NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

4 December 2024

09:00 GMT Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

Only PDFs are attached

- 0 Board of Directors in Public Agenda.pdf
- 3 Board of Directors in Public Minutes - 6 Nov.pdf
- 4 Action Log - Public Board.pdf
- 7 Chief Executive Officer Report.pdf
- 8.1 WUTH IPR Dashboard - Nov 2024 - 5 CFO.pdf
- 8.1.1 CFO Commentary M7 24-25 FINAL.pdf
- 8.2 COO.pdf
- 8.3 IPR.pdf
- 8.3.1 WUTH IPR Dashboard - Nov 2024 - Intro.pdf
- 8.3.2 WUTH IPR Dashboard - Nov 2024 - 1 COO.pdf
- 8.3.3 WUTH IPR Dashboard - Nov 2024 - 2 MD.pdf
- 8.3.4 WUTH IPR Dashboard - Nov 2024 - 3 CN.pdf
- 8.3.5 CN Commentary.pdf
- 8.3.6 WUTH IPR Dashboard - Nov 2024 - 4 CPO.pdf
- 8.3.7 CPO Commentary.pdf
- 8.3.8 WUTH IPR Dashboard - Nov 2024 - 6 CIO.pdf
- 8.4 Quarterly Maternity and Neonatal Services Report.pdf
- 8.5 Learning from Deaths Report.pdf
- 9 Infection Prevention and Control 2023-24 Annual Report.pdf

- 10 Accountable Officer Controlled Drugs 2023-24 Annual Report.pdf
- 11 WUTH Charity Annual Report and Accounts 2023-24.pdf
- 12 Annual Review of Standing Financial Instructions (SFI's).pdf
- 13 Annual Review of Terms of References.pdf
- 13.1 Finance Business Performance Committee.pdf
- 13.2 Research and Innovation Committee.pdf
- 13.3 People Committee.pdf
- 13.4 Audit and Risk Committee.pdf
- 13.5 Estates and Capital Committee.pdf
- 13.6 Charitable Funds Committee.pdf
- 13.7 Quality Committee.pdf
- 14.1 Estates and Capital.pdf
- 14.2 Quality Comm.pdf
- 14.3 Audit and Risk Committee.pdf
- 14.4 CFC.pdf

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 4 December 2024
Time	09:00 – 11:00
Location	Hybrid

Page		Agenda Item	Lead	Presenter
	1.	Welcome and Apologies for Absence	Sir David Henshaw	
	2.	Declarations of Interest	Sir David Henshaw	
5	3.	Minutes of Previous Meeting	Sir David Henshaw	
14	4.	Action Log	Sir David Henshaw	
		Items for Decision and Discussion		
	5.	Staff Story	Debs Smith	
	6.	Chair's Business and Strategic Issues – **Verbal**	Sir David Henshaw	
15	7.	Chief Executive Officer Report	Janelle Holmes	
	8.	Board Assurance Reports		
19	8.1)	Chief Finance Officer Report	Mark Chidgey	
26	8.2)	Chief Operating Officer Report	Hayley Kendall	
33	8.3)	Integrated Performance Report	Executive Directors	
57	8.4)	Quarterly Maternity and Neonatal Services Report	Julie Roy	Jo Lavery
63	8.5)	Learning from Deaths Report (Q1 2024/25)	Dr Nikki Stevenson	Dr Ranj Mehra
72	9.	Infection Prevention and Control 2023/24 Annual Report	Julie Roy	Jay Turner-Gardner
148	10.	Accountable Officer Controlled Drugs 2023/24 Annual Report	Dr Nikki Stevenson	Chris Green
160	11.	WUTH Charity Annual Report and Accounts 2023/24	Mark Chidgey	
162	12.	Annual Review of Standing Financial Instructions (SFI's)	Mark Chidgey	
164	13.	Annual Review of Committee Terms of References	David McGovern	

Committee Chair's Reports

198	14.	14.1)	Estates and Capital Committee	Steve Igoe
200		14.2)	Quality Committee	Dr Steve Ryan
202		14.3)	Audit and Risk Committee	Steve Igoe
204		14.4)	Charitable Funds Committee	Dr Steve Ryan

Closing Business

15.	Questions from Governors and Public	Sir David Henshaw
16.	Meeting Review	Sir David Henshaw
17.	Any other Business	Sir David Henshaw

Date and Time of Next Meeting

Wednesday 29 January 2025, 09:00 – 11:00

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 6 November 2024
Location	Hybrid

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Deputy Chair
SR	Dr Steve Ryan	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
LD	Lesley Davies	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
HK	Hayley Kendall	Chief Operating Officer
SW	Sam Westwell	Chief Nurse

In attendance:

DM	David McGovern	Director of Corporate Affairs
JJE	James Jackson-Ellis	Corporate Governance Officer
JC	Jo Chwalko	Director of Integration and Delivery
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.4
RT	Robert Thompson	Public Governor
TC	Tony Cragg	Public Governor
PB	Philippa Boston	Staff Governor

Apologies:

RM	Dr Rajan Madhok	Non-Executive Director
CM	Chris Mason	Chief Information Officer
SH	Sheila Hillhouse	Lead Public Governor
MP	Manoj Purohit	Public Governor

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed everyone to the meeting. Apologies are noted above.	
2	**Declarations of Interest**	

	No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 2 October were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story from a patient who had received a prostate cancer diagnosis. The video story described his experience of treatment and the exceptional clinical care provided. The story also identified areas of learning and improvement. SW stated learning had been identified in order to improve the experience in ED and to ensure the prompt dispensing of medicine when discharging patients. HK agreed and stated this cancer pathway had experienced significant challenges, however improvements continued to be made to enhance this pathway. SL queried about challenges relating to sharing patient data between Trusts. HK stated patient data for elective activity was shared but not for non-elective care and this was a national challenge. Members acknowledged there was an excellent level of care provided and requested the Board's thanks be passed onto the relevant teams. The Board **NOTED** the video story.	
6	**Chairs Business and Strategic Issues** DH provided an update on recent matters and highlighted the immediate recommendations arising from the Wirral System Review were in the process of being approved. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH reported in September 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 highlighted in September the Trust facilitated a visit from Matthew Patrick, MP for Wirral West and a visit from Chris Hopson, NHS England Chief Strategy Officer in October. JH referenced the launch of Change NHS, the national engagement exercise launched in October to develop the next 10 year Health Plan for the NHS. JH explained Emma James had won the RCN Impact Award and congratulated Emma on the award. JH stated in October the first Multicultural Staff Network event took place at Birkenhead Rugby Club and was attended by over 100 staff members to celebrate the range of nationalities and cultural traditions. JH summarised the recent meeting of the Cheshire and Merseyside Acute and Specialist Trust Board (CMAST) on 4 October and the Wirral Place Based Partnership Board on 17 October. DH queried about the Trust's position in relation to ambulance handovers. HK stated the Trust had experienced the highest level of ambulance conveyance increases in the region as well as one of the highest nationally and the Trust was also in the bottom quartile for ambulance handover times. HK added the Emergency Care Improvement Support Team (ECIST) had initiated a number of pilots with a goal to decrease demand to the ED by 20%. DH also queried about the Trust's approach to providing corridor care in light of the views from CQC and NHSE. NS highlighted corridor care was a national issue and there were likely to be no additional winter mitigations available by NHSE. NS added the Trust was committed to providing good quality care and patient experience to patients in the corridor instead of in ambulances where it was safer. NS explained the greatest risk was delaying ambulance handovers when these were needed in the community. HK reported that NWAS were now providing incident feedback to each organisation and in terms of Wirral there had been 1 category 2 incident fed back to the Trust. HK added Monday and Thursday were the days where the Trust had the longest handover delays but other days there was good performance noted.	

	LD queried if there was any data available to share with system partners on the type of patients attending ED. JH stated no data was currently available from primary care partners but as part of the integration with WCHC this would become available. HK agreed to provide the winter plan to the next Board meeting and include opportunities for joint working with WCHC. The Board **NOTED** the report.	Hayley Kendall
8	**Board Assurance Reports** **8.1) Chief Finance Officer Report** MC reported at the end of September, month 6, the Trust was reporting a deficit of £12.5m against the year to date plan of £5.7m, an adverse variance of £6.7m. MC added the Board had approved a mitigation plan to reduce run-rate in the second half of the year (H2 - October to March) and the Executive Directors were working within NHSE processes, as supported by PWC to identify further mitigations. 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 reported the outturn adverse variance to plan is forecast to be in a range between £7m and £20.3m and set out the reasoning for these two scenarios. MC provided an update on the statutory key financial risks for month 6, noting the RAG rating for each, highlighting that financial stability and financial sustainability were red, agency spend, financial efficiency and cash were amber, and capital was green. SL queried about the capital programme and if the Trust would be able to deliver the planned budget. MC stated the Trust was on trajectory to deliver the capital programme and explained there was a 3 year programme which provided flexibility to bring forward and delay any capital projects if required. The Board: • **NOTED** the report; • **NOTED** the risks to delivery of statutory targets including the planned deficit of £6.7m;	

	• **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 now back in line with agency target of 3.2%; and • **APPROVED** the increase in the capital budget from £18.754m to £20.707m in recognition of approved RAAC funding. **8.2) Chief Operating Officer Report** HK highlighted in September the Trust attained an overall performance of 99.04% against plan for outpatients and an overall performance of 92.74% against plan for elective admissions. HK added the Trust underachieved plan for both outpatient new appointments and elective inpatients/day cases and set out the specific reasons for this. HK summarised the referral to treatment standard, noting the requirement to have no patients waiting over 65 weeks by September and the Trust had 178 patients waiting and gave an overview of the reasons for delay. This was in line with the agreed trajectory with the elective recovery workstream. HK explained the cancer performance against the trajectory, noting the Trust did not meet the faster diagnosis standard for August at 74.4% below the standard of 75% but was assured that future months would demonstrate compliance. HK reported the DM01 performance standard was 96% at the end of September, achieving above the 95% standard by March 2025. HK reported in September type 1 unscheduled care performance was 44.73% and remains below the planned improvement trajectory. HK added the ECIST were providing support prior to winter and several pilots would be launched over the coming months to improve the position. HK reported the number of patients not meeting the criteria to reside at the hospital remained above the trajectory and the demand for patients attending the ED with mental health conditions was high and experienced lengthy delays for mental health beds. LD queried about 78 week wait breaches for gynaecology and colorectal and the reason for this. HK explained during COVID gynaecology was adversely impacted across all organisations and this has led to a significant increase in the backlog of patients waiting for treatment, and the service had also experienced significant increases in demand. HK added	

	another NHS Trust had offered to accept mutual aid patients and this had been welcomed. HK reported colorectal delays were due to pathway challenges and changes were being made to improve this. SR queried about the mental health challenges and if ECIST had provided any recommendations for improvement. HK stated this was outside of the scope of ECIST and the Chief Nurse was leading on a mental health transformation programme. JH agreed and added it remained important to manage patients with mental health challenges in the community setting rather than attending ED, where necessary, for their own safety. The Board **NOTED** the report. **8.3) Integrated Performance Report** NS stated the number of patients recruited to NIHR studies remained below trajectory and improvement was envisioned in the medium term, however the team remained focussed on good quality research and commercial studies. SW highlighted the number of C Diff cases in month exceeded the threshold and summarised the various improvement projects underway to reduce the number of cases. SW reported there was 1 category 3 hospital acquired pressure ulcer in month against a target of 0. SW explained the friends and family test for ED had reduced from 80% to 71% in month and outpatients reduced to 93.1%. Maternity and inpatients exceeded the 95% target. SW stated in month the Trust received its largest number of complaints and concerns for the past 18 months. SW added the Concerns and Complaints Policy was being relaunched and included a stronger emphasis on a single Divisional investigator to coordinate responses. SR queried about the limited number of toilets on each ward and the potential risk of increased infections. SW added the number of toilets on each ward were limited to ward configuration and toilets were cleaned regularly to avoid any cross infections of C Diff. DH queried about the involvement of WCHC in reducing C Diff in the community.	

	SW stated as part of the C Diff strategic plan WCHC focussed on reducing C Diff in the care home/nursing home setting. DH also queried about the outpatients' department and the progress so far to transform the ways of working. HK stated the space within the outpatients' department was not being used effectively and a project was within the productivity workstream to use the space more flexibly. HK added, subject to changes within the patient portal, it was anticipated there would be greater flexibility in the department from quarter 4. DS reported mandatory training and appraisal compliance were on target despite operational pressures. Turnover remains above compliance and is in line with seasonal trends. DS added sickness absence remains above target at 6.32% and is a concern. DS explained the employee assistance programme was being relaunched and there remained a strong focus on encouraging staff to get their COVID/flu jab. A review of the Attendance Management Policy would take place and it was expected some learning would be identified. MC highlighted staff vacancies within Digital Healthcare were at 12.5% which has impacted significantly on operational capacity. 2 posts were being submitted as vacancy freeze exceptions. MC added the Service Improvement Team had been asked to review the SARs processes to identify efficiencies. The Board **NOTED** the report. **8.4) 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 September. JL added there were no Patient Safety Investigation Incidents (PSII's), or Newborn Safety Incidents (MNSI) declared in September for maternity services. SR stated as Maternity Safety Champion he was aware of the pressures facing nurses and midwives in maternity services. SR added staff have been complimentary about the Divisional leadership. SL queried about the pay arrangements for the neonatal consultant. JL stated the CNST money had been used for this during the year and was recurrent.	

	The Board: • **NOTED** the report; and • **NOTED** the Perinatal Clinical Surveillance Assurance report. **8.5) Board Assurance Framework (BAF)** DM summarised the key changes to the BAF, noting no changes had been made to the risk scores since the BAF was last provided to Board in September. DM highlighted an internal audit review of risk maturity had been completed and the report was being drafted. The Board **NOTED** the current version of the BAF.	
9	**Emergency Preparedness Resilience and Response (EPRR)** **9.1) 2023/24 Annual Report** HK explained the Trust is required to have an Accountable Emergency Officer, supported by the Emergency Preparedness Officer along with the appropriate emergency planning meeting structure. HK added all of the mandated emergency plans to respond to a major incident are in place and published on the Trust intranet. HK gave an overview of the report, summarising performance for the EPRR Annual Core Standards, exercise outcomes including communications exercises and externally managed events. The Board **NOTED** the report. **9.2) 2024/25 Core Standards** HK explained all Trusts were required to undertake an annual assessment of their Core Standards for EPRR and for 2024/25 the Trust was 'partially compliant' with full compliance of 52 of the 62 standards. HK added an action plan has been developed 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. The Board **NOTED** the self-assessment and the action plan developed to act on the areas highlighted for improvement.	
10	**Committee Chairs Reports** **10.1) Finance Business Performance Committee**	

	SL stated the Committee met on 11 October and recommended a number of business cases for approval to the Board. SL added Committee received a presentation on the finance risk and mitigation plan and were provided with good assurance and the steps being taken to improve the Trust's financial position through enhanced controls. The Board **NOTED** the report.	
11	**Questions from Governors and Public** No questions were raised.	
12	**Meeting Review** Members discussed the continued challenges and acknowledged a number of these required solutions driven by the system, however the Trust continued to focus on robust patient safety and quality despite the challenges.	
13	**Any other Business** No other business was raised.	

(The meeting closed at 10:30)

Action Log
Board of Directors in Public
4 December 2024

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	6 November 2024	8.2	To provide the Winter Plan, including the opportunities for joint working with WCHC	Hayley Kendall	Complete. Scheduled for December meeting.	December 2024

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
4 December 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 was one Patient Safety Incident Investigations (PSII) opened in October under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety

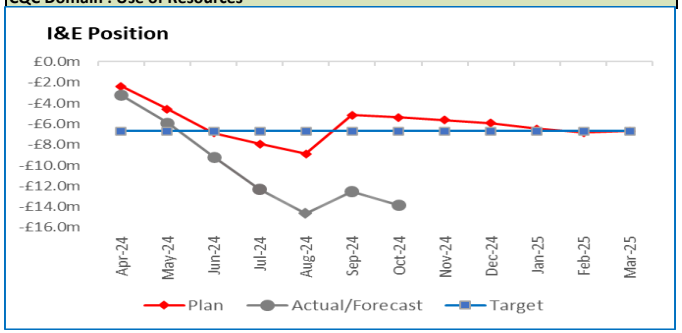
	Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. Duty of Candour has been completed. There was one Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in October. All RIDDORs reportable events 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** **Cyber Security Major Incident** On Tuesday 26 November the Trust declared a major incident following a targeted cyber security issue. After detecting suspicious activity, as a precaution, we isolated our systems to ensure that the problem did not spread further and this resulted in some IT systems being offline. Business continuity processes were enacted with paper being used rather than digital in the areas affected. The Trust continues to work closely with the national cyber security services and we are planning to return to normal services at the earliest opportunity. **Care Quality Commission (CQC) Report of Urgent and Emergency Care Services** The CQC inspection of Urgent and Emergency Care Services at the Trust was carried out in March 2024, during a time of high levels of attendances to the Emergency Department, which was a situation felt by Trusts nationally. The report rated the Trust as 'Good' in three out of five domains. It gave a rating of 'Good' for being Effective, Caring and Well-led and this is a testament to the continued hard work of our staff and the care provided to patients. I would like to thank staff working in Urgent and Emergency Care for their continued efforts and also to staff across the Trust who have worked hard to improve processes in their own areas to relieve some of the pressures in ED. **Martha's Rule Update** The Trust has been identified as one of the pilot sites for Martha's Rule and from 1 October ward 14 and 38 are testing component 2. Component 2 ensures patients, their relatives or staff members can contact the critical care outreach team 24/7 if they have concerns that a patient is clinically deteriorating or getting worse, despite concerns being raised to the ward team or using our embedded escalation process. WUTH is one of the phase one pilot sites to implement Martha's Rule and by the end of March 2025 all phase one sites will be testing and implementing all three components of Martha's Rule in all appropriate settings.

	Martha's Rule will give patients, families, carers and staff, round-the-clock access to a rapid review from a critical care outreach team (CCOT) or paediatric critical care outreach team (PCCOT) if they are worried about a person's condition. **Navajo Accreditation** The Trust is delighted to have been re-accredited with the Navajo Merseyside & Cheshire LGBTIQA+ Charter Mark. The Trust first received this prestigious accreditation for the first time in 2019 and was re-accredited in 2022. The Chartermark recognises the efforts that Wirral University Teaching Hospital have made in trying to improve services and support for our LGBTIQA+ staff, patients and wider community across Merseyside. **WUTH Doctor Receives CEO Star Award** Junior doctor Joe Clarkson has been awarded the very first CEO Star Award. The award was presented by the Trust's Chief Executive and Medical Director, in recognition of the 28-year-old's extraordinary efforts in saving a life while off duty. Joe sprang from his barber chair to the aid of Grant Williams, a military veteran who had collapsed while out running. Alongside Dr Mel Hamilton, they performed CPR until the ambulance arrived, ultimately saving Grant's life. Deeply grateful, Grant later put out an appeal on BBC Breakfast to find the doctors who had saved him, leading to an emotional reunion. Congratulations to Joe for this well-deserved award.
1.3	**System Working** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** CMAST Leadership Board met on 1 November discussing a number of system issues as follows: The Leadership Board was provided with an analysis of the aggregate C&M position in respect of NHS corporate services benchmarking (previously referred to as Model Hospital data) for 23/4 following recently released data. Model Hospital data highlights variation across the system using a variety of benchmarking tools, the review presented used the national median as a comparison, but did not take organisational differences into account, for example demographics, organisation type. The Board was then provided with an update on the development of a Liverpool Adult Acute and Specialist (LAASP) Trusts programme of work and the direction of travel toward a group model. The Board received an update on progress in delivery of the C&M Pathology target operating model and LIMS as a key enabler of this area of work.

	Discussions concluded by sharing UEC experiences from across each locality, summarising the initiatives that are seen to have had most impact. Update papers were also provided on the following areas: • System financial report • System performance update **Wirral Place Based Partnership Board (PBPB)** The PBPB met on 21 November and received an update on the Primary Care Access Recovery Plan. The Board were made aware Practices and Primary Care Networks (PCNs) continue to develop the asks and aspirations within the 4 key areas within PCARP of empowering patients, implementing modern general practice, build capacity and cut bureaucracy. The Board also received an update on the Wirral System Review, specifically the outcomes of phase two. The Board were informed about the governance arrangements to support the shared leadership model, including the Integration Programme Board being established. The Board acknowledged that a programme of work had also started to review Wirral Place governance and delivery arrangements and the outcomes of this work will require the support of the Wirral Place Based Partnership Board.

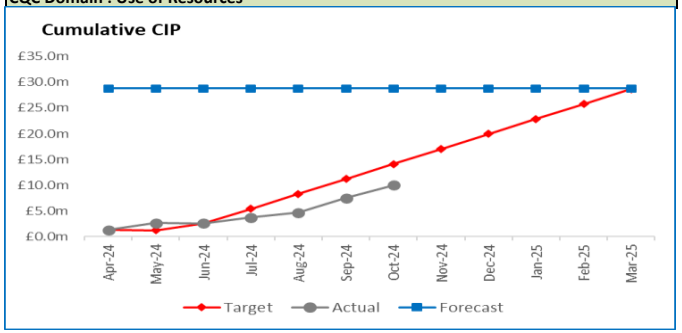
Chief Finance Officer

CQC Domain : Use of Resources



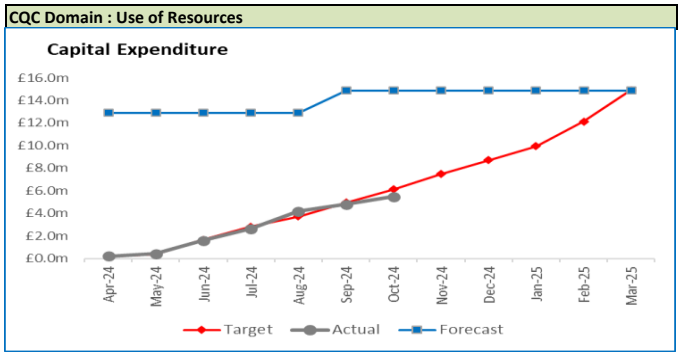
Oct-24
-£13.8m
Variance
Position worse than plan
Target
-£5.4m

CQC Domain : Use of Resources



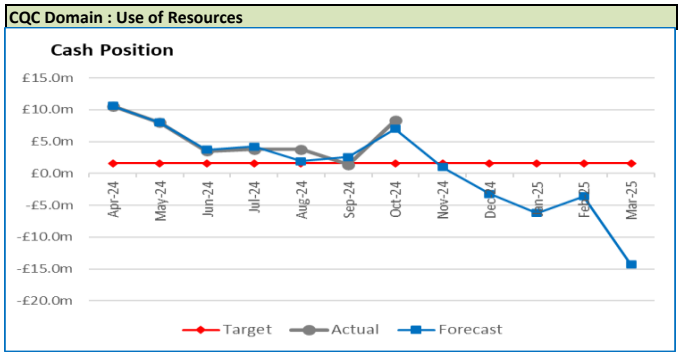
Oct-24
£10.0m
Variance
Position worse than plan
Target
£14.1m

CQC Domain : Use of Resources



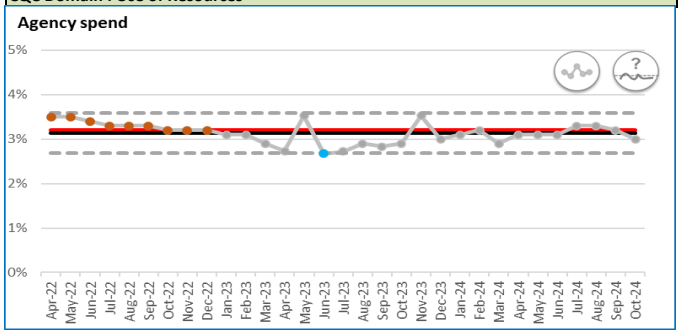
Oct-24
£5.5m
Variance
Position better than plan
Target
£6.1m

CQC Domain : Use of Resources



Oct-24
£8.3m
Variance
Position better than plan
Target
£1.6m

CQC Domain : Use of Resources



Oct-24
3.00%
Variance
Position better than threshold
Threshold
3.2%

Executive Summary

In October, M7, the Trust received a non-recurrent deficit support revenue allocation of £9.7m. As a result of this the Trust's plan was resubmitted as a £6.7m deficit. At the end of M7, the Trust is reporting a deficit of £13.2m, an adverse variance against plan of £7.4m.

There is significant risk to the Trust delivering the agreed annual deficit of £6.7m which is being managed through an NHSE process supported by PWC.

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

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

As a result the Trust's unmitigated forecast is a deficit of £6.4m, an adverse variance to plan of £19.8m. The Trust has fully engaged with NHSE and C&M ICB to plan actions to reduce expenditure to mitigate against these risks. Full implementation of these agreed actions will reduce the unmitigated forecast deficit to £13.6m, an adverse variance to plan of £7.0m. The Trust continues to work with the ICB to identify the additional mitigation options necessary to achieve the plan.

The deficit is placing 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 (M7)	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 that full implementation of agreed mitigations will significantly but not fully mitigate financial risk.
- Note that the Trust has submitted a cash support request in Q3 and will be submitting an additional request in Q4 (January to March 2025).
- Note that this report pre-dates the current cyber-incident and therefore the financial impact will be included within future reports.

I&E Position

Narrative:

The table below summarises this I&E position at M7:

	Year to Date			Unmitigated Forecast		
Cost Type	**Plan**	**Actual**	**Variance**	**Plan**	**Forecast**	**Variance**
Clinical Income from Patient Care Activities	£280.3m	£276.4m	-£3.9m	£478.3m	£469.7m	-£8.6m
Other Operating Income	£19.4m	£20.4m	£0.9m	£33.2m	£37.6m	£4.4m
Total Income	**£299.8m**	**£296.8m**	**-£3.0m**	**£511.6m**	**£507.3m**	**-£4.3m**
Employee Expenses	-£214.2m	-£215.8m	-£1.6m	-£367.9m	-£370.8m	-£2.8m
Operating Expenses	-£92.1m	-£91.3m	£0.8m	-£155.3m	-£160.5m	-£5.2m
Non Operating Expenses	-£3.5m	-£2.9m	£0.7m	-£6.0m	-£5.1m	£0.9m
CIP	£4.3m	£0.0m	-£4.3m	£11.0m	£2.6m	-£8.4m
Total Expenditure	**-£305.5m**	**-£310.0m**	**-£4.4m**	**-£518.2m**	**-£533.7m**	**-£15.5m**
Unmitigated Forecast	**-£5.8m**	**-£13.2m**	**-£7.4m**	**-£6.7m**	**-£26.4m**	**-£19.8m**

The unmitigated forecast position is before Board approved actions which are intended to reduce the forecast deficit to £13.6m.

Key variances within the position are:

Clinical Income – £4.6m adverse variance relates to underperformance against the value of the elective plan in Surgery.
Employee Expenses - £1.6m adverse variance relates to continued overspend on bank and medical bank in ED.
Operating Expenses - £0.8m positive variance largely relates to the under delivery of elective activity in Surgery.
Non-operating expenses – £0.7m favourable variance relates to PDC payments lower than plan.
Cost Improvement Programme – £4.3m adverse variance for CIP across clinical divisions. This is offset by non-recurrent underspends.

The Trust's agency costs were 1.8% of total pay costs in M7 and are 3.0% YTD. This is below 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 Elective Activity plan.
- The Trust fails to fully deliver the recurrent Cost Improvement Programme.
- The Trust fails to manage urgent care expenditure within planned levels.

Actions:
- Maximising elective capacity and recovery.
- Full delivery of recurrent CIP schemes and identification of non-recurrent underspends.
- Urgent care improvement plan.
- Full delivery of agreed mitigation plan.

Cumulative CIP

Narrative:

The Trust has transacted £17.7m of CIP at M7 which is £4.3m behind plan. The Trust has risk adjusted our CIP forecast to £20.4m, a shortfall against target of £8.5m.

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 £10.9m in M7 and £61.7m YTD, an adverse variance of £11.0m 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.

The Chief Operating Officer and Chief Finance Officer have completed a joint review of the CMSC that considered:

- whether there were any material changes to assumptions within the original business case.
- the extent to which the planned financial benefits of CMSC have been achieved.
- potential mitigation plans to deliver the Board approved return on investment.
- the contribution to income under-performance between CMSC and core capacity.

The review concluded that the income assumptions of business case needed to be revised in light of the reduced levels of mutual aid referrals and the lower than expected case mix and that corresponding reductions in expenditure were required to deliver the Trust approved contribution from the investment. This includes the commitment to consolidate theatre activity at the CMSC and reduce the number of theatres at Arrowe Park

Risks to position:

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

Actions:

- Implementation of the Board approved mitigation plan which includes increased productivity of core elective capacity and reduced reliance on non-core support.

Capital Expenditure

Narrative:

Description	Approved Budget at M1	Revision to Budget M2	Revision to Budget M6	Revision to Budget M7	Revised Budget
CDEL					
Internally Generated	£12.870m				**£12.870m**
ICB/PDC/WCT	£6.284m	-£1.400m	£1.953m		**£6.837m**
Charity	£1.000m			-£1.000m	**£0.000m**
Confirmed CDEL	**£20.154m**	**-£1.400m**	**£1.953m**	**-£1.000m**	**£19.707m**
Total Funding for Capital	**£20.154m**	**-£1.400m**	**£1.953m**	**-£1.000m**	**£19.707m**
Capital Programme					
Estates, facilities and EBME	£5.000m				£5.000m
Heating and chilled water pipework replacement	£2.100m				£2.100m
Operational delivery	£2.750m				£2.750m
Medical Education	£0.080m				£0.080m
Transformation	£1.000m				£1.000m
Digital	£0.750m				£0.750m
UECUP	£6.010m				£6.010m
Charity	£1.000m			-£1.000m	£0.000m
Approved Capital Expenditure Budget	**£18.690m**			**-£1.000m**	**£17.690m**
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**	**-£1.400m**	**£1.953m**	**£0.000m**	**£2.017m**
Total Anticipated Expenditure on Capital	**£20.154m**	**-£1.400m**	**£1.953m**	**-£1.000m**	**£19.707m**
Under/(Over) Commitment	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**	**£0.000m**

Spend at M7 totals £4.8m which is £1.4m behind plan. The delays primarily relate to the CSSD and Interventional Radiology business cases that have yet to be approved. However, we do not anticipate any underspend 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 M7 was £8.3m. This was due to the receipt of our non-recurrent deficit support received in month.

The reduction in the cash balance is presenting difficulties on a daily basis with a direct impact on the Better Payment Practice Code (BPPC) target by volume and value. The year-to-date position of bills paid within target stands at 71.8% which is 23.2% lower than the national target of 95%. In M7 the Trust was only able to pay 48.6% of invoices received within the timeframe required to achieve BPPC. This reduced performance is a direct consequence of the Trust managing its cash position.

The Trust has applied for cash support in December and will apply for further cash support in Q4.

Risks to position:

- Management of the cash trajectory is impacting significantly on 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 in December 2024 (Q4)

Wirral University Teaching Hospital NHS Foundation Trust

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

Title	Chief Operating Officer's Report
Area Lead	Hayley Kendall, 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

Report Purpose and 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 and progress in delivering improved elective waiting times.

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.

It is recommended that the Board of Directors note the report.

Key Risks

This report relates to these key risks:

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

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

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

1 Introduction / Background

1.1 As a result of the large-scale cancellation of all but the most urgent elective activities, aligned to the national Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway. In addition, cancer services and many surgical specialities have seen unexpected levels of increases in demand.

Urgent and emergency care performance remains a challenge, and there is an internal improvement plan 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 is in receipt of a Rapid Improvement Offer (RIO) from the national Emergency Care Improvement Support Team (ECIST).

2 Planned Care

2.1 Elective Activity

In October 2024, the Trust attained an overall performance of 96.6% against plan for outpatients and an overall performance of 91.5% against the plan for elective admissions, as shown in the table below:

Activity Type	Target for October	Actual for October	Performance
Out pt New	13115	11725	89.40%
Out pt Follow up	27355	25407	92.88%
Out pt procedures	3230	5089	157.55%
Total Out pts	43700	42221	96.62%
Day case	4700	4465	95.00%
Inpatients	803	570	70.98%
Total	5503	5035	91.50%

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

The under delivery of new appointments was seen across Surgery, Medicine and Women's and Children's. Medicine's performance was related to sickness in Dermatology and Gastroenterology. Surgery's under delivery was related to consultant sickness, Upper GI vacancies and vacancies in Orthopaedics. Women's and Children's related to under delivery of outpatient procedures.

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

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 October against these indicators was as follows:

- 104+ Week Wait Performance – 1

- 78+ Week Wait Performance – 11
- 65+ Week Wait Performance - 135
- 52+ Week Wait Performance – 1,433
- Waiting List Size - there were 47,234 patients on an active RTT pathway which is a decrease on the previously report Trust position.

The 1 104 week waiter was an internal referral within one specialty that was not captured at the time, patient received treatment in November.

The Trust reported 10 over 78 week breaches with the following breakdown:

- 3 patient choice
- 1 capacity (Gynaecology)
- 2 corneal grafts (national availability)
- 4 delayed pathways

The Trust had 135 65 week waiters at the end of October with the following breakdown:

- 56 patient choice
- 15 complex patients
- 53 capacity (Gynaecology)
- 11 corneal grafts (national availability)

WUTH have continued to provide mutual aid to treat very long waiting patients through the Cheshire and Merseyside Surgical Centre for Orthopaedic services and these patients are included in the above performance.

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 Cancer	75.00%	79.13%	74.42%	75.78%	76.58%
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	92.28%	90.00%	87.24%	90.01%
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	77.25%	79.77%	75.67%	77.61%

Sub Standards:

Standard	Indicator	Threshold	July-24	August-24	September-24
28 Day Wait	Individual Trust Provider Trajectory	Per Month	79.13%	74.42%	75.78%
28 Day Wait	Breast >=90%	90.00%	94.97%	91.28%	92.79%
28 Day Wait	Skin >=90%	90.00%	94.38%	94.64%	93.53%
62 Day Wait	Individual Trust Provider Trajectory	Per Month	77.25%	79.77%	75.67%

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%	71.52%

- *Faster Diagnostic Standard (FDS)* – The Trust did meet the FDS standard for September 2024 and for Quarter 2, with performance of 76.58% for the quarter.

- *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 September 2024.
- *62 day waiters* – the number of waiters decreased slightly again in October 2024, but remained above of plan by month end.

	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	07/10	14/10	21/10	28/10
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	88	81	80	74
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	60	60	60	60
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	51	51	51	51

- *104 day long waiters* – performance is ahead of trajectory for October, at 12 against a plan of 23.

	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	07/10	14/10	21/10
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	15	16	12
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	23	23	23
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	12	12	12

2.4 DM01 Performance – 95% Standard

At the end of October 95.9% 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.

2.5 Risks to recovery and mitigations

The clinical divisions are continuously working through options to reduce the backlogs of patients awaiting elective treatment and progress is being made to improve waiting times for patients. These include ensuring maximum utilisation of available capacity and proactive management of patient pathways.

Achievement of the elective recovery waiting times trajectory is based on the use of non-core spend and this will be required into the next financial year.

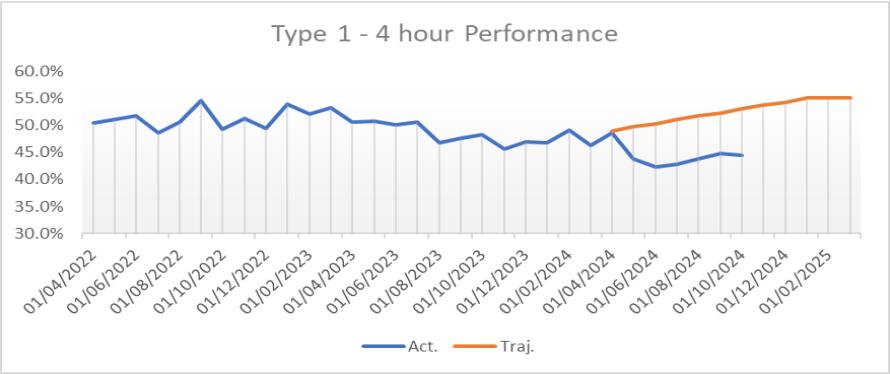
3.0 Unscheduled Care

3.1 Performance

October Type 1 performance was reported at 44.69%, with the combined performance for all Wirral sites at 73.91%:

Type 1 ED attendances:	Type 3 ED attendances:
• 7,655 in September (avg. 255/day) • 8,011 in October (avg. 258/day) • 4.6% increase from previous month	• 2,823 in September (avg. 94/day) • 3,357 in October (avg. 108/day) • 18.9% increase from previous month

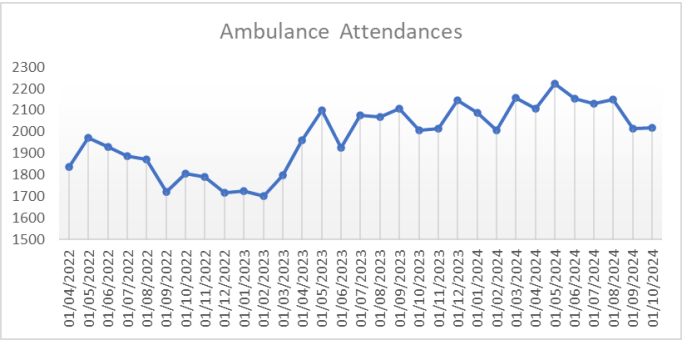
The performance of emergency care (UEC) in October remains below the planned trajectory. The department remains challenged with the number of attendances for both walk-in and ambulance conveyances resulting in an overcrowded department, making it difficult to trial new tests of change, although there are several planned for November, including two with system partners.



Several of the pilots that are planned to improve performance in emergency care have made progress and have go-live dates in November. These include 'urgent treatment centre streaming' at the ED front door, the Cheshire and Merseyside led 'call before convey' pilot and the expansion of the Trust's SDEC offer, including the appropriate use of SDEC space to ensure flow through units.

Ambulance handover remains a challenge with the Trust being in the bottom quarter in Cheshire and Merseyside in terms of handover.

Ambulance attendances remained similar to previous month but continued to track significantly above 2023/24.



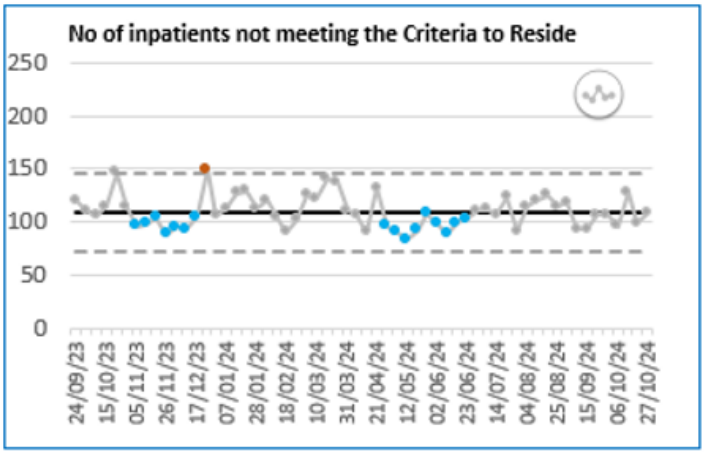
The Trust's Board has recently approved the business case for the expansion of core care in the ED, which includes staffing three corridors (up to 12 patients). The department is currently reliant on staffing the corridors with bank staff and taking nursing staff off the wards, which is impacting on staff morale. The recruitment of internal candidates is planned for November, with interviews for external candidates scheduled for early December.

The Trust continues to work with Place colleagues to focus on improving UEC performance through the three working groups focusing on A&E attendance avoidance and out of hospital flow.

During October the Trust experienced the expected increase in demands for inpatient beds entering the winter period. This will be an ongoing challenge given the bed deficit that the Trust will have.

3.2 **Transfer of Care Hub development and no criteria to reside.**

The number of NCTRs remained at an average of 115-120 patients in October. The hub is currently working with system partners to determine what capacity is needed to meet

	demand at the pathway level. The increase with the drive to discharge patients via pathway 1 has led to challenges in month with services such as Home First. The shift of patients from pathway 3 to pathway 2 has also led to an increase in waiting times for community intermediate care beds. The increase in demand in these areas shows that work is improving to ensure appropriate discharge prescribing to meet the needs of patients to ensure the best possible care for patients out of hospital whilst reducing costs.  The Hub team are working with the Divisions supporting reviews of patients who currently meet the criteria to reside and have a length of stay of more than 21 days to review and ask the ward teams if there is an opportunity to support the patient at home with community or social care support. The initial data suggests that a number of patients are now moving to no criteria to reside. Whilst this will contribute to an increase in overall numbers, it will also highlight the real capacity needed for out of hospital services to support discharges. There will be a focussed session with system leaders to improve the position during December.
3.3	**Mental Health** Demand for patients presenting to the ED with mental health problems remained high in month and there were a number of long waits for admission. Due to the increasing number of patients who do not meet the criteria to reside within an inpatient mental health bed, there were long waiting times for patients in ED. Escalations were made via the ICB and NHS England. The mental health provider held MADE events to drive flow out of the acute wards to more appropriate settings which did improve flow however this was not sustained. Further MADE events are planned for November and December. The Trust is working with the mental health provider to improve visibility of key performance indicators on response times to triage patients in ED, waiting times for admission and waiting times for discharge. The metrics will be monitored through the Trust Mental Health Transformation Group.
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 and waiting time standards. Performance and

	monitoring of improvements will be presented through the UEC Improvement Group and the sentinel metrics monitored by the Place leads and the ICB. There remains a risk that the continued high level of attendances and acuity will challenge the improvement plans and actions. Added to this is the need to increase the number of nurses in the ED to support the requirement to release ambulance crews as soon as possible (which includes staffing corridors as required) and vacancies in junior medical staff is increasing the pressure in the department.

4	Implications
4.1	**Patients** • The paper outlines good progress with elective recovery but still waiting times for elective treatment are longer than what the Trust would want to offer but given the backlog from the Covid pandemic the Trust is in a strong position regionally in delivering reduced waiting times for patients. The paper also details the extra actions introduced recently to improve UEC performance.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • Cost of recovering activity from medical industrial action to ensure the Trust delivers against the national waiting time targets. The paper details additional resource agreed as part of the winter plan that has been introduced. The cost of providing corridor care is above the Trust's financial plan.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets in the main due to the impact of medical industrial action, relating mainly to 65 weeks by the end of March 2024 and 76% 4 hour performance.

5	Conclusion
	The Board should note the ongoing improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the UEC Improvement Plan to ensure that the increase in demand can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED. Elective recovery remains a strong point and improvements continue, but medical industrial action remains the highest risk to the elective recovery programme.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.3**

04 December 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 October 2024. It is recommended that the Board: • Note performance to the end of October 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.

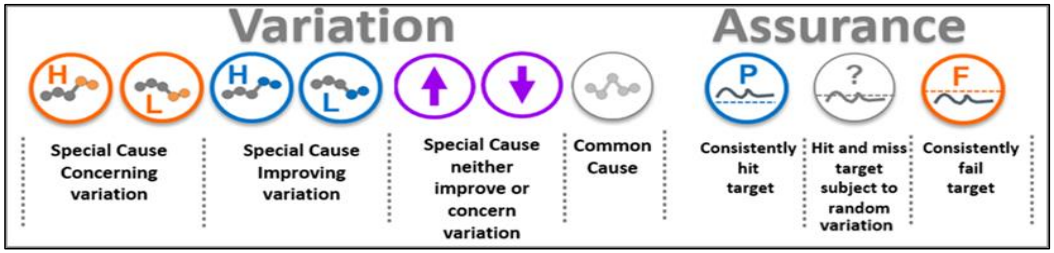
3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Integrated Performance Report, and at the regular operational meetings with the Clinical Divisions.

Integrated Performance Report - November 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:



Summary of latest performance by CQC Domain:

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

Issues / limitations

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

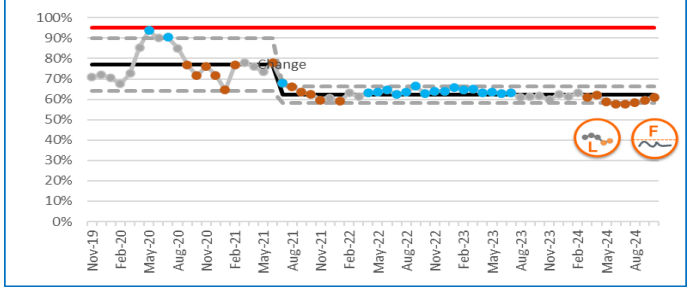
Changes to Existing Metrics:

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

Chief Operating Officer (1)

CQC Domain : Responsive

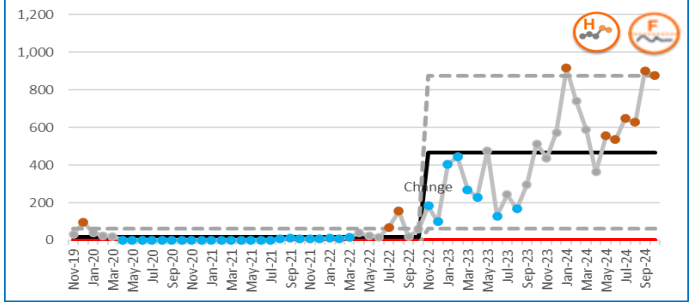
4-hour Accident and Emergency Target (including APH UTC)



Oct-24
60.8%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

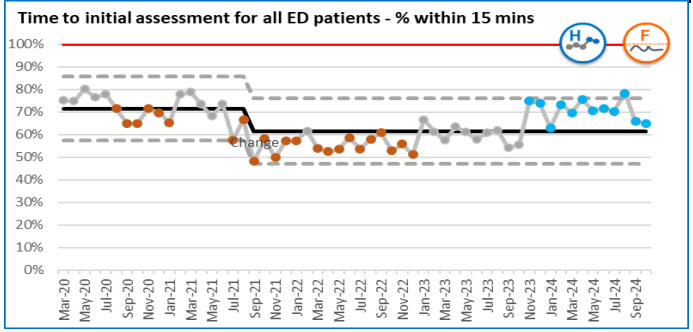
Patients waiting longer than 12 hours in ED from a decision to admit



Oct-24
878
Variance Type
Common cause variation
Threshold
0
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

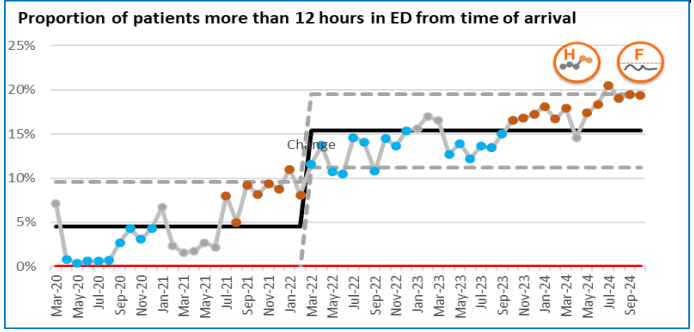
Time to initial assessment for all ED patients - % within 15 mins



Oct-24
64.9%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

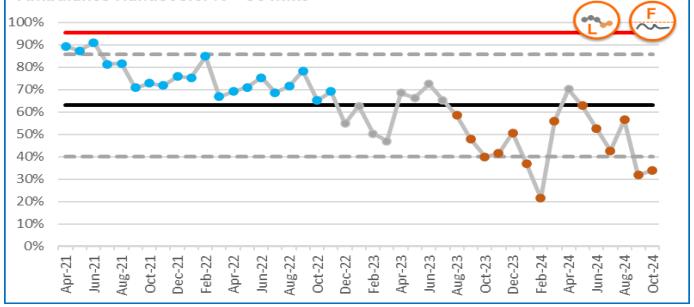
Proportion of patients more than 12 hours in ED from time of arrival



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

CQC Domain : Responsive

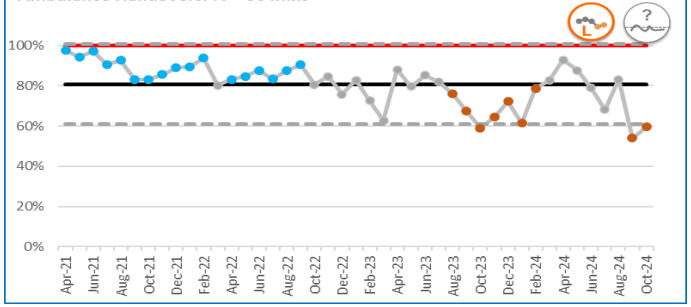
Ambulance Handovers: % < 30 mins



Oct-24
33.8%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Ambulance Handovers: % < 60 mins

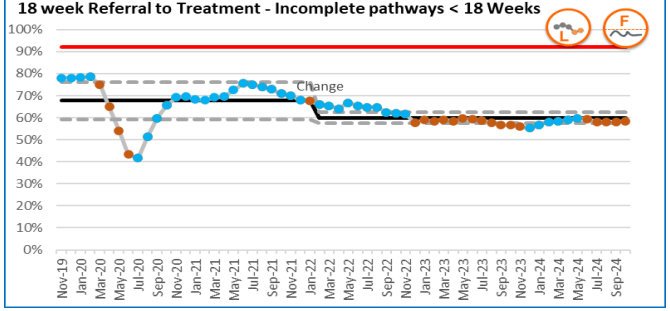


Oct-24
59.7%
Variance Type
Special cause variation - concerning
Threshold
100%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (2)

CQC Domain : Responsive

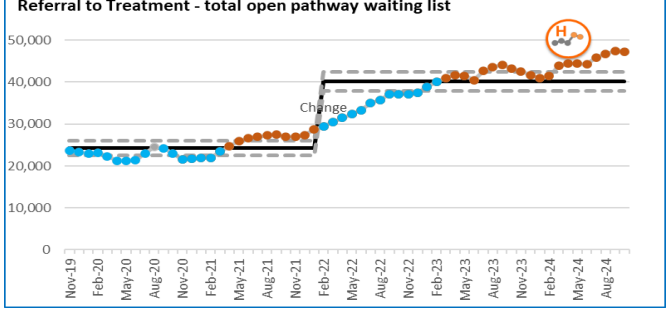
18 week Referral to Treatment - Incomplete pathways < 18 Weeks



Oct-24
58.41%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

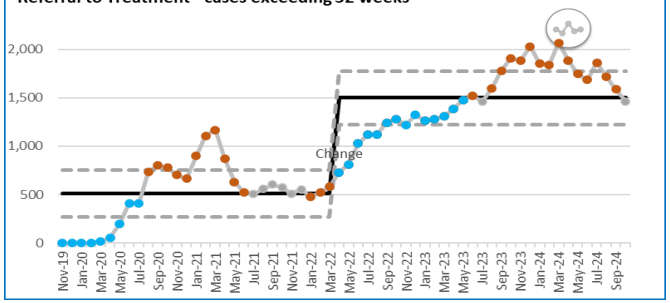
Referral to Treatment - total open pathway waiting list



Oct-24
47262
Variance Type
Special cause variation - concerning
Threshold
≤ 40511
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

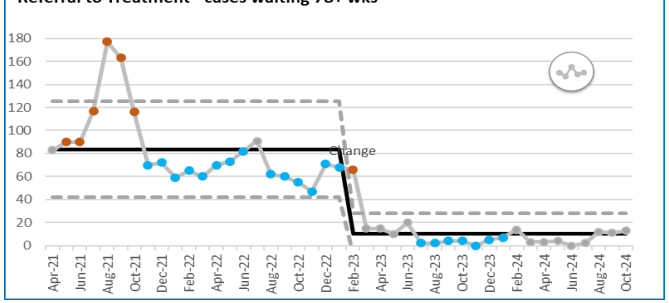
Referral to Treatment - cases exceeding 52 weeks



Oct-24
1461
Variance Type
Common cause variation
Threshold
≤ 1795
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

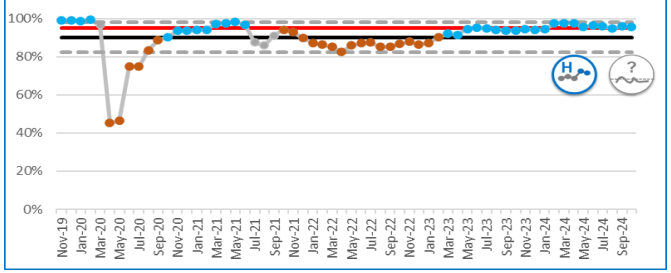
Referral to Treatment - cases waiting 78+ wks



Oct-24
13
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

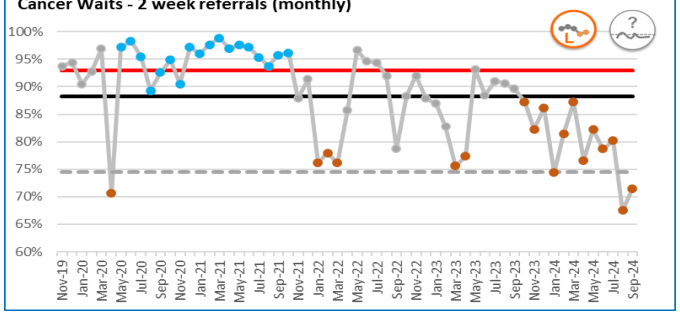


Oct-24
95.9%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

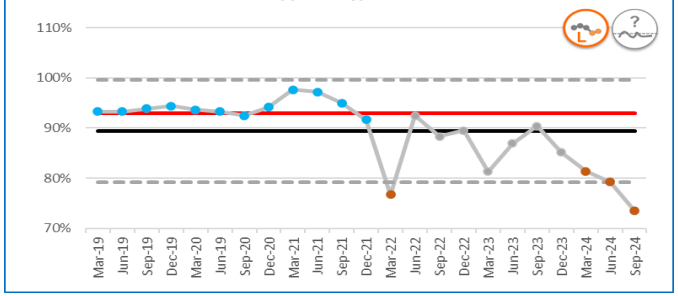
Cancer Waits - 2 week referrals (monthly)



Sep-24
71.5%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

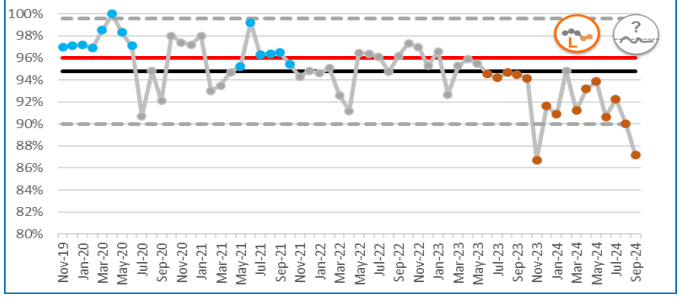
Cancer Waits - 2 week referrals (quarterly)



Sep-24
73.5%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

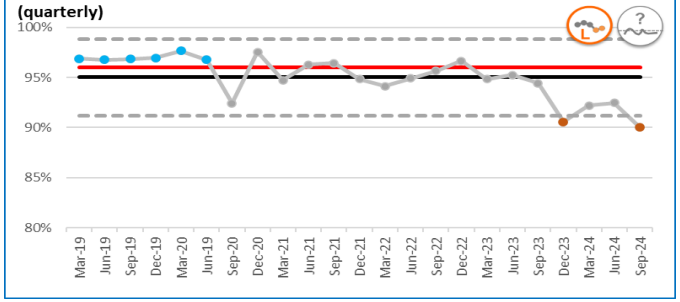
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



Sep-24
87.2%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

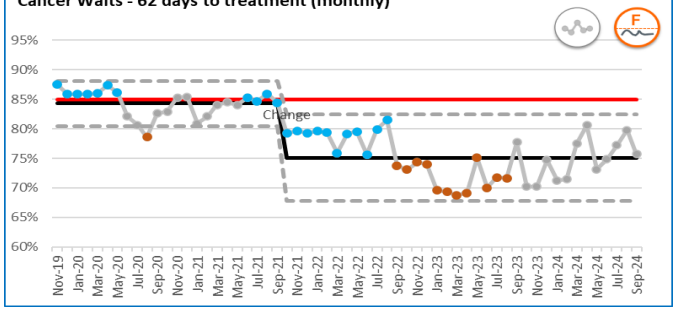
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



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

CQC Domain : Responsive

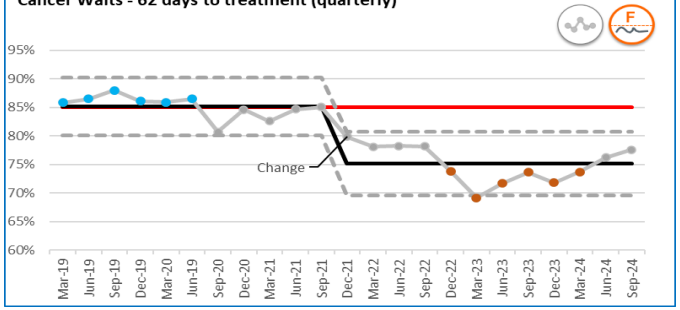
Cancer Waits - 62 days to treatment (monthly)



Sep-24
75.7%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

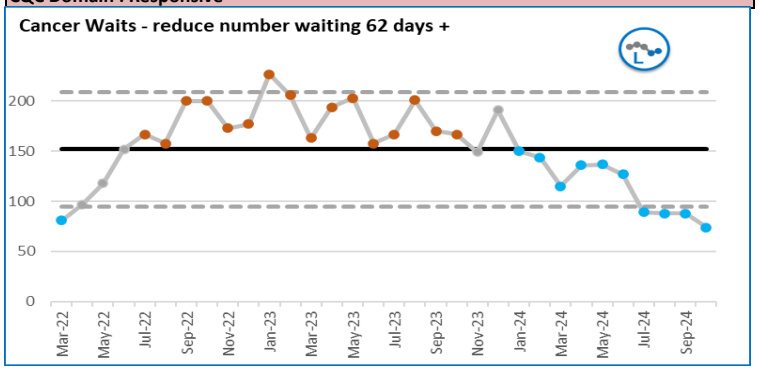
Cancer Waits - 62 days to treatment (quarterly)



Sep-24
77.6%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

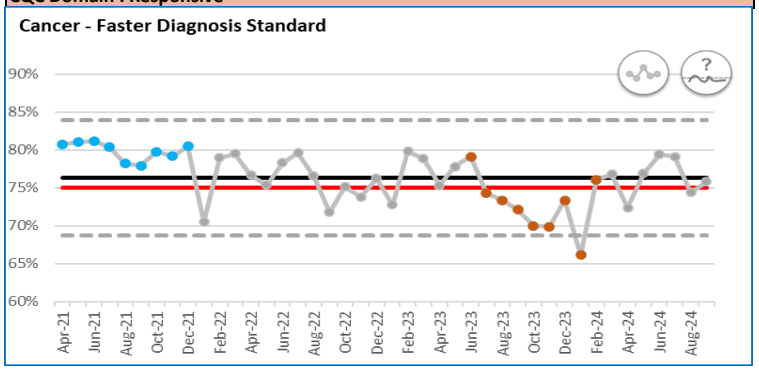
Chief Operating Officer (4)

CQC Domain : Responsive



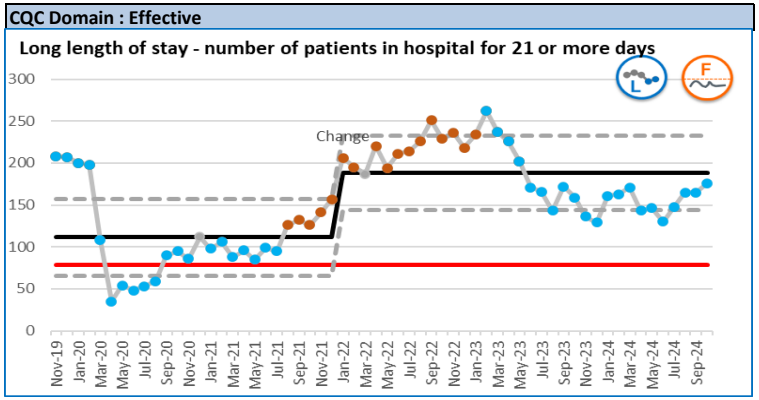
Oct-24
74
Variance Type
Special cause variation - improving
Threshold
83
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



Sep-24
75.8%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

CQC Domain : Effective

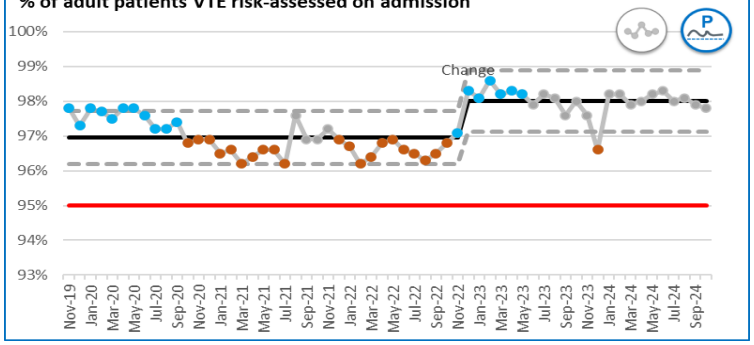


Oct-24
176
Variance Type
Special cause variation - improving
Threshold
≤79
Assurance
Performance consistently fails to achieve the target

Medical Director

CQC Domain : Safe

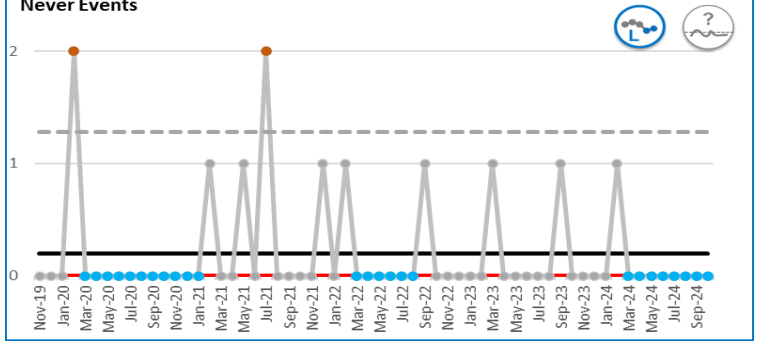
% of adult patients VTE risk-assessed on admission



Oct-24
97.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe

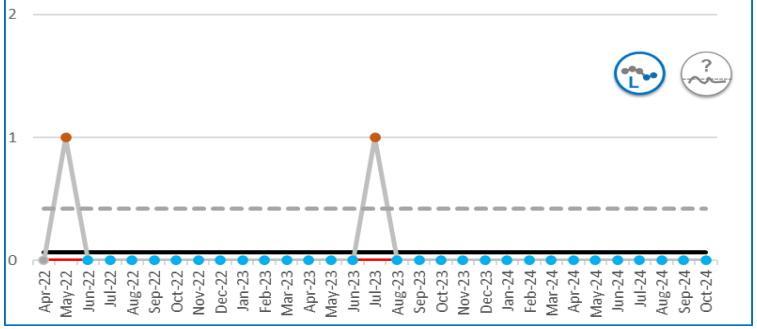
Never Events



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

CQC Domain : Well-led

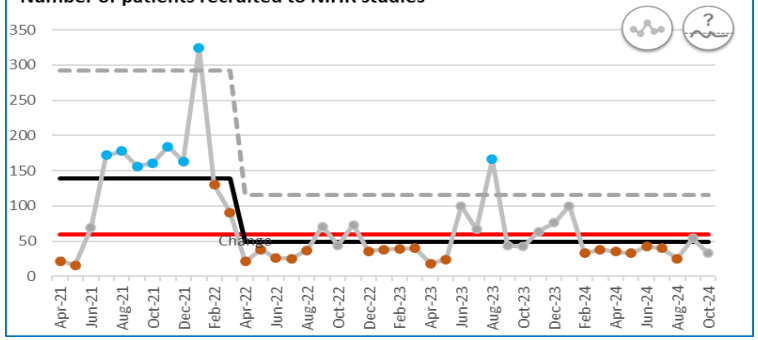
Duty of Candour compliance - breaches of DoC standard for Serious Incidents



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

CQC Domain : Well-led

Number of patients recruited to NIHR studies

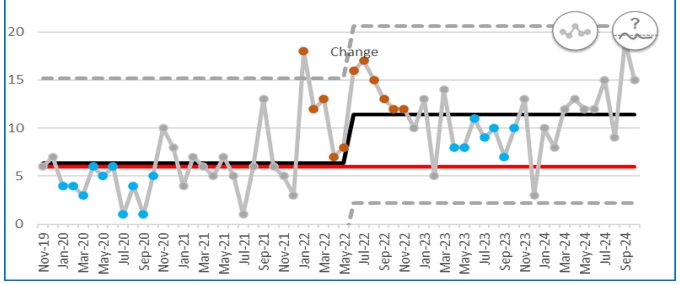


Oct-24
33
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse (1)

CQC Domain : Safe

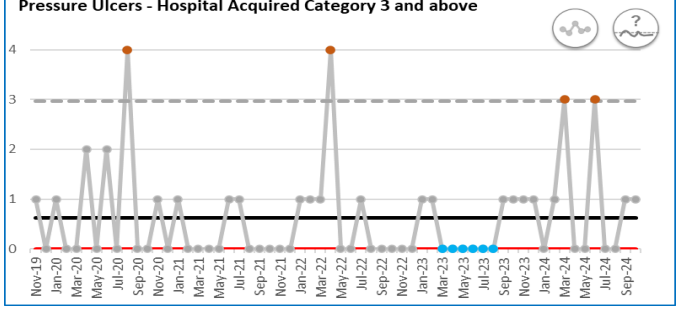
Clostridioides difficile (healthcare associated)



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

CQC Domain : Safe

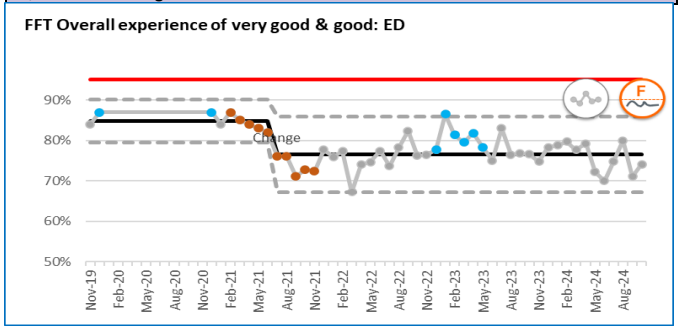
Pressure Ulcers - Hospital Acquired Category 3 and above



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

CQC Domain : Caring

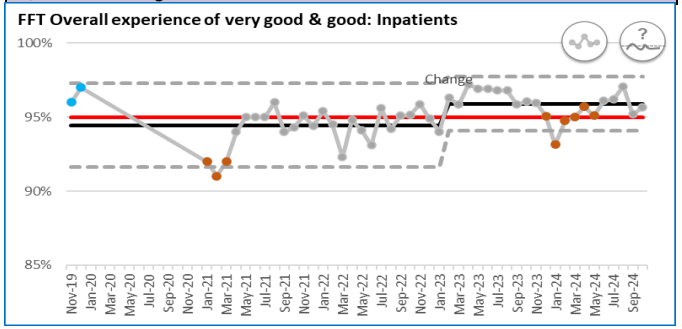
FFT Overall experience of very good & good: ED



Oct-24
74.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

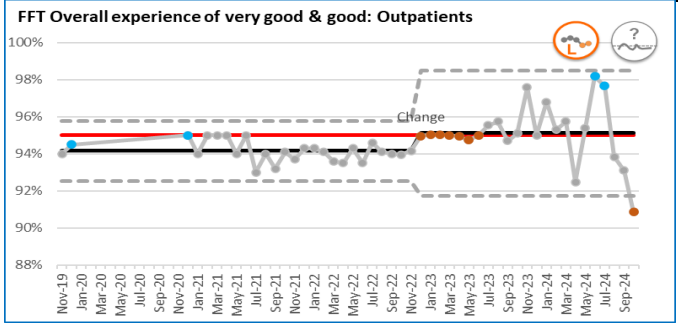
FFT Overall experience of very good & good: Inpatients



Oct-24
95.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

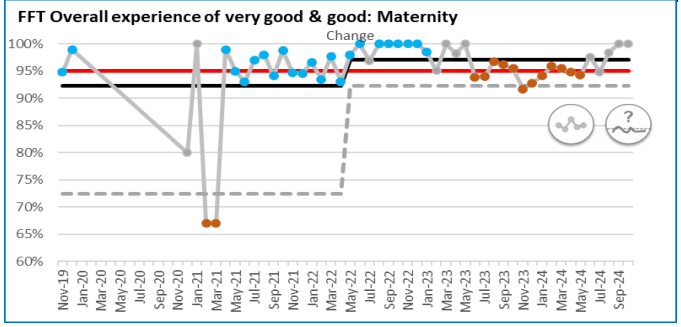
FFT Overall experience of very good & good: Outpatients



Oct-24
90.9%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

FFT Overall experience of very good & good: Maternity

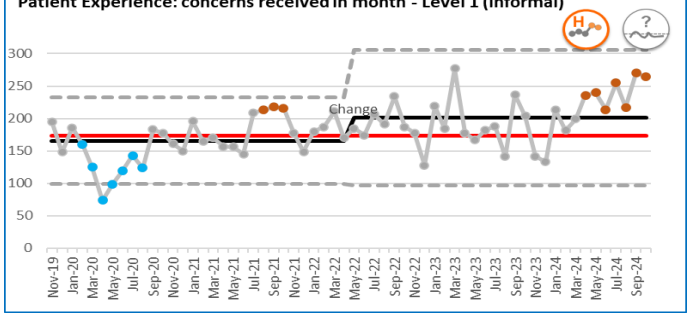


Oct-24
100.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse (2)

CQC Domain : Responsive

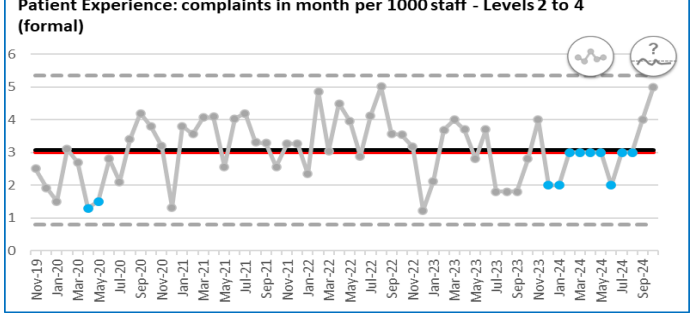
Patient Experience: concerns received in month - Level 1 (informal)



Oct-24
265
Variance Type
Special cause variation - concerning
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

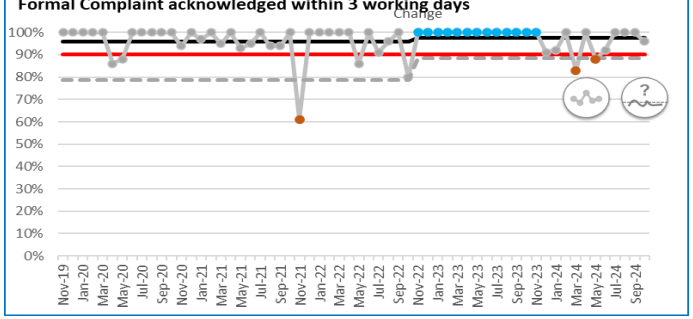
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)



Oct-24
5.0
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

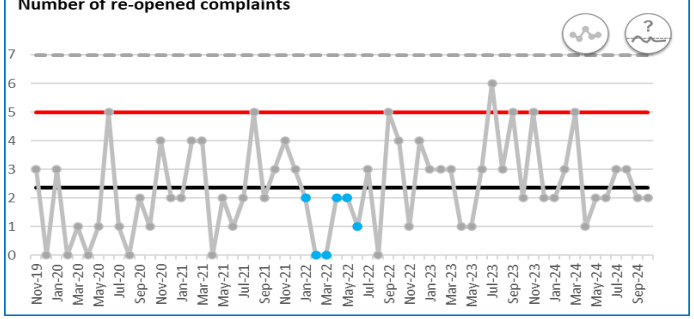
Formal Complaint acknowledged within 3 working days



Oct-24
96.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

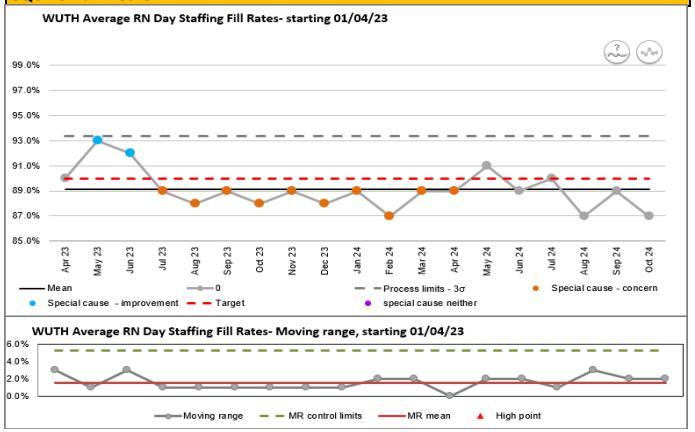
Number of re-opened complaints



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

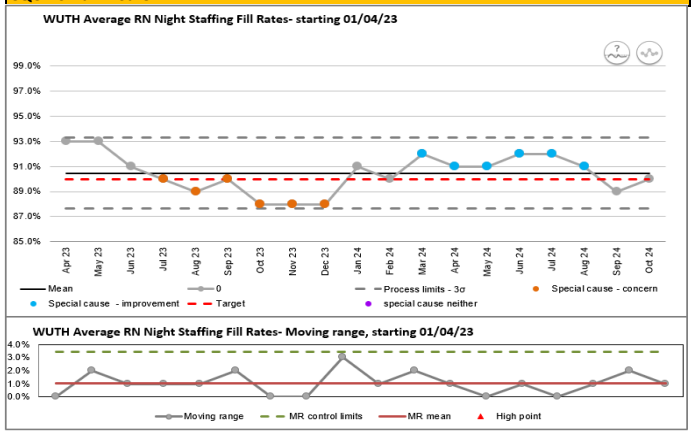
Chief Nurse (3)

CQC Domain : Safe



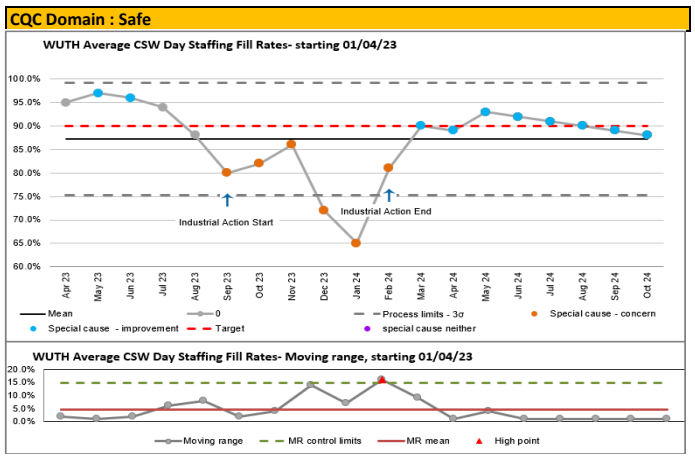
Oct-24
87.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



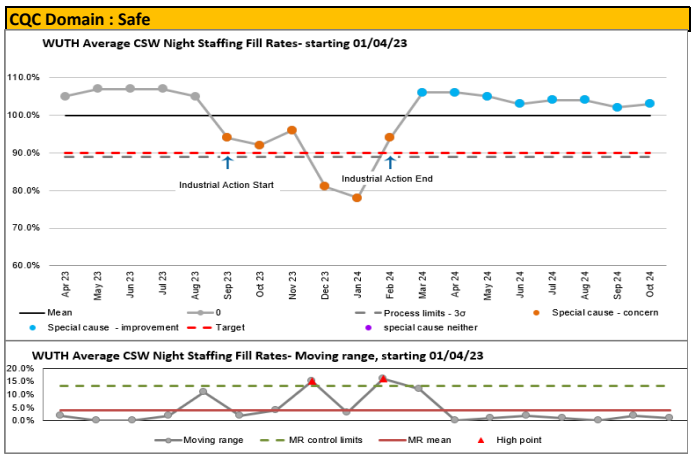
Oct-24
90.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



Oct-24
88.0%
Variance Type
Actual below threshold
Threshold
≥90%
Assurance

CQC Domain : Safe



Oct-24
103.0%
Variance Type
Actual above threshold
Threshold
≥90%
Assurance

Chief Nurse – October 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 15.

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

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

Friends and family test for ED 74.1%, outpatients reduced to 90.9%. Maternity and inpatients exceeded the 95% of those that responded were either satisfied or very satisfied with the service.

The number of level 1 concerns raised with the trust exceeded the threshold of 173 in month and the number of formal concerns per 1000 staff exceeded the threshold by 1.9.

RN and CSW fill rates are now added to the integrated performance report. In a threshold of 90% fill rate is set in October RN Days was below the threshold at 87% and CSW day fill rate was 88%. Nights exceed the threshold for both RN and CSW's.

Infection Prevention and Control

Narrative:

To achieve the annual threshold of ≤ 103 patients diagnosed with CDT in 24/25. The position at the end of October of 62 x Hospital onset health care associated (HOHA), 33 x Community onset healthcare associated (COHA). In October there were 5 HOHA and 10 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 October the wards in the improvement project had 7 patients diagnosed, of these AMU reported x 2 HOHA and ward 26 1 HOHA, the remaining were COHA, attributed to ward 36 x 3 and ED x 1.

The improvement project continues to focus on but not limited to:

- Education with staff regarding side room prioritisation
- Collaborative nursing & 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
- C&M IPC collaboration group focusing on CDT.

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. (21st 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.
- Support the wards in identifying additional QI projects with a reduction in CDT as a theme.
- Review sampling protocol anticipated that approval to complete a sample will come from a senior clinician.

Risks to position and/or actions

- Hospital occupancy- The daily demand for beds exceeds the availability.
- Continuous flow increases the demand for cleaning and the time allowed to complete.
- Competing staff priorities impacting engagement in the QI project.

- Low numbers of side rooms and/or side rooms with en-suites across the Estate does not support isolating all patients when needed. Risk assessment approach adopted.
- Old estate requiring ongoing maintenance and repairs to facilitate effective cleaning.
- Unable to decant in a timely manner due to challenges with staffing and competing pressures flow pressures.

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 was 74%. 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 90.9% 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 October there was 1 x Hospital Acquired Pressure Ulcer (HAPU) Category 3, to a patients sacral area which developed on ward 26.

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 October 2024, WUTH received 26 formal complaints (level 2-4) and 266 informal concerns (level 1).

Acute Care received in the highest number of complaints (12), then Medicine and Surgery (9), and then Women's and Children's (5). Informal concerns, Medicine (70), Surgery (63), Acute (49), and Women's and Children's (45).

Corporate Departments received 1 complaint and 18 concerns; it is of note that the majority of these reflected an increased volume of concerns regarding delays in SAR / Access to Information requests – which is a recognised capacity pressure for the organisation.

Otherwise, the top three themes for the organisation were:

- Communication (67% of cases): These mostly reflect communication failure rather than attitude.
- Treatment and Procedure (44% of cases): These mostly reflect delay.
- Medication / Transfer and Discharge / Access and Admission (each 22% of cases): Again, these mostly reflect forms of delay.

The highest featuring departments were ED (8 formal and 37 informal), followed again by Community Child Health (27 informal, reflecting the known access problems with waiting times for assessment by that service), Trauma and Orthopaedics (3 formal and 12 informal).

25% of responses to formal complaints were completed within WUTH's local standard of 40 working days, with an average response time of 52 working days. At the end of October, there were 77 formal complaints in progress, of which 24 had already breached 40 working days with the divisions.

Of the 266 concerns opened, 162 (54%) were resolved within three working days and 76% within 10 working days. Of those cases taking longer than 10 working days, these lay with Medicine (28), Acute Care (24), Women's and Children's (12), Corporate Departments (11), Surgery (5), Diagnostics and Clinical Support (5), and Estates, Facilities and Capital (3)

Actions:

Benchmarking with other local trusts has 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 has concluded that 80% of complaints should be concluded in 40 working days. This has been agreed with divisional triumvirates with an 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 is also being placed on the lead investigators in the divisions to update complainants directly when investigations are taking longer than expected. For further support, the divisional triumvirates have been provided with a revised SOP / guidance for divisional investigators, while monthly training session for staff continue to be offered and provided by the Complaints Team.

Risks to position and/or actions:

- Operational pressure

Nurse Staffing Fill Rates

Narrative:

Registered nurse and care support working fill rates should be reported to the board monthly to ensure compliance with NHSE developing workforce safeguards 2018 and the national quality board safe sustainable and productive staffing 2017. A ward level dashboard should also be available to demonstrate safe effective care is being delivered. Fill rate threshold is currently set at 90% day and night CSW and RN. In October, the RN fill rate on days was 87% and the CSW fill rate was 88%.

Actions:

Review of vacancies across the organisation, to fully understand the risk and impacts and determine the most effective recruitment process i.e., speciality-based recruitment events.

Acuity review completed with new safer nursing care tool; data currently being analysed. Report to board in Dec/Jan.

Assurance re effectiveness of absence management.

Weekly roster oversight review meetings.

Roster/establishment/ESR alignment project under way.

Proposal regarding the approach to maternity leave backfill in development.

ED recruitment to new establishment underway, staff being temporarily redeployed to ED from wards to maintain safety, impacting on the wards.

Retention group reinitiated.

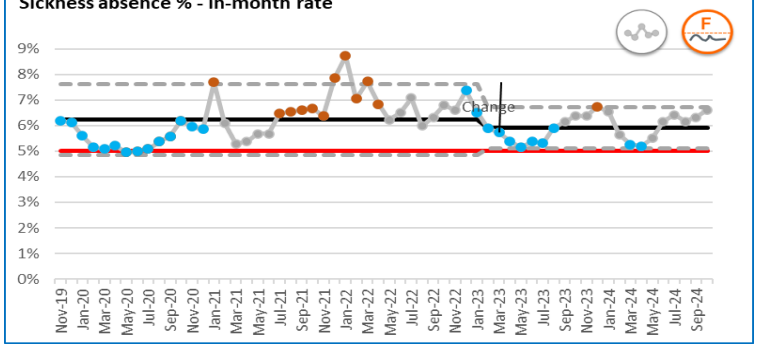
Risks to position and/or actions:

- High sickness absence rates.
- Staffing escalation areas and temporary escalation areas i.e., ED corridor.

Chief People Officer

CQC Domain : Safe

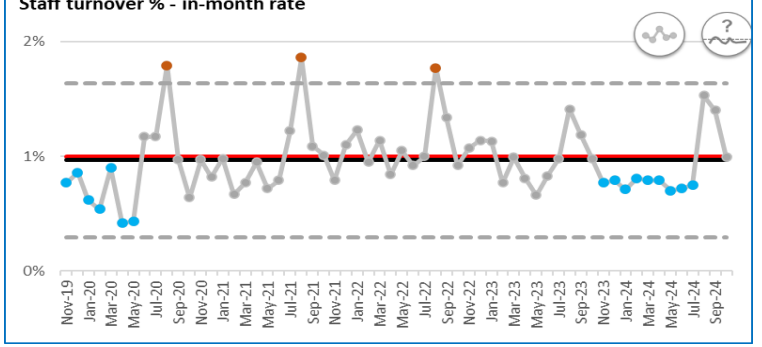
Sickness absence % - in-month rate



Oct-24
6.61%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe

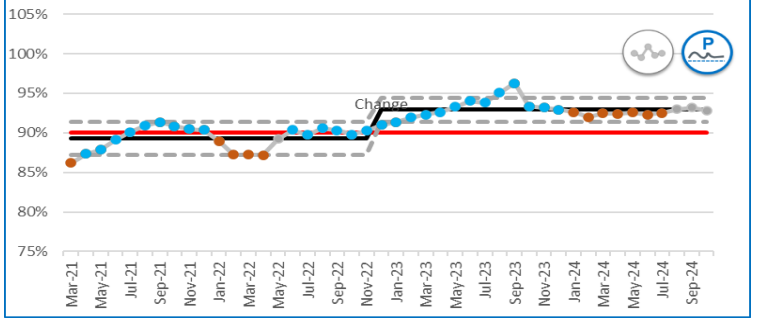
Staff turnover % - in-month rate



Oct-24
0.99%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

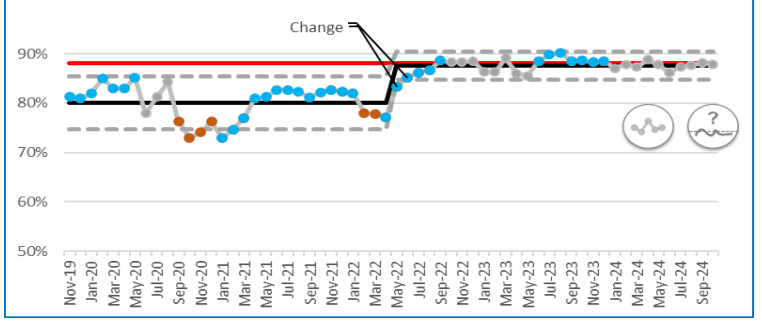
Mandatory training % compliance



Oct-24
92.80%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led

Appraisal % compliance



Oct-24
87.83%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – for Nov 2024 BoD

Overall position commentary

Mandatory training compliance continues to be achieved.

Appraisal has dipped below compliance by 0.29%, with Corporate trajectories in place to achieve target.

Sickness absence remains above target at 6.61% and an area of concern.

Turnover has reduced by 0.41% following the spike in August and seasonal trend.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is ≤5%. For October 2024 the indicator in-month was 6.61% and demonstrates common cause variation.

The majority of absences relate to short term (under 28 days) sickness at 5.24%. There has been an increase in absences relating to gastrointestinal problems and Cold/Flu. Absence relating to stress/anxiety/depression have reduced over recent months, although this remains a key are of focus.

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

Actions:

- Monitoring of the sickness absence KPI and associated actions are ongoing via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews. Managers continue to be supported by HR.
- New winter communication aligned to gastrointestinal illness and wellness has been developed to be communicated Trust wide to help reduce episodes and prevent transmission.
- Promotion of the EAP and extensive service offering continues with attendance at key Divisional and Corporate Meetings to increase awareness and uptake from staff to prevent sickness absence.
- Staff sign up to the EAP's new Wisdom app has increased, enabling staff to access 24/7 support and encouraging them to access support more quickly, track their wellness and improve their mental health.
- The staff winter vaccination programme is ongoing via drop-in clinics and roaming vaccinators; the delivery model also includes out of hours and a weekend service.
- The new OH Cority System continues to positively impact on OH waiting times.

- Increased number of staff hitting policy triggers and Attendance Management Hearings held.
- The recent Health and Wellbeing MIAA Audit achieved substantial assurance.
- Ongoing psychological support provided to targeted areas.
- Participation and support for the White Ribbon Campaign and it's 16 days of action during November and December to help prevent violence against women and girls.

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 October 2024 the indicator decreased to 0.99%, which mirrors the trend in 2023. This demonstrates a common cause variation.

When considering only permanent staff (excl fixed term) the in-month turnover for October 2024 was 0.90% a decrease of 0.13% from September 2024. The rolling 12-month turnover for permanent staff is 10.08%, which is a slight decrease of 0.12% from September 2024.

Whilst turnover remains above target, it is in line with annual trends and continues to show improvement in the longer term, particularly for permanent staff turnover.

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
- ED Nurse Staffing review

Risks to position and/or actions:

The impact of the work outlined above will achieve a downwards trend towards the 10% turnover target (which equates to ≤0.83% monthly 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.

Appraisal % compliance

Narrative:

The threshold for Appraisal compliance is ≥88% and for the month of October 2024 compliance remains slightly below the threshold at 87.83%, demonstrating common cause variation. Corporate Support (87.97%), Estates, Facilities & Capital (87.86%) and Surgery Division (82.25%) are all below target. Acute, Corporate Support and Surgery Divisions all saw improvements in compliance in October.

Actions

- Divisional improvement plans were agreed at July Workforce Steering Board with more regular updates required from those areas where further assurance was required.
- A further update and review of the Surgical improvement plan is scheduled for November Workforce Steering Board along with Corporate Service areas.
- Divisional leaders and HR business partners continue to identify areas of lower performance and work with service leads to address compliance gaps.
- The Learning and Development Team continue to contact all individuals that are out of compliance and due to become out of compliance with details about the appraisal process.
- Contact is also made with all line managers each month to actively highlight gaps in compliance and provide information and guidance on the process, note this is in addition to ESR automatic messages which are also issued.

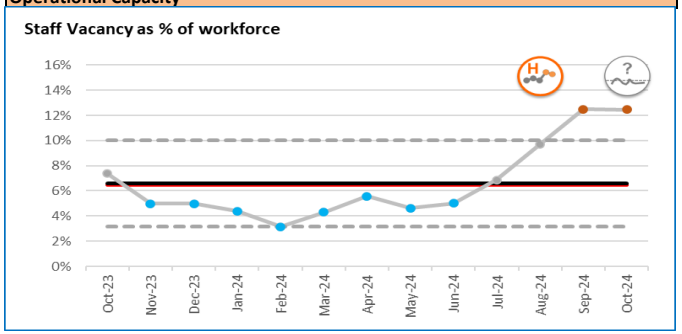
- Development for managers continues with online resources and guidance made available together with formal management training.
- The intranet has a comprehensive suite of guidance and ‘on-demand’ learning resources that brief staff and managers on the new process.
- The new appraisal ‘portlet’ continues to be promoted along with a short step by step video that was developed to support staff in recording appraisals.
- The Learning and Development Team continue to offer short-term interim support to divisions with recording of appraisals and have held a number of drop-in sessions at Arrowe Park and Clatterbridge

Risks to position and/or actions:

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

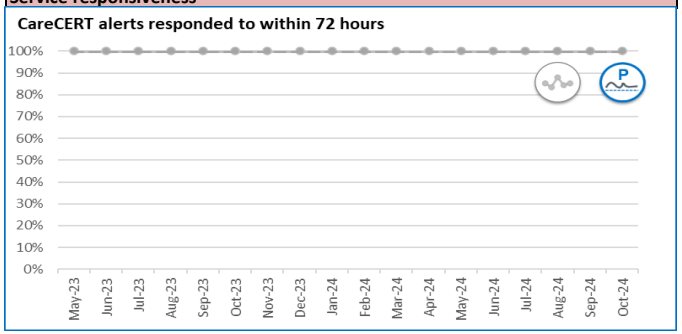
Chief Information Officer

Operational Capacity



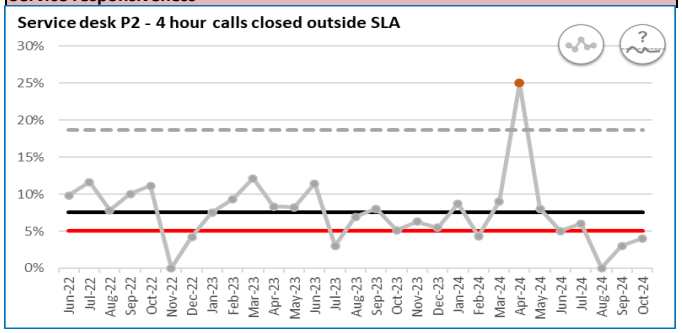
Oct-24
12.5%
Variance Type
Special cause variation - concerning
Threshold
<=6.5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



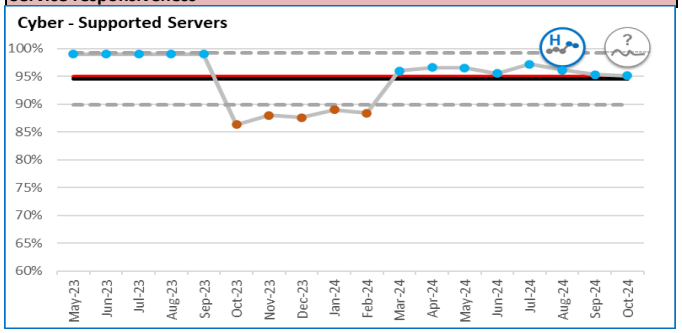
Oct-24
100%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently achieves the target

Service responsiveness



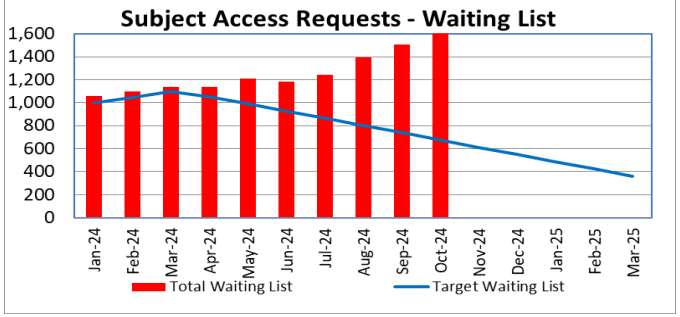
Oct-24
4.0%
Variance Type
Common cause variation
Threshold
<=5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



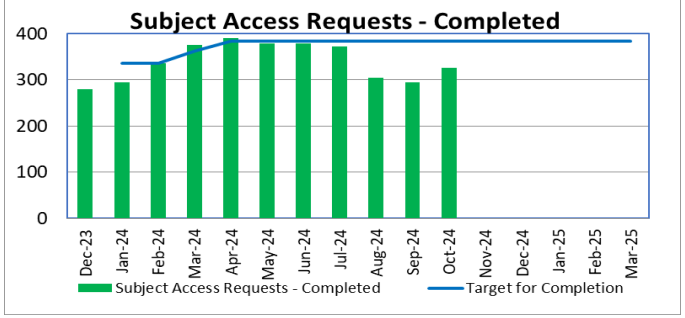
Oct-24
95.1%
Variance Type
Special cause variation - improving
Threshold
>=95%
Assurance
Hit & miss target subject to random variation

Service responsiveness



Oct-24
1635
Variance
Total requests waiting worse than target
Threshold
738

Service responsiveness



Oct-24
326
Variance
Completed requests worse than target
Target
384

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 8.4**

04 December 2024

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

Executive Summary and Report and Recommendations

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

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

This paper provides a specific update regarding MIS Year 6, Saving Babies Lives (SBLv3), Ockenden, the Three-Year Delivery plan, Ockenden, Midwifery staffing update, Maternity Continuity of Carer (MCoC) together with an update on the recent CQC national review publication and NHSE annual visit at WUTH.

It is recommended that the Board:

- Note the report.
- Note the Perinatal Clinical Surveillance Assurance report.
- Note the position of Patient Safety Incident Investigations (PSSI's) & Maternity and Newborn Safety Incidents (MNSI).
- Note the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3.
- Note the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals".
- Endorse option 2 of the Maternity Continuity of Carer Model options appraisal, which continues with current maternity continuity of carer teams supporting women/birthing people with enhanced needs as the national directive.
- Note the CQC national report and WUTH's response to include a review via a gap analysis.
- Note the outcome of the NHSE annual review.

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	As above	As above
November 2024	Safety Champion Monthly Meeting	As above	As above
December 2024	Patient Safety and Quality Board	As above	As above

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 (October 2024) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services. The dashboard is provided for information and whilst there is no indication to escalate any of the metrics to the Board of Directors, it should be noted since there is no longer a Northwest coast regional report being produced WUTH is no longer able to report on the benchmarking against other providers for rates such as stillbirth and neonatal deaths. Assurance has previously been provided to the Board of Directors this was escalated via the Local Maternity and Neonatal System (LMNS) for a resolution. However, a Northwest Regional Dashboard Tool for use by Regional Maternity and Neonatal Teams is available to provide bespoke reports for Regional Operational Performance reporting. The Maternity Services Data Set publications have a lag of circa three months 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. A further set of clinical quality metrics has been provided by Cheshire and

	Mersey LMNS and the reporting pack has been challenged in terms of accuracy and relevance of the measures.

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 October 2024 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date there are four ongoing cases. There were no Patient Safety Investigation Incidents (PSII's) declared in October 2024 for Neonatal services.

3	**Maternity Incentive Scheme (MIS) Year 6**
	A detailed MIS update is included to Board of Directors Monthly Maternity Services update, which will further inform Trust declaration with the MIS due for submission before a deadline of 12 noon on 3 March 2025. Now in its sixth year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. The compliance is being monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. An updated gap analysis is provided at **Appendix 2.** Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS and the declaration will also be required to be signed off by the ICB. The first request of evidence has been uploaded to the NHS future platform as requested by the LMNS for review. The compliance will be monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. A further compliance update will be included in the next maternity quarterly update report utilising the audit tool. Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS/ICB. The request to sign off will be presented to Board of Directors on 29 January 2025 with the LMNS present.

4	Saving Babies Lives v Three (SBLv3) Safety Action 6 of the MIS year 5 Scheme
	The Saving Babies' Lives Care Bundle (SBLCB) launched in July 2023 provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle (SBLCBv3) was redeveloped to include a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. On final review of all the evidence as of 30th June 2024 the Trust achieved 96% compliance against the 6 elements included at **Appendix 3**. The Trust continues to work towards full implementation and a further update will be in the next Board of Directors quarterly paper. Q2 evidence has been submitted and under review by the LMNS for compliance.

5	Ockenden Review of Maternity Services: Final Report – Update on Trust compliance with the Immediate and Essential Actions / Recommendations
	An initial gap analysis outlining compliance against these recommendations detailed within the 15 Immediate and Essential Actions (IEA's) was reported to the Board of Directors in December and updates have been provided quarterly. The gap analysis is included at **Appendix 4** and remains in the same RAG rated position as fully compliant.

6	Three Year Delivery Plan – Maternity and Neonatal
	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 5** and is RAG rated accordingly. The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion • Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support • Standards and structures that underpin safer, more personalised, and more equitable care. Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress is monitored via the Maternity and Neonatal Quality assurance board and WUTH continues to implement within the timescales. The Equity and equality guidance for local maternity services is the pathway followed to address health equalities and is also part of the three-year delivery plan.

7	Midwifery Workforce and update on Maternity Continuity of Carer Model (MCoC)
	The Maternity Service continues to deliver care via two models of maternity care – one that is traditional in its approach, and the other a Continuity of Carer (CoC) Model of care. Women being cared for by a team of midwives under the Continuity of Carer model appreciate the benefits of improved outcomes and experience compared to those cared for by a traditional model. As a provider WUTH has five maternity continuity of carer teams and in line with upskilling programs and safe staffing levels. There are no further teams planned to be launched and a continued focused approach to deliver the model of care to enhanced women/birthing people. A comprehensive review of MCoC has been undertaken and the outcome data is included at **Appendix 6**. An options appraisal was developed with support of the regional team to consider recommendations for WUTH's future model of maternity care considering safe staffing levels and meeting the enhanced element of continuity which evidences better outcomes for women/birthing people. This is included at **Appendix 7** and it is recommended Option 2 is supported by the Board of Directors. As previously presented to Board of Directors a full workforce review was last undertaken using the Birthrate+ tool in 2021, a repeat of this as recommended every 3 years in line with Ockenden is being undertake and publication is expected shortly.

8	CQC National Review of Maternity Services in England (2022-2024)
	Included at **Appendix 8** is the National review of maternity services in England 2022-2024 and the gap analysis and action plan at **Appendix 9** providing an update on the on the Trust's position.

9	NHSE Annual Visit
	An annual visit was hosted by WUTH on 23rd October 2024 by the Northwest Chief Midwifery officer and team on behalf of NHSE. The feedback was very positive and is included at **Appendix 10**. On the day a member of the maternity support staff group received an award recognising the significant and outstanding contribution the individual has made to exceptional contribution to midwifery practice and demonstrating NHS values.

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

11	Implications
11.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
11.2	**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.
11.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) and continue to deliver Maternity Continuity of Care as for women/birthing people with enhanced care needs, investment into the maternity and neonatal workforce is required and funding options continue to be explored. A paper has been submitted to BDISC for approval to increase establishment with funding received. • To achieve compliance of MIS Year 6 the Statement of case for an additional Neonatal Consultant has been approved to cover Monday to Sunday, the anticipated start date is January 2025 and will meet BAPM compliance.
11.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.5**
4 December 2024

Title	Learning from Deaths Report (Q1 2024/25)
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Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide the Board of Directors with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q1 2024-2025.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths.
- The Trust SHMI for the 12 months to Jan 2024 is 1.04 (within expected range)
- HSMR on the latest available data is 98 (within expected range)
- HSMR methodology will change in 2025 and this will likely result in a rise in the HSMR for WUTH
- The Mortality review group (MRG) is a multidisciplinary group that meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner.
- MRG continues to review Telstra Health data to benchmark nationally and highlight areas of concern.
- Learning form mortality reviews is fed back to clinical areas by the Divisional Mortality leads and via the Divisional Quality Boards. Specific learning points are also fed back to relevant Trust wide steering groups.

It is recommended that the Board:

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

Key Risks

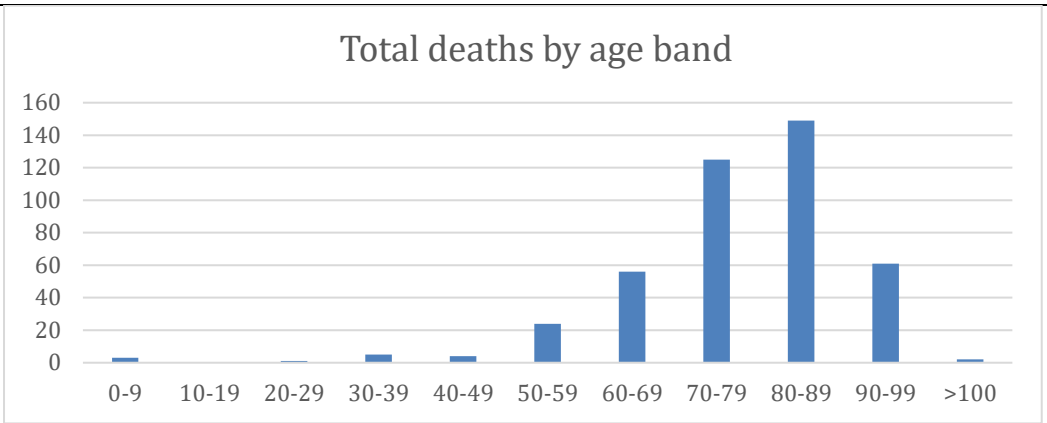
BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient. outcomes and an increase in patient complaints

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
November 2024	Quality Committee	As above	As above
October 2024	Patient Safety Quality Board	As above	As above

1	Narrative
1.1	This report provides a summary of all deaths that occurred within Wirral University Teaching Hospitals NHS Foundation Trust over Quarter 1 (Apr 24- Jun 24). It aims to identify key learning points, trends, and areas for improvement to enhance patient safety and care quality. Wirral University Teaching Hospital is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework: • Preventing people from dying prematurely. • Treating and caring for people in a safe environment and protecting them from avoidable harm. Wirral University Teaching Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare and benchmark against mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide an indication of potential problems and help identify areas for investigation. The Medical Examiner service provides independent scrutiny for all deaths that occur within WUTH, and escalates any concerns for a mortality review, coordinated through the Trust Mortality Group. Additionally, a random sample of non-escalated deaths (approx. 5% per quarter) are selected for a “quality assurance” mortality review. Lessons learnt from mortality reviews are fed back to each clinical Division via the Divisional Mortality leads who attend the Mortality Review Group, and by the circulation of this report through Divisional Quality Boards. **<u>Patient demographics</u>** There was a total of 420 deaths in Q1 24-25. Most recorded deaths are in the over 70 age group and the vast majority fall into the “White British” Ethnic band.



Ethnicity	Number of deaths
White - British	373
White - Irish	1
White - Any other White background	3
Mixed - Any other mixed background	0
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	1
Other Ethnic Groups -	4
Black/ Black British	1
Not stated/ Not known	37
Total	420

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The overall SHIMI for WUTH on the latest available data (12 months to January 2024) is 1.04 which is within the “as expected” range. SHIMI for WUTH has been relatively stable in the “expected” range for several quarters now.

Factors impacting SHIMI.

- Specific diagnostic groups

There were no specific SHIMI diagnostic groups that were flagged as outliers during Q1 (using NHSE over dispersal method)

- Deprivation

The Trusts continues to have a higher-than-average percentage of provider spells from the most deprived areas. Potential additional risks/complexities associated with these

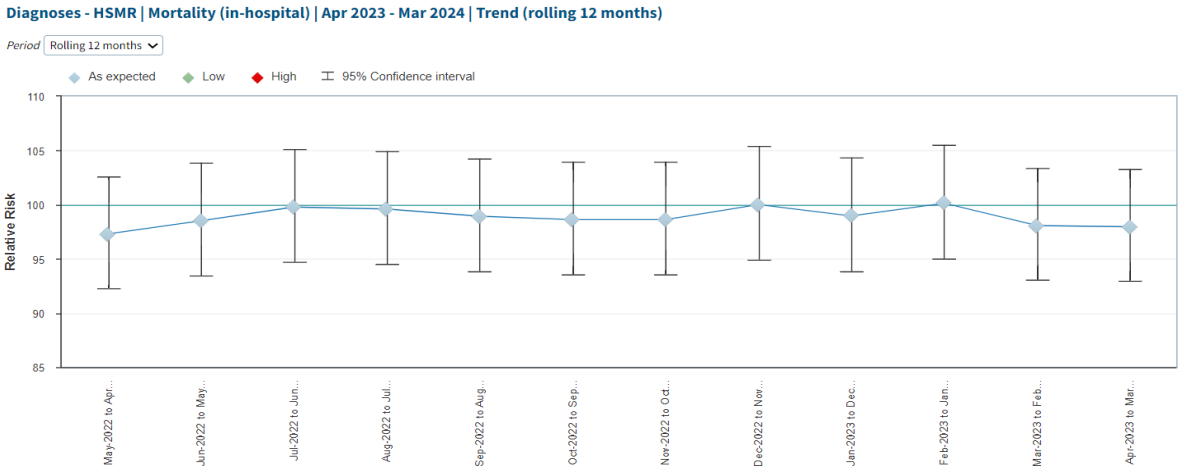
patients, is not factored into the SHMI calculation unlike HSMR, and can lead to a higher SHIMI.

- Palliative care coding

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

Hospital Standardised Mortality Ratio (HSMR)

The HSMR on the latest 12 months rolling trend is at 98 This is in the expected range.



HSMR+

From early 2025 Telstra health will be changing from HSMR to HSMR +. The main differneces between HSMR and HSMR + are summarised in the table below

	HSMR - Old Model	HSMR - New Model
Cohort	56 diagnosis groups which made up 80% of in-hospital mortality. Still births are included	41 diagnosis groups which now make up 80% of in-hospital mortality. Still births are NOT included
Variable changes:		
Deprivation	The current model uses the Carstairs Deprivation Index	The new model will use IMD (Index of Multiple Deprivation)
Covid-19	Covid-19 currently sits in the Viral Infections diagnosis group under the subgroup 'Other and unspecified viral infection'.	The new model will place Covid-19 within its own Covid-19 subgroup within the Viral Infections diagnosis group.
Comorbidity	The current model uses Charlson Comorbidity Index to identify comorbidities.	The Elixhauser-Bottle Comorbidity Index will be used within the new model to identify comorbidities.
Frailty	Frailty is not one of the casemix factors within the current HSMR model.	Frailty WILL be included within the new model, using the Global Frailty Index,
Palliative care	Currently adjusted for in the model	Not adjusted for in the model
All other casemix factors remain the same		

Analysis of the 22-23 data has shown that based on the new model the figure for HSMR+ would be 8 points higher than HSMR, but still within expected range. The main driver for this is the removal of palliative care coding from the new model.

		HSMR								
Provider Name	Financial Year	Spells	Superspells	Observed	Expected	Crude Rate	Relative Risk	Low Confidence Interval 95%	High Confidence Interval 95%	HSMR Banding
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	2022	36,925	36,845	1,390	1,457	0.04	95.38	90.43	100.53	Within

		HSMR +								
Provider Name	Financial Year	Spells	Superspells	Observed	Expected	Crude Rate	Relative Risk	Low Confidence Interval 95%	High Confidence Interval 95%	HSMR Banding
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	2022	29,665	29,585	1,360	1320	0.05	103.03	97.63	108.66	Within

Work is ongoing by Telstra Health to furher refine this model prior to launch. MRG have asked Telstra Helath ot give further analysis of more recent data for WUTH and potential impact for HSMR+.

Mortality Dashboard

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

9 cases escalated by the ME service during Q1 have been allocated for review using our Mortality Review form.

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 12 deaths were allocated for review in Q1 (3%) using the PMR template.

During Q1 41 mortality reports were discussed at MRG with the grading as below.

Summary of all Adult in patient deaths and case reviews					
	Total Adult In-patients Deaths	Deaths reviewed by ME service (%)	Total No of cases escalated for review by Medical Examiner	Quality assurance PMR's opened	Total number of case reviews opened by MRG
Q2 (23-24)	411	100%	16	13	29
Q3 (23-24)	477	100%	18	16	34
Q4 (23-24)	509	100 %	25	24	49
Q1 (24-25)	420	100%	9	12	21

Grading of Adult Care and avoidability following review in Q1 (Includes reviews opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
Number of cases	14	12	8	0

During Q1 there were no deaths reported for patients with a recognised learning disability

Learning Disability Mortality Reviews				
	Total No. of LD Deaths	No. reviewed	Problems in Health care Identified in this Quarter	Referred to National LeDeR Programme
Q2 (23-24)	4	4	0	4
Q3(23-24)	2	2	0	2
Q4 (23-24)	3	3	0	3
Q1 (24-25)	0	0	0	0

Changes to Medical Examiner Service

On the September 9th 2024 new legislation affecting the Medial Examiner service and death certificates (MCCD's) will be implemented in England and Wales.
As a result of this there will be several changes to the MCCD process as outlined below

- There will be new MCCD's forms for Adults & Children over 28 days old, and a new form for Neonates (aged under 28 days at time of death)
- There will be a new section to record ethnicity (if known)
- Medical devices and Implants will also need to be recorded.
- Pregnancy within 12 months of death will need to be recorded.
- Cause of death in section 1 will have a- b- c and now d (this is in line with other European countries)
- Cremation forms will become obsolete form Sept 9th 2024
- Any medical professional who has seen the patient at any time can potentially complete the MCCD - there is no longer the requirement to view the body after death if you did not verify death.

There will also be some national changes to the death review process, although many of these have been in place at WUTH for several years.

- It will be mandatory for **ALL** deaths to be reviewed by a Medical examiner who will need to sign the MCCD before it goes to the Registrar.
- It has been mandated by legislation that **ALL** deaths should be discussed with the ME by the Dr/Team who had responsibility for the care of the patient - this can be done via the Death summary or directly with the ME on duty if required. Deaths cannot be scrutinised by an ME until the death summary has been completed.
- The Registrar will no longer be able to refer cases if issues arise directly to the Coroner but will refer back to the ME.
- The next of kin will have 5/7 to register deaths from the time they receive the MCCD as opposed to 5/7 from date of death .
- The Coroner will be able to ask the ME to review cases they have been sent to see if a cause of death can be offered.

WUTH is well placed to accommodate these changes, having had a fully functional Medical Examiner service since 2020.

Perinatal and Neonatal deaths

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

	Stillbirths	Neonatal Deaths	Paediatric deaths	Cases sent for PMRT review
Q2 (23-24)	3	2	0	5
Q3 (23-24)	0	3	1	3
Q4 (23-24)	1	2	0	3
Q1 (24-25)	1	2	1	3

During Q1 there were 2 neonatal deaths and 1 stillbirth. There was 1 paediatric death during Q1.

Outcome of PMRT reviews reported in Q1				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, likely affected outcome
	2	2	0	0

Learning Identified from PMRT reviews.

There were 4 PMRT case reports finalised during Q1. Two of these were graded as A (no care issues) and two as B (care issues that would not have altered the outcome). For the 2 graded as “B” learning has been identified as below

- Delay in transfer to WUTH due to NWAS delay (fed back to NWAS and transferring organisation
- Inaccurate plotting of growth (mitigated by introduction of GROW app)
- Delay in giving safe sleep information.

Learning identified through review of mortality reviews during Q1.

Learning for mortality is derived from 3 main sources.

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

Specific learning and themes identified during Q1 as well as actions taken are listed in the table below.

Learning theme	Source	Action taken
Poor documentation/ copying and pasting of medical documentation (not affecting patient outcome)	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads. The EPR template has been adjusted to remind staff not to copy and paste notes as routine. A working group is being set up to look at documentation across all professions.
Medication errors (not causing harm)	Mortality reviews	All medication errors are feedback to relevant clinician. If a medication error has resulted in possible harm this is picked up under the PSIRF process
Issues with feeding and hydration for long stay patients (picked up in 2 reviews)	Mortality review	Both cases have been feedback to the Nutrition and Hydration steering group for learning.
Inaccurate recording of foetal growth	PMRT	Implementation of GROW app and electronic plotting of foetal growth
Delay in safe sleeping advice for new parents	PMRT	Process reviewed through Division and strengthened to ensure accurate advice is given

External Benchmarking Data

Telstra Health Data

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

There were no specific diagnostic groups highlighted during Q1.

The table below summarises ongoing as well as recently closed work resulting from Telstra Health data.

Diagnostic Group	Quarter Highlighted	Alert type	Work undertaken	Outcome/ Learning
Complication of device implant	Q3 23-24	CUSM alert	Case note review	16 cases reviewed. No issues identified with care of patients at WUTH. UTI and sepsis was a theme in patients with urinary catheters (but not statistical). However, this is being picked up by the incontinence group who are already looking at urinary catheter associated infections.
Carcinoma of Bronchus	Q2 23-24	CUSM alert	Case review by Trust Cancer lead	No specific cause for concern found. Most of the cases were known to palliative care team and received appropriate care. Delay in fast-track discharge

2	Implications
2.1	**Patients** • This report provides assurance around mortality statistics and shows that WUTH is not an outlier in terms of SHMI or HSMR when benchmarked against other Trusts.
2.2	**People** • Currently there is sufficient capacity in the Medical Examiner service to continue scrutiny of all inpatient deaths.
2.3	**Finance** • Effective patient care will have a positive impact on the financial position of the Trust
2.4	**Compliance** • This report supports the Trusts requirements to provide safe and effective care as set out in the CQC framework

Wirral University Teaching Hospital
NHS Foundation Trust

INFECTION PREVENTION & CONTROL 2023/24 ANNUAL REPORT

Board of Directors in Public
4 December 2024

Contents Pages

1.0 Executive Summary

Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are developed and maintained. The purpose of this report is to provide assurance to the Board of Directors on compliance with the 'Health & Social Care Act 2008: code of practice on the prevention and control of infections and related guidance', last updated 13th December 2022.

In 2023-2024 patient flow was particularly challenging and whilst continuing to acknowledge the '*Living with COVID* 'methodology IPC declared and managed 24 COVID outbreaks, along with 6 outbreaks of *Clostridioides difficile* and 21 outbreaks of Norovirus throughout the year.

During this challenging time with lots of competing pressures the Infection Prevention and Control (IPC) Team continued to work and support the wards and departments in promoting the health, safety, and well-being of patients, visitors, and staff to deliver the clean, safe, and effective care deserved by all.

The Trust this year was one of the 21 Trusts out of 24 in the Northwest who breached their annual objective for CDT and a similar result has also been seen when comparing our local objectives for gram negative bacteraemia.

Whilst promoting a 'zero tolerance' approach to MRSA bacteraemia the Trust reported 1 MRSA bacteraemia in 2023/24 which is a reduction of 1 compared to the previous year.

The Trust continues to report mandatory surveillance of SSI following orthopaedic surgery for every quarter and local surveillance of large bowel surgery for every quarter.

This report is testimony to the hard work of all the teams in WUTH and acknowledges the incredible results that can be achieved when an organisation shares the same vision and values and how when we get the basics right, we become better and then can progress through to best.

Over the next 12 months the Trust will further review existing work and projects to develop an increased scrutiny in our investigative procedures to further inform practice, working in collaboration with partners across the whole health economy to keep a focus on prevention of infections and compliance with good working practices.

In conclusion, I would like to acknowledge the hard work of the IPC Team and the divisions which they support, working as a team they have shown commitment in the delivery of good infection prevention practices by managing our infection risks together in a caring and competent manner.

Jay Turner-Gardner
Interim Director of Infection and Prevention and Control (DIPC)

2.0 Description of Infection Prevention

2.1 Nursing Team

The role of Chief Nurse sits within the Corporate Nursing Division. Tracy Fennell, the Chief Nurse/Director of Infection Prevention & Control had overall responsibility for leading the organisation's IPC (including cleanliness) strategy, and improvement plan until she left the Trust in Dec 2023 when Jay Turner-Gardner, the Infection Prevention & Control Specialist/Deputy Director of Infection Prevention and Control took over the role of Interim DIPC prior to a new lead being appointed.

During this time, the interim DIPC was managed by and professionally accountable to Janelle Holmes, Chief Executive.

The Infection Prevention & Control Matron has managerial responsibility for the Infection Prevention Team. The Infection Prevention Nursing Team establishment consists of:

- 3 x band 7 (3.0 WTE) Senior Infection Prevention Specialist Nurses.
- 3 x band 6 (3.0 WTE) Infection Prevention Specialist Nurses
- 1 x band 4 (1.0 WTE) Secretary.
- 1 x band 3 (1.0 WTE) Infection Prevention assistant

The team was not fully established throughout 2023/24 due to long-term sickness of several members of the team. In support of staff health and wellbeing 3 members of the IPC team had flexible working arrangements agreed in 2023/2024.

2.2 Infection Prevention on-call

There is no IPC on call service following consultation in 2022/23.

2.3 Medical Staff

The IPC team is supported by the microbiology team consisting of:

- 2 x WTE consultant microbiologists , including the Infection control doctor (sessions are not well-defined in their job plan)
- 2 WTE speciality doctors
- 1 WTE clinical scientist.

Additionally, there has remained one vacancy for a consultant microbiologist which continues to be advertised. There was long-term sickness (1 WTE clinical scientist) in the department in 23/24, this role crucially led on the microbiology aspects of Trust wide Water and Ventilation safety. Locum cover was not sought to cover the resulting gaps in the service.

The out-of-hours consultant microbiologist service is a shared between three Trusts, defined by an SLA. (Chester, Warrington) This support is available on call from 5pm – 9am, and weekends and bank Holidays for Microbiology.

The on-call Consultant Microbiologist service does not provide standalone IPC advice unless related to aspects of care related to Microbiology advice.

2.4 The Infection Prevention and Control Team

The Team meets regularly with the IP Doctor and led by the Interim DIPC they provide the Infection Prevention service to the Trust. The Deputy Director of Infection Prevention & Control is responsible for producing the 3-year IP strategy, delivering the Infection Prevention annual plan and annual audit plan on behalf of the DIPC, who reports to the Trust Board on behalf of the Infection Prevention & Control group.

2.5 Microbiology Laboratory Services

Chester and Wirral Microbiology Service (CWMS) is the Medical Microbiology laboratory providing high quality diagnostic bacteriology and virology services to Wirral and West Cheshire and it is based in Bromborough, Wirral. It provides most of the lab diagnostics for WUTH including routine cultures, infection screening tests (MRSA, VRE screens) and molecular testing for organisms such as Influenza, *C.difficile*, Norovirus, CPE and SARS-CoV-2. This is a 24/7 service, and an out of hours service restricted to urgent samples including blood cultures, CSF and COVID-19 tests.

The Point of care testing (POCT) for COVID-19/ Flu continues in the admission areas. Off-site services included tests done in CWMS and some referral work is now sent to Manchester Foundation Trust (MFT) labs rather than to Liverpool clinical laboratories.

2.6 Reporting Line to the Board of Directors

A schematic of the reporting arrangements for the Infection Prevention Control group within the Trust can be found in **Appendix 1**

2.7 The Infection Prevention and Control Group

This group continues to meet monthly, and each Division provides representation. The group is chaired by the DIPC; the deputy chair is the Deputy DIPC. Its purpose is to provide a two-way communication channel between the Trust Board via the Patient Safety and Quality Board (PSQB). The IPCG has an assurance/ management role and is authorised to approve Infection Prevention policies and to formulate recommendations for Infection Prevention and Control conveying these to the PSQB via a chairs report.

The Trust Infection Prevention & Control Terms of Reference can be found in **Appendix 2**. These are reviewed bi-annually.

2.8 Departmental/Divisional Infection Prevention and Control groups

The following Divisions/Specialties meet monthly supported by the IPCT, discussing IPC related issues and incidents whilst developing assurance reports for the Infection Prevention and Control Group (IPCG):

- Medicine
- Acute Specialties
- Orthopaedics
- Specialist Surgery/ Surgery
- Theatres
- Women's and Children's
- Diagnostics

2.10 The Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) is the new way that the NHS looks at Patient Safety Incidents. It has replaced the Serious Incident Framework (2015) and represents a significant shift in the way the NHS responds to patient safety incidents. In terms of IPC, the traditional route cause analysis (RCA) that was completed following incidences of hospital acquired infections have now been replaced by Rapid Evaluations of Care (REC). It has taken considerably longer to establish these as they were replacing an existing tool that was managed by the IPC team, the REC system is primarily managed by the Divisions to promote local ownership and as a result led to a considerable back log.

The Patient Safety Steering Group Chair's Meeting reviews all Rapid Evaluations of Care to assess if they can be closed or escalated to another meeting, such as Patient Safety Learning Panel, one of the Steering groups, or Patient Safety Response Planning Meeting, which takes place every week. At these meetings, escalated Rapid Evaluation of Care reports are assessed by a wider panel, consisting of AMDs, DDONs and key stakeholders for patient safety. The RECs are either closed or escalated for further review as a thematic review, Facilitated Reflective Session (After Action Review or MDT Reflective review) or Patient Safety Incident Investigation (PSII).

3.0 Reports to the Trust - Summary

Reports written and/or coordinated by the Deputy DIPC include:

- Daily IPC update including outbreak and surveillance summary for the patient flow team, senior management, the nursing teams, and facilities detailing all patients with alert organisms including any areas under increased surveillance due to an increase in prevalence of any specific organism.
- Daily Outbreaks in the community which could have an impact on our service by the WCT.
- Monthly Infection prevention data summary of activities for the IP divisional meetings and the IPCG.
- Monthly IPC chairs reports and updates for the PSQB/ Clinical Advisory Group
- Annual Infection Prevention Report once per year which includes the Annual Infection Prevention plan and Annual Infection Prevention audit plan.
- Ad hoc updates in relation to the Infection prevention board assurance framework
- Weekly Executive Team update for DIPC
- IPC BI portal
- Continence steering group Chairs report to PSQB
- Monthly integrated performance report

4.0 Budget Allocation to Infection Prevention

4.1 Microbiology and Laboratory Services

The medical microbiologists and the Laboratory are funded from the Pathology Division, which is within the Division of Diagnostics and Clinical Support.

4.2 Funding for Outbreaks of Infection

Funding for outbreaks of infection (excluding laboratory costs as detailed above), are funded locally by the Divisions.

4.3 The Infection Prevention and Control Nursing Team (IPT)

The IPC Team are funded from the Corporate Nursing budget and the Deputy DIPC is the budget holder for the Infection prevention service, the budget funds the nursing team and any Infection prevention initiatives identified during the year. This includes Infection Prevention signage, posters, study days and campaigns.

4.4 Investments in Infection Prevention at WUTH

In the year 2023/24 the Trust continued in its investment of:

- MRSA screening for all admissions.
- CPE and VRE screening for all Critical Care patients and patients admitted to Ward 30.
- Hydrogen Peroxide Vapor (HPV) 'fogging' following incidences of CDI, COVID, VRE, CPE when capacity/patient flow allows.
- Reactive and pro-active HPV programme when bed capacity/essential maintenance works allow.
- EvaluClean – A simple system utilised by the IPC team that uses a UV marker which is invisible to the human eye to mark objects, following environmental cleaning a UV torch is then used to see if the mark has been removed during the cleaning process.
- Adenosine triphosphate (ATP) – ATP is the energy carrying molecule used in cells and we use it to detect the presence of organic matter (contamination) by way of swabbing certain objects to determine if organic matter is detected to measure the effectiveness of cleaning.
- Increased cleaning in addition to the base line clean to support the increase in *C.diff* infection.
- Disposable curtains throughout the trust
- Deployment of Air purifiers in collaboration with Facilities for patients diagnosed with COVID.
- Daily cleanliness monitoring checklists introduced and completed on Tendable by the cleanliness supervisory team.

5.0 Health Care Associated Infection (HCAI)

Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections. The most well-known include those caused by Meticillin-resistant *Staphylococcus aureus* (MRSA), *Clostridioides difficile* (*C. difficile*) and in recent times COVID-19.

HCAIs pose a serious risk to patients, staff, and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention is a key priority for the NHS. The 3-year IP strategy and annual plan for 2023/2024 focused on revising and updating present arrangements, strengthening, and building on the work that has already been achieved in the previous year and planning for the new and continuing challenges ahead.

6.0 Surveillance/ Mandatory reporting

UK Health Security Agency's Data Capture System provides an integrated data reporting and analysis system for the mandatory surveillance of *Staphylococcus aureus*, *Escherichia coli*, *Klebsiella* spp., *Pseudomonas aeruginosa* bacteraemia and *Clostridioides difficile* infections. The monthly quality check of the mandatory data introduced in 2019 continues and in the absence of the Chief nurse/DIPC the data was signed off by the IPC analyst and the IPC matron and then 'signed off' by the Interim DIPC on behalf of the Chief Executive.

Carbapenemase Producing *Enterobacteriaceae* (CPE) bacteraemia are reported locally as are VRE bacteraemia.

COVID-19 data continued to be captured locally throughout the year.

6.1 Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia

The NHS have made it clear that they consider it unacceptable for a patient to acquire an MRSA bloodstream infection (MRSA BSI) while receiving care in a healthcare setting. The Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) published new guidelines for '*The prevention and control of meticillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities'* in 2021. The WUTH guidelines were reviewed in 2023/24 and the decision made to continue to complete screening for MRSA as per existing local policy, which was universal screening, and not to adopt targeted screening, this was based on a risk assessment approach.

6.2 Reporting and monitoring arrangements for MRSA bacteraemia

All Laboratory reported incidences are entered into the UKHSA data capture system (HCAI DCS) and a Post Infection Review (PIR) is completed by the MDT. There is no longer a mandatory requirement to enter these PIR reports into the DCS reporting system unless requested so by UKHSA as a high outlier.

Completed PIR reports are available to be shared with the Integrated care system* (ICS) and discussed at their quality meetings.

Following a laboratory confirmed MRSA bacteraemia a Multi-disciplinary Team, ideally the patient's clinician, Microbiologist, Deputy DIPC, Matron and Pharmacist meet to complete the investigation to determine the causative factors of the MRSA bacteraemia and identify any learning to support the development of a local action plan, it is the responsibility of the division to achieve the action plan. Causation is determined once the information is gathered.

MRSA Bacteraemia are apportioned according to the DOH guidelines below:

- Day 0 = Day of admission community attributed (pre day 2)
- Day 1 = community attributed (pre day 2)
- Day 2 = Trust attributed (on or post day 2)

*Clinical commissioning groups (CCGs) were established as part of the Health and Social Care Act in 2012 and replaced primary care trusts on 1 April 2013. On 1 July 2022, integrated care systems (ICSs) became legally established through the Health and Care Act 2022, and CCGs were closed.

6.3 The incidence of MRSA bacteraemia since April 2018.

SPC Chart 1 below provides a breakdown of **MRSA bacteraemia** by month.

Chart 1

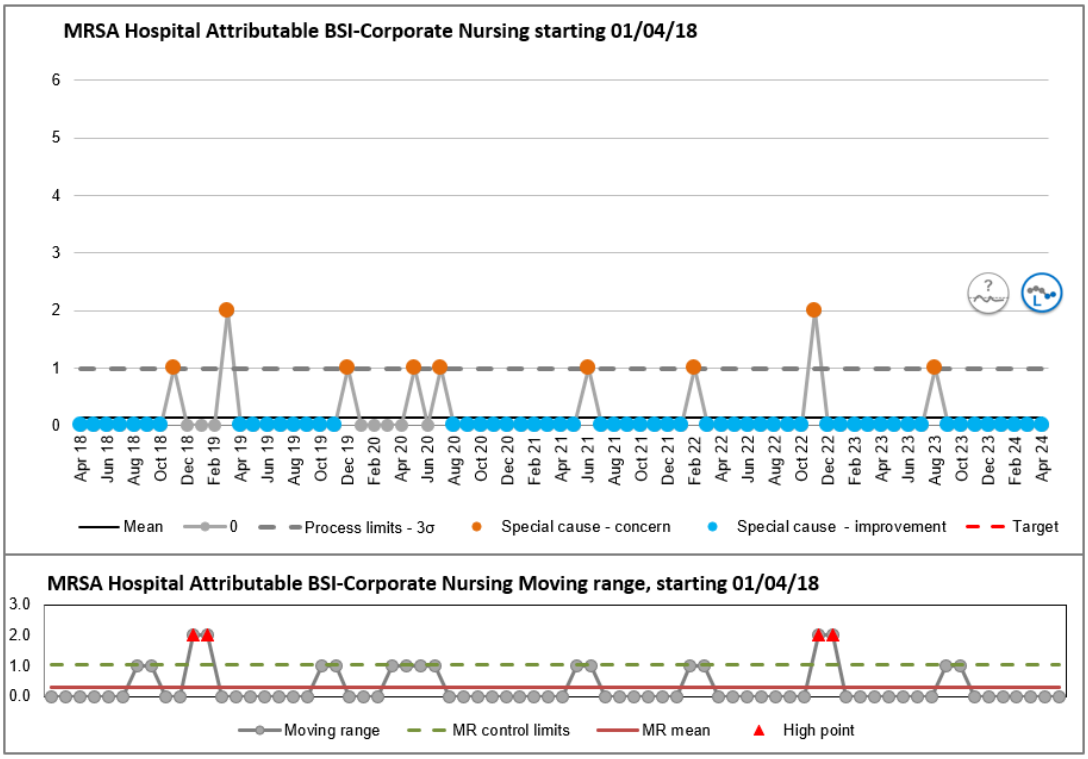


Table 1 below provides a breakdown of **MRSA bacteraemia** by year since 2014/15

Table 1

The incidence of MRSA Bacteraemia since 2014/15										
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Pre day 2 for WCT	4	5	3	0	3	2	0	3	1	2
Post day 2 for WUTH	3	1	1	2	3	1	2	2	2	1
Total for Wirral CCG	7	6	4	2	6	3	2	5	3	3

In 2023/24 we have reported 1 MRSA bacteraemia by month end March. This is a decrease of 1 when compared to 2022/23.

Table 2 below provides a breakdown of Hospital onset and Community onset Hospital Associated and Community Associated **MRSA bacteraemia** by month.

Table 2

Breakdown of MRSA cases in 2023/24													
Incidence	*Apr-23*	*May-23*	*Jun-23*	*Jul-23*	*Aug-23*	*Sep-23*	*Oct-23*	*Nov-23*	*Dec-23*	*Jan-24*	*Feb-24*	*Mar-24*	*Total*
HO-HA	0	0	0	0	1	0	0	0	0	0	0	0	1
CO-HA	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Associated	1	0	0	0	0	1	0	0	0	0	0	0	2

6.4 Themes from Post Infection review

The MRSA bacteraemia was thought to be related to the patient's indwelling devices. The patient had known MRSA and was refusing decolonisation/suppression treatment. The patient had a urinary catheter, which became dislodged as the patient kept standing on it and multiple peripheral lines were inserted which were disconnected by the patient on several occasions to leave the ward. Many of the peripheral lines were dislodged resulting in multiple cannulations being required to gain IV access. This review advised that this MRSA bacteraemia was unavoidable.

6.5 Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia

Methicillin-sensitive *Staphylococcus aureus* (MSSA), is a skin infection that is not resistant to certain antibiotics. MSSA normally presents as pimples, boils, abscesses, or infected cuts, but also may cause pneumonia and other serious skin infections. MSSA affects people of all ages and has been known to cause outbreaks among sports teams, families, prison inmates and people who live and work in close quarters, such as military recruits.

MSSA colonises the skin, causing no symptoms and without causing infection, but then may later lead to infection. The infection spreads via direct skin-to-skin contact and may spread via contact with contaminated items or surfaces. The sharing of contaminated personal items with someone who has MSSA — towels, sheets, razors, clothes, or sports equipment — increases the likelihood of spreading the infection.

All Laboratory reported incidences of MSSA bacteraemia are entered into the UKHSA data capture system (HCAI DCS) and a Route cause Analysis (RCA)/ REC is completed by the MDT.

There are no national or local objectives set against these at present and many are related to skin and soft tissue infections. Table 3 below provides a breakdown of **MSSA bacteraemia** by year and month since 2016/17.

Table 3

The incidence of MSSA Bacteraemia since 2016/17													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016/17	4	2	4	1	1	1	1	3	0	1	4	1	23
2017/18	1	1	1	1	1	2	4	1	3	2	3	2	22
2018/19	2	1	5	1	1	2	0	4	1	3	0	3	23
2019/20	3	5	1	0	2	1	1	2	1	3	3	2	24
2020/21	4	1	1	0	0	2	2	3	0	1	4	0	18
2021/22	1	2	2	0	0	0	4	0	3	5	4	4	25
2022/23	2	1	4	2	5	2	4	2	1	2	2	5	32
2023/24	5	5	0	0	4	2	3	4	1	5	2	1	32

In 2023/24 we have reported 32 MSSA bacteraemia by month end March. This is the same when compared to 2022/23. SPC Chart 2 below provides a breakdown of **MSSA bacteraemia** by month.

Chart 2

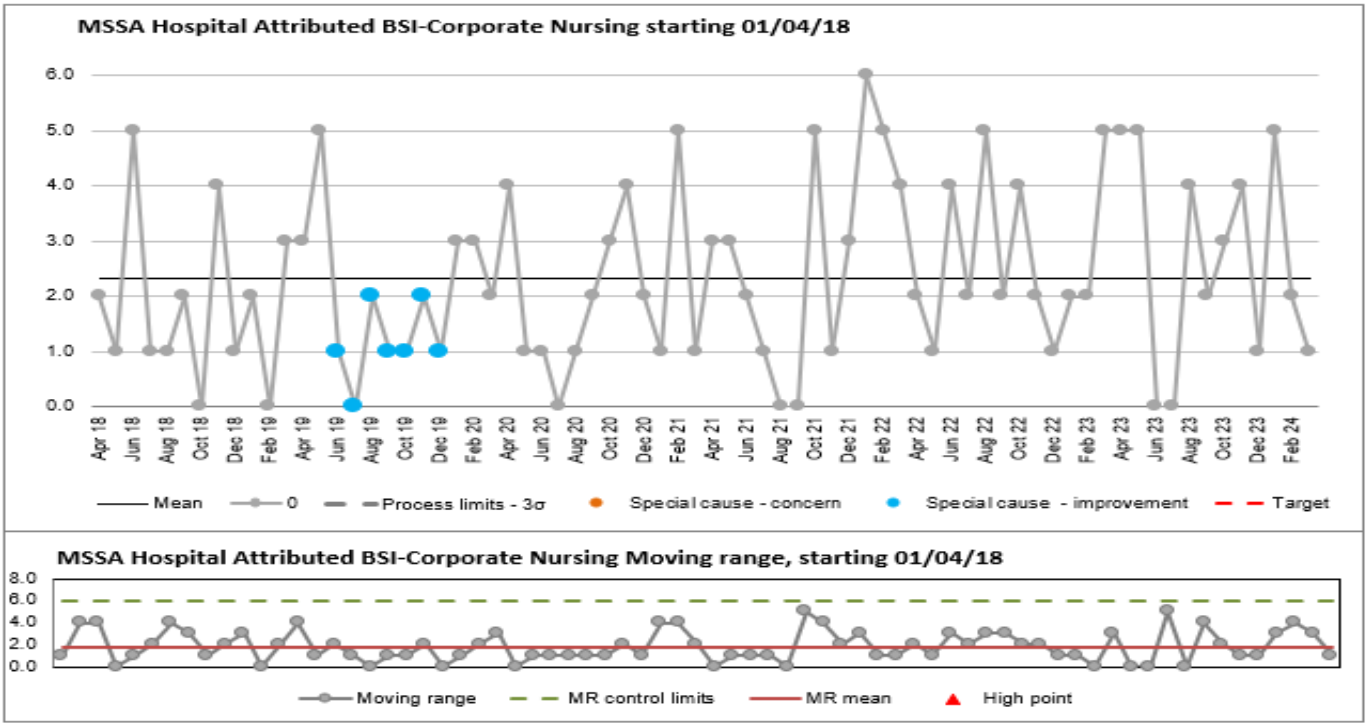


Table 4 below table provides a breakdown of Hospital onset and Community onset, Hospital Associated and Community Associated **MSSA bacteraemia** by month.

Table 4

Breakdown of MSSA infections in 2023/24													
	April	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	5	3	0	0	4	1	1	4	1	5	2	1	27
CO-HA	0	2	0	0	0	1	2	0	0	0	0	0	5
Community Associated	8	6	4	6	6	4	2	1	8	1	3	4	53

6.6 *Clostridioides difficile* Infection (CDI)

Clostridioides difficile (*C.difficile*) is a bacterium found in the intestine. It can be present in healthy people and cause no symptoms, however antibiotics can cause an imbalance of bacteria within the gut resulting in a proliferation of harmful bacteria and *C.diff* infection. *Clostridioides difficile* infection (CDI) is highly infectious and will spread through contact with a contaminated environment or person and is estimated to cause 20 to 30% of antibiotic-associated diarrhoea. The annual incidence of CDI has been relatively stable in the UK since 2013 and was 22.2 per 100,000 population between April 2020 and March 2021.CDI carries considerable risk of morbidity and 30-day all-cause mortality is estimated to be between 9 and 38%. As a significant healthcare associated infection, multiple infection control measures and treatment modalities have been explored and this remains an evolving field. Crucially, the management of severe CDI should be considered a medical emergency and urgently assessed and reviewed regularly to ensure that patients receive prompt and optimised care.

6.7 Reporting and Surveillance of *Clostridioides difficile*

Trusts are required under the NHS standard contract 2023/24 to minimise *C.difficile* infections so that they are no higher than the threshold levels set by NHS England and Improvement.

Objectives for this year are derived from a base line of the 12 months ending November 2022, as this is the most recent available data at the time that NHSE/I was calculating the figures.

If a trust had fewer than or equal to 10 cases during the 12 months ending November 2022, the threshold will be equal to that count. If a trust had more than 10 cases, the threshold will be one less than that count.

All thresholds were rounded down to the nearest whole number and pertain to healthcare-associated cases (i.e., HOHA and COHA cases).

NHS acute providers use the case assignment definitions:

- **Hospital onset healthcare associated**: (HOHA) Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
- **Community onset healthcare associated**: (COHA) Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

6.8 *Local reporting for CDI in 2023/24*

The national objective set for WUTH for healthcare associated *Clostridioides difficile* infections (CDI) this year was 71, which proved to be very challenging, having reported 109 infections, 38 over our objective.

Table 5 below provides a breakdown of ***Clostridioides difficile*** by year and month.

Table 5

Clostridioides difficile infections														
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total	Threshold
Threshold 2023/24	6	6	6	6	6	6	6	6	6	6	6	5	71	
2023/24	8	8	11	9	10	7	10	13	3	10	8	12	109	71
2022/23	7	8	16	17	15	13	12	12	10	13	5	14	142	72
2021/22	5	7	5	1	6	13	6	5	3	18	12	13	94	63
2020/21	6	5	5	1	4	1	5	10	8	4	7	6	62	88
2019/20	19	9	11	5	6	7	8	6	7	4	4	3	89	88

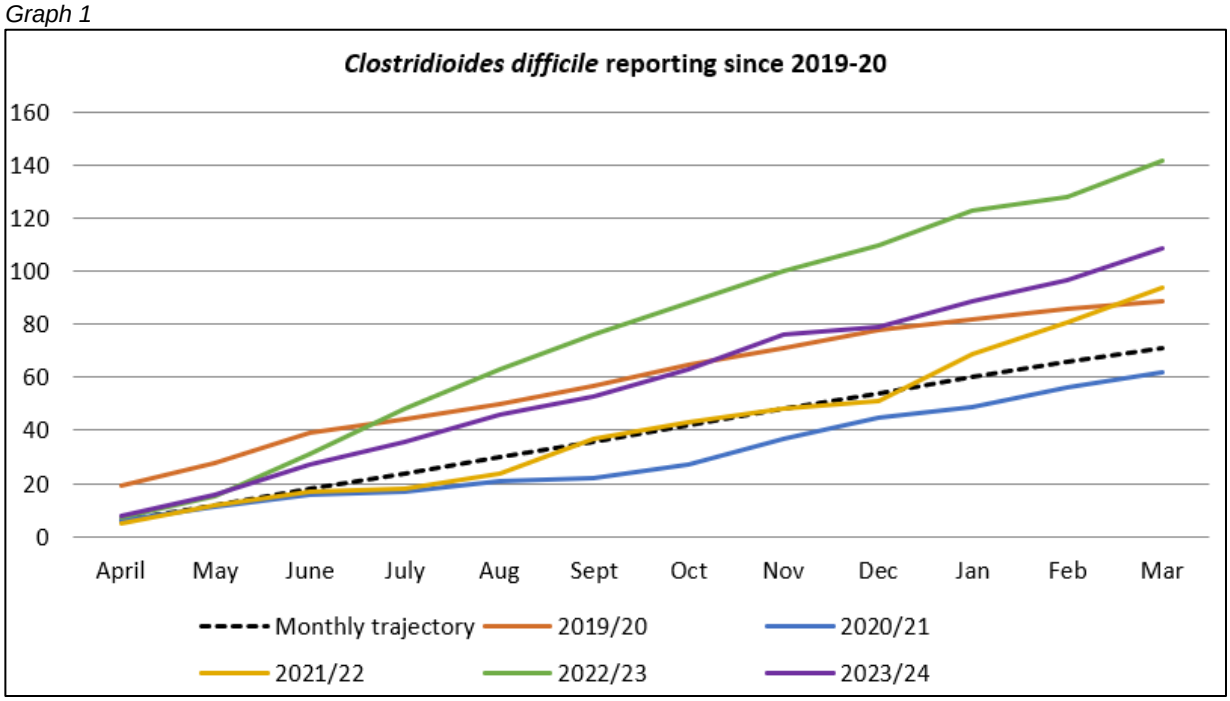
Whilst we have not met our annual objective, we have diagnosed 33 infections less compared to 2022/23 which is the greatest reduction seen across other trusts in the northwest. See table 6 below

Table 6

HCAI Area	Organisation Name	Cases 2023/24	Target 2023/24	Difference between cases and Target 2023/24	Cases 2022/23	Target 2022/23	Difference between Cases and Target 2022/23	Difference in Cases between 2022/23 and 2023/24
M&C	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	109	71	38	142	72	70	-33
M&C	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	161	133	28	182	134	48	-21
GM	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	56	52	4	70	53	17	-14
C&L	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	85	83	2	99	84	15	-14
C&L	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	80	89	-9	91	109	-18	-11
M&C	EAST CHESHIRE NHS TRUST	11	6	5	19	6	13	-8
GM	BOLTON NHS FOUNDATION TRUST	121	79	42	128	80	48	-7
M&C	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	40	39	1	47	49	-2	-7
GM	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	55	38	17	59	39	20	-4
M&C	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	77	56	21	80	57	23	-3
M&C	THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	12	13	-1	13	17	-4	-1
M&C	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	55	36	19	55	37	18	0
M&C	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	0	0	0	0	0	0	0
M&C	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	3	2	1	2	9	-7	1
M&C	THE WALTON CENTRE NHS FOUNDATION TRUST	11	6	5	7	8	-1	4
M&C	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	5	0	5	1	3	-2	4
GM	STOCKPORT NHS FOUNDATION TRUST	81	40	41	76	41	35	5
GM	THE CHRISTIE NHS FOUNDATION TRUST	56	36	20	51	37	14	5
C&L	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	203	121	82	196	122	74	7
M&C	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	51	31	20	39	32	7	12
M&C	ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	74	46	28	57	56	1	17
C&L	NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	78	43	35	46	53	-7	32
C&L	EAST LANCASHIRE HOSPITALS NHS TRUST	101	53	48	65	54	11	36
GM	NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	171	NA	NA	130	NA	NA	41
GM	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	275	173	102	202	174	28	73

Graph 1 below provides ***Clostridioides difficile*** reported infections since 2019/20 and annual trajectory.

Graph 1



SPC Chart 3 below provides a breakdown of ***Clostridioides difficile*** **infections (CDI)** by month.

Chart 3

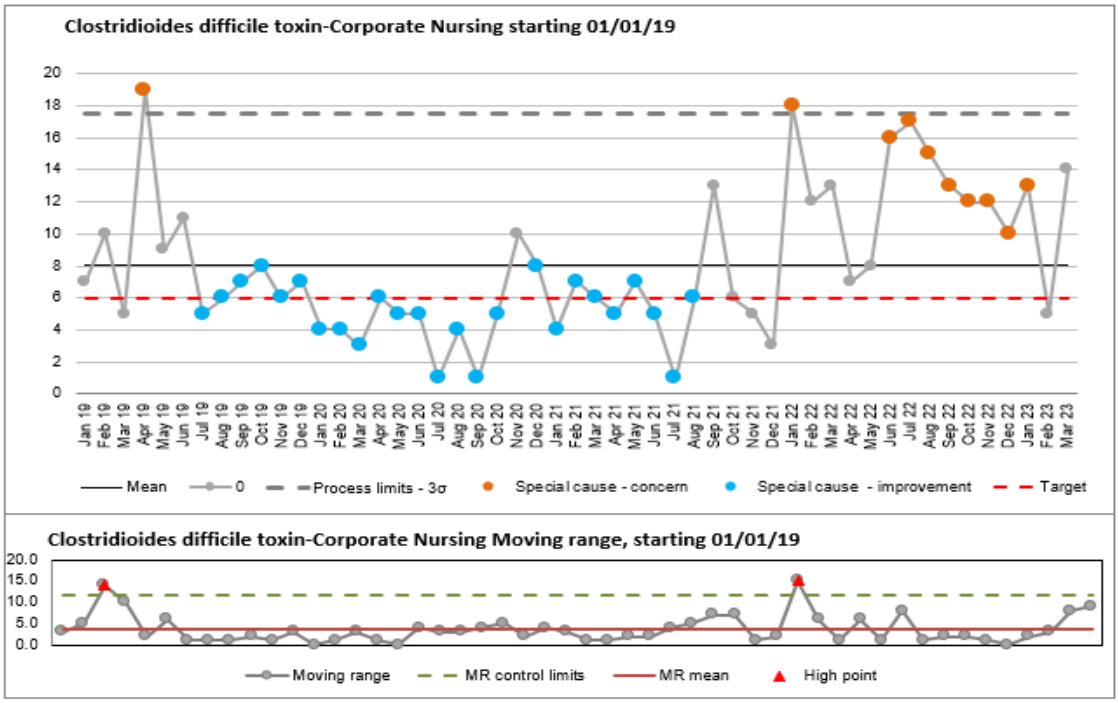


Table 7 below provides a breakdown of Hospital onset Hospital Associated, Community onset Hospital Associated, Community onset Indeterminate Associated, Community onset Community Associated, ***Clostridioides difficile*** **infections (CDI)** by month.

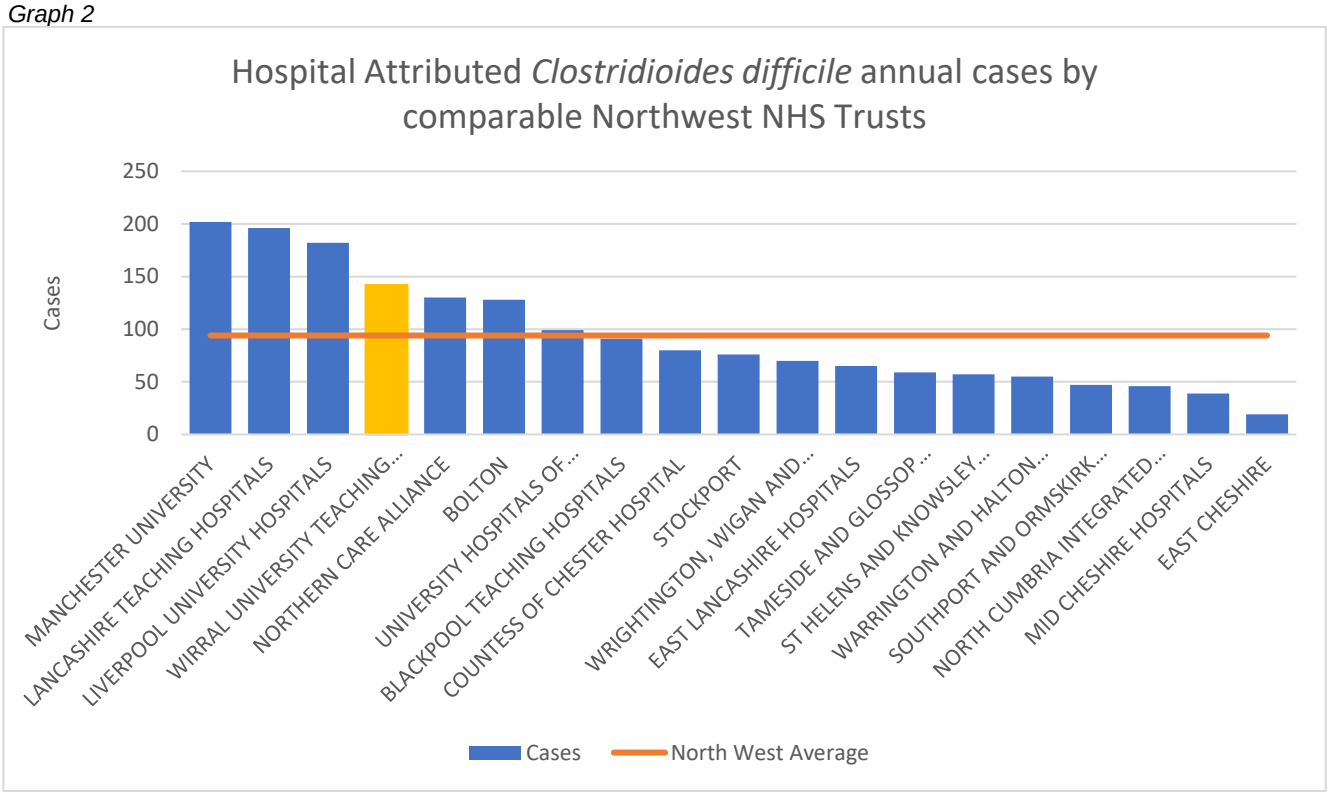
Table 7

Breakdown of *Clostridioides difficile* cases in 2023/24													
Incidence	*Apr-23*	*May-23*	*Jun-23*	*Jul-23*	*Aug-23*	*Sep-23*	*Oct-23*	*Nov-23*	*Dec-23*	*Jan-24*	*Feb-24*	*Mar-24*	*Total*
HO-HA	5	6	8	8	8	6	6	10	1	7	6	9	80
CO-HA	3	2	3	1	2	1	4	3	2	3	2	3	29
CO-IA	1	4	1	3	1	0	0	3	1	2	0	0	16
CO-CO	2	1	4	6	4	2	4	3	3	4	3	3	39

Wirral PLACE/CCG rates of *Clostridioides difficile* infection cases have been significantly higher than the national average since 2014. Whilst rates increased dramatically in 2019 the start of the pandemic in 2020 saw a huge reduction. Since January 2021 the rates started to increase again and reached a similar level as to what they were 2011.

Graph 2 below shows Hospital attributed ***Clostridioides difficile*** annual cases by comparable Northwest NHS Trusts

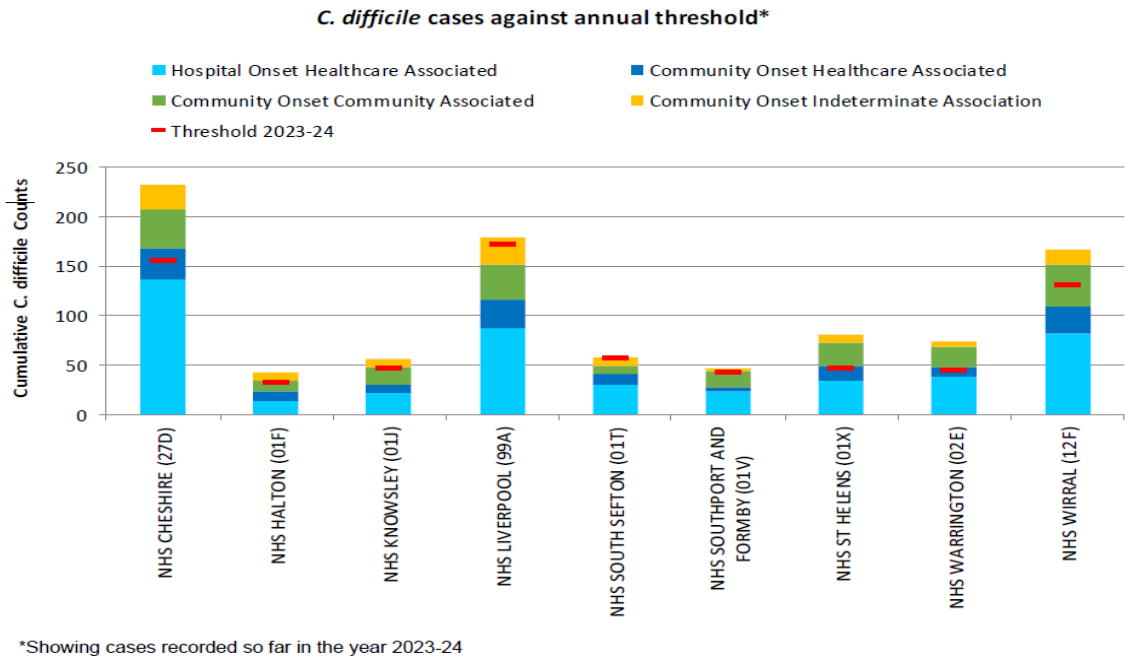
Graph 2



Wirral PLACE sits within Cheshire and Merseyside ICB and has a population of 330,000 with recognised challenges and inequalities in parts of the borough. WUTH is the only acute Hospital Trust, there is also a community care trust which delivers services elsewhere and a Mental Health Trust providing services for Wirral. There are over 300 GP's in over 40 GP practices and 120 Care/residential settings. See chart 4 below.

Chart 4

Cumulative *C. difficile* cases by sub-ICB location against sub-ICB location annual objective



*Showing cases recorded so far in the year 2023-24

Discussions surrounding the causes for the rise in case rates started in July 2022 when the Deputy DIPC introduced a quarterly CDI report and a Trust wide improvement plan, this was shared with the regional IPC lead. This local plan did not have the desired impact, therefore, it was agreed that a more thorough investigation of the entire Wirral system, to include Primary, secondary and community care would take place to help identify and support further initiatives that would support an improvement in the rates of *Clostridioides difficile*. The visit took place in April 2023 and the draft report for comments received in May 2023, the final official report has not been received by year end.

6.9 Themes from CDI RCA investigation

Although it is not always possible to ascertain the cause, some of the common themes and learning outcomes from the RCAs / RECs completed during 2023-24 (109) are listed below in table 8.

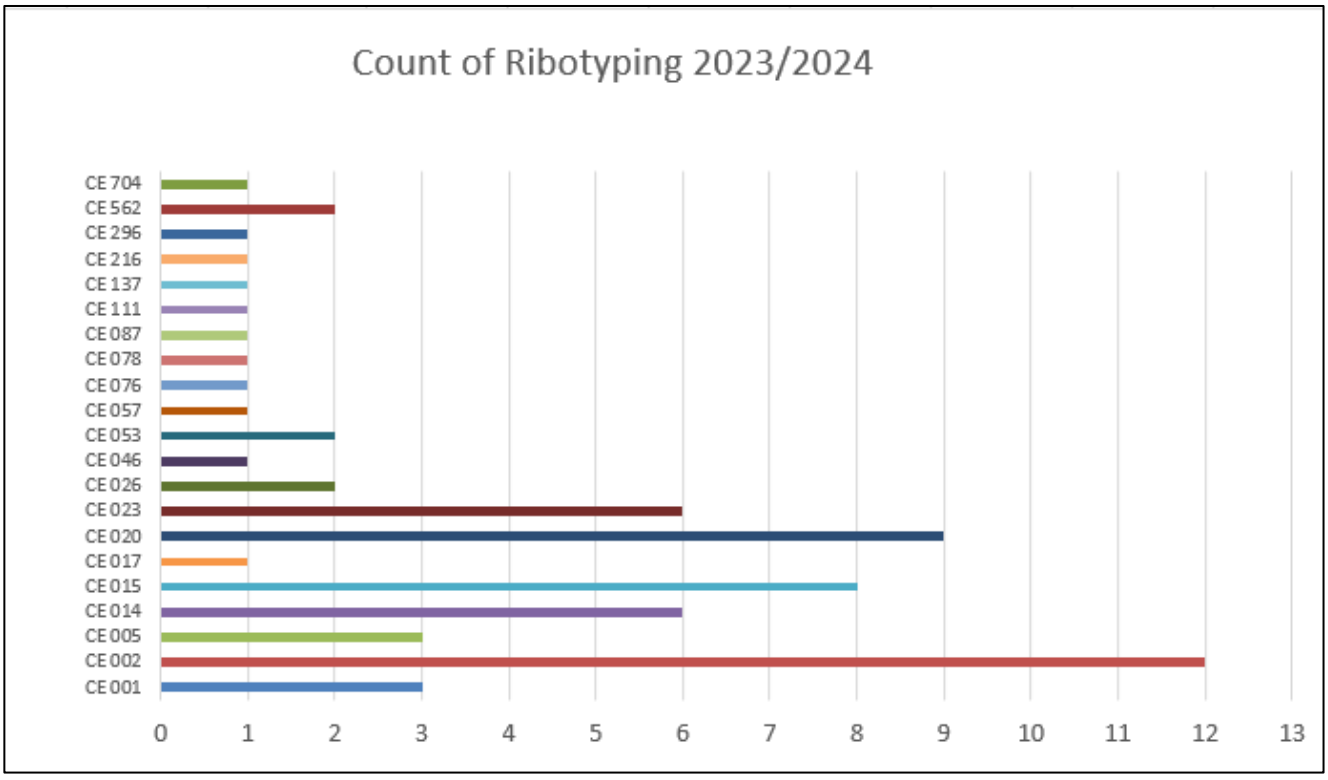
Table 8

Themes	Count	Percentage
Delayed sample collection	29	27%
Delay in suspicion of infection	30	27.5%
Delayed isolation (> 2 hours since positive result)	24	22%
Inadequate Documentation of bowel habit	33	30%

Inadequate cleaning	41	37.5%
Delayed testing	2	2%
Inappropriate handover on patient transfer	8	7.5%
Patient movements between bays/ ward > 2 in 2 days?	3	2.5%
No senior ward manager oversight	1	1%
Admitted to hospital with diarrhoea	37	34%
Crossover/contact with other *C.diff* patients	64	58.5%
Co-amoxiclav within 3 months prior to CDT	60	55%

Graph 3 below provides a count of ***Clostridioides difficile*** ribotyping results in 2023/24.

Graph 3



Molecular typing is an important infection control tool to monitor the prevalence of certain strains within a healthcare institution or to investigate if a cluster of infections are unrelated or part of an outbreak. Typing results since April 2023 show no *C.difficile* strain beyond those detected within specific outbreaks (CE 002, CE 020, and CE 023).

6.10 Gram-negative bloodstream infections (BSIs)

Since April 2020, reporting trusts were asked to provide information on whether patients with Gram-negative bloodstream infections had been admitted to the reporting trust within one month prior to the onset of the current case. This allows a greater granulation of the healthcare association of cases.

- **Hospital onset healthcare associated**: (HOHA) Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
- **Community onset healthcare associated**: (COHA) Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

Since 2021/22, trust-level thresholds comprise of total healthcare-associated cases (i.e., HOHA and COHA).

Objectives for this year are derived from a base line of the 12 months ending November 2022, as this is the most recent available data at the time that NHSE/I was calculating the figures.

For each of the three Gram-negative bloodstream infection types specified, if a trust had fewer than or equal to 10 cases during the 12 months ending November 2022, the threshold will be equal to that count. If a trust had more than 10 cases, the threshold will be 5% less than the count.

All thresholds were rounded down to the nearest whole number and pertain to healthcare-associated cases (i.e., HOHA and COHA cases).

Gram-negative bacteria - *Escherichia coli (E.coli)*, *Pseudomonas aeruginosa (P.aeruginosa)* and *Klebsiella* species (*Klebsiella* spp.) are the leading causes of healthcare associated bloodstream infections. The national ambition was to deliver a 25% reduction of healthcare associated Gram-negative blood stream infections by 2021-2022 with 50% by 2023-2024, (Jan 16 - Dec 16 data values). Since 2021/2022 Trusts have been given individual objectives for each organism.

E.coli

Escherichia coli (*E.coli*) bacteria are frequently found in the intestines of humans and animals and can survive in the environment. There are many different types of *E.coli*, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. *E.coli* bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. *E.coli* bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

Community-acquired *E.coli* bactereamia are most frequently the result of urinary tract infections in older adults, while hospitalised patients are more likely to develop bactereamia because of lower respiratory tract infections. *Escherichia coli* causes more than one-third of the bacteraemia cases in England each year, and the incidence of these infections is increasing.

Table 9 below provides a breakdown of Hospital attributed ***E.coli* bacteraemia** by month against the trajectory.

Table 9

The incidence of *E.coli* bacteraemia since 2021/22													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021/22	4	4	7	3	3	5	4	4	6	5	6	8	59
Trajectory 2022/23	5	5	4	5	5	4	5	5	4	5	5	4	56
2022/23	8	4	9	12	10	6	5	5	11	5	6	8	89
Trajectory 2023/24	5	4	5	4	4	5	4	4	5	4	4	5	53
2023/24	8	5	6	8	13	7	6	4	5	13	7	8	90

In 2023/24 we reported 90 *E.coli* bacteraemia by month end March. This is an increase of 1 when compared to 2022/23. We are 37 infections over our target for 2023/24.

Graph 4 below provides ***E.coli*** bacteraemia reported infections by month against the trajectory

Graph 4

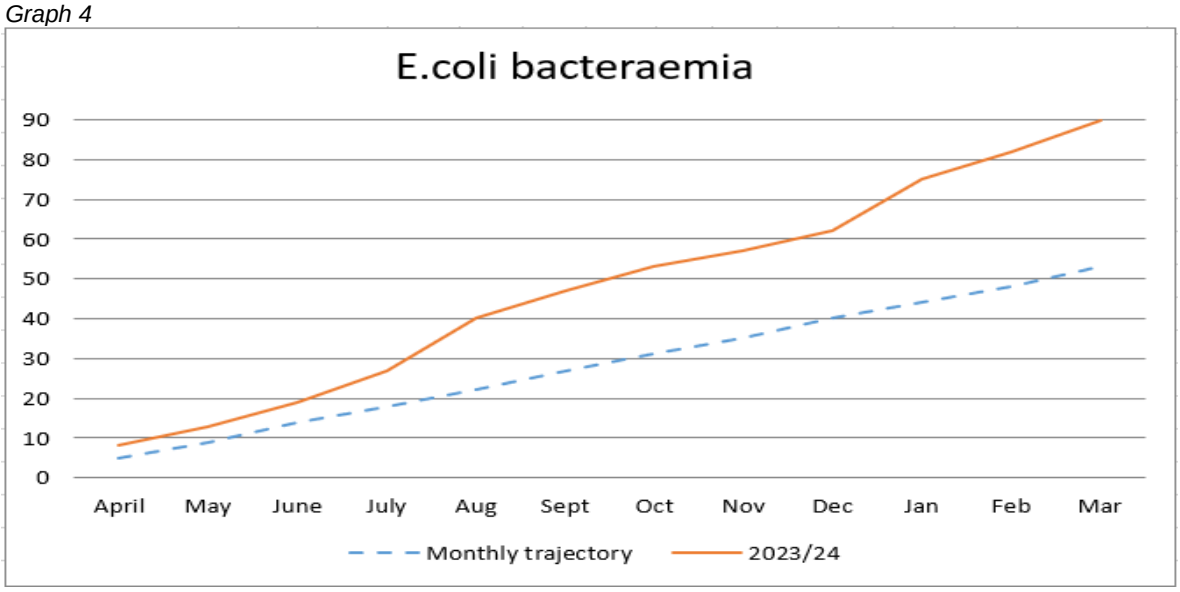


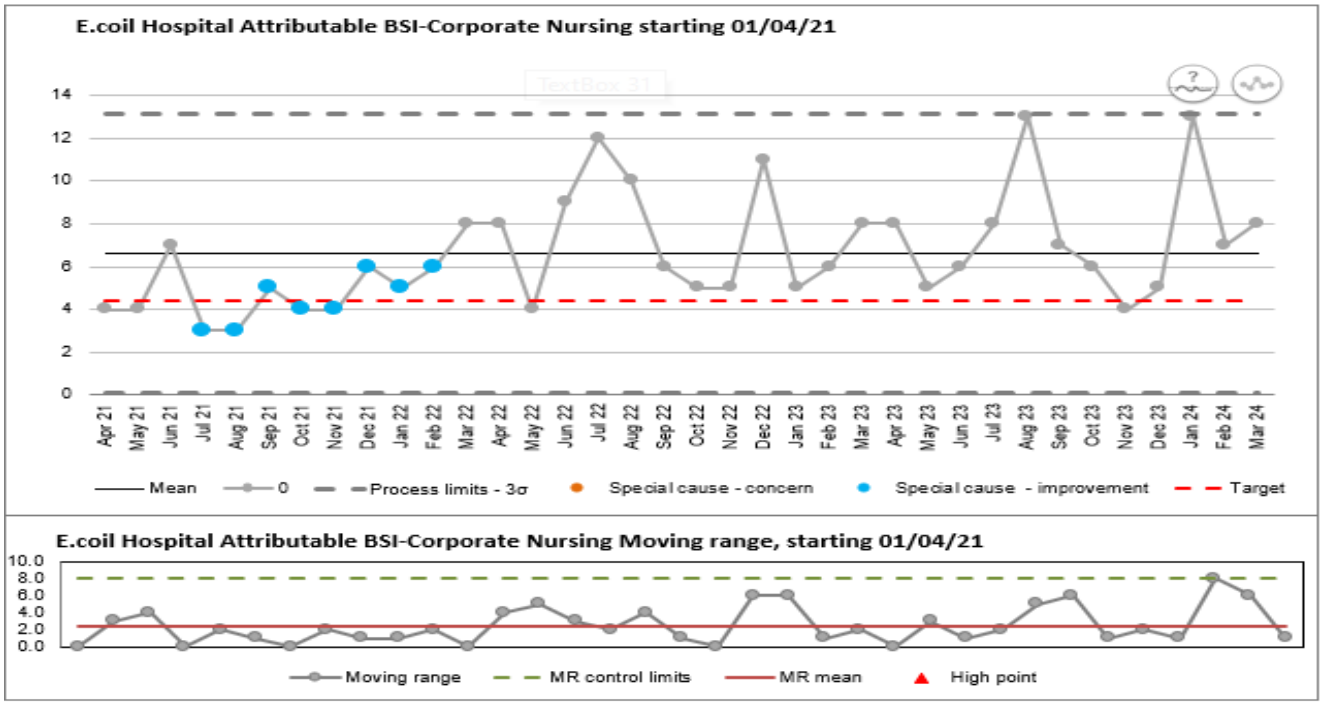
Table 10 below table provides a breakdown of Hospital onset and Community onset Hospital Associated and Community Associated ***E.coli* bacteraemia** by month.

Table 10

Breakdown of E.coli cases in 2023/24													
Incidence	*Apr-23*	*May-23*	*Jun-23*	*Jul-23*	*Aug-23*	*Sep-23*	*Oct-23*	*Nov-23*	*Dec-23*	*Jan-24*	*Feb-24*	*Mar-24*	*Total*
HO-HA	6	4	3	6	6	5	2	1	3	8	5	4	53
CO-HA	2	1	3	2	7	2	4	3	2	5	2	4	37
Community Associated	17	12	11	22	15	16	17	12	17	15	13	8	175

SPC chart 5 below provides a breakdown of *E.coli* bacteraemia by month.

Chart 5



Suspected Source of Hospital onset *E.coli* BSIs:

- 13 – Catheter Associated Urinary Tract Infections
- 12 – Biliary / intraabdominal
- 9 – UTI, not catheter related
- 6 – unknown source
- 3 – cholangitis / cholecystitis
- 3 – wounds / abscesses
- 2 – pregnancy related
- 2 – Neutropenic sepsis / immunocompromised
- 1 – PICC line
- 1 – ureteric stones
- 1 – respiratory

Klebsiella

Klebsiella bacteria are normally found in the human intestines and faeces (where they do not cause disease). In healthcare settings, *Klebsiella* infections commonly occur among sick patients who are receiving treatment for other conditions. Patients whose care requires devices like ventilators (breathing machines) or intravenous (vein) catheters, and patients who are taking long courses of

certain antibiotics are most at risk for *Klebsiella* infections. Healthy people usually do not get *Klebsiella* infections.

Table 11 below provides a breakdown of Hospital attributed ***Klebsiella* bacteraemia** by month against the trajectory.

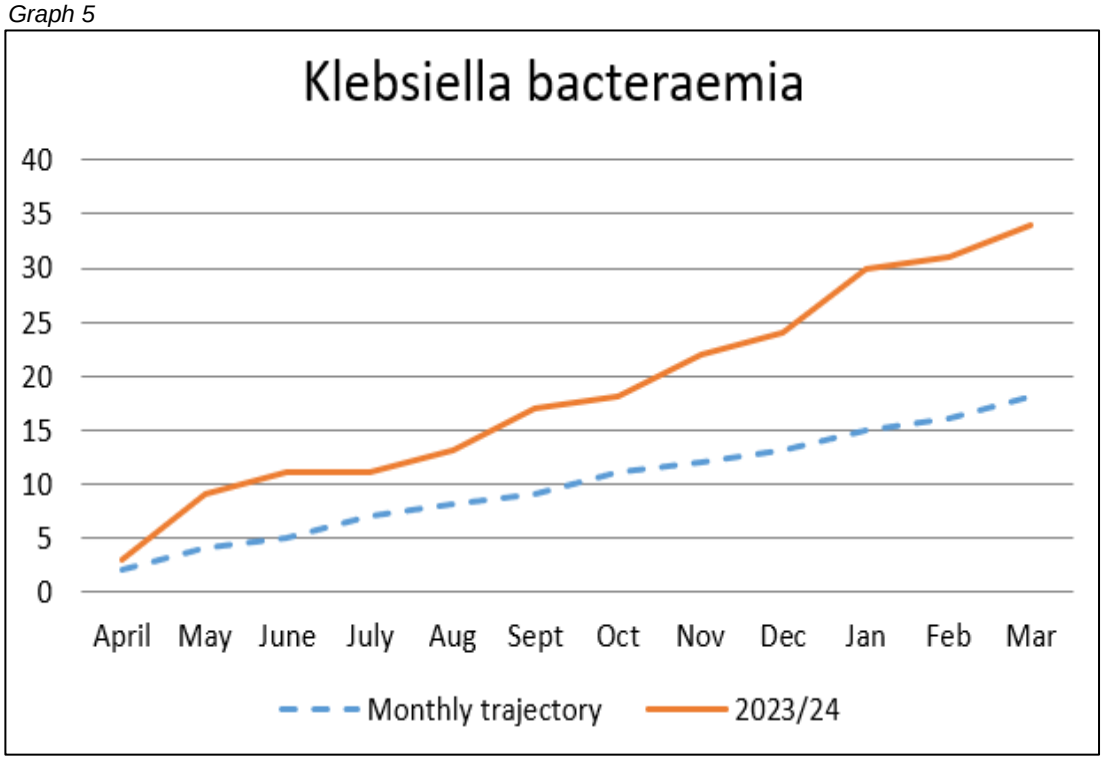
Table 11

The incidence of Klebsiella bacteraemia since 2021/22													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021/22	1	3	4	1	3	0	3	2	2	2	1	3	25
Trajectory 2022/23	2	1	2	1	2	1	2	1	2	1	2	2	19
2022/23	0	4	1	3	6	3	2	4	5	2	2	4	17
Trajectory 2023/24	2	2	1	2	1	1	2	1	1	2	1	2	18
2023/24	3	6	2	0	2	4	1	4	2	6	1	3	34

We reported 17 cases over our trajectory for 2022-2023.

Graph 5 below provides ***Klebsiella* bacteraemia** reported infections by month against the trajectory.

Graph 5



SPC chart 6 below provides a breakdown of *Klebsiella* bacteraemia by month.

Chart 6

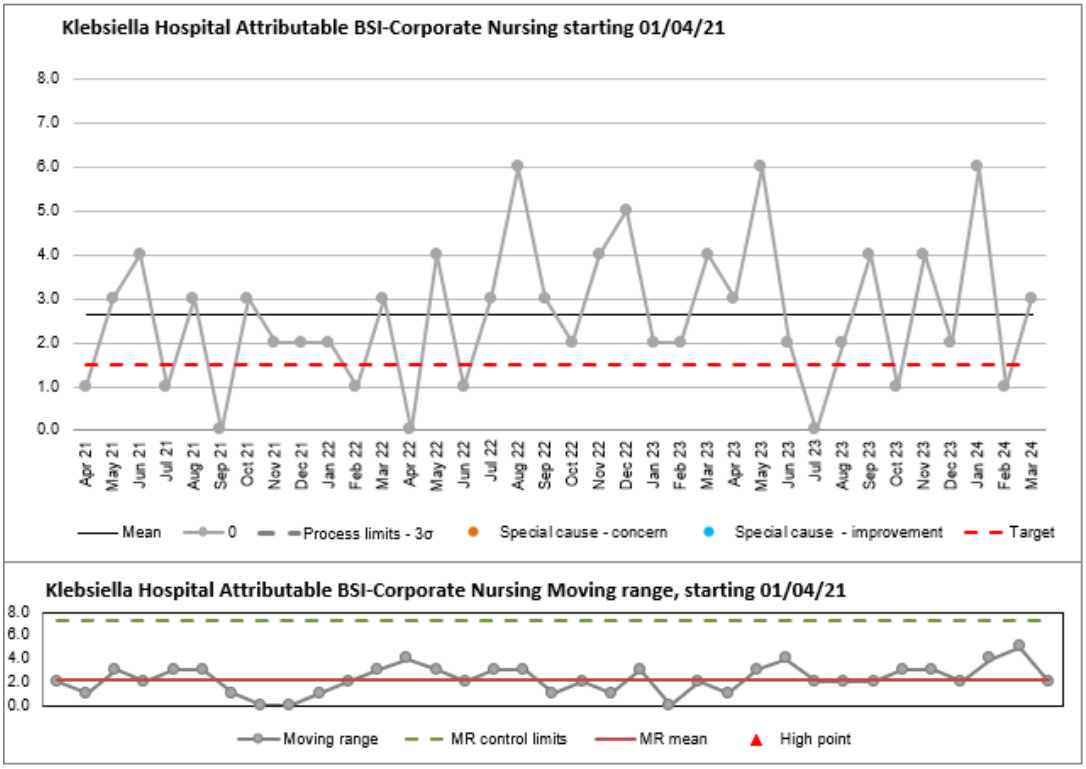


Table 12 below table provides a breakdown of Hospital Onset and Community onset Hospital Associated and Community Associated ***Klebsiella* bacteraemia** by month.

Table 12

Breakdown of Klebsiella cases in 2023/24													
Incidence	*Apr-23*	*May-23*	*Jun-23*	*Jul-23*	*Aug-23*	*Sep-23*	*Oct-23*	*Nov-23*	*Dec-23*	*Jan-24*	*Feb-24*	*Mar-24*	*Total*
HO-HA	1	4	2	0	2	2	1	2	1	5	0	0	20
CO-HA	2	2	0	0	0	2	0	2	1	1	1	3	14
Community Associated	1	4	4	4	5	4	3	0	4	3	1	3	36

Suspected Source of Hospital onset *Klebsiella* BSIs:

- 4 – CAUTI
- 3 – UTI, not catheter related
- 1 – unknown source
- 1 – respiratory
- 7 – intra-abdominal
- 1 – cholangitis
- 1 – femoral line
- 2 – abscesses

Pseudomonas

Pseudomonas aeruginosa lives in the environment and can be spread to people in healthcare settings when they are exposed to water or soil that is contaminated with these germs. Resistant strains of the germ can also spread in healthcare settings from one person to another through contaminated hands, equipment, or surfaces.

Table 13 below provides a breakdown of Hospital attributed ***Pseudomonas* bacteraemia** by month against the trajectory.

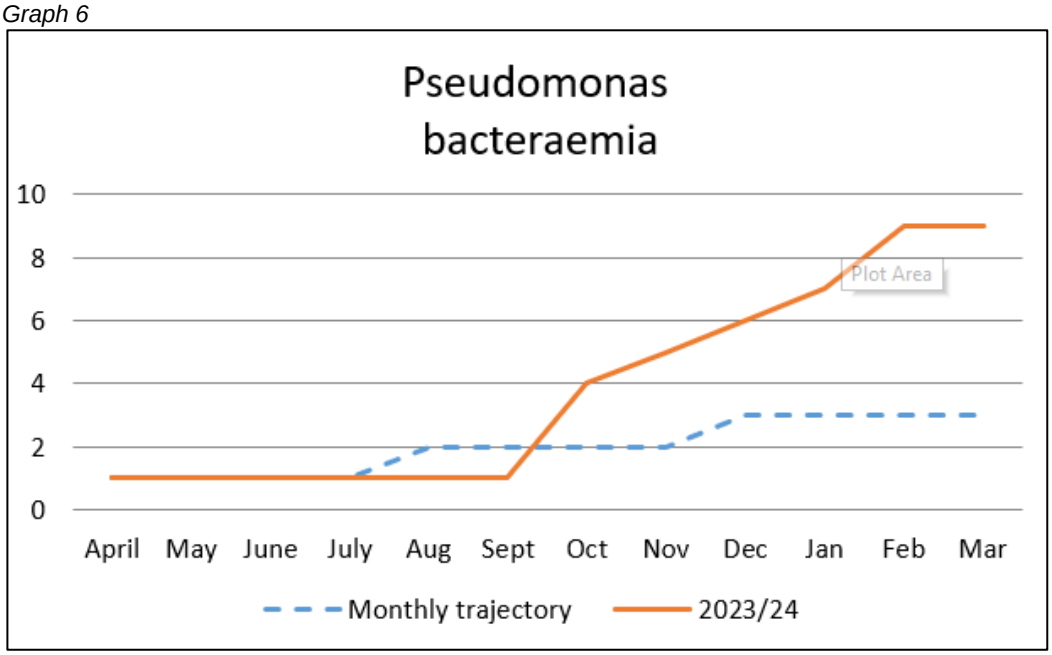
Table 13

The incidence of Pseudomonas bacteraemia since 2021/22													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021/22	1	0	0	0	2	3	0	1	0	0	0	1	8
Trajectory 2022/23	1	1	0	1	1	0	1	1	0	1	1	1	9
2022/23	0	0	0	0	1	0	0	1	1	3	1	1	8
Trajectory 2023/24	1	0	0	0	1	0	0	0	1	0	0	0	3
2023/24	1	0	0	0	0	0	3	1	1	1	2	0	9

We reported 6 infections over our trajectory for 2023-2024.

Graph 6 below provides Pseudomonas bacteraemia reported infections by month against the trajectory.

Graph 6



SPC chart 7 below provides a breakdown of ***Klebsiella* bacteraemia** by month.

Chart 7

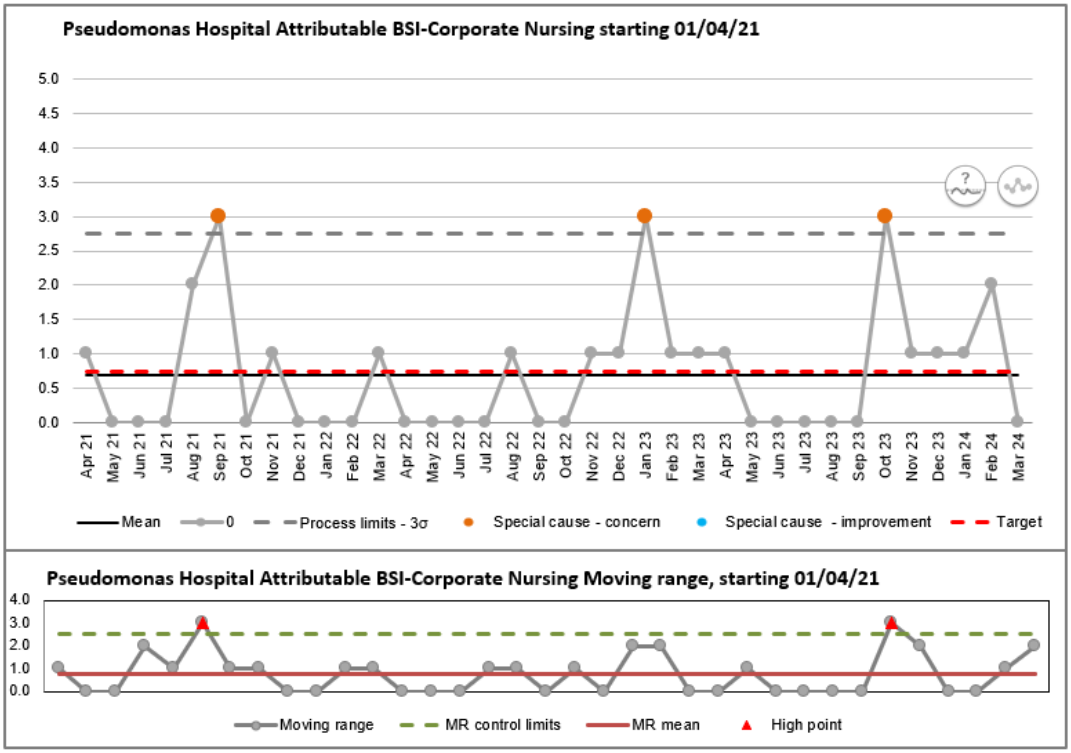


Table 14 below table provides a breakdown of Hospital onset and Community onset Hospital Associated and Community Associated ***Pseudomonas* bacteraemia** by month.

Table 14

Breakdown of Pseudomonas cases in 2023/24													
Incidence	*Apr-23*	*May-23*	*Jun-23*	*Jul-23*	*Aug-23*	*Sep-23*	*Oct-23*	*Nov-23*	*Dec-23*	*Jan-24*	*Feb-24*	*Mar-24*	*Total*
HO-HA	0	0	0	0	0	0	3	0	1	0	2	0	6
CO-HA	1	0	0	0	0	0	0	1	0	1	0	0	3
Community Associated	2	2	0	2	1	1	1	0	1	0	0	0	10

Suspected Source of Hospital onset *Pseudomonas* BSIs:

- 2 – unknown source
- 1 – CAUTI
- 1 – wound
- 1 – renal stones
- 1 – IV cannula

6.11 Themes from gram negative RCA investigation

An initial rapid review of all hospital onset gram negative BSIs is undertaken by IPC and Microbiology, to determine an initial source and if it requires further investigation, as often these bacteraemia are

unavoidable due to the complexities of these patients. An RCA / REC is recommended if the source is considered to be linked to either urinary catheter, intravascular device, chronic wounds, surgical or tracheostomy site infection, ventilator associated pneumonia, or if focus of infection is unknown.
A quarterly report is provided to IPCG to provide an update on GNBSI figures, how we compare regionally and what themes have been identified.

Below are the themes that have been identified from the initial reviews, RCAs or RECs:

- Blood culture policy not being followed
- Insertion and ongoing care of invasive devices not clearly documented in CERNER
- Line tips not sent to laboratory when line infection suspected, therefore unable to exclude line infection as source of BSI
- Appropriate samples not collected when infection suspected
- Urine dipstick has been used to diagnose CAUTI or UTI in people aged over 65 years
- Previous specimen sensitivities not taken into account when prescribing antimicrobials
- Hydration of patients not being considered, especially in patients who are prone to UTIs

A change in practice was introduced following a BSI REC:
- Larger dressings for femoral lines in Critical Care

6.12 Carbapenemase-producing *Enterobacteriaceae* (CPE)

The spread of antibiotic resistance in gram-negative organisms continues to be an increasingly significant public health threat and a matter of national and international concern. They are an emerging cause of healthcare-associated infections, which represent a major challenge to healthcare systems.

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. These organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Environmental and surface contamination plays a significant role in transmission. Bacteria can survive on dry surfaces for extended periods, increasing the risk of cross contamination between patients.

Table 15 below provides a breakdown of all CPE **bacteraemia** by year and month.

Table 15

The incidence of CPE Bacteraemia since 2019/20													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	0	0	0	1	0	0	0	0	0	0	0	0	1
2020/21	0	0	0	1	0	0	0	0	0	0	0	0	1
2021/22	0	0	0	0	0	0	0	1	0	0	0	0	1
2022/23	0	0	0	0	0	1	0	0	0	0	0	0	1
2023/24	0	0	0	0	0	0	0	0	0	0	0	0	0

As a result of the ongoing challenges faced in 2023-2024 the review of the current arrangements and introduction of a CPE policy, reflecting the national guidance was put on hold, this will now be part of the annual plan for 2024-25.

6.13 Mandatory Glycopeptide resistant *Enterococci* (VRE) bacteraemia

Enterococci bacteria are frequently found in the bowel of normal healthy individuals. There are many different species of enterococci, but only a few have the potential to cause infections in humans. They can cause a range of illnesses including urinary tract infections, bacteraemia (blood stream infections) and wound infections.

There has been no incidence of VRE bacteraemia reported at WUTH during the period April 2023 - March 2024. Unlike other organisms under mandatory surveillance, UKHSA employs a reporting year which runs from October–September to publish national G/VRE data. There is no requirement to apportion cases, only report incidences.

Table 16 below provides a breakdown of VRE **bacteremia** by month.

Table 16

The incidence of *VRE bacteraemia since 2019/20*													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	0	0	1	0	1	0	1	1	0	0	1	0	5
2020/21	1	0	0	0	0	0	0	0	0	0	0	0	1
2021/22	0	2	0	0	0	1	0	1	0	0	0	0	4
2022/23	0	0	0	0	0	1	0	0	0	0	0	0	1
2023/24	0	0	0	0	0	0	0	0	0	0	0	0	0

6.14 Quarterly Mandatory Laboratory Reporting (QMLR)

Whilst it is mandatory to submit 'Quarterly Mandatory Laboratory Reporting' data via the UKHSA Health Care Associated Infection (HCAI) Data Capture System this has not been completed in 2023/24 due to staff sickness.

This data includes:

- Total number of blood culture sets examined.
- Total number of glycopeptide resistant enterococci (GRE) positive blood culture episodes
- Total number of positive blood culture sets
- Total number of S. aureus positive blood culture sets
- Total number of *Clostridioides difficile* toxin positive reports in people aged 2 - 64 years.
- Total number of *Clostridioides difficile* toxin positive reports results in people aged >=65 years
- Total number of stool specimens tested for diagnosis of C. difficile infection.
- Total number of stool specimens examined.
- Total number of faecal specimens and rectal swabs taken for carbapenemase-producing *Enterobacteriaceae* (CPE) screening

6.15 Coronavirus (COVID-19)

The Government's aim throughout the COVID-19 pandemic was to protect the lives and livelihoods of citizens across the United Kingdom (UK).

The emergence of new variants will be a significant factor in determining the future path of the virus as new variants of COVID-19 will continue to emerge. This could include variants that render vaccines less effective as they become resistant to antivirals or cause more severe disease. The pathway to greater stability will be supported by utilising vaccines and other available treatments.

Living with and managing the virus will mean maintaining the population's wall of protection and communicating safer behaviours that the public can follow to manage risk.

During 2023/24 screening patients for COVID-19 on admission stopped as did screening those patients who were transferring to a community care home. Patients who were symptomatic were screened using PCR if it would change their management. Staff were no longer advised to screen and any time off for sickness due to COVID-19 was counted in their sickness/absence record.

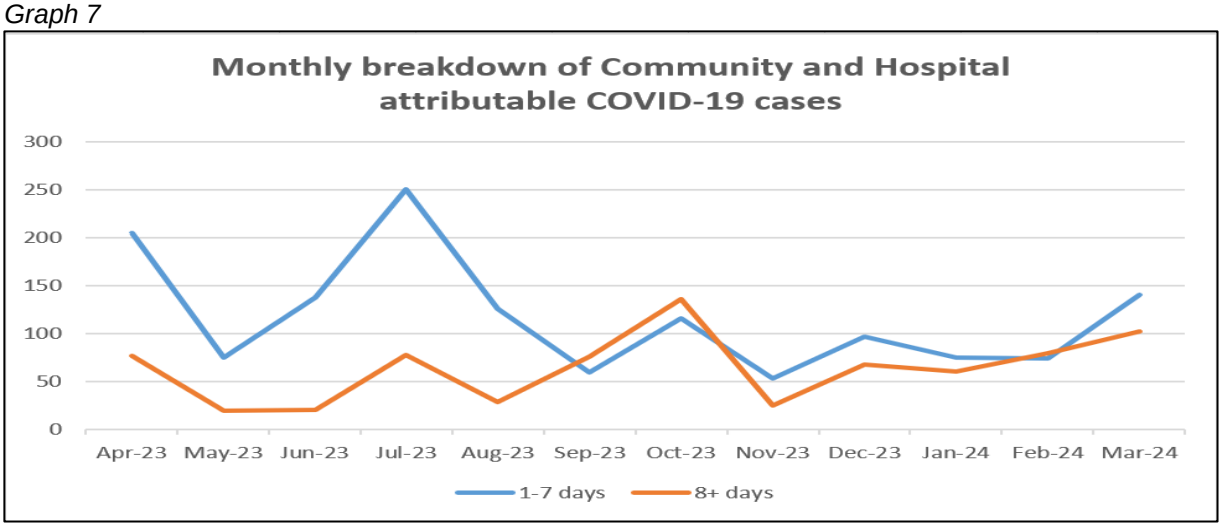
There remained a steady influx of patients identified with COVID-19 throughout the year with most as can be seen in table 17 below being detected shortly after admission which signifies that COVID-19 was still circulating in the community

Table 17

	No. of COVID-19 cases				Total No. of cases per month
	Community Onset		Hospital Onset		
Month	1-2 days	3-7 days	8-14 days	15+ days	
Apr-23	71	7	14	16	108
May-23	37	16	10	20	83
Jun-23	17	2	4	7	30
Jul-23	15	1	1	1	18
Aug-23	50	6	7	18	81
Sep-23	98	11	11	23	143
Oct-23	84	11	16	23	134
Nov-23	27	8	19	15	69
Dec-23	68	9	20	24	121
Jan-24	74	18	10	24	126
Feb-24	34	8	6	7	55
Mar-24	20	1	0	0	21
Total	595	98	118	178	989

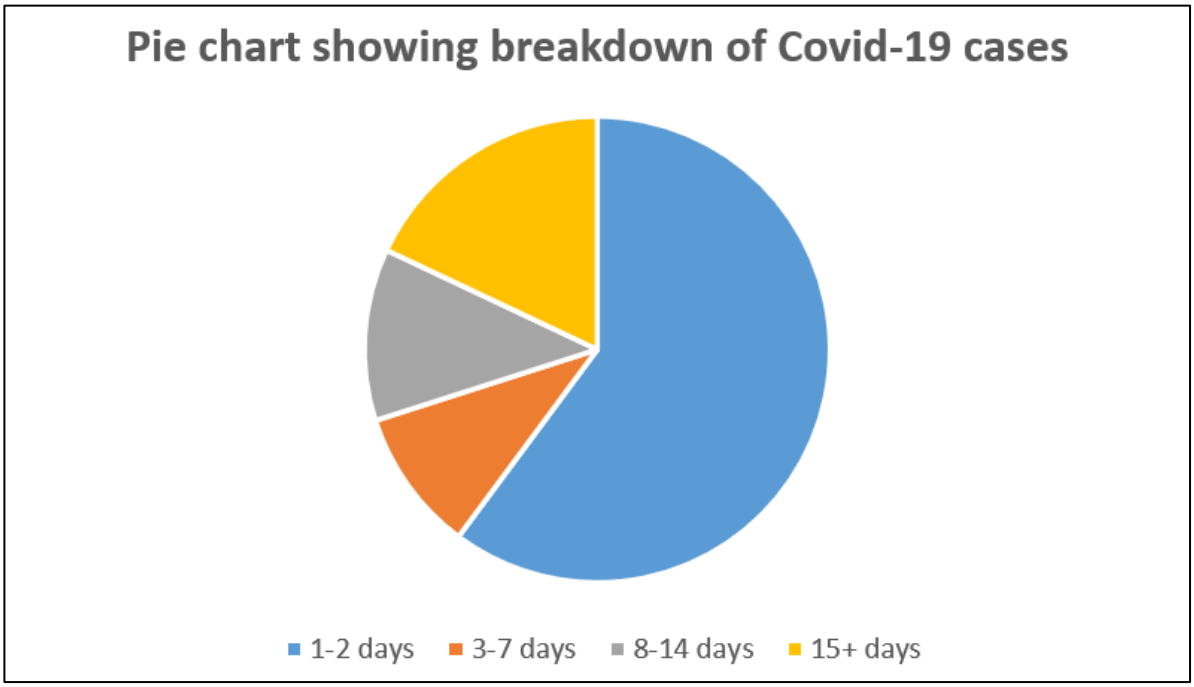
Graph 7 below shows the incidence of patient COVID-19 results in 2023/2024.

Graph 7



The Pie chart 1 below provides a breakdown of COVID-19 in 2023-2024

Pie chart 1



Over time, though hard to predict, it is likely that COVID-19 will become a predominantly winter seasonal illness with some years seeing larger levels of infection than others. This may take several years to occur, and waves of infection may occur during winter or at other times in the year.

6.16 Seasonal Influenza

WUTH participates in the Unify2 influenza surveillance scheme for reporting cases occurring in level two and level three care settings (ICU and HDU). Table 18 below shows the summary of Influenza Cases in Augmented care areas reported through Unify2 Surveillance Scheme since 2019-2020

Table 18

	Influenza A, H1N1pdm09	Influenza A (H3N2)	Influenza A, unknown subtype	Influenza B	Influenza other/unknown subtype
April 2019 - March 2020	3	4	3	0	0
April 2020 - March 2021	0	0	0	0	0
April 2021 - March 2022	0	0	0	0	0
April 2022 - March 2023	2	2	12	0	0
April 2023 - March 2024	1	5	4	0	0

Throughout the rest of the Trust there were 303 positive flu patients admitted in 2023/24, compared with 538 the previous year. There were 287 Flu A positives and 16 Flu B positives. Some cases were an incidental finding due to the type of test that was performed for COVID-19; as can be seen above 10 patients required level two and level three care settings (ICU and HDU).

There were 2 Flu A outbreaks declared in 2023-24:

- Ward 33 in January 2024 – 8 patients tested positive between day 5 and day 26 of admission.
- Ward M1 in February 2024 – 6 patients tested positive between day 23 and day 61 of admission, however patients had been on the ward between 5 and 47 days.

Of the reported cases of Influenza, 15 patients died during their inpatient stay, of these all but 4 came into hospital with Influenza. Of the 4 patients who caught flu whilst an in-patient, one patient had flu listed as Part 1a on their death certificate as direct cause of death. This patient acquired flu during an outbreak on Ward M1.

6.17 Surgical Site Infection (SSI)

There is a mandated requirement for all NHS Trusts in England to submit data with regards to Surgical Site Infections (SSI) to UKHSA comprising of at least 1 quarter per year for one orthopaedic category as a minimum. Throughout the year the Trust has been completing ongoing mandatory surveillance of:

Orthopaedic

- *Hip replacement* - Replacement of the hip joint including resurfacing of the joint, acetabulum replacement and revision of previous replacement and conversion from a previous hemiarthroplasty or bone fixation.

We stopped mandatory surveillance for repair of neck of femur and long bone in March 2023.

In 2023 local surveillance commenced for elective large bowel procedures with a view to completing a year surveillance from 1st July 2023 to 30th June 2024.

Colorectal

- *Large Bowel* - Incision, excision, or anastomosis of the large bowel, including procedures which involve anastomosis of small to large bowel.

Table 19 below identifies our number of SSIs.

Table 19

Category	Apr-Jun 2023		Jul-Sept 2023		Oct-Dec 2023	
	Total No	SSI	Total No	SSI	Total No	SSI
Hip replacement	182	4	127	3	137	0
Large bowel	NA	NA	47	5	57	10

All suspected SSIs are reviewed by the multidisciplinary team to agree if it is a confirmed SSI and identify learning.

Weekly MDT SSI RCA meetings are held, whereby incidents are reviewed, key learning is identified, and action plans are developed. The RCAs and action plans are shared with the ward/Theatre areas and clinicians for comments and learning. Action plans developed with the ward areas are being reviewed regularly to monitor progress. This is fed into divisional IPC for assurance. SSI has also been added to Division clinical governance meetings and any issues are being escalated via divisional quality board (DQB).

Learning identified from the RCA's include:

- Inconsistencies in completion of the wound assessment tool on Cerner.
- Inconsistencies with the documentation of wound checks.
- Body maps not used to identify location of postoperative wounds.
- Not all patients have their temperature maintained intra operatively.
- Pre theatre warming does not take place and limited availability of warming devices
- No clear documentation of wound site when requesting wound swab.
- Post operative wound care advice for wards not standardised.
- Limited ward involvement and knowledge of SSIs
- Wound closure and wound dressings to be discussed with consultants for alternative re stoma leaks.
- Skin prep not standardised
- Lack of education in theatre re dressing choice around stoma.
- ANTT training compliance for surgical wards inconsistent.
- Lack of information for patients regarding preoperative showering.
- Theatres estates and cleanliness.
- Inappropriate SSI diagnosis and antibiotic prescribing in the community setting.

Actions that have been identified from the RCA's include:

- Ward education regarding utilisation of the wound assessment tool, to standardise care and ensure wounds are checked each shift and information regarding wound obtained.
- Education provided regarding utilisation of body maps to ensure standardised care.
- Active warming commenced prior to transfer to theatre in order to maintain temperature intra operative, temperatures taken pre-op and actions identified.
- Explore usage of warming devices.
- Skin preparation standardised– Using Chlorhexidine applicators as per gold standard and NICE guidelines for Colorectal theatres.
- Education to staff regarding information inputted when swabbing a wound.
- Surgical wound SOP to be developed, through an MDT approach to standardised wound care management, with TVNs, IPC, clinicians, SSI nurse
- Wound care discharge booklet for Colorectal patients.
- SSI to be added to Division CG meetings and issues/ concerns raised at DQB.
- Communication and plans for stoma and wound care by Enhanced recovery nurse and theatre staff to discuss recommendations.
- Surgical educators to support wards with ANTT compliance.
- Information leaflet update for Colorectal patients regarding preoperative showering.
- Colorectal theatres to use Chlorhexidine applicators as per gold standard and NICE guidelines for Colorectal theatres.
- IPC and SSI nurse complete regular theatre walk rounds.
- Theatre leads invited to RCA meetings to discuss key findings and learnings.
- Education provided to ward areas regarding SSIs, prevention, and early recognition.
- SSI link nurse to attend ward safety huddles.
- Visit Walk in center to update on postoperative plans for Elective hip replacements.

7.0 Outbreaks /Increased Incidences/Clusters of Infection

Infection surveillance supports the early detection of outbreaks which enables control measures to be instigated early to avoid escalation. An outbreak, as defined in the National Infection Prevention manual is

- Two or more linked cases with the same infectious agent associated with the same healthcare setting over a specified time period

Or

- A higher than expected number of cases of HAI in a given healthcare area over a specified time period.

Once an Outbreak has been identified the senior IPC Team arrange outbreak meetings on a regular basis with the divisional teams to give support and advice until the outbreak is determined to be closed. Due to Trust operational pressures during 2023-24 regular meetings once outbreaks were declared were not as frequent and as a result updates were often given from the IPC team via e-mail to divisions.

7.1 Norovirus

Between 1st April 2023 and 30th March 2024 there were 21 confirmed Norovirus outbreaks, with some wards experiencing more than one outbreak. This is an increase of 9 when compared to the previous year. Due to significant operational pressures only 3 wards were closed, and only one of these remained closed for the duration of the outbreak, which lasted 5 days.

The length of outbreaks ranged from 5 days up to 23 days, with an average of 9-10 days. Due to the operational pressures in the Trust, following a risk assessment the Trust did not support the closure of wards when Norovirus was detected and as a result some new patients admitted to these wards did acquire Norovirus which potentially extended the length of their stay and the length of the outbreaks.

In total, 416 patients experienced diarrhoea and/or vomiting symptoms, of these 93 patients were confirmed to have Norovirus. When Norovirus is confirmed on a ward it is presumed that any further patients on the ward with symptoms are likely to have Norovirus, so not all patients are sampled. There were 62 staff who also reported symptoms during these outbreaks, however 6 outbreaks had no staff affected.

N.B. It is rare to receive samples from staff into the Lab for testing.

7.2 *Clostridioides difficile*

There were 6 wards that were identified as having a period of increased incidence of *C.difficile*, during 2023-24, compared with 9 the previous year:

- **OPAU –** 9 patients were diagnosed between June and July 2023, 7 with CDT and 2 with equivocal results. Of the samples sent for typing, 2 patients were identified as having ribotype CE 023, 2 patients had ribotype CE 14 and one patient had ribotype CE 020.
- **Ward 22** – 5 patients were diagnosed between July and August 2023 with CDT, 2 of the patients previously had equivocal results. 3 patients were identified as having ribotype CE 002 and one patient had ribotype CE 020, indicating transmission of infection and meeting the definition of an outbreak.
- **Ward 27** – 3 patients were diagnosed between October and November 2023, 1 with CDT and 2 with equivocal results. The 2 patients with equivocal results were both in the bay at the same time, with the initial patient having diarrhoea whilst in the bay for several weeks. Cross transmission is likely to have occurred, however this was not able to be confirmed with ribotyping as equivocal samples are unable to be typed.
- **Ward 38** – 4 patients were diagnosed in November 2023, 2 with CDT and 2 with equivocal results. One patient was identified as having ribotype CE 015 and one was ribotype CE 020.
- **Ward M1 Rehab** – 4 patients were diagnosed between November and December 2023, 3 with CDT and 1 with an equivocal result. 3 of the patients had recently been inpatient's before they tested positive for CD. Only one sample was sent for typing which was reported as CE 020.

- **Ward 33** – 6 patients were diagnosed between February and March 2024, 2 with CDT and 4 with equivocal results. There was insufficient sample to be sent for typing, however 3 patients were all in the same bay at the same time indicating that cross transmission is likely to have occurred.

Once a period of increased incidence (PII) is declared all wards are required to implement the Trust CDI improvement plan, enhanced cleaning is initiated and increased attention to outstanding Estates issues addressed. HPV of the ward is also required however this was not always possible due to operational pressures. When the PII is over all documentation is advised to be attached to the incident form which is commenced when the PII is declared.

7.3 COVID-19

COVID-19 outbreaks continued to be declared and data submitted throughout the year to the NHSE/I online reporting system. Wards and departments remained in 'outbreak' until 15 days had passed since the last positive COVID-19 case had been identified.

Due to significant operational pressures during the winter, attendance at outbreak meetings was sporadic, therefore the IPCT provided an email notification of outbreaks with a list of mitigating actions that needed to be implemented, this was supported with regular visits by the IPCT to the outbreak wards.

Between April 2023 and March 2024 there were 24 COVID-19 outbreaks declared, which is a reduction from the previous year when we reported 63.

In total 163 patients tested positive for COVID-19:

- 28 patients tested positive between day 3 and 7.
- 44 patients tested positive between day 8 and 15.
- 89 patients tested positive after day 15 of admission.

Only 16 staff tested positive as part of 6 of the outbreaks, however the true figure of affected staff is unknown as there is no longer a requirement for staff to test for COVID-19.

The number of outbreaks peaked in December, with 6 outbreaks declared followed by September when 5 outbreaks where declared.

7.4 *Pseudomonas*

In May 2023 it was identified that on ITU between February and April 2023 8 patients tested positive for *Pseudomonas aeruginosa* from clinical samples. It is unknown how many acquired *Pseudomonas* on Critical Care as there were no prior negative clinical samples. An incident meeting was held, and all samples were sent for typing; they all had unique profiles; therefore cross-transmission was excluded.

Between May and July 2023 there were 3 babies who acquired *Pseudomonas aeruginosa* on the Neonatal Unit, however there was no direct cross-over between the babies.

Between January and February 2024 there were 3 babies who acquired *Pseudomonas aeruginosa* on the Neonatal Unit that had been identified from routine weekly screening. 2 of the babies were twins and all had been in ITU cots 1-7. Regular outbreak meetings were held to ensure that mitigating actions were in place, and all guidelines and SOPs were reviewed.

7.5 MRSA

An MRSA outbreak that declared on the Neonatal Unit in February 2023. This was identified when one baby who was transferred to another Trust, was reported to have an MRSA bacteraemia on admission. Following this all babies on the unit were screened which identified one neonate who was colonised with MRSA, followed by a further neonate who was identified in March 2023. This outbreak continued to be managed in 2024 with regular outbreak meetings where an improvement plan was being monitored.

8.0 Incidents of communicable disease

Communicable diseases, also known as infectious diseases or transmissible diseases, are illnesses that result from the presence and growth of pathogenic (capable of causing disease) biologic agents in an individual human or other animal host. There may be occasions when patients or staff have been exposed to a specific infection e.g., scabies, Group A *Streptococcus*, identified by either the IPCT or PHE which results in the need for either staff and Patient screening / treatment or both. When these situations have been identified the IPC team support the ward teams to complete contact tracing and screening, if exposed patients / staff are identified immunisation records are checked by the patient's clinician and occupational health for verification of immunity and vaccination offered as required.

8.1 Group A *Streptococcus*

Group A *Streptococcus* (also known as GAS, group A strep, strep A, and *Streptococcus pyogenes*) is a bacterium which can colonise the throat, skin and any genital tract. Strep A infections are more common in children, but Adults can also sometimes get them. Most strep A infections are not serious and can be treated with antibiotics. But rarely, the infection can cause serious problems, this is called invasive group A strep (iGAS) It is spread by close contact between individuals, through respiratory particles and direct skin contact. It can also be transmitted environmentally, for example through contact with contaminated objects, such as towels or bedding, or ingestion of food prepared by someone with the infection.

During 2023-24, 10 patients had an iGAS identified from blood cultures collected on admission, which is a reduction from 22 in 2022-23. As this is sometimes only diagnosed post admission, 'warn and inform' letters were regularly issued to staff who may have been exposed, prior to confirmed diagnosis, without wearing a FRSM. There were no cases of healthcare workers who acquired GAS reported by Occupational Health or transmission to other patients identified.

8.2 Mpox

Mpox (previously known as monkeypox) is a rare disease that was first discovered in 1958 when outbreaks of a pox-like disease occurred in monkeys kept for research. The first human case was recorded in 1970 in the Democratic Republic of Congo (DRC), and since then the infection has been reported in several central and western African countries. Since May 2022, cases of mpox have been reported in multiple countries that do not usually have mpox virus in animal or human populations, including the UK. Prior to 2022, cases identified in the UK had been either been imported from countries where Mpox is endemic or contacts with documented epidemiological links to imported cases. Since May 2022 detection of mpox infection, acquired within the UK, were confirmed in England. Between 6 May 2022 and 31 March 2023 there have been 3,555 cases reported in England. The outbreak has mainly been in gay, bisexual, and men who have sex with men without documented history of travel to endemic countries.

In 2023-2024 (up to 31March 2024) there have been a total of 176 cases of mpox reported in the UK. Of these, 169 were in England, with 74 cases presumed to have acquired mpox in the UK, 60 were acquired outside the UK and 34 are awaiting classification.

There have been some patients admitted with suspected mpox and IPC ensured that the correct precautions and contact tracing was initiated, however testing later confirmed that there were no patients admitted to WUTH with confirmed mpox.

8.3 Tuberculosis

Tuberculosis (TB) is an infectious disease caused by the organism *Mycobacterium tuberculosis* (MTB). TB usually presents as a chronic disease of the respiratory tract but may also affect other organ systems. TB is spread by inhalation of infectious droplets, which may be coughed or sneezed by a patient with respiratory TB. People with TB in organs other that the respiratory tract or with latent TB are rarely infectious to others.

During 2023-2024 there were 2 TB ‘incidents’ that required a multi-disciplinary approach, this included staff from IPC, Microbiology, Occupational Health, and the TB Specialist Team. One of the incidents also required support from UKHSA, divisional representatives and Wirral Community Trust.

- In June 2023 a patient was initially identified as MTB complex and was later confirmed M.bovis*. The patient had been admitted from a care home and was nursed in an open bay in the hospital prior to the diagnosis. Notification letters had been circulated to all contacts regarding MTB, however the follow up was the same for M.bovis therefore was not altered. The TB service reported difficulty in bringing back the patients who had been identified as ‘exposed’ once they had returned home, especially in those aged over 80 years.

- In October 2023, the IPC were notified about a patient who had MTB that may be resistant, as an outpatient, and had recently attended ED for over 8 hours. On further review, it was noted that the patient was not coughing and it was confirmed to be a standard TB. Household contacts were following up by the TB service and as none of them were positive, it was agreed that wider contact tracing was not required.

There were a further 2 patients admitted with suspected TB which instigated IPC precautions to be implemented however they were not confirmed to have MTB complex.

*Bovine TB is caused by a bacterium called *Mycobacterium bovis* (M.bovis). M.bovis is closely related to the bacterium that causes human and avian tuberculosis. All mammalian species, including humans, are susceptible to bovine TB. It is mainly a respiratory disease. Transmission can occur through nose-to-nose contact and also through contact with saliva, urine, faeces and milk. Cattle can become infected when directly exposed to other infectious cattle (or other infectious animals) and their excretions. The movement of cattle with undetected infection is the most likely way that disease spreads to new areas.

8.4 Measles

Measles is caused by a morbillivirus of the paramyxovirus family. Early symptoms include the onset of fever, malaise (aches and pains), coryza (head cold), conjunctivitis (red eyes) and cough. The most common complications of measles include pneumonia, ear infection, diarrhoea and convulsions. Rarely, measles can and does cause encephalitis and death.

In January 2024 an increase in Measles cases nationally was noted, with 44 cases in the first week of 2024, compared with 29 in weeks 51 and 52 of 2023. To increase vigilance and awareness of Measles, posters were designed and displayed in all assessment areas. Trust Measles preparedness meetings were held to review all guidance and ensure all Divisions had plans in place to mitigate the risk from measles. A dedicated Measles tab was created on the WUTH intranet for easy access to updated guidance and regular communications were circulated.

There have been no confirmed Measles cases in Wirral residents up to the end of March 2024. However, in February 2024 we were informed of a person with confirmed Measles who had visited WUTH ED during their infectious period. Contact tracing was undertaken for both staff and patients, and all were reviewed to identify if anyone was vulnerable severely immunocompromised. Only one vulnerable patient had been identified and as they had been discharged, UKHSA were informed to trigger follow-up in the community. All other patient and staff contacts were sent a ‘warn and inform’ letter.

Occupational Health reviewed the measles status of all staff and those that had not said they had immunity on their health screening when employed were contacted and offered a blood test to identify if they were immune and vaccinations were then offered.

9.0 Antimicrobial Stewardship

Antimicrobial resistance resulting from infections with multidrug resistant organisms (MDROs) is a major public health concern. If MDROs continue to increase at the current rate, coupled with a limited pharmaceutical company pipeline of novel agents, even simple infections will become untreatable soon and most elective surgical procedures, such as joint replacements will become prohibitively dangerous. Common lifesaving operations and treatment regimens such as Caesarian sections and chemotherapy will carry a high risk of mortality.

One of the ways the rate of potentiation of MDROs is accelerating is through inappropriate use of broad-spectrum antimicrobials. Good antimicrobial stewardship practices limit their use to as short a duration as is clinically appropriate and promote use of narrower spectrum agents where possible.

NHS England and regulatory bodies such as the Care Quality Commission (CQC) expect secondary care organisations to be able to demonstrate adherence to guidance such as 'Start Smart Then Focus', a toolkit for antimicrobial stewardship in secondary care. Additionally, they must also be able to demonstrate good performance against other measures of effective antimicrobial stewardship such as consumption as well as the relevant indicators of the Commissioning for Quality and Innovation (CQUIN) framework.

9.1 Antibiotic Stewardship Team (AST)

The Antimicrobial Stewardship Team develops and support the implementation of policies, procedures and guidelines to ensure the safe and effective use of antimicrobials throughout the Trust. The AMS team meet quarterly and report to the Trust Medicines Safety and Optimisation Group (MSOP) and Trust Infection Prevention and Control group (IPCG). Membership consists of Consultant Medical Microbiologist (CMM), Consultants from each Division, Antimicrobial Pharmacists, Advanced Nurse Practitioners junior doctors and the Deputy Director of IPC. The Committee is well represented by the CMM and pharmacists, Acute Care, Critical care, Elderly care and Respiratory Consultant. Wider attendance remains a challenge however, the team engages directly with specific teams when required for certain pieces of work.

The AMS Team has the following strategies to improve AMS at WUTH:

- Prescriber education training program
- Specialist annual training for F1s, F2s, and pharmacists which is delivered by the AMS pharmacy team. Microbiology team also provide annual training for F1s, F2s, IMTs and Medical Students.
- All newly qualified Non-Medical Prescribers (NMP) attend a training session on AMS.
- Training also provided on an ad hoc basis when necessary.
- Maintaining an evidence-based antimicrobial formulary
- Audit program to monitor antimicrobial prescribing, consumption and identify areas for improvement.

9.2 Ward – focused Antimicrobial Stewardship Team

The ward-based AMS team consists of a CMM or Specialty Doctor or Clinical Scientist for microbiology and a specialist antimicrobial pharmacist to undertake ward rounds to provide patient specific interventions and prescribing feedback directly to prescribers.

The team also leads on service improvements to improve antimicrobial prescribing, such as new treatments, diagnostic tests, and developments to the e-prescribing system.

Areas which are high-users of broad-spectrum antibiotics or high incidence of *C.difficile* infections and areas with patients with critical or complex infections requiring long-courses of treatment have been identified by audits and prioritised for visitation by the ward focused AMS Team:

- Critical care (five times weekly)
- Acute Care (five times weekly) – AMU, MSSW, UMAC
- Older Persons Assessment Unit (weekly)
- Gastroenterology ward (weekly) – W33
- Elderly Care wards (weekly) W21, 22, 23 and 27
- Respiratory Unit (weekly) – W37 and 38 and 25
- Orthogeriatric wards/T&O x 3 (weekly) – W10,11,12 and WAFFU
- SEU (weekly)
- Colorectal unit (weekly)
- General medicine W20 (weekly) (new in 22/23)

The AMS ward-focused team are also available to attend all other areas in response to positive culture results from the microbiology lab and referrals from medical colleagues. Microbiology +/- AMS Pharmacist also attend the following weekly MDTs:

- Renal
- Haematology
- Endocarditis
- OPAT MDT and “virtual” ward round
- *C.difficile* infection MDT
- Prosthetic Joint MDT

9.3 Antibiotic Safe Prescribing Indicators Report (ASPIRE) and Point Prevalence Survey (PPS)

As part of the audit and feedback program, providers should monitor adherence to SSTF principles regularly in all clinical areas to show:

- Evidence of documenting indication and duration (or review date) on the prescription
- Evidence of antimicrobial stewardship review of antibiotics at 48-72 hours after initiation and documentation of the antimicrobial prescribing decision (stop, change, switch, continue, OPAT) on the prescription or in the notes
- Adherence with local guidance on the choice of antibiotic therapy (or documented reason for non-compliance)

At WUTH these parameters are audited quarterly as part of the Antibiotic Safe Prescribing Indicators Report (ASPIRE) audit which analyses antibiotic prescribing for 10 patients selected at random on each ward. The results are displayed as a dashboard demonstrating performance Trust wide as well as at a Divisional and Division level. Results from Q1-Q3 22/23 as seen below in table 20 demonstrate that average Trust-wide performance across the year was as follows (no data for Q4 due to reduced resource within the Pharmacy AMS team):

Table 20

ASPIRE Quality indicators (target >95% for all)	23-24
Compliance with antibiotic formulary	98%
Documentation of indication for antibiotics on prescription	96%
Stop / review date on antibiotic prescription	100%
Antibiotic clinical review undertaken within 72 hours of initiation	97%

These parameters are reported quarterly Trust-wide (via IPCG & MSOP Antimicrobial Stewardship Assurance Report) and divisionally via Lead Divisional Pharmacist Reports. Additionally, an antibiotic point prevalence survey reviews every antibiotic prescription for inpatients on the day of the audit. Data was collected in March 2023 and will be reported to MSOP later in November 2023

9.4 Restricted Antibiotic Use

Certain broad-spectrum antibiotics are restricted and should only be prescribed when recommended in the formulary for specific indications or on the advice of a microbiologist. The Pharmacy Department limits where these are stocked and receives a daily automated electronic report to allow follow up of these prescriptions to ensure this is the case. Restricted antibiotics which are not prescribed as per formulary or on microbiologist advice are referred to the ward pharmacist for discussion with the prescriber.

During 23/24, 2664 restricted antibiotics were audited, 98% of which were prescribed as per formulary, authorised by Microbiology or otherwise appropriate

9.5 Antibiotic Consumption

SSTF requires Trusts to understand their antibiotic consumption patterns. Antibiotic consumption is measured as defined daily doses (DDDs) which is the standard dose of that agent for an adult in a single day. Antibiotic consumption data is skewed by hospital occupied bed days and to introduce consistency is often measured by DDDs per 1000 admissions. National data analysis is also available on the RXInfo DEFINE and PHE Fingertips websites.

A service condition of the NHS Standard Contract for 2023/24 was to reduce consumption of broad-spectrum antibiotics (from the Watch & Reserve categories) by 10% by the end of March 2024 against the baseline figure of consumption for calendar year 2017. DEFINE website has shown WUTH has not met this target reduction, reporting an average 2.9% increase when compared to baseline.

In addition, the AMS team set a local target to reduce consumption of intravenous antibiotics by 1% compared to previous year. The Trust has not met this target having seen an increase of 9% (in DDDs per 1000 total admissions), however consumption reduced during the year with the increase dropping to 2.5% by the final quarter. The consumption data is collated using the national benchmarking software package DEFINE and displayed in table 21 below. Official figures are

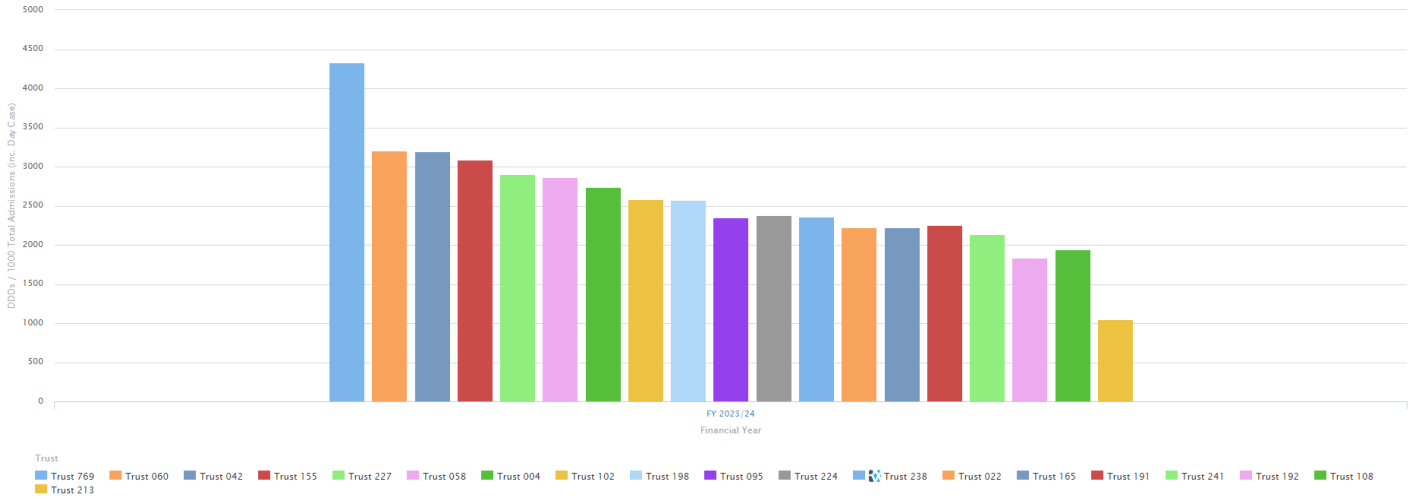
provided by UKHSA (with a 3–4-month delay) and may differ slightly to those reported on DEFINE due to differences in admissions data, this is being investigated nationally.

Table 21

	Table 1. Assurance position	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
1.1	Reduction of broad-spectrum antibiotics (Watch and Reserve)	10% reduction	3% increase	5% increase	0.9% increase	2.7% increase
1.2	Reduce consumption of intravenous antibiotics by 1% compared to previous year (DDDs/1000 admissions reported quarterly) (Baseline: 1122)	1% reduction (<1111)	12% increase	13% increase	9% increase	2.5% increase

Although the Trust has not met the target to reduce broad-spectrum antibiotics compared to 2017, there is ongoing work within the antimicrobial stewardship team to reduce broad spectrum prescribing via education and improvement projects. Graph 8 below shows prescribing of Watch & Reserve antibiotics for this financial year compared to similar North West NHS Trusts.

Graph 8

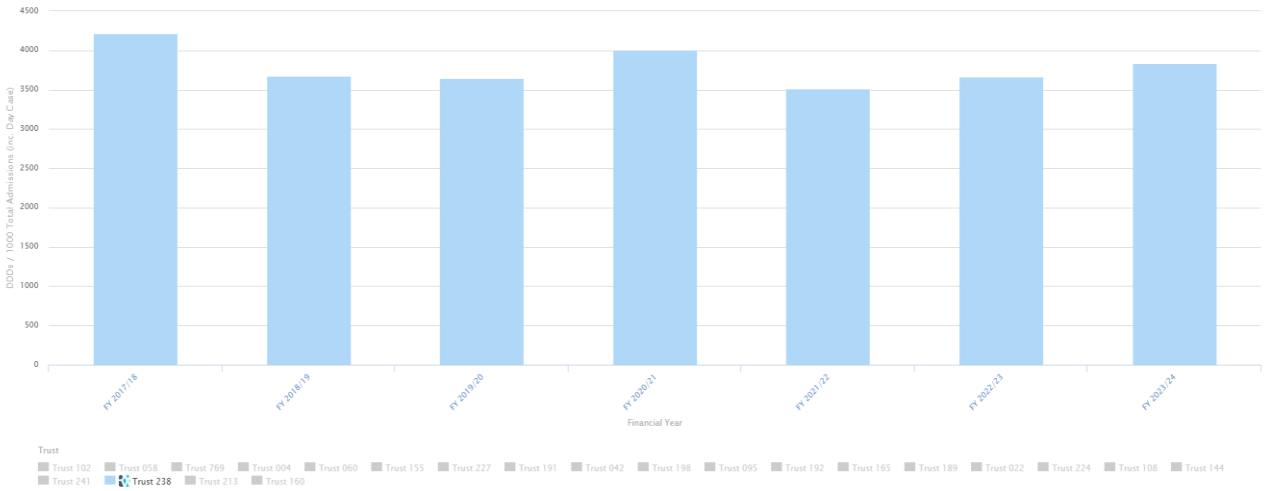


9.6 Total Antibiotic Consumption

Total antibiotic consumption no longer forms part of the national targets; however, usage is still benchmarked nationally. Data from DEFINE has shown an ongoing increase in total antibiotic consumption (DDDs per 1000 admissions) when compared to 2021/22 and 2022/23.

There is a time-lag in reporting accurate data on PHE Fingertips website which is currently showing only Q4 data but regardless of this increase, the Trust remained in the best quintile in England for total antibiotic consumption (data from PHE Fingertips website). Graph 9 below shows WUTH Total antibiotic usage (DDDs per 1000 admissions) over the past 7 years.

Graph 9

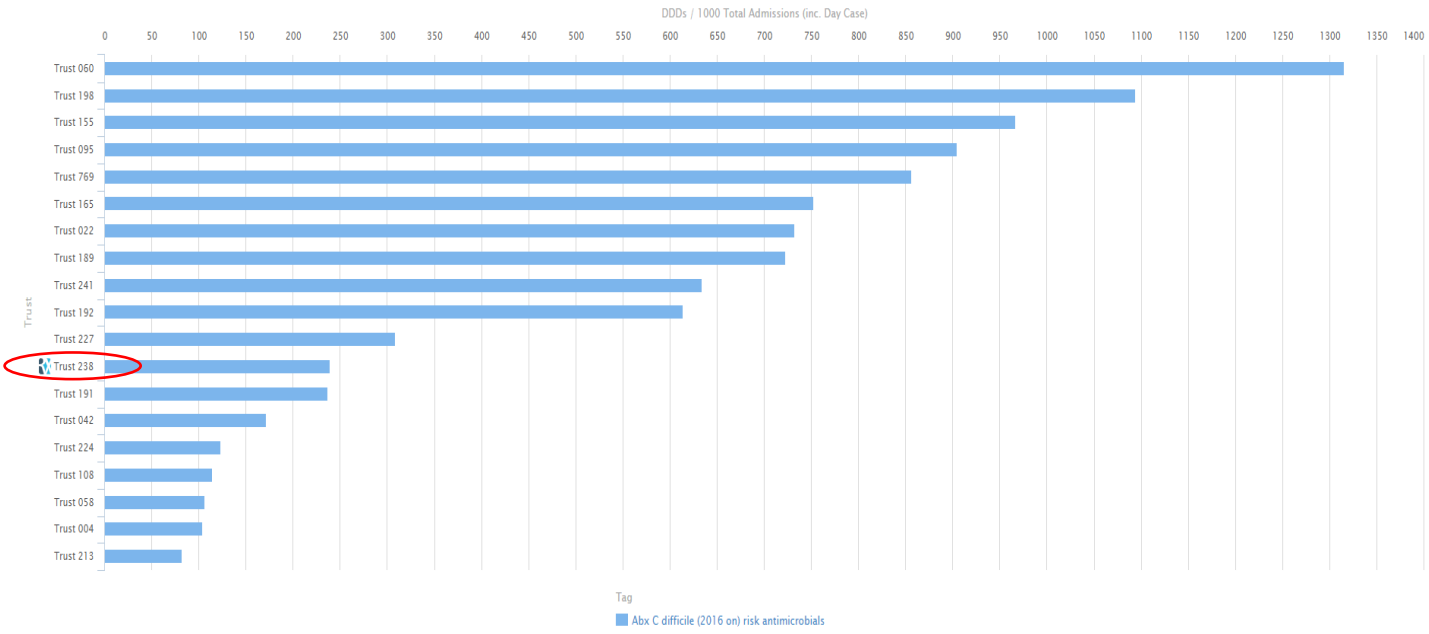


9.7 Consumption of antibiotics with higher *C.difficile* risk

Data from DEFINE suggests WUTH consumption of antibiotics considered high-risk for *C.difficile* is below average when benchmarked against other Trusts of similar type and size however we are further up the table than we were in 2022/23.

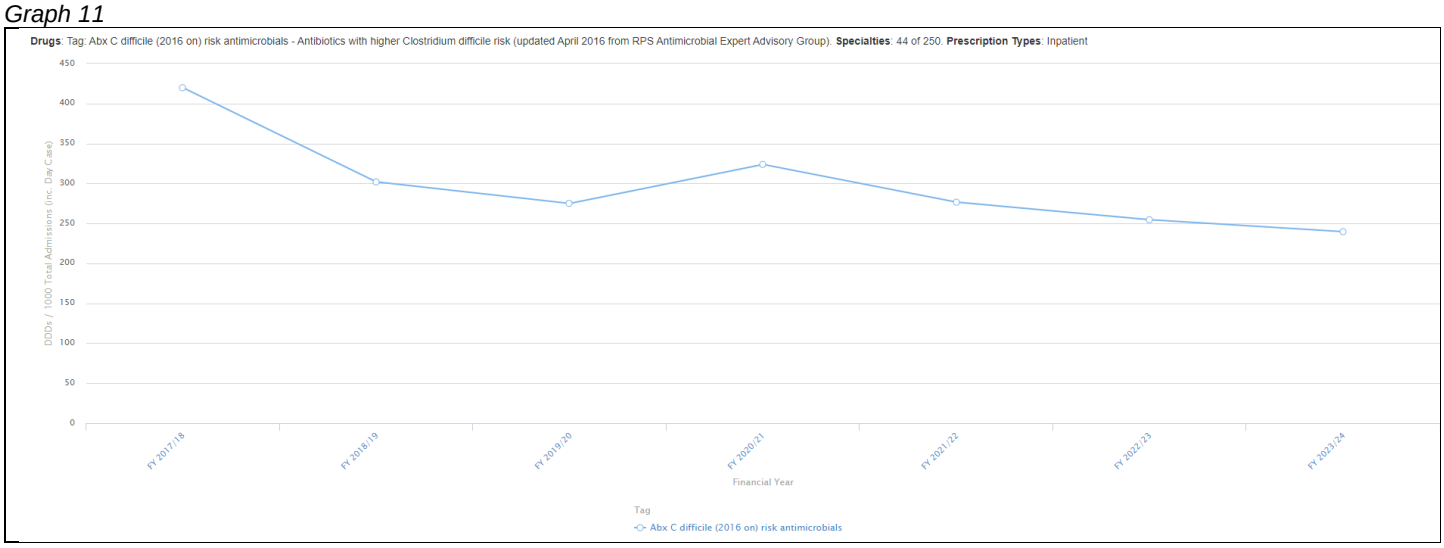
Consumption of antibiotics with higher *C.difficile* risk by Trusts of similar size and type (WUTH is Trust 238) in previous 12 months as shown in graph 10 below

Graph 10



Graph 11 below shows the consumption of antibiotics with higher *C.difficile* risk has been on a downward trend since 2017/18 with the exception of 2020/21 when prescribed trends were most affected by the coronavirus pandemic. (WUTH is Trust 238)

Graph 11



9.8 Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria (CQUIN03)

The CQUIN for 2023/24 was promoting a timely IV to oral switch (IVOS) of antimicrobials. There have been shown significant benefits from research literature around IVOS interventions, these include:

- Increasing hospital bed capacity
- Reducing exposure to broad spectrum antibiotics
- Increasing nursing workforce capacity
- Reducing drug expenditure
- Reducing carbon footprint of medicines
- Reducing healthcare-associated bloodstream infections

The CQUIN also supports reducing length of hospital stay by ensuring intravenous antibiotics are only used for as long as clinically necessary.

The CQUIN standard was to achieve 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria *(CQUIN03).* 40% is the level set for payment of the CQUIN, owing to the benefits of prompt IV to oral switch the AMS team is aiming to meet a target of 10%.

The switching criteria were a decision aid, aiding prescribers to make the decision on the appropriateness of an IV to oral switch. These included:

- If an infection required special considerations (e.g. deep-seated infection)
- If the enteral route was appropriate

- If clinical signs and symptoms were improving
- If infection markers were improving

Table 22 shows the results from each quarter this financial year. It is reassuring that WUTH consistently has exceeded the target set, with compliance well within the recommended target for every quarter with achievement of the IVOS CQUIN being <10% by Q4. WUTH has achieved one of the highest compliance rates among secondary care trusts within Cheshire and Merseyside.

Table 22

	Table 1. Assurance position	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
	Achieve 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria	≤40%	38%	24%	12%	9%

Continued education on AMS ward rounds provides real-time support for the reduction of antibiotics. Section 9.2 details AMS ward rounds. This work continues. WUTH has demonstrated high compliance with the IVOS CQUIN. By Q4 less than 10% of patients audited who were eligible to be switched to oral therapy were not already on oral therapy.

9.9 New developments/improvement strategies

During the 23/24 financial year, there was the introduction of elastomeric 24-hour infusion devices as a pilot within the Outpatient Antibiotic Treatment (OPAT) service. This has allowed access to narrow spectrum intravenous antibiotics flucloxacillin and benzylpenicillin in an OPAT setting for the first time, thus optimizing therapeutic choice.
In addition, piperacillin/tazobactam elastomeric 24hour infusion devices have been introduced giving a treatment option for patients requiring a more broad-spectrum agent. The pilot project is a collaboration between 4 acute trusts in Cheshire and Merseyside. The WUTH team have treated up to 6 patients per week using elastomeric devices. To date the project has saved 1859 bed days across the 4 sites and is on track to save £903K to the system.

Separately, the Antimicrobial Stewardship mPage was designed to improve the quality of antimicrobial reviews by highlighting antibiotic prescriptions which are due for review alongside relevant microbiology cultures. Technical fixes are required before its use can be promoted. Prioritisation of these fixes would have also supported the 23/24 IV to oral switch CQUIN that has been carried out this year. A potential new tool to improve the quality of antimicrobial reviews could be developed and this is being looked at by the informatics team for the next financial year.

9.10 AMS Team response to rise in CDT infections.

With regards to reducing CDI cases, the AMS team has focused on overall AMS improvement across the Trust.

Data from REFINE (Rx-Info) has identified ED minors pre-labelled antibiotic packs account for the largest proportion of broad-spectrum antibiotic usage across the Trust. Oral co-amoxiclav has limited formulary indications in the Trust guidance. Primary care (a similar patient cohort attending A&E minors) has a prescribing target of ≤ 10% for broad-spectrum prescribing.

An audit was carried out to look at co-amoxiclav use in ED minors. The audit looked at whether co-amoxiclav use was indicated and being used as per formulary and if course length was as per formulary.

N.B. To note that supply of 7-day pre-packs in many instances is excess to the recommended treatment duration of 5 days , this is contributing to waste , potentially patients storing antibiotics in their homes for use at a later date without medical input or even taking the full 7 days as healthcare messages are always reminding people to take the full course of antibiotics even if you feel better.

Results of the audit can be seen in table 23 below.

Table 23

Action	Person responsible	Progress
Meeting between AMS team and A&E leads to set actions to ensure appropriateness of co-amoxiclav prescribing	CW	Complete
Cerner report on indications for co-amoxiclav supply on discharge from A&E minors	HS	Cerner does not capture the indications for discharge medicines – therefore an audit is required.
Audit of co-amoxiclav pre-packs and discharge prescriptions vs WUTH antibiotic guidelines	JH	Complete.
To include AMS / prescribing & treatment challenges in induction programme MH to make introductions Microbiology to deliver	MH / AA	In progress
To include abx spectrum / diagnostic uncertainty e.g. chest vs urine / AMS and resistance info in general junior doctor training	AA / CW	In progress
Summary card – badges, posters etc based on key indications identified by audit Kelly / Clare to adapt	CW	In progress – drafted Scoping need and acceptability with A&E staff in progress
NMP training	HS	In progress
Review pre-pack volumes available in A&E	KA	In progress
Demonstrate reduction on co-amoxiclav pre-pack supply and present cost associated with 5 day pack downs to Pharmacy SLT for consideration	CW	Ongoing

Challenge

The audit of co-amoxiclav supplies in A&E minors has been completed and suggests that shorter courses could be supplied in 64% of cases. In addition, there is an opportunity to improve formulary compliance of co-amoxiclav prescribing.

10.0 Decontamination

10.1 Decontamination Arrangements

The Care Quality Commission and the Health and Social Care Act 2008 requires healthcare organisations to keep patients and visitors safe by having procedures and systems in place to ensure that all reusable medical devices are properly decontaminated prior to use, and that all single use devices are not re-used (Criterion 9).

Effective decontamination of reusable medical devices and equipment (including surgical instruments) is essential in minimising the risk of transmission of infectious agents to patients and staff.

Decontamination may involve a combination of processes (including cleaning, disinfection, and sterilisation) to render an item safe for further use on patients and for handling by staff. Any company supplying medical devices or equipment must offer clear instructions on suitable decontamination methods and it is essential that decontamination processes comply with manufacturers' guidelines and are available within the Trust. Failure to follow manufacturer's guidance may result in damage to items, invalidate warranties and transfer liability to the user, or the person authorising the decontamination process.

WUTH has a standard Trust wide approach for decontamination and any queries regarding decontamination of any medical equipment was directed to the Deputy DIPC during 2023/24 owing to a vacant post for the Decontamination Lead. The Decontamination Group met several times, chaired by the deputy DIPC with possible actions/resolutions agreed with the support of the Trust Microbiology representative, AE(D) and other group members. Actions remaining unresolved were escalated to IPCG via the Decontamination chairs report.

In March 2024 a new Decontamination Lead for the Trust was appointed and is currently working to address decontamination processes throughout the Trust, both automated and manual where instrumentation cannot be processed via the decontamination units.

All such devices should follow stringent protocols following Manufacturer's 'Instructions for use' to ensure efficacy, compliance, and the prevention of HCAI's following procedures.

Going forward internal audits will be performed regularly, and action plans developed to address any learning which will be reported through the Decontamination Group.

10.2 Sterile Services

Sterile Services sits within the Division of perioperative medicine and is situated at the APH site. The unit provides decontamination services to both Wirral University Teaching Hospital NHS Foundation Trust and to other NHS trusts and private facilities. The services include washing, decontamination, assembly packing and sterilisation of surgical instruments, theatre trays, soft packs, procedure packs and supplementary items. The service also provides an endoscopy decontamination unit at the CGH

site providing sterilisation and decontamination of flexible endoscopes used at the CBH site through wet sterilisation and dry holding.

The unit is committed to developing a comprehensive policy that gives assurance regarding the quality of the services provided to its customers, both internal and external on behalf of the organisation.

The unit conforms to the requirements of the Quality System Standard BS/EN/ISO 13485: 2016 and relevant requirements of European Directive 93/42/EEC through effective implementation of the department procedures.

The unit updates and reviews their protocols on a regular basis to ensure improvements in quality and customer service and their effectiveness is monitored through internal audits, complaints, and non-conformities. Assurance is provided to the Division of perioperative medicine Infection Control Group, IPCG and other Safety & Quality Boards.

11.0 Cleaning Services

Wirral University Teaching Hospital NHS Foundation Trust have adopted a 'Healthcare Cleaning Professional' Service Cleanliness model that fully conforms to the Department of Health guidelines on the specification for the planning, application, measurement, and review of cleanliness services in hospitals and our cleanliness standards are governed by the following legislation:

- National Standards of Healthcare Cleanliness 2021 has replaced the National Specification for Cleanliness in the NHS 2007.

In April 2021, NHS England and NHS Improvement launched the new National Standards of Healthcare Cleanliness 2021 that set out several key changes to how we perform and audit cleanliness to provide assurance of safe cleanliness standards across all our functional areas.

11.1 Management arrangements

The new standards set out to achieve the following ethos:

- Collaboration: A collaborative approach is essential to continuously improve cleanliness. The standards state that organisations should involve a board nominee, clinical colleagues, partner organisations and patients in setting and monitoring cleaning standards for consistently high levels of service.
- Transparency and Assurance: The standards emphasise transparency to assure patients, the public and staff that safe standards of cleanliness have been met. The transparency of audit and reporting methods, display of audit results and the commitment to cleanliness charter provides assurance that an organisation is serious about cleaning
- Infection Prevention and Control (IPC): Cleaning is a vital part of the overall Infection Prevention and Control process which aims to provide a clinically clean and safe environment for delivering safe patient care. Safe standards of cleanliness minimises risk to patient safety from inadequate cleaning. The new standards will be the measure by which we deliver cleaning services into the future

- Continuous Improvement: To encourage continuous improvement the standards combine mandates, guidance, recommendations, and good practice. The new standards will allow organisations to measure performance in a uniform way and to benchmark it against similar organisations. They seek to drive improvements while being flexible enough to meet the different and complex requirements of all healthcare organisations
- The Facilities Department provides a once daily baseline clean and an additional rapid response infection control cleaning service, which fully conforms and complies to all current legislation and recommendations. This service is audited using a recognised auditing tool to provide assurance of safe cleanliness standards.

11.2 Cleaning Programme

The Healthcare Cleaning Professional Team continues to provide a comprehensive range of cleanliness services to support the Trusts IPC agenda. These services include:

- Rapid Response
- Enhanced Cleans
- Hydrogen Peroxide Vaporisation (HPV) programme

Over the past 12 months there has been a significant impact on the continuity and standard of cleanliness achieved due to a more focused scrutiny on the outcomes. Improvements in the overall condition, appearance and maintenance of the environment and improved responsibility and collaboration across the multi-disciplinary groups has resulted in progress that has now started to show results across the hospitals.

During the challenges over the winter period the cleanliness service remained adaptable and high quality. We recognised the requirement for further development of systems and processes to manage the challenges of an aging estate, and the further developments of new estate at both Clatterbridge Hospital and on the Arrowe Park site. Therefore, we put in measures to support the organisation with the significant challenges ahead and provided assurance of cleanliness outcomes during 2023/24 which was as follows:

- Maximise staffing capacity to provide flexibility to meet the demand and needs of operational service delivery.
- Allocation of Healthcare Cleaning Professionals hours to support additional enhanced cleaning throughout the Trust when patients with infections have been identified.
- Increased cleaning frequency to twice daily cleaning and HPV of sluice areas and patient equipment in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.
- Cleaning frequencies of the Care environment of *C.diff* care areas were enhanced and single rooms, cohort areas and clinical rooms cleaned twice daily.
- Patient Flow continued to allocate the Terminal cleaning required to assist with patient flow.

11.3 Performance Monitoring

To support the assurance of our cleanliness standards the Facilities Department use an industry approved Micad auditing software. It provides our quality control in the form of a visual inspection audit that monitors the quality of cleanliness of all our functional areas across all the responsibility groups of Healthcare Cleaning Professionals, Nursing and Estates. These technical audits involve the scoring of 50 elements within each area assessed and generate a score reflecting the standard of cleanliness achieved.

The mandatory efficacy audits are a management tool to provide assurance that the cleaning standards are met using good practice and that the correct cleaning procedures are consistently delivered to satisfy IPC and safety standards by checking the efficacy of the cleaning process at the point of service delivery. Each patient facing functional area should be audited at least once a year and multidisciplinary attendance is key to providing a more rounded view of our cleanliness standards. Efficacy audits were introduced in 2022/23 on a rolling monthly programme with 7-8 functional areas randomly selected each month.

The Trust has adopted a multidisciplinary approach to technical and efficacy auditing periodically, to assess the cleaning from different perspectives and validate the audit score at ward/department level.

During 2023/24, daily cleanliness monitoring checklists were introduced and are now completed by the cleanliness Supervisory team on the Trust recognisable Tendable audit system to provide additional assurance of our cleanliness standards and to support quality improvement.

11.4 Patient-Led Inspection Programme (PLACE)

The Patient-led assessment of the care environment (PLACE) is an annual national inspection self-assessment programme, which is managed by NHS Digital on NHS England and NHS Improvement's behalf. The assessments mainly apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors, but other providers are encouraged and helped to participate in the programme. PLACE replaced the longstanding PEAT (patient environment action team) programme in 2013.

Under PLACE, organisations make an in-depth assessment of the non-clinical, patient-related aspects of the care environment for all qualifying inpatient settings. Responses contribute to scores across six domains, including one specifically for 'cleanliness'.

Questions within some of the other domains also relate to cleaning and associated services.

PLACE scores are released as an official statistic, and the results are published to help drive improvements in the care environment. The results show how healthcare organisations are performing both nationally and in relation to similar service providers.

We operated a full PLACE assessment within 2023/24 which was a full review with external and patient assessment. The cleanliness result for Wirral University Teaching Hospital was published as 98.7%.

11.5 New cleaning standards

The new National Standards of Healthcare Cleanliness 2021 were implemented within 2022-2023 and they primarily encompass all cleaning tasks throughout the NHS regardless of which department is responsible for it. They are based around being easy to use; freedom within a framework; fit for the future; efficacy of the cleaning process; cleanliness which provides assurance; and transparency of results.

The new standards are an update on the previously available guidance and provide a new framework within which healthcare establishments set out details for providing cleaning services and assessing 'technical' cleanliness. This will ensure that Wirral University Teaching Hospital has a sustainable, effective healthcare cleaning service that will:

- be patient focused.
- be achieved through collaboration of all responsibility groups.
- provide clarity for all cleanliness responsibility groups to ensure our healthcare environment is clean and safe.
- be consistent with infection prevention and control standards and requirements.
- have clear objectives that will provide a good foundation for service improvements.
- provide a culture of continuous improvement.
- provide an agreed and recognisable auditing and monitoring framework.

Compliance with these standards will enhance quality assurance systems, meet the requirements of CQC outcome standard Regulation 15, provide benchmarks and output indicators and offer a recognisable auditing and monitoring system and more importantly will be future proof. As an Acute Trust we started implementation from April 22 and the new standards are now fully in place across the organization.

11.6 The Decontamination Unit (Central Equipment Library)

The Decontamination Unit at Wirral University Teaching Hospital Foundation is under the Facilities Management Department covering Arrowe Park and Clatterbridge Hospital Sites.

The service is responsible for the cleaning, decontamination, and processing of non-invasive medical devices alternating mattress cells, covers and cushions. Recent Capital Investment involving a structural upgrade and new equipment has increased IPC assurance reducing the risk of cross infection and improved environmental hygiene.

The investment has improved redesign in collaboration with Deputy Director of IPC based on HBN 001 Infection Control in the built Environment, areas of improvement are:

- Flow Design - Separate Entry/ Exit
- Delineated work areas for Decontamination and Clean Processing
- Stainless steel decontamination tables and bespoke shelving for devices
- Improved standard operating procedures for staff to follow within defined work areas

- Improved cleaning guidance of medical devices in line with Medical Devices Policy
- Labelling, processing, and storage of medical devices
- Re-introduction of ATP swabbing following mattress decontamination

11.7 New Initiatives

Installation of Otex Decontamination Laundry System was successful in April 2022.This system is HTM 01-04 compliant and provides a validated chemical disinfection process by injecting a continuous flow of ozone into every wash cycle. Ozone disinfection system is effective against micro-organisms such as MRSA *E.Coli* and *C.difficile* spores. The Otex system shows a reduction in water and energy costs by 35% in line with NHS Plan for Carbon Reduction and provides validated assurance of Ozone with each wash cycle.

11.8 Service Improvements

- Education and Training of the Central Equipment Library Team to support the inspection, cleaning of foam mattresses in line with BHTA 2012.
- Identification of criteria for condemning of foam mattress supporting assurance for audit and working collaboratively with all ward staff.
- Purchase of new Trolleys for the safe transportation of foam mattress
- Central Equipment Library deploys Air Purifying Units on request to all areas to assist in the reduction of respiratory viruses.
- All exposed soft foam mattresses identified are processed for decontamination using the Otex Laundry System to support IPC with the reduction in transmission of *C.difficile*.

11.9 Water Safety Group (WSG)

A multidisciplinary Water Safety Group (WSG) including Estates & Facilities in conjunction with Microbiology and Infection Prevention continue to meet monthly. The Legionella risk assessment and Water safety plan (WSP) is a risk-management approach to water safety and provides assurance that systems are in place to control/minimise the risk of morbidity and mortality due to infections related to water systems. This is achieved through control, monitoring, maintenance and testing of water outlets and water systems as required.

The legionella risk assessment and WSP encompasses all areas of potential risk (*Pseudomonas aeruginosa* and Legionella) about water safety; this includes potable water, hot and cold-water systems, endoscopy waters (AER final rinse waters), hydrotherapy pool, birthing pool waters and renal waters. By employing innovative engineering and risk prevention strategies, leading to local reconfiguration of water system design, the WSG is working to reduce the risks and hazards at the point of provision of the water supply.

The WSG continue to give advice on remedial action when required where water systems or outlets are found to be contaminated and the risk to susceptible patients is increased. This includes an escalation procedure and convening extraordinary meetings to trouble shoot and instigate remedial actions to reduce risks to patients and staff. This group reports into the Health and Safety Management committee and the Infection Prevention and Control Group.

11.10 Ventilation Safety Group (VSG)

The multidisciplinary Ventilation Safety Group (VSG) comprising of Estates & Facilities in conjunction with Microbiology and Infection Prevention meet monthly to look at the legal and mandatory requirements of ventilation systems in healthcare premises, this includes the design, maintenance, and the operation of ventilation systems. This group reports into the Health and Safety Management committee and the Infection Prevention and Control Group.

11.11 Ventilation

Ventilation systems provide thermal comfort to patients and staff, enable the removal of pollutants and odours, provide protection from infection for vulnerable patients and reduce the risk of spread of infection. Patients and staff have a right to expect that it will be designed, installed, operated, and maintained to standards that will enable it to fulfil its desired functions reliably and safely.

Specialist ventilation systems are used extensively in healthcare premises in many areas to closely control the environment and air movement of the space that it serves to contain, control, and reduce hazards to patients and staff from airborne contaminants. This includes operating departments, intensive care units, isolation suites, pharmacy and sterile supply departments and laboratories.

The sophistication of ventilation systems in healthcare premises is increasing and their importance has been further highlighted at the beginning of the COVID-19 pandemic in 2020.

Good indoor ventilation can reduce the risk airborne transmission of SARS-CoV-2 beyond 2 meters. CO2 air monitoring can be used as a proxy to indicate areas of poor ventilation. It can give an effectiveness of ventilation in a multi-occupancy setting by monitoring levels of CO2 that can build up through exhaled air. It does not provide a direct measure of infection risk, or a direct measurement of ventilation rates. CO2 rates were first measured back in 2021 and to mitigate risk a total of 30 air purifiers were purchased. These air purifiers purchased use HEPA filters which can reduce the number of potentially infectious particles in the air, thereby reducing the risk of transmission of infection. It must be noted that this intervention does not reduce transmission via close range aerosols and droplets or via fomites.

These Air purifiers are now used when a patient who is nursed in a bay is diagnosed with COVID-19, this helps to clean the air within the bay to reduce the risk to others in the bay. When the patient gets isolated, the air purifier remains in the bay as that is where the risk remains. SOPs were developed to support their use.

Fig 1. Air purifier(AIRVIA AERO 100)

The IPC team acknowledge their use on the daily IPC report and the devices are held and distributed via the Central Equipment Library (CEL).

A longer-term trust wide ventilation improvement plan is awaited from the Estates and Facilities Division.

The Water & Ventilation safety groups promote Trust compliance to Criterion 1 and 2 of the Health and Social care Act 2008 which includes; 1) Systems to manage and monitor the prevention and control of infection and 2) To provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

12.0 Training Activities

12.1 Infection Prevention Link Practitioners

The IPC Link Practitioner programme continued during 2023-24. There are two replicated sessions during the day to allow staff to attend either in the morning or afternoon. The primary purpose of the meeting is educational with time set aside for discussion and to share good practice. Educational topics included:

- Overview of *C.diff* related audits to include; Commode, ATP and UV pen and how these audits are escalated.
- CAUTI audit, compliance, and improvements
- Intravenous access; audit, compliance & improvements
- CAUTI and Intravenous access combined session
- Overarching *C.diff* campaign

Unfortunately, these sessions were not well attended, however there was positive feedback received by those who did attend.

12.2 Student Nurse Training

Second and third-year student nurses have continued to shadow the IPC team on an ad hoc basis. The IPCT have also supported student inductions arranged by the Practice Educator Facilitators. These sessions provide a basic IPC overview in addition to knowledge gained in the University setting. These sessions are also arranged on an ad hoc basis.

12.3 Mandatory Training for Trust Staff

Infection prevention training is mandatory every 18 months for all WUTH staff based in the hospital and the community. Training is accessed online via the E-learning hub, which includes an e-learning Infection Prevention package for all clinical and non-clinical staff. The e-Learning package covers general principles of infection prevention, hand hygiene, the use of PPE and decontamination. The clinical package identifies more detailed information regarding alert organisms and standard precautions.

Evidence of completion of Infection Prevention and Control mandatory training is confirmed at appraisal and monitored at the Monthly IP performance meetings and reported to the Trust Board. Compliance is also monitored at the Subject Matter Expert meetings chaired by Workforce Development.

12.4 Trust Induction Training

The IPCT continue to attend and participate in the Trust Induction afternoon, which is twice per month. A member of the IPCT provides a 5-minute talk to new staff on IPC basic principles and being available to answer any specific questions. A newsletter is also provided to new starters on this Induction.

12.5 Wirral Enhanced Preceptorship Programme (WEPP)

WEPP is a 2-day development programme for all newly qualified staff that is held monthly. IPC provide a 2-hour session which covers the chain of infection, standard IPC precautions and alert organisms. The length of this session has been increased this year from 90 minutes.

12.6 Care Support Worker Training

This is a 2-day programme to support Clinical Support Workers to undertake the core skills course, which is part of the National Care Certificate , this is held at least monthly. The IPC provide an hour session which covers general IPC, hand hygiene, swab and specimen collection, diarrhoea management and essential mattress checks. The IPCT also support with competency assessment sign off for mattress checking.

12.7 Clinical Champions

This is a 1-day programme to provide senior staff with an update on aseptic non-touch technique (ANTT), peripheral cannulation, urinary catheterisation, care of PICC lines and blood culture

collection. IPC provide a 90-minute session which covers an update on HCAIs, learning from RCAs/RECs and the importance of correct management of invasive devices.

12.8 F1 Junior Doctor Induction Training

Twice a year the IPC team join other members of the multidisciplinary teams in an induction program aimed at orientating and familiarising new FY1 Doctors to the Trust. This session provides an overview of IPC expectations and how clinicians can access certain treatment pathways in relation to MRSA and *C.diff.*

12.9 Specific Training

The IPCT regularly provide ad hoc training when visiting wards and departments as required. They have also supported regular bespoke training to departments throughout the year including:

- Facilities Supervisor Training – providing underpinning knowledge on the risks associated with certain organisms from the environment and the different types of cleaning required.
- Medical Division Impact Training – held monthly by the Medical Division, IPC facilitate a 1-hour session. This is a practical session for CSWs covering cleaning of commodes / equipment, mattress checks, PPE donning and doffing, use of Chlorclean and importance of stool charts. The RGNs sessions are also provided with detailed information on organisms and routes of transmission.
- Theatre Audit Days – providing an IPC update, with a different topic covered on each audit day. It also provides an opportunity to answer IPC related questions. This also runs alongside a regular 'Basic Principles of IPC' for new theatre staff.
- Audit training for senior ward staff.

12.10 Aseptic Non-Touch Technique (ANTT)

The ANTT framework provides a clinical guideline for aseptic technique and is based on a theoretical evidence-based framework (Rowley 2001). The purpose is to standardise practice and raise clinical standards. It can be applied to any aseptic procedure, such as intravenous therapy, wound care and urinary catheterisation. ANTT is recognised as the 'gold standard' for aseptic practice and is followed throughout WUTH by members of staff who are required to undertake invasive clinical procedures, including those members of staff who work in the community. Training is provided by Clinical Skills and Divisional Clinical Educators.

The ANTT Policy was updated in November 2022 and introduced 3 Tiers:

- Tier 1 – Hand Hygiene
- Tier 2 – Standard ANTT
- Tier 3 – Surgical ANTT

Competency assessments for ANTT are required to be completed annually and compliance is monitored by Divisions at their monthly IPC meetings and reported monthly at the IPCG. However, there is limited availability of ANTT competencies for doctors.

Table 24 below shows the ANTT compliance data up to the end of March 2024 as recorded in the Core Mandatory Compliance Report.

Table 24

Division	Hand Hygiene		Standard ANTT		Surgical ANTT	
	#	%	#	%	#	%
Acute	42	95.45%	259	64.75%	204	63.16%
Clinical Support	665	90.11%	237	61.4%	137	50.18%
Corporate	534	94.18%	22	35.48%	15	41.67%
Estates and facilities	350	39.28%	1	100%	1	100%
Medicine	144	95.36%	707	68.05%	460	62.16%
Surgery	220	96.92%	733	73.23%	530	69.46%
Women and Children's	112	90.32%	362	70.16%	302	68.79%
Overall Trust	**2067**	**75.38%**	**2321**	**68.16%**	**1649**	**69.22%**

12.11 Monthly IPC Newsletter

During 2023-24 the IPC team published regular newsletters to promote various topics related to IPC, including a special newsletter for visitors:

- Hand Hygiene
- Waste
- Healthcare Associated Infections
- Hydration
- Without Gloves
- Food safety
- *Clostridioides difficile*
    - Cleaning
    - Environment
    - Isolation
    - Sampling
    - Bare below elbows
- Urinary Catheter Management

12.12 IPC Campaigns

World Hand Hygiene Day on 5th May 2023 was celebrated with the IPCT visiting wards and departments to promote hand hygiene and the importance of '*bare below the elbow'*. The World Health Organisation's campaign theme this year was '*Accelerate action together' – Together we can accelerate action to prevent infections and antimicrobial resistance in health care and build a culture of safety and quality in which hand hygiene improvement in given high priority.*

The UV light box was used to assess how well staff cleaned their hands, as well as asking staff to remove gloves which were covered with paint to demonstrate how hands can become contaminated even when wearing gloves. The team were also joined by representatives from SC Johnson who supported with staff hand hygiene training using the 'Semmelweis' machine to assess staff hand hygiene technique. The team also took samples of staff hands using Agar plates to see find out what was growing. Although there was lots of skin flora identified, which would be expected, some were in higher numbers than others.

Infection Prevention and Control Week in October 2023 had an international theme of 'celebrating the fundamentals of infection prevention' which highlighted getting back to basics of infection prevention for everybody. There was a stand in the main foyer and the team visited wards and departments throughout the week, providing freebies, quizzes and answering IPC queries. The week was also used to launch the IPC 'it's not difficile' campaign. A poster was designed to say thank you to all the staff who participated in the week's activities. Fig 2 below.

Fig 2

it's not difficile

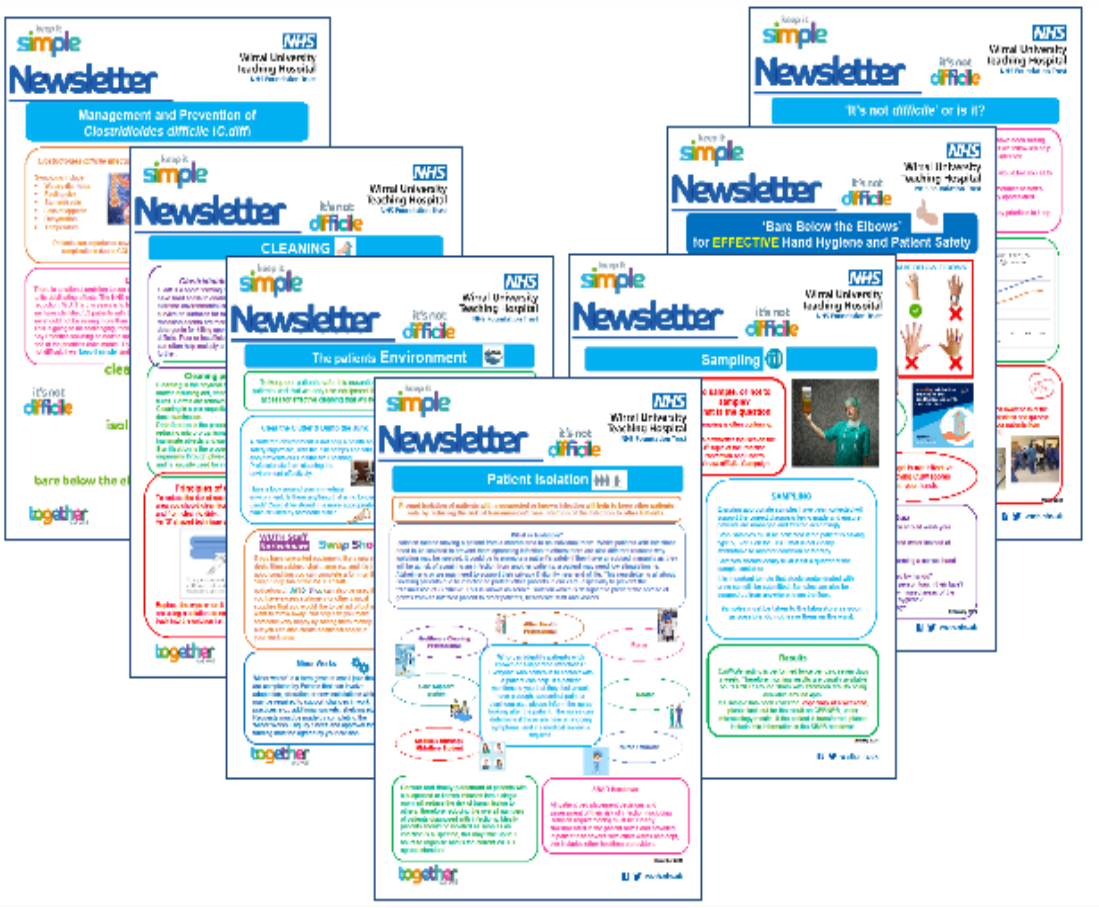
The IPC ***'it's not difficile'*** campaign was launched in October 2023 to support a reduction in *Clostridioides difficile* with a focus on 5 key priorities:

- Cleaning – providing a high standard of cleanliness.
- Environment – maintaining a safe and clutter-free environment.

- Isolation – promptly isolating patients
- Sampling – ensuing appropriate samples are collected to support diagnosis and management.
- Bare below the elbows – to ensure effective hand hygiene.

One priority was promoted each month with a focused newsletter (as illustrated in Fig 3 below) and weekly messages included in the weekly bulletin, which were promoted by the IPC team when they visited wards / departments and spoke with staff.

Fig 3



Health and Safety Awareness Week at the end of October 2023 was supported by the IPCT who provided virtual sessions on Microsoft Teams for Sharps Safety and Personal Protective Equipment.

13.0 Audit

13.1 <u>Audit programme for 2023/24</u>

The audit programme continued to focus on key policies which aim to prevent Health Care Associated Infection (HCAI), based on the Health and Social Care Act (2015).

13.2 IPC Environmental audit

The IPC Environmental Audit programme is aligned the with Wirral Individualised Safe Care Every time (WISE) Accreditation Plan. During 2023-24, 76 wards and departments had an IPC Environmental Audit undertaken, an increase of 9 from last year. In addition, 20 areas were audited more than once during the year. If a ward scores below 70% (red) a reaudit will be undertaken within 3 months, if a ward scores between 70% and 89% (amber) a reaudit will be undertaken within 6 months if capacity / workload permits. The Senior Nurses within the Divisions also undertake regular audits to ensure there is improvement, and when a green score is achieved, this is maintained. A monthly report is provided to IPCG with progress to date as well as the audit scores from the Divisional audits. Exceptions to the standards are captured in action plans which are managed locally by the Divisions and reported via their monthly IPC Divisional meeting. Table 25 below is a breakdown of the ward category scores by Division for 2023-24

Table 25

Division	Green	Amber	Red
Medicine	8	14	0
Acute	4	2	0
Surgery	11	6	0
Women's & Children	5	6	1
Clinical Support	0	12	4
Corporate	0	3	0
Total	**28**	**43**	**5**

13.3 Hand Hygiene Audit

The Hand Hygiene audit in Tendable All wards / clinical departments are expected to undertake weekly hand hygiene audits using the Tendable hand Hygiene Audit, which are increased to daily during an outbreak or increased incidence of infection.

The IPCT have also undertaken quarterly hand hygiene audits, however these have been recorded manually on paper so a comparison with the ward-based audits from Tendable can be done. The results have been submitted to IPCG and provide a breakdown of staff groups for the Divisions to review and act accordingly. The IPC audits demonstrate a more realistic compliance of hand hygiene than is provided by the wards. The IPCT have provided additional support to the auditors to ensure the correct process for auditing is undertaken.

In February 2024 yellow cards (fig 4 below) were developed by IPC with information about being bare below the elbow and the 5 moments hand hygiene, to give to staff who have been seen to be non-compliant.

Fig 4

The aim is to increase awareness and improve compliance.

13.4 Commode audit

Quarterly audits of commodes have been completed by the IPC team, and ad hoc audits are also completed following a patient being diagnosed with *C.difficile* toxin or a CD equivocal result. Audit results are fed back in real time for immediate improvement and reported by the Divisions in their exception report at the monthly IPC meetings.

13.5 Sharps audit

A Sharps Audit was undertaken by WUTH sharps bin supplier 'Daniels' in February 2024. In total 400 sharps containers were audited across the Trust. No bins were found to have protruding sharps, none were more than three quarters full, and all were at the correct height, which is consistent from the previous audit. The following non-compliance was identified.

- 3 (0.75%) containers were not assembled correctly
- 2 (0.5%) containers had mismatched lid and label
- 7 (1.75%) containers were not signed or dated after being assembled
- 6 (1.5%) containers had inappropriate contents
- 19 (4.75%) containers did not have the temporary closure in place when left unattended

The audit findings have been shared with the Divisions to action, and with the Health & Safety team.

13.6 WIVAT Audit

A canula audit was led by WIVAT in October 2023 with support from IV Access Team, IPC Team and Clinical Educators. All adult inpatient areas were audited, with 281 peripheral cannulas and 21 deep access cannulas audited.

- 83.1% of cannulas were documented on CERNER, and only 65.9% included who had inserted the cannula.
- 10.6% of cannulas did not have a VIP score recorded in the previous 12 hours.
- 82.8% of the VIP scores recorded matched the auditors VIP score at the time of the audit.
- 81.8% of patient cannulas were date and time labelled.

- 15.7% of cannula dressings were not secured properly or had visible breakthrough bleeding.
- 20.9% of cannula access sites were obscured.
- 94.7% of cannulas had a needle free extension.
- 17% of cannulas were not deemed to be clinically indicated, and 7% had not been used since they had been inserted.
- 98.7% of staff were able to describe the correct ANTT process.

The audit findings have been shared with the Divisions at the IPCG meeting.

13.7 CAUTI Audit

A Trust wide catheter associated urinary tract infection (CAUTI) audit was undertaken in March 2024 by IPC with support from the Divisional Clinical Educators, the Clinical Continence Educator, and some student nurses. In total 149 patients were noted to have an indwelling urinary catheter and were included in the audit. Results can be seen below.

- Urinary catheter prevalence was 19%, this is a decrease from 21% in the previous year.
- 4% patients had been diagnosed with a CAUTI in the previous 7 days: a decrease from 6% in the previous year.
- 95% of catheter insertions were documented; an increase of 75 from the previous year.
- 61% patients had a short-term catheter and 31% had a long-term catheter, it was unknow for the remaining patients.
- Only 13% patients had been given a catheter passport.
- 85% patients had the reason for catheterisation documented in the notes, however 16.5% were for reasons outside of HOUDINI principles.
- 87% patients were still considered to require the catheter at the time of the audit.
- 90% of staff were able to describe the correct ANTT procedure to collect a urine sample.
- 52% patients knew why they had a catheter, 11% did not, and 37% patients were not asked.
- Only 10% patients had been shown how to care for their catheter, 16% had not and 74% were recorded as not applicable or not answered.

The audit report will be shared at the IPCG meeting and recommendations actioned via the Continence Steering Group.

13.8 Other Audits via Tendable app

The following audits are undertaken by the staff on the wards and departments via the Tendable App:

- Personal Protective equipment
- Daily First Impression Audit
- High Impact Interventions (care bundles) for:
    - Central Venous Catheter Insertion
    - Central Venous Catheter ongoing care
    - Peripheral Vascular Insertion

- Peripheral Vascular ongoing care
- Surgical Site Infection Preoperative / Perioperative
- Ventilator Associated Pneumonia ongoing a
- Urinary Catheter Insertion
- Urinary Catheter Ongoing Care
- Chronic Wounds
- *Clostridioides difficile*
- ANTT

14.0 External Assurance Assessments

There have been none related to Infection Prevention & Control during 2023-2024.

15.0 Policy Development

The following policies have been reviewed and updated in 2023-24:

- Infection Prevention and Control Policy
- Pets as Therapy (PAT) and Assistance Dogs Visiting
- Water Coolers and Ice Makers
- Blood Culture Collection Policy

The National IPC Manual for England, an evidence-based practice manual for all those involved in England, was published in April 2022. There have been various updates provided with version 2.9 being the most current, updated in February 2024. WUTH has adopted this guidance and its principles as approved by IPCG. The manual has replaced the following policies:

- Hand Hygiene Policy
- Standard Precautions Policy

A link to the Manual is available on the WUTH Intranet and ensures that the most up to date version is available for staff to access.

The following policy is due to be ratified early in 2024-25:

- MRSA Infection: Control and Prevention

16.0 Infection Prevention & Control Board Assurance Framework

NHSE/I published the first version of the Infection Prevention and Control Board Assurance Framework in 2020. Since this time there have been several published that are updated and refined to reflect the increased learning around COVID-19. The framework, structured around the existing 10 criteria set out in the Infection Prevention Control Code of Practice (2008) that was updated in Dec 2022 to reflect

changes to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and the role of infection prevention and control (IPC) (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance. The new document takes account of changes to the IPC landscape that have occurred since the COVID-19 pandemic and link directly to Regulation 12 of the Health and Social Care Act (2008).

The Trust added one additional criteria of 'leadership' in recognition of the important part that this plays in hospital management arrangements (Table 26).

Table 26

	IPC BAF Standard
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and risks their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial stewardship to optimise service user outcomes to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care, or treatment nursing/medical in a timely fashion.
5	Ensure prompt identification of individuals who are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation precautions and facilities.
8	Provide secure and adequate access to laboratory/diagnostic support as appropriate.
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infection.
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.
11	The Trust can demonstrate effective and knowledgeable leadership in relation to IPC at all levels, relevant to roles.

The reporting arrangements for each version have been via the Infection Prevention & Control Group, into PSQB and the Quality Committee, and onto the Board of Directors.

The 2024/5 version is under review prior to being submitted on a quarterly basis to the ICB as assurance against the NHS standard contract for 2024/25.

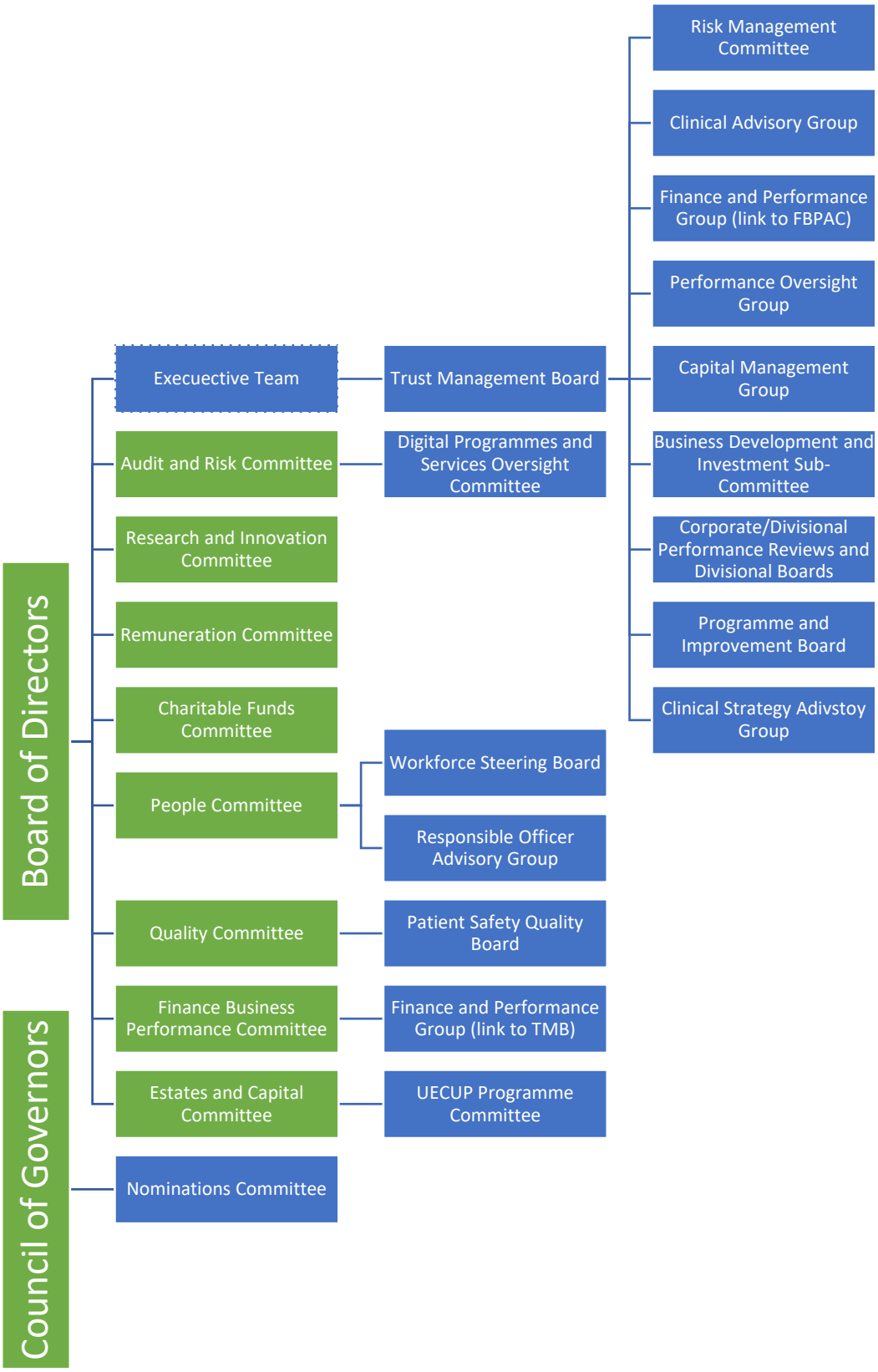
17.0 Conclusion

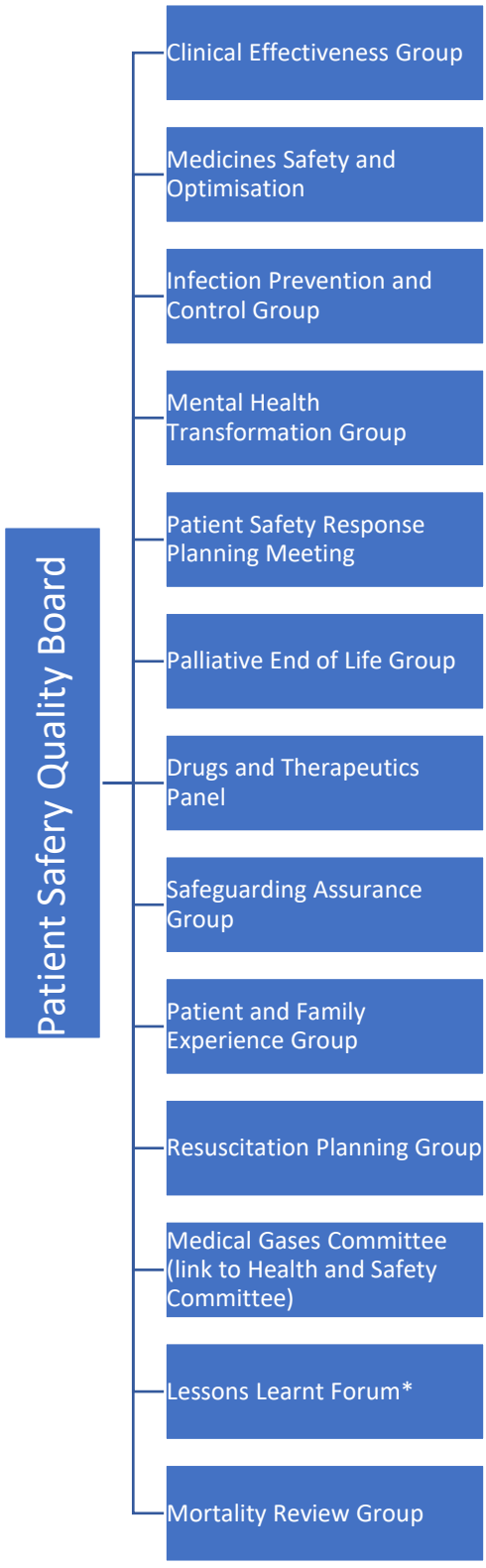
The above report details annual infection prevention & control activities in 2023/24 as reported to the monthly IPCG, it also details the forward Infection Prevention & Control plan for 2024/25. The infection control programme aims to continuously review and build on existing activity, driven by local needs, while incorporating and complying with the latest NHSE/I and UKHSA guidance and other relevant strategies and regulations pertaining to IPC.

Jay Turner-Gardner
Interim Director of Infection and Prevention and Control

APPENDIX 1

Governance Structure




Patient Safety Quality Board
Clinical Effectiveness Group
Medicines Safety and Optimisation
Infection Prevention and Control Group
Mental Health Transformation Group
Patient Safety Response Planning Meeting
Palliative End of Life Group
Drugs and Therapeutics Panel
Safeguarding Assurance Group
Patient and Family Experience Group
Resuscitation Planning Group
Medical Gases Committee (link to Health and Safety Committee)
Lessons Learnt Forum*
Mortality Review Group

APPENDIX 2

Infection Prevention and Control Group
Terms of Reference

1. CONSTITUTION

The Infection Prevention & Control group is authorised to formulate recommendations for Infection Prevention and Control within the Trust and reports to Trust board via the Quality Assurance Committee. The Infection Prevention & Control Group is chaired by the Director of Infection Prevention and Control (DIPC), who is the Chief Nurse. The deputy chair is the Deputy DIPC and/or the Deputy Chief nurse.

2. MONTHLY CORE MEMBERSHIP

- Chief Nurse / Director of Infection Prevention and Control (DIPC) (Chair)
- Deputy Director of Infection Prevention & Control
- Consultant Microbiologist/Infection Control Doctor
- Principal Clinical Scientist – Microbiology/ Infection Prevention and Control
- Occupational Health representative
- Antimicrobial Pharmacist
- Associate Director of Estates, Engineering and Capital Delivery
- Associate Director of Estates, Facilities and Capital Governance and Sustainability
- Head of Soft FM
- UKSHA Consultant for Cheshire and Merseyside
- Divisional Directors of Nursing
- Divisional Governance Leads

CLINICAL LEADS/MEDICAL REPRESENTATION FROM DIVISIONS ON A QUARTERLY BASIS

- Surgery
- Women & Children
- Medicine
- Acute
- Diagnostics and Clinical support

Members of the IPCG are expected to actively participate in discussions pertaining to IPCC ensuring that solutions and action plans have Multidisciplinary perspectives and have considered the impact across all the Divisions and departments.

Members have a responsibility to disseminate the minutes from this meeting within the relevant departments and organisations and inform them of issues discussed.

Members have a responsibility to share the learning gained from IPCG within their divisions and departments to ensure that organisational learning occurs.

Members have a responsibility to Communicate to the IPCG risk issues and solutions discussed in the departments/organisational meetings to support the organisational learning.

3. QUORUM

For decisions taken by the committee to be valid, the meeting must be quorate. This will consist of a minimum of 8 members from the core including the Director of Infection Prevention and control (or nominated deputy) and the Infection Prevention and control Doctor, the Associate Director of Nursing Infection Prevention and Control (or nominated deputy) , and 1 representative from each division.

4. ATTENDANCE AT MEETINGS

The Infection Control Group may require from time to time, the attendance of any Trust employee (or agent of the Trust) to attend the committee at the request of the Chair.

5. FREQUENCY OF MEETING

The Infection Prevention and Control Group will meet every month.

6. OVERVIEW

The Infection Control Group is a subcommittee of the Patient Safety and Quality Board (PSQB) and monitors the Infection Prevention and Control strategic objectives. The 3-year IPC Strategy is agreed by the Trust Board and is based on WUTH organisational priorities. The Trust IPCG oversee and monitor the annual IPC plan in meeting the 3 year Strategy.

7. SCOPE AND DUTIES

Oversee and directs all Infection Prevention and Control activity within the Trust and provide the Chief Executive and trust board with relevant information and advice.

Approve the Strategic plan and interpret and advise on the National Infection Prevention and Control manual.

Provide assurance that the Code of Practice on the prevention and control of infection NHS core standards and Department of Health recommendations on infection prevention and control are implemented.

Receive assurance and escalations that monthly infection surveillance data and performance, including Outbreaks relating to MRSA Blood-Stream Infections, *Clostridioides difficile* Infections, *Klebsiella* Bacteraemia, *Pseudomonas* bacteraemia and *E.coli* bacteraemia are monitored with learning from a review of these cases with appropriate actions being taken within the divisions to prevent further incidence.

Approve Infection prevention and control policies and guidelines that enable implementation of the National Infection Prevention and Control manual.

Advise the Trust on its statutory requirements in relation to Infection Prevention and Control inclusive of the decontamination of medical and surgical devices equipment, e.g., Health Act 2008 and receive assurance as such from the Divisions.

Receive assurance from the divisions that training and supervision systems regarding Infection Prevention and Control is in place for all staff and contractors working within the Trust and that those systems are regularly monitored by their management Teams

Have regard to NICE guideline NG15 (Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use)

Have regard to the Antimicrobial Stewardship Toolkit for English Hospitals.

Support the development of local plans to identify further actions required to meet the requirements of the National IPC Board assurance framework.

Approve the annual infection prevention and control plan and monitor and review progress on a quarterly basis.

8. ORGANISATION

Administration support is provided by the Deputy Director of Infection Prevention and Control's Secretary who organises the meetings and provides minutes.

The Deputy Director of Infection Prevention and Control will on behalf of the DIPC be responsible for the compilation of an agenda prior to each meeting.

A chairs report will be submitted to the PSQB monthly prepared by the Deputy DIPC

A chairs report will be presented from the Decontamination group, Antimicrobial Stewardship group, the Ventilation safety group, Water safety group, the WIVAT group and Monthly Divisional IP&C meetings be exception.

The Terms of Reference for the group will be reviewed every 2 years.

10. VERSION CONTROL

Version Control	Date	Comments
V1	August 2020	

V1.2	November 2022	Reviewed the membership and clarified reporting mechanisms.
V1.3	July 2023	Updated titles of core membership
V1.4	June 2024	To reflect requirements in the NHS standard contract 2024/25

11. DOCUMENT OWNER

Infection Prevention and Control Secretary/Team Administrator

APPENDIX 3

Annual Infection Prevention Audit Programme
2024/2025

Delivery of this audit plan is to support the Trust in meeting its Annual Objectives from the NHS Standard contract 2024-2025. This will be done by

- Reviewing current practices.
- Cross referencing the practices with national guidance i.e., National Infection Prevention and Control manual/National Institute for Clinical Effectiveness
- Supporting the Divisions in identifying areas for improvement to comply with national standards and the patient safety agenda.

	Audit topic	*Frequency*	*Where identified*	*Where reported*	*Responsibility*	*Lead*
1	Hand Hygiene (Compliance & technique)	Wards complete Weekly, inviting IPC at least once per month	IPC Audit plan Division IPC plan Tendable app	Division Governance meetings Monthly Infection Prevention & Control Group meetings Outbreaks PII PSIRF REC	Division	Ward/ Departmental Managers
2	Environmental audit	Annual by IPC as determined by scheduled Tendable audit plan	IPC Audit plan Division IPC plan Tendable app	Division Governance meetings Monthly Infection Prevention Control group meetings Outbreaks PII	IPC and Division	Ward/ Departmental Managers
3	Patient shared equipment	Monthly	IP Audit plan Division IPC plan Tendable app PLACE	Division Governance meetings Monthly Infection Prevention & Control Group meetings Incidence of reported alert organism	Division	Ward/ Departmental Managers
4	Food safety	Monthly	IPC Audit plan Tendable app PLACE	Monthly Infection Prevention performance meetings Division Governance meetings	Division	Ward/ Departmental Managers

5	*'Saving Lives'* care bundles Numbers 1-7	Monthly/as and when required	IPC Audit plan Division IPC plan	Monthly Infection Prevention & Control group meeting Division Governance meetings	Division	Ward/ Departmental Managers
6	Antimicrobial point prevalence audit	Monthly	IP Audit plan Division IPC plan Antimicrobial audit plan	Quarterly to the Monthly Infection Prevention & Control group meeting Division Governance meetings	Pharmacy	Antimicrobial pharmacist
7	External Commode audit	Annual or more frequently	IP Audit plan Division IPC plan	Division Governance meetings Monthly Infection Prevention & Control group meeting On incidence of CDT	Infection Prevention Team	Infection Prevention Team
8	Personal protective equipment	Monthly or more frequently	IP Audit plan Division IPC plan	IP Audit plan Division IPC Plan	Division	Ward/ Departmental Managers
11	Mattress audit	Weekly/after discharge of a patient by the ward. Annual for the whole Trust	Tendable app	Infection Prevention & Control group meeting Division Governance meetings	Division	Ward/ Departmental Managers
12	MRSA screening compliance	Monthly	IPC audit plan	IPCG	Division to comply with policy	Corporate information team to produce report

APPENDIX 4 Infection Prevention Annual Plan 2023/2024

The 2024-2025 IPC annual plan describes the methods that will be used to give assurance to the Board that we are meeting the requirements for the annual IPC quality schedule including

- Provider objectives as set out in the NHS Standard Contract 2024/25
- National Infection Prevention & Control Board assurance framework which provides an assurance structure for boards against which the system can effectively self-assess compliance with the 10 criteria outlined in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

Strategic objective	Action
Objective 1 Training and Education Regulation 12 & 7 (CQC) Criterion 1 (The Hygiene Code)	• Support and contribute to the induction programme and the ongoing learning and development of all levels of Trust staff • Introduce and support Trust wide patient safety initiatives pertinent to IPC i.e., 'Gloves are off' campaign. • Continue with the link nurse programme
Objective 2 Audit & Surveillance	• Complete mandatory surveillance of all alert organisms (Infections) • Complete the annual IPC audit plan on tendable to support W.I.S.E accreditation. • Support further development of the SSI programme, promoting ownership at divisional level of the lessons learnt from the themes identified contributing to infections.

Regulation 9(CQC) Criterion 4 (The Hygiene Code)	• Provide screening data in line with screening policies to promote compliance. • Work in partnership with commissioners/providers across Wirral to reduce the incidents of all alert organisms • Identify Outbreaks / PII's and infection related incidents in a timely manner • Introduce surveillance of multi-resistant organisms
Objective 3 Policies & Procedures Regulation 12 (CQC) Criterion 1 & 9 (The Hygiene Code)	• Develop a Carbapenemase producing *Enterobacteriaceae* (CPE) policy based on national guidance v risk-based benefits to patients. • Ongoing review of the new National IPC manual against WUTH local policies to promote compliance to the manual • Scheduled review of all IPC policies to ensure they reflect national guidance and are current.
Objective 4 Care Environment Regulation 15(CQC) Criterion 2 & 7(The Hygiene Code)	• Appropriate IPC representation at the beginning and throughout all scheme's meetings • Support MDT attendance at facilities efficacy audits. • Develop training tools to support the training needs of the Trusts Healthcare cleaning professionals. • Support the review of current cleaning equipment and solutions to ensure cost effective results
Objective 5 Communication & Information Regulation 17(CQC) Criterion 5 (The Hygiene Code)	• Ongoing review of the IPC patient information leaflets • Work with the communications team to ensure IPC updates are communicated trust wide. • IPC representation at IPC Divisional meetings • Work with information to develop the IPC BI portal.

	• Support the use of data to identify and deliver improvements. • Work in collaboration with the Division governance teams to strengthen how the reporting process of HCAI's and the resulting investigations and findings are shared and what impact any changes have made on practice and quality/patient safety. • Support the completion of the IPC Board Assurance Framework which provides a self-assessment of compliance against the measure set out in the national IPC Manual (2023), the Health & Social Care Act 2028, and other disease-specific IPC guidance issued by UK Health Security Agency.
Objective 6 Research & Innovation Criterion 9 (The Hygiene Code)	• To review and investigate any IPC innovations that can be introduced to support the teams with IPC improvements. • Support the introduction of new technologies. • Work in collaboration with procurement to promote cost effective care delivery. • Support ward led quality improvement projects based on lessons learnt from PSIRF investigations. • Work with Facilities to look at improvements in cleaning solutions and cleaning equipment to deliver a cost effective service
Objective 7 Antimicrobial Stewardship Regulation 12(CQC) Criterion 3 & 9(The Hygiene Code)	• Attendance at local and regional antimicrobial groups • Review antimicrobial practice as part of the CDI PSIRF (REC) programme. • Work in collaboration with the Sepsis group to support local antimicrobial stewardship

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 10**

4 December 2024

Title	Controlled Drug Accountable Officer Report
Area Lead	Chris Green, Director of Pharmacy and Medicines Optimisation
Author	Amy Janvier, Lead Pharmacist Procurement and Medicines Supply
Report for	Information

Report Purpose and Recommendations

This report provides the Board of Directors with an overview of Controlled Drug (CD) activity during 2023/24. It is a national requirement for Trusts to employ a Controlled Drugs Accountable Officer (CDAO) and that the CDAO provides assurance around CD management to Trust Boards or their delegated committee. The Trust CDAO is the Director of Pharmacy and Medicines Optimisation.

CD incidents are monitored in the Trust on a daily basis and incidents of note and trends are escalated to the CDAO. In addition, it is a legal requirement that Wirral University Teaching Hospital NHS Foundation Trust (WUTH) report any incidents or concerns regarding the management of controlled drugs within the organisation to the CD Local Intelligence Network (CDLIN) every quarter. 298 reports of issues involving CDs were submitted in 2023-24. 65 (22%) of the reports were actual incidents where patients received an incorrect medicine, incorrect dose, or a medicine via an incorrect route; 233 (78%) reports were classed as near misses. 8 incidents caused 'low harm' to patients while all other reports were 'no harm'. The Trust is noted by the regional CDLIN to be a high number, low harm reporter indicative of an open reporting culture.

Audits of controlled drugs were undertaken in quarters 1, 2 and 4 during 2023/24. The standards audited relate to CD legislation reflected in the Trust CD policy. Compliance was Q1 98%, Q2 98%, and Q4 95% for 2023/24.

The recommendations from the report will continue to support improvements in compliance with legislation, patient experience and safety, and monitoring of usage trends to highlight potential diversion:

- CD incidents review and trend analysis will continue with actions being implemented to prevent further incidents and any learning from incidents shared
- Ward and department CD audits will continue to be undertaken and presented to MSOP on a quarterly basis. Areas of non-compliance to be cascaded by Matrons to relevant Ward Managers. Divisional Directors of Nursing will be held accountable for improved performance via MSOP.
- WUTH will work with Wirral Place to support the safe prescribing and management of across all areas of Healthcare on Wirral

- Install CCTV cameras across all medicine rooms to discourage diversion of medicines and allow for easier investigation should areas of potential diversion be identified.

It is recommended that the Board:

- Note the report and approve the recommendations

Key Risks
This report relates to these key Risks: • Controlled drugs are potentially harmful medicines if they are not used in a safe and controlled manner. • Controlled drugs are highly susceptible to the risk of diversion as they are potentially abusable, and because of this they also present an opportunity for illicit sale and distribution.

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
November 2024	Quality Committee	As above	As above
July 2024	PSQB	As above	As above

1	**Narrative**
1.1	**Introduction** In accordance with the Controlled Drugs (CDs) Regulations 2013, Wirral University Teaching Hospital NHS Foundation Trust (WUTH) has an Accountable Officer (AO) for controlled drugs who has responsibility for the safe use and management of controlled drugs. The CDAO is the Director of Pharmacy and Medicines Optimisation. It is the CDAO's responsibility to report CD incidents and near misses to the Regional CD Local Intelligence Network (CDLIN). The CDAO must also produce an annual report for the Board of Directors or its delegated committee to provide assurance around the management of CDs within WUTH. During 2023/24, WUTH had 3 areas within the Pharmacy Department holding a wide range of CDs: the Pharmacy Dispensary and Aseptic Unit on the Arrowe Park Hospital site and Central Pharmacy Stores at Clatterbridge. In addition, the pharmacy satellite dispensaries stock gabapentin, pregabalin and tramadol which are schedule 3 CDs. These CDs are to be ordered in a CD order book, have

	additional prescription requirements but are not required to be stored in a CD cupboard. The pharmacy satellites do not stock schedule 2 CDs. CDs are supplied to over 80 wards and departments within WUTH. The Trust holds two Home Office Controlled Drug Licences which permit the supply of CDs to external organisations such as Wirral Hospice St Johns. There is a requirement to meet a range of standards covering procurement, receipt, storage, security, supply and destruction of CDs. These standards are applied across all Trust CD activity and their attainment gives external assurance that CD processes are tightly controlled.
1.2	**Monitoring of CD Incidents and Usage Trends** All incidents are monitored on a daily basis by the Trust Medicines Safety Officer (MSO) and incidents of note and trends including CDs are escalated to the CDAO. In addition, incident numbers are submitted to the CDLIN on a quarterly basis and incidents of note are submitted in real time for review by the CDLIN. There were 298 incidents involving CDs reported across WUTH between April 2023 and March 2024 compared to 211 reported the previous year. CD incident reports continue to show an upward trend (table 1). **Table 1: CD Incidents Reported April 2015 – March 2024**

Financial Year	Number of incidents	Percentage increase on previous year
2023-24	298	↑41%
2022-23	211	↑5%
2021-22	201	↑24%
2020-21	161	↓4%
2019-20	169	↑1%
2018-19	167	↑9%
2017-18	153	↑82%
2016-17	84	↑30%
2015-16	65	-

Figure 1 shows the breakdown of the 298 incidents reported for the 2023-24 year into quarters.

65 of the reports were actual incidents where patients received an incorrect medicine, incorrect dose or a medicine via an incorrect route; 233 reports were classed as near misses. 8 incidents caused ‘low harm’ to patients while all other reports were ‘no harm’. The number of reports is small in the context of the number of CD transactions carried out across the Trust on an annual basis. The Acute Medical Unit for example, carried out almost 12,000 CD transactions per annum and it is estimated that in excess of 200,000 doses of CDs are administered at WUTH each year. WUTH is noted to be a ‘high number, low harm reporter’ (in line with National Reporting and Learning System evidence) and it is considered to be good practice to submit all incidents reported rather than simply those of concern.

Figure 1: 2023-24 CD incident reports by quarter

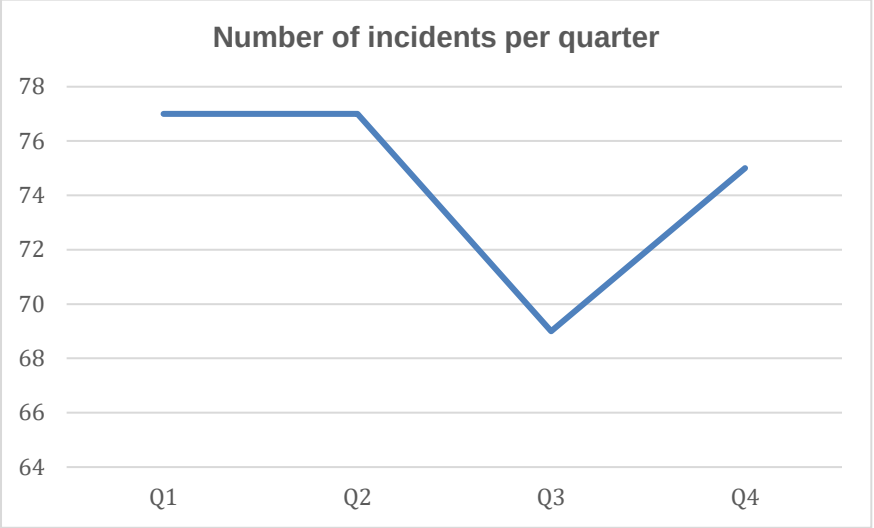
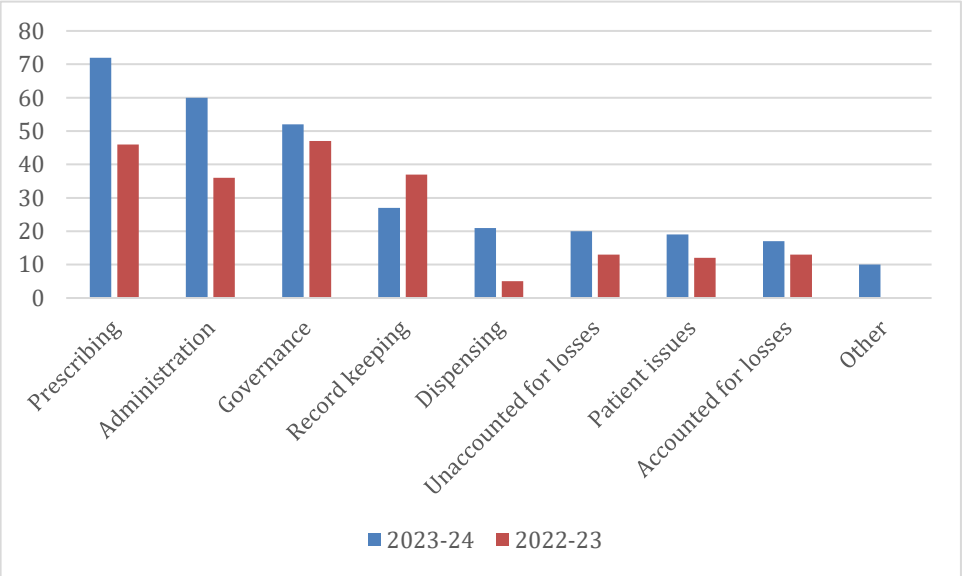


Figure 2 shows the break down in type of incident reported in CDLIN categories for the year 2023-24 compared to 2022-23.

Figure 2: Categories of CD Incidents Reported



279 incidents were reported as no harm or near miss with 19 incidents classified as low harm. ED and AMU were the areas of the trust with the most CD incidents. These are the areas were the majority of the prescribing incidents relating to substance misuse prescriptions occurred.

Figure 3: Regional CD incident reporting

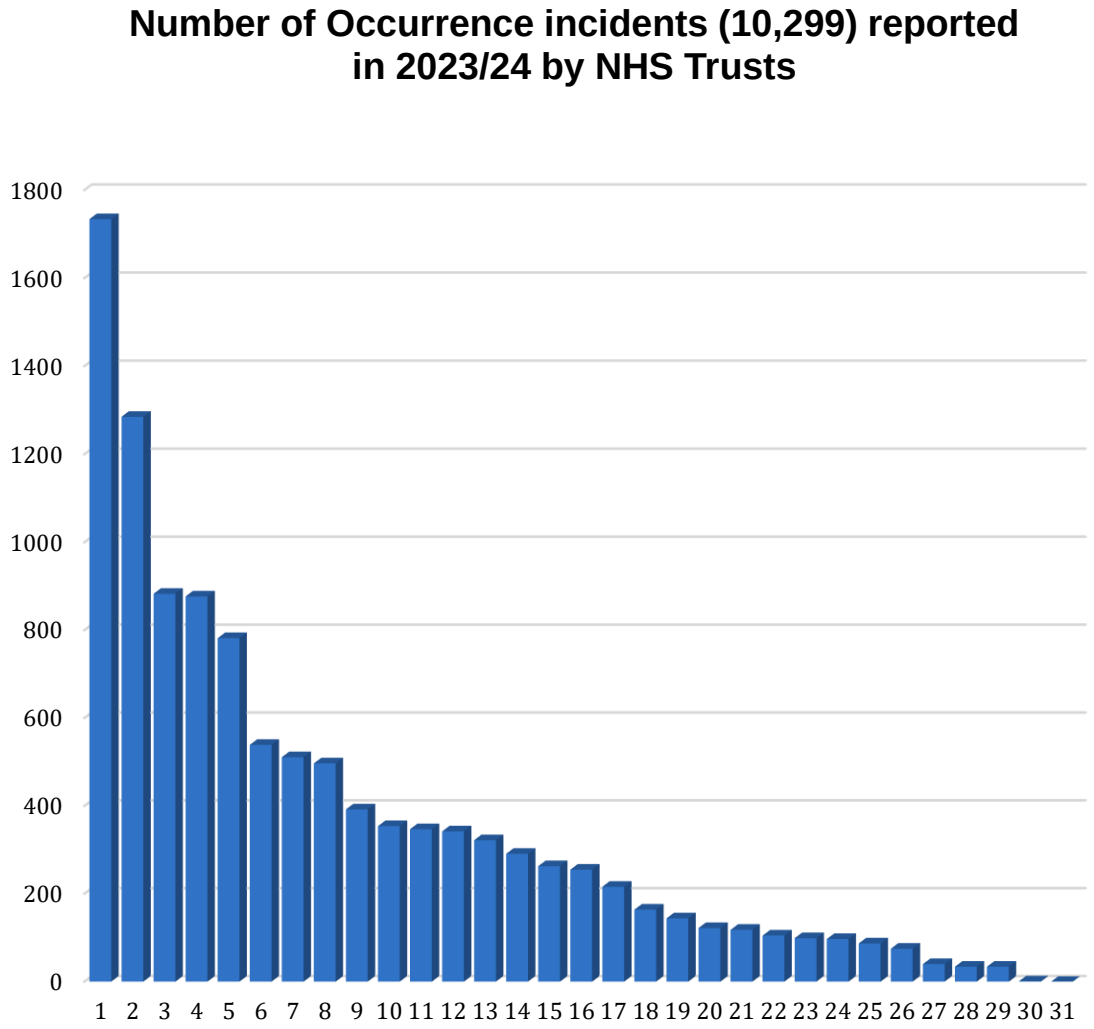


Figure 3 shows the number of incidents relating to controlled drugs reported by 31 NHS Trusts across the NW. WUTH is represented as Trust 14 having reported 291 reports, and is as such, around the middle of the overall group.

Prescribing incidents (n=72) was the most common incident type reported. In 56 of the prescribing incidents patients did not receive any incorrect medicines.

The main theme within the prescribing category was prescribing of methadone or buprenorphine without confirmation or documentation of the patient's usual prescription in line with the trust pathway (n=31). For the majority of patients, the prescription was appropriate but clear documentation of dose confirmation was not completed. Work is ongoing with substance misuse, Wirral Ways to Recovery and admitting clinicians to clarify process and policy.

There were 3 incidents of patients prescribed co-codamol alongside paracetamol with the potential to result in patient's receiving an overdose of paracetamol. Discussions have started with the clinical teams to consider removing co-codamol from use in the trust and change to using separate paracetamol and codeine.

Amendments to Cerner prescribing options have been made following 2 incidents of patients being prescribed and receiving a stat dose of lorazepam when the intention was for lorazepam to only be administered if required in the future for agitation. The

	automatic ‘stat’ prescription has been removed from the lorazepam order sentence. MXL, a brand of 24 hour modified release morphine capsules, has been removed from Cerner to prevent mis-selection of MXL in place of Zomorph which was reported in another prescribing incident. **Administration incidents** (n=60) again demonstrate an increase from 2022-23. Part of the increase can be attributed to incidents involving lorazepam, co-codamol, chlordiazepoxide and oxazepam being identified as CD incidents when in previous years they were not. Administration errors included patients being given the wrong drug, wrong formulation, incorrect doses in particular volumes of liquids or injectable controlled drugs and incorrect patients receiving doses. CD administration errors are identified more frequently than administration errors with other medicines due to the requirement to record doses given both on Cerner and within controlled drug registers. Discrepancies between quantities recorded in CD registers and the physical quantities in the CD cupboards are often traced to an administration error. As in previous years morphine and oxycodone continue to be the drugs most commonly involved in the administration errors reported. Buprenorphine and fentanyl patches being applied to patients without the removal of old patches (n=6) was a recurrent incident. Work has been done on Cerner to prompt nurses to check for old patches prior to application of new patches and nurses have to ‘sign’ on Cerner to acknowledge they have completed this. Nurses involved in administration errors are asked to reflect on any errors made to gain learning for mitigation strategies and were deemed necessary, attend further training. A contributing factor for administration errors has been identified in the AO report since 2016, which is that Cerner does not always fully display the prescription without needing to ‘hover over’ the medicine which means that all of the details are not ‘face up’ and available without this added step. This was a risk register entry at Cerner go live as it conflicts with national guidance requiring electronic prescribing and medicines administration record to have ‘face up’ medicines description. To date, Cerner have not committed to providing a fix for this direct patient safety issue and therefore this remains as a residual risk. Due to the number of prescribing and administration errors involving controlled drugs the Pharmacy Medicine Safety Team have identified opiate incidents as an area in which they are going to open a thematic review into in 2024-25. **Governance incidents** (n=52) include all incidents that have occurred because Trust policy relating to the safe and secure handling of medicines has not been followed. Policies and procedures relating to the management of CDs from delivery into the trust until they are used, disposed of or given to patients on discharge are more extensive than those for other medicines. This is because there is additional legislation that covers CDs and CDs are considered high risk medicines both in terms of clinical use and for risk of diversion. Examples of governance incidents include CDs not locked away in a CD cupboard, CD deliveries not dealt with immediately, leaving CDs in the transport bag, patient’s own CDs found in bedside lockers, expired CDs not removed from ward / department and CD stock checks not completed correctly. The incidents were all scored as no harm and spread across a range of

	wards/departments. No trends have been identified with wards, staff or the products involved. **Record keeping incidents** (n=27) include entries on incorrect pages of the CD record books, CDs not written out of the record books when given to patients on discharge and doses administered not recorded correctly either in the CD record book or on Wirral Millennium. **Dispensing incidents** (n=21) involving controlled drugs were significantly higher than in any year since 2015. During 2023-24 the dispensing service experienced significant pressures in terms of staffing. Each dispensing error is fully investigated and actions undertaken to try to prevent re-occurrence. As a result of investigations CD storage at Arrowe Park and Clatterbridge sites have been reviewed and altered to reduce the risk of mis-selection. Meetings have been held with Wirral Hospice St Johns to review prescription paperwork and processes. In addition, staff are offered additional training and support if it is identified as a need either by the individual staff members involved or by line managers. **Unaccounted for losses incidents** (n=20). Incidents which are originally reported as discrepancies (accounted for or unaccounted for losses) are investigated promptly by pharmacy staff. Mainly these are found to be due to poor documentation or sometimes due to incorrect administration and not actual CD losses. Incident reports of individual tablets or ampoules missing (n=9) are likely to have been dropped or disposed of by mistake, but this cannot be definitively proven. Where losses cannot be accounted for there are no trends or repeat areas and losses tend to be of 1 tablet, capsule or ampoule. There were no repeating areas that raised a concern in this regard during the year. Records of CD losses are maintained, and wards and departments are continually monitored for trends to mitigate the risk of misappropriation. 5 of the unaccounted for losses were oxycodone liquid discrepancies. Oxycodone liquid discrepancies were also identified in pharmacy which is unusual. Upon investigation it was found that the Wockhardt brand of oxycodone had underfilled bottles which could be causing the discrepancies. This was reported to the manufacturer and the MHRA as a medicine defect. **Accounted for losses** (n=17). These incidents include breakages or spillages and when the missing controlled drugs have been found and are accounted for following an initial report of a discrepancy. 6 incidents involved broken alfentanil ampoules across a number of different areas. For one of these incidents the batch number of the ampoules was obtained and this has been reported as a potential defective medicine. **Monitoring CD Usage Trends** The ‘Abusable Drug Investigational Software’ (ADIoS) is used to monitor usage trends of CDs across the Trust including prescribing on FP10 community dispensed prescriptions. Abnormal usage trends are reviewed, investigated by the Lead Pharmacist Procurement and Medicines Supply and any areas of concern are escalated to the CDAO. There have again been numerous movements and re-naming of wards and departments throughout the Trust over the last year. Throughout each

	move/opening/closure the audit trail and security of CDs and CD stationery has been maintained, however it is noteworthy that the moves and changes in specialty / area location makes the monitoring of usage trends in a given area much more difficult. **Misappropriation of CDs by Trust Staff** During 2023/24 there have been 4 investigations opened into potential misappropriation of CDs by staff in the Trust which are currently ongoing. Trust staff attended a NMC Fitness to Practice hearing in May 2023 to give evidence following identification and suspension of a nurse diverting medicines from a WUTH ward. WUTH staff who attended the hearing found the process extremely challenging and did not feel adequately prepared by the NMC and did not realise that additional support might be required from the trust. The experience of giving evidence has been fedback to the NMC and to the CDLIN but no responses were received. The nurse was found to have no case to answer by the NMC but no longer remains on the NMC register.
1.3	**Assurance Audits** **Quarterly Ward/Department CD Stock Checks by Pharmacy Staff** It is a requirement of the Department of Health Safer Management of CDs Guidance that pharmacy staff regularly check records of CD stocks held on every ward or department against their actual stock. The quarterly pharmacy CD audits are in addition to the monthly CD audits matrons complete using the Perfect Ward app. As well as a stock check the pharmacy quarterly ward / department CD checks cover the following areas of practice which are also subject to regulation: • Security of CDs e.g., management of keys and controlled stationary, ensuring daily CD counts have been completed. • Correct documentation in terms of entries and corrections These checks were completed for quarters 1 and 2 in 2023-24. Quarter 3 was not completed due to staffing constraints in the medicines safety team. For quarter 4 the audit has been reviewed and the wider pharmacy team is now involved in the audit alongside matrons to improve involvement. Compliance was 98% in quarter 1 and 2 which maintained the improvements seen across 2022-23. In the quarter 4 audit compliance had dropped to 95%. The drop in compliance was attributed to decline in correct CD register recording in theatres. Additional training sessions have been completed with theatre staff and spot checks have indicated that improvements are being seen. The quarterly audits are supported via regular tendable ward audits which allows immediate non-compliance feedback. **Quarterly CD Stock Checks in the Pharmacy Department** The WUTH Pharmacy Department is also subject to quarterly CD checks in all stockholding areas by a member of pharmacy staff who work in a different area of the department. These were all completed for 2023/24 without any stock discrepancies being noted. Although not a legal requirement, full CD stock checks are being carried out in Arrowe Park dispensary each month in line with the recommendation made by General Pharmaceutical Council Inspector in 2016. In addition, CD stock levels are checked each time a CD is dispensed, or a delivery is

	received into the pharmacy department which ensures stock levels are managed in real time. In addition to the quarterly CD checks other drugs with abuse potential e.g. codeine, zopiclone are counted on a weekly basis and any trends in discrepancies noted and investigated. Expired stock schedule 2 controlled drugs are destroyed in pharmacy with a member of staff who works elsewhere in the Trust delegated by the Accountable Officer in accordance with CD regulations. Arrowe Park and Clatterbridge Pharmacy Departments both hold an Environment Agency T28 (Sorting and denaturing of controlled drugs for disposal) Waste Exemption which allows the Trust to dispose of these medicines in accordance with Waste Legislation. **CQC Self-Assessment** The CQC self-assessment tool is completed annually and was undertaken in March 2024. A RAG rating is used to highlight any areas of CD management which may need improvement. The assessment results were mostly green and comparable to the 2023/24 assessment. All areas pertaining to process and procedures were green. The 3 areas which were red were: • have there been significant CD events in the last year. • have there been incidents involving CD prescribing in the last year. • have there been incidents involving a lapse in CD management in the last year. There have been incidents which fall into the above categories which gives a rating of 'red' for these questions. The incidents concerned were reported via the trust incident reporting system and to the LIN.
1.4	**Changes in Legislation / Policy** The trust's Controlled Drug Policy was updated in January 2024. Additions to the policy included: • Guidance about management of inpatients taking cannabis-based products added. • Access to controlled drugs outside of normal pharmacy opening hours • Patient bedside locker storage of midazolam for catastrophic haemorrhage
1.5	**Controlled Drug Home Office Licence** A CD Home Office Licence is required to allow the Pharmacy Aseptic Unit and Pharmacy Stores at Clatterbridge to supply CDs to external customers. The licence renewal applications were submitted in March 2024. The Home Office CD Annual Returns were completed and submitted in January 2024.

1.6	**CQC Annual Report** The 2022 report was published in July 2023. There were 4 recommendations included within the report: • **Make sure your governance processes are up-to-date and fit for purpose** The information provided in this report provides assurance that WUTH governance processes are up-to-date and fit for purpose. • **Make sure prescribing at transfer of care is completed safely.** Clinicians must have the relevant medical and medication history before prescribing controlled drugs to patients. As previously highlighted prescribing of methadone or buprenorphine without full confirmation of previous prescribing and administration details are per current policy has accounted for the largest number of incidents. Work is being undertaken with WUTH substance misuse team, WUTH clinicians and Wirral Ways to Recovery to review the current policy. • **Know the identity of your local controlled drugs accountable officer (CDAO) and police controlled drugs liaison officer.** Any organisation with a responsibility around controlled drugs must have these details and know how to report controlled drugs incidents. WUTH's police controlled drugs liaison officer has been contacted on multiple occasions to ask for advice and to share information as appropriate about CDs. • **Work collaboratively to improve the prescribing, managing and monitoring of controlled drugs.** WUTH's MSO, chronic pain pharmacist and Associate Director of Pharmacy Clinical Services have been attending the Wirral Place Community of Practice – Opioids and Drugs of Dependence group. This has been set up to promote collaborative working across WUTH, primary care, mental health and local substance misuse teams to improve safety within controlled drug prescribing, managing and monitoring of controlled drugs. • **Make sure you have a valid Home Office controlled drugs licence if you are required to have one.** This involves forward planning to check when licences are due to expire of when a new licence is needed. WUTH has 2 valid Home Office controlled drugs licences which have been successfully renewed.
1.7	**LIN Activity** Following the Shipman report the Cheshire and Merseyside LIN was established and is led by the NHS England Area Team Accountable Officer, Dr Devina Halsall. The

	LIN met virtually four times in 2023/24 and shared information and learning about the prescribing and management of CDs in the local geographical area. The CDAO has a statutory duty to submit quarterly occurrence reports to the LIN with information about any issues identified regarding prescribing or abuse of CDs. Incident occurrence reports were submitted in line with LIN guidance throughout 2023/24.
1.8	**Training** The medicines management induction and mandatory training sessions contain information on opiates as they are a high-risk class of medicines and information on medicine diversion. Induction sessions are attended by all staff starting work at WUTH. Opiate and controlled drug training continues to be provided to F1s and non-medical prescribers. Training is also provided to ward and pharmacy staff.
1.9	**Lessons learned** Actions we have taken - Cerner has been amended as a prompt for patches to be removed - Underfill of oxycodone liquid as a defect has been reported to the manufacturers - Alfentanil batch numbers are being recorded to potentially report repeated breakages as defects - MXL as a brand, has been removed from Cerner to prevent mistaken prescribing - Recruitment and retention of dispensary staff has significantly improved - Lone worker dispensing reduced - Analysis of dispensing errors has resulted in segregation of stock, working with St John's Hospice Actions currently underway, to be completed by 31.12.24 - Review of lorazepam and midazolam on Cerner around stat doses being given when clinical intent is only when patient is symptomatic e.g. fitting - Conversations with substance misuse (non-confirmation of doses prior to prescribing accounted for 31 of the prescribing incidents) - Planned thematic opiate review

2	**Conclusion**
2.1	The management of CDs continues to be monitored by the Trust AO via incidents reported through the Trust incident reporting system and the ADIoS software. The recommendations will continue to support improvements in compliance with legislation, patient experience and safety, and monitoring of usage trends to highlight potential diversion: • CD incidents review and trend analysis will continue with actions to prevent further incidents being implemented and any learning from incidents shared • Ward and department CD audits will continue to be undertaken and presented to MSOP on a quarterly basis. Areas of non-compliance to be cascaded by Matrons to relevant Ward Managers. Divisional Directors of nursing will be held accountable for improved performance via MSOP.

	• WUTH will work with Wirral Place to support the safe prescribing and management of CDs across all areas of Healthcare on Wirral • Install CCTV cameras across all medicine rooms to discourage diversion of medicines and allow for easier investigation should areas of potential diversion be identified.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 11**

04 December 2024

Title	WUTH Charity Annual Report and Accounts 2023/24
Area Lead	Mark Chidgey, Chief Finance Officer
Author	Peter Jardine, Financial Accountant
Report for	Information

Executive Summary and Report Recommendations
This report provides an overview of the 2023/24 Annual Report and Accounts for the Trust's Charity. It is recommended that the Board: • Note the report.

Key Risks
This report relates to these key risks: • No risks identified.

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
25 November 2024	Charitable Funds Committee	As above	Approval

1	Narrative
1.1	**Charitable Funds Annual Report and Accounts 2023/24** The draft annual report and accounts for the Charity were presented to the July meeting of the Charitable Funds Committee for review and comment prior to the commencement of the Independent Examination. The external auditors anticipate issuing an unqualified Independent Examiners Report. A meeting was held on 25 November 2023 to approve the accounts and these will now be submitted to the Charity Commission in accordance with the governance process.

2	Implications
2.1	**Patients** • None
2.2	**People** • None
2.3	**Finance** • None
2.4	**Compliance** • The Charity's Annual Report and Accounts is required to be formally approved and then submitted to the Charity Commission by 31 January 2025.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 12**

04 December 2024

Title	Annual Review of Standing Financial Instructions (SFI's)
Area Lead	Mark Chidgey, Chief Finance Officer
Author	Jillian Burrows, Assistant Director of Finance – Financial Services and Improvement
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is to approve the revisions to the Standing Financial Instructions (SFIs) following recommendation from the Audit and Risk Committee.

It is recommended that the Board:

- Approve the revised SFIs

Key Risks

This report relates to this key risk:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	No
Better quality of health services for all individuals	No
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	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey

Date	Forum	Report Title	Purpose/Decision
November 2024	Audit and Risk Committee	As above	Information

1	Narrative
1.1	The SFIs are reviewed annually and when there is a significant process change that needs reflecting in the document.
1.2	A full review has been completed and the following are the key changes within the document: • Removal of a retrospective requisitions process (section 8). • Inclusion of a breaches process (section 8). • Updating of PCR 2015 threshold values (Scheme of Delegation and Financial Limits). • Inclusion of a Deputy CFO delegation limit for the sign off of losses ≤ £1,000 (Scheme of Delegation and Financial Limits).
1.3	As previous discussed at the Audit and Risk Committee, the inclusion of breaches replaces the process for retrospective waivers. Any requisition that is raised after receipt of goods and services is now deemed to be a breach of SFIs.
1.4	Other changes include: • Removal of references to controlled stationery. • Updating of references to supporting NHSE information i.e. costing guidance. • Updating of references to other policies. Minor narrative changes have also been made to the document.
1.5	An informal exercise was completed across Cheshire and Merseyside to compare procurement thresholds. The Trust's requirement for a formal tender above £30k inclusive of VAT is the lowest of the 14 respondents, the most common threshold being £50k plus VAT. Given PCR2015 changes to PA23 Regulations from 1 February 2026 and changes have been brought about because of the Provider Selection Regime 2023, no changes to the Trust's thresholds are currently proposed.

2	Implications
2.1	**Finance** • The SFIs ensure that expenditure has been committed appropriately, with the correct level of scrutiny and authorisation in place.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 13**

04 December 2024

Title	Annual Review of Terms of References
Area Lead	David McGovern, Director of Corporate Affairs
Author	James Jackson-Ellis, Corporate Governance Officer
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is to provide the final Terms of References for approval for Board Assurance Committees following the annual review. All major amends are highlighted on the appended documents.

It is recommended that the Board:

- Approve the Terms of References

Key Risks

This report relates to these key Risks:

- The Trust should ensure that there is robust governance processes and documentation in place to support effective decision making and delivery of objectives.

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

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

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

August 2024	Finance Business Performance Committee	Draft Committee Terms of Reference	Approval
September 2024	Research and Innovation Committee	Draft Committee Terms of Reference	Approval
September 2024	People Committee	Draft Committee Terms of Reference	Approval
September 2024	Audit and Risk Committee	Draft Committee Terms of Reference	Approval
October 2024	Estates and Capital Committee	Draft Committee Terms of Reference	Approval
November 2024	Charitable Funds Committee	Draft Committee Terms of Reference	Approval
November 2024	Quality Committee	Draft Committee Terms of Reference	Approval

1	Narrative
1.1	**Terms of Reference** An annual refresh has been undertaken on the Terms of References for Board Assurance Committees. These were provided to each Committee for feedback and all the requested amendments have been made. The Board are asked to approve the appended Terms of Reference. As with all other Terms of Reference, these will continue to be live documents and will be reviewed annually in line with good governance practice. The Terms of References will also be uploaded the website.

2	Implications
2.1	Clear terms of reference will support effective decision making and good governance.

Wirral University Teaching Hospital NHS Foundation Trust

Finance Business Performance Committee Terms of Reference

Document Owner: David McGovern, Director of Corporate Affairs
Related Documents: **Corporate Governance Manual (including Scheme of Reservation and Delegation and Standing Financial Instructions)**

Review Date: October 2025
Issue Date: October 2017
Version: 5.0
Authorisation Date: December 2024

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to seek assurance about the Trust's financial and operational performance, delivery of the in-year plans and the development of future plans within the context of the requisite licence regulatory requirements, statutory obligations, and Trust strategy.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individual authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Financial Management and Assurance

3.1.1 To review the adequacy of the budget setting process and assumptions at Divisional and Corporate Services Level ahead of recommending the financial plan to the Board for approval.

3.1.2 To review the Trust's Financial Plan in accordance with agreed timescales and in line with the Trust's strategic objectives, making appropriate recommendations to the Board of Directors.

3.1.3 Consider the robustness of the M12 and year-end out turn ahead of review of the Annual Accounts by the Audit and Risk Committee to provide assurance on the reliance of these.

3.1.4 To review and recommend business, operational, and financial plans to the Board of Directors.

3.1.5 To seek assurance of effective due diligence in respect of business cases, including alignment to Trust strategies, approving those within the financial limits delegated and referring those in excess of delegated limits to the Board with recommendations. The limits currently set out in the Standing Financial Instructions, as approved in October 2022 are:

- Approval of revenue only business cases: up to £250k
- Approval of Capital or leave business cases within Board approval capital programme: up to £1m
- Approval of capital or lease business cases from contingency funds: up to £250k

3.1.6 To consider future options for all non NHS income with specific reference to private patient income and ensure that income derived from activities related to the Trust's principal purpose of the NHS meets the limits as set by national governing bodies.

3.1.7 To review, monitor and seek assurance on the achievement of value for money through use of benchmarking data, including reference costs and the work of the model hospital.

3.1.8 To monitor and seek assurance on provider to provider and third party contractor SLA's that present a material risk to the organisation.

3.1.9 To review and seek assurance on the development, implementation, and clinical engagement in the Service Line Management (SLM) process through Divisional representation.

3.1.10 To seek assurance on the Trust overall cash management position

3.1.11 Review proposed new investments, undertake due diligence, and make recommendations to the Board for approval in line with scheme of delegation.

3.2 Performance and Improvement

3.2.1 To monitor the operational financial performance and agree, as necessary, corrective action.

3.2.2 To instigate investigation into any aspect of performance that gives cause for concern, providing exception reports to the Board of Directors.

3.2.3 To monitor and seek assurance on compliance with the Agency Cap focussing particularly on recurrent risks and resource utilisation.

3.2.4 To review, monitor and seek assurance on the financial performance of the Trust including, income, expenditure, activity, oversight framework metrics and contract performance ensuring that actions are taken as necessary to remedy adverse variation.

3.2.5 To monitor the implementation of the Trust efficiency programme, and to receive assurance that any potential impact of that programme has been risk assessed with mitigations identified. Any areas of impact that are considered a concern may be referred to another relevant Board Committee for further assurance.

3.2.6 To monitor delivery and seek assurance of the CIP.

3.2.7 To review and seek assurance on the capital programme and expenditure as required.
3.2.8 To monitor delivery and seek assurance of digital healthcare performance.

3.3 Strategy

3.3.1 To review the Trust's Finance Strategy, recommending it to the Board of Directors for final approval, and to seek assurance that the associated areas of the annual operational plan actions are being implemented.

3.4 Risk

3.4.1 To review any areas of specific risk or assurance highlighted within the Board Assurance Framework and make recommendations for amendment if required.
3.4.2 Receive assurance on all aspects of the effective outturn delivery of financial, specified operational performance targets and significant variances to planned levels of achievement.
3.4.3 Review or undertake a "Deep dive" into areas of concern raised by the Board at the preceding meeting with a view to providing assurance to a subsequent Board meeting.

3.5 Governance

3.5.1 To review and seek assurance on compliance against relevant legislation.
3.5.2 To consider and seek assurance on the implementation and compliance of relevant national guidance, including directives from NHSI, CQC, DHSC, and national and local commissioning guidance where these have a new or significant financial impact on the Trust.
3.5.3 To approve the establishment, work plans, duration and ensure the effectiveness of Groups reporting to the Committee.
3.5.4 Ratify and review policies required for effective management of financial, performance and business development practice across the Trust.

The Committee will promote a holistic approach to managing risk that will encourage all staff to integrate the management of finance into achieving their objectives in order to provide safe, effective, timely and efficient care to patients.

The Committee Chair and Chief Finance Officer will work with the Executive Management Team and Board to integrate clinical, financial, and organisational governance and risk management processes and systems.

The Committee will work with other Committees including the Audit and Risk Committee to provide assurances required to support the Annual Governance statement.

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Nominated Non-Executive Director (Chair)

- Two additional nominated Non-Executive Directors
- Chief Finance Officer (Nominated Deputy – Deputy Chief Finance Officer)
- Chief Operating Officer (Nominated Deputy – Deputy Chief Operating Officer)
- Chief Strategy Officer (Nominated Deputy – Deputy Chief Strategy Officer)

6. Attendance

Meetings of the Committee may be attended by:

- Deputy Chief Finance Officer
- Chief Information Officer
- A senior clinical representative e.g., the Medical Director or Chief Nurse, or their deputy.
- A Governor to observe

Other officers of the Trust will be invited to attend as requested by the Committee.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend, they should consider sending a designated nominated deputy.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance, they will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be four members, to include two Non Executive Directors, and the Chief Finance Officer (or Nominated Deputy).

The Committee shall meet as needed and at least 4 times annually.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

The Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

10. Conduct of Meetings

The agenda and supporting papers will be sent out four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers must use the standard template and indicate the purpose of the paper – e.g., decision, discussion, assurance, approval.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

The Committee shall review its collective performance each year.

12. Review

The terms of reference of the Committee shall be reviewed at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Research and Innovation Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Research and Innovation Strategy 2021-2026** **Research Policies and SoPs** **UK Policy Framework for Health and Social Care**

Review Date: September 2025
Issue Date: October 2022
Version: 2.0
Authorisation Date: December 2024

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to ensure effective governance in respect of Research and Innovation activity across the Trust.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives and Duties

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 The primary purpose of the Committee is to drive, promote and support both the research and innovation cultures across the Trust and to ensure strong governance in line with relevant frameworks, policies, procedures and guidelines.

3.2 The Committee is responsible for developing and fostering a close and meaningful relationship between research activity and clinical practice. To this end, the core purpose of the committee is to create an environment across all parts to the Trust to support excellent clinical delivery and promote a culture of service innovation and evidence-based practice.

3.3 The Committee will lead decision-making regarding overall responsibility for research including sponsorship, study prioritisation and resolution of barriers to delivery.

The Committee will undertake the following duties:

3.4 **To develop, review and update the strategic direction and business planning for research and innovation by:**

3.4.1 Leading, contributing, and supporting the delivery of the Trusts strategic objectives, priorities and ambitions;

3.4.2 Developing and delivering the research and innovation strategy, promoting, and establishing collaborative relationships with universities, NHS partners, research and innovation networks and other key stakeholders such as social care and service user and carer groups;

3.4.3 identifying and reviewing changes in legislation and policy or guidance that impacts on the local delivery and management of Research and/or Innovation;

3.4.4 ensuring that service users/carers are involved with research and innovation activities;

3.4.5 monitoring outcomes arising from research and innovation carried out within the Trust and support the integration of findings, outcomes, R&I intelligence into business planning for clinical and corporate divisions;

3.4.6 overseeing, reviewing, and steering research and innovation finance and funding including management of any Research and Innovation fund;

3.4.7 embedding research and innovation at every level of the organisation.

3.5 **To develop and promote NIHR portfolio research by:**

3.5.1 monitoring the Trust's performance against DHSC high level objectives and regional metrics the NIHR high level objectives, including recruitment to portfolio studies;

3.5.2 providing infrastructure to support grant applications primarily for (but not exclusively) NIHR grant applications;

3.5.3 ensuring the communication of key messages regarding the importance of research and innovation as a routine part of clinical practice;

3.5.4 ensuring that a research advice and support service is provided to all Trust staff as required and contributes to new and innovative ways to support research and research related activity.

3.6 **To oversee and direct the activities which support the development of a research into action culture, bringing research and clinical application closer. Activities include:**

3.6.1 ensuring information is widely available regarding all research undertaken within the Trust;

3.6.2 ensuring that headlines from research, evaluation, and research related activity are regularly publicised, to include early findings, progress, and final outcomes;

3.6.3 profiling good practice regarding service improvements based on research findings;
3.6.4 ensuring that the library service resource is fully utilised to enable research application in clinical practice.

3.7 **To oversee and coordinate the activities relating to the development and promotion of innovation within WUTH. These activities will include:**

3.7.1 distributing and maintaining a Trust innovations framework and associated guidance;
3.7.2 developing regular communications to WUTH staff members to ensure they are aware of how to submit ideas and how to apply for innovation funding;
3.7.3 linking with individual staff, teams and/or service areas to generate and prioritise innovative ideas which align to the Trust objectives or which are designed to solve problems which have been identified in our clinical settings;
3.7.4 establishing WUTH as a leading organisation for innovation through a variety of methods e.g. networking, relevant event attendance, hosting of conferences;
3.7.5 identification of potential collaborative partners through external networks.

3.8 **To assure high robust management and governance of research and innovation:**

3.8.1 develop, monitor, and regularly review the Trust's Research and Innovation policies and procedures;
3.8.2 ensure that other research-related policies, guidelines, and standard operating procedures are developed and ratified as and when necessary;

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- A Non Executive Director (Chair)
- 3 other Non Executive Directors
- Medical Director (Nominated Deputy – Deputy Medical Director)
- Chief Strategy Officer (Nominated Deputy – Deputy Chief Strategy Officer)

Where members are unable to attend, they should send a designated nominated deputy.

6. Attendance

Attendance (in a non-voting capacity) will also be expected from the following members of the Trust:

- Deputy Medical Director
- Clinical Director for Research
- Research and Innovation Manager

Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.

Governors may attend to observe.

Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance, he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

A quorum shall be at least two Non-Executive Directors (including the Chair or Deputy Chair) and one Executive Director.

Meetings shall be held as required but not less than four times per year. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

The Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

10. Conduct of Committee Meetings

The agenda and supporting papers will be sent out four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the Board's annual performance review process, the Committee shall review its collective performance each year.

12. Review

The terms of reference of the Committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital NHS Foundation Trust

People Committee
Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: September 2025
Issue Date: December 2018
Version: 5.0
Authorisation Date: December 2024

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors in order to ensure effective governance in respect of the delivery of the People Strategy and other workforce-related initiatives, and the strategic monitoring of people-related issues, including medical education. The Committee will also seek assurance that the Trust has robust systems and processes to deliver a positive working environment to in turn deliver safe and high quality patient care.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk and Assurance

3.1.1 To monitor internal workforce performance indicators on behalf of the Board of Directors and report to the Board via the integrated performance report and on an exception basis;
3.1.2 To monitor and review the risks associated with the people agenda, workforce issues, and strategy as set out in the BAF, and recommend any new risks to the Board for inclusion;
3.1.3 To monitor progress on the Internal Audit Report actions that are relevant to workforce – related risks and provide progress updates to Audit and Risk Committee.

3.2 Strategy and Policy

3.2.1 To inform the direction and priorities for the development of workforce strategies, including approval of the Trust's People Strategy and monitoring its effectiveness on an ongoing basis.
3.2.2 To review reports relating to staff engagement and employee voice, including annual staff survey report, against the Trust's People Strategy, monitor progress and outcomes, and advise the Board.
3.2.3 To influence and drive improvements across the integrated workforce agenda, working with our partners across health and social care.

3.3 Regulation

3.3.1 To receive and monitor the implementation of Equality and Delivery statutory delegations under the single Equality Duty (2011). These include annual review of the Equality Delivery system, Equality Duty Assurance Report, Workforce Race Equality Standard (WRES) and other relevant reports. The Committee is to act as the Trust's champion for all workforce-related Equality and Diversity issues.
3.3.2 To receive any relevant reports as required by guidance or regulation.

3.4 Workforce

3.4.1 To oversee and monitor the evolution of a positive, forward thinking, people-focused culture in the Trust, including the embedding of just and learning culture principles. This will include consideration of the experiences of our staff and how we engage with them and will be underpinned by a focus on Trust values.
3.4.2 To oversee the development of workforce safeguards

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Non-Executive Director (Chair)
- 2 other Non- Executive Directors
- Chief People Officer (Nominated Deputy – Deputy Chief People Officer)
- Chief Nurse (Nominated Deputy – Deputy Chief Nurse)
- Deputy Medical Director – Professional Standards

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend, they should send a designated nominated deputy.

6. Attendance

Meetings of the Committee may be attended by:

- Medical Director
- Deputy Chief People Officers
- ~~Equality and Diversity Lead~~
- ~~Assistant Director of OD~~
- ~~Director of Communications and Marketing~~
- Head of People Experience
- Head of Learning and Organisational Development
- Head of HR
- Head of Occupational Health and Wellbeing
- Head of Employment Services
- Governor Representative

The Committee may invite other persons to attend a meeting as required, and the Chair will be informed of these additions where possible prior to the meeting.

7. Conflicts of Interest

Not withstanding the definition of material interests applicable to Directors as set out in the constitution, Executive Directors may not take part in any discussions or decisions which pertain to their own employment or performance.

It will be for the Chair of the Committee to determine whether or not it is appropriate for Directors to be in attendance to advise on these matters. In such circumstances where that person is in attendance, he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be a minimum of three members, including two Non-Executive Directors, and the Chief People Officer (or their nominated deputy).

Meetings shall be held as necessary and at least 4 times annually. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

The Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

10. Conduct of Committee Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the Board's annual performance review process, the Committee shall review its collective performance each year.

12. Review

The terms of reference of the Committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Audit and Risk Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: September 2025
Issue Date: April 2014
Version: 5.0
Authorisation Date: December 2024

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to ensure effective governance in respect of annual reporting, strategic risk oversight, and the amendment of governance documents. The Committee will also seek assurance that the Trust has robust systems and controls in place via an internal and external audit programme.

The Committee is a Non-executive Committee of the Board and has no powers other than those specifically delegated in these Terms of Reference.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The role of the Committee will be to take a wide responsibility for the overarching scrutiny for the Trust's risk and assurance structures and processes which affect all aspects of the Trust's business.

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Governance, Risk Management, and Internal Control

3.1.1 To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. This includes reviewing the effectiveness of the organisation's committee structure.

3.1.2 To review the adequacy of all risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

3.1.3 To review the adequacy of underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.

3.1.4 To review the adequacy of policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification.

3.1.5 To review the integrity of the statutory financial statements of the Trust and any formal announcements relating to the Trust's financial performance, reviewing statutory financial reports and judgements contained therein.

3.1.6 To review on behalf of the Board of Directors the operation of, and proposed changes to the Governance manual including standing financial instructions, scheme of delegation, the constitution, codes of conduct and standards of business conduct, including maintenance of registers.

3.1.7 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

3.1.8 To monitor and seek assurance on compliance against the procurement strategy.

3.1.9 To monitor and seek assurance on the digitalisation agenda, along with the controls in place specifically relating to digital controls and cyber security.

3.2 Internal Audit

3.2.1 The Committee shall ensure that there is an effective Internal Audit function established by management, which meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

3.2.2 This will be achieved by:

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;

- review and approval of the Internal Audit charter, strategy, audit operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework;
- consideration of the major findings of internal audit work, management's response, and progress on the implementation of recommendations;
- ensuring co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring adequate independent assurances are provided; and
- annual review of the effectiveness of internal audit.

3.2.3 The Committee will involve the Chief Finance Officer in the selection process of the Internal Auditor.

3.2.4 The internal auditors will have a right of access to the Chair of the Audit and Risk Committee.

3.3 External Audit

3.3.1 To make a recommendation on behalf of the Committee to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor. To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

3.3.2 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.

3.3.3 To assess the external auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

3.3.4 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor.

3.3.5 To review external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

3.3.6 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

3.3.7 To receive a statutory report and opinion on the annual report and accounts.

3.4 Counter Fraud

3.4.1 To review the adequacy of policies and procedures for all work related to counter fraud and as required by NHS Counter Fraud Authority, as well as reviewing the outcomes of counter fraud work.

3.4.2 To review the adequacy of annual plans / reports from the Local Counter Fraud Specialist and the Local Security Management Specialist.

3.4.3 To satisfy itself that the organisation has adequate arrangements in place for countering fraud and reviewing the outcomes of counter fraud work.

3.5 Other Assurance Functions

3.5.1 The Committee shall review the findings of other assurance functions, both internal and external to the organisation, and consider any governance implications.

3.5.2 These will include, but will not be limited to, any reviews by Department of Health arms length bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.).

3.5.3 To ensure the effective use of the Board Assurance Framework to guide the Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions and reports and assurances sought from Directors and managers and other investigatory outcomes so as to fulfil its functions in connection with these terms of reference.

3.5.4 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health sector and professional bodies with responsibilities that relate to staff performance and functions.

3.5.5 In addition, the Committee will work closely with the other Committees and be informed particularly on the work of risk through regular updates from the Risk Management Committee.

3.5.6 The Committee will review on an annual basis the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

3.6 Annual Accounts Review

3.6.1 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity, and accuracy. At this time the Committee will also receive the Annual Report which summarises the outcome of the external audit. This review will cover but is not limited to:

- The rigour with which the Auditor has undertaken the audit;
- the meaning and significance of the figures, notes and significant changes;
- areas where judgment has been exercised;
- changes in, and compliance with, accounting policies and practices;
- explanation of estimates or provisions having material effect;
- the schedule of losses and special payments;
- any unadjusted statements;

- any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved; and
- letter of representation.

3.6.2 To annually review the accounting policies of the Trust and make appropriate recommendations to the Board of Directors.

3.6.3 To review the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee before they are submitted to the Board of Directors to determine completeness, objectivity, integrity, and accuracy.

~~3.6.4 The Committee will also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.~~

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Non-Executive Director (Chair)
- 2 other Non-Executive Directors

Members will be appointed by the Board from amongst the Non-Executive Directors of the Trust (excluding the Chairman) and at least one member shall have recent and relevant financial experience.

The composition of the Committee should be given in the Trust's Annual Report.

6. Attendance

Attendance (in a non-voting capacity) will also be expected from the following members of the Trust:

- Chief Finance Officer (Nominated Deputy – Deputy Chief Finance Officer)
- Director of Corporate Affairs
- A Governor to observe

Other senior managers will attend when they have papers to present or when the Committee is discussing areas of risk or operation that are the responsibility of that Director/officer.

The Chief Executive will be invited to attend, at least annually, to discuss with the Audit and Risk Committee the process for assurance that supports the Annual Governance Statement.

Attendance is also anticipated from Internal and External Auditors and the Local Counter Fraud Specialist.

The Director of Corporate Affairs will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include taking minutes of the meeting and providing appropriate support to the Chairman and Committee members.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where non-voting members are unable to attend, they should send a designated nominated deputy.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance, he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

A quorum shall be two members.

Meetings shall be held as required but not less than four times per year. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

The Internal or External Auditors may request additional meetings if they consider such a meeting necessary.

Both the Internal and External auditors shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Executive Directors present.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

The Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

The Trust's Annual Report shall include a section describing the work of the Audit and Risk Committee in discharging its responsibilities.

10. Conduct of Meetings

The agenda and supporting papers will be sent out four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the Board's annual performance review process, the Committee shall review its collective performance each year.

12. Review

The terms of reference of the Committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital NHS Foundation Trust

Estates and Capital Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: October 2025
Issue Date: October 2020
Version: 4.0
Authorisation Date: December 2024

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to seek assurance with regards to the design, development and delivery of the Trust's capital programmes, and health and safety monitoring and compliance.

This includes the financial and operational delivery of capital programmes and development of future capital and estates plans, within the context of the requisite licence regulatory requirements and statutory obligations. This is a Non-Executive chaired committee.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to cooperate with any reasonable request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources within the delegated limits of the Committees members.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1 Risk and Performance

3.1.1 To receive, monitor and seek assurance on risks relating to capital, estates, and estates related safety management, as set out in the BAF and in accordance with the Risk Management Strategy.
3.1.2 To review the policies and risks associated with estates and capital related to maintenance, health and safety, fire, security, and other related areas.
3.1.3 To receive audit reports and action plans as relate to capital and estates management areas.
3.1.4 To agree a set of key performance indicators for the assessment of capital programmes, estates delivery, and health and safety compliance.
3.1.5 Review or undertake a "Deep dive" into areas of concern raised by the Board at the preceding meeting with a view to providing assurance to a subsequent Board meetings.

3.2 Estates Management

3.2.1 Ratify and review policies required for effective management the estates function and compliance across the Trust, and where appropriate delegate responsibility for this to associated groups and respond to requests which come from those groups.
3.2.2 To review the Trust's Estates Strategy, recommending it to the Board of Directors for final approval, and to seek assurance that the associated areas of the annual operational plan actions are being implemented.
3.2.3 Approval of the Campus Master Plans and strategies for estates and capital
3.2.4 To keep under review the land holdings of the Trust, advise the Board on acquisitions and disposals, and monitor progress against schemes.

3.1 Health and Safety

3.1.1 Ratify and review policies required for effective management the health and safety across the Trust, and where appropriate delegate responsibility for this to associated groups and respond to requests which come from those groups.
3.1.2 To approve the Trust's Health and Safety plan, recommending it to the Board for final approval.
3.1.3 To consider any findings of major investigations of internal control over safety critical matters, as delegated by the Board or on the Committee's initiative and management's response.
3.1.4 To review the effectiveness of the Trust's frameworks for and to provide scrutiny of occupational health and safety compliance, safety outcomes and achievement of KPI's, safety culture and staff experience/ satisfaction in relation to workplace safety, and any compliance disclosure made or to be made by the Board.

3.2 Capital Programme

3.2.1 Review proposed new developments and investments, undertake due diligence, and make recommendations to the Board for approval in line with scheme of delegation.
3.2.2 Ratify and review policies and procedures required for effective management of capital programme.
3.2.3 Receive assurance on all aspects of the delivery of capital programme and significant variances to planned levels of achievement.
3.2.4 To monitor the development of capital commercial opportunities across the Trust.
3.2.5 To monitor and review business cases associated with major and minor capital developments, and to approve as necessary those business cases that fall within the capital budget.
3.2.6 To approve and recommend to the Board the strategy for capital works, and to monitor the implementation of the capital strategy and annual capital plan.

3.2.7 To monitor capital delivery against plan.

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in all areas it touches.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Nominated Non-Executive Director (Chair)
- Three additional nominated Non-Executive Directors
- Chief Executive
- Chief Finance Officer (Nominated Deputy – Deputy Chief Finance Officer)
- Chief Operating Officer (Nominated Deputy – Deputy Chief Operating Officer)
- Chief Strategy Officer (Nominated Deputy – Deputy Chief Strategy Officer)

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend, they should send a designated nominated deputy.

6. Attendance

Meetings of the Committee may, at the request of the Chair, be attended by:

- Director of Capital Planning, Estates and Facilities
- Deputy Director of Estates, Facilities & Capital Planning
- Associate Director of Estates, Engineering and Capital Delivery
- Director of Corporate Affairs
- A Governor to observe

Other officers of the Trust will be invited to attend as requested by the Committee.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance, he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be a minimum of four members, including two Non-Executive Directors.

The Committee shall meet as needed and at least 4 times per year.

9. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

Where members are unable to attend, they should send a designated nominated deputy.

10. Conduct of Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the Board's annual performance review process, the Committee shall review its collective performance each year.

12. Review

The terms of reference of the Committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital NHS Foundation Trust

Charitable Funds Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution** **Charities Acts** **Trustee Acts** **Charity Treasury Management Policy**

Review Date: November 2025
Issue Date: October 2017
Version: 4.0
Authorisation Date: December 2024

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors in order to ensure that the Trust's duty as Corporate Trustee of its Charitable Funds has been discharged. Its purpose is to oversee management, investment, and use of charitable funds within regulations provided by the Charity Commission and ensures compliance with charity law, including responsibility for the charity's fundraising activities. It does not remove from the Board the overall responsibility and legal obligation for this area but provides a forum for a more detailed consideration of charitable matters.

The Charitable Funds Committee has delegated responsibility, from the Corporate Trustee, within the limits set out in these Terms of Reference, the charitable funds sections of the Scheme of Reservation and Delegations and Standing Financial Instructions for the efficient governance and running of the Wirral University Teaching Hospital (WUTH) Charity.

2. Authority

The Charitable Funds Committee has delegated authority from the Corporate Trustee to investigate any activity within its terms of reference. It is authorised to seek information it requires of any employee (or contractor working on behalf of the Trust) and all employees (or contractor working on behalf of the Trust) are directed to cooperate with any request made by the Committee. The Committee is authorised to obtain legal advice or other professional advice from internal or external sources. The Committee has delegated authority from the Board to:

i) Maintain the Charity's governing document and registration with the Charity Commission.

ii) Review and advise on those aspects of Standing Orders and Standing Financial Instructions that appertain to the charity and its operation.
iii) Apply all charitable funds in accordance with the NHS Acts, Charities Acts and good practice (including but not limited to WUTH Charity Expenditure Policy) and ensure that decisions on the use of investments of such funds are restricted to the explicit conditions or purpose of each donation, bequest, or grant.
iv) Make decisions involving the use of charitable funds for investments subject to the powers laid down in the "Declaration of Trust" and with regard to the Trustee Acts and any subsequent legislation.
v) Consider the appointment of investment advisors and monitor the performance of the charitable fund portfolio and consider changes when deemed necessary.
vi) To oversee the Investment Policy of the Charitable Funds as required by the Trustee Acts and the NHS Acts.
vii) Act as the control mechanism for any approved fundraising appeals which may be initiated and to be aligned to the Charity Income and Fundraising Guidance Policy. Appointment and control of fundraisers will be in line with the Charities Acts.
viii) Oversee and monitor the functions with regards to the investment, accounting and reporting on the use of charitable funds.
ix) Receive Annual Accounts and Annual Reports of the Trust's charitable funds for consideration and recommendation for final approval to the Board of Directors.
x) To develop the strategy, policies, and objectives for the Charity for consideration and approval by the Corporate Trustee.

3. Objectives

Act as the Committee that discharges the Board's responsibilities (as sole Corporate Trustee) as they relate to Charitable Funds under the Trust's custodianship.

3.1 Risk

3.1.1 To ensure that unacceptable risks and inadequate levels of assurance related to financial performance of the Charitable Fund or associated investments are reported to the Board for consideration.

3.2 Statutory duties

3.2.1 Ensure the approval and submission of statutory returns, annual accounts, and Trustee's Report in accordance with the Charity Commissions Statement of Recommended Practice.
3.2.2 Invest and apply the income, funds, and property of the Charity in accordance with the governing document and complies with all legal relevant requirements including the Charities Acts and agreed expenditure policy.
3.2.3 Maintain the solvency and continuing effectiveness of the Charity.
3.2.4 Safeguard permanent endowments.

3.3 Strategy

3.3.1 To review the Charity Strategy, recommending it to the Board of Directors for final approval, and to seek assurance that the associated areas of the annual operational plan actions are being implemented.

3.4 Other Duties

3.4.1 Invest and review the investment funds not needed for immediate applications, in accordance with the Charity's investment objectives and the principles outlined in the Treasury Management Policy.
3.4.2 Monitor the performance of fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met.
3.4.3 Review and monitor the effectiveness derived from grants of money and property to the Trust.
3.4.4 Operate a visible and transparent decision making process for grants of money and property.

3.5 Governance

3.5.1 Ratify and review policies and procedures required for effective management of the Charity. This will incorporate oversight of associated compliance arrangements such as those required by the Charity Commission.
3.5.2 Ensure the Charity Treasury Management Policy including any other applicable policies are adhered to when considering related actions.
3.5.3 Give the Board assurance on an annual basis that the systems, policies, and procedures they have put in place to deliver Charitable Funds plans are operating in compliance with appropriate standards, are effective, are focused on key risks and are driving the delivery of the Trust's objectives.
3.5.4 Consider, interpret, and disseminate guidance from relevant bodies including the Charity Commission and other regulatory/advisory bodies relating to the Charitable Funds agenda.
3.5.5 Approve the establishment, work plans, duration and effectiveness of sub-committees and working groups.
3.5.6 To review and respond to any areas escalated from the Trust Board or its Committees.

4. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

5. Membership

The Committee shall consist of:

- Nominated Non-Executive Director (Chair)
- Two additional Non-Executive Directors
- Chief Finance Officer (Nominated Deputy – Deputy Chief Finance Officer)
- Chief People Officer (Nominated Deputy – Deputy Chief People Officer)

6. Attendance

Meetings of the Committee may be attended by:

- Assistant Director of Finance (Financial Services)
- Deputy Chief People Officer
- Head of People Experience~~Fundraising~~
- ~~Director of Communication and Engagement~~
- Director of Corporate Affairs
- Medical Director or Chief Nurse, or their deputy
- A Governor to observe

A nominated lay person, with appropriate experience, may attend upon invitation by the Chair.

Other officers of the Trust will be invited to attend on an ad-hoc basis to present papers or to advise the committee. Professional advisors regarding investments may be invited to attend, when deemed necessary.

The Trust Chair and all Non-Executive Directors have a right to attend the Committee.

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Chair.

Where members are unable to attend, they should consider sending a designated nominated deputy.

7. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance, he/she will not have a vote or participate in the decision of the Committee.

8. Quorum and Frequency

The quorum shall be three members, to include the Chair (or nominated deputy) and one Executive Lead/member of the Senior Management Team.

The Committee will meet at least four times a year. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

9. Reporting

The Committee will report to the Board following each meeting via a Chair's report and will present a comprehensive annual report to the Corporate Trustee.

The Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

The are no groups reporting to this Committee.

10. Conduct of Meetings

The agenda and supporting papers will be sent out four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

11. Performance Evaluation

As part of the Board's annual performance review process, the Committee shall review its collective performance each year.

12. Review

The terms of reference of the Committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital NHS Foundation Trust

Quality Committee Terms of Reference

Document Owner: Director of Corporate Affairs
Related Documents: **Scheme of Reservation and Delegation** **Standing Financial Instructions** **Trust Constitution**

Review Date: November 2025
Issue Date: April 2013
Version: 4.0
Authorisation Date: December 2024

1. Constitution

The Committee is established as an Assurance Committee of the Board of Directors to provide assurance in relation to clinical quality and effectiveness, patient safety and patient experience (including complaints and serious incident learning); the effectiveness of the quality governance framework; and learning and quality improvement. The Committee shall also provide assurance concerning clinical Health and Safety arrangements which ensure a safe environment for patients.

2. Authority

The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Matters for consideration by the Committee may be nominated by any member of the Committee or Executive Director of the Trust.

The Committee is authorised to instruct professional advisers and request the attendance of individuals authorities from outside the Trust with relevant experience and expertise if it considers it necessary or expedient to the exercise of its functions.

In addition, the Committee is authorised to request that another Committee or the Board review, monitor, or approve any item that may be better suited to, or overlap with, their responsibility.

3. Objectives

The Committee will deliver the following objectives, along with any others that are assigned by the Board of Directors during the course of the year:

3.1.1 To review the policies and practices that relate to patient safety and experience, clinical health and safety, and quality governance.
3.1.2 To review and approve the Trust's Quality Strategy and Patient Experience Strategy, recommending them to the Board for final approval, and to seek assurance that the associated actions are being implemented.
3.1.3 To provide scrutiny of the Trust's patient safety record, clinical outcomes, patient experience ratings, compliance with fundamental standards of care, and learning effectiveness.
3.1.4 To provide scrutiny of the frameworks and processes in place for managing patient safety and quality governance. This may include reviewing operational challenges, resourcing, clinical audit programmes, and other key areas of quality control.
3.1.5 To consider and seek further assurance regarding any potential quality impact arising from Trust activities, as referred by other Committees.
3.1.6 To receive relevant reports as required by guidance or regulation and any other matters referred by the Patient Safety Quality Board, including Divisional quality performance.
3.1.7 To provide review and recommend the Quality Account/Report to the Board for approval on an annual basis.
3.1.8 To provide to the Board such assurances as it may reasonably require regarding compliance by the Trust with all CQC and other quality regulations or legal obligations to which they are subject. This will include assurance on the outcomes of CQC and other quality related inspections.
3.1.9 To monitor and review the BAF in accordance with the Risk Management Strategy, in particular the risks associated with patient safety, quality governance.
3.1.10 To consider any findings of major investigations of internal control over safety critical matters, clinical effectiveness, patient concerns, or clinical health and safety matters and agree subsequent actions required to keep residual risk under prudent control.
3.1.11 To consider and review the Trust's compliance with the statutory duty of candour, and to be satisfied that the Trust is being open, honest, and effectively engaging and supporting with patient's and relatives who have been victims of moderate or serious harm.

3. Equality and Diversity

The Committee will seek to promote and enhance equality, diversity, and inclusion across the Trust, both in the discharge of its duties and decision making processes, and in representing these values in its areas of activity.

The Committee will also have regard for the NHS Constitution and ensure that it complies with relevant legislation and best practice in the conduct of its duties.

4. Membership

The Committee shall consist of:

- Three Non-Executive Directors, one of whom shall be appointed the Chair
- Medical Director (Nominated Deputy – Deputy Medical Director)
- Chief Nurse (Nominated Deputy – Deputy Chief Nurse)

All members should aim to attend all scheduled meetings with attendance being reviewed annually. Attendance below 80% may result in discussions with the Committee Chair.

Where members are unable to attend, they should send a designated nominated deputy.

5. Attendance

Meetings of the Committee will generally be attended by:

- Deputy Director of Quality Governance
- Chief Executive
- Chief Operating Officer
- Chief People Officer
- Chief Strategy Officer
- Chief Finance Officer
- Director of Corporate Affairs
- A Governor to observe
- A representative from Healthwatch Wirral

The Committee may invite other persons to attend a meeting as required, and the Chair will be informed of these additions where possible prior to the meeting.

No officer shall be present for discussions about his/her own remuneration.

6. Conflicts of Interest

It will be for the Chair of the Committee to determine whether or not it is appropriate for a member to be in attendance to advise on these matters. In such circumstances where that person is in attendance, he/she will not have a vote or participate in the decision of the Committee.

7. Quorum and Frequency

A quorum shall be at least 2 Non-Executive Directors and either the Medical Director or Chief Nurse (or their deputy).

Meetings shall be held as necessary and at least 4 times annually. Meetings may be added, stood down, or rescheduled with the approval of the Chair.

There will be a scheduled meeting each year to approve the Quality Account.

8. Reporting

The minutes of all meetings shall be formally recorded. The Committee will report to the Board following each meeting via a Chair's report.

The Committee will also update the Council of Governors on recent Committee activity via the appropriate template.

The Committee will report annually on its work in support of the Annual Governance Statement and Quality Account/Report, as laid out in the reporting guidance for the creation of those documents.

9. Conduct of Meetings

The agenda and supporting papers will be sent out at least four working days prior to the Committee, unless there are exceptional circumstances authorised by the Chair.

Authors of papers should use the standard template.

Presenters of papers can expect all committee members to have read the papers and should keep to a verbal summary outlining the purpose of the report and its recommendations. Committee members may question the presenter.

10. Performance Evaluation

As part of the Board's annual performance review process, the Committee shall review its collective performance each year.

11. Review

The terms of reference of the Committee shall be reviewed as required and at least annually.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 14.1**
4 December 2024

Report Title	Committee Chair's Reports – Estates and Capital Committee
Author	Steve Igoe, Non-Executive Director & Meeting Chair

Items for Escalation/Action

- The Committee received the quarterly performance report on the Estates functions across the Trust, with the Director of Estates providing assurance on delivery of statutory estates compliance, reactive maintenance and cleaning standards.
- It was noted that Estates have made measurable progress and continued to improve statutory and HTM Compliance, with 95% of in-date periodic inspections completed across statutory maintained assets.
- In terms of cleaning, the Trust has fully implemented the NHS National Standards of Healthcare Cleanliness, with full cleanliness audit scores report for all functional areas completed on a monthly basis. Trust Average Cleanliness Scores have been above their target of 95% for the previous 18 months, with the current score being 99.2% for August 2024.
- The Committee has now included non-clinical health and safety functions within its remit and received a report on health and safety incidents, training and audits across the Trust. It was noted that the highest number of non-clinical incidents related to violence and aggression against staff, with 345 events recorded between June and September 2024. The Committee also requested benchmarking data for RIDDOR incidents, to allow the Committee to understand the incident rate compared to other Trusts.
- The Committee also received the NHSE Premises Assurance Model (PAM) submission for 2024, which had been undertaken as a self-assessment across the summer of 2024. This highlighted significant improvement across the Estates and Facilities functions over the past 3 years, with most metrics moving from requires improvement to good.
- The Committee was provided with assurances relating to capital expenditure across 2024/25 and the M5 delivery of capital programme to budget.
- The Committee was also provided with an overview of the capital projects delivered across 24/25, including the fire lifts, pipework replacement, fire compartmentation, boilers, medical gas infrastructure, nurse call systems and ITU ventilation replacement. The Committee were provided with an understanding of the lessons learnt from these major projects and the process undertaken by the Capital Team to improve project delivery and management across 25/26.
- The Committee were also provided with an update on the UECUP (Urgent and Emergency Care Upgrade Programme), highlighting progress to date and dates for the completion of Phase 4. The Director also noted the delays due to outer wall issues and impact on the overall timeframes.
- The Chief Strategy Officer provided update on the Frontis Building at Arrowe Park Hospital and ongoing legal action, with the Committee requesting that the Chief Strategy Officer provide ongoing updates to the Committee.

New/Emerging Risks

- A number of risks were identified and considered by the Committee:
    - The significant backlog maintenance risks across the Trust and mitigations in place to manage this risk.

- The number of violence and aggression incidents across the Trust
- The ongoing support required to the Principal Contractor for the UECUP Programme and weekly meetings in place to manage delivery of the programme

Overview of Assurances Received

- A number of assurances were provided through reports from Committee members and members of the Estates Management Team including:
  - statutory estates compliance, reactive maintenance, cleaning standards and health and safety
  - Capital programme delivery
  - Capital expenditure to budget

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 14.2**
4 December 2024

Report Title	Committee Chair's Reports – Quality Committee
Author	Dr Steve Ryan, Chair of Quality Committee

Items for Escalation/Action

- The Committee received an update on progress in responding to the NHS England Northwest Regional Review of the Wirral System of the causes of escalating *Clostridioides difficule* infections. A draft Strategic plan consisting of 4 pillars of action has now been agreed between the Trust and its Place partners and will be overseen by the Wirral Health Protection Board.

- Children with special educational needs and difficulties (SEND): The Quality and Safety Intelligence Report continues to highlight delayed access to SEND diagnostic and care pathways as an issue. Working with Place partners, the Trust is already adapting pathways to improve access - for example using a graduated approach to diagnosis rather than a single higher-level gateway. The Trust is currently in negotiation with the Integrated Care Board (ICB) to determine the best approach to deploying some additional ICB resource.

- Crisis mental health care for children and young people (CYP): The Committee received a presentation from the Assistant Director of Nursing for the Women and Children's Division. This outlined the frequency, circumstances, duration and impact of CYP who are admitted to the paediatric ward for crisis car; be that as a result of diagnosable mental health conditions or as a result of social and behavioural issues. The latter includes crisis breakdown of existing social care arrangements necessitating admission. The paediatric ward was not originally designed to provide such levels of care, especially where CYP are exhibiting extremely challenging behaviours. These can present a risk to themselves, other patients, staff and families. The Health Service Investigation Branch (HSIB) report of 2023 highlighted this as a national problem and recommended areas of action to address the issues identified. The Trust has undertaken number of actions in response including training for staff, improving MDT assessments, facilitating safe discharge from the emergency department. Given that there is always likely to be a significant lead for CYP to receive crisis care on the paediatric ward there is an ongoing need to consider improvements for the built environment to enhance the quality and safety of care.

New/Emerging Risks

- No new risks were identified.

Overview of Assurances Received

- Mortuary Services: The Committee received a biannual report which provided a high level of assurance about the quality of facilities, services and governance of these services. This included details of an Evidential Compliance Assessment by the Human Tissue Authority which was undertaken in May 2024. Two recommendations to further strengthen security arrangements had already been implemented before the outcome of the assessment was received.

- Learning from Deaths: This regular quarterly report provides on-going assurance that there is an effective system to allow scrutiny of any death at the Trust. The Mortality Review Group ensures that following scrutiny that learning is shared in relation to care or documentation issues identified by individual patient mortality reviews. In quarter one (Q1) of this year no care issues were identified that would have altered the outcome of patients who had died. Mortality rates remain within the statistically expected rate. No trigger alerts occurred in Q1 for any diagnostic group.

- Controlled Drug: The Committee received the annual report from the Accountable Officer for Controlled Drugs. This comprehensive report detailed the high quality of scrutiny and oversight of the use of these drugs across the organisation. There is a culture of high reporting of incidents and near misses and a culture of learning and quality improvement.

- Infection prevention and control (IPC): The annual report was received and gave a high level of assurance of the quality of oversight and delivery of IPC arrangements. Where deficits are identified, strategic plans are developed and tactical responses are undertaken appropriately. Risks - e.g. lack of isolation facilities are noted and mitigations are in place.

- Good assurance was provided in regard to the Quality Strategy (2022-2026) in which key performance indicators (KPIs) for actions within the 3 pillars of insight, involvement and improvement were demonstrating good progress. There was still some work to ensure 90% of relevant staff had completed the patient safety course syllabus.

Other comments from the Chair

- The reports provided to the Committee were high quality and contained the necessary detail for the Committee to test the assurances that were provided. Additionally, authors and area leads were able to respond to enquiries to assist the Committee in formulating its opinion on assurance. In addition, there were several areas where it was possible to triangulate between separate reports - enhancing the degree of assurance received.

- The Committee reviewed its terms of reference noting that a member of Healthwatch Wirral was now an attendee.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 14.3**
4 December 2024

Report Title	Committee Chair's Reports – Audit and Risk Committee
Author	Steve Igoe, Chair of Audit and Risk Committee

This report updates on the work of the Audit and Risk Committee at its meeting on 21 November 2024. The work of the Committee, as well as being documented in its Terms of Reference, is prescribed by Accounting/Auditing Standards and Regulatory requirements.

Items for Escalation/Action

- There were none. The Committee received a presentation and update from the Director of Pharmacy Dr Chris Green on the management of Waste and minimisation of stock losses regularly discussed at Audit Committee and were assured by the processes to minimise stock losses arising from whatever form and to minimise waste.

New/Emerging Risks

- There are no new/emerging risks. The BAF was discussed and the Committee recognised that this was likely to evolve as a result of the ongoing integration project with the Community Trust. The Committee noted the increase in risk 6 related to the Trust's financial performance and the ongoing dialogue with the ICB.A detailed presentation and took place at the last Board meeting following which an agreed Trust position was reached. The Committee agreed the Risks and controls appeared adequate and reflected the current position.

Overview of Assurances Received and Committee Activity

- The Committee received the updated Digital Maturity Assessment from the chief information officer Report and received good assurance on the Trust's position. The Trust across the 7 areas was placed in the top 3 providers in the Cheshire and Mersey ICS. However this remains and key area of vigilance and a further update will be provided in due course. The key issues discussed at the September and October Information Assurance Group meetings were presented for information, the most significant relating to challenges to staffing positions in the current staff constrained environment and the replacement of a soon to be de-supported pager system. Both of these are clearly being managed and are visible although the resolution of the former difficult given the current financial challenges.

- The Committee noted the Procurement Spend Controls Waivers Report and were pleased to hear the Trust continued to perform well against Model Health System Procurement Metrics. Committee were also assured by the continued control in relation to the number of retrospective waivers issued and acknowledged work continues to improve this position further. A Standard Procedure relating to the management and control of issues relating to retrospective waivers was presented and discussed. The Committee approved the amendment to the Standing Financial Instructions (SFI's).

- The Committee received its standing report providing Financial Assurance. Substantial discussion took place in relation to outstanding debtors and recoverability, particularly the recovery of sums owed in relation to salary overpayments and Council debt. It was agreed

that these debts would be subject to a detailed review in preparation for year end and as a means of justifying any future carrying value given the age of the debts in question.

- The Committee noted the Audit-Fraud Progress Report and the activity undertaken by the Anti-Fraud Specialist to raise awareness and investigate any fraud related activity. A detailed update was provided to members of the Committee in relation to specific investigation cases.

- The Committee reviewed three Internal Audit Report Progress Reports, noting substantial assurance being received for; IPR data quality (cancer waits) and Health and well-being. Discharge ("no criteria to reside") resulted in a moderate assurance opinion. The Internal Auditors also presented their Follow Up Summary Report, which indicated good progress continues to be made in embedding audit recommendations in a timely manner. This was re-affirmed by Internal Audit in their private meeting with Non-Executive Directors.

- The Committee were provided with the Trust's own Audit Tracker. This report summarised the 20 live actions (a reduction from 38 last time), of which 14 had been completed, 2 are in progress and within the approved timeline for implementation, and 3 are overdue. The Committee approved a series of revised implementation dates for those recommendations that are marked overdue.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public
4 December 2024

Item No 14.4

Report Title	Committee Chair's Reports – Charitable Funds Committee
Author	Dr Steve Ryan, Non-Executive Director & Meeting Chair

Items for Escalation/Action

- The Committee received an update on the plans for the development of the neonatal Unit at Arrowe Park Hospital. Following consideration of 3 options which had at their heart the development of clinical care areas in the unit, a preferred option has been identified which has the backing of key stakeholders including clinical teams. The Trust will now move forward with further planning and costing of this option. Charitable funding has been provided by the Trust's Tiny Stars Appeal and by fundraising by Incubabies Charity.

- The Committee received an update form the Charity Team on developing and implementing the approach to meet key objectives, including improving interaction and engagements with fund-holders and staff. In the Fundraising report a number of areas in both potential fundraising and disbursement of grants were identified and these proposals will be developed.

- The Committee were honoured to see that the League of Friends of Arrowe Park Hospital had generously made a significant donation of the remaining charitable funds they had raised as they closed their charity. The Committee discussed how these funds would be distributed in line with the wishes of the League of Friends.

New/Emerging Risks

- No new risks were identified. The Committee did discuss when remaining risks the register would be reduced and closed.

Overview of Assurances Received

- The Committee received an Independent Examiner's report to the corporate trustee that was prepared by Azets Audit Services and which did not find any matters of concern requiring attention.

- The Trustees' Annual Report and Financial Statements were provided to the Committee and give an overview of the constitution, mission, governance and running of the charity over the year 2023-2024.

Other comments from the Chair

- The Committee welcomed Ngozi Ikoku our new Fundraising manger.
- The annual review of Terms of Reference was reviewed and changes made in the list of attendees as a result of changes in job titles and post-holders.