NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

6 November 2024

09:00 GMT Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

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Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 6 November 2024
Time	09:00 – 11:00
Location	Hybrid

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	11.		Questions from Governors and Public	Sir David Henshaw	

12.	Meeting Review	Sir David Henshaw
13.	Any other Business	Sir David Henshaw

Date and Time of Next Meeting

Wednesday 4 December 2024, 09:00 – 11:00

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 2 October 2024
Location	Hybrid

Members present:

SI	Steve Igoe	SID & Deputy Chair (Meeting Chair)
CC	Chris Clarkson	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
RM	Dr Rajan Madhok	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
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
JC	Jo Chwalko	Director of Integration and Delivery
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 9.4
SH	Sheila Hillhouse	Lead Public Governor
TC	Tony Cragg	Public Governor

Apologies:

DH	Sir David Henshaw	Non-Executive Director & Chair
SR	Dr Steve Ryan	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
HK	Hayley Kendall	Chief Operating Officer

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** SI welcomed everyone to the meeting and explained DH was unwell and as Deputy Chair he would chair 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 4 September were **APPROVED** as an accurate record.	
4	**Action Log** SI requested further information be provided in relation to how end of life patients can access the numerous end of life services. The Board **NOTED** the action log.	Jo Chwalko
5	**Staff Story** The Board received a video story from a selection of staff at the Trust who had undertaken an apprenticeship. The video story described their positive experience of completing an apprenticeship whilst working and the encouragement they received from the Trust. DS explained there had been a misconception that apprenticeships were only suitable for school leavers and reiterated this was not the case. DS added apprenticeships were also a good mechanism for training and developing staff, however a key challenge was to back fill job roles for those undertaking an apprenticeship. LD highlighted there was an option to pay a small one off fee to allow staff to use certain post nominals upon completing an apprenticeship which they could use on their CV. The Board **NOTED** the video story.	
6	**Chairs Business and Strategic Issues** SI explained the Chair had not provided any discussion points to raise for this meeting.	
7	**Chief Executive Officer's Report** JH highlighted in August there were no Patient Safety Incident Investigations opened under the Patient Safety Incident Response Framework and one Reporting of Injuries, Diseases and Dangerous Occurrences were reported to the Health and Safety Executive. JH updated members on the Wirral System Review, highlighting phase 2 of the report had been released and a detailed update would be provided in Private Board. JH added the Trust was informed in August that it was one of five Trusts in Cheshire and Merseyside to be classified as Tier 1 for	

	unscheduled care. This related to the number of patients waiting more than 12 hours in ED for admission. JH added support would be provided by the Emergency Care Improvement Support Team (ECSIT) before the winter. JH stated the Trust was in the process of implementing a number of actions to support the delivery of the agreed financial plan following an external Cheshire and Merseyside ICS review of all providers. JH added the Trust was exploring with PWC and the ICB options for additional support. JH explained in line with guidance from the Joint Committee on Vaccination and Immunisation (JCVI) from mid-September all those pregnant will be offered the Pertussis vaccine and the RSV vaccine from 28 weeks. JH referenced that the Wirral Research and Innovation Centre had launched at Clatterbridge on 12 September. JH stated this was a positive achievement and would support the Trust further in delivering the research and innovation agenda. JH highlighted the Darzi Review, an independent investigation of NHS in England, had been published and a detailed report would be presented later in the meeting. JH summarised the recent meeting of the Cheshire and Merseyside Acute and Specialist Trust Board (CMAST) on 6 September, noting a key area of discussion was CMAST Annual Plan which outlined the main achievements for 2023/24 and priority areas for 2024/25. JH added during the meeting there was also an update on the system financial position and the measures to increase greater financial grip and control. LD queried about the key achievements from a CMAST perspective during 2023/24. JH stated the delivery of the elective recovery programme, which was a key collaboration of system partners to reduce the overall waiting list and winning the HSJ award for Provider Collaboration of the Year. LD commented these successes would be good to communicate with members of the public and stated greater visibility of those would be welcomed. JH stated successes were regularly communicated in the news bulletin and on social media. JH agreed to feed this back to the next CMAST meeting about the publication of good news stories with members of the public. The Board **NOTED** the report.	

8	**Lord Darzi Independent Investigation of the NHS** MS provided a summary of the report, indicating in early September the Darzi Review, an independent investigation of NHS in England, was published after being commissioned by the Secretary of State for Health and Social Care in July. MS highlighted the review undertook a rapid investigation of the state of the NHS, assessing patient access, quality of care and the overall performance of the health system. MS added the report includes detailed findings and the key drivers of performance as well as a number of themes on how to repair the NHS. Members discussed the report and acknowledged the findings and conclusions would be used to form the next NHS 10 Year Plan, due for publication in 2025. The Board **NOTED** the Lord Darzi Independent investigation of the NHS in England Report.	
9	**Board Assurance Reports** **9.1) Chief Finance Officer Report** MC reported at the end of August (month 5) the Trust was reporting a deficit of £14.7m, an adverse variance against plan of £5.0m. MC added there was significant risk to the Trust delivering the agreed annual deficit of £16.3m which is being managed through an NHSE process supported by PWC. MC set out the key drivers of this forecasted variance and the internal risks to achievement, including full delivery of elective activity, CIP, maintaining expenditure on urgent care within planned levels and delivering planned integration benefits. MC highlighted the Trust remained fully engaged with the NHSE and ICB finance review to plan actions to reduce expenditure to mitigate against these risks, noting full implementation of these actions would reduce the unmitigated forecast deficit to £23.3m MC provided an update on the statutory key financial risks for month 5, noting the RAG rating for each, highlighting that financial stability, agency spend, financial sustainability and financial efficiency was rated red, and capital was green. MC stated cash RAG rating was amber, explaining that the Trust would receive deficit funding of £9.668m and that this would be reflected in a revised plan submitted to NHSE.	

	LD queried about the risk relating to the elective activity plan and how much of this risk was associated with the utilisation of the Cheshire and Merseyside Surgical Centre (CMSC). MC stated CMSC was a factor and explained a recovery and mitigation plan would be discussed at the next Finance Business Performance Committee to consider if changes needed to be made to the finance and activity plan of CMSC. LD suggested also focusing on the administrative aspect of CMSC to improve productivity and efficiency. JH agreed and stated the Chief Operating Officer was leading on the multi-year admin and clerical transformation programme which would support the delivery of Trust wide efficiencies. SI commented there was a risk as the Trust approached mid-year any mitigation implemented would have a reduced effect on the financial position. MC agreed and highlighted the Executive Directors continued to balance the requirement for additional mitigation against maintaining performance and quality. The Board: • **NOTED** the report. • **NOTED** that full implementation of agreed mitigations will significantly but not fully mitigate financial risk. • **NOTED** that the Trust has submitted a request for additional cash support in Q3 (October to December 2024). • **NOTED** that the Trust is exceeding the agency cap both in month 5 and cumulatively. **9.2) Chief Operating Officer Report** NS highlighted in August the Trust attained an overall performance of 94.91% against plan for outpatients and an overall performance of 92.10 against plan for elective admissions. NS added the Trust underachieved plan for both outpatient new appointments and elective inpatients, with an overachievement on day cases and set out the reasons for underachievement. NS summarised referral to treatment standard, noting there was a requirement to have no patients waiting over 65 weeks by September but at the end of August the Trust had 12 patients who had breached the 65 weeks. NS added the Trust continues to support other Trusts across the region by offering mutual aid. NS explained the cancer performance against the trajectory, noting the Trust met the faster diagnosis standard for July at 79%.1 above	

	the standard of 75% and continued to maintain progress for 62 day treatment/waiters and 104 day long waiters. NS reported the DM01 performance standard was 96.1% in July and highlighted there were challenges regarding increases for endoscopy and Dexa scanning. NS reported in August type 1 unscheduled care performance was 43.83% and remains a significant challenge. NS stated the Trust with Wirral Place system partners have agreed four workstreams to improve performance. NS added the review carried out by Aqua would be shared with the Finance Business Performance Committee in October. NS stated ambulance handover performance continues to be a high priority for improvement and in August performance was back in line with other Trusts in Cheshire and Merseyside. NS reported the number of patients not meeting the criteria to reside at the hospital remained low, however, the demand for patients attending the ED with mental health conditions remained at lower levels than previously. The Board **NOTED** the report. **9.3) Integrated Performance Report** NS highlighted the number of patients recruited to NIHR studied remained below Trust trajectory and the Research and Innovation Team continued to have a strong focus on improving the position. SI queried about the Research and Innovation Strategy KPIs and if these could be shared with the Board to understand overall performance. NS stated KPIs were in place and work remained ongoing to ensure the KPIs were well defined. NS agreed to provide Board with greater visibility of performance against those KPIs. SW reported there had been a reduction of C Diff on the previous month and this was encouraging. SW added there had been good engagement from high prevalence wards with best practice being shared from wards with lower cases. SW explained following a mattress audit 50 mattress had been replaced. SW highlighted the number of 1 level informal concerns was above threshold and the number of formal complaints received was in line with Trust target. DS explained mandatory training compliance continues to be achieved at 93%. Sickness absence remains above target at 6.17% and is an area of concern. The top three reasons for absence for	Dr Nikki Stevenson

	August are stress/anxiety/depression, gastrointestinal problems and cough, cold & flu. DS added staff turnover has exceeded Trust target at 1.53%, however this is due to the planned turnover of junior doctors during the summer period. DS indicated appraisal compliance has improved but remains below compliance by 0.28%. Divisional trajectories are in place to achieve Trust target. CM reported the staff vacancy as a percentage of workforce had increased to 9.7% following two members of staff leaving and this had resource implications for the Digital Healthcare Team. CM added there was skills shortage across IT and one way forward may involve collaboration opportunities across other NHS providers to pool together resource. CM highlighted the Service Improvement Team had been asked to carry out a review of processes to identify opportunities for efficiencies in relation to Subject Access Requests (SARs). CC queried if there were any trends emerging from SARs. CM stated a new database was being implemented to provide a greater analysis of trends, but the requests continued to be driven by topics discussed in local or national press. Members discussed the workforce challenges within the Digital Healthcare Team, and it was agreed as this was a regional problem as well, to consider raising at the next CMAST meeting. The Board **NOTED** the report. **9.4) Monthly Maternity and Neonatal Services 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 for August. JL added there were no Patient Safety Investigation Incidents (PSII's) declared in August for maternity services. JL gave an update on MIS Year 6, summarising current progress and the compliance status to date for each of the ten Safety Action Standards. JL also gave an update on Saving Babies Lives, noting the Trust achieved 97% compliance against the 6 elements based on evidence submitted in August 2024. JL highlighted the Trust was first assessed in May 2023 for the Family Integrated Care accreditation (Fi-Care) and achieved green status. JL added re-assessment was undertaken in August and the Trust maintained the green status.	

	Members thanked JL for their continued hard work. The Board: • **NOTED** the report. • **NOTED** the Perinatal Clinical Surveillance Assurance report. • **NOTED** the achievement of the NNU Fi-Care accreditation. • **NOTED** the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3. • **NOTED** the contents of the National Review of Maternity Services in England 2022-2024; and • **NOTED** the Maternity Claims scorecard	
10	**Organ Donation Annual Report** NS provided an overview of the report, highlighting organ donation activity is monitored via the Potential Donor Audit through NHS Blood and Transplant and overseen locally by the Organ Donation Committee which is chaired by SR. NS explained organ donation takes place mainly within the Intensive Care Unit or Emergency Department. NS added 15 patients received an organ donation transplant during 2023/24 and there were 2 missed potential donations. NS added the Clinical Lead for Organ Donation was in the process of recruiting an ED clinician to join the Organ Donation Committee to champion donation in ED. The Board **NOTED** the report.	
11	**Complaints Annual Report** NS provided a summary of the report, indicating during 2023/24 the Trust logged 201 formal complaints – a decrease of 16% on 2022/23 and the Trust also logged 2190 level 1 concerns – a decrease of 1% on 2022/23. NS reported most formal complaints often involved more than one Division, with Acute receiving the most complaints followed by Medicine. NS added 'Communication' was an aspect of 63% of compliant cases, followed by 'Treatment and Procedure' at 53%. NS explained a key positive was that formal complaints comprised only 0.02% of patient contacts. NS stated response times to formal complaints in some instances was unsatisfactory, taking on average 60 working days against a performance metric of 40 working days.	

	CC queried if the 40 working day performance metric was realistic and if it was right to have this metric if it was not being achieved. NS stated the reason for the delay was due to the time taken for Divisions to provide full, detailed, and evidenced responses. NS added the Patient Experience Team regularly kept individuals up to date on the progress of their complaint. JH suggested reviewing this performance metric and to move towards a timescale based on the complexity of the complaint. NS agreed to consider if the 40 working day performance metric remained suitable and provide an update on the outcome at the next Board meeting. RM queried about the involvement of Healthwatch in Trust activity. NS stated Healthwatch were involved in some areas of the Trust activity. NS added Healthwatch were previously invited to observe Quality Committee prior to the pandemic but agreed to extend an invitation to future meetings. The Board **NOTED** the report.	Dr Nikki Stevenson Dr Nikki Stevenson
12	**Safeguarding Annual Report** SW provided an overview of the report, summarising the national and local context for safeguarding and the current Trust position. SW added the Trust continued to meet its statutory obligations and national safeguarding standards. SW highlighted the various safeguarding activity undertaken including progress made against the objectives set out in the 2023/23 Safeguarding Annual Report. SW explained the Trust safeguarding priorities for 2024/25, noting this included the roll out of the Oliver McGowan mandatory training which had already launched and had a good completion rate. LD queried about the safeguards in place for human trafficking. SW stated this was a key component of the Protecting Vulnerable People mandatory training. The Board **NOTED** the report.	
13	**Managing Conflicts of Interest Update** DM summarised the report, explaining 1550 staff were within the categories outlined in the Trust policy, and 1147 of those have completed their annual declaration for this financial year.	

	DM highlighted this equaled 74% of those required and compared to the position at this time last year of 57%. DM added best practice is considered 85% and the Corporate Governance Team aim to achieve this by March 2025. The Board **NOTED** the report.	
14	**Fit and Proper Persons Policy** DM reported the Trust fully adopted the new Fit and Proper Persons Test framework in September 2023 and had implemented this by March 2024. DM added all annual assessments against the new framework had been conducted for the required job roles and the Trust's policy continues to be fit for purpose. LD queried if social media checks had been carried out for those requiring one as part of the framework. DM stated social media checks had been completed and no concerns had been raised. The Board **NOTED** the policy.	
15	**Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement and Committee in Common Refresh** DM explained the CMAST Joint Working Agreement and Committee in Common terms of reference had been refreshed following a review and all relevant Trusts had been asked to endorse the updated documents. The Board **ENDORSED** and agreed the updated CMAST Joint Working Agreement and Committee in Common terms of reference as set out.	
16	**Committee Chairs Reports** **16.1) Audit and Risk Committee** SI stated the Committee discussed the Financial Assurance Report and requested further assurance on the controls in place to reduce pharmacy stock losses. SI explained the Committee received the Annual Auditor's Report which highlighted an unqualified opinion had been issued on the Trust's financial statements and that the accounts' consolidated schedules were consistent with the audited financial statements.	

	SI reported the Committee received three internal audit reports, two were of substantial assurance and one moderate assurance opinions. SI added the Committee were provided with the Audit Tracker and noted good progress continued to be made embedding audit recommendations. The Board **NOTED** the report. **16.2) People Committee** LD explained there were numerous workstreams as part of the People Strategy which were intended to deliver positive outcomes. Committee looked forward to seeing the impact of this work to ensure it was making the intended difference. LD stated Committee were updated on the rise in race related employee relations cases following the recent civil unrest during the summer. LD added the relevant HR team were monitoring these and any future related cases closely. LD highlighted the Committee discussed the Safe Staffing Report, noting the ward based nursing acuity review was overdue by 12 months. LD set out the reasons for the delay and indicated the Chief Nurse expected the results of the review to be ready for December at the earliest. The Board **NOTED** the report. **16.3) Research and Innovation Committee** NS stated she and Chair had given apologies for this Committee meeting and SR, the meeting Chair, was not present to provide an update on the meeting. The Board **NOTED** the report. **16.4) Quality Committee** SW reported the Committee discussed the ongoing concerns regarding C Diff and the focussed work of the Infection Prevention and Control Team to reduce cases within the hospital. SW added good progress had been made to focus on C Diff rates in the community through the work of the Wirral Place Quality Performance Group, noting a four pillar plan was being developed with Wirral system partners. SW explained a recent national quality audit report showed the Trust was achieving lower reported delirium screening rates than expected. SW added this continued to be monitored and plans were in place to address this.	

	SW highlighted there remained three overdue risks on the Care Quality Commission action plan and Committee requested further assurance on the residual risks for each. The Board **NOTED** the report.	
17	**Questions from Governors and Public** SH queried about the BBC News article regarding the North West Ambulance Service (NWAS) paramedic concerns about the delays in ambulance handovers. DS stated at the time this media enquiry had not provided the complete detail to allow the Trust to respond fully. DS added the Trust was developing its winter plan and this would be accompanied by a comms plan. NS explained the Trust aimed to release ambulance crews as soon as possible to ensure patients were cared for within the Trust. This resulted in corridor care which was considered lower risk than unattended patients in the community. NS added the Trust also had a good relationship with NWAS and representatives from both organisations were scheduled to meet in due course.	
18	**Meeting Review** No comments were made.	
19	**Any other Business** No other business was raised.	

Action Log
Board of Directors in Public
6 November 2024

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	2 October 2023	4	To provide further information in relation to how end of life patients can access the numerous end of life services	Jo Chwalko	Complete. Briefing note appended to action log.	November 2024
2.	2 October 2024	9.3	To provide greater visibility of performance against the research and innovation KPIs	Dr Nikki Stevenson	Complete. KPIs are to be discussed at the Research and Innovation Committee and visibility of performance will be included in the chairs report.	December 2024
3.	2 October 2024	11	To consider if the 40 working day performance metric for complaints remained suitable and provide an update on the outcome at the next Board meeting	Dr Nikki Stevenson/Sam Westwell	Complete. The Medical Director and Chief Nurse have discussed the performance metric in different forums and a decision has been made not to amend the metric, but to agree a target of >=80% response rate within 40 days.	November 2024
4.	2 October 2024	16.4	To extend an invitation to Healthwatch to observe future Quality Committee meetings	Dr Nikki Stevenson	Complete. Healthwatch invited to future Quality Committee meetings.	November 2024

Briefing Note

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting and Date	Board of Directors in Public – 6 November
Author	Jo Chwalko -Director of Integration and Delivery
Report Title	Operational End of Life Services – Community
Purpose	Information

Overview and Background

- Action from Public Board on 4th September. To provide further information in relation to how End of Life patients can access the numerous End of Life services. Contextual to potential delays in discharge from hospital to 'home'.

Background, Key Issues and Risks

- Following Public Board, the Director of Integration and Delivery liaised with Primary Care, Wirral Place, Wirral Borough Council, Wirral Community Health & Care Trust and the Voluntary Community & Faith Sector. The purpose was to establish what End of Life Community service provision is available.
- Feedback highlighted numerous Health and Care Community Services to support End of Life, including 'Fastrack' patients. For example, Marie Curie, St Johns Hospice services, Wirral Council, WCHC specialist nursing services, and GP. There are also 56 care homes who have received additional End of Life training. Equipping homes to provide specialist support.
- The Director of Integration and Delivery's chaired a Wirral system meeting on 17th October 2024 to explore provision further. A 'test' patient was used to follow the journey from Acute bed to being discharged home. This process identified several opportunities to strengthen pathways and processes. Requiring both internal and external focus.

Recommendation

- Board to be assured that End of Life provision is available in the Community.
- Board to be assured that work has commenced to explore further opportunities to enhance pathways.

Next Steps

- To continue the work to date to ensure pathways and processes enable and support a safe and timely discharge from hospital.
- Actions to be monitored via established internal and external governance arrangements.

Example of Community End of Life Services (List is not exhaustive)

Service	**Referral Pathway / Route**	**Criteria & Capacity**	**Offer**
Marie Curie – Night Sitting Service	Community Nursing Hospital Discharge teams Community specialist Palliative Care team	Adults 18+ living in Wirral. Patients in last 12 months of life – can live with family or alone.	Overnight sits HCAs 1-2 a week to relieve carer
Wirral Hospice St John's – Hospice at Home Visits	Community Nursing Hospital Discharge teams Community specialist Palliative Care team Hospice	Adults aged 18 + People with a prognosis of less than 12 months Patients currently being cared for at home where: - Carers who would benefit from respite provided through require short-term support visits. - Urgent Support prevents hospital admission resulting from a crisis	Day and / or nights support, complementing care already being provided by family members, other carers and health and social care services. Also offer of access to hospice bereavement service
Wirral Hospice St John's Hospice at Home Personal Care Service	Community Nursing Hospital Discharge teams Community specialist Palliative Care team Continuing Health Care Hospice	Adults aged 18 + People with a prognosis of up to 4 weeks	Deliver personal home care to patients with a rapidly deteriorating condition that are likely to be within their last 4 weeks of life and wish to die at home.

WCHC Community Specialist Palliative Care	GP Hospital Discharge teams	Pts within the last year of life when it is felt the patient would benefit from additional specialist intervention which is complex	Wirral Palliative Care Advice line. support to patient's, families and health professionals. End of life advanced care plans. Specialist advice on medication / symptom control Reduce unnecessary transfers of care from all settings so pts can die in their preferred place of care

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
6 November 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 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 September under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety

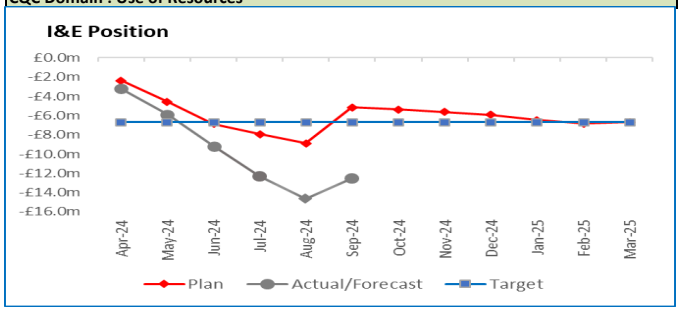
	Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. There was one Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in September. All RIDDORs reportable events are subject to a Health and Safety 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** **Visit from Matthew Patrick, MP for Wirral West** The new MP for Wirral West Matthew Patrick visited the Trust on 27 September and during his visit we discussed the innovation work happening across the organisation. Matthew also had a tour of the Transfer of Care Hub at Arrowe Park Hospital, which has significantly reduced the number of patients in hospital who no longer require a hospital stay, ensuring patients are home or back in the community as soon as they are fit and well. **Visit from Chris Hopson, NHS England Chief Strategy Officer** The Trust also welcomed Chris Hopson on 25 October. During his visit he received a tour of the Clatterbridge campus, including the Cheshire and Merseyside Surgical Centre and Community Diagnostic Centres. Discussions also took place surrounding the Wirral System Review and the integration opportunities to improve patient care. Following this Chris received a tour of the Urgent and Emergency Care Upgrade Programme (UECUP). **Launch of Change NHS: help build a health service fit for the future** On 21 October NHS England launched a national engagement exercise to develop the next 10-Year Health Plan and to deliver an NHS fit for the future. In September, Lord Darzi published his independent review of the NHS, which was intended to start an open and honest conversation about the state of our health and service and the reforms needed. Over the coming months, NHS England want to hear from staff and patients to help co-design the new 10-Year Health Plan. There is a national portal found at www.change.nhs.uk to share experiences and ideas. A series of face-to-face engagement events will take place across the regions early next year. **Emma James Wins RCN Impact Award** Emma James has been awarded the 2025 RCN Impact Award. Emma received a grant from the Royal College of Nursing (RCN), which allowed her to study the CPCAB Level 3 Certificate in Counselling Studies. Upon completing the course, Emma submitted a report to the RCN detailing how she utilised the grant, what she learned, and how she has applied these new skills in her role.

	Emma's counselling skills have greatly improved the psychological support she provides to Head and Neck Cancer Patients during supportive phone calls and Holistic Needs Assessments. Congratulations to Emma on this fantastic and well-deserved recognition. **Multicultural Staff Network Event** On Friday 25 October colleagues from across the Trust come together for the Multicultural Staff Network's first celebration event. The event was held at Birkenhead Rugby Club and brought together over 100 staff members to celebrate a range of nationalities and cultural traditions.
1.3	**System Working** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** CMAST Leadership Board met on 4 October discussing a number of system issues as follows. A discussion took place led by the ICB Medical Director on system UEC capacity and the impact on ambulance handovers and associated congestion. Alternative approaches were explored with both NWAS and Trust CEOs open to different thinking, but with a shared commitment to patient safety and minimising unintended consequences. Dr Rowan Pritchard – Jones agreed to continue exploring solutions, acknowledging the need for consistent and supported hospital discharge and admission avoidance in each of C&M's localities. The Board received updates on ICB commissioned organisational integration projects from the relevant acute Trusts involved in those activities and on a regionally based peer improvement role focussed on elective recovery. The Board was oriented and reminded on the milestones for delivery of a C&M Pathology operating model and associated design making with the LIMs system. A fuller update will be provided to the November meeting of the Leadership Board. Finally the Leadership Board received a briefing from Ged Murphy, its identified CEO lead, on progress made with the Data into Action Programme and the potential benefits of this Digital programme. Updates were also received on the System financial report and system performance. **Wirral Place Based Partnership Board (PBPB)** The PBPB met on 17 October and discussed several standing reports on Place Finance and Quality and Performance. The Board received an update on the programme delivery of the Wirral Health and Care Plan. The overall delivery RAG rating for delivery in September was green, with

	two programmes in the portfolio reporting red, three reporting amber and the rest reporting green. The Board also received an update on Unscheduled Care Improvement Programme. The programme has been refreshed and continues to make significant progress delivery and improve patient experience for Wirral residents.

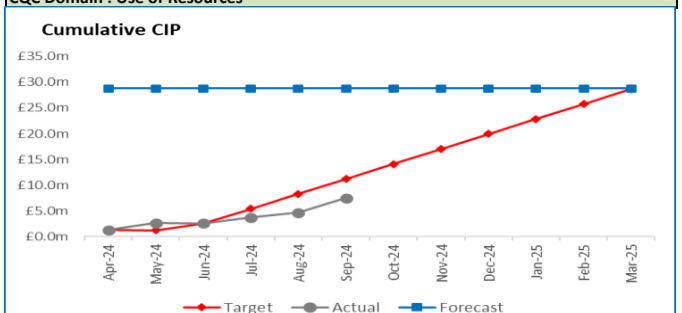
Chief Finance Officer

CQC Domain : Use of Resources



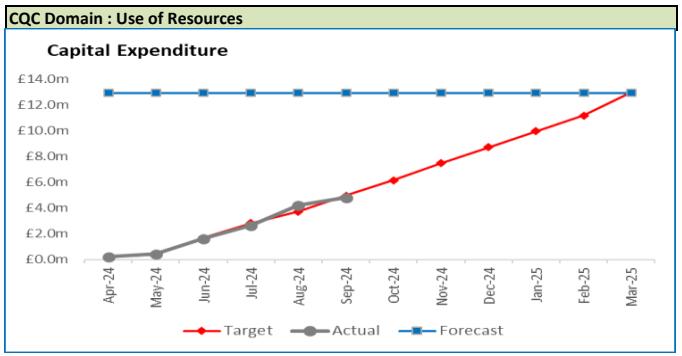
Sep-24
-£12.5m
Variance
Position worse than plan
Target
-£5.2m

CQC Domain : Use of Resources



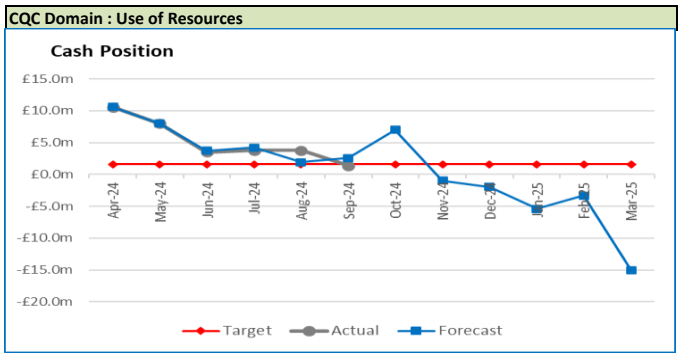
Sep-24
£7.5m
Variance
Position worse than plan
Target
£11.2m

CQC Domain : Use of Resources



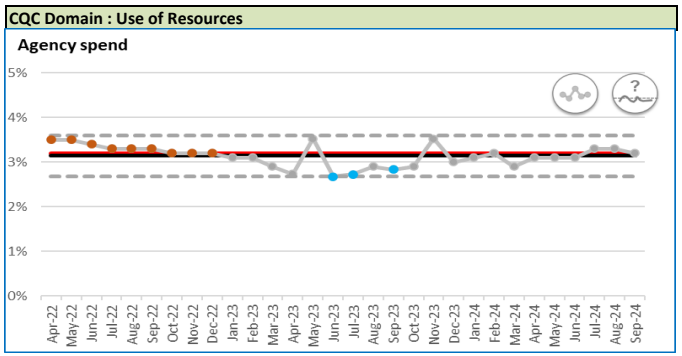
Sep-24
£4.8m
Variance
Position worse than plan
Target
£5.0m

CQC Domain : Use of Resources



Sep-24
£1.4m
Variance
Position worse than plan
Target
£1.6m

CQC Domain : Use of Resources



Sep-24
3.20%
Variance
Position not worse than plan
Threshold
3.2%

Executive Summary

At the end of September, M6, the Trust is reporting a deficit of £12.5m against the year to date plan of £5.7m, an adverse variance of £6.7m. The Trust Board has approved a mitigation plan to reduce run-rate in the second half of the year (H2 - October to March) and the executive team is working within NHSE processes, as supported by PWC to identify further mitigations.

The risk to delivery of the planned annual deficit is highlighted to the Board.

The key drivers of the 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 outturn adverse variance to plan is forecast to be in a range between:

- Scenario 1 - £7.0m, which requires full delivery of the board approved £8.4m mitigation plan and in addition £4.8m of non-recurrent mitigations.
- Scenario 2 - £20.3m, which is the current run-rate trajectory assuming no mitigations delivered and no additional risk materialising.

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 (M6)	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.
- Note the risks to delivery of statutory targets including the planned deficit of £6.7m
- Note that full implementation of agreed mitigations will significantly but not fully mitigate financial risk (see scenarios 1 and 2)
- Note that the Trust has submitted a request for additional cash support in Q3 (October to December 2024).
- Note that the Trust is now back in line with agency target of 3.2%.
- Approve the increase in the capital budget from £18.754m to £20.707m in recognition of approved RAAC funding.

I&E Position

Narrative:

The table below summarises this I&E position at M6 against scenario 2:

	In Month			Year to Date			Forecast		
Cost Type	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Forecast**	**Variance**
Clinical Income from Patient Care Activities	£43.0m	£42.2m	-£0.8m	£233.3m	£227.7m	-£5.6m	£464.7m	£454.5m	-£10.1m
Other Operating Income	£2.8m	£3.1m	£0.4m	£16.2m	£19.2m	£2.9m	£32.4m	£38.3m	£5.9m
Total Income	**£45.8m**	**£45.3m**	**-£0.5m**	**£249.6m**	**£246.9m**	**-£2.7m**	**£497.1m**	**£492.8m**	**-£4.2m**
Employee Expenses	-£29.4m	-£30.2m	-£0.7m	-£177.3m	-£179.3m	-£2.1m	-£355.5m	-£357.9m	-£2.4m
Operating Expenses	-£12.1m	-£12.4m	-£0.2m	-£79.0m	-£77.6m	£1.4m	-£155.5m	-£160.8m	-£5.3m
Non Operating Expenses	-£0.5m	-£0.7m	-£0.2m	-£3.0m	-£2.5m	£0.5m	-£6.0m	-£4.9m	£1.1m
CIP	£0.2m	£0.0m	-£0.2m	£4.0m	£0.0m	-£4.0m	£13.3m	£3.9m	-£9.4m
Total Expenditure	**-£41.9m**	**-£43.2m**	**-£1.3m**	**-£255.3m**	**-£259.4m**	**-£4.1m**	**-£503.7m**	**-£519.8m**	**-£16.0m**
Unmitigated Forecast	**£3.9m**	**£2.2m**	**-£1.8m**	**-£5.7m**	**-£12.5m**	**-£6.8m**	**-£6.7m**	**-£26.9m**	**-£20.3m**
				NR Mitigations				**£4.9m**	
				Mitigations Plan M7-M12				**£8.4m**	
				Mitigated Forecast			**-£6.7m**	**-£13.6m**	**-£7.0m**

Risk range = -£20.3m to -£7.0m

The unmitigated forecast position is before implementation of the Board approved actions.

Key variances within the position are:

Clinical Income – £5.6m adverse variance relates to underperformance against the value of the elective plan, primarily in Surgery.
Employee Expenses - £2.1 adverse variance relates to continued overspend on bank and medical bank in ED.
Operating Expenses - £1.4m positive variance is largely a consequence of under delivery of elective activity in Surgery.
Non-operating expenses – £0.5m favourable variance relates to PDC payments lower than plan.
Cost Improvement Programme – £4.0m adverse variance for CIP across clinical divisions, this is before non-recurrent mitigations.

The Trust's agency costs were 2.7% of total pay costs in M6 and are 3.2% YTD. This is at 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.
- The Trust fails to fully implement the approved mitigation plan.

Actions:

- Full identification and delivery of CIP schemes.
- Maximising elective capacity and recovery.
- Urgent care improvement plan.
- Full delivery of agreed mitigation plan.
- Each division to be set a control total for H2.

Cumulative CIP

Narrative:

The Trust has transacted £7.5m of CIP at M6 which is £3.7m behind plan. The Trust has risk adjusted our CIP forecast to recurrent £19.5m with a full year effect of £26.3m, an in-year shortfall against (recurrent) target of £9.4m and a recurrent gap of £2.6m

The Trust does not classify non-recurrent underspends as CIP but the forecast under-delivery of CIP is fully 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.
- Implementation of the Board approved mitigation plan which includes acceleration of enhanced controls over variable expenditure.

Elective Activity

Narrative:

The Trust delivered elective activity to the value of £8.2m in M6 and £50.8m YTD, an adverse variance of £8.9m 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 have completed a review into the full drivers of the CSMSC income position with a mitigation plan to address any remaining underlying issues impacting the Trust's delivery of elective activity in surgery. This has been presented to FBPAC and will be considered by the Board.

Capital Expenditure

Narrative:

The Trust has received confirmation of £1.953m additional capital funding to manage estate impacted by RAAC. The previous approved capital budget was £18.754m and approval is sought to increase the budget to £20.707m as a result of this additional funding.

Description	Approved Budget at M1	Revisions to Budget	Revised Budget
CDEL			
Internally Generated	£12.870m		**£12.870m**
ICB/PDC/WCT	£6.284m	£0.553m	**£6.837m**
Charity	£1.000m		**£1.000m**
Confirmed CDEL	**£20.154m**	**£0.553m**	**£20.707m**
Total Funding for Capital	**£20.154m**	**£0.553m**	**£20.707m**
Capital Programme			
Estates, facilities and EBME	£5.000m	-£0.200m	£4.800m
Heating and chilled water pipework replacement	£2.100m		£2.100m
Operational delivery	£2.750m	£0.700m	£3.450m
Medical Education	£0.080m		£0.080m
Transformation	£1.000m	-£0.500m	£0.500m
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
RAAC	£0.000m	£1.953m	£1.953m
Confirmed PDC	**£1.464m**	**£0.553m**	**£2.017m**
Total Anticipated Expenditure on Capital	**£20.154m**	**£0.553m**	**£20.707m**
Under/(Over) Commitment	**£0.000m**	**£0.000m**	**£0.000m**

Spend at M6 totals £4.789m which is almost £0.2m ahead of plan. We do not anticipate any overspend 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 cash balance at the end of M6 was £1.4m. Although this position is in line with plan, the reduction in the cash balance has a direct impact on the Better Payment Practice Code (BPPC) performance by volume and value. The year-to-date position of bills paid within target stands at 74.5% which is 20.5% lower than the national target of 95%. In M6 the Trust paid 47.1% of invoices received within the BPPC timeframe.

The Trust has applied for cash support for Q3 (£4.0m) and further cash support will be required in Q4 (£13.5m).

Risks to position:
- Management of the cash trajectory is impacting BPPC 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.
- Submission of 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**
6 November 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 – Performance and Planning
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 but the continued challenge in achieving reduced waiting times in a number of specialities.

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) and in particular 12 hour waiting times with non-elective demand continuing to provide a significant challenge.

The Board should note the engagement with ECIST under the Rapid Improvement Offer (RIO) to support plans for winter.

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 with all acute providers there is a significant backlog of patients waiting for elective treatment following the impact of the Covid-19 pandemic. 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 and there are clear steps in place to improve to achieve the year end trajectory agreed with NHS England.

2	Planned Care
2.1	**Elective Activity** In September 2024, the Trust attained an overall performance of 99.04% against plan for outpatients and an overall performance of 92.73% against the plan for elective admissions, as shown in the table below:

Activity Type	Target for September	Actual for September	Performance
Out pt New	12884	12347	95.83%
Out pt Follow up	31173	31288	100.37%
Total Out pts	44057	43635	99.04%
Day case	4504	4321	95.94%
Inpatients	739	541	73.21%
Total	5243	4862	92.73%

The Trust underachieved plan for both outpatient new appointments and elective inpatients / daycase.

The under delivery of new appointments was seen across Surgery and Diagnostics and Clinical Support. Surgeries under delivery was related to Upper GI where there was shorter new patient waits and capacity converted to support follow-up pressures and vacancies in Orthopaedics. DCS under delivery related to vacancies, with activity subsequently seen to start to increase.

Under achievement of plan for elective inpatients / daycase activity at Divisional level is largely attributed to Surgery, with underperformance in Orthopaedics relating to the surgical centre plans, sickness and theatre staffing and Urology where there was a reduction in additional activity and sickness.

2.2 Referral to Treatment (RTT)

The national standard is to have no patients waiting over 65 week waits by September 2024. The Trust's performance at end of August against these indicators was as follows:

- 104+ Week Wait Performance – 0
- 78+ Week Wait Performance – 11
- 65+ Week Wait Performance - 178
- 52+ Week Wait Performance – 1,585
- Waiting List Size - there were 47,469 patients on an active RTT pathway which is an increase on the previously report Trust position of 46,649.

Of the 11 over 78 week breaches, 10 were related to Gynaecology (7 x patient choice, and 3 x capacity, with 1 in Surgery (Colorectal patient).

The Trust achieved 178 x 65 week waiters at the end of September. 139 breaches related to Gynaecology as per the forecast, 112 were capacity related, 48 of the patients were related to patient choice, 10 corneal graft (national restrictions on tissue availability) and 9 complex patients.

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 for Orthopaedic services.

2.3 Cancer Performance

Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 2 to date:

Quarter	2
Period	01/07/2024 - 30/09/2024

National Standards:

Standard	Indicator	Threshold	July-24	August-24	September-24	Quarter 2
28 Day Wait	GP USC Referral or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Canc	75.00%	79.13%	74.42%	N/A	76.97%
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	92.28%	90.00%	N/A	91.20%
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	77.25%	79.77%	N/A	78.37%

Sub Standards:

Standard	Indicator	Threshold	July-24	August-24	September-24
28 Day Wait	Individual Trust Provider Trajectory	Per Month	79.13%	74.42%	N/A
28 Day Wait	Breast >=90%	90.00%	94.97%	91.28%	N/A
28 Day Wait	Skin >=90%	90.00%	94.38%	94.64%	N/A
62 Day Wait	Individual Trust Provider Trajectory	Per Month	77.25%	79.77%	N/A

Removed Standards (Not National Standards):

Standard	Indicator	Threshold	July-24	August-24	September-24
14 Day Wait	GP USC Referral to First Appointment	93.00%	80.17%	67.48%	N/A

- *Faster Diagnostic Standard (FDS)* – The Trust did not meet the FDS standard for August 2024, with performance of 74.4% (below the standard of 75%) but remains on track for the quarter. There are challenges in gynaecology and colorectal due to increases in demand.
- *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 achieved the local trajectory in August 2024 (see '62 Day Wait' in Sub Standards section of the table above).

- *62 day waiters* – the number of waiters decreased slightly in September 2024, but remained above of plan by month end (88 patients against a plan of 72).

	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	05/08	12/08	19/08	26/08	02/09	09/09	16/09	23/09	30/09
Actual 24/25	135	132	119	131	136	141	140	148	137	127	122	129	127	106	91	92	103	89	82	90	92	93	88	76	74	79	88
Trajectory	120	120	120	120	120	112	112	112	112	103	103	103	103	93	93	93	93	93	83	83	83	83	72	72	72	72	72
Pre-COVID Average	51	51	51	51	51	51	51	51	51	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 September, at 19 against a plan of 30.

	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	05/08	12/08	19/08	26/08	02/09	09/09	16/09	23/09	30/09
Actual 24/25	45	36	33	32	29	38	38	35	36	34	35	40	42	42	37	36	40	37	26	23	22	19	24	22	21	17	19
Trajectory	50	50	50	50	50	47	47	47	47	42	42	42	42	39	39	39	39	39	33	33	33	33	30	30	30	30	30
Pre-COVID Average	12	12	12	12	12	12	12	12	12	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 September 96.0% 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.

This continues to represent achievement against the revised national standard of 95%, and the requirement for Trusts to achieve 90% by March 2025. The Board should note that there remain challenges with sustaining 95% compliance through the next quarter due to ongoing increase in demand in endoscopy and dexa scans.

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, but this does rely on non-core spend.

The main area of concern in delivering 65 weeks 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. As noted above, plans are in place for another Trust to provide mutual aid from October onwards. In addition to Gynaecology, delivery plans for Colorectal and Upper Gastrointestinal Surgery are currently subject to further review and tracked on a weekly basis.

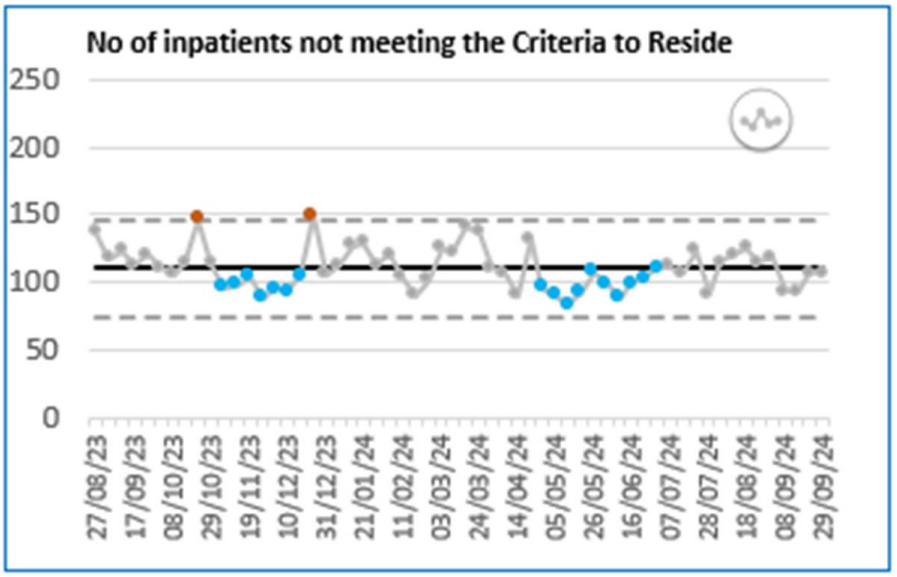
3.0 Unscheduled Care

3.1 Performance

September Type 1 performance was reported at 44.73%, with the combined performance for all Wirral sites at 73.25%:

Type 1 ED attendances:	Type 3 ED attendances:
• 7,488 in August (avg. 241/day) • 7,655 in September (avg. 255/day) • 2% increase from previous month	• 2,634 in August • 2,823 in September • 7% increase from previous month

	The performance of urgent and emergency care (UEC) in September remains below the planned trajectory. Continued overcrowding in the department is impacting on the ability to treat patients within the national quality standard of 4 hours. The Trust has been engaging with the Emergency Care Improvement Support Team (ECIST) as part of the national Rapid Improvement Offer (RIO) prior to winter. The working groups introduced in early September to focus on a collective local partner response to demand in the ED have now completed initial scoping and have key areas they are focusing on. Several pilot projects are to be launched in the coming months to create alternatives to the ED and increase the outflow from the department. A few of the key pilot projects are. - Urgent Treatment Centre (UTC) at the front door All walk-in patients will undergo initial triage and receive a baseline observation by the Urgent Treatment Centre senior nursing team. Once the patient has been seen, they will either be taken to the UTC or the Emergency Department. The pilot is expected to demonstrate an increase in patients being referred to the UTC. The results of the pilot will complement the work currently underway to develop the future front door pathways as part of the Urgent and Emergency Care Upgrade Programme. - Call before convey With the support of the Emergency Care Improvement Support Team (ECIST), the Trust is working with the local Community Trust and Northwest Ambulance Service (NWAS) to improve access to out-of-hospital services that may be able to support patients in the community rather than referring them to A&E. This work will support the ongoing data review to understand the reason for the sustained increase in ambulance attendances since Winter 2022 of 19%. - Same Day Emergency Care (SDEC) As part of a plan to strengthen the Trust's offer in supporting and caring for frail patients, the Trust is working to introduce a Frailty SDEC service which will work alongside existing services that are in place including Frailty and Respiratory Virtual Ward, specialist nurses for older people (SNoPs), community services and the Local Authority. Additional measures are being taken in collaboration with ECIST, including a review of the number of patients referred for a medical bed from the emergency department. The ‘criteria for admission’ audit will take place in mid-November, with input from ECIST medics and the Trust's ED and acute medical consultants. Ambulance handover performance continues to exceed the national quality metric after seeing an improved performance at the start of the year. There was an increase in infection prevention and control measures on the wards in September which impacted on patient flow in the Trust. The Trust actively engages with colleagues from external improvement teams and Cheshire and Merseyside ICB by providing updates on improvement activity and sharing learning with other Cheshire and Merseyside acute trusts.

3.2	**Transfer of Care Hub and No Criteria to Reside (NCTR)** The number of NCTR remained at an average of 115-120 patients in September, which is 30 patients away from the target. Some of the challenges faced by the Transfer of Care Hub (ToCH) relate to patients requiring more complex support on discharge, such as high levels of care packages or placement in care homes requiring higher nurse to patient ratios. The Trust is leading on identifying the capacity and needs required by the system to meet the targets for each discharge pathway (pathways 1-3). Local authority and community trust colleagues are focusing on how to reduce the number of NCTR patients in line with the trajectory. ToCH is also focusing on how patients can be discharged at the lower level of additional care, which should reduce the number of patients waiting on pathways 2 and 3 and move them onto pathway 1. 
3.3	**Mental Health** Demand for patients presenting to the ED with mental health conditions remains high, with peaks and troughs in demand for admission to specialist mental health beds. Due to the increasing number of patients who have NCTR within an inpatient mental health bed, there have been long waiting times for patients with regular escalations through to the ICB. The Trust is currently working with the mental health provider to develop a workforce model that includes RMNs for the new mental health rooms due to be completed in Q2 2025/26.
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 with the ongoing collaboration with ECIST. There remains a risk that the continued high level of attendances and acuity will challenge the improvement plans and actions, in particular with the continued high levels of ambulance conveyances.

4	Implications
4.1	**Patients** • Good progress is being made with recovering elective waiting times for patients. Access to UEC services is as expected and improvement plans are in place to improve experience for patients.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • Cost of delivering 65 week standards is a challenge. The cost of providing additional nursing staff in the ED to support ambulance handover is above the Trust's financial plan.
4.4	**Compliance** • There are challenges with achieving no 65 week breaches across two specialties. The 4 hour performance is behind the trajectory but improvement plans are in place.

5	Conclusion
	UEC demand, in particular ambulance activity, is placing strain on delivering improvements the ED have identified. There are a number of tests of change planned for November in an attempt to reduce/redirect demand to other services. Early indications are that the winter months are going to be ever more challenging. Elective recovery remains a strong point and improvements continue to be demonstrated.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.3**

06 November 2024

Title	Integrated Performance Report
Area Lead	Executive Team
Author	Executive Team
Report for	Information

Executive Summary and Report Recommendations
This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of September 2024. It is recommended that the Board: • Note performance to the end of September 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	6	17	23
Well-led	1	2	3
Use of Resources	2	3	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.

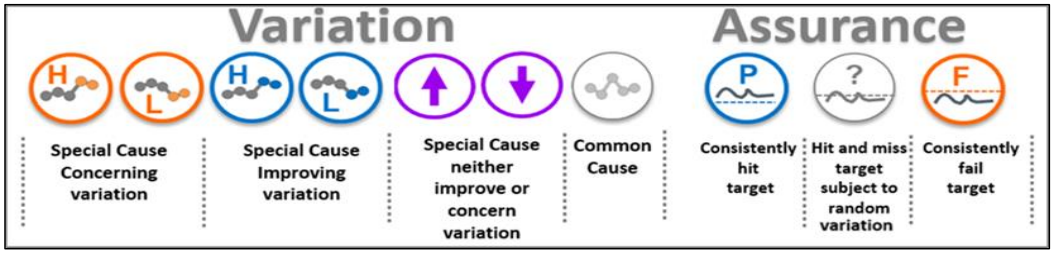
3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Integrated Performance Report, and at the regular operational meetings with the Clinical Divisions.

Integrated Performance Report - October 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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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.

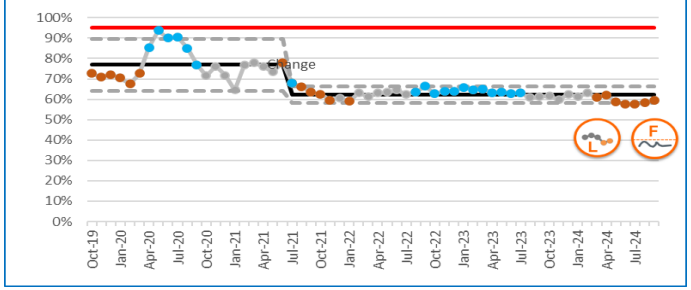
Changes to Existing Metrics:

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

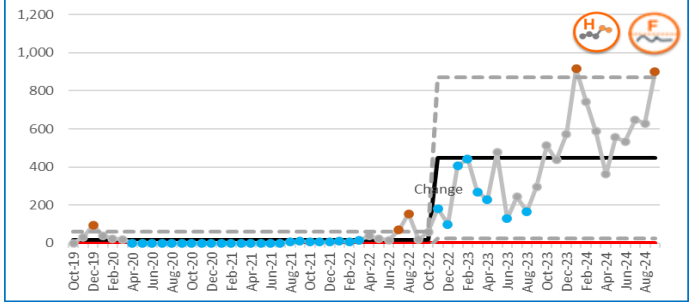
4-hour Accident and Emergency Target (including APH UTC)



Sep-24
59.5%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

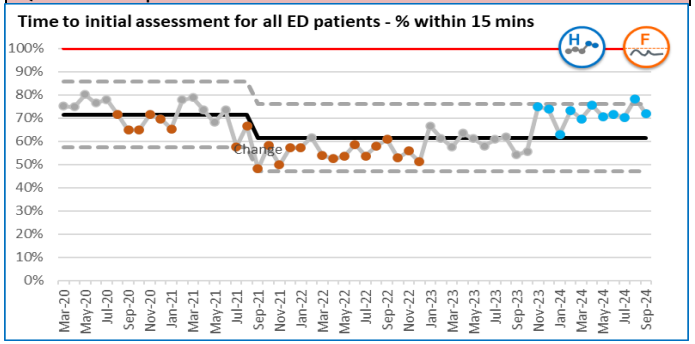
Patients waiting longer than 12 hours in ED from a decision to admit



Sep-24
899
Variance Type
Common cause variation
Threshold
0
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

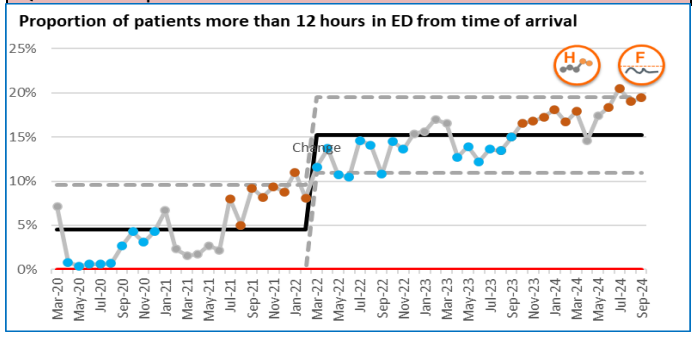
Time to initial assessment for all ED patients - % within 15 mins



Sep-24
71.9%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

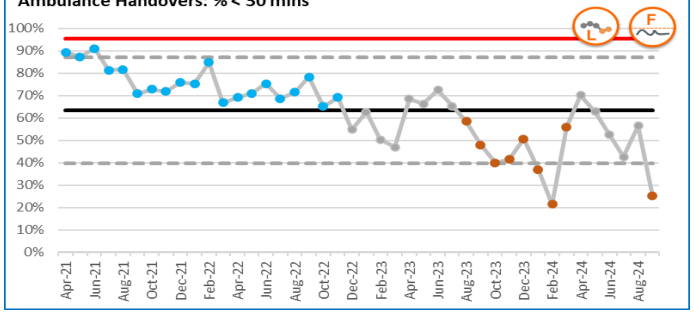
Proportion of patients more than 12 hours in ED from time of arrival



Sep-24
19.4%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

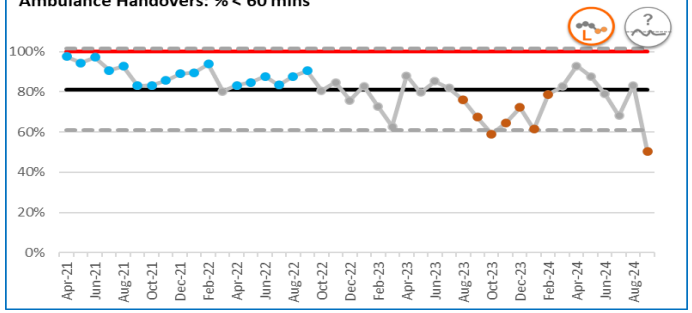
Ambulance Handovers: % < 30 mins



Sep-24
24.9%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Ambulance Handovers: % < 60 mins

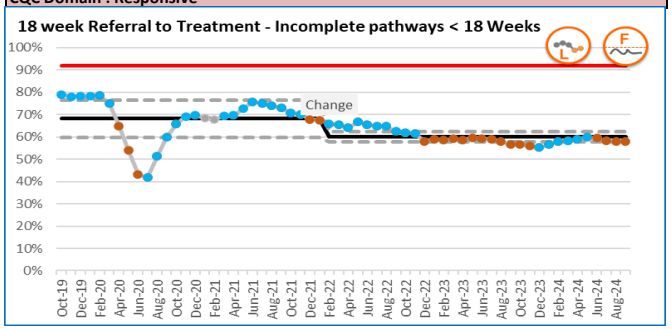


Sep-24
50.4%
Variance Type
Special cause variation - concerning
Threshold
100%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (2)

CQC Domain : Responsive

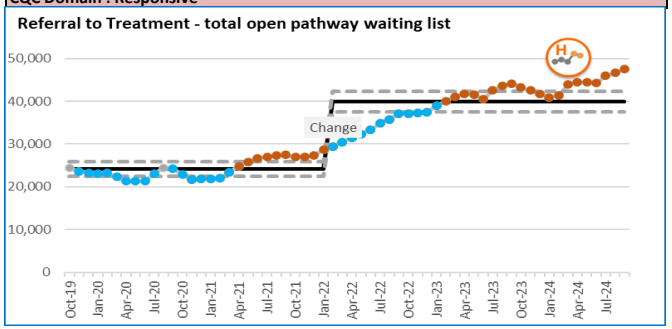
18 week Referral to Treatment - Incomplete pathways < 18 Weeks



Sep-24
58.06%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

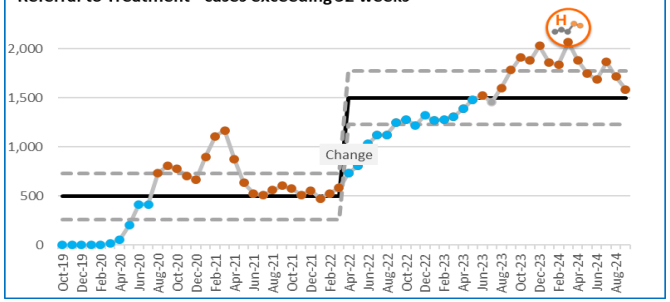
Referral to Treatment - total open pathway waiting list



Sep-24
47469
Variance Type
Special cause variation - concerning
Threshold
≤ 40511
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

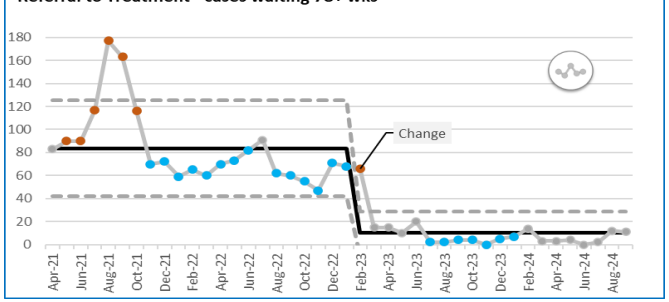
Referral to Treatment - cases exceeding 52 weeks



Sep-24
1585
Variance Type
Special cause variation - concerning
Threshold
≤ 1795
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

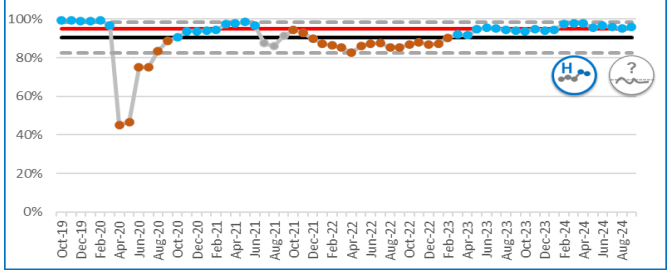
Referral to Treatment - cases waiting 78+ wks



Sep-24
11
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

Diagnostic Waiters, 6 weeks and over - DM01

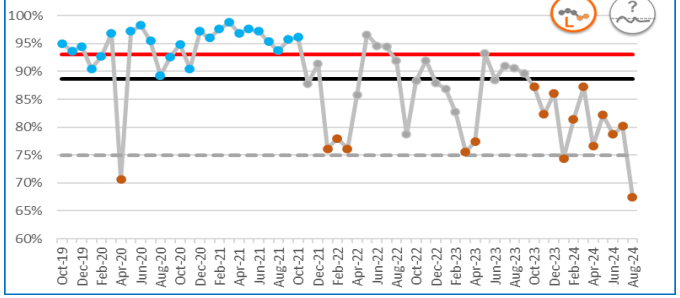


Sep-24
96.0%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

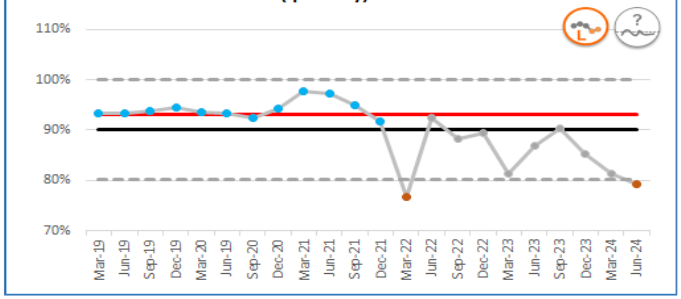
Cancer Waits - 2 week referrals (monthly)



Aug-24
67.5%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

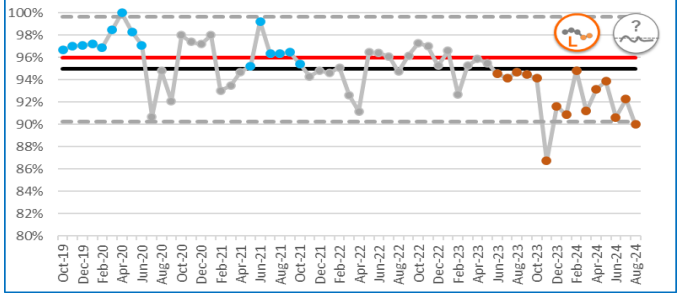
Cancer Waits - 2 week referrals (quarterly)



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

CQC Domain : Responsive

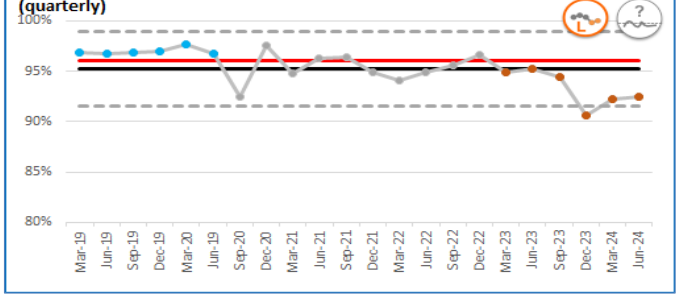
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



Aug-24
90.0%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

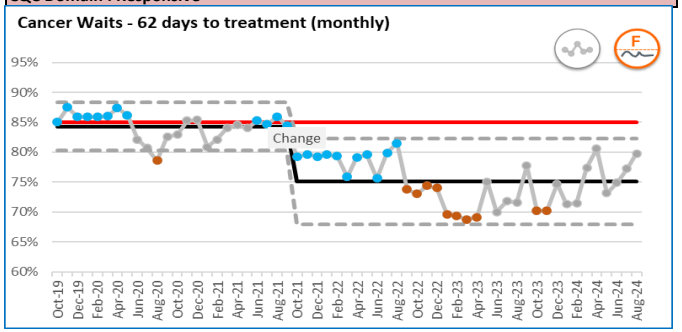
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



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

CQC Domain : Responsive

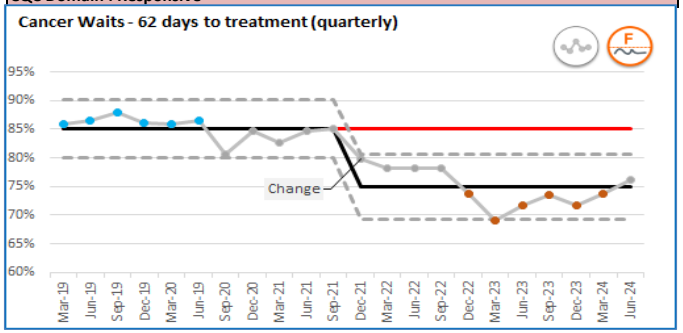
Cancer Waits - 62 days to treatment (monthly)



Aug-24
79.8%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

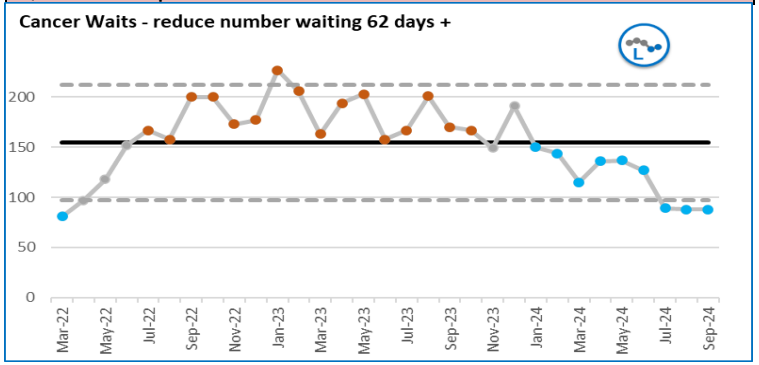
Cancer Waits - 62 days to treatment (quarterly)



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

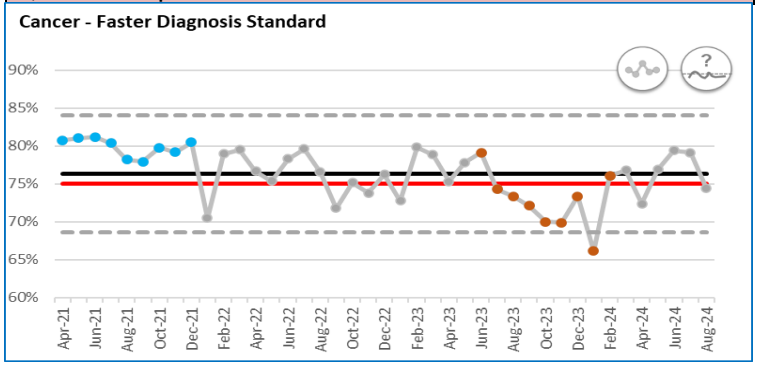
Chief Operating Officer (4)

CQC Domain : Responsive



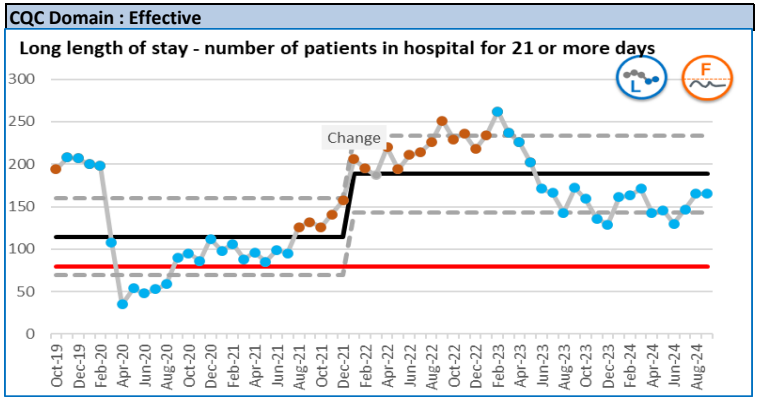
Sep-24
88
Variance Type
Special cause variation - improving
Threshold
83
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



Aug-24
74.4%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

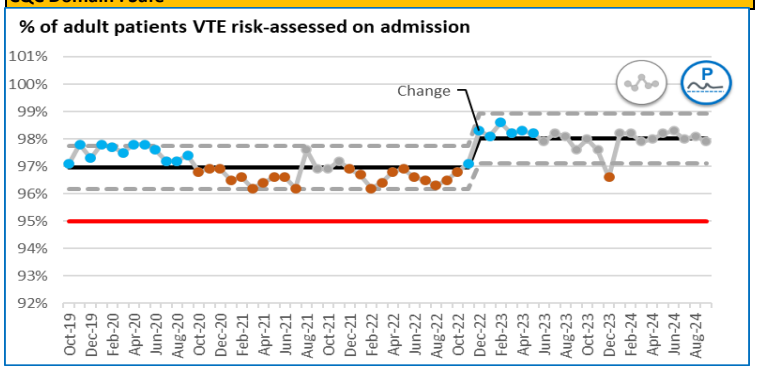
CQC Domain : Effective



Sep-24
165
Variance Type
Special cause variation - improving
Threshold
≤79
Assurance
Performance consistently fails to achieve the target

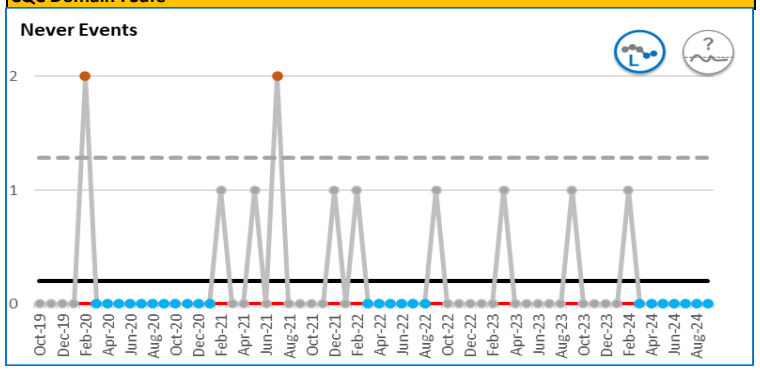
Medical Director

CQC Domain : Safe



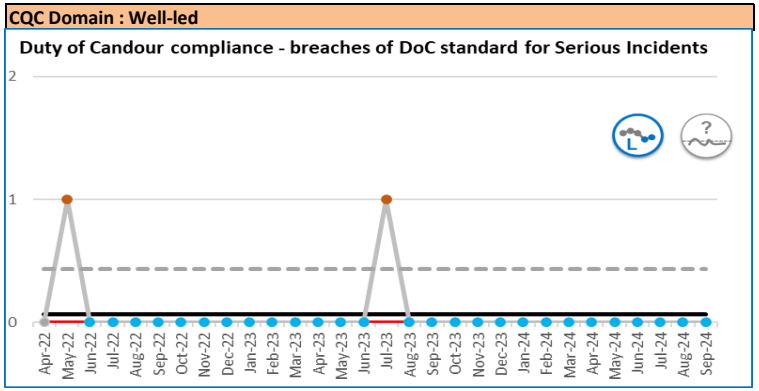
Sep-24
97.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



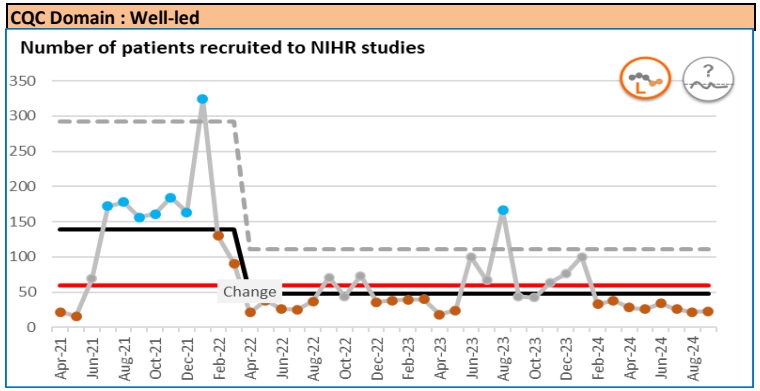
Sep-24
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led



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

CQC Domain : Well-led

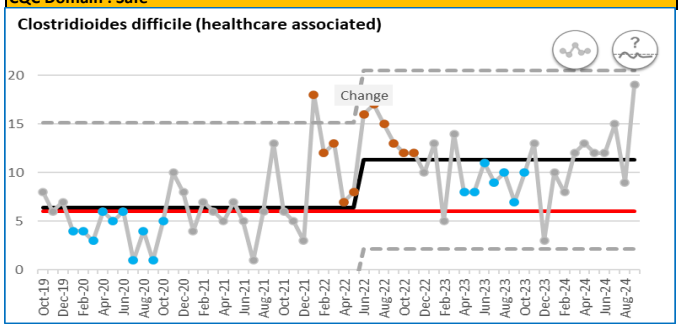


Sep-24
23
Variance Type
Special cause variation - concerning
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse (1)

CQC Domain : Safe

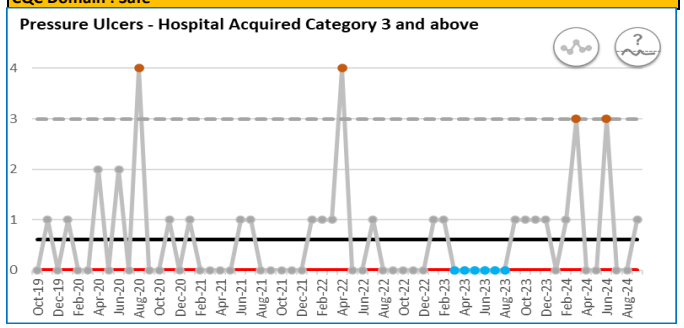
Clostridioides difficile (healthcare associated)



Sep-24
19
Variance Type
Common cause variation
Threshold
≤9
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

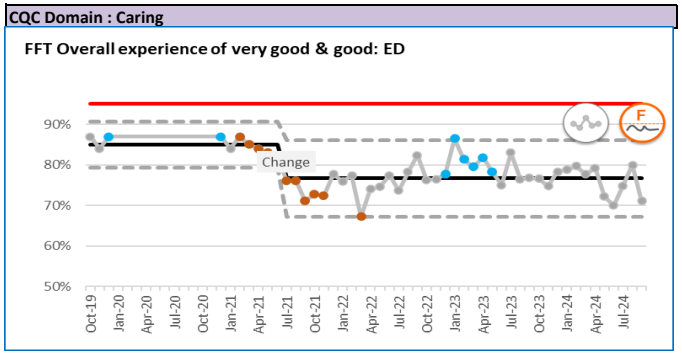
Pressure Ulcers - Hospital Acquired Category 3 and above



Sep-24
1
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

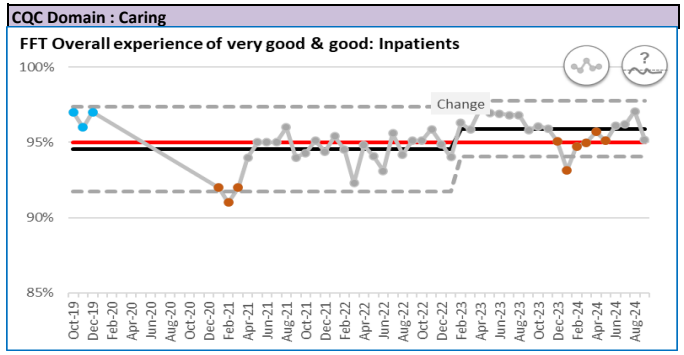
FFT Overall experience of very good & good: ED



Sep-24
71.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

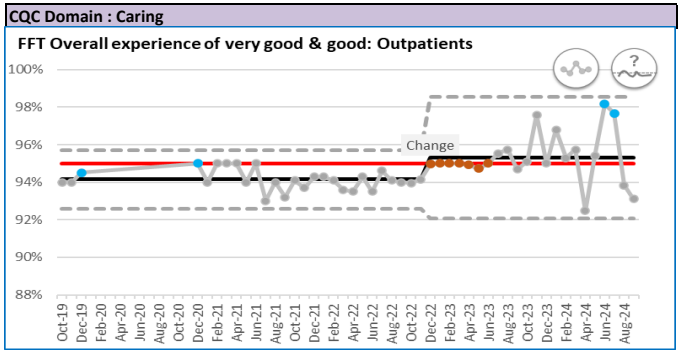
FFT Overall experience of very good & good: Inpatients



Sep-24
95.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

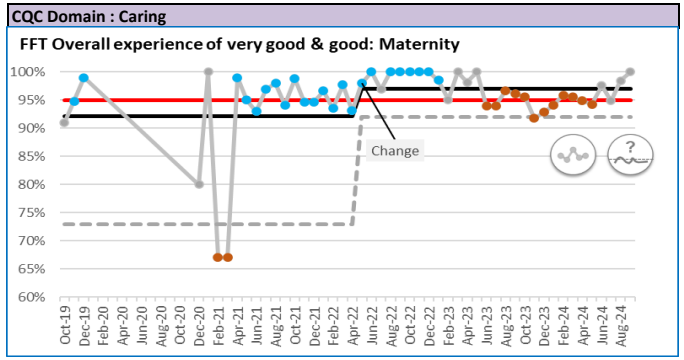
FFT Overall experience of very good & good: Outpatients



Sep-24
93.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

FFT Overall experience of very good & good: Maternity

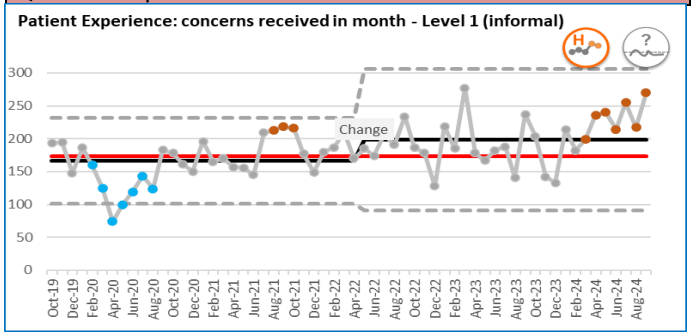


Sep-24
100.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse (2)

CQC Domain : Responsive

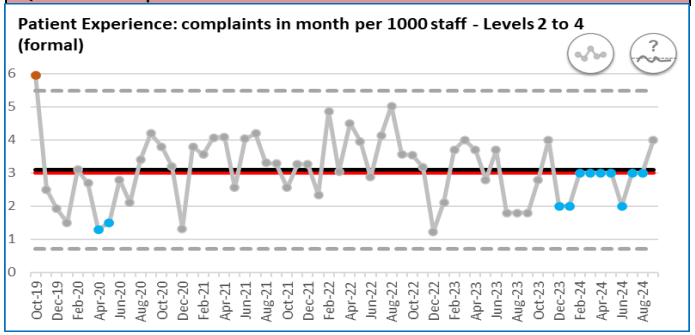
Patient Experience: concerns received in month - Level 1 (informal)



Sep-24
270
Variance Type
Special cause variation - concerning
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

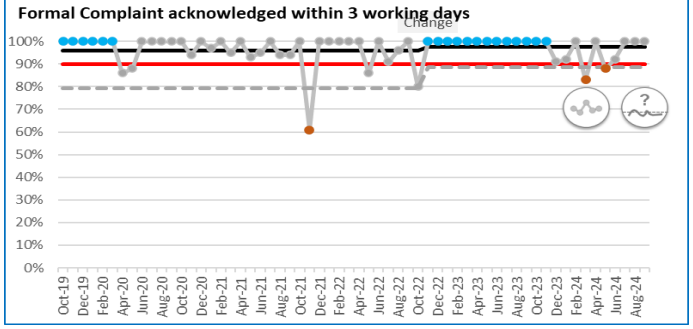
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)



Sep-24
4.0
Variance Type
Special cause variation - improving
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

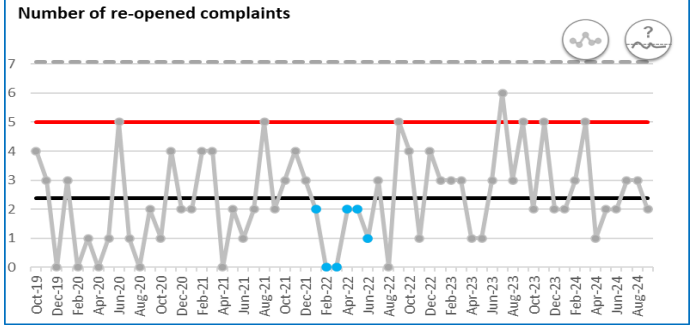
Formal Complaint acknowledged within 3 working days



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

CQC Domain : Responsive

Number of re-opened complaints



Sep-24
2
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

Chief Nurse – September 2024 data

Overall position commentary

The Trust quality KPIs all demonstrate no significant variation, with the exception of CDIF which had an increase in month to 19.

C Difficile remains above the target of 6 per month, there were 19 incidences in September 24 (15 HOHA/4 COHA)

There was 1 category 3 hospital acquired pressure ulcer in September against a target of 0.

Friends and family test for ED had reduced from 80% to 71% in September, outpatients reduced to 93.1%. Maternity and inpatients exceeded the 95% target.

Infection Prevention and Control

Narrative:

To achieve the annual threshold of ≤ 103 patients diagnosed with CDT in 24/25 there can be no more than 6 patients diagnosed with *Clostridioidies difficile* infection per month. We remain above the threshold of 6 per month with an average of 13 per month. That's an overall position of 57 x Hospital onset health care associated (HOHA), 23 x Community onset healthcare associated (COHA). In September there were 15 HOHA and 4 COHA. The wards in the CDI improvement project continue to meet bi-weekly to share their local improvement initiatives that each area has developed (wards 36, 26, 18, AMU, ED). In September the wards in the improvement project had 7 patients diagnosed. Ward 18 HOHA x1 , Ward 26 HOHA x 2, ED HOHA x 1, AMU HOHA x 1, Ward 36 HOHA x1 and COHA x 1.
The improvement project focuses on but not limited to:

- Education with staff regarding prioritization, use of side rooms and requesting early medical review if patients experience loose stools.
- During huddles discuss stool chart compliance and documentation.
- Daily scrutiny of side room occupancy and which patients would be the least risk to step out should one be required.
- Ward 36 in collaboration with E&F and IPC continue to pilot new cleaning equipment and cleaning solutions, these include microfiber flat head mops, which effectively pick up and trap 99.54% of dirt, dust and bacteria at microscopic level using water alone, and hypochlorous acid for hard surface cleaning and hand sanitization. This is a natural microbial agent, which will help to reduce the amount of chemicals we use thus promoting improved sustainability...
- Increased scrutiny re: taking samples in a timely manner when symptoms start and isolating the patient within 2 hrs (as per CDT policy)

Actions:
Completed or in place.

- Ongoing use of ward 44 as a decant ward to facilitate bay movements to allow for HPV to take place following a patient identified with CDT.
- Ongoing IPC visibility to wards and department offering expert advice and guidance.
- Robust process embedded to pick up weekend results.
- Senior nurse walk rounds focusing on IPC basics, including cleanliness, hand hygiene, bare below the elbows, decluttering and estates issues.
- Weekly CDT MDT in place involving, Pharmacy, Microbiology, IPC, and a clinician with an interest in CDT.
- A place wide 'working draft' improvement plan developed in partnership with WCT, the ICB and public health.
- Collaborative monthly meeting with WUTH IPC and the Community IPC team

Planned

- Re-scheduled showcase event sharing the improvement work trust wide for wards and departments to review and locally adopt the proven initiatives to support a reduction of incidences of CDT in their areas. (11th November 24)
- Draft 4 pillar system plan developed. Workstreams include, public health, Primary care, Community (inc care home/nursing homes) and acute. To progress though organisational governance for approval, with public health board overseeing delivery.
- Public health team review of cases to identify lines of enquiry.

Risks to position and/or actions

- Hospital occupancy
- Competing priorities preventing engagement in the QI project.
- Low numbers of side rooms and/or side rooms with en-suites across the Estate
- Limited numbers of toilets on each ward
- Old estate requiring maintenance and repair.

FFT Overall experience of very good and good.

Narrative:

The NHS Friends and Family Test (FFT) was created to help service providers, and commissioners understand if patients are satisfied with the service provided, or where improvements are needed. It's a quick anonymous way for patients to provide their views. The trust monitors FFT across a range of care settings, with a target rating of a minimum 95% for good or very good.

ED score decreased to 71%. Analysis of the patient comments for ED identifies waiting times and communication, as the main reasons for attributing negative ED response. OPD had reduced to 93.1% with no disenable commentary to indicate the reason for the change.

Actions:

- Proactively respond to feedback, making immediate rectifications when able to do so.
- Continued focus on providing people with access to provide feedback via FFT.
- Feedback to local teams' themes from FFT to identify areas of improvement.
- Regular announcements on waiting times within ED.
- Introduce new ways of working to enable a smoother patient journey.
- Rounding the department to check patients' needs are met.

Risks to position and/or actions:

- Bed occupancy is impacting on the length of time patients remain within ED. Processes are in place operationally to enable earlier egress from ED.
- National benchmark data only available to May 24
- Reduction in administrative support to deliver the patient experience strategy, due to current vacancy controls. Work being priorotised to mitigate risks to the strategy.

Pressure ulcers Hospital Acquired Category 3 and above

Narrative:

WUTH has a zero tolerance on Hospital Acquired Pressure Ulcers (HAPU) category 3 and above. During September there was 1 Hospital Acquired Pressure Ulcer (HAPU) Category 3 to a patient's heel reported which was a deterioration from a Category 2.

Actions:

- Changes have been made to the Ulysses system to improve reporting of all categories of pressure damage including mucous membrane and moisture associated skin damage.
- Tissue Viability team validated all HAPU category 3 and above.
- Pressure ulcer policy has been updated incorporating national guidance requires ratification.
- Stop the Pressure campaign will be taking place the week beginning 18th November. The theme is INCLUSIVITY – 'Are you really LOOKING, are you really LISTENING.' The Tissue Viability team are planning the event and comms will be sent out within the next few weeks.
- Review of products to support off-loading of heels.
- Development of Moisture Associated Skin Damage Pathway.
- Dynamic Mattress contract currently in progress.
- Trust wide link nurse network to be developed.
- A Trust wide Wound care formulary has been developed in collaboration with vascular, podiatry and dermatology specialist nurses.

Risks to position and/or actions:

- With increase in activity plus availability of beds and dynamic mattresses this can impact on the ability to review skin condition and undertake repositioning within the Emergency Department.
- Part time leadership within the tissue viability team.

Complaints

Narrative:

During September 2024, WUTH received its largest number of complaints and concerns for the past 18 months. Compared with the monthly average, there was a 33% rise in formal complaints (level 2) and a 37% rise in informal (level 1) concerns. The distribution across the divisions was even.
Top three themes;

- Access and Admission
- Communication
- Treatment and Procedure

The highest featuring departments were the ED (20 formal and 57 informal), followed by Community Child Health 35 informal, reflecting the known access problems with waiting times for assessment by that service.

35% of responses to formal complaints were completed within WUTH's local standard of 40 working days.

Actions:

Average complaint response time during the financial year to date has been 60 working days (compared with 70 working days in 2022/23, 58 working days in 2021/22, and 45 working days 2020/21. WUTH last met an average response time of below 40 working days in 2019/20 (34 working days).

Benchmarking with other local trusts, demonstrated target response times between 25, 40, and 60 working days, and even up to six months in line with the upper limit set by the national regulations.

Discussion with complaints team, governance, and deputy Medical and Nurse director concluded that 40 day response time was sufficient to provide a comprehensive response to complainants.

Plan to re-launch Trust's Concerns and Complaints Policy via a revised SOP, with highlighted emphasis on the role of a single divisional investigator to coordinate a unified response with all stakeholders, divisional triumvirate oversight, and executive escalation for support when it is apparent that targets will not be met. Greater ownership will also be placed on the lead investigators in the divisions to update complainants directly when investigations are taking longer than expected.

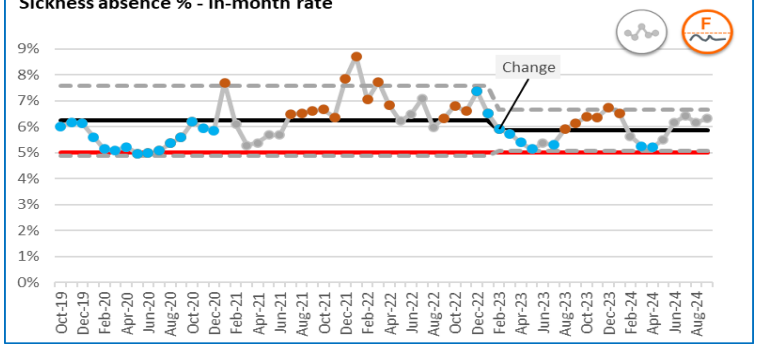
Risks to position and/or actions:

- Operational pressure
- Lack of individual ownership.

Chief People Officer

CQC Domain : Safe

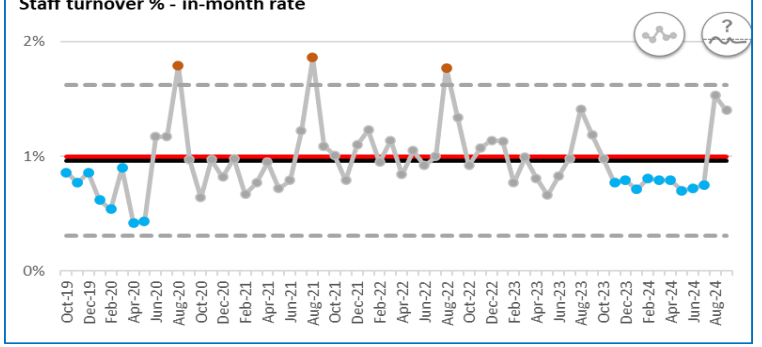
Sickness absence % - in-month rate



Sep-24
6.67%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe

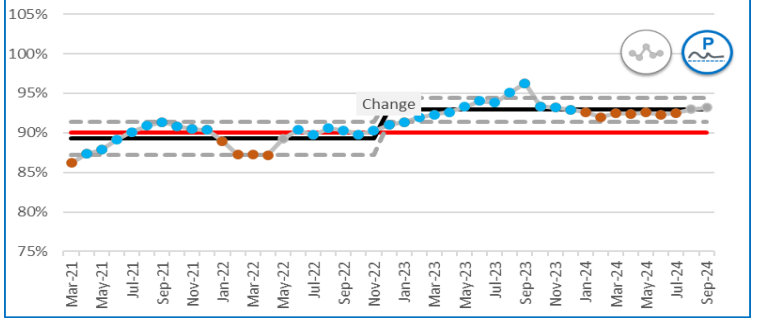
Staff turnover % - in-month rate



Sep-24
1.40%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

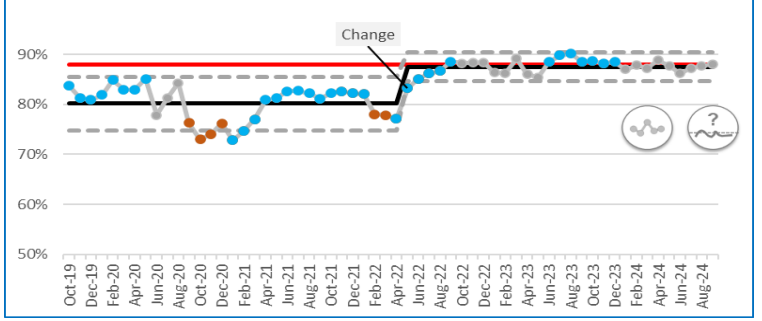
Mandatory training % compliance



Sep-24
94.40%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led

Appraisal % compliance



Sep-24
88.12%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – September 2024 data

Overall position commentary

Despite operational pressures the Trust's People KPIs for mandatory training and appraisal compliance are on target.

Turnover remains above compliance at 1.14%, this aligns with expected seasonal trends.

Sickness absence remains above target at 6.32% and remains an area of concern.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For September 2024 the indicator was 6.32% and demonstrates common cause variation.

The majority of absences relate to short term sickness. The top three reasons for absence in September are, Gastrointestinal problems, Stress/Anxiety/Depression and Cold/Flu.

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:

- Good start to the Winter Vaccination programme (commenced 3 October) supported by Trust wide promotional campaign to increase awareness and uptake.
- Freedom to Speak Up Month promotional materials, in collaboration with Trust Clinical Psychotherapist.
- New management guidance on effective use of OH service.
- Ongoing targeted psychological support provided to targeted areas.
- The new OH Cority System is positively impacting on OH waiting times and reductions in time-to-hire.
- Expedited appointments system for critical staff for OHA, OHP and pre-employments.
- Ongoing promotion of the Trust's EAP resulting in a maintained increase in uptake.
- Effective working with Talking Together Wirral to reduce Clinical Psychotherapist waiting list.
- Check-Ins recording to increase uptake, focusing on staff contribution, development and wellbeing.
- Divisions have presented their mitigation sickness plans to Workforce Steering Board which have been centrally collated into an action plan.

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.

Staff Turnover % compliance

Narrative:

The Trust threshold for turnover is 0.83%. In September the indicator decreased to 1.14% from 1.53% in August. This demonstrates a common cause variation.

Actions:

Continued development and implementation of the retention programme, with enhanced focus upon Nursing and AHPs. Examples of the work underway include:

- Staff career stories
- Executive engagement events
- Career shadowing opportunities
- Establishment Review to ensure adequate staffing levels.
- New non-medical (clinical) retention group.

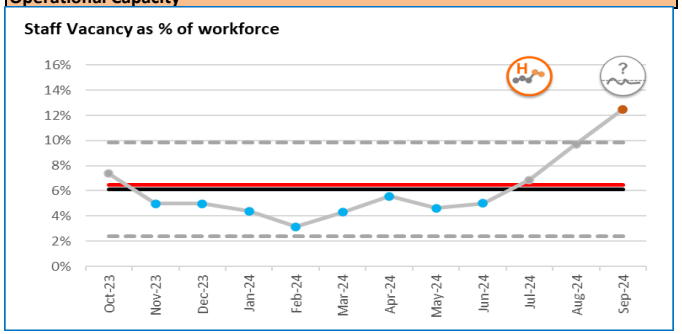
Risks to position and/or actions:

The impact of the work outlined above will achieve a downwards trend towards the <10% turnover target, the number or % of staff leaving within the first 12 months and voluntary turnover.

Risks to Trust financial management, quality, patient safety and operational performance due to the cost of high Turnover and the expense of bank and agency cover should also reduce as Turnover improves over time.

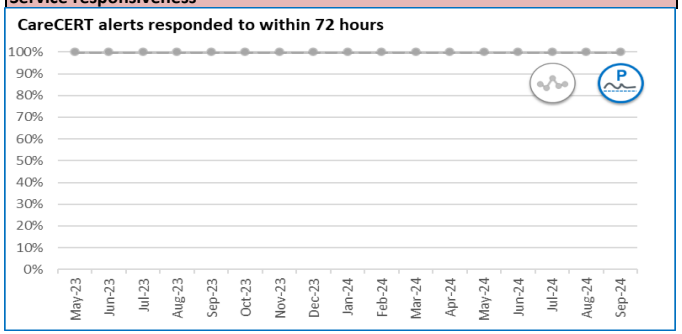
Chief Information Officer

Operational Capacity



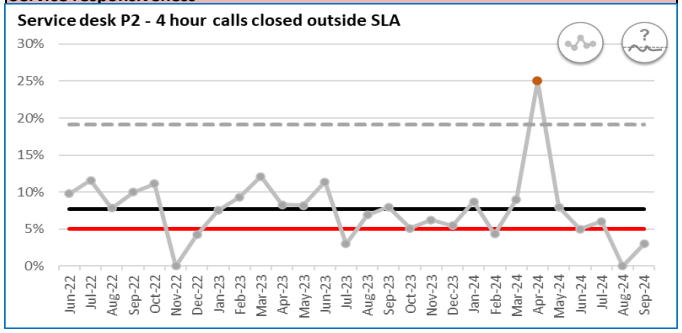
Sep-24
12.5%
Variance Type
Special cause variation - concerning
Threshold
<=6.5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



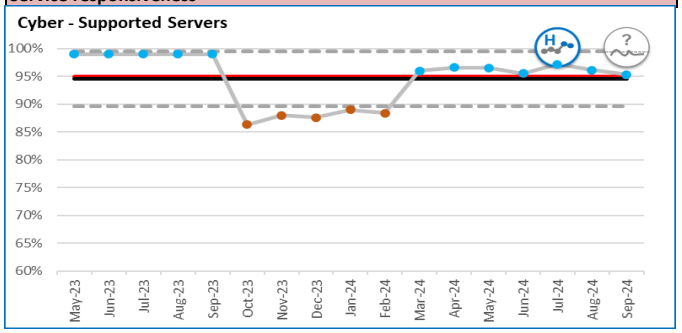
Sep-24
100%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently achieves the target

Service responsiveness



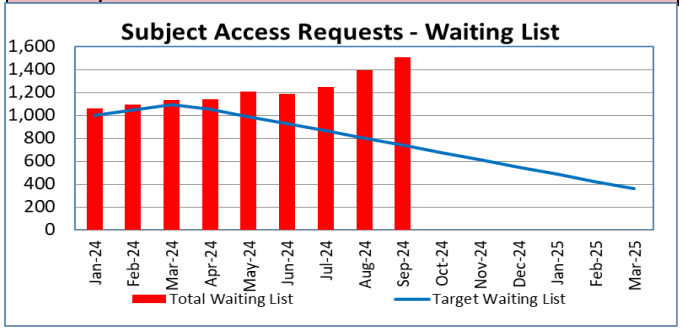
Sep-24
3.0%
Variance Type
Common cause variation
Threshold
<=5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



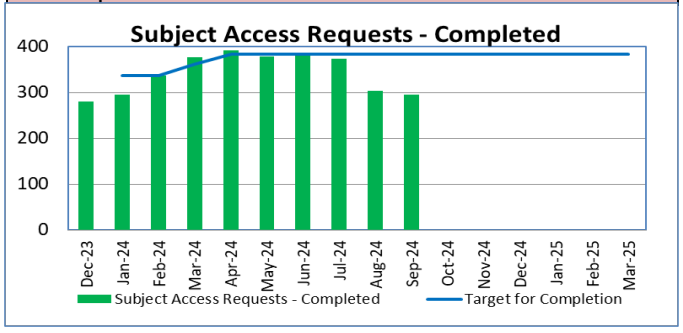
Sep-24
95.4%
Variance Type
Special cause variation - improving
Threshold
>=95%
Assurance
Hit & miss target subject to random variation

Service responsiveness



Sep-24
1507
Variance
Total requests waiting worse than target
Threshold
738

Service responsiveness



Sep-24
295
Variance
Completed requests worse than target
Target
384

Chief Information Officer – September 2024 data

Overall position commentary

Strong performance is maintained in:

- CareCERT alerts at 100% - a key control for cyber-security.
- Cyber supported servers continue above the 95% threshold figure.
- P2 calls closed outside SLA – achieved target for a second month.

Key areas for improvement are:

- Subject Access Requests (SARs) – completed requests were significantly below the trajectory which has increased the backlog further.
- Staff vacancies are currently at 12.5% of the workforce, a significant increase on previous months which has impacted on SARs capacity.

Service Responsiveness – Subject Access Requests

Narrative:

The organisation has experienced a year-on-year increase in volume and complexity of Subject Access Requests (SARs) totaling 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 demand. 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 1,000 requests, with approximately 650 of those requests being outside of the regulatory 30 day response target.

The improvement trajectory for completing requests was 89 behind target in September with 295 being processed against a target of 384
Total requests waiting increased to 1,507. This was largely due to the departure of 2 experienced staff in August from the team which is already challenged in meeting the increased demands.

The number of new requests received every month remains higher than in 2023 and above the average anticipated. In September, 407 requests were received, which continues to be in excess of the predicted levels. The continued increase in numbers is largely attributable to the heightened profile of Healthcare related media events such as the Cyber attack on the London Pathology services and the recent high profile maternity case at the Countess of Chester Hospital (CoCH)

Actions:

- Supplier planning meeting at end of October to discuss Implementation of new tracking software to help manage and streamline the process.
- Requested the support of the Service Improvement Team (SIT) for a review of processes to identify opportunities for efficiencies. Plans for SIT have been submitted to execs for approval.
- 2 posts are being submitted as vacancy freeze exceptions.

Risks to position and/or actions:

- Risk posed by any further increase in demand
- Risk of trajectory slippage depending on any personnel issues such as sickness, staff turnover
- Risk of not being able to appoint to established posts

Operational Capacity – Staff vacancy as a % of workforce.

Narrative:

The last reporting period has seen a further increase in staff vacancies as a percentage of the workforce, rising from 9.7% in August to nearing 12.5% in September. The increase is due to a number of staff departing to accept opportunities at a higher banding at other C&M organisations and the retirement of several long serving senior managers, particularly within the BI & Information department. There are some key areas of risk for the Trust in the areas of BI & Information, Development & Integration, Coding, Cyber Security, Access to Information, and more recently Clinical Analysis (with specialist knowledge of Laboratories)

The team continues to assess its workforce risks together with executive colleagues.

Actions:

- All departments across DHT have been risk assessed and proposals are being prioritised to address the high risk areas.
- Vacancy freeze exception being progressed for BI & Information Team & Access to Information posts
- Technical Cyber work being actioned by the Technical Infrastructure Team.
- Chief Technology Officer providing backup cover for Integration Team.
- Scoping work ongoing to understand the opportunity of collaboration with Community Trust in problem areas.
- Investigating Artificial Intelligence opportunities within the coding arena.

Risks to position and/or actions:

- Difficulties in recruiting the desired skill sets for vacated positions due to national skills shortages in those areas.
- Chief Technology Officer providing expert cover for Development & Integration is not sustainable.
- Vacancies are not approved at the exception process.
- Performance impacts across the department.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 8.4**

06 November 2024

Title	Monthly 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 September 2024 and an extended monthly paper presented in October 2024. The following extended monthly paper provides a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

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

It is recommended that the Board:

- Note the report.
- Note the Perinatal Clinical Surveillance Assurance report.

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**
November 2024	Maternity & NNU Assurance Board	Extended Monthly Maternity and Neonatal Services Report	For information
October 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 (September 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. 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 September 2024 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI). There were no Patient Safety Investigation Incidents (PSII's) declared in September 2024 for Neonatal services.

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

4	Implications
4.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
4.2	**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.
4.3	**Finance** • A workforce review in line with Ockenden requirements is underway. To achieve compliance of MIS Year 6 the Statement of case for an additional Neonatal Consultant has been approved to cover Monday to Sunday, recruitment is in process.
4.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Appendix 1 - Perinatal Clinical Surveillance Quality Assurance Report Sept 2024

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	No	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to and decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised; external review requested to support rise in still birth rate; no further trends identified as an outlier in 2024; new C&M data provided and validity underway in October 2024
	Outlier for rates of neonatal deaths as a proportion of birth	na	No escalation from SCN / LMNS on outlier report; internal thematic review undertaken and shared with BoD; Decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised.
	Rates of HIE where improvements in care may have made a difference to the outcome	na	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of PSII's	na	No PSSI's reported in September 2024
	Progress on SBL care bundle V3	no	SBLv3 launched and continued to be a key safety action of MIS Year 5 which was signed off as complaint meeting 81% (>70% was the requirement); Audits and evidencecontinue to be submitted for LMNS review and achieved complaince as at Q1 (April-June 2024) of 97%; compliance will be monitored by LMNS quarterley and updates provided to BoD quarterley
	Outlier for rates of term admissions to the NNU	na	The rate of avoidable term admissions; regular multi-disciplinary reviews of care take place; NW region outlier report no longer published and awaiting national guidance on monitoring processes
Service user and st	MNVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints; to date all complaints have been addressed for maternity in the target timeframesand there is nil to escalate
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey completed and divisional response has included staff engagement and continuation with the Pulse surveys; Score survey completed for MatNeo and cultural conversations commencing over x 4 sessions; Requirement to report to BOD Feb 2024 which was completed and evidence within meeting minutes
	CQC National survey	no	Published Feb 2024 and included within BoD report March 2024; action plan progressing; Sample provided for 2024 survey to be pulished early 2025
	Feedback via Deanery, GMC, NMC	no	Nil to esclate
	Poor staffing levels	no	Current vacancy rate is >1%; all new qualified midwives commenced in Sept 2024
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Nil of note; full establishment; governance structure review and revised structure implemented to meet requirements and maternity self assessment tool and continue to meet Ockenden Part 1
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates
	False declaration of CNST MIS	no	MIS Year 5 submission and declaration submitted by 12 noon on 1st February 2024 - complaince met; MIS Year 6 publication published April 2024 included within BoD report updates.
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month; funding options explored; 5 teams in total and two approach model in place; comparison data / research underway; one team disbanded in July 2024
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterley meetings held with MNSI
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident
	Learning from PSII's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all PSSI's, local reviews, rapid evaluations of care, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. No exceptions to report. Three year single delivery plan for maternity and neonatal services published 31th March 2023 - gap analysis in progress and will monitored via WUTH CG structure and BoD; CQC National Maternity Report published 20/09/24 reviewed and gap analysis prepared - to be shared with BoD at next quarterley meeting
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture
	Delays in reporting a PSSI where criteria have been met	no	Robust PSIRF framework followed with timely reporting of all cases that meet the PSSI framework; PSIRF with effect from 1/9/2023
	Never Events which are not reported	no	No maternity or neonatal never events in September 2024
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales
Governanc e processes	Unclear governance processes		Clear governance processes in place that follow the PSIRF framework - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated. Additional quality assurance framework agreed with effect from June 2023 to give the BoD addiitonal assurances in monitoring of MIS, Three year delivery plan etc. Governance structure strengthened
	Business continuity plans not in place	no	Business continuity plans in place
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month
CQC inspection and DH SC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	CQC reports published for maternity sites Seacombe Birth Centre and APH site for the domains Safe and Well led; both sites were rated 'GOOD'
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework Quarter 3 2024

Item 8.5

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

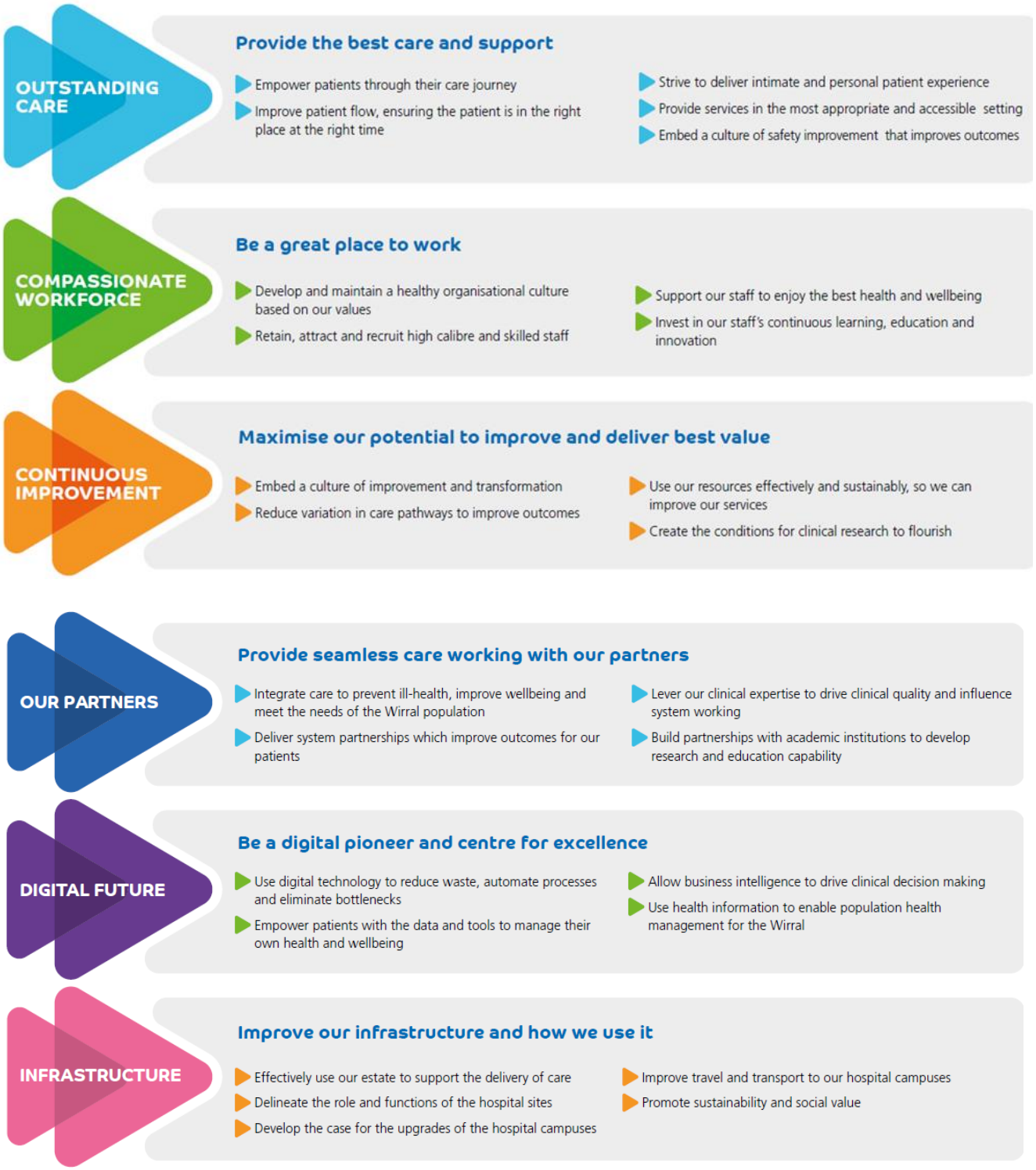
2. Vison, Strategy and Objectives

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

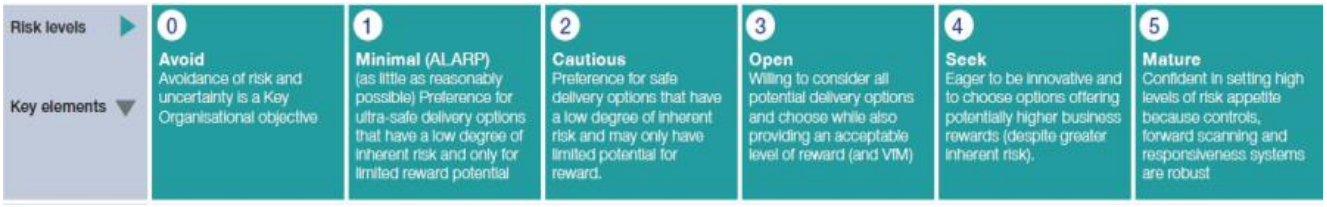
The Trust endeavours to establish a positive risk culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

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 Quarterly 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 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 is continuous 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 on the current version of the BAF.

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	Dec 24 TBD
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 • 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.	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy.

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 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
• 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. • Uncertainty of impact of industrial action • Approval of deficit plan.	• Continue delivery of CIP programme and maintain oversight of divisional progress. Ongoing. • Complete benchmarking and productivity opportunities review pack. • 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

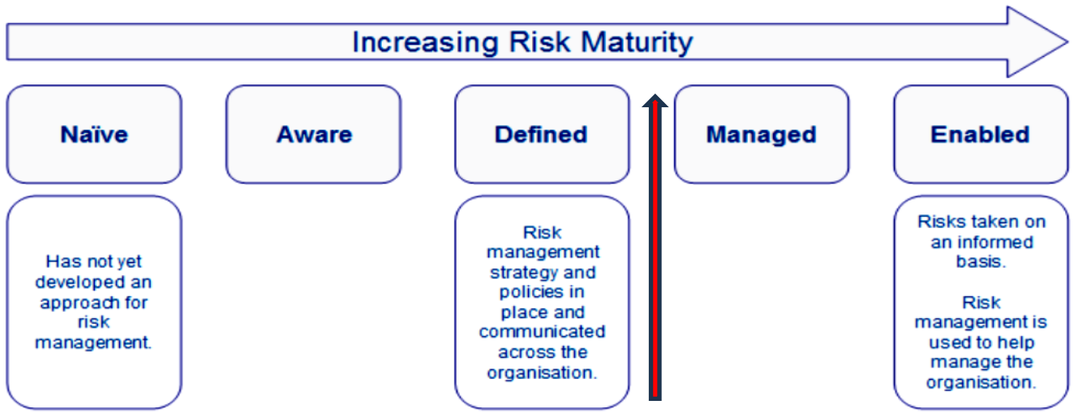
The likelihood score is a reflection of how likely it is that the adverse consequence described will occur.

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

Highest Scoring Risks

1199	D+CS	Ageing Aseptic Services Unit (ASU) and Aseptic Air Handling Unit (AHU) - Financial risk of failure	(5 x 5) 25	⇔
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	⇔
1728	Surg	SSD Washers/disinfector breakdown	(4 x 5) 20	⇔
1849	Surg	Failure to deliver Surgical Division Elective activity plan for 2024/25	(5 x 4) 20	⇔
1860	Corp	Inappropriate Accessing of Patient Records	(4 x 5) 20	⇔
1936	Corp	Unable to provide assurance on clinical staff competency	(4 x 5) 20	★
1938	Corp	No designated prevention of fundamentals of care harm lead.	(4 x 5) 20	★
1937	Corp	No designated resource to undertake EDI & EDS requirements	(4 x 5) 20	★

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9.1**

06 November 2024

Title	Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2023/24
Area Lead	Hayley Kendall, Accountable Emergency Officer and Chief Operating Officer
Author	Steve Povey, Head of Emergency Preparedness
Report for	Information

Executive Summary and Report Recommendations

The Emergency Preparedness Annual Report for 2023-24 is a review of the year from the perspective of Emergency Preparedness, Resilience and Response (EPRR). The report provides assurance as to the EPRR position for the Board of Directors and covers the core elements of a robust and reliable EPRR framework.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key risks:

- There are no significant risks directly associated with this report. Failure to produce it or for it to be an agenda item at a public board will result in a non-compliant element to the annual core standards. The report is designed to provide assurance to the public board for the EPRR readiness position of the trust.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	No
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	No
Compassionate workforce: be a great place to work	No
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	Yes

1	Narrative

1.1	The Emergency Preparedness Annual Report for 2023-24 is a review of the year from the perspective of Emergency Preparedness, Resilience & Response. The report contains details of the Trust performance for the EPRR Annual Core Standards, exercise outcomes including communications exercises and externally managed events.

2	**Implications**
2.1	**Patients** No direct implications for patients
2.2	**People** Report outlines the key areas for compliance with emergency preparedness and duties under the NHS contract, NHS EPRR framework and Civil Contingencies Act. Staff input and actions are crucial to the success of EPRR.
2.3	**Finance** No direct finance impact from the annual report.
2.4	**Compliance** The continued compliance with EPRR standards is crucial to meeting the trusts legal obligations under the Civil Contingencies Act and NHS guidance it is required to implement.

Wirral University Teaching Hospital
NHS Foundation Trust

Emergency Preparedness Resilience and Response (EPRR)

Annual Report

2023/24

Report date:
April 2024

Author: Steve Povey, Head of EPRR/EPO

Sponsor: Hayley Kendall, Chief Operating Officer, and Accountable Emergency Officer

Contents

Appendices

1. Executive Summary

The Civil Contingencies Act (CCA) (2004) requires category one responders, to show that they can deal with incidents while maintaining services to patients. As a category one responder under the Act, the Trust has a duty to develop robust plans to respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of our services in the event of a disruption.

The Trust has the required Accountable Emergency Officer (AEO), supported by the Emergency Preparedness Officer (EPO) along with the appropriate emergency planning meeting structure.

All of the mandated emergency plans to respond to a major incident are in place and published on the Trust emergency planning intranet page.

2. Introduction

The NHS needs to be able to plan for, and respond to, a wide range of incidents that could impact on health or patient care. These could be anything from extreme weather conditions, an outbreak of an infectious disease, or a major transport accident. A significant incident or emergency is any event that cannot be managed within routine service arrangements. It requires the implementation of special procedures and involves one or more of the emergency services, the NHS or a local authority.

The Civil Contingencies Act (CCA) (2004) requires category one responders, to show that they can deal with such incidents while maintaining services to patients. As a category one responder under the Act, the Trust has a duty to develop robust plans to respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of its services in the event of a disruption.

3. Purpose

The purpose of the annual report is to:

- Provide an overview of the emergency preparedness arrangements within Wirral University Teaching Hospital NHS Foundation Trust (WUTH)
- Describe the Trust's responses to incidents that have occurred during 2023-24
- Outline the work that has been undertaken in this area during the past 12 months
- Summarise the planned work streams and priorities for the year ahead

4. Emergency Preparedness Structure

4.1 Lead Officers

Accountable Emergency Officer (AEO)

The NHS Act 2006 (as amended) places a duty on providers to appoint an individual to be responsible for discharging their duties. This individual is known as the AEO. For the period covered in this report, the AEO was:

Hayley Kendall Chief Operating Officer	**01/04/23 – 31/03/24**

Emergency Planning Officer

The AEO is supported in this role with the role of Emergency Planning Officer (EPO). For the period covered in this report, the EPO was:

Steve Povey	**01/04/23 – 31/03/24**

4.2 Meeting Structure

In order to discharge the Trust's responsibilities effectively under the Civil Contingencies Act (2004), emergency preparedness arrangements have been embedded into the Trust's operational structure.

Trust wide ad-hoc planning meetings are initiated for any required emergency planning such as large scale community events, planned IT downtime planning, bank holiday planning, service/ward change or other operational pressure where services may be affected. Section 9 details the events that have been formally planned for during this period.

4.2.1 EPRR meeting structure:

- The Local Health Resilience Partnership (LHRP) meetings provide a forum to ensure that planning is not be conducted in isolation by a single organisation, but is undertaken in partnership with other local responders and commissioners. There are 2 levels of LHRP meetings; Strategic and Practitioner.
- The AEO, or their representative, attends the Strategic LHRP meetings for Cheshire & Mersey. These meetings are held three times a year at Strategic Level.
- A Deputy Executive Director, Deputy Chief Operating Officer or the EPO attends the Cheshire & Mersey LHRP Strategic LHRP meetings on behalf of the AEO should they be unavailable.
- The EPO attends the Cheshire & Mersey LHRP Practitioner level meeting.
- During the course of the report both the Strategic and Practitioner Level LHRPs meetings were regularly attended by a WUTH representative.
- Attendance at these meetings is required to comply with NHS Core Standards for EPRR.

4.3 Out of Hours Arrangements

4.3.1 On-call rota

The Trust operates an on-call rota which is on a 24/7/365 basis and ensures that 1st On Call Managers and 2nd On Call Directors are contactable at all times and are able to respond quickly to a major or serious incident at any given time. This structure is supported by specific clinical and departmental on-call rotas which are designed to respond to local service-related operational issues. There is central coordination of these rotas.

4.3.2 On-call booklet

The Hospital Manager/Executive On-call booklet is regularly reviewed and updated to ensure that current information is to hand for any operational issue and risk assessment forms for major incidents.

4.3.3 On-call training

Induction meetings are in place for members of the on-call executive director and manager rota, this includes major incident training. The on-call managers hold quarterly on-call forums where on-call issues, new guidance, updates and major incident refresher training is held.

NHS England and the Cheshire and Mersey ICB host Principles of Health Command Training throughout the year. Attendance on this course is mandatory for all oncall managers and directors with compliance measurable and part of the NHS England Cores Standards for EPRR response.

5. Risk Register (LHRP)

The Cheshire & Merseyside LHRP maintains a register of risks which are likely to present a threat to the wider community. These risks are updated at the LHRP quarterly meetings and provide the basis for setting the planning agenda and establishing emergency preparedness work plans for the Cheshire & Merseyside region.

6. Exercises and Training

The Civil Contingencies Act (2004) outlines the organisational responsibility to exercise plans. Under the Act, all NHS organisations are required to undertake:

- Live exercises (or incident) every three years
- Table top exercises annually
- Communications exercises every 6 months

Given the Trust and the NHS has been operating in an emergency state for the last two years through the COVID-19 pandemic, in line with national guidance, all EPRR exercises and training were stood down.

In May 2023, the response to Covid-19 was stepped down to allow the re-commencement of normal training and exercising. It should be noted that as the Trust was under a command structure for the entirety of the pandemic the Trust's EPRR was thoroughly tested.

6.1 Live exercise (or incident)

6.1.1 COVID 19 Pandemic

The Trust continued to run in a command and control structure in response to the national Level 4 incident - COVID-19 Pandemic. This meets the requirements of the three yearly live exercise. It is anticipated that an EMERGO exercise to coincide with the new Emergency Department opening will be the next live exercise.

6.1.2 Level 1 Business Continuity Incident

During the year the Trust experienced a number of incidents which involved an EPRR Response, these included live responses aswell as full EPRR Command & Control be stood up to deal with trust responses to known events.

Incident	Overview	Declared Date	Stepped Down Date
Clatterbridge Site Threat	Threat received by CWP which was taken as credible by Police and resulted in site lockdown for all trusts.	26/04/2023	26/04/2023
Clatterbridge Transformer Upgrades	Major power off events which required generator provision during duration of works	April & May	April/May on completion of works
M53 Bus Incident	Incident on motorway involving bus crash with children onboard	29/09/2023	29/09/2023
UECUP Power Upgrades	Power upgrades and connections for UECUP project involving 2 days and overnight loss of mains power to a number of areas including ED	20/01/2024	21/01/2024
WAFU Fire	Fire involving patient and oxygen supply	28/01/2024	28/01/2024
Industrial Action	Command & Control in place during all events of Industrial Action by RCN, UNISON, & BMA	April 2023	March 2024

6.2 Table top exercise

In line with the national guidance, exercises were stood down during the pandemic period and the Trust continued to run in line with command and control until May 2023 and have subsequently begun planning for the re-introduction of exercises.

6.3 Communications

The major incident contact list for in and out of hours was successfully tested during 2023/24 as outlined in the table below:

OUT OF HOURS
04/11/2023
IN HOURS
29/09/2023

In addition the regional ICB also conducted communications exercises into trusts which WUTH were part of, these were:

Exercise Hedwig
30/06/2023
Exercise Hermes
13/04/2024

7. External Review

7.1 NHS England Assurance for EPRR

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The Trust self-assessed against these standards between July and September 2023. Following assessment, the organisation self-assessed as demonstrating partial compliance level.

The process for Core Standards was changed during the year and a new set of criteria was published part way through the core standards assessment period. The revised guidance included a vast number or very specific requirements which trusts across the region had not been requested to demonstrate previously and resulted in WUTH along with a large number of other trusts being declared non-compliant by NHSE following review.

Following a challenge process between trusts and NHSE, WUTH made cases for a number of the standards in a bid to increase the compliance rating but all were rejected by NHSE.

Concern over the process that took place, its content and timing has been raised from a number of sources and the ICB EPRR Team have been working with trusts on the process for future submissions but there are still a number of concerns with the 2024/25 standards release approaching.

Core Standards Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address **six to ten** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address **11 or more** core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

A copy of this assessment along with the declaration of the level of compliance achieved was taken to the Public Board of Directors in September 2023.

8. Reports to Committee and Public Board

EPRR Reports to Board/Committee were presented on the following dates:

Item	Risk Management Committee	Public Board of Directors
EPRR Annual Report 2023/24	N/A	tbc
EPRR Core Standards 2023/24 Compliance Report	May 2023	tbc
Quarterly EPRR Report to Risk Management Committee	May 2023	
Quarterly EPRR Report to Risk Management Committee	August 2023	
Quarterly EPRR Report to Risk Management Committee	November 2023	
Quarterly EPRR Report to Risk Management Committee	February 2024	

9. Event Planning

During 2023-24 planning meetings supported by EPRR have taken place to ensure that safe robust plans were in place for the following events:

Event	Summary
Half Term/Bank Holiday Planning **Easter, early and late May, August, October Half-term, Christmas/New Year period, February Half-term**	Trust wide plans are developed to outline the arrangements that are put in place in the Trust and within key partner organisations in preparation for the Bank Holiday and selected Half Term periods. They provide assurance to the Wirral system and describe initiatives that have been put in place to maintain safe patient flow during a period of known increased demand. They provide robust plans for internal oncall teams to follow through the oncall structure. The planning also ensures that the process for bank holiday reporting to NHSE/I (NHSE daily operational pressures and NHSI SITREP) is in place during the bank holiday weekend period.
Trust wide Wirral Millennium planned upgrades/downtime:	Planned Wirral Millennium 'downtime' and system upgrades requires trust wide planning to ensure that issues/risk and actions have been identified and that staff in all areas are aware of the formal downtime process to follow to maintain patient safety. The EPO coordinates all such responses with leads from the specialty area. The EPO agrees all potential disruption plans with the AEO.
Multiple estates planning events: **Projects supported during this period included the Trust UECUP programme surveys, planned power outages at APH and CBH.**	Planned Estates projects that affect the Trust operationally require careful planning with key stakeholders to ensure that risk is identified and mitigation put in place to ensure patient and staff safety. The EPO is involved in the planning of all such events and approves the progression of such events with the AEO.

10. Work undertaken in 2023-24

The following work-streams were completed during the year under review:

- Provided assurance for NHS England Core Standards for EPRR
- Facilitated internal communication exercises, plus the end of the declared pandemic, that tested alerting procedures as part of incident response procedures
- Delivered major incident training to new on-call managers and directors
- Developed Trust wide plans for planned events such as IT planned downtime, Bank Holiday/Half Term periods and multiple estate projects

11. Progress with work programme for 2023-24

All actions are complete as detailed in appendix 2, these were the improvement actions from the 2021/22 plan.

12. Work programme for 2024-25

Work streams have been developed using recommendations from the Local Health Resilience Partnership. They will be undertaken during the 2023/24 financial year. Please refer to the plan in appendix 3.

EPRR Statement of Compliance

Wirral University Teaching Hospital, NHS Foundation Trust has a duty to protect the health of our community. This duty extends to times of emergency.

The purpose of this Major Incident Plan is to outline how we will respond in the event of an emergency, meet our responsibilities as a Category 1 Responder and comply with relevant guidance and legislation.

The Major Incident Plan is built on the principles of risk assessment, co-operation with partners, emergency planning, communication and information sharing. It is essential that we are prepared to look beyond a major incident, and put in place business continuity management arrangements, to secure the day to day running of the organisation.

The Management Team within Wirral University Teaching Hospital NHS Foundation Trust has an important role in ensuring we respond professionally to an emergency whilst maintaining vital services. It is essential that you are familiar with how the Trust will operate during such an event, what role you may play and the role of the other organisations we will be working with.

A Major Incident can take place at any time day or night and it may be necessary for staff to work in unfamiliar environments for flexible / extended periods. The plan will be subject to an annual test.

This Plan includes the provision of action cards for the different roles that may be involved.

Janelle Holmes

Chief Executive
Wirral University Teaching Hospital

Appendix 2

Progress with 2023/2024 Improvement Plan

Lead: Steve Povey, Head of EPRR

Recommendation /Issue (in line with EPPR Framework)	By end of Quarter 2023-24	Progress
Produce an annual report on Emergency Preparedness 2023/24 to Risk Management Committee September 2024	Q2	Complete
Undertake the self-assessment for the 2023/24 EPRR assurance process	Q3	Complete
Undertake a 'Deep Dive' into the preparedness of the Trust for the specified subject	Q3	Complete
Ensure RMC and the Public Board of Directors (BoD) has sight on the level of compliance against the 2020/21 revised process for the revised EPRR assurance	Q3	Complete
Carry out a Communication Exercise at a 6-month interval	Q3 & Q4	Complete
Carry out the 3-yearly review of all relevant emergency plans and note at BoD	Q4	N/a
Develop and deliver strategic refresher Major Incident Training to on-call Hospital Managers, Hospital Clinical Coordinators and Executives	Q4	Complete
Participate in multi-agency EPRR training and exercises in collaboration with partner organisations and the Cheshire & Merseyside LHRP – *N/a for this period*	Q4	N/a
Develop specific plans for all relevant local events in order to address potential demand management pressures in the health care system	Q4	Complete

Recommendation /Issue (in line with EPPR Framework)	By end of 2023/24
Undertake a table top exercise – Proposed July 2024	Q4
Produce an annual report on Emergency Preparedness 2023/24 to Risk Management Committee (RMC) May or September 2024 and ensure noted at the Public Board Meeting	Q3
Undertake the self-assessment for the 2024/5 EPRR assurance process	Q2
Undertake a 'Deep Dive' into the preparedness of the Trust for the specified subject	Q3
Carry out a communication exercise at a 6-month interval	Q1& Q3
Ensure the Board of Directors (BoD) has sight on the level of compliance achieved, the results of the 2024/25 self-assessment and the improvement plan for the forthcoming period	Q3
Carry out the 3-yearly review of all relevant emergency plans and note at BoD, where required	Due 2025
Update and deliver strategic refresher major incident training to on-call hospital managers, hospital clinical coordinators and executives, review On Call Training and re-publish On Call handbook.	All Quarters
Participate in multi-agency EPRR training and exercises in collaboration with partner organisations and the Cheshire and Merseyside LHRP	Q4
Develop specific plans for all relevant local events in order to address potential demand management pressures in the health care system	Q4

Appendix 3

2024/25 Work Plan

Activity	Review Date due	Progress
EPRR Annual Report to RMC	September 2024	Complete
NHSE Core Standards to RMC/BoD	September 2024	To Board meeting on xx October
Update report to RMC	March 2025	Date tbc
Plans		
Severe Weather Plan	March 2025	Brought forward for Core Standards – tbc
Pan Flu Plan	March 2025	Brought forward for Core Standards - tbc
Evacuation Plan	March 2025	Brought forward for Core Standards - tbc
Major Incident Plan & Action Cards	March 2025	Brought forward for Core Standards - tbc
CBRN Plan	March 2025	Brought forward for Core Standards - tbc
Power Failure Action Cards	September 2024	
Business Continuity Plans	September 2024	
Fuel Plan	December 2024	
Comms Tests (requirement 6-monthly)		
Out of Hours Comms Test	July Q2	

	November Q3	
In Hours Comms Test	April Q1	Complete
	February Q4	
Training & Exercising		
On-Call Training 1:1	At induction	Refer to on-call spreadsheet
Via On-call Forum – ad-hoc	June/Sep/Dec/Mar	Managed via Paul McNulty
On Call Competencies Portfolios	December 2024	
Tabletop Exercise – Cyber with DHT	July 2024	
Tabletop Exercise – Winter Preparations	October 2024	
Meetings		
LHRP Strategic	Mar, July, Nov	Reported in Annual Report
LHRP Practitioner	May/Jul/Sep/Nov/Jan/Mar	
CBRN training		
CBRN Train the trainer	2026	NWAS Course dates released
PRPS Training for ED Staff	April 2024 – July 2024	Ongoing
Contact Numbers		
On-call staff update to Switchboard	January 2025	
Loggists	Q3 2024	Sessions to be programmed

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9.2**

06 November 2024

Title	EPRR Core Standards 2024/25
Area Lead	Hayley Kendall, Accountable Emergency Officer
Author	Steve Povey, Head of EPRR
Report for	Information

Executive Summary and Report Recommendations

The Department of Health and Social Care and NHS England require all Trusts to undertake an annual assessment of their Core Standards for Emergency Preparedness, Resilience and Response (EPRR). For any standard that is not fully compliant the required actions to improve its position are added to the action plan which is contained within the core standards spreadsheet.

Trusts are required to complete their core standards assessment and submit to a central repository on Resilience Direct by the 27th September 2024. Following this the ICB reviewed six standards per Trust with one standard being the same for all Trusts for benchmarking. Responses were received w/c 14th October 2024.

Significant work has been undertaken since the last core standards submission in ensuring compliance with the recommendations. Through Industrial Action the Trust has utilised its command and control structure and BCP and these have been well tested. The assessment identified a number of areas for the Trust to develop the EPRR response and these have been included within the action plan attached at appendix 1 that will be monitored through Executive and Assurance Risk Committee.

It is recommended that the Board:

- Note the self-assessment and the action plan developed to act on the areas highlighted for improvement.

Key Risks

This report relates to these key risks:

- 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 ability to deliver services to patients'

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	No
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.	Yes

1	Narrative
1.1	**Core Standards Board Report** This paper provides a high level overview which is reviewed by the Board of Directors before being disseminated to any other committee. As part of the core standards declaration the standards are required to be signed off by the trust Accountable Emergency Officer (AEO) and Chief Operating Officer (COO), Hayley Kendall, then presented to a Public Board Meeting, the date of which needs to be documented on the Trust declaration. EPRR core standards consist of 66 standards, of which 62 are applicable to WUTH, the standards are spreadsheet based with columns for standard detail, supporting information examples and organisational evidence along with RAG Status and actions to be taken. The Trust uploaded 135 supporting documents to the central repository with some documents being reference in multiple standards. Following the change of approach to core standards in 2023 by NHS England which resulted in much discussion, the 2024 process is now led by the Cheshire and Mersey ICB EPRR Team. The methodology involved Trusts submitting their self-assessment with the ICB EPRR team then reviewing six standards, five randomly selected and one standard which was used for benchmarking across all regional trust responses. For 2024/25 the Trust has declared 84% - 'partially compliant'. The declaration identified full compliance with 52 of the 62 standards. For standard 16 – evacuation and shelter all Trusts have recorded partially compliant as the working group for the subject has been paused with no guidance available to Trusts. At a Peer Review event for acute Trusts, ahead of standards completion, the acute Trusts present suggested they were heading towards a range of compliance from 51% to into the 80%. Post completion during review discussions C&M ICB indicated that WUTH were positioned in the middle of all regional responses. Standards 2, 4, 17, 20, 32 & 52 were reviewed from the WUTH submission and a summary of the assessment is provided below: • Standard 2 covers the EPRR policy statement within the EPRR policy, observations for this standard included some referencing needing updating along with further information on the types of debrief, KPI updating relating to debriefs

	and partner consultation. Reference was made to supplier and contractor assurance which is contained in another plan (the Trust Business Continuity Plan) and partner consultation which is being met by a partner viewable page on Resilience Direct. • Standard 4 referenced a more detailed annual plan including RAG rating. The Trust response is that for the 2025 standards there will be in place a dedicated Training and Exercising Plan for EPRR which will include the recommendations. • Standard 17 relates to lockdown and is a Security Policy. The 2023 return recommended some updates which were included in a revised policy submitted this year. Further observations have been made this year regarding terminology which will be addressed in the revised policy which is due shortly. Security and lockdown action cards will be submitted as further evidence to support the policy. Proof of use/test of the policy provided for credible threat incident at Clatterbridge in April 2023. • Standard 20 covers on call and the use of command and control. The Trust has submitted additional information supporting the use of command and control within the trust Major Incident Plan. The submitted on call handbook v34 is currently under review along with on call training and the creation of an On Call Policy for the Trust which will further enhance our response in future years. • Core Standard 32 covers access to information on the response to chemical, biological radiological and nuclear incidents. The Trust were found to be fully compliant with no recommendations required. • Core Standard 52 relates to business continuity. There is an observation that continued improvement has limited reference, however, it is referenced and the plan is based on an NHS England template. The plan is in use but was not clear on the document front page which has been updated. Going forward the action plan for all standards will be worked through by the Head of EPRR who will identify any additional resources required to ensure that the Trust continue to evolve and improve its position for emergency preparedness. Regular updates will be provided through the Executive Assurance Risk Committee (EARC).
1.2	In addition to the main core standards, this year's deep dive investigation focused on cyber security with a score of 82%. The deep rive is a focus area with 11 standards and is not formally rated and does not count towards the main Core Standards compliance rating. The full cyber deep dive is available at appendix 2.

2	**Implications**
2.1	**Patients** • There is no direct link to patient safety or experience. Failure to prepare for an emergency and therefore not be ready to respond is when patients may be impacted.
2.2	**People** • In the event of a major emergency staff will be pivotal to the response. There are specific action cards in place to follow that show how roles may vary and evolve during a response. • External stakeholders are integral to the trust preparedness and response and are included in the regional planning for incidents
2.3	**Finance**

	• Financing of the EPRR function is done within the trust budget. Any specific or additional resources required will be subject to a business case. Response to a major incident has set procedures within the trust policies.
2.4	**Compliance** • Achieving compliance with the EPRR core standards will ensure the trust meets the requirements of its NHS contract and also the requirements of the NHSE Framework for EPRR, thereby leading to meeting its obligations under the Civil Contingencies Act.

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2024-2025

STATEMENT OF COMPLIANCE

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

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

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

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

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

Signed by the organisation's Accountable Emergency Officer

27/09/2024

Date signed

06/11/2024
Date of Board/governing body meeting

06/11/2024
Date presented at Public Board

Date published in organisations Annual Report

Appendix 1 WUTH Core Standards Self assessment October 24 - Final

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance										
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Section 3 of the Trust EPRR Policy (WUTH001) identifies the Chief Operating Officer as the Accountable Emergency Officer for EPRR and outlines their duties and responsibilities as role holder.	Fully compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Document WUTH001 is the Trust EPRR Policy and is subject to an approval and consultation process with ratified, published and review dates along with version control. Section 1 includes WUTH's commitment as a Category 1 responder to assess risks, develop and maintain plans, share information and co-operate on civil contingency response matters. Section 4 of document WUTH001 identifies the EPRR arrangements including resourcing commitments and access to funding. Sections 1, 2, 3 & 4 outline the coommittment to EPRR and section 6 for training and exercising. The trust commitment to Business Continuity is within document WUTH002 - Business Continuity Policy.	Fully compliant				
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activities.	The trust EPRR function produces a quarterly report to Risk Management Committee which are then sent to trust Board (document WUTH003) . In addition an annual report is produced (WUTH004) which goes to the Board, Minutes/Agenda to show this will be in the Board Meeting agenda for the 6th November 2024. The trust annual assurance core standards are taken as a seperate item to the trust board and will be on the agenda for the meeting on the 6th November.	Fully compliant				
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	The EPRR Annual Plan is part of its quaterly report (WUTH003)	Fully compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The trust EPRR Policy (WUTH001) identifies the resources required within section 4 'EPPRR arrangements' to respond to an incident along with the roles of EPRR and wider staff in the event of a major incident within section 3. Document WUTH005 is the job descrition and person specification for the Head of EPRR role. Structure for EPRR reporting is contained within documnet WUTH006	Fully compliant				
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Section 6.4 of the EPRR Policy (WUTH001) contains the trust position for 'Learning from Exercises and Incidents'. In addition sections 3.10 & 3.11 of the Major Incoident Plan (WUTH007) has details of Major Incident Stand Dodown and debried & Purpose of the debrief respectively. Document WUTH008 - Exercise Calliope internal trust debrief is a completed example of the trust approach.	Fully compliant				
Domain 2 - Duty to risk assess										
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Document WUTH010 shows a series of screenshots showing EPRR risks on the trust risk register, these are subject to periodic review as per the trust Risk Management Policy (WUTH009). As part of the trust LHRP attendace the regional risk register is referenced and aligned to trust risks and local risks relevant to the trust.	Fully compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	The trust has a dedicated Risk Management Policy (WUTH009) and within the EPRR Policy sections 1 & 4 (WUTH001), in particular section 4.3. the trust risk matrix is within WUTH091.	Fully compliant				
Domain 3 - Duty to maintain Plans										
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	The WUTH approach to sharing information with partners is via Resilience Direct (Screenshot on document WUTH133), this is currently a page under construction with invites to request access to be shared by the WUTH AEO when it is complete). All WUTH plans are consulted upon following committee approval (WUTH011) as identified within the 'Policies & procedures (trust-wide) - Development & Management Policy (WUTH012). The trust works with partners in other specialties where patients may attend ritha have specialist needs, training has been provided by CWP re Mental Health patients (WUTH099 (attendance in WUTH124)) and the Prometheus Service spec is within WUTH100. The Cheshire & Mersey system mutual aid agreement is in document WUTH111. the trust shares details with other local organisations which are collated in the MRF contacts directory (WUTH112).	Partially compliant	The trust will be consulting with partners and making the trust policies available on a Resilience Direct Landing page to ensure all policy contents are available	S Povey	Apr-24	
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust Major Incident Response is documented within policy WUTH007 - Major Incident Plan, this follows current guidance in line with the NHSE EPRR Framework and is in line with risk assessments documented within the trust risk management system (summary WUTH010). Activation of the policy is tested with in and out of hours communications tests (WUTH013 & 014) , along with activations for genuine events e.g. M53 Bus incident . Training is covered by section 4 of the plan with training for switchboard (WUTH015) and both internal and external training for on call managers and directors (WUTH016 & WUTH017). Equipment required as part of a major incident response is identified within the policy and the trust major incident room has a pre-populated cupboard containing key resources which are managed by the tust EPO. The trust has a patient safety incident response plan and policy (WUTH100 & WUTH101). The trust cyber security incident response is contained within WUTH115. the Trust Fire Safety Policy is within document WUTH129 and the nedical gas policy in WUTH130	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The trust has an Adverse Weather Plan (WUTH018) based upon the UKHSA Adverse Weather and Health Plan 2024/25 2nd Edition (WUTH019). The policy considers the risks from adverse weather and climate change within the trust risk management system (WUTH009). Trust EPRR are registered with the Met Office and receive Heath Health & Cold Weather Planning advise directly whilst also being a registered user of Met Office Hazard Manager.. Major weather alerts are passed directly to teams that may be affacted (email to departments re a weather warning example within WUTH020). A link to the Met Office weather warnings page is included within the weekend plan for on call managers and directors to use, example slide within WUTH021. the policy is circulated across the trust and is held on the EPRR intranet pages along with being in the managers and directors on call teams groups. A C&M update on climate adaption is included in WUTH109.	Fully compliant				
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	We currently have: •Infection control team that is reactive to current guidance and legislation •Infection prevention Dr •Weekly Mpox meetings •Outbreak policy (WUTH022 & WUTH022a) •Weekly task and finish group looking at FFP3 resilience •Isolation policy inc side room prioritisation (WUTH023) •Regular clinical advisory group meetings with senior leaders to discuss new and emerging threats and sign of local plans Close liaison with Occupational health should vaccinations be required following local alerts i.e Pertussis, RSV, Measles. The trust PPE Policy is available in WUTH075 and contains details of the wearing of masks and respirators. the trust oandemic flu plan is within document WUTH104. The trust policy for the management of suspected or confirmed MPox cases is in document WUTH122. the trusy norovirus outbreak policy is document WUTH128	Fully compliant				
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	We currently have an Infection Control Policy (WUTH028) along with an •Infection control team that is reactive to current guidance and legislation •Infection prevention Dr •Weekly Mpox meetings •Outbreak policy (WUTH022 & WUTH022a) •Weekly task and finish group looking at FFP3 resilience •Isolation policy inc side room prioritisation (WUTH023) Regular clinical advisory group meetings with senior leades to discuss new and emerging threats and sign off local plans. The trust PPE Policy is available in WUTH075 and contains details of the wearing of masks and respirators. PRPS buddy ytaining details are in WUTH105. Daily trustwide sagety huddle where any new or emerging threats can and will be raised.	Fully compliant				
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	We currently have •Infection control team that is reactive to current guidance and legislation •Infection prevention Dr •Weekly Mpox meetings •Outbreak policy (WUTH022 & WUTH022a) •Weekly task and finish group looking at FFP3 resilience •Isolation policy inc side room prioritisation (WUTH023) Regular clinical advisory group meetings with senior leades to discuss new and emerging threats and sign of local plans •Annual vaccination plans for COVID & Influenza led by the Occupational Health dept •Monthly meetings with the community IPC team Countermeasures led by the Pharmacy team will utilise the NHSE Countermeasures guidance (WUTH131) Pharmacy resources and stock requests are in documents WUTH125 & Wuth126	Partially compliant	Further work is required to ensure that arrangements are fully in place and tested. S Povey will liaise with Pharmacy and IPC to ensure plans are linked and consulted on.	S Povey	Apr-25	
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	The Royal Liverpool Hospital is the Mass Fatalities centre for the region. All casualties would be sent directly to the mortuary at Liverpool who would co-ordinate the DVI. WUTH may be asked to supply mortuary staffing to assist and this would be co-ordinated the the Merseyside LRF (MRF) MRF Policies (WUTH024 & WUTH025) contain the details. The regional mass casualty distribution plavs are in WUTH092. Document WUTH113 is the NHSE Concept of operations for managing mass casualties which is used in planning at C&M level. The trust PREVENT policy is contained in document WUTH116. The trust has a major trauma SOP which is contained in document WUTH127	Partially compliant	Review of ED Plans and Action Cards is required to ensure they are up to date and include al elements that are required of the standard	S Povey	Mar-25	
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Email to ICB 18th June, repeat request made. RESPONSE: Hi Steve, Short answer is nothing as such. The group is paused currently whilst we wait for the core standards period to pass, and the draft the regional evacuation framework. Regarding SMART Evac, the group thought it had benefit, but the feeling was not strong enough to really support it fully. Discussed at Peer Review, all trusts are awaiting updated guidance and have questions about the scope ofwhat needs to be covered. I have contacted Wirral Council contact who set up the joint council and NHS group to discuss such matters aand these meetings are being resurrected.	Partially compliant	This was discussed at the Core Standards Peer Review Meeting. As the Evac & Shelter working grup has been paused there is no further actions that trusts can take. This subject is to be further investigated by all trusts together post the standards being completed	S Povey	Timescale to be agreed	Awaiting next LHRP meeting to discuss further.
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust Lockdown Policy (WUTH026) contains the required elements.	Partially compliant	Policy needs to be consistent with Trust MI Policy for command and control and policy needs to reference Action cards. A test of the plan needs to take place at APH following a Lockdown Incident at Clatterbridge in April 2023			
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust has A VIP, celebrity & media representative policy (WUTH027), in addition the Major Incident Plan (WUTH007) section 2.6 is a section relating to visits by VIP's and the need for co-ordination with an executive director. The trust also has policies in place: Chaperone Policy (WUTH029), for during downtime periods: Safeguarding Adults (WUTH030), Safeguarding Children (WUTH031), safeguarding maternity (WUTH032) also a Safeguarding referral SOP(WUTH042)and a Social Media Policy (WUTH033).	Fully compliant				
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	WUTH mortuary manager is part of the MRF group which forms the multi agency response for the regions excess deaths policy. This group monitors capacity to prompt contingency measures such as increased cremations and additional storage. Excess deaths mnagement has been tested during the covid pandemic without any areas of concern in the North West,. See also Core Standard 15.	Fully compliant				
Domain 4 - Command and control										

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	The Trust has a two tier on call system. 1st on call (manager) and 2nd on call (Director). Command and Control and On Call Arrangements along with the on call rota and contact details are in section6 of the EPRR policy (WUTH001). To support the on call function a Manager/Director On Call Handbook is published (WUTH034) (currently under review). All documents are available on the trust intranet (screenshot WUTH035) and also in the On Call Teams Groups (WUTH036). The trust on call rota is published quarterly with version control in place for any changes/swaps etc. (WUTH037 & WUTH038). Major Incident switchboard policies are in WUTH106 and WUTH108	Fully compliant				
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	The EPRR training process is included in section 6.1 of the trust EPRR policy (WUTH001) with reference to compliance with NOS standards, the trust EPRR Training Needs Analysis (WUTH039) details the sessions required by role within an emergency with timescales. the training slides for On Call Managers and Directors is in WUTH044 and is also currently under review. All on call staff are trained in the Principles of Health Command (also see Core Standard 20 &22). the PCHC Learner Handbook is in WUTH045. Specific AEO training ins included in WUTH046	Fully compliant				
Domain 5 - Training and exercising										
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	The use of the training needs analysis is within section 6.1 of the EPRR Policy (WUTH001). Training is recorded within individual folders within Microsoft Teams, a screen shot of the training repository is within WUTH040 and WUTH041 and the Training Needs Analysis is available in WUTH039. The same repository is where invidual portfolios are held, secreenshots are within WUTH040 and WUTH041 and the completed portfolios for Steve Povey (WUTH043) are included. Training for a major incident which is available to divisions is in document WUTH103.	Fully compliant				
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements. (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	The trust holds six monthly communication tests for both in hours and out of hours, latest tests are available in WUTH013/014. The need for a live exercise and command post exercise was met with Covid reponse with further exercises sheduled for 2025/6. The exercise and training schedule is within WUTH047. Exercises have taken place in 2024 (Cyber in September, reportnot yet available. Comms Exercises are in WUTH008.. Discussion at Peer review about the inclusion of Covid as part of response. ICB indicated real response can be included as a test and official stand down of covid response was May 2023.	Fully compliant				
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Training for responders is within their individual evidence files, screenshots in WUTH040 and WUTH041 and evidence for Steve Povey include within WUTH043. Training is ongoing over a three year cycle and is on target.	Fully compliant				
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Staff awareness of their roles in an incident is within the training for on call staff and within departmental training for other areas including the Emergency Department, Switchboard, Digital, Estates & Security as examples. Training is referenced within the EPRR quarterly report. On Call staff are required to attend Principles of Health Command Training and maintain a training portfolio which is located on Teams (screenshot on WUTH040 and WUTH041. The trust EPRR Policy (WUTH001), section 3 contains details of roles within an emergency. SLides on Induction referring to EPRR are in document WUTH114.	Partially compliant	EPRR does not currently have a section in induction training, it is mentioned in Induction slides but we will investigate whether additional information needs to be included.	S Povey	Mar-25	
Domain 6 - Response										
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	The location of the trust ICC's is within section 2.2 of the trust Major Incident Plan (WUTH007), this identifies a primary location and two back up locations. The ICC does not have any equipmnt that needs to be physically tested, all equipment to be used is provided by responders who bring their own equipment. Training is identified in the Training Needs Analysis within WUTH039. Action Cards are maintained for all areas, a screen shot of cards are available in WUTH048 & WUTH 049. An example of a completed action card is in WUTH050. The primary ICC is within a secure room and is able to be locked down. In the event of loss of voip telecommunications the room has two pstn lines with identical numbers for incoming and outgoing calls and plug in handsets in the Major Incident store cupboard. which also contains paper forms for essential information, patient transfer forms, site plans and aerial photographs, a stationary store with paper/pens/markers/flipchart/cameras/incident commander and hi viz tabards/log books/policies/laminated action cards. Also included is a sealed box for NWAS response and a box file with Communications response and lanyards with press ID. The room has 4 large screens that can be connected to the trust network, have an external source connected independant of the network and a connection to live tv & radio. There are no windows to the room. Major Incidet Switchboard policies and call priorities are contained within WUTH106 & WUTH108. The trust attends the Wirral Events Safety Advisory Group, the latest agenda for this is in WUTH107. For major incident nootification the trusts uses the JESIP M/ETHANE form conatvcined within WUTH121	Fully compliant				
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	All trust EPRR policies are on the intranet (screenshot of landing page WUTH051), within the Director Manager On Call S drive folder and on the On Call Teams groups for Managers & Directors (WUTH036).	Fully compliant				
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Business continuity response plans have an intranet page within the EPRR pages (screenshot WUTH035) and contain phased response and escalation arrangements. The trust has begun the roll out of a new BCP plan with selected departments and a full roll out to the new policy is taking place Q4 of 2024. The plan uses Plan, Do, Check, Act over a cycle period identified with the BCP rollout plan (WUTH132) and is in progress and on target. Examples on Trust BCP's are in WUTH052/053/054/055/056/057/058. The trust has a Full Capcity Protocol (WUTH089) which is used for clinical pressures.	Fully compliant				
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	The trust has trained loggists that may be called upon to assist in an incident response, training attendance from an in house course is in WUTH059, further training through external providers is evidenced in WUTH060 for the most recent recruit. Section 3.3.1 of the major incident plan (WUTH007) refernces the Loggist Action Card (WUTH061), Log books, call out procedure and information on the use of Loggists.	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Within the trust major incident plan (WUTH007), section 3.14 references the procedures for SitReps and section 3.14.1 details the approval process, Appendix 13 of the policy has the SitRep template. In addition to this SitReps may also be distributed and collected via the Strategic Data Collection Service (SDCS). SitReps through SDCS are submitted via a specific teemplate which is MS Excel based and submitted by the BI department or additional named individuals given access to SDCS. An example of an SDCS SitRep ready for upload is within WUTH090	Fully compliant				
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	Copies of this are available elctronically along with hard copies in the Emergency Department. The document is also stored in the CBRN folder of the On Call Manager and On Call Director MS Teams group.	Fully compliant				
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Copies of this are available elctronically along with hard copies in the Emergency Department. The document is also stored in the CBRN folder of the On Call Manager and On Call Director MS Teams group.	Fully compliant				
Domain 7 - Warning and informing										
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The trust Major Incident Plan (WUTH007) contains a dedicated section, 5, that is dedicated to Communications and the media and was co-written with the Communications Department to ensure compatability with communiations expectations. Sub sections includes: 5.1 overview, 5.2 internal Communications, 5.3 Key Internal Audiences, 5.4 Key communications channels, 5.5 briefings to staff, 5.6 guidance for staff, 5.7 working with the media, 5.8 external communications including sub sections for key audiences, key communication channels, vulnerable groups, interpreting services, out of hours cover & access to secured/preferred routes. 5.9 communications in an emergency including overview, NHS incident levels, communications during a major incdent, local and national media, VIP visits, local and national media during a major incident, key methods for communication messages, helpline, further information. Major Incident Communications Plan. the plan also includes appendix 4 - message recording sheet & appendix 6 - communication cascade. Document WUTH062 contains contact details for out fo hours media support via a slide within the weekend plan. This has been briefed seperately to all 1st and 2nd on call staff.	Fully compliant				
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	The Incident Communications Plan is within section 5 of the trust major incident plan (WUTH007), in addition an action card is available on the trust intranet pages (WUTH048). The plan includes updating NHSE & Cheshire & Mersey ICB (section 5.8.1). Sign off for communications is detailed within the different sections according to the incident level and agencies involved (the trust response may be to refer to NHSE, C&M ICB, Police etc.) as per section 5.9.1. The trust shares its information with others in the MRF contacts directory (WUTH112).	Fully compliant				
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Section 5.9 of the trust Major Incident Plan (WUTH007) includes all communications routes, key methodology is demonstrated in section 5.9.7. Individual divisions have within their BCP's the procedure for contacting patients regarding the status of any of their appointments. Contact details for partner organisations are held within the Merseyside Resilience Forum Contacts Directory, copies of which are held within the On Call Directors Teams group and a hard copy in the trust major incident room. ELected officials and union contact details are held by the HR department. Patient relatives contact details are within section 5.2. External communications to get messages out to a wider audience is within section 5.8.	Fully compliant				
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Sections 5.9.3 & 5.9.4 of the trust major incident plan (WUTH007) considers communications during a major incident and local and national media respectively alorng with 5.9.6 local and national media during a multi agency incident and 5.9.7 Key methods for communication messages which is a table of who does what in and out of hours. Section 5.9.10 includes the role of Trust Spokesperson. The trust has a specific policy for Social Media use (WUTH033).	Fully compliant				
Domain 8 - Cooperation										
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	The trust has been represented in 50% of the last 6 strategic meetings and 75% of the lat 4 tactical meetings. Attendances are recorded in WUTH063 & WUTH064	Partially compliant	LHRP Meetings to be attended or appropriate deputy sent.	H Kendal, S Povey	Sep-24	
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	The trust is represented at LRF (Mersey Resilience Forum) by NHS Cheshire & Mersey with an agenda item at LHRP Strategic and Tactical meetings to cascade subject matter. Please see Strategic and Tactical minutes/agenda on WUTH065 & WUTH066 to see LRF as discussed items. The Cheshire Resilience Forum Concept of Operations which confrim this is in WUTH088.	Fully compliant				
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	WUTH has a mutual aid agreement in place with the Spire Murrayfield. Across the LHRP a Memeorandum of Understanding was signed across all trusts in 2024 and is referenced in WUTH067, this is available to on call teams via their respective Teams groups. Additionally WUTH works with system partners at Super MADE events, SCC co-ordination meetings, Mental Health co-ordination. the process for making MACA requests is in section 3.13 of the Major Incident Policy (WUTH007)	Fully compliant				
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Information is available to on call staff in the on call teams groups for Information Sharing in an Emergency (WUTH068/069/070). The trust has also signed the C&M memorandum of understanding between trusts (WUTH067)The trust has in place a structure in relation to Freedom of Inforomation requests (WUTH071 & 072). WUTH - How we use your information is availble via this link https://www.wuth.nhs.uk/about-us/how-we-use-your-information/ Trust senior roles in data protection is available on https://www.wuth.nhs.uk/your-wuthtrust-guidance-and-documentation/information-governance/data-protection/senior-roles-in-data-protection/ IG information is on: https://www.wuth.nhs.uk/your-wuthtrust-guidance-and-documentation/information-governance/	Fully compliant				
Domain 9 - Business Continuity										

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	The trust has a Business Continuity Policy (WUTH002) which is adaopted from the NHSE Business Continuity Toolkit, this identifies the strategic direction within section 1 and its approach within section 6. The plan is approved by the trust Risk Management Committee to demonstrate the trust commitment. Section 4 of the policy is based upon Risk Assessment and how divisions will identify BC risks through the risk process.	Fully compliant				
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	The trust Business Continuity Plan (WUTH002), adopted from the NHSE toolkit includes section 9 on external suppliers and contractors and identifies roles, responsibilities and resources within section 3. the associated templates to the plan identify key areas to consider with regard to business continuity to allow divisions to consider all parts of their function and ensure arrangements are in place and are scaleable. the trust Risk Management policy (WUTH009) states the roles and responsibilities in relation to risk. Section 2 of the Major Incident Plan (WUTH007) references responsibilities.	Fully compliant				
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	The trust Business Continuity Plan (WUTH002) adopted from the NHSE toolkit contains section 5 on Business Impact Analysis, this includes consideration of the Maximum Tolerable Period of Disruption (MTPD) and Recovery Time Objectives (RTO). Roll ot across all departments of the NHSE toolkit methods ensures consistency in the approach to BIA's.this is underway and on target	Fully compliant				
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	All divisions within WUTH are required to have in place appropriate business continuity plans, this is facilitated by using the NHSE toolkit. The trust has undertaken a pilot scheme to commence the roll out of this with continued roll out taking place. There is a schedule in place following approval of the policy for training, divisional & departmental completion of Impacts and contingencies through to testing and exercising. This is in place and on target. Exisinting BCP's are in place and examples are available in WUTH052/053/054/055/056/057/058. In addition Cyber related plans are available in the Deep Dive sectio in WUTHDD01/02/03/04/05/06/07/08/09/1012. Training for divisions is in document WUTH087. The outgoing template for BP's is within WUTH093. the trust escalation policy is document WUTH118 and the maternity version in WUTH119. The response to bombs and suspect packages is within WUTH120.	Partially compliant	Full compliance will be achieved as the new policy is fully implemented with plans in place available to test and audit. The new policy seeks to increase the number of areas with specific Business Impact Assessments and Business Continuity Plans.	S Povey	Aug-25	
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	The trust has in place a schedule (WUTH132) of the implementation of new business continuity plans and testing and exercising which are subject to exercise planning, implementation and learning, including debriefing. This has followed the writing of a new dedicated Busisnss Continuity Management Policy which divisions and departments are following. A timeline with milestones is available within WUTH132 and is in progress as part of the Plan-Do-Check-Act process which is running into 2025 in its first stage. The trust has continued to undertake exercises whilst the new BCS has been introduced with a Cyber exercise in September (Report not yet available) along with Communications tests in April and August, August report is in WUTH008	Fully compliant				
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The trust has met the requiremnst of the Data Protection and Security Toolkit, the report is available within WUTH073.	Fully compliant				
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	The trust business continuity plan includes quarterly reporting via the EPRR assurance report and continuous monitoring through the Plan, Do, Check, Act (PDCA) cycle. The plan is a new plan and is on target. The timeline for revisoin on BIA and BCP followed by testing and exercising is in WUTH132	Fully compliant				
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	The annual report for EPRR will contain a section on Business Continuity preparedness and the rolling schedule of testing and exercising. Please note that this will only commence in the report published in 2025. At present with a new dedicated policy the cycle has not yet fully completed to the audit stage.	Partially compliant	Full compliance will be achieved as the new policy is fully implemented with plans in place available to test and audit	S Povey	Aug-25	
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	The trust Business Continuity Plan (WUTH002) which uses the NHS England Business Continuity Toolkit, includes continuous review of the policy and of business continuity plans in divisions. This is an ongoing process through the life of the policy which is currently within its first year. All of the required elements are included in the dedicated Business Continuity Plan and continuous improvement included. The plan is in place and on target.	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	The trust Business Continuity Plan (WUTH002) section 9 specifically includes external suppliers and contractors to consider their own resilience and arrangements to ensure continued supply to the trust. Centrally procured suppliers/items are monitored by NHS Supply Chain with locally procured goods subject to checks through divisions and trust procurement. This is in progress as the policy is within its first year and on target. Procurement state that the process for procurement checks is based on the contract value: *The process does depend on the value as per the Trust's SFI's. Ad hoc purchases below £5k would not be subject to these checks, official quotations (£5,001 to £30k) that were conducted by Procurement would have certain checks dependent on the requirement. Tenders (£30,001 to PCR Threshold) and PCR Tenders would require cyber essentials as minimum and also request business continuity plans. This is quite a broad statement as it does always depend on the requirement.*	Partially compliant	EPRR are currently liaising with procurement to implement the structure within the trust Business Continuity Policy (WUTH002) which is based upon the NHSE Business Continuity Toolkit. We will be looking at contrac value and a tiered approach towards assurance information from suppliers that are not covered by NHS Supply Chain/central procurement.	S Povey	Apr-25	
Domain 10 - CBRN										
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	The trust CBRNe plan (WUTH074) identifies the specific actions1.7, training & 1.8 maintenance, The Trust EPRR Policy (WUTH001) section 2, identifies the Accountable Emergency Officer for the succesful implementation of Emergency Preparedness, Resilience & Response and the assessment of EPRR risks.	Fully compliant				
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Document WUTH010 shows the EPRR risks on the trust risk register. The process uses the trust Risk Mangement Process as identified in policy WUTH009. The trust CBRNe plan (WUTH074) details the procedure for hazardous waste. The trust has a COSHH policy for hazardous substance management which is document WUTH117. The trust radiation safety policy is document WUTH123	Fully compliant				
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	The ED accesses advice and information on a Hazmat/CBRN advice line and had has access to the National Poisins Information Service, Toxbase and UKHSA the following links are availbale for staff fo advice: https://www.wuth.nhs.uk/media/9062/cbrn-handbook-2018.pdf ,https://www.wuth.nhs.uk/media/9709/nhse-managing-mass-casualties.pdf and the trust CBRNe plan (WUTH074) The ED department uses and has displayed the IOR remove guidance shown in WUTH094/095/096/097/098.Specialist advice for nerve agents is in document WUTH110.	Fully compliant				
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	Command & Control structures are identified within section 5.2 of the trust EPRR policy (WUTH001). Collaboration with NWAS is met through sharing of the relevant trust policies and a site visit is also scheduled or 15th October 2024 to further discuss this and the trust MoU under section 4.3.3 of the CBRNe Plan (WUTH015). The CBRNe plan (WUTH074 relates to the following sections: Details of alerting other stakeholders (via the ROCC) is within section 4.3 of the CBRNe plan. Declaration and activation are in sections 3 and 4 of the CBRNe plan. The location of the decontamination units is within Appendix 6 of the CBRNe plan which has space for two aire shelters and one aire shower which are aligned to ensure a flow from the 'dirty' end to the 'clean' end and beyond for treatment. the designated area is away from the ambulance arrival zone and inbetween the ED entrance and the mainentrance/outpatients entrance which could be used as a receiving area once dencontamination has been completed. the are has fitted running (hot/warm) water and a fixed electrical supply to supply power to equipment. the policy includes decontamination protedures within section 5.4 for 5.4.1 dry dentamination and 5.4.2 wet decontamination. Section 5.2 details cordons for patients awaiting decontamination and access through the cordons. Sections 5.5 Mass decontamination, 5.6 waste management, 5.7 removal and disposal of contaminated waste, 5.8 decontamination run off, 5.9 external triage, 5.10 people requiring treatment, 5.11 decontaminating live patients, 5.12 decontaminating deceased, 5.13 deceased decontaminated patients, 5.14 living contaminated patients, 5.15 people not requiring treatment, 5.16 trust holding area - all day walk in centre and 5.17 recovery add to the information held within the policy. Sections 4 and 5.15 relate to activation of plans and recovery.Business continuity arrangements and The trust has recently completed a full training schedule for all ED staff with an ongoing schedule for new staff or those requiring refresher training, training details are available in WUTH076 & WUTH077). The decontamination equipment includes a control board on which the designated roles v person fulfilling are documented, this also includes spaces to document times within PRPS suits for staff.. the trust has MoU's in place with MFRS and NWAS. EPRR risk assessments identify local hazards (WUTH010). An audit of equipment initiated by NWAS is available in WUTH078. The inventory of PRPS suits and their service status is within WUTH079.	Fully compliant				
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource		Fully compliant				
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	The trust has an inventory of all CBRNe equioment held by it along with risk assessments along with planning for the replacement of equipment within the trust CBRNe plan (WUTH074). PRPS suits are maintained under a service contract and kept in secure storage. Next service visit is scheduled for the 4th November 2024. The Emergency Department has Risk Assessments in place for the department. An audit of equipment initiated by NWAS is available in WUTH078. The inventory of PRPS suits and their service status is within WUTH079	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	The trust has a routine plan to check equipment and identify any issues or shortfallswithin the CBRNe policy (WUTH074). Equipment is managed by the ED Stoes keeper. PRPS suits are maintained on a service contract (next visit 4th November 2024) from the suit manufacturers to ensure competency. An audit of equipment initiated by NWAS is available in WUTH078. The trust has more suits available than the designated amount to ensure continuity in the event of any damage. The inventory of PRPS suits and their service status is within WUTH079. A full audit of equipment including tents and shelters is within WUTH082.	Fully compliant				
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultation with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	The trust SOP for removal of contaminated waste is in document WUTH080 Contaminated waste is held in the Waste compound in estates pending removal under the contract with Veolia (WUTH081) which is managed by NWAS and audited by them. Any contaminated waste is stored in the designated area in the estates waste compound pending collection.	Fully compliant				
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training programme to deliver capability against the risk assessment	The trust has 8 trainers to deliver hazmat training, as per section 1.7 of the CBRNe plan (WUTH074). Details of training are within WUTH083/084/085. The trust has a sufficient number of training and/or decommissioned suits for training and have hosted two courses for NWAS using the trust resource. The training delivered is within WUTH077 and the lesson plan to accompany in WUTH076.	Fully compliant				
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	The training delivered to staff used the training material within WUTH076 & WUTH077. For Staff traing **ALL** ED staff have been re-trained between February and July 2024. NHS England guidance (WUTH086) on the initial guidance for self presenters is followed should any self presenters arrive outside of a main incident scene who have missed decon at scene.	Fully compliant				
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	All ED staff have been trainied in the use of PRPS suits and all staff are required to be trained in the use of two different FFP3 masks. This is an ongoing process and has been reinformed in preparations for a possible Mpox outbreak. The trust currently has a programme of ensuring all required staff have the training in the use of two FFP3 models and that they rotate usage. To facilitate this the trust has 7 portacount machines to assist with staff training. In addition for bearded staff the trust has powered hoods for staff with beards that mean a face fit seal is not possible for masks. Additional stocks of these are also being procured.	Fully compliant				
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Hazmat exercising has taken place between April and July 2024 to ensure that all ED staff have been trained in Hazmat response, the schedule of training attendance is being completed following the last training session and a programme of ongoing training is being confirmed in a meeting on Friday 4th October.	Fully compliant				

Ref	Domain	Standard	Deep Dive question	Supporting evidence- including examples of evidence	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) = Not evidenced in EPRR arrangements. Amber (partially compliant) = Not evidenced in EPRR arrangements but have plans in place to include in the next 12 months. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Cyber Security and IT related incident response (NOT INCLUDED WITHIN THE ORGANISATION'S OVERALL EPRR ASSURANCE RATING)										
DD1	Deep Dive Cyber Security	Cyber Security & IT related incident preparedness	Cyber security and IT teams support the organisation's EPRR activity including delivery of the EPRR work programme to achieve business objectives outlined in organisational EPRR policy.	-Cyber security and IT teams engaged with EPRR governance arrangement and are represented on EPRR committee membership (TOR and minutes) - Shared understanding of risks to the organisation and the population it serves with regards to EPRR - organisational risk assessments and risk registers -Plans and arrangements demonstrate a common understanding of incidents in line with EPRR framework and cyber security requirements. -EPRR work programme -Organisational EPRR policy	The Digital Team have a Major Incident Departmental Plan WUTHDD01) along with a sries of Action Cards (WUTHDD02). For Cyber security incidents the is a Cyber Security Incident Procedure (WUTHDD03) and a Cyner incident Emergency Contacts List (WUTHDD04). The Trust Risk Register includes cyber and digital risks (WUTHDD14). The trust has an overarching EPRR Policy (WUTHDD15) and work programme (WUTHDD16). the Trust has an Information Assett Database which covers testing and exercising of all Level 3 and 4 assets (WUTHDD11)	Fully compliant				
DD2	Deep Dive Cyber Security	Cyber Security & IT related incident response arrangements	The organisation has developed threat specific cyber security and IT related incident response arrangements with regard to relevant risk assessments and that dovetail with generic organisational response plans.	Arrangements should: -consider the operational impact of such incidents -be current and include a routine review schedule -be tested regularly -be approved and signed off by the appropriate governance mechanisms -include clearly identified response roles and responsibilities -be shared appropriately with those required to use them -outline any equipment requirements -outline any staff training needs -include use of unambiguous language -demonstrate a common understanding of terminology used during incidents in line with the EPRR framework and cybersecurity requirements.'	Trust has a cyber incident policy, perform cyber exersices local and in the regionally (ICS Exercise debrief - WUTHDD08). The Trust cyber position is reviewed yearly within national audit DSPT/ CAF. Issues from audits are added to the cyber programme for remediation. In the event of an incident the trust has a number of templates that can be followed to ensure consistency, Major Incident Call procedure advice (WUTHDD05) , Major Incident Floorwalknig Log (WUTHDD06) and Major Incident Form Call Logging (WUTHDD07).Exercise reports for trust exercises are available in WUTHDD09 & 10. A report into WUTH IT Disaster recovery exercises is contained within WUTHDD12	Partially compliant	Update IT related incident action cards and ensure common terminology consist with EPRR plans/policies. A regional cyber exercise follow up in November 2024 will test the revised regional plan and allow trusts to complete their own plans.	Digital Team	Mar-25	
DD3	Deep Dive Cyber Security	Resilient Communication during Cyber Security & IT related incidents	The organisation has arrangements in place for communicating with partners and stakeholders during cyber security and IT related incidents.	Arrangements should consider the generic principles for enhancing communications resilience: 1. look beyond the technical solutions at processes and organisational arrangements 2. identify and review the critical communication activities that underpin your response arrangements 3. ensure diversity of technical solutions 4. adopt layered fall-back arrangements 5. plan for appropriate interoperability https://www.england.nhs.uk/wp-content/uploads/2019/03/national-resilient-telecommunications-guidance.pdf	There are regional and national communications within IT teams , what's app group, ICB. The national CSOC has a hotline number for cyber management support. In addition the trust EPRR Policy and major Incident Plan have sections dedicated to communications in an emergencyboth internal and external.	Fully compliant				
DD4	Deep Dive Cyber Security	Media Strategy	The organisation has Incident communication plans and media strategies that include arrangements to agree media lines and the use of corporate and personal social media accounts during cyber security and IT related incidents	- Incident communications plans and media strategy give consideration to cyber security incidents activities as well as clinical and operational impacts. - Agreed sign off processes for media and press releases in relation to Cyber security and IT related incidents. - Documented process for communications to regional and national teams - Incident communications plan and media strategy provides guidance for staff on providing comment, commentary or advice during an incident or where sensitive information is generated.	The Media Strategy is in section 5 of the trust Major Incident Plan (WUTHDD17) covers all aspects of communications	Fully compliant				
DD5	Deep Dive Cyber Security	Testing and exercising	The exercising and/ or testing of cyber security and IT related incident arrangements are included in the organisations EPRR exercise and testing programme.	- Evidence of exercises held in last 12 months including post exercise reports - EPRR exercise and testing programme	Regional exercise 21st March, report in WUTHDD08 and local cyber exercises have occurred and planned, see WUTHDD08/09/10. A trust exercise also took place on Friday 6th September, the report for this should be available soon.	Fully compliant				
DD6	Deep Dive Cyber Security	Continuous Improvement	The organisation's Cyber Security and IT teams have processes in place to implement changes to threat specific response arrangements and embed learning following incidents and exercises	- Cyber security and IT colleagues participation in debriefs following live incidents and exercises - lessons identified and implementation plans to address those lessons -agreed processes in place to adopt implementation of lessons identified - Evidence of updated incident plans post-incident/exercise	Updated regional policy from the last exercise on 21st March WUTHDD08 and the follow up exercise scheduled for 21st November . RCA occur for all major incidents within IT. Post exercsie reoport axamples are in WUTHDD 09/10. The exercise report for Friday 6th September will also cover this wehen available.	Fully compliant				
DD7	Deep Dive Cyber Security	Training Needs Analysis (TNA)	Cyber security and IT related incident response roles are included in an organisation's TNA.	- TNA includes Cyber security and IT related incident response roles - Attendance/participant lists showing cybersecurity and IT colleagues taking part in incident response training.	The trust has a training needs analysis matrix, a future devleopment is to have a seprtate EPRR Training and Exercising Policy, the current matrix is within WUTHDD18	Partially compliant	Training Needs Analysis to be included in the new trust Training & Exercising Plan which is scheduled for introduction in 2025.	EPRR	May-25	
DD8	Deep Dive Cyber Security	EPRR Training	The oranisation's EPRR awareness training includes the risk to the organisation of cyber security and IT related incidents and emergencies	-Cyber security and IT related incidents and emergencies included in EPRR awareness training package	EPRR training is given to key staff in departments and to staff on the on call rotas	Fully compliant				
DD9	Deep Dive Cyber Security	Business Impact Assessments	The Cyber Security and IT teams are aware of the organisations's critical functions and the dependencies on IT core systems and infrastrucure for the safe and effective delivery of these services	-robust Business Impact Analysis including core systems -list of the organisations critical services and functions -list of the organisations core IT/Digital systems and prioritisation of system recovery	DHT holds an Asset database for ALL IT assets. It has service owners and suppilers. IT has a restore order for servers which is in the process of being reviewed. Please see WUTHDD11 for the assett database. Level 4 is Trust wide assest, level 3 is division wide asset.	Fully compliant				
DD10	Deep Dive Cyber Security	Business Continuity Management System	Cyber Security and IT systems and infrastructure are considered within the scope and objectives of the organisation's Business Continuity Management System (BCMS)	-Reflected in the organisation's Business Continuity Policy -key products and services within the scope of BCMS -Appropriate risk assessments	The trust has adopted a new Business Continuity Pan (WUTHDD13) which has been introduced and has been the subject of a pilot in three divisions. The rollout of the plan trust wide is scheduled and on time	Fully compliant				
DD11	Deep Dive Cyber Security	Business Continuity Arrangments	IT Disaster Recovery arrangements for core IT systems and infrastructure are included with the organisation's Business Continuity arrangements for the safe delivery of critical services identified in the organisation's business impact assessments	- Business Continuity Plans for critical services provided by the organisation include core systems -Disaster recovery plans for core systems -Cyber security and IT departments own BCP which includes contacts for key personnel outside of normal working hours	Cyber incident plan within major incident documemtation on all DJT desktops. This has all contract details to support an incident. The digital team have plans in place for the main It infrastructure,as demonstrated in WUTHDD01 and WUTHDD03. Divisions and depaartments reinforce this with their own plas at local level.	Fully compliant				

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 10.1**
6 November 2024

Report Title	Committee Chair's Reports – Finance Business Performance Committee
Author	Sue Lorimer, Chair of Finance Business Performance Committee

Items for Escalation/Action

- The Committee approved a business case to make recurrent the non-recurrent investment in ED staffing enabling the recruitment of 25wte registered nurses and 20wte clinical support workers at a cost of £1,030,000. This will represent a saving of £300,000 on the current cost of temporary staffing although the Committee noted that there was no funding in the plan to support this. The investment was approved on the grounds of clinical quality and safety and compliance with recommended staffing ratios. The Committee noted that no KPI's were included in the case. Therefore, the team was requested to provide details of target improvements in safety and quality indicators so that benefits from the investment can be measured. There was agreement to a formal review in 6 months' time.

- The Committee received an update on the Finance Risk and Recovery Plan together with a copy of the PwC report on trust finances commissioned by the ICB. It was noted that the trust is under significant scrutiny from the ICB resulting from its variance from the financial plan. The team had advised a likely £15m variance but have now identified mitigating actions of £8m resulting in a variance of £7m. This has not been approved by the ICB who wish to see a forecast in line with original plan, but any further improvement is unlikely without impacting on clinical quality or elective activity throughput. The Committee asked for clearer reporting on workforce numbers as this is critical to the financial position. Mitigating actions are expected to start to make an impact in October's position. The PwC report included a number of recommendations and offers of consultancy support which are currently under review by the trust.

- The Committee received a report on the performance of the Cheshire and Merseyside Surgical Centre (CMSC). At month 5 daycase and elective activity income is forecast as £13m behind plan and is the major cause of the adverse financial variance to plan. The Committee acknowledged the forensic detail behind the paper and the work involved in tracking activity against initial assumptions. The key issues identified were:

    - New consultants did not work solely in theatre as assumed but also undertook outpatient sessions which generate less income;
    - Urology consultants operate 37 weeks and not 45 weeks pa as planned due to urgent cover requirements;
    - T&O activity has not transferred to the trust at the volume anticipated;
    - Activity transferred in both T&O and Urology comprises lower casemix than assumed in the business case.

  3 mitigations were agreed as follows:
    - Stop plans to appoint to 45 posts approved in the business case;
    - 210 mutual aid procedures to be reinstated
    - Reduce theatre capacity on the Arrowe Park Hospital site.

- The Committee were informed that the actions identified above would return the CMSC to the level of contribution originally planned. The Committee agreed that work should continue on clarification of wider elective capacity and delivery of elective activity.

- The Committee reviewed and approved a business case for an additional Urology Consultant with an interest in Robotics. This would expedite the treatment of Cancer cases both locally and potentially further afield. The trust has problems with waiting times currently and is using additional sessions at premium rates to try to maintain waiting time standards. The cost in 2024/25 is £150,000 and will be funded by income from the Cancer Alliance. Thereafter the full year cost will be funded by additional income and a reduction in premium rate activity.

New/Emerging Risks

- Achievement of the mitigated forecast of £7m adverse variance to plan continues to present a risk.

- Cash balances continue to present a risk and there has been no confirmation of cash support from NHSE as yet.

Overview of Assurances Received and Committee Activity

- The PWC report received by the Committee did not identify any significant gaps or areas which the trust is not already undertaking work in.

Other comments from the Chair

- The Committee was impressed to see the continued appetite and drive expressed by the team to improve the financial position in a sensible and sustained manner.