NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Public Board of Directors

1st December 2021

together we will

wuth.nhs.uk

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting of the Board of Directors in Public
Wednesday 1 December 2021
12 noon – 2.00 pm
Via Teams

Item	Item Description	Presenter	Verbal or Paper
1	Apologies for Absence	Chair	Verbal
2	Declaration of Interests	Chair	Verbal
3	Patient Story	Interim Chief Nurse	Video
4	Minutes of Previous Meeting - 03 November 2021	Chair	Paper
5	Board Action Log	Chair	Paper
6	Chair's Business	Chair	Verbal
7	Key Strategic Issues	Chair	Verbal
8	Chief Executive's Report	Chief Executive	Paper
9	Chief Operating Officer's Report	Chief Executive	Paper
10	Board Champion Roles	Director of Corporate Affairs	Paper
11	Quality and Performance Dashboards and Exception Reports	Chief Operating Officer, Medical Director, Director of Workforce & OD and Interim Chief Nurse	Paper
12	Finance Report for Month 7 incl. CIP	Chief Finance Officer	Paper
13	Guardian of Safe Working Quarterly Report	GOSW Guardian	Paper
14	Chief Nurse Six Monthly Nursing Establishment Review Staffing Report	Interim Chief Nurse	Paper
15	Monthly Safe Nurse Staffing Report	Interim Chief Nurse	Paper
16	WISE Ward / Service Accreditation progression from Level 3 to Level 4	Interim Chief Nurse	Paper
17	Diversity and Inclusion (D&I) Annual Report	Diversity & Inclusion Lead	Paper
18	Annual Appraisal and Revalidation: Annual Board Report and Statement of Compliance	Medical Director	Paper
19	Chair's Report Trust Management Board	Chief Executive	Paper
20	Chair's Report Workforce Assurance Committee	Committee Chair	Paper
21	Chair's Report Quality Assurance Committee	Committee Chair	Paper
22	Chair's Report Audit Committee	Committee Chair	Paper
23	Chairs Report Safety Management Assurance	Committee Chair	Paper

	Committee		
24	Communications and Engagement Report	Director of Communications and Engagement	Paper
25	Questions from the Public	Chair	Verbal
26	Any Other Business	All	Verbal
27	Date of Next Meeting – 26 January 2022	Chair	Verbal
28	**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

MINUTES OF MEETING HELD IN PUBLIC

03 NOVEMBER 2021

VIRTUAL MEETING VIA MICROSOFT TEAMS

Commencing at 12 NOON
Concluding at 2.22 pm

Present

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

In attendance

Chris Mason	Interim Chief Information Officer
Jonathan Lund	Associate Medical Director
Molly Marcu	Interim Director of Corporate Affairs
Sally Sykes	Director of Communications & Engagement
David McGovern	Director of Corporate Affairs
Craig McGuire	Interim Board Secretary
Debbie Edwards	Director of Nursing and Midwifery

Apologies

Sheila Hillhouse	Public Governor
Jayne Coulson	Non-Executive Director
Mags Barnaby	Interim Chief Operating Officer

*Denotes attendance for part of the meeting

Reference	Minute	Action
1	**Apologies for Absence**	
	Apologies for absence were noted as reported above.	
2	**Declarations of Interest**	
	No interests were declared at the meeting.	
3	**Patient Story**	
	The Board viewed a version of the Patient Story video, featuring Mr P. Mr P had attended the Arrowe Parke Hospital and had an operation following an accident. Mr P identified that he wanted to provide a massive thank you to everyone at the hospital. In particular he was pleased with the communication he experienced from staff and enjoyed sharing a sense of humour with the staff.	

Reference	Minute	Action
	The Chair reported that it was overall a positive story and was good to hear. The Chair commented that the patient was the star of the show and wished the patient well. **The Board NOTED the patient story**	
4	**Minutes**	
	The minutes of the meeting held on 06 October 2021 were approved as an accurate record subject to minor amendments.	
5	**Board Action Log** The Board reviewed the actions log noting that items had either been actioned or were on the agenda.	
21/22-130	**Chair's Business**	
	The Chair reported that it was fair to say it was brisk on a number of fronts obviously in relation to operational performance which would be covered later as well as developments in terms of the Wirral system. The Chair reported that there was significant progress being made towards the new arrangements in the Wirral system which come in place from April next year, and all system partners of different organisations are working together well with the respective chairs, focusing on particular areas, particularly against strains that the Trust was experiencing at the front door because of the sheer demand which caused issues with urgent care. The Chair commented that he considered that the Executive were handling challenges well and that was reflected in the feedback which was being received in relation to Patient Experience. Furthermore, the Chair commented that looking forward it was clear that there would be massive demand during the Winter. **RESOLVED:** **That the Board NOTED the Chair's Business**	
7	**Key Strategic Issues**	
	The Chair identified that there were no additional strategic issues to report. **RESOLVED:** **That the Board NOTED the update**	
8	**Chief Executive's Report**	
	The Chief Executive presented her report which gave an overview of work undertaken in October and important announcements for the month of November 2021. It was reported that there are robust escalation and site plans in place for the management of all infectious respiratory conditions, including Covid, Respiratory Syncytial Virus (RSV) and flu. The number of Covid positive cases is currently rising in the community and in the Trust. The weekly rate is 412 per 100 000 population. As noted previously, the largest proportion of cases (33%) are in children and young adults, aged 10-19 years. Covid	

Reference	Minute	Action
	inpatients are now managed within two designated wards, compared to one at the time of the last Board report, as well as in the critical care footprint where clinically appropriate. The Trust continues to monitor cases of RSV in children but have not yet experienced any anticipated surge. All flu cases are being closely monitored with a small number of flu positive admitted as inpatients. It was reported that the Trust declared 4 serious incidents (SI) in the month of September 2021; this is a decrease on the previous month. The Serious Incident panel report and investigate all serious incidents in line with the "Serious Incident Framework" so that learning can be identified and shared. It was identified that there were no common themes or areas identified from the 4 reported incidents, which spanned areas of the trust, including the Surgical Services (1) Women's and Children's (1) and Medicines and Acute (2) Duty of Candour has been undertaken in line with legislation and national guidance. It was reported that There were no RIDDOR reportable incidents in September 2021. It was reported that the Covid-19 vaccination programme continues across the local health economy. To 21st October 2021, 458,219 vaccinations (236,964 1st dose and 221,255 2nd dose) have been given across Wirral place in GP practices, PCN local vaccination sites, the WUTH vaccination centre, in pop up clinics and using the vaccination bus. The national data states this currently equates to 80% and 75% of the local eligible population respectively. The first allocation of flu vaccines has also been received in the Trust and are being administered in an Arrowe Park pop up clinic, via roaming vaccinators and concurrent vaccination of Covid-19 and flu vaccination at our Clatterbridge Centre. As of 24th October, 2906 flu vaccinations had been delivered which equates to 44% of Trust staff. This will continue to increase in line with the flu vaccine supply roll out. SL wanted to ask about respiratory syncytial virus given that there was huge pressure in critical care across the nation and at Alder Hey. The Medical Director commented that the Trust had escalation plans in place in case of need. In the event that Alder Hey gets overwhelmed by RSV then the Trust have agreed mutual aid in that the Trust would take older children without RSV who are physiologically more like adults to our critical care. We would not provide care for babies ior young children with RSV since the expertise for this lies within Alder Hey. The Medical Director commented that the Trust had not actually seen an escalation of cases in RSV, even though the Trust still had robust escalation plans in place. It was reported that the Trust was probably seeing about one child today admitted to our paediatric assessment wards for RSV at the moment. The CEO commented that in her view the local authority did not have an achievable plan to increase the domiciliary care capacity; and that there was a reliance on the spot purchasing capacity. The Chair commented that the labour market had changed with a fundamental lack of labour in the domiciliary market; a lot of the labour pool had left this area and moved into higher paying positions.	

Reference	Minute	Action
	It was reported that the Deloitte well led review was now entering its final phase, with a significant amount of progress having been made by the end of October. At the time of the report, Board and senior manager interviews had been completed, as well as stakeholder engagement events internal and external to the Trust. The Trust Board meeting observation originally scheduled for the October meeting was rescheduled to November 2021. Informal feedback is due to be delivered to the Trust in mid-November 2021, with a full report anticipated at the end of the same month. It was identified that areas of improvement will begin being implemented from December 2021, with assurance feeding through to the Board, leading up to the annual report submission in May 2022. Further to NHS England's release of the Guidance on the development of the place-based partnerships, in late September 2021, the Trust has continued to work with NHS organisations across Wirral and Wirral Council to develop the future 'Place' based governance arrangements. This has included a number of workshops with Wirral NHS and council executives and Cheshire and Merseyside Integrated Care System leaders to review the emerging legislation and guidance and debate the future governance arrangements. This includes roles and responsibilities at Place, working in partnership and leadership. It is expected that an outline of these future governance arrangements will be presented to Trust Board in early 2022, with an aim for these arrangements to be implemented from April 2022. It was highlighted that the Trust has been working with Clatterbridge Cancer Centre NHS Foundation Trust (CCC) and other campus partners in the development of a capital master plan for the Clatterbridge Health Campus, with the support of BDP Architects and Archus Health Planners. This master plan is in its final stages and expected to be presented to Boards in November 2021. It was identified that in mid-July 2021, the Department of Health and Social Care (DHSC) announced an Expression of Interest (EOI) process for NHS Trusts to bid for capital funding for one of eight new hospitals, with bids due in September 2021. WUTH and CCC decided to develop and submit an Expression of Interest for the Clatterbridge Health Campus redevelopment, using the emerging master plan as a basis for the submission. The submission includes a new integrated hospital building incorporating an elective centre with 9 theatres, a breast surgery centre, outpatient and ambulatory care facilities, rehabilitation wards, chemotherapy and FM services. NHS England and the Department of Health and Social Care have indicated that the review of EOIs this will be undertaken through a two stage process, with the aim to make a final decision on the successful bids in the spring 2022.The Trust has commenced the procurement process for architectural and health planning specialist support in the development of the campus master plan for Arrowe Park Hospital. The Trust is aiming to complete the master planning exercise by the summer of 2022, with a focus on short and medium term capital improvements and developments to the hospital campus as well as the longer term redevelopment of the hospital site. It was emphasised that at the October meeting, the Workforce Assurance Committee received a comprehensive presentation on the Workforce Wellbeing winter plan, due to be rolled out during the winter months to promote our staff wellbeing. This proactive approach is specific to the Wirral	

Reference	Minute	Action
	University Teaching Hospital Trust. The purpose of the Workforce Wellbeing Winter Plan is to build upon our current health and wellbeing tools, resources and initiatives. The current workforce wellbeing provisions have been reviewed through staff engagement, use of evidence and national best practice guidance to implement further support for staff during the winter period. The plan will launch in November 2021 until 31 March 2022. The plan is focussed on physical health, mental health, building resilience and morale boosters. All of the wellbeing provisions within the plan will be funded via charitable funds, funding available via a successful bid to NHS England or existing OD resource. On-going monitoring, evaluation and adjustment of the plan are essential and form a key part of implementation and roll out. One of the key risks to achieving improvements in health and wellbeing via this plan are barriers to access. The Workforce Wellbeing Winter Plan Lead will therefore undertake a specific piece of work with staff to understand those barriers and implement appropriate solutions, including delivering the plan differently where required. A full evaluation of the plan will take place in April 2021, to inform the Trust's wellbeing approach going forward. Progress updates will be given to the Workforce Assurance Committee and Board as appropriate. It was reported that an unannounced CQC inspection was undertaken at WUTH in October 2021 focusing on the Emergency Department, Acute and Medical Services. Initial Feedback was provided to members of the Executive Team noting staff were open, welcoming and kind, showing caring interactions with patients throughout all areas. This was validated during the inspection by patients who praised all the staff for their caring attitude. CQC confirmed they had no immediate patient safety concerns. CQC initial feedback described additional focus being given to the effectiveness of streaming in the Emergency Department and the suitability of the environment in the Mental Health Suite located in the emergency department. The discharge lounge was found to be an example of positive practice that worked well to support patient discharge in an appropriate environment. Areas of outstanding practice included the use of telemedicine to support quick access to stroke thrombolysis and staffing levels for patients who required non-invasive ventilation and tracheostomy support. It was reported that the CQC are concluding their inspection with a series of staff focus groups before their final report is drafted and submitted to WUTH for factual accuracy. It was anticipated this will be with the Trust in January 2022. **Action**: Interim Director of Workforce Advice to be provided to Board on the management of vaccinations to staff with details of existing vaccination rates, assessment of push back on vaccinations and where that may impact labour market availability. **RESOLVED:** **That the Board RECEIVED and NOTED the report.**	
9	**Chief Operating Officer Report**	
	The Chief Executive outlined the paper as previously circulated. The paper was taken as read. It was highlighted that whilst progress against elective plans remains strong,	

Reference	Minute	Action
	achievement of the 95% ED 4 hour performance remains significantly challenged especially as we move into the Winter period. The impact of non-elective demand compromises elective recovery if Trust & system capacity is not actively managed over the next half of the year. Improved performance is heavily reliant on the Trust working with the Wirral system to achieve the trajectory submitted as part of the overall Wirral Urgent Care Improvement Programme. The Trust Winter plans are being finalised to support achievement of the trajectory and to meet the increased demand the Trust will be challenged with this winter. **RESOLVED:** **That the Board RECEIVED and NOTED the report.**	
10	**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 September 2021 for their respective areas. 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 September 2021. It was highlighted that 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. The Medical Director highlighted on the exception report the,VTE assessment which is an assessment of the risk of developing VTE linked to prescribing LMWH where appropriate, The Trust have consistently met the national standard that 95% of patients receive a VTE assessment during their admission. However, there is a Trust internal standard that 95% patients receive a VTE assessment within 12 hours of admission. This is currently at 94.5% There have been no patient safety issues associated with this slight reductiont, but clearly the Trust is working to achieve the 95% target. The other area reported by the Medical Director related to her portfolio in about research. It was a positive exception in that the research target is being exceededIt was reported that the Trust have done a lot of good work through COVID research, and that's continued with non COVID research. A new research and innovation manager has recently been appointed, so we are hoping to continue on that upward trajectory in terms of research. The Chair congratulated the Medical Director and it was great to see us taking our rightful place as a proper teaching hospital with a proper research profile. He added that the Trust needed to focus on innovation.	

Reference	Minute	Action
	The Interim Director of Workforce highlighted that she was most concerned about, which is staff absence. On page 44 of the pack was displayed the data and it was reported that sickness absence was a challenge with the view offered that it will continue to be a real challenge over the winter period. JS commented that in terms of short term absence the biggest category was cold cough, flu, and influenza and asked how confident the Trust was that was a true reflection for the absence or whether it masked other underlying problems. The Interim Director of Workforce commented that it may or may not mask staff exhaustion, mental health related issues that staffs sometimes don't want to discuss or other things like menopause related medical issues. This was an issue with regards to the quality of return to work interviews, and that's where we would get our intelligence to inform our answer, to that question. The absence policy review and the roll out of the new managing attendance and leadership program should also pick up on the issues associated with whether the real reasons for absence were being concealed. It was reported that prior to Covid there had been a real NHS wide issue in relation to mental health of staff and Covid may have exasperated the issue. **RESOLVED:** **That the Board of Directors RECEIVED and NOTED the Quality and Performance Dashboard and the Exception Reports for the period to end of September 2021**	
11	**ED Inpatient Survey**	
	The Interim Chief Nurse presented the report as previously circulated. It was reported that the report provided an overview of the Urgent and Emergency Care (UEC) Care Quality Commission (CQC) 2020 Patient Experience Survey results. The report described actions that were being taken as a result and the associated monitoring arrangements that have been defined to ensure improvements are made. People responding to the CQC National Patient Experience Survey of UEC rated their overall experience in the Trust's ED as 8.4 (which was a good rating). The findings and recommendations have been incorporated into ED improvement programmes. The Trust has a series of robust patient experience feedback methodologies aligned to the areas identified within this report that will provide a localised measure to monitor improvement actions. PQSB have received the report in October 2020 and supported the actions/monitoring arrangements required to ensure improvements are seen. **RESOLVED:** **That the Board NOTED the report.**	
12	**Month 6 Finance Report**	
	The Chief Finance Officer presented the report as previously circulated which was taken as read. The Trust reported a surplus of £0.089m at M6, an adverse variance against plan of £0.086m.No income in was generated through the Elective Recovery Fund in M6, where the value of activity was below 95% of the value of activity of M6 19/20. However, NHSEI have confirmed a net £1.219m of additional	

Reference	Minute	Action
	ERF funding in respect of previous periods after the regional position improved significantly from initial estimates in M3. Total employee expenses excluding COVID-19 were £144.808m at M6, this represents an overspend against our budget of £0.801m. However, this figure includes a significant overspend of £3.875m in respect of Medicine and Acute offset by underspends in other parts of the Trust. The Trust has yet to receive confirmation of its funding for H2 and the plan for the period will not be confirmed until after the completion of M7 reporting. The Board noted that the Trust continued to deliver a strong financial performance during the first half of the financial year with a performance of broadly breakeven at the end of month 6. It was recognised that strong Elective Recovery Funding (ERF) was supporting this position non-recurrently. It was noted that the allocation methodology for this funding is to change in H2 to clock stops for elective waiters which will have to be at least 89% of 19/20. The Board noted that capital expenditure was £2.5m behind plan at the end of month 6. This was due to tendering and procurement delays but executives considered there to be minimal risk to the year-end position. The Board was informed that a bid for £10m had been submitted for capital funding for Clatterbridge. It was recognised that the tight timescale given by the Dept of Health of 48 hours precluded the bid going through standard timings for governance procedures. The Chief Finance Officer took the committee through the planning guidance for H2. It was identified that Trust expenditure for H2 was currently forecast at £4.6m above H1 and income was not yet clear. In the meantime the CIP programme continued to make steady progress through each stage of scheme maturity. Work within the H2 planning processes was ongoing. Committee members were pleased to see that £1.2m CIP had been achieved in H1 against a target of £1m. Furthermore, 180 projects have progressed to implementation at a value of £3.7m part year and £4.5m full year. **Action**: CFO Addition of glossary of terms in Finance Report. **RESOLVED:** **That the Board NOTED the report.**	
13	**Freedom to Speak Up – Quarter 2 Update**	
	The FTSU Lead Guardian presented her report which was the Freedom to Speak Up – Quarter 2 update as previously circulated. It was taken as read. It was reported that the highlights from me or this quarter are we've seen a reduction in the number of people speaking up this quarter. So 32 people in quarter 2 have spoken up compared with 46 last quarter. There was also a reduction in the number of patient safety concerns coming through this quarter, so they had reduced from 15% last quarter down to 12 1/2%. The FTSU Lead Guardian wanted to pick up a correction for the minutes in relation to the topic of patient safety in the report specifically relating to a collective grievance, it should read disclosure. It's not a formal grievance process, and it was just to identify that one particular concern came in on behalf of a group of staff names which weren't identifiable, and it was identified that the number of concerns relate to the number of people.	

Reference	Minute	Action
	It was highlighted that there had been a reduction in the breadth of occupational groups reporting this quarter. The Medical Director commented that the Trust had done a lot of work around the junior doctors. The Trust had a guardian of Safe working who the junior doctors tend to go to share their concerns with as well. **Action**: FTSU Lead Guardian FTSU Lead Guardian to bring benchmarking information on speaking up when available. **RESOLVED:** **That the Board NOTED the report.**	
14	**Monthly Safe Nurse Staffing Report**	
	The Interim Chief Nurse presented the report as previously circulated which was taken as read. She reported that it had been another challenging month for staffing both in adult and maternity services due to increased patient acuity, sickness, and staff absence due to staff isolating because of the increase in COVID community prevalence. Mitigations are in place across the Trust; enhanced monitoring, escalation processes, NHSP, agency staffing, and absence monitoring processes. It was reported that the Trust had seen improved staffing levels with a further reduction in the vacancies and this is in response to the international recruitment programme that's been highly successful. The intention was to have zero vacancies and she was working with executive colleagues on drafting and international recruitment plan for next year to submit a bid for further funding. Resilience planning was on-going locally and regionally to ensure plans are in place ahead of the predicted pressures over the forthcoming months. The Trust had approved an incentive bonus payment program for nursing staff, which was to keep the Trust on track with winter plan and to make sure that the Trust can cover our gaps open till January until the rest of the international recruits are due to arrive. This has been really successful already. The Trust had seen a 15% increase in fill rates in response to that. It was reported that during M6 495 shifts fell below minimum RN staffing levels as reported on the SSOT. This is a reduction of 50 shifts compared to M5 (545). To reduce the risks in areas with reduced staffing levels 299 staff were relocated from other areas (M6); this is comparable with M5 (301). In M6, 2 shifts were assessed by the Senior Nursing Team as a professional judgement of red (high risk of care standards falling below expected levels), which is a reduction of 4 compared to M5 (6). Both shifts were reported on the neonatal ward in the Women's and Children's Division. It was reported that recommendations presented by the Interim Chief Nurse to implement releasing time to care initiatives were approved by the Executive Management Team on 12 October 2021. The paper provided	

Reference	Minute	Action
	recommendations to reduce some audit processes and nursing care requirements to release time to care whilst maintaining assurance for all essential areas. This approach was to support safe staffing and quality care during times of unprecedented pressures that are anticipated during the winter. It was identified that the Trust remains on track with the IR nurse programme in line with agreed plans to recruit 160 IR nurses before the end of M9. Funding has been sourced to support recruitment of a further 20 IR nurses bringing the total to 180 with the ambition of landing in the Trust by M9. **RESOLVED:** **That the Board NOTED the report.**	
15	**Board Assurance Framework**	
	The Interim Director of Corporate Affairs presented the report as previously circulated. The paper was taken as read. It was identified that following the adoption of the Board Assurance Framework at the September meeting of the Board, the updated risks are now submitted for assurance as part of the agreed bi-monthly process. The purpose of the report was to enable the Board to review, and if deemed appropriate agree the updates in risk mitigations as put in place by Executive Directors in their capacity as risk owners. **Action**: Interim Director of Corporate Affairs Summary to be provided to Board into whether there should be changes to board seminars and what Committees do and how the formal boundaries will be affected. **RESOLVED That the Board:** 1. **NOTED** and received the attached assurance update to the Board Assurance Framework for the month of November 2021 2. **NOTED** and **APPROVED** the addition of risk 1.4 onto the BAF document, as highlighted in section 2 3. **NOTED** and **APPROVED** the change in rating of risk 5.2 on the BAF document, as set out in section 3 4. **NOTED** and received the general updates highlighting developments in risk mitigation in section 4	
16	**CQC Statement of Purpose**	
	The Interim Director of Corporate Affairs presented this to the Board. It was identified that The Trust was required under Schedule 3 of the Care Quality Commission (Registration) Regulations to have in place a Statement of Purpose that is publicised on the Trust website, and kept up to date as soon as relevant changes occur. In addition, the document is required to be submitted to the CQC in a timely manner once updated. This document was therefore submitted to the Board, in advance of its submission to the CQC, as well as to provide assurance of the Trust's compliance with the CQC Registration Regulations requirements. As part of this process, an additional requirement was identified to register the Seacombe Children's Centre as a registered location, and at the time of writing this process had commenced, with a view to completion for submission by the 30th of November 2021.	

Reference	Minute	Action
	In formulating this view, the Trust has followed the CQC's registration of locations guidance, which requires certain criteria to be met in order for a location to be eligible for registration with the CQC. Firstly, the site carries out a wide range of midwifery and maternity services that are managed from the site, including the management of a birthing unit with out of hour's access. Secondly, Seacombe Children's Centre falls within the scope of the registration on the basis that children's audiology services are provided there, which in itself is classified as a stand-alone site for the provision of diagnostic and screening requirements. Progress was being made at the time of writing to ensure the submission would be made to the CQC on the 30th of November 2021, with sufficient due diligence undertaken to ensure CQC compliance assurance would be in place. **RESOLVED:** **That the Board NOTED and APPROVED the Statement of Purpose in advance of its submission to the Care Quality Commission.** **RESOLVED:** **That the Board NOTED and APPROVED the addition of Seacombe Children's Centre as a registered location of the Trust with effect from the 30th November 2021.**	
17	**Annual Board of Directors Fit and Proper Persons Checks Report**	
	The Interim Director of Corporate Affairs presented the report as previously circulated. The report was taken as read. **RESOLVED: That the Board NOTED and received the Annual Fit and Proper Persons compliance checks for Board members.** **RESOLVED:** **That the Board NOTED and received the assurance update on the implementation of the policy.**	
18	**Chair's Report – Finance, Business Performance & Assurance Committee**	
	Sue Lorimer reported on the work carried out by the Finance & Business Performance Assurance Committee in its meeting on 27October 2021. It was highlighted that : - The Committee received assurance from Steve Ryan, chair of Quality Assurance Committee (QAC) that the QAC has oversight of the impact of patients exceeding agreed waiting times for scheduled care. - The Committee agreed that the divisional appendices were no longer required in the Finance report as it was felt there was now sufficient confidence in the Finance team to rely on their judgement on bringing material divisional variances to Committee. It was further reported that the Committee received several reports from the Executive team with the key points being as follows: Financial position and Cost Improvement Plan (CIP)	

Reference	Minute	Action
	- The Committee was pleased to note that the Trust continued to deliver a strong financial performance during the first half of the financial year with a performance of broadly breakeven at the end of month 6. - It was recognised that strong Elective Recovery Funding (ERF) was supporting this position non-recurrently. It was noted that the allocation methodology for this funding is to change in H2 to clock stops for elective waiters which will have to be at least 89% of 19/20. - The Committee noted that capital expenditure was £2.5m behind plan at the end of month 6. This was due to tendering and procurement delays but executives considered there to be minimal risk to the year-end position. - The Committee was informed that a bid for £10m had been submitted for capital funding for Clatterbridge. It was recognised by the committee that the tight timescale given by the Dept of Health of 48 hours precluded the bid going through normal governance procedures and this will addressed subsequently. It was discussed that there appear to be an increasing number of calls for bids with a tight turnaround and it would be helpful for Audit Committee to provide a view on how the Trust can take full advantage of funding opportunities while maintaining sufficient governance of the process. - The Chief Finance Officer took the Committee through the planning guidance for H2. It was noted that Trust expenditure for H2 was currently forecast at £4.6m above H1 and income was not yet clear. Submission date is 11th November but the plan will have to go through ICS governance first. - The CIP programme continues to make steady progress through each stage of scheme maturity. Committee members were pleased to see that £1.2m CIP had been achieved in H1 against a target of £1m. Furthermore, 180 projects have progressed to implementation at a value of £3.7m part year and £4.5m full year. - The Committee received a presentation from the Estates and Facilities division which demonstrated the process and governance associated with identifying and delivering the divisional CIP target. The committee were impressed by the progress made in setting up this infrastructure and the engagement of staff within it. - The Committee had a brief discussion on the value of service line reporting now that income was not reliant on payment by results for each service. It was agreed that there was still value in reviewing service expenditure against the model hospital and other national benchmarks and that the Committee would continue to receive reports on that basis. In relation to operational performance it was reported that: - The Committee received an update from the Director of Planned Care on service improvement in the ED as there had been some concern at potential lack of progress at last month's meeting. The committee was assured that this work was moving forward despite a continued increase in attendances. He expected performance against the 4 hour standard and ambulance handovers to improve in October. He informed the Committee that all of the 12 hour breaches were due to difficulties in securing appropriate support for patients with Mental Health problems. This was being addressed by the Wirral system. - The Director of Operations for Unscheduled Care updated the Committee on elective performance. The waiting list continues to	

Reference	Minute	Action
	grow despite the Trust's strong performance in delivering elective activity. There is a new directive to ensure all waiters over 104 weeks are treated. The committee noted that the number of waiters over 104 weeks is not included in the performance report and that due to the current situation it would be useful to see more information on the number of weeks people are waiting between 52 and 104 weeks and over 104 weeks. - The Committee noted that the 31 and 62 day waiting time targets for patients with Colorectal and Urological cancers are likely to be breached in Q2. - The Committee noted that the diagnostic waiting standard had been breached due mainly to problems with Endoscopy. Improvements have been made in Endoscopy and performance is expected to increase. **RESOLVED:** That the Board NOTED: • the achievement of the financial plan including CIP in H1. • the risks regarding Trust income for H2 and the impact on the financial plan. • the request for increased information on waiting times for elective care. • the capital bid for £10m and the need for expedited governance processes for future bids.	
19	**Change Programme Summary, Delivery and Assurance**	
	The Director of Strategy and Partnerships presented highlights of the report as previously circulated. The report was taken as read. It was identified that the Board had touched on elements of the change programme at the seminar around urgent care this morning. The Chair congratulated the Director of Strategy and Partnerships as well as commenting that he had a great grip on this area and that was a huge step forward from where the Trust used to be. The CEO commented that it was very positive the work that's been going on from an improvement perspective, considering how hot the site is and has been in the pandemic, etc. It was noteworthy that the Trust still managed to continue to deliver against some of those improvement projects, and gave a massive thank you to the Trust's clinical teams ,operational teams, service improvement teams as well as to the Director of Strategy and Partnership. **RESOLVED:** **That the Board NOTED** the Trust's Change Programme Assurance Report and recognised the impact the current staffing situation within the organisation and the competing priorities within clinical and operational teams has had on the delivery of key projects.	
20	**H2 Priorities for the Trust**	
	The Director of Strategy and Partnerships presented the paper as previously	

Reference	Minute	Action
	circulated. The paper was taken as read. It was reported that in January 2021, the Trust launched its 2021-26 Strategy, setting out the strategic objectives and priorities for the next five years. Following this launch, the Trust has developed and published a number of enabling strategies to support the 21-26 Strategy, including the Clinical Service Strategies and Digital Strategy. The H2 Priorities for the Trust were outlined: from Outstanding care; Compassionate Workforce; Continuous improvement; Digital future; Working with partners; through to improvement in use of infrastructure. It was identified that additional actions were the Deloitte Well-led review, board development, executive recruitment, management and completion of investigations, as well as Divisional leadership support and recruitment. **RESOLVED:** **That the Board NOTED the report.**	
21	**Communications and Engagement Monthly Report**	
	The Director of Communications and Engagement presented the report as previously circulated 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. The report was taken as read. In addition to the content of the report it was identified that the Trust had just firmed up hosting in the Clinical Skills Suite the Metro Mayor for the launch of the Liverpool Ventures Innovation Fund with the Northwest Innovation Agency. **RESOLVED:** **That the Board NOTED the report.**	
22	**Questions from the Public**	
	There were no questions from the public.	
23	**Any other business**	
	There was no other business conducted during the meeting.	
24	**Date of Next Meeting** 01 December 2021 via MS Teams	
25	**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 is 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

PUBLIC Board of Directors
1 December 2021
Action Log

No.	Minute Ref	Action	By Whom	Action status	Due Date
1	**21/22-109** **Digital Strategy** **August 2021**	To provide the Board with projected costings associated with the strategy after an assessment of divisional requirements has been undertaken	Chief Information Officer	Open. This will be picked up and dealt with as part of Operational and Financial Planning for 2022/23	Quarter 1 2022
2	**21/22-134 M4 Finance Report September 2021**	Investigate the risk of a new cost base-line in excess of 20% as well as a cost base-line review for the Board	CFO	Open. This will be picked up and dealt with as part of Operational and Financial Planning for 2022/23	Quarter 1 2022
4	**Oct 6 2021 COO report**	To identify and propose solutions addressing the root causes of patient flow in unscheduled care	COO	Open. To be dealt with at a Board Seminar in January 2022.	January 2022
7	**Oct 6 2021** **Risk Management Strategy**	To review terms of reference for risk management committee and SMAC, and ensure that the significant aspects of the role of SMAC are maintained	Director of Corporate Affairs	Open and incorporated into the wider review of all TORs and the Committee structure	January 2022
8	**Nov 3 2021 CEO Report**	Advice on managing vaccinations to staff with details of existing vaccination rates, assessment of push back on vaccinations and where that may impact labour availability	Interim Director of Workforce	Closed. In CEO Report.	December 2021
10	**Nov 3 2021 Freedom to Speak Up**	FTSU Guardian to provide comparative benchmarking data on speaking up	FTSU Guardian	Open	January 2022

Agenda Item: 8

BOARD OF DIRECTORS
1 December 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 December 2021.

Recommendation: (e.g. to note, approve, endorse)
The Board is asked to note and receive the Chief Executive's 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	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)
This report incorporates narrative on an update on the governors' elections as well as the Annual Members Meeting

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

November 2021

Chief Executive's Report

Purpose

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

Introduction / Background

1. Respiratory Infections Update

The Covid prevalence on Wirral remains relatively static at 336 cases per 100,000 population. Currently 5% of the Trust's beds are occupied by Covid positive inpatients, with a small number on Critical Care. We have not yet experienced the anticipated surge of either RSV or influenza cases.

The numbers of inpatients with Covid, influenza and RSV are monitored through the WUTH daily dashboard and through the command structures. There are robust escalation plans in place to manage each of these respiratory infections separately with strict infection prevention and control guidance.

2. Serious Incidents

The Trust declared 5 serious incidents (SI) in the month of October 2021; this is a decrease of one on the previous month. The Serious Incident panel report and investigate under the "Serious Incident Framework" so that learning can be identified.

Two Serious incidents declared were related to clinical assessment, diagnosis and scans. The 5 reported incidents spanned areas of the trust, including Diagnostics and Clinical Support (1) Acute Medicine (2) Medical Division (2). The Trust reported no Never Event in the month of October.

Duty of Candour has been commenced in line with legislation and national guidance.

RIDDOR

There were two events reported to the Health & Safety Executive in October 2021 as required under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR).

A Slip Trip Fall was reported to the HSE as it resulted in an over 7 day absence to a member of staff who reported tripping due to a defect to the flooring.

The second incident related to three porta-count machines that had not been calibrated and where used to Fit Test staff on a range of FFP3 masks.

Both events have been investigated in line with Trust governance processes. All staff potentially affected by the porta count machine incident have been identified and recalled for re-fit testing.

3. Surgery Core Service Monitoring

CQC undertook a focussed inspection for the surgical division on 4th October. The CQC inspector noted that the team were open, honest and enthusiastic about improvement. It was noted that, since the last inspection, improvements had been made with the Malnutrition Universal Screening Tool (MUST) compliance and Surgical

Site Infection (SSI) monitoring. No regulatory action will be initiated following this review which is not associated with a formal report, nor will it change the current CQC rating.

4. Liverpool Women's Hospital Incident – Response and assurance

On the morning of Sunday 14th November 2021, a major incident occurred at Liverpool Women's Hospital. As part of the incident response the Trust provided mutual aid to Liverpool Women's Hospital, with maternity cases diverted to Wirral University Teaching Hospital and St. Helens and Knowsley.

As part of the response, the Trust immediately put in place additional security across both hospital campuses (Arrowe Park and Clatterbridge). In addition, Merseyside Police attended the Arrowe Park Hospital campus on the afternoon of Sunday 14th November to provide additional security and support to the Trust, which was maintained on site until Friday 19th November 2021. Merseyside Police are continuing to provide regular patrols of the hospital campuses.

Following the incident response, the Trust has undertaken a risk assessment of access and egress across the campuses, building on the additional security controls put in place in October 2020, to support manage patient and visitor access as part of our COVID response. As part of the risk assessment the Trust has enhanced security presence across the campuses and extended access restrictions in the evenings as well as put in place traffic enhancements and parking restrictions near the main entrances.

5. Integrated Care Board – Designate Chief Executive

The Cheshire and Merseyside Health and Care Partnership have confirmed that following a robust recruitment process, Graham Urwin has been appointed to the position of Designate Chief Executive of the Cheshire and Merseyside Integrated Care Board (ICB).

Graham is well known in his current role as Director of Performance and Improvement at NHS England North West, a role with responsibility for system leadership and oversight of NHS Commissioners and Providers in the North West region. Graham has a finance background in both local government and the NHS. He has worked at local, regional and national level. He has also worked across both commissioning and provider organisations. Graham has also been the Regional Incident Director throughout the Covid Pandemic.

The confirmation of Graham in this role is a significant step in the development of integrated care in Cheshire and Merseyside and the establishment of an NHS Integrated Care Board which, subject to legislation, will hold a substantial budget for commissioning high quality patient care, and have the authority to establish performance arrangements to ensure this is delivered.

The partnership is now moving on to recruit Non-Executive Members and Executive Directors to the ICB over the coming weeks.

Whilst the substantive Board appointments are made and the ICB becomes a legal entity in April 2022, interim arrangements have been out in place. A System Oversight Board chaired by David Flory is in the process of being established with interim membership drawn from the current HCP Leadership Team and representatives from across Cheshire & Mersey.

6. Vaccination as a condition of deployment for all healthcare workers

The Department of Health and Social Care (DHSC) has formally announced (9 November) that individuals undertaking CQC regulated activities in England must be fully vaccinated against COVID-19 no later than 1 April 2022 to protect patients, regardless of their employer, including secondary and primary care.

The government regulations are expected to come into effect from 1 April 2022, subject to parliamentary process. This means that unvaccinated individuals will need to have had their first dose by 3 February 2022, in order to have received their second dose by the 1 April 2022 deadline.

There are three phases to the Trust response to this new policy:

Phase 1: Campaign (immediate)
Enhanced efforts to encourage uptake across the workforce and address vaccine hesitancy.
Phase 2: Planning (following receipt of NHS England implementation guidance)
Implementation planning – production of local policy based on NHS England implementation guidance. The Trust will work with partners across Cheshire and Merseyside to ensure a consistent approach.
Mitigation planning – service level mitigating planning, based on current numbers of unvaccinated staff members.
Phase 3: Implementation (from 1 April 2022)
This phase will be dependent upon the outcome of phase 3

The policy takes into account specific exemptions, including those who are medically exempt; under 18 years of age; do not have contact with patients; or are a participant in a clinical trial investigating COVID-19 vaccination. Further details on exemptions will be detailed within the DHSC Code of Practice which the NHS is expecting to be published imminently. The policy applies to the first and second dose of the COVID-19 vaccination, and not to boosters or the flu vaccination at this stage.

NHSE and NHSI are supporting organisations and individuals with the publication of advice and documentation and providing direct support to organisations where there is currently a low uptake.

7. Recommendation

The Board is asked to note and receive the Chief Executive's report.

Agenda Item: 9

BOARD OF DIRECTORS
1 December 2021

Title:	Trust Performance – Planned & Unscheduled Care
Responsible Director:	Chief Operating Officer
Author:	Head of Business Improvement - Planned Care Director of Operations Unscheduled Care
Presented by:	Chief Executive Officer

Executive Summary

This report provides the current Organisational performance data for Planned (Elective) and Unscheduled (Non Elective) Care.

The report covers the performance against the reset & recovery planned trajectories which includes:

- Outpatient New & Follow Up
- Day case & Elective Inpatients
- Diagnostics (Planned and Unplanned)
- Priority 1(P1) & Priority 2 (P2) Elective patients
- 52 & 104 week waiters
- Waiting list size
- Cancer

The report also provides performance against the following Unscheduled Care standards:

- Emergency Department (ED) Performance
- Ambulance Conveyances
- Long Length of Stay

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

To note performance, risks and mitigations.

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)		
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)		
Essential Standards: NHSI CQC		
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)		
-		
Specific communications and stakeholder /staff engagement implications		
-		
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)		
-		
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)		
-		
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
December 2021

Chief Operations Officer Report to Trust Board

1.0 Purpose

This paper provides an overview of the Trusts current performance against the Re-set and Recovery Programme for Planned Care and standard reporting for Unscheduled Care.

For Planned Care activity volumes, it highlights the Trust's 4-week average for weeks concluding 31/10/21 and the current October/November performance (snapshot at 23.11.21) as well as providing comparative data nationally, across Cheshire & Merseyside (C&M) and the North West.

For Unscheduled Care, the report details performance and highlights the ongoing challenges around increase in attendances and long length of stay patients and the impact this has on 4 hour performance. The report also highlights the percentage number of patients who remain in the department for longer than 12 hours since arrival. This is in preparation for the proposed new National standards.

The report also highlights current risks in the Trust's ability to return to pre-Pandemic activity levels and general Emergency Department (ED) performance overall on a sustainable level together with associated mitigations underway to manage these.

2.0 Introduction / Background

March 2020 saw the first large scale cancellation of all, but the most urgent elective activities aligned to the National Emergency Preparedness Resilience & Response (EPRR) to the COVID 19 pandemic. Over the last 20 months elective activity has been re-started and suspended during the 2nd and 3rd COVID19 waves alongside general disruption due to ongoing COVID19 pressures during this period. This has impacted negatively on both waiting list numbers and waiting times for treatment.

From an unscheduled care perspective at the start of the pandemic & during subsequent lockdowns non COVID19 emergency attendance & admission numbers declined significantly. However since the summer these numbers have continued to increase and have surpassed 19/20 pre pandemic activity by around 20%.

The delivery of reset & recovery elective activity commenced in earnest in 2021 with the main focus areas being on treating the most clinically urgent patients first followed by the long waiters. To do this all Trusts were asked to:

- Clinically prioritise their waiting list into 6 categories (P1 – P6) based on how long it was deemed clinically safe to wait for treatment. P1 being the most urgent e.g. cancer through to P6 least urgent. National focus has been on P2 performance with these patients requiring to be treated within 1 month.
- Increase elective activity to an agreed proportion of the 19/20 rates (taking into account the productivity impact of the COVID environment on managing electives) as

a sliding trajectory back to 95%
- Work as a system of providers within their Integrated Care System (ICS) establishing mutual aid, green site working and shared waiting lists.
- Reduce cancer waits to pre pandemic levels

Since the last meeting as part of H2 planning for Reset and Recovery, Trusts are now requested to:

- Eradicate 104+ week waiters by the end of March 2022 excluding P5/P6 patient choice waiters
- Hold 52-week breach numbers to be no greater than end September 2021 position at the end of March 2022.
- Hold waiting list size numbers to be no greater than end September 2021 position at the end of March 2022.
- The number of 62-day cancer pathways not to be greater than 57 each month (locally agreed).

In terms of unscheduled care once the lockdown was fully released the numbers of attendances to ED have continued to increase far surpassing the 19/20 levels. In addition, the numbers of patients who occupy a hospital bed but no longer meet the criteria to reside (deemed fit for discharge) continues to increase with acute bed occupancy over 95%. This is a national picture and is recognised as such, being driven in part by changes in patient behaviour, access to face-to-face GP appointments, increasing levels of acuity in the population based on previous ability to access services during the pandemic, COVID restrictions & a fragile out of hospital care market. The level of demand experienced is putting increased pressure into the system across all points of delivery. This is further compounded by a number of workforce issues which include:

- Higher than average sickness absence rates & continued COVID isolation.
- Fatigued staff who are reluctant to work additional shifts
- Recruitment to domiciliary care to support the out of hospital care sector

3.0 Elective Performance

The elective performance to date is outlined below

Activity

The National Standard was to achieve 95% of 2019 comparable month's activity across all Points of Delivery (PODs). However, 3 things to note:

1. The actual is based on the value of the activity with activity numbers used as a proxy
2. The threshold has been revised for H2 21/22 to 89% of closed RTT pathways not activity value for access to the Elective Recovery Fund (ERF)
3. To clear backlog systems need to be undertaking in excess of 100%

The table below summarises the 4-week average for weeks concluding 31/10/21

POD	National	North West	Cheshire & Mersey	WUTH
OP New	89%	102%	99%	95%
OP FU	95%	104%	100%	111%
Day Case	85%	88%	80%	94%
Elective IP	80%	92%	95%	95%

Diagnostic Activity

Planned & Unplanned activity levels are as expected.

Diagnostics %			
Planned		UnPlanned	
Div Trajectory	Actual	Div Trajectory	Actual
100	86	100	93

Priority 2 Performance (P2)

The Trust continues to overachieve against the P2 month end trajectories with October's position better than plan at 35 open pathways against a month end plan of 49 open pathways.

November's position is on plan against a trajectory of no more than 51 open at month end with a trajectory of no more than 59.

There are currently 289 patients at WUTH that have an assigned P2 category of which 70% having date scheduled for their procedure (TCI). This compares to 2867 P2 patients across the Cheshire & Mersey ICS with 68% having a TCI in place.

52 Week Wait Performance

The 52 weeks wait number is 575. This position is an improvement on last month and remains below the trajectory of 800. Across C&M there are currently 14,286 52 + week waiters.

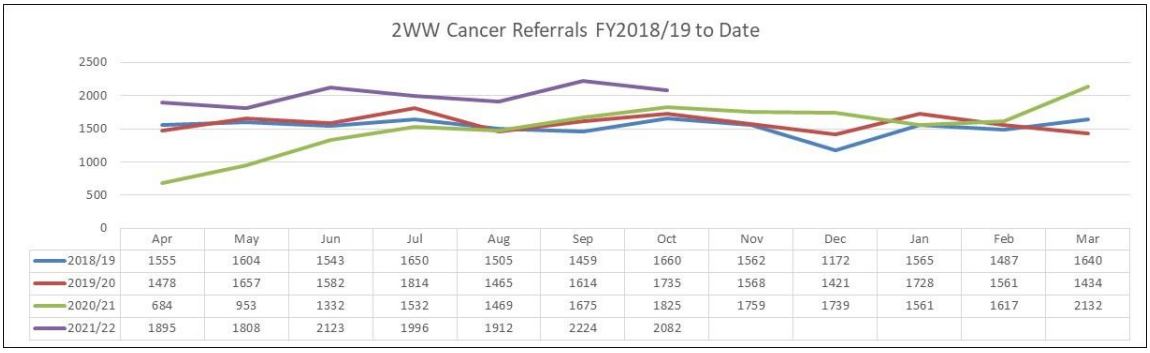
104+ Week Wait Performance

As of 31.10.21, the Trust had a total of 9 104+ week patients. This is an increase of 2 on end September 2021 position but 5 below month end trajectory. This compares to 463 across C&M.

Cancer Backlog Performance

TWW referrals as demonstrated in Table A below remain high. Cancer performance for Q1 and Q2 has been achieved as illustrated in table B. However, Q3 performance will not be achieved due to the number of Breast, Urology and Colorectal breaches which is driven by increase in referrals & capacity constraints. Recovery actions are underway to reduce this risk in Q4

Table A



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2018/19	1555	1604	1543	1650	1505	1459	1660	1562	1172	1565	1487	1640
2019/20	1478	1657	1582	1814	1465	1614	1735	1568	1421	1728	1561	1434
2020/21	684	953	1332	1532	1469	1675	1825	1759	1739	1561	1617	2132
2021/22	1895	1808	2123	1996	1912	2224	2082					

Table B

2WW performance	Q3 (21/22)	
2WW performance	Q4 (21/22)	
28 day performance	Q3 (21/22)	
28 day performance	Q4 (21/22)	
31 day performance	Q3 (21/22)	
31 day performance	Q4 (21/22)	
62 day performance	Q3 (21/22)	
62 day performance	Q4 (21/22)	
Long waiting patients (maintaining pre-pandemic levels)	Ongoing	
H2 Performance Planning	Ongoing	
Outstanding harm reviews	Ongoing	

Risks to Recovery

There remain significant risks to elective recovery which include:

- Staff shortages & fatigue impacting on uptake of additional sessions
- Movement of theatre and anaesthetic staff to support critical care
- Balancing clinical priority against long waiters
- Winter non elective surge
- Failure to deliver agreed activity levels (Insourcing)
- Increased cancer referrals

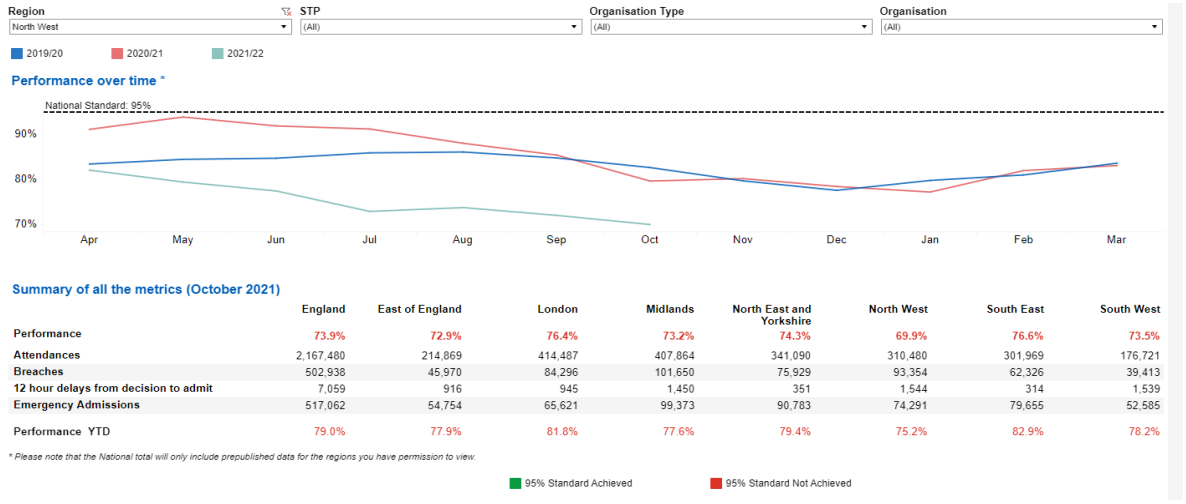
Mitigations

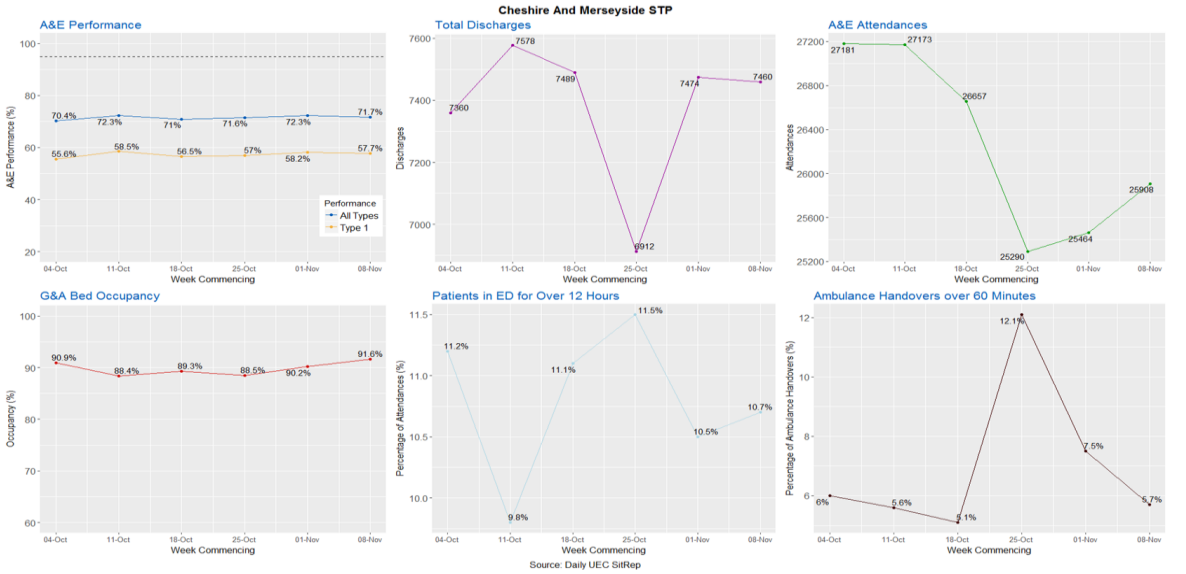
Recognising these risks there are a number of mitigations in place which include:

- Full participation in the C&M elective recovery programme which is supporting the coordination of:
    - Use of the Independent Sector
    - Regional/National capital, revenue & technology bids to increase capacity and throughput.
    - Regional review and agreement around staffing requirements to maximise qualified staff utilisation, particularly in critical care
    - Introduction of HVLC (High Volume Low Complexity) surgical pathways including theatre lite alongside organisational bench marking.
    - Green site working
- Divisional Director led cancer remedial action plans to recover in Q4 for Breast, Urology and Colorectal.
- Appraisal of robot usage by non-CA specialities/patients along with full service and staffing review.
- Patient level tracking & active management in place monitored by the Divisional Directors via the weekly operation delivery group (ODG)
- Full participation in regional performance governance arrangements

4.0 Unscheduled Care

Performance against the 4-hour standard remains challenged in Wirral, across C&M, the Northwest and across the rest if England as can be seen below. The Northwest is the most challenged region for 4-hour performance in England.





Performance for APH site type 1 for October was 49.89% and YTD 59.71%, for the APH site; including UTC this was 62.61% and YTD 68.62%. The All-type Wirral Performance for October was 74.61% and 77.73% YTD.

The Trust saw average daily attendances of 267 which is an increase compared to the average of 244 for the same period in 19/20. Total attendances for October were 8274 against 7691 for same period in 19/20 an increase of 4.3%, a 23.6% increase for the same period in 20/21.
The proportion of patients waiting more than 12 hours in the department from time of arrival was 5% in October compared to 9.3% in September. This compares favourably both within C&M & Northwest where the average is around 10%.
There was a total of 8 formal 12-hour breaches from DTA in September which are reportable to NHS E/I. This brings a total of 29 reportable 12-hour trolley breaches between April - October 2021. All breaches were due to the challenges in accessing timely mental health beds, which is mirrored nationally.

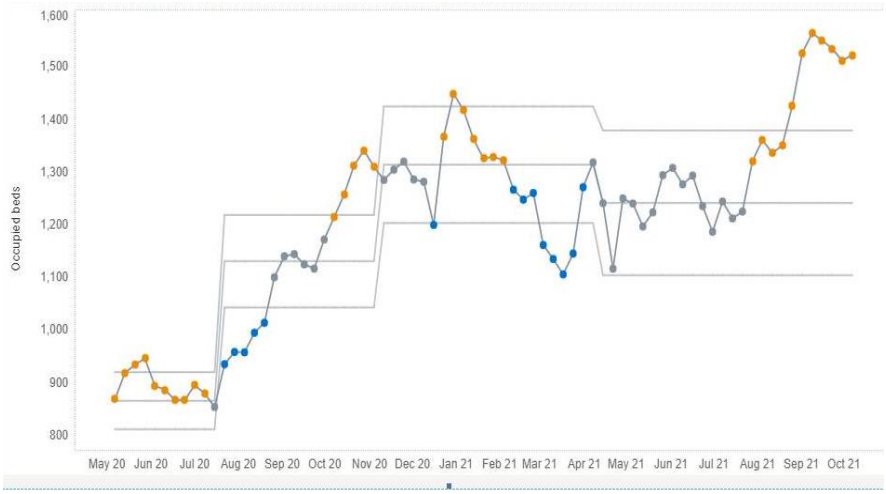
Total ambulance turnaround time was not achieved in September 2021 with a mean time of 44 mins against the 30minute standard. Mean time for handover to Trust was 34 against the

15-minute standard. There were a total of 2041 ambulance conveyances in October, accounting for 24.7% of ED attendances. There were 204 ambulances that had a greater than 60mins handover in October compared to 241 in September.

G+A bed occupancy for October 90.53% compared to 90.27% in September, however excluding 'silver elective beds' occupancy was consistently over 95%.

The average number of super stranded patients (>21days LOS) in October was 144 compared to 132 in September. Work is ongoing both internally and externally with system partners to improve the current position.

This is mirrored in the Cheshire & Mersey position outlined in the graph below.



Cheshire and Merseyside STP Days Occupying Beds 14+

Risks to Unscheduled Care Performance

There are a number of risks to improving performance as outlined below:

- Increased attendances at ED is significantly compromising capacity in ED
- Physical environment is compromised during periods of overcrowding
- Increasing mental health activity and significant increases of attendances under S136
- The fluctuation in Covid attendances and admissions, alongside nosocomial infections compromise flow as a result of closed hospital beds
- Flu attendances have started to impact on bed capacity
- Staff shortages across the Trust impacting on patient flow and reduces the ability to open additional escalation areas
- Increase in delayed transfers of care resulting in patients staying in hospital longer than required.
- The lack of domiciliary care provision in the community is impacting on overall hospital occupancy and resulting in reduced patient flow through the Trust.
- T2A (Transfer to Assess) beds availability in the Wirral system as new providers have not been able to come online within agreed time frames due to staffing challenges in the community.
- Availability of Mental health inpatient beds

Mitigations

There are a number of mitigations in place which include

- System wide Winter plan in line with the National UEC Recovery Action Plan
- Full participation in the unscheduled Care transformation programme which includes Working with Wirral Community Trust to improve streaming and reduce the numbers of patients attending the ED department who can have their care needs met away from ED.
- Trust level Winter resilience director now in place from November 2021 until April 2022
- Revised operational winter resilience command structure has commenced 22nd November, with executive level oversight.
- Additional spot purchase care home beds now commissioned on a block basis.
- Participation in C&M winter room including mutual aid arrangements
- NWAS Divert Deflection policy

4.0 Conclusions

Whilst progress against elective plans remains strong, achievement of the 95% ED 4 hour performance remains significantly challenged especially as we move into the Winter period. The impact of non-elective demand compromises elective recovery if Trust & system capacity is not actively managed over the next half of the year.

Improved performance is heavily reliant on the Trust working with the Wirral system to achieve the trajectory submitted as part of the overall Wirral Urgent Care Improvement Programme. The Trust Winter plans are being finalised to support achievement of the trajectory and to meet the increased demand the Trust will be challenged with this winter.

5.0 Recommendations to the Board

To note performance, risks and mitigations.

Agenda Item 10

BOARD OF DIRECTORS
1 December 2021

Title:	Committee Membership and NED Portfolios
Responsible Director:	Chief Executive Officer
Author:	David McGovern, Director of Corporate Affairs
Presented by:	David McGovern, Director of Corporate Affairs

Executive Summary
The purpose of this report is to enable the Board to review interim arrangements for the filling of Board Champion roles following the recent resignation of Jayne Coulson as a NED.

Recommendation:
The Board is asked to approve the interim arrangements outlined in the report.

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)
Weak arrangements for monitoring the delivery of strategy and associated risks expose the organisation to gaps in internal control, which may adversely impact on quality of care and reputation
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
The Foundation Trust Code of Governance places specific responsibilities on NHS Board to monitor delivery of strategy and associated risks
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Not applicable at this current stage
Specific communications and stakeholder /staff engagement implications
Not applicable
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Not applicable
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)

not applicable		
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	Not applicable	
Background papers / supporting information	Not applicable	

1. Background and Purpose

Current Position and Proposals
In addition to the substantive roles of Non-Executive Directors, the Trust has in place a small number of Board Champion Roles that are in place to either fulfil the requirements of guidance or support in particular areas of the Trusts work.

Following the resignation of Jane Coulson from her position as a NED some of these roles are empty and require filling on an interim basis.

The table below outlines the current Champion roles along with vacancies and proposals for the interim filling of those roles:

Board Champions and Roles	
Wellbeing Champion	Vacancy – John Sullivan (Proposed)
Security Champion	John Sullivan
Procurement Champions	Steve Igoe Sue Lorimer
CNST (Maternity) Champion	Steve Ryan
Cyber Security Champion	John Sullivan
Emergency Preparedness EPPR Champion	Vacancy – Chris Clarkson (Proposed)
Freedom to Speak Up Champion	Vacancy – Steve Igoe (Proposed)

It is proposed that these arrangements remain in place until further reviewed in April 2022 and following the imminent recruitment process for NED vacant positions.

Board Champion Role Profile
In order to support Board Champions a short role profile has been produced and attached to this report for information. Following Board approval discussions will be arranged for Champions along with Trust leads to discuss requirements and role.

2. Next Steps

Work is ongoing to recruit to the current (and future) vacant Board positions under the auspice of the Council of Governors Nominations Committee.

3. Recommendations

The Board is asked to approve the proposals for interim arrangements and appointments to Board Champion positions which will be subject to further review in April 2022.

Role Description
Board Champions

Principal Responsibility

In addition to their responsibilities as a Board Member, the Board Champion will take a lead in an area of business defined by the Board and work with the Executive Team and other staff to assist in the development of strategy and policy.

Representing the Board

- To take a lead responsibility in a defined cross cutting area of the business;
- To be consulted on the development of strategy and policy prior to the consideration by the Board or Committee;
- Undertake visits to the Trust sites to observe activity in relation to the chosen area of business and meet with lead staff;
- To offer a Board member perspective to staff in relation to the cross cutting issue; and
- To contribute to learning events.

Working with Staff

- To support the lead officer in the defined area of the business in the preparation of strategy and policy papers;
- To offer an advanced level of scrutiny on proposals prior to their consideration by the Board or Committee;
- To support joint working between Board members and staff;
- To ensure that Board members roles and responsibilities do not cross into the operational duties of staff.

All Champions can do the following things

- Be clear about their role;
- Advice on best and comparative practice;
- Review and influence;
- Review policies and procedures;
- Create awareness;
- Scrutinise/critique e.g. Board reports;
- Raise standards on materials;
- Help to embed;
- Raise the profile of the business area;
- Point of contact and ‘sounding board’ for advice; and
- Network other organisation.

Agenda Item: 11

BOARD OF DIRECTORS
1 December 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 October 2021.

Of the 46 indicators that are reported (excluding Use of Resources):

- 22 are currently off-target or failing to meet performance thresholds
- 24 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)

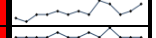
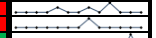
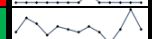
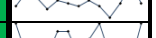
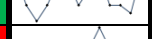
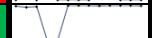
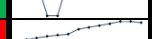
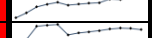
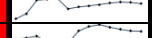
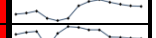
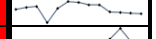
For noting.

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	

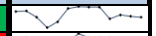
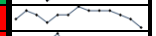
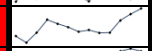
Quality Performance Dashboard

November 2021
Upated 17-11-21

	Indicator	Objective	Director	Threshold	Set by	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-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	0.00	0.11	0.21	0.15	0.11	0.16	0.10	0.20	0.05	0.05	0.10	0.10	0.05	0.09	
	Eligible patients having VTE risk assessment within 12 hours of decision to admit	Safe, high quality care	MD	≥95%	WUTH	95.1%	95.3%	94.7%	94.2%	94.9%	94.0%	94.4%	94.5%	94.7%	93.3%	95.2%	94.5%	94.5%	94.44%	
	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	96.8%	96.9%	96.9%	96.5%	96.6%	96.2%	96.4%	96.6%	96.6%	96.2%	97.6%	96.9%	96.9%	96.7%	
	Serious Incidents declared	Safe, high quality care	CN	≤48 per annum (max 4 per month)	WUTH	3	2	4	4	5	4	5	4	8	7	4	5	7	40	
	Never Events	Safe, high quality care	CN	0	SOF	0	0	0	0	1	0	0	1	0	2	0	0	0	3	
	CAS Alerts not completed by deadline	Safe, high quality care	CN	0	SOF	0	0	0	0	0	0	0	1	0	0	0	0	0	1	
	Clostridium difficile (healthcare associated)	Safe, high quality care	CN	Maximum 79 cases for 2021-22, with a varying trajectory of a max 6 to 8 cases per month	WUTH	5	10	8	4	7	6	5	7	5	1	6	13	6	43	
	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	National	7	3	1	3	6	6	3	5	7	3	3	2	7	30	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	0	0	0	0	0	0	0	1	0	0	0	0	1	
	Hand Hygiene Compliance	Safe, high quality care	CN	≥95%	WUTH	100.0%	100.0%	100.0%	99.3%	98.9%	100.0%	99.2%	99.2%	99.0%	99.3%	99.0%	99.2%	99.2%	99.2%	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	1	0	1	0	0	0	0	1	1	0	0	0	2	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	94%	91%	93%	Not avail	Not avail	96%	96%	96%	95%	96%	96%	96%	95%	96%	
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	CN	≥90%	WUTH	73.2%	75.1%	76.6%	77.9%	79.1%	79.9%	84.3%	85.9%	87.5%	89.1%	91.0%	91.1%	90.0%	88.4%	
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	CN	≥90%	WUTH	74.5%	77.6%	81.3%	82.9%	84.1%	82.3%	83.0%	83.6%	83.9%	86.1%	85.9%	87.2%	86.9%	85.2%	
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	CN	≥90%	WUTH	54.7%	60.9%	77.8%	79.0%	80.1%	67.0%	69.5%	70.8%	72.3%	74.3%	75.5%	75.0%	73.6%	73.0%	
	Attendance % (12-month rolling average)	Safe, high quality care	DoW	≥95%	SOF	93.58%	93.61%	93.66%	93.48%	93.42%	93.48%	93.79%	93.90%	93.95%	93.88%	93.83%	93.79%	93.78%	93.78%	
	Attendance % (in-month rate)	Safe, high quality care	DoW	≥95%	SOF	93.81%	94.04%	94.14%	92.30%	93.91%	94.71%	94.62%	94.32%	94.32%	93.52%	93.47%	93.38%	93.33%	93.85%	
	Staff turnover % (in-month rate)	Safe, high quality care	DoW	Annual ≤10% (equates to monthly ≤0.83%)	WUTH	0.64%	0.97%	0.82%	0.98%	0.67%	0.77%	0.95%	0.72%	0.79%	1.22%	1.86%	1.09%	1.01%	1.09%	
	Staff turnover (rolling 12 month rate)	Safe, high quality care	DoW	≤10%	WUTH	12.6%	13.2%	13.3%	13.7%	13.9%	13.0%	13.5%	13.2%	13.3%	13.0%	12.6%	12.9%	13.3%	13.3%	
	Care hours per patient day (CHPPD)	Safe, high quality care	CN	Between 6 and 10	WUTH	8.5	10.1	9.5	8.1	8.9	9.0	8.7	8.3	8.8	8.5	8.4	8.2	8.2	8.4	

Quality Performance Dashboard

November 2021
Upated 17-11-21

	Indicator	Objective	Director	Threshold	Set by	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021/22	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	97.4%	97.5%	96.2%	94.1%	95.3%	98.0%	98.4%	98.3%	98.3%	95.9%	96.7%	96.4%	96.2%	97.2%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	96%	98%	97%	95%	97%	97%	99%	98%	98%	98%	97%	96%	94%	97.1%	
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	MD / COO	≥33%	National	17.7%	18.5%	17.9%	18.4%	18.9%	18.0%	18.0%	17.7%	18.4%	18.5%	18.1%	17.9%	18.5%	18.2%	
	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	305	279	319	371	354	341	323	329	318	319	368	393	416	416	
	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	95	86	112	98	106	88	96	85	99	95	126	132	126	126	
	Length of stay - elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤5.3 days average	WUTH	3.9	4.1	3.4	2.8	3.2	3.1	3.6	3.3	3.5	3.8	3.8	3.6	3.6	3.6	
	Length of stay - non elective (actual in month - Patient Flow wards only)	Safe, high quality care	COO	≤7.3 days average	WUTH	5.8	5.4	4.3	4.7	4.4	4.2	3.8	4.0	4.0	4.1	4.2	4.4	4.7	4.2	
	Emergency readmissions within 28 days	Safe, high quality care	COO	≤1,110 per month	WUTH	1007	992	1020	1027	938	1097	1149	1131	1084	1115	1018	1010	1070	1082	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	79.2%	81.3%	77.7%	71.9%	81.3%	84.9%	84.5%	85.5%	82.5%	79.8%	82.0%	83.4%	83.7%	83.0%	

Quality Performance Dashboard

November 2021
Upated 17-11-21

	Indicator	Objective	Director	Threshold	Set by	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021/22	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	0	0	3	2	0	0	2	2	3	4	1	2	2	16	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	87.0%	84.0%	87.0%	85.0%	84.0%	83.0%	82.0%	76.0%	76.0%	71.1%	72.8%	77.8%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	TBC	92.0%	91.0%	92.0%	94.0%	95.0%	95.0%	95.0%	96.0%	94.0%	94.3%	94.8%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	95.0%	94.0%	95.0%	95.0%	95.0%	94.0%	95.0%	93.0%	94.0%	93.2%	94.1%	94.0%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	National reporting suspended	National reporting suspended	80.0%	100.0%	67.0%	94.0%	99.0%	95.0%	93.0%	97.0%	98.0%	94.1%	98.8%	96.4%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-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 2020-21, and Q2 21-22	SOF	71.6%	76.2%	71.8%	64.6%	76.8%	77.8%	76.1%	73.5%	78.0%	67.8%	66.2%	63.4%	62.6%	69.7%	
	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	1	7	11	8	27	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	TBD	National	64.9%	71.4%	69.6%	65.3%	77.8%	78.8%	73.4%	68.1%	73.4%	57.7%	66.7%	48.1%	58.1%	63.7%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	TBD	National	4.3%	3.1%	4.3%	6.7%	2.3%	1.6%	1.7%	2.6%	2.3%	7.9%	4.9%	9.2%	8.0%	5.2%	
	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	12.8%	9.2%	13.2%	18.0%	6.6%	6.8%	8.2%	10.4%	7.6%	14.5%	14.3%	23.5%	21.9%	14.4%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	NHSI Trajectory: minimum 80% for WUTH through 2020-21	SOF	65.66%	69.16%	69.81%	68.40%	67.89%	69.26%	69.61%	72.57%	75.64%	75.13%	74.14%	72.88%	70.84%	70.84%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSEI H2 Plans Trajectory : Oct 21 to March 22	National	22945	21633	21792	21880	21955	23444	24774	25873	26671	26979	27306	27424	26935	26935	
	Referral to Treatment - cases waiting 0-18 wks	Safe, high quality care	COO	n/a	WUTH	15065	14962	15213	14965	14906	16238	17246	18775	20174	20270	20244	19986	19080	19080	
	Referral to Treatment - cases waiting 19-26 wks	Safe, high quality care	COO	n/a	WUTH	1565	2010	2570	2813	2903	2793	3054	2763	2552	3103	3302	3508	3807	3807	
	Referral to Treatment - cases waiting 27-40 wks	Safe, high quality care	COO	n/a	WUTH	3666	2083	1254	1876	2328	2802	2985	2843	2555	2222	2297	2445	2703	2703	
	Referral to Treatment - cases waiting 41-52 wks	Safe, high quality care	COO	n/a	WUTH	1872	1874	2089	1327	710	443	615	859	864	877	903	879	770	770	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSEI H2 Plans Trajectory : Oct 21 to March 22	National	777	704	666	899	1108	1168	874	633	526	507	560	606	575	575	
	Referral to Treatment - cases exceeding 104 weeks	Safe, high quality care	COO	NHSEI H2 Plans Trajectory : Oct 21 to March 22	National	0	0	0	0	0	0	1	1	1	3	3	7	10	10	
	Diagnostic Waiters, 6 weeks and over -DM01	Safe, high quality care	COO	≥99%	SOF	90.5%	93.7%	94.9%	94.0%	94.3%	97.4%	97.7%	98.5%	96.8%	87.5%	86.0%	91.3%	94.3%	93.2%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	94.9%	90.5%	97.2%	96.0%	97.6%	98.8%	96.9%	97.6%	97.2%	95.4%	93.7%	95.7%	96.1%	96.1%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	-	-	94.20%	-	-	97.64%	-	-	97.21%	-	-	94.95%	-	96.1%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	98.0%	97.4%	97.2%	98.0%	93.0%	93.5%	94.7%	95.2%	99.2%	96.3%	96.4%	96.5%	94.5%	96.1%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	-	-	97.55%	-	-	94.73%	-	-	96.26%	-	-	96.41%	-	96.3%	
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	82.9%	85.3%	85.4%	80.9%	82.1%	84.1%	84.5%	84.1%	85.3%	84.7%	85.9%	84.4%	78.6%	83.9%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	-	-	84.60%	-	-	82.56%	-	-	84.66%	-	-	85.05%	-	84.9%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	178	161	150	196	165	170	157	156	145	209	213	218	216	188	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	3.80	3.20	1.32	3.80	3.56	4.07	4.09	2.56	4.04	4.20	3.31	3.29	2.56	3.44	
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	100%	94%	100%	97%	100%	95%	100%	93%	95%	100%	94%	94%	100%	97%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	1	4	2	2	4	4	0	2	1	2	5	2	3	2	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-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 21/22 (cumulative 59 per month until year total achieved)	National	329	215	163	599	206	87	19	35	104	276	453	608	794	794	
	% Appraisal compliance	Safe, high quality care	DoW	≥88%	WUTH	73.0%	74.1%	76.2%	72.9%	74.7%	77.0%	81.0%	81.3%	82.7%	82.7%	82.2%	81.2%	82.2%	82.2%	

	Indicator	Objective	Director	Threshold	Set by	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	2021/22	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	0.8	0.7	0.5	-0.2	-5.4	3.5	0.8	-0.5	-0.2	0.0	0.2	-0.2		0.0	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	0.4	0.5	0.3	-0.1	-5.4	3.9	0.8	-0.4	-0.4	0.0	0.2	-0.1	0.6	0.7	
	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	3.02%	6.03%	9.05%	14.50%	Not reported	Not reported	
	NHSI Agency Performance (monthly % variance)	Effective use of Resources	CFO	On Plan	NHSI	12.1%	0.5%	10.2%	18.5%	-22.5%	-21.9%	-50.5%	-27.7%	-32.4%	-40.5%	-11.7%	-5.2%	-50.0%	-31.1%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-15.0	-15.6	-17.4	-28.0	-17.8	-16.9	-15.0	-15.5	-10.4	-15.7	-15.4	-15.2	-16.2	-16.2	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	41.8%	46.2%	66.3%	67.5%	-74.8%	100.0%	2.0%	5.6%	12.5%	18.0%	22.6%	24.4%	30.7%	30.7%	

(*) Updated Metrics

Responsive : Referral to Treatment - open pathways

Metric Change

Breakdown of RTT open pathways by week-band now included, including 104+ week waiters

(**) Updated Thresholds

Responsive : Referral to Treatment - open pathways

Threshold Change

Thresholds for Oct-21 to March-22 to reflect WUTH H2 plans to NHSEI

Wirral University Teaching Hospital NHS Foundation Trust

Appendix 2

WUTH Quality Dashboard Exception Report November 2021

Safe Domain

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

Executive Lead: Medical Director

Performance Issue:

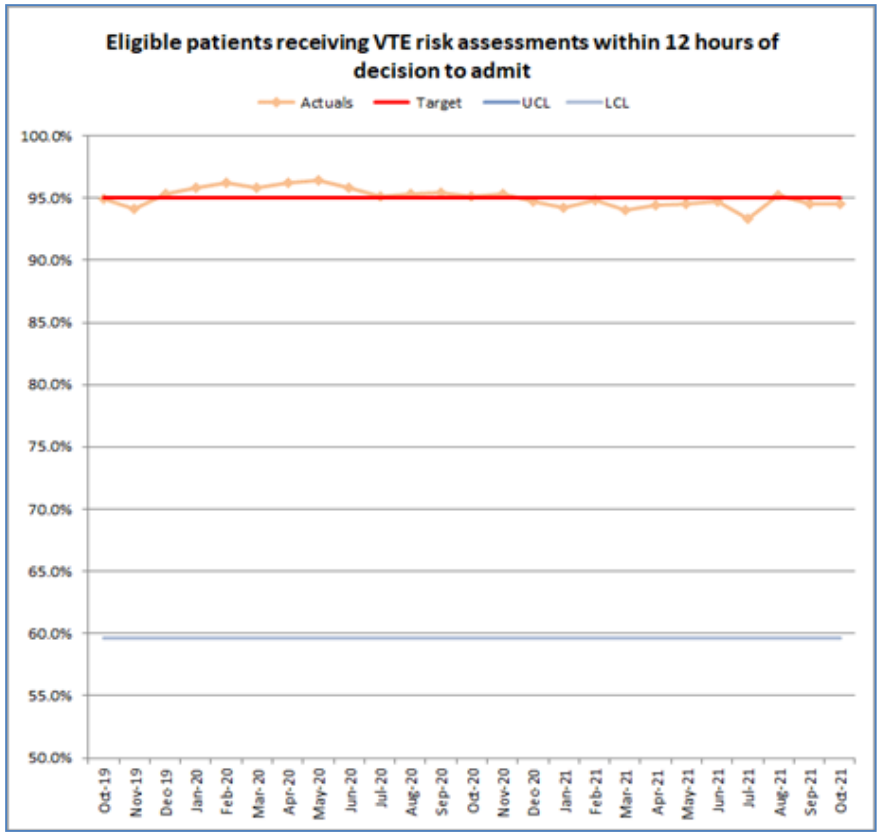
A WUTH target has been set that at a minimum 95% of eligible patients will have a VTE risk assessment performed within 12 hours of the decision to admit. October performance was again slightly below at 94.5%.

The nationally reported standard of all patients receiving a VTE risk assessment on admission to hospital is consistently met.

Action:

VTE compliance in each division is tracked through divisional governance reports to PSQB and through DPRs. A monthly report of all patients who did not receive as 12-hour assessment is shared with all AMDs to feedback to clinical teams. VTE compliance can also be tracked through the live BI portal.
Issues with data quality are being addressed to ensure all patients who do not clinically require a 12-hour assessment are not being inappropriately counted in the performance data.
Performance will continue to be closely monitored to ensure that there is not a significant deterioration in assessment and that there are no patient safety issues.

Expected Impact:
Improvement of performance to achieve minimum target value.



Gram-Negative Bacteremia

Executive Lead: Chief Nurse

Performance Issue:

The Trust maximum threshold for 2021-22 is set at 63, with a varying trajectory of a maximum 5 or 6 cases per month. There were 7 cases in October 2021.

The cumulative number to the end of October was 30 cases, this is below the cumulative threshold.

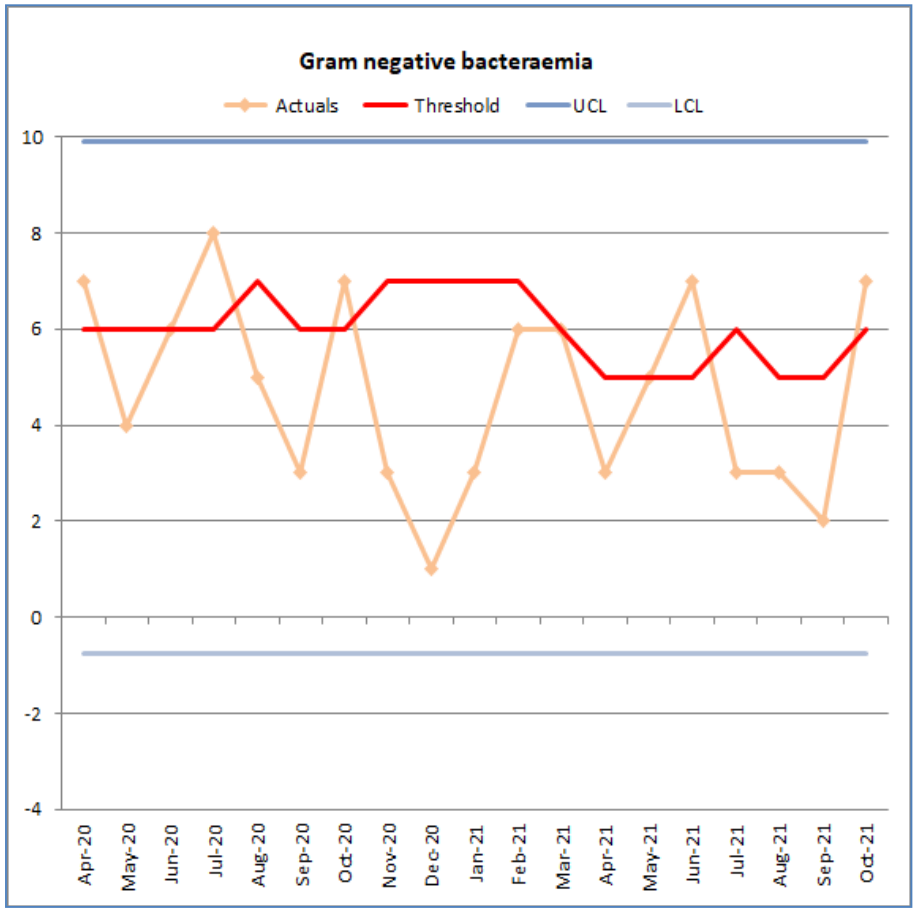
Action:

MDT investigations are completed following the reported incidents of a Gram–Negative bacteremia. The results of the investigations are presented at the weekly Patient Safety Learning Panel, areas for improvement and common themes are discussed and action plans agreed. Lessons learnt are shared at local ward safety huddles.

Divisional Infection Prevention Control meetings monitor delivery of the action plans along with compliance with High Impact Interventions. Training and education reflecting local policies is in place to ensure staff are supported to reduce the incidence. Summaries of each incident are fed back at the monthly IPCG meetings to enable trust wide learning.

Expected Impact:

Gram-Negative Bacteremia cases to be below the monthly and annual threshold for 2021 - 2022.



Protecting Vulnerable People Training - % Compliant Level 2

Executive Lead: Chief Nurse

Performance Issue:
Compliance target for level 2 training is set at a minimum of 90%. Performance against this standard has been improving since February 2021, though October had a slight deterioration to 86.9% compliance. Overall an increase in compliance since Q1 (83.9%) to Q2 (87.2%) has been achieved.

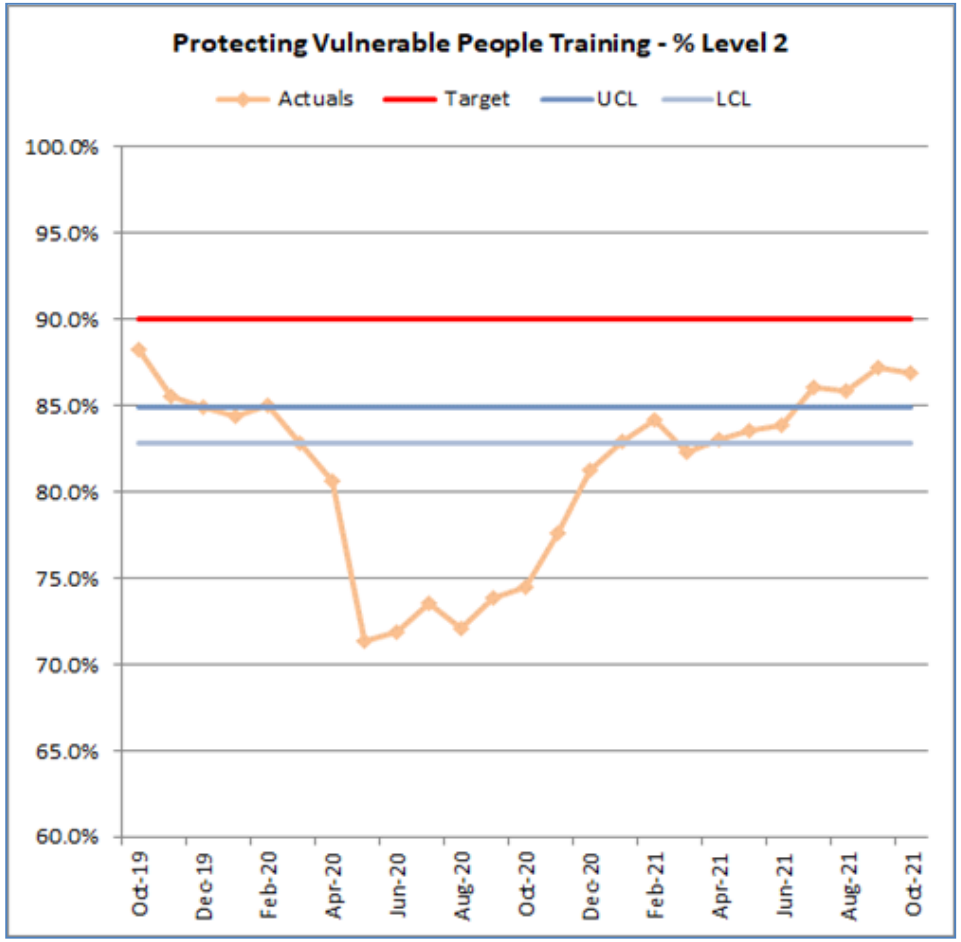
Action:
Divisional Nurse Directors provided updates regarding PVP training at the Safeguarding Assurance Group (SAG) in October 2021. All divisions have plans in place to make further improvements by December (Q3). With the support of the Associate Director of Nursing for Safeguarding, divisions are reviewing the training needs analysis to confirm staff are allocated to the correct training requirements in line with the intercollegiate documents.

Training is available as eLearning via ESR; there are no capacity challenges for delivery of the training.

The Associate Director of Nursing for Safeguarding will continue to provide detailed monthly breakdown of compliance to the divisions to enable key areas to be focused upon.

Expected Impact:

Level 2 PVP training is expected to increase to the mandatory 90% compliance and above mark by end of Q4.



Protecting Vulnerable People Training - % Compliant Level 3

Executive Lead: Chief Nurse

Performance Issue:

Compliance target is set at a minimum of 90% of relevant staff to have undertaken training every 3 years (available via eLearning). Performance against this standard has improved from Q1 (72.3%) to Q2 (75%). October 2021 compliance had a slight deterioration at 73.6%.

To comply with Working Together Intercollegiate (2019) requirements identified staff are required to have additional hours of face-to-face learning: this is set at a minimum of 90%. An improvement has been noted; achieving 72.9% at the end of September for Q2 position compared to 70.9% in Q1.

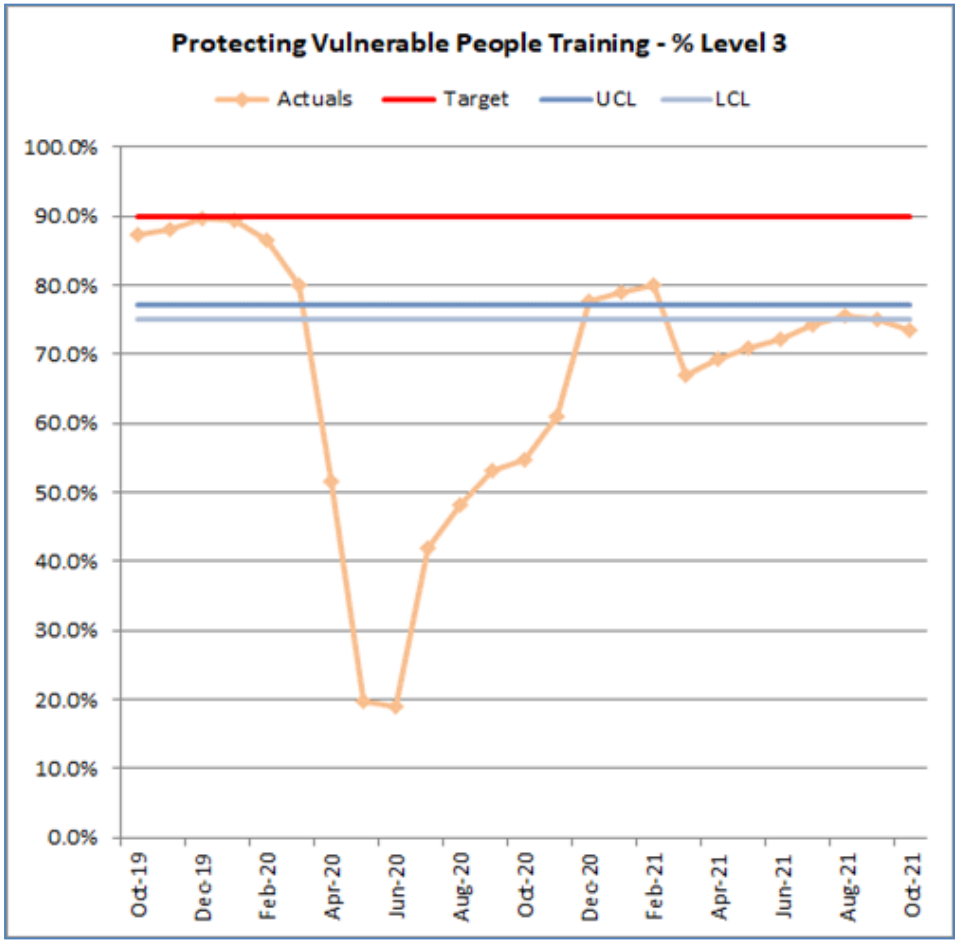
Action:

Divisional triumvirates developed trajectories to determine when compliance of each aspect of level 3 will be achieved; due to unprecedented pressures across the Trust targets were not achieved in all areas. Trajected targets have been reset.

The Associate Director of Nursing for Safeguarding provides monthly reports to enable triumvirates to focus on areas of low compliance and meetings are taking place to determine how the Safeguarding Team will support divisions to improve training uptake.

The eLearning PVP programme has been reviewed to enhance uptake and improve feedback.

Expected Impact:
Level 3 safeguarding training is expected to increase to achieve the compliance requirement of 90% and above by the end of Q4.



Staff attendance % (in-month rate)

Executive Lead: Director of Workforce

Performance Issue:

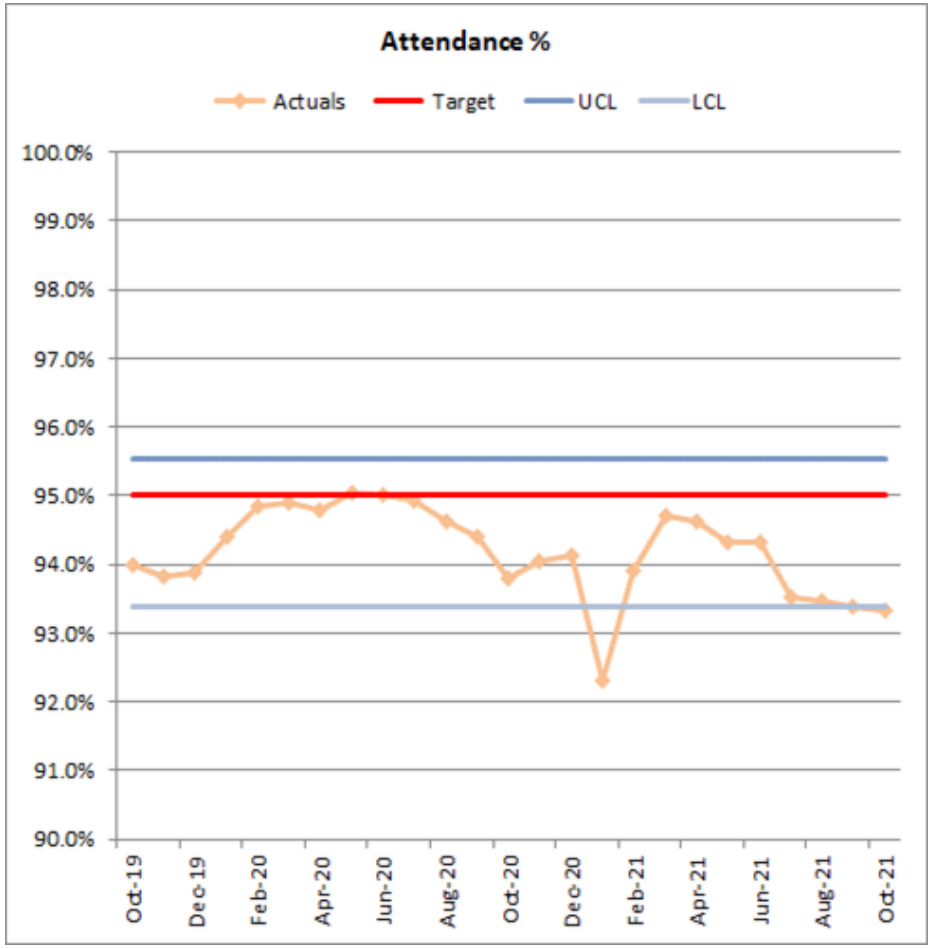
The Trust compliance threshold for sickness absence is 5%, both for in-month sickness and over a rolling 12-month period. Sickness absence in October 2021 was 6.67%. For context, the most recent benchmarking data shows that the Northwest region has a sickness rate of 7.1%.

All Divisions have exceeded the 5% KPI in October 2021. Diagnostics & Clinical Support, Corporate Support and Estates & Hotel Services decreased. It is noted that Estates & Hotel Services decreased by 0.43% – a significant reduction.

In October 2021, there was a further decrease in long-term sickness absence as compared to September, although proportionately, short term sickness absence continues to account for the majority (75%) of sickness absence.

Anxiety, Stress and Depression remains the highest reason (35%) for long term sickness absence. The 'Cold, Cough, Flu – Influenza' category was the highest reported reason for short-term sickness at 29%.

RTW Interviews have seen a slight performance increase to 75.54% in October 21 from 74.18% in September but the variability across the Divisions in terms of compliance is significant.



Action:
Managing Sickness Absence

There is an agreed HR Business Partner Action Plan in place with NHSE/I

to deliver against the six Deep Dive themes.

Informal sickness audits have been undertaken in each Division. Some of the key themes are; lack of awareness and completion of stress risk assessments (work related and personal), poor quality RTWs, lack of self cert and fit note records kept/provided, poor filing of documents.

Work continues of the Attendance Management Policy. A working group (with Staff Side) is reviewing some more fundamental proposed changes aligned with policies seen in lower absence Trusts. The working group will consider a range of elements such as changing reference periods, increasing the length of warnings, reducing triggers, reviewing the number of formal stages etc.

The New Supporting People to Manage Attendance which is being delivered in partnership by North West Employers (NEW) and Innovas (sponsored by the NHS Leadership Academy) from the 24th Nov-9th Dec.

Workforce Wellbeing Winter Plan

The new Winter Wellbeing Plan sets out the enhanced support for our workforce during the 2021/22 winter period. Aim of the Plan is to enhance our Health and Wellbeing provisions above and beyond what we currently offer.

Normally the two main contributors to high sickness absence rates are mental health and physical health (MSK related problems) so;

- **Mental health:** strengthening our Phase 3 mental health response, guided by the Psychological Support Framework, by recruiting an additional Psychotherapist to provide more higher-level therapeutic interventions i.e., trauma-based therapy.
- **Physical Health:** Recruiting an OH Specialist Physiotherapist to focus on fitness and returns to work, especially in staff with long term MSK related sickness absences and provide MSK resilience training to Managers that would educate them on how to prevent MSK related injuries amongst staff.

A Sickness Absence Presentation has been prepared to be presented to Workforce Assurance Committee on 19th November 21.
Expected Impact: The impact of high sickness is increased pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance and safety. 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.

Staff turnover % (in month rate)

Executive Lead: Director of Workforce

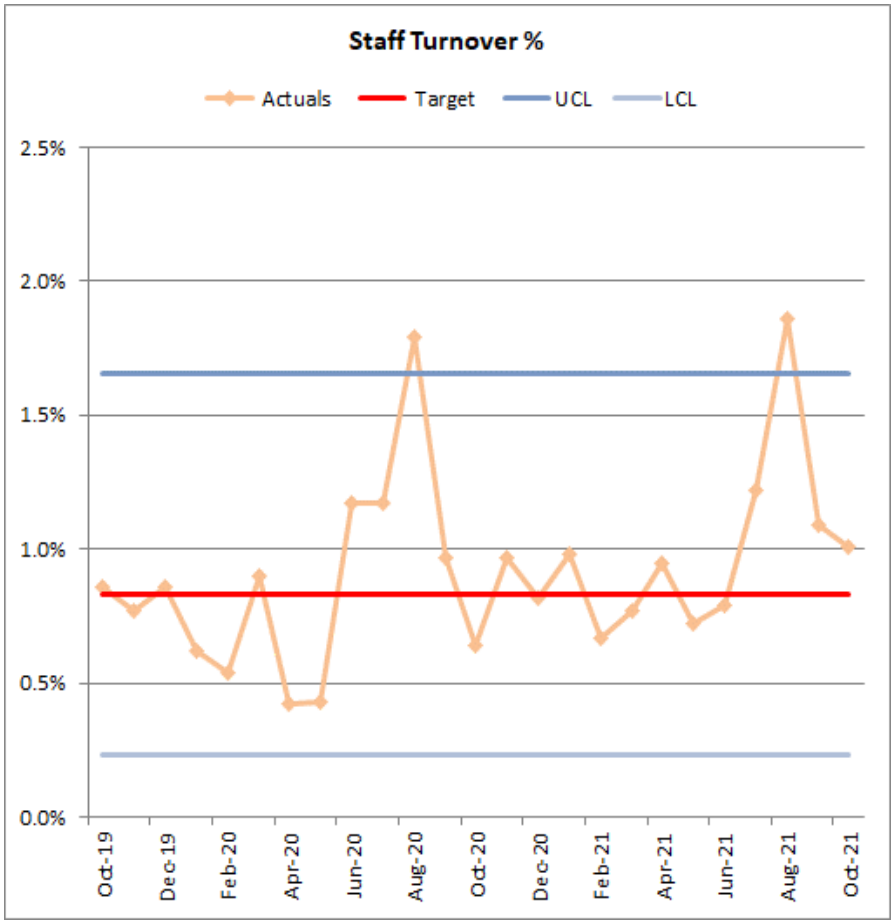
Performance Issue:

The Trust target is set as a maximum rolling 12-month turnover threshold of 10%. Turnover in October has reduced to 1.01%, although this remains above the in-month KPI of 0.83%.

If turnover is calculated based on permanent assignments only, therefore excluding fixed term employees, the in-month figure for October 21 is 0.92% which is a reduction of 0.07% from September 21.

Performance in Estates and Hotel Services both in the rolling 12 months (9.74%) and in-month (0.845) below the Trust Turnover KPI.

All other Divisions are over the 10% KPI for the rolling 12 months. There has been high turnover within the clinical divisions and within Corporate specifically in HR & OD and Finance.



Actions:

Monitoring of the Turnover KPI is on-going via Divisional Management, Divisional governance infrastructure, and via Divisional Performance Reviews (DPRs).

A Deep Dive Learning in Estates & Hotel Services provided insight into good practice which has been shared appropriately. The lessons learnt have been presented to Workforce Assurance Committee.

<u>Current Interventions to support retention.</u>

The Trust is part of a regional project – REPAIR in collaboration with local universities and practice education network to improve the retention of

student and newly qualified nurses

Wirral Enhance Preceptorship programme is currently in development and will provide all newly qualified nurses with a 12-month development programme

The Trust are investing in a total of 16 Professional Nurse Advocate's (PNA) who will lead the implementation of 'restorative supervision' across the Trust that will support resilience and wellbeing of our clinical workforce; preventing burn-out'. The Advocates will link in with Wellbeing Staff to ensure they are looking after their own wellbeing and are supported in their roles.

The new Winter Wellbeing Plan sets out the enhanced support for our workforce during the 2021/22 winter period. This includes increased access to mental and physical health services, access to a wide range of additional wellbeing initiatives as well as a focus upon 'back to basics' such as ensuring staff take their breaks and recognition. In addition, we are strengthening our mental and physical health response through the recruitment of more specialist staff and improving our physical infrastructure across both sites to meet the varying Health and Wellbeing needs of our Workforce.

A range of additional actions and work streams are planned and a presentation setting these out was presented to Workforce Assurance Committee in November 2021.

Expected Impact:

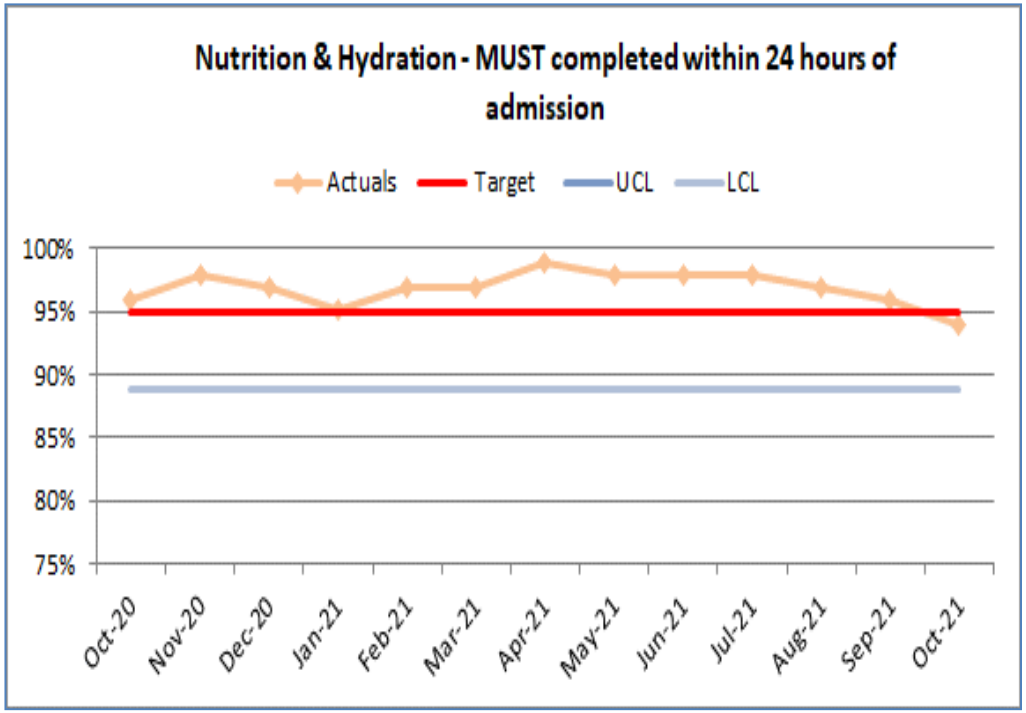
The impact of high Turnover increases pressure on existing staff whose resilience is already compromised and an over reliance on temporary staff which may impact on quality, performance, and safety.

Risks to Trust financial management, quality, patient safety and operational performance due to the cost of high Turnover and the expense of bank and agency cover will reduce as Turnover improves over the next quarter with the interventions outlined above.

Effective Domain

Nutrition and hydration – MUST completed within 24 hours of admission

Executive Lead: Chief Nurse
Performance Issue: An internal target is set at a minimum 95% compliance with MUST assessment to be completed within 24 hours of admission. This has been consistently achieved since July 2020; for October 2021 compliance has reduced to 94%.
Action: Monitoring processes have identified that a high proportion of non-compliance occurred on the assessment areas (30) in the month of October 2021. Despite AMU reaching an individual compliance rate of 95% the overall Trust score reduced. Senior Nursing team are aware of the decline and the importance of completing MUST assessments within 24 hours has been reiterated at safety huddles. Processes are in place to offer areas support from the Corporate Nursing team when 95% compliance has not been achieved for 3 consecutive months. Women and Children's Ward 54 have been invited to the Patient Safety Learning Panel for supportive discussions.
Expected Impact: MUST assessments completed within 24 hours of admission is expected to achieve compliance of 95% by Dec 2021.



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%.

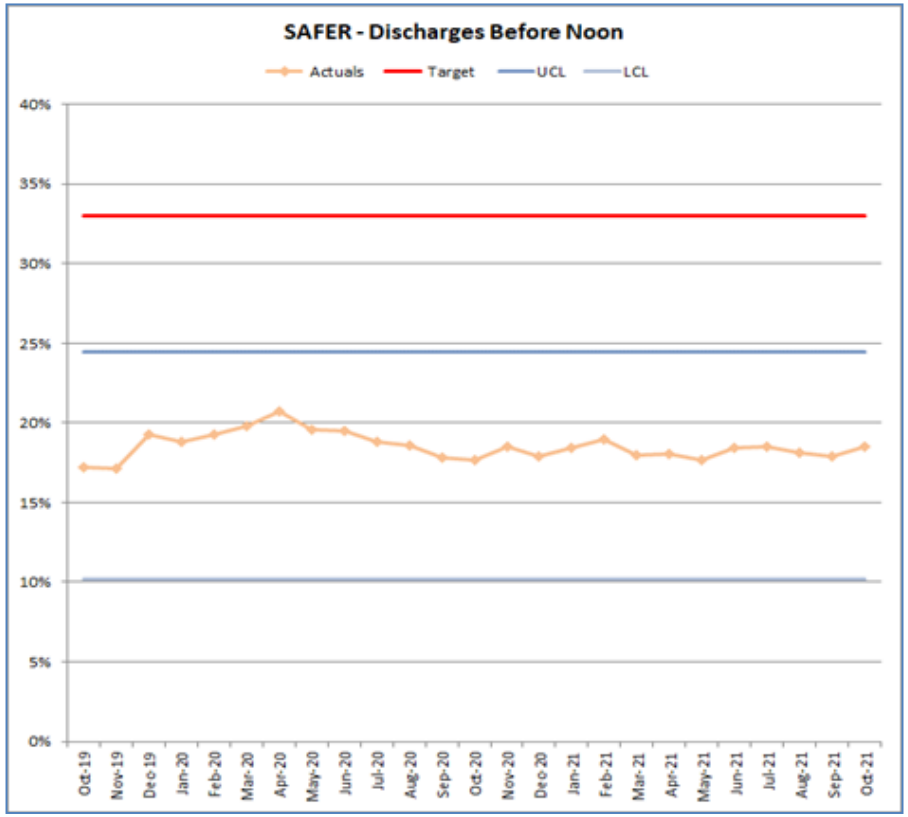
Action:

The Trust have developed a rolling programme of weekly Multi Agency Discharge Events (MADE) to support focused discussions on discharge plans on a large number of patients between ward MDT and MADE team.

Val McGee, COO at Wirral Community Health and Care Trust, has been seconded to WUTH for two months to support developing and implementing improvements in internal flow and discharge processes.

Expected Impact:

October data shows we were at 18.5% for patients discharged before midday.



Theatre in session utilisation %

Executive Lead: Chief Operating Officer

Performance Issue:

The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised.

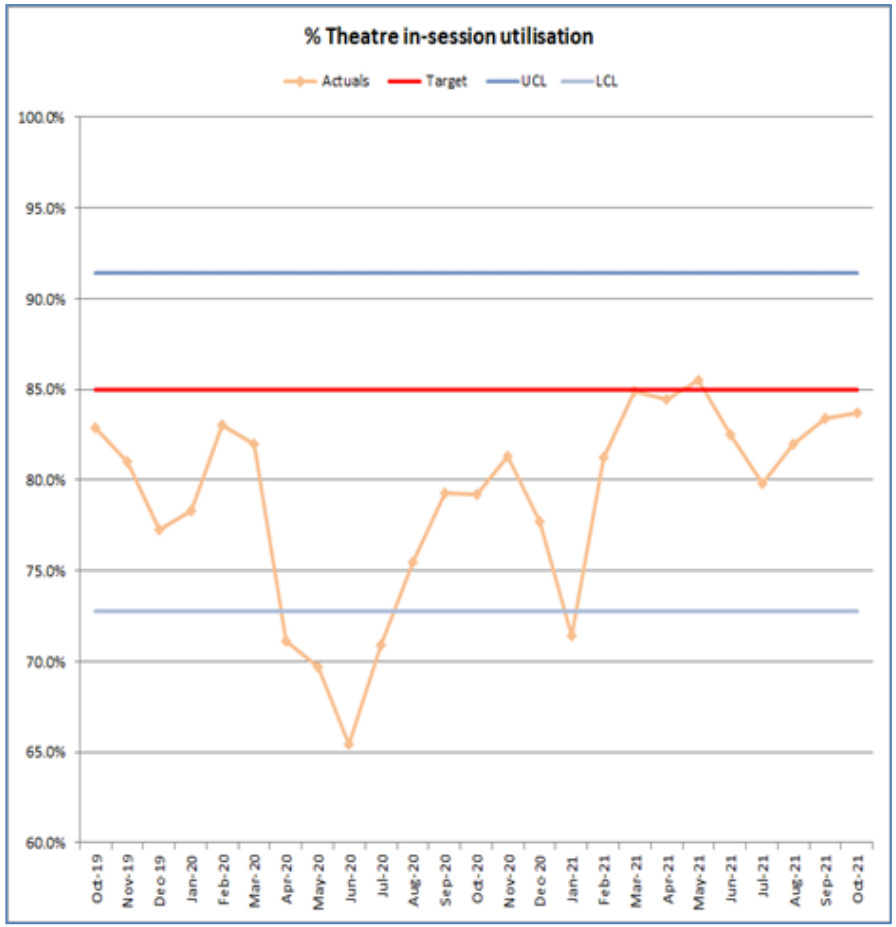
Since September additional challenge was put in via the Division at Theatre Resource Group to increase the number of cases per session while balancing the likelihood of over-running theatres. This had a positive result with September and October performance continuing to improve taking in-session utilisation up to 83.7%. The focus continues to be improving CGH in-session utilisation, however due to the higher throughput of patients operating time is lost while turning theatres around between patients. This is being minimised via list order where patient safety is not compromised.

COVID prevalence continues to see a direct impact on in-session utilisation due to patients being cancelled if their pre-admission COVID swab was positive and lists are unable to be backfilled at such short notice due to clinical requirements/pathways.

COVID measures regarding PPE remain in place.

The close monitoring of lists and a tactical approach to critical care bed requirements I.e. minimising CC bed demand on a Monday seems to be effective as no patients have been cancelled this month due to lack of a CC bed.

Action:



Continuation with pilot of increasing the number of cases per session. Application of the Winter Plan Establishing of the High Volume Low Complexity lists to increase throughput while minimising theatre turnaround times
Expected Impact: The increase in utilisation rates is expected to continue as activity returns to pre-pandemic levels on a consistent basis. On the day cancellations continue to be a risk due to unplanned absence in both theatres and critical care.

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.

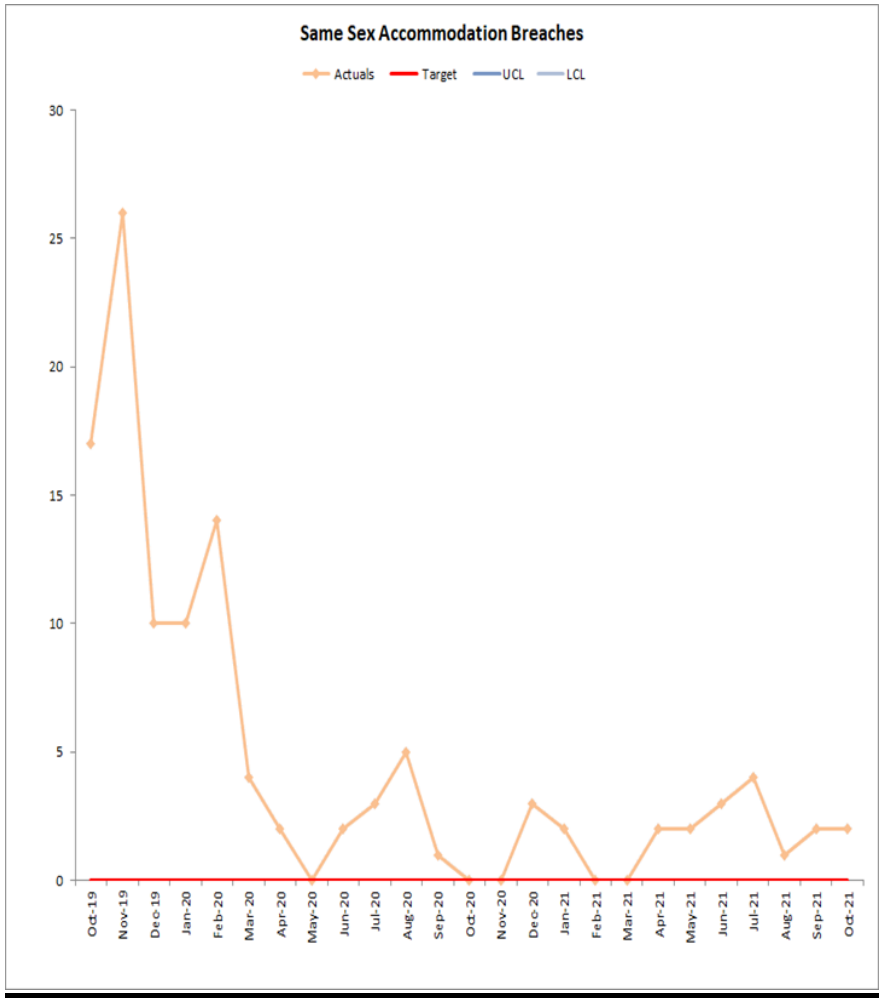
Mixed sex breaches are largely due to patients waiting more than 24 hours for transfer from critical care areas to general wards – there were 2 such breaches in October 2021. These reported breaches did not cause any delays or refused admissions to the Critical Care Unit as sufficient critical care bed 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.

Action:

Joint working continues between Critical Care and Patient Flow teams to expedite discharges in response to an increase in acuity of patients and extremely poorly Covid-19 positive patients.

Robust processes remain in place to ensure that mixed sex breaches remain a high priority and are managed via Bed Capacity and Bronze Command Meetings.

Expected Impact:
All patients are transferred to their specialty bed within 24 hours of discharge.



Responsive Domain

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

Executive Lead: Chief Operating Officer

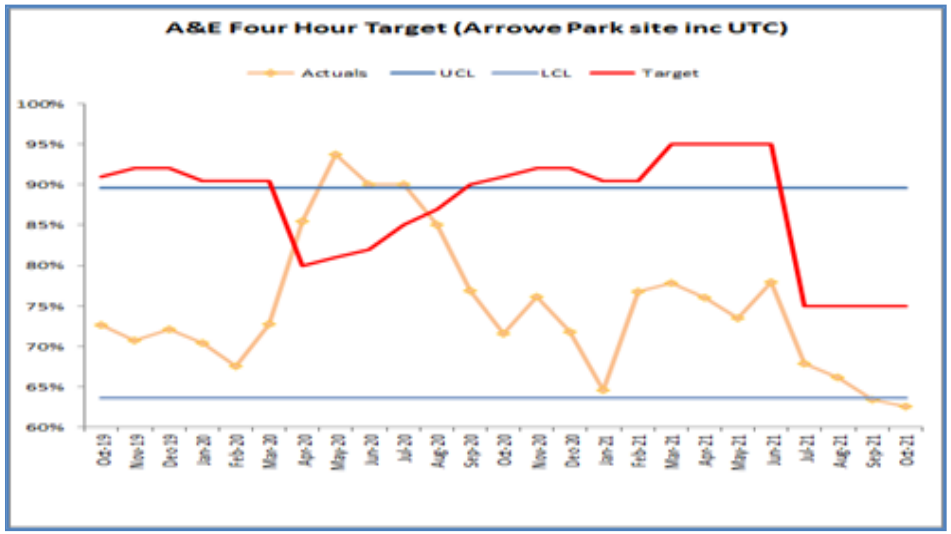
Performance Issue:
Performance for APH site type 1 for October was 49.89% and YTD 61.03%.
For the APH site including UTC this was 62.61% and YTD 69.59%.
The All-type Wirral Performance for October was 74.61% and 78.26% YTD.

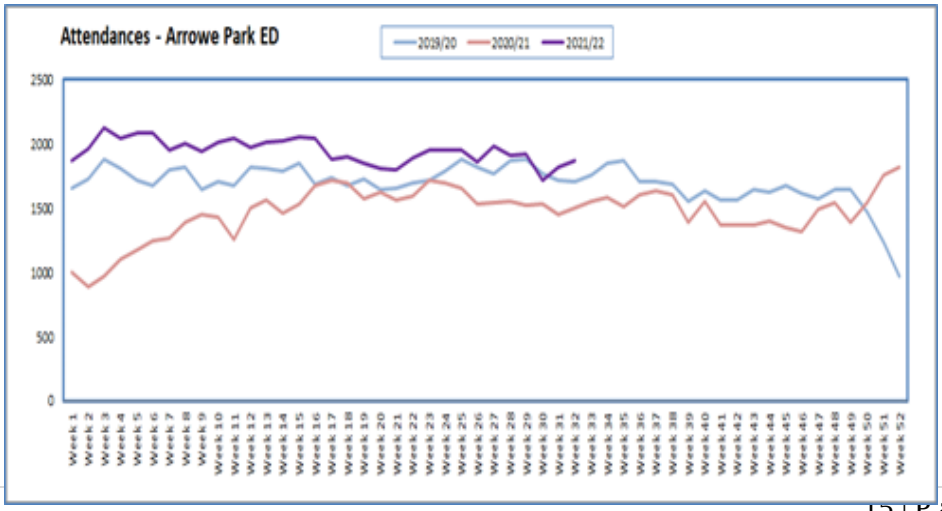
The Trust saw average daily attendances of 267 which is an increase compared to the average of 256 for the same period in 19/20. Total attendances for October was 8,274 against 7,948 for same period in 19/20 - an increase of 4.1%, and a 23.7% increase for the same period in 20/21.

The proportion of patients waiting more than 12 hours in the department from time of arrival was 8.0% in October compared to 9.3% in September. There were a total of 8 formal 12-hour breaches from DTA in October which are reportable to NHSEI. This brings a total of 27 reportable 12-hour trolley breaches between April and October 2021. All breaches were due to challenges in accessing timely mental health beds, which is mirrored nationally.

There were a total of 2,041 ambulance conveyances in October, accounting for 24.7% of ED attendances. Of these 21.9% (404) had a handover greater than 30 minutes – an improvement from the 23.5% in September. 246 ambulances had a greater than 60 mins handover in October compared to 242 in September.

The average number of super stranded patients (>21days LoS) in October was 126 compared to 132 in September. Work is ongoing both internally and externally with system partners to improve the current position.





Action:

There are a number of actions in place which include:

- Appointment of new Interim Director of Winter Resilience commenced 1st November
- Winter Delivery Programme commenced with focused work on:
  - Increasing streaming at the front door
  - Improving ambulance handovers
  - Increase SDEC capacity and utilisation
  - Discharge
  - Patient Flow
- Monitoring of plan by Director of Winter Resilience through to Executive Team and through to Wirral System COO Group
- Health Economy CEO Oversight of discharge cell.
- Additional spot purchase care home beds in place
- Participation in C&M winter room including mutual aid arrangements
- NWAS Divert Deflection policy
- Communications out to primary care and to Wirral residents on only using A+E for urgent care, and from 25th Oct streaming away from ED is to be increased.

Expected Impact:

The Trust winter plan and the ED workforce plan is expected to bring the Trust back in line with its ED performance trajectory.

Referral to Treatment – incomplete pathways < 18 weeks

Executive Lead: Chief Operating Officer

Performance Issue:

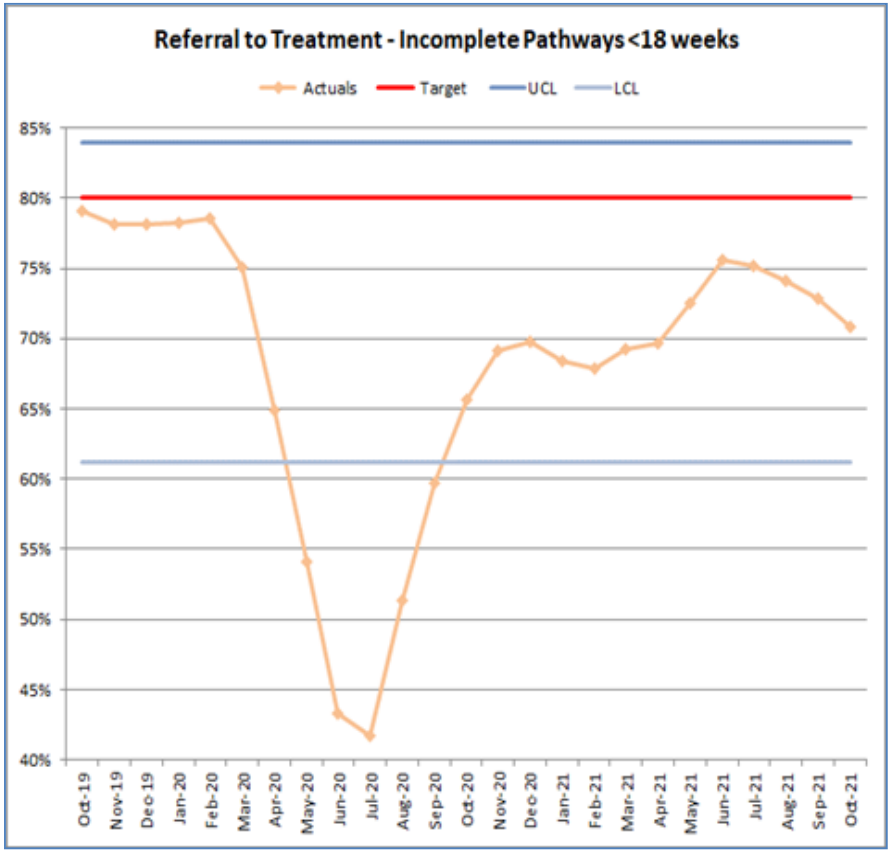
The Trust had a trajectory agreed with NHSI for 2020-21 to maintain at an open RTT position of 80%.

Following the directive to cease all non-urgent elective activities as part of the COVID response this metric sharply declined.

Referral to Treatment performance has continued to deteriorate, with October's position at 70.84%.

Factors impacting activity delivery:

- Inability to staff extra lists (WLIs)
- Staff sickness/isolation
- Staff moved to support ED demands



Actions:

- Continue to offer consultants WLIs and extension of nurse incentive scheme.
- Use the independent sector, Insourcing & Outsourcing where possible with bids submitted to the National team for additional funding.
- Establishing High Volume Low Complexity lists at CGH
- Establishing three session operating days at CGH to aid volume throughput, pilot day successful, but concern over staff fatigue. A split day is being explored
- Active monitoring and tracking of actions via Divisional A&P

meetings
- To open POCU to allow more complex procedures at CGH
- Divisional remedial activity plans requested for H2
- Robust Winter plan including escalation triggers to minimize unscheduled care pressures on planned care activities.

Expected Impact:

It is expected that the performance will stabilise in Q4 if use of IS yields requested activity.

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 also includes those patients that become overdue their planned procedure date. 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 October 2021 was 94.2%.

The main area of underperformance lies within Endoscopy diagnostics.

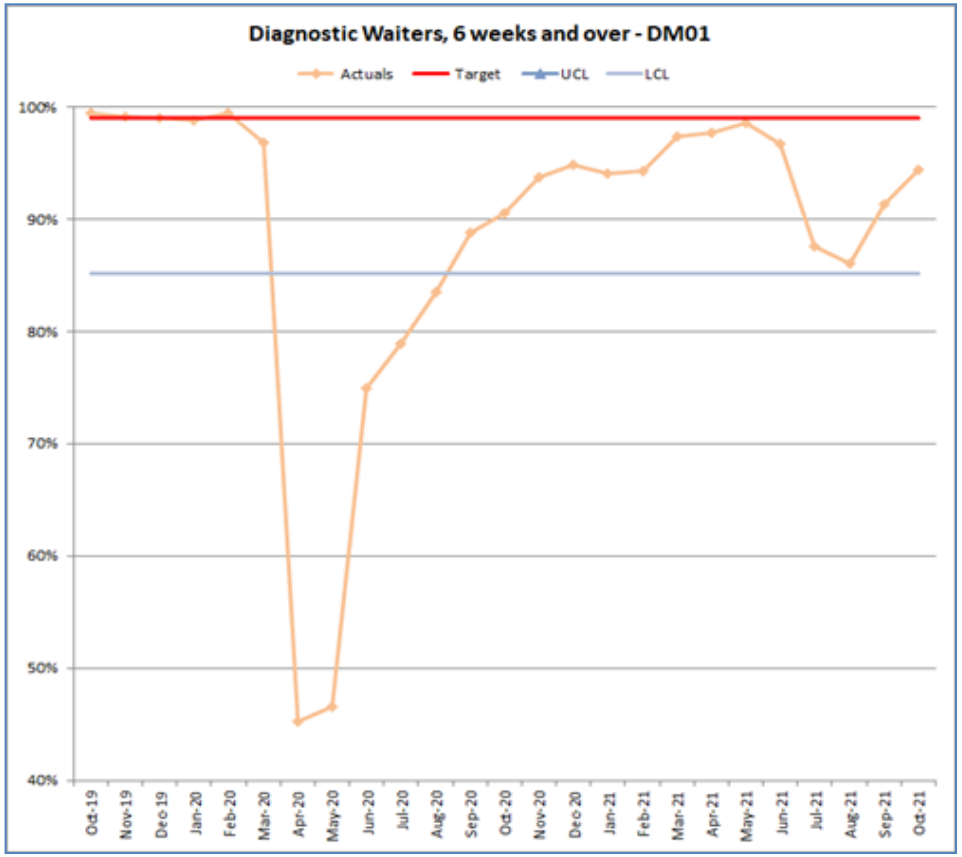
Action:

Endoscopy work force review underway.
Remedial action plans requested at modality level which will be tracked at ODG chaired by the COO.
Full overview of DM01 tracking and reporting underway to streamline process and give greater visibility with live daily data by end December 2021.

Expected Impact:

Endoscopy -:
1) successfully sourced a second insourcing provider to deliver additional activity
2) decontamination washer replacement programme is now fully in place.
This will result in steady improvements in performance.

Modality level tracking against trajectories will result in improved performance over the quarter.



Well-led Domain

Appraisal compliance %

Executive Lead: Director of Workforce

Performance Issue:

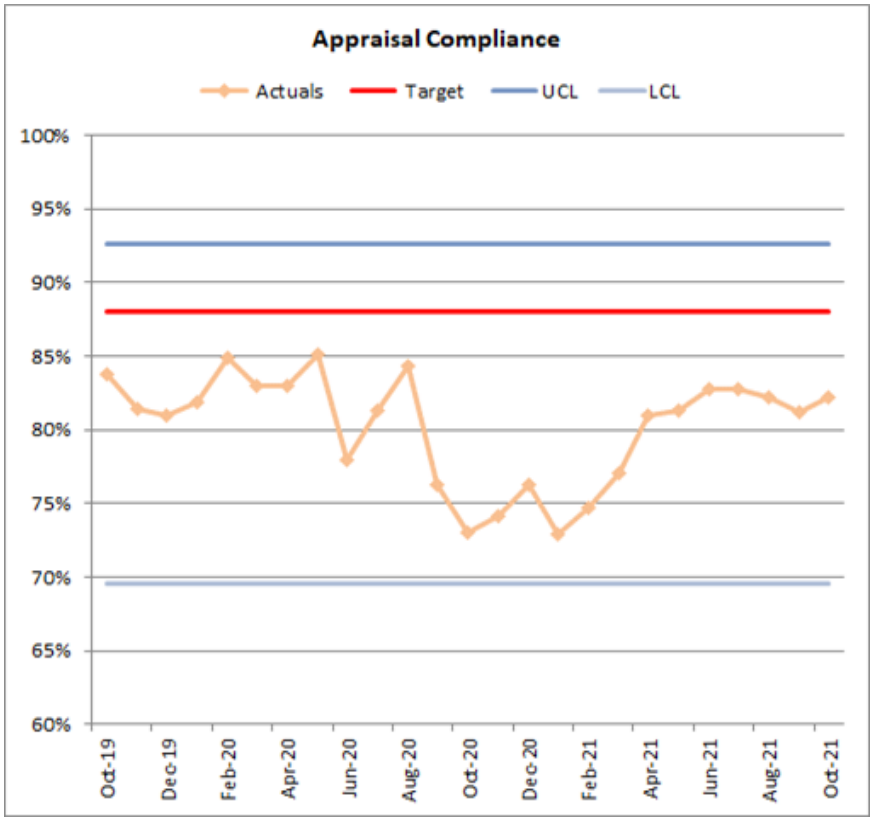
The target for annual appraisal compliance is 88%. Compliance at the end of October 2021 was 82.21%.

This is a marginal increase on September compliance.

From a divisional perspective, all divisions with the exception of Surgery have seen a small reduction in compliance since the end of August 2021. Women's and Children's continue to meet the 88% compliance target, and Surgery's improvement in compliance see them also achieving the Trust's KPI.

Corporate Division continues to have the lowest compliance rate which now stands at 68%

Please note that Medical appraisal is currently excluded from the above figures.



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. Targeted action has commenced to alert leads of outstanding appraisals in their area and this will continue through the next

reporting period. 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 performance as the Trust returns to business as usual although it is acknowledged that winter pressures may create some challenges in maintaining appraisal completion rates across clinical areas over forthcoming months.

BOARD OF DIRECTORS
1 December 2021

Title:	M7 Finance Report
Responsible Director:	Claire Wilson, CFO
Author:	Robbie Chapman, Deputy CFO
Presented by:	Claire Wilson, CFO

Executive Summary

Financial planning for the second half of the financial year was still in development as the October (month 7) financial position was finalised. In the absence of an agreed plan at this stage, this report focuses on actual income & expenditure for the period and compares to run rate where appropriate. We expect that normal reporting will resume next month (month 8) once the Trusts financial plan is approved.

The Trust is reporting a deficit of £1.132m in October 2021 (deficit of £1.107m year to date) primarily as a result of a number of system allocations which had not been agreed as the month 7 position was reported.

During November 2021, further work has been undertaken across the system to finalise the distribution of system allocations and to address a system wide financial gap.

The Trusts financial plan, as submitted to Cheshire and Merseyside Integrated Care System (C&M ICS) on 25th November 2021, is for a break-even position for the second half of the year (H2). Delivering this is dependent upon receiving £4.5m of ERF income and this remains a key risk to the delivery of a break-even position by the end of the year.

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

The Board of Directors are asked to note the contents of 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 M7 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	FPBAC reviews financial position on a regular basis.	
Background papers / supporting information	N/A	

1. Executive Summary

Financial planning for the second half of the financial year was still in development as the October (month 7) financial position was finalised. In the absence of an agreed plan at this stage, this report focuses on actual income & expenditure for the period and compares to run rate where appropriate. We expect that normal reporting will resume next month (month 8) once the Trusts financial plan is approved.

The Trust is reporting a deficit of £1.132m in October 2021 (deficit of £1.107m year to date) primarily as a result of a number of system allocations which had not been agreed as the month 7 position was reported.

During November 2021, further work has been undertaken across the system to finalise the distribution of system allocations and to address a system wide financial gap. The Trusts financial plan, as submitted to Cheshire and Merseyside Integrated Care System (C&M ICS) on 25th November 2021, is for a break-even position for the second half of the year (H2).

2. Financial Position

The table below provides a summary of the Trusts financial performance for the period ending 30th September 2021 together with a comparison against the run rate in the first half of the year (H1)

Table 1: Financial position for the period ending 30th September 2021.

WUTH	In Month	YTD		
Month 7 Financial Position	**Actual £'000**	**Actual £'000**	**M1-6 Run Rate £'000**	**Run Rate Movement £'000**
NHS income - patient care	30,217	210,941	30,121	(96)
Covid 19 income	1,486	12,601	1,852	366
Non NHS income - patient care	940	12,994	2,009	1,069
Other income	3,076	17,392	2,386	(690)
Total Income	**35,719**	**253,928**	**36,368**	**648**
Employee expenses	(24,450)	(169,258)	(24,135)	315
Operating expenses	(10,929)	(72,933)	(10,334)	595
Covid 19 costs	(276)	(3,794)	(586)	(310)
Total Expenditure	**(35,656)**	**(245,986)**	**(35,055)**	**600**
Non Operating Expenses				
Depreciation	(935)	(6,560)	(937)	(2)
Impairment	12	16	1	(11)
Non-Operating Income	0	7	1	1
Non-Operating Expense	(365)	(2,604)	(373)	(8)
Actual Surplus / (deficit)	**(1,225)**	**(1,200)**	**(1,308)**	**(20)**
Control Total adjustment	93	93		
Surplus/(deficit) - Control Total	**(1,132)**	**(1,107)**	**(1,308)**	**(20)**

Key issues to note are:

The Trust is reporting a deficit of £1.132m in (month 7) and a deficit of £1.107m year to date (YTD).

Total income was £35.719m in M7, a reduction against run rate in M1-6 of £0.648m. This reflects continued 'block' contract arrangements with CCGs with the reduced income in respect

of system funding. We do anticipate increase in system funding once the planning process for the second half of the year (H2) is finalised but expect it to be at least £0.8m less than H1 given requirements to generate efficiencies.

No income in was recognised from the Elective Recovery Fund (ERF) in M7. The mechanism for calculating ERF is no longer based on the value of activity but the number of 'clock stops' compared with the same period in 19/20. Our plan for H2 does include £4.5m of ERF income and some that will relate to M7 but until system wide performance has been confirmed we will not recognise it within our reported position.

Total employee expenses, excluding COVID-19, were £24.450m in M7, an increase against run rate of £0.315m. This was largely attributable to increased Nursing costs, both in respect of the increased bank shifts and the premium associated with the reintroduced nurse incentive scheme. The breakdown is set out below:

Table 2: Pay cost analysis

Pay analysis (exc Covid)	Actual (Mth 7) £'000	Year To Date Actual £'000
Substantive	(21,848)	(151,712)
Bank	(1,255)	(7,419)
Medical Bank	(478)	(4,012)
Agency	(743)	(5,458)
Apprenticeship Levy	(126)	(658)
Total	(24,451)	(169,259)

Operating expenses were £10.929m in M7, an increase in run rate from M1-6 of £0.595m. The largest aspect of this increase relates to Surgery, specifically high-cost procedures in Orthopaedics as more activity is delivered to support the elective recovery programme.

3. Cost Improvement Plan (CIP) Performance

The Trust achieved CIP of £1.202m in H1. The target for H2 has yet to be confirmed but we have included plans for £5.558m within our submissions to C&M ICS.

As at the 16th November, 288 opportunities have been identified with a value of £7.166 in year effect (IYE) and £8.223m full year effect (FYE), this is an increase of £0.314m in month. A breakdown by division can be seen in table 3 below.

Table 3: CIP breakdown by Division

Division	IYE Identified £m (H1 & H2)	FYE Identified £m (H1 & H2)	Total 2021/22 FOT £m
DCS	2.021	2.118	1.524
M&A	1.817	2.404	1.428
Surgery	1.457	1.806	0.801
W&C	0.327	0.476	0.186
Corporate	0.963	0.833	0.902
Estates and Hotel Svs	0.581	0.586	0.578
Non-Recurrent	-	-	0.245
Other schemes not yet assigned to divisions	-	-	0.702
Total	**7.166**	**8.223**	**6.366**

- 18 projects with a value of £0.066m have currently been identified as areas of opportunity and are awaiting sign off from the divisional directors to progress to gateway 2.
- 39 projects with a value of £0.874m have progressed to design & plan (gateway 2), meaning documentation is now being completed on PM3 with indicative costings.
- 22 projects with a value of £0.146m have now moved into governance and assurance (gateway 3), meaning the QIA/EA has been completed and is awaiting panel review in November.
- 147 projects with a value of £3.591m have been approved at QIA panel and are now in the implementation gateway.

4. Statement of Financial Position (SOFP)

The movement in total assets employed at M7 is minimal.

Statement of Financial Position (SoFP)

Actual as at 31.03.21 £'000		Actual as at 30.09.21 £'000	Actual as at 31.10.21 £'000	Variance (monthly) £'000	Month-on-month movement
	Non-current assets				
163,560	Property, plant and equipment	161,832	161,918	86	↑
12,864	Intangibles	12,343	12,219	(124)	↓
869	Trade and other non-current receivables	948	955	7	↑
177,293		**175,123**	**175,092**	**(31)**	↓
	Current assets				
4,788	Inventories	4,542	4,404	(138)	↓
16,848	Trade and other receivables	21,676	16,284	(5,392)	↓
0	Assets held for sale	0	0	0	→
21,294	Cash and cash equivalents	15,753	22,775	7,022	↑
42,930		**41,971**	**43,463**	**1,492**	↑
220,223	**Total assets**	**217,094**	**218,555**	**1,461**	↑
	Current liabilities				
(44,124)	Trade and other payables	(41,985)	(45,237)	(3,252)	↑
(4,622)	Other liabilities	(4,662)	(4,191)	471	↓
(1,090)	Borrowings	(1,056)	(1,067)	(11)	↑
(7,256)	Provisions	(7,238)	(7,240)	(2)	↑
(57,092)		**(54,941)**	**(57,735)**	**(2,794)**	↑
(14,162)	**Net current assets/(liabilities)**	**(12,970)**	**(14,272)**	**(1,302)**	↑
163,131	**Total assets less current liabilities**	**162,153**	**160,820**	**(1,333)**	↓
	Non-current liabilities				
(2,479)	Other liabilities	(2,425)	(2,416)	9	↓
(5,193)	Borrowings	(4,818)	(4,818)	0	→
(7,318)	Provisions	(6,744)	(6,644)	100	↓
(14,990)		**(13,987)**	**(13,878)**	**109**	↓
148,141	**Total assets employed**	**148,166**	**146,942**	**(1,224)**	↓
	Financed by Taxpayers' equity				
171,121	Public dividend capital	171,121	171,121	0	→
(64,220)	Income and expenditure reserve	(64,195)	(65,419)	(1,224)	↓
41,240	Revaluation reserve	41,240	41,240	0	→
148,141	**Total taxpayers' equity**	**148,166**	**146,942**	**(1,224)**	↓

5. Capital Expenditure

At month 7 capital spend is behind plan by £2.56m which is set out in Table 4 below.

Slippage has remained consistent with M6. The shortfall is due to the delay in delivery of the CT scanner and the commencement of work on staff changing and Bowman's Restaurant. The profile of spend is likely to remain out of line with the plan submitted to NHSE/I in April 2021 as the remaining large equipment purchases which were expected in Q3 are now scheduled for delivery in Q4.

In addition, estates spend will remain behind planned levels until work starts on the staff changing area later in quarter 3.

At this stage there remains minimal risk to the achievement of the full capital envelope for the financial year.

Table 4: Capital Programme expenditure to month 7

Capital programme 2021/22 - Spend	M1	M2	M3	M4	M5	M6	M7	TOTAL
Pre-commitments	297	375	396	437	409	97	454	**2,465**
Estates	0	0	0	112	94	34	226	**466**
Informatics	0	0	69	0	14	0	10	**93**
Equipment - Medicine and Acute	0	93	310	0	17	0	18	**438**
Equipment - Clinical Support and Diagnostics	0	0	0	118	8	62	20	**208**
Equipment - Surgery	0	0	101	102	10	58	153	**424**
Equipment - Women and Children's	0	0	99	0	0	0	0	**99**
Other	0	0	0	0	0	0	0	**0**
Donated assets	0	7	0	8	95	(1)	0	**109**
UEC	9	0	0	0	1	0	0	**10**
TOTAL	**306**	**475**	**975**	**777**	**648**	**250**	**881**	**4,312**
NHSE/I PLAN	**562**	**678**	**511**	**889**	**983**	**2,295**	**953**	**6,871**
VARIANCE FROM PLAN	**(256)**	**(203)**	**464**	**(112)**	**(335)**	**(2,045)**	**(72)**	**(2,559)**

6. Conclusion

During November 2021, further work has been undertaken across the system to finalise the distribution of system allocations and to address a system wide financial gap. The Trusts financial plan, as submitted to Cheshire and Merseyside Integrated Care System (C&M ICS) on 25th November 2021, is for a break-even position for the second half of the year (H2).

It is anticipated that final system allocations from both C&M ICS and national TIF funding streams will be confirmed in mid-November 2021, and they will then be reflected in the month 8 financial position.

Draft H2 plans include £4.5m of ERF income and this is dependent upon both our own elective activity performance but also performance across Cheshire and Merseyside over the challenging winter period. This remains a key risk to the delivery of a break even position by the end of the year.

7. Recommendation

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

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 13

BOARD OF DIRECTORS
1 December 2021

Title:	Guardian of safe working quarterly report
Responsible Director:	Dr Stevenson
Presented by:	Dr Helen Kerss

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

The Guardian of Safe Working is a senior person, independent of the management structure, within the organisation by whom the doctor in training is employed. The Guardian is responsible for protecting the safeguards outlined in the 2016 TCS for doctors and dentists in training.

This report provides:

- Details of the actual number of doctors in training.
- Details of the exception reports submitted for the reporting period by speciality and grade.
- Details of breaches of safe working hours and fines incurred.

Recommendation:
(e.g. to note, approve, endorse)
What action / recommendation is needed, what needs to happen and by when?

- Board to note the Guardian of Safe Working (GOSW) report
- There has been a steady increase in reporting to the GOSW which reflects the growing confidence that junior doctors have in the GOSW and actions being supported by the Trust to improve the quality of their training.

Which strategic objectives this report provides information about:	
Outstanding care	Yes
Compassionate Workforce	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)
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
CQC staffing
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
CIP in reducing locum spend
Specific communications and stakeholder /staff engagement implications

Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)	
Previous considerations by the Board / Board sub-committees	
Background papers / supporting information	

BOARD OF DIRECTORS MEETING IN PUBLIC
1st December 2021

GUARDIAN OF SAFE WORKING REPORT

Purpose

Provide a concise statement of the purpose of this report

To provide an update on compliance with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

Introduction / Background

The number of gaps present in the trainee medical workforce continues to be a focus for the Trust to ensure compliance with the safe working directive and to reduce overall locum and agency spend. There are currently a total of 307 doctors/dentists in training in the Trust.

To monitor compliance with the working hours directive, Doctors/Dentists in Training (DiT) continue to submit exception reports via the appropriate process and in accordance with the 2016 Terms and Conditions of Service. This report details a summary, exception reports and response to breaches for the Q2 2021 (July to September).

Table 1.1 below shows the number of vacancies per month

Staff vacancies are managed by medical staffing in a proactive manner. It is important for them to be noted as it will have an impact on both doctor and patient safety. Reasons behind the vacant posts include less than full time doctors, long term sickness, parental leave, and requirement of some doctors that they do not participate in the on call rota due to individual reasons.

Table 1.1

Vacancies by month						
Division	Grade	July	August	September	Total gaps (average)	Number of shifts uncovered
Medical & Acute	F1	12	2	0	4.66	0*
Medical & Acute	F2	3	0	0	1	0*
Medical & Acute	ST1-2	1	2	1	1.33	0*
Surgery	ST3-5	2	0	0	0.66	0*
Total		18	4	1	7.66	0*

*vacancy shifts filled by agency/bank

There were no uncovered shifts as these were mitigated by bank and agency doctors.

Exception reports

The tables below provide a summary of the exception reports submitted during the Q2 period. There is an increase compared to Q1 (148 vs 50) due to the proactive encouragement of the Guardian of Safe Working to submit exception reports. Exception reports for this reporting period were all submitted by all levels of junior doctors.

All exceptions approved for payment have been actioned.

Table 1.2. Exception reports by specialty

Exception reports by specialty				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
A&E	**0**	**7**	**7**	**0**
General Medicine	**0**	**91**	**91**	**0**
General Practice	**0**	**2**	**2**	**0**
General Surgery	**0**	**45**	**45**	**0**
Paediatrics	**0**	**1**	**1**	**0**
T&O	**0**	**2**	**2**	**0**
Total	**0**	**148**	**148**	**0**

Table 1.3. Exception reports by grade

Exception reports by grade				
Grade	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1	**0**	**113**	**113**	**0**
F2	**0**	**4**	**4**	**0**
F3/CMT	**0**	**23**	**23**	**0**
SPR	**0**	**8**	**8**	**0**
Total	**0**	**148**	**148**	**0**

Table 1.4. Response time for exception reports

Exception reports (response time)				
	Addressed within 48 hours	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
F1	**38**	**55**	**20**	**0**
F2	**3**	**1**	**0**	**0**
F3/CMT	**5**	**9**	**9**	**0**
SPR	**5**	**1**	**2**	**0**
Total	**51**	**66**	**31**	**0**

There has been a slight increase in the response time due to the increase in exception reports this quarter.

Breach of Safe Working Hours

The majority of the exception reports submitted were in connection with working hours; however, some were submitted due to missed educational opportunity. The Director of Medical Education reviews these. Even though there has been an increase in exception reports there have been no fines issued, as the Trust is actively working with the junior doctors to manage issues in real time. Doctors in training are paid for any extra hours worked.

Locum and agency bookings

There continues to be a high requirement for locum bookings, particularly within ED and

medicine. ED is currently undertaking a medical staffing review to address this issue as medical staffing vacancies could contribute to breaches of safe working hours.

Conclusions

Doctors in training continue to submit exception reports as appropriate. Exception reports are dealt with in a timely manner. No fines have been issued this quarter. The increase in exception reports is positive as junior doctors feel safe to raise concerns in an open forum and trust that the issues will be acted upon. The Guardian of Safe Working will continue to work in a proactive way via the junior doctors forum, linking with regional Guardians of Safe Working to assure good practice.

Recommendations to the Board

What action / recommendation is needed, what needs to happen and by when?

It is recommended that the Board note the content of this report and support the ED workforce review to mitigate risk, safeguard the safe working hours for doctors in training, ensure patient safety and deliver a sustainable medical workforce.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 14

BOARD OF DIRECTORS
1 December 2021

Title:	Chief Nurse Six Monthly Nursing Establishment Review Staffing Report
Author:	Tracy Fennell – Interim Chief Nurse Johanna Ashworth Jones – Programme developer, Corporate Nursing Team
Responsible Director:	Tracy Fennell Interim Chief Nurse
Presented by:	Tracy Fennell Interim Chief Nurse

Executive Summary

This report provides assurance the Trust has met its Trust has met its regulatory requirements in accordance with guidance set out in NHS Improvements, 'Developing Workforce Safeguards' guidance (2018).

The Trusts has completed a minimum six monthly acuity, dependency and establishment review which has been undertaken in Q2 2021/22. As a result 2 wards increased the establishment, 2 wards reduced establishment and one ward was approved for a temporary uplift due to increased acuity. The changes made remained cost neutral and no further investment was required to support the changes.

The Emergency Care Services have been supported by a full review by ECIST results will be presented to Workforce Assurance Committee in January 2022

In Maternity Services the Trust has been successful in recruiting midwives to these positions to meet the 35% Continuity of Carer requirement. A business case in being developed to source funding for the remaining deficit of midwives required to meet 100% as identified in the Maternity Incentive Scheme (MIS) / NHS Planning Guidance.

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

To note the content of the report.

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 1,2,4,6. **Positives.** • WUTH continues to demonstrate adherence against National NHSI Developing Workforce Safeguards (2018) requirements. • The Trust has met the requirement to achieve 35% Continuity Of Carer • The Trust has robust staffing Monitoring processes in place **Gaps.** • The Trust is not currently established to meet the 100% Continuity Of Carer required to be implemented by March 2022.	
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	
Previous considerations by the Board / Board sub-committees	Monthly Safe Staffing Board of Director reports
Background papers / supporting information	

Board of directors 1 December 2021
Chief Nurse - Six Monthly Nursing Establishment Staffing Report.

Purpose

The purpose of this paper is to provide the Board of Directors with assurance that the Trust has met its regulatory requirements in accordance with guidance set out in NHS Improvements, 'Developing Workforce Safeguards' guidance (2018). The NHSI document sets out expectations for nurse staffing to ensure the right staff, with the right skills are deployed in the right place at the right time.

This report provides an oversight on how the Trust has met its effective governance requirements set out in the guidance to ensure that the Trust Board can be assured workforce decisions promote patient safety and so comply with the Care Quality Commission (CQC) fundamental standards. As part of this process the Trust is required to complete a minimum six monthly acuity, dependency and establishment review which has been undertaken in Q2 2021/22.

1 Current position

The challenge for the Board of Directors is to ensure that staffing deployment does not have an adverse impact on the quality of care for patients, staff experience and staff recruitment and retention (NHS Improvement 2018). To enable the Board of Directors to have oversight of the visibility of safe staffing assurances including any known consequence on patient care, safety or experience a monthly report is received at the Public Board of Directors for scrutiny and challenge. This report includes a comprehensive dashboard providing a month by month review of a range of patient outcome measures, workforce data including progress with international recruitment, Care Hours Per Patient Day (CHPPD) data, 'Red Flags' and patient experience metrics. Any known risk is highlighted along with mitigations and future plans to enhance staffing assurances moving forward.

1.1: Adult Non Acute Areas

In July 2021 (M4) the Trust initiated its routine six monthly establishment review process. This process includes the completion of an acuity and dependency audit. The Trust uses the recognised Shelford - Safer Nursing Care Tool SNCT to undertake the review, these audit results are then used as part of a full establishment review that takes into consideration 75 indicators across nurse sensitive, quality, operational and workforce metrics.

The establishment review and indicators are appraised by the Ward Manager, Matron, Associate Director of Nursing and Divisional Director of Nursing for each area. This data is then subject to scrutiny at a confirm and challenge meeting with the Deputy Chief Nurse,

Workforce and Finance colleagues. Any identified proposed changes to establishment are presented to the Chief Nurse /Chief Finance Officer for final approval.

The table below provides a summary of the number of wards that modified their establishment or remained static.

Establishment outcome	Number of wards
Reduction in establishment	**2**
Change of establishment with no financial impact	**1**
Temporary fixed term increase to establishment	**1**
Increase to establishment	**2**
No change to current establishment	**19**

A full breakdown table of the establishment review outcomes for each area is attached as appendix 1.

1.2: Emergency and Acute Care

The Emergency and Acute care services have been supported by a full review by ECIST which includes recommendations in relation to establishment setting. WUTH completed a BEST audit which is the recommended RCN staffing tool for Emergency Departments April 2021 (M1); these results have been shared within the Division and used as supporting documentation within the ECIST review. A separate paper will be presented to WAC in January 2022 outlining the outcomes and recommendations of the ECIST review following its conclusion in quarter 3.

1.3: Maternity Services

A paper was presented to WAC 18 August 2021 on a review of Midwifery staffing using the Birthrate + acuity tool. This is in line with Royal College of Midwives recommendations who advocate using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements. BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour.

The paper outlined the results of the review indicating a deficit of -10.14 WTE based on the Birthrate +calculation (to meet the current requirement of 36% Continuity of Carer rate) providing a recommended total 151.37 WTE compared with current funded establishment of 141.23 WTE.

As the Trust moves forward to meet a continuity of carer rate of 100% (by March 2022 as set out in Maternity Incentive Scheme (MIS)/NHS Planning Guidance) the deficit is increased to -17.0 WTE however the deficit in both has been reduced by a successful bid to NHSE securing additional midwifery funding of 10.1wte.

The Trust has been successful in recruiting midwives to these positions to meet the 35% Continuity of Carer requirement. A business case in being developed to source funding for the remaining deficit required to meet 100%.

1.4: Children's Services

Both neonatal and paediatric staffing are reviewed every 6 months to identify whether there are increasing demands. Staffing is calculated daily within Children Services using a modified recognised acuity tool – SCAMPS (Scottish Children's Acuity Measurement in Paediatric Settings). Neonatal staffing is assessed against standards outlined in British Association of Perinatal Medicine (BAPM).

There has been an increase in neonatal activity across the region during the last 3 months resulting in providers diverting services elsewhere – the North West Cot Bureau are responsible for overseeing cot allocation across the region.

Paediatric nurse staffing remains a challenge given the predicted increase in Respiratory Syncytial Virus (RSV) anticipated over the winter months, although presently the Trust is not seeing these pressures escalation plans remain in place. There are currently 4 WTE vacancies with in Children's Services that are being recruited to.

2. Conclusions

WUTH have a series of robust systems in place to consistently monitor safe staffing and utilise the nationally recommended tools to support the setting of establishments in line with NHSI guidance. The Trust has undertaken acuity and dependency studies and associated establishment reviews in line with NHSI guidance hence remains compliant for this reporting period.

Women's and Children's has identified further investment will be required to meet Continuity of Carer requirements in line with national recommendations. A business case is being developed to identify further requirements.

Emergency and Acute Care are awaiting the outcome of the ECIST review which will be presented to WAC in January 2021.

3. Recommendations to the Board

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

Appendix 1

WUTH Establishment Review table September 2021

Division and Ward		Funded Establishment	Establishment out come	Comments
Surgical Division	Ward 10	28.3	No Change	
	Ward 11	38.94	Proposed Change	Reduction of RN Day and uplift of second Band 6 Deputy
	Ward 12	23.01	Reduction in Establishment	Reduced bed base and proposed reduced establishment to reflect bed base changes
	WAFFU	17.42	No Change	
	M2 Ortho	29.23	Reduction in Establishment	Reduction of two RN days (early shift) on the weekend model
	Colorectal Unit/ 14	43.45	No Change	No immediate change. Plans for Additional 7 beds which will require additional staffing
	SEU /17	49.19	No Change	
	Ward 18	40.8	Increase to Establishment	Increase of 1 RN Twilight shift
	Ward 20	39.37	No Change	May require winter uplift to support change in patient case mix
	M2 Surg	combined with CADW	No Change	Business case required for POCU additional beds, some flex in current establishment but will require some additional staffing funding
Medical Division	Ward 21	40.49	No Change	
	Ward 22	40.26	No Change	
	Ward 23	40.49	No Change	
	Ward 24	32.1	No Change	
	Ward 25	46.35	No Change	Establishment changes taken place as a result of relocation of LAU
	Ward 26	40.57	Fixed term Increase to Establishment	Temporary three month increase to establishment additional RN Late and RN Twilight. Backfill for band 6 due to current secondments .
	Ward 27	38.88	Increase to Establishment	Increase of 1 CSW on early shift - costs covered by M1 rehab reduced beds and staffing.
	Ward 30	36.45	No Change	
	Ward 32, CCU, CDS	64.36	No Change	
	Ward 33	38.18	No Change	
	Ward 36	44.12	No Change	
	Ward 38 & 37	61.75	No Change	
	D1	23.59	No Change	
	M1 Rehab	40.26	No Change	Reduction in Establishment already taken place due to reduction in bed base.
	CRC	39.72	No Change	

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 15

BOARD OF DIRECTORS
1 December 2021

Title:	Monthly Safe Nurse Staffing Report
Author:	Vic Peach – Interim Deputy Chief Nurse Johanna Ashworth Jones – Programme developer, Corporate Nursing Team
Responsible Director:	Tracy Fennell Interim Chief Nurse
Presented by:	Tracy Fennell Interim Chief Nurse

Executive Summary

Staffing has remained challenging during October 2021(M7). Proactive plans to mitigate risks are in place resulting in an improving position in many areas; the Trust has reported a 15% reduction in the number of red flag registered nurse (RN) shifts compared with M6 and a 2.08% reduction in RN vacancies.

Regional maternity pressures are evident for the 7th consecutive month. Maternity staffing is reviewed on a regional basis, supported by the revised Maternity Escalation and Divert Policy with oversight from NHS England through daily situational reporting. The Trust is in a positive staffing position with < 1 % maternity vacancies.

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

To note the content of the report.

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 1,2,4,6.
Positives.

- The Trust is fully established for clinical support workers (CSW's).
- No confirmed serious harm occurred as an impact of reduced staffing.
- Reduction in the number of shifts falling below minimum safe staffing levels was reported for RN shifts.

Gaps.

- 10 shifts had a professional judgement of red in M7: 9 within Medical Division and 1 on the Neonatal Ward.
- 7 patients indicated a perception of reduced staffing: 1 formal complaint, 1 level one concern and 5 Friends and Family Test (FFT) responses.
- Staff isolating due to increasing COVID -19 community prevalence continued to impact staffing during M7.

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	
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
1 December 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

1.1 Vacancies

The RN band 5 vacancy rate reduced by 2.08%: 11.08% (M7) from 13.16% (M6). There are currently 50 staff who are awaiting Nursing and Midwifery (NMC) registration that will reduce this figure further in forthcoming months. The International Recruitment (IR) Programme remains on track with the aim of 180 arrivals before the end of M9. Plans to extend the IR nurse programme for 2022 – 2023 have been proposed and are currently being reviewed via the relevant committees.

CSW posts continue to be fully established with a vacancy rate of -0.41% (M7). This is a significant achievement with previous CSW vacancy rates being as high as 8.11% (November 2020).

1.2 Absence

Sickness, isolation, and absence figures remain static during M7 as displayed in the staffing dashboard (appendix 1). Absence due to COVID – 19 continues to provide a pressure on staffing across the Trust.

The Incentive Scheme for NHSP shifts commenced in M7; from the 1 October 2021 to 31 December 2021. Additional bonus payment will be made to contracted staff who complete 34.5 hours in month and NHSP only staff who complete 57.5 hours in month. Nurses, midwives, clinical support workers, nursing associates, assistant practitioners, and ODPs irrespective of grade are eligible. The Trust noted a 15% increase in uptake of vacant shifts in the first 2 weeks of the scheme being active.

1.3 Safe Staffing Oversight Tracker (SSOT) Review

During M7 434 shifts fell below minimum RN staffing levels as reported on the SSOT. This is the 3rd consecutive month reporting a continuous reduction in the number of shifts classified as below minimum; a total reduction of 61 shifts compared to M6 (495).

To manage the risks in areas with reduced staffing levels 281 staff were relocated from other areas (M7); this is comparable with M6 (299).

In M7, 10 shifts were assessed by the Senior Nursing Team as a professional judgement (PJ) of red (high risk of care standards falling below expected levels), which is a significant increase compared to M6 (2). 9 shifts were within the Medical Division and 1 shift was in Women's & Children's Division. There were 2 Early shifts, 5 Late shifts and 3 Night shifts.

Medical Division

The Medical Division's 9 PJ red shifts occurred due to short notice sickness and unfilled NHSP shifts.

Standard mitigation across the Medical Division includes:

- Divisional review of ward staffing numbers across the week to redeploy staff where there is greater assessed risk due to staffing gaps.
- Divisional review and alignment of skill mix to support staff at ward level.
- Cross divisional staffing review at daily senior oversight staffing meeting.
- Daily reviewing of shifts with NHSP fill and escalation to agency where appropriate.
- Matron and / or ward managers work clinically and additional hours when necessary by staying on shift later to provide senior support.
- Trust wide support via enactment of Winter Nurse Staffing Escalation Plan

Women's and Children's Division

One shift on the Neonatal Unit was classified as a PJ red shift due to patient acuity. Mitigating actions took place in line with Maternity Escalation and Divert Policy; closure of the Neonatal Unit for transitional care beds and support was provided by an additional staff member of the maternity team.

1.4 Impact on Care

9 falls occurred in M7 where staffing levels were less than expected, which is a significant decrease from M6 (22). A review indicated that reduced staffing was not a contributing factor to any of these falls.

Keys impact areas recorded within the SSOT for all red flag shifts have reduced:

- Staff missed break: 73 (M7) compared with 86 (M6).
- Delayed / Missed observations: 168 (M7) compared with 223 (M6).
- Delayed / Missed NEWS: 191 (M7) compared with 265 (M6).
- Number of 1:1 specials not covered: 3 (M7) compared with 11 (M6).

During M7 there was a significant increase noted in the number of recorded red flags relating to delays / missed pressure care instances with 176 (M7) compared with 96 (M6)

1.5 Patient Experience

During M7 there was 1 formal complaint received in relation to a perception of reduced staffing on the Maternity ward, the details indicated that this resulted in the patients planned induction of labour being delayed. A level 1 concern was received in relation to a perception of reduced staffing on ward 11 but with no impact on care.

There was a total of 5 FFT feedback forms received during M7 that indicated people felt staffing was reduced. 3 of these were in relation to the Maternity Services. FFT in the Maternity Service continues to be above the localised target of 95%; with 100% recommended rate for labour and birth, and 95% recommended rate for the Maternity Ward in M7.

2 Actions to Mitigate Risks

NHSP CSW demand increased by 20.9%, a total of 5,328 hours. RN demand increased by 13.8%, a total of 3,511 hours. The most significant reason for these increases was the opening of escalation areas. This increase is in line with expectation to provide safe staffing to all areas.

The releasing time to care initiatives, approved by the Executive Management Team on 12 October 2021, continue to support safe staffing during these unprecedented times of pressure by reducing audit processes and nursing care requirements whilst maintaining assurance for all essential areas.

3 Children's and Maternity Staffing

3.1 Maternity

Maternity staffing continues to be challenging with several providers across Cheshire and Merseyside requesting mutual aid from other providers. The Trust is in a positive position with <1% vacancies. There have been no requests for support and high periods of acuity has been managed in M7. Daily situational reports, supplemented by the weekly situational reports, are submitted to NHSE as per national requirement.

The close monitoring of acuity and senior support in and out of hours has been provided. The Birth Rate Plus Acuity tool is in use both on delivery suite and the ward. It is anticipated that this will be adapted for use regionally with real time RAG rated acuity submitted by each provider.

3.2 Children's

Staffing within Children's services continues to be monitored using a modified recognised acuity tool, Scottish Children's Acuity Measurement in Paediatric Settings (SCAMPS). Paediatric nurse staffing has improved in M7 and no significant increase in Respiratory Syncytial Virus (RSV) has been noted to date. There are currently no vacancies following successful recruitment. Short term absence has reduced to 7% sickness management processes are followed with Divisional HR support as necessary.

3.3 Neonates

Neonatal staffing has been reviewed in line with the workload/staffing analysis undertaken by the Neonatal Operational Delivery Network (ODN). This analysis has identified a shortfall in staffing when considering the overall workload over the last 3 years. In view of this the Neonatal ODN will use these findings to inform a bid for additional monies for staffing.

The ratio of staff in the Neonatal Unit who hold a qualification in speciality (QIS) certificate (specific neonatal training) has been reviewed; the compliance threshold of over 70% of nurses holding this qualification has been achieved.

4. Conclusions

M7 has demonstrated improved staffing levels and reduced vacancies as well as a continuation of a full CSW establishment.

COVID-19 community prevalence continues to provide challenges in relation to patient acuity, staff sickness, and staff absence due to staff isolation. Mitigations are in place across the Trust; enhanced monitoring, escalation processes, NHSP, agency staffing, and absence monitoring processes. Due to this, wards and maternity services have remained safe in M7.

Resilience planning is on-going locally and regionally to ensure plans are in place ahead of the predicted pressures over the forthcoming months.

4. Recommendations to the Board

The Workforce Assurance Committee are requested to note the contents of report.

In line with current governance review recommendations it is recommended the Monthly Nurse Safe Staffing Report is assured via the Workforce Assurance Committee reporting to the Board of Directors via the WAC chairs report. This should be supplemented with the overarching 6 Month Chief Nurse Safe Staffing Report in line with NHSE/I Development Workforce Safeguards(2018) requirements.

Appendix 1 – Safe staffing dashboard Oct 2020- Oct 2021

	Safe Staffing Board Assurance Dashboard 2020 /21 - 2021/2022														
Data Source	Indicator	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Spark line
Corporate Nursing	Care Hours Per Patient Day - Total	8.5	10.1	9.5	8.1	8.9	9	8.7	8.3	8.8	8.5	8.4	8.2	8.2	
Corporate Nursing	Care Hours Per Patient Day - Registered Nurses	4.1	5.2	4.8	4	4.3	4.4	4.1	4.1	4.4	4.1	4.2	4	4.1	
Corporate Nursing	Care Hours Per Patient Day - CSW's	3.7	4.1	3.8	3.4	3.7	3.8	3.5	3.5	3.6	3.6	3.6	3.4	3.5	
Corporate Nursing	Number of ward below 6.1 CHPPD	0	0	0	1	1	0	1	4	1	3	2	3	1	
Corporate Nursing	National Fill rates RN Day	83%	84%	85%	79%	81%	83%	84%	83%	84%	82%	83%	82%	81%	
Corporate Nursing	National Fill rates CSW Day	89%	94%	88%	86%	91%	91%	92%	93%	100%	97%	98%	95%	102%	
Corporate Nursing	National Fill rates RN Nights	79%	81%	82%	77%	84%	78%	84%	80%	82%	78%	81%	81%	79%	
Corporate Nursing	National Fill rates CSW Nights	104%	100%	99%	95%	71%	101%	98%	99%	98%	96%	103%	103%	99%	
Informatics	Trust Occupancy Rate	79.50%	76.10%	79.30%	83.50%	80.20%	80.80%	81.40%	83.90%	82.30%	81.50%	84.10%	85.50%	88.10%	
Informatics	Occupancy Rate - APH	79.10%	76.00%	80.30%	82.30%	80.30%	83.50%	83.90%	86.70%	85.00%	84.80%	87.30%	88.90%	90.30%	
Informatics	Occupancy Rate - CBH	46.10%	39.00%	37.90%	50%	50%	52%	55%	55%	53%	51%	54%	56%	65%	
Workforce	Vacancy Rate (Band 5 RN's)	16.61%	17.66%	18.10%	19.42%	18.81%	18.57%	15.92%	13.97%	13.10%	13.44%	14.56%	14.41%	12.90%	
Workforce	Vacancy rate (Band 5 inpatient wards)	17.11%	17.72%	18.49%	19.89%	19.01%	17.92%	15.35%	12.59%	11.47%	12.31%	13.94%	13.16%	11.08%	
Workforce	Vacancy Rate - All RN (All grades)	8.67%	9.79%	9.57%	10.79%	10.03%	9.69%	8.26%	7.47%	7.15%	6.97%	7.69%	7.44%	6.41%	
Workforce	Vacancy Rate (CSW's)	7.77%	8.11%	6.28%	6.79%	5.94%	5.97%	5.82%	2.99%	3.08%	0.49%	0.21%	-1.09%	-0.41%	
Workforce	Sickness Rate - RN	6.80%	6.95%	6.49%	9.17%	7.14%	6.01%	5.96%	5.92%	5.51%	6.79%	6.01%	6.43%	6.63%	
Workforce	Sickness Rate - CSW	8.82%	7.59%	8.18%	12.34%	9.47%	8.11%	8.46%	10.04%	9.89%	9.16%	9.68%	9.63%	9.64%	
Workforce	Absences Rate - RN	1.55%	1.76%	1.50%	2.39%	1.78%	2.24%	0.07%	0.03%	0.30%	1.12%	0.40%	0.35%	0.42%	
Workforce	Absences Rate- CSW	1.55%	2.17%	1.56%	2.64%	2.71%	2.47%	0.05%	0.14%	0.50%	1.88%	0.67%	0.44%	0.60%	
Corporate Nursing	Number of Professional Judgment Red Shifts	0	0	0	0	0	0	0	0	2	11	6	2	10	
Corporate Nursing	Number of RN Red Shifts *	454	243	499	689	330	383	323	427	446	614	545	495	434	
Corporate Nursing	RN Red Shift Impact : Number of Falls	17	4	19	26	36	16	16	21	19	29	17	22	9	
Corporate Nursing	RN Red Shift Impact : Number of Falls with Harm	1	0	0	0	1	1	0	0	3	1	1	4	0	
Corporate Nursing	RN Red Impact : Meds Errors / Misses	7	1	27	2	1	27	2	2	1	2	2	3	2	
Corporate Nursing	RN Red Impact : Patient relative complaints	3	0	0	1	2	0	0	1	2	2	0	5	3	
Corporate Nursing	RN Red Impact : Staffing incident submitted	18	7	23	33	6	14	14	9	4	7	15	13	10	
Corporate Nursing	RN Red Impact : Special 1:1 (uncovered)	9	0	26	38	2	3	1	10	2	12	4	11	3	
Corporate Nursing	RN Red Impact: Missed Breaks	26	10	107	119	34	41	42	71	57	100	50	89	73	
Corporate Nursing	RN Red Impact: Delayed / Missed Obs	122	1	287	278	31	126	75	248	74	198	129	223	168	
Corporate Nursing	RN Red Impact: Delayed / Missed nMEWS	12	31	239	237	72	286	90	226	120	367	222	265	191	
Corporate Nursing	RN Red Impact: Delayed / Missed Pressure Care	24	23	145	46	23	58	15	43	44	82	64	96	176	
Corporate Nursing	RN Red Impact : Delayed Meds	127	6	582	299	88	193	55	199	79	263	248	217	192	
Governance support	Number of SI's where staffing has been a contributing factor	0	0	1	1	0	1	0	0	0	0	0	0	0	
Corporate Nursing	Total Number of staffing incidents	75	25	90	102	42	57	48	93	80	105	92	134	82	
Complaints team	Formal complaints in relation to staffing issues	0	1	0	0	1	0	0	1	0	0	0	0	1	
Complaints team	Informal Concerns raising staffing levels as an issue	1	0	0	1	0	1	0	0	1	0	0	0	1	
Corporate Nursing	Patient Experience feedback raising staffing levels as a concern	0	0	0	0	0	0	0	1	1	1	0	2	5	
Corporate Nursing	Staff Moves	140	164	172	606	337	337	288	341	302	407	301	299	281	
NHS Professional	Number of RN hours requested	28432	31103	28638	43952	35299	34182	24465	24192	24382	27501	28042	24544	28055	
NHS Professional	Number of CSW hours requested	32505	28386	30651	42759	33056	30218	24122	24171	23421	25435	25286	25635	30971	
NHS Professionals	% of requested filled RN's	60.20%	72.70%	58.90%	57.50%	54.60%	62.80%	64.50%	68.22%	65.90%	59.00%	61.30%	67.40%	68.80%	
NHS Professionals	% of requested CSW filled	71.10%	85.30%	68.10%	62.80%	68.00%	75.00%	77.60%	84.20%	86.20%	84.00%	85.60%	84.10%	84.00%	
NHS Professionals	% of Agency staff used RN	2%	6%	1%	2.30%	7.00%	7.00%	5.00%	1.70%	4.80%	6.00%	7.00%	3.20%	3.40%	
NHS Professionals	% of Agency staff used CSW	0%	0%	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

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 16

BOARD OF DIRECTORS
1 December 2021

Title:	WISE Ward / Service Accreditation progression from Level 3 to Level 4
Responsible Director:	Tracy Fennell - Interim Chief Nurse, Executive Director for Midwifery and Allied Health Professionals and Director of Infection Prevention & Control
Author:	Victoria Peach - Interim Deputy Chief Nurse Les Porter - Associate Director of Nursing; Corporate Nursing Fiona Morris – Lead Nurse, Corporate Nursing
Presented by:	Les Porter - Associate Director of Nursing; Corporate Nursing

Executive Summary

Currently the processes for attaining levels 1 - 3 of WISE Ward Accreditation are clearly defined; progression to level 4 (the highest level of WISE) are yet to be approved. This paper identifies the recommended methodology and processes for wards / services to progress from WISE level 3 to WISE level 4.

The review processes of wards / services who have achieved WISE level 4 are set out as are the requirements when a new manager inherits a WISE level 4 ward / service. In addition, the paper outlines the processes if a ward / service reverts from WISE level 4 to a lower WISE status having not sustained the standards required.

Recommendation:

For approval of the proposed criteria and processes for wards / services to:

- Achieve level 4 WISE accreditation status.
- Review level 4 WISE accreditation status.
- Follow when a ward / service manager inherits a level 4 WISE accredited ward / service.
- Follow if the ward / service does not maintain level 4 WISE accreditation.

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.	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)		
Nil		
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)		
CQC Essential Standards		
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)		
Nil		
Specific communications and stakeholder /staff engagement implications		
WISE 3 – 4 Level discussed at Senior Nurse Management Meeting – April 2021 Matron and ADNS WISE Engagement Meeting – July 2021 PSQB – September 2021		
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)		
Nil		
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)		
Nil		
FOI status	Document may be disclosed in full	X
	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
1 December 2021

Wirral **I**ndividual **S**afe care **E**very time **(WISE) Ward / Service Accreditation**
Proposal for progression from Level 3 to Level 4

Purpose

This paper proposes the methodology and processes to enable progression from level 3 to level 4 WISE accreditation and requirements to be met when a new manager inherits a WISE level 4 ward / service. The paper outlines the processes should a ward or service revert from level 4 to a lower WISE status.

1. introduction / Background

Delivering safe, high quality and appropriate care to patients is of paramount importance. nursing teams are accountable for the quality of care that they deliver, care that is evidence based and appropriate to the needs of the patient.

WISE accreditation is designed to support nurses, and the wider ward / service-based staff, to review and reflect upon the care they deliver, identify successes and where required deliver improvements. WISE accreditation reviews wards and services against local policies, procedures, and guidelines. The WISE accreditation has been adapted from exemplar organisations that have been using this methodology successfully for several years.

WISE is designed around 14 standards:

1. Organisation and Management
2. Safeguarding*
3. Pain
4. Patient Safety
5. Environmental safety
6. Patient Safety
7. Nutrition and Hydration
8. End of Life
9. Personalised Care
10. Pressure Ulcers
11. Elimination
12. Communication
13. Infection Prevention and Control*
14. Falls

*Infection Prevention and Control and Safeguarding Inspections are carried out by independent internal expert teams.

2. WISE Levels

The WISE accreditation identifies four levels of achievement, level 1 representing the lowest score attainable and level 4 indicating that the ward / service provides exemplary and highly reliable standards of care.

Level 1	5 or more audit scores below 70%
Level 2	Less than 5 audit scores below 70% and less than 7 audit scores above 90%
Level 3	7 or more audit scores above 90% and none below 70%
Level 4	Exemplar status granted to those areas that show consistent high performance and meet further criteria

3. Level 4 WISE status

Achievement of level 4 WISE accreditation is recognition of the delivery of exemplary care and effective sustained leadership. As such, ward / service teams will demonstrate; continuous low rates of patient harms as a result of lapses in care; a consistent good reporting culture; positive patient feedback; embedding learning and sustaining good practice; engagement with quality improvement methodology for the benefit of positive patient outcomes; and deliver consistent high standards of care.

4. Proposed Criteria for WISE Accreditation Level 4

For level 4 WISE accreditation the following must be achieved:

- Sustainment of level 3 WISE status for three consecutive inspections, this will take a minimum of two years.

- Completion of a quality improvement (QI) project within 6 months of WISE level 4 application, under the guidance of the WISE assessor team. The project must be aligned to the Trust's core values, be patient focused, incorporate activity from all members of the ward team, demonstrate that outcomes, and learning are shared across the organisation in line with the Trust agreed QI methodology.

- Completion of a WISE level 4 application led by the ward / service manager. The application must include evidence of the ward's cultural stability through vacancy rates, sickness rates, retention and recruitment, friends and family test outputs, and thematic review of complaints and compliments.

- Confirmation from the Governance Support Unit and Infection Prevention and Control Team that ward / service has had no significant concerns where patient harm has occurred because of lapses in nursing care: Inclusive of, but not limited to, Trust priorities such as MRSA bacteraemia or acquired Clostridium Difficile, falls with fractures, hospital acquired category 3 / 4 or unstageable pressure ulcers.

- Evidence that any action plans for ward / service associated with the safe delivery

of patient care are progressing in line with desired time frames.

5. Proposed Process for WISE Accreditation Level 4

- Prior to completion of the application for level 4 WISE accreditation the WISE assessor team will work with the ward / service to confirm that the criteria for achievement is fulfilled and support the application process.

- Ward / service manager will submit the completed application and WISE level 4 accreditation pack with supporting evidence to the Chief Nurse and Deputy Chief Nurse via the WISE assessor team.

- WISE assessor team will arrange a WISE panel meeting within two weeks of receipt of the fully completed application. The panel meeting will be led by the Chief Nurse accompanied by the Medical Director (or their deputies) and a Non-Executive Director. Additional panel members will be determined by the speciality of the ward / service presenting to panel and where possible will use a peer review approach.

- WISE panel members will visit the areas prior to panel: Quality Improvement project will be presented to the panel at the visit. Discussions will take place with available staff and patients during this visit.

- Ward / service manager and selected team members will attend the panel meeting to present the evidence within the WISE level 4 accreditation pack and discuss any key elements.

- The panel will recommend one of two outcomes: Achievement or deferment of WISE level 4 status. Feedback on areas for improvement with recommended timescales will be provided to a ward / service being deferred.

- The recommendation for achievement or deferment will be presented by the Chief Nurse, or the deputy, to the Trust Board of Directors for approval.

6. Achieving WISE Level 4 Status

- Ward / service staff members will each receive a certificate from the Trust Board stating they have gained WISE Level 4.

- Each ward / service member of staff will be provided with a WISE badge.

- Each ward / service will be presented with a plaque to be displayed on entry to the area.

- Ward / service staff will be recognised at the Staff Award Ceremony.

- Ward / service teams will be required to use their leadership expertise and experience to support other areas to achieve improvements in WISE accreditation.

- Ward / Service managers will have greater degree of autonomy being recognised as a Ward or Service Matron. Ward / Service Matrons will have a different uniform and will access a Quality Matron for coaching / mentoring enabling them to retain level 4 WISE status.

- Ward / Service Matron will be required to lead the team to maintain excellent standards of care demonstrated through engagement with quality improvement initiatives, support to other areas sharing good practice, cultural stability, good reporting culture with no significant concerns where patient harm has occurred due to lapses in care.

- Ward / Service Matron will maintain WISE level 4 accreditation pack: demonstrating engagement with quality initiatives, support to other areas and the sharing of good practice, cultural stability, and maintaining excellent standards of care.

7. Review for WISE Accredited Level 4

- Ward / service teams achieving level 4 WISE accreditation will be subject to an annual assessment. The Chief Nurse and Deputy Chief Nurse reserves the right to bring forward a review should ward / service intelligence and data indicate such.

- Two weeks prior to the annual review the level 4 WISE accreditation pack will be submitted to the Deputy Chief Nurse and Senior Nursing Team via the WISE assessor team.

- Ward / Service Matron, deputies, and senior nursing team will be invited to a meeting with the Deputy Chief Nurse and the WISE assessor team to demonstrate how the team is sustaining WISE Level 4. Outcome of the annual review meeting will confirm continued achievement or recommend adjustment to WISE level 4 attainment.

In the event WISE level 4 status is not maintained:

- Deputy Chief Nurse will report the outcome of the annual review to the Chief Nurse providing details of key areas where attainment was not achieved.
- Chief Nurse will review outcome decision and confirm recommended adjustment to WISE level.
- Ward / Service Matron reverts to Ward Manager (title and uniform).
- WISE level 4 plaque and WISE badges are removed.
- Appropriate support plans must be put in place by the Divisional Senior Nursing team.
- WISE assessor team / Corporate Nursing Team will provide support as required.
- Future WISE inspection will occur dependent upon revised WISE accreditation score and the needs of the ward / service.

8. Changes to Ward / Service Matron

In the event the incumbent Ward / Service Matron leaves their position the:

- Ward / service will retain WISE level 4 status.
- Vacant post will be recruited to as a Ward / Service Manager.
- Newly appointed Ward / Service Manager will meet with the Divisional Senior Nursing team, WISE assessor team and the Deputy Chief Nurse to share, review and discuss the current WISE level 4 accreditation pack.
- An additional WISE level 4 review may take place to enable newly appointed Ward Manager time to demonstrate sustainability of level 4 status.
- Ward / Service Manager will achieve Ward / Service Matron status having been in post for one year and maintaining level 4 WISE status.

9. Conclusions

The proposals set out in this paper have emerged over time following engagement with Senior Nursing Teams within all divisions. Discussions have included clarification of the Quality Matron role and that of a Ward / Service Matron.

Achieving WISE level 4 accreditation is recognition of excellence in care. As such, assessment and recognition of this achievement will be overseen by the Executive team and approved by the Trust Board. The Patient Safety and Quality Board supported these proposals in September 2021.

10. Recommendations to the Board of Directors

For approval of the proposed criteria and processes for wards / services to:

- Achieve level 4 WISE accreditation status.
- Review level 4 WISE accreditation status.
- Follow when a ward / service manager inherits a level 4 WISE accredited ward / service.
- Follow if the ward / service does not maintain level 4 WISE accreditation.

Agenda Item: 17

BOARD OF DIRECTORS
1 December 2021

Title:	Diversity and Inclusion (D&I) Annual Report
Responsible Director:	Debs Smith, Interim Executive Director of Workforce
Author:	Sharon Landrum, Workforce D&I Lead
Presented by:	Sharon Landrum, Workforce D&I Lead

Executive Summary
This report seeks to provide an update on the work undertaken to achieve the areas identified within the Diversity and Inclusion Strategy 2018-2022 and underpinning action plan. This report seeks to provide assurances on the progress made in not only complying with statutory requirements under the Equality Act 2010 and associated public sector duties, but also work to meet requirements contained within the Trusts standard contract with local commissioners. The Trust is currently compliant with all D&I reporting requirements however is overdue with reviewing the performance against the Equality Delivery System (ESD2) framework.

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

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

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)
None
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Required to uphold Equality Act 2010, Public Sector Equality Duties, CQC well led domain and actions contained within Trust's standard contract
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
None
Specific communications and stakeholder /staff engagement implications
Engagement required with staff and patients to review D&I performance
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Required to uphold Equality Act 2010, Public Sector Equality Duties, CQC well led domain and actions contained within Trust's standard contract
Council of Governors implications / impact (e.g. links to Governors' statutory role,

significant transactions)		
No		
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		
Background papers / supporting information		

Board of Directors
1 December 2021

Diversity and Inclusion Annual Report for 2021/22

Purpose

This report seeks to provide assurances on the progress made in not only complying with statutory requirements under the Equality Act 2010 and associated public sector duties, but also work to meet requirements contained within the Trusts standard contract with local commissioners

Introduction / Background

Under section 149 of the Equality Act (2010), a public sector equality duty was created, which is a statutory obligation for all public authorities. This is defined in legislation as the ***general duty*** and all public authorities must adhere to the following obligations:

- To eliminate unlawful harassment and victimisation and other conduct prohibited by the Act
- To foster good relations between people who share a protected characteristic and those who do not
- To advance equality of opportunity between people who share a protected characteristic and those who do not

In addition to the previously referred to **general duty**, there are specific duties which require public bodies to publish relevant, proportionate information showing compliance with the Equality Duty and to set equality objectives. The information that is contained within this report meets the requirement of the specific duties of the PSED.

The Equality Act also defined a number of groups that have protected characteristics, as follows:

- Sex / Gender
- Age
- Disability
- Race
- Sexual Orientation
- Religion or belief
- Pregnancy and Maternity
- Marriage and Civil Partnership
- Gender reassignment

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

The Trust is required to submit annual data for:

1) Annual workforce demographics
2) Workforce Race Equality Standards (WRES)
3) Workforce Disability Equality Standards (WDES), (introduced from April 2019)
4) Gender Pay Gap Analysis

Along with producing and displaying reports for all of the above we are required to produce:

5) Annual and 6-month update reports
6) Review of progress towards achievement of equality and diversity by using the Equality Delivery System (EDS2) framework

The Diversity and Inclusion Steering Group seeks to support achievement of the overarching diversity

and inclusion agenda and feeds into the Workforce Steering Board.

The Trust is required to have key objectives in place, along with monitoring additional areas such as:

7) The introduction and ongoing monitoring of the Accessible Information Standard
8) Consideration of equality related impacts on redesign of services and evidence that findings have been considered by decision makers prior to making changes.
9) Interpretation and translation services
10) Review of usage of services benchmarked against local population and disaggregated by protected characteristic
11) Reports to include work undertaken in achieving achieve the PSED general duties

The Trust's diversity and inclusion strategy 2018-22 and last annual report are available for review on the public section of the Trust's Diversity and Inclusion webpages.

The strategy identifies the Trust's vision of creating an environment for patients and staff where the principles of equality legislation are fully embraced and where people feel respected, valued and treated with dignity. The strategy also highlights the aim of ensuring that our services are accessible to all members of our community, that they are delivered equally regardless of any differences and that our staffing reflects the communities we serve.

Action plans have been developed with annual progress reported at the Workforce Assurance Committee in September. The plan is also scheduled for review as part of the Patient and Family Experience Group in November. A full review has also been conducted on all diversity and inclusion related action plans and whilst not included as part of this report, they are accessible via the Trust's diversity and inclusion webpages.

This report seeks to provide assurance that we are complying with the requirements outlined above and identifying any key areas for concern and consideration.

Data

1 Progress Report - Reporting Requirements

1.1 Workforce Demographics

Appendix 1 provides the breakdown of workforce demographics as of 31 March 21, compared with community demographics where available.

1.2 WDES and WRES Reporting

Reporting data for both WRES and WDES have bow been submitted via the national portals following approval from the Board of Directors meeting in August. In addition to the submission of data, organisations are required to publicise a detailed narrative report, including the data submitted, supporting narrative and action plans to address areas of concern or bring about improvements. Action plans were approved at Septembers Workforce Assurance Committee and therefore both reports have now been uploaded to the public section of the Trusts website. The Trust is therefore compliant with reporting requirements in these areas.

1.3 Gender Pay Gap Reporting

2019/20 gender pay gap reporting was delayed nationally due to COVID, however the Trust has now submitted data via the national portal and the narrative report is also available via the diversity and inclusion section of the website. 2020/21 reporting has commenced however review and approval of the data was postponed. Reporting is not however required to be completed until 30 March 2022 and will therefore be presented for review at the next appropriate committee.

1.4 Annual and six-month update reports

This report seeks to provide the annual update for workforce information and includes detailed workforce demographic information at appendix 1. A six-month update was provided to Workforce Steering Board in April 2021.

1.5 Equality Delivery System (EDS2)

Trusts are required to conduct a review of services against the nationally developed equality delivery system (EDS2) framework. WUTH conducted a full review of all areas in 2019 and actions identified where included within the overarching diversity and inclusion action plan. A further review has not however been completed due to COVID-19 implications and capacity; however, the Trust has linked with Merseyside D&I Leads and clinical commissioning colleagues to ensure best practice is considered and ideas shared.

A national review has also been conducted on EDS2 itself and a new EDS3 framework has been developed to ensure greater effectiveness. This has been piloted and final information and launch dates are awaited. More details will follow as soon as they are confirmed.

Review against the EDS2 framework is however unfortunately overdue and will therefore be completed as soon as possible. Trusts are not required to review against all indicators, however, must select a minimum of 3 to focus on.

Following discussions and agreement, the following 3 indicators have been selected for review this year:

Indicator No.	Indicator	2018/19 rating
1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	**Achieving**
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	**Achieving**
4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	**Developing**

All indicators and current ratings (including definitions) are outlined in appendix 2.

Engagement has commenced with stakeholders and evidence is being collated so as to determine recommendations for this years' ratings. These will be presented for ratification in the next D&I update report.

1.6 Accessible Information Standard (AIS)

This is a national standard that supports those with disabilities, impairments and sensory loss and requires organisations to ensure they have access to information and communication in a format suitable for them. The Trust launched a pilot within Outpatient and Pre-Operative Assessment in Jan 2019; however implementation has stalled due to difficulties with roll out. A review group was established to identify key actions in moving forwards and further pilot sites identified. Further training and support is being provided to outpatient areas to ensure roll out can continue and progress will continue to be monitored

1.7 Equality Analysis (EA) / Impact Assessments and Quality Impact Assessments (QIA)

As identified in section 2, reporting area no.8 highlights that consideration must be given to equality related impacts on redesign of services and evidence that findings have been considered by decision makers prior to making changes. Equality impact assessments must also be conducted on new and revised policies.

The Trust launched an EA policy in 2018 and equality analysis is now embedded within the policy approval process. All policies are therefore required to have this completed and support is offered via the D&I Lead. There has therefore been a significant increase in the number of equality analysis impact assessments being completed however the quality of these continues to be of concern, with "neutral" impact selected for all areas often without due consideration.

In addition, gaps were also highlighted within areas of service improvement, with QIA / EA's not being completed or done so at the earliest opportunity. This has resulted in the early identification of potential barriers and caused delays in the effective progression of service improvement plans. There is also no standardised form / process for completion, resulting in a variety of forms being used.

The service improvement team have however conducted a thorough review of the EA and QIA processes within the Trust and identified a series of recommendations. A task and finish group has now commenced to ensure prompt completion of the identified actions. Actions include:

i) The production of a new QIA policy and standardised form
ii) Refresh of the EA policy with revised governance arrangements
iii) 2 stage EA/QIA panels to review and identify potential impacting factors
iv) The usage of Project Management (PM3), to complete and record QIA/EAs

It is currently proposed that the workforce policy approval process continues in its current format, as this appears to be working well, with EA embedded within it and displayed as part of the document.

With regards to clinical policies, whilst EA is embedded within the documentation, the quality of their completion is still a concern. Trust wide awareness raising of the importance of their completion, including support to do so, will be included as part of a wider plan to launch the new QIA /EA processes.

1.8 Interpretation and Translation Services

The Trust conducted a full review of its interpretation and translation services in 2019/20 however following a variety of reviews, decided to change providers on 5 October 2020 to DA Languages.

A full breakdown of service data is available as part of the full diversity and inclusion annual report, available on the diversity and inclusion webpage.

Arabic and Bengali were the most commonly used languages for 2020/21.

Browsealoud software is also installed on the Trust's website which allows enhanced accessibility of information including the translation of information on our webpages into 99+ languages, including approximately half of those in audio format too.

1.9 People Plan

The NHS people priorities for 2021/22 include D&I related actions are also included with the Trust's response to the NHS People Plan and key areas required are:

i) Ensuring recruitment and promotion practices reflect the community, regional and national labour markets
ii) D&I considerations to be linked with wellbeing conversations
iii) Published progress against the model employer goals to ensure the workforce leadership is representative of the overall BAME workforce
iv) 51% organisations to eliminate the ethnicity gap when entering formal disciplinary processes

The Trust is currently in the process of reviewing and consolidating all D&I related action plans and this will be shared in future reports.

1.10 Review of usage of services benchmarked against local population and disaggregated by protected characteristic

Appendix 1 encompasses comparative data for service users, disaggregated by protected characteristic and compared to community and workforce demographics. Patient data is taken from a snapshot date of 31 March 2021.

Data continues to be reviewed to ensure identification of any themes / trends and actions required are incorporated within the overarching diversity and inclusion action plan.

1.11 Additional Actions Undertaken to Support Achievement of the PSED General Duties

1.11.1 Mandatory Training

The Trust continues to have a mandatory diversity and inclusion training programme for all staff which is primarily delivered via e-learning, particularly due to COVID. The Trust has a mandatory training handbook in place for designated areas and diversity and inclusion training is contained within it. Compliance on 31 July 2021 was 95.97% and is therefore above the compliance level required.

1.11.2 Work undertaken to support staff with disabilities and long-term conditions

The Trust has placed a focus on improving support and experiences for our staff with disabilities and long-term health conditions with actions completed including:

i) Launch of the new Disability and long-term health condition policy and reasonable adjustment guidance documentation
ii) WUTH Sunflowers staff network, for those with disabilities and long-term health conditions, which sees staff coming together to not only offer support to each other but to identify areas for improvement across the Trust
iii) Launch of the Hidden Disabilities sunflower initiative, providing badges to staff who have a disability and promoting awareness and training across the Trust
iv) Variety of Trust wide communications to recognise national and international disability related awareness days, sharing staff experiences, internally or externally via video or the local press, offering various internal and external support options
v) The Trust continues to be a member of the Governments Disability Confident Scheme and is currently at level 1, Disability Confident Committed and is hoping to progress to level 2 within 20021/22.

Impact – WDES Results
It is felt that the enhanced focus on supporting our staff with disabilities and long-term conditions has contributed to a number of positive improvements within the WDES data this year.

Staff survey data shows a positive improvement in 8 out of the 9 indicators, with significant progress made in some areas (improvement of 5% or more) >8.2% since 2018. All except 2 indicators are now above the national average.

There is also an increase in the number of disabled staff who reported if they had experienced bullying, harassment or abuse in the last 12 months (from 46.6% last year to 49.2% this year), as this was identified as an area of concern in the 2019/20 report.

Recruitment data also identifies an improvement in the likelihood of disabled applicants being appointed compared to non-disabled staff, with an improvement from 2:14 to 1:17.

A particular area of concern this year however is the number of disabled staff who feel their work is valued by the Trust, which has unfortunately reduced from 32.5% last year to only 30.1% this year and falls significantly lower than the national average of 37.4%.

1.11.3 Lesbian, Gay, Bisexual and Transgender and non-binary (LGBT+) Staff
The Trust continues to hold the Merseyside In Touch LGBT+ Navajo Chartermark, in recognition of our commitment to supporting LGBT+ staff and patients. The Trust is due for re-assessment in 2022.

The Trust's LGBT+ staff network, the Rainbow Alliance continues to offer support opportunities for staff and despite COVID and additional pressures for the network Chairs, the network is continuing to meet and regaining continuity of meetings. Current key priorities for the network are:
i) Supporting work towards achievement of the Navajo Chartermark,
ii) Contributing to the review of a number of policies, so as to ensure LGBT+ inclusion and support
iii) Opportunities to engage with the wider WUTH LGBT+ community
iv) Consideration of gender-neutral toilets
v) Refreshed communications to promote the NHS rainbow pin badge initiative

The Trust is also part of a regional transgender task and finish group, working together to review improvements and raise awareness of trans-related issues and areas for development.

1.11.4 Black, Asian and Ethnic Minority (BAME) Staff
The Trust re-launched its BAME staff network last year and since then, they have continued to meet regularly, with membership growing steadily.
Network members are becoming actively involved in supporting fellow BAME colleague and Trust wide communications in a number of ways:
i) To show our commitment to being anti-racist by supporting the first ever Race Equality Week and "showing racism the red card"

ii) Staff promoting the importance of completing Health Risk Assessments

iii) Members involved in identifying suggestions for improvements
iv) Members are preparing to share their experiences across the Trust and support the development of cultural awareness events (as soon as COVID restrictions permit)
v) Ultimately, the network seeks to be a safe space for colleagues to come, meet others and share as they feel able and even have some fun along the way!

In addition to the staff network, additional actions have included:

- **International recruitment -** A huge recruitment drive has taken place to strengthen the nursing team at the Trust has resulted in nurses travelling from as far as Kenya, Zimbabwe and India to work at its Arrowe Park, Wirral Women and Children's and Clatterbridge hospitals. The Trust also wants to ensure additional support is in place for our new recruits and so has appointed designated pastoral support.

- The Trust currently has three BAME Freedom to Speak Up champions to offer additional support to BAME colleagues

- Various Trust communications to focus on additional awareness / support for BAME staff e.g. to encourage take up the COVID vaccine

Impact – WRES Results

Whilst the network continues to grow and the Trusts striving to ensure improvements in experiences for our BAME staff, WRES data results this year provide a mixture of positive and negative areas. The following positives can be seen:

- Overall increase in BAME workforce (from 7.2% last year to 7.6% this year)
- Increase in the number of BAME staff feeling the Trust offers equal opportunities for career or promotion and
- Reduced number of BAME staff reporting harassment, bullying and abuse from patients and visitors

However, particularly concerning results are that negative increases can be seen in:

- the number of BAME staff who have experienced bullying, harassment or abuse from staff
- BAME staff reporting experiencing discrimination from their manager, team leader or other colleagues
- Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants

The Trust is currently reviewing all D&I action so as to ensure key priorities are identified and improvements for our BAME staff in particular can be seen. The work of the staff networks will provide a fantastic opportunity to hear the experiences of our BAME staff and develop much needed awareness and engagement opportunities across the Trust however it is the responsibilities of all staff to ensure improvements in this area.

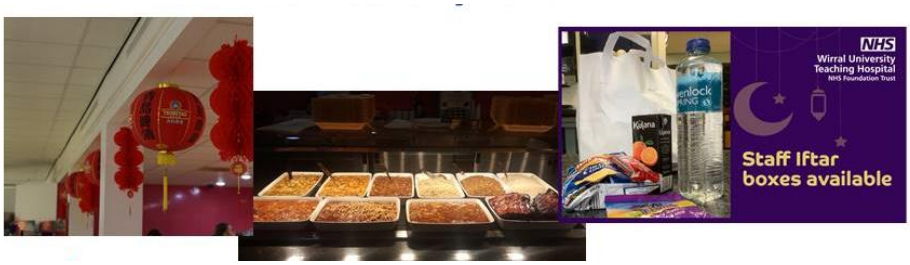
1.11.5 Chaplaincy and Spiritual Care

The Chaplaincy and spiritual care team continue to support our staff and patients' spiritual needs. The chaplaincy team relies on a number of volunteers to provide chaplaincy support, however due to COVID restrictions, those that were able to continue to work, were unfortunately significantly reduced. That said, the chaplaincy team have continued to provide much needed multi-faith support to our staff and patients, particularly during such challenging times.

There has also been an increased focus on recognising and celebrating key religious festivals. Additional advice and support has also been promoted during COVID-19, particularly with regards to concerns with the COVID vaccine for some faith groups and also for those staff observing Ramadan and wanting to fast.

Additional support, consideration and celebration took place this year, with:

- Trust wide recognition and celebration of key religious and spiritual dates / festivals
- Additional prayer spaces made available for Ramadan, with prayer mats across sites, including Microbiology.
- Links with the Catering team for special menus during key festivals e.g. Chinese New Year
- Iftar boxes provided this for the first time for staff fasting during Ramadan along with spice cakes and nuts to celebrate Eid



1.11.6 Military Veterans and Armed Force Personnel

Dr Ranj Mehra has been identified as the Trust Lead for Military Veterans and Armed Force Personnel and together with the Trust's D&I Lead, are part of a new regional task and finish group to consider additional actions required to improve experiences and support for both staff and community members.

Actions are currently under review so as to ensure the Trust is "Force-friendly" and will be included as part of the overarching D&I action plan and updates on progress will be provided in future reports.

1.11.7 Patient Information Leaflets

The Trust uses EIDO as the contractor for providing patient information leaflets. The Trust has upgraded its provision to ensure access to leaflets in other languages. These are therefore now accessible more easily for staff using the sign on codes via the intranet. Where required languages are not accessible on screen, these can be requested online.

1.11.8 Patient Engagement

i) **Patient and Family Experience Group –** The Trust continues to hold a regular meeting with internal and external stakeholders

ii) **Patient Information Reading Group (PIRG) -** The Trust has re-established its patient information reading group, led by the knowledge and library service. This group allows the opportunity for community members to review patient literature and provide feedback.

iii) **Patient Feedback -** Whilst patient experience surveying was suspended for most of 2020 / 21 due to the pandemic, 28,446 friends and family test responses were still gathered. Unfortunately however, as data collection was limited, it cannot be compared with previous years data or indeed benchmarked against other Trusts. That said, the chart below highlights some data received for 2020/21 (Disability and sexual orientation data is also unfortunately unavailable).

	Everyone	BAME	Female	Male	Age 16-30	Age 31-50	Age 51-69	70+
FFT Recommend rate	94%	90%	94%	94%	83%	90%	95%	95%

A variety of comments received link to negative feedback and in particular, a number were in relation to mental health. This will therefore be monitored by the Trust in Q1.

2 Key Issues/Gaps in Assurance

i) Completion of the Trust's review against the EDS2 framework is required as soon as possible
ii) Some negative results can be seen within our WRES data this year and therefore requires attention
iii) Capacity to deliver the D&I agenda is currently stretched and is therefore under review.
iv) D&I key priorities and action plans require review and consolidation and are also therefore under review
v) Lack of dedicated support for staff with disabilities – a recurring theme raised by staff is the lack of designated support for staff with disabilities and long-term conditions. This would be to include practical advice and support, including access to work applications, reasonable adjustments and linking up with specialist services where necessary. A Disability Adviser role has been included within the actions for consideration in our local People Plan as this has been in place previously.

3 Staff Survey Data

It is pleasing to report an increase in the Trust scores for the Equality, Diversity and Inclusion theme, within the last staff survey report. The Trust increased from 9.2 to 9.3 and is above the national average of 9.1.

Staff feedback relating to WDES and WRES is included within section 3.10 and in more detail within the full reports that will soon be made available on the Trust's D&I section of the website.

4 Next Steps

i) Agreement reached on the EDS2 indicators to be reviewed against and engagement and evidence collection to commence
ii) Launch of the new QIA / EA process
iii) Clarification of key D&I priorities and consolidation of D&I associated action plans
iv) Review of resources available in order to support achievement the key priorities
v) Particular attention to be paid to improving WRES related actions and improving experiences for our BAME staff
vi) Particular attention to be paid to ensuring our staff with disabilities and long-term conditions feel valued
vii) Preparation for re-assessment of the Merseyside In Touch, LGBT+ Navajo Accreditation
viii) Progression to Level 2 of the Disability Confident Government Scheme

Conclusion

The Trust has been working hard to not only ensure it achieves and upholds national and commissioner led requirements and regulations but to ensure a proactive approach to equality, diversity and inclusion for the benefit of its staff, patients and wider community.

This report seeks to provide an overview on the variety of work undertaken within 2020/2021 to work towards improvements in these areas, whilst also providing assurance on progress required. Additional emphasis was placed on ensuring improvements for our staff with disabilities and long-term health conditions and it is therefore pleasing to see such improvements in the WDES data this year.

It is therefore hoped that with further efforts improvements can be made for our BAME staff.

Recommendations

Members to note the progress made

Appendix 1 – Workforce Composition as of 31 March 2021

Workforce Composition (data as of 31 March 2021)

Understanding the workforce composition by equality and diversity demographics is important in order to ensure that we are a fair and open organisation and to monitor the effectiveness of our policies and procedures.

There has been an increase in the workforce numbers from 6258 staff last year to 6474 this year.

Sex / Gender

79.2% of the WUTH workforce is female and 20.8% is male. The numbers therefore reflect that the largest staff group is nursing, and that this group is predominately female. This is reflective of most NHS Acute Trusts.

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

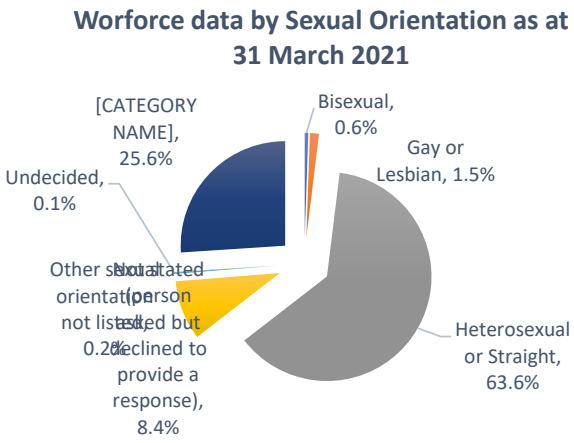
Sex / Gender

	Workforce	Patients	LA: Wirral	STP: Cheshire & Merseyside	Region: North West
Male	20.80%	39.00%	48.11%	48.76%	49.13%
Female	79.20%	61.00%	51.89%	51.24%	50.87%

Sexual Orientation

Charts below highlight the workforce sexual orientation data on 31 March 2021, along with comparative data for community members within the North West.

Sexual Orientation	% of Workforce
Bisexual	0.59%
Gay or Lesbian	1.52%
Heterosexual or straight	63.62%
Not stated (person asked but declined to provide a response)	8.40%
Other sexual orientation not listed	0.19%
Undecided	0.06%
Unspecified	25.62%
Grand Total	**100.00%**



Sexual Orientation Data Comparison with Community Demographics

	Workforce	Region: North West
Gay / Lesbian / Bisexual	1.9%	1.66%
Heterosexual / straight	62.6%	94.89%
Unknown	35.5%	3.45%

Appendix 1 – Workforce Composition as of 31 March 2021

Gender Reassignment / Identity

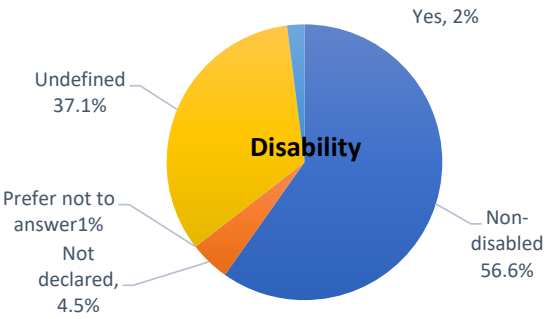
ESR currently only has the functionality to record male, female or unspecified. The Trust has been working hard to further understand the needs of its staff and patients and as such, understand that more accurate recording options are needed. A number of staff may not identify with a specific gender or have a variation of gender identities and therefore national updates are being awaited that will allow greater options for staff and accurate data in this area. The Trust can only therefore report against the number of staff recorded as male or female. This has been raised at a national level and updates awaited.

It can however be reported that staff have been supported to transition within the workplace within 2020/21, however this is currently not centrally monitored.

Disability

As of the 31st March 2021, the self-reporting rate for those staff with a disability within WUTH is 2%. A total of 131 staff have identified they have a disability, with 86 staff in a clinical role and 45 staff in a non-clinical role.

Breakdown of workforce data by disability status



	Total Clinical Staff 2021	% of Clinical 2021	% of Clinical 2020	Total Non-Clinical Staff 2021	% of non-clinical 2021	% of non-clinical 2020	Combined 2021	% overall 2021	% overall 2020
Disabled	86	2.0	1.8	45	2.1	1.9	131	2.0	1.9
Non-disabled	2721	63.0	60.5	1150	53.4	48.4	3871	59.8	56.6
Not declared	196	4.5	4.1	109	5.1	5.3	305	4.7	4.5
Prefer not to answer	1	0.0	0.0	0	0.0	0	1	0.0	0
Unspecified	1316	30.5	33.5	850	39.5	44.4	2166	33.5	37.1
TOTAL	4320	100.0	100.0	2154	100.0	100	6474	100.0	100

Religion or Belief

The chart below highlights the religious beliefs of our workforce and patients compared with the community demographics as of 31 March 2021. The categories are grouped together so as to aid ease of comparison; however, it is important to recognise some of the heading below subgroup heading: e.g. Christianity include Catholicism, Anglican etc.

Religious belief

	Workforce	Patients	LA: Wirral	STP: Cheshire & Merseyside	Region: North West
Atheism / Not religious	10.57%	26.94%	21.33%	19.08%	19.82%
Buddhism	0.21%	0.12%	0.28%	0.26%	0.29%
Christianity	40.34%	58.01%	70.41%	72.54%	67.25%
Hinduism	1.01%	0.08%	0.23%	0.32%	0.54%
Islam	0.87%	0.72%	0.57%	1.07%	5.05%
Judaism	0.07%	0.04%	0.08%	0.17%	0.43%
Other	7.10%	0.04%	0.26%	0.24%	0.27%
Sikhism	0.05%	0.08%	0.07%	0.08%	0.13%
Unknown	39.78%	13.57%	6.77%	6.24%	6.20%

Appendix 1 – Workforce Composition as of 31 March 2021

Ethnicity

The following chart shows the breakdown of the workforce by ethnicity and compared to patient and community demographics as of 31 March 2021.

Ethnicity

	Workforce	Patients	LA: Wirral	STP: Cheshire & Merseyside	Region: North West
White - British (inc English, Scottish & Cornish)	87.22%	86.95%	94.97%	92.81%	87.08%
White - Irish	0.77%	0.40%	0.83%	0.83%	0.92%
White Traveller / Gypsy / Irish Traveller	0.02%	0.00%	0.02%	0.05%	0.06%
White - other	1.92%	1.45%	1.17%	1.85%	2.15%
Mixed - White & Black Caribbean	0.13%	0.08%	0.30%	0.40%	0.56%
Mixed - White & Black African	0.22%	0.04%	0.17%	0.26%	0.26%
Mixed - White & Asian	0.27%	0.04%	0.30%	0.33%	0.43%
Mixed - Any other mixed background	0.30%	0.28%	0.25%	0.30%	0.32%
Asian or Asian British - Indian	3.72%	0.24%	0.42%	0.56%	1.52%
Asian or Asian British - Pakistani	0.10%	0.00%	0.07%	0.21%	2.69%
Asian or Asian British - Bangladeshi	0.10%	0.24%	0.27%	0.15%	0.65%
Asian / Asian British: Chinese	0.36%	0.32%	0.52%	0.61%	0.68%
Asian or Asian British - Any other Asian background	1.02%	0.60%	0.33%	0.40%	0.66%
Black/African/Caribbean/Black British: African/Black British: Caribbean or Black British - Caribbean	0.68%	0.24%	0.18%	0.61%	1.17%
Any other Black African / Caribbean	0.19%	0.00%	0.04%	0.13%	0.22%
Arab	0.00%	0.00%	0.07%	0.30%	0.35%
Any Other	1.31%	0.12%	0.10%	0.20%	0.28%

Age

The charts below highlight the workforce and patient demographics, compared with local communities as of 31 March 2021. Workforce data is not directly comparable due to the age range brackets, however can provide an indication as to potential areas of focus.

Age Band	*% of Workforce*
<=20 Years	0.63%
21-25	7.63%
26-30	11.72%
31-35	11.47%
36-40	11.62%
41-45	11.67%
46-50	12.32%
51-55	12.28%
56-60	11.97%
61-65	6.81%
66-70	1.61%
>=71 Years	0.27%
Grand Total	**100.00%**

	LA: Wirral	*WUTH patients*	*STP: Cheshire & Merseyside*	*Region: North West*
Under 25	12.99%	16.22%	14.60%	14.99%
25-29	6.89%	6.70%	7.64%	8.15%
30-34	6.57%	5.78%	7.03%	7.50%
35-39	7.36%	4.82%	7.62%	7.86%
40-44	8.72%	5.02%	8.80%	8.99%
45-49	9.35%	4.94%	9.29%	9.12%
50-54	8.60%	6.95%	8.40%	8.12%
55-59	7.78%	7.07%	7.44%	7.15%
60-64	8.35%	7.99%	7.85%	7.68%
65-69	6.54%	7.27%	6.08%	5.98%
70+	16.86%	27.26%	15.22%	14.47%

Appendix 2

2018/19 Equality Delivery System 2 Assessment Ratings

(Rating options are: Excelling, Achieving, Developing or Under-developed)

Goal 1: Better Health Outcomes

Indicator		Self-assessment Rating
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	**Developing**
1.2	Individual people's health needs are assessed and met in appropriate and effective ways	**Developing**
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	**Developing**
1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	**Developing**
1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	**Achieving**

Goal 2: Improved Patient Access and Experience

Indicator		Self-assessment Rating
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	**Achieving**
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	**Developing**
2.3	People report positive experiences of NHS	**Achieving**
2.4	Peoples' complaints about services are handled respectfully and efficiently	**Developing**

Goal 3: A Representative and Supported Workforce

Indicator		Self-assessment Rating
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	**Developing**
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	**Achieving**
3.3	Training and development opportunities are taken up and positively evaluated by all staff	**Developing**
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	**Developing**
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	**Achieving**
3.6	Staff report positive experiences of their membership of the workforce	**Developing**

Goal 4: Inclusive Leadership

Indicator		Self-assessment Rating
4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	**Developing**
4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	**Developing**
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free form discrimination.	**Achieving**

Note with regards to grading:

Organisations to focus on "how well do people from protected groups fare compared with people overall?" There are four grades:

- **Undeveloped** - if there is no evidence one way or another for any protected group of how people fare or if evidence shows that the majority of people in only two or less protected groups fare well
- **Developing** - if evidence shows that the majority of people in three to five protected groups fare well
- **Achieving -** if evidence shows that the majority of people in six to eight protected groups fare well
- **Excelling -** if evidence shows that the majority of people in all nine protected groups fare well

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 18

BOARD OF DIRECTORS
1 December 2021

Title:	Appraisal and Revalidation Annual Board Report and Statement of Compliance
Responsible Director:	Dr Nicola Stevenson
Presented by:	Dr Nicola Stevenson

Executive Summary
Revalidation is the process by which doctors are assessed as being up to date and fit to practise by their Responsible Officer. This is based on satisfactory annual appraisal. Appraisal is a professional process in which the doctor being appraised has a formal structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved. WUTH has a process in place for appraisal of senior medical staff which is quality assured and compliant with the Annual Organisational Audit (AOA) standards monitored by NHS England. This report refers to the appraisal year April 2020 - March 2021.

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

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)
None to note
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
None to note
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)

Funding will be needed to access and maintain a revalidation management system which will need to be in place from April 2022.	
Specific communications and stakeholder /staff engagement implications	
Not applicable	
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)	
Not applicable	
Council of Governors implications / impact (e.g. links to Governors' statutory role, significant transactions)	
Not applicable	
Previous considerations by the Board / Board sub-committees	Not applicable
Background papers / supporting information	Not applicable

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Wirral University Teaching Hospital

Annual Board Report

Appraisal round April 2020 – March 2021

Section 1 – General

The executive management team of Wirral University Teaching Hospital can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Action from last year: None recorded

   Comments: Dr Stevenson remains in post as Responsible Officer. She has accessed all necessary training and engages regularly with the Responsible Officers Network via NHS E/I North as well as the GMC RO Reference Group.

   Action for next year: Ongoing engagement with RO Network events.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes

   Action from last year: Develop a new Medical Professional Standards Manager post to replace the Appraisal & Revalidation Manager post.

   Comments: The Job description for the above post has now been agreed and recruitment to the role should take place before the end of 2021, with the appointee to commence 1 April 2022. The retired Appraisal & Revalidation Manager has agreed to continue to provide limited support until the end of March 2022.

   Action for next year: Recruit to Medical Professional Standards Manager post to commence 1 April 2022.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Action from last year: Collaborate with HR to develop a system whereby information is provided for all starters and finishers in real time, and to provide a list of nil hours doctors who have not worked within the last six weeks.

   Comments: System still to be implemented.

Action for next year: Collaborate with HR to ensure information is provided for starters and leavers in real time, and identify doctors who have not worked in the last six weeks.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Continue to monitor national updates in relation to the future direction of Medical Appraisal & Revalidation.

Comments: The Senior Medical Staff Appraisal Policy was last ratified in January 2019 following updates. National changes to the appraisal system are due to be announced later in 2021 by the GMC and NHS E/I and these will be taken into account when the policy is next due for review. The review date has been extended until April 2022 to allow us to ensure our local process is consistent with any released guidance.

Action for next year: Review and ratify Senior Medical Staff Appraisal Policy. Continue to monitor national updates in relation to Medical Appraisal & Revalidation.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: Self-assessment was undertaken in 2018/19. The only outstanding action from this is that a departmental standard operating procedure should be produced in line with WUTH's Information Governance Policy.

Comments: This action remains outstanding due to retirement of Appraisal & Revalidation Manager, and reduced hours being undertaken in support of the department.

Action for next year: Standard operating procedure to be completed by the end of 2021.

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

Action from last year: SAS Lead role to be asked to work with Medical Appraisal Lead to ensure all agile doctors are aware of their appraisal and revalidation requirements, and to support them to achieve these.

Comments: Agile doctors now sit within the ARCP system led by Professor Barrett (Director of Medical Education).

Action for next year: Ensure strong links with Education Centre Team and ARCP process are maintained to inform revalidation recommendations. (Data is already available for the Summer 2021 ARCP round).

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: None recorded

Comments: There was a national directive to pause the medical appraisal process during March – September 2020. WUTH adopted an interim process in September 2020 based on the national Appraisal 2020 model which focussed on the wellbeing of doctors and verbal reflection. This process has been well-received by both doctors and appraisers, with good engagement by relevant medical staff across all Divisions.

Action for next year: Prior to the pandemic WUTH used the MAG (Medical Appraisal Guidance), an appraisal document produced by NHSE to manage the appraisal process. This will not be fit for purpose once the new appraisal arrangements come in to force and therefore an external revalidation management system will need to be acquired.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: None recorded

Comments: The reasons for any missed appraisals are recorded, and timely support is provided by the Medical Appraisal Lead or a Senior Appraiser for doctors who are struggling to engage in the appraisal process. The RO is involved when necessary.

Action for next year: None required

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

Action from last year: None recorded Comments: The Senior Medical Staff Appraisal Policy remains in date and has been approved by JLNC. Action for next year: Policy to be reviewed and ratified in 2022, following anticipated publication of national guidance.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: None recorded Comments: We currently have 58 trained medical appraisers, and each will carry out 5-6 appraisals per calendar year. Action for next year: Regular appraiser training will recommence in November 2021, so that we continue to train appraisers to meet our future needs.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Run planned Appraiser Refresher Days when safe to do so. Continue with current quality assurance processes. Comments: There are several quality assurance and performance measures in place: appraisers receive annual feedback from the doctors they have appraised and are encouraged to attend the Appraiser Support Group meetings. All appraisals are quality assured by a member of the A&R Team during the 'sign-off' process. New appraisers undergo a face-to-face performance review with a senior appraiser after their first three appraisals, and are observed once by the A&R Manager. Action for next year: Run planned Appraiser Refresher days at the beginning of 2022 if pandemic restrictions allow. Continue with current quality assurance processes. Formal quality assurance of one appraisal per year

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

using the ‘excellence tool’ or similar will recommence once the interim appraisal process has ended in April 2022

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: None recorded

Comments: The Medical Appraisal Lead/Senior Appraisers review appraisal documentation of all doctors each year. The Responsible Officer reviews the doctor’s documentation within the revalidation year, or where there are concerns. An annual report is presented at Trust Board, and progress is reviewed monthly at the Responsible Officer meeting.

Action for next year: None required

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2021	354
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	**258**
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	**96**
Total number of agreed exceptions between 1 April 2020 and 31 March 2021	**92**
Total number of unapproved exceptions between 1 April 2020 and 31 March 2021	**4**

Doctors employed on trust-grade contracts (e.g. trust grade doctors / clinical fellows) are provided with an annual local ARCP, which is run by the Director of Medical Education. Of this group four did not engage with the process. These doctors have now left the trust to take up training posts.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None recorded Comments: While the GMC deferred all revalidation recommendations for one year in March 2020 due to the COVID-19 pandemic, we have continued to recommend those doctors who are ready for revalidation rather than waiting for their postponed revalidation date. There were 68 revalidation recommendations and no recommendations of deferral in the period April 2020 – March 2021. WUTH's deferral rate was 0%, against the national deferral rate of 1.7% reported by the GMC. All revalidation recommendations were completed on time. Action for next year: None required

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None recorded Comments: The Medical Appraisal Lead or Senior Appraisers will speak to doctors about reasons for deferral and all doctors receive confirmation of their GMC recommendation by email. Action for next year: None required

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Continue to send weekly bulletins, and move to regular Safety Summits in late 2020. Comments: All doctors are encouraged to report clinical incidents and near misses as they arise. A risk management report is produced for each doctor annually, and uploaded to the appraisal document in advance. Doctors are

required to reflect on any incidents, complaints or legal claims either in writing, or during a documented discussion in their appraisal meeting.

Due to the social distancing requirements and clinical pressures associated with the Covid-19 pandemic, Safety Summits have not recommenced. However, Divisional Quality Boards are held monthly, and weekly Serious Incident panels are held with senior Divisional representation in order to ensure senior Trust-wide oversight of incident investigations and provide assurance on key/urgent actions. Additionally, Mortality Review Group is now held every 2 weeks and attended by the Divisional Mortality Leads to feedback learning to individuals and teams.

Action for next year: Further work to ensure a 'Just Culture' is in place within WUTH, and that this guidance is used to inform all serious incident reviews or concerns raised about a doctor.

Further strengthen the dissemination of learning from clinical incidents, serious incident reviews and mortality reviews across the organisation to all relevant professional groups.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None recorded

Comments: The following information is uploaded to the doctor's appraisal document for reflection and discussion at appraisal: letter from RO asking for reflection on specific incidents or concerns (if required); risk management report detailing any incidents, complaints and litigation; 360 feedback; research information where applicable. The A&R Team are made aware of any concerns about an individual doctor during the monthly RO meeting (to ensure this is covered during their appraisal), and a quarterly RO Advisory Group meeting is held so that the response to concerns and progress of any investigations may be reviewed.

Action for next year: None required

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None recorded

Comments: The Trust has appropriate and established policies in place to deal with fitness to practise concerns. Any doctor who is under investigation is expected to declare and reflect upon this on their appraisal documentation (and will receive a letter from RO asking them to do so).

Action for next year: None required

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: The policies 'Procedure for handling concerns about the conduct, performance and health of medical and dental staff' and 'Medical Staff Remediation' require review.

Report data relating to the protected characteristics of any doctors discussed by the ROAG at the end of year one (April 2021).

Comments: ROAG continues to meet quarterly; no MHPS investigations currently ongoing. Due to low number of investigations in recent years, it is not possible to provide a report that would enable meaningful conclusions to be drawn. Of the doctors discussed, there has been a mix of gender and ethnicity.

Action for next year: Continue to embed current processes.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: Work with Workforce to enable timely access of information needed to complete the transfer of information.

Comments: Procedure agreed and in place.

Action for next year: None required

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

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

Action from last year: None recorded Comments: Concerns raised regarding a doctor's practice are escalated to the Responsible officer as per the 'Procedure for handling concerns about the conduct, performance and health of medical and dental staff'. Any formal meetings will be attended by a senior HR representative. The Human Resources Department will encourage the adoption of a consistent approach in accordance with accepted standards of good personnel practice and employment legislation as well as the policy mentioned above. Action for next year: None required

Section 5 – Employment Checks

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

Action from last year: Development of a streamlined process to ensure that RO to RO forms are processed for all medical staff in order to enable a consequent exchange of information is under review. Comments: Review of TOI (transfer of information) process ongoing. WUTH adheres to NHS recruitment guidelines and vetting check requirements; after interview all employment offers are made on a conditional basis so that all checks (detailed in the Safe Employment Policy) are completed and verified within the Trust prior to any new starters commencing in post. Agency workers are sourced through agencies on the HTE framework which gives us assurance that these workers have met satisfactory checks. Compliance is checked before booking a temporary external worker. Action for next year: Continue to streamline and embed TOI process.

Section 6 – Summary of comments, and overall conclusion

General review of actions since last Board report

- **Actions still outstanding**
- Recruitment of Medical Professional Standards Manager
- Development of standard operating procedure in line with WUTH's Information Governance Policy
- **Current Issues**
- An interim medical appraisal process remains in place; all processes will need to be reviewed once new national guidance is published and the appraisal policy will be updated accordingly.
- Our previous appraisal template (Medical Appraisal Guide or 'MAG' form) is no longer fit for purpose, and NHS E/I does not intend to update this document. We will therefore need to move to a web-based medical appraisal platform by April 2022, and this will require funding. A business case is in development.
- **New Actions:**
- Collaborate with HR to ensure information is provided for starters and leavers in real time, and identify doctors who have not worked in the last six weeks
- A web-based appraisal and revalidation management system will need to be procured and implemented by April 2022.
- Review and ratify Senior Medical Staff Appraisal Policy once web-based system has been commissioned and implemented. Continue to monitor national updates in relation to Medical Appraisal & Revalidation.
- Ensure strong links with Education Centre Team and ARCP process are maintained to inform revalidation recommendations.
- Recommence regular Appraiser Training Days from November 2021
- Run planned Appraiser Refresher days at the beginning of 2022.
- Quality assurance of one appraisal per year using the 'excellence tool' or similar will recommence once the interim appraisal process has ended in April 2022
- Further work to ensure a 'Just Culture' is in place within WUTH, and that this guidance is used to inform all serious incident reviews or concerns raised about a doctor.
- Further strengthen the dissemination of learning from clinical incidents, serious incident reviews and mortality reviews across the organisation to all relevant professional groups.
- Continue to streamline and embed Transfer of Information (TOI) process

Overall conclusion:

This has been an unusual year for Appraisal & Revalidation, due to the impact of the Covid-19 pandemic and the requirement to pause the appraisal process during March-September 2020. We recommenced fully in September 2020, which was earlier than many other acute trusts, and before it was nationally mandated. Due to the national pause, the completed appraisal rates are lower than usual, but we expect this to return to our usual high level of attainment once the 2021/22 data is available. Engagement of doctors and appraisers remains excellent, and we look forward to moving to a web-based appraisal platform during 2022.

Section 7 – Statement of Compliance:

The executive management team of Wirral University Teaching Hospital has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Official name of designated body: Wirral University Teaching Hospital

Signed on behalf of the designated body

Janelle Holmes, Chief executive

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

Agenda Item: 19

BOARD OF DIRECTORS
1 December 2021

Title:	Report of the Trust Management Board
Responsible Director:	Chief Executive
Author:	David McGovern, Director of Corporate Affairs
Presented by:	Janelle Holmes, Chief Executive

Executive Summary
The purpose of this report is to provide the Board with an assurance summary of the Trust Management Board meeting held in November 2021

Recommendation:
The Board is asked to note and receive the November 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	NA	
Background papers / supporting information	NA	

BOARD OF DIRECTORS MEETING IN PUBLIC
1 December 2021

REPORT OF THE TRUST MANAGEMENT BOARD

Purpose

The purpose of this report is to provide the Board with an assurance summary of the Trust Management Board meeting held in November 2021

Overview of main

A summary of the topics covered is provided below:

1. Finance

It was reported that financial planning for the second half of the financial year (H2) was underway and still in development as the October (month 7) financial position was finalised. It was therefore an unusual month for reporting due to the national and regional financial planning process being underway. In the absence of an agreed plan at this stage, the report focused on actual income & expenditure for the period. It was expected that normal reporting will resume next month (month 8) once the Trust's financial plan is approved. The Trust reported a deficit of £1.132m in October 2021 (deficit of £1.107m year to date) primarily as a result of a number of system allocations which had not been agreed as the month 7 position was reported. This compared favourably with other Trusts in the region. The Trusts financial plan, as submitted to Cheshire and Merseyside Integrated Care System (C&M ICS) on 25th November 2021, is for a break-even position for the second half of the year (H2). It was highlighted that delivering this was dependent upon receiving ERF income and this remains a key risk to the delivery of a break even position by the end of the year. The CEO highlighted that 2022/23 would be challenging and the fundamental aim was for the Trust to recover from Covid and support the clinical pathways of patients whilst targeting reducing waiting times for patients.

2. Staff Survey Update

The Director of Communication and Engagement provided a presentation in relation to Staff Survey. At the time reported the overall response rate across the Trust was 39 %, the target was 47 %. The highest response rate to date was in the Corporate Support Division where there had been a response rate of 61 % with the lowest response in the Women and Children's Division. It was reported that the survey closes on 26 November 2021. It was identified that there would be a push to secure a higher response rate so that the target of 47 % was attained or hopefully exceeded. It was stressed by the CEO that staff participation in the Staff

Survey was to be encouraged by the Trust with a focus on encouraging responses in the parts of the Trust where there was presently a low response. It was identified that levels of response was a measure of how engaged staff were.

3. GDE

The Chief Information Officer presented in relation to Global Digital Exemplar Options. The options were outlined for the organisation in light of the impending closure of the Global Digital Exemplar programme. The TMB approved the recommendations relating to the Global Digital Exemplar programme: to continue to strive for achievement of the HIMSS Level 6 & 7 accreditation outside of the GDE programme by factoring in the outstanding requirements to our clinical and IT operational plans; with Clinical leadership from key stakeholders being imperative to success; scope the work involved in providing Positive Patient ID functionality within the hospital to improve patient safety levels and look to implement within the next 18 months; continue to work with the organisation to implement further patient safety elements in line with those identified in the relevant clinical strategies; and accept National Digital Leadership accreditation and exit the Global Digital Exemplar Programme. It was agreed that GDE should not simply be an IT project as there should be a focus on patient outcomes. The CEO identified that the GDE proposals and recommendations were due to be discussed at Trust Board in December for final agreement.

4. Update on ICS

The TMB were brought up to speed with developments with the ICS. It was explained that the ICS would bring together NHS organisations, councils and wider partners in a defined geographical area to deliver a more joined up approach to improving health and care outcomes. Cheshire and Merseyside would have their own ICS and would be fully operational in April 2022. It was explained within the ICS there was an ICP as well as an ICB. The ICB will be responsible for implementing the overall NHS strategy across Cheshire and Merseyside, assigning resources, securing assurance and ensuring best outcomes for the community. It was highlighted that after 1 April 2022 Clinical Commissioning Groups would operationally cease. It was intended that the Cheshire and Merseyside ICB will be a Unitary Board, with members having shared corporate responsibility. The ICP will provide a forum for NHS leaders and local authorities to come together. It was reported that there was ongoing work with Health System Chairs and Chief Executives to discuss governance. Work was ongoing to finalise an operating model. It was identified that there would need to be a staff communication programme for staff in connection with changes

The CEO highlighted that there would be a major change in the approach of the NHS where there was a move from competition with instead a focus on collaboration which would require a different mind-set. It would be a requirement for NHS provider organisations to work collaboratively.

5. Update on Capital

A presentation on Capital was provided to TMB. It was identified that all 2021/22 BAU Planned Programmes are in flight. It was highlighted that there were 12 completed projects and there were 16 projects in flight of which: 4 with on-site delivery; 4 awaiting on-site start; 5 were in procurement/evaluation and 3 were at design stage. Just in this last quarter the following projects were completed: D Sub Transformer; Chiller installations at Clatterbridge; Fire Alarm Update; Endoscopy washer enablement; and gas main condition survey. There was increasing demand on the Capital team to support divisional schemes which is included but were not limited to: ward 24/25 reconfiguration Covid-19 related; ward 14 Chiller replacement; Clatterbridge theatre; and ED works. It was highlighted that in the development of the Capital Programme that there was clinical input and engagement which encompassed the development of a schedule of accommodation and high level clinical flow model.

6. Divisional Updates

The Divisional directors presented their respective Divisional Updates. It was highlighted that there was a need to integrate the accountability programme in relation to DPR for Clinical Divisions. The TMB reviewed and noted the key issues in the previously circulated updates from each operational division. There were no issues to escalate.

7. Policy on Violence and Aggression

It was identified that there would be a review of Trust policies on violence and aggression to factor in work in this area from the Divisional Director of Acute. The Acting Director of Strategic Estates, Capital & Facilities identified that he would pick up on this action with security to update the policy on violence and aggression to enhance the safeguarding of staff.

8. Recommendations to the Board

The Board is asked to note and receive the report of the Trust Management Board.

Wirral University Teaching Hospital NHS Foundation Trust

Agenda Item: 20

BOARD OF DIRECTORS
1 December 2021

Title:	Workforce Assurance Committee Chair's Report
Author:	John Sullivan
Responsible Director:	Debs Smith
Presented by:	John Sullivan

Executive Summary *Contextual and background information pertinent to the situation / purpose of the report.*
The Workforce Assurance Committee met on 19 November 2021. Positive progress was reported in a number of workforce related areas. However, higher than target sickness absence and turnover levels remain the most significant Trust workforce risks.

Recommendation: (e.g. to note, approve, endorse)
• To note the progress made in a number of Workforce Assurance areas. • To continue to support the proposed reorganisation of the Workforce Directorate • To support the business case for additional overseas nurse recruitment in 2022 • To routinely demonstrate our Board's commitment to promoting diversity and inclusion within and beyond our Trust • To review the focus and priority given to line manager leadership behaviours, communication skills, and compliance with Trust workforce policies. To include this area of manager development in the Workforce and Education Strategy as a means to reduce future sickness absence and improve employee retention.

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)
Risks 2.1, 2.2, and 2.3 the BAF
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)

Specific communications and stakeholder /staff engagement implications
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Compliance with Disability Equality Standards and Race Equality Standards
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)

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

BOARD OF DIRECTORS
1 December 2021

Workforce Assurance Committee Meeting held 19 November 2021 -- Chair's report

Purpose

To provide the Trust Board with assurance on Workforce matters including:

- Freedom to Speak Up
- Workforce and Education strategy formulation progress
- Implementation progress of the 2018-2022 Diversity and Inclusion Strategy
- Workforce performance metrics and 'deep dives' into Sickness Absence and Employee Retention.
- Support for the NW NHS Pledge to shift the focus from sickness absence to holistic wellbeing for everyone
- Employee Relations metrics and trends
- Workforce Policies for approval
- Monthly Safe Nurse Staffing reports (September & October 2021)
- 6 Month Nursing Establishment Review
- International Recruitment 2022/2023 Proposal
- International Recruitment Update at October 2021
- Guardian of Safe Working Report
- Board Assurance Framework -- Workforce review

Introduction / Background

The Workforce Assurance Committee met on 19 November 2021. The Chair addressed the committee and sought greater focus on building organisational and individual workforce resilience, workforce planning (short and long term) and talent management processes that drive internal succession outcomes.

Conclusions

- The committee received a staff story which reinforced the value of a supportive manager who recognised an individual's diversity and then modified working arrangements to better suit the individual's strengths and contributions.
- The committee received a Workforce Director Report for the first time. This allows the committee opportunity to scrutinise and support the Trust's workforce priorities.
- The Trust's Workforce & Education Strategy process was endorsed and supported. A progress report will be reviewed at the January 2022 meeting.
- The committee welcomed the 'deep dive learning' analyses presented for sickness absence and employee retention.
- The Workforce KPIs are characterised by large variation in workforce performance outcomes from division to division. For example, return to work

interview compliance was 94.9% in Estates but only 55% in Medicine & Acute.

- Compliance with workforce systems and procedures also shows large variation. For example, of the recent 38 Band 5 Nurse leavers only 2 completed an exit questionnaire.
- The combination of sickness absence at 6.67% with turnover at 13.3% and the 2021 bow wave of untaken staff leave is creating intense pressure on the staff at work as they cope to cover absence, onboard new starters and ensure safe handovers of workplace responsibilities when staff leave.
- An Employee Relations Report was received for the first time at this committee. The report was welcomed and will feature in all future committee agendas.
- The Board Assurance Workforce risks were reviewed and no changes to risk ratings were suggested.

Recommendations to the Board

- To note the progress made in a number of Workforce Assurance areas.
- To continue to support the proposed reorganisation of the Workforce Directorate
- To support the business case for additional overseas nurse recruitment in 2022/2023
- To routinely demonstrate our Board's commitment to promoting diversity and inclusion within and beyond our Trust
- To review the focus and priority given to line manager leadership behaviours, communication skills, and compliance with Trust workforce policies. To include this area of manager development in the Workforce and Education Strategy as a means to reduce future sickness absence and improve employee retention.

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 21

BOARD OF DIRECTORS
1 December 2021

Title:	Report of the Quality Assurance Committee
Author:	Steve Ryan, Non-Executive Director
Responsible Director:	Dr Nikki Stevenson, Executive Medical Director/Deputy CEO
Presented by:	Steve Ryan, Non-Executive Director

Executive Summary
This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 24th November 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	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)
Principle BAF Risk 4: Catastrophic Failure in Standards of Care
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
CQC standards on safety and effectiveness
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	Quality Assurance Committee
Background papers / supporting information	

BOARD OF DIRECTORS
1st December 2021

Report of the Quality Assurance Committee
Held on 24th November 2021

Purpose

This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 24th November 2021.

Introduction / Background

1. Serious incident reporting, investigation and learning

The Committee received the Serious Incident (SI) Panel Chair's reports for October and November, having sight of the full investigations noting the quality and detail of the investigations and pertinent recommendations. The progress made in learning from previous never events was noted, where executive oversight and divisional scrutiny has been associated with no further such events being reported. The Committee were reminded that intelligence & learning from incidents is coordinated with other sources of information to ensure triangulation and the identification of themes. Six transfusion incidents that resulted in no harm were also highlighted, fail-safe processes noted, as well as focused feedback and learning to relevant clinical areas.

The Board will receive these SI reports in its private meeting.

2. Emergency Department

The Committee received reports on the CQC 2020 Patient experience report, on the ED Thematic Review Improvement Plan Quality and Safety Pillar and also noted the emergency care metrics in the Quality Improvement Dashboard. The Committee were assured that comprehensive actions were in place to respond so as to maintain quality of care despite persistent high levels of demand and despite limitations of the current physical environment. Actions included escalation to enhanced executive oversight and the engagement of a senior CCG quality lead to support governance development. Actions to recruit relevant clinical staff were noted, but significant risk remains with staffing levels and risks to staff health and wellbeing. A high level of attention and support will be required throughout the winter.

3. Learning from deaths

The Committee was assured that appropriate processes were in place for scrutiny of individual patient deaths and for the oversight of mortality rates. Overall Trust mortality rates are as expected or lower. Alerts from Dr Foster Intelligence around small numbers of diagnoses are received from time to time and are reported to the Mortality Review Group. Case note review is undertaken to determine if any care issues or coding issues can be identified. None have been so far. It was agreed that an internal audit report into clinical coding would be shared by the Audit Committee with this Committee as accuracy

in coding is important in the calculation of accurate mortality rates.

4. Cervical screening

The Committee received the annual report for April 2020 to March 2021 and were assured on the quality of services delivered. An area of active focus in turnaround times for histology which is under pressure as a result of a histopathologist vacancy (of which there is a national shortage). Significant progress on previously reported issues around compatibility of relevant informatics platforms (noted in external assurance reviews and currently mitigated manually) was noted and solutions are expected to be in place imminently.

5. CQC action plan

Further progress was noted on completing actions with 89.7% of overall requirements being completed. Only 1 of 94 "must do" actions remains at risk and relates to integrated discharge processes and identifying relevant support packages. As we move to complete and close the action plan in the new year, it will be important to identify actions where changes that have occurred that mean that the specific action is no longer relevant.

6. WISE Ward/ Service Accreditation

The Committee received and supported the proposal set out in a paper from the Interim Chief Nurse. Building on improvements in care already seen, and having identified high performing wards and leaders, it is proposed that a new higher level of accreditation (Level 4) is established with appropriate processes to support its awarding and retention. The Committee were pleased to see that Ward Managers leading there multidisciplinary team to this level would be identified as Matrons and would work with leaders of services/wards at lower levels of accreditation to further enhance improvements n care.

7. Risk and assurance

The Committee did not believe there was a need to modify the level of likelihood and impact for key risks for which it has oversight.

Conclusions

The Committee received appropriate and detailed documentation in relation to the items it considered on 24th November and was able to scrutinise this and note areas of progress, areas for development and areas of risk, receiving relevant assurance on actions to meet the objective of providing outstanding care

Recommendations to the Board

The Board is requested to note this report.

Agenda Item: 22

BOARD OF DIRECTORS
1 December 2021

Title:	Audit Committee Chair's Report
Author:	Steve Igoe
Responsible Director:	Claire Wilson
Presented by:	Steve Igoe

Executive Summary
To update the Board on the Audit Committee meeting held on 19th November 2021

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 / 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)
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential standards, competition law)
Financial implications / impact (e.g. CIPs, revenue/capital, year-end forecast)
Specific communications and stakeholder /staff engagement implications
Patient / staff implications (e.g. links to the NHS Constitution, equality & diversity)
Council of Governors implications / impact (e.g. links to Governors statutory role, significant transactions)

Previous considerations by the Board / Board sub-	

committees	
Background papers / supporting information	

BOARD OF DIRECTORS
1 December 2021

Report to the Board on the Audit Committee meeting held on 19th November 2021

1.Introduction

This report updates the Board on the details considered at the Audit Committee meeting on 19th November 2021.

2.Internal control and risk Management

The Committee received reports on losses and special payments and a summary of outstanding debts. Since the last Audit Committee:

- Total stock losses were recorded as £14,480 mainly related to pharmacy breakages and drug expiration.
- 2 ex gratia payments were made relating to hearing aid losses.
- Losses relating to NHSR were detailed with the total excess for the period since the last Audit Committee standing at £9,324

The Committee also discussed the current bad debt position which had fallen slightly from £738k in August to £614k as at end October. There is one old debt for £200k which is the subject of a dispute between Wirral Borough Council and the CCG. The debt is fully provided for and dependent upon the availability of evidence may be written off in full or in part.

A detailed proposal was received in relation to amendments to the SFI's concerning tender and quotation limits and cumulative spend across the year. The issue was highlighted in a detailed Internal Audit report from MIAA discussed later. The amendments were approved.

A report on spend controls and waivers was presented. The trust raised purchase orders to the value of £16.284m in the period Sept 21 to Oct 21.92.7% were compliant with the Trust's SFI's under the model hospital metric. It was clear that there was a high degree of transparency where SFI's were waived and it was confirmed that there is a robust process for authorisation of requests to waive SFI's with the relevant authorisation being given at a senior level.

The CIO updated the Committee on actions being taken in response to an earlier MIAA audit on Data quality. Good progress was being made in responding to the issues raised with all but one scheduled to be delivered to target by the end of this calendar year. Due to operational pressures one action has slipped but again this will be completed by the end of this year.

3.Internal Audit

This section of the agenda covered a detailed follow up report from MIAA on previous issues raised as well as a progress report on ongoing audit outcomes.

In terms of follow up the Internal Audit service reported positive progress in responding to and resolving previous recommendations made.

In relation to the latest reports, their work focussed on Medical bank staffing and Estates procurement. Both of these received limited assurance.

It should be noted however that in both instances the IA team had been requested by management to review these areas in the light of information which has been uncovered in terms of operational control matters over recent months.

The resolution of the HR issues is currently being overseen by the Extraordinary Audit Committee and it is expected that these will be signed off by the end of December 2021.

In relation to the Estates procurement issues it was clear that the issues raised cold also be characterised as “sins of the past”. In terms of the current position Colleagues in procurement reported extremely positive engagement by the current teams with appropriate procurement practices in the light of the substantial staffing changes over recent months.

4.Annual Governance statement

No specific issues were raised in relation to the Annual Governance Statement

5.Committee work plan

It was noted that with the turnover of staff involved with Governance matters, that the Committee work plan would be revisited over the coming months along with those of other Assurance Committees. An updated plan would be discussed by the Committee at its January 2022 meeting.

Steve Igoe
Chair of Audit Committee
22nd November 2021

Agenda item: 23

BOARD OF DIRECTORS
1 December 2021

Title of Report	Report of the Safety Management Assurance Committee
Date of Meeting	12th November 2021
Author	Steve Igoe, Non-Executive Director
Accountable Executive	Nikki Stevenson, Medical Director
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	
Level of Assurance • **Positive** • **Gap(s)**	
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	To note
Reviewed by Assurance Committee	Not applicable
Data Quality Rating	Not applicable
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	Not applicable

Report of the Safety Management Assurance Committee

This report provides a summary of business conducted during a meeting of the Safety Management Assurance Committee on 12th November 2021.
Under matters arising the Committee spent some time discussing the location for reporting of Estates issues. It was recognised that given the breadth of issues being dealt with a number of committees were receiving updates on these matters which led to a duplication/triplication of effort and oversight. It was agreed that the Director of Strategy and Partnerships would liaise with executive colleagues to ensure that the Governance processes were appropriate, effective and efficient.

1.Occupational Health and Wellbeing update

A report was received from the Head of Occupational Health and Workforce Wellbeing. The trust has a small service which has focused on core OH activities throughout the pandemic. Key issues being overseen relate to:

- Sickness Management and pre-employment screening
- Flu Vaccination
- SEQOHS re-accreditation
- PCR testing for symptomatic staff
- Contact tracing
- Asymptomatic self-testing

In addition, further psychological support was put in place via:

- Well-being hubs
- Training and awareness raising
- Specialist therapy support
- And a new staff rest and relaxation area to be completed.

Whilst a wide range of staff support services have been developed and used during the pandemic, it was recognized that this can sometimes seem fragmented in approach. This is being resolved by the creation of a single integrated service.

2.Radiation Protection Bi-Monthly report

Due to unplanned downtime in July 2021, 4 radiation incidents occurred. All incidents were reported to medical experts, and it was deduced that the incidents were in the minimal or negligible risk category. Nonetheless they were reported to the CQC and investigated as a serious incident. IRS visited the department in May 2021to audit compliance against regulations and a generally positive report was received. Where issues were identified the department has reacted positively and ensured relevant corrective measures have been implemented.

3.Health and Safety Management Committee Chair's report

The report provided the Committee with an update on key work undertaken by the H&S Management Committee in September and October 2021.Sub Committee chair's reports on Water safety, Violence and Aggression prevention, Needlestick injuries and trends of sharps (NTS) group, PPE group, Ventilation group and Environmental group were all discussed.

4.Trust Health and Safety Dashboard

The Paper as presented updated the Committee on data and progress against previously identified actions and provided further information on performance and assurance.
A total of 6 RIDDOR incidents between1 April and 26th September were recorded of which 4 related to slips, trips and falls.
There was a total of 797 non-clinical incidents reported in the same period compared with 582 across a similar period the previous year. Of the 797 incidents reported, 500 resulted in on harm whilst the balance resulted in low harm.IT is felt that the increase may be a result of enhanced awareness and reporting by staff.

6 duty of care notices were issued since April 2021 and as of 1 September there were no new EL/PL claims.
There are currently 55 risks relating to Health and Safety on the risk register. No risk is scored as a significant risk.24are scored as a high risk the balance being reported as either low or moderate.

5. Corporate Health and Safety Dashboards and exception reports

Detailed reports and verbal updates were received from:

- Estates
- Informatics
- Diagnostics and clinical support
- Medicine and acute
- Surgery
- Women's and children's

There is excellent detail in both the reports and the verbal updates. The information provided clearly shows divisions engaged with, and prosecuting, the Health and Safety agenda.

8.Summary

The above and attached serve to update the Board of Directors on the work and discussions of the Safety Management Assurance Committee at its meeting on 12th November 2021

S J Igoe
Chair of Safety Management Assurance Committee
16th November 2021

Wirral University Teaching Hospital
NHS Foundation Trust

Agenda Item: 24

BOARD OF DIRECTORS
1 December 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 November 2021 to date, including media relations, campaigns, marketing, social media, employee communications and engagement, WUTH Charity and staff engagement.

Recommendation
To note the progress in communications and engagement.

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 Risk Framework (new) Risk 1.1 – Unscheduled care demand (communications interventions to support addressing this risk and Trust initiatives like ED streaming, addressing winter pressures and patient flow) Risk 2.1 – Failure to fill vacancies (communications support on recruitment, retention and reputation) Risk 3.4 – Failure of Transformation programmes (communications and engagement, including stakeholders and patients for WUTH Improvement activities for service transformation and Winter Plan) Risk 6.1 – Estates related risks (Communications, stakeholder and staff engagement to support delivery of Estates Strategy, Masterplans and capital programme developments. In month communications for Clatterbridge Diagnostics Centre)
Regulatory and legal implications (e.g. NHSI segmentation ratings, CQC essential

standards, competition law)
None
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 with staff, patients and system and stakeholders.

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. Staff engagement supports providing the best patient care.
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, Workforce Steering Group, quarterly reports WUTH Charity Committee and Workforce Assurance Committee.
Background papers / supporting information	Report attached with appropriate links embedded.

Public Board of Directors

1 December 2021

Communications and Engagement Report

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 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, myth busting and the opening up of vaccine for new eligible cohorts – including younger age groups and the booster COVID-19 vaccine. Work will also now commence to prepare for mandatory vaccines for frontline healthcare staff when the detailed guidance is received. The seasonal flu campaign is also supported with regular communications.

- We prepared a media release that was covered locally highlighting the number of people we have vaccinated, which is roughly one third of the population of Wirral 100 thousand vaccinated at Clatterbridge Hospital vaccination hub

- We promoted World Antimicrobial Awareness Week (WAAW), 18-24th November, which aims to increase awareness of global antimicrobial resistance (AMR) and to encourage best practices for using antimicrobials responsibly among the general public, health workers and policy makers, to avoid the further emergence and spread of drug-resistant infections. The Trust has joined the over 145,000 individuals and organisations pledging to be an Antibiotic Guardian - details **here**.

- On 18th November, which was World Pancreatic Cancer Awareness Day, we used our channels to raise awareness of symptoms such as this example video **here**

- We joined with NHS organisations to promote Self Care Week 15-21 November, which is an annual UK-wide national awareness week that focuses on embedding support for self-care across communities, families and generations. The Self Care

Forum has been organising Self Care Week since 2011.In addition to helping people look after their own health, Self-Care Week is also used to promote better use of the NHS by signposting people to the right service relevant to their health needs – in particular, signposting people to pharmacy for accessible health care and advice. Promoting self-care is one of the ways in which we support ensuring people only use the Emergency Department for the right reasons.

- Other in month campaigns included Trans Awareness Week 13th – 19th November and Transgender day of Remembrance 20th November; and International Men's Day on 19th November.

- We supported the CCG's campaign around Alcohol Awareness Week 15-21 November -including signposting the Wirral system's 'Lower My Drinking' app.

- One Kind Word' was the theme of this year's Anti-Bullying Week 15-19 November, which highlighted how kindness is more important today than it has ever been. The isolation of the last year has underlined how little acts of consideration can break down barriers and brighten the lives of the people around us. We used the awareness week to also highlight the Freedom to Speak up process.

Media

- We joined with the nation for the acts of Remembrance on Armistice Day and Remembrance Sunday and Wirral University Teaching Hospital also promoted the fact that we have signed the Armed Forces Covenant. The Covenant is a pledge that those who serve or who have served in the armed forces, and their families, should be treated with fairness and respect. The Covenant also recognises the need for UK Armed Forces personnel to be supported throughout their lives in areas including healthcare, career, transitioning to civilian life after service and in older age.

- Many members of staff at WUTH have a forces background. Some are ex-forces and bring skills and expertise, acquired during their service, to the hospital setting. The Trust is keen to support their continued career development. Others are Reservists and are supported, as required, to meet their forces' commitments.

- Dr Nikki Stevenson, WUTH Medical Director and Deputy Chief Executive and Dr Ranjeev Mehra Deputy Medical Director and Consultant Intensivist signed the Covenant on behalf of the Trust.

- Further support for veterans can also be found on this website here and the Covenant signing was covered by the Wirral Globe Wirral University Teaching Hospital signs Armed Forces Covenant

- We responded to the media enquiries for our Trust arising from the terrorist bomb at the Liverpool Women's Hospital on 14th November as other hospitals in the area provided mutual aid. We also communicated the raised threat levels out to our staff and sign-posted counter terrorism training and security measures.

- The opening of our new Clatterbridge Diagnostics Centre was also promoted New diagnostics service aims to boost care access in Wirral as it offers more choice and convenience for patients needing diagnostic tests

- Finally, we were pleased to take part in a national BBC radio focus on the NHS when BBC Radio 5 Live broadcast their entire breakfast programme from Arrowe Park Hospital on 15th November. BBC'S Rachel Burden was on site talking to colleagues about the hard work of our dedicated staff throughout the COVID-19

pandemic, our journey from hosting the quarantine site supporting quests repatriated from Wuhan and the Diamond Princess Cruise Liner in early 2020, how we set up our COVID-19 Vaccination Centre and our plans as we head into winter.

- Pippa Roberts Director of Pharmacy and Medicines Management gave an overview of our work at our Vaccination Centre and Victoria Burrows, Head of Fundraising at WUTH Charity spoke about the re-launch of the Tiny Stars Appeal. Dr Nikki Stevenson, Medical Director and Deputy Chief Executive, gave an overview of our plans as we head into a busy winter, highlighted the importance of the COVID-19 vaccination and talked about our ED streaming pilot.

- Volunteer Rob Hughes was interviewed and talked about how he joined the hospital as a volunteer .Tracy Fennell, Interim Chief Nurse, spoke about the hard work of our nurses and other colleagues throughout the pandemic and highlighted the excellent recruitment campaign to recruit new international nurses to the Trust. Mike Gibbs, Associate Director of Integration and Partnerships talked about what it was like managing the quarantine facility in early 2020, the support that was given by people in the community and the strong partnership work between organisations across Wirral.

Internal Communications and staff engagement

We maintained a schedule of two or more staff 'In Touch' Bulletins a week with important information on trust matters, patient feedback and thanks, clinical guidance, staff wellbeing and support and charity updates

- We held our second new format Leaders in Touch forum where leaders were briefed on the Winter Plan, the Staff Survey, mandatory vaccinations for frontline healthcare staff and our Patient Experience Strategy.

- The 2021 NHS Staff Survey is in its closing stages. We have promoted it extensively to increase the WUTH response rate, which currently stands at 39% on 19th November with a week to go. Our Staffside colleagues have been very supportive, donating an IPad for the prize draw and the chair of Staffside did a video to promote the survey.

- Staff wellbeing is a key people priority and we continue to promote the range of services and offers for staff as well as the new activities in the Workforce Winter Wellbeing Plan. Additional resources have been secured from region to invest in important services like psychological support.

WUTH Charity

The Charity team have been extremely busy planning festive activity and organising the Wirral Winter Ball during November.

- Wirral Winter Ball 13th November – .270 people attended the event in aid of the Tiny Stars Neonatal Appeal. A total of £40,000 was raised on the evening. Event sponsors included Grosvenor Insurance, KMC Legal and Harrogate International. An additional offer from the Red Fox Thornton Hough was made for an 80-seat lunch (fully catered) in the new year.

- Corporate support – New charity of the year status for KMC legal, Grosvenor Insurance and Biffa Waste have been confirmed.

- Elf run – over 1000 children from primary schools across the Wirral have signed up to take part in this new event for the Tiny Stars appeal. Every child will receive a

fundraising pack from WUTH Charity.

- BTR Santa Dash – 20 runners will be taking part in this year's Santa Dash in Liverpool on Sunday 5th December.

- Owen Drew Candles Christmas lunch - Tiny Stars Neonatal Appeal to has been chosen to benefit from a Christmas Lunch at Heatherfield House on the 10th December.

- Birkenhead School and Eastham Church have chosen the Tiny Stars Neonatal Appeal to benefit from their Carol Services this year.

- Christmas collections - the following dates are confirmed for WUTH Charity community collections

    - Sat 20th / Sun 21st November Gordale Garden Centre
    - Thurs 25th Nov / Sat 11th Dec / Liverpool One
    - Fri 10th December Sainsbury's, Cheshire Oaks
    - Tues 14th December Morrison's New Brighton
    - Thurs 16th December Starbucks New Brighton

    - A Liverpool Football Club legends dinner is being organised in the New Year and is a unique evening with John Barnes, Robbie Fowler and Jan Molby in aid of the Tiny Stars Neonatal Unit. This private dinner and drinks package will be held at Thornton Hall hotel on Friday 28th January 2022.

- The Charitable Funds Committee at its meeting of 29th October received the audited report and accounts for WUTH Charity and approved plans to spend on a refurbishment of Bowman's Restaurant as an investment in staff welfare and wellbeing.

Stakeholders

- WUTH is engaging with system partners as preparations for the creation of Integrated Care Systems become more concrete.

- The WUTH Patient Experience Vision and steps have been finalised following extensive staff, patent and stakeholder engagement. Work will now commence to launch the vision in the New Year.

Conclusions

The Board is asked to note the report.

Recommendations to the Board

None

External website links are provided for the purposes of this report only and not for download or reproduction elsewhere.