NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

2 April 2025

09:00 GMT+1 Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

Only PDFs are attached

- 0 Board of Directors in Public Agenda.pdf
- 3 Board of Directors in Public Minutes - 5 Mar.pdf
- 4 Action Log - Public Board.pdf
- 7 Chief Executive Officer Report.pdf
- 8 IPR.pdf
- 8.1 WUTH IPR Dashboard - Mar 2025 - Intro.pdf
- 8.2 WUTH IPR Dashboard - Mar 2025 - 1 COO.pdf
- 8.3 WUTH IPR Dashboard - Mar 2025 - 2 MD.pdf
- 8.4 WUTH IPR Dashboard - Mar 2025 - 3 CN.pdf
- 8.5 CN Commentary - February 2025.pdf
- 8.6 WUTH IPR Dashboard - Mar 2025 - 4 CPO.pdf
- 8.7 CPO Commentary - for Feb BoD - FINAL.pdf
- 9 Chair's Report - Charitable Funds Committee.pdf
- 10 Chair's Report - Research and Innovation Committee.pdf
- 11 Extended Monthly Maternity & Neonatal Report April 2025.pdf
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15. Board Assurance Framework.pdf

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 2 April 2025
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	
8	3.	Minutes of Previous Meeting	Sir David Henshaw	
20	4.	Action Log	Sir David Henshaw	
	5.	Staff Story	Debs Smith	
	Standing Items			
	6.	Chair's Update – **Verbal**	Sir David Henshaw	
21	7.	Chief Executive Officer Report	Janelle Holmes	
24	8.	Integrated Performance Report	Executive Directors	
	Committee Chairs Reports			
43	9.	Charitable Funds Committee	Lesley Davies	
45	10.	Research and Innovation Committee	Sir David Henshaw	
	Strategic Objective: Outstanding Care			
47	11.	Monthly Maternity and Neonatal Services Report	Sam Westwell	Jo Lavery
51	12.	Learning from Deaths Report Q3 2024/25	Dr Ranj Mehra	
	Strategic Objective: Continuous Improvement			
59	13.	Chief Finance Officer Report	Mark Chidgey	
65	14.	Chief Operating Officer Report	Hayley Kendall	
	Governance and Assurance			
74	15.	Board Assurance Framework (BAF)	David McGovern	
	Closing Business			
	16.	Questions from Governors and Public	Sir David Henshaw	

	17.	Meeting Review and BAF Review	Sir David Henshaw	
	18.	Any other Business	Sir David Henshaw	
	Date and Time of Next Meeting			
	Wednesday 7 May 2025, 09:00 – 11:00			

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 4 March 2025
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
CC	Chris Clarkson	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
SW	Sam Westwell	Chief Nurse
RM	Dr Ranj Mehra	Deputy Medical Director
DS	Debs Smith	Chief People Officer
MS	Matthew Swanborough	Chief Strategy Officer
MC	Mark Chidgey	Chief Finance Officer
HK	Hayley Kendall	Chief Operating Officer & Deputy Chief Executive

In attendance:

DM	David McGovern	Director of Corporate Affairs
JC	Jo Chwalko	Director of Integration and Delivery
JJE	James Jackson-Ellis	Corporate Governance Manager
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 14
AA	Dr Alice Arch	Guardian of Safe Working – item 16
CJ	Clare Jefferson	Associate Director of Estates, Facilities and Capital Governance and Sustainability – item 19
TC	Tony Cragg	Public Governor
RT	Robert Thompson	Public Governor

Apologies:

SL	Sue Lorimer	Non-Executive Director
JH	Janelle Holmes	Chief Executive

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 29 January 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 new mum and her baby. The video story described her positive experience from Maternity Services during antenatal and postnatal care. Members welcomed the video story and acknowledged the positive experience the new mum and her baby had. The Board **NOTED** the video story.	
6	**Chair's Update** DH reflected on the integration between WUTH and WCHC so far and commented clinical teams were keen to collaborate and this was positive. DH added WCHC also had a good telephony system and were using this to drive improvements for patient access. The Board **NOTED** the update.	
7	**Chief Executive Officer Report** HK reported in January there were no Patient Safety Incident Investigations opened under the Patient Safety Incident Response Framework and there was one Reporting of Injuries, Diseases and Dangerous Occurrences reported to the Health and Safety Executive. HK highlighted on 18 February the Trust held a Quality Priorities workshop which was attended by staff, internal and external stakeholders across Wirral Place. HK added the purpose of the workshop was to gain views on what the Trust should be focussing on to improve patient safety and patient care in the year ahead. HK stated on 14 February Ward M1 at Clatterbridge hosted a special Valentine's movie night for older patients. HK added all patients on this ward were aged 74 and above and cares for patients who are medically fit but awaiting support services such as a social worker assessment, a package of care or a bed in a rehabilitation facility.	

	HK explained on 9 February the Trust had a spotlight on Autism Sunday to raise awareness of autism. HK added the Trust has put in place a number of important initiatives to support autistic patients and that all staff are required to complete the Oliver McGowan training on learning disability and autism. HK summarised the recent meetings of the Cheshire and Merseyside Acute and Specialist Trust Board on 7 February and the Wirral Place Based Partnership Board on 20 February. The Board **NOTED** the report.	
8	**Board Assurance Framework (BAF)** DM summarised the key changes to the BAF including the direction of travel for each strategic risk, noting the score for risk 4 had increased from 9 to 12 because of the repeatedly high levels of sickness absence being experienced. Members discussed the BAF and agreed the risks and controls appeared accurate and reflected the current position. The Board **NOTED** the BAF.	
9	**Integrated Performance Report** RM stated the number of patients recruited to NIHR studies remained below target and expected there to be between 400-500 patients this year vs a target of 700. RM added at the next Research and Innovation Committee a new suite of key performance indicators would be discussed. SW explained C Diff remained above the target of 6 per month with 12 incidents in January. SW added the Health Protection Board were meeting on Friday and the Wirral C Diff Strategic Plan progress would be discussed. SW stated there was 1 category 3 hospital acquired pressure ulcer in January against a target of 0. SW reported friends and family test for ED was 75.6%, Maternity, Outpatients and inpatients exceeded the 95% threshold. SW highlighted the number of level 1 concerns raised exceeded the threshold of 173 in month, however positively the number of formal concerns per 1000 staff was below the agreed threshold. SW indicated RN and CSW staffing fill rates were above the threshold of 90% with the exception of CSW days which was 85%. DH queried about the engagement of primary care networks in regard to C Diff.	

	MS stated through the creation of the Wirral Provider Collaborative this will include primary care networks, which will provide a greater opportunity to work collaboratively to address the C Diff challenges. DH requested MS provide an update to the Integrated Management Board regarding primary care networks' involvement in the Wirral Provider Collaborative and how they can be further supported. DH referenced a patient story from the WCHC Board meeting which was from an end of life patient and the challenges they experienced accessing end of life care. DH commented about the challenges accessing services across the system and suggested exploring a one Wirral number for patients to call to understand what services were available. Members discussed this and agreed with the idea, noting the financial and operational efficiencies which could be made and utilising the telephony system already available at WCHC. DH requested MS incorporate as part of the integration programme the development of a one Wirral number telephony system for patients to access information by dialling one number. DS stated the key performance indicators for mandatory training, appraisal compliance and turnover were on target. However, sickness absence remained above target at 6.62% and an area of concern and focus. DS explained the BAF score for risk 4 had increased from 9 to 12 because of the repeatedly high levels of sickness absence being experienced and she had given a deep dive on sickness absence controls and mitigation to Audit and Risk Committee in February. DS reported sickness absence would be part of the workforce transformation workstream for 2025/26, including maximising the use of health and wellbeing resources as well as further improvements to the management of sickness absence. SR commented it was positive both appraisal and mandatory training had been maintained during the recent major incidents. DS agreed and stated mandatory training had become embedded and was part of the culture at the Trust but explained further work was required to embed this for appraisals. The Board **NOTED** the report.	Matthew Swanborough Matthew Swanborough
10	**Committee Chairs Report – Estates and Capital Committee** DH alerted members that the Committee discussed the quarterly Health and Safety update and acknowledged the number of	

	violence and aggression incidents towards staff and patients continued to remain high and this was cause for concern. DH also alerted members that Committee also discussed Fire Safety Level 2 training compliance, noting this continued to be significantly below the 90% compliance target across most of the Divisions. The Committee recommended that this be referred to and discussed in more detail at the People Committee. DH commented about the Estates improvement journey since 2021 and requested MS document this. MS agreed. The Board **NOTED** the report.	Matthew Swanborough
11	**Committee Chairs Reports – People Committee** LD alerted members that the Committee continues to monitor the workforce key performance indicators. Committee remained concerned regarding sickness absence as this continues to be above the Trust's target at 6.62% in January 2025. LD stated this is mainly driven by short term sickness absence. Additional Clinical Services, Nursing and Midwifery, and Estates and Ancillary staff groups have the highest levels of sickness absence. LD also alerted members that the Committee had requested a deep dive from the Estates and Capital Team in April, updating on presentation previously given to Committee in March 2024 on the areas of concern and focus. LD further summarised the various advise and assure matters from the People Committee meeting on 7 February 2025. The Board **NOTED** the report.	
12	**Committee Chairs Reports – Audit and Risk Committee** SI alerted members that the Internal Audit Report on LocSSIPs produced a limited assurance outcome. SI added the Committee requested that the report be considered by the Quality Committee. SI also alerted members that work was ongoing in relation to Multi Factor Authentication (MFA) and password security following the recent cyber incident. SI further summarised the various advise and assure matters from the Audit and Risk Committee meeting on 20 February 2025.	

	DH queried about the recommendations arising from the LocSSIPs review. RM stated these primarily related to the consistent application of the relevant policy including correct recording and training for staff. The Board **NOTED** the report.	
13	**Committee Chairs Reports – Finance Business Performance Committee** SR alerted members that the Trust had submitted a request for cash support for £11.3 million. SR explained pending approval of this request the Committee noted the significant mitigation actions that the Chief Finance Officer would have to consider if some or all of this request was not met. SR also alerted members that the Committee received a quarterly financial plan update. This presentation indicated that there had been an improvement in the financial stability measure in month 10 to a variance of £10m and the Chief Finance Officer confirmed a subsequent improvement to a forecast variance to plan of £7m million. SR highlighted the Committee received a presentation from the Chief Finance Officer and the Chief Operating Officer outlining the work towards meeting the requirements of the 2025/26 planning round for finance and activity. SR referenced the challenging position in relation to unfunded inflation pressures, capped income from elective activity and the convergence requirement. SR further summarised the various advise and assure matters from the Finance Business Performance Committee meeting on 26 February 2025. Members discussed the Trust's financial position and acknowledged since 2023/24 the Trust had met its 5% CIP target for 2 consecutive years and transacted £46m of recurrent CIP. The Board **NOTED** the report.	
14	**Quarterly 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 January. JL stated there were no Patient Safety Investigation Incidents (PSIIs) declared for Maternity Services or Neonatal Services in January. JL added to date there were four Maternity and Newborn Safety Investigations (MNSI).	

	JL gave an update on Maternity Incentive Scheme (MIS) Year 6, noting this was approved by Board in January and submitted on schedule. JL added as advised by MBBRACE and NHS Resolution Safety Action 1 was declared as non-compliant in the first instance. JL stated no guidance has been released for MIS Year 7 presently. JL explained the position in relation to Saving Babies Lives, noting the Trust achieved 89% compliance against the 6 elements based on evidence as of 30 September 2024. JL added the Trust continues to work towards full implementation. JL summarised the Ockenden gap analysis and the 15 immediate and essential actions, noting the Trust remained in the same RAG rated position as fully compliant. JL reported progress against the recommendations of the three year delivery plan for maternity and neonatal services. JL also updated on progress regarding implementing a Continuity of Carer Model and referred to the 6 monthly workforce report. JL referenced the Care Quality Commission annual maternity survey, noting the overall results indicate that Wirral Women and Children's Hospital has been providing quality care to expectant and new mothers. JL highlighted the LMNS annual visit on 11 December 2024 and the North West Neonatal Operational Delivery Network visit on 6 Decembre 2024, both had provided positive feedback on the Trust's Maternity and Neonatal Services. SR commented there remained a robust level of assurance provided to Board in regard to maternity and neonatal services. SR also commented that it was positive the Trust continued to maintain the shift leader as supernumerary at start of shift and throughout as best practice. The Board: • **NOTED** the report. • **NOTED** the Perinatal Clinical Surveillance Assurance report. • **NOTED** the position of Patient Safety Incident Investigations (PSSI's) & Maternity and Newborn Safety Incidents (MNSI). • **NOTED** the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3. • **NOTED** the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals". • **NOTED** the 6 monthly workforce and staffing report for maternity along with Trust investment to increase the	

	maternity establishment to permanent posts in line with associated funding. • **NOTED** the results of the CQC maternity survey. • **NOTED** the outcome of the UNICEF accreditation. • **NOTED** the outcome of the LMNS annual review. • **NOTED** the North West Neonatal Operational Delivery Network annual visit. • **NOTED** the PMRT report for Q3 24/25.	
15	**6 Monthly Safe Staffing Report** SW explained the last establishment review was conducted in June 2023 and set out the reasons for the delay, noting these related to the extensive periods of Clinical Support Worker industrial action, changes in senior nurse leaders and the launch of a new Adult Inpatient Safer Nursing Care Tool. SW set out the methodology for the new Adult Inpatient Safer Nursing Care Tool to determine the appropriate level of staffing for adult inpatient wards. SW indicated no changes were proposed at this time following the establishment review. SW highlighted the next steps, including re-establishing 6 monthly establishment reviews and reviewing the format of the bi-monthly Safe Staffing Report to People Committee. SR commented it was positive to see this being re-established and welcomed the iterative approach. SR suggested there may also be workforce transformation opportunities arising from the integration with WCHC for nursing teams. The Board **NOTED** the report.	
16	**Guardian of Safe Working Reports Q3 2024/25** AA summarised the number of exception reports during the period, noting there had been a return to a majority of exception reports from foundation doctors. AA explained there were a number of exception reports during the major incident however this had not resulted in an overall rise. AA added there were a relatively large number of educational reports, half of which were from internal medicine year 2 and this was being reviewed with the educational support team. AA stated the overall trend in exception reports was lower than the previous year. DS queried about the number of educational exception reports and if this was a concern.	

	AA stated these exception reports were handled by the Director of Education and related to postponed classroom based learning during the major incident. AA added all postponed educational activity would be rescheduled. RM confirmed any postponed teaching had to be approved by him and cancellation of teaching was rare. DS also required about the overall trend in exception reports, noting this was lower than the previous year. AA stated she had been the Guardian of Safe Working for a year which had provided opportunity for new processes to be embedded. AA added if a reoccurring theme from an exception report was observed these were proactively managed through prompt intervention to ensure further similar exception reports were minimal. DH queried about the other mechanisms available for junior doctors to raise any concerns. RM stated there were a number and these included the Junior Doctor Form, Joint Local Negotiating Committee as well as annual GMC and NETS surveys. The Board **NOTED** the report.	
17	**Chief Finance Officer Report** MC reported at the end of January, month 10, the Trust was reporting a deficit of £16.0m, an adverse variance against plan of £9.7m. MC set out the key drivers of this forecasted variance and the internal risks to achievement of plan, indicating these related to the cost and lost income associated with the cyber incident, full delivery of elective activity plan, the Cost Improvement Programme (CIP), maintaining expenditure on urgent care within planned levels and delivering planned integration benefits. MC explained the Trust's unmitigated forecast was a deficit of £22.6m, an adverse variance to plan of £15.9m. Full implementation of the NHSE and C&M ICB actions would reduce the unmitigated forecast deficit to £13.6m, an adverse variance to plan of £7.0m. MC indicated the deficit position continued to place significant pressure on both the Trust's cash position and compliance with the Better Payment Practice Code. MC confirmed the Trust's application for £3.5m of support had been approved and no additional cash would be needed before March.	

	MC provided an update on risk ratings for delivery of statutory targets, noting the RAG rating for each, highlighting that financial stability and financial sustainability were red, financial efficiency, cash and agency spend were amber and capital was green. Members acknowledged there was an opportunity to discuss the financial position including the 2025-26 financial plan during the Private meeting. The Board: • **NOTED** the report. • **NOTED** that full implementation of agreed mitigations will significantly but not fully mitigate financial risk. • **NOTED** that the Trust will be submitting an additional cash support request in M12.	
18	**Chief Operating Officer Report** HK highlighted in January the Trust attained an overall performance of 105.7% against plan for outpatients and an overall performance of 91.6% against plan for elective admissions. HK indicated the Trust overachieved planned level for outpatient new appointments, however two Divisions underachieved day case elective admitted activity plans impacting the overall Trust position. HK summarised the referral to treatment standard and current performance against this, reporting the Trust had 88 65 week waiters at the end of January against a standard to have no patients waiting 65 weeks by September 2024. HK set out the types of patients waiting 65 weeks. HK also summarised cancer performance against the trajectory, DM01 performance and the Faster Diagnostic Standard, noting the impact of the cyber security incident continues to be felt. HK highlighted in January type 1 unscheduled care performance was 46.28% and continues to remain below the planned improvement trajectory. HK added challenges relating to staff shortages due to vacancies and sickness, and limited bed capacity continue to cause overcrowding, long waiting times, and treatment delays. HK added various improvement initiatives continued in January with further pilots planned, specifically the further roll out of Same Day Emergency Care (SDEC). HK stated the number of patients not meeting the criteria to reside had remained static since January which was positive.	

	DH queried about the low uptake of the call before convey service and commented this was disappointing. JC agreed and stated this was driven by the ambulance provider not fully utilising the service. JC added a missed opportunities audit took place and identified patients would have benefited from accessing the service. The Board **NOTED** the report.	
19	**Green and Sustainability Plan – Annual Progress Update** MS gave an overview of progress to date, noting in 2022/23 19 actions were complete or ongoing, 62 started or partially completed and 47 not started/limited progress. MS added data collection for 2023/24 would take place in March 2025. MS also provided a summary of the key updates across staff engagement, energy, travel and transport/medical gases, greenspace/biodiversity and external engagement. CJ highlighted the plan for 2025/26 which included the reduction in anaesthetic gases and applying for funding for solar panels and electric vehicle chargers. Members discussed the various elements of the Green Plan and agreed the Trust had a strong track record of working with colleagues and partners to delivery improvements to reduce the Trust's carbon footprint. Members also thanked CJ and the team for their work. The Board **NOTED** the report and presentation.	
20	**Trust Constitution Update** DM highlighted in order to establish and embed effective governance arrangements to facilitate the integration between WUTH (Wirral University Teaching Hospital) and WCHC (Wirral Community Health and Social Care) there is requirement to update the Trust Constitution. DM explained Constitution has been updated to reflect that the Trust may exercise joint working and joint committee powers under s.65Z6 of the NHS Act. DM noted the Constitution requires both the Council of Governors and Board of Directors to approve any change and added the Council of Governors approved the changes at a meeting in February. The Board **APPROVED** the Trust Constitution.	

21	**Annual Review of Corporate Governance Manual** DM explained the Corporate Governance Manual was subject to an annual review and summarised the various amends, noting these primarily related to the Constitution, Scheme of Reservation and Delegation and Terms of References. DM added the Audit and Risk Committee met in February to review the Manual and recommended it to the Board for approval. DM stated once approved the Corporate Governance Manual would be uploaded to the Trust website for transparency purposes. The Board **APPROVED** the Corporate Governance Manual, following recommendation from the Audit and Risk Committee.	
22	**Questions from Governors and Public** TC commented he had received positive feedback from members of the public in regard to the care they received in Maternity Services. TC also congratulated DH on his extension and reappointment as Chair. RT commented he welcomed the approach being taken by the Trust to collaborate more closely with primary and secondary care.	
23	**Meeting Review** No comments were made.	
24	**Any other Business** No other business was raised.	

(The meeting closed at 11:00)

Action Log
Board of Directors in Public
2 April 2025

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	4 December 2024	9	To provide at a future Board Seminar the 4 pillar Wirral C Diff strategic plan, with WUTH and WCHC IPC teams presenting	Sam Westwell	Complete. Scheduled for April Board Seminar.	April 2025
2.	29 January 2025	17	To provide an update on the comparators for how the Trust compares regarding recommending WUTH as a place to work and receive treatment	Debs Smith	In progress. Due May 2025.	May 2025
3.	5 March 2025	9	To provide an update to the Integrated Management Board regarding Primary Care Networks involvement in the Wirral Provider Collaborative and how they can be further supported	Matthew Swanborough	Completed- PCNs now included as part of Provider Collaborative membership. Presented to Joint Board meeting on 26th March	April 2025
4.	5 March 2025	9	To incorporate as part of the integration programme the development of a one Wirral number telephony system for patients to access information by dialling one number	Matthew Swanborough		August 2025
5.	5 March 2025	10	To document the improvement journey in relation to Estates	Matthew Swanborough	Complete. Presentation to be provided to Estates and Capital Committee on 10 April.	April 2025

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
2 April 2025

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 two Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs) reportable events reported in February. 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. There were no Patient Safety Incident Investigations (PSII) opened in February under the Patient Safety Incident Response Framework (PSIRF).
1.2	**News and Developments** **Prime Minister's announcement on NHS structural reforms** On 13 March the Prime Minister announced that NHS England (NHSE) will be abolished and brought back into the Department for Health and Social Care (DHSC), reversing the 2012 reorganisation of the NHS. Work will begin immediately on the changes, moving many of NHSE's current functions to DHSC and there will then be a longer-term programme of work to deliver the changes in full. It is expected to take up to two years to complete. **NHS staff survey results** On 13 March NHSE published the annual NHS staff survey results. The Trust achieved an impressive response rate in this year's NHS Staff Survey, with 47% of staff sharing their views - an increase from 38% last year. This rise reflects the commitment of our staff to shaping the future of our Trust and follows the launch of our 'It Starts With You' campaign, which encourages every staff member to share their voice and drive positive change. People Committee will receive a detailed presentation on the staff survey results in April followed by a Board presentation in May. **COVID-19 Day of Reflection** The Trust commemorated COVID-19 Day of Reflection on 9 March with two wreath laying ceremonies at Arrowe Park and Clatterbridge Hospital on the fifth anniversary of the pandemic. Dr Nikki Stevenson laid the wreath at Arrowe Park and Rev Malcolm Cowan, Lead Chaplain laid the wreath at Clatterbridge. Rev Cowan led the proceedings with special readings and a minute silence. Thank you to staff who attended the ceremonies as we remembered those who had sadly lost their lives in the pandemic and reflected on the dedication of our NHS staff. Books of reflection have been placed at the Chapels at Arrowe Park and Clatterbridge, for those who wish to share their thoughts and reflections of the pandemic and the past five years.
1.3	**System Working** **Wirral Place Based Partnership Board (PBPB)** The PBPB met on 27 March and discussed a number of Place issues as follows.

	PBPB received the regular Quality and Performance Report which gave an overview of the Place aggregate position against key metrics. Members acknowledged some metrics had deteriorated and others were being maintained. PBPB also received an update on the Cheshire and Merseyside Dental Improvement Plan and the progress against each of the pathways. Members discussed the significant challenges to patients accessing NHS Dental Services, both locally and nationally. The NHS Dental Contract, at the current time, is not fit for purpose and reforms to the contract have been limited. PBPB considered the updates to the Wirral Place Governance Manual, noting this would return in July 2025 with inclusion of the Wirral Provider Collaborative Terms of Reference. PBPB received the Place Finance Report and noted the Wirral system had an actual reported deficit of £39.4m compared with a planned year-to-date deficit of £20.5m, which represents an adverse variance of £18.7m. An improvement on month 9 reporting of £1.6m.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 8**

02 April 2025

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 February 2025. It is recommended that the Board: • Note performance to the end of February 2025.

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.

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.

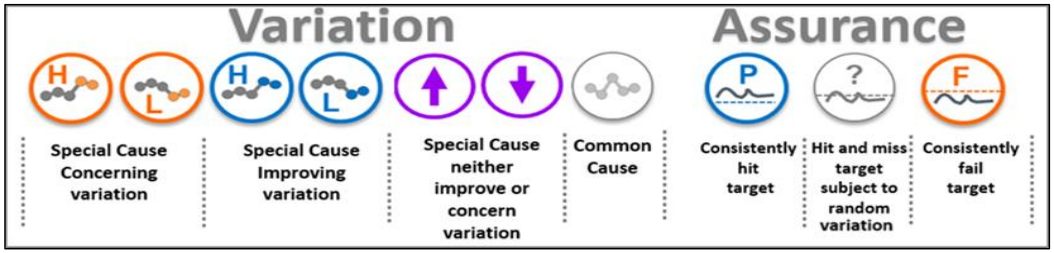
3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Integrated Performance Report, and at the regular operational meetings with the Clinical Divisions.

Integrated Performance Report - March 2025

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:

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

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.

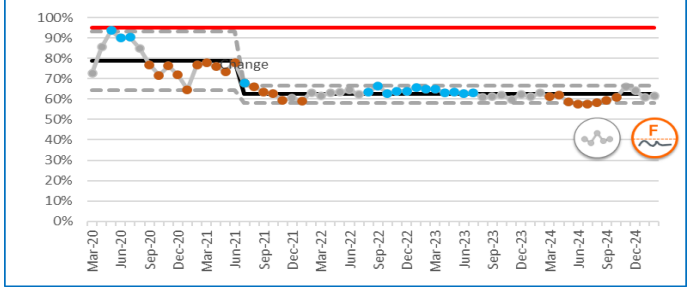
Changes to Existing Metrics:

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

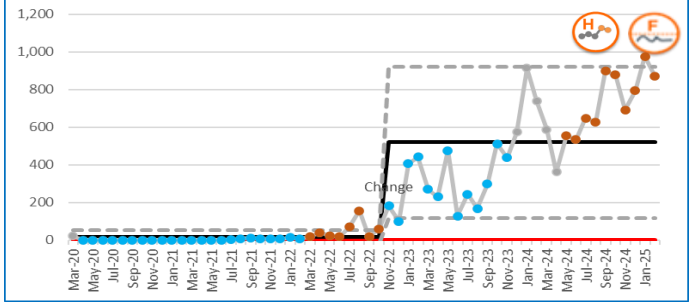
4-hour Accident and Emergency Target (including APH UTC)



Feb-25
61.5%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

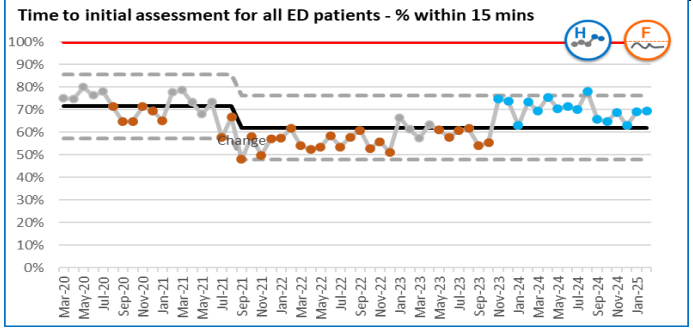
Patients waiting longer than 12 hours in ED from a decision to admit



Feb-25
871
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

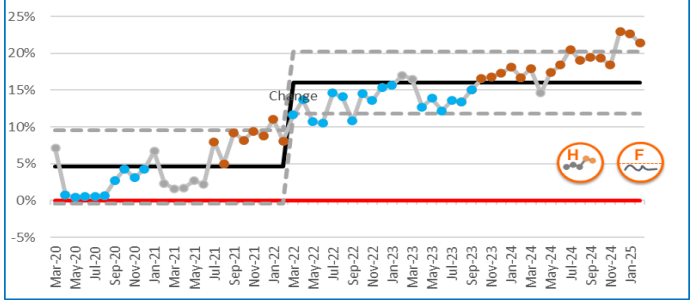
Time to initial assessment for all ED patients - % within 15 mins



Feb-25
69.6%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

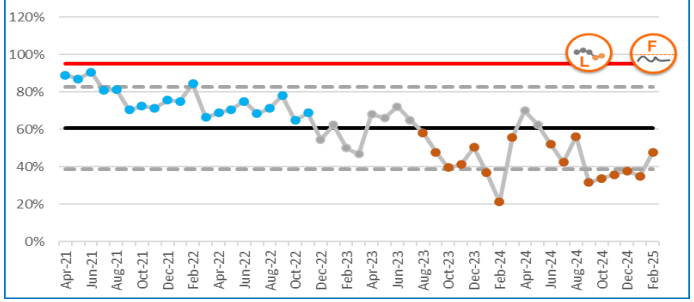
Proportion of patients more than 12 hours in ED from time of arrival



Feb-25
21.4%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

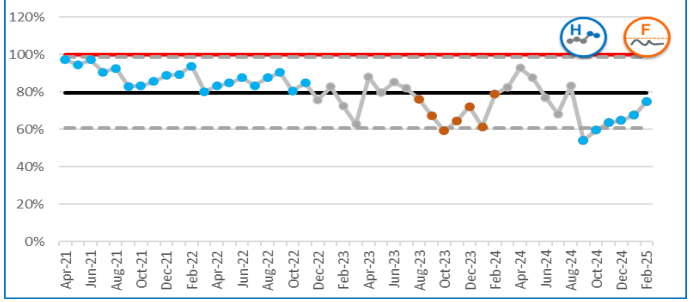
Ambulance Handovers: % < 30 mins



Feb-25
47.6%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Ambulance Handovers: % < 60 mins

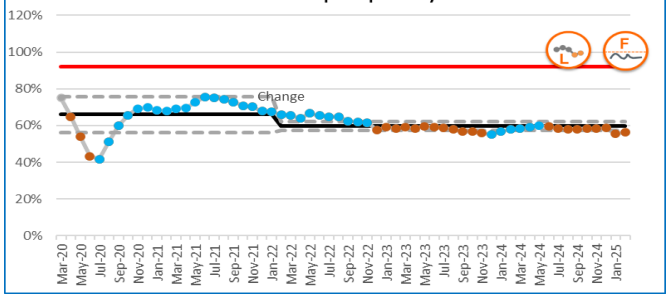


Feb-25
74.8%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

Chief Operating Officer (2)

CQC Domain : Responsive

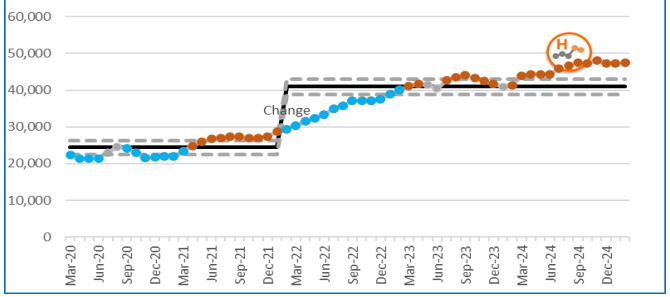
18 week Referral to Treatment - Incomplete pathways < 18 Weeks



Feb-25
56.53%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

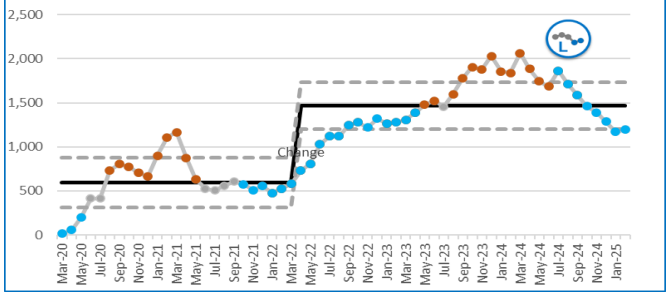
Referral to Treatment - total open pathway waiting list



Feb-25
47438
Variance Type
Special cause variation - concerning
Threshold
≤ 40511
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

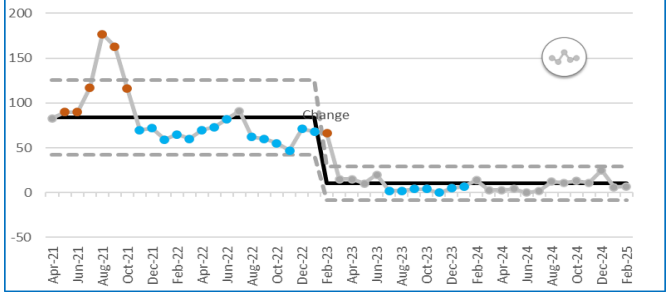
Referral to Treatment - cases exceeding 52 weeks



Feb-25
1196
Variance Type
Special cause variation - improving
Threshold
≤ 1795
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

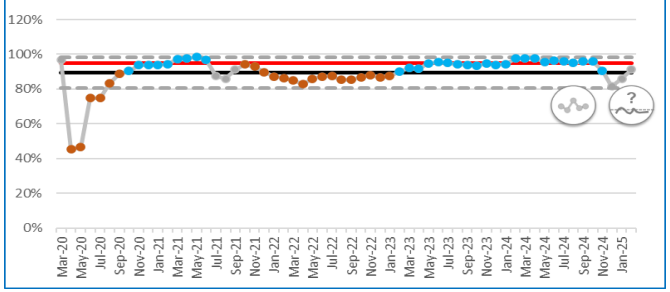
Referral to Treatment - cases waiting 78+ wks



Feb-25
7
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

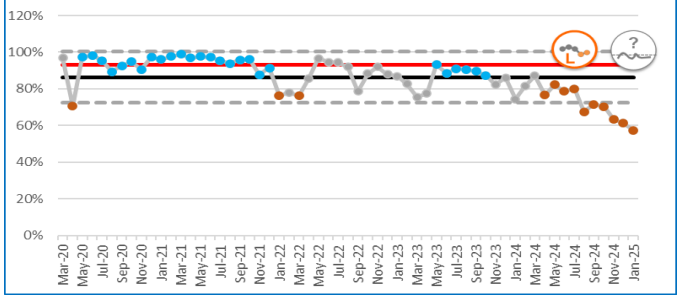


Feb-25
91.3%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

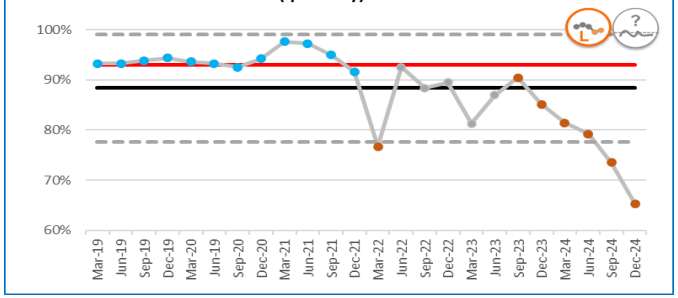
Cancer Waits - 2 week referrals (monthly)



Jan-25
57.4%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

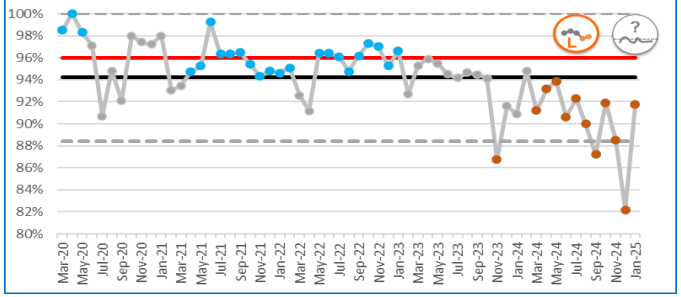
Cancer Waits - 2 week referrals (quarterly)



Dec-24
65.3%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

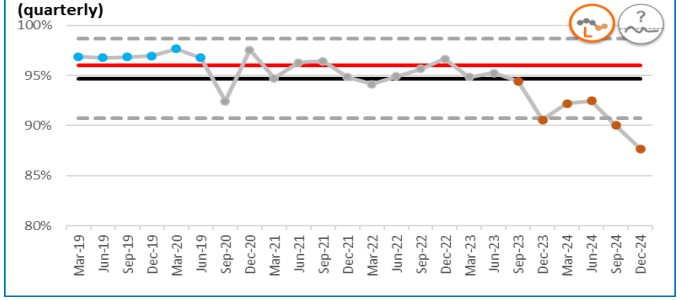
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



Jan-25
91.7%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

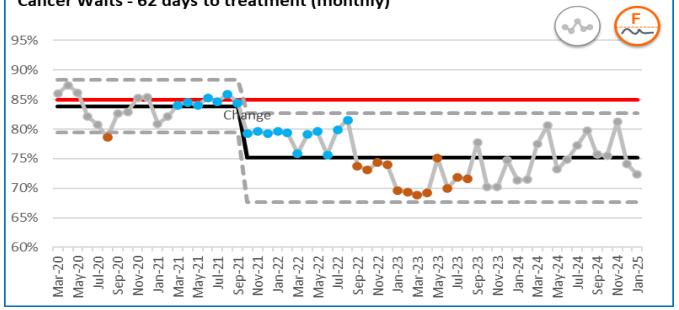
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



Dec-24
87.7%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

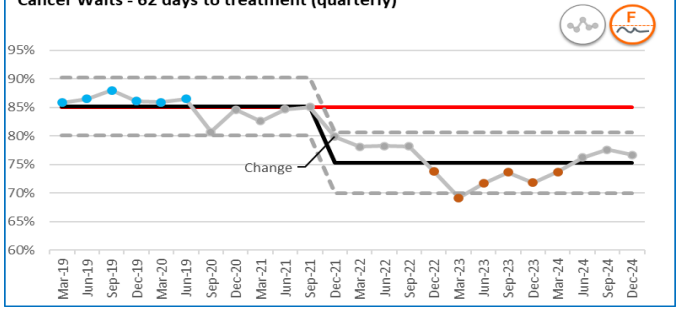
Cancer Waits - 62 days to treatment (monthly)



Jan-25
72.3%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

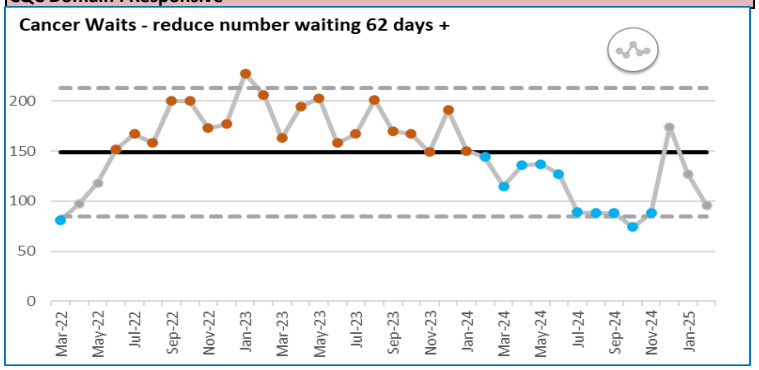
Cancer Waits - 62 days to treatment (quarterly)



Dec-24
76.6%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

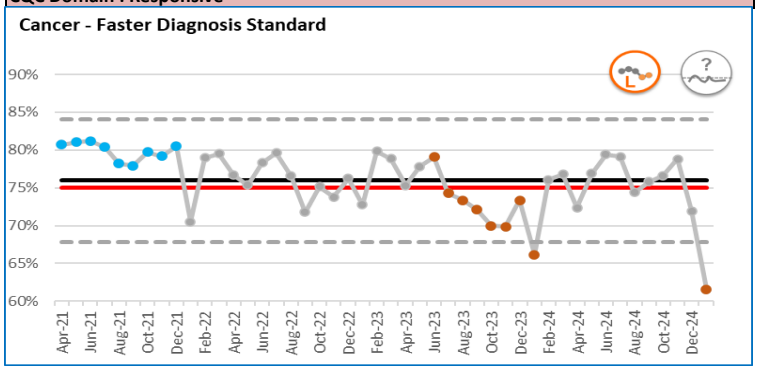
Chief Operating Officer (4)

CQC Domain : Responsive



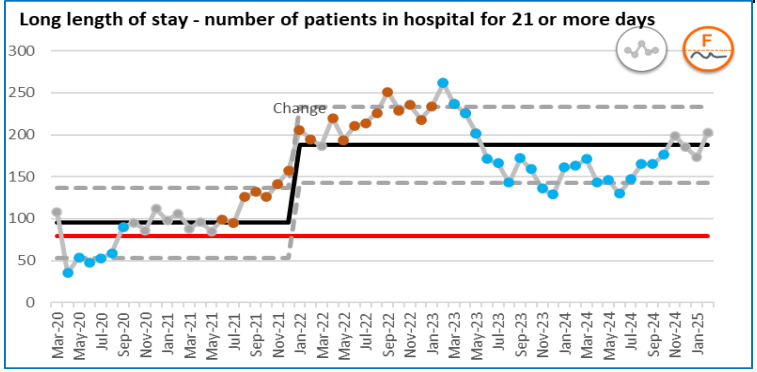
Feb-25
96
Variance Type
Common cause variation
Threshold
83
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



Jan-25
61.6%
Variance Type
Special cause variation - concerning
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

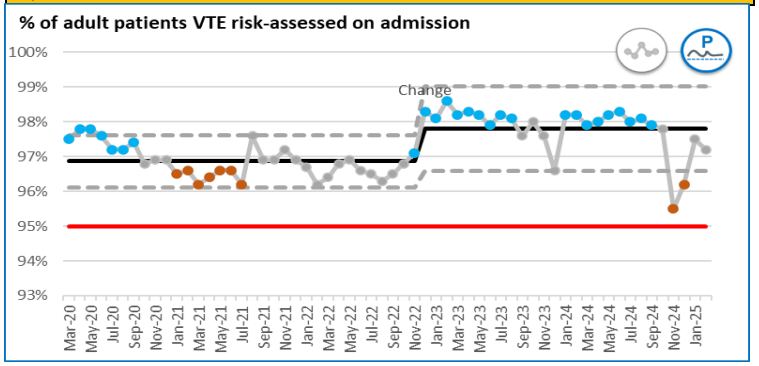
CQC Domain : Effective



Feb-25
203
Variance Type
Common cause variation
Threshold
≤79
Assurance
Performance consistently fails to achieve the target

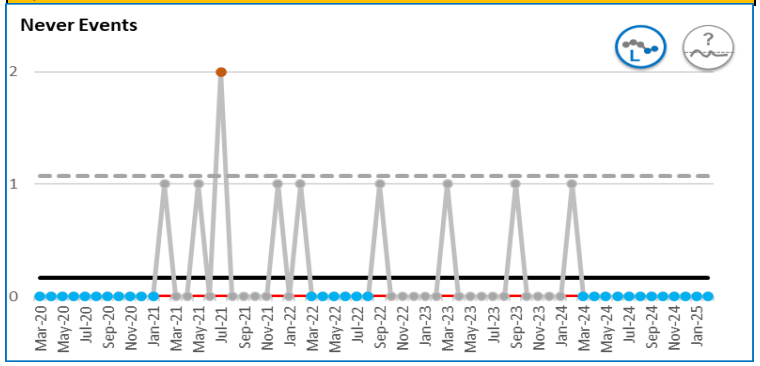
Medical Director

CQC Domain : Safe



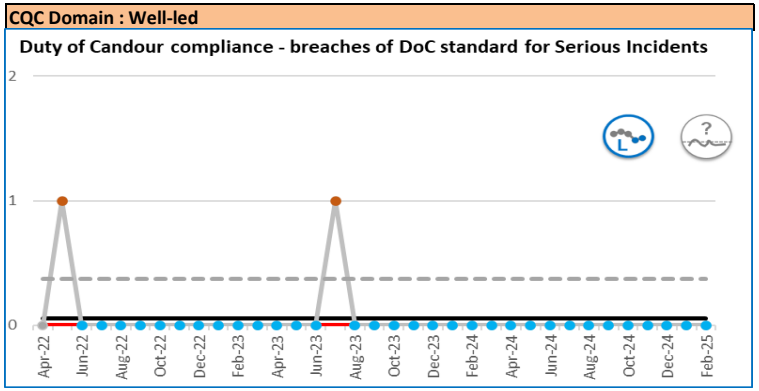
Feb-25
97.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



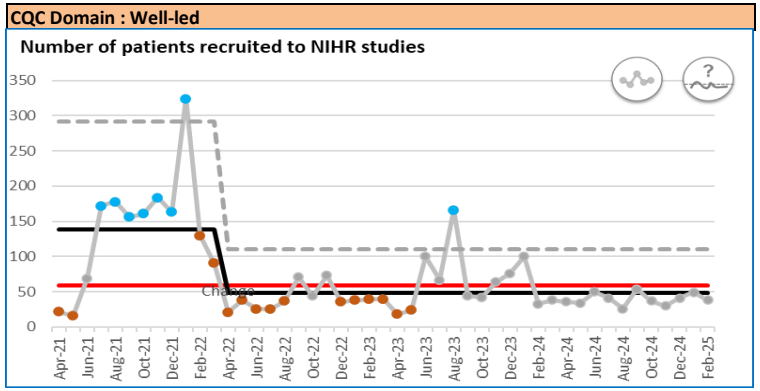
Feb-25
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led



Feb-25
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led

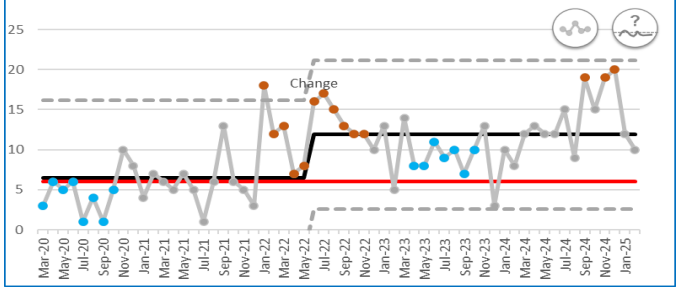


Feb-25
38
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse (1)

CQC Domain : Safe

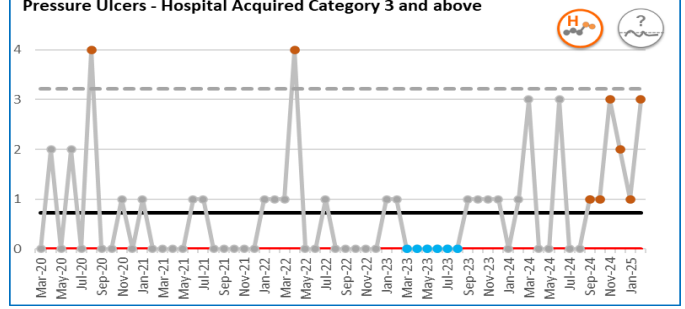
Clostridioides difficile (healthcare associated)



Feb-25
10
Variance Type
Common cause variation
Threshold
≤9
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

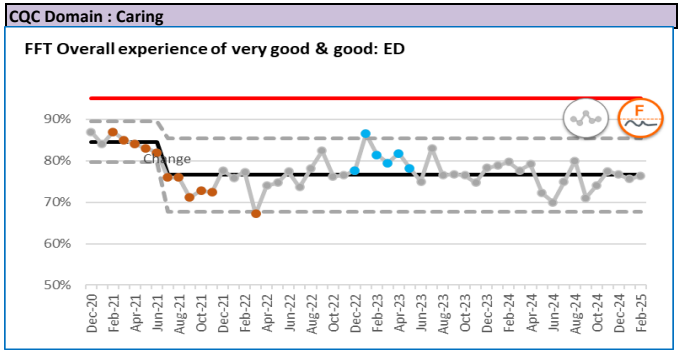
Pressure Ulcers - Hospital Acquired Category 3 and above



Feb-25
3
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

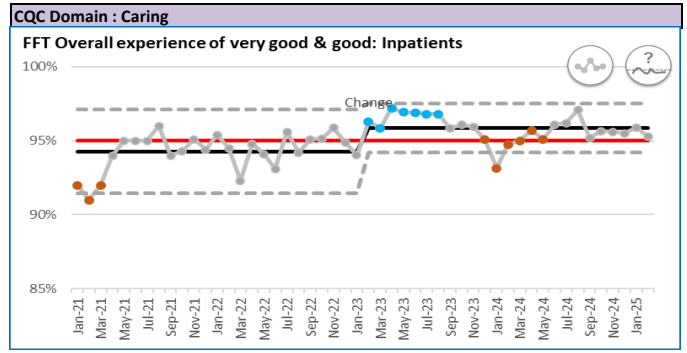
FFT Overall experience of very good & good: ED



Feb-25
76.4%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

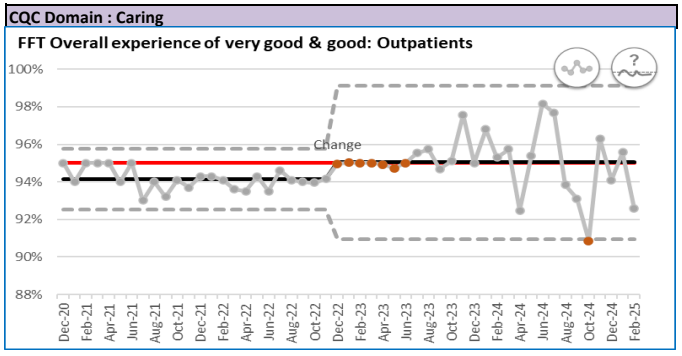
FFT Overall experience of very good & good: Inpatients



Feb-25
95.3%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

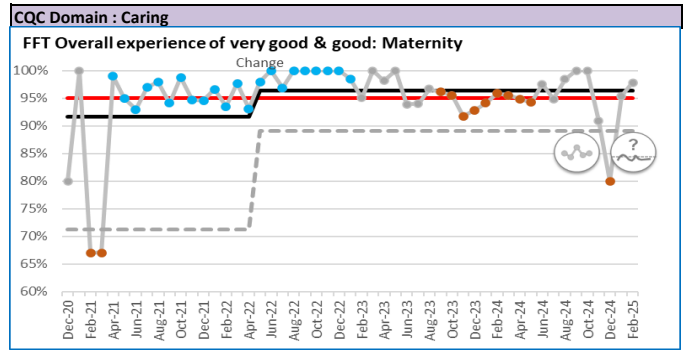
FFT Overall experience of very good & good: Outpatients



Feb-25
92.6%
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: Maternity

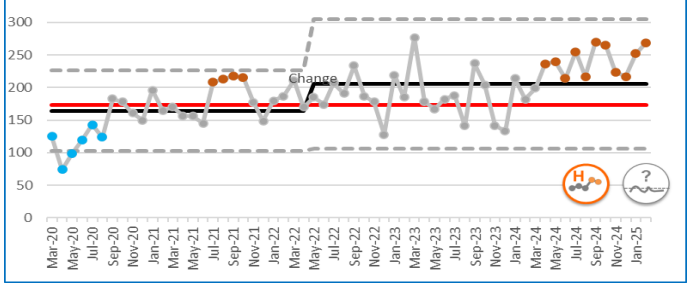


Feb-25
97.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse (2)

CQC Domain : Responsive

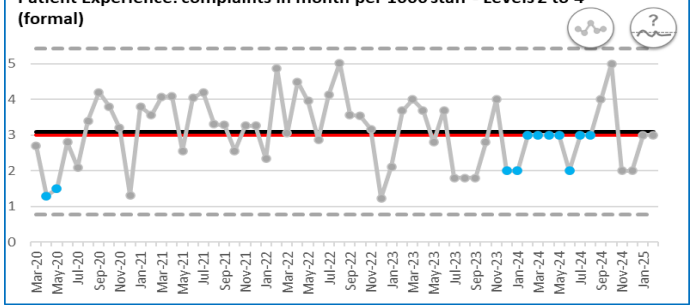
Patient Experience: concerns received in month - Level 1 (informal)



Feb-25
269
Variance Type
Special cause variation - concerning
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

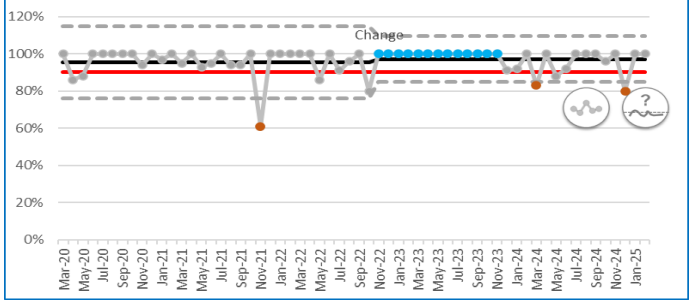
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)



Feb-25
3
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

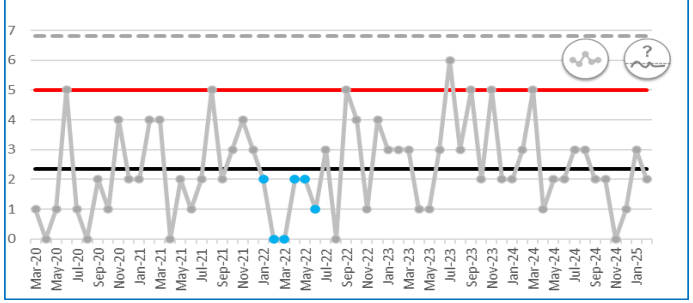
Formal Complaint acknowledged within 3 working days



Feb-25
100.0%
Variance Type
Special cause variation - concerning
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

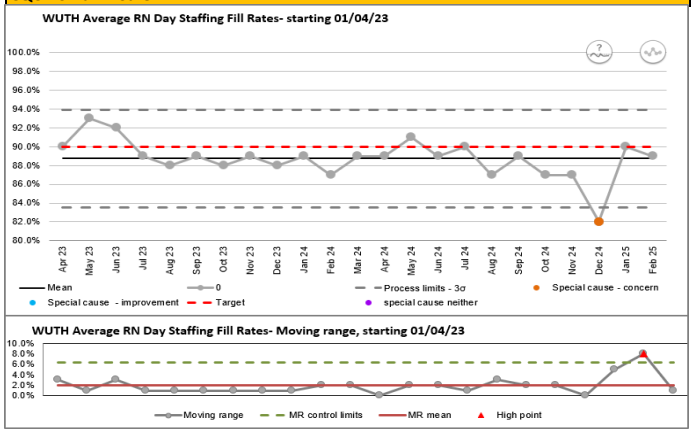
Number of re-opened complaints



Feb-25
2
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

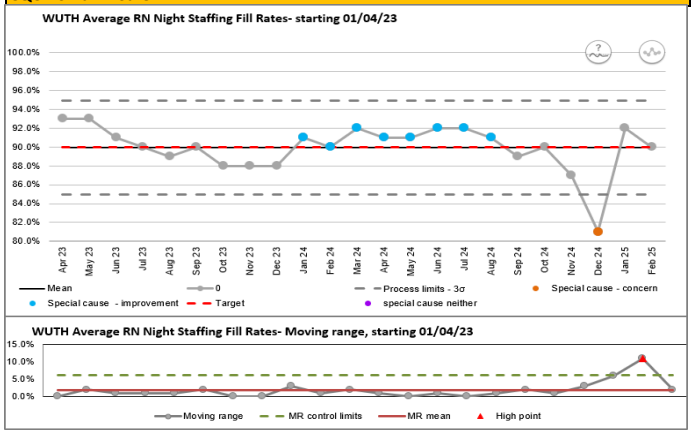
Chief Nurse (3)

CQC Domain : Safe



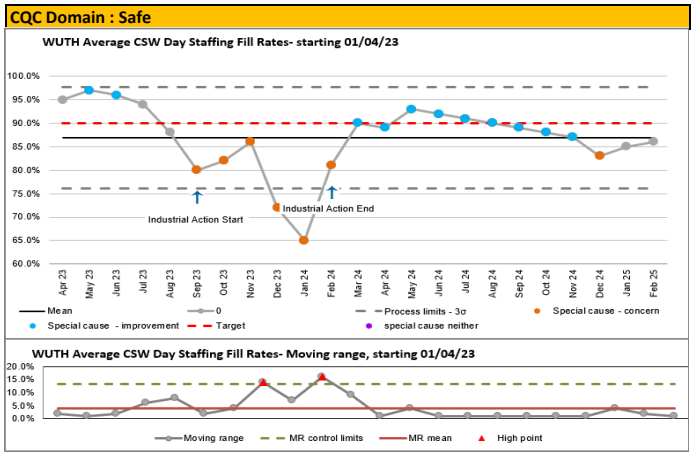
Feb-25
89.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



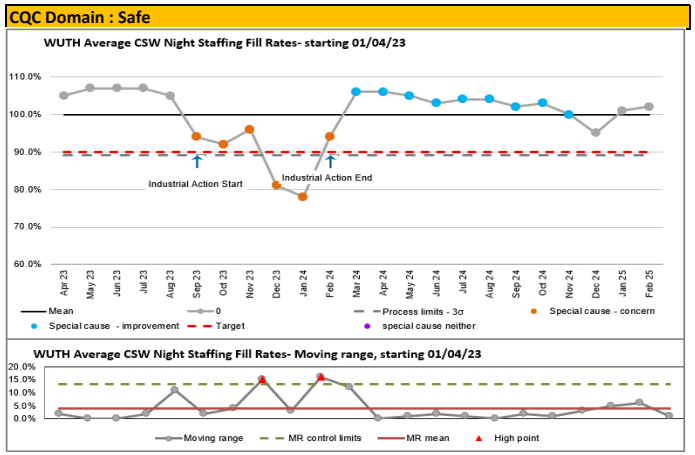
Feb-25
90.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe



Feb-25
86.0%
Variance Type
Actual below threshold
Threshold
≥90%
Assurance

CQC Domain : Safe



Feb-25
102.0%
Variance Type
Actual above threshold
Threshold
≥90%
Assurance

Chief Nurse – February 2025 data

Overall position commentary

The Trust quality KPIs all demonstrate no significant variation in month.

C Difficile remains above the target of 6 per month, there were 10 Incidents in February 2025, second month of reduction.

There was 3 category 3 hospital acquired pressure ulcer in February 2025 against a target of 0.

Friends and family test for ED 76.4%, Outpatients 92.6%, 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 was below the agreed threshold.

RN and CSW staffing fill rates were above the threshold of 90% at nighttime and slightly below during the day.

Infection Prevention and Control

Narrative:

To achieve the annual threshold of ≤ 103 patients diagnosed with CDT in 24/25.
Since 1st April 24 – 28th February 25 there has been 156 patients diagnosed with *Clostridioides difficile* Infection, of those reported there are 108 Hospital-onset health care associated (HOHA) and 48 Community onset healthcare associated (COHA). In February there were 10 HOHA and 0 COHA. This is an overall reduction of 2 when compared to the previous month.

The IPC Doctor is reviewing the patients who have had relapses since 1st April 2024 for themes, as these patients will have been reported in our figures more than once.

Collaborative working with the Community Trust is ongoing and the Wirral Wide *Clostridioides difficile* strategy developed by the Directors of Infection Prevention & Control and Associate Director of Quality continues to be progressed locally

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.
- Collaborative monthly meeting with WUTH IPC and the Community IPC team
- C&M IPC collaboration group focusing on CDT
- IPC daily review of all side rooms in the medical division to identify who can be moved out should a side room be needed for a patient with loose stools.
- Place based AMR champion funded by public health being progressed.
- Review of patients that relapse to identify common themes.

Risks to position

High site occupancy levels

Patients with competing needs for isolation

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 76.4%. Analysis of the patient comments for ED identifies waiting times and communication, as the main reasons for attributing negative ED response.

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.
- 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 February there was 1 patient who developed 3 x deep tissue injuries that evolved into unstageable pressure ulcers (category 3) on ward 14, the patient was end of life and was admitted with deep tissue injuries that deteriorated.

Actions:

- Tissue Viability Ward Information boards being produced within the division of surgery.
- Tissue Viability Team are developing a pressure ulcer guide for clinical staff
- Tissue Viability team walkabouts are currently being initiated within the division of surgery
- HAPU meetings are being instigated within surgery.
- Roll out of the RED campaign

Risks to position and/or actions:

- Part time leadership within the tissue viability team.

Complaints

Narrative

During February 2025, WUTH received 18 formal complaints (level 2-4) and 269 informal concerns (level 1). The monthly averages year to date are 19 and 236 respectively.

Acute Care received in the highest number of formal complaints.

Medicine received the most informal concerns, then Surgery, then Women's and Children's, then Diagnostics and Clinical Support, and then Acute Care.

Top three themes for the organisation (concerns and complaints) were:

- Access and Admission (34%, mostly reflecting delays and cancellations).
- Communication (19%, mostly communication failure rather than attitude).
- Treatment and Procedure (17%, again, mostly forms of delay)

The highest featuring departments were ED, followed Community Child Health.

Average response time of 71 working days. At the end of February, there were 44 formal complaints in progress.

Actions:

Average complaint response time during the fiscal year to date remains is at 68 working days (compared with 70 working days in 2022/23, 58 working days in 2021/22, and 45 working days 2020/21).

Performance oversight continues to be provided to the divisional triumvirates via daily reports and weekly meetings with the central Complaints Team, which also continues to provide monthly training sessions for staff.

Risks to position and/or actions:

· Operational pressures
· Variable skillsets evident in investigations

Nurse Staffing Fill Rates

Narrative:

Registered nurse and care support working fill rates should be reported to the board on a monthly basis 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. February saw adequate fill rates for RN day and Night and CSW night shift.

Actions:

Review of vacancies across the organisation, to fully understand the risk and impacts and determine the most effective recruitment process ie; speciality based recruitment events. Including ED.

Acuity review completed with new safer nursing care tool, data currently being analysed. Report to board in March 2025, second round data collection to commence in March 25

Assurance re effectiveness of absence management.

Weekly roster oversight review meetings undertaken by DCN/CN to review use of bank and agency, and roster KPI's

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.

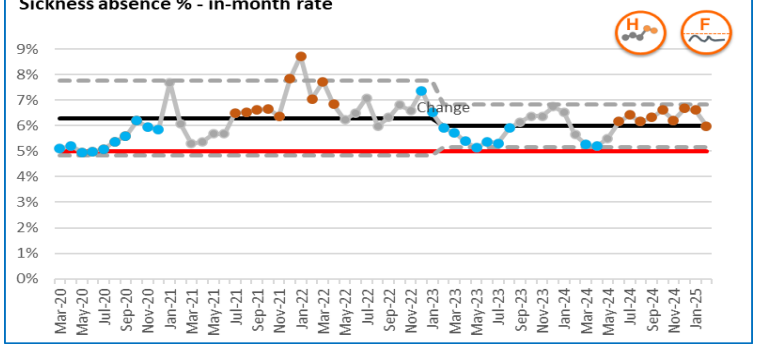
Risks to position and/or actions:

- High sickness absence rates.
- Staffing escalation areas and temporary escalation areas ie; ED corridor.

Chief People Officer

CQC Domain : Safe

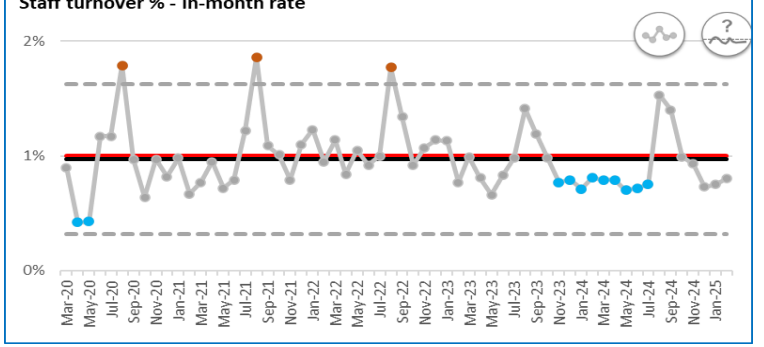
Sickness absence % - in-month rate



Feb-25
5.99%
Variance Type
Special cause variation - concerning
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe

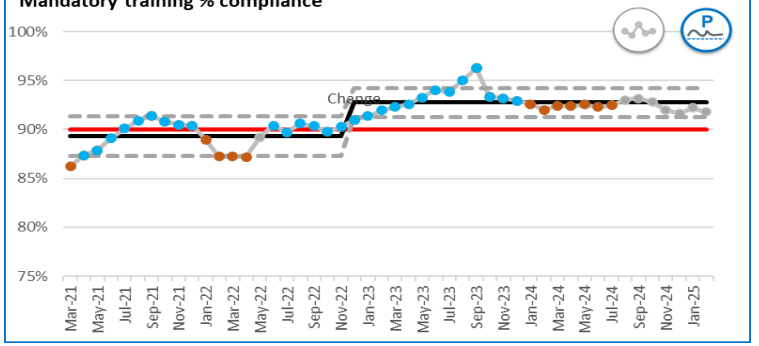
Staff turnover % - in-month rate



Feb-25
0.80%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

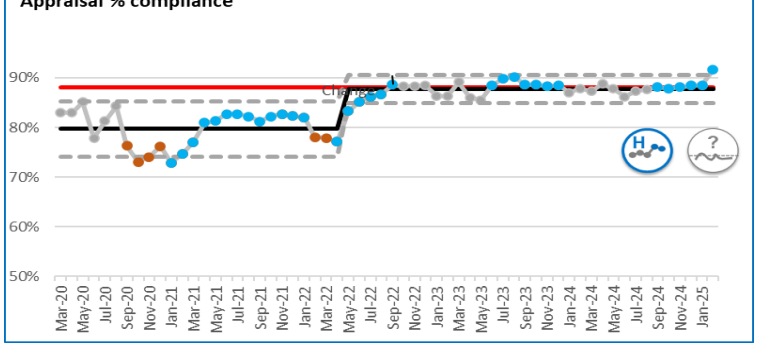
Mandatory training % compliance



Feb-25
91.79%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led

Appraisal % compliance



Feb-25
91.61%
Variance Type
Special cause variation - improving
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – for Feb 2025 BoD

Overall position commentary
The Trust's People KPIs for mandatory training, appraisal compliance and turnover are on target. Sickness absence has improved by 0.7% in February however it remains above target at 5.99% and an area of concern and focus.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is ≤5%. For February 2025 the indicator was 5.99% and demonstrates special cause variation - concerning.

The majority of absences relate to short term sickness. Cold/flu, anxiety/depression and gastrointestinal illnesses account for just under 50% of all absences in February 2025. Additional Clinical Services, Nursing and Midwifery, and Estates and Ancillary staff groups continue to experience high levels of absence, although all have improved in month.

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

Actions:

Proactively supporting Physical Health & Wellbeing

- Targeted psychological support for teams, as issues arise via OH Clinical Psychologist.
- A new 12-month program for psychoeducation on 'Burn out' and 'Resilience' is under development for launch in April 2025.
- New Mental Health First Aid training delivered.
- Mental Health First Aid events are planned throughout the year.
- Improvement in Occupational Health waiting times for both physicians and nurse advisors.
- Additional Occupational Physician (OHP) session to reduce waiting times.
- Route to allow expedited OH access.
- Revised approach to metal health referrals has been implemented in OH to ensure earlier and appropriate interventions to improve access to treatment.

Managing Absence

- 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.
- There are an increased number of cases being formally managed through the new Attendance Management Policy.

- Revised approach to local attendance management audits is implemented.
- New reporting of local Attendance Management Audits has been implemented which include Divisional Triumvirates, DPRs and Workforce Steering Board.

Risks to position and/or actions:

The local risk (397) score is 15 and BAF risk is 12.

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, financial controls and staff morale / engagement. Effective attendance management is critical and contributes to productivity and patient care. The negative impact of both sickness absence and presenteeism on the workforce and patient care are well known and understood across the Trust. The Trust is committed to the health and wellbeing of its staff aligned to the NHS People Promise. This is set out in the Trust Strategy – Be a great place to work and in our People Strategy – Looking After Ourselves and Each Other.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 9**
2 April 2025

Report Title	Committee Chairs Reports – Charitable Funds Committee
Date of Meeting	28 February 2025
Author	Lesley Davies, Non-Executive Director and Meeting Chair

Alert	• The Committee wish to alert members of the Board of Directors that: ○ The Charity will be launching a successor appeal to Tiny Stars which concludes planned fundraising in March 2025. There are several steps that will be undertaken by the charity as part of selecting the next appeal. These steps include investigation, engagement and planning. The new appeal is expected to launch in January 2026. ○ The Committee has asked for an impact analysis on other funds, events and operational costs for the period April 2025 to December 2026. ○ Some fundraising events will continue until December 2025 ○ The Committee requested a formal completion paper for the Tiny Stars appeal as part of good governance and oversight of the completion of the campaign.
Advise	• The Committee wish to advise members of the Board of Directors that: ○ The Committee was provided with the fund-raising events list which commences March 2025. The list includes a range of activities that will contribute to the charity's fund raising and income for the forth coming year. Activities include coastal walks, Boogy Bingo, Windermere swim and Elf run; it was good to see the diversity of the planned events which will provide opportunities for a wide engagement from staff and supporters. ○
Assure	• The Committee wish to assure members of the Board of Directors that: ○ The Neo Natal Unit re-development is progressing well and is now at the detailed design phase and RIBA stage 4. The re-development will provide an additional 9 cot bays and will enhance facilities for parents/guardians and babies. The team continues to engage with parents regarding the re-development and recently held an event to demonstrate the improvement plans and take feedback. The Committee took good assurance from the progress being made with this redevelopment.

	○ Fund raising is on track against the agreed annual target and currently stands at 83% of total year's income with the expectation that the target will be reached.
Review of Risks	• Allocation of overheads – The period following Tiny Stars completion and before the new campaign is launched in January 2026 is likely to see significant changes to the distribution across funds of the Charity's overheads. It was agreed that the charity would look to review the impact of the delay in launching new campaign
Other comments from the Chair	• No other comments.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 10**
2 April 2025

Report Title	Committee Chairs Reports - Research and Innovation Committee
Date of Meeting	6 March 2025
Author	Sir David Henshaw, Chair of Research and Innovation Committee

Alert	The Committee wish to alert members of the Board of Directors that: • Current recruitment to studies is below target of 700 and this puts the Trust at risk of reduction/loss of funding from the Regional Research Delivery Networks (RRDNs) once the new funding model comes into effect from March 2026. • There is a risk of underutilisation of the Wirral Research and Innovation Centre at Clatterbridge. However, 3 studies currently in set up that will utilise this space once open.
Advise	The Committee wish to advise members of the Board of Directors that: • Key performance metrics in the future will be number of open studies, diversity of research speciality, set up times and number of commercially sponsored studies as opposed to number of recruits. • Portfolio has been rationalised and only 2 studies not performing as anticipated. Action plan in place to address this. • The Trust is a spoke site for the Commercial Research Delivery Centre for Cheshire & Merseyside which promises participation in more commercially sponsored studies. • The Trust also maintains good relations with the Wirral Research Collaborative, linking research in the primary and secondary sectors. • Early discussions have been held with the Clinical Lead from Wirral Community Health Trust in relation to merging the Research Teams. • Business proposal for 2 x B6 research nurses to join the team on fixed term contract using existing research funding
Assure	The Committee wish to assure members of the Board of Directors that: • Research Champions initiative has proved very worthwhile with 8 champions in post across 5 specialities. • 42 studies open and recruiting, 10 in set up (3 commercial), 8 expressions of interest sent to sponsors. • Research Bank set up currently with 2 active staff. • Discussions held with Divisional Nurse Leads regarding nurse (ANPs and CNs) involvement in research • Revised study approval process proving beneficial in that set up times now well within 40 day target.

Review of Risks	• No additional risks were identified.
Other comments from the Chair	• The innovation side will be taken on by alternative teams – quality assurance/ continuous improvement.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 11**

02 April 2025

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

Report Purpose and Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in March 2025.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).

Included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (February 2025) key quality and safety metrics and the position of patient safety incidents.

This paper provides a specific update regarding MIS Year 7, Saving Babies Lives (SBLv3), Maternity Programme Online Portal (MPOP).

It is recommended that the Board:

- Note the report.
- Note the Perinatal Clinical Surveillance Assurance report.
- Note the summary of Maternity Incentive Scheme Year 7.
- Note the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3.
- Note the position with the MPOP and NETS feedback report.

Key Risks

This report relates to these key Risks:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes

Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
March 2025	Divisional Quality Board (DQB)	Quarterly Maternity and Neonatal Services Report	For information
April 2025	Maternity & NNU Assurance Board	Quarterly Maternity and Neonatal Services Report	For information
April 2025	Patient Safety and Quality Board	Quarterly Maternity and Neonatal Services Report	For information

1	**Perinatal Clinical Surveillance Quality Assurance Report**
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (February 2025) 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. There have been no further datasets shared or any feedback provided.

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 February 2025 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date there are two active cases, two received in draft for comments and two final agreed reports. There were no Patient Safety Investigation Incidents (PSII's) declared in February 2025 for Neonatal services.

3	Maternity Incentive Scheme (MIS) Year 7
	The declaration for MIS Year 6 was submitted to NHSR and the feedback for the external verification for Safety Action 1 is awaited. The Maternity Incentive Scheme Year 7 is due to be launched on 2 April 2025 and a summary overview of the expected changes at **Appendix 2.**

4	Saving Babies Lives v Three (SBLv3) Safety Action 6 of the MIS 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 31st December 2024 (Q3) the Trust achieved 91% 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.

5	Maternity Programme On-line Portal (MPOP)
	The gap analysis is included at **Appendix 4** and remains in the same RAG rated position as fully compliant. The LMNS gave exemplary feedback to the organisation on the National Education and Training Survey 2024 for student Midwives in maternity services and a full report is included at **Appendix 5**.

6	MBRRACE UK PMRT Report – 2023 Births
	The Perinatal Mortality Review of 2023 births is (PMRT) is included at **Appendix 6.**

7	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.

8	Implications
8.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
8.2	**People** • Submission to NHSR that 9 safety standards have been met with a manual revalidation requested for safety standard 1, providing 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.
8.3	**Finance** • In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) and continue to deliver Maternity Continuity of Care for women/birthing people with enhanced care needs, investment into the maternity and workforce is required and funding options continue to be explored. A paper has been approved at EARC for an increase in the maternity establishment to permanent posts with funding received for 25/26, not confirmed as recurrent. • BR Plus workforce planning has indicated investment is required to support safe staffing maternity levels and confirmed a deficit in midwifery staffing levels. A business case will be prepared in order to support and achieve Safety Action 5.
8.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Wirral University Teaching Hospital
NHS Foundation Trust

Title	Learning from Deaths Report (Q3 2024-2025)
Area Lead	Dr Nikki Stevenson, Executive Medical Director
Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board of Directors with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q3 2024-2025.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths.
- The Trust SHMI for the 12 months to Aug 2024 is 98.17 (within expected range)
- Deaths due to Myocardial Infarction have a higher than expected SHMI (154.12)
- HSMR on the latest available data is 100.9 (within expected range)
- The rise in HSMR from the previous quarter is due to Telstra Health using new methodology
- Telstra Health have flagged a CUSUM Alert for deaths due to congestive cardiac failure
- 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

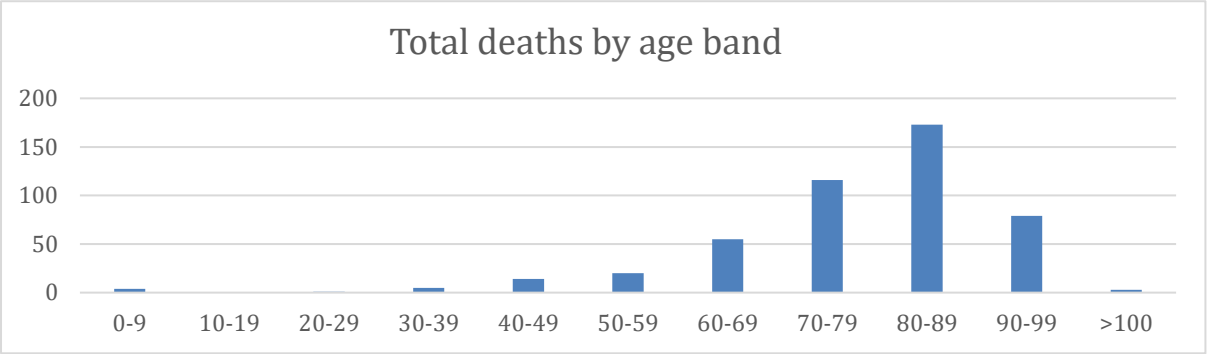
This is a standing report.

1	Narrative
1.1	This report provides a summary of all deaths that occurred within Wirral University Teaching Hospitals NHS Foundation Trust over Quarter 3 (Oct 24- Dec 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.

Patient demographics

There was a total of 471 deaths in Q3 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	436
White - Irish	3
White - Any other White background	2
Mixed - Any other mixed background	0
Asian or Asian British - Indian	1
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	3
Other Ethnic Groups -	1
Black/ Black British	1
Not stated/ Not known	24
Total	471

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The overall SHIMI for WUTH on the latest available data (12 months to August 2024) is 98.17 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

During this period one diagnostic group is alerting a high SHIMI. This is in deaths due to Acute myocardial infarction (SHIMI 154.12). Work is underway to examine this and is described in more detail later in this report

- Deprivation

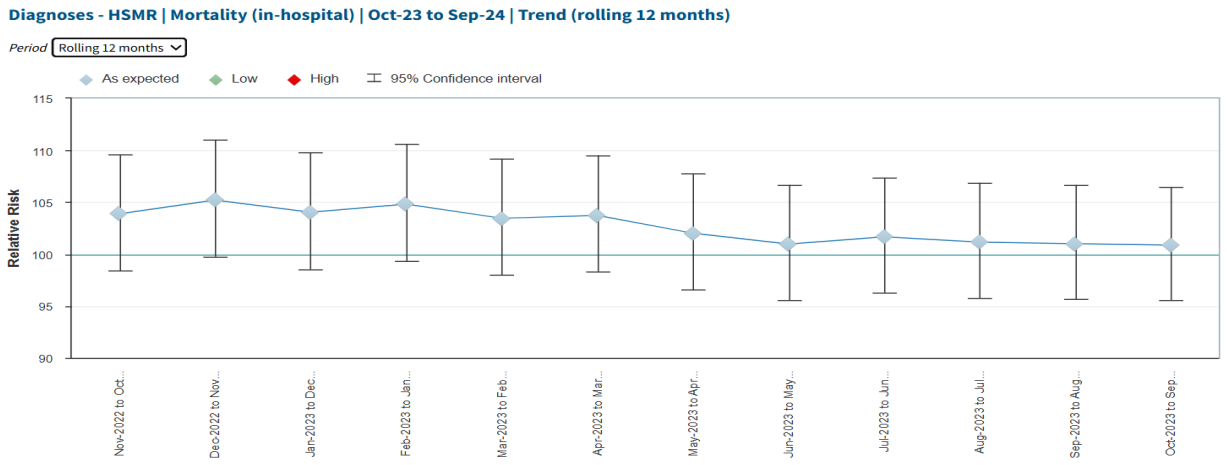
The Trusts continues to have a higher-than-average percentage of provider spells from the most deprived areas. Potential additional risks/complexities associated with these patients, is not factored into the SHMI calculation unlike HSMR, and can lead to a higher SHIMI.

- 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 100.9 This is in the expected range.
As dsicussed in previous reports Telstra Health has now moved to HSMR + which has resulted in a rise in the absolute value (increase from 98 to 100.9)



As can be seen from the graph HSMR has shown a slight downward trend over the past four rolling 12-month periods

Mortality Dashboard

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

41 cases escalated by the ME service during Q3 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 27 deaths were allocated for review in Q3 (6%) using the PMR template.

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
Q4 (23-24)	509	100 %	25	24	49
Q1 (24-25)	420	100%	9	12	21
Q2 (24-25)	436	100%	16	32	48
Q3 (24-25)	471	100%	14	27	41

Grading of Adult Care and avoidability following review in Q3 (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	16	6	0	1

During Q3 23 reviews were discussed at MRG and graded as above. One case was sent for further review under PSIRF (missed opportunity for earlier theatre intervention)

During Q3 there was 1 death 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
Q4 (23-24)	3	3	0	3
Q1 (24-25)	0	0	0	0
Q2 (24-25)	5	5	0	5
Q3 (24-25)	1	1	0	1

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
Q4 (23-24)	1	2	0	3
Q1 (24-25)	1	2	1	3
Q2 (24-25)	0	3	3	3
Q3 (24-25)	4	5	4	9

All neonatal deaths and stillbirths will be reviewed using the PMRT process

There were 4 paediatric deaths (IP and community) during Q3. Two of these deaths were expected medical causes.
Two paediatric deaths will be investigated through SUDIC. One was a RTA and one death due to non-accidental injuries.

Outcome of PMRT reviews reported in Q3				
	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
	1	0	0	0

Learning Identified from PMRT reviews.

During Q3 one PMRT report was received that graded care as B (care issues identified that would not have affected outcome)

The mother was assessed as high risk and in need of Aspirin that was not prescribed. As a result, the Aspirin protocol has been reviewed to ensure high risk patients are highlighted.
.

Learning identified through review of mortality reviews during Q3.

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 Q3 as well as actions taken are listed in the table below.

Learning theme	Source	Action taken
DNACPR forms are not always fully completed	Mortality reviews	Learning is fed back on an individual basis in real time. From April 2025 the Trust will be participating in the national cardiac arrest audit (NCAA) that will help identify learning
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. Themes and trends are discussed at MSOP and feedback to all clinical areas
Missed opportunity to prescribe aspirin	PMRT	Aspirin protocol reviewed to ensure high risk patients are not missed
Nosocomial Infections prolonging length of stay	Mortality reviews	SOP for side room allocation reviewed. Proactive HPV cleaning programme initiated for C Diff cleans

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.

During Q3 an alert around congestive cardiac failure was highlighted. SHIMI also alerted for deaths due to Myocardial Infraction. As a result we are undertaking a review of these two diagnostic groups that will include a review of national audit data (MINAP and Heart failure audits) as well as a case review of a sample of deaths in the category. This will be coordinated through MRG.

	Conclusion • Mortality Indicators remain in the “as expected” category • Two areas have been flagged as requiring in depth review to provide assurance around mortality (Deaths due to Myocardial Infarction and Congestive heart failure). This work will be coordinated through MRG • MRG continues to meet every 2 weeks to scrutinise and review mortality across the Trust • The Medical examiner service continues to provide 100% scrutiny of all inpatient and Emergency Department deaths

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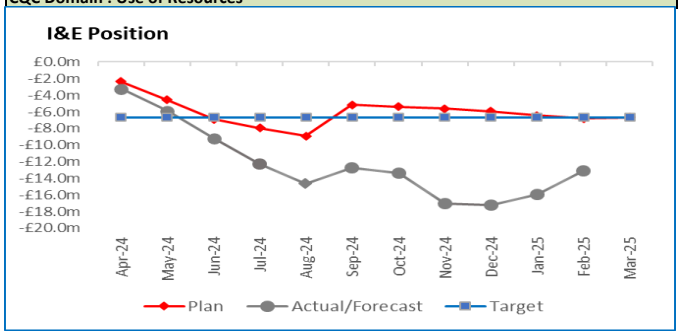
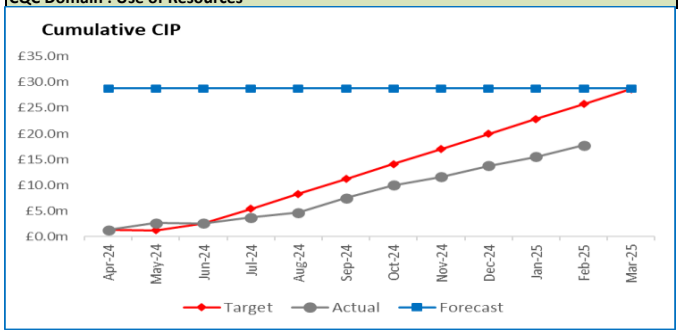
Chief Finance Officer

CQC Domain : Use of Resources



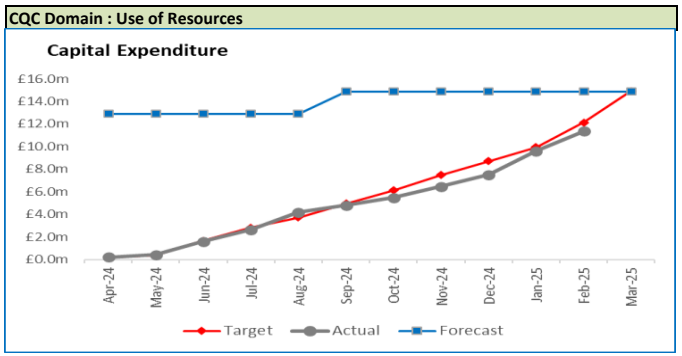
Feb-25
-£13.1m
Variance
Position worse than plan
Target
-£5.9m

CQC Domain : Use of Resources



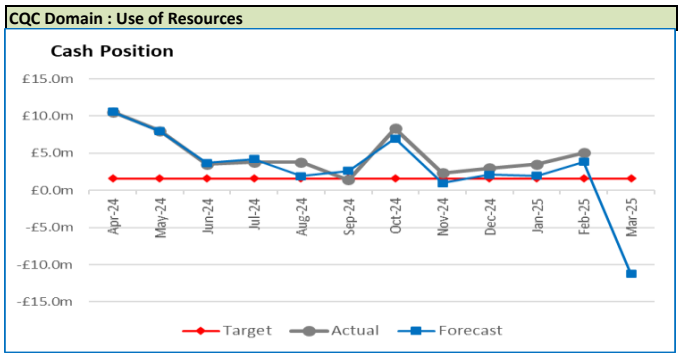
Feb-25
£17.8m
Variance
Position worse than plan
Target
£19.9m

CQC Domain : Use of Resources



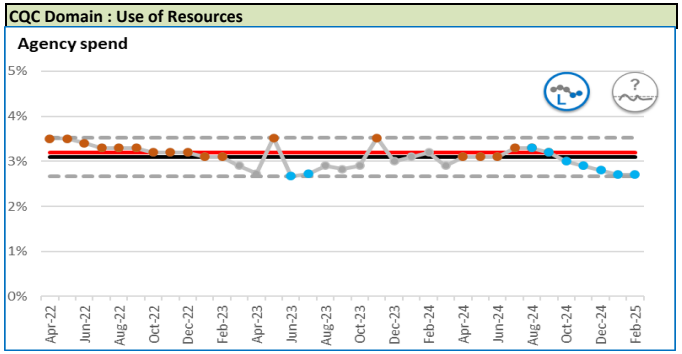
Feb-25
£11.4m
Variance
Position better than plan
Target
£8.7m

CQC Domain : Use of Resources



Feb-25
£5.1m
Variance
Position better than plan
Target
£1.6m

CQC Domain : Use of Resources



Feb-25
2.70%
Variance
Position better than threshold
Threshold
3.2%

Executive Summary

At the end of February, M11, the Trust is reporting a deficit of £13.1m, an adverse variance against plan of £6.6m. The Trust will implement a further £7.8m of mitigations prior to year-end, resulting in a mitigated forecast of £9.8m, an adverse variance to plan of £3.1m.

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

- the cost and lost income associated with the Cyber Incident.
- the full delivery of the elective activity plan.
- the Cost Improvement Programme (CIP).
- maintaining expenditure on urgent care within planned levels.
- delivering planned integration benefits.

The Trust has fully engaged with NHSE and C&M ICB to plan agree the mitigation actions to reduce expenditure and increase income so that the Trust variance to plan is minimised.

The deficit continues to place significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP). The Trust request for additional cash in March was not approved and therefore working capital measures have been significantly escalated in M12.

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 (M11)	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.
- Approve a revision to reporting to reflect the forecast £3.1m variance to plan.
- Note that the Trust request for cash support in M12 was declined and that the agreed escalated working capital plan has been implemented.

I&E Position

Narrative:

The table below summarises this I&E position at M11:

	Year to Date			Forecast		
Cost Type	Plan	Actual	Variance	Plan	Forecast	Variance
Clinical Income from Patient Care Activities	£439.9m	£437.5m	-£2.5m	£479.5m	£472.2m	-£7.3m
Other Operating Income	£30.8m	£31.9m	£1.0m	£33.6m	£39.6m	£6.0m
Total Income	**£470.7m**	**£469.3m**	**-£1.4m**	**£513.1m**	**£511.8m**	**-£1.3m**
Employee Expenses	-£336.9m	-£339.3m	-£2.4m	-£367.5m	-£369.7m	-£2.2m
Operating Expenses	-£142.6m	-£138.7m	£3.9m	-£155.2m	-£155.4m	-£0.2m
Non Operating Expenses	-£5.5m	-£4.4m	£1.1m	-£6.0m	-£5.0m	£1.0m
CIP	£7.8m	£0.0m	-£7.8m	£9.0m	£0.7m	-£8.2m
Total Expenditure	**-£477.2m**	**-£482.4m**	**-£5.2m**	**-£519.7m**	**-£529.3m**	**-£9.6m**
Unmitigated Forecast	**-£6.5m**	**-£13.1m**	**-£6.6m**	**-£6.6m**	**-£17.6m**	**-£10.9m**

The unmitigated forecast position is before Board approved actions which will reduce the forecast deficit to £3.1m.

Key variances within the YTD position are:

Clinical Income – £2.5m adverse variance relates to underperformance against the value of the elective plan in Surgery and the impact of the Cyber Incident. This has been offset by the release of historic deferred income balances.
Employee Expenses - £2.4m adverse variance relates to the approved increase in nursing staff and the continued pressure on medical bank in ED.
Operating expenses – £3.9m favourable variance relates to underspend on consumables driven by the under delivery of the elective plan in Surgery.
Cost Improvement Programme – £7.8m adverse variance for CIP across clinical divisions. This is offset by non-recurrent underspends.

The Trust's agency costs were 2.3% for the month and 2.7% for the YTD, the Trust is below the NHSE threshold of 3.2% of total staff costs.

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 £19.5m of CIP at M11 which is £8.3m behind plan. The Trust has risk adjusted our CIP forecast to £20.5m, a shortfall against target of £8.0m.

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 £11.8m in M11 and £96.3m YTD, an adverse variance of £16.6m for the year. This is primarily driven by underperformance in respect of the Cheshire and Merseyside Surgical Centre (CMSC), a shortfall of elective and day cases in Surgery, a lower case mix within the Division and the impact of the Cyber Incident.

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:

The table below confirms the Trust's final capital budget for 2024/25.

Description	Approved Budget at M1	Revision to Budget M2	Revision to Budget M6	Revision to Budget M7	Approved Revisions M10	Future Anticipated Revisions	Revised Budget
CDEL							
Internally Generated	£12.870m						**£12.870m**
ICB/PDC/WCT	£6.284m	-£1.400m	£1.953m		£1.074m	£6.060m	**£13.971m**
Charity	£1.000m			-£1.000m			**£0.000m**
Confirmed CDEL	**£20.154m**	**-£1.400m**	**£1.953m**	**-£1.000m**	**£1.074m**	**£6.060m**	**£26.841m**
Total Funding for Capital	£20.154m	-£1.400m	£1.953m	-£1.000m	£1.074m	£6.060m	£26.841m
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
LED Lighting	£0.000m				£0.990m		£0.990m
DEXA scanner	£0.000m				£0.084m		£0.084m
IMS	£0.000m					£0.060m	£0.060m
Critical Infrastructure	£0.000m					£4.000m	£4.000m
Non-Central Programme	£0.000m					£2.000m	£2.000m
Confirmed PDC	**£1.464m**	**-£1.400m**	**£1.953m**	**£0.000m**	**£1.074m**	**£6.060m**	**£9.151m**
Total Anticipated Expenditure on Capital	£20.154m	-£1.400m	£1.953m	-£1.000m	£1.074m	£6.060m	£26.841m
Under/(Over) Commitment	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m	£0.000m

Spend at M11 totals £11.4m which is £0.2m ahead of plan. We do not anticipate any underspend or overspend at year end.

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

Risks to position:

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

Actions:

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

Cash Position

Narrative:

The cash balance at the end of M11 was £5.1m including both cash support received from NHSE in January and re-profiled ICB contract payments.

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 76% which is 19% lower than the national target of 95%. In M11 the Trust paid 61.3% 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 continues to need deficit and working capital support and the Board supported requesting cash support from NHSE for March, this was declined. The Trust has therefore implemented an agreed escalated mitigation plan, focused on working capital.

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.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 14**
April 2025

Title	Chief Operating Officer's Report
Area Lead	Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Baily, Director of Operations 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. The Board should note the ongoing positive performance with recovering 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.

The Board should note 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 along with system partners.

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	In line with other organisations WUTH continues to recover elective waiting times as an output of the Covid-19 pandemic. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny to ensure delivery of timely ambulance handover. The Trust has also been supported by external agencies on improving the 4 hour performance standard.

2	Planned Care
2.1	**Elective Activity** In February 2024, the Trust attained an overall performance of 94.13%% against plan for outpatients (85.76% for New outpatients) and an overall performance of 99.25% against the plan for elective admissions, as shown in the table below: See table 1 below The Trust overachieved planned level of outpatient new appointments within Medicine, and Women's and Children's Divisions, with underperformance in Surgery and a small reduction in Diagnostics and Clinical Support. Surgery underperformance was seen across GI Surgery and Trauma and Orthopaedics where there are consultant vacancies. Underperformance on elective inpatients was seen in Medicine and Surgery Divisions. Within the Surgery Division it is noted that activity was lost as a result of technical issues within Theatres, where operating resulting in cases being lost.
2.2	**Referral to Treatment (RTT)** The national standard is to have no patients waiting over 65 week waits by end of March 2025. The Trust's performance at the end of February against these indicators was as follows: • 104+ Week Wait Performance – 0 • 78+ Week Wait Performance –7

Activity Type	Target for February	Actual for Febraury	Performance
Out pt New	11,364	9,746	85.76%
Out pt Follow up	23,738	22,582	95.13%
Out pt procedures	2,785	3,335	119.75%
Total Out pts	37,887	35,663	94.13%
Day case	4,348	4,453	102.41%
Inpatients	710	567	79.86%
Total	5,058	5,020	99.25%

- 65+ Week Wait Performance - 63
- 52+ Week Wait Performance – 1,196
- Waiting List Size - there were 47,438 patients on an active RTT pathway which is an increase on the previous position of 47,362.

Despite a small increase in the total number of patients waiting, the Trust continues to make progress on the reduction of the number of long waiting patients. The number of 65 week waiters has reduced by 79% since April 2024 (-238 patients), while the number of over 52 week waiters has reduced by 37% (-688 patients).

The patients waiting over 78 weeks are 2 x Orthopaedic mutual aid patients, 2 Ophthalmology graft patients and 3 x Gynaecology patients as a result of patient choice so no WUTH capacity breaches.

2.3 Cancer Performance

Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 4 to date:

Quarter	4
Period	01/01/2025 - 31/03/2025

National Standards:

Standard	Indicator	Threshold	January-25	February-25	March-25	Quarter 4
28 Day Wait	GP USC Referral or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	75.00%	61.57%	N/A	N/A	61.57%
31 Day Wait	Decision to Treat / Earliest Clinically Appropriate Date to Treatment	96.00%	91.74%	N/A	N/A	91.74%
62 Day Wait	GP USC Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	72.33%	N/A	N/A	72.33%

Sub Standards:

Standard	Indicator	Threshold	January-25	February-25	March-25
28 Day Wait	Individual Trust Provider Trajectory	Per Month	61.57%	N/A	N/A
28 Day Wait	Breast >=90%	90.00%	59.55%	N/A	N/A
28 Day Wait	Skin >=90%	90.00%	89.74%	N/A	N/A
62 Day Wait	Individual Trust Provider Trajectory	Per Month	72.33%	N/A	N/A

Removed Standards (Not National Standards):

Standard	Indicator	Threshold	January-25	February-25	March-25
14 Day Wait	GP USC Referral to First Appointment	93.00%	57.43%	N/A	N/A

- *Faster Diagnostic Standard (FDS)* – The Trust failed to meet the FDS standard for January 2024, with performance of 61.57%. The cyber incident was seen to have an impact here, with performance forecast to recover in February.
- *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. Trust performance was below trajectory of 76.5% in January 2025 (see '62 Day Wait' in Sub Standards section of the table above).
- *62 day waiters* – the number of waiters increased in January 2025 and is above trajectory (127 patients against a trajectory of 33).

	01/04	06/05	03/06	01/07	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	04/11	11/11	18/11	25/11	02/12	09/12	16/12	23/12	30/12	06/01	13/01	20/01	27/01
Actual 24/25	135	141	127	106	82	90	92	93	88	76	74	79	88	88	81	80	74	83	88	88	88	116	137	146	146	174	167	174	148	127
Trajectory	120	112	103	93	83	83	83	83	72	72	72	72	72	60	60	60	60	50	50	50	50	40	40	40	40	40	33	33	33	33
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

- *104 day long waiters* – performance is ahead of trajectory for December, at 30 against a plan of 10.

	01/04	06/05	03/06	01/07	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	04/11	11/11	18/11	25/11	02/12	09/12	16/12	23/12	30/12	06/01	13/01	20/01	27/01
Actual 24/25	45	38	34	42	26	23	22	19	24	22	21	17	19	15	16	12	12	18	20	20	20	25	21	24	24	29	31	33	37	30
Trajectory	50	47	42	39	33	33	33	33	30	30	30	30	30	23	23	23	23	20	20	20	20	14	14	14	14	14	10	10	10	10
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

Forecasts for February see an improvement in 28 day performance, but 62 day performance remain below trajectory.

2.4 DM01 Performance – 95% Standard

At the end of December 91.25%% of patients had been waiting 6 weeks or less for their diagnostic procedure for those modalities included within the DM01, with the requirement for Trusts to achieve 90% by March 2025. This is an improvement on the previous month's performance of 85.9%.

The impact of the cyber incident continues to affect performance across modalities. Non-obstetric ultrasound, as a high-volume modality, remains the area most notably impacted with a significant number of cancellations. A recovery plan is in place to restore non-obstetric ultrasound with support from other Trusts and outsourcing company explored.

Endoscopy also remains an area of pressure, with external funding secured from the Cancer Alliance to support additional lists.

2.5 Risks to recovery and mitigations

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

There is a risk that a small number of patients will not be treated within 65 weeks by the end of March 2025, mainly patient choice, mutual aid patients referred late, and corneal grafts.

3.0 Unscheduled Care

3.1 Performance

February Type 1 performance was reported at 44.51%, with the combined performance for all Wirral sites at 74.22%:

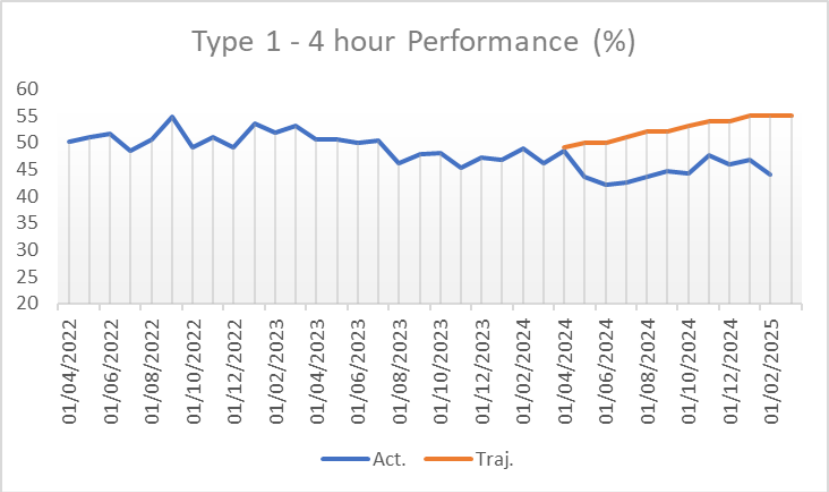
Type 1 ED attendances:	Type 3 ED attendances:
• 7,419 in January (avg. 239/day) • 6,626 in February (avg. 237/day) • 10% decrease from previous month *To note: fewer days in February*	• 2,955 in January (avg. 97/day) • 3,002 in February (avg. 107/day) • 1.59% increase from previous month

The performance of urgent emergency care (UEC) in February remained below the planned trajectory; however, sustained efforts are underway to drive improvement. Persistent challenges, including workforce shortages due to vacancies and sickness absence, along with constrained bed capacity, have contributed to overcrowding,

extended waiting times, and treatment delays. Ongoing pressures have continued with seasonal factors such as infection prevention outbreaks.

In February, corridor care continued due to the number of patients waiting admission in the ED.

Despite these operational pressures, the Trust remains fully committed to improving patient flow, efficiency, and overall service delivery. Although achievement of the 4-hour standard continues to present difficulties, ongoing improvement programmes are progressing, with particular focus on enhancing non-admitted performance.



Urgent care improvement initiatives continued throughout February, with the focus remaining on optimising patient flow, improving timely access to care, and reducing pressure on emergency department. Collaborative efforts across the Trust and system partners remain key to driving these improvements.

The expanded front-door triage service, led by the Urgent Treatment Centre (UTC) nursing team, has continued to deliver an increase in streaming numbers from ED to the UTC. Operating hours have been extended into the evening period, supporting the Emergency Department (ED) during peak times of walk-in attendance. This enhanced triage model is planned to remain in place until at least March 2025, ensuring patients are appropriately streamed and directed to the most suitable service at the earliest opportunity.

The ‘call before convey’ service offered to the Northwest Ambulance Service (NWAS) remains under active review. Despite being embedded as a core offer, uptake has been lower than anticipated. To address this, work is ongoing to increase awareness and utilisation of the pathway among paramedics. Provider leads are due to meet in March to agree next steps, which will include actions to enhance engagement, increase referrals, and optimise use of alternative care pathways where clinically appropriate.

Work to integrate urgent care services across Wirral continues at pace. Several services have been identified as potentially benefiting from co-location onto the acute site, to improve accessibility and patient flow. Discussions and option appraisals are ongoing, with the aim of presenting a proposal for service configuration and future estate planning during the first quarter of the 2025/26 financial year.

Significant progress has been made in preparations for the launch of the Frailty Same Day Emergency Care (SDEC) service, which will formally go live on 24th March 2025. Initially, referrals will be from within the ED, with plans to expand access to the

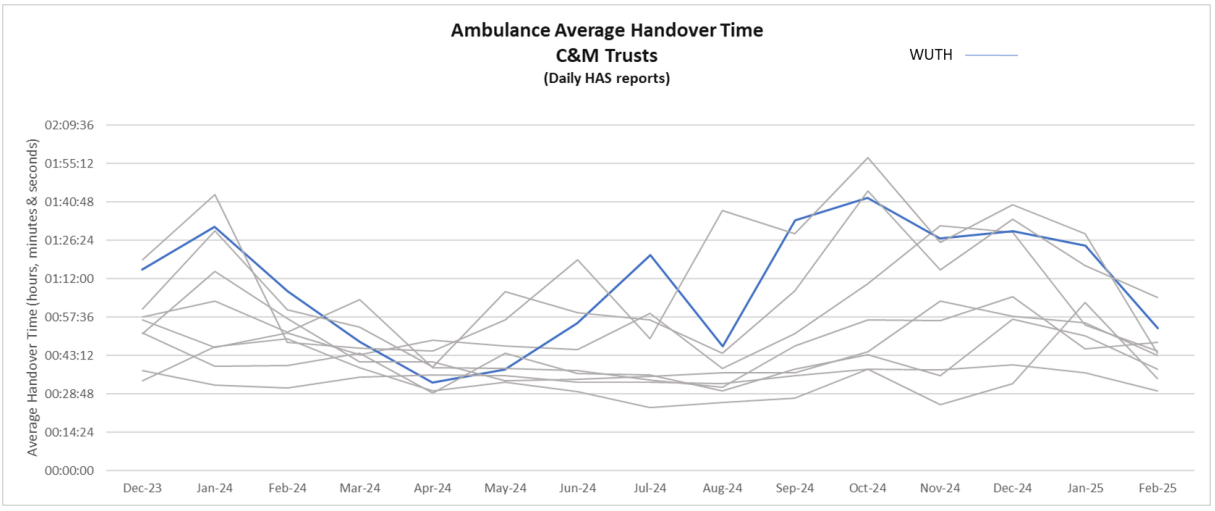
ambulance service via the Single Point of Access (SPA), enabling frail patients to bypass ED where appropriate and access same-day assessment and treatment.

The pilot of the Clinical Decision Unit (ED SDEC) commenced in February and has already demonstrated early positive outcomes. An evaluation of the pilot is due to be completed in early April. Initial indications suggest the service is contributing to improved patient flow, with the intention to continue and further embed the SDEC model moving forward.

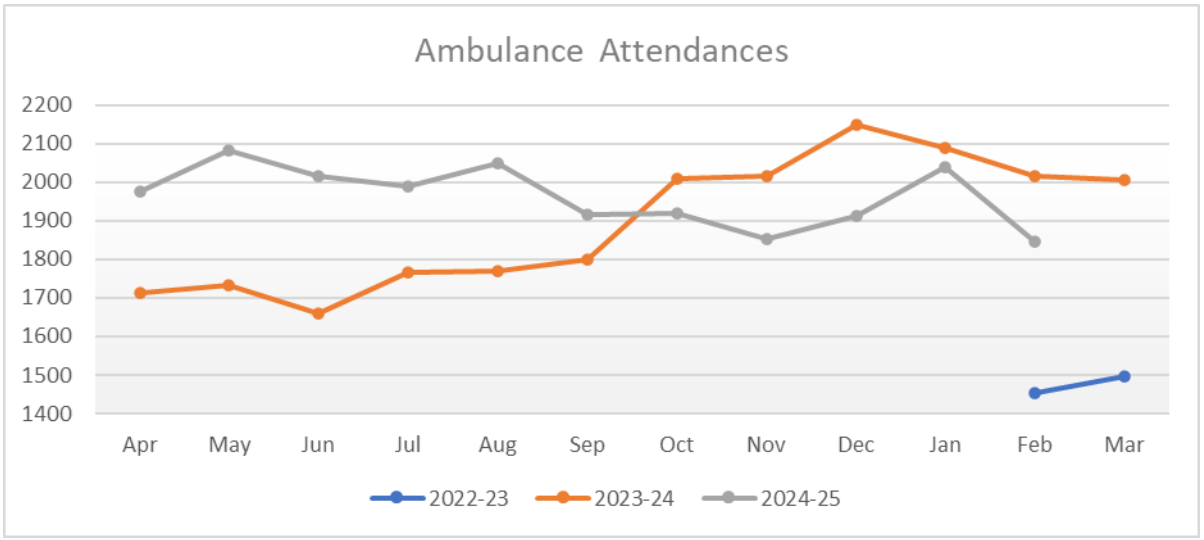
Ambulance turnaround times remain a key area of focus, with delays linked to many of the same operational pressures affecting 4-hour ED performance. Efforts to improve turnaround times include ongoing recruitment for additional nursing staff and clinical support workers, with dedicated recruitment events scheduled in the coming months to increase the workforce capacity and reduce the risk of delaying ambulance handover.

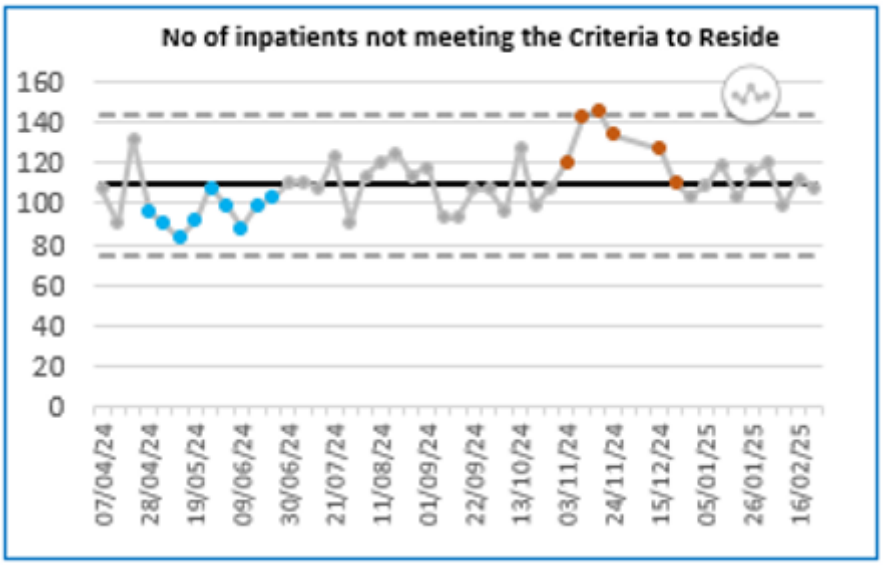
Overall handover performance in February was an average of one hour, meeting the target set by NHSE for the Trust in January.

The Trust continues to focus on improving the position.



Ambulance attendances saw a reduction compared to the previous year in the month of February.



3.2	**Transfer of Care Hub development and no criteria to reside (NCTR).** The number of No Criteria to Reside (NCTR) patients remained stable throughout February. However, the Trust has recently experienced a rise in more complex discharges, seeing an increase in the need for multi-agency collaboration and coordination. The operational team is currently developing the proposed trajectory for 2025/26, with plans aimed at achieving a step reduction from the average NCTR levels observed during 2024/25. This work will focus on strengthening discharge planning processes and enhancing system-wide partnerships to support timely and appropriate discharge pathways.  The Trust performance for NCTR remained in a strong position in comparison to other Trusts in C&M. The most recent position shows a performance of 14.3%. **Latest Date: 23 February 2025** |	Trust	Trajectory	Current	PP Var
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1	Wirral	10.0%	14.3%	4%
2	East Cheshire	12.3%	18.5%	6%
3	Mid Cheshire	22.6%	19.7%	-3%
4	LUHFT	23.9%	20.7%	-3%
5	Mersey and West Lancs	25.0%	21.3%	-4%
6	Countess of Chester	17.9%	22.7%	5%
7	Warrington & Halton	22.0%	24.3%	2%
	Total	20.7%	20.3%	0%	 **3.3** **Mental Health** Mental health demand remained high throughout February, with continued pressures on access to acute mental health beds resulting in prolonged waits for some patients. The Trust continues to follow the established escalation process for delays within the Emergency Department in collaboration with the local mental health provider, the

	Integrated Care Board (ICB), and NHS England (NHSE). Despite these processes, capacity constraints continue to limit the availability of timely solutions. The Trust and system partners are committed to working towards improvements in mental health provision. This includes ongoing discussions regarding capacity gaps and the development of plans to address them. Capital funding submissions have been shared with the ICB, requesting access to nationally ringfenced capital funding for mental health services, with the aim of increasing capacity and improving patient flow in the longer term.
3.4	**Risks and mitigations to improving urgent care performance** The Trust continues to make steady progress in delivering the actions outlined within its urgent care improvement plans, aimed at achieving key quality standards. Performance against these plans is being closely monitored through the Urgent and Emergency Care (UEC) Improvement Group, with oversight of sentinel metrics provided by Place leads and the System Control Centre (SCC). Despite this progress, several risks remain. Increase levels of patient acuity, and sustained demand for beds, continue to place significant pressure on the delivery of improvement initiatives. Furthermore, the need to strengthen nursing capacity within the ED, both to support timely ambulance handovers and to staff corridor care where required alongside increasing vacancies among junior medical staff, presents ongoing operational challenges. Winter pressures have also been compounded by infection prevention outbreaks, which continue to impact patient flow from the ED to inpatient wards. While every effort is made to avoid bed closures, in instances where closures are necessary, Infection Prevention and Control (IPC) teams carry out daily reviews to ensure that capacity can be safely reopened at the earliest opportunity.

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.

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NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework Quarter 4 (To March) 2025 Year End

Item

1 Board Assurance Framework
David McGovern Director of Corporate Affairs

Contents

1. Introduction

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

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

Baker Tilly 2021

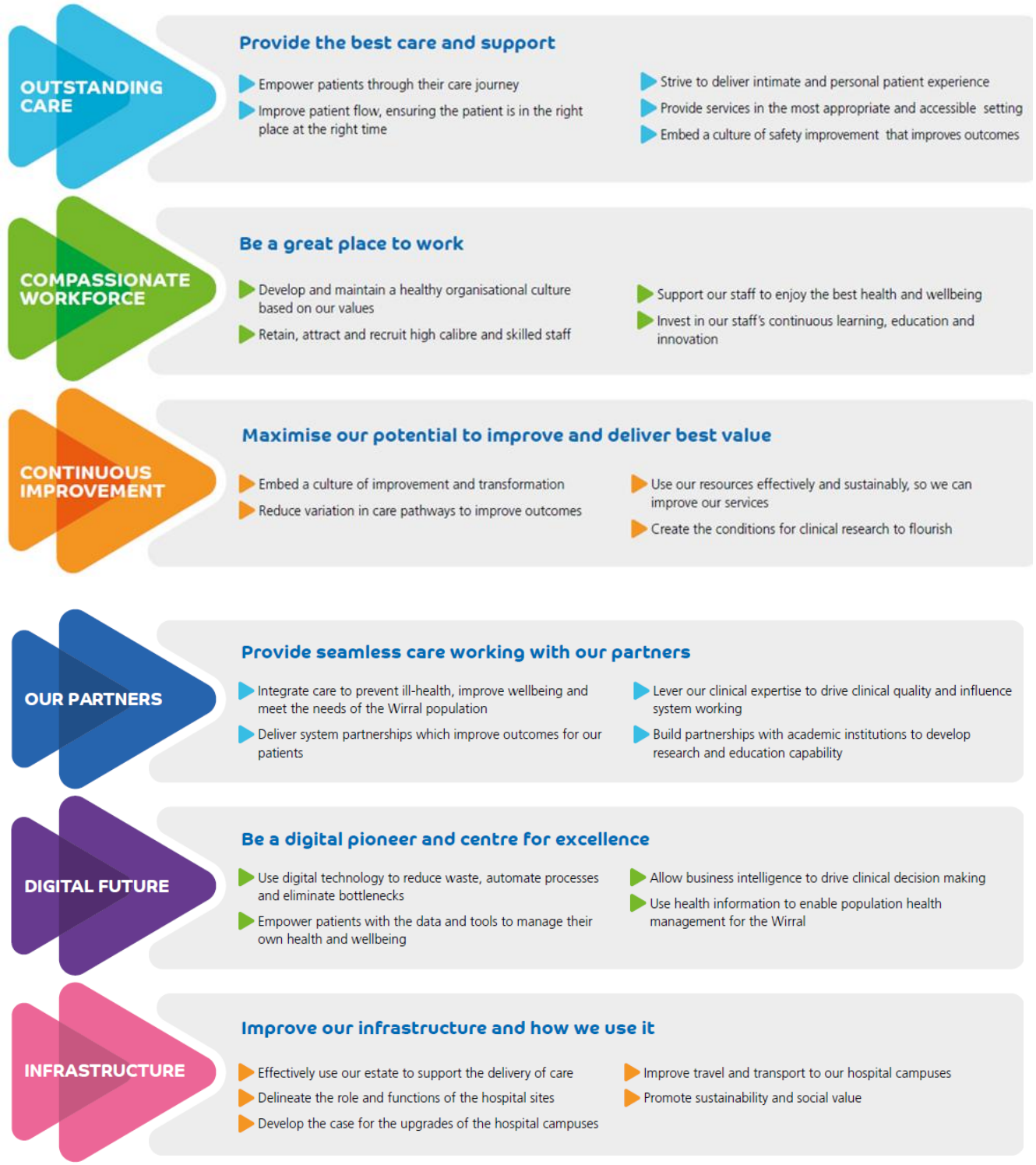
2. Vison, Strategy and Objectives

2.1 Our Vision

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

2.2 Our Strategic Objectives

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



3. Our Risk Appetite

3.1 Risk Appetite Statement

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

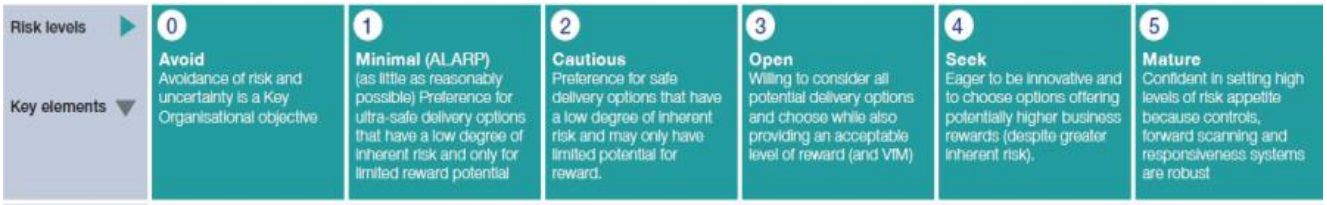
The Trust Board is committed to ensuring a robust infrastructure to manage risks from ward to board level, and where risks crystallise, to evidencing improvements are put in place.

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

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

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

Discussion: Board are asked to consider current levels of Risk Appetite prior to May seminar.



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

SO3: Continuous improvement – Maximise our potential to improve and deliver best value.	OPEN	The Trust Board is prepared to accept risk in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and ensuring we deliver our goals and targets.
SO4: Our partners – Provide seamless care working with our partners.	SEEK	The Trust Board recognises there may be an increased inherent risk faced with collaboration and partnerships, but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.
SO5: Digital Future – Be a digital pioneer and centre for excellence.	SEEK	The Trust Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: Infrastructure - Improve our infrastructure and how we use it	OPEN	The Trust Board has an open risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.

4. Operational Risk Management

4.1 Operational Risk Management

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

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

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

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

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

- All risks are identified that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust.
- Priorities are determined, continuously reviewed and expressed through objectives that are owned and understood by all staff.

- Risks to the achievement of objectives are anticipated and proactively identified.
- Controls are put in place, effective in their design and application to mitigate the risk and understood by those expected to use them.
- The operation of controls is monitored by management.
- Gaps in control are rectified by management.
- Management is held to account for the effective operation of controls.
- Assurances are reviewed and acted on.
- Staff continuously learn and adapt to improve safety, quality and performance.
- Risk management systems and processes are embedded locally across divisions, directorates and within corporate services including business planning, service development, financial planning, project and programme management and education.

The Trust shall achieve this by:

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

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

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

4.2 Risk Categorisation

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

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

4.3 Link to Strategic Objectives

All BAF risks are aligned to the relevant Strategic Objectives in the Corporate Plan and highlighted in the dashboard.

5. Creating and Monitoring the BAF

5.1 Creation of the BAF

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

5.2 Monitoring the BAF

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

- Is Updated on a quarterly basis.
- Reports to the Board at every other meeting.
- Reports to every other meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy.
- Reporting to every other meeting of relevant Board Committees.
- Reporting to every meeting of the Executive Assurance and Risk Committee (EARC).
- Cyclical (at least yearly) circulation to Divisional Boards for information and to raise awareness.

6. Update Report

6.1 Purpose

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

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

6.2 Changes to the previous version

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

Including in the key changes for this report are as follows:

- Risk 1 – Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience. This risk has been increased from a 16 to a 20.
- Risk 4 - Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy. This risk has increased its score from 9 to 12.

6.3 Annual Refresh – April 2025

Work is ongoing with the annual refresh of the BAF and consideration is given to:

- Current high level risks and descriptions.
- Validity of those risks.
- Consideration of new risks or amended wording.
- Risk scores for Q1.
- Alignment of risks to the Risk Appetite Statements.
- Review of Risk Appetite.

The final review of the refreshed BAF will be carried out at a Board seminar at its meeting in May.

6.4 Risk Appetite and Risk Maturity

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

6.5 Recommendations

Board is asked to:

- Note and comment on the current version of the BAF.
- Note the plan for the BAF annual refreshment 2025/26.

12 Month – Dashboard and Current and Quarterly Trend

Impact x Likelihood

Risk No	Strategic Priority	Risk Description	Initial Score (I x L)	Target	Mar 24	June 24	Sept 24	Dec 24	Direction	Mar 25 Current
1	Outstanding Care **R, O, C, F**	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)	↑	20 (4 x 5)
2	Outstanding Care **R, O, C, F**	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
3	Outstanding Care **R, O, C, F**	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)	↔	16 (4 x 4)
4	Compassionate Workforce **O, C, F**	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↑	12 (3 x 4)
5	Compassionate Workforce **R, O, C, F**	Failure of the Trust to have the right culture, staff experience and organisational conditions to deliver our priorities for our patients and service users.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
6	Continuous Improvement **R, O, F**	Failure to embed the Trust's approach to financial planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans.	16 (4 x 4)	8 (4 x 2)	12 (4 x 3)	12 (4 x 3)	16 (4 x 4)	20 (4 x 5)	↔	20 (4 x 5)
7	Digital Future and Infrastructure **R, O, F**	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.	12 (4 x 3)	8 (4 x 2)	N/A	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
8	Continuous Improvement **R, F**	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
9	Our Partners **R, S, F**	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and Wirral review as a long term threat or opportunity to service sustainability.	12 (4 x 3)	6 (3 x 2)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)
10	Digital Future and Infrastructure **R, S, F**	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	↔	12 (4 x 3)
11	Digital Future and Infrastructure **R, O, C, F**	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.	20 (5x4)	10 (5x2)	N/A	15 (5x3)	15 (5x3)	15 (5 x 3)	↔	15 (5 x 3)
12	Outstanding Care **R, O, C**	Failure to reduce health inequalities for the Wirral population due to the absence of effective partnership working.	16 (4 x 4)	9 (3 x 3)	N/A	N/A	12 (3 x 3)	9 (3 x 3)	↔	9 (3 x 3)

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

Strategic Priority	Outstanding Care				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (4 x 5)	16 (4 x 4)	20 (4 x 5)	12 (4 x 3)

Controls	Assurance
• Annual preparation and presentation of a system wide Winter plan in line with the National UEC Recovery Action, **although the actions do not mitigate the demand and capacity gap.** • Full participation in the Unscheduled Care transformation programme which includes working with Wirral Community Trust to reduce the numbers of patients attending the ED department who can have their care needs met away from ED. • Onsite support from Wirral Community Trust with the Chief Operating Officer focusing on admission avoidance and supporting early and timely discharge. • Monitoring of ED improvement plan and Wirral system urgent care plan by system Chief Operating Officers including Director of Adult Social care. • Health Economy oversight of Executive Discharge Cell. • Additional spot purchase care home beds in place. • Participation in C&M winter room including mutual aid arrangements. • Rapid reset programme launched with a focus on hospital flow and discharge. • Continued communications out to primary care and to Wirral residents around only use A+E for urgent care requirements. • Regular meetings with the divisional leadership teams to ensure actions for improvement are delivered. **With Executive Triumvirate.** • Business Continuity and Emergency Preparation planning and processes in place. **This includes escalations to Critical Incident as required.** • Winter plan initiated that includes additional resource and capacity to aid strong UEC flows and performance • Full review of post take model to ensure sufficient resource is allocated to manage volumes • Implementation of continuous flow model to improve egress from ED.	• EARC Assurance • Divisional Performance Review (DPR) • Executive Committee • Wirral Unscheduled Care Board • Weekly Wirral COO • Board of Directors • Finance Business and Performance Committee • Full unscheduled care programme chaired by CEO • Trust wide response to safe staffing of ED when providing corridor care

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

Progress
Key Changes to Note • Additions in red.

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

Strategic Priority	Outstanding Care				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

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

Gaps in Control or Assurance	Actions
• National challenge relating to medical staff rates of pay creating uncertainty with regards to additional capacity. • **Impact of the Cyber-attack was significant and deteriorated the Trust's progress with recovering elective waiting times.** • 2 specialities are challenged in delivery of 65 and 75 weeks. • **One specialty is challenged in delivering 65 weeks by the end of the financial year given the impact of the cyber-attack.**	• Continue with delivery of mitigation plans for scheduled care, managing the risk with the utilisation of the national policy on clinical prioritisation. • Explore alternative avenues of providing additional core surgical capacity to reduce the backlog of long waiting patients. • Utilisation of the LLP to deliver the gap in recurrent capacity. • **Cyber-attack recovery plan.**

Progress
Key Changes to Note • N/A.

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

Strategic Priority	Outstanding Care				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Medical Director and Chief Nurse	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)	12 (4 x 3)

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

Gaps in Control or Assurance	Actions
• Fully complete and embedded patient safety and quality strategies. • Current operational impacts and organisational pressure. • Capital availability for medical equipment. • Medical workforce gaps. • Impact of unscheduled care demand. • Significant financial controls in place. • Update required to WISE accreditation programme. • **Lack of BI capacity impacting on patient outcome data**	• Complete implementation, monitoring and delivery of the patient safety and quality strategies. • Monitoring Mental Health key priorities • Complete delivery of the Maternity Safety action plan • Ongoing review of IPC arrangements – SIT Review. • CQC preparedness programme and mock inspections. • Delivery of Mental Health key priorities. • Unscheduled Care Board action plan. • Trust and C and M elective recovery programme. • Wirral system strategy for CDiff.

Progress
Key Changes to Note • Additions in red.

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

Strategic Priority	Compassionate Workforce				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	12 (3 x 4)	6 (3 x 2)

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives, including apprenticeship recruitment. • Vacancy management and recruitment systems and processes, including TRAC system for recruitment and the Established and Pay Control (EPC) Panel. • Achievement of Armed Forces Employer Silver Accreditation • E-rostering and job planning plans to support staff deployment. • Strategic retention closed down as consistent achievement of the Turnover KPI; appropriate targeted work will continue via the task and finish groups. • Facilitation in Practice programme. • Training and development activity, including leadership development programmes aligned to the Trust LQF. • Utilisation of NHS England and NHS National Retention programme resource to review and implement evidence based best practice. • Effective utilisation of the Trust's EAP has increased uptake across the organisation and is enabling staff to access support more quickly and on-site presence at the Wellbeing Surgeries. • Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy. • Career clinics have recommenced within Divisions • New Flexible working policy, toolkit and training embedded. New FW brochure, intranet page, electronic application process launched and FW Ambassadors in place • New Engagement Framework launched, and all Divisions now have agreed objectives with key lines of enquiry now included withing Divisional Performance Reviews (DPRs) • New monthly recognition scheme has launched, with monthly Employee or Team of the month winners identified for Patient Care and Support Services and new CEO Star Award launched. • Chief Executive and Executive Team breakfast engagement sessions • Understanding staff experience Listening Event with Black, Asian and Minority Ethnic staff • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • EAP app (Wisdom) launched • Restorative supervision provided trust wide following significant events • SEQOHS annual reaccreditation approved • Representation of OH at Induction, Preceptorship Programme and Managers Essentials • Phase 1 upgrade of Cohort to Cority successfully implemented. • Targeted psychological support for Divisions, as issues arise • Health Surveillance programme successfully relaunched • OH & Wellbeing intranet page updated • Quarterly People Pulse Survey and associated actions to address concerns • Leadership Qualities Framework and associated development programmes and masterclasses. • Bi-annual divisional engagement workshops • Staff led Disability Action Group. • Staff drop in sessions. • Retention group annual plan approved at Workforce Steering Board • New Attendance Management Policy • Buddy system for new CSWs introduced & evaluated • Staff career stories linked to EDI on intranet • Promotion of CPD development opportunities • Increased senior nurse visibility – walkabouts led by Chief Nurse & Deputy • Succession planning launched as part of the new Talent Management Approach • Trust wide communications sent out re Covid-19 outbreak and precautionary measures to prevent further transmission including the wearing of face masks and adherence to IPC protocols in outbreak areas. • The return-to-work guidance for staff with respiratory illness including COVID-19 result has been reviewed and updated for monthly review at CAG, and recirculated across the Trust • Signed up to the NHSE Sexual safety Charter and met all objectives required. Trust comms delivered and Intranet page updates e.g. how to make and respond to disclosures • Questions PSS survey added to reflect sexual safety at WUTH • Trust Wide legal awareness session delivered • Completed action plan set against NHSE Sexual Safety Charter & core principles, and updates provided via Workforce Steering Board • Achieved Bronze status in June 2024 as set within the Anti-Racism Charter and was identified as one of four Trust in the region to achieve this.	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy. • Monthly Workforce monitoring.

Gaps in Control or Assurance	Actions
• National shortages in certain roles and full rollout of clinical job planning are pending workforce planning processes. • Availability of required capabilities and national shortage of staff in key Trust roles. • Increases in illness related to stress and anxiety.	• Focus remains on supporting the health and wellbeing of our workforce, as well as close management of absences in line with the revised Attendance Management Policy. • Wellbeing Surgeries across sites • OH Capacity and Demand Review • Targeted retention work via the task and finish groups - focusing on Nurses, Midwifery & HCSWs and AHP's Clinical Scientists & Pharmacy led by Corporate Nursing • Talent mapping exercise for senior leaders • Task and finish Sexual Safety Working group to set out phase 2 priorities for next 12 months. • The electronic resignation and exit interviews are being built in Smartsheet; now the new FW one has been completed and rolled out.

Progress
Key Changes to Note • Changes in red

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

Strategic Priority	Compassionate Workforce				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

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

Gaps in Control or Assurance	Actions
• Full understanding of the experience of Multi-Cultural staff across the Trust	• Debriefing tools (hot and cold) and guidance on the intranet for supporting staff affected by unplanned events. • Develop and implement the WUTH Perfect Start • Work ongoing to resolve dispute in theatres • Working in progress to progress the settlement for CSWs – led by DCN • Q1 project planned for Q3 to address team working – led by CN

Progress
Key Changes to Note • Changes in red

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

Strategic Priority	Continuous Improvement				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Finance Officer	16 (4 x 4)	20 (4 x 5)	20 (4 x 5)	8 (4 x 2)

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document. • Finance Gold Command implemented. • **25/26 Planning process in place.**	• Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • Monthly COO checks and monitoring. • CFO presents quarterly forecasts to FBPAC and Trust Board. • Approval of 24/25 plan. • FBPAC meeting more frequently. • **24/25 risk Mitigated from 21m to 3m.** • **Board briefed on 25/26 plan and drivers of the gap to control total.** • **PWC programme in final stages and completion of handover.** • **Board considered additional actions in relation to finance and associated risk.**

Gaps in Control or Assurance	Actions
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Approval of deficit plan. • Mitigated forecast of 7m variance to plan. • Unmitigated forecast of 29m variance to plan. • **Significant variance for 25/26 to approved control total.**	• Continue delivery of CIP programme and maintain oversight of divisional progress. Ongoing. • Complete benchmarking and productivity opportunities review pack. • Develop 3 year CIP Plan to include all trust wide strategic and transformational plans. • Expand current mitigation plan to measure risk. • **Exec meetings with divisions to consider additional actions to mitigate gap control total.**

Progress
Key Changes to Note • **Additions in red.**

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

Strategic Priority	Digital Future				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Finance Officer	12 (4x3)	12 (4 x 3)	12 (4 x 3)	8 (4x2)

Controls	Assurance
• Programme Board oversight. • Service improvement team and Quality Improvement team resource and oversight. • QIA guidance document implemented as part of transformation process. • Implementation of a programme management process and software to track delivery. • FBPAC Oversight. • Audit Committee oversight. • Integration of PMO and Digital Project Teams. • DIPSOC Oversight.	• Scale of projects versus resources. • FBPAC Committee. • Governance structures for key projects. • Capital Process Audit with significant assurance. • DSPT Audit with significant assurance. • MIAA Audit. • Digital Maturity Assessment.

Gaps in Control or Assurance	Actions
• Resources to remain up to date with emerging technology. • **Current team vacancy levels.**	• Delivery of DHT annual plan. • **Prioritise delivery of Digital workload with Executives.**

Progress
Key Changes to Note • N/A.

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

Strategic Priority	Continuous Improvement				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

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

Gaps in Control or Assurance	Actions
• Lack of protected time due to conflicting priorities in service delivery, particularly in relation to clinical staff. • Ability to deliver system wide change across Wirral NHS organisations and wider partners.	• Delivery of 24/25 improvement projects to plan • Strong Governance through PMO working of all schemes, risk and outputs • Detail improvement staff training approach and programme • **Implementation of Improvement for All approach and training to staff** • **Development of Improvement Programme for 25/26**

Progress
Key Changes to Note • **Commencement of Improvement for All training from April 2025** • **Changes to Wirral Programme Delivery Unit resourcing and focus to support integration and Wirral wide programmes**

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

Strategic Priority	Continuous Improvement				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Executive Officer	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• WUTH senior leadership engagement in ICB and Wirral Place • WUTH Strategic intentions are aligned with the ICB. • ICB design framework. • NHS Oversight and Assessment Framework • Input of Trust CEO and Chief Strategy Officer into Outline of the Wirral Place governance. • Creation of IMB to oversee the outcomes of the Wirral Review. • Joint Chair and CEO now in place with WCHC. • Joint Chief People Officer in place with WCHC • Provider collaborative approach agreed • Partnership Agreement with WCHC • Integration Methodology for Corporate Functions • Workforce agreement and strategy	• CEO and Chief Strategy Officer updates to Board and Executive Director meetings. • CEO attendance at Wirral Place Partnership Board • Executive participation in CMAST professional network groups • Chief Strategy Officer attendance at Wirral Health and wellbeing Board • Monthly reporting to Board of Wirral System Review progress • Recommendations of the Wirral Review • 100 Day Integration Plan • Integration Management Board (Joint Committee) Terms of Reference • Partnership Agreement with WCHC • Integration Methodology for Corporate Functions • Workforce agreement and strategy

Gaps in Control or Assurance	Actions
• Formal mechanisms to ensure delivery of partnership working with Wirral Place partners. • Lack of capacity and resources in place to deliver the integration programme in line with timescales required. • Determination of future hosting arrangements for staff as part of Integration	• Continue identification of partnership opportunities with Wirral Community Health and Care NHS Trust • Continued implementation of actions of the Wirral Review. • Refresh Governance processes at Place. • Development of Provider Collaborative approach • Stand up the WPP and IMB. • Implement proposal for transaction

Progress
Key Changes to Note • In red.

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

Strategic Priority	Infrastructure				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

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

Gaps in Control or Assurance	Actions
• Delays in backlog maintenance and funding of backlog maintenance and minor works • Timely reporting of maintenance requests.	• Develop Arrowe Park development control plan and Prioritisation of estates improvements • Heating and ventilation programme completion • Replacement of generators and ventilation systems • Delivery of 2024/25 Capital Programme to plan and budget allocation. • Development of bids in preparation for potential NHSE Capital Grants for 2024/25 and 2025/26 • Examination of options to relocate corporate and clinical functions to community

Progress
Key Changes to Note • Ongoing delivery of 24/25 Capital Programme • Preparations for 25/26 Capital Programme • Commencement of Neonatal Redevelopment • Continuation of RAAC Improvement scheme to Birch House, Clatterbridge Hospital • Commencement of CSSD (Sterilisation) Unit redevelopment

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

Strategic Priority	Infrastructure				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	Chief Operating Officer	20 (5x4)	15 (5 x 3)	15 (5 x 3)	10 (5x2)

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

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

Progress
Key Changes to Note • N/A

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

Strategic Priority	Our Partners				
Review Date	31/03/25	Initial Score	Last Quarter	Current	Target
Lead	All Executive Directors	16 (4x4)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Wirral Place Based Partnership Board Governance Manual. • Wirral Place Target Operating Model. • ICB. • Wirral Review Terms of Reference. • **Joint Chair and CEO in place across WCHC and WUTH.**	• Wirral Place Based Partnership Board. • Health and wellbeing Board. • Wirral Review Steering Committee. • CORE 20+5 Board. • Unscheduled Care Board. • Wirral Place Partnership Committees and fora. • **IMB for Integration.**

Gaps in Control or Assurance	Actions
• Lack of strategic alignment between partner bodies.	• Board discussion on Phase 1 of Wirral Review. • Consider outcomes of full review. • Implement outcomes of the full review. • Board to Board sessions. • Council of Governors Joint session. • **Standing up of the IMB.** • **Standing up of the WPP.** • **Refreshment of Wirral Place Governance.** • **Stand up Health inequalities Board.**

Progress
Key Changes to Note • **Changes in red.**

Appendix – Risk Scoring Matrix

Table 1 – Impact scores.

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

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

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

Consequence

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

Table 2 – Likelihood

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

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

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

Appendix – Risk Appetite

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

Appendix – Significant Operational Risks

Highest Scoring Risks

1179	D+CS	Risk to patient treatment pathways due to the delay in supply of aseptically made medicinal products if the Aseptic Unit fails	(5 x 4) 20	⇔
1286	Corp	Inability to scan and monitor the network for connected devices (particularly medical devices)	(5 x 4) 20	⇔
1547	Corp	Cash management	(5 x 5) 25	⇔
1728	Surg	SSD Washers/disinfector breakdown	(4 x 5) 20	⇔
1849	Surg	Failure to deliver Surgical Division Elective activity plan for 2024/25	(5 x 4) 20	⇔
2015	Corp	Weaknesses in Trust's password procedures and associated compliance	(5 x 4) 20	⇔
639	Corp	Medical Devices - Unsupported operating systems that cannot be cyber patched.	(5 x 4) 20	⇔
895	Corp	Disruptive cyber-attack effecting multiple systems - such as a Ransomware Attack	(5 x 4) 20	⇔