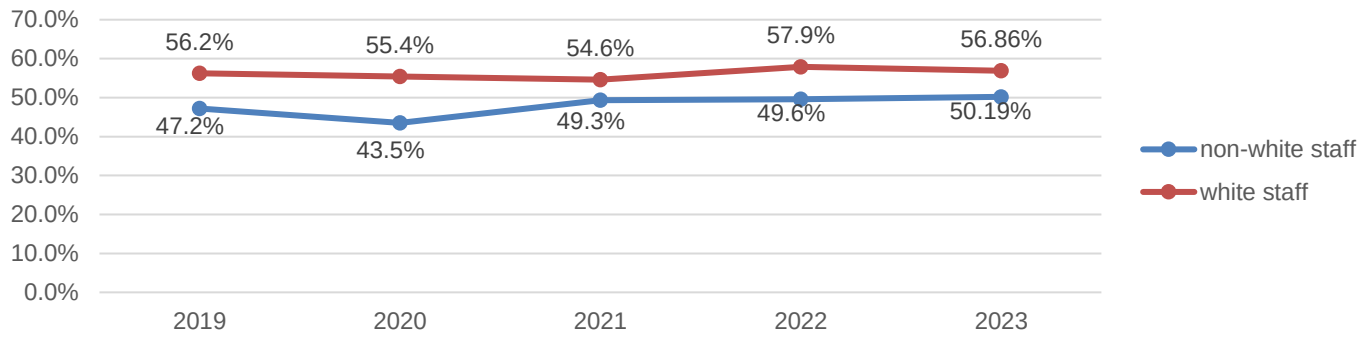
Data prior to 2019 is not included as a national error was identified 2022/23 and available data updated to 2019 only.

Chart 5 - Annual Comparison

	2019	2020	2021	2022	2023	National Average 2023
non-white staff	47.2%	43.5%	49.3%	49.6%	**50.19%**	49.64%
white staff	56.2%	55.4%	54.6%	57.9%	**56.86%**	58.84%

	2019	2020	2021	2022	National Average 2022
BAME Staff	47.2%	43.5%	49.3%	49.6%	47.0%
Non BAME colleagues	56.2%	55.4%	54.6%	57.9%	58.6%

Chart 6 - Annual Data Comparison



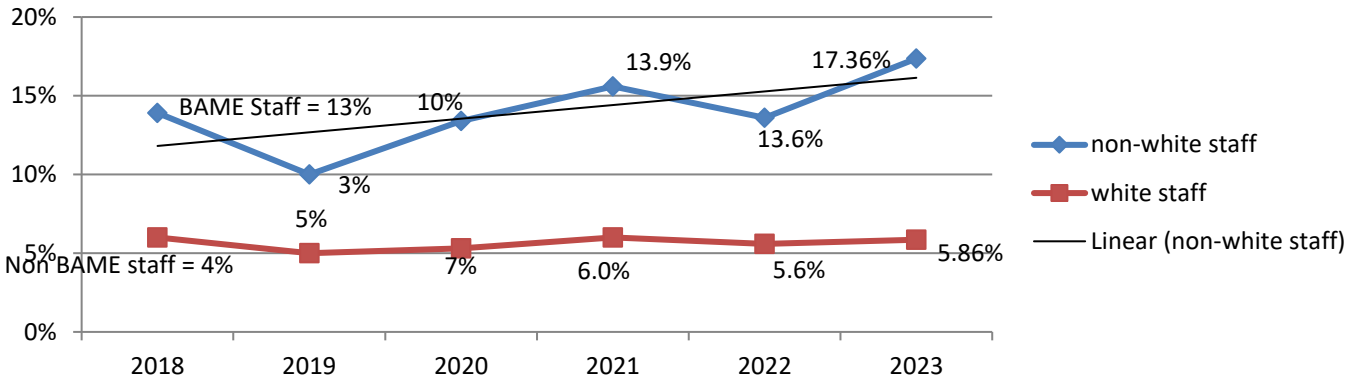
Indicator 8

In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?

Chart 7 -Annual Data Comparison

	2018	2019	2020	2021	2022	2023	National Average 2023
non-white staff	13.9%	10.0%	13.4%	15.6%	13.6%	**17.36%**	16.17%
white staff	6.0%	5.0%	5.3%	6.0%	5.6%	**5.86%**	6.73%

Chart 8 -Annual Data Comparison


20%
15%
10%
5%
0%
2018
2019
2020
2021
2022
2023
BAME Staff = 13%
Non BAME staff = 4%
10%
3%
5%
13.9%
17.36%
13.6%
7%
6.0%
5.6%
5.86%
non-white staff
white staff
Linear (non-white staff)

Indicator 9

Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated:

- **By voting membership of the Board**
- **By executive membership of the Board**

Key Finding:
The Trust has 14 Board members, 12 of whom are voting members and 11 identify as white (which includes all white categories as defined within ESR).

This gives a percentage difference for both the Trust boards voting and executive membership and its overall workforce of – 7%.

Additional WRES Data Collections Introduced for 2023/24

The national WRES team introduced two additional data collections in 2022/23:

- Bank WRES
- Medical WRES

Whilst these were submitted as required last year, collections have currently been postponed for 2023/24.

Conclusion

The Trust has seen a mixture of improvements and also a number of areas of decline this year.

Improvements can be seen in:

- Trust demographics – with increases in non-white staff across clinical and non-clinical roles.
- The likelihood of non-white staff entering the formal disciplinary process
- Staff feeling that the Trust provides equality opportunities for career progression or promotion.

However, the remaining areas have declined, with staff experiences appearing less positive this year.

Whilst deterioration can be seen in a number of areas this year and is concerning, it is also pleasing to see an overall improving trend since 2018 in the majority of staff experience related indicators, with the exception of staff unfortunately experiencing discrimination.

Further to the data received, WUTH has identified race equality as a key priority for 2024/25, with a commitment to undertaking actions to understand and improve staff experiences. It is vital that bullying, harassment, abuse and discrimination is eradicated and a zero tolerance approach is taken. The action plan detailed in appendix B therefore outlines key areas of focus this year to ensure improvements.

has now signed up to the North-West Anti-Racist framework and has publicly declared its commitment to being an anti-racist organisation.

Appendix A

WRES Indicator Summary table for NHS trusts in England compared to WUTH 2023/24

WRES Indicator			NHS Trusts in England 2022/23	Acute Trusts 2022/23	NHS Trusts in North West 2022/23	National Average 2023/24	WUTH 2021/22	WUTH 2022/23	WUTH 2023/24
1	% of BAME Staff	Overall	26.4%	28.9%	17.1%		10.4%	12.3%	13.66%
		VSM					0%	5.3%	0%
		Clinical					14.6%	17.0%	18.75%
		Non-Clinical					1.7%	2.5%	3.01%
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants		1.59	1.58	1.58		0.96	1.28	2.02
3	Relative likelihood of BAME staff entering the formal disciplinary process compared to white staff		1.03	1.02	1.11		0.48	0.22	0.6
4	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BAME staff		1.12	1.15	1.14		1.1	1.0	1.0
5	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**BAME**	**30.4%**	**30.6%**	**26.9%**	**27.34%**	**27.8%**	**25.6%**	**30.03%**
		White	26.8%	26.8%	24.2%	24.05%	23.4%	22.8%	21.25%
6	% of staff experiencing harassment, bullying or abuse from staff in the last 12 months	**BAME**	**27.7%**	**28.5%**	**26.8%**	**25.25%**	**26.2%**	**21.6%**	**28.93%**
		White	22.0%	23.1%	20.7%	22.12%	24.8%	21.5%	22.35%
7	% of staff believing that the Trust provides equal opportunities for career progression or promotion	**BAME**	**46.4%**	**46.3%**	**46.1%**	**49.64%**	**49.3%**	**49.6%**	**50.19%**
		White	59.1%	58.9%	59.5%	58.84%	54.6%	57.9%	56.86%
8	% of staff personally experiencing discrimination at work from a manager, team leader or other colleagues	**BAME**	**16.6%**	**17.0%**	**17.0%**	**16.17%**	**15.6%**	**13.6%**	**17.36%**
		White	6.7%	6.7%	6.3%	6.73%	6%	5.6%	5.86%
9	BAME Board membership		-10.9%	-14.9%	-5.8%		-10.4%	-6.4%	-7.0%

Key:

- Improved from last year and above the national average
- Improved from last year however below the national average **or** reduced from last year however above the national average
- Reduced from last year and below the national average

Workforce Race Equality Standard (WRES) Action Plan 2024/25

Elements		Action	Responsibility	Deadline
Seek to Understand	1	Develop process of regular recruitment audits of processes for under-represented areas / roles to understand challenges / barriers or areas of potential bias	Recruitment / SL	30/09/2024
	2	Working with the Trust's multicultural staff network to undertake a series of listening events to understand experiences of working at WUTH and identify potential reasons for areas of deterioration and actions needed to ensure improvements.	CPO	31/08/2024
	3	Develop a process to identify and triangulate data relating to incidents/concerns and employee relations case linked to protected characteristics	TN / SL	31/12/24
Support	1	Build capacity and capability of Trust staff networks, with appointment of new co-chairs and re-establishment of regular meetings.	SL / Exec Partners	31/03/2025
	2	Increase the number of non-white FTSU Champions to promote and encourage staff to speak up	TN	31/12/24
	3	Continue to encourage staff to enter/update personal information via ESR self-service, with guidance documents and support offered to complete.	Comms / Workforce Information / SL	31/03/25
Educate and Develop	1	Visible Respect at Work campaign to promote zero tolerance to bullying, harassment or abuse within the workplace	HR / H&S	Ongoing
	2	Application submitted for NHS Northwest Anti-Racist Framework Bronze Status with outcome reviewed and further areas of priority to be identified.	SL	30/06/24
	3	EDI training to support leaders in understanding how to ensure WUTH is an anti-racist organisation and upholds the principles of the sexual safety charter.	CPO	31/03/25
Celebrate and Promote	1	Annual calendar of events to ensure proactive celebration of diversity and raising awareness of key EDI events / festivals/ awareness days sharing staff experiences and linking external / internal support mechanisms to aid and enhance understanding and support	SL	Ongoing
	2	Promoting WUTH as an inclusive employer that celebrates diversity and harnesses individuality	SL / Comms / Recruitment	Ongoing
	3	Develop a series of staff stories to share experiences of non-white staff	SL / Staff network	

Wirral University Teaching Hospital
NHS Foundation Trust

Workforce Disability Equality Standards (WDES) Report

June 2024

Sharon Landrum, Workforce Engagement and Inclusion Lead

together we will

Contents

Background

Research has shown that disabled staff have poorer experiences in areas such as bullying and harassment and attending work when feeling ill, when compared to non-disabled staff. The Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) that have been reviewed as part of a consultation process with NHS staff across the country and seek to enable Trust to compare the experiences of disabled and non-disabled staff.

Full details of the metrics are attached at Appendix i.

The WDES has been mandated by the NHS Standard Contract since 1 April 2019 and all Trusts must ensure data is uploaded to a government portal by no later than 31 May each year. Detailed reports including action plans to address areas of further work needed must also be developed and made public by no later than 31 October.

WUTH has declared its commitment to supporting staff to feel they belong in our organisation as outlined in our People Strategy 2022 – 2026 and to address areas of inequality. This is delivered through our equality, diversity and inclusion strategic commitment:

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

WUTH is also committed to ensuring that it upholds the principles of the Public Sector Equality Duty to:

- To eliminate unlawful harassment and victimisation.
- To foster good relations between people who share a protected characteristic and those who do not.
- To advance equality of opportunity between people who share a protected characteristic and those who do not.

WRES data provides an invaluable opportunity to annually review staff experiences and Trust performance against a series of nationally agreed indicators and support identification of key areas of progress and areas requiring additional attention.

Executive Summary

WDES allows an enhanced insight into how disabled staff feel they are treated compared with non-disabled staff and whether any bias conscious or unconscious is shown during key Trust processes such as recruitment.

There are a number of pleasing results this year, with improvements seen in:

- Self-reporting on ESR – with more disabled staff declaring they have a disability.
- Likelihood of being appointed – disabled applicant now as likely to be appointed as non-disabled applicants.
- Experiences of bullying, harassment or abuse (BHA) by managers in the last 12 months – with less staff experiencing this compared to last year and results now above the national average.
- Reporting of the last experience of bullying, harassment or abuse – with more staff reporting this year and results are now above the national average.
- Pressure coming to work, despite not feeling well enough to perform their duties – disabled staff are feeling less pressure this year, with results now above the national average.

However, it is concerning to see a deterioration in experiences of our disabled staff, with disabled staff declaring they have experienced more bullying, harassment or abuse patients, relatives or the public and particularly concerning is that it has also increased from colleagues too. Results highlight increases from 21.87% of disabled staff in 2022 staff survey to 24.72% in the 2023 staff survey experiencing BHA from colleagues in the last 12 months.

Staff survey data also highlights a lower staff engagement score this year, with disabled staff feeling less valued by the organisation this year, with less provision of opportunities for career progression or promotion and less satisfaction with provision of adequate reasonable adjustments. Results for these all now unfortunately fall below the national average when compared to comparable Trusts.

Whilst a deterioration can be seen this year in a number of the staff experience related metrics (metrics 4-8), it is still pleasing to see an improved position from commencement of the WDES metrics in 2018 with all except one metric (4b) seeing improvements.

Appendix i outlines the national indicators that the Trust is required to submit data for and monitor progress against.

Appendix ii provides a summary overview of the Trust's performance against the required indicators, compared to national averages.

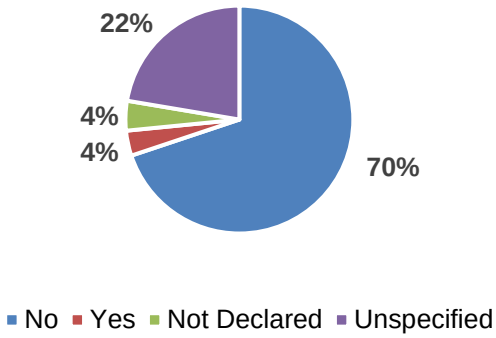
Appendix iii provides a summary overview of key actions required in order to sustain and improve further the experiences of our disabled staff.

Metric 1

Staff breakdown for 2023/4 (all staff)

As of 31st March 2024, the self-reporting rate for those staff with a disability within WUTH is 3.6%, 244 people (as entered on staff ESR records). This has continued to improve from last year, whereby only 2.8% of staff (186 people) had declared. Whilst it is positive to see continued improvements in declaration rates, rates continue to still be low, with 22% of staff ESR records still remining unspecified. Work will therefore continue to support improvements.

Chart 1 – Disability Status as of 31 March 2024



Data shows improvements in both clinical and non-clinical representation with 3.2% (150) staff in a clinical role, increasing from 2.7%, (121 staff) in 2022/23 and 4.2% (94 staff) in a non-clinical role, increasing from 3% (65 staff) in 2022/23.

Breakdown of workforce data by disability status as at 31 March 2024 and compared to 2022/23 data.

Chart 2 - Breakdown of disability declaration categories by clinical and non-clinical as at 31 March 2024

	Total Clinical Staff	% of clinical	Total non-clinical	% of non-clinical	Combined 2024	% overall 2024	% overall 2023
Disabled	150	3.2%	94	4.2%	244	3.6%	2.8%
Non-disabled	3363	72.7%	1414	63.9%	4777	69.9%	67.1%
Not declared	197	4.3%	94	4.2%	291	4.3%	4.7%
Unspecified	915	19.8%	610	27.6%	1525	22.3%	25.4%
Total	4625	100.0%	2212	100.0%	6837	100.0%	100.0%

Further work is still required to ensure staff are encouraged and supported to be able to update their disability status within ESR. This would then ensure that data can be truly representative of the disabled staff within the Trust and thus contribute to actions for improvement.

Percentage of staff in A4C paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce as at 31 March 2024.

Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.

		Non Clinical				Clinical				Total Headcount	Total WTE	Total % Of Column Total
Cluster	Disability	Headcount	WTE	% of Row Total	% Of Column Total	Headcount	WTE	% of Row Total	% Of Column Total			
Cluster 1	No	1137	811.42	50.35%	47.82%	964	800.23	49.65%	19.99%	2101	1611.65	28.28%
	Not Declared	82	55.42	62.02%	3.27%	44	33.94	37.98%	0.85%	126	89.36	1.57%
	Prefer Not To Answer			0.00%	0.00%	1	1.00	100.00%	0.02%	1	1.00	0.02%
Bands 1-4	Unspecified	523	391.11	65.13%	23.05%	255	209.42	34.87%	5.23%	778	600.53	10.54%
	Yes	70	51.56	56.23%	3.04%	46	40.13	43.77%	1.00%	116	91.69	1.61%
Cluster 1 Total		1812	1309.51	54.69%	77.18%	1310	1084.72	45.31%	27.10%	3122	2394.23	42.01%
Cluster 2	No	179	173.81	10.04%	10.24%	1757	1557.31	89.96%	38.90%	1936	1731.12	30.37%
	Not Declared	10	9.56	9.26%	0.56%	117	93.65	90.74%	2.34%	127	103.21	1.81%
Bands 5-7	Unspecified	70	65.33	13.00%	3.85%	520	437.32	87.00%	10.93%	590	502.65	8.82%
	Yes	15	14.24	17.21%	0.84%	80	68.50	82.79%	1.71%	95	82.74	1.45%
Cluster 2 Total		274	262.94	10.87%	15.50%	2474	2156.79	89.13%	53.88%	2748	2419.73	42.45%
Cluster 3	No	70	69.25	32.75%	4.08%	153	142.23	67.25%	3.55%	223	211.49	3.71%
	Not Declared	2	2.00	23.57%	0.12%	7	6.48	76.43%	0.16%	9	8.48	0.15%
Bands 8a & 8b	Unspecified	14	13.60	17.92%	0.80%	68	62.31	82.08%	1.56%	82	75.91	1.33%
	Yes	5	4.80	50.10%	0.28%	5	4.78	49.90%	0.12%	10	9.58	0.17%
Cluster 3 Total		91	89.65	29.35%	5.28%	233	215.81	70.65%	5.39%	324	305.46	5.36%
Cluster 4	No	28	27.60	58.69%	1.63%	21	19.43	41.31%	0.49%	49	47.03	0.83%
Bands 8c – 9 & VSM	Unspecified	3	3.00	60.00%	0.18%	2	2.00	40.00%	0.05%	5	5.00	0.09%
	Yes	4	4.00	100.00%	0.24%			0.00%	0.00%	4	4.00	0.07%
Cluster 4 Total		35	34.60	61.76%	2.04%	23	21.43	38.24%	0.54%	58	56.03	0.98%
Cluster 5	No			0.00%	0.00%	238	223.14	100.00%	5.57%	238	223.14	3.91%
	Not Declared			0.00%	0.00%	13	12.50	100.00%	0.31%	13	12.50	0.22%
Consultants	Unspecified			0.00%	0.00%	59	55.52	100.00%	1.39%	59	55.52	0.97%
	Yes			0.00%	0.00%	3	3.00	100.00%	0.07%	3	3.00	0.05%
Cluster 5 Total				0.00%	0.00%	313	294.16	100.00%	7.35%	313	294.16	5.16%
Cluster 6	No			0.00%	0.00%	46	33.17	100.00%	0.83%	46	33.17	0.58%
	Not Declared			0.00%	0.00%	5	3.76	100.00%	0.09%	5	3.76	0.07%
Career Grades	Unspecified			0.00%	0.00%	11	9.15	100.00%	0.23%	11	9.15	0.16%
	Yes			0.00%	0.00%	1	0.22	100.00%	0.01%	1	0.22	0.00%
Cluster 6 Total				0.00%	0.00%	63	46.30	100.00%	1.16%	63	46.30	0.81%
Cluster 7	No			0.00%	0.00%	184	163.20	100.00%	4.08%	184	163.20	2.86%
	Not Declared			0.00%	0.00%	8	5.07	100.00%	0.13%	8	5.07	0.09%
Trainee Grades	Prefer Not To Answer			0.00%	0.00%	2	2.00	100.00%	0.05%	2	2.00	0.04%
	Yes			0.00%	0.00%	15	13.40	100.00%	0.33%	15	13.40	0.24%
Cluster 7 Total				0.00%	0.00%	209	183.67	100.00%	4.59%	209	183.67	3.22%
Grand Total		2212	1696.70	29.77%	100.00%	4625	4002.88	70.23%	100.00%	6837	5699.58	100.00%

Metric 2

This refers to the relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

Data for this indicator has improved again this year with disabled applicants more likely to be appointed than non-disabled applicants. The relative likelihood is 1.19 and is now considered to be within an equal range as non-disabled applicants.

Metric 3

This indicator looks at the relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. This metric is based on data from a two-year rolling average of the current year and the previous year.

The two-year rolling average of the current year and the previous year (April 2022 to March 2023 and April 2023 to March 2024) is 10 and none were identified as disabled. The relative likelihood is therefore “0” = zero likelihood of occurrence.

National NHS Staff Survey Findings

Metrics 4 - 8 are taken directly from the staff survey results and relate to staff experiences of bullying and harassment, career progression opportunities and personally experienced discrimination. A summary overview can also be found at appendix iii.

Metric 4

Results of this metric are based on Q14 of the National Staff survey.

a) looks at the percentage of staff experiencing harassment, bullying or abuse from:
   i) Patients, relatives or the public in last 12 months (chart 1)
   ii) Managers (chart 2)
   iii) Other colleagues (chart 3)

Chart 1 (4a.1) - Percentage of staff experiencing harassment, bullying or abuse from patients, service users, their relatives or other members of the public in last 12 months

	2018	2019	2020	2021	2022	2023	National Average 2023
Disabled staff	34.4%	31.86%	24.85%	27.54%	28.63%	28.83%	29.83%
Non-disabled staff	23.9%	23.95%	20.60%	22.64%	21.68%	20.17%	23.11%

Chart 2 (4a.2) - % of staff experiencing harassment, bullying or abuse at work from managers in the last 12 months

	2018	2019	2020	2021	2022	2023	National Average 2023
Disabled staff	26.3%	23.65%	18.09%	18.64%	15.88%	14.98%	15.33%
Non-disabled staff	15.5%	14.59%	12.26%	11.64%	9.89%	9.32%	8.56%

Chart 3 (4a.3) - Percentage of staff experiencing harassment, bullying or abuse at work from other colleagues in the last 12 months

	2018	2019	2020	2021	2022	2023	National Average 2023
Disabled staff	34.9%	28.74%	25.40%	25.19%	21.87%	24.72%	25.26%
Non-disabled staff	19.5%	19.35%	15.61%	17.49%	14.92%	16.25%	16.12%

Chart 4 (4b) - % of staff saying that the last time they experienced bullying, harassment or abuse at work, they or a colleague reported it

	2018	2019	2020	2021	2022	2023	National Average 2023
Disabled staff	55.3%	46.57%	49.21%	51.29%	53.05%	53.07%	50.64%
Non-disabled staff	43.8%	45.39%	43.06%	46.30%	47.34%	49.32%	49.31%

Metric 5

This metric is also taken from the national staff survey results and is the percentage of staff believing that the Trust provides equal opportunities for career progression or promotion (Q15).

	2018	2019	2020	2021	2022	2023	National Average 2023
Disabled staff	51.5%	51.51%	46.25%	45.81%	52.51%	51.12%	51.54%
Non-disabled staff	56.5%	56.52%	56.56%	56.57%	58.07%	57.72%	57.52%

Metric 6

This metric is again taken from the national staff survey results (Q11e) and looks at the percentage of disabled staff compared to non-disabled staff who say that they have felt pressure coming to work, despite not feeling well enough to perform their duties.

	2018	2019	2020	2021	2022	2023	National Average 2023
Disabled staff	39.9%	35.13%	30.00%	32.15%	30.67%	27.84%	28.55%
Non-disabled staff	26.8%	23.44%	27.56%	25.74%	25.29%	21.62%	19.46%

Metric 7

This metric looks at the percentage of disabled staff compared with non-disabled staff saying that they are satisfied with the extent to which the organisation values their work (Q4b).

	2018	2019	2020	2021	2022	2023	National Average 2023
Disabled staff	29.1%	32.48%	30.12%	28.85%	32.42%	30.43%	35.66%
Non-disabled staff	40.8%	44.13%	44.30%	40.20%	41.23%	42.93%	47.19%

Metric 8

This metric is also taken from the national staff survey results and seeks to identify the number of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work (Q28b)

	2018	2019	2020	2021	2022	2023	National Average 2023
Disabled staff	66.5%	72.9%	75.4%	70.2%	71.1%	70.8%	70.9%

Metric 9

This metric is also taken from the national staff survey results and comprises of two elements:

a) The staff engagement score for disabled staff, compared to non-disabled staff and the overall staff engagement score for the organisation.

b) Has the Trust taken action to facilitate the voices of disabled staff in the organisation being heard?

Part a - Staff Engagement Scores

	2018	2019	2020	2021	2022	2023	National Average 2023
Disabled staff	6.3	6.39	6.45	6.28	6.26	6.19	6.46
Non-disabled staff	6.8	6.93	6.94	6.80	6.82	6.86	7.04

Part b

A number of actions have taken place to facilitate the voices of disabled staff.

The Trust has a WUTH Sunflowers staff network for staff with disabilities and long-term conditions. The network has two staff network co-chairs and an Executive Partner. That said, there have been some challenges this year that have impacted on network members meeting together. The network has lost both co-chairs due to differing reasons and the changeover to a new intersectional meeting approach has however led to meetings being stood down due to industrial action.

An action on disability co-creation task and finish group was however established which involved a number of key stakeholders and WUTH Sunflower staff network members. Key priorities were identified and actions undertaken to ensure achievement. Engagement events were held with staff to understand experiences and key actions needed and these were the focus for 2023/24. The group has now concluded (June 2024) and a series of promotional opportunities will commence to highlight work undertaken and support available for staff and managers.

WUTH has agreed for two days per month per network to be granted for all networks, with a network toolkit developed, development plan for co-chairs and recruitment for replacement co-chairs has commenced and a budget allocated for network activities. Building capacity and capability of our network will be a focus for 2024/25.

Staff stories continue to be shared across the Trust, with a number of staff network members sharing video and written narratives, also linked to national and international awareness days e.g. Deaf Awareness Week.

Staff network members are invited to a range of different events and engagement opportunities to shape decision making and meet together to have some fun too, with invitations shared for other network activities to ensure an intersectional approach.

WUTH continues to roll out the Hidden Disabilities sunflower initiative and give badges out to staff with hidden / invisible disabilities if they want one, including on our induction programme for all new starters.

Regular communications are produced to raise awareness of key national and international awareness days and links made to areas for consideration, action needed and support services available for both staff and patients.

The Trust's equality, diversity and inclusion (EDI) strategic commitment underpins the Trust's People Strategy and seeks to ensure that EDI is a golden thread throughout all of our people practices and processes.

EDI has been embedded within our new leadership for all and management development programmes and individuals encouraged to seek support for themselves and offer support and compassionate and inclusive leadership to others.

Dedicated EDI sessions are also held as part of Manager Essential and Leading Teams programmes, with themes of Inclusive Leadership and Inclusive Recruitment delivered.

A new engagement plan has been developed and launched which aims to also support wider recognition and engagement for all staff.

Metric 10

Percentage difference between the organisations Board voting membership and its overall workforce disaggregated:

- **By voting membership of the Board**
- **By executive membership of the Board**

The Trust has 14 Board member, 12 of whom are voting members and none identify as disabled.

Conclusion

There are a number of pleasing results this year, with improvements seen in:

- Self-reporting on ESR – with more disabled staff declaring they have a disability.
- Likelihood of being appointed – disabled applicant now as likely to be appointed as non-disabled applicants.
- Experiences of bullying, harassment or abuse (BHA) by managers in the last 12 months.
- Reporting of the last experience of bullying, harassment or abuse.
- Pressure coming to work, despite not feeling well enough to perform their duties – disabled staff are feeling less pressure this year, with results now above the national average.

However, it is concerning to see a deterioration in experiences of our disabled staff, with disabled staff declaring they have experienced more bullying, harassment or abuse patients, relatives or the public and particularly concerning is that it has also increased from colleagues too. Results highlight increases from 21.87% of disabled staff in 2022 staff survey to 24.72% in the 2023 staff survey experiencing BHA from colleagues in the last 12 months.

Staff survey data also highlights a lower staff engagement score this year, with disabled staff feeling less valued by the organisation this year, with less provision of opportunities for career progression or promotion and less satisfaction with provision of adequate reasonable adjustments.

Whilst a deterioration can be seen this year in a number of the staff experience related metrics (metrics 4-8), it is still pleasing to see an improved position from commencement of the WDES metrics in 2018 with all except one metric (4b) seeing improvements.

WDES Metrics

Workforce Metrics For the following three workforce Metrics, compare the data for both Disabled and non-disabled staff.	
Metric 1	**Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.** Organisations should undertake this calculation separately for non-clinical and for clinical staff. Cluster 1: AfC Band 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, Non-consultant career grade Cluster 7: Medical and Dental staff, Medical and dental trainee grades **Note:** Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.
Metric 2	**Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.** **Note:** i) This refers to both external and internal posts. ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.
Metric 3	**Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.** **Note:** i) This Metric will be based on data from a two-year rolling average of the current year and the previous year. ii) This Metric is voluntary in year one.
National NHS Staff Survey Metrics For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff.	
Metric 4 Staff Survey Q13	**a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:** i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues **b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.**

WDES Metrics

Metric 5 Staff Survey Q14	**Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.**
Metric 6 Staff Survey Q11	**Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.**
Metric 7 Staff Survey Q5	**Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.**
The following NHS Staff Survey Metric only includes the responses of Disabled staff	
Metric 8 Staff Survey Q28b	**Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.**
NHS Staff Survey and the engagement of Disabled staff For part a) of the following Metric, compare the staff engagement scores for Disabled, non-disabled staff and the overall Trust's score For part b) add evidence to the Trust's WDES Annual Report	
Metric 9	**a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.** **b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)** **Note: For your Trust's response to b)** **If yes,** please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. **If no,** please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance.
Board representation Metric For this Metric, compare the difference for Disabled and non-disabled staff.	
Metric 10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.

Appendix ii

2023/24 WDES Indicator Summary of Indicators Compared to Regional and National Comparators

WDES Indicator			National Average 2023 where available / Aim	WUTH 2021	WUTH 2022	WUTH 2023
1	% of disabled staff			2%	2.8%	3.6%
2	Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts		1	1.8	1.3	1.19
3	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. This metric is based on data from a two-year rolling average of the current year and the previous year		1	0	0	0
4a.1	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**Disabled**	**29.83%**	**27.5%**	**28.63%**	**28.83%**
		Non-Disabled	23.11%	22.6%	21.7%	20.17%
4a.2	% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	**Disabled**	**15.33%**	**18.6%**	**15.88%**	**14.98%**
		Non-Disabled	8.56%	11.6%	9.9%	9.32%
4a.3	% of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months	**Disabled**	**25.26%**	**25.2%**	**21.9%**	**24.72%**
		Non-Disabled	16.12%	17.5%	14.9%	16.25%
4b	% of staff saying that the last time they experienced bullying, harassment or abuse at work, they or a colleague reported it	**Disabled**	**50.64%**	**51.3%**	**53.0%**	**53.07%**
		Non-Disabled	49.31%	46.3%	47.3%	49.32%
5	% of staff believing that the Trust provides equal opportunities for career progression or promotion	**Disabled**	**51.54%**	**45.8%**	**52.5%**	**51.12%**
		Non-Disabled	57.52%	56.6%	58.1%	57.72%
6	% of disabled staff compared to non-disabled staff who say that they have felt pressure coming to work, despite not feeling well enough to perform their duties	**Disabled**	**28.55%**	**32.2%**	**30.7%**	**27.84%**
		Non-Disabled	19.46%	25.7%	25.3%	21.62%
7	% of disabled staff compared with non-disabled staff saying that they are satisfied with the extent to which the organisation values their work.	**Disabled**	**35.66%**	**28.8%**	**32.4%**	**30.43%**
		Non-Disabled	47.19%	40.2%	41.2%	42.93%
8	% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work	**Disabled**	**73.38%**	**70.2%**	**71.1%**	**70.79%**
9a	Staff engagement score	**Disabled**	**6.46**	**6.3**	**6.3**	**6.2**
		Non-Disabled	7.04	6.8	6.8	6.86
9b	Has the Trust taken action to facilitate the voices of disabled staff in the organisation being heard?		N/A	Yes	Yes	Yes
10	Board membership			+3.6	-2.8%	-4%

Key:

- Improved from last year and above the national average
- Improved from last year however below the national average **or** reduced from last year however above the national average
- Reduced from last year and below the national average

Appendix iii

WDES Action Plan for 2024-25

Elements		Action	Responsibility	Deadline
Seek to Understand	1	Develop process of regular recruitment audits of processes for under-represented areas / roles to understand challenges / barriers or areas of potential bias	Recruitment / SL	30/09/2024
	2	Enhanced review of 2024 staff survey results to understand potential impact of action on disability co-creation group and associated actions.	SL	31/03/25
	3	Develop a process to identify and triangulate data relating to incidents/concerns and employee relations case linked to protected characteristics	TN / SL	31/12/24
Support	1	Build capacity and capability of Trust staff networks, with appointment of new co-chairs and re-establishment of regular meetings.	SL / Exec Partners	31/03/2025
	2	Enhanced promotion of support available, including staff network, access to work and examples of reasonable adjustments and health passport for staff	DG / SL / Sunflowers	31/03/25
	3	Continue to encourage staff to enter/update personal information via ESR self-service, with guidance documents and support offered to complete.	Comms / Workforce Information / SL	31/03/25
Educate and Develop	1	Visible Respect at Work campaign to promote zero tolerance to bullying, harassment or abuse within the workplace	HR / H&S	Ongoing
	2	Deliver education and training sessions to promote key priorities e.g. Deaf awareness, neurodiversity awareness and general advice and support for manager	SL / DG	31/03/25
	3	EDI training to support leaders in understanding how to ensure WUTH is an anti-racist organisation and upholds the principles of the sexual safety charter.	CPO	31/03/25
Celebrate and Promote	1	Annual calendar of events to ensure proactive celebration of diversity and raising awareness of key EDI events / festivals/ awareness days sharing staff experiences and linking external / internal support mechanisms to aid and enhance understanding and support	SL	Ongoing
	2	Promoting WUTH as an inclusive employer that celebrates diversity and harnesses individuality	SL / Comms / Recruitment	Ongoing
	3	Launch and promote actions completed by the Action on Disability Co-Creation group	SL / DG	31/08/24

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 10**

04 September 2024

Title	2023-2024 Annual Submission to NHS England Northwest Appraisal and Revalidation
Area Lead	Dr Nikki Stevenson, Medical Director & Deputy CEO
Authors	Dr Catherine Hayle, Medical Appraisal Lead & Cheryl Chaffe, Medical Appraisal & Revalidation Manager.
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is to provide assurance to the Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for quality visits to Designated Bodies.

WUTH has a process in place for appraisal of senior medical staff which is quality assured and compliant with the Annual Organisational Audit (AOA) standards monitored by NHS England. This report refers to the appraisal year April 2023 - March 2024.

It is recommended that the Board:

- Approve the report

Key Risks

This report relates to these key risks:

- None to note.

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
5th July 2024	Responsible Officer Meeting	As above	As above
19th July 2024	People Committee	As above	As above

1	**Narrative**
1.1	On an annual basis, Designated Bodies have been required to complete an Annual Organisational Audit (AOA) which is an element of the Framework of Quality Assurance for responsible officers. Each designated body is expected to submit a report to their own board or equivalent management team; where a Responsible Officer and supporting team have responsibility for more than one designated body, separate reporting is required to ensure each board is sighted on the information specific to their organisation. In essence, one separate report should be completed for each individual Designated Body as registered with the General Medical Council. Attached at Appendix 1 is the report due to be submitted on behalf of WUTH. The report has been designed to: • Help the designated body in its pursuit of quality improvement • Provide the necessary assurance to the higher-level responsible officer, and act as evidence for CQC inspections. • This template for an Annual Submission to NHS England Northwest is used as evidence for the Board of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to own board report where a local template exists, to give clear guidance on the structure, roles and process to deliver an appraisal system which is quality assured and fit for revalidation. Appraisal is underpinned by continuing professional development and if used properly can help to develop a reflective culture within service and training. Regular successful annual appraisal will provide the foundation stone upon which a positive affirmation of continued fitness to practice can be made every five years by the doctor's Responsible Officer to the General Medical Council. For the individual, appraisal is based on the domains in "Good Medical Practice" (General Medical Council) [1]. This describes the standards of competence, care and conduct expected of doctors in all aspects of their professional work. These seven domains are: • good clinical care • maintaining good medical practice • teaching and training • relationship with patients • working with colleagues • probity

	• health To be revalidated a doctor must collect a folder of supporting information, participate in annual appraisal in the workplace and collect independent feedback from colleagues and patients (where applicable). This multi-source feedback or 360 degree feedback must be completed at least once in a 5 year revalidation cycle. The doctor must declare all the roles they have and organisations they work in as the appraisal must cover all aspects of their work (Whole Practice Appraisal). Supporting information must be provided for all roles so that the appraiser can review this. This is the appraisal process which over a five year period will enable the Responsible Officer to make a positive recommendation of fitness to practise to the General Medical Council.
1.2	The statement of compliance should be signed off by the Chief Executive of the Designated Body's Board and submitted by 31st October 2024.

2	Implications
2.1	**Patients** • This document focuses on assurance and improvement of professional standards processes for doctors, plus a responsibility to undertake continuous quality improvement to enhance patient care. Equality, diversity, and inclusion are at the centre of the Good Medical Practice. www.gmc-uk.org/guidance
2.2	**People** • The Responsible Officer has a duty under the RO regulations to assure and improve professional standards function for doctors with whom they hold prescribed connections.
2.3	**Finance** • Ongoing funding will be required to maintain the electronic revalidation management system (L2P) which was implemented in June 2022.
2.4	**Compliance** • The Framework of quality assurance and improvement will help the RO and organisation to provide assurance that our professional standards processes meet the relevant statutory requirements and support quality improvement.

NHS England North West
Medical Directorate
Professional Standards Team

2023-2024 Annual Submission to NHS England North West:

Framework for Quality Assurance and Improvement

This completed document is required to be submitted electronically to NHS England North West at england.nw.hlro@nhs.net by **31st October 2024**.

As this is a national deadline, failure to submit by this date will result in a missed submission being recorded. We are unable to grant any extensions.

2023-2024 Annual Submission to NHS England North West:

Appraisal, Revalidation and Medical Governance

Please complete the tables below:

Name of Organisation:	Wirral University Teaching Hospital, NHS Foundation Trust.
What type of services does your organisation provide?	Wirral University Teaching Hospital is a busy Acute NHS Foundation Trust. The Trust comprises of Arrowe Park and Clatterbridge Hospitals, and the Wirral Women and Children's Hospital.

	Name	**Contact Information**
Responsible Officer	Dr Nicola Stevenson	n.stevenson2@nhs.net Direct dial: 0151 604 7710 Internal extension: 8912
Medical Director	Same as above	
Medical Appraisal Lead	Dr Catherine Hayle	catherine.hayle@nhs.net Direct dial: 0151 552 1892 Internal extension: 8656 (Palliative Care) 2740 (Appraisal & Revalidation)
Appraisal and Revalidation Manager	Cheryl Chaffe	cheryl.chaffe@nhs.net Medical Appraisal & Revalidation Team. Ext:2740 DD 0151 604 7461
Additional Useful Contacts	Anita Kane Medical Staff Appraisal Coordinator	anitakane@nhs.net Appraisal and Revalidation Team DD 0151 604 7461

Service Level Agreement

Do you have a service level agreement for Responsible Officer services?

Yes

If yes, who is this with?

Organisation: Wirral Hospice St John's.

Please describe arrangements for Responsible Officer to report to the Board:

Dr Stevenson is also Responsible Officer for Wirral Hospice St John's. An RO Board Report is prepared each year, in collaboration with the Medical Director of Wirral Hospice St John's (Dr Emma Longford). Dr Stevenson visits Wirral Hospice St John's periodically to meet with Dr Longford and review the Hospice's clinical governance processes.
Date of last RO report to the Board: November 2023

Action for next year: None required.

Annex A

Illustrative designated body annual board report and statement of compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance before completing.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 – Summary and conclusion
Section 4 – Statement of compliance

Section 1: Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of Wirral University Teaching Hospital, NHS Foundation Trust.
can confirm that:

1A(i) an appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	1 April 2023 – 31 March 2024). Ongoing engagement with RO Network events.
Comments:	Dr Stevenson remains in post. Dr Stevenson has accessed all necessary training and engages regularly with the Responsible Officers Network via NHSE/I North as well as the GMC RO Reference Group.
Action for next year:	Ongoing engagement with RO Network events.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	N/A
Comments:	We have a well-resourced Appraisal & Revalidation Department, comprising the Medical Appraisal Lead (3PA), Appraisal & Revalidation Manager (1.0 WTE), 3 Senior Appraisers (1PA each) and an Appraisal Administrator (0.6WTE).
Action for next year:	N/A

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	N/A
Comments:	The Trust Workforce Information Dept provides a monthly starter & leavers report taken from ESR to ensure accuracy. The Recruitment team also provide the A&R dept a weekly starters report taken from Trac for all medical starters, in addition a monthly pipeline report is run at the beginning of every month. With the above processes in place a SOP has been created for accurately managing connections, which are reviewed at least monthly.
Action for next year:	To continue to monitor agreed processes.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	N/A
Comments:	WUTH's Senior Medical Staff Appraisal Policy was updated, ratified, and approved in 2023. All appraisers and doctors were informed of the changes to the policy via email, and in-person updates at Appraiser Support Groups. The Medical Appraisal Lead speaks to Medical Board annually and sought feedback on proposed changes in advance. A copy was emailed to all senior medical staff and uploaded on the Trust

	Intranet site, also under the resource section of L2P. The policy is regularly monitored for accuracy along with local processes and standard operating procedures (SOPs).
Action for next year:	None

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	To reinstate the quality assurance process for appraiser performance through appraiser performance excellence tool.
Comments:	We have reinstated the quality assurance process for appraiser performance using our excellence tool. A SOP has been produced and agreed to ensure consistency of quality assurance. This covers performance reviews of new appraisers and annual reviews of trained appraisers. We have close links with Clatterbridge Cancer Centre and provide appraisal training for their appraisers.
Action for next year:	We will carry out a review of our departmental processes against the Framework of Quality Assurance for Responsible Officers and Revalidation.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	To create an ARCP SOP.
Comments:	The ARCP SOP has been completed, discussed, and ratified at the Medical Education Oversight Group. The A&R Team has joined together with the Medical Education team to deliver a joint education session for our locally employed doctors. Locally Employed Doctors (LEDs) within WUTH participate in an Annual Review of Competency Progression (ARCP) as part of yearly appraisal process. This includes review of consultant supervisor report, personal development plan, participation in CPD, reflection on clinical cases (including clinical incidents if applicable) and learning events attended, yearly multi-source feedback, participation in quality improvement and review of mandatory training. Additionally, if in revalidation year, a patient survey. LEDs receive induction through medical education department and subsequent local departmental induction processes.
Action for next year	A&R team will continue to work closely with the Trust Medical Education team to ensure all doctors are included in their appropriate appraisal system.

	Review feedback from the joint delivered education session for our locally employed doctor and consider any updates to the programme appropriately.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a General Medical Council (GMC) licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	N/A
Comments:	The doctor must declare all the roles they have and organisations they work in, as the appraisal must cover their whole scope of work (i.e., a whole practice appraisal). Supporting information must be provided for all roles. Doctors should maintain an evidence log or portfolio relating to their whole scope of practice and use this to populate their appraisal documentation. The A&R Team will upload risk management reports for each doctor. The report covers a two-year window detailing any reported incidents, complaints, and legal claims. Evidence for external roles must also be provided, if not included in appraisal documentation the appraisal will be referred back until provided. If a doctor has been involved in a clinical incident or received a complaint relating to their practice, they should provide a written reflection on this in advance of the appraisal meeting. If this is not done, a verbal reflection within the appraisal meeting must be carefully recorded by the appraiser. Any doctor undergoing an MHPS investigation, GMC investigation or participating in a grievance procedure will be asked to reflect on this in their appraisal. The appraisal also offers an important opportunity to ensure that doctors going through these often-stressful processes are provided with the appropriate level of support.
Action for next year:	

1B(ii) Where in question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	N/A
Comments:	If the appraisal cannot go ahead within the timescales described in the Trust policy, the A&R Team are informed as soon as possible. The Medical Appraisal Lead will consider whether the appraisal month should be adjusted (due to exceptional circumstances), or whether an 'approved missed' appraisal should be recorded (e.g., due to sickness absence or maternity leave). Detailed records are kept by the A&R Team in relation to delayed and missed appraisals. If it becomes apparent during the appraisal that there is a serious health, performance or conduct issue (not previously identified) that requires further investigation, the appraisal meeting is stopped. The appraiser confirms the reason why the meeting is being stopped, and that the matter will be referred to the CL, AMD or the Medical Director/RO immediately. The Medical Appraisal Lead or a Senior Appraiser may also be informed. Maintaining the safety of patients, the doctor and other staff members is paramount. It is crucial that the doctor is provided with immediate support from their line manager (or other appropriate medical manager), a trusted colleague or mentor, and healthcare services as appropriate (including Occupational Health).
Action for next year:	None

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	Review and update Senior Medical Staff Appraisal.
Comments:	Senior Medical Staff Appraisal - Policy Reference: 215 Ratified By: Joint Local Negotiating Committee, February 2023. .
Action for next year:	None

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	
Comments:	WUTH has 70 trained medical appraisers. All appraisers attend a locally delivered one-day training course before they can appraise. Training days are scheduled twice a year to ensure appraiser capacity is maintained. The current ratio at WUTH is 5.60 appraisal per year for each trained appraiser.
Action for next year:	To maintain delivery of Appraiser Training Workshops twice a year. To continue to invest in quality CPD opportunities for Medical Appraisers.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality assurance of medical appraisers or equivalent).

Action from last year:	N/A
Comments:	There are several quality assurance and performance measures in place under the WUTH system. The appraiser's outputs are reviewed by either a senior appraiser or the medial appraisal lead for Appraisal and Revalidation for quality, and to assess for revalidation, feedback is given as appropriate. All appraisers receive an excellence tool review annually, in addition to a performance review report. This should be used as supporting information in the appraiser's own appraisal. New appraisers undergo a face-to-face performance review with a senior appraiser after their first three appraisals and are observed once by the A&R Manager. All appraisers must attend at least one of the two ASG meetings annually. Quality CPD is provided at least twice a year at the Trust's Appraiser Refresher Training days, of which all appraisers are encouraged to attend. The same day is run twice to maximise attendance.
Action for next year:	Training and Development: Provide regular training, quality CPD opportunities and updates for our Medical Appraisers.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	N/A
Comments:	An annual report is presented at Trust Board each year, and progress is reviewed monthly at the monthly Responsible Officer's meeting.
Action for next year:	None

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	N/A
Comments:	GMC Connections are monitored regularly by the Trust's A&R Manager via GMC Connect. Revalidation dates are also recorded on L2P and flag on the L2P dashboard via a traffic light system. Revalidation evidence is reviewed 4 months in advance of submission date with the RO to ensure timely recommendations are submitted.
Action for next year:	None

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	
Comments:	Revalidation evidence is reviewed 4 months in advance of submission date with the RO to ensure timely communication. If a deferral is suggested, reasons are recorded and the doctor is written to inviting to meet and discuss with the MAL prior to the recommendation being submitted. During this meeting an action plan will be put in place to support the doctor take the appropriate action.
Action for next year:	None

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	N/A
Comments:	Annual audit plan, Mandatory training, incident reporting system with a high reporting culture, active risk management with BAF regularly updated. Quality Improvement training and QI programme. Annual appraisal for all permanent medical staff. Freedom to speak up champions embedded and a commitment from the Trust Board to leadership development and creating an open and honest culture.
Action for next year:	None

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	N/A
Comments:	The Trust has a policy in place - Procedure for handling concerns about the conduct, performance and health of medical and dental

	staff'. This implements the framework as set out in 'Maintaining High Professional Standards in the Modern NHS', issued under the direction of the Secretary of State for Health on 11 February 2005. This policy has been agreed between the Trust and the Local Negotiating Committee outlining the Trust's procedure for handling concerns about doctors' and dentists' conduct and capability. The Trust has a Responsible Officer Advisory Group (ROAG) which reports to the People Committee via the Head of HR. The statutory responsibilities remain with the Responsible Officer with regards to the Medical Workforce. This relates to the appraisal, revalidation, and fitness to practise concerns. The Responsible Officer (RO) has a key role in ensuring the effective implementation of the Responsible Officer Regulations in their designated body. The advisory group will support the role of the RO and provide the opportunity for greater calibration of decision-making and the involvement of lay members. The group will provide input to the decision-making with regard to appraisal, revalidation recommendations, performance concerns about doctors, employment processes and any other aspects relevant to the RO Regulations. Since it is an advisory group, final decisions rest with the RO. The Responsible Officer Advisory Group will consider key items requiring decision-making to support the role of the RO, including: Concerns regarding a doctor and the application of the Trusts MHPS or other, relevant policies, including but not limited to: • Police investigations • Safeguarding • Behaviour/Conduct • Fitness to practise • Health matters • Capability The Appraisal and Revalidation Team are made aware of any concerns regarding an individual doctor during the monthly RO Meeting and they ensure that this is covered during their appraisal. Furthermore, if required, a letter is sent from the RO requiring the individual to reflect on a specific incident or concern, this is uploaded on to their appraisal record in L2P.
Action for next year:	

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	
Comments:	The A&R team populate L2P six weeks in advance of the appraisal month with relevant appraisal Trust reports; i.e, Risk Management / Research reports. The appraisal platform is web based and accessible to doctors to populate at any time.
Action for next year:	

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	
Comments:	Procedure for handling concerns about conduct, performance, and health of Medical and Dental staff – reviewed and up-dated 24th June 2022, next review – 24th June 2025 Medical Staff Remediation Policy (Medical Staff) – published in 14th February 2024 and is currently under review. ROAG meet quarterly and extraordinarily if required.
Action for next year:	Review and publish the Medical Staff Remediation Policy

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	N/A
Comments:	The Procedure for Handling Concerns about the Conduct, Performance and Health of Medical and Dental Staff has been reviewed and updated. The policy sets out the role of the RO Advisory Group, who meet

	quarterly. The policy is consistent with the application of 'just culture principles'. Between 1 April 2023 to 31 March 2024 there were no MHPS investigations. Therefore, a meaningful analysis is not possible.
Action for next year:	None

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	N/A
Comments:	Under WUTH Policy, information flows to support governance and Responsible Officer Statutory Function are facilitated by the A&R Team via the NHS Medical Practice Information Transfer form. A welcome letter is sent out to all new doctors joining the Trust from the RO informing them of the specific responsibilities to obtain information about doctors taking up new posts and as such, the need to formally request confirmation of the following details from their previous Responsible Officer: • Revalidation date • The date of your last appraisal • Any previous concerns that have now been resolved • Any current investigation about your practice in progress • Any current restrictions on practice Any unresolved actions/referrals in relation to the GMC
Action for next year:	None

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (reference GMC governance handbook).

Action from last year:	N/A
Comments:	All serious concerns are raised with the RO as per the WUTH MHPS Policy and discussed at the Responsible Officer Advisory Group (ROAG). The Trust MHPS Policy was recently updated in May 2022 and is consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology is applied that provides for full and careful consideration of context and prevailing factors when determining next steps. Formal meetings are supported by HR for example support management to ensure reasonable adjustment are in places as required and help identify and remove barriers which may impact on

	engagement. Policies and practices are also reviewed in line with current and emerging EDI challenges and risks. The Trust has an incident reporting process where any concerns raised including concerns raised via Appraisal and Revalidation process are investigated. The Trust has Safeguarding, LADO (Local Authority Designated Officer) in place and staff are made aware that they can raise concerns via this route.
Action for next year:	None

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, for example, from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture (give example(s) where possible).

Action from last year:	N/A
Comments:	WUTH has policies in place to ensure we are compliant with national guidelines. Regular Clinical Advisory Group that reviews latest guidance/ reports and incorporates learning into Trust policies and procedures. Annual appraisal for all doctors where CPD is reviewed and a PDP set for following year based on individual and organisational development needs.
Action for next year:	

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (reference Messenger review).

Action from last year:	N/A
Comments:	WUTH recognises the importance of an effective induction for all new employees into the Trust. A structured induction programme consisting of both Corporate and Local induction elements ensures that new employees receive the essential information they require to enable them to operate effectively as quickly as possible and in doing so ensures their safety, the safety of patients and minimises the risk to the organisation. Our Trust values and expected behaviours are emphasised throughout. The Trust believes that harnessing the talents of our workforce is essential to providing the best care and being a great place to work. Since the launch of our People Strategy in 2022 we have invested in talent management and development in a range of ways, all aligned to our Leadership for All principle. Leadership for All means that every member of staff in the Trust has the potential to develop and display the qualities that make great leaders at WUTH. The Trust's Leadership Development programme is inspired the principles of 'Leadership for All' and aligned to our Leadership Qualities Framework (LQF) our leadership development programmes offer something for everyone. • Leading Self Programme: Cultivate self-awareness, the cornerstone of effective leadership. • Leading Team: Unite and inspire colleagues. • Leading Service Programme: Elevate patient care with excellence. • Leading Organisation Programme: Thinks strategically and act decisively. • Leading System Programme: Collaborating for system transformation. • Management Essentials: Foundation knowledge and skills for all managers. • Leadership Master Class: Bitesize development opportunities from a diverse range of experts. Good quality appraisal and check in conversations help our staff to identify development needs and aspirations. There is a huge offering that staff can choose from to meet their needs. Based on staff feedback, and in response to the findings in the 2022 staff survey, a collaborative team of people from different parts of the workforce have come together and designed an approach to Appraisal and Management Supervision (Check In) that focusses on Contribution, Wellbeing and Development. The process is person centred, with lots of flexibility, enabling meaningful discussions about performance in the areas that most matter. The EDI strategic commitment has also

	been developed to ensure an inclusive, welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported, and celebrated, as referenced further in this report under section 1F(ii). As we continually strive to be a high performing Trust we follow the NHS England, Executive Support Offer Guidance, for senior leadership onboarding and support. Exploring national onboarding resources that have been curated for newly appointed Chairs and Non-Executive Directors. These resources are designed to support senior leaders in developing leadership in a complex and changing landscape.
Action for next year:	Trust Strategy: Priorities and Actions for 2024 / 25 • Play the leading role in system work, across Wirral Place and ICB footprints, including enhancing the interface between primary and secondary care • Examine and implement partnership and integration opportunities with local NHS providers, to support service delivery and improvements in clinical care provision across Wirral and Cheshire and Merseyside • Develop and embed governance to support partnership working and integration of services, with local partners • Continue to develop our relationships and activities with local and regional universities, supporting research, innovation and education • Drive the continued delivery of the Cheshire and Merseyside Surgical Centre, working with partners to increase use • Deliver year three of Estate and Capital Strategy, including year 2 of the Trust's Green and Sustainability Plan • Develop model for future clinical service provision across hospital campuses and future service locations • Develop options to utilise community space and provision to support access to services and improve space utilisation across Wirral NHS providers and Wirral Council • Continue to delivery the Urgent and Emergency Care Programme • Deliver capital programme to timetable and budget • Continue to work with partners to improve access to hospital campuses for patients and visitors.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	Full review of the Safe Employment Policy (192).
Comments:	As a result the introduction of the Safe Recruitment and Selection Policy (392) and the revised Safe Employment Policy (136) reflects WUTH's commitment to maintaining high standards of safety, fairness, and transparency in its employment practices. By aligning these policies with NHS Employers guidelines and vetting requirements, WUTH ensures the recruitment and retention of competent and trustworthy staff, ultimately contributing to the provision of high-quality patient care. Through the Safe Recruitment and Selection Policy Wirral University Teaching Hospital (WUTH) adheres to the NHS Employers recruitment guidelines and vetting check requirements, ensuring all recruitment processes align with national standards. Conditional Employment Offers: After interviews, all employment offers at WUTH are made on a conditional basis. This means that offers are contingent upon the completion and verification of all necessary checks within the Trust before new employees can commence their posts. Minimum Standards for Safe Employment: The Safe Recruitment and Selection Policy (392) outlines the minimum standards for due diligence in terms of safe employment, ensuring comprehensive pre-appointment screening. The standards include: Satisfactory References: Obtaining and verifying references from previous employers to assess the candidate's work history and reliability. Occupational Health Clearance: Ensuring candidates are medically fit to perform the role through health assessments. Qualification and Professional Registration Checks: Validating the candidate's educational qualifications and professional registrations to confirm their eligibility for the role. Disclosure & Barring Service (DBS) Clearance: Conducting DBS checks to ensure candidates are suitable to work in environments involving vulnerable groups. Legal Right to Work in the UK: Verifying that candidates have the legal authorisation to work in the UK. WUTH's Safe Recruitment and Selection Policy (392) sets rigorous pre-appointment standards to ensure the safety and reliability of all employees. By adhering to NHS Employers guidelines and conducting thorough checks on all new and temporary staff, WUTH maintains high standards of care and safety within the organisation. Wirral University Teaching Hospital (WUTH) is committed to the continuous review and improvement of its pre-employment practices. This ongoing process ensures that the recruitment and selection procedures remain robust and effective, aligning with the latest standards and requirements.
Action for next year:	To maintain compliance with the evolving legal and regulatory landscape, WUTH will: Regular Policy Reviews: Conduct periodic reviews of the Safe

	Recruitment and Selection Policy (392) and the Safe Employment Policy (136) to identify areas for improvement and ensure they reflect current best practices and legal requirements. Legislative Updates: Monitor changes in employment legislation, NHS Employers guidelines, and other relevant regulatory updates. This proactive approach will ensure that any new legal requirements are promptly incorporated into the Trust's policies and procedures. Stakeholder Involvement: Engage with key stakeholders, including HR personnel, legal advisors, and department managers, to gather insights and feedback on the effectiveness of current policies and identify any gaps or areas needing adjustment. Training and Development: Provide regular training and updates for HR staff and managers involved in recruitment. This will ensure they are well-informed about any changes in legislation and understand how to implement new requirements effectively.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	N/A
Comments:	The Trust attaches the greatest importance to the continuing education and training of its professional staff and values education as an integral part of delivering excellent care. The Trust has a study / professional leave policy for medical staff. There is a robust system in place across all specialties to manage requests for study/ professional leave in line with Trust policy. The Director of Education (DME) is supported by the deputy DME and three Clinical Tutors work alongside Educational Supervisors and Senior Clinicians, to ensure all training grade staff receive the support and guidance they require. Teaching sessions are run within the Education Centre, in addition to a full lunchtime teaching programmes open to all postgraduate trainees. The hospitals Clinical Skills Lab offer dedicated training programmes to all trainees. An OD Development Programme has been launched in 2024 which is available to all clinical leaders. Training days have been scheduled covering the below topics. • Essentials for Management

	• Duty of a Doctor Programme WUTH encourages a wide range of general and professional training opportunities for all our staff. For all the many and varied educational events taking place we have excellent facilities spread across the two sites of Arrowe Park Hospital and Clatterbridge Hospital. As a Trust we want to make sure everyone has access to leadership development, so we have created a Leadership Qualities Framework (LQF). This Framework will provide the basis for our extensive development opportunities, not only for staff in management roles, but for all staff to be able to broaden their personal leadership skills or who aspire to progress into a management role. We want to nurture our future leaders and ensure we grow and support leadership talent. WUTH Improvement launched as an approach to team-working for our Trust's ambitious programme of developing services, patient experience, clinical quality, and ways of working. This project comprises of three teams handing different aspects of service transformation, quality improvement, efficiency and change projects across the Trust.
Action for next year:	Complete Medical Engagement Survey.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	N/A
Comments:	A number of aspects are in place at WUTH including: • Trust core values are 'Caring for everyone', 'Respect for all', 'Embracing Teamwork' and 'Committed to Improvement'. These were developed following extensive engagement with staff across the organisation, with behavioural expectations of our staff, also developed and regularly promoted. • Trust core values are embedded in all aspects of the Trust, including recruitment and selection processes – with interview questions to be aligned to our values and behaviours • The Trust People Strategy 2022 – 2026 is underpinned by the Core values and NHS People Plan with equality, diversity and inclusion embedded as a golden thread. An EDI strategic commitment has also been developed to 'ensure an inclusive, welcoming environment, where everyone feels a sense of belonging and the diversity of our staff is valued, supported and celebrated'. • A leadership qualities framework has been developed which comprises of a suite of programmes aimed at leaders of all level 'leadership for all'. The framework focusses on key themes of supporting leaders to become 'compassionate and inclusive', 'self aware', 'transformational', 'outcome focussed' and 'enabling people', to support and develop leaders in role modelling the required behaviours and supporting others to do the same. Dedicated EDI sessions are held on all leadership and management programmes, with an introduction to EDI also contained on our induction programme for all new starters. • A robust governance structure is in place for monitoring and reviewing progress of the EDI agenda and shaping the Trust's future direction and key priorities. From a workforce perspective, this includes the EDI Steering Group that comprises of a range of key stakeholders to lead and shape the EDI agenda, with biannual EDI update reports shared with the group on a variety of key areas including national and statutory reporting regulations, Public Sector Equality Duty and activities to advance the EDI agenda at WUTH. The EDI Steering Group feeds into the Workforce Steering Board, with final assurance and oversight provided by the People Committee. Biannual reports are shared at Board meetings, with Board seminars held to focus on key areas of focus. Five staff networks are also currently in place, to allow additional opportunities for staff feedback to be shared as part of the EDI steering group. As part of the Trust's People Strategy, a focus was placed on supporting

	staff with disabilities and long-term conditions for 2023-24. As such, an additional Action on Disability Task and Finish group was established and also reported progress into the EDI Steering Group. • From a patient perspective, EDI is also integrated within the Trust's Patient Experience Strategy, with Inclusion identified as one of its main pillars. As part of this strategy, a number of task and finish groups have been established to focus on key priorities, all feeding into an Inclusive Promise Group. This group is accountable to the Patient and Family Experience Group which reports into a wider Patient Safety and Quality Board and is included as part of the biannual EDI update to Board. • An Annual EDI calendar of events is maintained with regular Trust-wide promotion of information, support, activities and events. • Staff experiences are also monitored via the annual staff survey and quarterly pulse surveys and as part of a range of engagement and feedback events held across the Trust. • A new staff engagement framework has been developed, with enhancements made in our staff recognition schemes. Compassion, respect diversity and inclusion have been integrated as part of the criteria for our annual awards, with a new dedicated EDI award category introduced this year. A new monthly staff recognition scheme has also been launched, with areas also included as part of the criteria. • All staff must also complete their mandatory training module on equality and diversity, with compliance monitored and currently achieving compliance.
Action for next year:	Continue as above

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	N/A
Comments:	At WUTH, we are committed to achieving the highest possible standards of service for the benefit of our patients and staff. However, where standards are not meeting demands, we expect staff to be able to raise concerns. We are supportive of colleagues who have concerns regarding possible dangers, risks, wrongdoing, or malpractice in the workplace. Therefore, we promote an open and transparent culture which encourages staff to act promptly, and report concerns appropriately.

	We have a number of support mechanisms for staff who would want to raise a concern, all of which are outlined in the Trusts Raising Concerns Policy. This policy is for all staff. The NHS People Promise commits to ensuring that 'we each have a voice that counts, that we all feel safe and confident to speak up and take the time to really listen to understand the hopes and fears that lie behind the words'. Trust employees are required to complete the eLearning modules on speaking up, which can be found within their electronic staff record (ESR). In relation to our Freedom to Speak Up (FTSU) processes: • The Trust has a Lead FTSU Guardian with a network of FTSU champions in place. • A tracking system is in operation by the Lead FTSU Guardian who monitors a range of elements, including the number and themes of people speaking up, occupational groups, demographics and whether there are patient safety concerns, elements of bullying, harassment or abuse and whether staff have suffered detriment as a result of speaking up. This data is monitored regularly for themes and trends and forms part of a lessons learned forum, where data is triangulated with other sources to identify wider areas of learning or intervention needed. • Biannual FTSU reports are produced and shared as part of the Workforce Governance structure. This includes presentation by the FTSU Guardian at Workforce Steering Board, People Committee and at Board. • Regular meetings are held with the FTSU Guardian and both Executive and non-Executive FTSU Leads to review the FTSU agenda and further actions needed. • All staff must complete mandatory training that encompasses Duty of Candour along with role essential sessions on the FTSU agenda. WUTH have integrated the national learning package as part of our role essential training matrix with compliance continuing to increase. • The Lead FTSU Guardian delivers dedicated speak up sessions from induction of new recruits (including Junior Doctors) and on all leadership and management programmes. • Staff experience data is regularly reviewed, with annual staff survey data and quarterly pulse survey information reviewed and themes identified and triangulation of key areas of focus. • Regular walkabouts are undertaken by Lead FTSU Guardian and support within departments / service areas as necessary to promote speaking up. • Lead FTSU Guardian is a member of the regional and National Guardians Office forum and submits quarterly data for national review as part of agreed reporting requirements.
Action for next year:	Continue as above

1F(iv) Mechanisms exist that support feedback about the organisation'

professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	N/A
Comments:	When concerns arise, the Trust is committed to a just and learning process and recognises that the fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. An objective and prompt examination/preliminary investigation of the issues and circumstances will be carried out to establish whether there are truly grounds for a formal investigation and/or formal action. Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology is applied that provides for full and careful consideration of context and prevailing factors when determining next steps, this is clearly set out in our Trust procedure for handling concerns about conduct., performance and health. This procedure applies to all Medical and Dental staff employed by the Trust. The Trust has a formal complaints policy and procedure. The policy and procedure apply to all Trust staff responding to a concern or formal complaint about care or services delivered by the Trust.
Action for next year:	None

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	N/A
Comments:	A disciplinary register is kept of all cases. The register logs the nature of allegation, the case manager, names of investigators, welfare and support contact, a record of the case progress and outcome along with the ED&I information. The country of primary medical qualification is not currently reported via the disciplinary register however this information can be provided if required as it can be obtained from the GMC register.
Action for next year:	None

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	
Comments:	We have close links with Clatterbridge Cancer Centre and provide appraisal training for their appraisers. We also work closely with the A&R team at the Countess of Chester hospital. We recently welcomed the MAL & A&R Manager from CoCH who attended our Appraiser Training Day to observe. We routinely complete a review of our departmental processes against the Framework of Quality Assurance for Responsible Officers and Revalidation. NHS England North West RO Network events are regularly attended by the RO, MAL & A&R Manager. The A&R Manager has joined the regional A&R Network group. The group meets four times a year for 2-3 hours at various locations/via teams. Members are required to attend at least two meetings per year. The role of the Appraisal and Revalidation Managers/Administrators Network Group is: • To act as a forum to discuss issues surrounding medical appraisal and revalidation for doctors working in any health

	care environment in the region to encourage consistency in approach. • To foster and assist NHS England and the GMC's work around Medical Appraisal and Revalidation compliance and quality improvement. Keeping up to date, accessing updates via NHS England North West Professional Standards Practitioners Hub.
Action for next year:	Ongoing attendance at regional meetings, working closely with our neighboring Trusts and sharing best practice.

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 to 31 March 2024.

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	457

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	341 consultants, associate specialists, specialty doctors, senior fellows (post CCT) and locum consultants. 92 Locally Employed Doctors – ARCP process. LED doctors are overseen by the DME and Deputy DME who hold an ARCP each June / July for these doctors.
Total number of appraisals approved missed	12
Total number of unapproved missed	0

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	85
Total number of late recommendations	1
Total number of positive recommendations	82
Total number of deferrals made	3
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	3

2D – Governance

Total number of trained case investigators	9
Total number of trained case managers	10
Total number of new concerns registered	5

Total number of concerns processes completed	0
Longest duration of concerns process of those open on 31 March	0

Median duration of concerns processes closed	0
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	5

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	157
Number of new employment checks completed before commencement of employment	148

2F – Organisational culture

Total number claims made to employment tribunals by doctors	0
Number of these claims upheld	0
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	0

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
Actions outlined in last years report have been completed, except for the review of departmental processes.
Actions still outstanding
We carried out a review of our departmental processes against the Framework of Quality Assurance for Responsible Officers and Revalidation in 2018/19. We plan to repeat this during the 2024/25 appraisal year.
Current issues
Need to re-embed the full suite of QA processes, including appraisal observations, appraiser performance reviews and annual completion of the excellence tool for each appraiser.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Ongoing engagement with RO Network events. • To continue to monitor agreed processes to maintain accurate prescribe connections. • Complete review of A&R departmental processes against the Framework of Quality Assurance for Responsible Officers and Revalidation. • A&R team will continue to work closely with the Trust Medical Education team to ensure all connected doctors are included in their appropriate appraisal system. • Review feedback from the joint delivered education session for our LED's and consider any updates to the programme appropriately. • To maintain delivery of Appraiser Training Workshops twice a year. • To continue to invest in quality CPD opportunities for Medical Appraisers. • Review and publish the Medical Staff Remediation Policy.

- Employment checks, maintain compliance with the evolving legal and regulatory landscape:
    - Regular Policy Reviews: Conduct periodic reviews of the Safe Recruitment and Selection Policy (392) and the Safe Employment Policy (136) to identify areas for improvement and ensure they reflect current best practices and legal requirements.
    - Legislative Updates: Monitor changes in employment legislation, NHS Employers guidelines, and other relevant regulatory updates. This proactive approach will ensure that any new legal requirements are promptly incorporated into the Trust's policies and procedures.
    - Stakeholder Involvement: Engage with key stakeholders, including HR personnel, legal advisors, and department managers, to gather insights and feedback on the effectiveness of current policies and identify any gaps or areas needing adjustment.
    - Training and Development: Provide regular training and updates for HR staff and managers involved in recruitment. This will ensure they are well-informed about any changes in legislation and understand how to implement new requirements effectively.
- Complete Medical Engagement Survey.
- Ongoing attendance at regional meetings, working closely with our neighboring Trusts and sharing best practice.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

Our Trust Strategy for 2021-2026 was launched in January 2021, and encompasses 6 key strategic objectives:

- Outstanding care – provide best care and support
- Compassionate workforce – be a great place to work
- Continuous improvement – maximise our potential to improve and deliver best
- Our partners – provide seamless care working with our partners
- Digital future – be a digital pioneer and centre for excellence
- Infrastructure – improve our infrastructure and how we use it

We are making excellent progress with the delivery of our strategic priorities, with key priorities for 2024/5 including the following:

- Play the leading role in system work across Wirral Place and ICB footprints, including enhancing the interface and collaboration between primary, community and secondary care
- Examine and implement partnership and integration opportunities with local NHS providers, to support service delivery and improvements in clinical care provision across Wirral and Cheshire and Merseyside
- Develop and embed governance to support partnership working and integration of services, with local partners
- Continue to develop our relationships and activities with local and regional universities, supporting research, innovation and education
- Drive the continued delivery of the Cheshire and Merseyside Surgical Centre, working with partners to increase use
- Deliver year three of Estate and Capital Strategy, including year 2 of the Trust's Green

and Sustainability Plan

- Develop model for future clinical service provision across hospital campuses and future service locations
- Develop options to utilise community space and provision to support access to services and improve space utilisation across Wirral NHS providers and Wirral Council
- Continue to deliver the Urgent and Emergency Care Programme
- Deliver capital programme to timetable and budget
- Continue to work with partners to improve access to hospital campuses for patients and visitors.

In relation to appraisal and revalidation, it is positive that following a period of significant change (related to the pandemic, industrial action, new A&R Manager & administrative support), the new electronic appraisal system has embedded and that both our appraisal and revalidation rates remain high. Additionally, improved processes for supporting LEDs have been developed, as this group of doctors previously represented our highest deferral rates. Our priority for the year ahead is to re-embed the full suite of appraisal QA processes, including appraisal observations, appraiser performance reviews and annual completion of the excellence tool for each appraiser.

Section 4 – Statement of compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body	

Name:	
Role:	
Signed:	
Date:	

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 11**

04 September 2024

Title	Annual Review of Terms of Reference
Area Lead	David McGovern, Director of Corporate Affairs
Author	James Jackson-Elis, Corporate Governance Officer
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide the Terms of Reference for the Board of Directors as part of the annual review of all Terms of References.

No amends have been proposed this year and the Terms of Reference remain unchanged.

It is recommended that the Board:

- Note the Terms of Reference

Key Risks

This report relates to these key Risks:

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

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

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

1	Narrative
1.1	**Terms of Reference**

	The Terms of Reference were created last year as part of the wider corporate governance review and consolidates information already set out in the Trust Constitution. The Terms of Reference is attached at Appendix 1. No amends have been proposed this year and the Terms of Reference remain unchanged.

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

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors
Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Constitution** **Standing Orders** **Scheme of Reservations and Delegations**

Review Date: September 2024
Issue Date: September 2023
Version: 1.0
Authorisation Date: September 2023

1. Constitution

The Board of Directors is established to set the strategic direction of the Trust, to set and guide the delivery of the Trust's values, mission, and culture, and is responsible for the overall performance of the Trust. It is derived from NHS Act 2006 and as amended by the Health and Social Care Acts 2012 and 2022. This document should be read in conjunction with the Acts and the Trust Constitution.

2. Authority

The Board of Directors' authority is set out in the Trust Constitution and is derived from the legislation noted above.

It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Board within the scope of its authority.

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

In addition, the Board will establish Committees with delegated authority to carry out specific functions and may request that any item be considered first or further by a Committee.

3. Objectives and Duties

The general duty of the Board of Directors and of each Director individually is to act with a view to promoting the success of the Trust, so as to maximise the benefits for the members of the Trust and as a whole for the public.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy

- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Board and the organisation

The main duties of the Board of Directors, underpinning these three roles, are as follows:

- To set the strategic direction of the Trust within the overall policies both regionally and nationally, to define its annual and longer-term objectives, and to agree sufficiently resourced plans to achieve these
- To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary
- To ensure effective financial stewardship through value for money, financial control and financial planning and strategy, and taking approvals in line with the Scheme of Reservation and Delegation.
- To ensure that high standards of corporate governance are implemented and maintained, to support compliance with its statutory and regulatory requirements, and to support high standards of transparency, probity, and integrity in the conduct of the business of the whole Trust
- To ensure that high standards of clinical governance are implemented and maintained, to ensure clinical services are effective and safe, and take into account patient experience
- To appoint, appraise and remunerate senior Executives
- To ensure that there is effective dialogue and partnership working between the Trust and the local community on its plans and performance and that these are responsive to the community's needs

The Board of Directors delegates duties and responsibilities to Board Committees and to the Trust Executive Team in accordance with the Trust's Standing Orders, Schemes of Reservations and Delegations and Standing Financial Instructions.

4. Equality and Diversity

The Board of Directors will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches. The Board will have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Constitution requires that the Board of Directors shall consist of:

- a Non-Executive Chair; and
- not more than seven other Non-Executive Directors; and
- not more than seven Executive Directors,

At least half of the Board of Directors, excluding the Non-Executive Chair, shall at all times comprise Non-executive Directors.

One of the Executive Directors shall be the Chief Executive. The Chief Executive shall be the Accounting Officer.

One of the Executive Directors shall be the Director of Finance.

One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

One of the Executive directors is to be a registered nurse or a registered midwife.

The Trust chooses to interpret these four constitutional roles to mean the Chief Executive, Medical Director, Chief Finance Officer, and Chief Nurse.

Attendance at meetings will be monitored and shall be reported in the Annual Report.

6. Attendance

Meetings of the Board of Directors may be attended by:

- Director of Corporate Affairs
- Board Secretary
- Other officers of the Trust as requested by the Board of Directors.

Meetings of the Board of Directors shall be held in public may be attended by any member of the Trust, the public, or staff who have notified the Board Secretary in advance.

Meetings of the Board of Directors in private, held under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, may be attended by a non-Board member, only at the request of the Board.

7. Conflicts of Interest

Not withstanding the definition of material interests applicable to Directors as set out in the constitution, due consideration of interests will be regularly monitored.

Both Executive and Non-Executive Directors may not take part in any discussions or decisions which pertain to their own employment, performance, or remuneration.

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

8. Quorum and Frequency

A quorum shall be six Directors, including at least three executive Directors (one of whom must be the Chief Executive, or another executive Director nominated by the Chief Executive) and at least three non-executive Directors (one of whom must be the Chair or the Deputy Chair).

An Officer in attendance for an executive Director but without formal acting up status may not count towards the quorum.

Meetings of the Board of Directors shall be held at least three times in each financial year at such times and places that the Board of Directors may determine.

Meetings shall be open to the public unless the Board of Directors in its absolute discretion decides otherwise in relation to all or part of such meetings for reasons of commercial confidentiality or on other proper grounds. Private sessions of the Board will be held under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960.

9. Reporting

The Board of Directors will develop a Cycle of Business where scheduled items throughout the year will be presented.

The minutes of all meetings shall be formally recorded and presented to the next meeting for approval.

The agenda prior to any meeting of the Board of Directors will be provided to the Council of Governors, and a copy of the approved minutes as soon as is practicable afterwards.

The agenda and supporting papers of each meeting shall be displayed on the Trust website.

The Board has established a number of assurance Committees and will receive regular Chair's updates from those Committees.

The Trust reports activity externally through Trust's annual report and accounts. This shall be laid before Parliament annually and published in line with national guidance.

10. Conduct of Meetings

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

Authors of papers must use the standard template.

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

11. Other Committees

The Board of Directors acting as corporate Trustee has established the Charitable Funds Committee.

12. Effectiveness Review

As part of the annual performance review process outlined in the Board Effectiveness and Evaluation Policy, the Board of Directors shall review its collective effectiveness annually.

13. Review

The Board of Directors shall review its Terms of Reference as required and at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
4 September 2024

Item 12.1

Report Title	Committee Chairs Report – People Committee
Author	Lesley Davies, Chair of People Committee

Items for Escalation/Action

- There were no areas to escalate.

New/Emerging Risks

- There is a local dispute with Unite in relation the banding of 25 band 5 theatre workers. Strike action took place in April, May, June, and July. Meetings have taken place with UNITE representative to discuss a resolution to the issues and these discussions are on-going, although to date Unite have declined to participate in any of the Trust processes to review the banding of the staff group in question.

Overview of Assurances Received and Committee Activity

- The Committee had a good discussion and received good assurance on the work being carried out in relation to ensuring that staff from Black, Asian and Minority Ethic staff and those with Disabilities have a good start at the Trust and that their experience of working at the Trust is positive and that they feel valued. The 2023/24 Workforce Race Equality Standards (WRES) and the Workforce Disability Equality Standards (WDES) survey, demonstrated some mixed results, with some areas that require particular focus. Priority has been given to understanding the lived experience of our Black, Asian and Minority Ethic staff. The Chief People Officer has partnered with the Multi-Cultural Network Chair and Staff Side Equality Lead to host a series of listening events.

- The Guardian of Safe Working Report provided the committee with assurance on the exception reports submitted by Junior Doctors and Dentists at the Trust. Additional information was provided to the committee which provided good assurance that no Doctors or Dentists had individually worked excessive hours and it was good to see that no fines were levied. It was also good to learn that, in response to feedback, the Junior Doctors mess has been refurbished and expanded.

- The Safe Staffing Report provided good assurance on the Trust's oversight of the daily nurse staffing arrangements. The Trust has set its own target to ensure that patients receive 6 hours of care per patient day, and this has been achieved. However, the sickness rate of Care Support Workers (CSW) although reduced, is at 8% and the vacancy rate at 10% again is reducing but is being closely monitored. The Chief Nurse provided good assurance on the work being undertaken to ensure that the Trust's practices, its monitoring of absenteeism and the vacancy rate is being well managed, and action identified where appropriate.

- The Committee noted the consistent achievement of mandatory training target, which gives good assurance that robust systems and processes are in place in relation to this. The Committee also received assurance that scrutiny of topic specific compliance, and divisional compliance, take place via Education Group and Workforce Steering Board.

- The Committee also received the 2023/24 Annual Submission to NHS England North West: Appraisal and Revalidation which was comprehensive and areas where the Trust will concentrate its efforts for 2024/25 identified.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 12.3**
4 September 2024

Report Title	Committee Chairs Reports – Quality Committee
Author	Dr Steven Ryan, Chair of Quality Committee

Items for Escalation/Action

- Infection prevention and control- Clostridioides *difficile:* The Committee had previously requested and update on progress in our and the Wirral Place response to an NHS Northwest review into the high prevalence of Clostridioides difficile (*C diff*) in Wirral that was commissioned by NHS Place Wirral. After a substantial delay, the final report was received. The Committee had noted that though the Trust was able to progress actions entirely within its remit to prevent and control C diff acquired in hospital, it was not as well assured on the joint actions required to deal with the high prevalence in the community. A clear and helpful paper authored by the Trust's Director of Infection Prevention and Control highlighted where opportunities lay in progressing system wide action to tackle the problem. A number of actions were agreed, including the following:

    1. Sharing the Trust's position paper with the head of quality governance for Wirral Place and placing the son the agenda at appropriate quality governance meetings.
    2. Sharing our findings with the Local Medical Committee so that Primary Care are fully sighted on the issues, noting a strong appetite in local primary care for quality controls such as antimicrobial stewardship.
    3. Chief Nurse liaison with Wirral Community Health NHS FT to look at collaboration in this area.
    4. Consideration of how we use information on geographical hotspots to identify such locations for specific focus.

    The Committee will receive an update in the Autumn to monitor progress on these actions.

- A benchmarked national clinical audit report on dementia had demonstrated that the Trust was a negative outlier for the frequency of screening for delirium (a key marker for the presence of dementia) during admission of our patients. Gaps in specific leadership for this process and the recording and use of date were identified. Actions including improving data and establishing a specific working group to work on this problem are being progressed.

- The Committee received a paper on the challenges of caring for children with acute mental health and behavioural crisis on the children's ward when a more suitable care setting is not available. The Committee asked if the leaders of the children's team could attend its next meeting to gain more insight into this.

- In receiving the Learning from Deaths report the Committee was assured that processes are in place to scrutinise deaths, monitor mortality rates and promulgate learning from review of

relevant deaths. The report includes perinatal deaths (of stillborn and live born babies). It was noted that understanding a temporal cluster of stillbirths was hampered by lack of access to relevant data benchmarking stillbirth rates (The Board may remember funnel plots that had previously been available). This issue has been escalated to regionally but in the interim the service has undertaken analysis and learning and made changes including to the maternity triage process. It should also be noted that there will be changes to mortality review processes in the new year with adaptations to the national statistical analysis of mortality rates and the expansion of review of into deaths in the community by Medical Examiners.

New/Emerging Risks

- An escalated risk in relation to obstetric ultrasound was noted. This relates to the difficult in recruiting sonographers which is known to be shortage specialty. Mitigations are in place and the maternity service maintain a very high degree of surveillance for evidence of any impact.

Overview of Assurances Received

- The Committee received a substantial level of assurance in progress being made in delivering the patient Experience Strategy (2021-2026). The benefits of engaging our patients and partners from a wide-ranging and diverse community were evident and providing a large range of insights that were enabling progress to be made across a wide range of areas. Using social media, face-to-face meetings and walkabouts as well as working with local students ensured that a whole range of needs and opportunities could be identified. These include signage, improving experience for patients living with hearing difficulties and being better in providing appropriate care across our gender diverse community were good examples.

- The Committee received assurance from the intelligence report that there was learning, and action developed from the range of ways that information is gathered and triangulated at the Trust. It was possible to see down to the level of individual cases in the very detailed report. The Committee asked if a summary could be developed of the most key themes in this report but was keen to keep the detailed report for a deep dive where necessary.

Other comments from the Chair

- The reports provided to the committee were high quality and contained the necessary detail for the committee to test the assurances that were provided. Additionally, authors and area leads were able to respond to enquiries to assist the committee in formulating its opinion on assurance.

- The Committee received a brief paper produced by Mersey Internal Audit Agency that benchmarked the constitution and processes of NHS Quality Committees. The Committee felt that it our make-up and ways-of-working were unsurprisingly comparable to our peers and felt that our current frequency of meetings enabled the Committee to discharge its duties effectively, especially given the Trust Board's oversight of quality. No changes are therefore advised.