Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

07 July 2021

together we will

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Wirral University Teaching Hospital
NHS Foundation Trust

Meeting of the Board of Directors in Public
12.30 - Wednesday 07 July 2021
At Room M49, Edge Hill University

AGENDA

Item	Item Description	Presenter	Verbal or Paper	Page Number
21/22-079	**Apologies for Absence**	Chair	Verbal	N/A
21/22-080	**Declaration of Interests**	Chair	Verbal	N/A
21/22-081	**Patient Story**	Chief Nurse	Video	N/A
21/22-082	**Minutes of Previous Meeting – 02 June 2021**	Chair	Paper	1
21/22-083	**Board Action Log**	Chair	Paper	10
21/22-084	**Chair's Business**	Chair	Verbal	N/A
21/22-085	**Key Strategic Issues**	Chair	Verbal	N/A
21/22-086	**Chief Executive's Report**	Chief Executive	Paper	11
Performance & Improvement				
21/22-087	**Quality and Performance Dashboards & Exception Reports**	Chief Operating Officer, Medical Director, Director of Workforce & OD and Chief Nurse	Paper	17
21/22-088	**Finance Report for Month 2**	Chief Finance Officer	Paper	38
Governance				
21/22-089	**Quality and Safety on Maternity Services Quarterly Report (CNST Compliance)** ***(Debbie Edwards to attend)***	Chief Nurse	Paper	54
21/22-090	**Monthly Safe Nurse Staffing Report**	Chief Nurse	Paper	129
21/22-091	**System Improvement Board (SIB) Update**	Chief Finance Officer	Paper	135
21/22-092	**Change Programme Summary, Delivery & Assurance**	Director of Strategy and Partnerships	Paper	157
21/22-093	**Chair's Report – Finance, Business Performance & Assurance Committee**	Committee Chair	Paper	178
21/22-094	**Report of Trust Management Board**	Chief Executive	Paper	182

21/22-095	**Communications and Engagement Report**	Director of Communications and Engagement	Paper	187
21/22-096	**Any Other Business**	Chair	Verbal	N/A
21/22-097	**Date of Next Meeting – 04 August 2021**	Chair	Verbal	N/A
21/22-098	**Exclusion of the Press and Public** To resolve that under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, the public and press be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.			

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF MEETING HELD IN PUBLIC

02 JUNE 2021

VIRTUAL MEETING VIA MICROSOFT TEAMS

Commencing at 10.00 and Concluding at 12.30

Present

Sir David Henshaw	Chair
John Sullivan	Non-Executive Director/Vice Chair
Chris Clarkson	Non-Executive Director
Steve Igoe	Non-Executive Director
Mrs Sue Lorimer	Non-Executive Director
Steve Ryan	Non-Executive Director
Janelle Holmes	Chief Executive
Nicola Stevenson	Medical Director / Deputy CEO
Anthony Middleton	Chief Operating Officer
Hazel Richards	Chief Nurse / DIPC
Claire Wilson	Chief Finance Officer
Matthew Swanborough	Director of Strategy and Partnerships
Debs Smith	Interim Director of Workforce

In attendance

Kathryn Brodbelt	Associate Medical Director
Helen Kerss*	Guardian of Safe Working
Jonathan Lund	Associate Medical Director
Chris Mason	Chief Information Officer
Oyetona Raheem	Board Secretary
Sally Sykes	Director of Communications & Engagement
Philippa Boston	Staff Governor
Eileen Hume	Public Governor
Alison Owen	Public Governor
Ann Taylor	Staff Governor
Allen Peters	Public Governor
Angela Tindall	Public Governor

Apologies

Mrs Jayne Coulson	Non-Executive Director
Jacqui Grice	Director of Workforce

*Denotes attendance for part of the meeting

Reference	Minute	Action
21/22 055	**Apologies for Absence**	
	Apologies for absence were noted as reported above.	
21/22 056	**Declarations of Interest**	
	The meeting noted the declaration by Debs Smith (Interim Director of Workforce) in respect of her substantive position as the Deputy Chief People Officer at Warrington and Halton Teaching Hospitals NHS Foundation Trust. She confirmed that the interest would remain throughout the period of the secondment to WUTH and she would make further declarations in future Board meetings if there is a specific interest.	
21/22 057	**Patient Story**	
	The Board viewed the video from Mr JC a patient who had undergone surgery for bowel cancer at Arrowe Park Hospital whilst also waiting for	

Reference	Minute	Action
	treatment at Liverpool Heart and Chest Hospital for a heart bypass. Mr JC praised all the staff for his care and treatment and noted especially how much the general atmosphere of the hospital and staff morale had improved since his previous encounters with the hospital a few years ago. The Chair thanked Mr JC for sharing his story.	
21/22 058	**Minutes**	
	The minutes of the meeting held on 05 May 2021 were approved as an accurate record.	
21/22 059	**Board Action Log** The Board reviewed the actions log noting that items had either been actioned or were on the agenda.	
21/22 060	**Chair's Business**	
	The Chair informed the meeting that IncuBabies, which raises funds for neonatal facilities at The Wirral Women and Children's Hospital, had received the Queen's Award for Voluntary Service. He sent congratulations to the team on behalf of the Board. **RESOLVED:** **That the Board NOTED the Chair's Business**	
21/22 061	**Key Strategic Issues**	
	There were no additional strategic issues to report.	
21/22 062	**Chief Executive's Report**	
	The Chief Executive presented her report and highlighted that there were no COVID-19 patients when her report was written but five patients had since been admitted and the increase was being monitored closely. She added that the reset and recovery plan had been on track against trajectory and national expectations. The vaccination centre had continued to deliver the vaccines in collaboration with local partners and that the vaccination exercise would continue for as long as required. Other issues highlighted by the CEO included the collaborative work with Wirral health and care system partners on development of Integrated Care System (ICS); progress report on the Clatterbridge Master Planning; ongoing review of the HR and OD profession within the NHS; easing of visitors' restrictions from 26 April 2021 in line with the National Roadmap for easing of lockdown; and the selection of WUTH Charity 'Tiny Stars appeal' as one of two charities to benefit from the Wirral Mayor's support. There had been five serious incidents reported in the month of April 2021 relating to a delayed outpatient appointment due to COVID 19; follow up waiting list management; external reporting error of a CT scan; incorrect patient discharge; and recognition of an acutely unwell patient during admission. All the incidents were being investigated under the Serious Incident Framework to identify opportunities for learning and actions to drive improvement and reduce future risk.	

Reference	Minute	Action
	RESOLVED: **That the Board RECEIVED and NOTED the report.**	
21/22-063	**Quality and Performance Dashboard and Exception Reports**	
	The Executive Directors briefed the Board on the content of the Quality & Performance Dashboard up to end of April 2021 for their respective areas. The COO reported that most Trusts had seen a surge in ED attendance from late April to May 21, recognising that other parts of the sector (primary care and healthcare centres) were yet to fully open. All the working centres in Wirral were due to be opened from 16 May 21. The COO added that ED attendance had almost returned to the pre-COVID-19 level and that most of the breaches of the 4-hour targets were within the ED settings and not waiting for beds. The continued focus of the team was for patients to see the doctors within the first hour. Even with the exceptional demand, there had not been a re-emergence of the 12-hour trolley wait. The COO advised that there had been good progress in recovery and referrals. There had been improvements in the number of patients classified as needing treatments within a month (P2 patients) which were clinically deferred as part of COVID-19 response. He anticipated that the waiting list for P2 patients would be cleared by the end of June 21. The COO advised that there had been significant improvements in the 52-weeks wait and that waiting list for cancer treatment at end of May 21 was lower than it was pre-COVID-19. The only area where there had been issues related to diagnostics target. In response to a question from Steve Ryan on planning for increased access to cancer screening in the future, the COO replied that Bowel screening had been a concern across the region with emergence of waiting lists. He gave explanations on the available capacity for bowel screening and the plans to further expand the capacity across the system. John Sullivan noted the recovery in theatre utilisation and commended the team for getting that back to 85%. The COO explained the shift from APH to Clatterbridge which enabled that to happen. The Medical Director highlighted that the national threshold for reporting VTE of had continued to be met. There had been a slight dip in the Trust's own VTE assessment within 12 hours from a target of 95% to 94.4%. The dip had not translated into patient safety issues and compliance was being monitored through the Patient Safety and Quality Board. The Medical Director reported that WUTH was the 7th highest recruiter for research in the UK and that a number of the non-COVID-19 trials that were paused had restarted. She advised that a new Research and Innovation Manager had been appointed to support the Trust's research activities. The Interim Director of Workforce highlighted the improvement in staff attendance compared to the previous month, although attendance was still below the 95% target (94.62%) in April 21. She highlighted that the major cause of sickness absence was anxiety and mental health issues. A range of staff wellbeing services introduced had impacted positively. She also informed the Board of two new pieces of work being piloted with NHS	

Reference	Minute	Action
	England and NHS Improvement; a project to take forward a range of recommendations following a deep dive into sickness absence across the North West and a leadership development programme to support first line managers in creating a wellbeing culture. The Interim Director of Workforce highlighted the steps being taken to reduce staff turnover which had increased due to a number of short term contracts that ended. She also highlighted the continued improvements in staff appraisal rates in the month of April 21. John Sullivan noted the shift in the data between long and short term absences which used to be 50/50 and that the work done on long term absence had yielded positive results. He requested that further attention should be paid to possible correlation between staff members who were yet to have their performance appraisals and short-term absences. The Chief Nurse highlighted the mixed sex breaches in critical care due to the surge in ED attendance. She also highlighted that there had been a rise in complaints, majority of which were related to COVID-19 issues in the previous year. The Chair asked for clarification on the nature of the increase in complaints received and how they were being resolved. The Chief Nurse explained that majority of the complaints related to cross-organisational issues during the first and second waves of the pandemic. The complaints were broad-based including failure in communication or service expectations. A complaints team had been set up to ensure a timely response. **RESOLVED:** **That the Board of Directors RECEIVED and NOTED the Quality and Performance Dashboard and the Exception Reports for the period to 30 April 2021**	
21/22-064a	**Month 12 Finance Report**	
	The Chief Finance Officer (CFO) presented the Month 1 finance report and highlighted a surplus of £0.76m which represented a positive variance against initial draft plan of £6k. She added that divisions were in the process of finalising their plans which were expected to be in line with the agreed budget. The CFO also highlighted the capital spend of £306k in the first month which was in line with the plan submitted to NHSI/E. John Sullivan asked if it would be possible to capitalise the spending on master plans developments in the future. The CFO gave explanations on why it would not be possible to capitalise the spending on master plans, which had been met from the revenue budgets. **RESOLVED:** **That the Board NOTED the report.**	
21/22-064b	**Financial Plan 21/22 update**	
	The CFO gave a verbal update on the financial planning process at the Cheshire and Mersey Region. She added that there was a financial gap that needed to be filled across the system. A number of organisations with	

Reference	Minute	Action
	increases in their planned expenditure had been asked to reduce them. All organisations have also been requested to identify increased CIP. **It was proposed and agreed that an appropriate plan should be prepared for review by the Finance, Business & Performance Assurance Committee on behalf of the Board.** Detailed discussions took place on the issue of collective responsibility for financial shortfalls under the partnership working arrangements. The Board requested that clarifications be made on how individual organisations would be held accountable for their finances. **RESOLVED:** **That the Board NOTED the report.**	**CW**
20/21-065	**Patient Experience Strategy – The Approach**	
	The Chief Nurse made a presentation on the approach to patient experience strategy which would consist of two main elements - Patient Experience Vision and the Patient Experience Delivery Plan. During the presentation, the Chief Nurse highlighted that the proposed approach would include holding a series of patient experience workshops with a wide range of stakeholders including staff members and families of patients. The Board acknowledged the efforts that had gone into the planning and looked forward to **receiving the Patient Experience vision in August 21 and the Patient Experience Delivery Plan in September 21**. **RESOLVED** **That the Board SUPPORTED the approach to developing the Patient Experience Strategy.**	**HR**
21/22-066	**Guardian of Safe Working Quarterly Report**	
	Dr Helen Kerss presented the Guardian of Safe Working Report for the quarter ending April 2021. The report contained details of the actual number of doctors in training; the exception reports submitted for the reporting period; and breaches of safe working hours and fines incurred. She reminded the Board of her role in protecting the safeguards outlined in the 2016 Terms and Conditions for NHS doctors and dentists in training. Dr Kerss also gave explanations on the requirement to produce exception reports by junior doctors and on how issues raised in the reports were promptly addressed. She drew attention to the reduction in the number of safe working breaches compared to the previous quarter (from 51 to 42) and to the fact that the Trust had not received any fine for breaches during the reporting period. The Chair expressed that the Board would like to meet with the new intake of junior doctors in August, subject to COVID-19 restrictions being lifted, as had been done previously. Sue Lorimer sought clarification on the consequences of breach of safe working hours, particularly on the patients. Dr Kerss gave explanations on instances when junior doctors had worked an hour or hour and half longer	

Reference	Minute	Action
	than schedule. There was a strict requirement for junior doctors to complete the exception reports when they had worked half hour or more over schedule to allow adequate monitoring of staffing levels and impact on patient safety. Dr Kerss thanked the Medical Director and Deputy CEO, for her support with securing the Doctors' study budget, which had been raised as an issue. **RESOLVED** **That the Board NOTED the report.**	
20/21-067	**Development of Trust Clinical Service Strategies 2021-26**	
	The Director of Strategy and Partnerships made a presentation on the Development of Trust Clinical Service Strategies 2021-26. He highlighted the process undertaken to develop the 32 speciality level Clinical Service Strategies, including engagement with clinical Divisions and clinical service teams. John Sullivan commended the clinical service strategies for its clarity. He pointed out that a workforce planning was not included and wanted to know when this would be completed. The Director of Strategy and Partnership advised that work was ongoing on workforce modelling as part of capacity planning. It was agreed that when the exercise was complete, it would be made available to the Workforce Assurance Committee for review. Steve Ryan commended the team work involved in the development of the clinical strategies and how the clinical strategies were linked to the overall Trust strategies, particularly the aspect on putting the patient first and public safety. The CEO acknowledged the hard work and commitments from the divisions that had been working to develop the clinical strategies through the pandemic. **She advised that each division would be making presentations to the Board on their respective plans in due course**. **RESOLVED** **That the Board NOTED the report.**	**MS**
20/21-068	**Process for developing the BAF 21/22**	
	The Chief Nurse presented the report which outlined the timetable for discussing and agreeing the risk appetite for Trust's strategic objectives and for completing a comprehensive BAF for 2021/22. The Board agreed the plan for initial discussions and reviews that would deliver a new BAF by September 2021. **RESOLVED** **That the Board NOTED the report.**	
20/21-069	**Monthly Safe Staffing Report**	
	The Chief Nurse presented the safe staffing report and highlighted that in Month 1, vacancies had fallen to 15.9% which was the lowest it had been since June 2018. There had been improved RN fill rates, influenced by a	

Reference	Minute	Action
	reduction in RN sickness to 5.96% (M1) and a reduction in RN absence to 0.07% (M1). The Chief Nurse advised that in response to the delay in the arrival of 41 international nurses from India, ward vacancies had been reviewed and a number of actions had been taken to ease the pressure on wards with higher vacancy rates including use of agency nurses, AHPs and pharmacy technicians to fill gaps. **RESOLVED:** **That the Board NOTED the report.**	
20/21-070	**Change Programme Summary, Delivery & Assurance**	
	The Director of Strategy and Partnerships made a presentation to highlight the progress on the Change Programme and the current areas of focus. Attentions were drawn to one of the previously tracked Service Improvement projects (Electronic Referral Triage (Phase 2) – Outpatients Programme) which had been completed and no longer subject to assurance. The project had reporting Green ratings for both Governance and Delivery in April. Attentions were also drawn to the ratings for the three priority Transformation programmes which had improved in May with all three attracting Green for Delivery; two rated Green for Governance and one Amber. **RESOLVED:** **That the Board NOTED the report.**	
20/21-071	**Chair's Report – Quality Assurance Committee**	
	The Committee Chair highlighted the key issues discussed at the Committee held on 20 May 2021 including: The Committee received a detailed report into the work undertaken to reduce the risk of extended waiting times in ophthalmology; and harm reviews of patients waiting longer than 52 weeks and the ongoing efforts to resolve outstanding issues. The Committee had reviewed reports relating to learning from incidents – developing safer systems; assurance in infection control and prevention; quality strategy and quality improvement programme. **RESOLVED:** **That the Board NOTED the report.**	
20/21-072	**Chair's Report – Safety Management & Assurance Committee**	
	The Board received the key issues discussed at the Committee held on 14 May 2021 including: The Committee had reviewed the divisional dashboard and exceptional reports and noted the decrease in the number of COVID-19 related incidents. The Committee had received the H&S Committee Chair's Report and the Effectiveness and Terms of Reference review.	

Reference	Minute	Action
	The Committee had also reviewed the H&S Annual Work Plan which was commended for its clarity and definition of statutory and non-statutory actions. **RESOLVED:** **That the Board NOTED the report.**	
20/21-073	**Chair's Report – Charitable Funds Committee**	
	The Committee Chair presented the report of the Committee held on 10 May 2021 and highlighted some of the key issues including: The Committee had received the Head of Fundraising Report together with a detailed presentation on fundraising activities for the period November 2020 to May 2021. The Committee had also reviewed the fundraising strategy and requested that the fundraising targets be scaled down to reflect the present economic realities. The Committee had received the Finance Report for the year ended 31 March 2021 and noted that there had been a total recognized income of £610K, against a total expenditure of £349k, with £194k of the expenditure spent on two 'Static Echo' machines paid for by the Heart fund. **RESOLVED:** **That the Board NOTED the report.**	
20/21-074	**Report of Trust Management Board**	
	The CEO presented the TMB Chairs report and highlighted some of the key issues discussed at the meeting held on 13 May 2021 including: • There had been a review of the Urgent and Emergency Care Upgrade Programme (UECUP) which had progressed to full business case. • There had been a review of the Month 1 finance report which indicated a projected surplus of £0.76m, a positive variance against plan of £6k, in line with the draft plan submitted to Cheshire and Merseyside HCP. • There had been a review of the proposals to free up space at Arrowe Park and Clatterbridge sites including removal of live case notes away from Trust premises to an off-site storage facility. • Diversity and Inclusion updates had been received together with Freedom to Speak Up report. **RESOLVED:** **That the Board NOTED the report.**	
20/21-075	**Communications and Engagement Monthly Report**	
	The Board received the report on the Trust's communications and engagement activities since the last Board meeting, including media relations, campaigns, marketing, social media, employee communications and staff engagement.	

Reference	Minute	Action
	The Director of Communications and Engagement highlighted campaigns supported by the Communications and Staff Engagement Team such as Deaf Awareness Week, Type 2 Diabetes Prevention Week; Mental Health Awareness Week; and the International Day of the Midwife and International Nurses' Day. **RESOLVED:** **That the Board NOTED the report.**	
20/21-076	**Any other business**	
	None	
20/21-077	**Date of Next Meeting** 7 July 2021, 10.00 (Physical or via MS Teams TBC)	
20/21-078	**Exclusion of the Press and Public**	
	RESOLVED: That under the provision of Section 1, Subsection 2 of the Public Bodies (Admissions to Meetings) Act 1960, the public and press be excluded from the remainder of the meeting on the grounds that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.	

……..……

Chair

……..

Date

Board of Directors Action Log
Updated – 02 June 2021
Completed Actions moved to a Completed Action Log

No.	Minute Ref	Action	By Whom	Progress	BoD Review	Note
Date of Meeting 02.06.21						
1	BM22-22/064b	**It was proposed and agreed that an appropriate plan should be prepared for review by the Finance, Business & Performance Assurance Committee on behalf of the Board.**	**CW**	Financial and CIP Planning for 2021/22 had been reviewed by FBPAC held on 24 June.	COMPLETE	
2	BM22-22/065	**Prepare the Patient Experience vision for August 21 Board and the Patient Experience Delivery Plan for September 21 Board**	**HR**	The items have been added to the Board Cycle of Business for August and September 21	COMPLETE	
3	BM22-22/066	**Divisions to be asked to present their individual plans to the Board**	**MS**			

Agenda Item: 21/22-086

BOARD OF DIRECTORS
07 July 2021

Title:	Chief Executive's Report
Responsible Director:	Janelle Holmes, Chief Executive
Presented by:	Janelle Holmes, Chief Executive

Executive Summary
This is an overview of work undertaken and important announcements for the month of June 2021

Recommendation: (e.g. to note, approve, endorse)
For noting

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
N/A
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
N/A
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
N/A
Specific communications and stakeholder /staff engagement implications
N/A
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
N/A

Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)		
N/A		
FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No
Previous considerations by the Board / Board sub-committees	Trust Board	
Background papers / supporting information	N/A	

BOARD OF DIRECTORS
07 July 2021

Chief Executive's Report

Purpose

This report provides an overview of work undertaken and any important announcements in June 2021.

Introduction / Background

1. COVID-19 Update

The community prevalence of COVID-19 continues to increase with an incidence of 182 per 100,000 over 7 days at the time of writing. The number of inpatients has also slightly increased but not at the rate witnessed during the 3rd surge. We are anticipating a doubling of inpatients within the next 12 days and have escalation plans in place to address this.

Staff members are being encouraged to participate in LAMP testing, in addition to vaccination and infection, prevention and control practices. Hospital visiting remains restricted with exceptions for birth partners, end of life care and those patients who may require additional support such as people with dementia. These actions will reduce the risk of nosocomial transmission. There is a pro-active communication plan in place for all wards across the Trust to ensure that families and friends receive regular updates in the absence of visiting.

2. Reset and Recovery

The Trust has delivered against its trajectory for reset and recovery during May and is on plan for the increased expectation during June with the exception of Daycase, primarily due to breakdown issues within the endoscopy unit. Those issues have now been resolved and recovery is expected during July.

It should be noted that the Trust's trajectories exceed the national expectation of 80%.

Activity - April	Trust Trajectory	Actual	Variance
Outpatients	96%	103%	+7%
Daycase	94%	84%	-10%
Inpatients	77%	91%	+14%

The activity performed is based on clinical priority which is borne out by the continued reduction in cancer patients awaiting surgery and whose pathways exceed 62 days.

3. Vaccination Hub

Since the last report the national vaccination programme has been opened to all adults age 18 years and over. Across Wirral place 384,576 vaccinations (214,586 1st

dose and 167,533 2nd dose) have been delivered across GP practices, PCN local vaccination sites and the WUTH vaccination centre. This equates to 79% and 62% respectively.

The Clatterbridge Vaccination Centre moved on to the national booking system on 12th June as part of the national hospital hub plus scheme. This has been recently introduced for hospital sites that are operating as a system partner vaccinating cohorts outside of NHS staff. Activity has increased as a result which is supporting the sustainability of the centre until the requirement to continue into the autumn booster programme has been clarified.

The Trust Chief Pharmacist continues to provide pharmaceutical support to the Cheshire and Mersey Vaccine Silver Command and Control structure and the WUTH hosted Medicine Delivery Driver continues to move vaccine across Cheshire and Mersey footprint to support the national mutual aid process to avoid vaccine wastage.

4. Urgent and Emergency Care Upgrade Programme – Appointment of Principal Supply Chain Partner

As part of the Urgent and Emergency Care Upgrade Programme, the Trust undertook a procurement process, utilising the NHS Procure 22 Framework and process, to appoint a principal supply chain partner to lead the design and construction of the urgent and emergency care precinct at Arrowe Park Hospital. This process included formation of a Bid Panel, submission of proposals from bidders, site visits, presentations and interviews with bidders between January and May 2021.

Following this process, the Panel recommended the appointment of Tilbury Douglas Construction Ltd (Interserve) as the principal supply chain partner, to the Board, who approved the appointment at the June Board meeting. Tilbury Douglas will commence work with the Trust from late July 2021.

5. Serious Incidents

The Trust declared 3 Serious Incidents in May in relation to a Never Event due to a wrong site biopsy; a patient lost to follow up in ophthalmology; and a baby fulfilled the criteria for cooling, the incident was reported to Healthcare Safety Investigation Branch (HSIB) and therefore declared a serious incident in accordance with NHSI guidelines.

All incidents are being investigated under the Serious Incident Framework to identify opportunities for learning and actions to drive improvement and reduce future risk. Duty of Candour has been commenced in line with legislation and national guidance.

6. RIDDOR Update

There was one incident reported to the HSE, in accordance with RIDDOR in May 2021. The incident involved a member of staff who sustained a back injury during a manual handling activity involving a patient, which was reported as an over seven day absence. Subsequent rapid review investigation identified that the member of staff had actually only been away from work for four days and had undertaken work outside of the Trust prior to reporting their absence.

The event having been reported to the HSE cannot be retracted. However internally, this event will not be included in future Trust RIDDOR data.

7. Quality Visit by University of Liverpool

A revisit was conducted on the 15th April 2021. The revisit focussed on Job planning, educational governance, induction, data collection and student evaluation.

The University commended the Trust on the focus for undergraduate supervision and formal training within current job plans. The University acknowledged the positive steps taken by the Trust in delivery of simulation training and recent work to improve the educational governance structure with the introduction of a Medical Education and Staffing Oversight Group (MESOG) and the transfer of the educational portfolio to the Medical Director.

Whilst significant improvements have been made on undergraduate induction, evidence of consistency and quality at a clinical departmental level is still required.

The dean did raise variation between student evaluation scores for Medical and Surgery attachments, particularly in relation to educational supervision which the Trust is exploring.

The University do not require another visit and have suggested issues regarding departmental induction and educational supervision can be resolved via communication between the quality team at the University and the Trust. This will be monitored for assurance via MESOG.

It is anticipated that from next year all trusts will provide an annual self-assessment to the University and scheduled school visits will be every 5 years.

8. Pandemic Response Public Enquiry

Work is underway as part of the Trust's preparation for the pandemic response inquiry. A key focus of this work includes maintaining evidence of key decisions made during the pandemic at an operational and strategic level, with evidence held centrally.

In making preparations for this process the Trust has been sharing best practice with other NHS trusts across the country, as well the COVID-19 response framework which was undertaken by Kings Fund and published in April 2021 as part of the *Assessing England's response* to COVID-19 report.
The Kings Fund framework's purpose is to provide a mechanism for assessing the UK's response to the pandemic, which may provide a structured process for undertaking this work. A link to the document is incorporated below.
Assessing England's response to Covid-19: A framework (kingsfund.org.uk)

In addition, consideration has been given to the work of the Health Foundation. The foundation is holding a free webinar on 6th July 2021, to discuss the findings of the COVID-19 impact enquiry, which will be attended by some senior members of staff directly involved in this work.

At present a process is underway to determine the most effective direction of travel in relation to resources and infrastructure.

9. Chief Operating Officer role

On the 30th of June 2021, Anthony Middleton will be stepping down from his role as Chief Operating Officer (COO) with the Trust, in order to take up an exciting role of Executive Director of Performance and Improvement for the Cheshire and Merseyside Integrated Care Partnership (ICP).

On behalf of the Board I would like to thank Anthony for his significant contributions in the last four years. A process is currently underway to recruit both an interim COO and the substantive COO. The appointment will be confirmed at the August Board meeting.

10. Board Seminar Sessions

Board members will be aware that we are holding two seminar events on the 7th of July 2021 on risk appetite and cyber security. Going forward, Board days will incorporate some dedicated time to enable the Board to receive presentations that facilitate updates on key areas such as strategy, ICP, and patient experience amongst others. As the year progresses, the Board's requirements on the content of these sessions will evolve and also include relevant aspects of Board development.

Conclusions

N/A

Recommendations to the Board

The Board is requested to note the Chief Executive's report.

Agenda Item: 21/22–087

Meeting of the Board of Directors
7 July 2021

Title:	Quality & Performance Dashboard
Author:	J Halliday Assistant Director of Information
Responsible Director:	COO, MD, CN, DoW, DoF
Presented by:	COO, MD, CN, DoW, DoF

Executive Summary
Contextual and background information pertinent to the situation / purpose of the report.

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note performance to the end of May 2021.

Of the 45 indicators that are reported for April (excluding Use of Resources):
- 23 are currently off-target or failing to meet performance thresholds
- 22 of the indicators are on-target

Please note during the current Covid-19 pandemic some metrics have been suspended from national reporting, and departments within the Trust have been focused on operational priorities over some internal reporting. Where the information is still available and reported within the Trust it has been included.

The metrics included are under continual review with the Directors to consider the appropriateness and value of inclusion and the performance thresholds being applied. Amendments to previous metrics and/or thresholds are detailed below the dashboard.

Recommendation:
(e.g. to note, approve, endorse)

For noting.

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

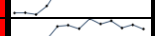
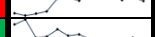
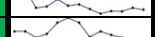
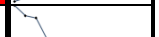
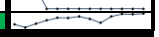
Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)		
Quality and Safety of Care. Patient flow management during periods of high demand.		
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)		
The dashboard Includes NHSI Oversight Framework metrics, considered as part of provider segmentation.		
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)		
N/a		
Specific communications and stakeholder /staff engagement implications		
N/a		
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)		
N/a		
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)		
N/a		
FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees	N/a	
Background papers / supporting information	N/a	

Quality Performance Dashboard

June 2021
Upated 22-06-21

	Indicator	Objective	Director	Threshold	Set by	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	2021/22	Trend
Safe	Falls resulting in moderate/severe harm per 1000 occupied bed days reported on Ulysses	Safe, high quality care	CN	≤0.24 per 1000 Bed Days	WUTH	0.14	0.29	0.13	0.18	0.21	0.00	0.11	0.21	0.15	0.11	0.16	0.10	0.20	0.20	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	96.4%	95.8%	95.1%	95.3%	95.4%	95.1%	95.3%	94.7%	94.2%	94.9%	94.0%	94.4%	94.5%	94.50%	
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital (all patients)	Safe, high quality care	MD	≥95%	SOF	97.8%	97.6%	97.2%	97.2%	97.4%	96.8%	96.9%	96.9%	96.5%	96.6%	96.2%	96.4%	96.6%	96.6%	
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	CN	≥95%	National	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	National reporting ceased	
	Serious Incidents declared	Safe, high quality care	CN	≤48 per annum (max 4 per month)	WUTH	4	1	4	4	2	3	2	4	4	5	4	5	4	4	
	Never Events	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	0	0	0	1	0	0	1	1	
	CAS Alerts not completed by deadline	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	0	0	0	0	0	0	1	1	
	Clostridium difficile (healthcare associated)	Safe, high quality care	CN	≤88 WUTH maximum from 2019-20 retained, with a varying trajectory of a max 6 to 8 cases per month	SOF	5	5	1	4	1	5	10	8	4	7	6	5	7	7	
	Gram negative bacteraemia	Safe, high quality care	CN	Maximum 63 for financial year 2021-22, with a varying trajectory of a maximum 5 or 6 cases per month	WUTH	4	6	8	5	3	7	3	1	3	6	6	3	5	5	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	1	0	1	0	0	0	0	0	0	0	0	0	0	0	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	99.1%	99.0%	99.5%	99.0%	99.6%	100.0%	100.0%	100.0%	99.3%	98.9%	100.0%	99.2%	99.2%	99.2%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	2	0	4	0	0	1	0	1	0	0	0	0	0	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	91%	95%	95%	98%	96%	94%	91%	93%	Not avail	Not avail	96%	96%	96%	96%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	88.7%	71.6%	79.3%	75.9%	72.9%	73.2%	75.1%	76.6%	77.9%	79.1%	79.9%	84.3%	85.9%	85.9%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	71.4%	71.8%	73.5%	72.1%	73.9%	74.5%	77.6%	81.3%	82.9%	84.1%	82.3%	83.0%	83.6%	83.6%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	19.7%	19.0%	42.0%	48.3%	53.2%	54.7%	60.9%	77.8%	79.0%	80.1%	67.0%	69.5%	70.8%	70.8%	
	Attendance % (12-month rolling average)	Safe, high quality care	DoW	≥95%	SOF	94.20%	94.25%	94.35%	94.41%	94.40%	93.58%	93.61%	93.66%	93.48%	93.42%	93.48%	93.79%	93.90%	93.90%	
	Attendance % (in-month rate)	Safe, high quality care	DoW	≥95%	SOF	95.04%	95.01%	94.92%	94.63%	94.41%	93.81%	94.04%	94.14%	92.30%	93.91%	94.71%	94.62%	94.32%	94.32%	
	Staff turnover % (in-month rate)	Safe, high quality care	DoW	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	0.43%	1.17%	1.17%	1.79%	0.97%	0.64%	0.97%	0.82%	0.98%	0.67%	0.77%	0.95%	0.72%	0.72%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DoW	≤10%	WUTH	10.7%	11.1%	11.7%	11.1%	12.7%	12.6%	13.2%	13.3%	13.7%	13.9%	13.0%	13.5%	13.2%	13.2%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	National reporting suspended	National reporting suspended	National reporting suspended	9.9	8.0	8.5	10.1	9.5	8.1	8.9	9.0	8.7	8.3	8.3	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	2021/22	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	96.5%	96.4%	99.1%	99.0%	96.8%	97.4%	97.5%	96.2%	94.1%	95.3%	98.0%	98.4%	98.3%	98.3%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	98%	97%	98%	98%	96%	96%	98%	97%	95%	97%	97%	99%	98%	98.0%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	19.6%	19.5%	18.8%	18.6%	17.8%	17.7%	18.5%	17.9%	18.4%	18.9%	18.0%	18.0%	17.7%	17.7%	
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	MD / COO	≤156 (WUTH Total)	WUTH	209	210	202	239	309	305	279	319	371	354	341	323	329	329	
	Long length of stay - number of patients in hospital for 21 or more days	Safe, high quality care	MD / COO	Maintain at a maximum 52 (revised Sept 2020)	WUTH	54	48	53	59	92	95	86	112	98	106	88	96	85	85	
	Length of stay - elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤5.3 days average	WUTH	5.5	6.2	3.6	3.8	4.8	3.9	4.1	3.4	2.8	3.2	3.1	3.6	3.3	3.3	
	Length of stay - non elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤7.3 days average	WUTH	4.7	4.7	4.2	4.5	5.4	5.8	5.4	4.3	4.7	4.4	4.2	3.8	4.0	4.0	
	Emergency readmissions within 28 days	Safe, high quality care	COO	≤1,110 per month	WUTH	870	941	1016	1012	1014	1007	992	1020	1027	938	1097	1149	1131	1131	
	Delayed Transfers of Care	Safe, high quality care	COO	Maximum 3.5% of beds occupied by DTOCs	WUTH	3.3%	2.3%	2.1%	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	69.7%	65.4%	70.9%	75.6%	79.3%	79.2%	81.3%	77.7%	71.9%	81.3%	84.9%	84.5%	85.5%	85.5%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	2021/22	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	0	2	3	5	1	0	0	3	2	0	0	2	2	2	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	87.0%	84.0%	87.0%	85.0%	84.0%	83.0%	83.0%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	TBC	92.0%	91.0%	92.0%	94.0%	95.0%	95.0%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	95.0%	94.0%	95.0%	95.0%	95.0%	94.0%	94.0%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	National reporting suspended	80.0%	100.0%	67.0%	94.0%	99.0%	95.0%	95.0%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	2021/22	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	NHSI Trajectory for 2020-21	SOF	93.7%	90.0%	90.4%	85.0%	76.9%	71.6%	76.2%	71.8%	64.6%	76.8%	77.8%	76.1%	73.5%	73.5%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	TBD	National	80.1%	76.4%	78.0%	71.4%	64.8%	64.9%	71.4%	69.6%	65.3%	77.8%	78.8%	73.4%	68.1%	68.1%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	TBD	National	0.4%	0.6%	0.6%	0.7%	2.7%	4.3%	3.1%	4.3%	6.7%	2.3%	1.6%	1.7%	2.6%	2.6%	
	Proportion of patients spending more than one hour in A&E after they have been declared Clinically Ready to Proceed	Safe, high quality care	COO	TBD	National	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	3.8%	3.5%	3.2%	4.2%	8.3%	13.8%	9.2%	13.2%	18.0%	8.7%	9.1%	11.0%	13.0%	13.0%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	54.05%	43.29%	41.67%	51.30%	59.76%	65.66%	69.16%	69.81%	68.40%	67.89%	69.26%	69.61%	72.57%	72.57%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSI Trajectory: maximum 22,980 for WUTH by March 2021	National	21288	21383	23034	24486	24212	22945	21633	21792	21880	21955	23444	24774	25873	25873	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSI Trajectory: zero through 2020-21	National	200	413	616	733	806	777	704	666	899	1108	1168	874	633	633	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	46.5%	74.9%	78.8%	83.5%	88.8%	90.5%	93.7%	94.9%	94.0%	94.3%	97.4%	97.7%	98.5%	98.5%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	97.2%	98.3%	95.5%	89.3%	92.6%	94.9%	90.5%	97.2%	96.0%	97.6%	98.8%	96.9%	97.6%	97.6%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	-	90.2%	-	-	92.48%	-	-	94.20%	-	-	97.64%	-	-		
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	98.3%	97.1%	90.7%	94.8%	92.1%	98.0%	97.4%	97.2%	98.0%	93.0%	93.5%	94.7%	93.9%	93.9%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	-	98.6%	-	-	92.44%	-	-	97.55%	-	-	94.73%	-	-		
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	86.2%	82.1%	80.7%	78.6%	82.6%	82.9%	85.3%	85.4%	80.9%	82.1%	84.1%	84.5%	87.4%	87.4%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	-	85.3%	-	-	80.68%	-	-	84.60%	-	-	82.56%	-	-		
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	99	119	143	124	183	178	161	150	196	165	170	157	156	156	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	1.50	2.80	2.10	3.40	4.20	3.80	3.20	1.32	3.80	3.56	4.07	4.09	2.56	2.56	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	88%	100%	100%	100%	100%	100%	94%	100%	97%	100%	95%	100%	93%	93%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	1	5	1	0	2	1	4	2	2	4	4	0	2	2	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	2021/22	Trend
Well-led	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	CN	100%	National	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	Under review	
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	700 for FY 20/21. Threshold for 21/22 TBC	National	181	152	86	31	126	329	215	163	599	206	87	15	18	33	
	% Appraisal compliance	Safe, high quality care	DoW	≥88%	WUTH	85.1%	77.9%	81.3%	84.3%	76.3%	73.0%	74.1%	76.2%	72.9%	74.7%	77.0%	81.0%	81.3%	81.3%	

	Indicator	Objective	Director	Threshold	Set by	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	2021/22	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.0	0.0	0.0	0.8	0.7	0.5	-0.2	-5.4	3.5	0.8	-0.5	0.3	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.0	0.0	0.0	0.4	0.5	0.3	-0.1	-5.4	3.9	0.8	-0.4	0.4	
	NHSI Risk Rating	Effective use of Resources	CFO	On Plan	NHSI	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2	
	CIP Performance	Effective use of Resources	CFO	On Plan	WUTH	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0%	
	NHSI Agency Performance (monthly % variance)	Effective use of Resources	CFO	On Plan	NHSI	25.9%	27.4%	25.0%	34.5%	22.3%	12.1%	0.5%	10.2%	18.5%	-22.5%	-21.9%	-50.5%	-27.7%	-27.7%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-98.4	-98.2	-98.0	-97.9	-16.3	-15.0	-15.6	-17.4	-28.0	-17.8	-16.9	-15.0	-15.5	-15.5	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	100.4%	61.1%	53.0%	44.6%	42.1%	41.8%	46.2%	66.3%	67.5%	-74.8%	100.0%	52.8%	62.9%	62.9%	

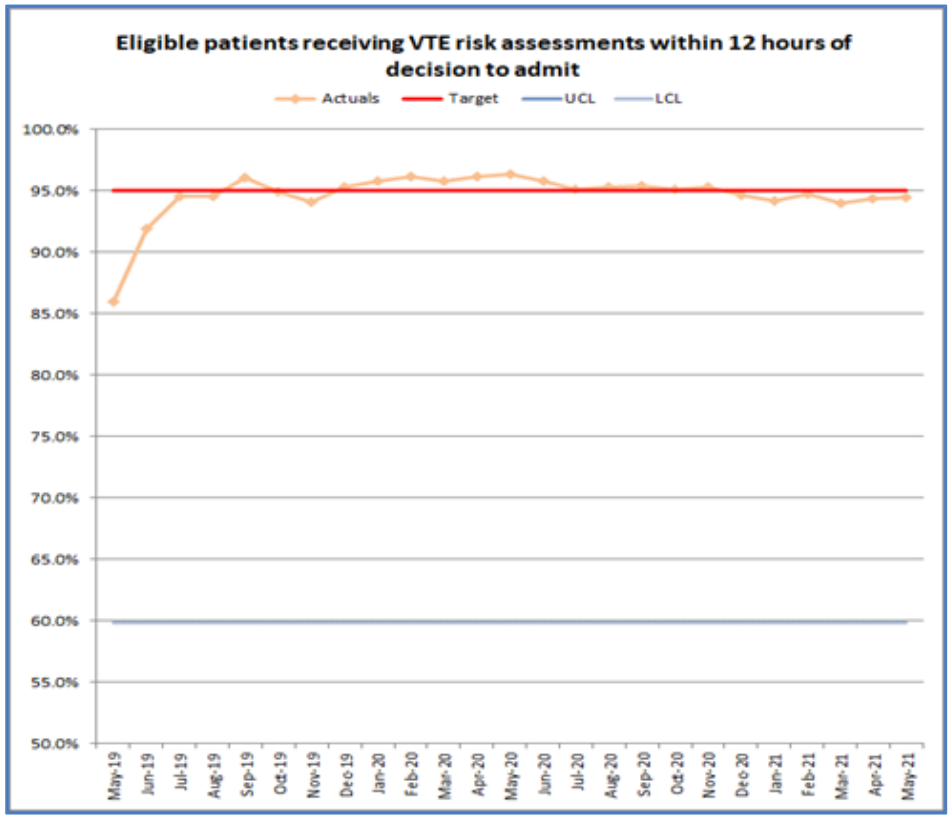
(*) Updated Metrics

(**) Updated Thresholds

Safe Domain

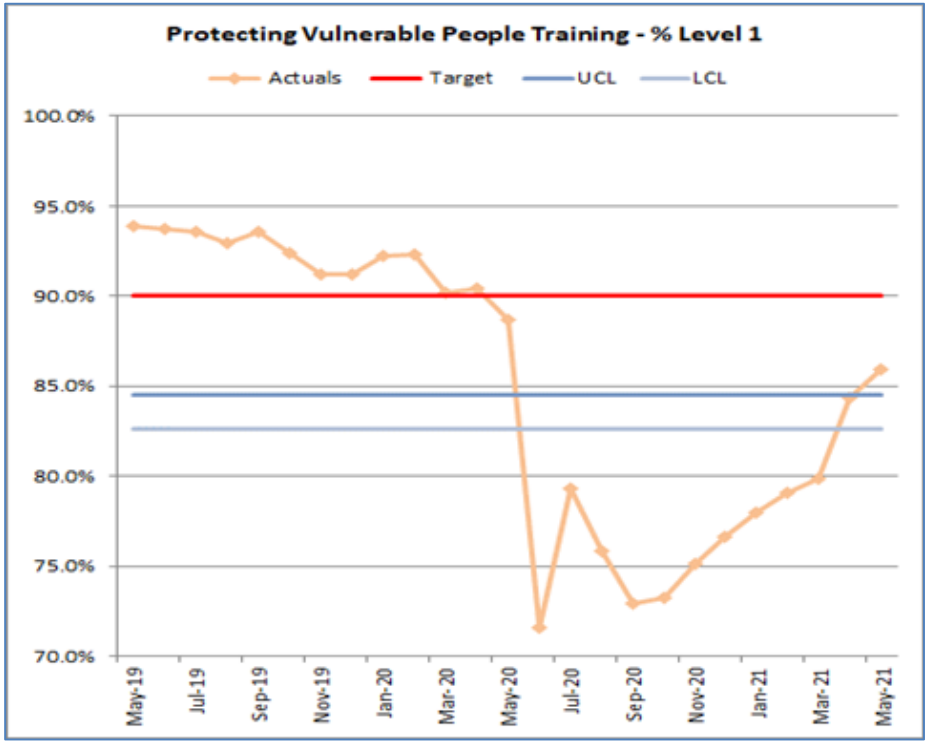
Eligible patients having VTE risk assessment within 12 hours of decision to admit

Executive Lead: Medical Director
Performance Issue: A WUTH target has been set that at a minimum 95% of eligible patients will have a VTE risk assessment performed within 12 hours of the decision to admit. May performance was again slightly below at 94.5%. The nationally reported standard of all patients receiving a VTE risk assessment on admission to hospital has been consistently met.
Action: VTE compliance in each division is tracked through divisional governance reports to PSQB. Performance will continue to be closely monitored to ensure that there is not a significant nor sustained deterioration in assessment and that there are no patient safety issues.
Expected Impact:



Protecting Vulnerable People Training - % Compliant Level 1

Executive Lead: Chief Nurse
Performance Issue: WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard has been improving in recent months, with May at 85.9%.
Action: A monthly breakdown report of non-compliance is available to divisions to enable a proactive approach to improve compliance. Divisions are holding targeted conversations and are scheduling protected time for staff to complete the online training. The Trust Safeguarding Team continue to monitor staff knowledge via the Perfect Ward Audits and are offering additional support and training in wards with identified risks.
Expected Impact: There is an expectation that PVP level 1 training compliance will continue to increase further during Q2.



Protecting Vulnerable People Training - % Compliant Level 2

Executive Lead: Chief Nurse

Performance Issue:

WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard had been improving, with a further increase in May 2021 to 83.6%.

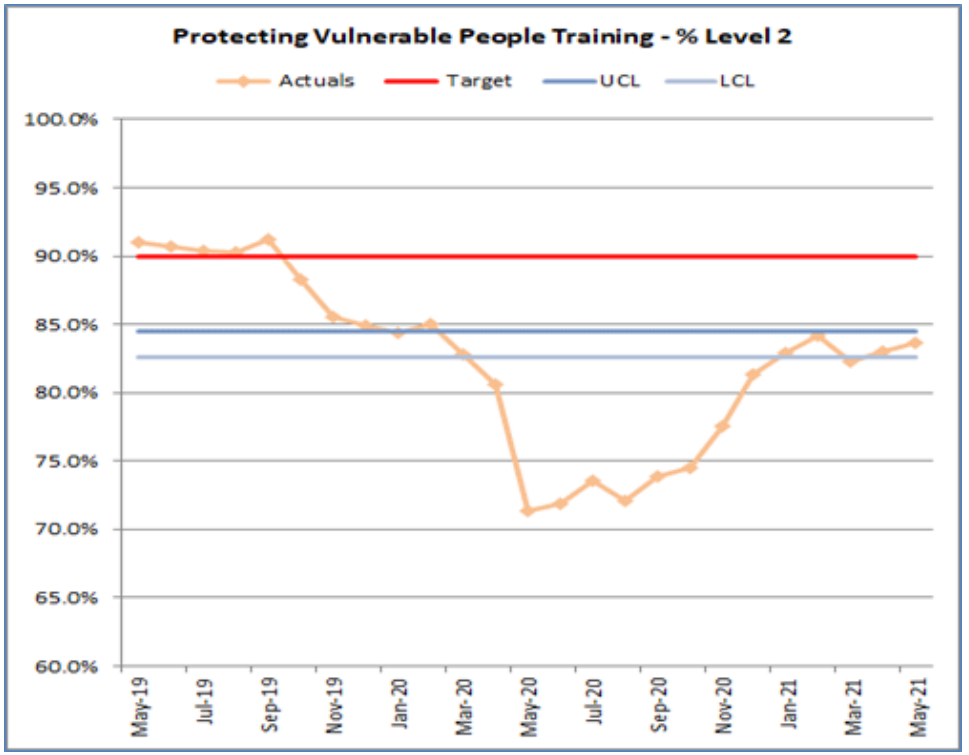
Action:
PVP level 2 is an E-Learning package that can accessed directly by staff at any time.

Monthly detailed non- compliance reports are provided to all divisions to enable targeted conversations to occur to improve compliance.

The Safeguarding Team continues to monitor risks and staff knowledge gaps through the use of Perfect Ward Audits, quality monitoring of MCA applications and the Wise Accreditation Programme. Additional support and bespoke training are provided where necessary to support staff where areas of risk are identified.

Expected Impact:

PVP level 2 training compliance is expected to increase further during Q2.



Protecting Vulnerable People Training - % Compliant Level 3

Executive Lead: Chief Nurse

Performance Issue:

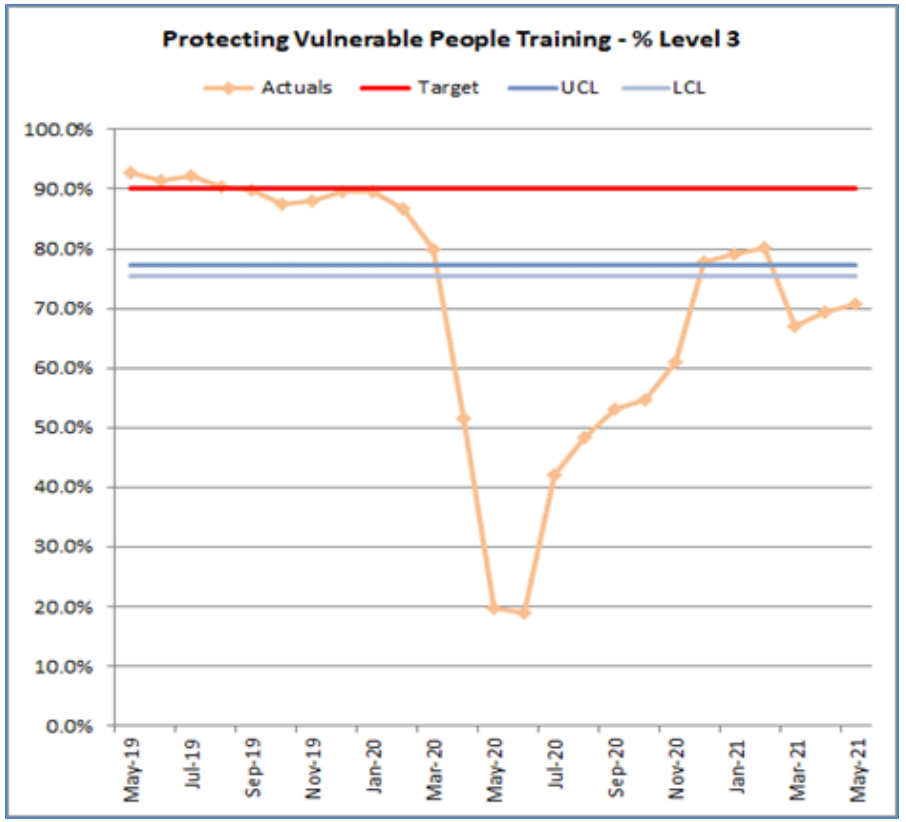
WUTH has a target set at a minimum 90% of relevant staff being compliant with training. Performance against this standard had been steadily improving, with Mays compliance increasing to 70.8%.

Action:
There has been a continued increase in the number of staff accessing Level 3 training providing a steady improvement in compliance to the E-Learning element of Protecting Vulnerable Adults Level 3 (PVP) training.

The face to face element of level 3 for identified staff continues to remain a challenge. Session sizes are currently limited to 33 people due to social distancing requirements and the limited availability of large venues. Divisions are prioritising staff to undertake the E-Learning element of the course to enhance their knowledge in the anticipation of face to face training availability. Due to the standards outlined in the Safeguarding Intercollegiate Document staff will not be considered fully compliant until face to face training has also been completed. All available venue space has been booked for the forthcoming year to enable Divisions to plan training sessions accordingly. Other external venues are currently being explored.

Expected Impact:

There is an expectation that PVP level 3 training compliance will continue to increase slowly further during Q2.



Staff attendance % (in-month rate)

Executive Lead: Director of HR / OD

Performance Issue:
The Trust compliance threshold for sickness absence is 5%, both for in-month sickness and over a rolling 12-month period.

In-month sickness in May 2021 was 5.68% compared to 5.44% in April 2021 and 5.36% in March 2021. This is a significant improvement from the position in January 2021, which was 7.82%.

The rolling 12-month figure in April 2021 was 6.10% which was an improvement on last month from 6.21%.

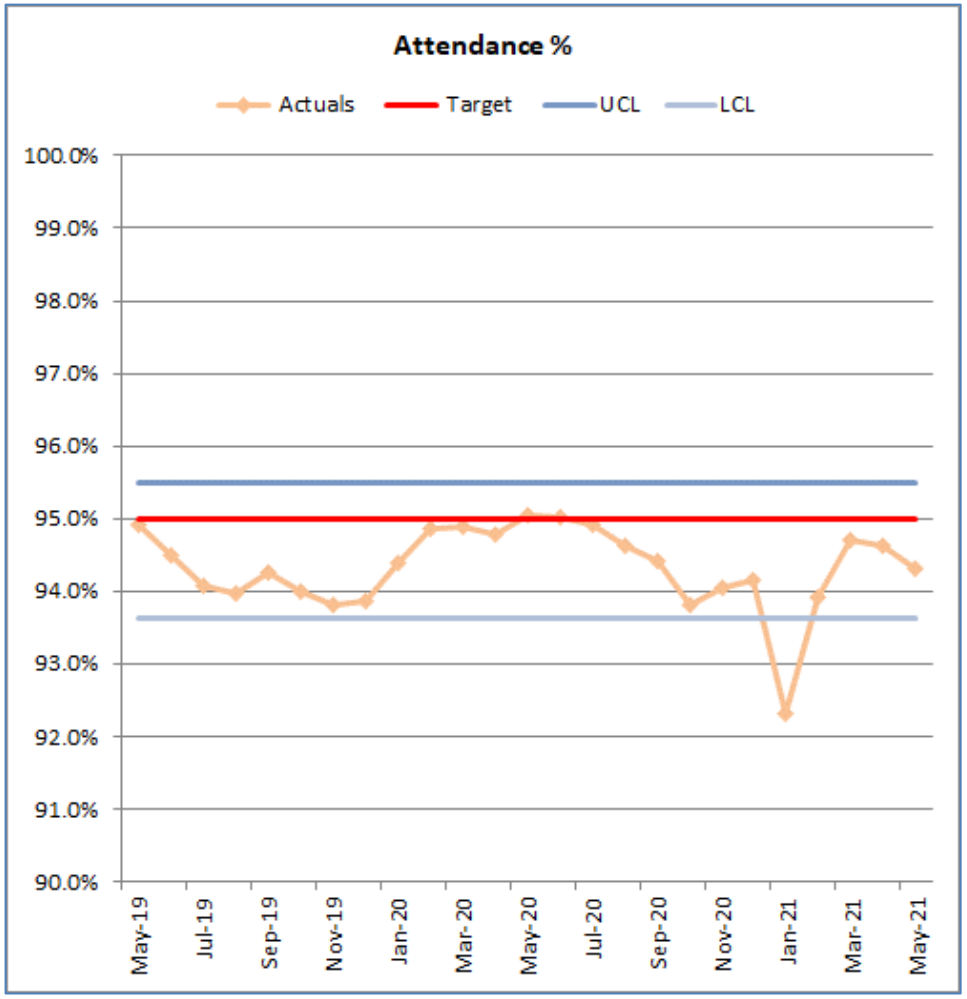
4 Divisions have exceeded the 5% KPI in May 2021;

- Estates and Hotel Services (7.33%)
- Medicine and Acute (6.78%)
- Surgery (6.27%)
- Women and Children's (5.48%)

In May 2021 there were 295 episodes of long-term sickness (28 days+) across the Trust which accounted for 28.84% of total sickness. There were 728 episodes of short-term sickness which accounted for 71.16%.

Anxiety, Stress and Depression remains the highest reason for long term sickness absence at 33.56% (99 episodes), followed by Musculoskeletal Health at 12.20% (36 episodes).

Gastro problems was the highest reported reason for short term sickness absence at 18.52% (135 episodes) followed by Anxiety, Stress and Depression at 13.05% (95 episodes).



Action:

Supporting and Promoting Wellbeing

Divisional Triumvirates with support from their HR Business Partners have developed Divisional specific improvement plans with a heavy focus on Health, Wellbeing and Attendance. These will help improve sickness absence levels whilst also appropriately aligning with the results of both the Trust staff survey and their respective Divisional reports.

Weekly communications related to wellbeing have been included in the InTouch Bulletin and a leaflet attached to pay slips to highlight support available. Wellbeing will be a focus of the Leaders in Touch session in June 2021. During May we used Mental Health Awareness week to remind the Trust of the Health & Wellbeing folders and sign post Public Health England's 'Every Mind Matters' platform, tools and free online plan.

There are a series of Executive Engagement Meetings with staff in key areas week commencing 14th June 2021 as part of COVID wellbeing support.

The Trust is working with NHS England and NHS Improvement (NHSEI) North West People Team to pilot a leadership development program aimed at supporting first line managers in creating a wellbeing culture and managing attendance.

Managing Sickness Absence

Work continues strategically and operationally from HR to support Divisions and Managers to manage sickness absence effectively. HRBPs and HR Managers are focusing on supporting managers to conclude a number of complicated protracted long-term sickness cases.

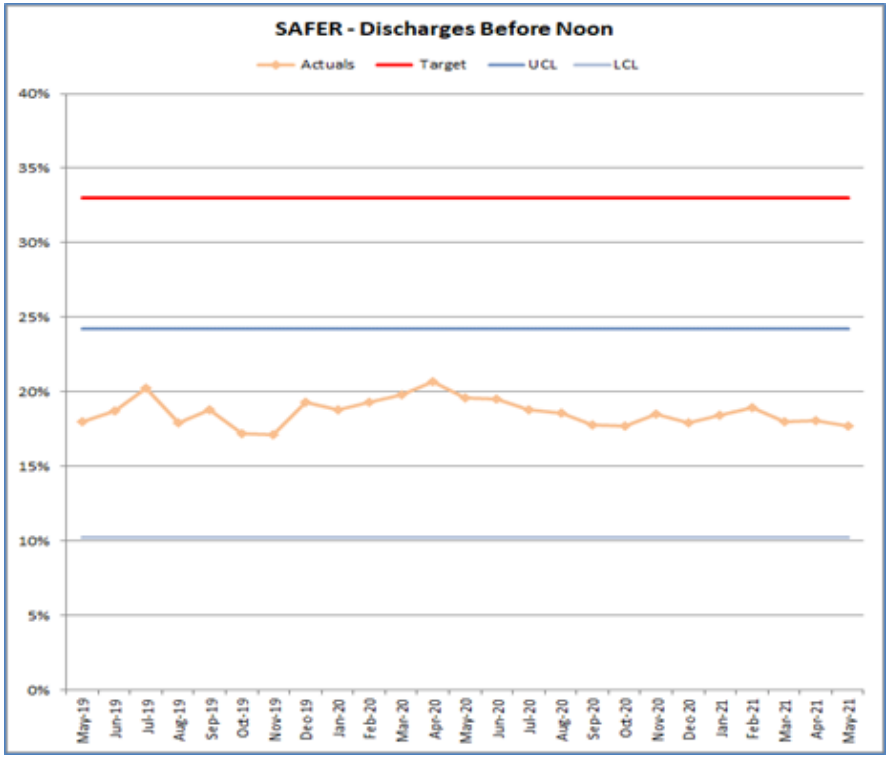
RTW interviews for all episodes of sickness remains a priority and performance against this indicator is improving. It is now 77.10% for May 2021 compared to 74.19% last month (April). This focus will remain a priority for the foreseeable future.

North West Attendance Deep Dive Initial engagement work has begun on the pilot in place with the NHSEI North West People Team to take forward a range of recommendations following a deep dive into sickness absence across the North West.
Expected Impact: Risks to Trust financial management, quality, patient safety and operational performance due to cost of sickness absence, expense of bank and agency cover will reduce as the sickness absence is gradually improved over the next quarter.

Effective Domain

SAFER bundle: % of discharges taking place before noon

Executive Lead: Medical Director / Chief Operating Officer
Performance Issue: A WUTH target has been set that at a minimum 33% of inpatients are to be discharged before noon. The pattern of delivery has improved over the long term but is short of the optimum figure of 33%.
Action: The patient flow improvement programme contains a key workstream around ward processing and has been implemented across a number of medical wards and has begun roll out in surgery. Operational controls have been put into place to ensure ward rounds have commenced as planned and is comprehensively staffed by senior decision makers.
Expected Impact: During May 33% of discharges were delivered by 1.55pm.



Caring Domain

Same sex accommodation breaches

Executive Lead: Chief Nurse

Performance Issue:

The national standard is set that providers should not have mixed-sex accommodation, except where it is considered in the overall best interests of the patient or reflects personal choice.

WUTH mixed sex breaches are largely due to patients waiting more than 24 hours for transfer from critical care areas to general wards – there were 2 such breaches in May 2021.

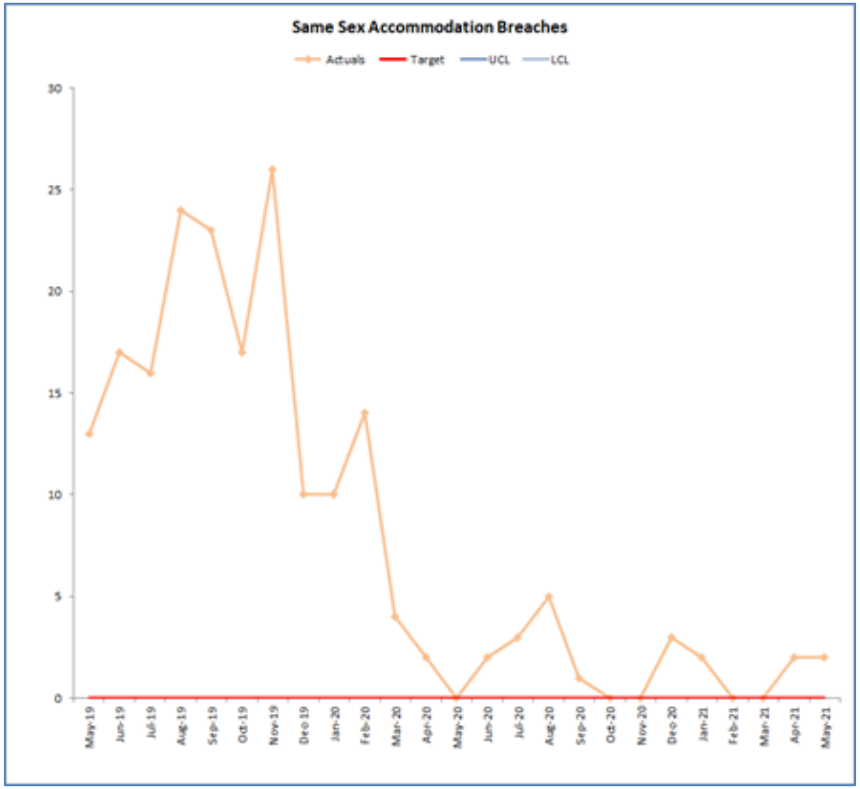
Action:

This month due to unexpected increases in ED attendances and admissions there were 2 mixed sex breaches. The management of mixed sex breeches is considered as high priority and is managed via Bed Capacity and Bronze Command Meetings to ensure actions are taken to address these timely. The Critical Care Matron attends the bed meetings to ensure focus remains high on any patients that are at risk or reported as mixed sex breaches.

These two reported breaches did not cause any delays or refused admissions to the Critical Care Unit as sufficient critical care bed capacity was available at this time. Patient's privacy and dignity needs are met whilst in critical care and the team ensures their specialty care is not compromised due to a lengthened critical care stay.

Expected Impact:

There will be a reduction in same sex accommodation breaches.



Responsive Domain

4-hour Accident and Emergency Target (including Arrowe Park Walk in Centre)

Executive Lead: Chief Operating Officer

Performance Issue:

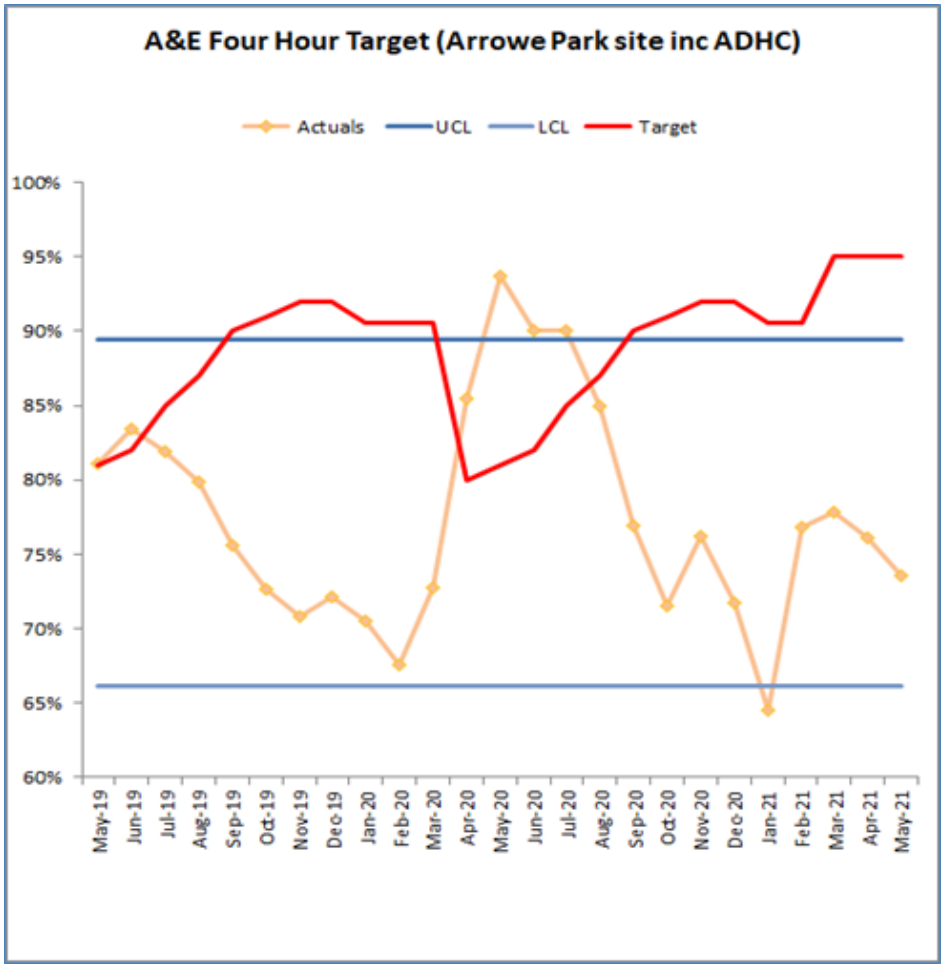
Performance during the first wave of COVID resulted in much reduced attendances, lower bed occupancy due to faster discharge and reduced elective activities creating better flow. During the third wave of Covid from January 2021, ED attendances again reduced but the number of Covid inpatients were greatly increased and so occupancy levels remained high despite the elective programme again being reduced. Since late March attendances have continued to exceed pre-covid levels.

Action:

There have been demonstrative improvements in breaches related to bed availability and the focus is now on delays within the ED itself.
A focus on triage times and the time taken for initial assessment is the focus of the improvement plan and is tracked through the transformation agenda.
The weekly performance framework is now focused on ED and there are weekly Exec led meetings with the Department and a further trust wide meeting to address issues and track progress.

Expected Impact:

The above measures are targeted to improve performance and maintain a zero approach to 12-hour trolley waits.



Referral to Treatment – incomplete pathways < 18 weeks

Executive Lead: Chief Operating Officer

Performance Issue:

The Trust had a trajectory agreed with NHSI for 2020-21 to maintain at 80% of patients waiting on incomplete Referral to Treatment pathways to be under 18 weeks.

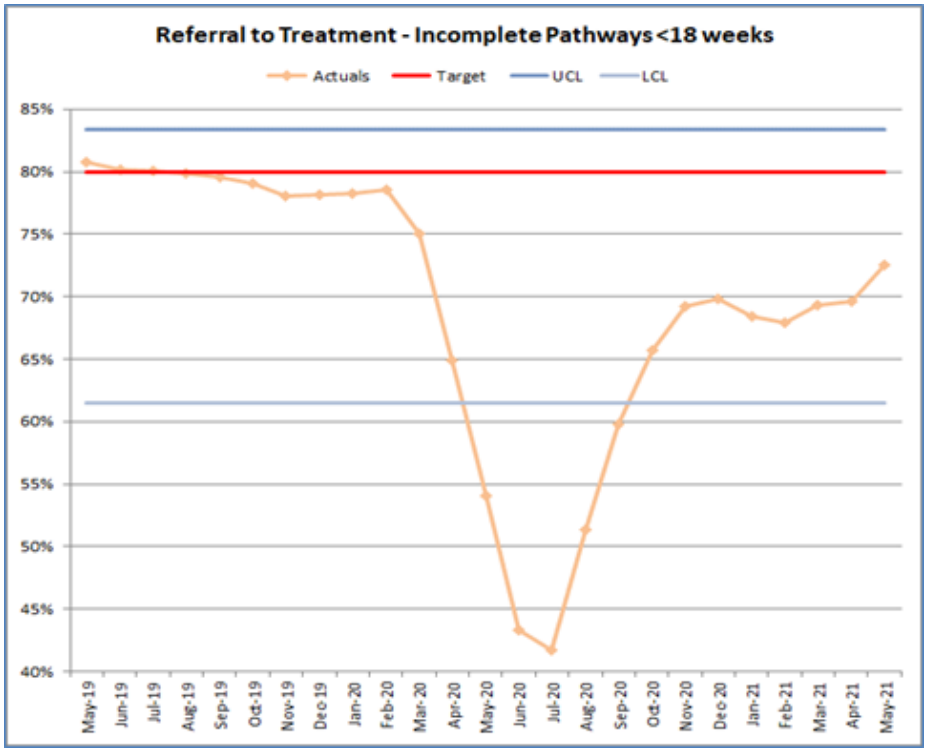
Following the directive to cease all non-urgent elective activities as part of the COVID response this metric sharply declined. The subsequent resumption of elective activity from July saw performance improve, until the onset of the Covid third wave from January 2021.

Action:

From March 8th the Trust has restarted non urgent activities and has developed activity and performance trajectories.

Expected Impact:

It is expected that the performance will improve moderately month on month but scenarios around referral growth will be monitored closely.



Diagnostic Waiters, 6 weeks and over

Executive Lead: Chief Operating Officer

Performance Issue:

There is a national standard that patients awaiting diagnostic investigations should wait a maximum of six weeks. This is measured based on a specific subset of investigations, and with an expected tolerance that 99% or more patients waiting will be under six weeks.

The position at the end of May 2021 was 98.5%. The improvement previously seen from Summer 2020 is now continuing following the third Covid wave experienced at the beginning of 2021.

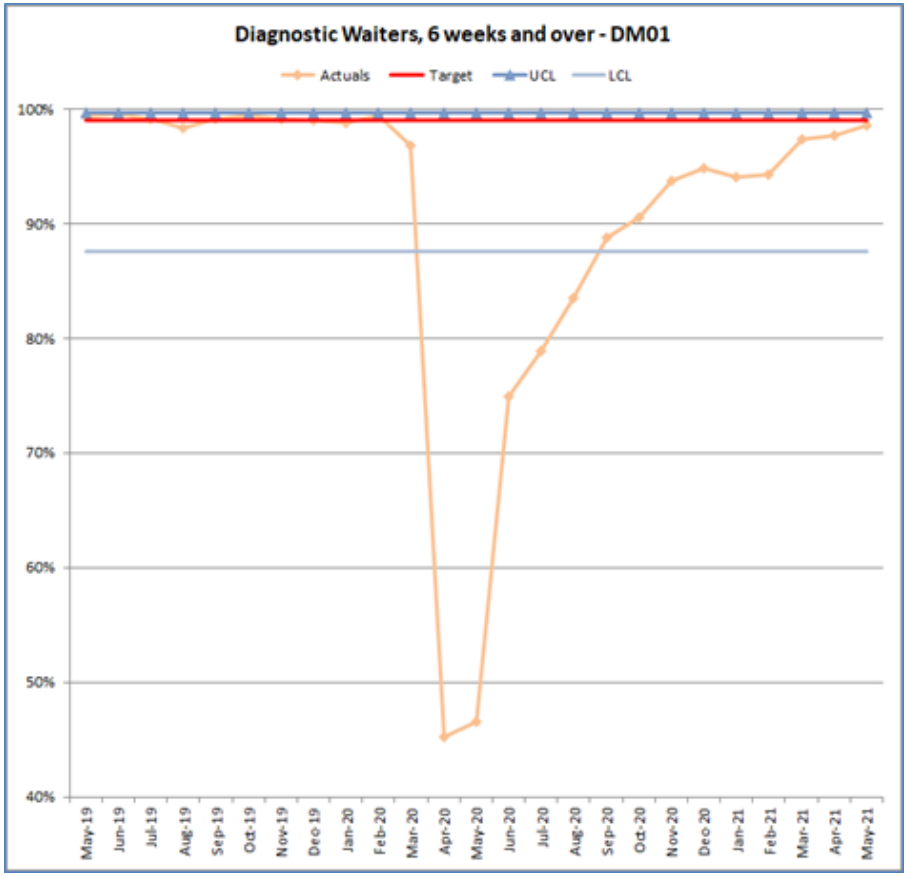
Action:

During the third wave access to diagnostics was clinically prioritised with a negative impact on clinically triaged routine waiting times.

The recovery of diagnostic backlogs is part of the overall reset and recovery programme and trajectories, and the variance from plan is now limited to routine endoscopy where a recovery plan is in place.

Expected Impact:

A return to delivery of the standard is expected by the end of August.



Well-led Domain

Appraisal compliance %

Executive Lead: Director of HR / OD

Performance Issue:

The target for annual appraisal compliance is 88%. Compliance at the end of May 2021 was 81.27%. Although this standard has not been achieved, there has been sustained improvement since February 2021.

There was significant improvement in 4 divisions in May 2021:

- Clinical Support 81.61% (+6.47%)
- Estates and Facilities 87.82% (+4.74%)
- Surgery 79.43% (+8.37%)
- Women's and Children's 88.95% (+4.94%)

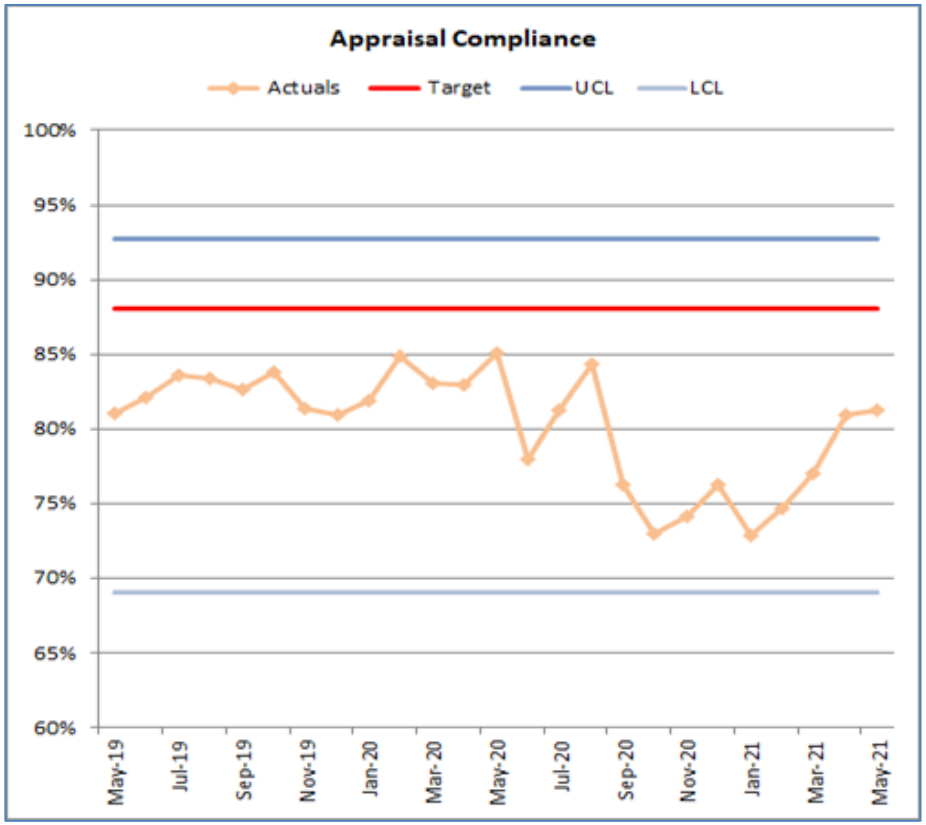
Medicine and Acute Division and Corporate Division are both areas of challenge at 78.93% and 68.56% respectively.

Action:

Workforce compliance data is available to Divisions and the HR Services team to enable them to manage non-compliance for their areas and alerts of appraisals due are generated via the ESR system.

Detailed compliance reports are received by the Education Governance Group and the OD team and HR Business Partners continue to support Divisional Management teams to identify and deliver actions to address low levels of compliance in specific areas.

Managers within the Corporate Support Division are developing improvement plans against the detailed compliance reports. Within the Medicine and Acute



Division, further analysis has identified specific areas of challenge and additional review meetings are in place with the HR Manager. Check and challenge discussions take place at a divisional triumvirate levels and recommencement of divisional performance review meetings will see this challenged further.
Expected Impact: Improvement in trajectory as the Trust returns to business as usual.

Agenda Item:BM21/22-088

BOARD OF DIRECTORS

07 July 2021

Title:	M2 Finance Report
Responsible Director:	Claire Wilson, CFO
Author:	Robbie Chapman, Deputy CFO
Presented by:	Claire Wilson, CFO

Executive Summary
The Trust is reporting a surplus of £0.268m at M2, a positive variance against plan of £0.360m. Despite this positive variance we expect to perform in line with our plan for a break-even position in the first half of the year (H1).

Recommendation: (e.g. to note, approve, endorse)
The Board of Directors are asked to note the report.

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
PR3: failure to achieve and/or maintain financial sustainability.
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
N/A
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)

Summary of financial performance at M1 with implications for year-end forecast.		
Specific communications and stakeholder /staff engagement implications		
N/A		
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)		
N/A		
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)		
N/A		
FOI status	Document may be disclosed in full	✓
	Document includes FOI exempt information	
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees	N/A	
Background papers / supporting information	N/A	

Contents

1. Executive summary

Wirral University Teaching Hospital NHS Foundation Trust

1.1 **Table 1: Financial position – M2**

Month 2 Financial Position	Budget (Mth 2) £'000	Actual (Mth 2) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
NHS income - patient care	30,427	30,712	285	60,819	61,614	795
Covid 19 income	1,930	2,129	199	3,890	4,442	552
Non NHS income - patient care	409	442	32	819	821	2
Other income	2,187	2,381	193	4,320	4,489	169
Total Income	**34,953**	**35,663**	**710**	**69,848**	**71,367**	**1,518**
Employee expenses	(23,549)	(24,066)	(517)	(46,831)	(47,193)	(361)
Operating expenses	(10,830)	(11,150)	(320)	(21,723)	(21,945)	(222)
Covid 19 costs	(254)	(572)	(318)	(622)	(1,230)	(608)
Total Expenditure	**(34,633)**	**(35,788)**	**(1,156)**	**(69,177)**	**(70,368)**	**(1,191)**
Non Operating Expenses	(382)	(366)	16	(763)	(730)	32
Actual Surplus / (deficit)	**(61)**	**(491)**	**(430)**	**(91)**	**268**	**360**
			0			0
Surplus/(deficit) - Control Total	**(61)**	**(491)**	**(430)**	**(91)**	**268**	**360**

1.2 The Trust is reporting a surplus of £0.268m at M2, a positive variance against plan of £0.360m. Despite this positive variance we expect to perform in line with our plan for a break-even position in H1.

1.3 Total income was £71.367m at M2. This reflects the revised 'block' contract arrangements with CCGs with the reduced income compared to draft plans, confirmed values in respect of specialist and direct commissioning and ERF income of £2.584m.

1.4 The figure accrued in respect of ERF has yet to confirmed and will not be received until M4 at the earliest. The figure represents a prudent estimate of our activity against national trajectories and is subject to change.

1.5 We have received £4.442m in respect of COVID, a positive variance of £0.552m. This is due to income in respect of the vaccination programme and COVID testing that were not included in our budget but are fully offset by expenditure.

1.6 Total employee expenses excluding COVID-19 were £47.193m at M2, this represents an overspend against our budget of £0.361m. Employee expenses can be broken down as follows:

Table 2: Pay cost analysis

Pay analysis (exc Covid)	Budget (Mth 2) £'000	Actual (Mth 2) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Substantive	(21,623)	(21,233)	390	(42,961)	(42,008)	953
Bank	(734)	(1,123)	(389)	(1,476)	(2,177)	(701)
Medical Bank	(444)	(808)	(364)	(888)	(1,143)	(256)
Agency	(665)	(815)	(150)	(1,341)	(1,690)	(349)
Apprenticeship Levy	(83)	(86)	(3)	(167)	(174)	(8)
Total	(23,549)	(24,066)	(517)	(46,831)	(47,193)	(361)

1.7 Operating expenses were £21.945m at M2, an overspend of £0.222m. This reflects lower spend against clinical supplies and services than budget offset by increased expenditure on drugs, estates and education and training.

1.8 Cash balances at the end of M2 were £22.2m.

1.9 The Trust has recorded capital spend of £0.78m which is behind plan but spend is expected to be back on track over the coming months.

2. Background

2.1 The Trust has now completed the planning process for the first half of the financial year (H1). As part of this process, Cheshire and Merseyside was require to break-even as a system. This resulted in a redistribution of moneies within the system and a reduction of funding for WUTH of approximately £8m compared with our draft plan. £4.2m of this reduction was offset against our original planned surplus. The remainder of the reduction is offset against an increased CIP target and ERF income for a break-even budget for the H1.

2.2 Plans will be resubmitted to NHSE/I on 22nd June we do not expect any significant changes.

2.3 The funding arrangements for H2 have yet to be confirmed but it is likey that we will have to undertake a second planning procress ahead of the 2nd half of the year.

3. Dashboard and risks

3.1 **Table 3: M1 Performance Dashboard**

Indicator	Director	Threshold	Set by	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	2021/22
I&E Performance (monthly actual)	CFO	On Plan	WUTH	0.5	-0.2	-5.4	3.5	0.8	-0.5	0.3
I&E Performance Variance (monthly variance)	CFO	On Plan	WUTH	0.3	-0.1	-5.4	3.9	0.8	-0.4	-0.4
NHSI Risk Rating	CFO	On Plan	NHSI	2.0	2.0	2.0	2.0	2.0	2.0	2
CIP Performance	CFO	On Plan	WUTH	0.0	0.0	0.0	0.0	0.0	0.0	0.0%
NHSI Agency Performance (monthly % variance)	CFO	On Plan	NHSI	10.2%	18.5%	-22.5%	-21.9%	-50.5%	-27.7%	-27.7%
Cash - liquidity days	CFO	NHSI metric	WUTH	-17.4	-28.0	-17.8	-16.9	-15.0	-15.5	-15.5
Capital Programme (cumulative)	CFO	On Plan	WUTH	66.3%	67.5%	-74.8%	100.0%	52.8%	62.9%	62.9%

3.1.1 Although thresholds have yet to be confirmed for 2021/22, we have reported against the most recent thresholds.

3.1.2 The performance in respect of I&E performance is explained by the adjustments made due to the redistributions of funding since M2.

3.1.3 Agency spend is above threshold. This is discussed in more detail at 4.2.3.

3.1.4 Despite significant improvement over the last year, the Trust's liquidity days measure is below threshold. This is based on net current liabilities compared against operating expenses. Steps are being taken to reduce historic accruals which will serve to improve this measure.

3.2 **Risk summary (as per risks identified in risk register)**

3.2.1 Risk 1 – Failure to manage financial position

- The H1 financial envelope has now been confirmed and our ability to operate within this envelope will be dependent on effective cost management alongside the delivery of activity trajectories, the management of COVID activity and the centrally funded vaccination and testing programmes. This report demonstrates that, as of M2, we are managing this position within envelope.

3.2.2 Risk 2 – Failure to deliver CIP

- The confirmed H1 CIP target is £1m and this has been incorporated into our plans submitted to NHSE/I. This figure will likely increase in H2 and work has already begun to identify schemes for the period.

3.2.3 Risk 3 – Failure to complete capital programme

- Our capital programme target for 21/22 is £14m which contains work carried forward from the previous financial year and significant work throughout the Trust. M2 performance is slightly behind plan but we are confident that this can we will continue to monitor spend.

4. Financial Performance

4.1 **Income**

4.1.1 The Trust has received £71.367m at M2.

Table 4: Income analysis for M1

	Budget (Mth 2) £'000	Actual (Mth 2) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Elective & Daycase	3,754	3,973	218	7,357	7,634	278
Elective excess bed days	52	76	24	152	124	(28)
Non-elective	8,669	8,711	41	16,590	16,777	186
Non-elective Non Emergency	1,103	1,153	50	2,154	2,188	34
Non-elective excess bed days	389	198	(191)	689	423	(266)
A&E	1,348	1,389	41	2,651	2,741	90
Outpatients	3,069	3,431	361	6,030	6,331	301
Diagnostic imaging	261	281	19	516	473	(42)
Maternity	493	442	(51)	947	885	(62)
Non PbR	6,046	5,214	(833)	11,944	10,692	(1,252)
HCD	1,297	1,434	137	2,546	2,880	334
CQUINs	190	190	(0)	380	380	(0)
National Top up	1,757	308	(1,449)	3,514	3,514	(0)
Income Guarentee	288	471	183	1,966	2,344	378
Other	1,018	1,018	0	2,037	2,037	0
Sub-Total Board Clinical Income	29,736	28,288	(1,448)	59,472	59,423	(49)
Other patient care income	82	183	101	163	254	91
Elective Recovery Fund (ERF)	925	2,584	1,659	1,816	2,584	768
COVID-19 Income	1,930	2,129	199	3,890	4,442	552
Non-NHS: private patient & overseas	29	27	(2)	58	36	(22)
Injury cost recovery scheme	64	69	5	128	127	(2)
Total Patient Care Income	32,766	33,281	515	65,528	66,866	1,338
Other operating income	2,187	2,382	195	4,320	4,501	181
Other non operating income		0	0		0	0
Total income	34,953	35,663	710	69,848	71,367	1,518

4.1.2 Clinical income in M2 was in line with forecast. The lower patient care activity income in respect of non-PbR activity and non-elective excess bed days was offset by strong performance in respect of outpatients, elective and daycase and the National Top Up we received in M1.

4.1.3 Total patient care income had a positive variance of £1.349m. This includes the re-imbursement of expenditure in respect of vaccination and COVID-19 testing and overperformance against ERF of £0.768m.

4.1.4 Other Operating income was £4.489m at M2, in line with draft plans. The largest aspects of this funding relates to education and training income and SLA income. Both of these are offset by expenditure.

4. Financial Performance

4.2 **Expenditure: Pay**

4.2.1 The Trust has spent £47.193m on pay costs at M2. Table 5 details pay costs by staff group and Table 6 details pay costs by pay category type.

Table 5 Pay costs by staff type (excluding COVID-19)

Pay analysis (exc Covid)	Budget (Mth 2) £'000	Actual (Mth 2) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Consultants	(3,906)	(4,302)	(396)	(7,763)	(8,026)	(263)
Other medical	(2,644)	(2,772)	(128)	(5,287)	(5,266)	21
Nursing and midwifery	(6,253)	(6,330)	(77)	(12,432)	(12,633)	(201)
Allied health professionals	(1,331)	(1,373)	(41)	(2,663)	(2,762)	(99)
Other scientific, therapeutic and technical	(597)	(495)	102	(1,140)	(998)	142
Health care scientists	(1,062)	(1,085)	(23)	(2,118)	(2,177)	(60)
Support to clinical staff	(4,445)	(4,365)	80	(8,808)	(8,621)	186
Non medical, non clinical staff	(3,228)	(3,259)	(31)	(6,454)	(6,534)	(80)
Apprenticeship Levy	(83)	(86)	(3)	(167)	(174)	(8)
Total	(23,549)	(24,066)	(517)	(46,831)	(47,193)	(361)

Table 6: Pay analysis by pay type

Pay analysis (exc Covid)	Budget (Mth 2) £'000	Actual (Mth 2) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Substantive	(21,623)	(21,233)	390	(42,961)	(42,008)	953
Bank	(734)	(1,123)	(389)	(1,476)	(2,177)	(701)
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Total	(23,549)	(24,066)	(517)	(46,831)	(47,193)	(361)

4.2.2 Total pay costs in M2 were £47.193m, an overspend of £0.361m.

4.2.3 This is largely driven by additional demand for agency support within ED at junior doctor level and additional support required to meet the surge in activity since March. The additional support to cover for junior doctors should remain high until the appointment of new trainees after the summer. However, the support required to meet demand is likely to continue for some time.

4. Financial Performance

4.3 Expenditure: Non-Pay

4.3.1 The Trust has spent £21.945m on non-pay operating expenditure at M2.

Table 6: Non-pay analysis (excluding COVID-19 costs)

Non Pay Analysis (exc Covid)	Budget (Mth 2) £'000	Actual (Mth 2) £'000	Variance £'000	Year To Date Budget £'000	Year To Date Actual £'000	Variance £'000
Supplies and services - clinical	(3,110)	(2,931)	179	(6,185)	(5,649)	536
Supplies and services - general	(417)	(355)	62	(842)	(741)	100
Drugs	(1,931)	(2,165)	(234)	(3,866)	(4,349)	(483)
Purchase of HealthCare - Non NHS Bodies	(801)	(734)	67	(1,620)	(1,390)	231
CNST	(1,152)	(1,151)	1	(2,303)	(2,301)	2
Consultancy	(11)	(80)	(69)	(22)	(101)	(79)
Other	(2,455)	(2,789)	(333)	(4,986)	(5,533)	(547)
Sub-Total	(9,877)	(10,204)	(327)	(19,824)	(20,064)	(240)
Depreciation	(953)	(941)	12	(1,899)	(1,882)	17
Impairment	0	(5)	(5)	0	1	1
Total	(10,830)	(11,150)	(320)	(21,723)	(21,945)	(222)

4.3.2 The overspend in respect of non-pay is being driven by pressure in respect of higher than expected costs for high cost drugs, non-capital pressures in estates and an increase in expenditure around education and training offset by a reduction in spend in respect of supplies and services.

4.3.3 NHS Improvement are no longer directly funding independent sector spend through the nationally agreed contract. This is currently below budget but we expect this to increase significantly in the course of H1.

4. Financial Performance

4.4 **Expenditure: COVID–19**

4.4.1 The Trust spent £1.230m on Covid-19 costs at M2, with £0.686m on pay and £0.544m on non-pay.

Table 9: YTD COVID-19 revenue costs

COVID-19 COSTS	Apr (M1) £'000	May (M2) £'000	Year to Date £'000
Medical Staff	(35)	(14)	(49)
Other Clinical Staff	(343)	(172)	(515)
Non Clinical Staff	(72)	(49)	(121)
Total Pay	(450)	(236)	(686)
Clinical Supplies	(101)	(207)	(309)
Other Non-Pay	(106)	(129)	(235)
Total Non-Pay	(208)	(337)	(544)
Total Covid Expenditure	**(658)**	**(572)**	**(1,230)**

4.4.2 The vaccination costs were £0.301m at M2 which was in line with plan and is funded centrally.

4.4.3 The testing costs were £0.2m at M2 and is funded centrally so offset in income.

5. Financial Position

5.1 **Statement of Financial Position (SOFP)**

5.1.1 The movement in total assets employed at M2 is minimal.

Statement of Financial Position (SoFP)

Actual as at 31.03.21 £'000		Actual as at 30.04.21 £'000	Actual as at 31.05.21 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
163,560	Property, plant and equipment	163,030	162,676	(354)	⇩
12,864	Intangibles	12,759	12,655	(104)	⇩
869	Trade and other non-current receivables	867	885	18	⇧
177,293		**176,656**	**176,216**	**(440)**	⇩
	Current assets				
4,788	Inventories	4,361	4,356	(5)	⇩
16,848	Trade and other receivables	16,591	17,513	922	⇧
0	Assets held for sale	0	0	0	⇨
21,294	Cash and cash equivalents	24,442	22,227	(2,215)	⇩
42,930		**45,394**	**44,096**	**(1,298)**	⇩
220,223	**Total assets**	**222,050**	**220,312**	**(1,738)**	⇩
	Current liabilities				
(44,124)	Trade and other payables	(43,187)	(42,982)	205	⇩
(4,622)	Other liabilities	(6,752)	(5,869)	883	⇩
(1,090)	Borrowings	(1,102)	(1,114)	(12)	⇧
(7,256)	Provisions	(7,232)	(7,170)	62	⇩
(57,092)		**(58,273)**	**(57,135)**	**1,138**	⇩
(14,162)	**Net current assets/(liabilities)**	**(12,879)**	**(13,039)**	**(160)**	⇧
163,131	**Total assets less current liabilities**	**163,777**	**163,177**	**(600)**	⇩
	Non-current liabilities				
(2,479)	Other liabilities	(2,470)	(2,461)	9	⇩
(5,193)	Borrowings	(5,193)	(5,193)	0	⇨
(7,318)	Provisions	(7,244)	(7,144)	100	⇩
(14,990)		**(14,907)**	**(14,798)**	**109**	⇩
148,141	**Total assets employed**	**148,870**	**148,379**	**(491)**	⇩
	Financed by Taxpayers' equity				
171,121	Public dividend capital	171,121	171,121	0	⇨
(64,220)	Income and expenditure reserve	(63,490)	(63,982)	(492)	⇩
41,240	Revaluation reserve	41,240	41,240	0	⇨
148,141	**Total taxpayers' equity**	**148,871**	**148,379**	**(492)**	⇩

5. Financial Position

5.2 **Capital Expenditure – May 2021**

Capital Programme - 31 May 2021

	Full Year Budget			Full Year Forecast		YTD
	NHSI plan	Mvmnts	Trust Budget[1]	Forecast	Variance	Actual
	£'000	£'000	£'000	£'000	£'000	£'000
Funding						
Total Internally Generated Funding	12,738	0	12,738	12,738	0	12,738
PDC (Public Dividend Capital) - UTC	1,300	0	1,300	1,300	0	1,300
External Funding - donations/grants	0	552	552	552	0	552
Total funding	**14,038**	**552**	**14,590**	**14,590**	**0**	**14,590**
Expenditure						
Pre-commitments 20/21	5,007	226	5,233	5,233	0	671
Estates	2,671	0	2,671	2,671	0	0
Informatics	784	0	784	784	0	0
Medicine and Acute	715	0	715	715	0	93
Clinical Support and Diagnostics	1,914	20	1,934	1,934	0	0
Surgery	688	54	742	742	0	0
Women and Children's	236	0	236	236	0	0
Other	90	0	90	90	0	7
Contingency[2]	633	(300)	333	333	0	0
UEC	1,300	0	1,300	1,300	0	9
Total expenditure (accruals basis)	**14,038**	**0**	**14,038**	**14,038**	**0**	**780**
Capital programme funding less expenditure	**0**	**552**	**552**	**552**	**0**	**13,810**
Capital expenditure	14,038	0	14,038	14,038		773
NBV asset disposals	0	0	0	0		0
Donated assets	450	0	450	450		7
CDEL impact	**14,488**	**0**	**14,488**	**14,488**		**780**

[1] This is the NHSI plan, adjusted for approved business cases including additional donated, leased and PDC funded spend.
[2] Funding is transferred as business cases are approved.

5.2.1 Spend in M2 is in behind plan. Divisions are in the process of finalising their plans and tenders have recently been issued for a number of capital works schemes so we expect spend to increase over the coming months.

5. Financial Position

5.3 Statement of Cash Flows – May 2021

Detailed cash variances through SoCF

	Month Actual £'000	Year to date Actual £'000
Opening cash	**24,442**	**21,294**
Operating activities		
Surplus / (deficit)	(491)	268
Net interest accrued	17	33
PDC dividend expense	352	703
Unwinding of discount	(3)	(6)
(Gain) / loss on disposal	0	0
Operating surplus / (deficit)	(125)	999
Depreciation and amortisation	941	1,882
Impairments / (impairment reversals)	0	0
Donated asset income (cash and non-cash)	(7)	(7)
Changes in working capital	(1,919)	2,251
Investing activities		
Interest received	1	2
Purchase of non-current (capital) assets [1]	(1,100)	(4,182)
Sales of non-current (capital) assets	0	0
Receipt of cash donations to purchase capital assets	0	0
Financing activities		
Public dividend capital received	0	0
Net loan funding	0	0
Interest paid	(1)	(1)
PDC dividend paid	0	0
Finance lease rental payments	(5)	(11)
Total net cash inflow / (outflow)	**(2,215)**	**932**
Closing cash	**22,227**	**22,226**

[1] Outflows due to the purchase of non-current assets are not the same as capital expenditure due to movements in capital creditors.

5. Financial Position

5.4 Treasury

Borrowings summary May 2021

Borrowings summary

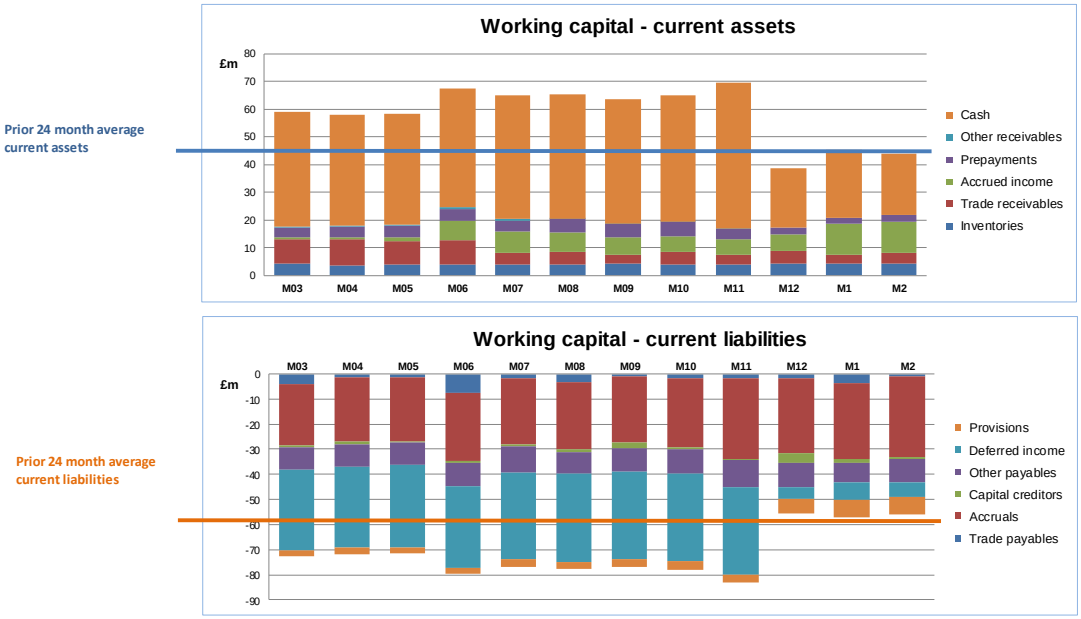
	Initial Loan Value	Loan Term	Interest rate (fixed)	Loan Balances Mar21	Conversion to PDC Sept20	Forecast Repayment 20/21	Forecast Closing Balance Mar21
	£'000	Years	%	£'000	£'000	£'000	£'000
1. ITFF capital loan	7,500	10	1.96	3,375	0	(750)	2,625
2. ITFF capital loan	6,500	25	4.32	3,848	0	(265)	3,583
3. Interim revolving working capital support	23,289	5	3.50	23,289	(23,289)	0	0
4. Uncommitted interim revenue support	40,389	3	1.50	40,389	(40,389)	0	0
5. Uncommitted interim revenue support	20,206	3	3.50	15,700	(15,700)	0	0
	97,884			86,601	(79,378)	(1,015)	6,208

This table does not include finance lease balances, which are included in Borrowings balances in the SoFP.
All listed borrowings are with the Department of Health and Social Care (DHSC).

5.4.1 The Trust's borrowings, comprising capital loans, will be repaid at a level of £1m per year.

5.5 Working capital profiles by month

5.5.1 2021/22 working capital profiles below show May 2021 (M2) working capital balances in the context of the previous 12 months, compared with an average of the previous 2 financial years. The credit risk associated with aged debt is monitored quarterly by the Audit Committee.



5.6 Single oversight framework: Use of Resources (UoR) rating (financial) summary table

Use of Resources (UoR) Rating

Summary table

	Metric	Descriptor	Weight %	Year to Date Actual	
				Metric	*Rating*
Financial sustainability	**Liquidity (days)**	Days of operating costs held in cash-equivalent forms	20%	-15.5	4
	Capital service capacity (times)	Revenue available for capital service: the degree to which generated income covers financial obligations	20%	2.3	2
Financial efficiency	**I&E margin (%)**	Underlying performance: I&E deficit / total revenue	20%	2.1%	1
Financial controls	**Distance from financial plan (%)**	Shows quality of planning and financial control : YTD deficit against plan	20%	0.0%	1
	Agency spend (%)	Distance of agency spend from agency cap	20%	-50.0%	3
	Overall NHSI UoR rating				**2**

5.6.1 The liquidity rating of 4 remains unchanged from 2020/21. The capital service capacity metric remains at 2 which again is in line with 2020/21. The I&E margin is slightly improved as a result of the YTD surplus. Agency spend is higher than anticipated and is therefore rated as a 3. The overall UoR rating of 2 is expected to continue for the remainder of the year.

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 21/22-089

Board of Directors
7th July 2021

Title:	Maternity Services Quarterly update including an overview of compliance with CNST Safety Actions (Maternity Incentive Scheme –Year 3).
Responsible Director:	Hazel Richards, Chief Nurse, Executive Director of Midwifery and Director of Infection Prevention and Control (DIPC)
Presented by:	Debbie Edwards Director of Nursing & Midwifery, Women & Children's Division Anne Marie Lawrence, Interim Deputy Head of Midwifery/ Governance Lead, W&C Division.

Executive Summary

Following an in-depth assurance report presented to the Board of Directors in September 2020, a further maternity service update was presented to Board in March 2021 which centered on the findings of Part 1 of the Ockenden Report. One of the key recommendations from this report was a quarterly update to Trust Board providing oversight of the quality and safety of maternity services at Wirral University Teaching Hospital NHSF Trust (WUTH).

The quarterly paper was scheduled for the June meeting, however this was deferred until July given that submission of the Maternity Incentive Scheme (MIS) declaration is for sign-off by the Board. In addition, MIAA were tasked with undertaking an internal audit of all evidence supporting compliance with the MIS 10 Safety Actions and a separate report will be presented by Mersey Internal Audit Agency (MIAA).

This paper provides an overall update on maternity services covering some key points and a summary of compliance with the MIS 10 Safety Actions.

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)	
BAF references 1, 2, 4 and 6 1. The Trust has provided evidence to NHSE/I to support its compliance with the 7 IEAs from the Ockenden Report 2. The Trust is compliant with the 10 Safety Actions within the Maternity Incentive Scheme	
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)	
CQC; NHSE/I	
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)	
NHS Planning Guidance 2021-22	
Specific communications and stakeholder /staff engagement implications	
Stakeholder confidence	
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
NHS People Plan	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
N/A	
FOI status	Document may be disclosed in full
Previous considerations by the Board / Board sub-committees	Maternity Services update – Board of Directors report in September 2020 and March 2021.
Background papers / supporting information	

1. Compliance with the Immediate and Essential Actions (IEAs) outlined in Part One of the Ockenden Report

The completed Assessment and Assurance Tool was presented to Board in March 2021 which included a compliance status against the 7 IEAs. Further detailed evidence of compliance against each these IEAs was required from all providers by NHSE/I, with a request to upload all such evidence onto a designated portal before 30th June 2021.

The evidence submitted has met the minimum evidence requirements as detailed in Appendix 1, however this will be scrutinised further by NHSE/I.

Following the Ockenden Report there has been opportunity to bid for additional monies for staffing – both medical and midwifery. A bid has been submitted for an additional 1.0 WTE Consultant Obstetrician; 6.0 WTE Band 6 midwives and 12.0 WTE Band 5 midwives (a total of 18 WTE midwives). The current staffing establishment meets the needs of the service but the additional staffing requirements have been identified to meet the increased training requirements for maternity staff, and due to the need to change in its entirety the model of maternity care delivered at WUTH. These requirements are further described later in the paper and the outcome of the bid is awaited.

Recent communication from NHSE/I has outlined the opportunity for providers to bid for monies to further support IT systems within maternity services. The Trust is linked in with the Director of IT and the Local Maternity System to progress a bid for funding improvements to the maternity IT system.

2. Maternity Incentive Scheme (MIS)

Now in its third year, the MIS supports the delivery of safer maternity care through an incentive element to discount provider trusts' contributions to CNST. The MIS rewards trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both maternity and neonatal care.

Following its pause during the Covid-19 pandemic, NHS Resolution relaunched the MIS in November 2020, and have revised the scheme several times since (the latest changes are detailed below in red).

Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?	Confirmation has been received from the Clinical Network that all cases meeting the PMRT criteria have been reviewed using the PMRT tool. All such cases have been reported to MBRRACE and have external clinical input to provide an independent professional opinion. WUTH is the only provider across C&M that has 100% external representation at the PMRT case reviews.
Safety Action 2: Are you submitting data to the Maternity Service Data Set (MSDS) to the required standard?	NHS Digital send a monthly scorecard that confirms Trust compliance with the submission of the dataset. Confirmation was also received into the Trust from NHSD that confirmed full compliance with MSDSv2 Information which also included the Standards notices; DCB1513

	and 10/2018.
Safety Action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme? The revised action does not require an agreed clinical pathway for transitional care, nor does this require auditing. Activity does not need to be captured but the HRG XAA04 coding does need to continue.	Transitional Care (TC) provision is delivered on the maternity ward supported by the bespoke Neonatal Support Worker (NSW) team. The clinical pathway (including admission criteria of HRG XAA04) that supports the delivery of the service clinically is in place and audited. The number of avoidable term admissions into the neonatal unit at WUTH is one of the lowest across C&M and is monitored monthly.
Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Revision of this action no longer includes feedback from the survey and the formal minuting of the O&G trainee gaps. An agreed strategy/action plan is no longer required for this action nor the sign off by the Trust Board.	The 2019 GMC National Trainees survey was completed and feedback from juniors regarding educational/training opportunities lost due to gaps in the rota captured. The Neonatal workforce has been reviewed regionally within the Cheshire and Merseyside Neonatal Operational Delivery Network (NODN) leads and WUTH meets the national standards of staffing which includes nursing and medical staff including junior medical staffing. A gap was identified post review by the NODN and this has been met through a pilot of consultants working an additional two hours daily, and will be supported on a more permanent basis by the Division following the three month pilot. The anaesthetic medical workforce currently meet the Anaesthesia Clinical Services Accreditation (ACSA) standards.
Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard? The revised action has stated that a staffing oversight report to Board is required at least annually and has not specified every six months. It states a reporting period of December 2019 – July 2021.	A detailed midwifery workforce review has been undertaken by Birthrate+ (which specifically looks at acuity and demand within the Maternity service to determine safe staffing levels). A draft report has been received into the Trust and a paper is to be presented at Workforce Steering Board in August 2021 outlining the midwifery staffing requirements. Midwifery workforce updates have been provided to Board every six months as per the initial Safety Action requirement.
Safety Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle v2?	All five elements of the Saving Babies Lives care bundle (SBL) v2 have been implemented and the North West Coast Strategic Clinical Network, NHSE/I and the Local Maternity System (LMS) have monitored compliance with all elements of the Care Bundle. Evidence includes training delivered by the Fetal Surveillance Midwife/Obstetrician; development of policies and audit undertaken. Such audits are included in the Divisional FAAP. CO2 monitoring which is an element of the

	bundle was paused during the pandemic, however this recommenced with audit of compliance monitored at booking and at 36 weeks of pregnancy.
Safety Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to co-produce local maternity services?	The Wirral MVP Chair meets at least weekly with the maternity leads to discuss service user feedback. The consultant midwife and the MVP Chair do a joint live 'open session' for service users to update on service provision and to answer any queries service users may have. Significant work including the co-production of services is evidenced in meeting compliance with this Safety Action.
Safety Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year? The revised MIS action withdrew the 90% target with advice to trusts to commit to addressing any shortfall as soon as possible. Given the recommendation within the Ockenden Report, WUTH continued on its trajectory to meet the 90%.	The multidisciplinary staff training - PROMPT training has been delivered in different ways which in the main has focused on online learning and 1:1 drills. The Trust has met the 90% compliance rate in June 2021 which has included staff from across the W&C Division and the Surgical Division. The support from the Surgical Division in particular theatre staff is acknowledged in supporting the Trust meeting the 90% target.
Safety Action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Regular meetings of the Trust Safety Champion were paused during Covid19 but walkabouts have taken place separately. A quarterly update by the (NED) Safety Champion to Board with escalation of any concerns is to be included in the Board agenda from July 2021. Oversight of maternity services at Board level is crucial in the safe delivery of maternity services. An ongoing plan of improvement and action log has been developed by the Safety Champions with plans to further develop the role within both maternity and neonatal services.
Safety Action 10: Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme(ENS)	In April 2020 the process regarding reporting changed with cases reported to the ENS via the Health and Safety Investigation Board (HSIB). Confirmation was received from NHSR that all cases meeting the HSIB criteria were reported. The Director of N&M and Q&S Lead for the W&C Division meet with HSIB on a quarterly basis. A monthly update report is also received from HSIB to support timely progress of each case review.

Provider compliance with the 10 Safety Action Standards across C&M has been closely monitored by the Local Maternity System (LMS) and NHSE/I. A letter was received into the Trust from Kathy Thompson (SRO, C&M Health & Care Partnership) with an ask that MIS evidence goes through a process of internal audit.

MIAA were asked to undertake an internal audit of compliance against each of the Safety Actions which took place over a period of several weeks in June 2021, with the terms of reference included as Appendix 2. MIAA will present their findings separately to Board, however from initial feedback the Trust can demonstrate and evidence compliance with all ten Safety Actions. The Trust is required to report its compliance with the MIS Safety Actions to NHSR before the 15th July 2021 through completion of the declaration form.

There is confirmation that a Year 4 MIS will be launched towards the end of 2021, however there is no detail of this at present.

3. Perinatal Quality Surveillance Model (PQSM)

A national recommendation from the Ockenden Report was the proposed introduction of a Perinatal Quality Surveillance Model (PQSM). The regional NHSE/I team and the LMS has reviewed its governance framework and reporting processes, and a Quality and Safety Surveillance Group has been set up with its inaugural meeting on 30th June 2021.

Oversight, action and response should take place at provider level with the support of the Safety Champions and Trust Board with a range of intelligence sources being drawn on to appraise the Board that the quality of care is not deteriorating.

The purpose of the PQSM nationally is to implement five principles for improving oversight for effective perinatal clinical quality to ensure a positive experience for women and their families. The principles integrate perinatal clinical quality into developing integrated care system (ICS) structures and provide clear lines for responsibility and accountability for addressing quality concerns at each level of the system.

The five principles include:

Principle 1 – Strengthening trust-level oversight for quality
Principle 2 – Strengthening LMS and ICS role in quality oversight
Principle 3 – Regional oversight for perinatal clinical quality
Principle 4 – National oversight for perinatal clinical quality
Principle 5 – Identifying concerns, taking proportionate action and triggering escalation

A new Maternity Safety Surveillance and Concerns Group (MSSCG) was set up at national level in November 2020. This enables the timely identification and escalation of any trust-level concerns by national partners who have insight into maternity and neonatal services.

3.1 The Perinatal Clinical Surveillance Quality Assurance Report

Following the last Board meeting it was agreed that a Trust Safety Dashboard be developed that would provide oversight to the Board against some key metrics. The Perinatal Clinical Surveillance Quality Assurance Report has been developed and key metrics are reported against the following themes:

- Clinical care
- Service user and staff feedback
- Leadership and relationships
- Safety and learning culture
- Incident reporting
- Governance processes
- CQC Inspections & DHSC / NHSE/I request for support.

The report for the last quarter is included in the paper as Appendix 3 and refers to data from the regional outlier report (Appendix 4).

3.2 The C&M Clinical Outcome / Outlier Report

The Outlier Report (Appendix 4) is particularly useful in identifying outcomes for improvement should they be identified as an outlier, for example, at the last Board meeting there was reference to a lower than average elective caesarean section rate and a higher than average emergency caesarean section rate. When this data was further analysed it identified a gap in elective capacity for caesarean section. This has resulted in the introduction of an additional elective caesarean section list which has reduced risk associated with undertaking emergency caesarean sections out of normal working hours. Both of these outcomes will continue to be reviewed to ensure they positively reflect the change and provision of additional capacity.

3.3 Serious Incidents

Serious incidents (SIs) continue to be reported monthly on the regional dashboard by all maternity providers in C&M and in Lancashire and South Cumbria. SIs are also reported to the LMS and the newly formed QSSG will have further oversight of all SI's across the region.

There are no maternity SIs reported during the last quarter, however an SI was declared for the neonatal service in June with a report to follow in the next quarterly maternity services update to the Board.

3.4 Health Care Safety Investigation Branch (HSIB)

HSIB undertake independent investigations into incidents within maternity services which fall under defined criteria that include maternal deaths, stillbirths and babies that require cooling**.**

From April 2021 a revised process has been introduced to the HSIB investigations. There will be external representation working with HSIB when reviewing cases and if it is evident that harm has been caused, this revised process supports involvement from NHS Resolution at an early stage. The process also requests that all cases reported to HSIB are declared as serious incidents through STEIS – this will undoubtedly result in an increase in the rate of SI's in maternity services. However, once the case has been

reviewed by HSIB and it is evident that no harm has resulted from care provided then the incident will be stood down by STEIS.

The Trust is provided with a monthly update of cases by HSIB to support effective communication and to support the progression of the investigation. HSIB case reviews are shared with the Trust for accuracy prior to being finalised and shared with the woman and her family.

3.5 CQC Review

As part of the CQC transitional review of core services, a review of the Trusts maternity service took place on the 18 May 2021. A presentation was forwarded to the CQC prior to the review and was positively received. An email has since been received into the Trust confirming that no further information is required and that no concerns had been identified. Whilst the review does not impact on the current Maternity CQC rating of 'good', the positive feedback was welcomed by the team.

3.6 Safety Champion Report

The role of the Safety Champions is continuing to develop and the findings from walkabouts and from the bi-monthly meetings has been captured into an action log. An update from the Non-Executive Safety Champion is scheduled to take place at least quarterly at the Board of Directors meeting with escalation of any concerns in between the dates should the need arise.

4. Maternity and Neonatal Staffing

Birth Rate+ (a nationally recognised Acuity / Staffing tool used to assess safe staffing levels in maternity services) have recently undertaken a review of midwifery staffing within the maternity service at the Trust. A draft BR+ report has been received into the Trust which has identified that the current establishment meets the needs of the maternity service. However, the need for additional staffing has been identified given the need for further progress a continuity of carer model of care.

A paper will be presented to the Workforce Steering Board in August 2021 outlining the additional staffing requirements including a plan regarding the management of change process that will need to be implemented to transition staff from the current model of care to that of continuity of carer**.**

Maternity staffing is included in the Trust's Safe Staffing Report, however following the publication of the final BR+ Report a more detailed staffing report will be included in the next quarterly maternity service update to Board in September 2021.

Neonatal staffing is monitored by the regional NODN and the establishment currently aligns with the acuity, capacity and demand of the service. However, a more detailed review of medical staffing within the neonatal service identified a small deficit in senior cover. This equated to two hours daily with the need to extend the clinical cover provided by the neonatologists. This deficit resulted in a pilot of revised hours being led by the consultant team which has filled the gap. On conclusion of the pilot, a more permanent solution will be implemented which will further support the neonatal service which is currently undergoing a service review.

5. Continuity of Carer

Following on from Better Births in 2016 the Maternity Transformation Programme has supported the roll-out of a revised model of midwifery care – Continuity of Carer. The benefits of a woman being cared for by the same team of midwives throughout her pregnancy, including the delivery and following, cannot be underestimated. Clinical outcomes are improved with this model of care, with women reporting positive birth experiences with the woman less likely to experience postnatal illness.

To date WUTH is one of only two trusts within Cheshire and Merseyside that has reached the required continuity of carer rate of 35% as outlined in the LMS Continuity of Carer report (Appendix 5). The compliance with this model of care is to be audited by MIAA in Q3 with a TOR to be agreed. The ask by NHSE/I in its planning guidance is that by March 2022 the target is 51% of all women and 100% by the end of March 2023. The recent Birth Rate+ staffing review has highlighted the need for additional staff to deliver this model of care to a rate of 51%, however given the target of 100% requires only an additional 4 WTE compared to the 51%, the intention is to aim for the 100%. This prevents a two tier system being delivered in maternity services where care with the continuity of carer team is favoured by women and their families with improved experiences.

Progression to a continuity of carer rate of 51-100% is on hold pending the outcome of the NHSE/I Bid for additional staffing, when a review of what additional resource is needed within the service will take place and presented to Board. A plan has been developed with a proposal to introduce additional continuity of carer teams as per the NHS Planning Guidance.

6. Findings

The paper outlines all key points for Board with the outlier report further evidencing Trust performance against clinical outcomes when compared to other providers across the North West Coast. The Perinatal Clinical Surveillance Quality Assurance Report in its initial format has potential to further develop but provides clear oversight for Trust Board members of maternity service status. The regional QSSG will also introduce further scrutiny to maternity care and outcomes.

7. Recommendation

The Board of Directors are asked to note:

- The content of the Perinatal Clinical Surveillance Quality Assurance Report and the Outlier report.
- Trust compliance to the Safety Actions that link to the Maternity Incentive Scheme.

The Board of Directors is also asked to approve the signing of the declaration form to NHSR before the 15th July 2021 deadline.

Appendices :

APPENDIX 1: Ockenden Minimum Evidence Requirements.

APPENDIX 2: Mersey Internal Audit Agency Terms of Reference.

APPENDIX 3: Perinatal Clinical Surveillance Quality Assurance Report

APPENDIX 4: Cheshire & Merseyside Outlier Report

APPENDIX 5: LMS Continuity of Carer Report

Appendix 1

Ockenden - Minimum evidence requirements					
SECTION 1: Immediate and Essential Actions 1 to 7				Assessment Criteria	Minimum Evidence Requirements
Immediate and Essential Action 1: Enhanced Safety					
IEA 1	Q1		Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.	**Confirmation of a Maternity Services Dashboard** **Confirmation this is seen by the LMNS at least Quarterly**	• SOP required which demonstrates how the trust reports this both internally and externally through the LMS. • Submission of minutes and organogram, that shows how this takes place. • Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken. • Dashboard to be shared as evidence.
	Q2		External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.	**Confirmation of external specialist opinion on reviews**	• Policy or SOP which is in place for involving external clinical specialists in reviews. • Audit to demonstrate this takes place.
	Q3		All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	Confirmation that **SI GO TO Trust Board** (nab not a sub group of board such as Quality group) Confirmation that a *SUMMARY* of SI key issues goes to Trust Board Confirmation that SI **GO TO LMNS Board** Confirmation that a **SUMMARY** of SI key issues goes to LMNS Board Each of the above happen **quarterly**	• Submit SOP • Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed • Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion
Link to Maternity Safety actions:					
IEA 1	Q4	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	**Confirmation that PMRT is undertaken** see PMRT Tab	• Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. • Audit of 95 % of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.
	Q5	Action 2	Are you submitting data to the Maternity Services Dataset to the required standard?	**Confirmation that Monthly score card completed** (13 mandatory criteria)	• Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.
	Q6	Action 10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	Confirmation that **100% of** cases are reported to HSIB & NHS Resolution	• Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.
Link to urgent clinical priorities:					
IEA 1	Q7	(a)	A plan to implement the Perinatal Clinical Quality Surveillance Model	Confirmation that Trust / LMNS / ICS responsibilities of the model are implemented	• Full evidence of full implementation of the perinatal surveillance framework by June 2021. • Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. • LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.
	Q8	(b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Confirmation that SI go to Trust Board (nab not a sub group of board such as Quality group) **Confirmation that SI go to LMNS Board** **Each of the above happen Monthly**	• Submit SOP • Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed • Individual Si's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion
Immediate and Essential Action 2: Listening to Women and Families					
IEA 2	Q9		Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.	No expectation that this action is met - national guidance awaited	
	Q10		The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.	No expectation that this action is met - national guidance awaited	
	Q11		Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.	Confirmation of an identified Trust Board Non Exec	• Name of NED and date of appointment • Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions • Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed • Evidence of how all voices are represented: • Evidence of link in to MVP; any other mechanisms • NED JD
Link to Maternity Safety actions:					
IEA 2	Q12	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Confirmation that PMRT is undertaken Confirmation that Parents are involved	• Local PMRT report. • PMRT trust board report. • Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. • Audit of 95% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.
	Q13	Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Confirmation of approach to gathering Service User feedback (i.e. 15 steps / FFT / You Said We Did) **AND** MVP in place that **COPRODUCES** services	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.
	Q14	Action 9	Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Identified Safety Champions **WORKING WITH** Exec and Non Exec Board Leads for Maternity	• SOP that includes role descriptors for all key members who attend by-monthly safety meetings. • Log of attendees and core membership. • Action log and actions taken. • Minutes of the meeting and minutes of the LMS meeting where this is discussed.
Link to urgent clinical priorities					
IEA 2	Q15	A	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Same score as Q13	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.
	Q16	B	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal	Confirmation of an identified Trust Board Executive Director **AND** a Non Executive Director	• Name of ED and date of appointment • Name of NED and date of appointment • Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken Role descriptors

Immediate and essential action 3: Staff Training and Working Together					
IEA 3	**Q17**	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.		**Training together:** Confirmation of MDT training **AND** this is validated through the LMNS x 3 per year	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA.
	Q18	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.		**Working together:** Confirmation of **ALL** criteria requested	• SOP created for consultant led ward rounds. • Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night, 7 days a week (e.g. audit of compliance with SOP)
	Q19	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only (e.g. Maternity Safety Fund, Charities monies, MPET/SLA monies etc that is specifically given for training)		Confirmation of ring fenced Maternity training budget	• Evidence that additional external funding has been spent on funding including staff can attend training in work time. • Evidence of funding received and spent. • Confirmation from Directors of Finance • Evidence from Budget statements. • MTP spend reports to LMS
Link to Maternity Safety actions:					
IEA 3	**Q20**	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	See Section 2	**See section 2**
	Q21	Action 8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	90% achieved on MDT training of all Staff groups (Obstetrics / Anaesthetists / Maternity / Neonates / Support Workers)	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA. • Attendance records - summarised
Link to urgent clinical priorities					
IEA 3	**Q22**		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	See Q18	• SOP created for consultant led ward rounds. • Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)
	Q23		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	See Q17	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA.
Immediate and essential action 4: Managing Complex Pregnancy					
IEA 4	**Q24**		Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.	Agreement reached on Criteria for referral to Mat Med Specialist Centre	• SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. • Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians
	Q25		Women with complex pregnancies must have a named consultant lead	Named consultant lead for all women identified = Yes	• SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnanices but who do not require referral to maternal medicine network must have a named consultant lead. • Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.
	Q26		Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team	Referenced to specialist involvement AND management plans developed	• SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. • Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are developed by the cinical team in consulation with the woman.
Link to Maternity Safety actions:					
IEA 4	**Q27**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Confirmation of compliance with **ALL** elements	• SOP's • Audits for each element. • Guidelines with evidence for each pathway
Link to urgent clinical priorities:					
IEA 4	**Q28**	A	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	Confirmation of consultant lead **AND** regular Audit of Compliance in place	• SOP that states women with complex pregnancies must have a named consultant lead. • Submission of an audit plan to regularly audit compliance
	Q29	B	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Confirmation that Trust is developing their local actions as part of an agreed Network approach	• The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. • Criteria for referrals to MMC • Agreed pathways
Immediate and essential action 5: Risk Assessment Throughout Pregnancy					
IEA 5	**Q30**		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	Risk Assessment at **EVERY** AN Contact	• SOP that includes definition of antenatal risk assessment as per NICE guidance. • How this is achieved within the organisation. • What is being risk assessed. • Review and discussed and documented intended place of birth at every visit. • Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.
	Q31		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Review of place of birth in risk assessment at **ALL** AN contacts	• SOP that includes review of intended place of birth. • Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. • Out with guidance pathway. • Evidence of referral to birth options clinics
Link to Maternity Safety actions:					

IEA 5	Q32	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	• SOP's • Audits for each element • Guidelines with evidence for each pathway
Link to urgent clinical priorities:					
IEA 5	Q33	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.		Are PCSPs in place **AND** are they audited	• SOP to describe risk assessment being undertaken at every contact. • What is being risk assessed. • How this is achieved in the organisation. • Review and discussed and documented intended place of birth at every visit. • Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. • Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)
Immediate and essential action 6: Monitoring Fetal Wellbeing					
IEA 6	Q34	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal wellbeing.		**BOTH** MW and Obstetrician in place	• Name of dedicated Lead Midwife and Lead Obstetrician • Copies of rotas / off duties to demonstrate they are given dedicated time. • Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. • Incident investigations and reviews
	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of monitoring fetal wellbeing - Consolidating existing knowledge of monitoring fetal wellbeing - Keeping abreast of developments in the field - Raising the profile of fetal wellbeing monitoring - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. - The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. - They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. - The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.		JD fulfils **ALL** criteria	• Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post • Improving the practice & raising the profile of fetal wellbeing monitoring • Consolidating existing knowledge of monitoring fetal wellbeing • Keeping abreast of developments in the field • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision • Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. • Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.
Link to Maternity Safety actions:					
IEA 6	Q36	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	• SOP's • Audits for each element • Guidelines with evidence for each pathway
	Q37	Action 8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	See Q21	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA. • Attendance records - summarised
IEA 6					
	Q38	Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.		See Q34	• Name of dedicated Lead Midwife and Lead Obstetrician • Copies of rotas / off duties to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. • Incident investigations and reviews
Immediate and essential action 7: Informed Consent					
IEA 7	Q39	All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.		**ALL** place of birth information easily accessible	• Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.
	Q40	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care		**ALL** information is easily accessible	• Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.
	Q41	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care		Confirmation that trust **HAS** a method of recording decision making processes that includes women's participation & informed choice	• SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded. • An audit of 1% of notes demonstrating compliance. • CQC survey and associated action plans
	Q42	Women's choices following a shared and informed decision-making process must be respected		Reference made to how Women's choices are respected and evidenced	• SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. • An audit of 5% of notes or a total of 150 which is ever the least from january 2021, demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction. • CQC survey and associated action plans
Link to Maternity Safety actions:					
IEA 7	Q43	Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	See Q13	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.
Link to urgent clinical priorities:					
IEA 7	Q44	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.		All information **ON** trust website	• Gap analysis of website against Chelsea & Westminster conducted by the MVP • Co-produced action plan to address gaps identified • Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.

SECTION 2: WORFORCE PLANNING			Assessment Criteria	Minimum evidence requirements
Link to Maternity Safety Actions:				
Q45	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard	Midwifery workforce planning system in PLACE	• Most recent BR+ report and board minutes agreeing to fund. • Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. • Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan
Q46	Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Confirmation of a maternity workforce gap analysis AND a plan in place (with confirmed timescales) to meet BR+ standards	• Most recent BR+ report and board minutes agreeing to fund.
Midwifery Leadership				
Q47	Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director		Evidence the Director/Head of Midwifery responsible and accountable to an executive Director	• HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director
Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: 1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service 2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable midwifery leadership in education and research 6. A commitment to fund ongoing midwifery leadership development 7. Professional input into the appointment of midwife leaders		Meets ALL that apply Note - Trusts would not lead on actioning all seven steps	• Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care • Action plan where manifesto is not met
NICE Guidance related to maternity				
Q49	We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.		ALL guidance assessed & implemented = Yes (GREEN)	• SOP in place for all guidelines with a demonstrable process for ongoing review. • Audit to demonstrate all guidelines are in date. • Evidence of risk assessment where guidance is not implemented.

Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Review Terms of Reference

Wirral University Teaching Hospital NHS Foundation Trust

1 Introduction and Background

The review of Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) will be conducted in accordance with the requirements of the 2021/22 Internal Audit Plan, as agreed by the Audit Committee.

The quality and safety of maternity care is of paramount importance as obstetric incidents can be catastrophic and life-changing, with related claims representing the biggest area of spend in the Clinical Negligence Scheme.

The MIS is now in its third year and supports the delivery of safer maternity care through an incentive element to discount provider Trusts contributions to the CNST. The MIS rewards Trusts that meet all ten safety standards designed to improve the delivery of best practice in both Maternity and Neonatal care. This is an annual submission and the Trust reported full compliance with the standards set in both year 1 and year 2, with the Trust benefitting from a reduction of over £500k to the Trust's CNST premium in 2019/20. This submission (2020/21) is the first year that MIAA has been asked to support in the submission process.

The MIS is a self-certified scheme with the Trust's submission requiring formal sign off by the Trust Board in the July 2021 meeting to enable submission by the 15th July 2021 NHS Resolution deadline.

2 Audit Objective

The overall objective is to prepare a position statement based on the evidence and information provided to confirm the Trust's compliance with the ten MIS safety action standards.

3 Overall System Risks

Key risks identified in relation to the system under review, and which could affect the achievement of the objective shown above, includes:

- The MIS is not effectively owned and governed to ensure appropriate sign off of the Trust's annual submission;
- Evidence provided to support the Trust's submission is not appropriate nor is it sufficient to declare compliance;
- Any issues not identified and subsequently arising can be used by NHS Resolution as evidence of self-certification failure at the Trust. As a result, NHS Resolution may decide to investigate further to establish if there is a maternity governance concern; and,
- This may result in a financial implication if an inappropriate submission is made to NHS Resolution (an increase in CNST premiums).

4 Audit Scope

Using the NHS Resolution Maternity Incentive Scheme - Year 3 guidance (that was updated in March 2021) and based on the evidence provided to us as at May/June 2021, we will establish the extent to which the Trust's complies with the 10 MIS safety actions. This will provide a position statement for the Trust to consider prior to submission to NHS Resolution in July 2021.

In addition, the Board needs to consider whether there are any reports covering either this year (2020/21) or the previous financial year (2019/20) that relate to the provision of maternity services that may subsequently provide conflicting information to the declaration (e.g. Care Quality Commission (CQC) inspection reports).

MIAA will also consider any changes to the control environment due to COVID-19.

The limitations to scope are as follows:

- The review will be limited to the testing areas as set out in Appendix 1.
- This review will not consider the Trust's internal governance system to support the MIS submission.
- This review will complement the Trust's compliance oversight that will reported to the Board of Directors in July 2021 and the assessment will be undertaken by the Board of Directors for sign off of the submission.

5 Audit Approach

Following discussion with Trust management, it has been agreed that the review is to be undertaken remotely, while access on site will be available if required. As such, we have set out below key points as to how we will conduct the audit and our expectations in undertaking the work remotely:

- We fully recognised that a number of staff are working flexibly, as such, we will work with you to agree our information requirements in advance, including at key points during the audit. This will include the timetable for delivery and availability of key contacts.
- We will confirm the designated contact point at your organisation, to support the provision of the identified information requirements and to assist the audit process as required. This may include providing access to the organisations systems, including the intranet, if required.
- We will use software such as Skype/ MS Teams to conduct virtual meetings and to share screens to support the auditor in documenting and assessing the controls and operating effectiveness of the system being reviewed.
- Whilst working remotely, we will ensure that regular contact is maintained throughout the audit process to feedback on progress and matters arising.

- We are aware that there may be restrictions which could potentially impact on the delivery of the review. We will ensure that any potential issues are escalated appropriately.

Following completion of the audit fieldwork we will meet with operational managers and/or the audit sponsor to discuss the audit findings and proposed recommendations. A draft report will be produced; your responses to these recommendations and a timetable for any actions to be carried out will be agreed and incorporated into the final report, along with the names of staff who will be responsible for their implementation. The final report will be approved by the lead Executive Director. The conclusion of all final reports are reported to the Audit Committee.

6 Information Requirements

We have provided below details of documentation we require to undertake the review. Please note that this list is not exhaustive and there maybe other documents that we request once we have commenced the fieldwork. Similarly, if you are aware of any other documents that would assist the review which are not listed below, we would be grateful if you could make these available to us:

- Please refer to the separate list provided.

7 Proposed Timescales

Stage	Proposed Date
Fieldwork commences	May 2021
Discussion document to client	June 2021
Responses by client	June 2021
Final report	June 2021

8 Key Contacts and Report Distribution

Name	Title	Report
Hazel Richards	Chief Nurse	Draft/Final
Debbie Edwards	Director of Nursing & Midwifery – Women's and Children's Division	Draft/Final
Christine Griffiths-Evans	Deputy Director of Patient Safety and Governance	Draft/Final
Claire Wilson	Chief Finance Officer	Final
Robbie Chapman	Deputy Chief Finance Officer	Final

9 Data Protection and Freedom of Information

MIAA takes its responsibility for the security and protection of information acquired and use during the delivery of its work seriously.

MIAA are compliant with the requirements of the NHS Data Security and Protection Toolkit and are Cyber Essentials certified. We have in place a comprehensive Information Security and Privacy Management system based upon ISO 27001 and ISO 27701 and have implemented a range technical controls to protect data.

In delivering this assignment MIAA will acquire supporting information from you, some of which may be confidential or otherwise sensitive. This information will be used solely for the completion of this assignment and for informing our Head of Internal Audit Opinion.

In this context, MIAA are considered data controller for that information and, thus are subject to the requirements of the Data Protection Act and the EU General Data Protection Regulation, where personally indefinable information is concerned, and the Freedom of Information Act, where corporate information is concerned.

MIAA will, therefore, be required to not only comply with the laws and regulation in respect of our control of the data but will also be responsible for any appropriate disclosure under the Acts.

10 Your Acceptance

Please do not hesitate to contact MIAA should you have any comments regarding the Terms of Reference (these will be assumed as agreed if MIAA are not informed otherwise).

11 MIAA Key Contacts

Name	Angharad Ellis	Name	Sarah Blackwell
Title	Senior Audit Manager	Title	Senior Audit Manager
	07469378328		07887644955
	Ann.Ellis@miaa.nhs.uk		Sarah.Blackwell@miaa.nhs.uk
Name	Anne-marie Harrop		
Title	Regional Director		
	07920150313		
	Anne-marie.Harrop@miaa.nhs.uk		

Appendix 1 – Testing against the safety actions will be limited to the following:

Safety Action Ref	Safety Action Title	MIAA test
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	i) Select a sample of 10 perinatal deaths that have happened since 11 January 2021 to date (how many since 11 January 2021?) and test the following: • that they have been notified to MBRRACE-UK within seven working days; and, • surveillance forms completed within four months of the death (where four months have lapsed in our testing). *Perinatal deaths include the following:* • *All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)* • *All stillbirths (from 24+0 weeks' gestation)* • *Neonatal death (up to 28 days after birth)* ii) Select a sample of 10 deaths (include home births) that have happened since 20 December 2019 to 15 March 2021 (how many during this time) and test the following: • confirm that a review been completed using the PMRT; • confirm this been done by a multidisciplinary review team; • this should be at least in draft report (before 15th July 2021) *if not note finding in MIAA report*; • confirm that parents have been told that a review of their baby's death will take place; • confirm that parents' perspectives and any concerns have been sought (any received and recorded). If any delays in completing reviews parents should be notified. iii) Confirm that quarterly reports have been submitted to the Trust Board from 1st October 2020 onwards that include details of all deaths reviewed/action plans.
2	Are you submitting data to the Maternity Service Data Set (MSDS) to the required standard?	i) Obtain confirmation by NHS Resolution that the Trust fully conforms with MSDSv2 Information Standards notices; DCB1513 and 10/2018. ii) Obtain MSDS data for December 2020 as submitted to NHS Digital and confirm the following: • submitted in line with deadlines February 2021;

		• confirm requirements numbers 5 – 13 have been met.
3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme (D-G)? *Sections A-C have been deleted from the guidance*	i) Obtain evidence to confirm that the returns for Healthcare Resource Groups (HRG) 4/X404 have been shared with the Operational Delivery network and commissioner. ii) Confirm that there is an audit trail in place which provides evidence that a review has been undertaken by the Trust of admissions to the neonatal unit (1/3/2020 - 31/8/2020). Evidence that the review specifically considered the impact of closures/reduced capacity of TC, parental access, staff redeployment and changes to postnatal visits on admission rates including those for jaundice, weight loss and poor feeding. iii) Confirm that there is an audit trail in place which provides evidence and rationale for developing the agreed action plan to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. Evidence that the action plan has been shared and agreed with the maternity and neonatal safety champion and Board level champion? Has progress with the revised ATAIN action plan been shared with the maternity, neonatal and Board level safety champion?
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	i) Anaesthetic medical workforce - Determine whether Trust Board minutes formally recording the proportion of ACSA standards 1.7.2.5, 1.7.2.1 and 1.7.2.6 that are met. If not met these standards, determine whether an action plan has been produced (ratified by the Trust Board) stating how they are working to meet the standards. ii) Neonatal medical workforce - Determine whether Trust Board formally record within the minutes whether it meets the recommendations of the neonatal medical workforce training action. If the requirements are not met, an action plan should be developed to meet the recommendations and should be signed off by the Trust Board. iii) Neonatal nursing workforce - Determine whether recorded in the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. An action plan should be developed for areas that do not meet the standard. This should be signed off by the Trust Board and a copy submitted to the Royal College of Nursing and Neonatal Operational Delivery Network (ODN).
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	i) Obtain a copy of the Trust's Birthrate+ report. ii) Determine if this has been reported to the Board. iii) Determine how the required establishment has been calculated (an acuity tool), details of planned versus actual midwifery staffing levels, if shortfalls - action plan in place to demonstrate an increase in staffing levels. Ensure that the

		midwife to birth ratios takes into account management positions and specialist midwives.
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	i) Evidence of Board demonstrating compliance with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. *Note: Full implementation of the SBLCBv2 is included in the 2019/20 standard contract.* ii) Evidence that the quarterly care bundle survey has been completed unless the trust has fully implemented the SBLCBv2 including the data submission requirements iii) Evidence of the completed quarterly care bundle surveys for 2020/21 should be submitted to the Trust board, demonstrating compliance of over 80%. This should include elements 1 - 5 as noted in the guidance and should be recorded on the Trust's maternity Information System (MIS) and included in the MSDS submissions to NHS Digital. Note in some instances audits may have to be done instead to assess compliance. iv) If compliance is less than 95 % (elements 1 - 4) or 85% (element 5), an action plan should be in place to demonstrate there is a plan to improve compliance levels.
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	i) Obtain a copy of the Terms of reference for MVP ii) A minimum of one set of minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback. (MPV should meet no less than 4 times a year). (Testing period from 20/12/19 to 15/7/21). iii) Evidence of examples of service developments resulting from coproduction with service users. iv) Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses. v) Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data. Check agendas, mins, TOR
8	Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	i) Evidence Covid-19 specific e-learning training has been made available to the multi-professional team members? ii) Evidence of signature sheets, compliance rates for training to demonstrate that the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating new born infant have attended Trust in-house neonatal resuscitation training or Newborn Life Support (NLS) course since the launch of MIS year three in December 2019?

	Note: this safety action was reported as being at risk of being met as part of the Patient Safety and Quality Board report in April 2021	iii) Minutes from Trust Board meeting to evidence a written commitment to facilitate local, in-person, MDT training when this is permitted including fetal monitoring training once this is permitted.
9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	i) Evidence of a written pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other b) the Board c) the LMS and d) Patient Safety Networks. ii) Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. iii) Evidence that Board level safety champions are completing feedback sessions every other month for maternity and neonatal staff. Evidence that were concerns are raised, these are actioned. iv) Evidence that Board level safety champions have reviewed their continuity of carer action plan in light of Covid-19. Plans should reflect how the Trust will continue or resume continuity of carer models so that at least 35% of women booking for maternity care are being placed onto continuity of carer pathways. In light of the increased risk facing, women from Black, Asian and minority ethnic backgrounds and women from the most deprived areas, local systems should consider bringing forward enhanced continuity of carer models primarily targeting these groups. v) Evidence that local outcomes have been reviewed as outlined in criteria by the frontline safety champions and the Board safety champion vi) Evidence of a safety dashboard or equivalent, visible to both maternity and neonatal staff which reflects action and progress made on identified concerns raised by staff and service users. This should include concerns relating to the Covid-19 pandemic vii) Evidence that discussions regarding safety intelligence, concerns raised by staff and service users in relation to, but not exclusively, the impact of Covid-19 on maternity and neonatal services; progress and actions relating to the local improvement plan(s) and QI activity are reflected in the minutes of Board, LMS and Patient Safety Network meetings. Minutes should also include discussions on where efforts should be positively recognised. viii) Evidence of Board level oversight and discussion of progress in meeting the revised continuity of carer action plan.

		ix) Evidence that the frontline and Board safety champions have reviewed local outcomes as set out in the standard above and are addressing relevant learning, drawing on insights and recommendations from the two named reports and undertaking the requirements within the letter targeting perinatal support for Black, Asian and Minority Ethnic groups x)Evidence of how the Board has supported staff involved in the four key areas outlined in part e) of the required standard and specifically to: • work with Patient Safety Networks, local maternity systems, clinical networks, commissioners and others on Covid-19 and non Covid-19 related challenges and safety concerns, ensuring learning and intelligence is actively shared across systems • utilise SCORE safety culture survey results to inform the Trust quality improvement plan and Undertaking of improvement work aligned to the MatNeoSIP national driver diagram and key enablers
10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?	i) Trust Board sight of Trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to HSIB and the NHS Resolution Early Notification team. ii) Trust Board sight of evidence that the families have received information on the role of HSIB and EN scheme. iii) Trust Board sight of evidence of compliance with the statutory duty of candour. iv) Reporting to NHS Resolution Monday 1 April 2019 to Tuesday 31 March 2020. Reporting to HSIB Wednesday 1 April 2020 to Wednesday 31 March 2021

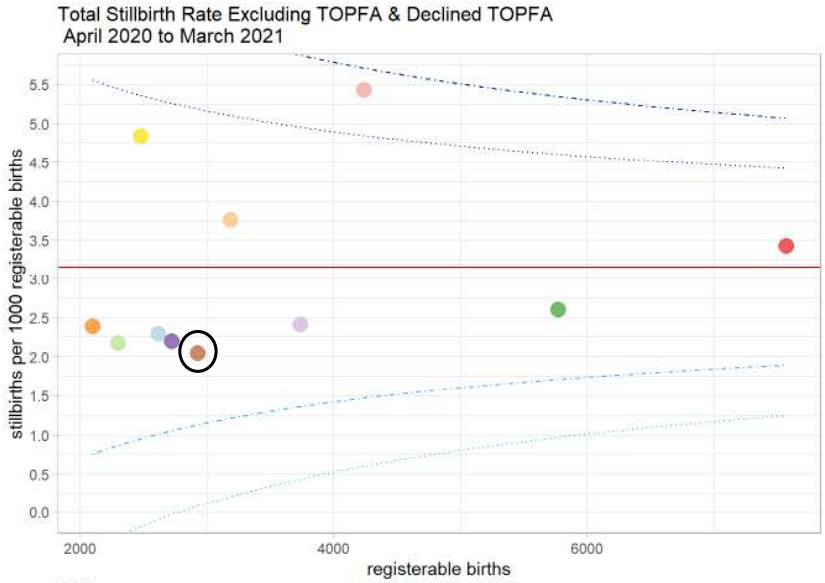
Appendix 3 Perinatal Clinical Surveillance Quality Assurance Report

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	Currently sitting well below the regional mean for total stillbirths, with the lowest rate in the region based upon total stillbirth rate excluding TOPFA and declined TOPFA.
	Outlier for rates of neonatal deaths as a proportion of birth	yes	All deaths are reviewed using the perinatal mortality review tool with external panel members present; there were no clinical concerns identified with the care provided by WUTH.
	Rates of HIE where improvements in care may have made a difference to the outcome	no	Very low rates of HIE, sitting way below the lower control limit for the region.
	Number of SI's	no	X3 SI's reported for maternity in 2020. During 2021, there have been 2 SI's so far, one in maternity and one in neonates.
	Progress on SBL care bundle V2	no	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP.
	Outlier for rates of term admissions to the NNU	no	WUTH are way below the lower control limit for term admission to NNU - all admissions are reviewed at a weekly term admission meeting and any cases wherby admission was felt to have been avoidable are incident reported.
Service user and staff feedback	MVP or Service User concerns/complaints not resolved at trust level	no	Very good position in terms of complaints, sitting with the lowest within the region which is comparable to our outcome data.
	Trainee survey	no	Consistently high scoring year on year.
	Staff survey	no	As a Division, we have maintained or improved in all domains, scoring higher than the Trust average for the majority of domains. Action plan in place to address areas for improvement.
	CQC National survey		
	Feedback via Deanery, GMC, NMC	no	
	Poor staffing levels	no	Current carrying vaccancies which have been recruited to but due to notice periods staff have not started in post. Escalation process in place which works well and care has been able to continue without service disruption.
	Delivery Suite Coordinator not supernummary	no	Supernummary status is maintained for all shifts.
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Some interim arrangements have been in place within the leadership team since September 2020 however these have created stability and imporoved quality and safety.
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams.
	False declaration of CNST MIS	no	Externally audited by MIAA in preparation for the submission.
	Concerns raised about other services in the Trust e.g. A&E	no	Not aware of any issues, good working relationships in place.
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Not aware of any issues, bi-monthly listening events in place.
Safety and learning culture	Lack of engagement in HSIB or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead.
	Lack of transparancy	no	Being open conversations are regularly had and 100% DOC evident.
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all SI's, local reviews, rapid reviews, complaints and compliments.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations.
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations.

Incident reporting	Low patient safety or serious incdient reporting rates		Consistent rates of reporting across the speciality groups. Any months were lows numbers were reported are usually associated with a reduction in clinical acitivity or low birth rate figures/ low NNU admissions.
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework.
	Never Events which are not reported	no	No, no maternity or neonatal never events.
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales.
Governance processes	Unclear governance processes - SAT		Clear governance processes in place that follow the SI framework - Task and finish group in place which will address the ask for the new PSIRF to be launched later this year which will ensure the Division is ready to implement the new guidance once released.
	Business continuity plans not in place	no	Business continuity plans in place.
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	The service was able to continue to provide an acute service from the start of the pandemic due to the robust contingency plans in place. Business as usual was operated following changes necessary to safegaurd staff and service user well being.
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Recent CQC core service review was undertaken in May 2021 which did not highlight any concerns.
	An overall CQC rationg of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	N/a
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

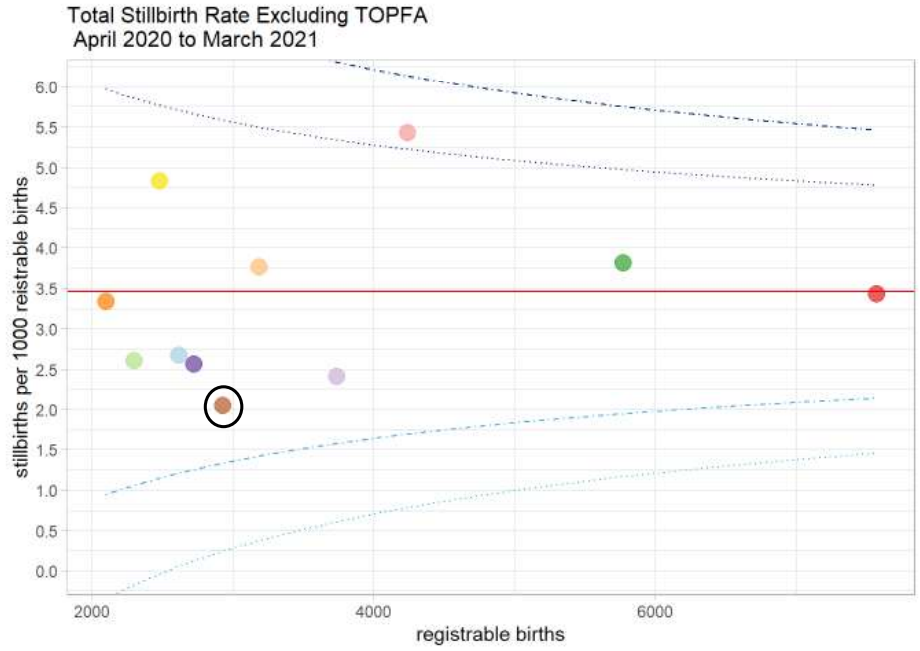
Appendix 4

1.1 Total Stillbirth Rate Excluding TOPFA & Declined TOPFA



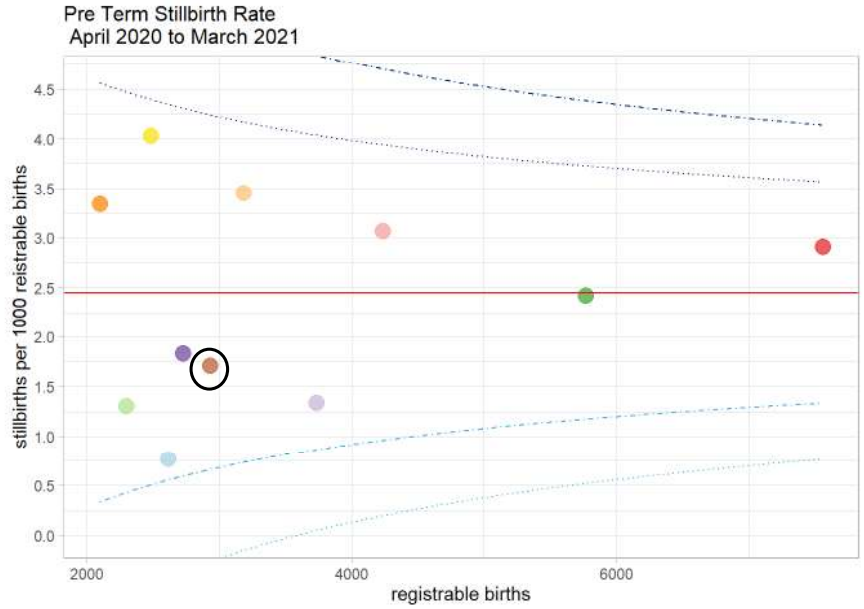
- **WUTH**

1.2 Total Stillbirth Rate Excluding TOPFA



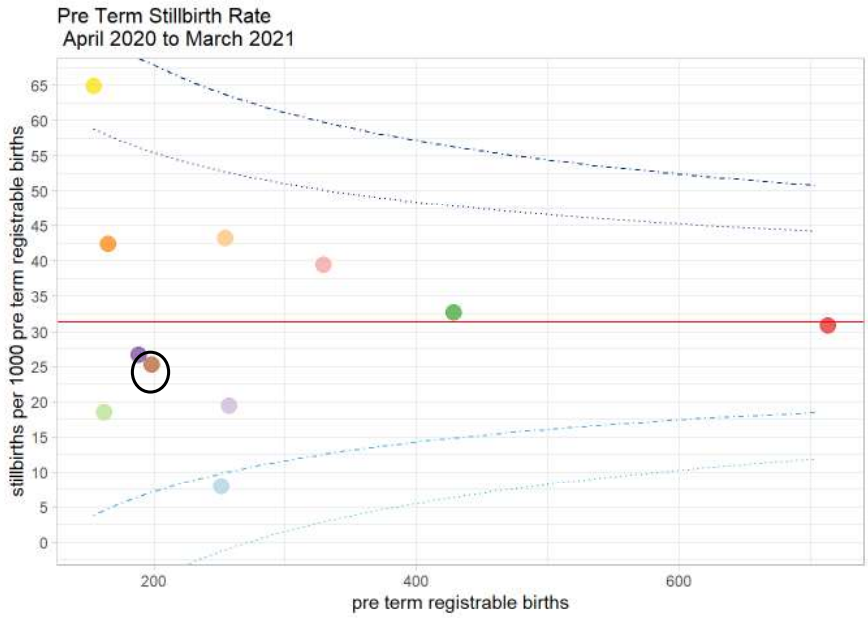
- **WUTH**

1.3 Pre Term Stillbirth Rate



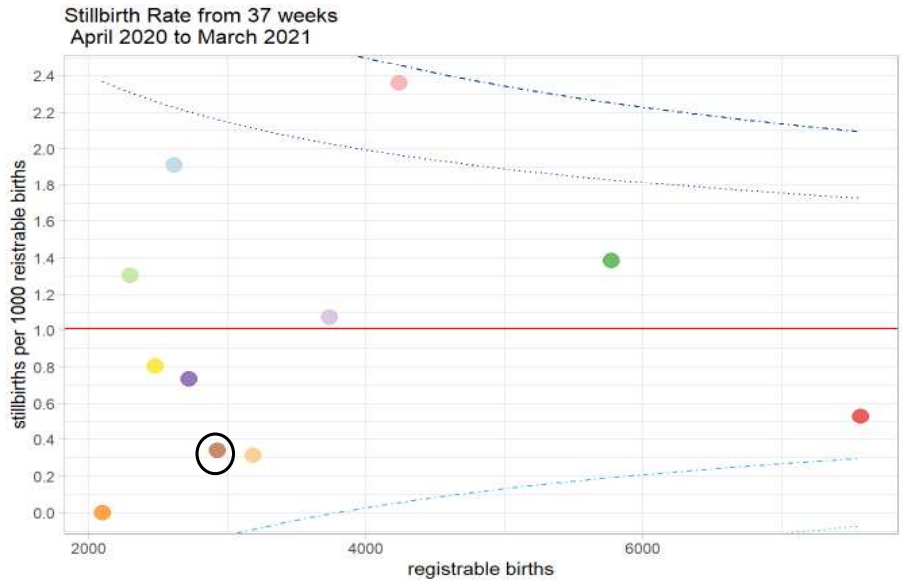
- **WUTH**

1.4 Pre Term Stillbirth Rate in Pre Term Births



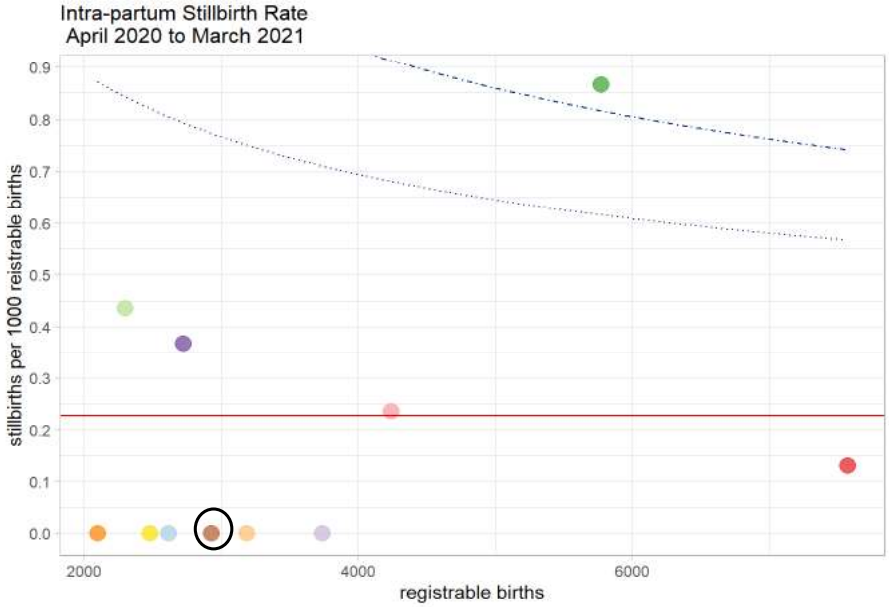
- **WUTH**

1.5 Stillbirth Rate from 37 weeks



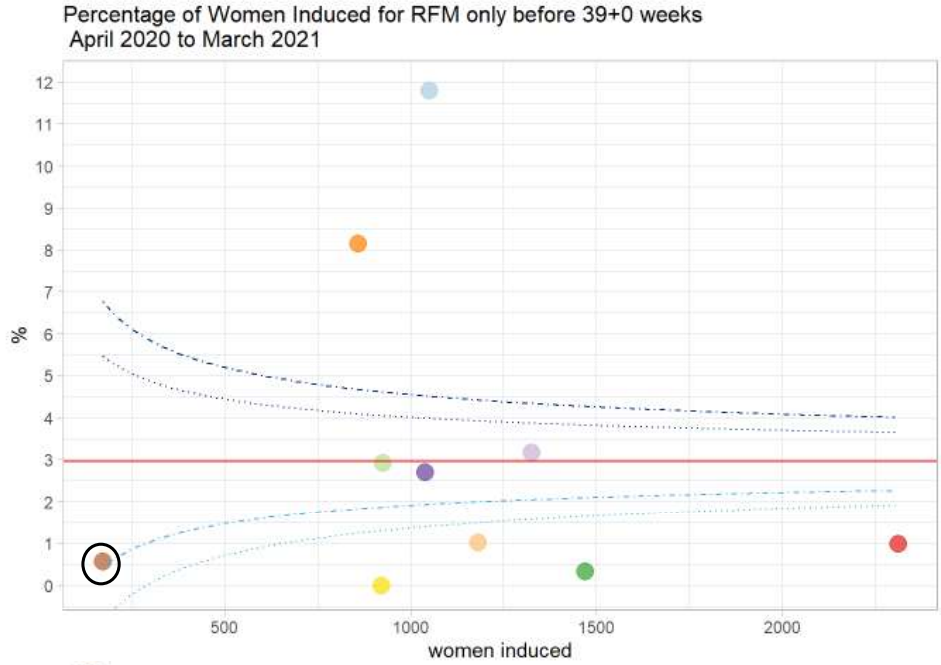
- **WUTH**

1.6 Intra-partum Stillbirth Rate



- **WUTH**

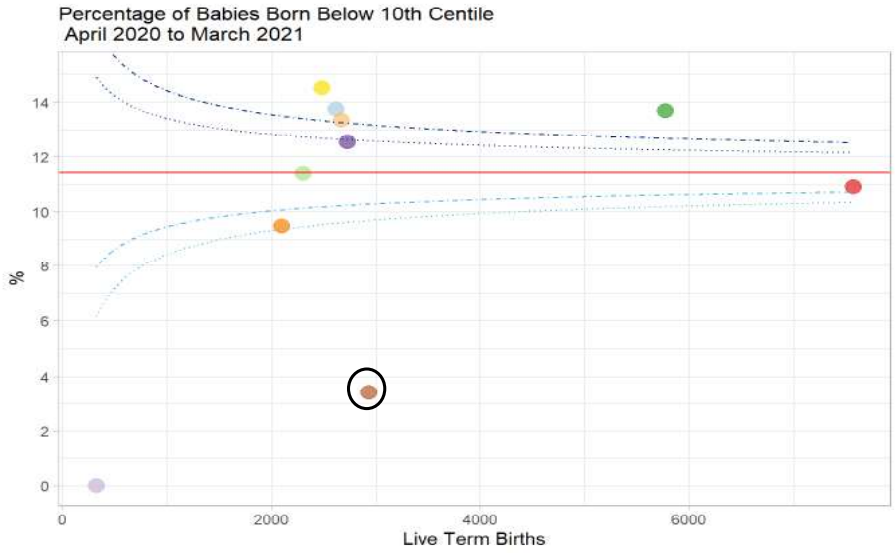
1.7 Induction for Reduced Fetal Movement Only



- **WUTH**

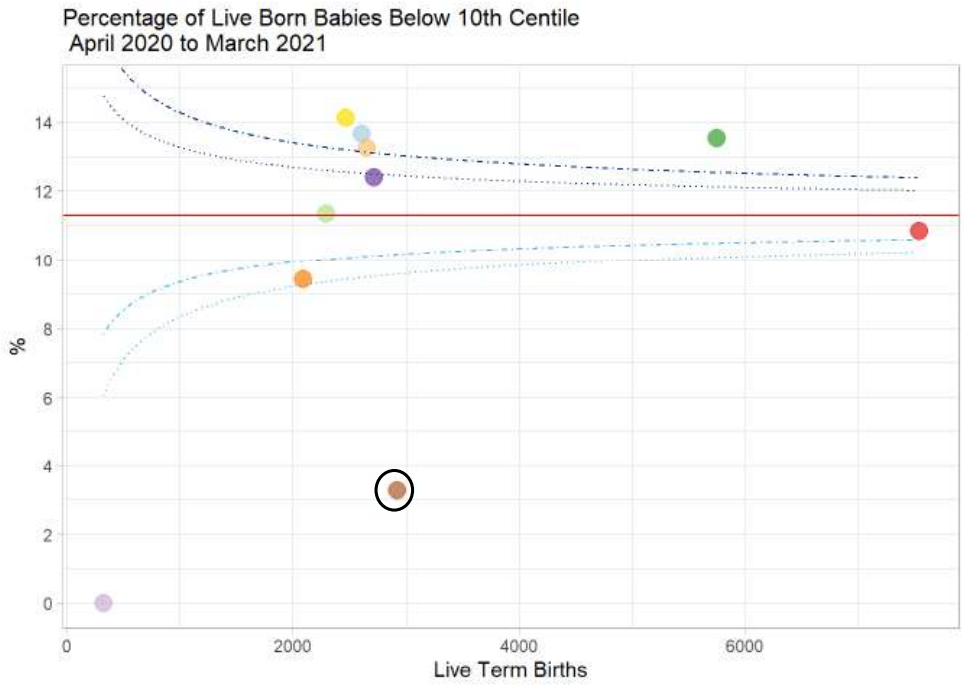
1.8 Low Birth Weight

1.8.1 Percentage of Babies Born Below 10th Centile



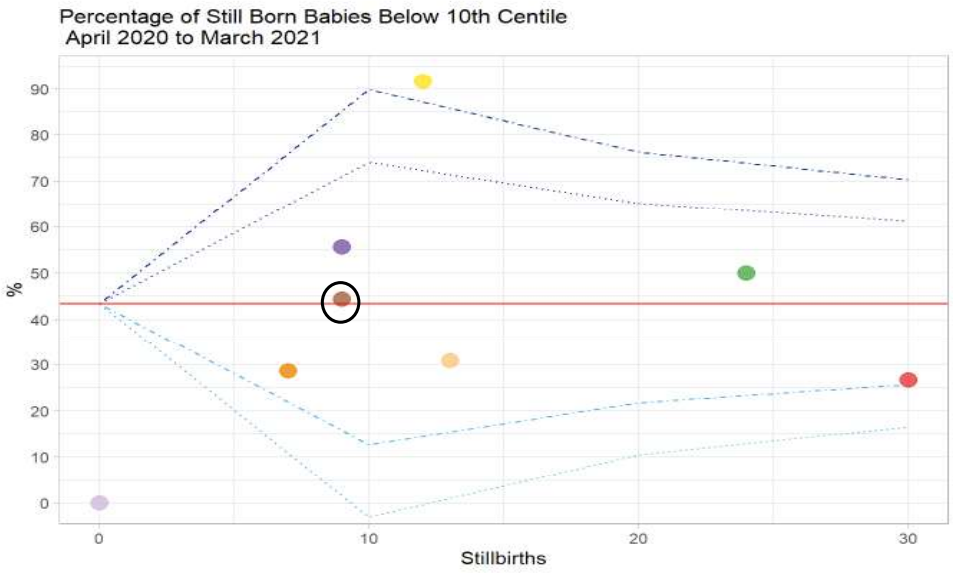
- **WUTH**

1.8.2 Percentage of Live Born Babies Below 10th Centile



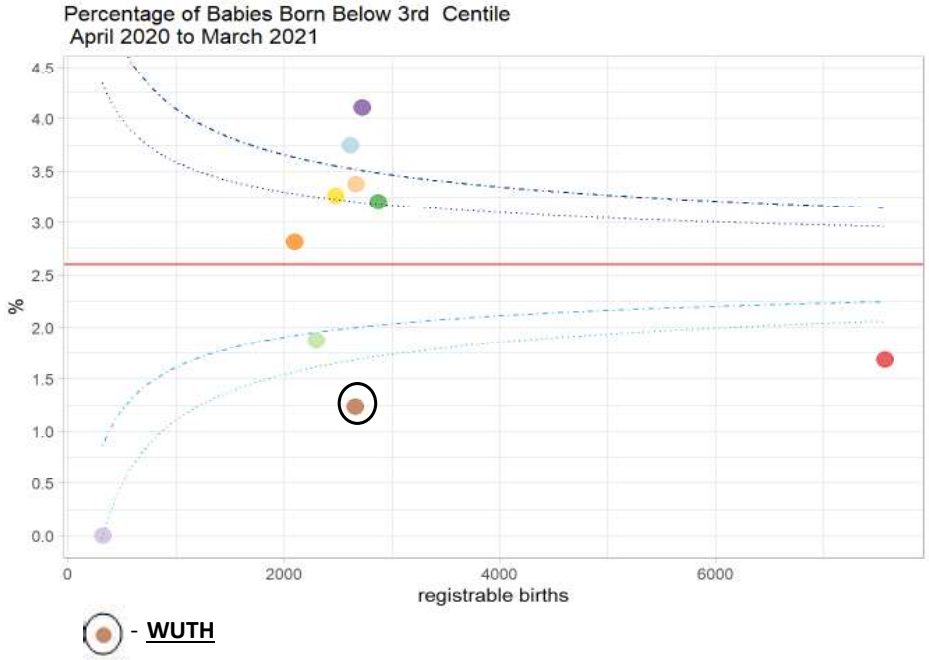
- **WUTH**

1.8.3 Percentage of Still Born Babies Below 10th Centile



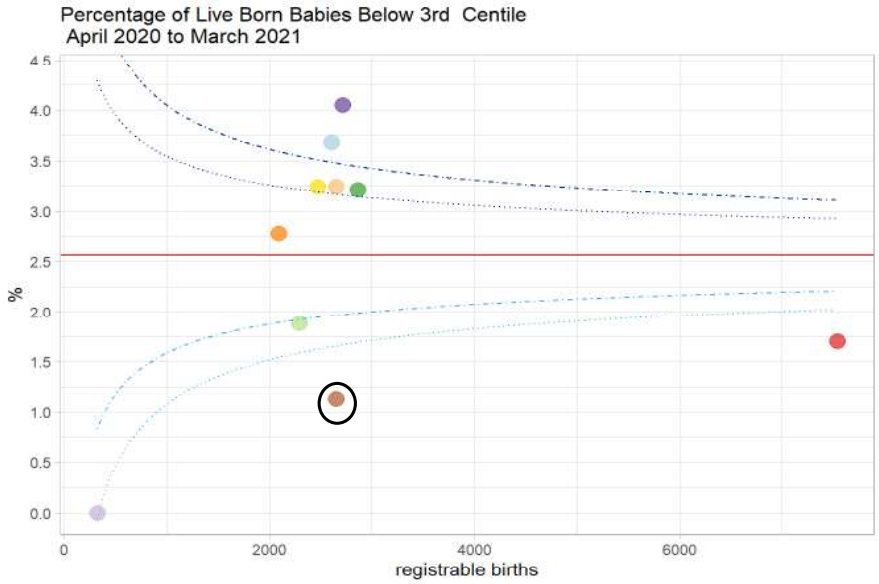
- **WUTH**

1.8.4 Percentage of Babies Born Below 3rd Centile



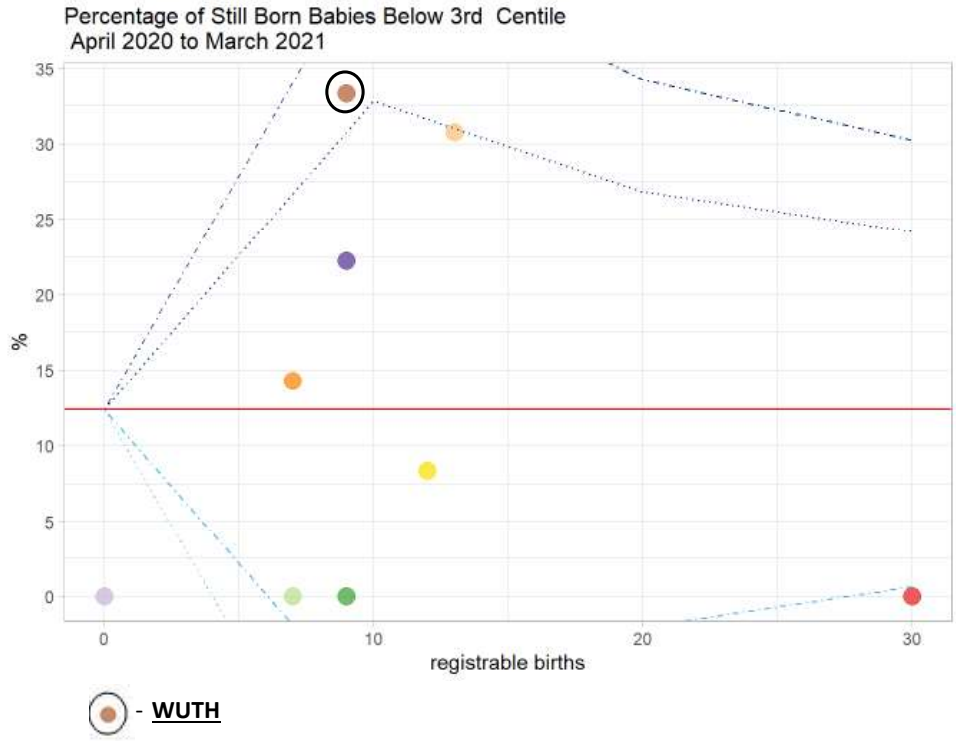
- **WUTH**

1.8.5 Percentage of Live Born Babies Below 3rd Centile



- **WUTH**

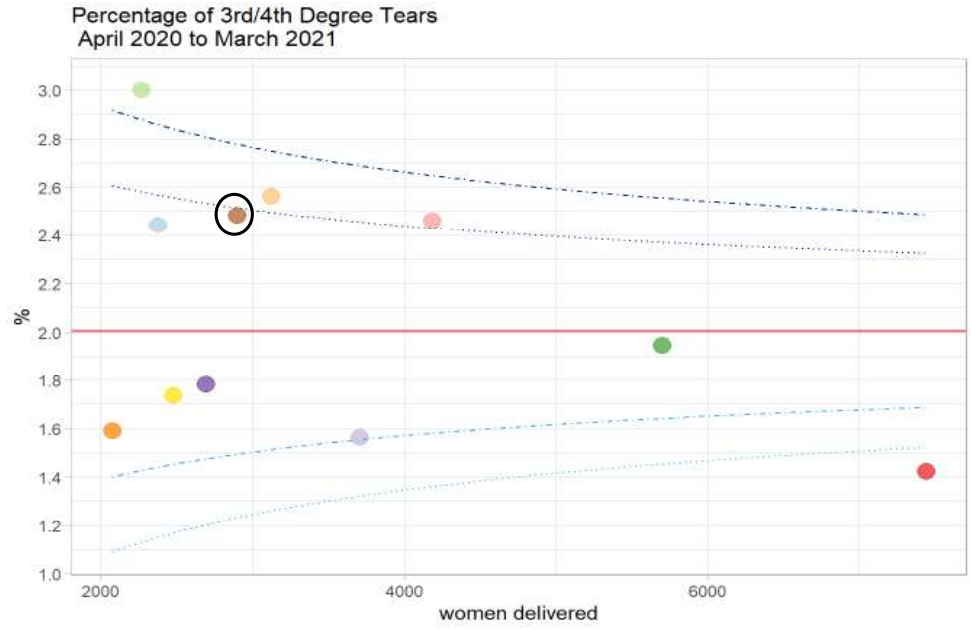
1.8.6 Percentage of Still Born Babies Below 3rd Centile



2 Safety

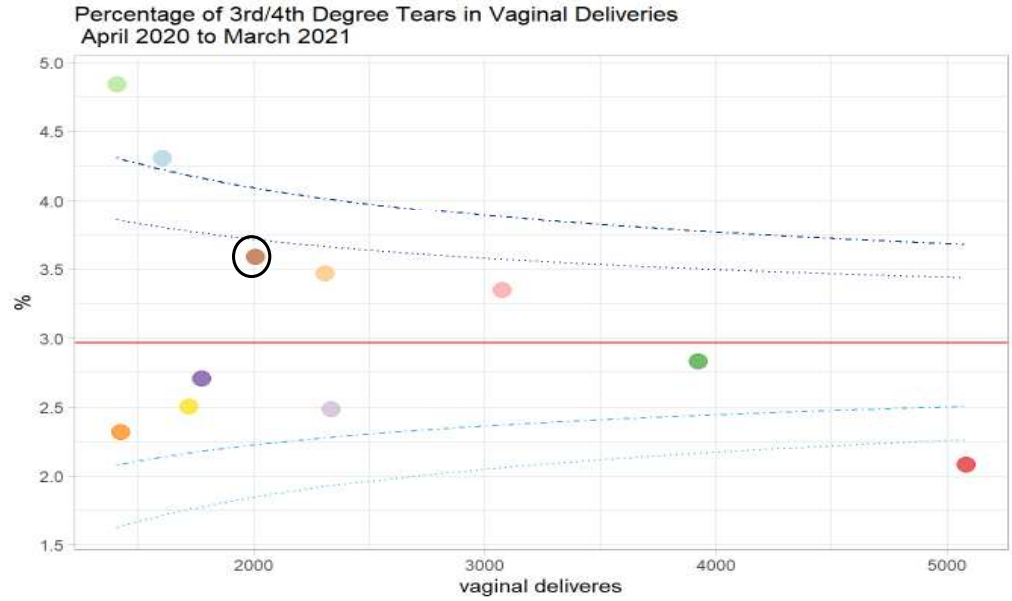
2.1 3rd/4th Degree Tears

2.1.1



- **WUTH**

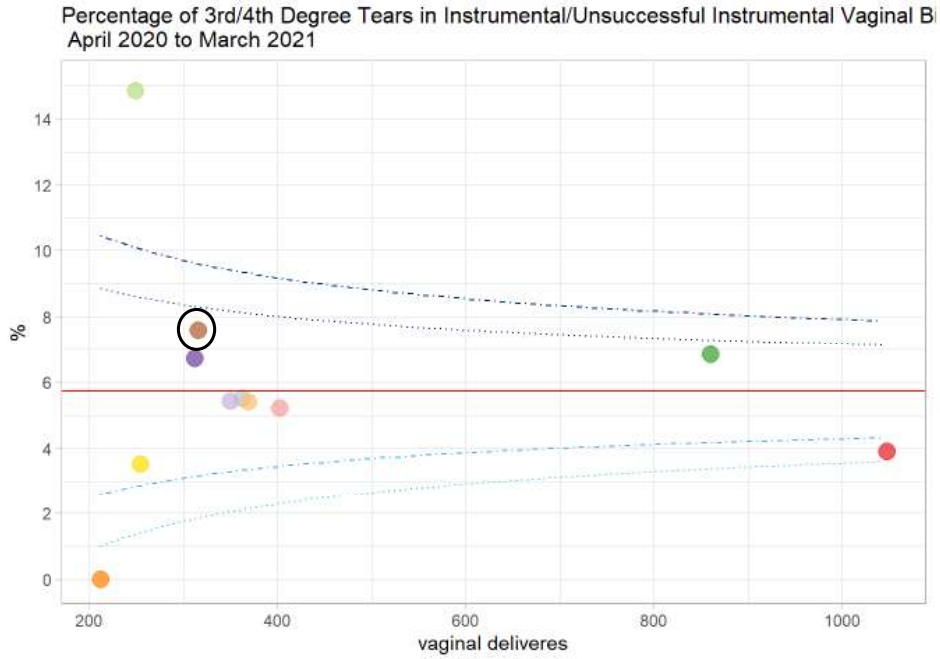
2.1.2 3rd/4th Degree Tears in Vaginal Deliveries



Run Chart for Percentage of 3rd/4th Degree Tears in Vaginal Deliveries

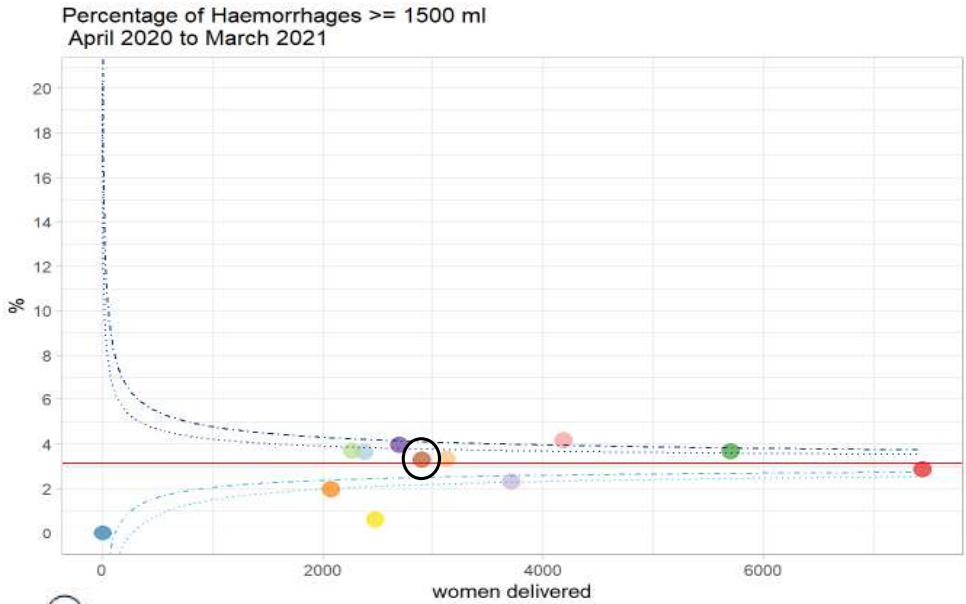
- **WUTH**

2.1.3 3rd/4th Degree Tears in Instrumental/Unsuccessful Instrumental Vaginal Births



- **WUTH**

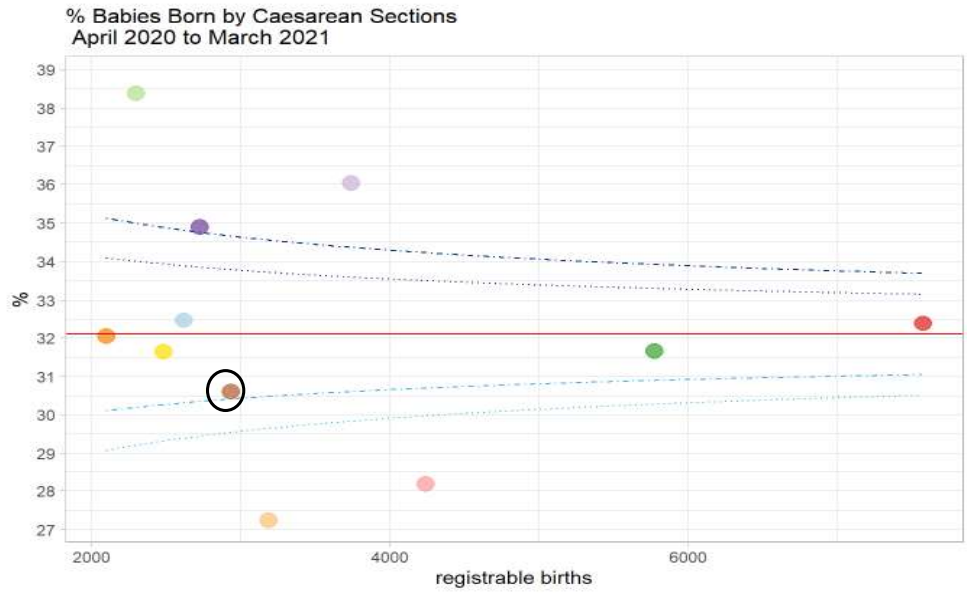
2.2 Percentage of Haemorrhages ≥1500 ml



- **WUTH**

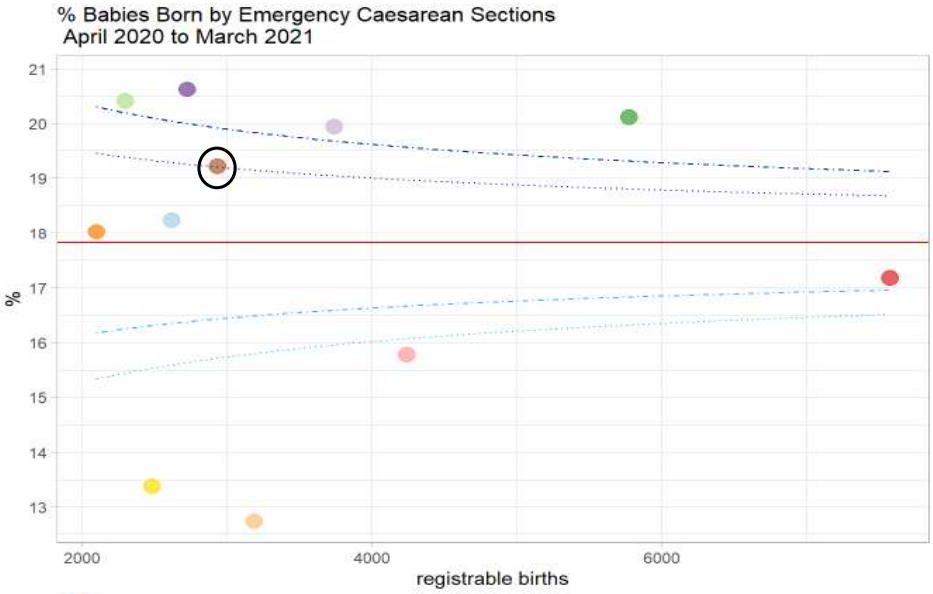
2.3 Caesarean Sections

2.3.1 Total Caesarean Sections



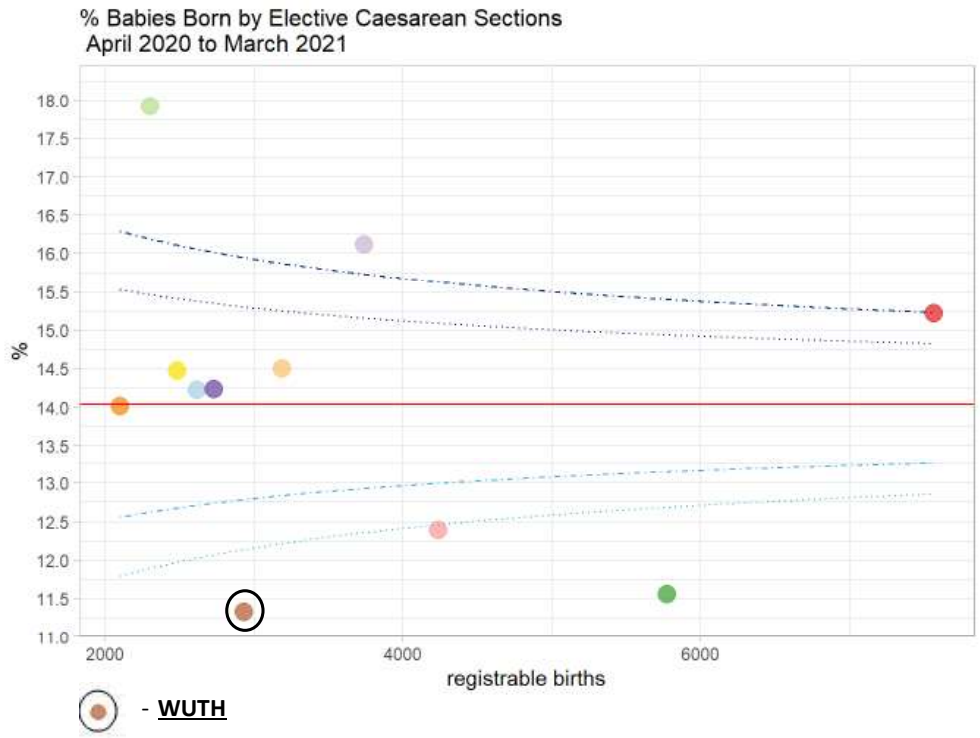
- **WUTH**

2.3.2 Emergency CS Rate

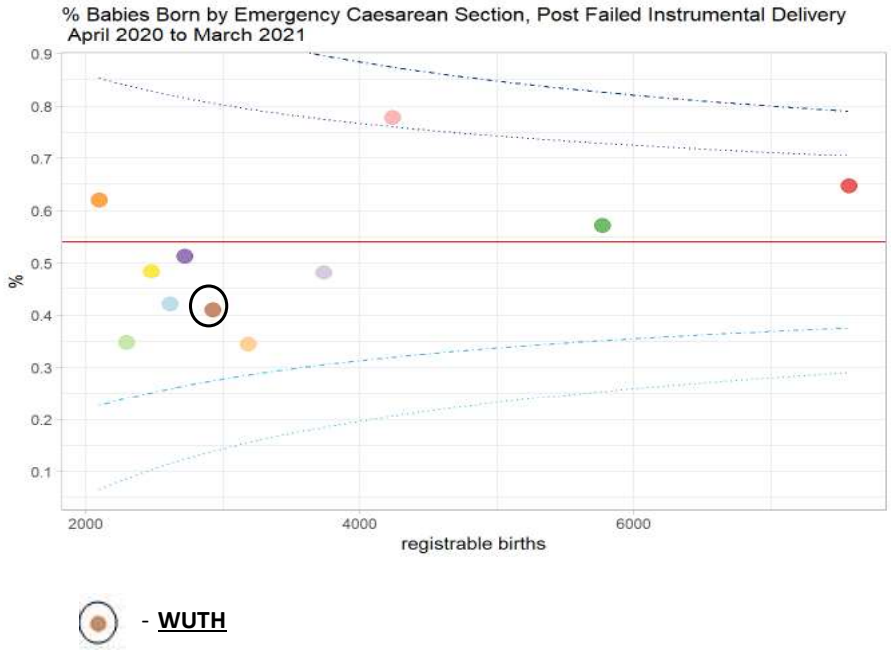


- **WUTH**

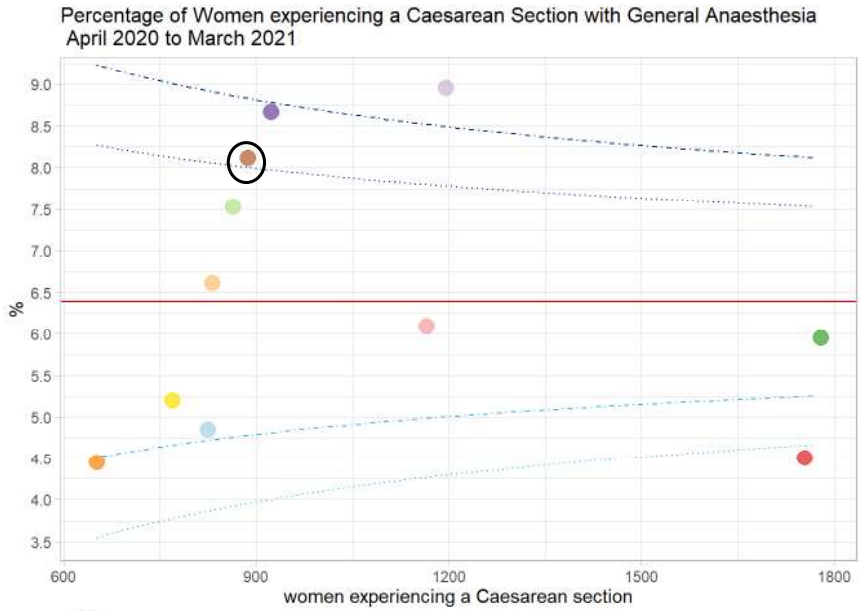
2.3.3 Elective (Cat 4) Caesarean Section



2.3.4 Percentage of Babies Born by Emergency Caesarean Section, Post Failed Instrumental Delivery

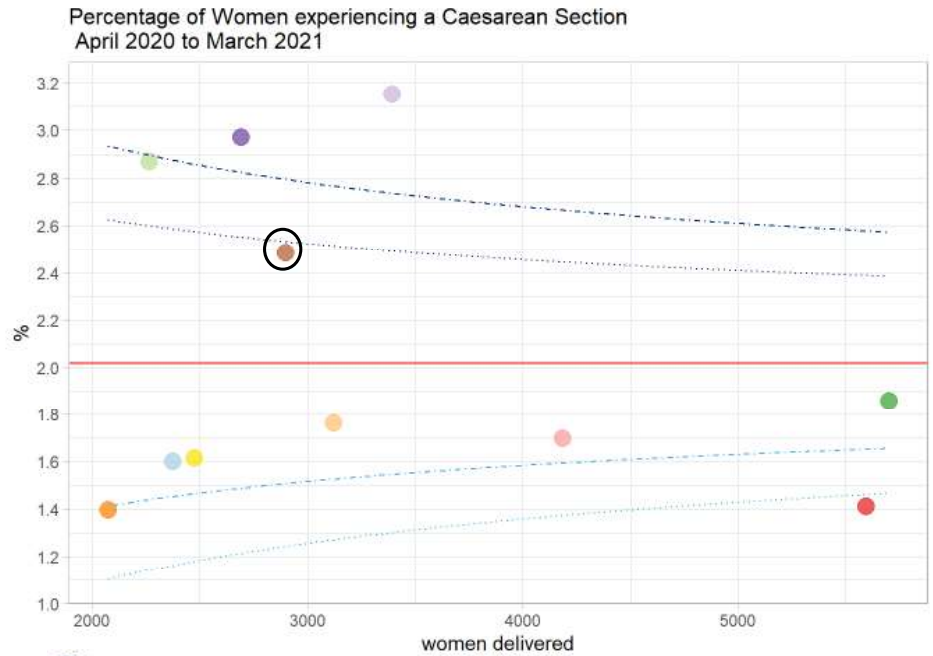


2.3.5 Women experiencing a Caesarean Section with General Anaesthesia



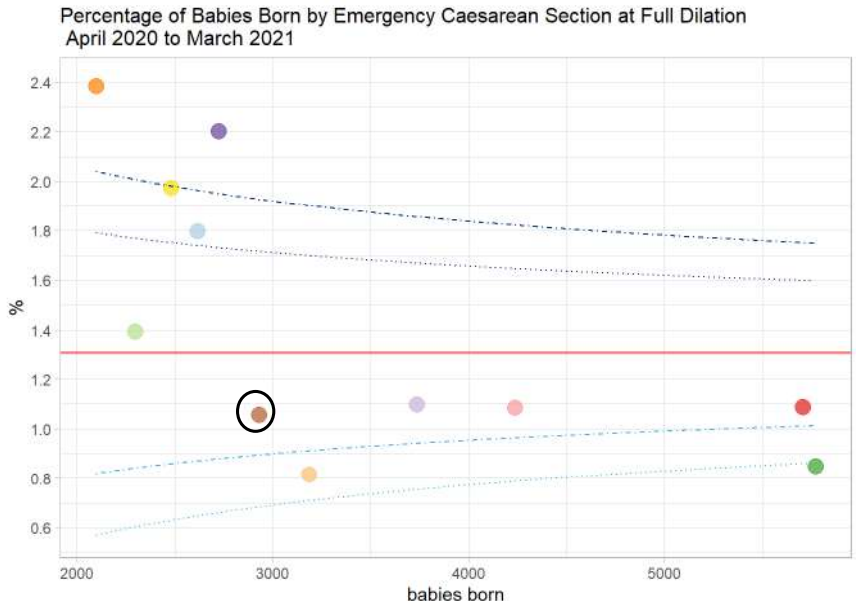
- **WUTH**

2.3.6 Women experiencing a Caesarean Section



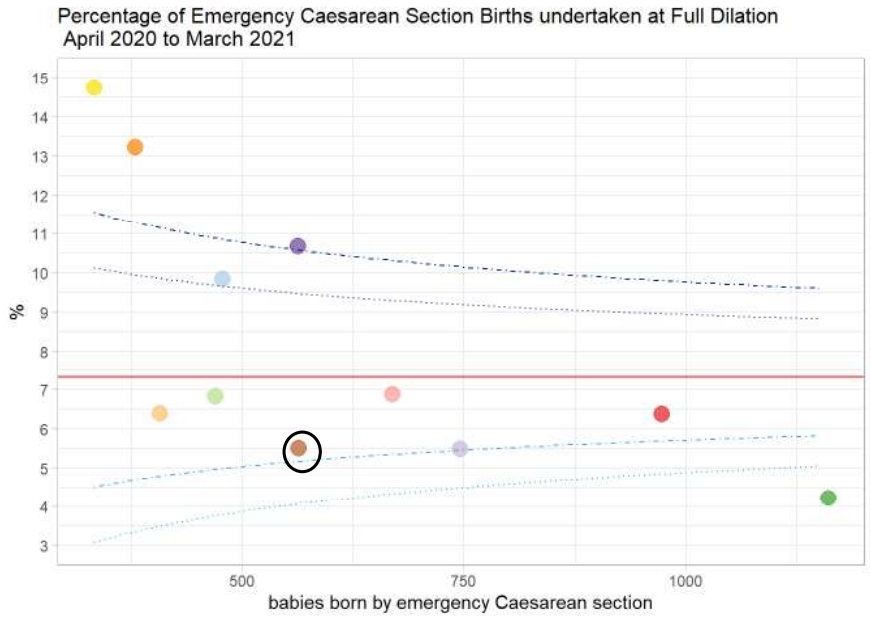
- **WUTH**

2.3.7 Babies Born by Emergency Caesarean Section at Full Dilation



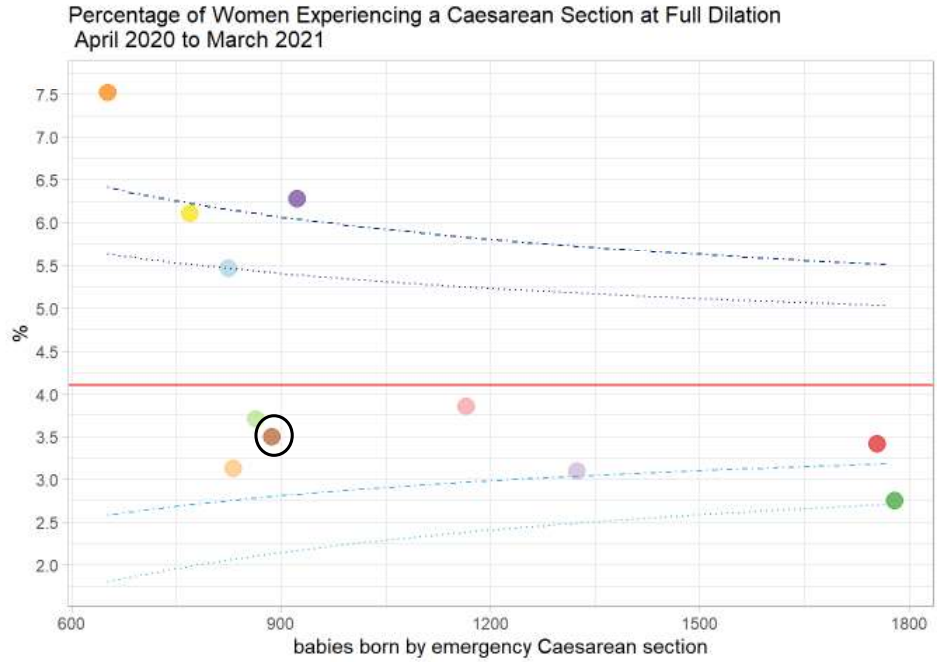
- **WUTH**

2.3.8 Emergency Caesarean Section Births undertaken at Full Dilation



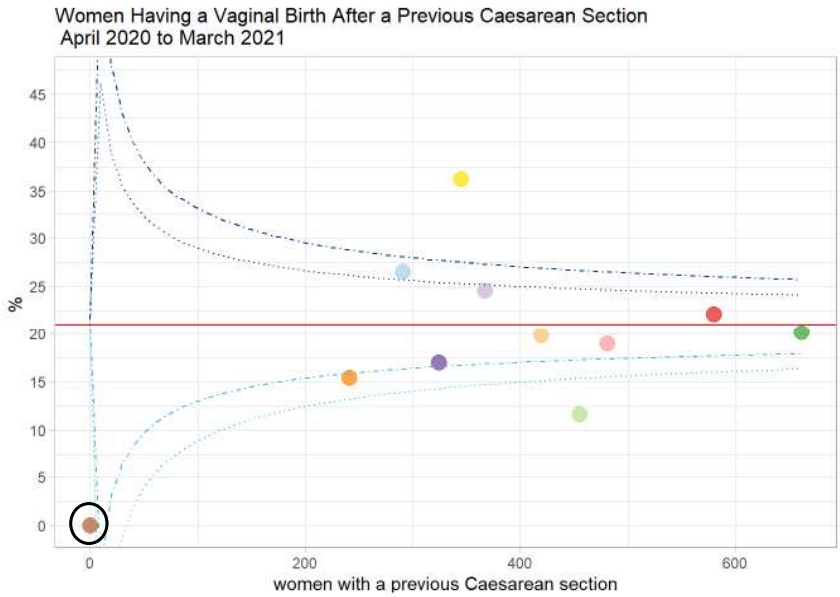
- **WUTH**

2.3.9 Women Experiencing a Caesarean Section at Full Dilation



- **WUTH**

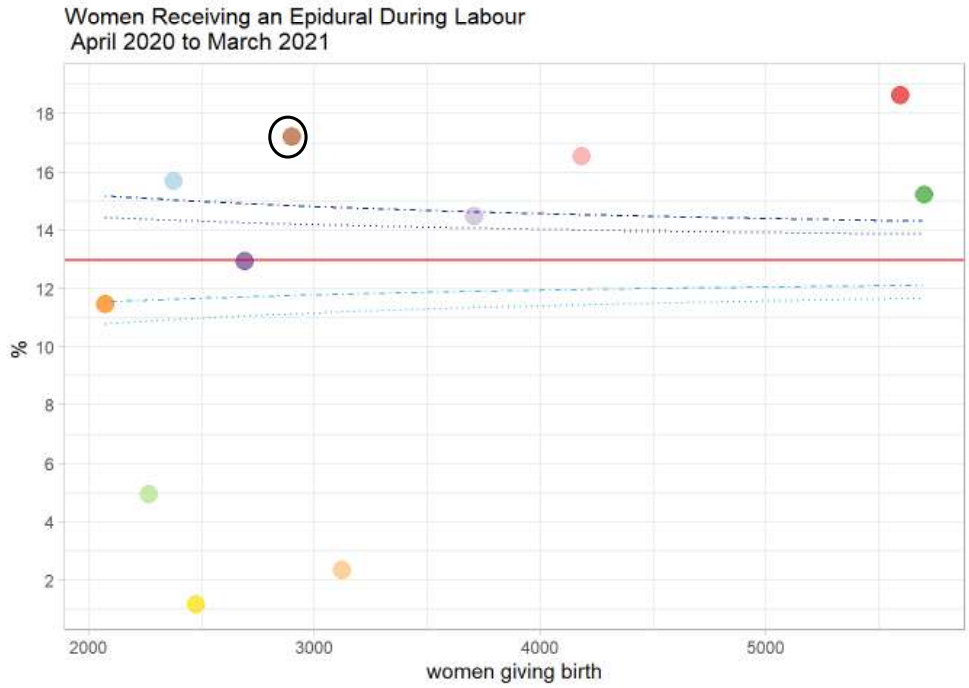
2.3.10 Women Having a Vaginal Birth After a Previous Caesarean Section



- **WUTH**

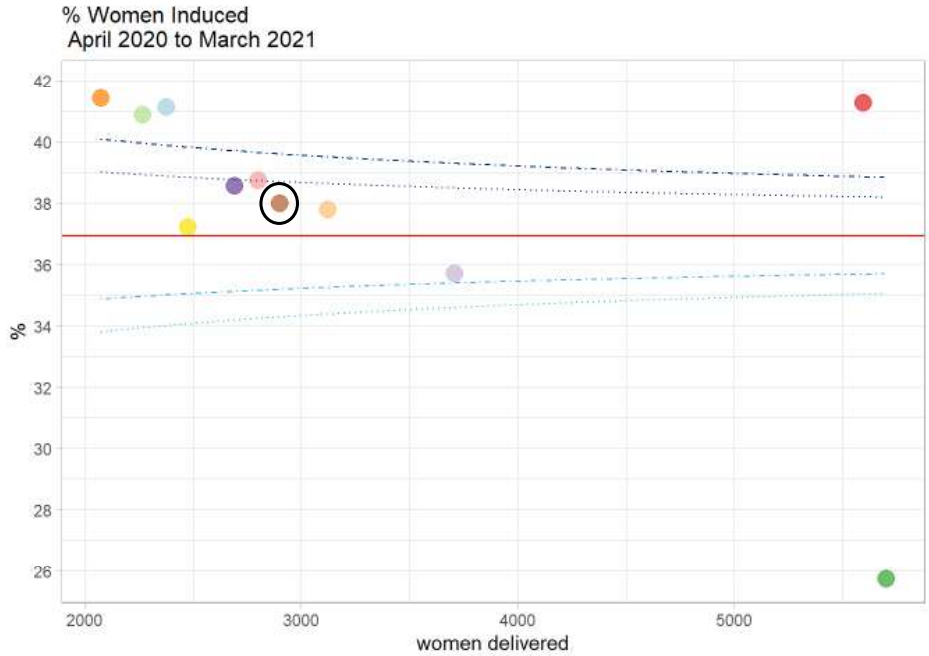
2.4 Epidural

2.4.1 Women Recieving an Epidural During Labour



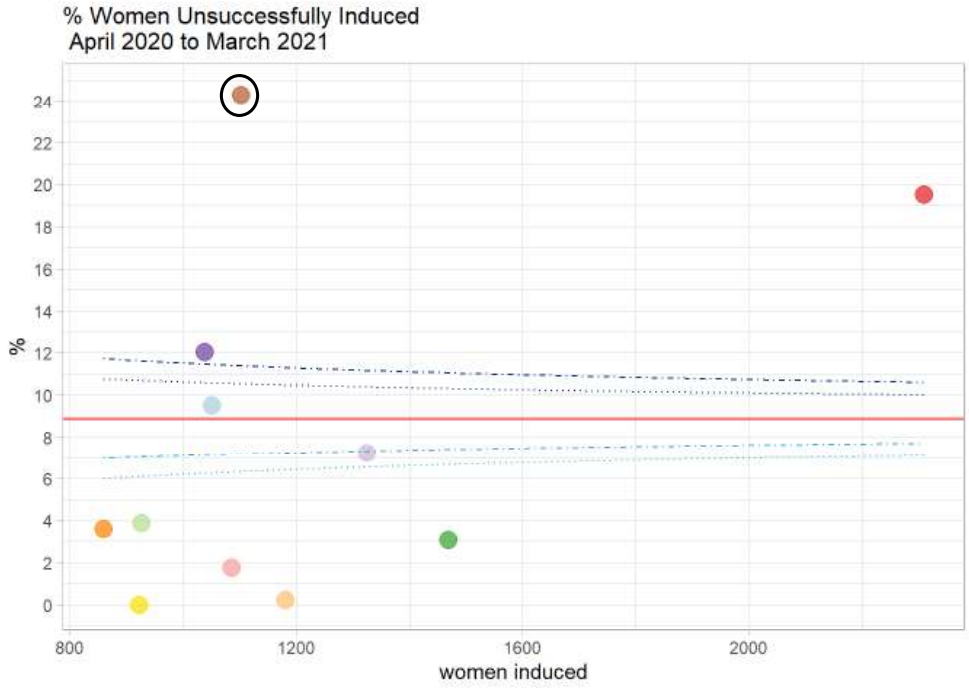
- **WUTH**

2.5 Induction of Labour



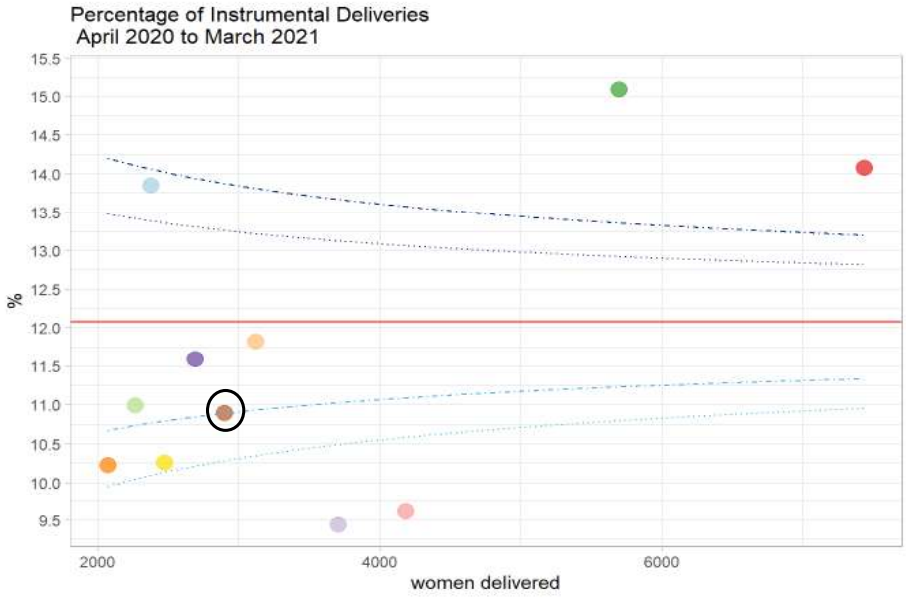
- **WUTH**

2.5.1 Unsuccessful Induction of Labour



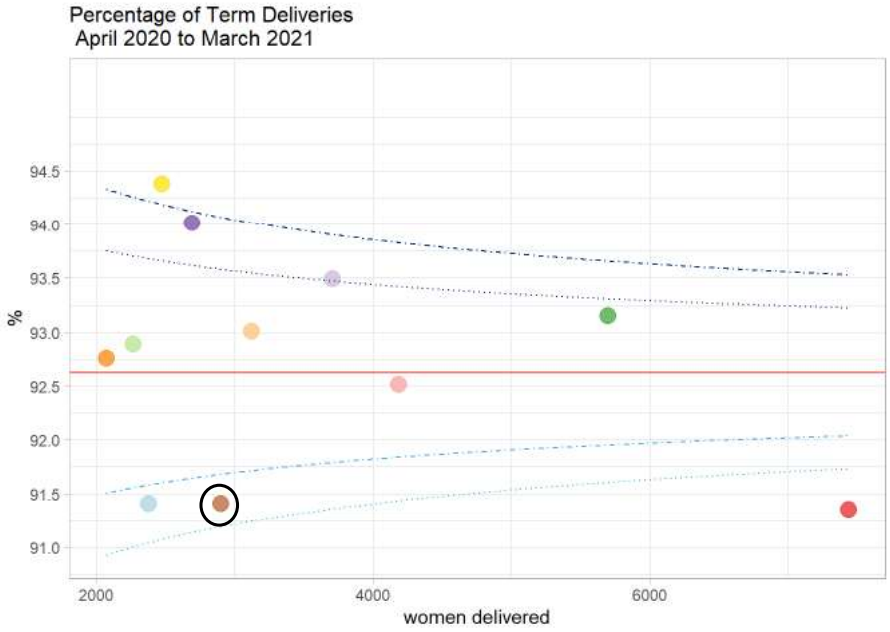
- **WUTH**

2.6 Instrumental Deliveries



- **WUTH**

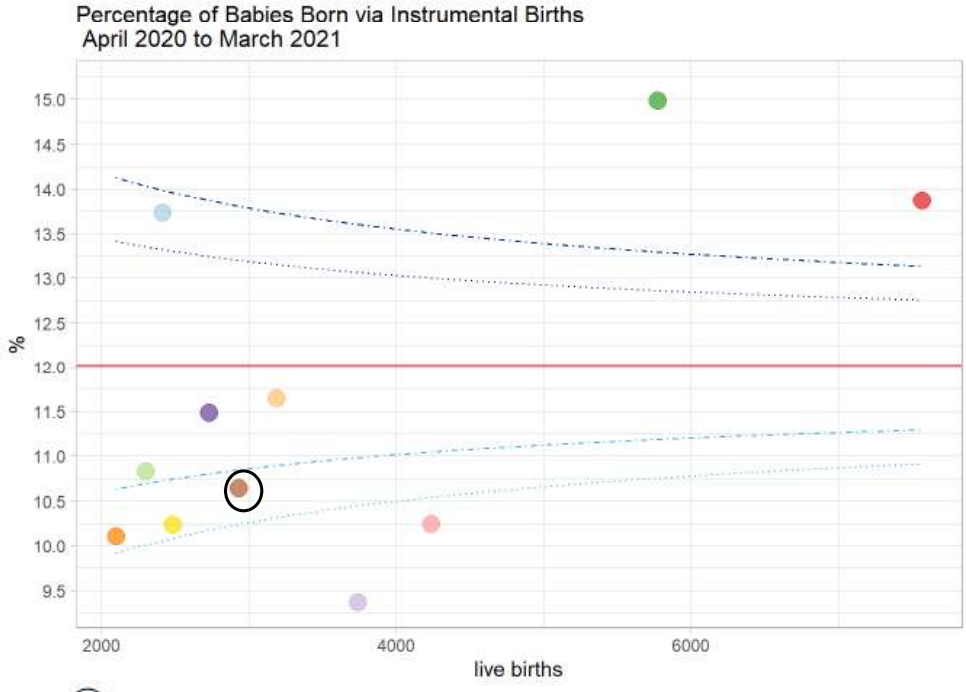
2.7 Term Deliveries



- **WUTH**

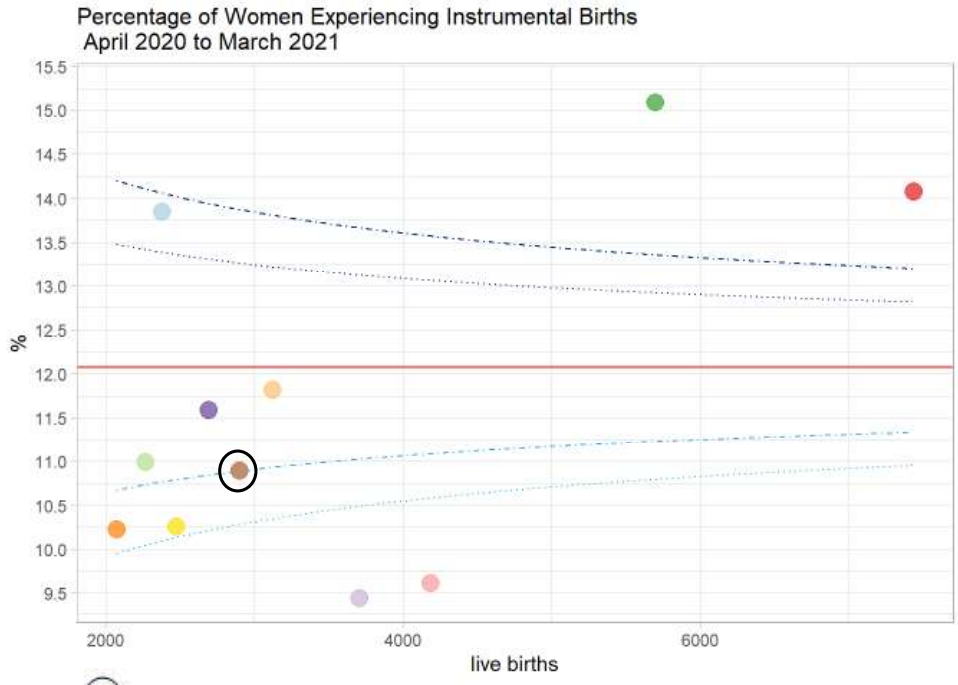
2.8 Assisted Vaginal Births

2.8.1 Percentage of Babies Born via Instrumental Births



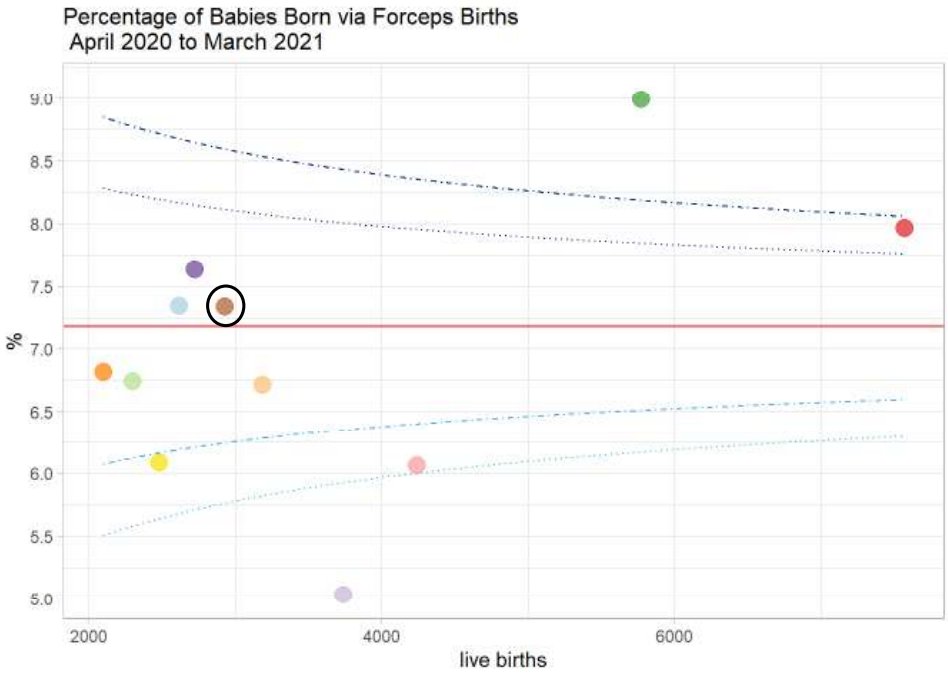
- **WUTH**

2.8.2 Percentage of Women Experiencing Instrumental Births



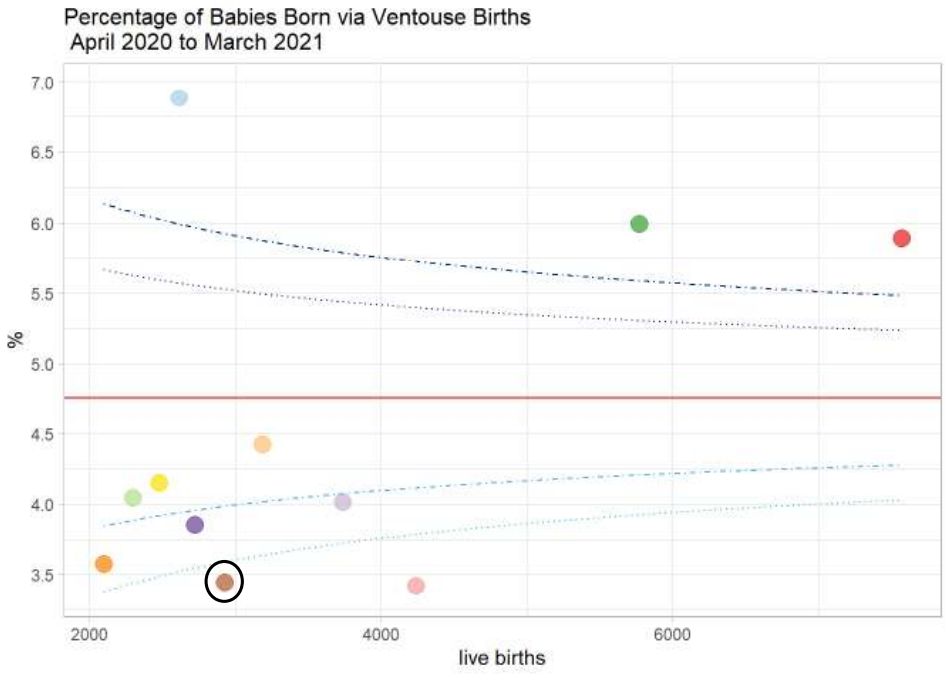
- **WUTH**

2.8.3 Percentage of Babies Born via Forceps Births



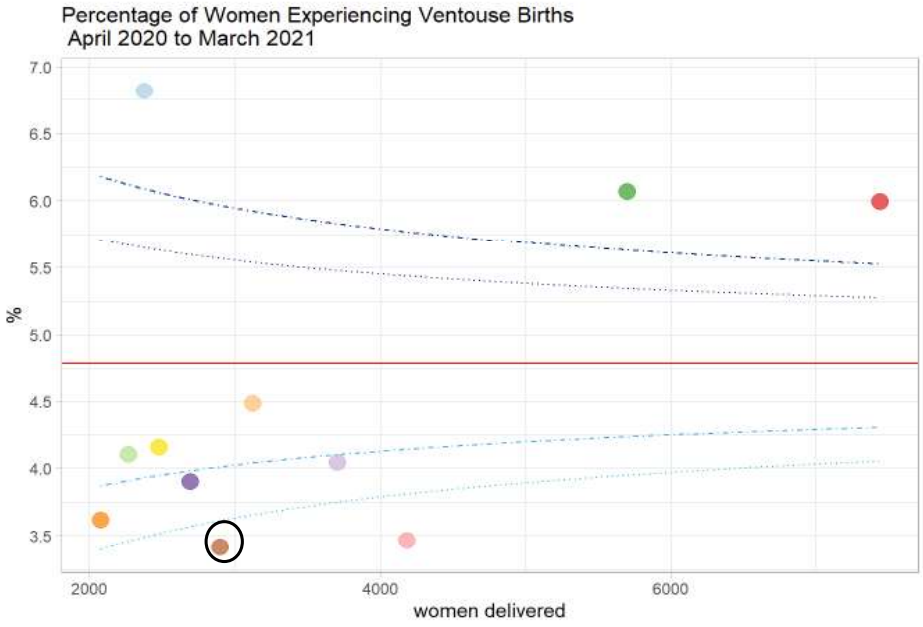
- **WUTH**

2.8.4 Percentage of Babies Born via Ventouse Births



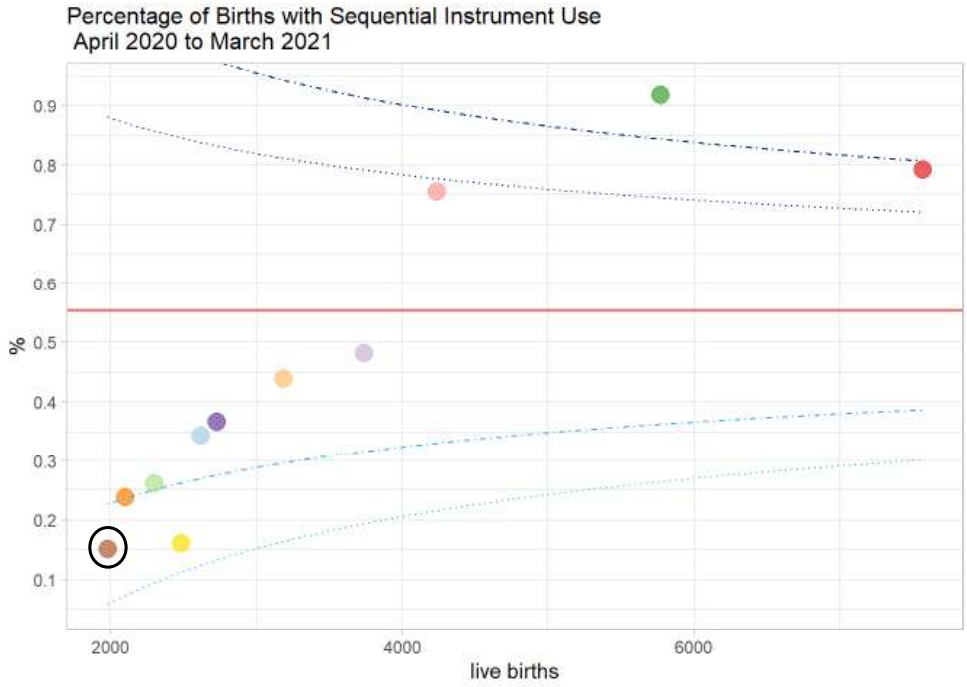
- **WUTH**

2.8.5 Percentage of Women Experiencing Ventouse Births



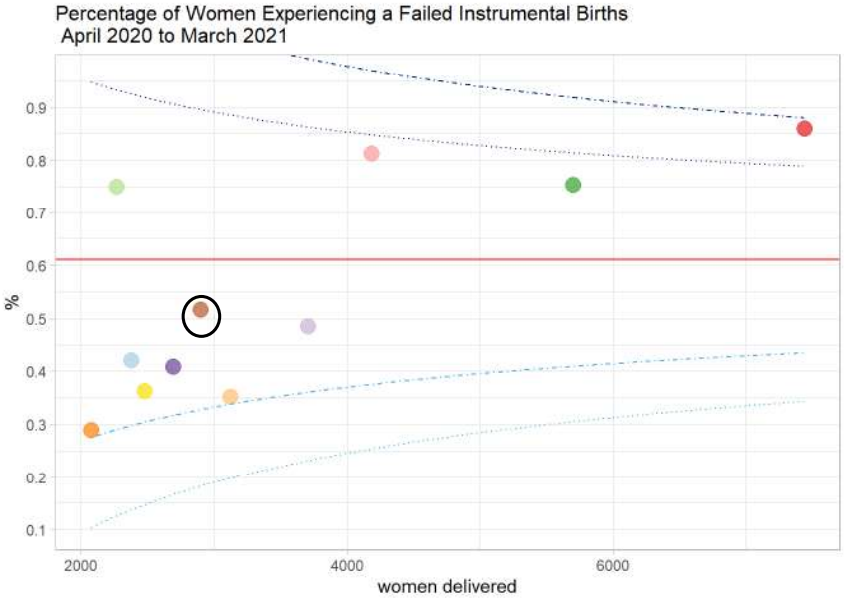
- **WUTH**

2.8.6 Percentage of Births with Sequential Instrument Use



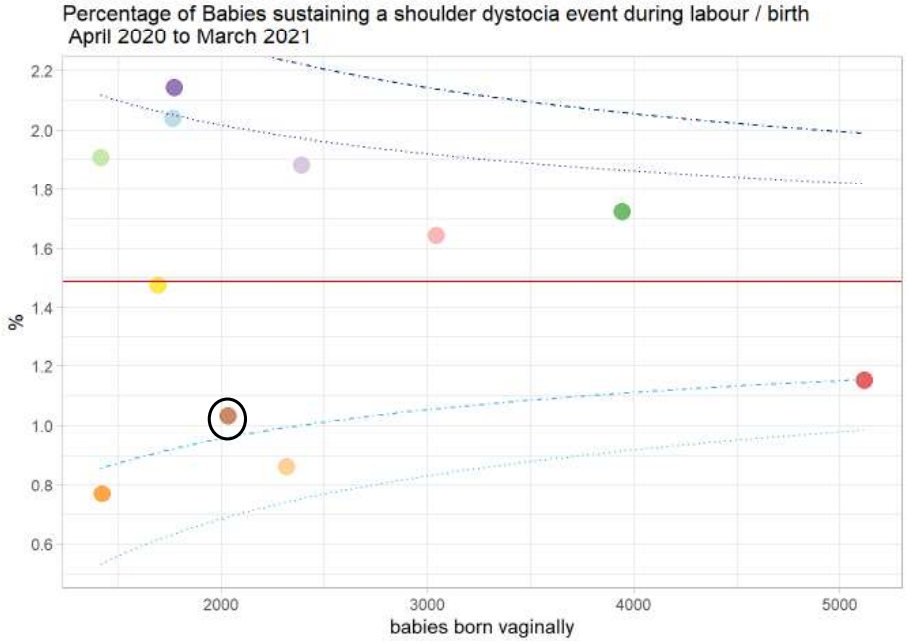
- **WUTH**

2.8.7 Percentage of Women Experiencing a Failed Instrumental Births



- **WUTH**

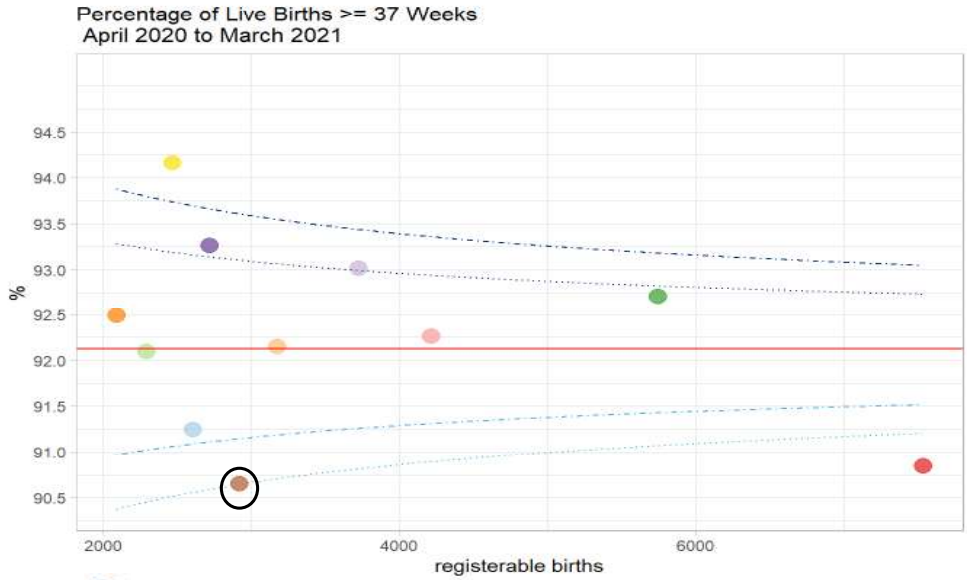
2.9 Babies sustaining a shoulder dystocia event during labour / birth



- **WUTH**

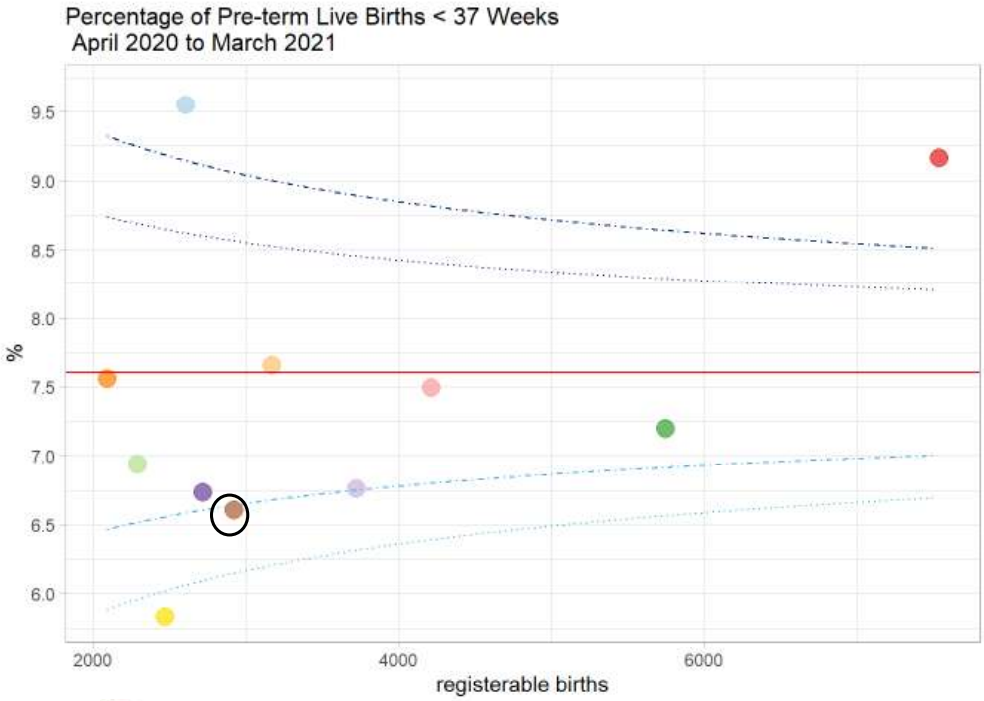
3 Pre Term

3.0.1 Percentage of Live Births >= 37 Weeks



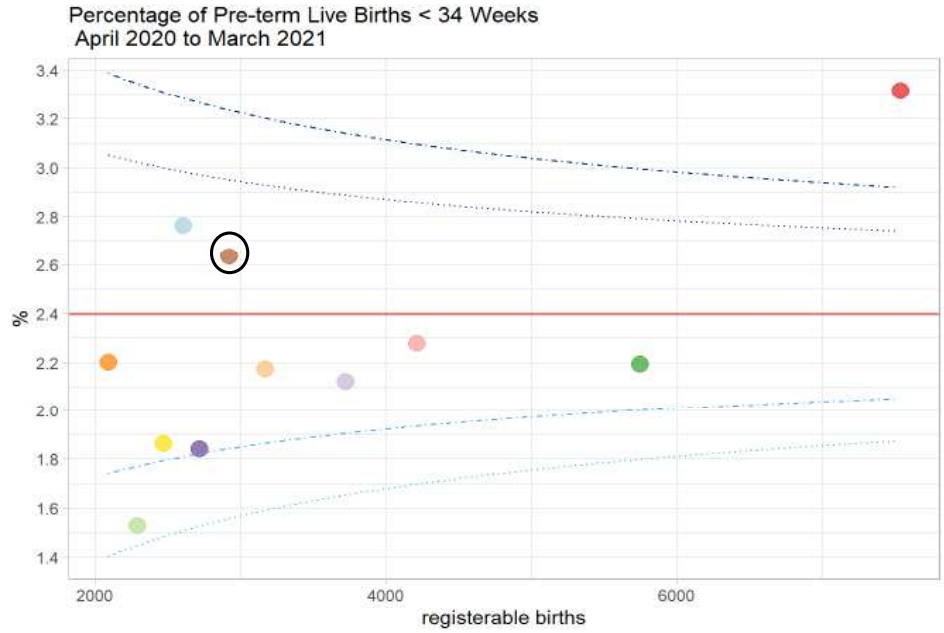
- **WUTH**

3.0.2 Percentage of Pre-term Live Births < 37 Weeks



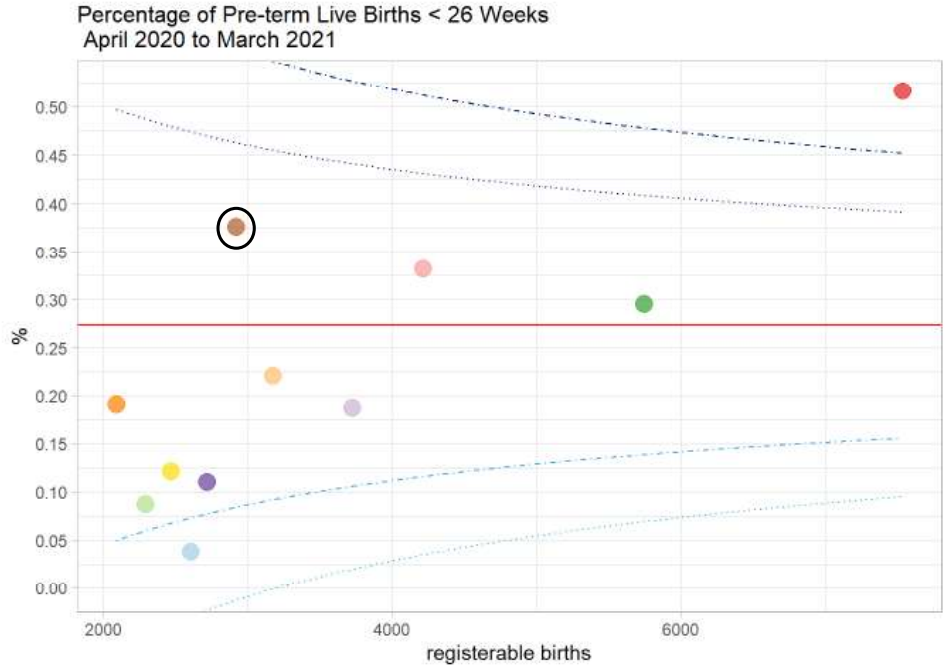
- **WUTH**

3.0.3 Percentage of Pre-term Live Births < 34 Weeks



- **WUTH**

3.0.4 Percentage of Pre-term Live Births < 26 Weeks

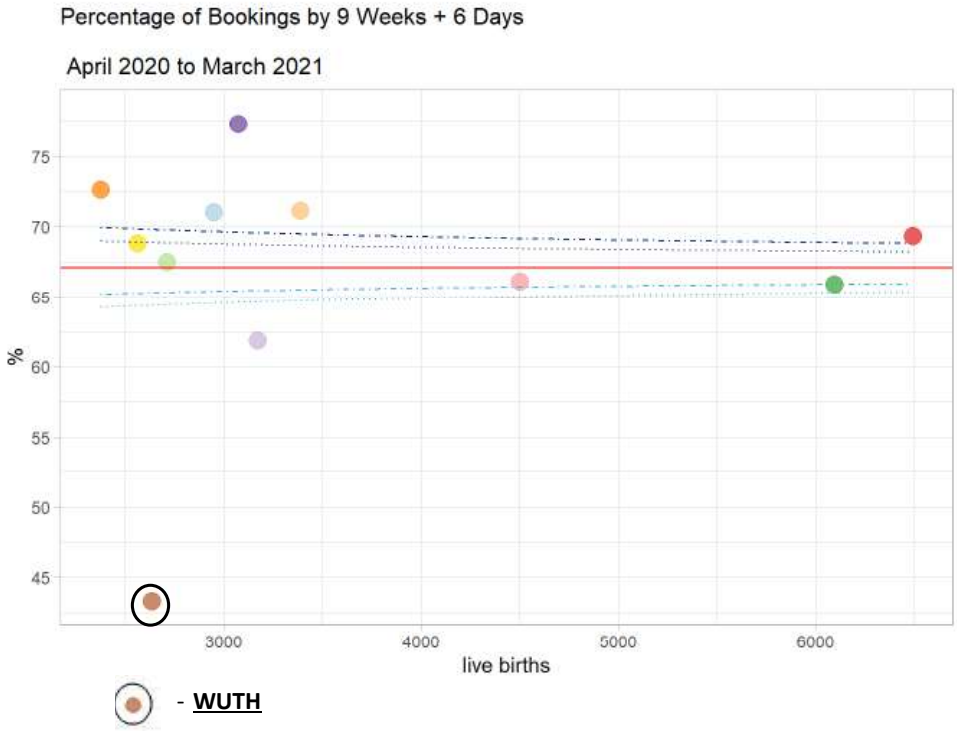


- **WUTH**

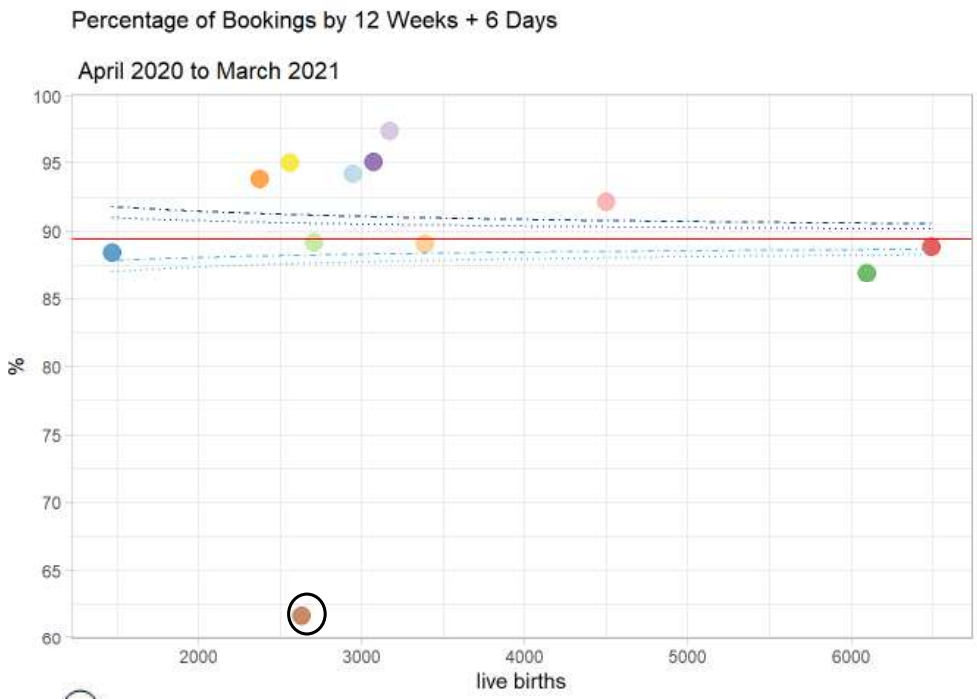
4 Additional Metrics

4.1 Bookings

4.1.1 Percentage of Bookings by 9 Weeks + 6 Days



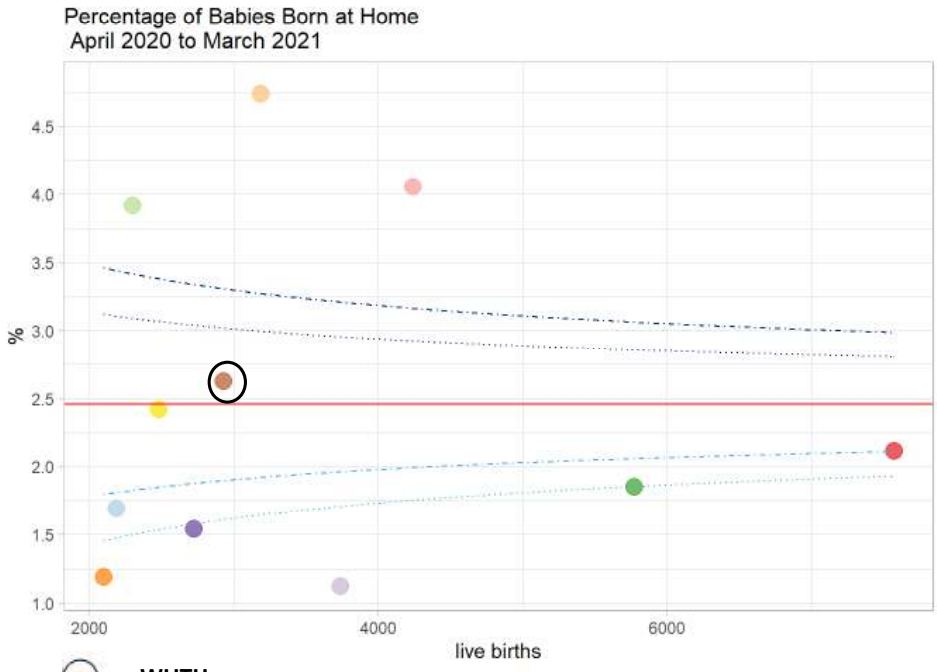
4.1.2 Percentage of Bookings by 12 Weeks + 6 Days



- **WUTH**

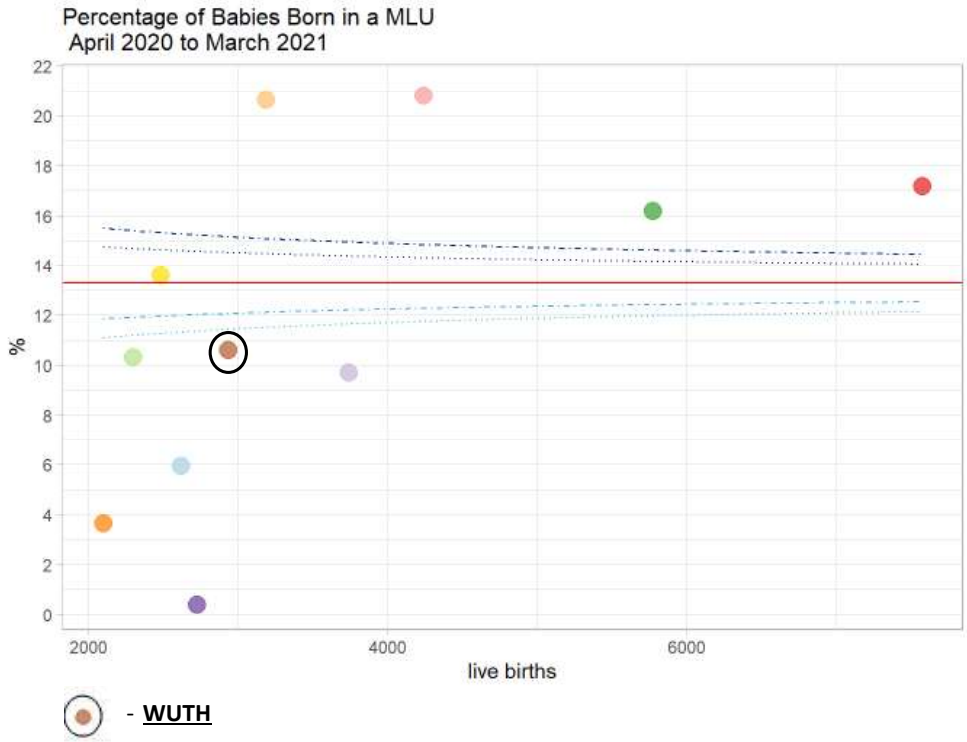
4.2 Birth Location

4.2.1 Percentage of Babies Born at Home

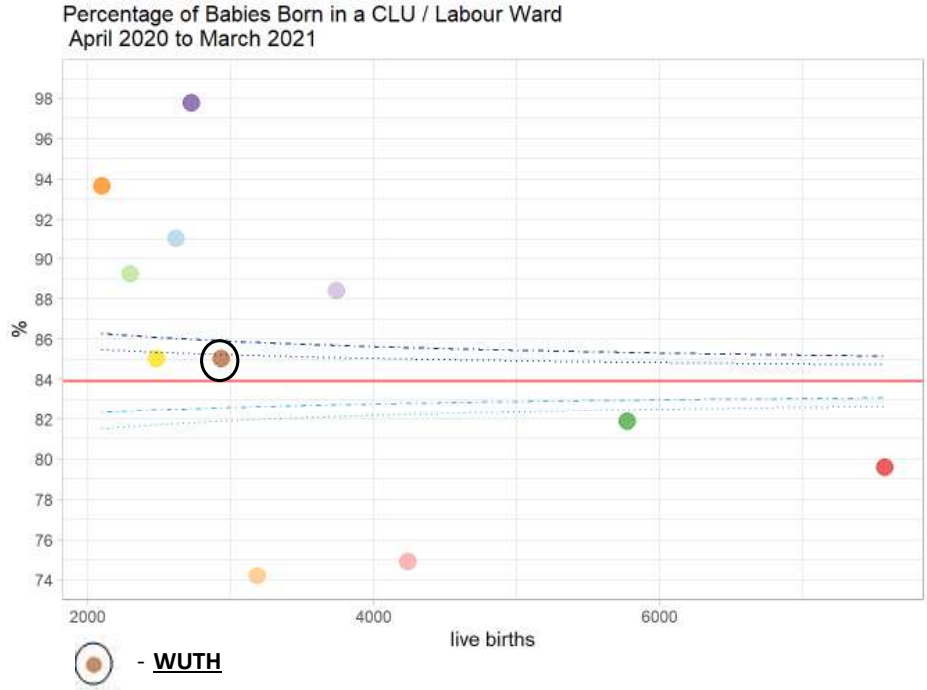


- **WUTH**

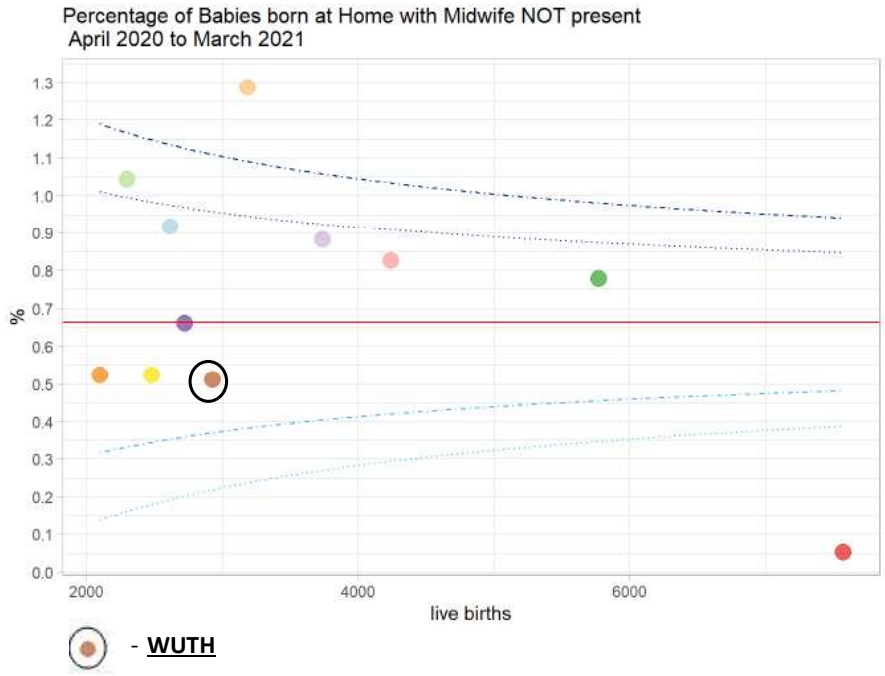
4.2.2 Percentage of Babies Born in a MLU



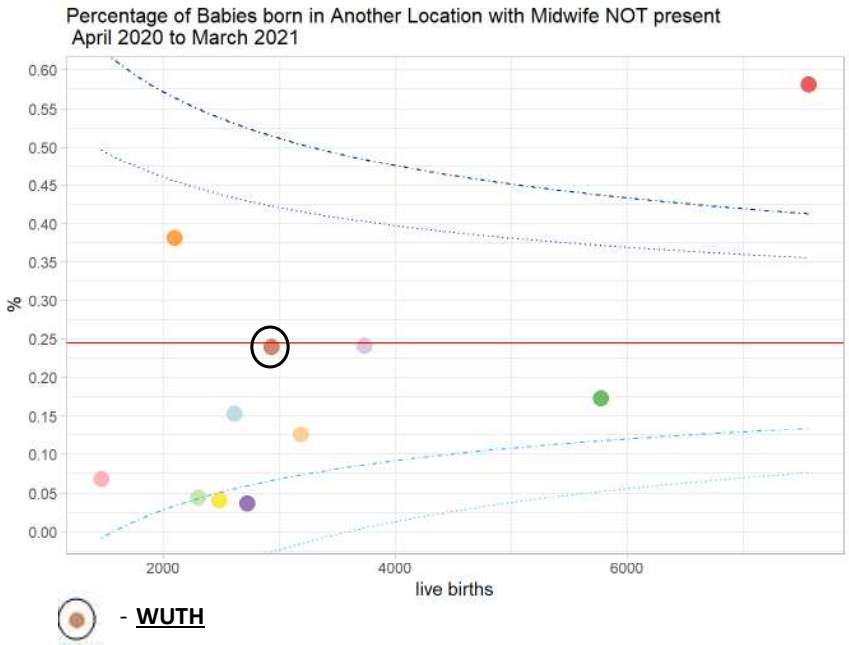
4.2.3 Percentage of Babies Born in a CLU / Labour Ward



4.2.4 Percentage of Babies born at Home with Midwife NOT present



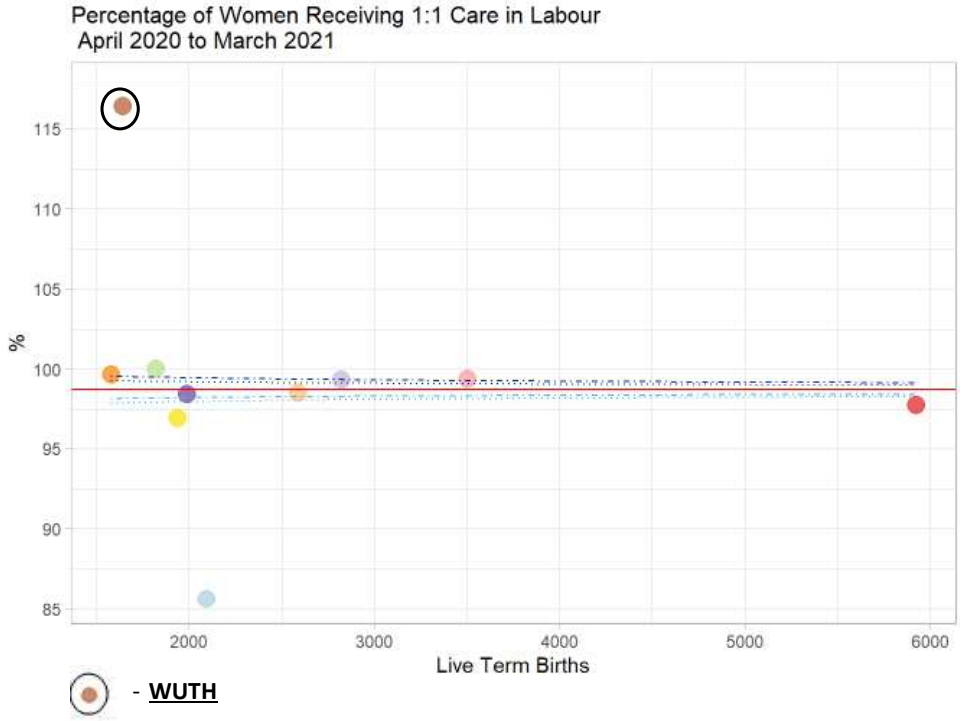
4.2.5 Percentage of Babies born in Another Location with Midwife NOT present



4.3 Care in Labour

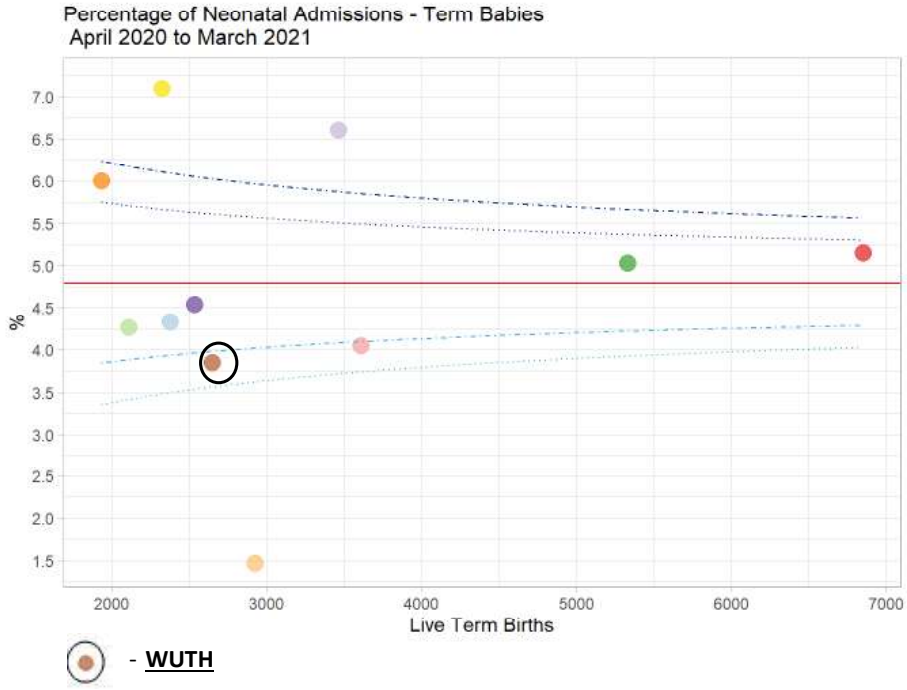
4.3.1 Midwife to Birth Ratio

4.3.2 Percentage of Women Receiving 1:1 Care in Labour



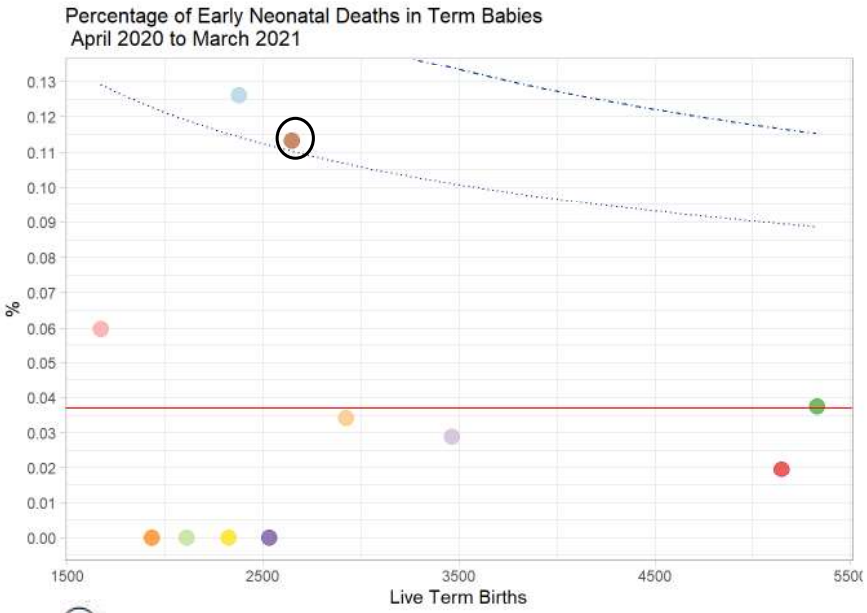
4.4 Neonatal Care

4.4.1 Percentage of Neonatal Admissions in Term Babies



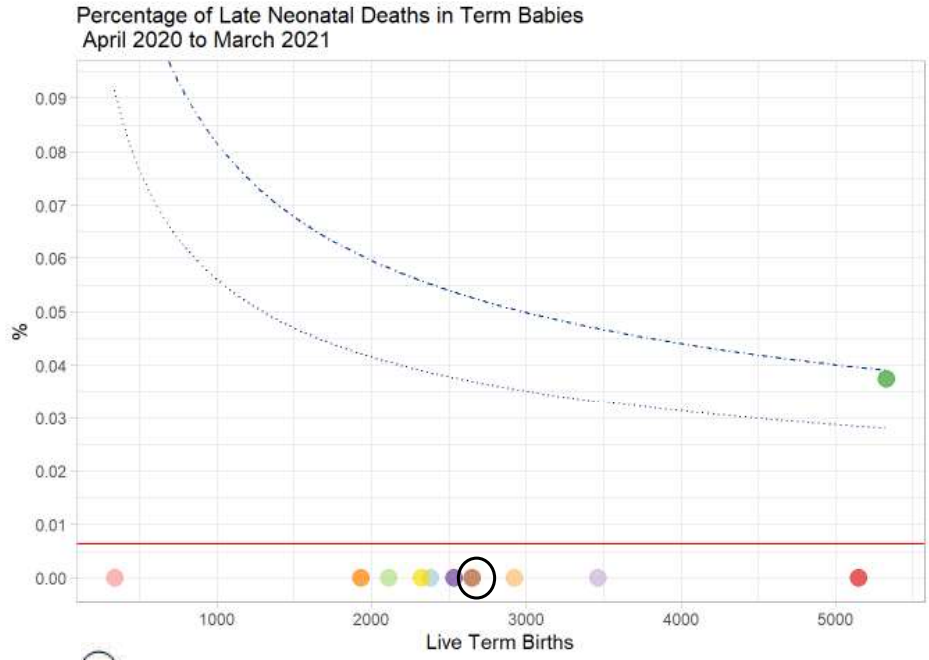
- **WUTH**

4.4.2 Percentage of Early Neonatal Deaths in Term Babies

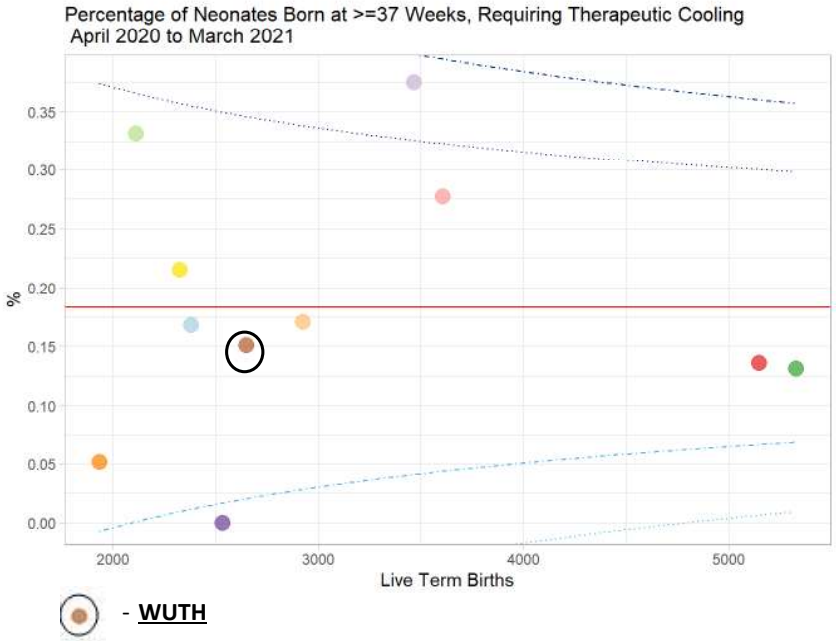


- **WUTH**

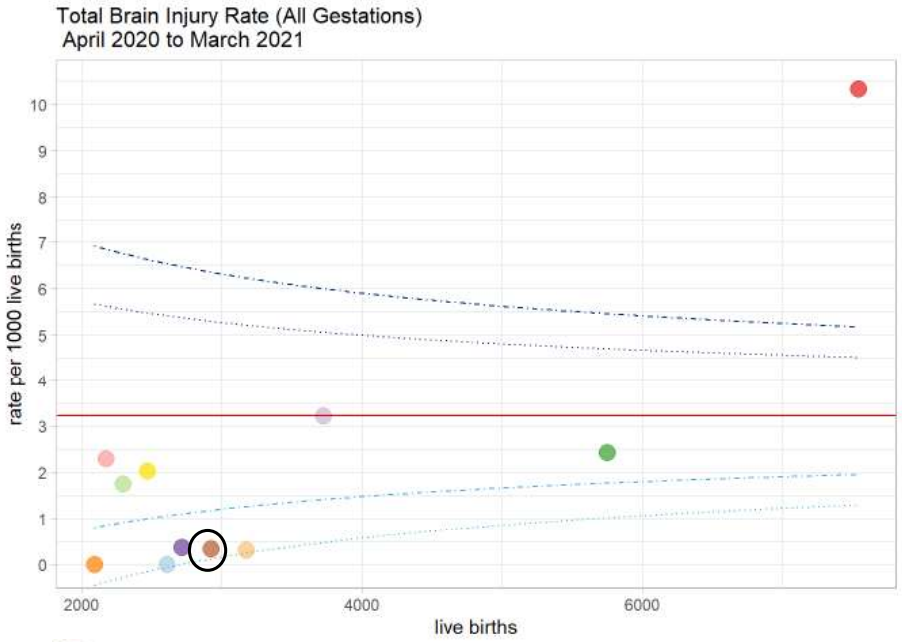
4.4.3 Percentage of Late Neonatal Deaths in Term Babies



4.4.4 Percentage of Neonates Born at >=37 Weeks, Requiring Therapeutic Cooling

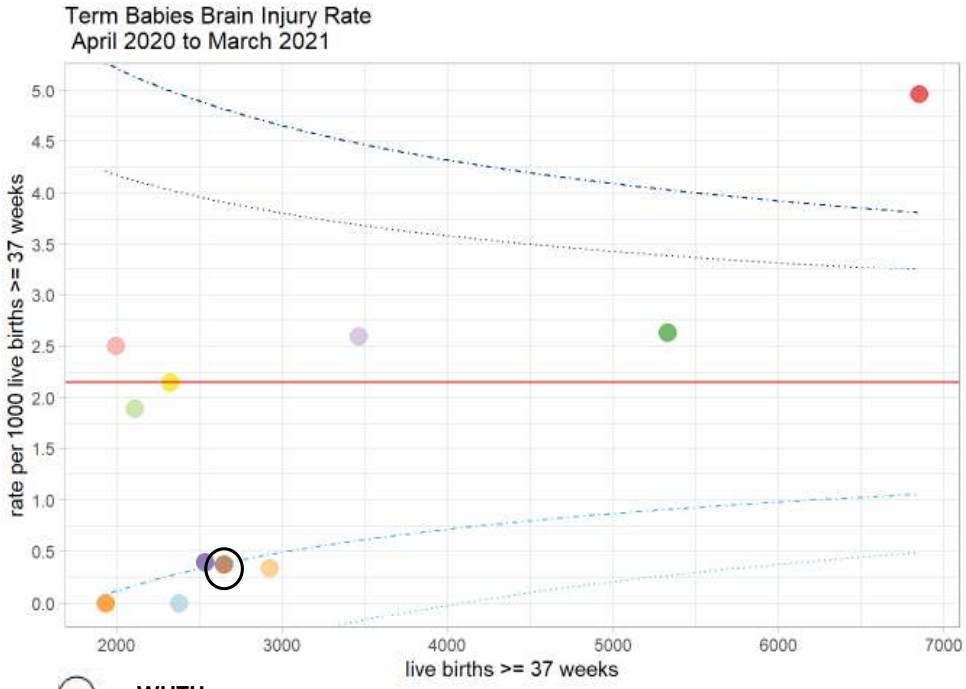


4.4.5 Total Brain Injury Rate (All Gestations)



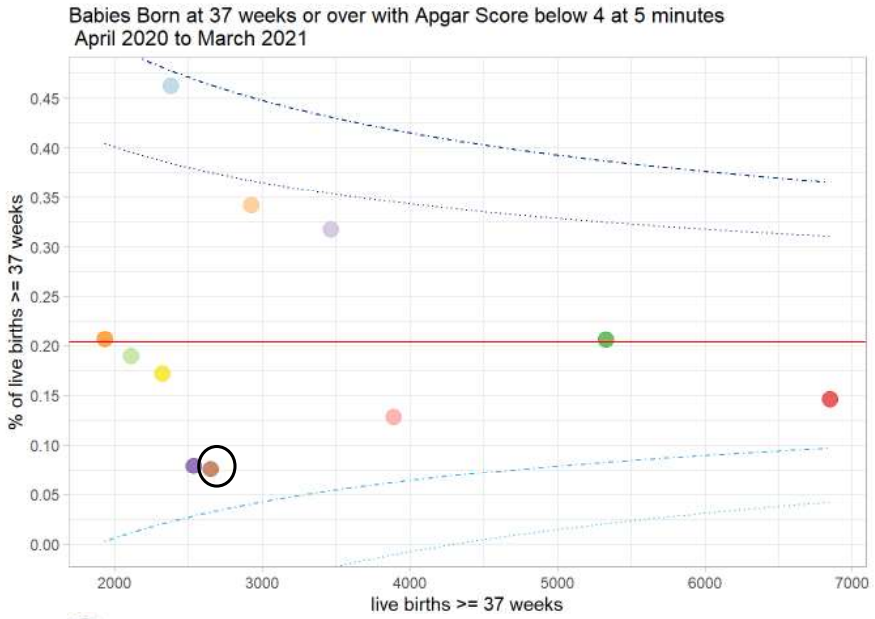
- **WUTH**

4.4.6 Term Babies Brain Injury Rate



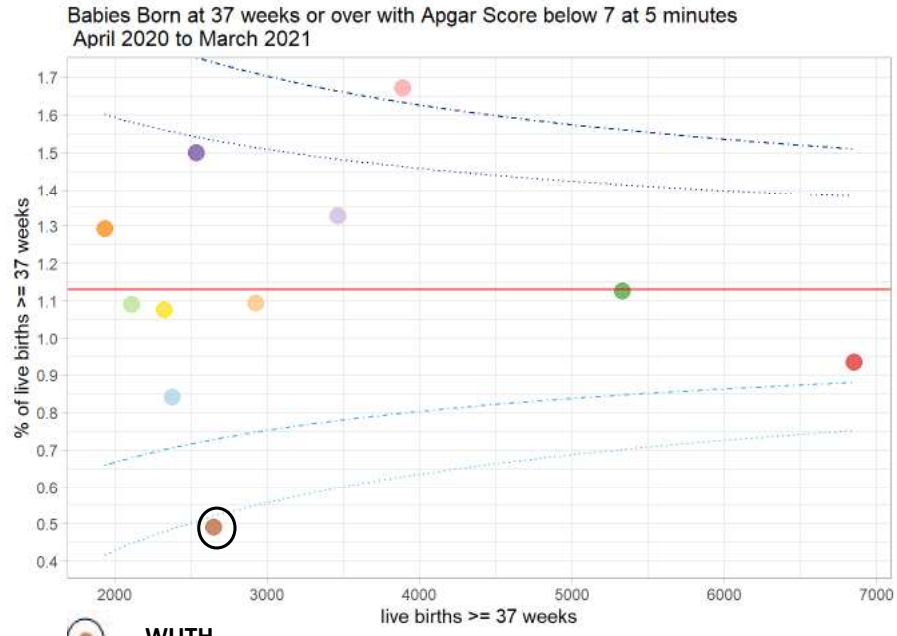
- **WUTH**

4.4.7 Babies Born at 37 weeks or over with Apgar Score below 4 at 5 minutes



- **WUTH**

4.4.8 Babies Born at 37 weeks or over with Apgar Score below 7 at 5 minutes

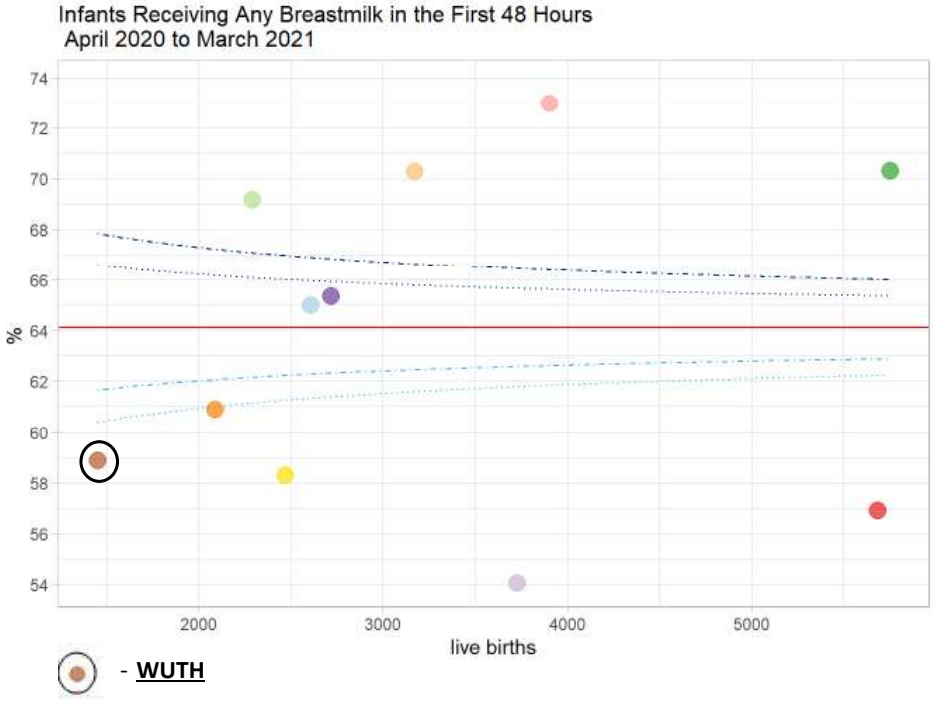


- **WUTH**

5 Health Promotion

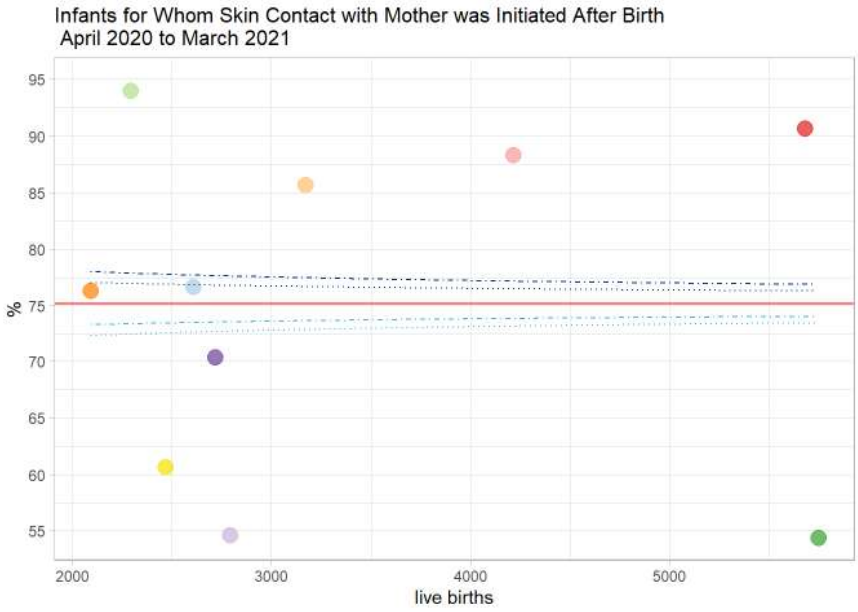
5.1 Breast Feeding

5.1.1 Infants Receiving Any Breastmilk in the First 48 Hours

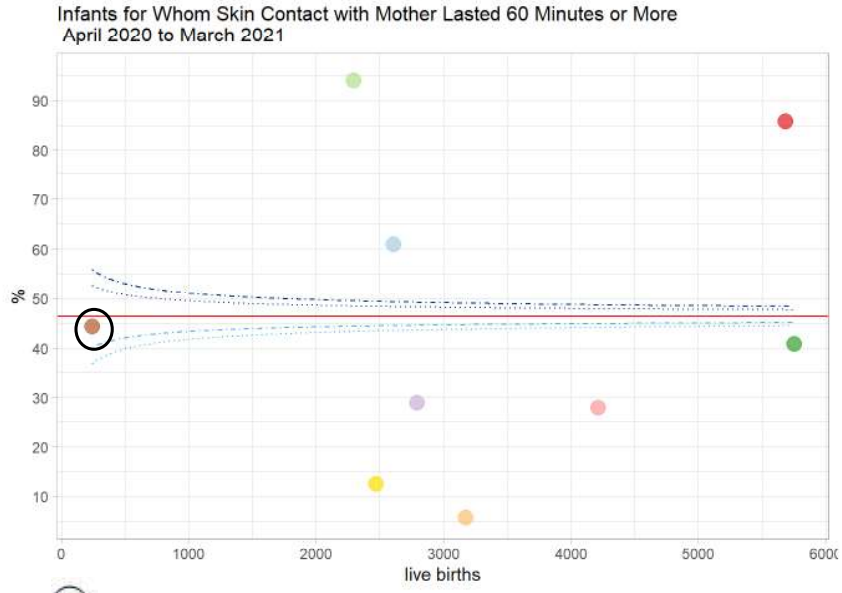


- **WUTH**

5.1.2 Infants for Whom Skin Contact with Mother was Initiated After Birth

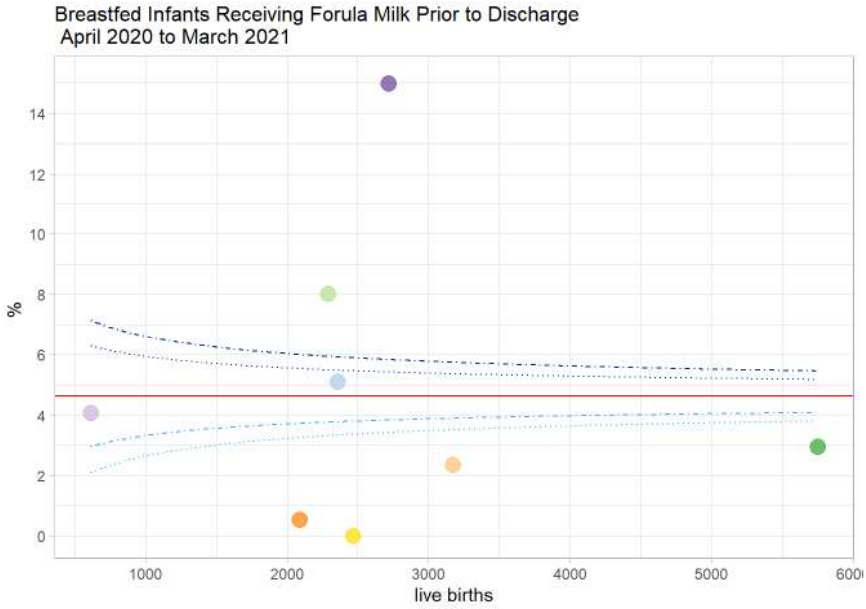


5.1.3 Infants for Whom Skin Contact with Mother Lasted 60 Minutes or More

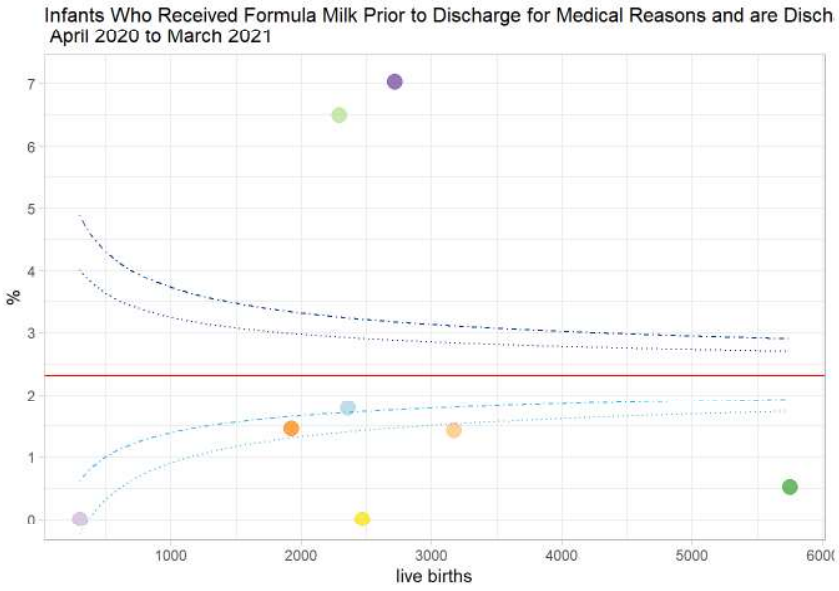


- **WUTH**

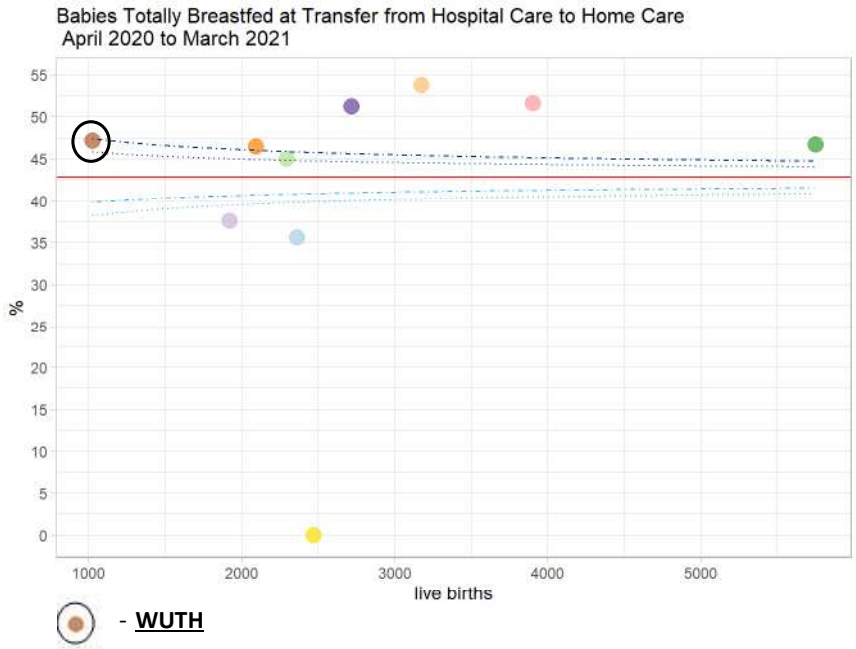
5.1.4 Breastfed Infants Receiving Formula Milk Prior to Discharge



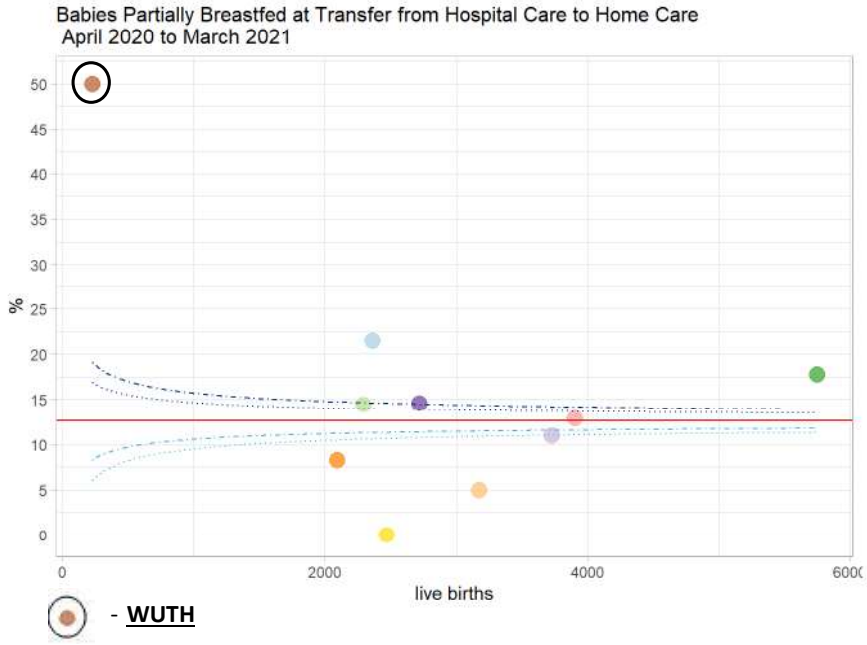
5.1.5 Infants Who Received Formula Milk Prior to Discharge for Medical Reasons and are Discharged Breastfeeding



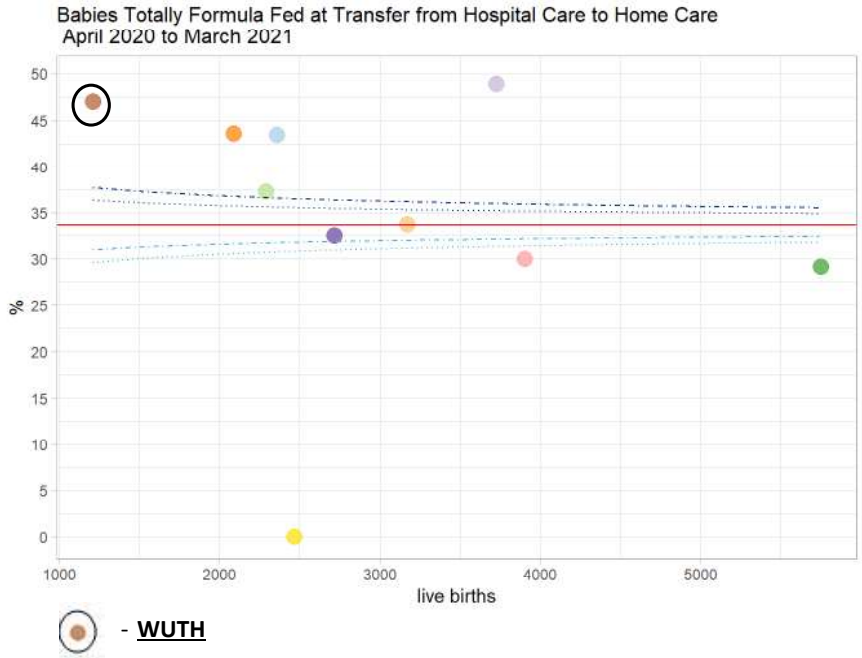
5.1.6 Babies Totally Breastfed at Transfer from Hospital Care to Home Care



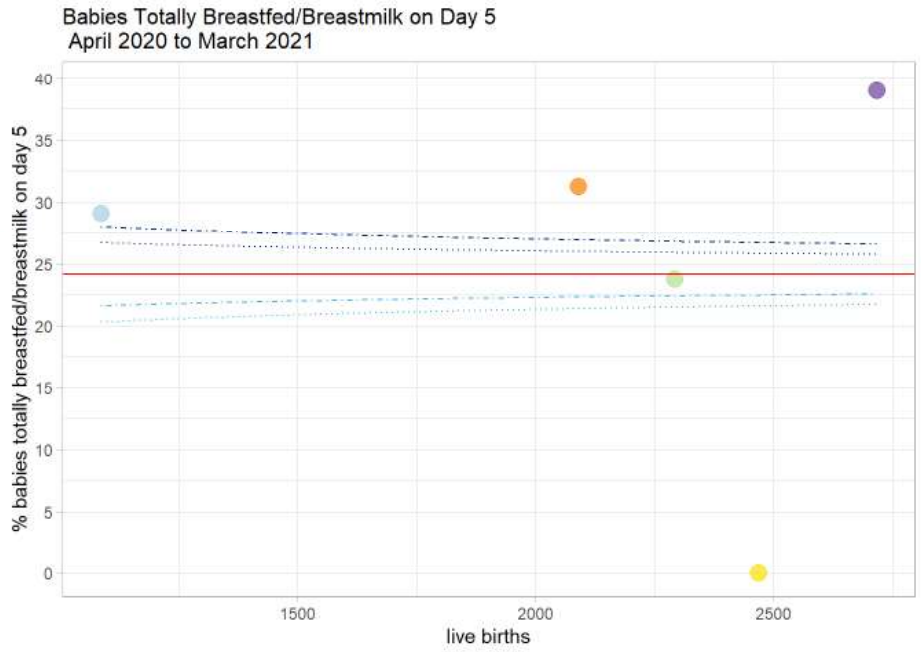
5.1.7 Babies Partially Breastfed at Transfer from Hospital Care to Home Care



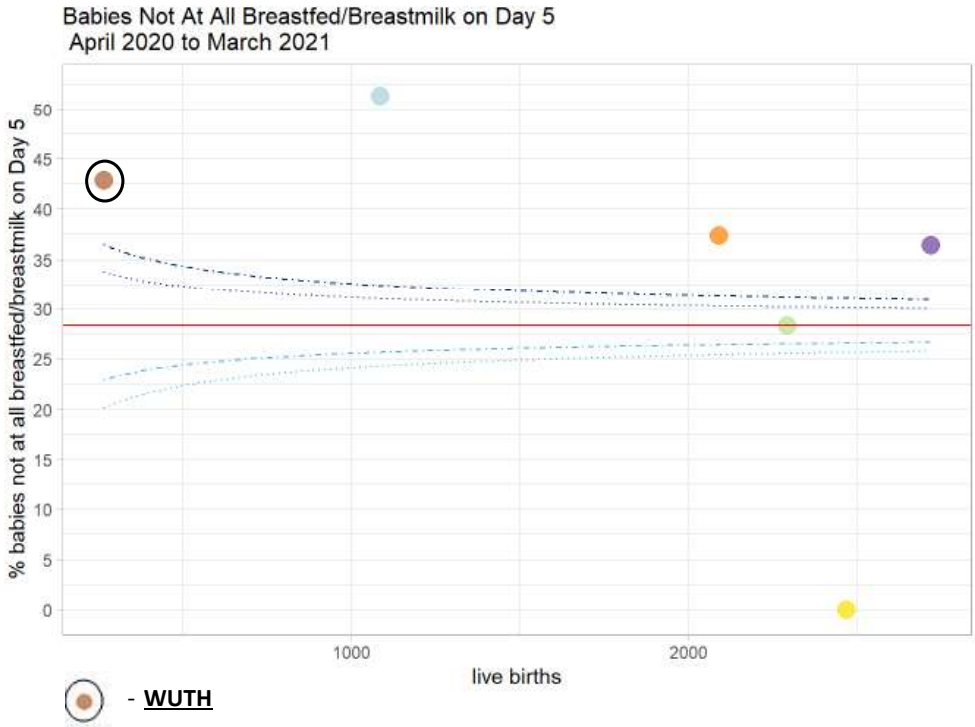
5.1.8 Babies Totally Formula Fed at Transfer from Hospital Care to Home Care



5.1.9 Babies Totally Breastfed/Breastmilk on Day 5

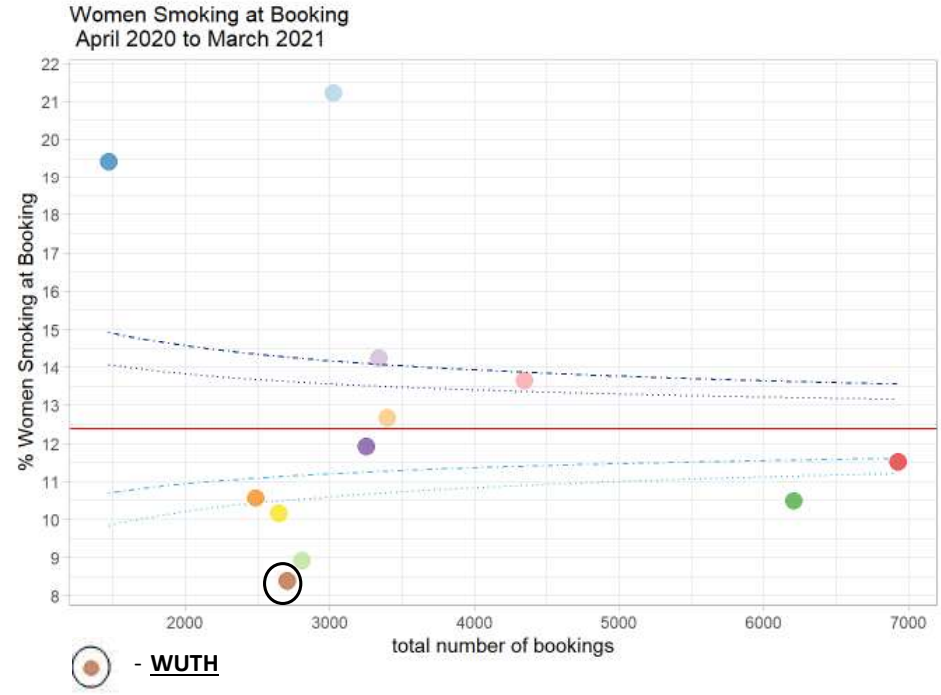


5.1.10 Babies Not At All Breastfed/Breastmilk on Day 5

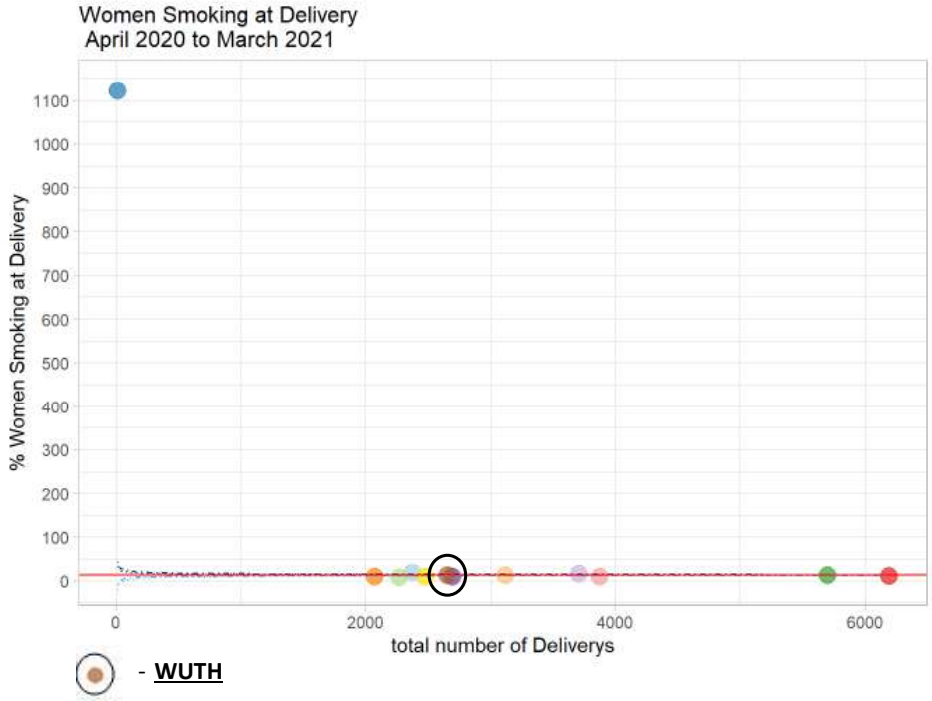


5.2 Smoking in Pregnancy

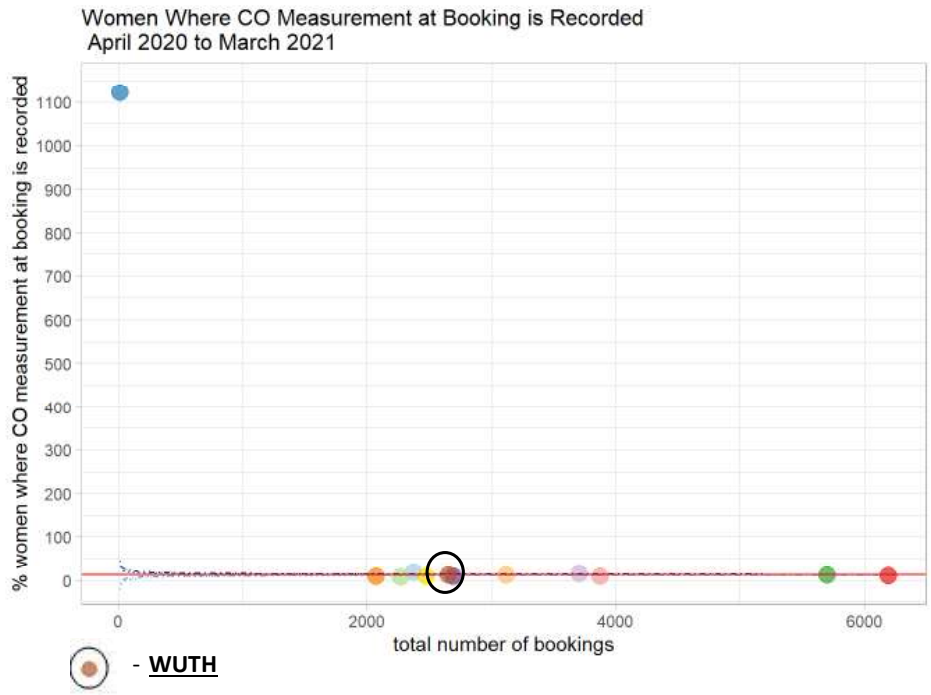
5.2.1 Women Smoking at Booking



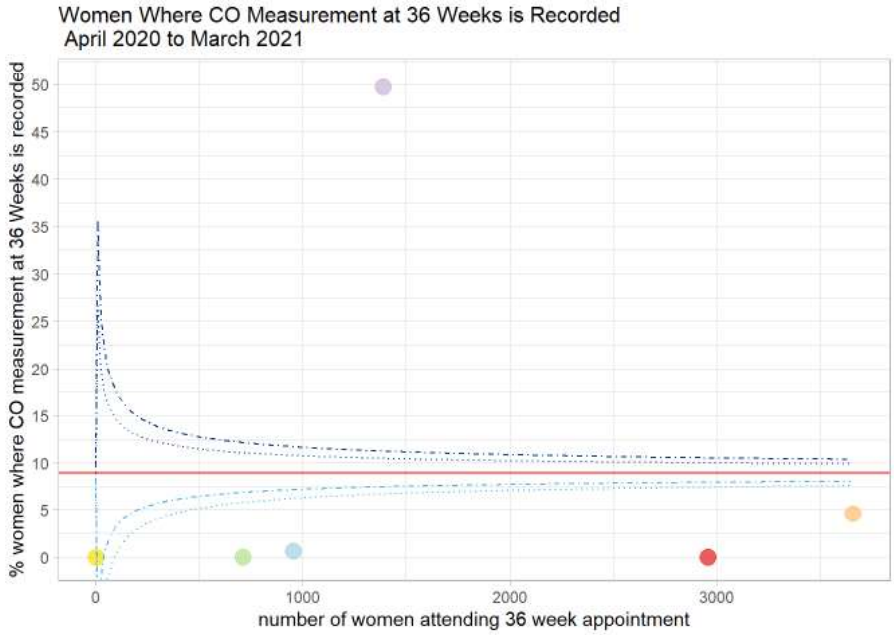
5.2.2 Women Smoking at Delivery



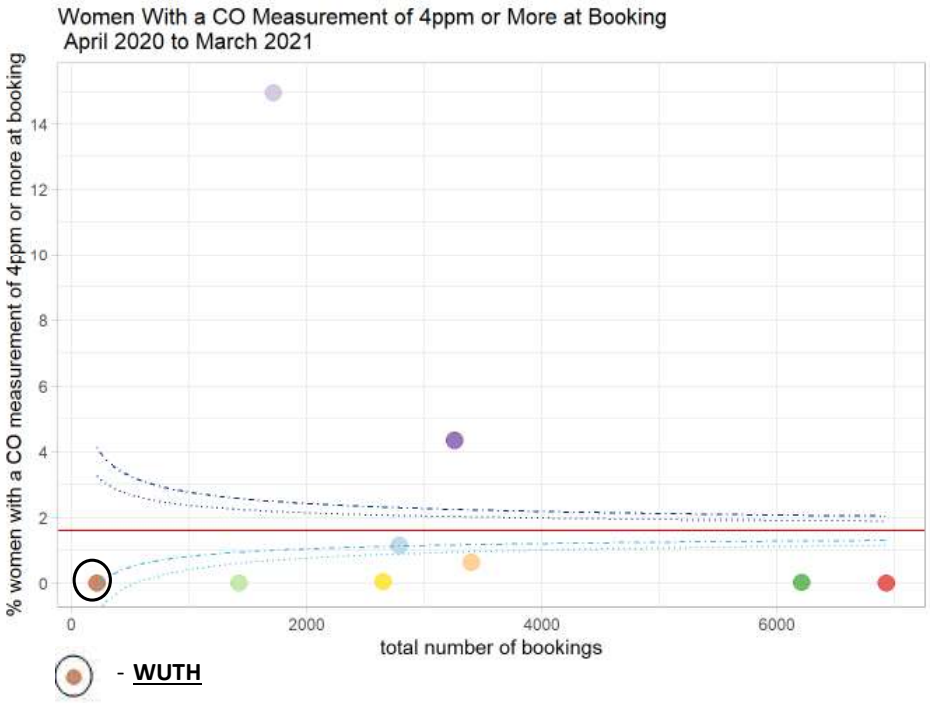
5.2.3 Women Where CO Measurement at Booking is Recorded



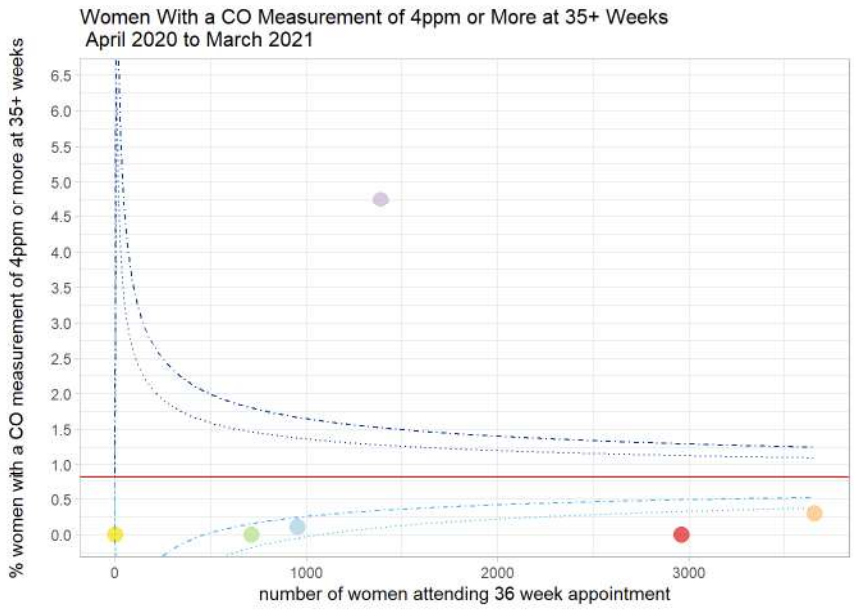
5.2.4 Women Where CO Measurement at 36 Weeks is Recorded



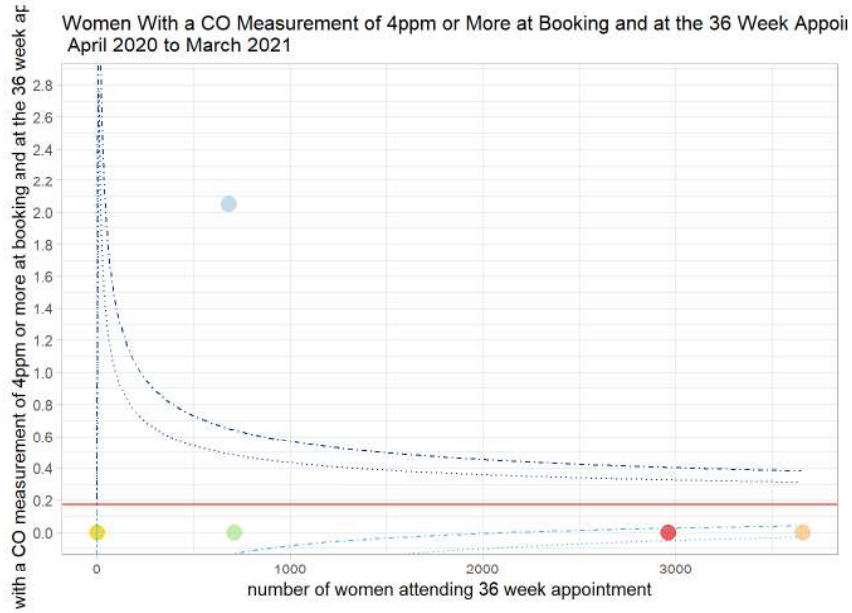
5.2.5 Women With a CO Measurement of 4ppm or More at Booking



5.2.6 Women With a CO Measurement of 4ppm or More at 35+ Weeks

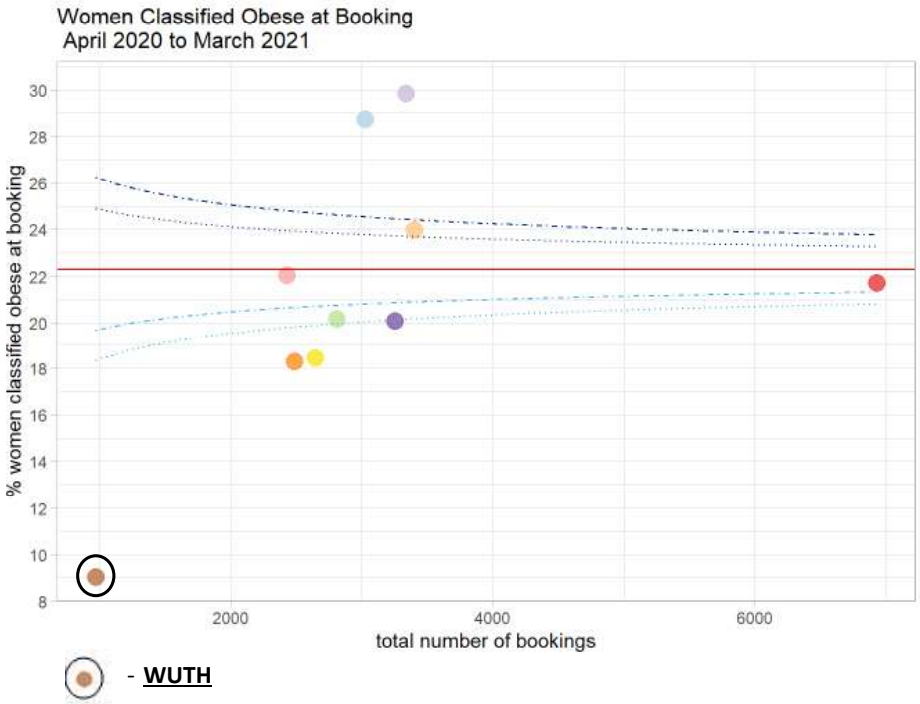


5.2.7 Women With a CO Measurement of 4ppm or More at Booking and at the 36 Week Appointment

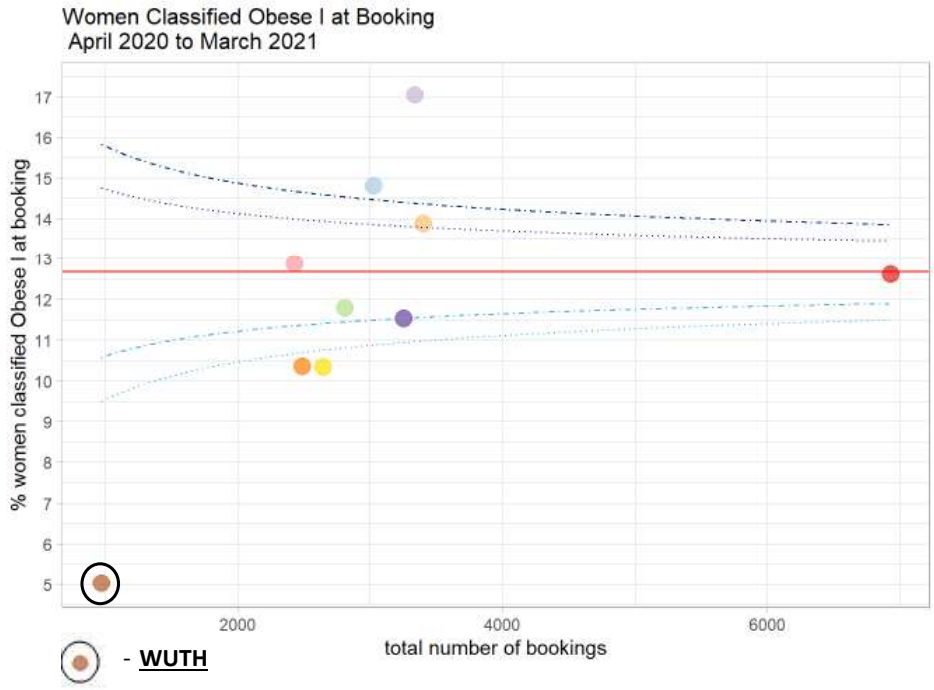


5.3 Obesity

5.3.1 Women Classified Obese at Booking

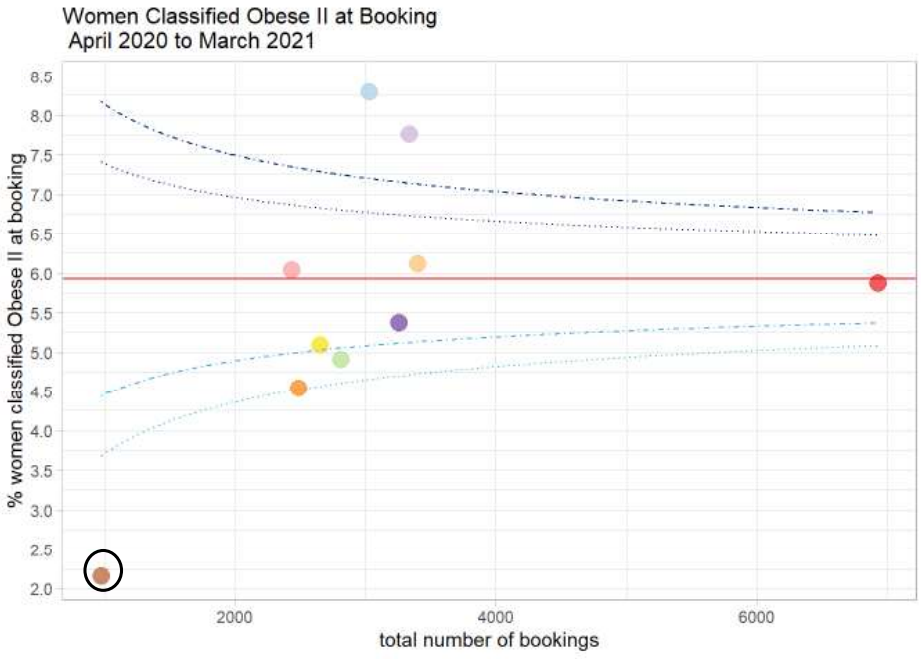


5.3.2 Women Classified Obese I at Booking



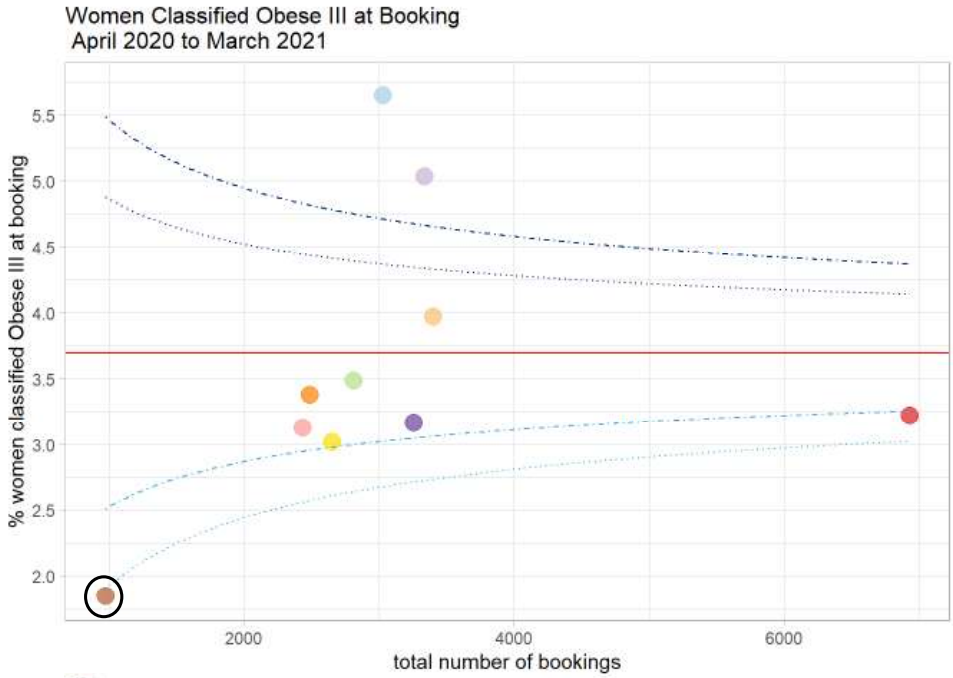
- **WUTH**

5.3.3 Women Classified Obese II at Booking



- **WUTH**

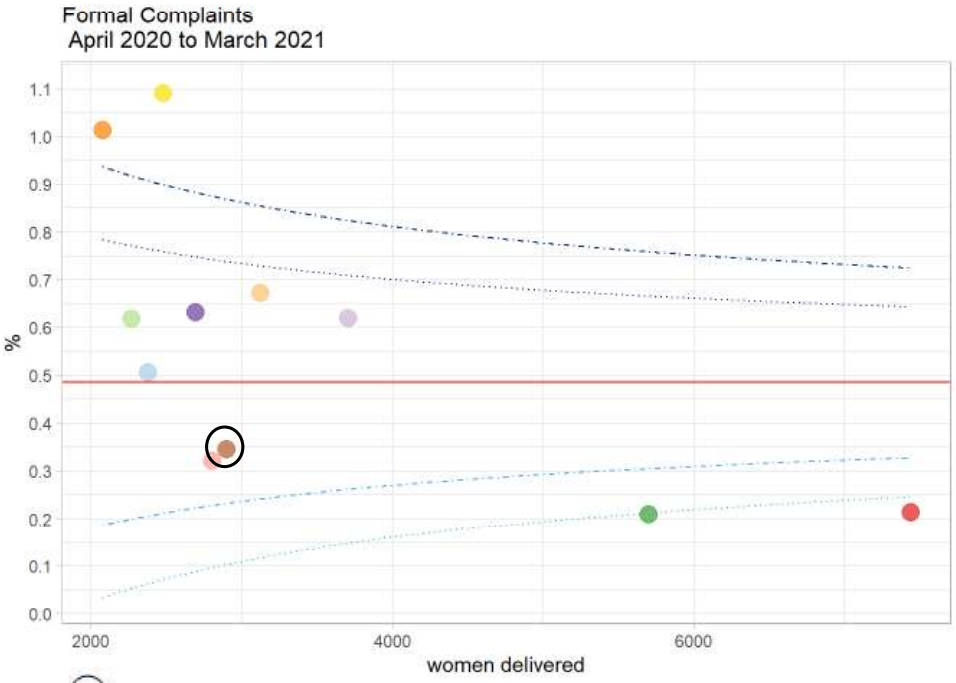
5.3.4 Women Classified Obese III at Booking



- **WUTH**

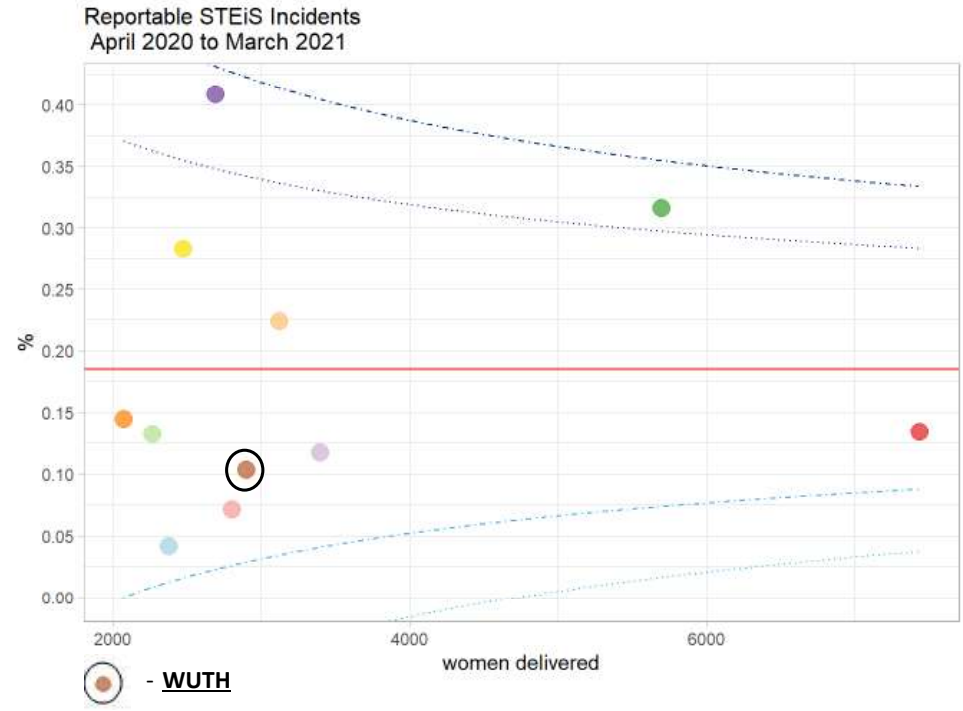
6 Complaints & Incidents

6.1 Formal Complaints

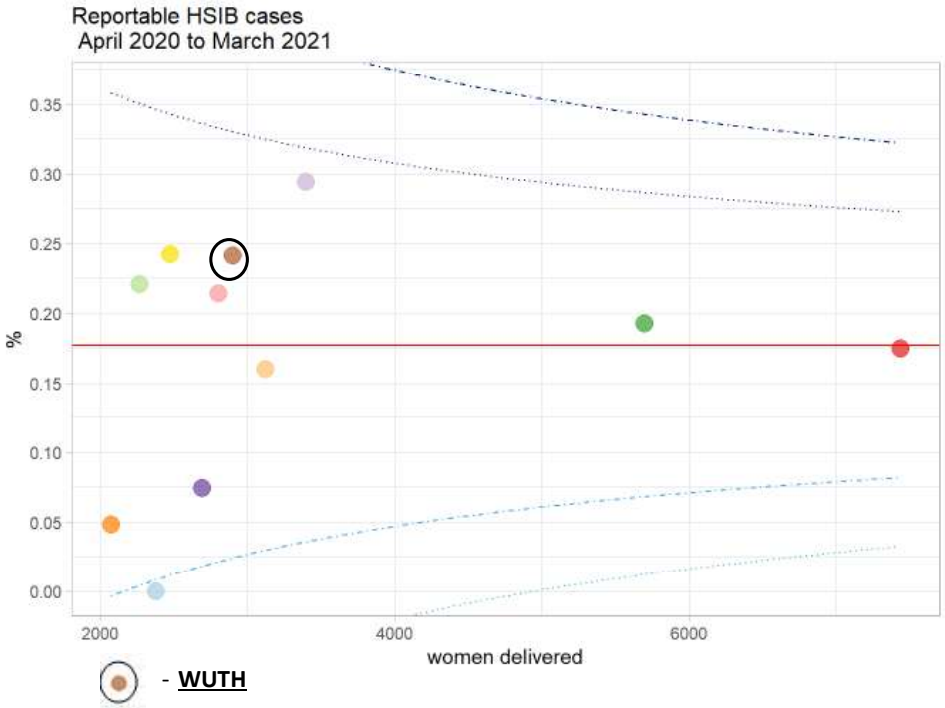


- **WUTH**

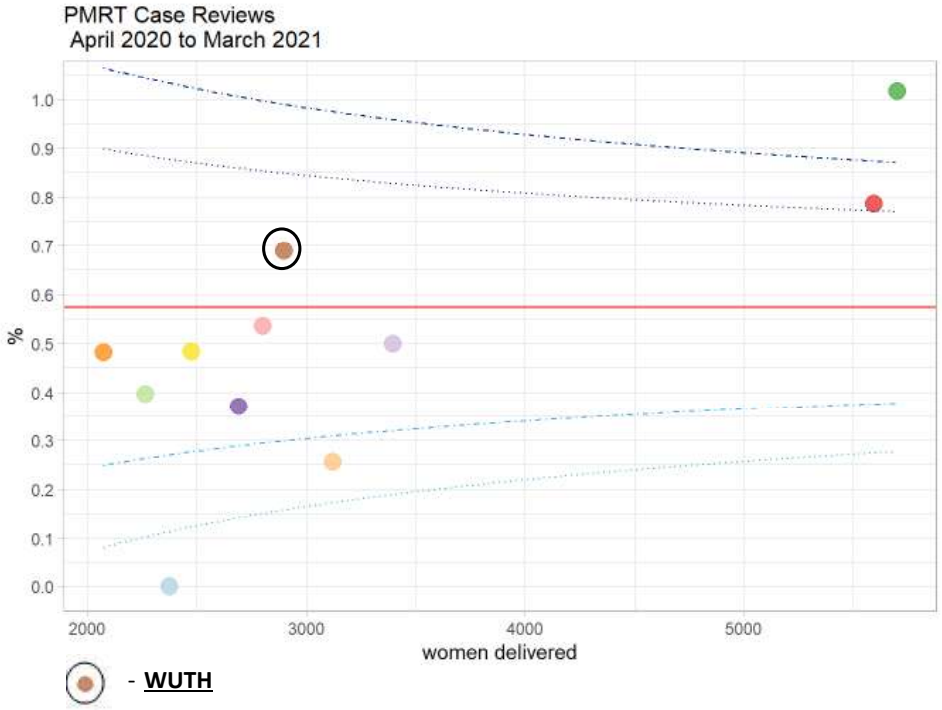
6.2 Reportable STEiS Incidents



6.3 Reportable HSIB cases



6.4 PMRT Case Reviews



Cheshire and Merseyside April 2020 to March 2021

April 2020 to March 2021

Provider	Formal Complaints	Reportable STEiS Incidents	Reportable HSIB cases	PMRT Case Reviews
[redacted]	NA	NA	NA	NA
[redacted]	14	3	5	9
[redacted]	16	10	13	NA
[redacted]	21	7	5	8
[redacted]	21	3	1	10
[redacted]	23	NA	NA	NA
[redacted]	27	7	6	12
Wirral University Teaching Hospital NHS FT	10	3	7	20

Appendix 5

C&M Continuity of Carer (CofC) exception report: May 2021

Introduction

This report outlines the current status of Cheshire and Merseyside (C&M) providers in their bid to achieve the national CoC targets, progress to date.

Background

Within the NHS priorities and operational planning guidance: Implementation guidance (March 2021, p14) it is clear that by March 2023, Continuity of Carer will be the default model of maternity care in England. All providers must have a board level, agreed plan demonstrating how they will achieve this, by July 2021. This plan must be co designed with Midwives, Obstetricians and service users and comply with national principles and standards.

This has refocused attention on Continuity of Carer and whilst the majority of C&M providers revised their CoC models during the first phase of the COVID-19 pandemic to achieve 35% booked on a CoC pathway, there is a need to advance plans significantly across the LMS. The ongoing offer of support and engagement with the national CofC lead professor, together with the regional CoC lead, has provided assurance that CofC progress and improved outcomes for women remains the priority rather than targets. Together with the regional and local teams, the lead professor is providing ongoing mentorship and support to providers in C & M.

In addition to the support offered by the national and regional CofC teams, C&M LMS currently has a Lead Midwife (1 x WTE) and a CofC lead (0.4WTE) to support Trusts. The LMS has also funded 0.4wte (0.6 wte in LWH), band 7 CofC lead in each of the Trusts. Funding for the provider CofC leads roles commenced in April 2019 and is secured until 1st April 2021. 2021-2022 LMS finances are yet to be identified and providers must recognise that this is a commissioned service, the LMS funding may not continue.

C&M LMS has also provided significant investment to facilitate the purchase of equipment Trusts required to aid implementation of CoC teams. In return for the investment, Trusts are required to:

- Attend monthly meetings with the LMS lead midwife, CoC lead and CoC leads from each of the Trusts.
- Provide a timely report each month, detailing the progress made toward the trajectory
- Collate and submit monthly data to the LMS

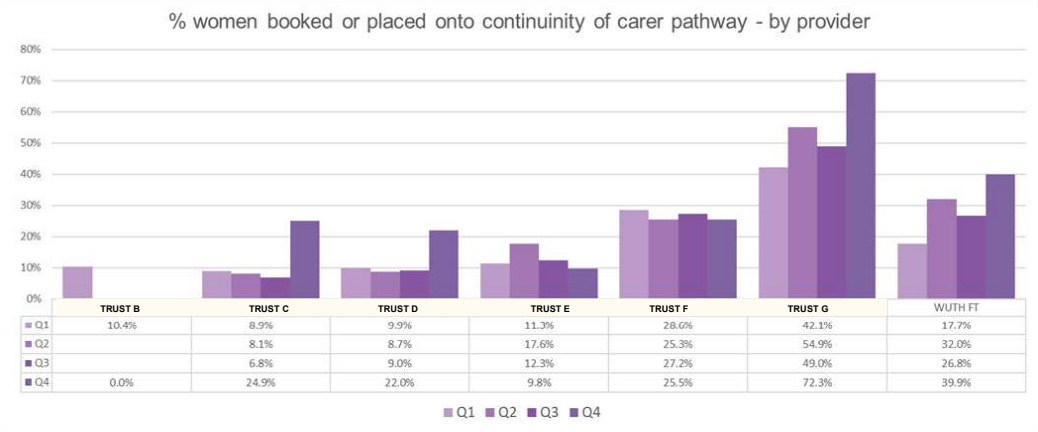
- Engage with the national and regional CofC leads to assist progress.
- Attend the regional CofC meetings chaired by NHSE/I

Progress

The information in the tables below has been extracted from the monthly proformas each provider submits.

As at March 2021 overall the LMS is at 27% against a trajectory of 35%.

This reflects the national picture and is better than expected given the restrictions of the pandemic.



	TRUST B	TRUST C	TRUST D	TRUST E	TRUST F	TRUST G	WUTH FT
Q1	10.4%	8.9%	9.9%	11.3%	28.6%	42.1%	17.7%
Q2		8.1%	8.7%	17.6%	25.3%	54.9%	32.0%
Q3		6.8%	9.0%	12.3%	27.2%	49.0%	26.8%
Q4	0.0%	24.9%	22.0%	9.8%	25.5%	72.3%	39.9%

- Exceptions – to note:

Unfortunately, Trust A was served formal notice in February 2021 and current maternity care provision is under review. The C&M CofC lead resigned from the role in March 2021 and no representative attended the March leads meeting, no data was submitted. As a unique community maternity service offering AN, PN and homebirths, CoC was unable to be progressed.

Moving forward, C&M LMS will calculate two sets of CofC data until a decision on the future of the service Trust A offers is reached. One sets of figures will include Trust A's data and the other will not.

Cheshire & Merseyside Continuity of carer: Provider status April 2021

Cheshire and Merseyside Maternity provider	RAG rating
TRUST A	**No plans identified to achieve 35% CoC**
	No plans identified to achieve 51% CoC
TRUST B	**Plans to achieve 35% CoC in early stages of development**
	No robust plans to achieve 51% CoC as yet
TRUST C	**Robust plans to achieve 35% CoC**
	No robust plans to achieve 51% CoC
TRUST D	**Robust plans to achieve 35% CoC**
	Robust plans to achieve 51% CoC
TRUST F	**Plans to achieve 35% CofC**
	No robust plans to achieve 51% Coc
TRUST G	**No robust plans to achieve 35% CoC**
	No robust plans to achieve 51% CoC
TRUST H	**35% CoC achieved**
	51% CoC achieved
WIRRAL UNIVERSITY TEACHING HOSPITAL (WUTH)	**35% CoC achieved**
	Robust plans to deliver 51% Coc

Conclusion

Delivery of CofC has been challenging for all eight C&M providers. Providers have been required to address staff apathy and reluctance to engage, whilst simultaneously implementing new service delivery with minimal disruption to existing service provision during a pandemic with its accompanying increased workforce pressure and staff exhaustion. Nevertheless providers have progressed their CofC teams during 2020-21 and in January 2021 C&M LMS achieved 32.3% CofC. (**35% of women who are 29 weeks pregnant during March 21 are placed on a CofC pathway).** As expected, once women were transferred onto CofC pathways and caseloads stabilised, this figure reduced in February 2021. The expected C&M LMS CofC for February 2021 will be 20.1% if Trust A is included in C&M calculations and 23% if they are not.

All providers of maternity care are committed to delivering CofC to the women of C&M so that they may benefit from the improved outcomes and benefits that this model of care yields. The decision to change how CofC is measured in March 2021, and the resultant data that is generated, may not reflect the hard work that has been occurring to implement

It is acknowledged that the new CofC measure may impact on the final CofC data submission in March 2021. The combined effort within C&M to achieve CofC has been recognised and has provided assurance that CofC within C&M is progressing.

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: BM21/22-090

BOARD OF DIRECTORS
7 July 2021

Title:	Monthly Safe Nurse Staffing Report
Author :	Tracy Fennell - Deputy Chief Nurse Johanna Ashworth Jones – Programme developer, Corporate Nursing Team
Responsible Director:	Hazel Richards - Chief Nurse and Director of Infection Prevention and Control (DIPC)
Presented by:	Hazel Richards - Chief Nurse and Director of Infection Prevention and Control (DIPC)

Executive Summary

RN band 5 vacancy rate has reduced further to 13.97% (M2) due to the success of the International Recruitment Programme. 42 delayed international nurses are expected to arrive in the Trust in July 2021. Interviews are underway for future cohorts planned to arrive from August 2021.

CSW vacancy rate has reduced to 2.99% (M2). Weekly recruitment is ongoing to ensure an ongoing number of CSWs are available via the “talent pool”.

RN sickness reduced to 5.92% (M2) however CSW sickness increased to 10.04% (M2) due to short term sickness in specific areas in the Medical Division and the Emergency Department.

The number of shifts that fell below minimum RN staffing levels increased by 104 shifts however these gaps were filled by supernumerary international nurses awaiting their PIN numbers.

There has been an increase in episodes where care standards fell below expected levels when lower staffing levels have not been planned. A number of these relate to 1 medical ward, appropriate action has been taken to ensure effective leadership and enhanced monitoring is in place. The surgical division show an increase in episodes where care standards fell below expected levels due to a spike in RN sickness on two wards.

Recommendation: (e.g. to note, approve, endorse)
To note

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	Yes

best value	
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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)

BAF references 1,2,4,6.
Positives.

- RN vacancy rate has reduced to 13.97%
- CSW vacancy rate has reduced to 2.99%
- 42 International nurses are planned to arrive in July now flight restrictions have been lifted.
- Enhanced local recruitment to commence from July 2021.
- 9 additional offers have been accepted from international nurses to arrive in August , further interviews are scheduled for July 2021
- Maternity staffing levels remain within the agreed recommended Birth Rate Plus parameters.

Gaps.

- CSW sickness has risen to 10.04%
- A rise in short term RN sickness has been noted in SEU (ward 17) and ward 14.
- 1 ward in medicine some wards in the surgical division have noted increase in care standards falling below expected levels.

Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)

NHSI – developing Workforce Safeguards , CQC Essential Standards

Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)

Nursing expenditure

Specific communications and stakeholder /staff engagement implications

Stakeholder confidence

Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)

NMC Code , NHS Constitution, NHS People Plan

Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)

NA

FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No

Previous considerations by the Board / Board sub-committees	Monthly safe nurse staffing report to Board since October 2020
Background papers / supporting information	

BOARD OF DIRECTORS
7 July 2021

Monthly Safe Nurse Staffing Report

Purpose

This report provides the Board of Directors with information regarding safe nurse staffing and the actions to improve the vacancy rates.

1 Current position: areas to note

1.1 Vacancies

RN band 5 vacancy rate has reduced further to 13.9% (M2) due to the benefits of the International Recruitment Programme. The travel restrictions that were imposed following the recent increase of COVID infections in India have now been lifted. As a result arrangements are in place for the 42 delayed nurses to arrive in the Trust early July. They will undertake their Objective Structured Clinical Examination and move to working on the wards in August 2021.

Interviews have also commenced for the next cohorts of international nurses planned to arrive in August / September 2021, 9 offers of employment that have been made so far have been accepted.

CSW vacancy rate has reduced to 2.99% (M1) from 5.82% (M2). Recruitment checks are ongoing for individuals progressing into the remaining vacancies. Recruitment is also ongoing to ensure the CSW “talent pool” is available to enable an ongoing supply of CSWs for immediate recruitment for future vacancies.

1.2 Sickness

RN sickness has reduced overall to 5.92% (M2) from 5.96% (M1). RN absence has also reduced from 0.07% (M1) to 0.03% (M2).

A higher RN sickness has been noted in some surgical wards predominately SEU (Ward 17) and Ward 14. 14 episodes of RN sickness were noted on SEU (Ward 17) in May equating to 685 hours. The majority of these episodes are reported as on day sickness. This also led to an increase in the number of staff moves and missed breaks as staff ratios become diluted when staff were dispersed across the wards to mitigate risks. This spike in sickness has also caused an increase in the number of episodes where care standards fell below expected levels across the surgical division.

CSW sickness has seen an increase to 10.04% (M2) from 8.46% (M1) this is due to an increase in short term sickness in the general medical wards and the Emergency Department. Wards are being supported by HR colleagues with sickness clinics to ensure

sickness is managed in line with policy. Health and wellbeing initiatives continue and the Staff Support Team has been reinstated offering ongoing reassurance and support to staff.

1.3 Safe Staffing Oversight Tracker (SSOT) review

During M2 the SSOT reported the number of shifts that fell below minimum RN staffing levels as 427, an increase of 104 shifts since M1. A large number of these shifts relate to the commencement of the international nurses working on the ward who are awaiting their PIN number and are classed as supernumerary. These shifts have been assessed by the Senior Nursing Team as a professional judgement of green (low risk of care standards falling below expected levels).

1.4 Impact on Care

There has been an increase in episodes where care standards fell below expected levels when lower staffing levels have not been planned. A number of these relate to a medical ward that has been reviewed, support given, improvements made, and remains monitored. The WISE assessment will be undertaken in the coming weeks to understand progress.

10 shifts were recorded where staff were not available to provide 1:1 observation for patients who were high risk of falls. These risks were mitigated using “bay tagging” processes. The lead nurse for falls has reviewed the all the falls that occurred on shifts where staffing levels were lower than the planned minimum staffing levels. This review concluded none of the 21 falls recorded in the SSOT were deemed to be a result of short staffing during M2.

1.5 Staff Moves

There has been an increase in staff moves this month to 341 (M2) from 288 (M1). This has been to cover the areas that have had increased short term sickness.

2. Actions to mitigate risks

To aid retention the Trust has recruited a Preceptorship Lead to enhance pastoral support and clinical competence through a revised Preceptorship Programme. This programme aligns to the International Nursing Pastoral Support and Development Programme that has already commenced.

A review is underway of workforce data to establish plans to retain other high risk groups of staff. This will be presented to Workforce Steering Group in Q2.

Recruitment plans have also been reviewed to enhance our current marketing to also attract local talent. Enhanced local recruitment drives will commence from July 2021.

3. Maternity staffing.

Maternity staffing is monitored every 4 hours using the Birth Rate Plus Acuity Tool. This process is being replaced by the Birth Rate Plus Application which will have the ability to produce reports which will include red flags, missed staff breaks and delays in care. The

Trust commenced piloting the new application from the end of June and will progress to providing full reports in line with the Trusts adult ward SSOT by the end of Q2.

Using Birth Rate Plus the ratio of births to midwife continues to be 1:27 which is within agreed parameters (1:22-1:29).

The Birth Rate Plus draft report has been received into the Trust and this has identified a shortfall in midwifery staffing should the maternity teams exceed its current Continuity of Carer rate of 35%. A verbal update was provided at June 2021 Workforce Steering Board with an agreement to present a paper in Q2 outlining the requirements that will be required to implement 51% Continuity of Carer by March 2022 and 100% Continuity of Carer by the end of 2023 as per NHSE planning guidance.

In response a bid has been submitted to NHSE to gain funding to support an increase in midwifery staffing – the outcome of which is awaited. The bid has included a request for 6 WTE Band 6 midwives and a total of 12 WTE Band 5 midwives – this will provide an uplift of 24% and will enable the Trust to roll out of Continuity of Carer to 100% should this be approved.

4. Conclusions

RN vacancies continue to reduce due to the benefits of the International Recruitment programme. 42 international nurses who had been delayed due to flight restrictions will arrive in July 2021. Further international and local recruitment interviews are planned throughout July 2021.

A large number of shifts have been reported where staffing numbers are below minimum agreed staffing levels however these wards have been supplemented by supernumerary international nurses awaiting their PIN numbers.

Some surgical wards have seen a spike in short term sickness leading to greater staff moves, missed breaks and an increase in the number of episodes where care standards fell below expected levels.

One ward in the Medicine Division is flagging as an area where care standards have fell below expected levels. Action has been taken divisionally to ensure effective leadership is in place and corporately to ensure enhanced monitoring is maintained.

Maternity staffing levels remain within the agreed recommended Birth Rate Plus parameters.

4. Recommendations to the Board

The Board of Directors are requested to note the contents of report.

Appendix 1 – Safe staffing dashboard July 2020- February 2021

APPENDIX 1

	Safe Staffing Board Assurance Dashboard 2020 /21 - 2021/2022												
Data Source	Indicator	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Spark line
Corporate Nursing	Care Hours Per Patient Day - Total		9.6	8	8.5	10.1	9.5	8.1	8.9	9	8.7	8.3	
Corporate Nursing	Care Hours Per Patient Day - Registered Nurses		4.8	3.8	4.1	5.2	4.8	4	4.3	4.4	4.1	4.1	
Corporate Nursing	Care Hours Per Patient Day - CSW's		4.2	3.5	3.7	4.1	3.8	3.4	3.7	3.8	3.5	3.5	
Corporate Nursing	Number of ward below 6.1 CHPPD		0	2	0	0	0	1	1	0	1	4	
Corporate Nursing	National Fill rates RN Day		79%	76%	83%	84%	85%	79%	81%	83%	84%	83%	
Corporate Nursing	National Fill rates CSW Day		76%	86%	89%	94%	88%	86%	91%	91%	92%	93%	
Corporate Nursing	National Fill rates RN Nights		94%	72%	79%	81%	82%	77%	84%	78%	84%	80%	
Corporate Nursing	National Fill rates CSW Nights		97%	90%	104%	100%	99%	95%	71%	101%	98%	99%	
Informatics	Trust Occupancy Rate	57.20%	66.90%	79.50%	79.50%	76.10%	79.30%	83.50%	80.20%	80.80%	81.40%	83.90%	
Informatics	Occupancy Rate - APH	63.10%	72.10%	81.50%	79.10%	76.00%	80.30%	82.30%	80.30%	83.50%	83.90%	86.70%	
Informatics	Occupancy Rate - CBH	16.00%	24.90%	51.90%	46.10%	39.00%	37.90%	50%	50%	52%	55%	55%	
Workforce	Vacancy Rate (Band 5 RN's)	18.46%	18.05%	16.94%	16.61%	17.66%	18.10%	19.42%	18.81%	18.57%	15.92%	13.97%	
Workforce	Vacancy rate (Band 5 inpatient wards)	20.57%	20.16%	18.73%	17.11%	17.72%	18.49%	19.89%	19.01%	17.92%	15.35%	12.59%	
Workforce	Vacancy Rate - All RN (All grades)	9.81%	9.90%	9.40%	8.67%	9.79%	9.57%	10.79%	10.03%	9.69%	8.26%	7.47%	
Workforce	Vacancy Rate (CSW's)	5.89%	5.86%	7.86%	7.77%	8.11%	6.28%	6.79%	5.94%	5.97%	5.82%	2.99%	
Workforce	Sickness Rate - RN	5.69%	6.12%	6.38%	6.80%	6.95%	6.49%	9.17%	7.14%	6.01%	5.96%	5.92%	
Workforce	Sickness Rate - CSW	10.46%	9.58%	10.09%	8.82%	7.59%	8.18%	12.34%	9.47%	8.11%	8.46%	10.04%	
Workforce	Absences Rate - RN	4.84%	2.36%	2.60%	1.55%	1.76%	1.50%	2.39%	1.78%	2.24%	0.07%	0.03%	
Workforce	Absences Rate- CSW	4.96%	3.33%	3.17%	1.55%	2.17%	1.56%	2.64%	2.71%	2.47%	0.05%	0.14%	
Corporate Nursing	Number of Professional Judgment Red Shifts		1	0	0	0	0	0	0	0	0	0	
Corporate Nursing	Number of RN Red Shifts *		359	445	454	243	499	689	330	383	323	427	
Corporate Nursing	RN Red Shift Impact : Number of Falls		7	9	17	4	19	26	36	16	16	21	
Corporate Nursing	RN Red Shift Impact : Number of Falls with Harm		0	1	1	0	0	0	1	1	0	0	
Corporate Nursing	RN Red Impact : Meds Errors / Misses		3	0	7	1	27	2	1	27	2	2	
Corporate Nursing	RN Red Impact : Patient relative complaints		2	0	3	0	0	1	2	0	0	1	
Corporate Nursing	RN Red Impact : Staffing incident submitted		6	16	18	7	23	33	6	14	14	9	
Corporate Nursing	RN Red Impact : Special 1:1 (uncovered)		3	7	9	0	26	38	2	3	1	10	
Corporate Nursing	RN Red Impact: Missed Breaks		14	26	26	10	107	119	34	41	42	71	
Corporate Nursing	RN Red Impact: Delayed / Missed Obs		10	19	122	1	287	278	31	126	75	248	
Corporate Nursing	RN Red Impact: Delayed / Missed nMEWS		12	33	12	31	239	237	72	286	90	226	
Corporate Nursing	RN Red Impact: Delayed / Missed Pressure Care		3	14	24	23	145	46	23	58	15	43	
Corporate Nursing	RN Red Impact : Delayed Meds		8	20	127	6	582	299	88	193	55	199	
Governance support	Number of SI's where staffing has been a contributing factor	0	0	0	0	0	1	1	0	1	0	0	
Corporate Nursing	Total Number of staffing incidents	30	53	80	75	25	90	102	42	57	48	93	
Complaints team	Formal complaints in relation to staffing issues	0	0	0	0	1	0	0	1	0	0	1	
Complaints team	Informal Concerns raising staffing levels as an issue	0	0	0	1	0	0	1	0	1	0	0	
Corporate Nursing	Patient Experience feedback raising staffing levels as a concern	0	0	0	0	0	0	0	0	0	0	1	
Corporate Nursing	Staff Moves		232	329	140	164	172	606	337	337	288	341	
NHS Professional	Number of RN hours requested	19909	22878	24734	28432	31103	28638	43952	35299	34182	24465	24192	
NHS Professional	Number of CSW hours requested	20155	25196	25007	32505	28386	30651	42759	33056	30218	24122	24171	
NHS Professionals	% of requested filled RN's	67.80%	62.80%	61.70%	60.20%	72.70%	58.90%	57.50%	54.60%	62.80%	64.50%	68.22%	
NHS Professionals	% of requested CSW filled	86.30%	80.20%	76.50%	71.10%	85.30%	68.10%	62.80%	68.00%	75.00%	77.60%	84.20%	
NHS Professionals	% of Agency staff used RN	3%	3%	3%	2%	6%	1%	2.30%	7.00%	7.00%	5.00%	1.70%	
NHS Professionals	% of Agency staff used CSW	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	

** The National Safe Staffing submission reports the total actual hours filled against the agreed funded establishment. RN Red shifts are defined as shifts that are below both the agreed funded establishment and below the agreed minimum staffing model.*

*Blue text denotes where an amendment to the previous figures has been made following a review of establishment figures. These figures are correct at the time of the divisional sign off process at the beginning of each month for the retrospective month

Agenda Item:BM21/22-091

BOARD OF DIRECTORS
07 July 2021

Title:	System Improvement Board (SIB) Update
Responsible Director:	Claire Wilson, Chief Finance Officer
Presented by:	Janelle Holmes, Chief Executive

Executive Summary
This paper provides an update on the Trusts challenged provider status which was recently reviewed by NHS Improvement. Following submission of evidence to the Wirral System Improvement Board (SIB), the regulators have removed the Trust from challenged provider status and future SIB meetings have been stood down.

Recommendation: (e.g. to note, approve, endorse)
For noting

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
N/A
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
System Improvement Board regime
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
N/A

Specific communications and stakeholder /staff engagement implications
N/A
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
N/A
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)
N/A

FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No

Previous considerations by the Board / Board sub-committees	Trust Board
Background papers / supporting information	N/A

BOARD OF DIRECTORS
07 July 2021

System Improvement Board (SIB) Update

Purpose

This paper provides an update on the Trusts challenged provider status which was recently reviewed by NHS England / Improvement. (NHSE/I)

Following submission of evidence to the Wirral System Improvement Board (SIB), the regulators have removed the Trust from challenged provider status and future SIB meetings have been stood down.

Background

The Wirral healthcare system is currently subject to enhanced monitoring by NHS Improvement in the form of a System Improvement Board (SIB). This was established approximately 3 years ago following a number of quality and performance concerns, which needed an enhanced regulatory focus and a joined-up system wide response.

In January 2021, the SIB regulatory team set out the four areas where system partners have been asked to demonstrate sustainable improvement. System partners submitted evidence against each area (see Appendix 1)

- Quality and safety improvement
- Urgent care performance
- Culture and organisational development in Wirral University Teaching Hospitals NHS Foundation Trust (WUTH)
- System wide financial sustainability
- Wirral system governance and COVID-19 response

Significant progress is demonstrated across each domain and whilst it is acknowledged that in some areas, further improvement will be required, the leadership, relationships and governance processes now in place within the Wirral system mean that the improvement journey can now revert back to business-as-usual monitoring and scrutiny processes with NHSE/I as regulator.

Conclusion

ON 17th July 2021, the Trust received written confirmation of the outcome of the NHS North West Region's recent decision that Wirral University Teaching Hospitals NHS FT be removed from challenged provider status (see Appendix 2).

This decision was taken based on recognition of the substantial progress made against the improvement plan by the Trust organisation notably:

- Strengthened executive leadership and governance
- Sustained focus on improving organisational culture and development
- Collaborative working across Wirral to improve urgent and emergency care pathways and financial planning and management

Recommendations to the Board

The Board is requested to note the contents of the report.

Wirral System Partners

Evidence in Support of System Improvement Board Review

March 2021

1. Introduction

The Wirral healthcare system is currently subject to enhanced monitoring by NHS Improvement in the form of a System Improvement Board (SIB). This was established approximately 3 years ago following a number of quality and performance concerns, which needed an enhanced regulatory focus and a joined-up system wide response. In addition, WUTH has been under Enhanced Quality Surveillance, overseen by NHS Wirral CCG and reported via the Cheshire and Merseyside Quality Surveillance Group (QSG). The Trust received confirmation from NHS Wirral CCG, that a decision to move the Trust from Enhanced Quality Surveillance to Routine Quality Surveillance was made at the QSG held on 7 April 2021. Within the letter of notification, the work undertaken over the past 3 years, to further strengthen the processes to ensure patient quality and safety, was acknowledged.

This paper sets out evidence in support of the proposal to stand down the enhanced SIB regulatory monitoring given the trajectory of sustained improvements made to date.

In January 2021, the SIB regulatory team set out the four areas where system partners have been asked to demonstrate sustainable improvement. This paper addresses each area in turn.

- Quality and safety improvement (section 2)
- Urgent care performance (section 3)
- Culture and organisational development in Wirral University Teaching Hospitals NHS Foundation Trust (WUTH) (section 4)
- System wide financial sustainability (section 5)
- Wirral system governance and COVID-19 response (section 6)

Significant progress is demonstrated across each domain and whilst it is acknowledged that in some areas, further improvement will be required, the leadership, relationships and governance processes now in place within the Wirral system mean that the improvement journey can now revert back to business-as-usual monitoring and scrutiny processes with NHSE/I as regulator.

2. Quality and Safety Improvement

2.1. Background

Following a CQC inspection in 2018, WUTH was rated Requires Improvement and Inadequate in the Well Led domain. A subsequent Quality Risk Profile (QRP) was undertaken by commissioners and regulators and as result of this the Trust was placed under Enhanced Quality Surveillance. It is likely that the Trust would have been subject

to a Single Item Quality Surveillance Group (SIQSG), however with the establishment of the System Improvement Board, this process was superseded.

Table 1: 2018 CQC Inspection (WUTH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← May 2018	Requires improvement ↓ May 2018	Good →← May 2018	Requires improvement →← May 2018	Inadequate ↓ May 2018	Requires improvement →← May 2018
Medical care (including older people's care)	Inadequate ↓ May 2018	Requires improvement ↓ May 2018	Requires improvement ↓ May 2018	Requires improvement →← May 2018	Inadequate ↓ May 2018	Inadequate ↓ May 2018
Surgery	Requires improvement →← May 2018	Requires improvement ↓ May 2018	Good →← May 2018	Requires improvement ↓ May 2018	Requires improvement ↓ May 2018	Requires improvement ↓ May 2018
Critical care	Requires improvement →← May 2018	Good →← May 2018	Good →← May 2018	Good ↑ May 2018	Requires improvement →← May 2018	Requires improvement →← May 2018
Maternity	Requires improvement May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018
Services for children and young people	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
End of life care	Good ↑ May 2018	Good ↑ May 2018	Good →← May 2018	Good ↑ May 2018	Good ↑↑ May 2018	Good ↑ May 2018
Outpatients	Requires improvement Sept 2015	Not rated	Good Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015	Requires improvement Sept 2015
Overall*	Requires improvement →← May 2018	Requires improvement →← May 2018	Good →← May 2018	Requires improvement →← May 2018	Inadequate ↓ May 2018	Requires improvement →← May 2018

Appendix 1 sets out the very high risks (score of 16 and above) identified during the QRP process. Risk ratings were based on consideration of assurance of the underpinning systems and processes within the Trust to maintain quality and safety of patients and did not reflect solely performance in relation to national targets. Several processes have been established to monitor progress made by the Trust in reducing these risks and these are described below. Progress against the risks and the associated evidence is included in appendix 1.

The Trust was inspected by the CQC in 2019 and the published report in March 2020 rated the Trust as Requires Improvement overall and in the Well Led domain.

Table 2: 2019 CQC Inspection (WUTH)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement →← Jan 2020	Good ↑ Jan 2020	Good →← Jan 2020	Requires improvement →← Jan 2020	Requires improvement ↑ Jan 2020	Requires improvement →← Jan 2020
Medical care (including older people's care)	Requires improvement ↑ Jan 2020	Requires improvement →← Jan 2020	Good ↑ Jan 2020	Requires improvement →← Jan 2020	Requires improvement ↑ Jan 2020	Requires improvement ↑ Jan 2020
Surgery	Requires improvement →← Jan 2020	Requires improvement →← Jan 2020	Good →← Jan 2020	Requires improvement →← Jan 2020	Requires improvement →← Jan 2020	Requires improvement →← Jan 2020
Critical care	Requires improvement May 2018	Good May 2018	Good May 2018	Good May 2018	Requires improvement May 2018	Requires improvement May 2018
Maternity	Requires improvement May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018
Services for children and young people	Requires improvement →← Jan 2020	Requires improvement ↓ Jan 2020	Good →← Jan 2020	Good ↑ Jan 2020	Requires improvement →← Jan 2020	Requires improvement →← Jan 2020
End of life care	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018	Good May 2018
Outpatients	Requires improvement Jan 2020	N/A	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020
Diagnostic imaging	Good Jan 2020	N/A	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Overall*	Requires improvement →← Jan 2020	Requires improvement →← Jan 2020	Good →← Jan 2020	Requires improvement →← Jan 2020	Requires improvement ↑ Jan 2020	Requires improvement →← Jan 2020

2.2. Quality and Safety: Current Position

There is evidence that significant progress has been made within the Trust throughout this period which has reduced the risks that were identified within the original QRP in 2018. Systems to support delivery of safe and high-quality care across the Trust have been strengthened. Focus has also been given to patient safety and experience within the urgent care areas and infection prevention and control across the Trust. Whilst some risks remain, these risks have been resolved or reduced through changes within the Executive Team, resulting in effective leadership, coupled with robust governance processes. In addition, a dedicated Quality Improvement Team have been established to both support improvement capacity and capability within the organisation.

Monthly CQPGs, which have monitored progress of the actions arising from the QRP, have been in place and are attended by the Chief Nurse and Medical Director from WUTH. Outside of this meeting, the Chief Nurse and Director of Quality (CCG) meet weekly, the deputies also meet monthly; recently the Chief Nurse from WUTH, the Community Trust and Director of Quality from the CCG meet weekly, and the Medical Directors from these organisations meet monthly.

2.2.1 Infection Prevention and Control

WUTH had a CQC Infection Prevention and Control (IPC) focussed inspection in February 2021. This report is not rated by the CQC, however, their findings are extremely positive, and no major concerns were identified. Two areas of “Outstanding Practice” are noted and three “Should Do’s” were identified. Of these, two have been completed and the third, the IPC Strategy will be completed in Q1.

The report is contained in Appendix 2c and provides significant evidence and assurance of robust and inclusive IPC practice and governance from Ward to Board. The CQC findings are testament to the leaders in the Trust who have focussed on systematically improving the culture to ensure staff feel supported and able to speak up and have significantly improved the effectiveness of governance and risk management systems. Whilst this has been extremely challenging during the pandemic, the findings of CQC provide assurance that real, tangible changes have been made.

The report is included for full details; however, it is worthy of note that CQC reported:

- Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

- The trust had a clear vision and plan for continuously improving practices related to infection prevention and control and an action plan to meet identified goals. The action plan was aligned to local plans within the wider health economy.

- Staff felt respected, supported, and valued. The trust had an open culture where staff could raise concerns without fear. They were focused on the needs of patients receiving care.

- Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities. Governance structures and the communication within

them were effective to ensure that changes and learning supported patient safety across the trust.

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.

- All staff were committed to continually learning and improving services.

2.2.2 Update on progress against CQC Action Plan 2020

The CQC inspected the Trust during October and November 2019, with the final report published on 31 March 2020. The report was utilised to support the Trusts consideration of which areas needed to improve. Significant progress has been made in response to the requirements and recommendations made. Divisions, Corporate and Executive teams have reviewed the findings and developed action plans to address the 31 must do's, 76 should do's (Total 107) and the associated 351 actions to support achievement of full compliance:

- The quality improvement action plan (for Must do's) had 122 specific actions/work-plans for implementation on or before 31st March 2021.
- The quality improvement action plan (for Should do's) had 229 specific actions/work-plans for implementation on or before 30th April 2021

In developing the action plan, the following areas of consideration were included:

- The outcome, the Trust hoped to achieve (referencing the CQC must/should do's; regulatory requirements; clinical expertise) i.e. how can the Trust improve safety and quality for our patients
- What changes (actions) would lead to the improvement
- How the actions which were being implemented would be monitored
- What resources were required to make the change

For assurance, Divisions within the Trust provide evidence against each of their actions appropriate to the stage in the implementation cycle. Actions are RAG rated as follows:

Embedded	The action has been completed and reviewed; it is embedded and there is evidence that the desired outcome has been consistently met and has been tested.
Completed & Assured	The action is completed, and assurance has been given by way of evidence
Completed	Verbal assurances that action has been completed
On track	Action is on track with target date
At risk	Action is at risk of not meeting its target date
Overdue	Action is overdue

During the period of escalation, due to the Covid-19 pandemic, there has been a delay in the implementation of some actions. In addition, there is recognition that given the changes/impact of the pandemic some actions have now been superseded or need updating. As the “confirm and challenge sessions” re-start such actions will be revisited and updated to ensure we are achieving the desired outcome for the regulatory breach.

This paper provides an update as to progress against the CQC action plan and highlights:

- overdue actions
- completed actions and level of assurance

There are currently:

- 3 must do actions overdue.
- 8 should do actions overdue.
- 24 actions embedded (the outcome of the action has been in place for >= 3 months).

Of the 107 overall requirements, 75 have all actions completed so therefore 70% of the action plan has been achieved.

Please see:

Appendix 2a: Table with all actions and associated RAG rating on progress

Appendix 2b: Table of actions that are overdue with an update, as of 6 April 2021 and revised date for completion.

Appendix 2c: CQC IPC report (April 2021)

3. Urgent Care Performance

The sections below provide a summary of the key performance indicators for urgent care performance in Wirral highlighting the main areas of improvement together with the ongoing work to further develop and embed change**.**

3.1. System winter plan

System partners collaborated on a system wide winter plan which was underpinned by a shared demand and bed capacity model. This was the first time that a single jointly owned bed model has been developed in Wirral and it enabled clear and decisive decisions to be made on out of hospital bed capacity for winter 2020/21. The winter plan has been previously shared with the SIB and is available on request.

3.2. Ambulance handovers

Chart 1 below shows the year-on-year improvement in ambulance handover times since August 2018. Key improvement actions have included:

- Participation in "Action On" programme – specifically the super 6 programme
- Implementation of Ambulance Triage Nurse roles
- Development of reverse cohort area

Chart 1: Ambulance handover times (Aug 2018 to March 2021)

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
NWAS 30-60 mins	341	429	342	362	372	283	268	284	332	132	94	93	116	159	178	217	278	207	144	157	142	59	81	70	77	126	159	147	174	246	115	45
NWAS over 1hr	121	206	169	201	156	169	161	121	245	48	9	19	61	113	80	238	279	113	56	35	6	4	1	1	6	36	96	46	130	158	11	2

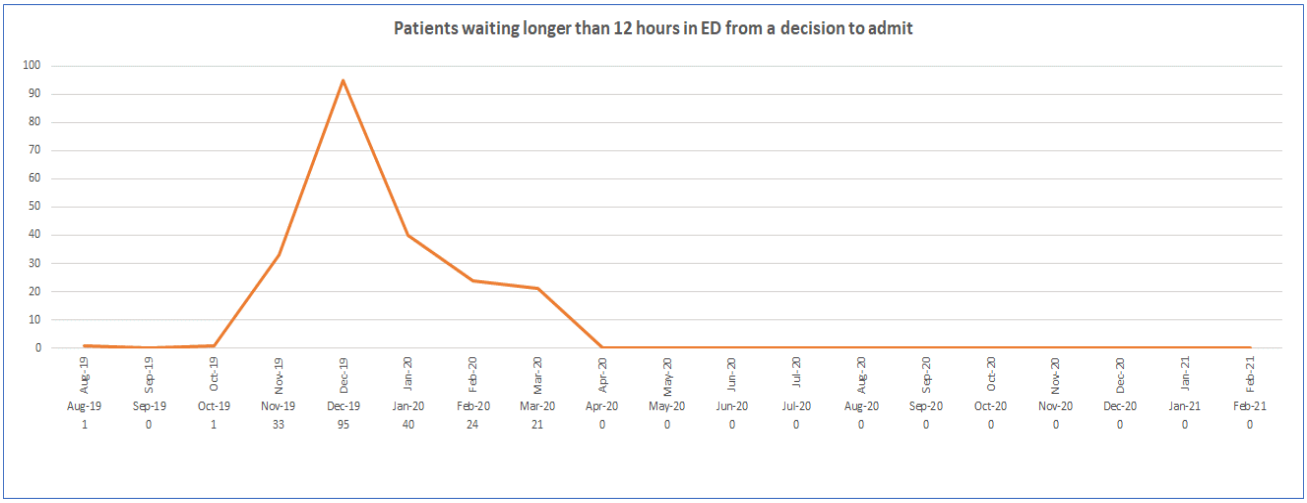
3.3. 12 Hour Decision to Admit Breaches

Chart 2 below shows the number of 12 hour decision to admit breaches since August 2019 and demonstrates the strong improved performance seen over winter 2020/21. Key improvement actions have included:

- System wide improvement approach supported by Emergency Care Improvement Support Team (ECIST)
- Focus on departmental leadership
- Development of inter professional standards
- Ward / Board rounds

- Appointment of Head of Patient Flow
- Bed management team form and function amended
- Implementation of real time capacity management IT system

Chart 2: 12 Hour Decision to Admit Breaches (Aug 2019 to Feb 2021)



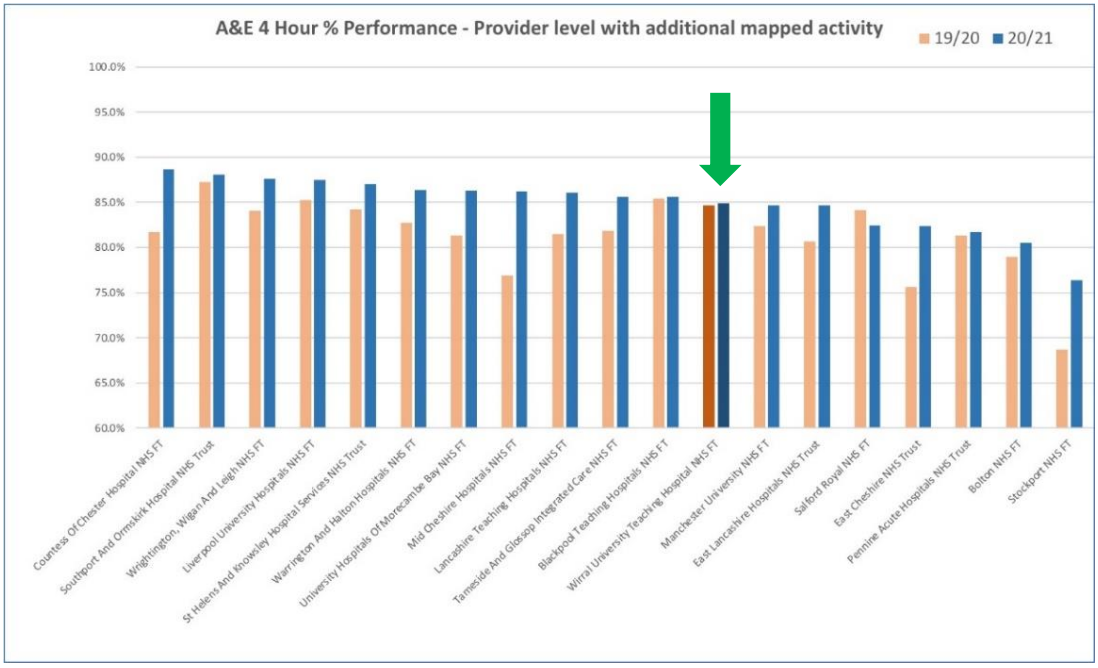
3.4. 4 Hour Wait Performance

Performance against the A&E 4-hour performance continues to be a challenge across both the Wirral system, and the North West more widely. This is a key priority and significant progress has been made in the way this is now managed between partner organisations.

The approach adopted by system partners has been the subject to regular discussion at SIB over the last 2 years and has included:

- System and organisation transformation programmes
- ECIST Support
- Action On programme participation
- Focus on back to basics to reduce complexities of urgent care model and service provision

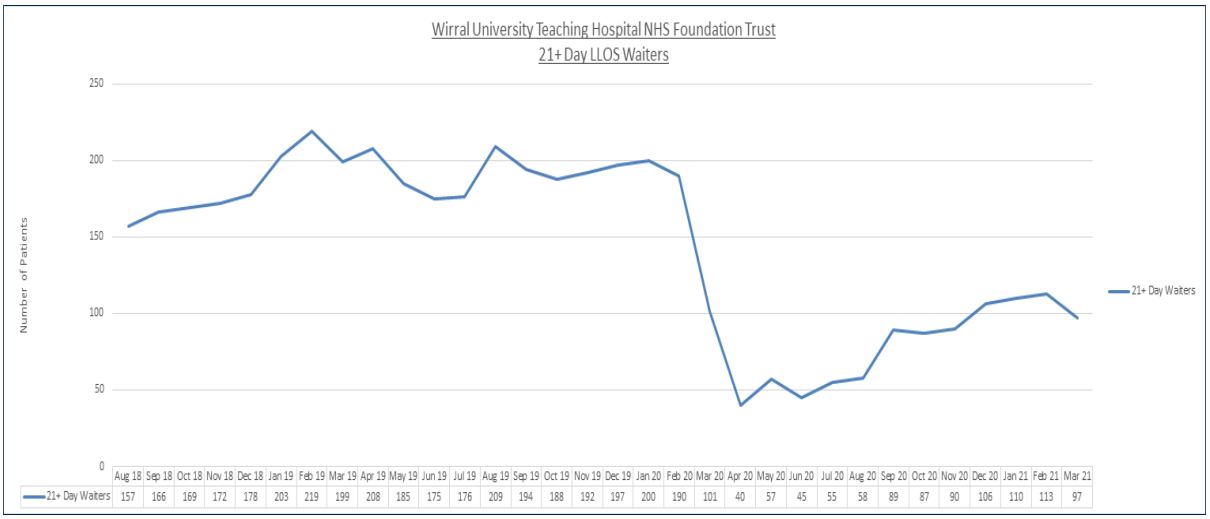
Chart 3: Wirral A&E Performance 2019/20 to 2020/21



3.5. Long Lengths of Stay (>21 days)

Chart 4 below provides an analysis of patients in WUTH with a long length of stay since August 2018.

Chart 4: Long Lengths of Stay (>21 days) at WUFT (Aug 2018 to March 2021)



The reduction in the number of patients in hospital over 21 days over this period have been achieved through a peer review approach with colleagues from WCHC, WBC and WUTH taking shared responsibility with all areas open to scrutiny and challenge. Discharge processes are seen as a system responsibility with system wide solutions.

Actions were focussed in the following areas:

- The senior staff involved had dedicated protected time to be onsite and really understand the issues.
- Focused on immediate and quick wins, actioned within the time the group was on site together and then developed longer-term plans for sustainability.
- Strong programme management and data analytical support, including establishment of discharge trackers.
- Focussed on a number of key interfaces namely, wards /IDT interface and IDT Interface with the care market.
- Team had a direct route to COOs and CEOs for any issues which needed escalating and unblocking. This included regular reporting on process by Associate Director for Adult Social Care, who was supported by the system to take a neutral approach so that all issues were identified fairly. Results were monitored as a key measure of system improvement programme.
- Moved away from firefighting towards earlier identification and forward planning. Focus on the NFD lists, identifying planned discharges not just for today but the days coming.
- Reviewed: Pathways
  Processes,
  Practice,
  Staffing resources,
  Effectiveness of communication,
  Quality of practice (adherence to legislation etc)

3.6. Out of Hospital Services

System partners have agreed an approach as set out below to assess, redesign and commission out of hospital services in support of urgent care pathways for 2021/22 with the aim of having new models of provision in place from October 2021.

- Whole system capacity and demand model
- Agreed direction to reduce number of providers
  - Focus on throughput measurement
  - 7-day access
  - Uniform IPC standards
- Patient focused not organisation
- “Open Book” approach
- Full system partner involvement
- Proactive and responsive balance during COVID-19 pressures
- Current contracts on phased extensions

4. Staff engagement and organisational development at WUTH

4.1. Organisational Development

WUTH has been on a journey of cultural improvement since 2018. To support this, an Organisational Development (OD) Plan for 2018-21 was agreed, implemented, and monitored based on seven key objectives to improve organisational culture and thereby improve the quality and safety of patient care as well as patient and staff experience.

The OD plan forms a key part of the overall Workforce Strategy and the seven objectives were:

i. Leadership development at every level
ii. Vision,Values and Behaviours
iii. Staff Engagement
iv. Valuing our workforce
v. Learning organization
vi. Healthy workforce
vii. Inclusivity

Given the need for cultural improvement within the organisation, a gap analysis of our OD plan against the NHSI Culture and Leadership Programme was undertaken and assurance provided from Professor Michael West that our focus and plans were robust. In autumn 2020 we undertook a gap analysis against The NHS People Plan and again updated our OD plan to reflect the continued focus on Recruitment, Well-Being and Diversity & Inclusion.

The impact of COVID-19 over 2020/21 has meant that the education and OD teams have needed to focus on a number of additional priorities including COVID-19 training, Health and Wellbeing of the workforce and the induction of Pre F1 doctors, nursing students and recruitment of volunteers. This has led to a recent temporary pause on some of the areas within the OD plan, however, a significant amount has been achieved since launch in 2018 and a detailed analysis of progress to date is set out in Appendix 3.

WUTH continues its journey of improvement and therefore a key area of focus for the Trust for the financial year 2021/22 is development and coaching for middle managers and supervisors, which is also identified as an action from the 2020 staff survey results. We will also develop a new management development framework that sets out the development of our managers throughout the organisation. We will work to support creating and sustaining effective team working, which will be enabled through the OD team and divisional triumvirates utilising QI methodology to support staff led change. Values based team development sessions will also aim to improve team working and build upon team working interventions that were offered throughout the pandemic.

During the next few months, we intend to develop a fresh OD plan now the Trust strategy has been approved and we have the NHS 2021/22 priorities and operational planning guidance.

Our priority actions will include:

- Staff Health & Wellbeing with an increased focus on psychological safety and individual health plans for staff. We aim to work on Wirral wide programmes where possible and are mid recruitment for a new Head of Well Being. This postholder will drive innovation in this key area of work.
- Improving our community links to aid local recruitment and support career planning for disadvantaged communities. Again, we intend to work across Healthy Wirral partnerships to ensure we can provide the widest possible range

of career opportunities, education, and training, and expect to see even stronger working relationships with. Wirral Metropolitan and local Universities.

- Diversity & Inclusion- raising the cultural awareness across the Trust to ensure all staff and patients feel valued and fully represented. Our recent successful recruitment of International nurses will increase our numbers of overseas staff and we intend to ensure they enjoy their time as a member of the WUTH family and act as willing ambassadors to attract further cohorts of international staff.
- Team working- increasing the cross team working using initiatives such as QI. This will be progressed across clinical divisions and corporate teams.
- We intend to develop a new Management Development Framework as we recognise line manager development will lead to improved staff experience, decision making, high performing team cultures and support managers and supervisors to feel confident in communicating and holding difficult conversations.

4.2. Measuring Improvement

It was agreed that the OD Plan would be monitored via the outputs of Medical Engagement Score (MES), the annual National Staff Survey and the quarterly Staff Friends and Family Test (FFT), which would provide a temperature check that the actions identified were having an effect. The Trust intends to make use of quarterly Pulse surveys to track improvement against our key priority areas.

4.2.1. Medical Engagement Survey (MES)

In 2017, the MES survey showed all ten MES scales fell within the lowest relative engagement band compared to the external norms. Since then, there have been changes in leadership and culture. Specifically, the Trust has focused on leadership development, and expected values and behaviours through extensive engagement with staff.

The MES survey was repeated in 2019 to reassess senior clinician engagement. There was a 42% improvement in overall medical engagement. There were large percentage improvements in medical engagement with respect to all the MES scales between the 2017 and the 2019 MES surveys. In particular, the three largest overall changes occurred with respect to:

- Having Purpose and Direction 48% Improvement
- Participation in Decision-Making & Change 44% Improvement
- Climate for Positive Learning 42% Improvement

Medical staff with managerial responsibility were highly engaged with respect to nine of the ten MES scales.

The detailed results of the survey were presented to the System Improvement Board in 2019. The Trust plans to repeat the MES survey in 2022

4.2.2. Staff Survey results 2018, 2019 & 2020

Recent results of the National Staff Survey provide assurance of positive progress, recognising that culture change takes a significant amount of time to achieve.

Table 2: Staff Survey Results 2018 to 2020 (WUTH)

Theme/Question	2018 WUTH	2018 National average	2019 WUTH	2019 National average	2020 WUTH	2020 National average
Equality, Diversity and Inclusion	9.2	9.1	9.2	9.0	9.3	9.1
Health and Wellbeing	5.6	5.9	5.7	5.9	6.0	6.1
Immediate Managers	6.4	6.7	6.7	6.8	6.6	6.8
Morale	5.9	6.0	6.1	6.1	6.1	6.2
Quality of Care	7.3	7.4	7.4	7.5	7.5	7.5
Safe environment – Bullying & harassment	7.7	7.9	7.8	7.9	8.1	8.1
Safe environment-violence	9.4	9.4	9.4	9.4	9.5	9.5
Safety Culture	6.3	6.7	6.5	6.7	6.6	6.8
Team-working	6.2	6.5	6.3	6.6	6.3	6.5
Staff Engagement Score	6.7	7.0	6.8	7.0	6.9	7.0
Recommendation to family and friends for work (From National Staff Survey)	55.2	62.3	60.4	62.5	62.1	66.9
Recommendation to family and friends for Care (From National Staff Survey)	65.7	71.2	67.9	70.5	72.1	74.3
Feeling secure raising concerns about unsafe clinical practice	64.8	69.3	67.8	70.4	67.0	71.8

Whilst recognising that there is still much more to be done to improve the staff survey metrics, and in recognising the impact of the COVID-19 pandemic on the workforce, it should be noted that all themes or questions above have shown improvement for WUTH or sustained above average levels.

It is particularly noteworthy that the Trust's focus on EDI has seen an above average and above sector score result for this theme. This recognises the intensive work undertaken with our networks and the cultural reviews undertaken over the last 18

months. With further work planned on cultural awareness, we intend to ensure we remain above the sector average.

Across the next 12 months we intend to improve our scores to at least sector average in Health & Well Being, Staff Morale & Engagement, and Immediate Line Management. In respect of Health & Well Being, within 2 years we would see ourselves in the top quartile nationally.

The Trust recognises that historic vacancy levels have impacted morale and intend to ensure a reduction in vacancy levels of at least 50% in order to support our staff to deliver excellent care to the local community.

Despite demonstrating an improvement trajectory against the themes in the national staff survey, it is recognised there is still much to do for the Trust to do to progress to Good and Outstanding measured against the higher performing acute Trust sector benchmark. The engagement and wellbeing of our staff is critical to this journey so feedback, as well as actions arising from the staff survey, is recognised as key to improvement. Divisional action plans will be developed in partnership with divisional triumvirates, workforce colleagues and staff members to address the challenges.

The new NHS People Plan provides a further set of ambitions for improving employee experience and modernising managerial and workplace practice. The Trust aims to work with a wide range of partners, adopt good practice and become an employer of choice.

The Trust has a clear organisational strategy for 2021-26 and within this, investment is earmarked for substantially upgrading work environments as well as planned investment in staff wellbeing and rest facilities.

4.2.3. Well led CQC Inspection

In their 2019 inspection, the CQC provided an assessment of the Trusts performance under the well led domain. Whilst there is clearly work still to do across a range of indicators as set out in the CQC report, there were also early areas of improvement identified. This resulted in an improvement in score in this domain from Inadequate in May 2018 to Requires Improvement in January 2020.

A number of positive examples of this from the CQC report are drawn out below:

- Since the previous inspection, the governance structures had been reviewed and strengthened and were beginning to support improvements across services. Divisional leaders were clear about their roles and accountabilities.
- Improved medical engagement scores since the last inspection. The three largest percentage improvements were having purpose and direction, participation in decision making and change and climate for positive learning (see section 4.3 below)
- Leaders were seen as having the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. Leaders in services were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.
- All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.
- Leaders encouraged innovation and participation in research.

4.3. Executive development programme

Following a period of instability, the last member of the current executive team joined the Trust in June 2020. It was recognised that, in order to lead the Trust well, the executive team needed cohesion, and an opportunity to reflect on leadership style and approach. This was particularly important working as a new team during a global pandemic.

The executives worked with Ice Creates, an independent company, specialising in leadership and organisational behavioural change. Sessions to date have focussed on team building and developing a joint narrative to lead the Trust to our vision of becoming an outstanding organisation. Executives have also been deeply engaged in developing the Vision, Values and Strategy for the organisation.

The executives have undertaken individual psychometric testing and, as a team, undertaken culture and talent mapping, along with behavioural strategy development.

Further sessions are planned. The programme will be extended to the development of deputies and the divisional triumvirates commencing Q1 2021.

5. Financial Sustainability

Wirral Finance Leaders have worked with NHSE/I to review the financial position of the Wirral system both for 2020/21 and recurrently.

The agreed outcome is a recommendation that:

- ***Individual and collective financial risk should be managed through NHSE/I business as usual assurance processes.***

5.1. The headlines from the review are:

- NHSE/I (NW) is considering a recommendation to remove Wirral CCG from legal directions.
- Wirral is the only sub-system of Cheshire and Merseyside which (as at month 10) has delivered a surplus position for 2020/21 and has not required additional financial support from C&M HCP in Q4 *(nb. this excludes year end annual leave adjustments)*
- The review of exit run-rates* shows that Wirral system has the lowest net run-rate in C&M and has seen the lowest rate of increase in net run-rate.
- Significant within the net run-rate drivers are the absence of a national 20/21 QIPP programme and prudent income assumptions pending national policy announcements.

* Note: The 20/21 exit run-rates is a very specific technical finance measure which is not equivalent to the 21/22 recurrent surplus/deficit - the 21/22 recurrent position can only be calculated when planning guidance and allocations are issued.

5.2. Summary position:

Attached as Appendix 4 are slides which describe:

- **2020/21 Outturn (Table 1)**: The outturn organisational positions for 2020/21 with all Wirral organisations at least at breakeven and Wirral as the only C&M sub-system delivering a surplus.

- **Recurrent Exit Run-Rate (Table 2 & Table 3)**: Table 2 shows the net run-rate as we exit 2020/21 and the change in net run-rate during 2020/21. This confirms that:

    1) During the pandemic the low rate of change in run-rate evidence Wirral's strong financial control whilst delivering an effective and co-ordinated CV-19 response for our population.
    2) Wirral has the lowest run-rate in Cheshire and Mersey whether this is measured; in absolute terms, or as a change during 2020/21, or as a percentage of CCG allocation.

- **Table 3 confirms that the main factors driving the exit run-rate are:**

    1) The NHS-wide suspension of significant QIPP programmes during the CV-19 pandemic has impacted all NHS organisations. This is one of many financial issues that the national planning guidance will seek to address from a policy and funding perspective and that Wirral partners must then deliver on operationally.
    2) In the absence of national policy guidance it has been necessary to take a prudent approach to income assumptions. All this £18.8m of income remains within national NHS funding and it is hoped will be accessible to Wirral from April 2021.

5.3. Financial sustainability - recommendation

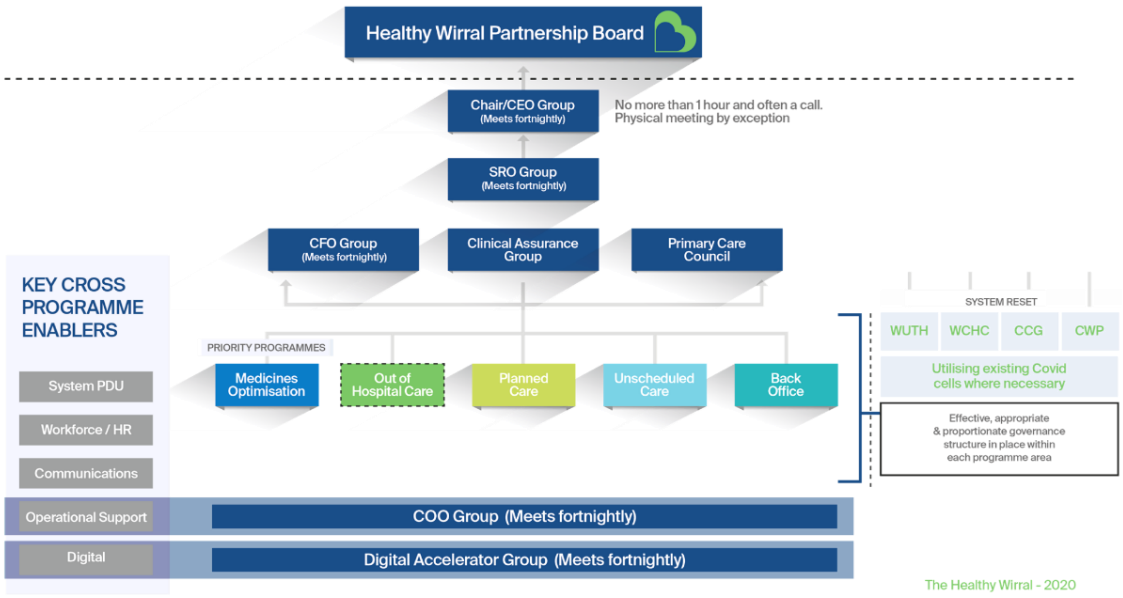
Whilst the Wirral system undoubtedly faces significant financial challenge, the level of challenge is consistent with that of most systems. In addressing this challenge, the Wirral Finance Leaders have established strong, positive working relationships and effective joint governance.

Therefore, individual, and collective financial risk should be managed through NHSE/I business as usual assurance processes.

6. Wirral system governance and the COVID-19 response

6.1. The Wirral health and social care system has established a robust governance structure to support collaboration and transformation within the 'Healthy Wirral programme. Overall leadership and accountability is provided by the Healthy Wirral Programme Board which is comprised of the chairs and CEOs of the constituent organisations. This structure is set out in Chart 5 below.

Chart 5: Wirral system governance



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6.2. Closer working relationships developed over recent years have enabled the system to work successfully on a number of significant issues. For example, the system worked collectively on its winter planning for 2020/21, underpinned by a jointly owned system wide bed plan, the first time this has been done in Wirral in recent years. The plan attracted positive feedback from our regulators.

6.3. In addition, a transparent, open book and collective approach to planning and financial risk management has also enabled a successful financial performance this year as set out in section 5 above. The system recognises that there is still work to do on its underlying financial position and believe that the relationships we now have in place will be key to delivering this.

6.4. Wirral System Strategic Response to COVID-19

6.4.1. This stronger governance and closer working relationships have enabled the system to respond quickly and decisively to the COVID-19 pandemic. We quickly established system wide command structures which aligned to the command structures across both C&M and within each individual organisation.

6.4.2. The Wirral Health and Social Care Cell meets on Monday, Wednesday and Friday. Since 7th January 2021 this has been supplemented by additional Tactical Cell meetings twice a day. The Chief Executive's call takes place weekly on a Thursday and, since 7th January 2021, has been supplemented by twice daily meetings to focus on discharge and flow. WHHC/NHS Wirral CCG staff also provided additional support to the Wirral and Cheshire and Merseyside system over weekends as well.

6.4.3. Wirral Council's Strategic Co-ordinating Group (SCG) has also continued to meet. The SCG has oversight of the whole Wirral population response to managing the COVID-19 pandemic and for recovery.

6.4.4. To support vaccine delivery in Wirral, the Chief Officer of Wirral CCG chairs a pan-organisational strategic group twice a week. The Deputy Director for Patient Safety and Quality chairs a daily tactical group to resolve any immediate operational issues. These meetings link into Cheshire and

Merseyside co-ordination mechanisms with work covering data and technology, demand modelling, estates, logistics and consumables, workforce and training, commercial and contracting, finance and communications.

6.4.5. The systems and processes that we have put in place in Wirral, outlined above, have supported a collaborative and focused response by the local health and care economy to the challenge of COVID-19. These systems and processes have also supported (a) the restoration of services in an operating environment where COVID-19 is present and (b) preparing for and responding to surges in activity due to winter pressures and/or fluctuating rates of COVID-19 infections. All partner organisations have worked exceptionally hard to maintain services, elective and non-elective, and to tackle the challenges of doing so in a COVID-19 positive environment collaboratively.

To: Janelle Holmes
janelleholmes@nhs.net

NHS England and NHS
Improvement
North West
Regatta Place
Brunswick Business Park
Summers Road
Liverpool
L3 4BL

17 June 2021

Dear Janelle,

RE: RSG Wirral Outcome

My purpose in writing to you today is to inform you of the outcome of the NHS North West Region's recent decision that Wirral University Teaching Hospitals NHS FT be removed from challenged provider status. This decision was taken based on recognition of the substantial progress made against the improvement plan by your organisation notably:

- Strengthened executive leadership and governance
- Sustained focus on improving organisational culture and development
- Collaborative working across Wirral to improve urgent and emergency care pathways and financial planning and management

The enforcement undertakings agreed between NHS Improvement and the Trust in 2020 will be reviewed as a consequence of the Regional team's recognition of the Trust's progress against those relating to Quality and A&E performance. NHSE-I will write to in due course regarding these.

Therefore, the Regional team intends to step down the Wirral System Improvement Board with responsibility for quality and safety oversight reverting to Cheshire and Merseyside Quality Surveillance Group.

Yours sincerely

Dr David Levy

FRCP FRCR
Regional Medical Director
NHS North West

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: BM21/22-092

BOARD OF DIRECTORS
07 July 2021

Title:	**Change Programme Summary, Delivery & Assurance**
Author:	Clare Jefferson, Head of Service Improvement
Responsible Director:	Matthew Swanborough, Director of Strategy and Partnerships
Presented by:	Matthew Swanborough, Director of Strategy and Partnerships

Executive Summary
Contextual and background information pertinent to the situation / purpose of the report.

The Programme Board of 16th June 2021 received the assurance evidence and that evidence (coupled with attendance at the programme meetings) forms the basis of this assurance report to the Board of Directors.

No projects were removed from or added to the assurance scope in June.

The table below give a summary of the assurance ratings in June in comparison to May.

	Governance				Delivery			
Month	Red	Amber	Green	Suspended	Red	Amber	Green	Suspended
May-21	0	2	8		0	2	8	
Jun-21	**0**	**0**	**10**		**0**	**2**	**8**	

The ratings for the three priority Transformation programmes have improved in June with all three programmes now attracting overall Green ratings for Delivery and Governance.

Recommendation:
(e.g. to note, approve, endorse)

For noting

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)	
N/A	
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)	
N/A	
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)	
N/A	
Specific communications and stakeholder /staff engagement implications	
N/A	
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
N/A	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
N/A	
Previous considerations by the Board / Board sub-committees	
Background papers / supporting information	

BOARD OF DIRECTORS MEETING IN PUBLIC
07 July 2021

Change Programme Summary, Delivery & Assurance

Purpose

To inform how the Transformation Programmes and the Projects that support them are progressing and to indicate the confidence level for delivery.

Introduction / Background

At the Programme Board of 16th June 2021, the members received a presentation from the Outpatient Programme Lead, 'Outpatients: Journey to Date' detailing the progress made 12-months on following the introduction of the Outpatient Standards. Members, as usual, received full update presentations on the priority Transformation programmes; Patient Flow, Perioperative Medicine and Outpatients Transformation. The Programme Board also received the assurance evidence and that evidence (coupled with attendance at all the programme meetings) forms the basis of this assurance report to the Board of Directors.

Ten assurance reviews were undertaken for June 2021 *(the same as reviewed in May)*; this includes the three priority Transformation Programmes along with three Service Improvement projects and four Digital Enabler projects, all of which are attached to one of the Priority Programmes.

Conclusions

1.1. Governance Ratings

For June, all three Transformation Programmes were Green rated for Governance in addition to all the Digital Enabler and Service Improvement projects achieving a green rating.

1.2. Delivery Ratings

June saw all three Transformation Programmes maintaining Green ratings for Delivery. For the Digital Enabler and Service Improvement projects, eight were Green rated, two Amber (due to requests to extend the 111 First Phase 2 and Pre-op Assessment project closure milestones by 3 and 4 weeks respectively). Both projects requested extensions at Programme Steering Meeting 07 June 2021 which the Chair granted and therefore these are anticipated to track green at the next assurance review assuming the revised milestones are met).

2. Programme Assurance - Ratings

The attached assurance report has been undertaken by the Head of Service Improvement and provides a detailed oversight of assurance ratings per programme / project. The report provides a summary of the assurance as a gauge of the confidence in eventual delivery and the actions needed to improve those confidence levels are described in the assurance statements for each.

Recommendations to the Board

The Board of Directors is asked to note the Trust's Change Programme Assurance Report and to recognise the work undertaken by the SRO and Programme Leads which has resulted in improved rating across the three Transformation Programmes and associated projects.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Change Programme Summary

Programme Assurance
June 2021

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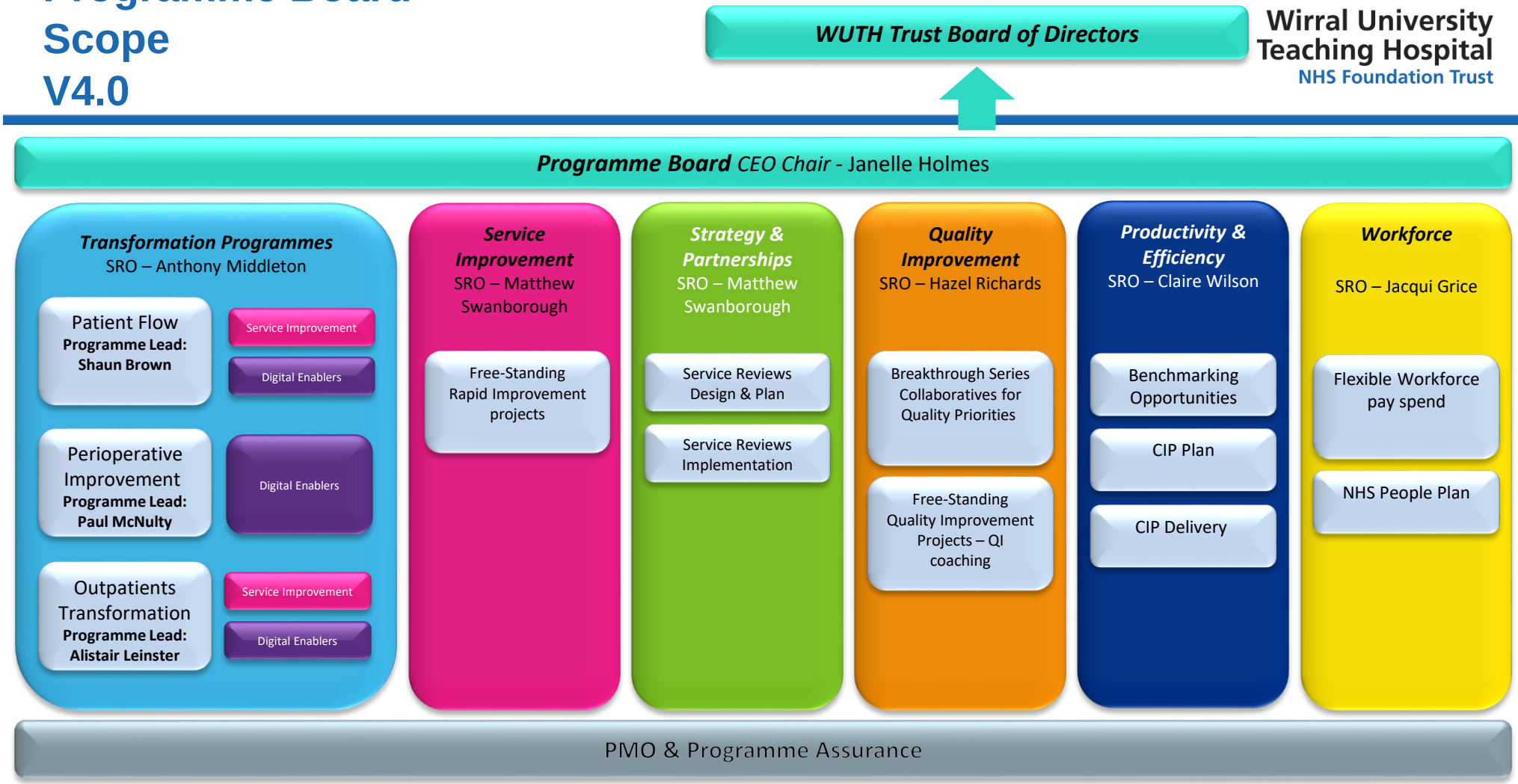
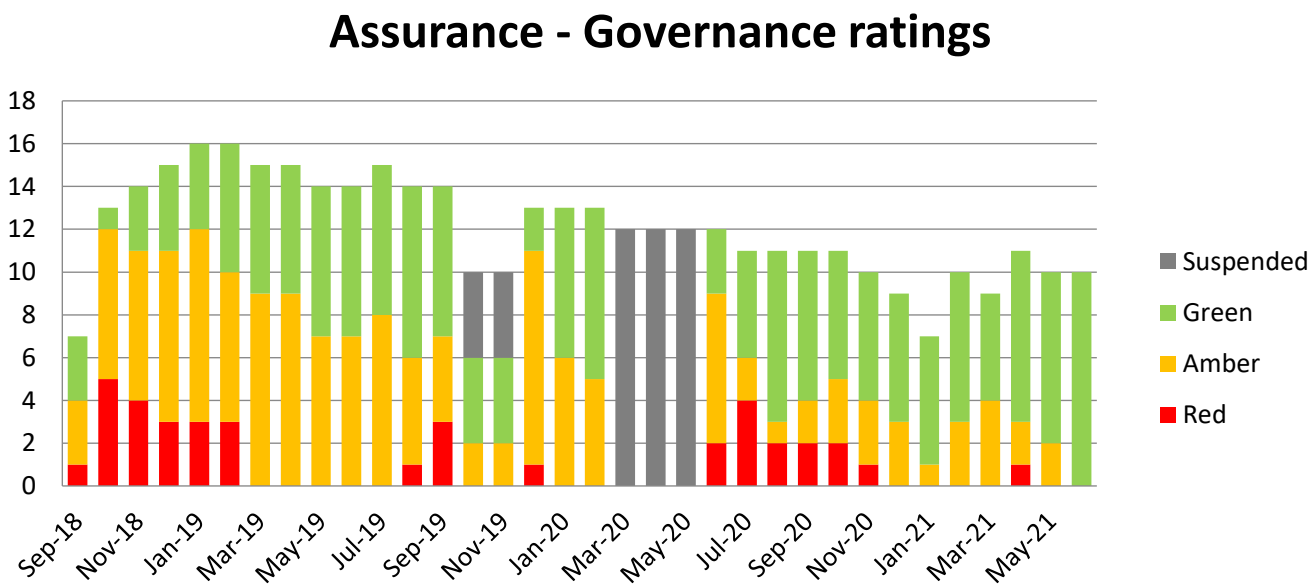
Programme Board Scope V4.0

Wirral University Teaching Hospital NHS Foundation Trust



Assurance – Governance ratings

Wirral University Teaching Hospital
NHS Foundation Trust



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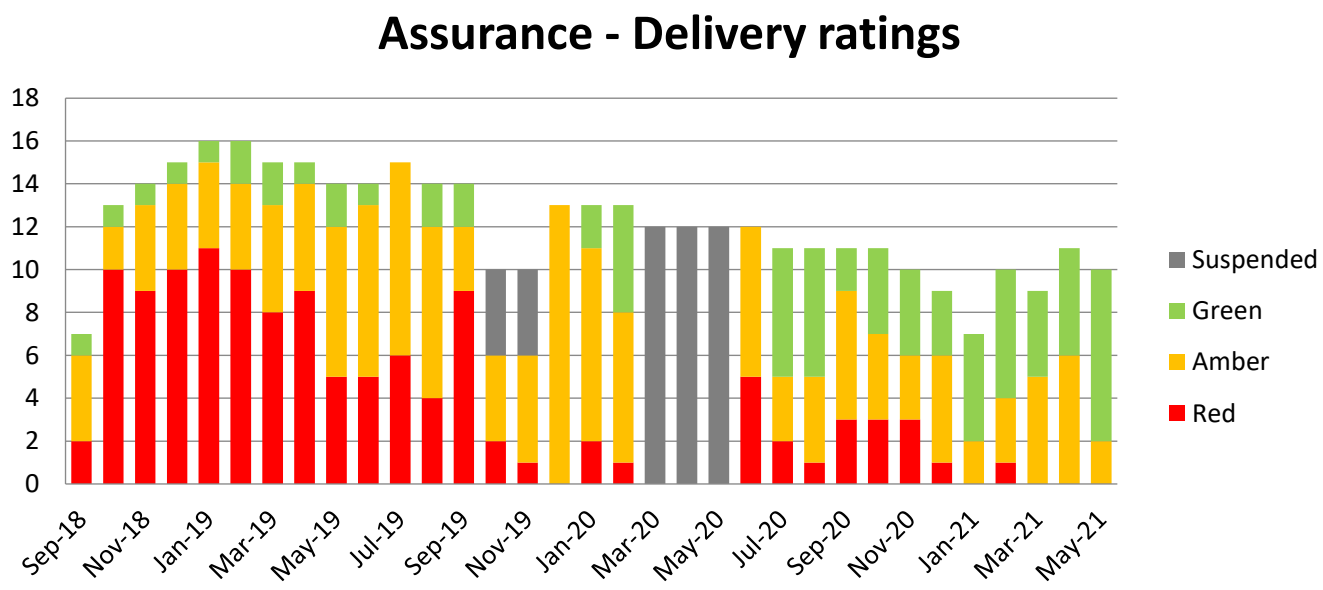
Assurance – Delivery ratings

Wirral University Teaching Hospital
NHS Foundation Trust



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NHS Foundation Trust

Programme Assurance Ratings

11 June 2021

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Change Programme Assurance Report - June 2021
Top 3 Priority Projects - Summary

Wirral University Teaching Hospital
NHS Foundation Trust

Improving Patient Flow	Governance	Green	Delivery	Green

- The scope of the Patient Flow Programme has been narrowed to focus improvement work on a small number of key standards in the Flow Vision during Q1 21/22.
- The reported Metrics will be those directly linked to active improvement projects: Discharge Before Midday, ED Triage within 15 Minutes, Bloods & ECG in ED within 30 minutes.
- **Plans are in place for improvement projects which will contribute to an increase in the number of Discharges before Midday and the ED Performance KPIs as described above, including the associated benefits to staff and patients. Trajectories have been developed to show *what will improve, by how much and by when*. This will be tracked by those accountable for delivery and assurance.**

Perioperative Medicine Improvement	Governance	Green	Delivery	Green

- The revised PID v1.0 dated 3 Mar 20, as approved by the Programme Board - including an extensive schedule of benefits and measures - remains extant. The programme has devised revised trajectories and these are now being monitored.
- Only Digital Enabler projects remain within the Scope of this Transformation Programme; therefore Programme Management responsibility transferred from Service Improvement to Informatics as of 01/04/2021 *(approved by Programme Steering Group 08/03/2021)*
- **The KPIs declared by the programme, as agreed by the Programme Board, continue to be monitored through the Programme Board.**

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Change Programme Assurance Report - June 2021
Top 3 Priority Projects - Summary

Wirral University Teaching Hospital
NHS Foundation Trust

Outpatients Improvement	Governance	Green	Delivery	Green

Overall Aim: The aim of the Outpatients Transformation Programme is to contribute towards and act as an enabler for whole system transformation of elective Outpatient services. Building on the substantial amount of evidence and best practice available nationally we have aligned the transformation programme to the NHS long term plan around the following key themes:

- First Contact Services - services accessible through self-referral in primary/community setting
- Advice & Guidance - for primary care and health professionals
- Standardised Referral Pathways & Templates across the Wirral System
- Virtual Assessment and Virtual Appointments – video/telephone consultations & virtual care
- Deliver Outpatient care in the right place with the most appropriate health care professional
- Patient Initiated Follow Up (PIFU) – self-management and patient empowerment

Overall Progress: The Programme is achieving the total non-f2f target for April (25%) at 31.2%, but not achieving total target where no procedure is recorded (40%) at 33%. Following on from the 2021/22 Operational & Financial Guidance it was agreed by Programme Steering Group to focus Outpatient Improvement efforts initially on initiatives that will support delivery against the challenges for outpatient services. These initiatives have been identified as Advice & Guidance, Patient-Initiated Follow Up, Electronic Referral Triage & Outpatients One Patient Record (Paperless). The Outpatients Programme is working with the Divisions to identify any underlying reasons as to why there was a decrease in Non-F2F performance in April.

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Improving Patient Flow - Programme Assurance Update – 11 June 2021

Exec Sponsor	Programme Lead	Service Improvement Programme Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Shaun Brown	Jane Hayes-Green	Implementation	Green	Green

Independent Assurance Statement

1. The Approved 'Vision for Patient Flow' is uploaded to PM3. PSG 07 June 21 reviewed Programme Scope v4.1_25th May 21 and following approval of closure reports at PSG this has been updated to the current scope v5.0_7th June 21. **2.** Action Tracker available up to meeting of 25 May 2021. **3.** ToR updated Oct 20. **4.** There is a Comms Plan attached in PM3 that has been updated and associated milestones have been added to the Programme Project in PM3 all are on track.
5. QIA for the Programme was approved at the Patient Flow Steering Group meeting 5 Jan 21 and has been reviewed by the Chief Nurse who has approved (email 01 June 2021) pending confirmation of understanding of who and how the team have consulted with to determine "no impact" - confirmation reviewed by Patient Flow steering group and has now been sent to Patient Experience and Diversity & Inclusion lead for oversight**. 6.** Programme and associated Projects are effectively managed in PM3 (any delays in the RI projects: '111 First Phase 2' and 'Barriers to Discharge' are RAG rated separately for that project line). **7.** The 4 Programme KPIs from the Flow Dashboard along with associated trajectories for each, approved by Programme Board 21 Apr 21, are being monitored ahead of improvement implementations reviewed at PSG 07 June 21. **8. & 9.** Programme risks and issues are managed in PM3 and were reviewed by the Patient Flow Steering Group 25 May 21.
Most recent assurance evidence submitted 11 June 21.

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2.1	Patient Flow Programme	The Flow programme will work to ensure that all patients receive care and treatment in accordance with the standards within the Trust Flow Vision V2.0 The Flow programme will implement and monitor projects to support the delivery of specific flow standards in the Flow Vision	Anthony Middleton		●	●	●	●	●		●	●	●	●

SERVICE IMPROVEMENT: 111 First Phase 2 - Project Assurance Update – 11 June 2021

Exec Sponsor	Programme Lead	Change Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Shaun Brown	Jane Hayes-Green	Implementation	Green	Amber

Independent Assurance Statement

1. Project proposal revised following restart and exception report to extend project by 2 weeks to encompass a 111 Phase 2 workshop approved by Programme Board 21 Apr 21. Further Extension of 3 weeks Approved at PSG 07 June 21.
2. The Project team is defined; evidence of weekly project team meetings up to 11 June 21.
6. Project is effectively managed in PM3; Milestones have been updated to reflect agreed extension as of PSG 07 June 21. Rated Amber this month to highlight the extension to original timeframes.
7. There are National '111 Sitrep' metrics and 'ED Sitrep' metrics. The '111 First Local Metrics' report and a Benefits & Controls report are available up to Apr 21.
8 & 9. Risks and Issues have been added to PM3 and have been reviewed by the Project Team 11 June 2021.
Most recent assurance evidence submitted 11 June 21.

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2.1a	**111 First Phase 2** (Service Improvement Project)	Expand and refine the offer from Phase 1 of 111 First: Offer slots and set up direct booking into assessment units and specialty clinics by the 111 and the Wirral CAS service Review of "111 First" phase 1 using information from bespoke reports/ patient feedback	Anthony Middleton		●	●					●	●	●	●

SERVICE IMPROVEMENT: Barriers to Discharge: Phase 1 - Project Assurance Update – 11 June 2021

Exec Sponsor	Programme Lead	Change Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Shaun Brown	Jane Hayes-Green	Implementation	Green	Green

Independent Assurance Statement

1. The project is defined by the Proposal which has been uploaded to PM3. Exception report to extend project by 2 weeks to encompass more intensive support for the 4 wards was approved by Programme Steering Group 10 May 21. PSG 07 June 21 approved Project Closure pending amends to Closure report due 18 June 21.
2. The Project team is defined; evidence of meetings up to 09 June 21.
6. Milestone plan in PM3 - all complete.
7. Discharge by Midday KPI is defined and will be tracked as part of the Programme going forward.
8 & 9. Project risks & Issues have been reviewed by the project team and will move across to Phase 2 or Programme Project when project formally closed on PM3.
Most recent assurance evidence submitted 11 June 21.

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
2.1b	**Barriers to Discharge: Phase 1** (Service Improvement Project)	Bed Occupancy in the Trust is running at around 96% which makes it difficult to manage the flow of patients. This problem is intensified by the current situation with the need to place suspected and confirmed covid patients in appropriate locations. There are internal delays to discharge which are within the control of the Trust . There are patients in acute beds who do not meet the Criteria to Reside and whose needs would be better serviced in a community setting. Wards routinely carry out morning Board Rounds and some wards hold afternoon Huddles. The SAFER care patient flow bundle is not systematically adhered to and monitored. Wards do not categorise red and green days for patients and therefore the Trust is missing an opportunity to identify, escalate and unblock discharge delays.	Anthony Middleton		●	●					●	●	●	●

Perioperative Medicine Improvement – Programme Assurance Update – 10 June 2021

Exec Sponsor	Programme Lead	Informatics Programme Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Nickee Smyth	Implementation	Green	Green

Independent Assurance Statement

1. The revised PID v1.0 dated 3 Mar 20 was signed-off by the Proj. Steering Group (and is updated by the Oct 20 'Scope' slide). The Exception Report and Re-start Plan (post-COVID Wave 1) was approved by the Prog. Board in June 20. PSG 8 Mar 21 approved the revised Programme Scope V5.0 - this is the current scope.
2. Action Tracker available up to Steering meeting of 01 June 21
3. The Perioperative Steering Group revised ToRs were signed off at the May steering group meeting (04 May 21) and are attached in PM3.
4. Comms Plan updated now V2.0 signed off by Programme Lead 07 May 21. **5.** The renewed QIA signed off Dec 20 is evidenced in PM3
6. Programme and associated Projects are effectively managed in PM3; however milestone extensions within 2 of the 3 active projects have been observed one impacting on the project closure, for which an extension was granted at PSG 07 June 21
7. KPIs are defined and reviewed at PSG 07 June 21.
8 & 9. Programme risks and issues are managed in PM3 (all reviewed in June Steering Group).
Most recent assurance evidence submitted 10 June 21.

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3.1	**Perioperative Programme**	The specific focus/brief of the Theatre Productivity Group, to achieve our objectives, was to: Reconfigure the Theatre Schedule; Enable the planning of theatre staff and anaesthetics; implement a system to track and monitor 45 week usage; reduce specialty level variation so that all lists are achieving 85% utilisation target; implement a weekly process to enable prospective and retrospective assessment of session utilisation.	Anthony Middleton		●	●	●	●	●		●	●	●	●

DIGITAL ENABLEMENT: Electronic Booking Form- Project Assurance Update – 10 June 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Katherine Hanlon	Implementation	Green	Green

Independent Assurance Statement

1. PID v1.0 approved at steering meeting 6 Apr 21
2. The Perioperative Digital Enabler projects are discussed at the Perioperative Digital Enablers Project Meeting, evidence of meetings on 01 June 21.
6. Milestone plan on PM3; project is due to close 30 June 21 but is reporting delays to Go Live for T&O and Breast originally 01/06/21 and 12/06/21 respectively; revised date of 30/06/21 in PM3 for both. It is still anticipated that this project will close as planned 30 June 21.
8. & 9. Project Risks and Issues are managed in PM3 all reviewed at project meeting 01 June 21.
Most recent assurance evidence submitted 10 June 21.

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3.2b	**Electronic Booking Form** (Digital Enablement - Perioperative Care)	Revise processes to enable clinicians to order procedures directly in Millennium in the patients record Remove paper request forms for surgery. Perioperative processes have been recognised by the Trust as a Transformational priority. Following work by the transformation team over the past year and the introduction of improvement managers within the Division a number of issues have been identified with the perioperative processes. Requests have been made to Informatics to review and develop the IT systems to help support process improvement. This project forms a part of this work.	Anthony Middleton		●	●					●		●	●

DIGITAL ENABLEMENT: Electronic Consent - Project Assurance Update – 10 June 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Nickee Smyth	Initiation	Green	Green

Independent Assurance Statement

1. PID approved at Steering meeting 06 Apr 21 and has been approved by the project team 12 May 21.
2. Good attendance at Project meetings action log to 09/06/21
6. The milestone plan in PM3 is on track.
8. & 9. Project risks and issues documented in PM3 and updated following project meetings.
Most recent assurance evidence submitted 10 June 21

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3.2c	**Electronic Consent** (Digital Enablement - Perioperative Care)	This project aims to deliver an electronic consent solution within Wirral University Hospital Trust, one which does not rely on paper. Currently the consent process is paper based, forms are scanned into the patients electronic medical record, these are then viewed and verified electronically at the point of visit. Whilst the current process is fully mapped out it is not without risks, it has yet to have a SOP formally signed off by the Trust Consent Lead. This project will deliver a clear consistent process for consent which will minimise clinical risk and ensure that patients are well informed about their procedures.	Anthony Middleton		●	●					●		●	●

DIGITAL ENABLEMENT: Pre-Op Assessment - Project Assurance Update – 10 June 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Paul McNulty	Katherine Hanlon	Initiation	Green	Amber

Independent Assurance Statement

1. PID approved at Steering meeting 06 Apr 21 and is attached in PM3. A 4-week extension on Milestones to push Delivery Stage to complete 30th July, due to the lack of availability of the Informatics Developers was approved at PSG 07 June 21.
2. The Pre-op assessment project is discussed as part of the Perioperative Digital Enablers meeting, evidence this meeting took place 01 June 21.
6. Milestones have been updated to reflect agreed extension as of PSG 07 June 21. Rated Amber this month to highlight the extension to original timeframes.
8. & 9. Project risks and Issues are documented in PM3 all reviewed June 21.
Most recent assurance evidence submitted 10 June 21.

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
3.2d	**Pre-Op Assessment** (Digital Enablement)	To deliver IT improvements to support more effective management of the preoperative assessment stage. Specifically, to improve tracking of the patient's readiness for surgery in order to ensure that the process is as efficient as possible and optimise utilisation of surgical resources by minimising late cancellations of surgical procedures. The project includes the display of such information within theatres to provide detail of daily operating lists but also patient level detail to support 'safety huddles' prior to surgery.	Anthony Middleton		●	●					●		●	●

Outpatients Improvement - Programme Assurance Update – 10 June 2021

Exec Sponsor	Programme Lead	Service Improvement Programme Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Jordon Bailey	Implementation	Green	Green

Independent Assurance Statement

1. Outpatient PID 5.0 approved at Outpatient Transformation Steering Group 10/05/21. The key benefits are defined therein. PSG 10 May 21 approved the revised Programme Scope now v7.0 - this is the current scope. **2.** Action Tracker available up to steering meeting held 02 June 21, Divisional workshops took place 24/05/21 Medicine; 08/06/2021 Surgery; 21/05/2021 W&C. **3.** Programme ToR v3.0 and Divisional Workshop ToR v1.0 approved at steering meeting 01 Apr 21. **4.** There is a tracked Comms Plan in place and a supporting stakeholder matrix. **5.** Programme EIA/QIA signed off at Clinical Executive Level. **6.** Programme and associated Projects are effectively managed in PM3 (any delays in the assured Digital Enabler or Service Improvement projects are RAG rated separately for that project line). **7.** KPI dashboard presented at PSG 07 June 21 illustrating the Outpatient KPIs to be tracked and monitored ahead of improvement implementations; it was agree that the Non-F2F measures will undergo monitoring to ensure no slippage. **8. & 9.** Programme risks and issues are managed in PM3 - all reviewed in steering meeting 02 June 21.

Most recent assurance evidence submitted 10 June 21

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
4.1	Outpatients Programme	The primary focus of the programme is to ensure Value at Every Encounter. This is value to the patient, the Clinician(s) and the Trust. To the patient, the aim is to ensure that they are provided with the diagnosis, treatment, or information that they need. To the clinician, the aim is to ensure that every time they see a patient, they have the information and time they need to provide a quality clinical encounter. For the Trust, the aim is to ensure a high quality, clinical encounter, with no waste of resource and which results in positive patient experience/feedback.	Anthony Middleton		●	●	●	●	●		●	●	●	●

DIGITAL ENABLEMENT: Outpatients One Patient Record - Project Assurance Update – 10 June 2021

Exec Sponsor	Programme Lead	Technology Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Nickee Smyth	Implementation	Green	Green

Independent Assurance Statement

1. The Project is defined in the PID v2.0 dated 3 Jul 20.
2. Project discussed at Divisional workshops 24/05/21 Medicine; 08/06/2021 Surgery; 21/05/2021 W&C.
6. Milestones are tracked in PM3; the Milestone for integrated scales has been revised again due to the lack of availability from Cerner. This is not expected to impact the delivery date of the project at this stage.
8. & 9. Project risks and issues are managed in PM3; all reviewed May/June 21
Most recent assurance evidence submitted 10 June 21.

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
4.2a	**Outpatients One Patient Record** (Digital Enablement - Outpatients Improvement)	The key deliverables from this project are: - Removing Case Notes from Outpatients - Reducing the amount of paper produced within the Outpatient environment - Solutions to make unavoidable paper available electronically.	Anthony Middleton		●	●					●		●	●

SERVICE IMPROVEMENT: Advice and Guidance: Phase 1 - Project Assurance Update – 10 June 2021

Exec Sponsor	Programme Lead	Change Lead	Stage of Development	Overall Governance	Overall Delivery
Anthony Middleton	Alistair Leinster	Jordan Bailey	Implementation	Green	Green

Independent Assurance Statement

1. The project is defined by the Proposal that has been uploaded to PM3. A 6-week extension to the Project was approved at PSG 10 May 21 to complete a comprehensive options appraisal following the benchmarking exercise that has been completed.
2. A 'core team' is listed on PM3 and regular catch ups have taken place during the benchmarking process; these have continued to take place to develop the options appraisal.
6. Project is effectively managed in PM3; Milestones have been updated to reflect agreed extension and associated new tasks - all on track.
7. Part of the project is to identify how activity can be tracked. Consultant Connect data is being collated and is evidenced.
8. & 9. Project risks and issues are managed in PM3; all reviewed June 21.
Most recent assurance evidence submitted 10 June 21.

PMO Ref	Programme Title	Programme Description	SRO/Sponsor Assures	OVERALL GOVERNANCE	1. Scope and Approach Defined	2. An Effective Project Team is in Place	3. Proj. Governance is in Place	4. All Stakeholders are engaged	5. EA/Quality Impact Assessment	OVERALL DELIVERY	6. Milestone plan is defined/on track	7. KPIs defined / on track	8. Risks are identified and being managed	9. Issues identified and being managed
4.3b	**Advice and Guidance - Phase 1** (Service Improvement Project)	The purpose of this project is to implement a standardised Advice & Guidance process within Wirral University Teaching Hospital. Advice and Guidance services will provide primary care with continued access to specialist clinical advice, which will enable a patient's care to be managed in the most appropriate setting, strengthening shared decision making and avoiding unnecessary outpatient activity. Phase 1 will identify which Options the Trust wish to utilise moving forwards whilst Phase 2 will specifically oversee implementation.	Anthony Middleton		●	●					●	●	●	●

Agenda Item: BM21/22-93

BOARD OF DIRECTORS
7th July 2021

Title:	Report of the Finance Business Performance and Assurance Committee
Responsible Director:	Claire Wilson, Chief Finance Officer Sue Lorimer, Non-Executive Director
Presented by:	Sue Lorimer, Non-Executive Director

Executive Summary
This report provides a summary of the work of the FBPAC which met on the 24th June 2021. The Committee recommends that the Board of Directors ratify the submission of the financial and operational plans.

Recommendation:
For noting

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
No new risks identified.
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
NA

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<tr><td>Specific communications and stakeholder /staff engagement implications</td></tr>
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<tr><td>Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)</td></tr>
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<tr><td>Previous considerations by the Board / Board sub-committees — Paper reports on the activities of Board sub-committee.</td></tr>
<tr><td>Background papers / supporting information — NA</td></tr>
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BOARD OF DIRECTORS
7th July 2021

Report of the Finance, Business, Performance and Assurance Committee (FBPAC)

This report provides a summary of the work of the FBPAC which met on the 24th June 2021.

1. Finance Report for the period ending May 2021

The Committee received the Month 2 finance report and noted the overall position of a surplus of £0.268m at M2, a positive variance against plan of £0.360m.

The Committee was pleased to note the recruitment into five consultant posts including in Ophthalmology and Cardiology which had previously been staffed through high-cost locum arrangements.

The Committee noted the slippage in capital funding and the expectation that the capital programme would be delivered in line with original forecast. The Committee received explanations on how COVID-19 related costs were treated in the accounts and recognition of temporary changes in the cost base.

The Committee requested for a separate report on productivity loss as a result of the pandemic and to keep in view how that is regained, as part of long term financial strategy.

2. Operational and Financial planning for 2021/22 (H1)

The Committee received detailed explanations on the planning process for the first half of the financial year and the requirement for Cheshire and Merseyside to break-even as a system.

The Committee reviewed the redistribution of monies within the system and a reduction of funding for WUTH of approximately £8.6m, £4.6m of which was offset against the Trust's original planned surplus. The Committee also reviewed the plan to offset the balance of the reduction in funding against an increased CIP target and ERF income for a break-even budget for the H1.

The Committee raised questions about the statutory powers for enforcing financial discipline on individual organisations, and incentives for good performance and there was a discussion about the drivers of the gap and approach to sharing the shortfall.

3. CIP Planning 2021/22

The Committee received an update report on identification and implementation of CIP through PM3, and confirming next steps.

The Committee noted that the provisional 2% CIP Target of £8.5m FYE would likely increase once the H2 planning regime was known. The Committee also noted that £4.4m of opportunities had been identified against the target, leaving a gap of £4.1m as at 18th June 2021.

The Committee was advised that a comprehensive RAG rated report from the Project Management system will be presented on a monthly basis to provide further assurance.

The Committee requested further assurance about the cash releasing nature of the CIP savings across the divisions. The Committee was informed that the Financial Business Partners had been supporting the divisions and that the clinical divisions had been held to account for the delivery of CIP as well as delivery of a balanced budget.

4. Patient Flow Team Investment – Benefits Analysis

The committee received a presentation on the benefit analysis of the investment to enhance the patient flow team and provide a 24/7 cover.

The Committee noted the delivery against the key metrics for success of the £431K investment as including:

- Re-designed Patient Flow team, with an integrated service covering both Medicine and Surgery
- 24/7 Senior Nurse patient flow cover
- Development of patient flow toolkit
- Released senior nursing team from patient flow work back to day-to-day activity, to act as a point of escalation only.
- Reduction in ambulance handover delays
- Zero 12 hour breaches from DTA seen in the last 12 months
- A reduction in the average time from bed request to departure from 227 minutes in January 2021 to 149 minutes in May 2021, a reduction of 34%

The Committee received detailed explanations on how the exercise had supported ED waiting times and achieving high rates of direct admission into assessment units. The Committee noted however that more work was needed to translate the patient flow work into improved ED performance data.

Agenda Item: 21/22-94

BOARD OF DIRECTORS

07 July 2021

Title:	Report of the Trust Management Board
Responsible Director:	Nikki Stevenson, Medical Director and Deputy Chief Executive
Author:	Oyetona Raheem, Board Secretary
Presented by:	Nikki Stevenson, Medical Director and Deputy Chief Executive

Executive Summary
To provide a summary of the Trust Management Board held on 22 April 2021 via Microsoft Teams.

Recommendation: (e.g. to note, approve, endorse)
To note the Report of the Trust Management Board.

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

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Across all BAF priorities.
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
N/A
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Specific communications and stakeholder /staff engagement implications
N/A
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
N/A
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)

N/A		
FOI status	Document may be disclosed in full	✓
	Document includes FOI exempt information	
	Entire document is exempt under FOI	
Previous considerations by the Board / Board sub-committees		
Background papers / supporting information		

BOARD OF DIRECTORS MEETING IN PUBLIC
7th July 2021

REPORT OF THE TRUST MANAGEMENT BOARD

Purpose

To provide a summary of the Trust Management Board held on 22 June 2021 via Microsoft Teams.

Introduction / Background

A summary of the topics covered is provided below:

1. Month 2 Finance Report

TMB received the Month 2 finance report and noted the £0.268m positive variance against plan of £0.360m and the expectation to break even at end of H1. Explanations were received on the delay in the finances for the capital programme but with anticipation that the capital programmes will be delivered as planned.

TMB received explanations on the planning process for the first half of the financial year and how the projected funding for the Trust had reduced by about £8m in order to make up the deficit (about £100m) in funding available to the Cheshire and Merseyside as a system. £4.2m of the reduction was offset against the Trust's original planned surplus whilst the remainder was offset against an increased CIP target and ERF income for a break-even budget for the H1.

2. Workforce Steering Board – Key issues Report

TMB considered the report from the Workforce Steering Board and noted that discussions had been held on the following issues:

- National OD Plan and Strategy
- North West Workforce Regional Update
- Workforce Performance Report
- Covid-19 Staff Asymptomatic Self-Testing (LAMP)
- Respect at Work
- Freedom to Speak Up (FTSU) Annual Report (including Q4 Data)
- Gender Pay Gap Report
- Diversity and Inclusion Update Report
- Trust Response to Service Improvement Board
- Results of the 2020 NHS Staff Survey
- Organisational Development Response to the 2020 NHS Staff Survey
- Apprenticeship and Widening Participation Update
- Communications and Engagement Update
- Safe Employment / Corporate and Local Induction Report

TMB noted that Jayne Coulson had been appointed as the Interim Director Non-Executive Director for Wellbeing Guardian and that staff wellbeing would feature more prominently in future CQC inspections and that there was plan to have a

dedicated FTSE Lead role, separate from the Diversity and Inclusion Lead role.

TMB noted that issues relating to culture and discrimination, team-working and management development will form part of the Trust-wide staff survey actions for 2021. TMB noted the plan to reflect cultural insensitivity in future training and development.

3. Risk Management Committee Key Issues Report

TMB reviewed the report of the Risk Management Committee held on 01 June 2021 summarising the key quality initiatives and noted that there were currently 480 live risks on the Risk Register which represented a decrease of 3 since the previous meeting.

TMB also noted that there were currently 17 risks with a risk scoring of 15 which represented a reduction of 3 since the previous meeting.

4. PSQB Report

TMB reviewed the report of the Patient Safety and Quality Board (PSQB) held on 3rd June 2021 and noted the key issues discussed including:

- Assurance & Oversight Reports
- Safeguarding Performance Report
- Clinical Harm Review Status Update
- Infection Prevention & Control Board Assurance Framework
- Learning from Deaths
- CQC Core Services Reviews – Initial Feedback
- Assurance processes for the delivery of reliable safe care within the Emergency Department
- Draft Annual Quality Account Quality
- Patient Safety Intelligence Quarterly Report
- SEND Briefing Paper
- National Safety Standards for Invasive Procedures (NatSSIPs) – Gap Analysis
- Trust Response to COVID
- Complaints Quarterly Report
- Reporting Structures into PSQB
- SI Panel Chair's Report
- Medicines Safety Optimisation Group Chair's Report
- End of Life Chair's Report
- Patient & Family Experience Group Chair's Report
- Infection Prevention & Control Group Chair's Report

TMB received detailed explanations on the continuing efforts to improve the quality of care in the ED, noting the current surge in ED attendance.

TMB noted that the Trust had a lower number of complaints upheld / partially upheld by the PHSO compared to other Trusts and that a Complaints and Claims Management Group had been established, which will report into PSQB.

5. Operational Performance Committee

TMB reviewed the minutes of the Operational and Performance Committees held on 20 May and 10 June 2021 and noted the key issues including:

- Business Cases - Pipeline planning
- Endoscopy Planning
- Trust and Divisional Quality Performance Dashboards
- Reset & Recovery Updates
- Clinical Harm Reviews
- Overdue Follow up Appointments
- Clinical Prioritisation Codes
- Business Cases

- Corneal Graft Surgery
- Pipeline planning

- Endoscopy Capacity & Demand Analysis
- Elective orthopaedic winter planning
- Clinical Harm Reviews
- Management of Overdue Follow up Appointments & Pending Investigations
- Clinical Prioritisation Update
- Cancellation of elective activity during COVID-19

TMB noted the good progress that had been recorded on elective recovery and expressed appreciation to all the team members that made it possible. TMB noted that two Business Cases were being developed and would be presented for ratification in due course.

6. Divisional Updates

The TMB reviewed and noted the key issues in the previously circulated updates from each operational division.

Recommendations to the Board

The Board of Directors is requested to review and note this report.

Agenda Item: BM21/22-095

BOARD OF DIRECTORS
7 July 2021

Title:	Communications and Engagement Report
Responsible Director:	Debs Smith Interim Director of Workforce
Presented by:	Sally Sykes, Director of Communications and Engagement

Executive Summary
The report covers the Trust's communications and engagement activities in June 2021, including media relations, campaigns, marketing, social media, employee communications, WUTH Charity and staff engagement.

Recommendation: (e.g. to note, approve, endorse) *What action / recommendation is needed, what needs to happen and by when?*
To note the progress in communications and engagement this month.

Which strategic objectives this report provides information about:	
Providing the best care and support	Yes
Be a great place to work	Yes
Maximise improvement and deliver best value	Yes
Digital pioneer and centre for excellence	Yes
Work seamlessly with partners to deliver care	Yes

Please provide details of the risks associated with the subject of this paper, including new risks (x-reference to the Board Assurance Framework and significant risk register)
Board Assurance Framework risks PR2 (staff engagement) and PR 6 (stakeholder confidence)
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Workforce Risk 133 – reputation and loss of stakeholder confidence
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
None
Specific communications and stakeholder /staff engagement implications
Fundamental purpose of the team's activity is to ensure positive relations are maintained
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Patient confidence and staff engagement are influenced by communications, media relations, campaigns, issues management and positive engagement.
Council of Governors' implications / impact (e.g. links to Governors' statutory role, significant transactions)
None, unless reputation risks manifest in an unforeseen way

FOI status	Document may be disclosed in full	Yes
	Document includes FOI exempt information	No
	Entire document is exempt under FOI	No
Previous considerations by the Board / Board sub-committees	Monthly reports to Board and WAC	
Background papers / supporting information	Report attached with appropriate links embedded.	

BOARD OF DIRECTORS
7 July 2021

Report of the Director of Communications and Engagement

Purpose

To advise the Board of significant progress in communications, marketing, media relations, employee communications, patient communications, awareness campaigns and stakeholder and staff engagement.

Introduction / Background

This is the report of the Director of Communications and Engagement, providing an update on the team's work to generate proactive media and social media coverage of WUTH, to keep staff informed of critical matters to help them work safely and to keep patients safe.

Campaigns, media, social media, internal communications, staff engagement and stakeholder relations

Campaigns

- The team supported a number of national campaigns and events like disease awareness days, months and weeks. These provide important opportunities to inform the public, staff and patients on healthcare topics and issues.

- June continued to be an exceptionally busy time for various proactive campaigns and a number of charities and campaign organisations had deferred their activities until later in the year, so there were more causes to promote in June 2021. These included Cervical Screening Awareness Week, Breastfeeding Celebration Week and Men's Health Week .

- N&H Week | Nutrition and Hydration Week was celebrated in June as it had been deferred from earlier in the year and we also promoted the work of our amazing WUTH volunteers during Volunteers' Week in early June. Each volunteer received a personal thank you letter from our CEO Janelle Holmes thanking them for the invaluable contribution to the Trust.

- June also highlighted the work of carers during Carers Week and we promoted the annual Learning Disability Week 2021
.
- The Vaccination Hubs continued to require campaign and communications support whether for changes to advice and guidance or to communicate to staff and the public the availability of booking slots and the opening up of vaccine for new eligible cohorts – including younger age groups and the ability to book into Clatterbridge directly from the national booking system.

Big uptake for first jab in Wirral among people in their 20s | Wirral Globe
WUTH experts were very willing to support our work addressing vaccine hesitancy - for example, from members of the Black, Asian and Minority Ethnic communities.

- As our Emergency Department, along with others in the region, continued to experience significantly increased demand, we increased the frequency and focus on the NHS 111 First campaign to ensure that the public are signposted to alternative options to ED. We continued working with NWAS and system partners to reach a wider audience with the message 'Keep A&E free for emergencies'. While the key message is to contact NHS 111 in the first instance, face-to-face appointments with GPs have resumed and Walk-in Centres on the Wirral are now fully open, including the Urgent Treatment Centre at Arrowe Park, if it is not an emergency. There's an example of the campaign **here**

Media

The team has continued to produce proactive news stories from the wealth of positive work being done by staff, volunteers, clinicians and fundraisers. The following were covered in the month :

- Staff on ward 14 and our Medical Photography Team pulled out all the stops to support a patent and her partner's wedding plans, a poignant story that was covered in Liverpool Echo , The Wirral Globe and The Daily Mirror- Dying bride marries partner of 22 years in touching hospital wedding ceremony - Mirror Online

- Along with other Trusts and NHSE/I we provided background information on the use of Do Not Attempt Cardiac Pulmonary Resuscitation (DNACPR) orders to the Daily Telegraph; although WUTH did not feature in the resulting coverage, which raised awareness of the correct use of DNACPR orders for people with learning disabilities.

- Increased community prevalence of COVID-19 cases and new variants of concern meant that we had to reintroduce visiting restrictions, which was communicated to the public and via the media.

Internal Communications and staff engagement

- We maintained a schedule of two or more staff 'In Touch' Bulletins a week with important information on PPE, patient feedback and thanks, clinical guidance, staff wellbeing and support; thank yous to staff and charity updates.

- We have placed significant emphasis in communications to encourage staff to have the COVID-19 vaccine and to take their LAMP tests, which are an important line of defence against nosocomial infections and detecting infections in asymptomatic staff.

- We recognise the many challenges our staff are facing during the COVID-

19 pandemic. We regularly promote the range of staff support available along with some national services on the health and wellbeing website pages. In addition to the payslip leaflet, wellbeing posters and a wellbeing services directory folder for every ward and key departments in the hospitals, we promoted the national resources now available to support Wellbeing Conversations between Managers and staff. The Leaders in Touch session for the whole Trust in June also featured a comprehensive summary of the health and wellbeing support available to staff.

- Workshops were held with the Divisions and Corporate Departments to support local action planning on themes arising from the 2020 Staff Survey.

- We encouraged the local community and staff to take part in the forthcoming NHS Big Tea event on July 5th NHS Big Tea day will help Wirral's intensive care baby unit | Wirral Globe although we had to scale back some of the broader community and business involvement planned owing to the extension of COVID-19 restrictions in July (see progress reported in the following WUTH charity update).

WUTH Charity

The team continues to plan future events and deliver some activity safely and in line with restrictions.

- Wirral Mayor's Charity of the Year – The first event for the Mayor's Charity to be confirmed is the Mayor's Ball which will take place on 15th October at Thornton Hall Hotel. Further details about the event are to follow.

- National Farmers' Union Mutual has joined our list of corporate supporters with a £6500 donation for the Tiny Stars appeal. Plans are underway with Santander and Starbucks local branches and we hope to confirm their support very soon.

- NHS Big Tea 5th July – a pared back version of the initial plans will take place for staff to allow for social distancing. To mark the day, staff can claim a free cup of tea from Bowman's, Annabelle's and Firtrees on Monday 5th July The Charity team will also be out and about visiting areas across the Trust with cake for staff. In the community, WUTH Charity is encouraging as many people as possible to get involved at work or home with tea parties in the Garden or hosted virtually. A number of local businesses including local branches of Santander will be saying thank you by joining in a national tea break at 3pm.

- Arrowe Park Abseil 10th/11th September. Registration for the event opened on Monday 21st June, initial interest in the event is positive.

- Charity Golf Day – 15th September 2021 at Carden Park. PGA international golfer and Charity champion John Singleton has confirmed his attendance. John is a strong supporter of the Charity and will be playing in the competition and also lending his support to the Charity before the day. Unison have kindly sponsored the morning's refreshments for £500, and a number of small businesses have confirmed their support by sponsoring a hole. Team places and sponsorship opportunities are still available.

- Spring Raffle closes on Wednesday 30th June. 1st prize is £250 cash with other prizes including a 32inch Smart TV.

More information about all the events planned can be requested via WUTH.Charity@nhs.net

Stakeholders

- We continued to with system partners to promote different ways to access healthcare in the light of substantially increased pressures on A&E.

- Maternity Voices are providing their expertise to help us refresh the Wirral Women and Children's website in line with the recommendations of The Ockenden Review (Part 1).

- Dame Angela Eagle, MP for Wallasey, visited Seacombe Children's Centre earlier this month. The visit was to recognise the recent award received by the Food Bank, which is located there. She spent time with the other services in the centre, including Seacombe Birth Centre where women under the care of the Highfield Birth Team can choose to have their babies. She spoke to the midwives about the impact of the COVID-19 pandemic. Dame Angela said: "I visited the brilliant Seacombe Children's Centre, including the birthing unit, to see first-hand the fantastic work that they have been doing to support parents, children and families and to see the outreach work that they have been doing during the pandemic to continue supporting those who use the centre.'

- The Facebook post includes a short video, which features Angela Eagle and Carly Nulty, a member of the Highfield Team. The video can be seen **here**

Conclusions:

NA

Recommendations to the Board

The Trust Board is asked to note the report.