Wirral University Teaching Hospital NHS Foundation Trust

Council of Governors

25 July 2022

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Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Council of Governors
Date	Monday 25 July 2022
Time	16:30 – 18:00
Location	Microsoft Teams Meeting

Agenda Item		Lead
1.	Welcome and Apologies for Absence	Sir David Henshaw
2.	Declarations of Interest	Sir David Henshaw
3.	Minutes of Previous Meeting	Sir David Henshaw
4.	Action Log	Sir David Henshaw
5.	Chair's Business and Strategic Issues – **Verbal**	Sir David Henshaw
6.	Lead Governor Feedback – **Verbal**	Sheila Hillhouse
7.	Lead and Deputy Lead Governor Role Profiles	Cate Herbert
8.	Quality and Performance Dashboard	Executive Directors
9.	COVID-19 Update – **Verbal**	Nikki Stevenson
10.	WUTH Strategy 2021/26 Update – **Presentation on the day**	Matthew Swanborough
11.	Feedback from Board Assurance Committees	Committee Chairs
	11.1 Quality (25 May) 11.2 Capital (13 June) 11.3 Finance Business Performance and Assurance (29 June) 11.4 Workforce (18 July) – **Verbal** 11.5 Charitable Funds (21 July) – **Verbal**	

Wallet Items for Information

12.	Board of Directors' Minutes	Sir David Henshaw

Closing Business

13.	Any other Business	Sir David Henshaw

Date and Time of Next Meeting

Monday 24 October 2022, 16:00 – 18:00

Meeting	Council of Governors
Date	25 April 2022
Location	Microsoft Teams Meeting

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
CC	Chris Clarkson (until 17:30)	Non-Executive Director
SI	Steve Igoe	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
SR	Steve Ryan	Non-Executive Director
SH	Sheila Hillhouse	Public Governor
SE	Steve Evans	Public Governor
SE	Sarah Evans	Public Governor
PI	Paul Ivan	Public Governor
AM	Alan Morris	Public Governor
AK	Anand Kamalanathan	Staff Governor
EH	Eileen Hume	Public Governor

In attendance:

JH	Janelle Holmes	Chief Executive
NS	Nikki Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
DS	Debs Smith	Chief People Officer
MS	Matthew Swanborough	Director of Strategy and Partnerships
RC	Robbie Chapman (until 17:30)	Interim Chief Finance Officer
DMC	David McGovern	Director of Corporate Affairs
SS	Sally Sykes (from 17:30)	Director of Communication and Engagement
JJE	James Jackson-Ellis	Corporate Governance Officer (Minutes)

Apologies:

PB	Phillipa Boston	Staff Governor
CH	Cate Herbert	Board Secretary
HK	Hayley Kendall	Chief Operating Officer
JS	John Sullivan	Non-Executive Director
RT	Robert Thompson	Public Governor
IW	Irene Williams	Appointed Governor (Local Authority)
SH	Christine House	Public Governor
TC	Tony Cragg	Public Governor
DT	(Gitana) Diana Tyson	Staff Governor
PP	Peter Peters	Public Governor
AT	Andrew Tallents	Public Governor
MC	Mike Collins	Appointed Governor (Local Authority)

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** The Chair welcomed everyone to the Council of Governors meeting. Apologies are noted above.	
2	**Declarations of Interest** No new declarations of interest were raised.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting were agreed as an accurate record.	
4	**Chair's Business and Key Issues** The Chair updated the Council of Governors on recent matters. The key points were: • Wirral Health Partners continued to work closely putting the arrangements together for the new structure to take effect from July. • The Trust continued to face length of stay issues for patients in the hospital and difficulties remained supporting them back into the community or into residential homes and this was caused by lack of domiciliary care and residential care homes.	
5	**Quality and Performance Dashboard** The Executive Directors briefed the Council of Governors on metrics in the dashboard. DS drew attention to staff sickness absence. The percentage for February was 7% with 1.15% related to COVID and there was a further increase in March, due to COVID. The biggest pressure remained short term sickness absence instead of long term. The Trust remained in line with other acute Trusts in Cheshire and Merseyside. Staff turnover excluding fixed term contracts for February was 0.75% against a threshold of 0.83%, however this had increased for March. Several actions were in place to reduce turnover and improve retention and an internal working group had been set up to focus on initiatives. Appraisals had reduced to 78% compliance, and it was noted a lower percentage would impact on staff turnover and higher sickness absence. Conversations had been ongoing with Divisions	

	to focus on improving their performance for sickness absence and mandatory training and this was being monitored through Divisional Performance Reviews. PI queried how the sickness absence percentage was calculated. DS confirmed the percentage was calculated based on full-time equivalent available against full-time equivalent in work and this was the standard calculation in any NHS Trust. TF drew attention to the safeguarding training compliance and the reduced mandatory training compliance percentage. Actions are ongoing to improve compliance and processes are in place in the hospital to assess staff while they're working. There had also been an increase in patients being admitted to hospital with pressure damage, two cases were a category three and one a category four. Patients receive a review upon admission and receive an appropriate mattress and good nutrition were necessary. NS drew attention to the number of serious incidents declared by the Trust. All incidents are reviewed by the Serious Incident Review Panel and a duty of candour is performed where an incident is rated moderate or severe harm. A Never Event took place in February due to the misplacement of a feeding tube. The number of complaints has also increased given the pressures faced the Trust around waiting times for treatment and overcrowding in the emergency department. SH queried if the Trust was utilising other resources such as volunteers given the number of staff off due to sickness absence. NS confirmed the Trust was being helped by volunteers and the third sector to provide care where possible. The Estate and Facilities Team had also been providing food and drink to patients while they wait in the emergency department. DH noted that the emergency department was built for 180 attendees per day and the Trust was on average receiving 240 attendees' before COVID with 330 attendees per day now. The new Urgent & Emergency Care Centre would provide additional capacity. The Council of Governors **NOTED** the report.	
6	**Operational and Financial Planning Update** NS presented to the Council an operational update and provided a recap on the Trust's 2022/23 priorities, highlighting the Trust would	

deliver significantly more elective care to tackle the elective backlog, reduce long waits, improve performance against cancer waiting times standards and improve the responsiveness of urgent and emergency care.

RC explained the Trust's elective plan excluding obstetrics and highlighted the strong performance planned for the financial year. The expectation was for all Trust's to achieve 104% of 2019/20 elective activity and Trust was on track to achieve this. Challenges at the start of the financial year occurred due issues with theatre ventilation and the surge of COVID patients in the hospital.

RC also explained the Trust's outpatient plan excluding obstetrics and highlighted the instruction by NHSEI to reduce the number of follow-ups by 25%. However, the Trust's plan does not include this due to the large backlog of patients held by the Trust and considered this not clinically right to do so. The Trust would reduce the number of follow-ups once the backlog had been cleared.

NS presented the Trust's performance targets and highlighted no patients had been waiting longer than 104 weeks for treatment. The Trust was focussed on addressing the 78-week backlog and outlined the performance trajectories to decrease this over the financial year. Several patients continue to wait over 52-week for treatment and this continued to be impacted by staff sickness across as well as ongoing theatre ventilation issues. The development of the South Mersey Surgical Hub may increase breaches.

NS outlined the risks to delivery and mitigation in place such as the inability to recruit and retain additional workforce and lack of uptake of additional sessions as well as non-elective demand continuing at current levels along with a future COVID surge.

AM queried how the Trust was increasing the amount of throughput to deal with the backlog and acknowledged additional infrastructure was being added but cautioned about staff working longer hours or at weekends.

NS confirmed three sessions days would take place in theatres such as later starts, and this would improve efficiency. The South Mersey Surgical Hub would also be staffed by the Countess of Chester staff as well as Trust staff.

SH queried how expectations and the narrative was being managed for those patients waiting longer than 78-weeks for treatment.

NS confirmed the Integrated Care Board (ICB) currently in development would replace the Clinical Commissioning Groups and work cross Cheshire and Merseyside. The ICB would have

	responsibility setting out expectations and the narrative. However, the Trust would need to ensure patients were supported while they wait, and this was a joint approach between the Trust, GP's and Wirral Community Health and Care NHS Foundation Trust to keep patients informed. RC presented to the Council a financial update and highlighted the Trust was forecasted to report a deficit of £6.197m and a deficit of approximately £200m for Cheshire and Merseyside as a whole. RC also highlighted the 2022/23 deficit for the Trust and the current risks continued to focus on inflation, high-cost drugs, workforce recruitment issues, pressure on maintenance and the potential for termination of the Gazprom contract. RC confirmed Cheshire and Merseyside were currently managing one of the largest deficits in country and any remaining changes to the Trust budget was likely to be high level. The next and final submission was due to be made on 28 April. The Finance Business Performance and Assurance Committee would receive full and final budget on day of submission. SL sought clarity on how the Trust deficit had reduced from £17.5m at the last Finance Business Performance and Assurance Committee compared to £6.197m deficit in the presentation. RC confirmed the most significant movement was in respect of additional funding from Cheshire and Merseyside regarding COVID and system money, which equated to £9.1m. Other improvement included additional costs associated with performance above the 104% activity. SI noted the unrealistic assumption of inflation above the core inflation guidance from NHSEI, given it was currently at 7% and the impact this could cause on the 2022/23 budget. RC confirmed HM Treasury recognised inflation pressures and all Trusts had been asked to identify costs above inflation and provide evidence therefore it was considered some costs could be funded from the HM Treasury. The Council of Governors **NOTED** the update.	
7	**Feedback from Board Assurance Committees** **7.1 Finance Business Performance Assurance Committee** SL provided a report to the Council of Governors on recent proceedings of the Committee. It was noted the Committee scrutinised the 2022/23 operational plan and budget. The Committee were pleased with the level of detail and assurance	

provided. The budget had several risks and the appropriate mitigation had been put in place where necessary. The final plan would be presented to the Board of Directors on 4 May for approval.

The Council of Governors **NOTED** the report.

7.2 Capital Committee

SI provided a verbal report to Council of Governors on recent proceedings of the Committee. It was noted the Committee received an update on the modular theatre development at Clatterbridge Hospital and how the infrastructure would further reduce those on the waiting list. The Committee also received an update on the Urgent and Emergency Care Upgrade Programme, which will see the refurbishment and part new build facilities to enhance urgent and emergency services at Arrowe Park Hospital.

The Council of Governors **NOTED** the report.

7.3 Charitable Funds Committee – Verbal

SL provided a report to the Council of Governors on recent proceedings of the Committee. It was noted the Committee received the Head of Fundraising Report which detailed the 2022/23 events calendar and preparation for the Tiny Stars appeal relaunch. The Committee also received the charity targets for years 1-3 of the Trust's Charity Strategy. The Committee had also been informed due to the Urgent and Emergency Care Upgrade Programme the Charity Office would be moved to the Family Support Hub.

The Council of Governors **NOTED** the report.

7.4 Workforce Assurance Committee

The Council of Governors **NOTED** the report.

7.5 Quality Committee

SR provided a report to the Council of Governors on recent proceedings of the Committee. It was noted that there had been temporary modification of infection control procedures to balance risks to patient safety and this resulted in a reduction in capacity of around 65 beds. Increased numbers of patients had been subjected to corridor care. There was an increasing number of ambulances experiencing delays in transferring patients into the emergency department, therefore increasing the NWAS response time to attend Category 2 patients.

The Council of Governors **NOTED** the report.

	7.6 Audit Committee – Verbal SI provided a verbal report to the Board on recent proceedings of the Committee. The Committee focussed on a range of year end activity to support the preparation of the 2021/22 annual accounts. The Committee received the Internal Audit Annual Report and Head of Internal Audit Opinion for 2021/22. The Trust received a substantial assurance opinion, highlighting that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. In total 1 high assurance opinion was received, 12 substantial assurance opinions and 6 limited assurance opinions. The Committee approved the internal audit plan for 2022/23. The Council of Governors **NOTED** the report. DH highlighted to the Council of Governors that a get together would be organised for Governors as soon as possible to reconnect in person.	David McGovern
8	**COVID-19 Update** NS highlighted to the Council of Governors that following an increase in community transmission the Trust had experienced an increase in COVID patients during March and April and up to four and half wards had been used for COVID patients. There had been a reduction towards the end of April and two wards were now being used. NS explained most vaccinated patients experience mild symptoms and 77% of patients had been admitted as an asymptomatic patient. The Trust had suffered in patients acquiring COVID infections within the hospital and this was due to the more transmissible variant. The Council of Governors **NOTED** the update.	
9	**NHS Staff Survey Results** DS presented to the Council of Governors the 2021 NHS Staff Survey Results for the Trust and highlighted 2907 staff completed the survey; this represented a 46% response rate and a 5% increase from the previous year. DS explained how the Trust compared with other Trusts in terms of the NHS People Promise, staff engagement and morale and the Trust was in line with the overall average. DS further explained the survey results by Directorates. DS highlighted some of the areas of decline and improvement. For example, staff engagement and morale had declined over the	

	period. However, the ability to raise concerns and personal connections to teams had improved. DS reported the number of priority focus areas for 2022 and the next steps. From April to May there would be engagement activities with staff networks and wider staff forums to inform plans and from May priority activities would be reflected in 2022/23 plans for the People Strategy and other enabling strategies. The Council of Governors **NOTED** the report.	
10	**Non-Executive Director Appointments** DH reported to the Council that an appointment panel shortlisted 6 candidates and these were interviewed on the 31 March. As part of the selection process, the 6 interviewees provided a video statement for stakeholders to view. The rankings received from stakeholders were anonymised and provided to the appointment panel for their consideration. Following the interviews and the incorporation of stakeholder feedback, the panel selected Rajan Madhok and Lesley Davies. The Council of Governors **RATIFIED** the process followed to recruit two new Non-Executive Directors and **APPROVED** the revised terms of reference of the Nominations Committee. DH requested DMc email Governors once the appropriate recruitment checks had been completed to notify Governors the appoints had been successful. DS highlighted that any Governor wishing to be considered for Nominations Committee membership should contact the CH, so that the next meeting can approve a revised membership.	David McGovern
11	**Board of Directors' Minutes** The Council of Governors **NOTED** the January and March 2022 Board of Directors' Minutes.	
12	**Cycle of Business Annual Update** DH requested DMc circulate the 2022-23 Board, Committee and Council of Governors meeting dates to Governors for information. The Council of Governors **NOTED** the Cycle of Business.	David McGovern
13	**Any other business** No other business was raised.	

(The meeting closed at 18:00)

Action Log
Council of Governors
25 July 2022

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	25 April 2022	Feedback from Board Assurance Committees	To organise a get together for Governors as soon as possible to reconnect in person.	David McGovern	Complete. A get together for Governors took place on 31 May.	May 2022
2.	25 April 2022	Non-Executive Director Appointments	To email Governors once the appropriate recruitment checks had been completed to notify Governors the appoints had been successful.	David McGovern	Complete.	July 2022
3.	25 April 2022	Cycle of Business Annual Update	To circulate the 2022-23 Board, Committee and Council of Governors meeting dates to Governors for information	David McGovern	Complete.	April 2022

Council of Governors

25 July 2022

Title	Lead and Deputy Lead Governor Role Profiles
Area Lead	David McGovern, Director of Corporate Affairs
Author	Catherine Herbert, Board Secretary
Report for	Approval

Report Purpose and Recommendations

The purpose of this report is to request approval for the role profiles that have been developed for the Lead Governor and the Deputy Lead Governor.

It is recommended that the Governors:

- Approve the role profiles attached at Appendix 1 and 2.

Key Risks

This report relates to these key Risks:

- Ensuring clarity around the role of the lead governor, and deputy lead governor.

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

Governance journey

N/A – this is the first report on this topic.

1	Narrative
1.1	**Lead Governor and Deputy Lead Governor** Foundation Trusts are required to have in place a nominated 'Lead Governor'. The role of the Lead Governor is to be a conduit for direct communication between NHSI and the Council of Governors in the limited number of circumstances in which it may not be appropriate to communicate through the normal channels of Trust Chairman and Company Secretary.

	The lead governor will also have the responsibility for chairing any Council of Governors meeting where the Chair may have a conflict of interest or is unavailable. Provision for the appointment of a Lead Governor is set out in the WUTH Constitution (Annex 5 section 4). The appointment of a deputy lead governor is not a requirement, but Trusts are allowed to make this appointment should they wish to. <u>Current appointments</u> Sheila Hillhouse was appointed Lead Governor in October 2021. As part of this same process, Eileen Hume was appointed Deputy Lead Governor. For the purposes of clarity, role profiles have been developed for both the lead governor and deputy lead governor. They reflect the duties drawn from NHSI guidance, and from the WUTH Constitution. The Council of Governors retain the right to approve any further constitutional duties that these two roles may be required to undertake. <u>Term of appointment</u> As per the constitution, Sheila's appointment will last two years. There is no specification for the deputy lead governor, and therefore it is recommended that the same term of appointment is put in place so that the roles are aligned.

2	**Implications**
2.1	The role profiles will ensure that there is clarity around these two roles, not only for Governors but for anyone who may conduct an inspection of the Trust.

3	**Conclusion**
3.1	The Council of Governors are asked to approve the attached role profiles.

Author	Catherine Herbert, Board Secretary
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Job Description

Wirral University Teaching Hospital NHS Foundation Trust

Job Title	Lead Governor
Department	Council of Governors

Role

The lead governor is a statutory role intended to provide a lead for the Board of Governors where the Chair and/or NEDs may have a conflict of interests, and to act as a liaison between NHSI and the Council of Governors.

Key Responsibilities

- To take the Chair of any Council of Governors' meeting where the Chair has a conflict of interest or is unable to attend.
- To serve as a point of contact between the governors and NHSE/I should NHSE/I have concerns around leadership
- To serve as a point of contact between the governors and NHSE/I where it would be inappropriate for the Chair to contact NHSE/I
- To act as a liaison between the Governors and the Executive, should this be required.

Duties and Key Tasks

- To attend Council of Governors' meetings where possible
- To attend Board meetings where possible
- To foster working relationships with the Chair, NEDs, and other governors
- To encourage participation in Governor training and development opportunities, and member engagement
- If required, to participate in the process to remove a governor as stipulated within the Constitution
- To discharge all other duties of a duly elected governor, notwithstanding this lead governor role

Extra Factual Information

- The lead governor shall be appointed for 2 years, as specified within the Constitution
- The establishment of the role of lead governor does not preclude any other governor from making contact with NHSE/I should they feel it necessary.

Job Description

Wirral University Teaching Hospital NHS Foundation Trust

Job Title	Deputy Lead Governor
Department	Council of Governors

Role

The deputy lead governor role has been established to ensure that the duties of the lead governor are carried out, should the lead governor be unavailable or conflicted.

Key Responsibilities

- To deputise for the lead governor in each of the following capacities, should the lead governor be unavailable or conflicted:
    - To take the Chair of any Council of Governors' meeting where the Chair has a conflict of interest or is unable to attend.
    - To serve as a point of contact between the governors and NHSE/I should NHSE/I have concerns around leadership
    - To serve as a point of contact between the governors and NHSE/I where it would be inappropriate for the Chair to contact NHSE/I
    - To act as a liaison between the Governors and the Executive, should this be required.

Duties and Key Tasks

- To attend Council of Governors' meetings where possible
- To attend Board meetings where possible
- To foster a working relationship with the lead governor
- To work with the lead governor to encourage participation in Governor training and development opportunities, and member engagement
- If required, to deputise for the lead governor in the process to remove a governor as stipulated within the Constitution
- To discharge all other duties of a duly elected governor, notwithstanding this deputy lead governor role

Extra Factual Information

- The deputy lead governor shall be appointed for 2 years, in line with the term of appointment for the lead governor
- The establishment of the role of deputy lead governor does not preclude any other governor from making contact with NHSE/I should they feel it necessary.

Council of Governors
25 July 2022

Item No 8

Title	Quality and Performance Dashboard
Area Lead	Executive Team
Author	John Halliday, Assistant Director of Information
Report for	Information

Report Purpose and Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of May 2022.

It is recommended that the Council of Governors:

- Note the report and performance to the end of May 2022

Key Risks

This report relates to the key Risks of:

- Quality and safety of care
- Patient flow management during periods of high demand

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

1	Narrative
1.1	Of the 49 indicators that are currently reported against thresholds (excluding Use of Resources): - 34 are off-target or failing to meet performance thresholds - 15 are on-target Following the recent discussions with the Executive Team and the Board as part of the Performance Management Framework Review, the metrics included in the Quality & Performance dashboard have been assessed for continued inclusion, alongside the relevant thresholds.

	Some thresholds only apply from April 2022 onwards as they are components from the 2022/23 operational plans. Further development work is continuing to clarify the precise definitions and thresholds on a small number of metrics. Amendments to previous metrics and/or thresholds are detailed below the dashboard.

2	Implications
2.1	The issues and actions undertaken for those metrics that are not meeting the required standards are included in the additional exception reports or covered within the Chief Operating Officers Report.

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

Report Author	John Halliday, Assistant Director of Information
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Quality Performance Dashboard

June 2022
Upated 24-06-22

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	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	0.20	0.05	0.05	0.10	0.10	0.05	0.19	0.18	0.18	0.22	0.04	0.22	0.09	0.15	
	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	96.6%	96.6%	96.2%	97.6%	96.9%	96.9%	97.2%	96.9%	96.7%	96.2%	96.4%	96.8%	96.9%	96.9%	
	Never Events	Safe, high quality care	CN	0	SOF	1	0	2	0	0	0	0	1	0	1	0	0	0	0	
	Clostridioides difficile (healthcare associated)	Safe, high quality care	CN	Maximum 72 for 2022-23. Max 6 cases per month	WUTH	7	5	1	6	13	6	5	3	18	12	13	7	8	15	
	Gram negative bacteraemia : e-coli	Safe, high quality care	CN	Maximum 56 for 2022-23. Max 4 cases per month	National	-	-	-	-	-	-	-	-	-	-	-	8	4	12	
	Gram negative bacteraemia : klebsiella	Safe, high quality care	CN	Maximum 19 for 2022-23. Max 1 case per month	National	-	-	-	-	-	-	-	-	-	-	-	0	4	4	
	Gram negative bacteraemia : pseudomonas	Safe, high quality care	CN	Maximum 9 for 2022-23. Max 0 cases per month	National	-	-	-	-	-	-	-	-	-	-	-	0	0	0	
	MRSA bacteraemia - hospital acquired	Safe, high quality care	CN	0	National	0	1	0	0	0	0	0	0	0	1	0	0	0	0	
	Pressure Ulcers - Hospital Acquired Category 3 and above	Safe, high quality care	CN	0	WUTH	0	1	1	0	0	0	0	0	1	1	1	4	0	4	
	Medicines Storage Trust wide audits - % of standards fully compliant for all areas Trust-wide	Safe, high quality care	CN	≥90%	WUTH	96%	95%	96%	96%	96%	95%	96%	96%	94%	95%	92%	89%	91%	90%	
	Safeguarding Audits	Safe, high quality care	CN	≥90%	WUTH	-	-	-	-	-	-	-	-	-	-	82.6%	71.6%	93.5%	83%	
	Mandatory Training compliance	Safe, high quality care	CPO	≥90%	WUTH	87.9%	89.1%	90.1%	90.9%	91.3%	90.8%	90.5%	90.4%	89.0%	87.2%	87.2%	87.17%	89.21%	89.2%	
	Sickness Absence % (12-month rolling average)	Safe, high quality care	CPO	≤5%	SOF	6.10%	6.05%	6.12%	6.17%	6.21%	6.22%	6.24%	6.40%	6.48%	6.53%	6.70%	6.79%	6.83%	6.8%	
	Sickness Absence % (in-month rate)	Safe, high quality care	CPO	≤5%	SOF	5.68%	5.68%	6.48%	6.53%	6.62%	6.67%	6.37%	7.86%	8.72%	7.05%	7.73%	6.84%	6.23%	6.54%	
	Staff turnover % (rolling 12 month rate)	Safe, high quality care	CPO	≤10%	WUTH	13.2%	13.3%	13.0%	12.6%	12.9%	13.3%	13.2%	13.4%	13.7%	13.9%	14.1%	14.1%	14.4%	14.4%	
	Care hours per patient day (CHPPD) - number of wards below 6.1	Safe, high quality care	CN	No of wards ≤3	WUTH	-	-	-	-	-	-	-	-	-	-	3	1	4	2.5	

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	Trend
Effective	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	CN	≥95%	WUTH	98.3%	98.3%	95.9%	96.7%	96.4%	96.2%	93.8%	92.6%	91.7%	96.7%	96.9%	94.6%	97.1%	95.9%	
	Nutrition and Hydration - MUST completed within 24 hours of admission	Safe, high quality care	CN	≥90% to June 2020, ≥95% from July 2020	WUTH	98.0%	98.0%	98.0%	97.0%	96.0%	96.4%	95.5%	94.6%	95.2%	97.3%	96.3%	97.7%	98.3%	98.0%	
	Long length of stay - number of patients in hospital for 21 or more days	Safe, high quality care	MD / COO	Maintain at a maximum 79 (Revised April 2022)	WUTH	85	99	95	126	132	126	141	157	206	195	187	220	194	194	
	% Theatre in session utilisation	Safe, high quality care	COO	≥85%	WUTH	85.5%	82.5%	79.8%	82.0%	83.4%	83.7%	82.0%	77.9%	77.2%	77.9%	83.7%	79.3%	83.1%	81.5%	

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	Trend
Caring	Same sex accommodation breaches	Outstanding Patient Experience	CN	0	SOF	2	3	4	1	2	2	3	8	3	2	3	1	1	2	
	FFT Overall experience of very good & good: ED	Outstanding Patient Experience	CN	≥95%	SOF	83.0%	82.0%	76.0%	76.0%	71.1%	72.8%	72.4%	77.7%	75.9%	77.3%	67.2%	74.0%	74.7%	74.3%	
	FFT Overall experience of very good & good: Inpatients	Outstanding Patient Experience	CN	≥95%	SOF	95.0%	95.0%	95.0%	96.0%	94.0%	94.3%	95.1%	94.4%	95.4%	94.5%	92.3%	94.8%	94.1%	94.5%	
	FFT Overall experience of very good & good: Outpatients	Outstanding Patient Experience	CN	≥95%	SOF	94.0%	95.0%	93.0%	94.0%	93.2%	94.1%	93.7%	94.3%	94.3%	94.1%	93.6%	93.5%	94.3%	93.9%	
	FFT Overall experience of very good & good: Maternity	Outstanding Patient Experience	CN	≥95%	SOF	95.0%	93.0%	97.0%	98.0%	94.1%	98.8%	94.7%	94.6%	96.6%	93.5%	97.7%	93.1%	98.0%	95.5%	

Quality Performance Dashboard

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	Trend
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	≥95%	National	73.5%	78.0%	67.8%	66.2%	63.4%	62.6%	59.5%	60.6%	59.1%	63.1%	61.5%	63.1%	63.4%	63.2%	
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	1	7	11	8	6	6	13	7	17	39	24	63	
	Time to initial assessment for all patients presenting to A&E - % within 15 minutes	Safe, high quality care	COO	100%	National	68.1%	73.4%	57.7%	66.7%	48.1%	58.1%	49.8%	57.2%	57.3%	61.7%	54.0%	52.5%	53.5%	53.0%	
	Proportion of patients spending more than 12 hours in A&E from time of arrival	Safe, high quality care	COO	0%	National	2.7%	2.2%	8.0%	5.0%	9.2%	8.2%	9.4%	8.8%	11.0%	8.1%	11.6%	13.7%	10.7%	12.2%	
	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	78.9%	74.6%	73.9%	82.4%	86.9%	91.2%	85.0%	88.1%	
	Ambulance Handovers: > 30 minute delays	Safe, high quality care	COO	<5%	WUTH	10.4%	7.6%	14.5%	14.3%	23.5%	21.9%	22.8%	19.2%	18.0%	15.5%	25.2%	23.9%	21.9%	22.9%	
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	≥92%	SOF	72.57%	75.64%	75.13%	74.14%	72.88%	70.84%	70.14%	67.84%	67.57%	65.89%	65.38%	64.08%	66.72%	66.72%	
	Referral to Treatment - total open pathway waiting list	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	25873	26671	26979	27306	27424	26935	27046	27406	28665	29445	30430	31504	32373	32373	
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	633	526	507	560	606	575	510	557	475	525	582	730	811	811	
	Referral to Treatment - cases waiting 78+ wks	Outstanding Patient Experience	COO	NHSEI Plan Trajectory 2022-23	National	90	90	117	177	163	116	70	72	59	65	60	70	71	71	
	Referral to Treatment - cases exceeding 104 weeks	Safe, high quality care	COO	NHSEI Plan Trajectory 2022-23	National	1	1	3	3	7	10	5	5	4	5	1	0	0	0	
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥99%	SOF	98.5%	96.8%	87.5%	86.0%	91.3%	94.3%	93.0%	89.8%	87.3%	86.4%	85.2%	82.8%	86.0%	84.4%	
	Cancer Waiting Times - 2 week referrals (monthly provisional)	Safe, high quality care	COO	≥93%	National	97.6%	97.2%	95.4%	93.7%	95.7%	96.1%	87.9%	91.4%	76.2%	78.0%	76.2%	85.8%	96.6%	91.2%	
	Cancer Waiting Times - 2 week referrals (final quarterly position)	Safe, high quality care	COO	≥93%	National	-	97.21%	-	-	94.95%	-	-	91.63%	-	-	76.7%	-	-		
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (monthly provisional)	Safe, high quality care	COO	≥96%	National	95.2%	99.2%	96.3%	96.4%	96.5%	95.4%	94.3%	94.8%	94.6%	95.1%	92.6%	91.2%	93.3%	92.3%	
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis (final quarterly position)	Safe, high quality care	COO	≥96%	National	-	96.26%	-	-	96.41%	-	-	94.85%	-	-	94.1%	-	-		
	Cancer Waiting Times - 62 days to treatment (monthly provisional)	Safe, high quality care	COO	≥85%	SOF	84.1%	85.3%	84.7%	85.9%	84.4%	79.2%	79.7%	79.3%	79.6%	79.3%	75.9%	79.2%	79.2%	79.2%	
	Cancer Waiting Times - 62 days to treatment (final quarterly position)	Safe, high quality care	COO	≥85%	SOF	-	84.66%	-	-	85.05%	-	-	79.38	-	-	78.1%	-	-		
	Cancer Waits - reduce number waiting 62 days +	Outstanding Patient Experience	COO	NHSEI 2022/23 plans trajectory - max 68	National	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	81	97	118	118.00	
	Cancer - Faster Diagnosis Standard	Outstanding Patient Experience	COO	≥75% within 28 days	National	81.0%	81.2%	80.4%	78.2%	77.9%	79.8%	79.2%	80.5%	70.5%	78.9%	79.5%	76.7%	75.8%	76.2%	
	Patient Experience: Number of concerns received in month - Level 1 (informal)	Outstanding Patient Experience	CN	≤173 per month	WUTH	156	145	209	213	218	216	177	149	180	187	211	170	185	178	
	Patient Experience: Number of complaints received in month per 1000 staff - Levels 2 to 4 (formal)	Outstanding Patient Experience	CN	≤3.1	WUTH	2.56	4.04	4.20	3.31	3.29	2.56	3.27	3.26	2.34	4.87	3.05	4.50	3.96	4.23	
	Formal Complaint acknowledged within 3 working days	Outstanding Patient Experience	CN	≥90%	National	93%	95%	100%	94%	94%	100%	61%	100%	100%	100%	100%	100%	86%	93%	
	Number of re-opened complaints	Outstanding Patient Experience	CN	≤5 pcm	WUTH	2	1	2	5	2	3	4	3	2	0	0	2	2	2	
	NEWS2 Compliance	Outstanding Patient Experience	MD/CN	≥90%	WUTH	-	-	-	-	-	-	-	-	-	-	85%	85.2%	88.3%	87%	

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

June 2022
Upated 24-06-22

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	Trend
Well-led	Duty of Candour compliance - breaches of the DoC standard for Serious Incidents	Outstanding Patient Experience	CN	0	WUTH	-	-	-	-	-	-	-	-	-	-	-	0	1	1	
	Number of patients recruited to NIHR studies	Outstanding Patient Experience	MD	700 for FY 22/23 (cumulative 59 per month until year total achieved)	National	38	107	279	457	613	774	958	1121	1445	1575	1666	20	53	53	
	% Appraisal compliance	Safe, high quality care	CPO	≥88%	WUTH	81.3%	82.7%	82.7%	82.2%	81.2%	82.2%	82.7%	82.3%	82.0%	78.0%	77.9%	77.16%	83.24%	83.2%	

	Indicator	Objective	Director	Threshold	Set by	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	2022/23	Trend
Use of Resources	I&E Performance (monthly actual)	Effective use of Resources	CFO	On Plan	WUTH	-0.5	-0.2	0.0	0.2	-0.2		-0.7	-0.6	2.3	-0.1	0.1	-956.0	-421.0	-421.0	
	I&E Performance Variance (monthly variance)	Effective use of Resources	CFO	On Plan	WUTH	-0.4	-0.4	0.0	0.2	-0.1	0.0	1.0	-0.9	1.9	-0.5	-0.3	-886.0	319.0	319.0	
	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	Not reported	Not reported	Not reported	
	CIP Performance (YTD Plan vs Actual)	Effective use of Resources	CFO	On Plan	WUTH	0.0	3.02%	6.03%	9.05%	14.50%	Not reported	77.21%	48.24%	78.70%	78.61%	91.33%	7.26%	45.26%	45.26%	
	NHSI Agency Performance (YTD % variance)	Effective use of Resources	CFO	On Plan	NHSI	-27.7%	-32.4%	-40.5%	-11.7%	-5.2%	-50.0%	-25.1%	-6.7%	-4.3%	-8.0%	-15.0%	-43.9%	-315.0%	-315.0%	
	Cash - liquidity days	Effective use of Resources	CFO	NHSI metric	WUTH	-15.5	-10.4	-15.7	-15.4	-15.2	-16.2	-15.9	-18.0	-16.2	-18.6	-20.0	-21.4	-12.0	-12.0	
	Capital Programme (cumulative)	Effective use of Resources	CFO	On Plan	WUTH	5.6%	12.5%	18.0%	22.6%	24.4%	30.7%	36.3%	48.0%	59.0%	76.2%	100.0%	0.7%	6.0%	6.0%	

Metrics Added

Metrics Amended

Responsive : Threshold added for 'Time to initial assessment for all patients presenting to A&E - % within 15 minutes'
Responsive : Threshold added for 'Proportion of patients spending more than 12 hours in A&E from time of arrival'

Safe Domain

Clostridioides difficile (Healthcare Associated)

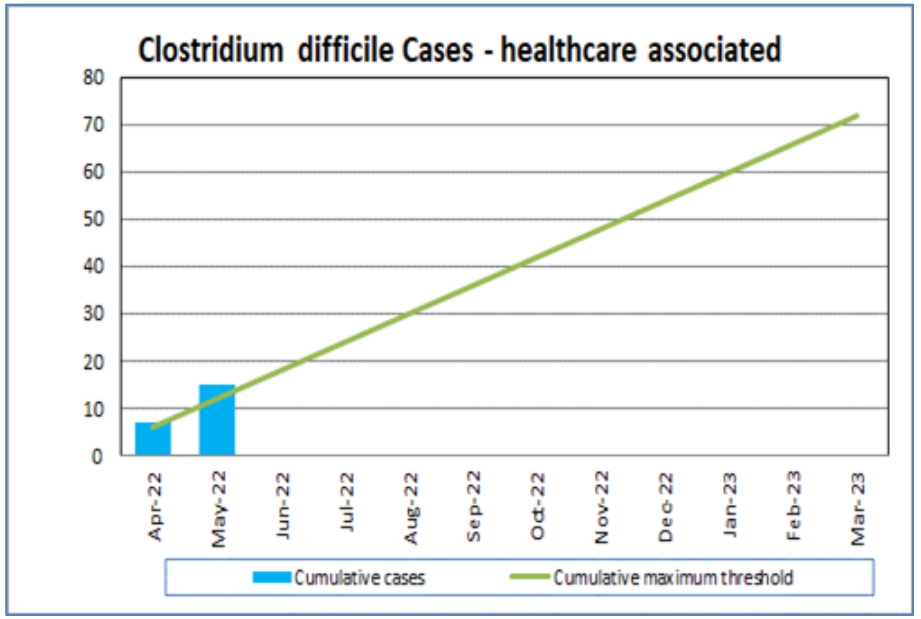
Executive Lead: Chief Nurse

Performance Issue:
The National objective set for WUTH for healthcare associated *Clostridium difficile* infections (CDI) for this year 2022-23 is 72, this is derived from a base line of the 12 months ending November 2021, as this was the data available to NHSE/I at time of calculating the figures. The figures were calculated as below

- If a trust had fewer than or equal to 10 cases during the 12 months ending November 2021, the threshold will be equal to that count. If a trust had more than ten cases, the threshold will be one less than the count.
- All thresholds were rounded down to the nearest whole number and pertain to healthcare-associated cases i.e., Hospital onset, hospital associated (HOHA) and Community onset, Hospital associated (COHA)cases.

The monthly trajectory has been calculated by dividing the objective by 12, so a maximum 6 cases per month.

There were 8 cases in May, making a cumulative 15 cases for the year-to-date. This is 3 higher than the cumulative threshold.



Action:

The weekly Chief Nurse led CDT meeting continues which reviews each patient pathway, identifies the causative factors which inform the local

action plans to focus on improvements. The common themes are being addressed by the QI initiative. Focus is being made on early sampling in assessment areas. A system-wide action plan is being developed that will be presented to the first ICB quality meeting. A regular report is also now being provided to wards listing patients who are having diarrhoea, but a sample has not been collected to ensure samples are collected at the earliest opportunity. A new daily digital sit rep has also been created to improve overview of side rooms to ensure patients are isolated promptly.
Expected Impact: Reduction in patients diagnosed with healthcare associated *Clostridioides difficile*

Gram-Negative bloodstream infections - klebsiella

Executive Lead: Chief Nurse

Performance Issue:

For 2022-23 the maximum threshold for Gram-negative blood stream infections has been separated into the component elements of *E-coli, klebsiella* and *pseudomonas*. All thresholds are derived from a baseline of the 12 months ending November 2021, as this is the most recent available data at the time of calculating the figures.

For each of the three Gram-negative bloodstream infection types specified, if a trust had fewer than or equal to 10 cases during the 12 months ending November 2021, the threshold will be equal to that count. If a trust had more than 10 cases, the threshold will be 5% less than the count. All thresholds were rounded down to the nearest whole number and pertain to healthcare-associated cases i.e., Hospital onset, Healthcare associated (HOHA) Community Onset, Hospital associated (COHA)

The threshold for Gram-negative klebsiella is set at a maximum nineteen cases, with a monthly threshold of a maximum one per month for monitoring purposes.
There were four cases reported in May 2022.

Action:

Senior representation continues at the weekly Patient Safety Learning Panel to enable in-depth scrutiny of the RCA investigations to ensure all learning areas are captured and action plans can be developed to promote improvements. Only one case was considered to have a lapse in care actions have been enacted to address the identified issue.

Expected Impact:

The number of patients diagnosed with a Gram-negative blood stream infection is reduced to below the monthly threshold and the annual objective for 2021 – 2022 is achieved.

Mandatory Training %

Executive Lead: Chief People Officer

Performance Issue:

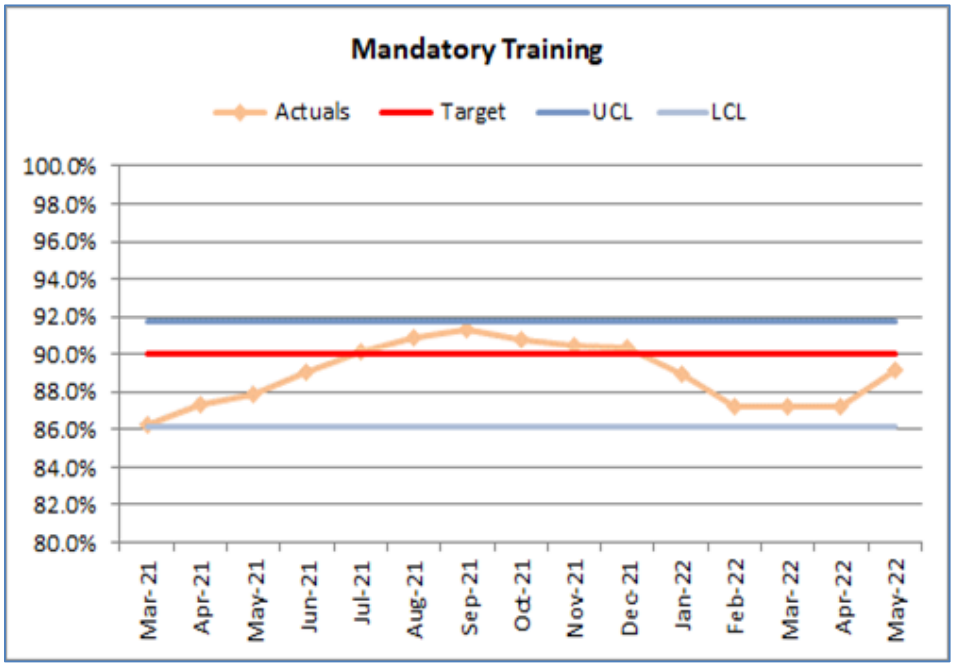
The Trust has an internal standard for 90% of staff to be compliant with applicable Mandatory Training. The rate for May 2022 was 89%

In May 2022, Clinical Support and Surgery both met the KPI. The highest compliance is Clinical Support at 91%, the lowest is Acute at 84.01%. Improvements this month were seen in all Divisions.

There is a wide variance in compliance by staff group, with Add Prof, Scientific and Technical with the highest compliance rate at 98%, and Medical and Dental with the lowest compliance rate at 74%.

Of the 15 requirements for mandatory training, there are 7 subjects that are meeting the KPI of 90% compliance which are Conflict Resolution, Data Security, Equality and Diversity (Level 1), Fire Safety (Level 1), Infection Control (Level 1), Moving & Handling (Inanimate Load) and Moving & Handling (People Handling).

All other subjects are below 90%, with the lowest compliance levels seen in CPR and PVP Level 3 which stand at 82.39% and 82.73% respectively.



Action:

Workforce compliance data is available to Divisions and the HR Services team to enable them to manage non-compliance for their areas. HR Business Partners continue to support Divisional Management teams to identify and deliver actions to address low levels of compliance in specific areas. Increased focus upon appraisal compliance is being placed at Divisional performance review (DPR) meetings. All Divisions have produced

improvement trajectories and have confirmed expected date of compliance to Trust Management Board.

Steps have been taken by the Learning and Development Team to improve access to mandatory training. This includes significant efforts to target non-compliance by subject. There has been particular focus over the last two months on increasing Health and Safety training which has successfully resulted in an increase in compliance for this subject, and this approach will be implemented for other subject areas of below 90% compliance moving forward.

Arrangements for the re-establishment of the SME Network have commenced as planned, with the first meeting due to take place in July. The aim of the network is to increase engagement and collaboration with SMEs across the Trust, as well as provide a channel for two-way feedback through the Trust's Education Governance Group.

Plans for a phased re-introduction of face-to-face Induction from mid-July 2022 have also now been agreed by the Education Governance Group. From August, this will also see the inclusion of some mandatory training subjects to ensure that staff are able to gain compliance prior to starting in the workplace. Plans are also underway to re-introduce face-to-face e-Learning drop-in sessions which will provide hands on support to people accessing online mandatory training modules.

Expected Impact:

The impact of covid on training provision has been significant and there are a number of challenges in sustaining compliance. It is anticipated that continued focus on targeting completion will continue a trajectory of improvement that enables the Trust to achieve its KPI. However, it must be recognised that a strategic and long-term approach is required, particularly in relation to the provision of face-to-face provision, to achieve sustained increases in compliance.

Sickness absence % (in-month rate)

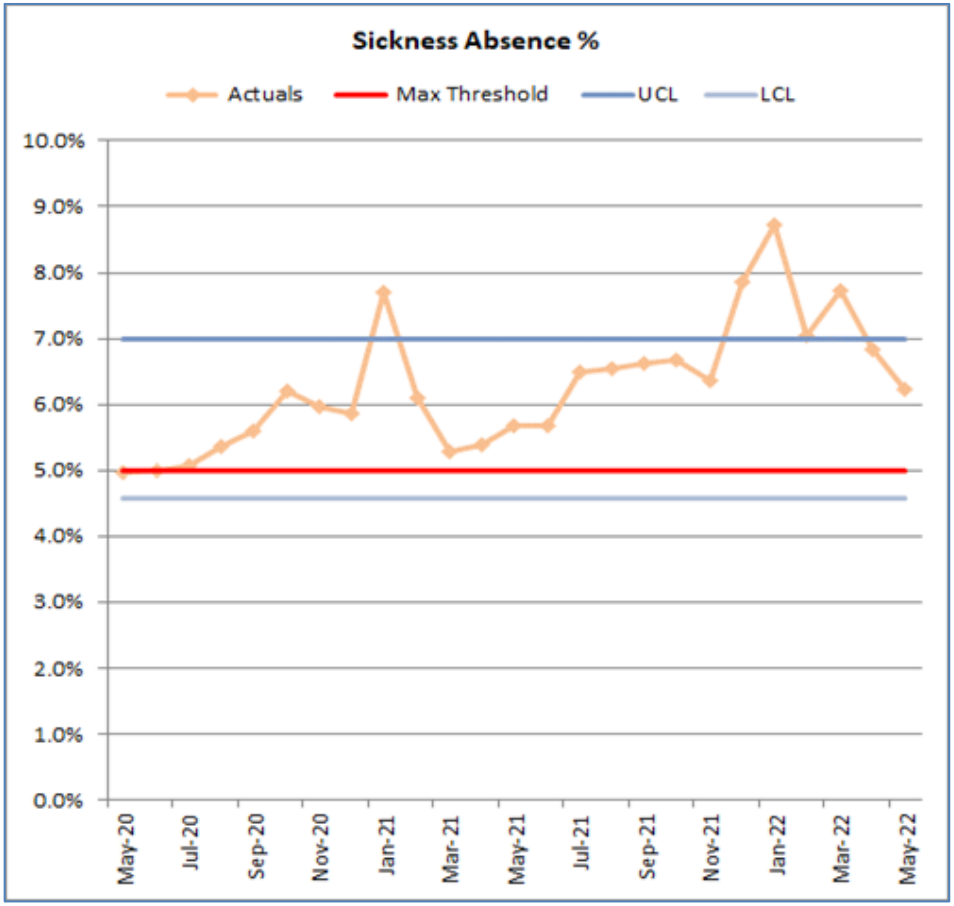
Executive Lead: Chief People Officer

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 May 2022 has improved to 6.23%, from 6.84% in April. Of this 0.67% is related to COVID-19.

All Divisions, with the exception of Women and Children's, in May 2022 have exceeded the 5% KPI, although all Divisions, except Corporate Support, showed an improvement in May 2022.

Anxiety, Stress and Depression remains the highest reason for long term sickness absence. The 'Gastro Problems' category was the highest reported reason for short-term sickness, followed by 'Cough, Cold & Flu'.



Action:

Monitoring of the Sickness Attendance KPI and associated actions is on-going via Divisional Management, Divisional governance infrastructure and via Divisional Performance Reviews (DPRs). All Divisions have reintroduced Sickness Auditing to ensure the Attendance Management Policy is being consistently applied at departmental level.

The HR Services Team is now fully established and in turn there is now a greater level of oversight and focus on short term sickness. Additionally, on average long term sickness case length, which has reduced with a number of key cases being concluded utilising support from Occupational Health, as appropriate.

NHS E/I have now shared the evaluation report from the Supporting People to Manage Attendance Programme that ran at the end of 2021. The pilot included three Trusts – WUTH, Liverpool Women's and the Walton Centre,

with WUTH staff taking 47.4% of available places. The evaluation found staff are now more willing to discuss sensitive issues that may affect attendance at work, and an increase in participant confidence to manage attendance was reported. The evaluation clearly highlighted that the programme had positive benefits for the individuals who took part. Following evaluation of the pilot, NHS North-West Leadership Academy will now develop a product with an accompanying training package and resources so that this can be cascaded across the Trust.

Health and Wellbeing Conversations and Day continue to be promoted and uptake will be monitored following the recording function going live on ESR so we can capture the data.

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 time and as we emerge from the pandemic and transition into Living with Covid-19 response.

Staff turnover % (12-month rolling average)

Executive Lead: Chief People Officer

Performance Issue:

The Trust target is set as a maximum rolling 12-month turnover threshold of 10%. Turnover was 14.38% for the rolling 12 months to May 2022, which is a similar position to that reported in April 2022 (14.1%). Rolling 12-month turnover to May 2022, calculated on permanent assignments only, is 12.18%.

The in-month performance in Estates, Facilities & Capital are below the Trust Turnover KPI. All other Divisions are above.

All Divisions are over the 10% KPI for the rolling 12 months.

Actions:

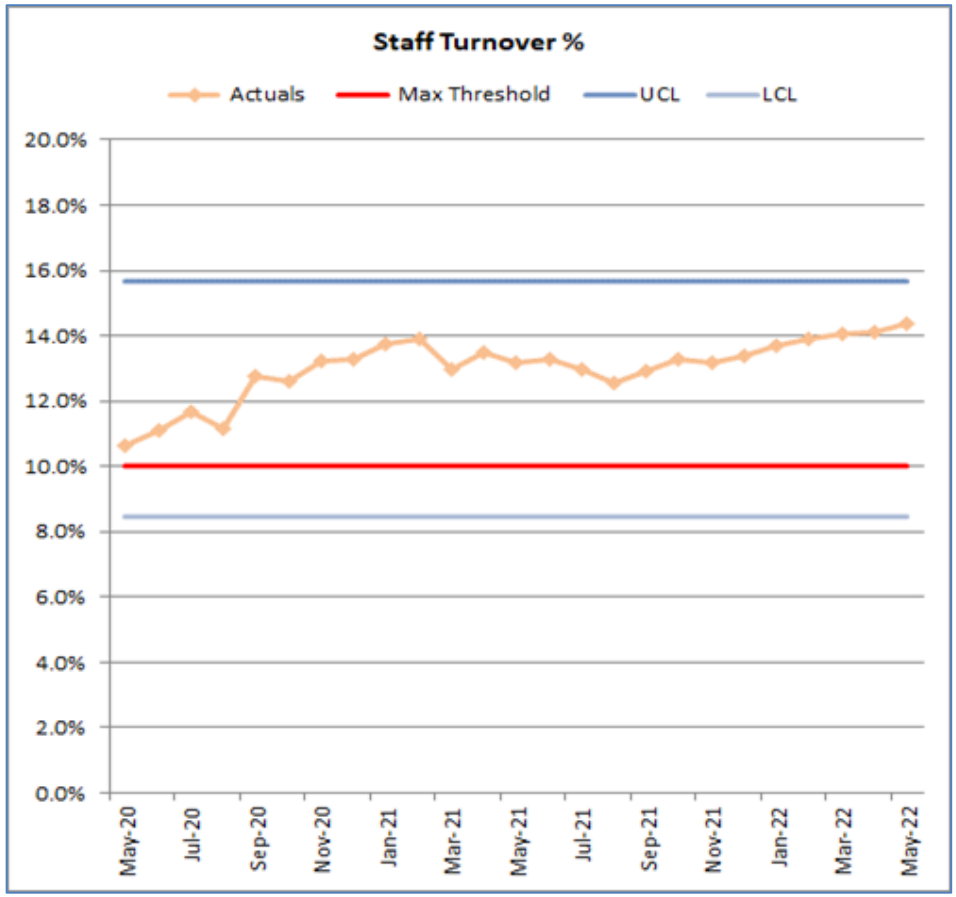
Monitoring of the Turnover KPI is on-going via Divisional Management, Divisional governance infrastructure, and via Divisional Performance Reviews (DPRs), with specific actions in place according to the local feedback. A specific focus on Registered Nurse and CSW turnover is also discussed at the Recruitment and Retention Working Group which meets monthly.

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

A Retention workstream has been included as part of the People Strategy 2022-2026 Delivery Plan and an HRBP project lead identified with key quarterly deliverables to aid the improvement of retention across all staffing groups.

Q1 Activity includes National, Regional and Local activities:

- Utilise into NHS England and NHS National Retentions programme resource to review and implement evidence based best practice.
- Review retention plans from across the Cheshire Mersey network and understand success to date.



- Identify existing retention workstreams and development of a Trust Retention Group which incorporates all staffing groups.
- Commence a gap analysis to understand stand still position and to identify key deliverables to aid in the improvement of retention within WUTH.
- Scope out Q2 activities to understand current position with data mining with reference to source accuracy, time frames of completion and are they fit for purpose.
- Identified Data Sources: ESR, Exit Surveys and Staff Survey

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 should reduce as Turnover improves over time with the interventions outlined above.

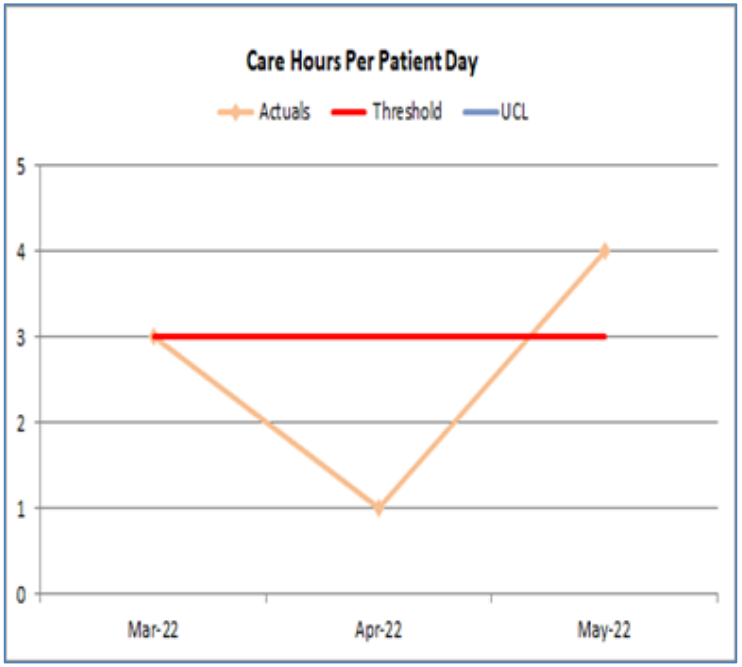
Care Hours Per Patient Day – number of wards below 6.1

Executive Lead: Chief Nurse

Performance Issue:

WUTH monitors the number of wards that are below a Care Hours Per Patient Day threshold of 6.1. The metric for the Trust overall is set at a maximum of three wards to be below this threshold.
The number of wards for May 2022 was four.

The wards that had a CHPPD of <6.1:
Ward 27 = CHPPD 6
Ward 36 = CHPPD 6
Colorectal Unit = CHPPD 6
Ward 38 = CHPPD 5.7



Action:

Three of the wards who had a CHPPD of <6.1 had a variance of 0.1, this is equivalent to 6 minutes of care.

The wards identified will be monitored to see if this is a continuous occurrence using a CHPPD tracker. This tracker will be shared monthly as part of the safe staffing oversight tool data report provided to Divisional Senior Nurse Management Teams. CHPPD is monitored as part of the six-monthly Establishment review process. The Trust is currently in the review process period and will be consider as part of the establishment setting process.

Expected Impact:

A reduction in the number of wards with a consistent CHPPD of <6.1

Effective Domain

Theatre in session utilisation %

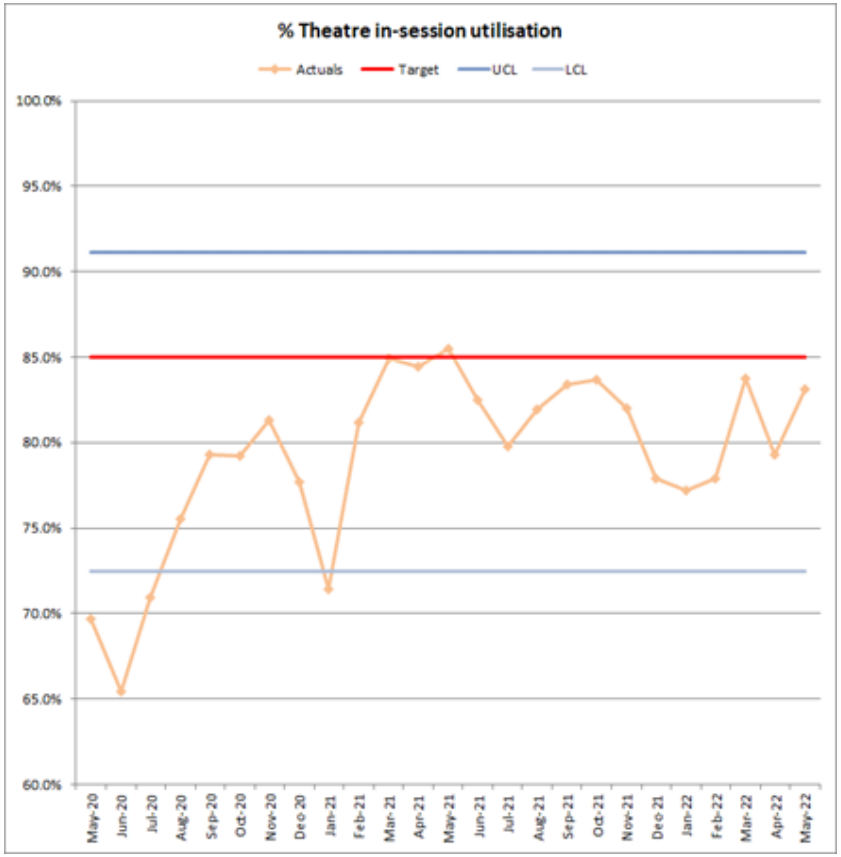
Executive Lead: Chief Operating Officer

Performance Issue:
The Trust has an internal efficiency trajectory of a minimum 85% of theatre time to be utilised. Overall, May's performance was 83.1%, up from April's 79.3%.

Focus remains on improving utilisation of core sessions as part of reset and recovery. This has been critical given the loss of 6 theatres due ventilation failures resulting in theatres M1 – M5 and G1 being closed to maintain patient safety. Works have been completed in M3-5 and the second fix remedial work of M1 & M2 are holding. G1 remains out of action. Core session utilisation is currently above the target at 98.7%.

Proposals to change the process under "living with COVID" was approved at CAG with in session performance showing an improvement. This was expected to have greater impact however, during June we saw an increased in cancelations on the day for non-clinical reasons due to lack of a bed and lack of operating time though we did see an increase in the number of cases performed.

Recent Peri-op GIRFT measures have been released which WUTH benchmarks favorably against for theatre optimisation. Following the change in COVID pathways the application of the 4-week lockdown of theatres has been achieved.
COVID measures regarding PPE remain in place.



Action:

- Maintain the daily TCI meeting to prevent cancellations on the day for inpatients and risk further reduction in in-session utilisation

• Heavier focus on CGH theatre to ensure >85% in-session delivery, recognizing 4+ patients per list loses circa 8% of capacity • Through TRG focus on the case mix to ensure theatre time maximised
Expected Impact: Increase in in session utilisation and increase in case throughput.

Caring Domain

Same sex accommodation breaches

Executive Lead: Chief Nurse

Performance Issue:

The national standard is set that providers should deliver same sex accommodation, except where it is considered in the overall best interests of the patient or reflects personal choice.

Same sex accommodation breaches are most often due to patients waiting more than 24 hours for transfer from critical care areas to general wards – there was 1 such breach in May 2022. This 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:

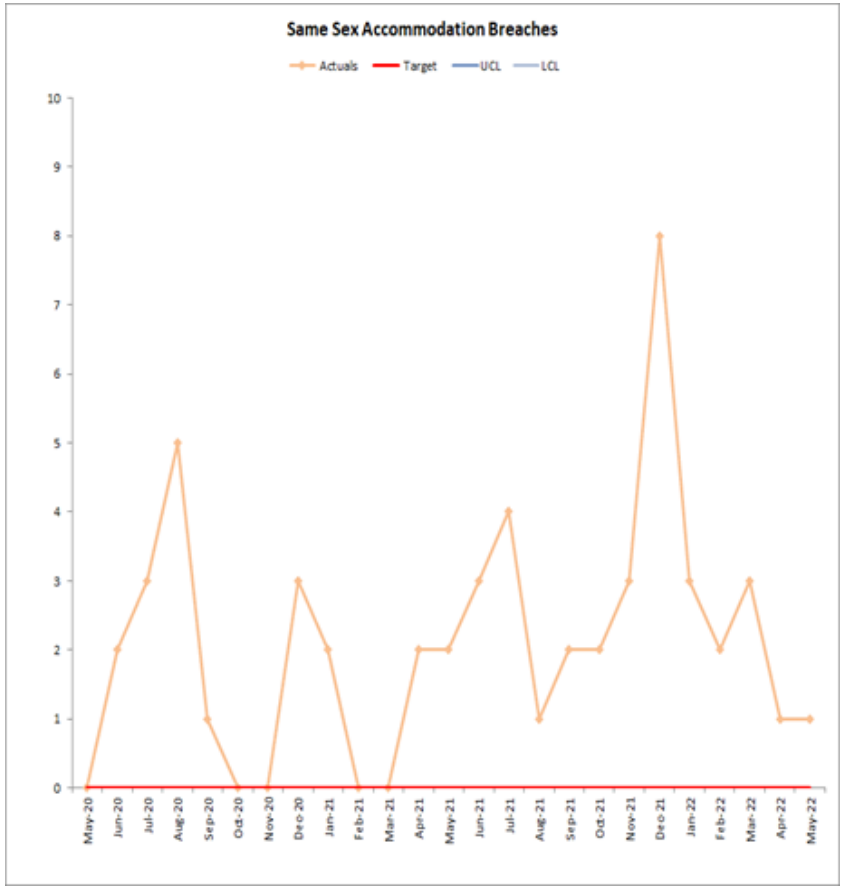
Increased pressure due to system challenges resulting in high levels of activity throughout the hospital and an increased proportion of patients with no criteria to reside continued in May 2022.

Joint working processes are in place, between critical care and the Patient Flow Team, to expedite discharges in response to an increase in acuity of patients.

Robust processes remain in place to ensure that delivering same sex accommodation continues to be a high priority and that breaches are managed promptly via bed capacity and operational meetings.

Expected Impact:

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



Friends & Family Test – Overall Experience

Executive Lead: Chief Nurse

Performance Issue:

A WUTH standard is set for achieving an overall experience rating of very good or good for each of the main care settings.

Performance against the 95% threshold for May 2022 was:

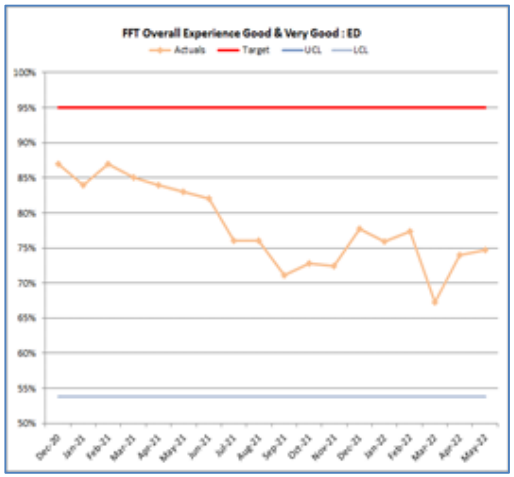
- ED - 74.7%
- Inpatients – 94.1%
- Outpatients – 94.3%
- Maternity 98.0%

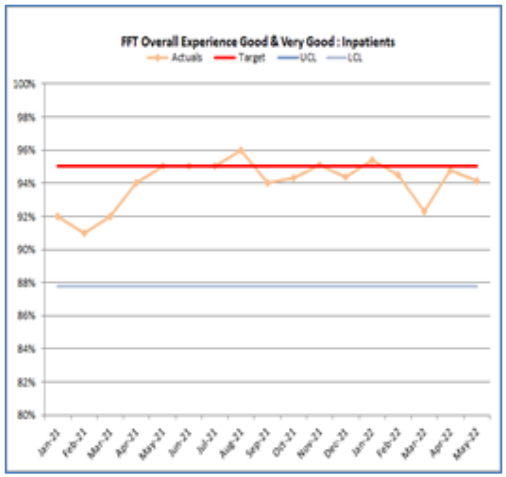
Action:
The Trust formally launched its Patient Experience Strategy on the 4th April 2022 with five strategy promises: Welcome, Safe, Inclusive, Care and Supported. Promise action groups will focus on identifying improvement opportunities to improve the patients' experience.

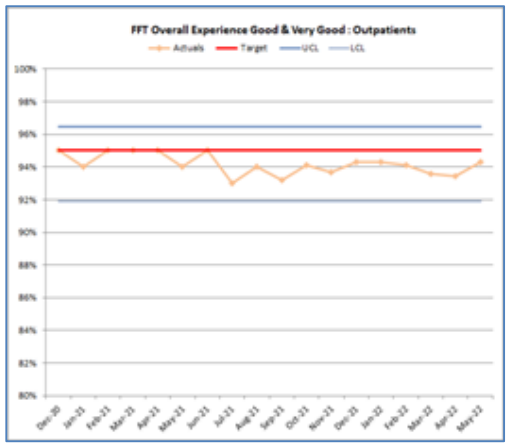
Operational pressures continue within the Emergency Department as they do nationally, whilst FFT scores are low they are in line with other regional organisations and negative feedback focuses on waiting times. ED has a newly appointed Divisional Nurse Director and a meeting to review patient experience feedback has been arranged for August 2022.

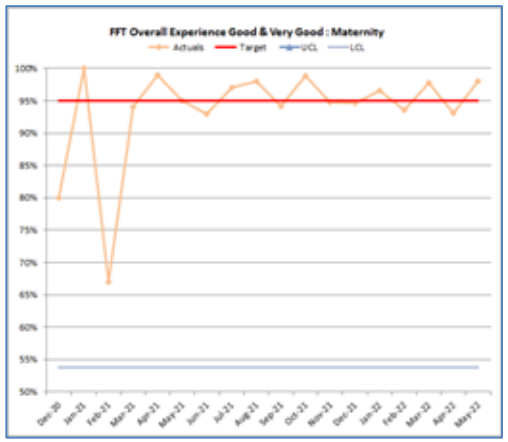
There were fourteen wards that did not meet the target of 95%, of these three wards have now developed a responding to feedback action plan in place. The eleven wards without will be expected to have agreed their action plans by the end of July 22.

Themes from feedback are being coded against the patient experience strategy promise group to support trust wide improvement workstreams.







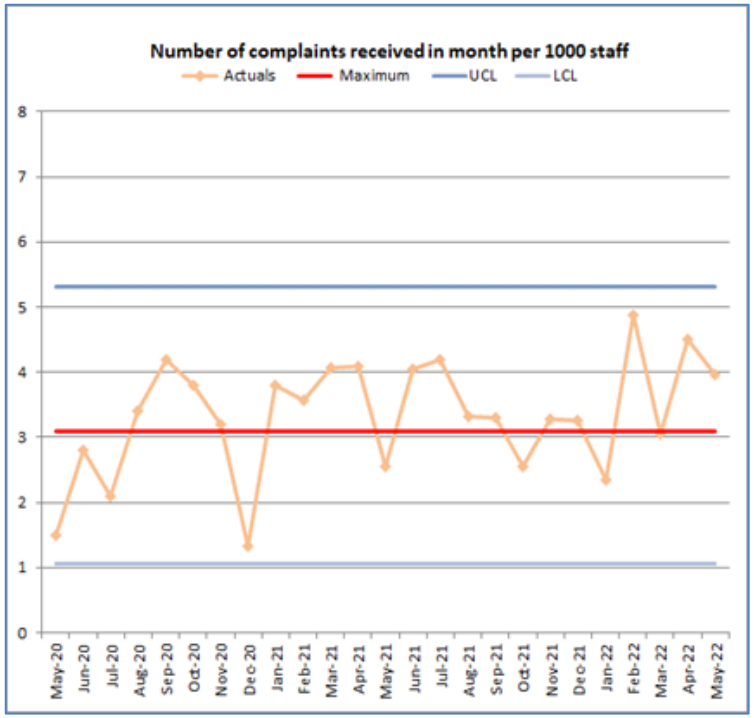


All areas receive regular patient experience feedback and areas are monitored for themes and trends.
Expected Impact: Improved FFT scores with an expectation to reach the Trust target for Inpatients, Maternity Services, and Outpatients.

Responsive

Number of complaints received in month per 1000 staff

Executive Lead: Chief Nurse
Performance Issue: WUTH has set a maximum threshold for the number of complaints received in month at less than or equal to 3.1 per one thousand staff. The rate for May 2022 was 3.96.
Action: Complaint numbers remain broadly in line with historical performance. Over time, the numbers of complaints received each month have consistently increased in line with the trend seen nationally. Divisions have localised plans to address the main continuing causes of complaint (communication / staff attitude and capacity pressures) and the ways in which these might be addressed.
Expected Impact: Actions being taken will strengthen the approach to complaint management within the Trust.



NEWS2 Compliance

Executive Lead: Chief Nurse

Performance Issue:

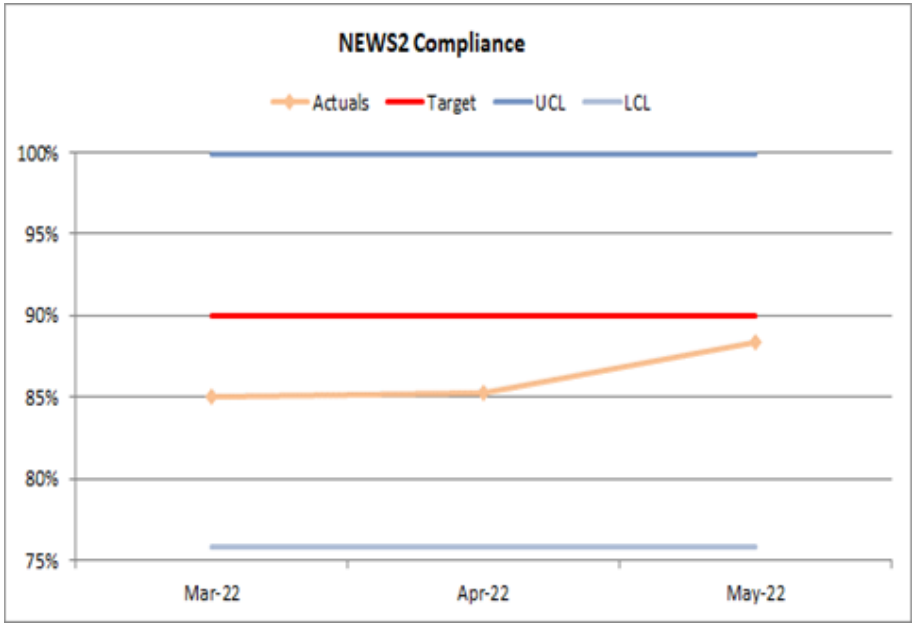
WUTH has set a threshold of greater than 90% compliance with NEWS2 patient observations conducted within timeframes agreed within national guidelines and Trust NEWS2 policy. Compliance is measured by a rolling programme of monthly ward audits - for May compliance was at 88.34%.

Action:

The Trust has progressed two workstreams to support an increase in compliance with the timeliness of recording NEWS2 observations.

Fast-Track Improvement Work

A fast-track improvement plan led by the Trust Medical Director has developed advanced communications in the form of a 'Deteriorating Patient Take 5' poster and a created a live report from the Trust's electronic patient record that identifies each ward / department NEWS2 compliance status. The 'Deteriorating Patient Take 5' communication poster has been presented at Chief Nurse Check-in and has been provided to all areas via Ward Managers as part of their Safety Huddles. To support staff accessing the new live NEWS2 compliance report a "Knowing How You are Doing" presentation has been delivered to all Ward and Department Managers. NEWS2 compliance is reported to the executive Management Team fortnightly as part of a series of Nursing Quality Metrics.
The fast-track improvement plan also includes the planned introduction of integrated systems. This will allow observations recorded on modified observations machines to instantly migrate into patient medical records, increasing compliance with the timeliness of observations.



Quality Improvement Focused Work

The Trust has also established a Deteriorating Patient Faculty, led by the Chief Nurse, to oversee Deteriorating Patient Quality Improvement (QI) work on eight wards across the Trust.
Wards have participated in workshops to identify issues and potential solutions by using QI tools such as Fishbone and Driver Diagrams. Solutions are then assessed on wards using 'Plan, Do, Study, Act' cycles. The solutions are refined on the wards and presented at the executive-led Deteriorating Patient Faculty. Solutions considered successful and sustainable are to be compiled into a Deteriorating Patient Bundle for Trust-wide use

Expected Impact:

The expectation is for all areas to achieve greater than 90% for completing NEWS2 observations within national and locally agreed timeframes.

Well-led Domain

Appraisal compliance %

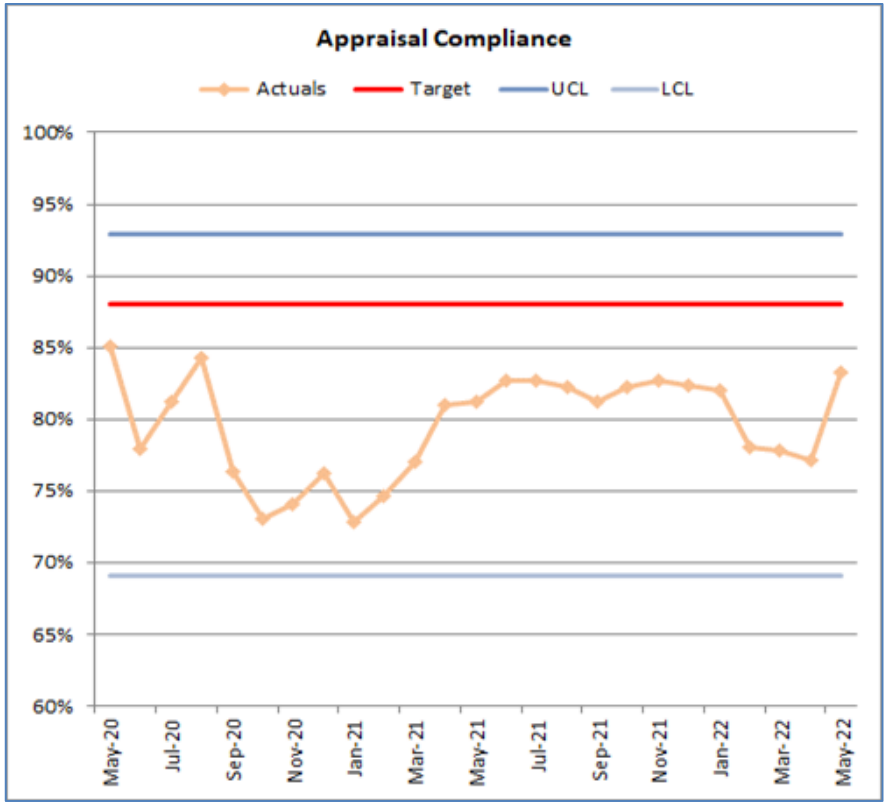
Executive Lead: Chief People Officer

Performance Issue:

The target for annual appraisal compliance is 88%. At the end of May 2022 83% of the workforce had received an appraisal in the last 12 months. This is an improvement of 6% on April's position.

From a Divisional perspective, Clinical Support (88.14%) and Women & Children's (89.44%) have achieved the Trust KPI of 88% appraisal and compliance is currently under 80% in Acute and Surgery. All Divisions, with the exception of Corporate Division, have seen an increase in compliance this month.

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 with alerts of appraisals due generated via the ESR system. HR Business Partners continue to support Divisional Management teams to identify and deliver actions to address low levels of compliance in specific areas. Increased focus upon appraisal compliance is being placed at Divisional performance review (DPR) meetings. All Divisions have produced improvement trajectories and have confirmed expected date of compliance to Trust Management Board.

All outstanding appraisals have been reviewed by the Learning and Development Team, who have directly targeted areas of low compliance in each Division to provide staff with support. This includes prompts of an over-due appraisal with supportive guidance that includes advice on how to record their appraisal onto ESR. Given that this action appears to have had a positive impact on compliance

levels, the Team will maintain this targeted approach with further correspondence being issues by the end of June 2022. As highlighted in previous reports, a review of appraisal has now commenced. Feedback to further inform our future approach has been gathered this month from Trust leaders through a Leadership Conference workshop and recommendations from the review to strengthen the quality of the appraisal experience, enhance its value across the Trust and subsequently drive improvements in both quality and compliance are expected in July 2022.
Expected Impact: Whilst actions will continue to increase compliance within the existing appraisal framework, the longer-term solution for maintaining compliance is to place a longer-term focus on quality improvement. It is acknowledged that any increase in clinical pressures may create continuing challenges in maintaining appraisal completion rates over forthcoming months.

Wirral University Teaching Hospital
NHS Foundation Trust

Council of Governors **Item No 11.1**
25 July 2022

Title	Committee Chairs Reports - Quality Committee
Area Lead	Dr Nikki Stevenson, Executive Medical Director/Deputy CEO
Author	Steve Ryan, Non-Executive Director
Report for	Information

Report Purpose and Recommendations

This report provides a summary of business conducted during a meeting of the Quality Assurance Committee held on 25 May 2022. It is recommended that the Council of Governors:

- Note the report

Key Risks

This report relates to these key Risks:

- Principle BAF Risk 4: Catastrophic Failure in Standards of Care

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

1	Narrative
1.1	**Learning from deaths report (Q4 2021-2022)** In receiving this report and gained good assurance that there are robust processes in place for the review of all deaths that take place at the Trust, with the Medical Examiner role now well embedded. There is appropriate monitoring of mortality rates (presently within expected levels) and an early warning system in place for possible high rates within diagnostic groups. The Mortality Review group through its Chair were complimented on the significant progress made in the last year in developing the quality of their processes and their clearer interaction with other quality monitoring processes at the Trust.
1.2	**Approval of Quality Account 2021-2022**

	Subsequent the Audit Committee, this Committee approved the Quality Account for forwarding to the Board for final approval. The account as set out is constrained in style and layout by national specifications, but the Committee felt that a more engaging format could be developed in addition which we could share with our wider stakeholders.
1.3	**Care Quality Commission Action Plan** The Committee noted this updated action plan (following the inspection report received by the CQC in January 2022) which blended the few remaining in completed items from the existing action plan with the new ones. Actions ongoing and closed were noted and the Committee will receive regular updates on progress.
1.4	**Infection Prevention and Control Board Assurance Framework and Risk Assessment** The Committee received a report that confirmed the arrangements currently in place to control the risk of Covid-19 infection and still allow good access to care for all patients. These are consistent national and regional guidance and have previously been reported the Trust Board.
1.5	**Mental Health Care in the Emergency Department** The Committee received a report about improvement activity following a clinical audit that showed improvement in the metric for Trust staff reviewing patients in mental health crisis after their assessment by a mental health practitioner. It was felt however that despite this, further work was required to provide full assurance that improvement was consistently established.
1.6	**Internal Audit Report into Mortality and Sepsis Clinical Coding** Already considered at the Audit Committee, this report provided substantial assurance about clinical coding and indicated high reliability of our clinical coding processes but also an opportunity to improve them even further. Actions are in place to make those improvements.
1.7	**Serious Incident Review Panel's Chair's report** Following discussion of the Serious Incident (SI) Panel's Chair's report it was agreed to consider how better we could consolidate our understanding of the actions and improvements recommended in SI action plans. It was agreed that a retrospective review on a thematic basis, which tied in relevant areas of quality improvement, as well as assurance on actions being completed would be helpful and a proposal will be brought back to the Committee.

2	**Conclusion**
2.1	The Committee received appropriate and detailed documentation in relation to the items it considered on 25th May 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.

Report Author	Steve Ryan, Non-Executive Director
Contact Number	n/a
Email	n/a

Council of Governors **Item No 11.2**
25 July 2022

Title	Chair's Report – Capital Committee 13 June 2022
Area Lead	Matthew Swanborough, Director of Strategy
Author	Steve Igoe, Non-Executive Director
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide an update to the Council of Governors on the discussions at the Capital Committee on 13 June 2022.

Key Risks

This report relates to these key Risks:

- Failure to deliver the capital programme
- Failure to effectively plan the capital development of the Arrowe Park Site
- Management of the Frontis building and its associated legal and financial liabilities
- Management of the security requirements for the Trust

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

1	Narrative
1.1	This report updates on the work of the Capital Committee at its meeting on 13 June 2022. The Committee considered the following areas.
1.2	**Arrowe Park Master Planning** The Committee received an oral update relating to the ongoing challenges in support of the Master planning of the Arrowe Park Site. It was noted that funding was a challenge, but the strategic importance of the work noted. It was agreed that the Exec would continue to seek funding for the works and continue the planning in the meantime.

1.3	**Urgent and emergency upgrade programme** An update was received on the progress of the Trust's Urgent Emergency care upgrade Programme (UECUP). The Trust is well on with this project. The Trust submitted its FBC to NHSI/E on 6th May 2022. Prior to submission the case was subjected to rigorous review through the Trust's own Governance processes. The FBC will now go through a detailed review in June after which it will be subject to evaluation by the Joint Investment Sub Committee (JISC) leading to final sign off on 15th August. Funds will flow within 4 weeks of JISC approval. Enabling works are progressing to allow a prompt start on site following approval with areas due for demolition works to be completed by September 2022.
1.4	**Frontis Building** Due to the commercially sensitive nature of these discussions and the associated documentation, the chair concluded that this information whilst able to be discussed at capital committee should not be available for general circulation and any discussion at Board level to be within the Private section.
1.5	**Capital Programme Delivery 2022/23** A detailed report was introduced highlighting the substantial amount of capital works undertaken at the Trust during 2021/22 .This was arguably the busiest year ever for such investment .Delivery and spend covered 43 specific projects which included planned , contingency and specially funded schemes such as the CGH Theatres phase1.Four of the 43 projects above have been carried forward into 22/23 and are part of a further 17 projects with a projected spend of £22m to be completed in year.
1.6	**Capital Risk and Backlog Maintenance** The Committee received a detailed report and presentation providing an overview of backlog maintenance risk across the Trust Estate. This included an examination of historic capital expenditure and allocations, levels of backlog maintenance and estimated costs and equipment maintenance. The discussion also covered the approach and progress with assessing and recording all assets across the Trust along with a timeline for the development and implementation of a CAFM system to manage trust assets and backlog maintenance.
1.7	**Estates Improvement Plan** The Committee received and oral update and presentation on the ongoing works to develop the Estates area and enhance its effectiveness and control. Work was continuing on multiple projects and in multiple areas and positive results were already becoming evident
1.8	**G4S Building Security review** The Committee received a detailed presentation on the current state of affairs relating to the Trust's effectiveness and vulnerabilities associated with current security threats in particular focusing on those key threats and vulnerabilities across the WUTH property portfolio. The Committee were pleased to see the outcomes from this important piece of work. Noted the risk assessment outcomes from the report, the priority recommendations identified, and the next steps recommended in the plan. The Committee also noted that

	following the implementation of the improvement plan there may be a need for further investment or changes to operating models. These will be considered in appropriate for a in due course.

2	Implications
2.1	The Council of Governors can use the report from the Capital Committee to update more generally on Capital issues and challenges.

3	Conclusion
3.1	The Capital Committee is effectively managing and providing oversight of major capital issues and associated processes and systems for the benefit of the Board.

Report Author	Steve Igoe, Non-Executive Director
Contact Number	077 333 14675
Email	stephen.igoe@nhs.net

Council of Governors **Item No 11.3**
25 July 2022

Title	Chair's Report – Finance and Business Performance Committee 29th June 2022
Area Lead	Mark Chidgey, Chief Finance Officer
Author	Sue Lorimer, Non-Executive Director
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide assurance on the financial performance of the trust, performance against access targets and to scrutinize the process for awarding contracts prior to recommendation to the Board of Directors.

It is recommended that the Council of Governors note that:

- the financial plan was updated to include additional income and a release of balance sheet accruals to enable a target performance of breakeven for the year;
- financial performance to month 2 was £0.6m behind plan due to theatre closures, staffing of escalation wards, locum costs and shortfall in cost improvements;
- CIP was significantly behind plan, there is continued risk in achievement of the current years CIP and actions to identify further areas of potential savings were discussed;
- there are continued difficulties in achieving access targets, particularly in ED due to rising attendances and a shortage of community and domiciliary care to enable discharges;
- contract awards were approved for managed laboratory services, heating and cold water pipework to wards 11, 12 and 14 and the provision of 2 additional operating theatres on the Clatterbridge site;
- medical staffing establishments have been reviewed and action plans were in place to reduce the high level of locum expenditure;
- the production of service line reports will be reintroduced through close working between finance, operations and clinicians;
- and the committee reviewed the plans for the trust to engage with a limited liability partnership formed by its consultants to increase elective capacity.

Key Risks

This report relates to these key Risks:

- 1.2 Failure to meet constitutional targets, resulting in an adverse patient experience and quality of care.
- 3.1 Failure to deliver sustainable cost improvements.
- 3.2 Failure to deliver the financial plan.

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

Report Author	Sue Lorimer, Non-executive Director
Contact Number	07803 584 723
Email	Sue.lorimer@nhs.net

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 6 April 2022
Location	Microsoft Teams Meeting

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
JS	John Sullivan	Non-Executive Director & Vice Chair
SI	Steve Igoe	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
SR	Steve Ryan	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Nicola Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
HK	Hayley Kendal	Chief Operating Officer
DS	Debs Smith	Chief People Officer
RC	Robbie Chapman	Interim Chief Finance Officer
MG	Michael Gibbs	Associate Director of Integration and Partnerships (deputy for Matthew Swanborough)

In attendance:

TC	Tony Cragg	Public Governor
AM	Alan Morris	Public Governor
RT	Robert Thompson	Public Governor
SH	Sheila Hillhouse	Public Governor
DT	Diana Tyson	Public Governor
CM	Chris Mason	Chief Information Officer
DMcG	David McGovern	Director of Corporate Affairs
JN	Jonathan Lund	Associate Medical Director
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer (minutes)
DE	Debbie Edwards	Divisional Director of Nursing and Midwifery for Women's and Children's Division (item 11)

Apologies:

CC	Chris Clarkson	Non-Executive Director
MS	Matthew Swanborough	Director of Strategy and Partnerships
SS	Sally Sykes	Director of Communications and Engagement

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** The Chair welcomed everyone to the Board meeting. Apologies were received from Chris Clarkson, Matthew Swanborough and Sally Sykes.	
2	**Declarations of Interest** No new interests were declared and no interests in relation to the agenda items were declared.	
3	**Patient Story** The Board received a video story of the experiences of a patient and their partner. The story highlighted how staff at the Clatterbridge Vaccination Centre had responded positively with guidance and support, after the patient raised concerns about the risk of blood clots as a side effect from COVID vaccination. The team also assisted with advice and information in light of the patient's partner's severe allergies to allow both to have their COVID vaccines. The patient wished to thank the Clatterbridge team for their time, providing reassurance and a willingness to listen. The Board welcomed the positive feedback and recognised the dedication and hard work being carried out by the team at the Clatterbridge Vaccination Centre. The Chair agreed to sign a thank you note to staff on behalf of the Board, provided by TF.	TF, DH
4	**Minutes of the Previous Meeting** The minutes of the meeting held on 2 March 2022 were approved as an accurate record.	
5	**Action Log** The Board noted that all actions had been closed or completed.	
6	**Chair's Business and Strategic Issues** The Chair updated the Board on recent matters. The key points were: • Interviews for the Non-Executive Directors positions were held on 30 March, a recommendation will be made to the	

	Council of Governors at the April meeting and to seek approval to appoint two applicants. • Acknowledged and thanked the hard work being carried out by the Capital and Estate teams to improve the patient and staff experience at both Arrowe Park and Clatterbridge. • Good progress continued to be made with the Health Wirral Partnership Board.	
7	**Chief Executive Officer's Report** JH reported that the prevalence of COVID in the community continued to rise, therefore the Trust was experiencing an increase in the number of inpatients and the current bed occupancy due to COVID was 11.8%. The Trust was also experiencing an impact on sickness absence due to the number of staff testing positive, and this was creating challenging operational pressures. NHS England had provided an update on the testing guidance following the publication of the living with COVID plan on 30 March. Testing within the healthcare setting would not change, but from 1 April LAMP testing would no longer be available for NHS staff and instead advised continuing testing twice weekly with lateral flow tests. The Trust was also continuing to work with external advisers to scope and prepare for the COVID public inquiry. JH also reported that the Trust had declared four serious incidents in February 2022 and highlighted the Serious Incident Panel report and investigate under the Serious Incident Framework to identify any relevant learning. No common themes or areas were identified from the four serious incidents and had spanned multiple areas of the trust. JH reported one Never Event in the month of February and noted that there was no harm to the patient. One incident was reported to the Health and Safety Executive in accordance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). JH highlighted Simon Banks had been appointed as the Wirral Place Director. Simon was currently the Accountable Officer for Wirral Clinical Commissioning Group and will formally commence in post on 1 July 2022. JH also highlighted that the Arrowe Park theatre and ventilation system was experiencing operational challenges. Six theatres had to be shut with the remedial work due to be completed in the next 8 weeks. The clinical teams continued to prioritise the most urgent patients requiring surgery and were reviewing additional weekend sessions and day working.	

	SR queried if the Trust had forecasted when the current COVID wave would peak for the hospital. JH explained that forecasting had become more challenging due to the new guidance on testing, however the NHS expected the peak to occur towards the end of April. NS commented that the Trust was dealing with a high degree of uncertainty and the hospital continued to face increasingly difficult pressures. The Board **NOTED** the report.	
8	**Chief Operating Officer's Report** HK provided an overview to the Board of the Trust's current performance against the re-set and recovery programme for planned care and standard reporting for unscheduled care. During February the Trust delivered high levels of elective care and continued to be on track with 52 week and 104 week waiting targets. The Trust continued to be in a similar situation in January for the cancer backlog and the Board would hear more information in May about the recovery plans. Regarding unscheduled care, February and March had seen unprecedented levels of occupancy across the Trust with 98% occupancy during the week. This presented difficulties when responding to infection, prevention, and control outbreaks in the hospital due to the COVID. Due to the high bed occupancy ambulance turnaround times had been difficult to meet national targets. SL queried the endoscopy recovery plan. HK confirmed that a recovery plan would be presented on 18 April by the divisional team. The Board would be provided with the operational plan in May and would include further information about the endoscopy recovery plan. The Board **NOTED** the report and the performance and mitigations in place to support the Trust.	
9	**Board Assurance Reporting** **9.1) Quality and Performance Dashboard** The Executive Directors briefed the Board on metrics in the dashboard. It was noted that of the 47 indicators that were	

reported, 28 were off plan or failing to meet performance thresholds and 19 were on-target.

NS drew attention to the Trust declaring a Never Event and highlighted that such events had been increasing across all other NHS Trusts. Trusts had also seen a rise in the number of complaints received.

DS drew attention to staff sickness absence. The percentage had improved in February following a peak in December and January of 7%. Appraisals had reduced to 78% compliance, and it was noted a lower percentage would impact on staff turnover and higher sickness absence.

The Chair queried the balance between long term and short-term sickness absence.

DS confirmed the biggest pressure remained short term sickness absence and this was mostly caused by COVID, colds and flu.

SI queried given the recent theatre and ventilation failures does the Trust have the right critical maintenance and reliability strategies in place.

HK reassured the Board that a planned maintenance programme was in place, however significant risks remain due to the aging estate and equipment across the Trust.

RC drew attention to the recruitment and reliance on agency staff and it remained one of the Trust's largest financial risks. Work was ongoing to establish historic accruals and determine if any can be released and overall, the Trust's balance sheet was in a positive position.

The Board **NOTED** the report.

9.2) M11 Finance Report

RC introduced Month 11 Finance Report. The Trust was reporting a deficit of £0.163m at M11, a positive variance against a budget of £0.039m. The Trust was forecasting a break-even position for the financial year.

The Board **NOTED** the report.

9.3) Learning from Deaths Quarterly Report

NS introduced the Learning from Deaths Quarterly Report and highlighted the medical examiners continue to provide 100% scrutiny of adult deaths. The Summary Hospital Level Mortality Indicator (SHIMI) had remained stable when compared to the previous quarter. The latest available data (up to August 2021)

	highlighted the SHIMI to be 107. Although the SHIMI is higher than the expected 100, it is still within acceptable range. The Mortality Review Group meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner. Learning from mortality reviews is fed back to clinical areas by the Divisional mortality leads. The Chair of the Quality Committee commented that he observes the Mortality Review Group and noted the high degree of information and thorough analysis of statistics. The Board **NOTED** the report, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group. **9.4) Maternity Quarterly Report** DE introduced the report and provided a specific update regarding the evidence submitted to NHS England and Improvement to support compliance with Ockenden recommendations (Part 1) and reported the Trust was in full compliance. The Board would receive an update at the May meeting regarding recommendations from Part 2 of the Ockenden report with an associated gap analysis of how the Trust compares. The Chair suggested the topic would be good to have in an open Board Seminar. The Board noted the Trust had full compliance with seven immediate and essential actions, however this wasn't the case for the region. The report noted Perinatal Clinical Surveillance Quality Assurance, Oversight of HSIB and SI reviews, and noted the Trust had met its requirements with year 3 of the Maternity Incentive Scheme. The Board also heard the Trust was progressing with continuity of carer although this would be risk assessed as per Ockenden 2 recommendations. DE confirmed some actions had been outstanding from a recommendation point of view. However due to the collaborative work during the previous months the local maternity system had now actioned all the recommendations in part 1. The Board **NOTED** the report and **DISCUSSED** the Trust's compliance with the Ockendon recommendations and the submission of compliance to NHSE/I.	TF TF/CH
10	**Children and Young People Patient Survey**	

	TF introduced the survey, highlighting in 2020 the Care Quality Commission commissioned a Children's and Young Person's Survey in line with the scheduled patient experience survey programme. The results would be used to support preliminary intelligence as part of the Care Quality Commission inspection process. The survey was undertaken between November 2020 and January 2021 during the second wave of COVID. Response rates were low at 16% compared with the national average of 24%. The Trust's overall results had been positive with seven indicators being recognised as "Better" when compared with other hospital trusts and no indicators being recognised as "Worse". An improvement plan had been developed to ensure that where possible children, young people and their families experience the best care and services delivered by the Trust. This improvement plan will be monitored at the Children's Clinical Governance meeting and via the Patient Experience and Family Group reporting to Patient Safety Quality Board. The Board **NOTED** the report.	
11	**Maternity Inpatient Survey** TF introduced the survey, highlighting it was an annual requirement and the results would be used to support preliminary intelligence as part of the Care Quality Commission inspection process. Due to the pandemic no survey was undertaken in 2020, therefore comparative data was made with 2019. The Trust's overall results had been positive with four indicators recognised by CQC as better, these and other areas where the Trust scored well in, centred on excellent communication and caring staff. No indicators had been recognised as worse. However, areas of suggested improvement had been identified and would form part of an improvement plan monitored via the Patient Experience and Family Group reporting to Patient Safety Quality Board. The Board **NOTED** the report.	
12	**Communications and Engagement** DS introduced the Communications and Engagement Report in absence of the Director of Communications and Engagement. The key points were: • On 4 May 2022 the Trust would celebrate 40 years of Arrowe Park Hospital	

	• The Communications team ran a campaign for International Women's Day • In March the Trust highlighted in the media the new investment in the £10.6 million funding for a new operating theatre – the new South Mersey Elective Hub • Additional media coverage included the 10,000 patients on Wirral who benefits from earlier access to diagnostics • WUTH Charity events had been planned in May and July The Board **NOTED** the report.	
13	**Committee Chairs Report** **13.1) Finance, Business, Performance and Assurance** The Board **NOTED** the report. **13.2) Quality** The Chair of the Quality Committee provided a report to the Board on recent proceedings of the Committee. It was noted that there had been temporary modification of infection control procedures to balance risks to patient safety and this resulted in a reduction in capacity of around 65 beds. Increased numbers of patients had been subjected to corridor care. There was an increasing number of ambulances experiencing delays in transferring patients into the emergency department, therefore increasing the NWAS response time to attend Category 2 patients. The Board **NOTED** the report. **13.3) Workforce Assurance** The Chair of the Workforce Assurance Committee provided a report to the Board on recent proceedings of the Committee. It was noted staff issues with attitudes and behaviours formed two thirds of recent Freedom to Speak Up reporting. The Monthly Nurse Safe Staffing Report provided assurance regarding patient safety but there was evidence the patient experience was deteriorating due to increased infections, demand pressures and high levels of staff absence. The 2021 NHS 2021 Staff Survey results demonstrated the Trust was at or close to the average of 126 comparator acute Trusts across all the survey themes. The Board **NOTED** the report.	
14	**Questions from the Public** Those members of the public in attendance were invited to ask questions relating to items on the agenda.	

	SH queried if the Board was aware when the Care Quality Commission (CQC) would carry out their inspection of the Trust. NS confirmed the CQC had already undertaken inspections locally in urgent care settings, however, was unaware when they would inspect the Trust.	
15	**Any other Business** No other business was raised.	

(The meeting closed at 11:33)

Wednesday 4 May 2022

Chair Date

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	4 May 2022
Location	Boardroom, Education Centre, Arrowe Park Hospital

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
JS	John Sullivan	Non-Executive Director & Vice Chair
SL	Sue Lorimer	Non-Executive Director
SR	Steve Ryan	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Nikki Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
HK	Hayley Kendall	Chief Operating Officer
DS	Debs Smith	Chief People Officer
RC	Robbie Chapman	Interim Chief Finance Officer
MS	Matthew Swanborough	Director of Strategy and Partnerships

In attendance:

SH	Sheila Hillhouse	Public Governor
TC	Tony Cragg	Public Governor
PI	Paul Ivan	Public Governor
PB	Philippa Boston	Public Governor
DMcG	David McGovern	Director of Corporate Affairs
CM	Chris Mason	Chief Information Officer
SS	Sally Sykes	Director of Communications and Engagement
JN	Jonathan Lund	Associate Medical Director
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer (Minutes)
DE	Debbie Edwards	Divisional Director of Nursing and Midwifery for Women's and Children's Division
JL	Jo Lavery	Delivery Suite Sister
NP	Natalie Park	Divisional Director of Women & Children's (Item 11)
LS	Libby Shaw	Consultant (Item 11)
CC	Catherine Cumberlidge	Patient Safety Manager (Item 11)
AK	Angela Kerrigan	Consultant (Item 11)

Apologies:

SI	Steve Igoe	Non-Executive Director

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** The Chair welcomed everyone to the Public Board Meeting. Apologies were received from Steve Igoe.	
2	**Declarations of Interest** No new interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on 6 April were approved as an accurate record.	
4	**Action Log** The Board noted that all actions had been closed or completed.	
5	**Patient Story** The Board received a video story of the experience of a patient who had experienced a range of services provided by the Trust. The patient described the multiple procedures she received across the Trust and commented on the quality of care and professionalism of staff. The Board acknowledged the patient had had several experiences and each one had been positive and was pleased the patient felt she had been treated as a person rather than a number. DH enquired whether there was a forum for patients to share their experiences for the purposes of learning. TF commented that an approach was already being taken by the Trust's Promise Groups whereby families, carers and patients on the Group provide intelligence for the Trust to improve and enhance the future patient experience. The Board **NOTED** the patient story.	
6	**Chair's Business and Strategic Issues** The Chair updated the Board on recent matters. The key points were: • The Trust continues to be in a strong position with system partners and build and maintain positive relationships • There will be an adjustment period for the Trust as change comes to the system	

	• Good opportunity to review the existing contracts to ensure cost and efficiency effectiveness • The Trust was being highlighted positively nationally for several reasons, for example the recruitment of international nurses The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH reported the number of patients in hospital with COVID was beginning to decrease. At the beginning of April there were over 100 inpatients in hospital with COVID and this had decreased to circa 65 patients by the end of month. There had been no patients requiring critical care for several weeks. The prevalence in the community remained uncertain due to the ending of community testing. However, hospital inpatients continue to be routinely screened on admission, and on day 3 and 6 of their admission. JH highlighted infection prevention and control measures had been updated following recent national guidance. However, due to high bed occupancy and the transmissibility of the current variant, there have been several COVID outbreaks within the Trust and these had been managed with close supervision from the infection prevention and control team. DH queried if the Office for National Statistics (ONS) infection survey provided a figure for the prevalence of COVID in the community for Wirral. NS confirmed Wirral had 113 cases per 100,000 and was the third lowest in Cheshire and Merseyside. Cheshire East and Warrington had the highest number of cases per 100,000 at 152. NS added the Trust's Clinical Advisory Group was forming decisions based on daily inpatient figures with COVID. JH noted the Trust declared 6 serious incidents (SI) in March 2022 and 3 RIDDOR events were reported to the HSE. JS queried if RIDDORs were being shared with the Audit Committee for the purposes of ensuring actions are completed. NS commented RIDDORs were being brought to Trust's Patient Safety and Quality Board and then to Quality Committee for oversight and assurance. CH would ensure the Audit Committee were provided with assurance that actions following a RIDDOR were completed. DMc highlighted that a new dashboard was being created in terms of a health and safety perspective as part of the new assurance reporting process for the Board.	Cate Herbert

	The Board **NOTED** the report.	
8	**Chief Operating Officer's Report** HK highlighted March and April had been challenging for both elective and non-elective patients and this was due to the unavailability of 5 theatres because of improvements being made to ventilation. 52 weeks wait performance had declined and there were now 637 patients waiting longer than 52 weeks, which was above the Trust's submitted trajectory of 550. The temporary loss of theatres had contributed to this position. Across Cheshire and Merseyside there are currently 16,695 patients waiting longer than 52 weeks for treatment. Cancer backlog performance against 31- and 62-day treatment continue to face pressures within colorectal and urology with the position unlikely to be achieved until quarter 4 2022/23. There were 17 patients that breached the 12 hours in emergency department (ED) target in month, the highest figure year to date. The Trust experienced significant bed occupancy levels as well as one of the highest months of ED attendances; this was also at the same time of the most recent surge of COVID-19 affecting the Trust. SR commented it was positive see a dynamic response from both clinical and medical specialities teams and queried how the approach taken could become business as usual to deliver sustainable elective and non-elective care for patients. HK confirmed there was a meeting with Clinical Leads w/c 9 May to review the systems and processes put in place to determine if any were sustainable to maintain for the medium/long term. Regular engagement with Clinical Leads also takes place fortnightly to consider resource implications and if the necessary impact is being made. DH queried when the 52 week wait performance target would be back on track. HK stated she was optimistic that the 52 week wait performance would be back on track for the beginning of quarter 3. This was due to volume of patients waiting and the challenges due to the theatre of ventilation issues. JS queried if a presentation could be provided on the lessons learned from the theatre ventilation issues as this had affected the Trust's ambition to catch up on the backlog.	

	MS confirmed the team would be able to provide a presentation to the Capital Committee once the work had been completed on the theatres. The Board **NOTED** the report.	Matthew Swanborough
9	**Board Assurance Reporting** **9.1 Quality and Performance Dashboard** The Executive Directors briefed the Board on metrics in the dashboard. It was noted that of the 35 indicators that were reported 23 were off off-target or failing to meet performance thresholds and 12 are on-target. DS drew attention to the 4 workforce indicators. Mandatory training and appraisal remained challenging to achieve the desired compliance target. Divisions have set an improved trajectories over the next 3 months and this was being managed in the Divisional Performance Reviews. Work was ongoing to review the appraisal approach around quality to ensure individuals have constructive conversations. Sickness absence increased in March after a reduction in February and this was due to COVID-19. The Trust was broadly in line with other Cheshire and Merseyside Trusts with a 6% – 7% sickness absence rate. Staff turnover over the 12-month period continues to increase. An internal working group had been set up to focus on both recruitment and retention, and there has also been an increased focus on retention due to the increasing rate of staff turnover. The working group would report to the Workforce Steering Group and onto Workforce Assurance Committee. JS welcomed the increased focus on retention and observed that despite the high numbers of staff joining the same number or higher were leaving at the same rate. JS queried if there was a patient safety risk because staff joining had generally less experience and knowledge of NHS processes. DS confirmed there was no indication about patient safety due to new staff joining the NHS but agreed to review the matter further to understand if there was correlation CC queried if any trends were known about the reasons for leaving the Trust. DS confirmed exit interviews are encouraged and one of the questions asked was the reason for leaving and no new trends had been identified.	Debs Smith

DH noted the lead time from appointment to start date was long for new staff joining the Trust. Discussion also took place around the aging workforce and risk of many retirements at one time.

NS highlighted the number of formal complaints received in the year had increased and this was mainly due to patient visitor restrictions at the hospital. NS confirmed the hospital was open to visitors from today (4 May) therefore the number of complaints may reduce.

Complaints were acknowledged in a timely manner, but challenges remain when responding fully to some complaints. Several complaints had been regarding access and over-crowding in the ED, and they had been the most pressured team in terms of workload.

JH highlighted the Trust was continuing to work towards the delivery of the WISE accreditation programme and objectives were being set for each Division through the Diversional Performance Reviews.

The Board **NOTED** the report.

9.2 M12 Finance Report

RC introduced the Month 12 Finance Report. The Trust was reporting a surplus of £0.028m, a negative variance against budget of £0.162m.

The Trust would receive £5.401m in respect of Elective Recovery Fund (ERF) for quarter 4 2021/22. However, these figures were based on estimates for month 12 and the figure is subject to change. This gives total ERF for 21/22 of £17.688m

The improved income position was offset by significant increase in expenditure in month 12, with variances of £0.390m in respect of pay (including COVID) and £3.784m in respect of non-pay.

The Board **NOTED** the report.

9.3 IPC Assurance Framework

TF presented to the Board the IPC Assurance Framework. In April the Trust made decisions outside of national guidance to ensure operational effectiveness and this resulted in the effectiveness of archiving full assurance.

TF reported to the internal Patient Safety and Quality Board in April that 4 areas had limited assurance and those main areas where the ability to identify infectious patients, isolating patients and preventing the risk of spread of infections.

	Since April national guidance had been updated and the Trust was now reporting only 3 areas of limited assurance. SR acknowledged the limited assurance related primarily to the structure of the building and queried if there was an opportunity for dynamic risk assessments and to use digital tools. TF confirmed there were opportunities to be explored and these would be led by the internal Clinical Advisory Group. Other Trusts had asked for advice regarding swapping patients and how the Trust uses existing clinical systems. The Board **NOTED** the report and **ACKNOWLEDGED** the controls in place to minimise the levels of risk associated with COVID-19 and the hard work during challenging times to sustain safe standards of care. **9.4 Monthly Maternity Services Update Report** TF presented the report and highlighted NHSEI recommended the Perinatal Clinical Surveillance Quality Assurance Report be presented monthly to the Board of Directors to ensure ongoing oversight of the quality of care in Maternity and Neonatal Services. TF confirmed there was nothing to escalate to the Board this month and the Trust was fully compliant. The Board **NOTED** the report.	
10	**People Strategy** DS presented to the Board the People Strategy and provided an overview of how the strategy was developed and the key priorities for the period 2022-26. JS commented the strategy had been well developed and it was positive that the relevant staff groups had been consulted throughout the process. JS queried the impact of artificial intelligence in the NHS on workforce, and if the Trust were relying on NHS providing guidance on how this would work or if the Trust would lead this. DS confirmed the Trust would have a role to play in artificial intelligence and the Trust's Digital Strategy would support us further with this. DH commented the People Strategy would provide a new narrative for the Trust to reconnect with staff directly now that Trust and the NHS was emerging from the pandemic. DH queried the metrics in determining successful delivery of any outputs.	

	DS confirmed the metrics would be set each year through a delivery plan and would be overseen by the Workforce Steering Group and Workforce Assurance Committee. SR queried about the connection between the yearly NHS staff survey and the Trust's own strategy to ensure both are not treated separately. DS confirmed the Trust would continue to encourage staff to take part in the yearly NHS staff survey as well as quarterly pulse surveys. Both would act as a continuous check and be used to inform delivery of the yearly strategic plan with any outputs used as key metrics. The Board **APPROVED** the People Strategy.	
11	**Ockenden 2 Gap Analysis** TF highlighted the final report of the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust, led by Donna Ockenden, was published on 30 March, and identified 15 immediate and essential actions essential actions for acute Trusts to undertake. DE presented to the Board the gap analysis of Ockenden 2 and the risk assessment of continuity of carer. HK queried what the Division's plans were regarding the escalation and accountability section of the gap analysis and what the plans were regarding the Trust aiming to increase resident consultant obstetrician presence where this is achievable. DE confirmed that from a medical workforce perspective, NHS England are working on a toolkit that specifically looks at obstetrics and gynaecology medical staffing. However, from a Local Maternity and Neonatal System (LMNS) perspective and NHS England the report focusses on transformation of services and staffing required. SL queried the escalation and accountability section of the gap analysis and enquired in regard to the details of the assurance mechanism to ensure staff were competent. DE provided detail on the assurance mechanisms and noted that the Trust was not able to provide an onsite consultant 24/7 and the Trust needed further advice to improve compliance with this recommendation. The Trust does meet the recommendation from Ockenden 1 regarding the two ward rounds and the number of hours that consultants spend on the ward. DE also confirmed the Trust had been critical on the gap analysis. This was due to the amount of evidence required for Ockenden 1,	

	and the team wishing to err on the side of caution when measuring compliance at this stage. NS confirmed no evidence had been found in the patient safety intelligence reports regarding any harm to patients due to inexperienced doctors, trainees, or locum doctors. JH confirmed an updated report should be brought back to Board for June to determine a more accurate gap analysis and an agreed timescale for those rated partially complaint. The Board **NOTED** the report, specifically the current compliance status with all 15 immediate and essential actions essential actions from part 2 of the Ockenden report recommendations.	Tracy Fennell/Debbie Edwards
12	**Communications and Engagement** SS introduced the Communications and Engagement Report, and the key points were: • Celebrating 40 years of Arrowe Park Hospital from 4 May, 40 years since Her Majesty, The Queen opened Arrowe Park Hospital. Several commemorative events were planned or underway to mark the occasion with staff, stakeholders, and the local community • The Vaccination Hubs continued to require campaign and communications support – especially stepping up of the booster programme, the changes to cohort eligibility and the roll out of the fourth booster dose to over 75s and the further roll out to children aged 5-11 years. • In month campaigns, included World Health Day 2022 where the climate change theme enabled us to highlight our Green Plan and we also took part in Bowel Cancer Awareness Month • In month media relations were reduced owing to being in the 6-week pre-election period ahead of the local elections on 5 May The Board **NOTED** the report.	
13	**Committee Chairs Reports** **13.1 Audit Committee** The Board **NOTED** the report. **13.2 Council of Governors** The Chair of the Council of Governors provided a verbal report to the Board on recent proceedings of the meeting held on 25 April.	

	The Council of Governors heard about the NHS Staff Survey and received a COVID-19 update. The Council of Governors also approved the recommendation to appoint two new Non-Executive Directors and a date for a future get together was being arranged for the Governors to meet in person with the Chair and JH. The Board **NOTED** the report. **13.3 Finance Business and Performance Assurance** The Chair of the Finance Business and Performance Assurance Committee provided a verbal report to the Board on recent proceedings of the meeting held on 28 April. The Committee were pleased to hear the Trust met its breakeven plan for the financial year. The Committee noted a 22% underperformance in gynaecology and the Committee sought more information. The Committee expressed concern about the backlog patient of equipment and the cost and were assured that this didn't pose a danger to patient and understood it was rather a risk to productivity. The Committee also considered and recommended several business cases for approval by the Board. The Board **NOTED** the report.	
14	**Cycle of Business** The Board **NOTED** the Cycle of Business.	
15	**Questions from the Public** No questions from the public were raised.	
16	**Any other Business** No other business was raised.	

(The meeting closed at 12:00)

Wednesday 1 June 2022

Chair Date

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 1 June 2022
Location	Boardroom, Education Centre, Arrowe Park Hospital

Members present:

DH	Sir David Henshaw	Chair
JS	John Sullivan	Non-Executive Director & Vice Chair
SR	Steve Ryan	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
SI	Steve Igoe	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Nicola Stevenson	Medical Director & Deputy Chief Executive
TF	Tracy Fennell	Chief Nurse
HK	Hayley Kendall	Chief Operating Officer
DS	Debs Smith	Chief People Officer
RC	Robbie Chapman	Interim Chief Finance Officer
MS	Matthew Swanborough	Director of Strategy & Partnerships

In attendance:

RM	Rajan Madhok	Non-Executive Director (observing)
SS	Sally Sykes	Director of Communications and Engagement
CM	Chris Mason	Chief Information Officer
DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
AM	Alan Morris	Public Governor
EH	Eileen Hume	Public Governor
TC	Tony Cragg	Public Governor
DT	Diana Tyson	Public Governor
PI	Paul Ivan	Public Governor

Apologies:

SL	Sue Lorimer	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
SH	Shelia Hillhouse	Public Governor

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence**	

	The Chair welcomed everyone to the Board of Directors in Public Meeting. Apologies were received as noted above. DH thanked JS for his contributions as a Non-Executive Director and Vice Chair, who would step down from the Board at the end of June.	
2	**Declarations of Interest** No new interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting were approved as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story of the experience of a patient who had motor neurone disease. The video described his and his carers experience of the Trust's emergency department (ED), ward setting and discharge. The Board acknowledged the patient and family experience was poor. TF agreed that it was disappointing to see this incident and highlighted the learning that it presented and the changes that can be made because of it. HK commented that she had discussed with the clinical teams about disaggregating minor illness/injury from majors and resuscitation in ED to support improved patient flow, response and waiting times. More discussions were planned to take place in June with a testing phase in July and HK agreed to provide an update at the July Board meeting. The Board enquired if this was an isolated incident and whether there is a systematic issue with dealing with vulnerable patients and patients with disabilities. JH added there is a general issue with community provision, which often means that those with long term conditions who become unwell are sent to A&E rather than put through a specialty specific referral. JH noted that solutions that have been explored are a passport for patients with long term conditions that describes the best place to go to seek treatment when they were unwell, and a carer's passport	Hayley Kendall

	SR suggested a carers corner in the ED to provide any necessary support to patients while they wait. It was also noted that staff in ED should have access to wellbeing and compassionate support given the difficult nature of their role. This is being reviewed with the People team. The Board **NOTED** the Patient Story.	
6	**Chair's Business and Strategic Issues** The Chair updated the Board on recent matters and highlighted that continued engagement at Wirral Place and Integrated Care System (ICS) level is required to ensure the ICS has a fresh perspective and provides strong leadership and positive outcomes. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH highlighted the prevalence of COVID in the community was reducing and this was reflected in the number of COVID inpatients within the hospital – currently 10. NHSE/I had reclassified the COVID incident from a Level 4 (National) to a Level 3 (Regional) Incident due to community cases and hospital inpatient numbers now seeing a sustained decline. JH highlighted the full business case had been submitted to NHS for the redevelopment of the urgent and emergency care unit at Arrowe Park Hospital. The new modular theatres had been delivered to Clatterbridge Hospital in April. The theatres were currently being fitted out and equipped, with commissioning and handover to the Trust scheduled for August 2022. JH reported that in April the Trust declared 8 serious incidents (SI), an increase of 3 on the previous month. Two incidents were reported to the Health & Safety Executive in accordance with Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). JH highlighted the Trust's Endoscopy Service had achieved the Joint Advisory Group (JAG) accreditation certificate from the Royal College of Physicians, demonstrating the Service meets the best practice quality standards. CC commented on the positivity from staff regarding Clatterbridge being refurbished. SR commented that the JAG accreditation was a great achievement. SR also queried if the Trust had received any monkeypox cases.	

	NS confirmed the Trust's Clinical Advisory Group had a process in place for identifying and treating any patients who display monkeypox symptoms; in addition to staff safety measures Arrowe Park Hospital had no inpatients at present but any presenting requiring admission would be referred to Royal Liverpool University Hospital where there was a specialist Tropical and Infectious Diseases Unit. DH requested a joint letter be drafted with Wirral Community Health and Care regarding the contract tenders and awards. The Board **NOTED** the report.	Janelle Holmes
8	**Chief Operating Officer's Report** HK highlighted in April 101.9% of outpatient activity was delivered against a performance target of 104.3%. For elective admissions 86.2% of activity was delivered against a target of 109.5%. Due to unplanned ventilation works, 6 theatres on the Arrowe Park Hospital were unavailable throughout April resulting in a reduction of elective admissions. The Trust did not meet the priority 2 performance (P2) month end trajectories for April. The month end final position was over reporting 81 P2 breaches against a month end plan of 66, due to the prioritisation that had to take place due to the lack of operating theatres. In April 730 patients waited longer than 52 weeks, which was higher than the Trust's trajectory of 550. The loss of 6 theatres led to this position with an 300 procedures lost as a direct result. No patient was waiting longer than 104 weeks. Cancer backlog performance against 31- and 62-day treatment continue to face pressures within colorectal and urology, with the position unlikely to be achieved until quarter 4 2022/23. The breast surgery 2-week wait was expected to recover by June 2022 with no patient waiting more than 7 days for an appointment. Ambulance handover delays were challenged within April with 23.9% of ambulances experiencing a 30-minute delay or more. Daily ED attendances averaged 257 in month, 1% higher than in the same period of the previous financial year. There were 39 patients that breached the 12 hours in ED target in month, the highest figure year to date. SI queried what was driving the total volume of daily ED attendances. HK confirmed there had been a general increase in minor injuries, and that behaviours had also changed as patients want to be seen in person.	

	JS commented that Wirral had an aging population, and it was possible that those on the waiting list would present in ED. JS queried if the there was a risk to staff wellbeing and morale for those working in ED. HK confirmed it was difficult to give assurance, given the challenges with demand and space but was confident that the new leadership team along with HR were engaging with the staff and providing support. The Board **NOTED** the report.	
9	**Board Assurance Reports** **9.1 Quality and Performance Dashboard** The Executive Directors briefed the Board on metrics in the dashboard. It was noted that of the 46 indicators that were reported 33 were off off-target or failing to meet performance thresholds and 13 are on-target. TF drew attention to the 4 pressure ulcers declared in April that were patients admitted with skin damage that had deteriorated during admission. DS reported that mandatory training remained static at 87% against a target of 90%. DS confirmed that improvement trajectories for Divisions had been set and was being monitored through the Divisional Performance Reviews. Sickness absence had reduced to 6.74% and short-term sickness absence had improved. Staff turnover for April remained the same as March at 14.1%. JS queried if there was a correlation between individuals who had a high sickness absence rate and no history of an appraisal. DS confirmed there is correlation with areas with low compliance on appraisal, high sickness absence and high turnover. SI queried if the Trust's mandatory training list had been reviewed recently and if the list remained current. DS confirmed a review of education governance was ongoing. JS commented on the dashboard itself and noted the Trust was achieving less than 1/3 of the indicators and queried if the dashboard reflected the Trust accurately given the level of senior leadership presence and assurance in place.	

	HK confirmed the dashboard needed to include certain statutory indicators but there were opportunities to include other indicators on specific focus areas. DM confirmed a date was to be arranged for statistical process control training in July for the Board. DH commented that he had called the hospital switchboard recently and found it difficult to reach the operators. It was confirmed that this was being looked into and telephony technology being reviewed. The Board **NOTED** the report. **9.2 Board Assurance Framework** DM highlighted that the annual review of the BAF was currently taking place to align current strategic risks with the Trust to annual objectives. DM confirmed a fully refreshed BAF would be presented to the Board in September. SI commented that good progress had been made to understand the nature of the risks and noted the Trust would be unable to mitigate all risks as some risks would inevitably be system owned. SR suggested the risk likelihood for the risk number 1.4 *(Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints)* was too high. DH requested SR raise this at the next Quality Committee meeting to discuss in more detail. The Board • **NOTED** the current BAF; • **APPROVED** the proposed amendments to the BAF; and • **NOTED** the proposals for the annual refreshment and updating of the BAF. **9.3 Month 1 Finance Report** RC introduced the Month 1 Finance Report, noting the Board has approved a deficit budget of £6.197m for the year. However, the budget has not yet been approved by NHSE/I and further operational planning is ongoing with NHSE/I RC highlighted about the importance of a achieving a break-even balance and outlined the options and self-imposed stretch targets the Trust was taking to deliver this. RC confirmed the ICB had explained there would be consequences for Trusts who did not receive a break-even balance.	

The Trust was reporting a deficit of £0.956m at month 1, an adverse variance against budget of £0.886m. This variance was attributed to our overspend on employee costs, driven largely by the continued use of escalation wards staffed at premium rates and underperformance in respect of Cost Improvement Programme. This was offset by reductions in non-pay spend, specifically clinical supplies, because of the unavailability of theatres due to ventilation issues.

RCE confirmed that the full balance of Elective Recovery Fund (ERF) income included within the plan would be received and would not be dependent upon activity. However, the introduction of the Aligned Incentive Payment (AIP) scheme represented a risk of financial penalties in respect of underperformance associated with the elective programme.

The Board **NOTED** the report.

9.4 Monthly Maternity Update (including Ockenden 2 Progress)

TF reported to the Board the monthly Perinatal Clinical Surveillance Quality Assurance Report to ensure ongoing oversight of the quality of care in Maternity and Neonatal Services. TF confirmed there were no areas of concern to raise this month.

TF highlighted that Ockenden 2 progress continues and confirmed the Board would be provided with a full review of actions at the July Board meeting, following an initial assessment of the 15 Immediate and Essential Actions at May's Board meeting.

SR commented that good progress continued to be made against Ockenden 2 and the Maternity Unit was safe and effective. No issues had been reflected by the Local Maternity and Neonatal System (LMNS). The Trust had also appointed a new Director of Midwifery following the retirement of the previous post holder.

The Board **NOTED** the report.

9.5 Digital Healthcare Update

CM provided the Board with a progress update on the development and agreement of operational plans to deliver the Digital Strategy strategic priorities of the Trust over the next 12 months.

CM also indicated future plans for reporting to Board to provide assurance at this level.

SI queried if the Trust had still been experiencing a delay in receiving IT equipment due supply chain issues.

	CM confirmed the duration had improved but some IT equipment such as servers and laptops were typically taking 2-3 months to be received. The Board **NOTED** the update. **9.6 Estates and Facilities Update** MS provided to the Board an overview of the report, including the proposed assurance dashboard for strategic priorities for the Estates Strategy which would be provided on an ongoing basis to the Board. SR queried if the asset management and maintenance survey had been completed yet. MS confirmed the survey was taking place and would be discussed further at a future Capital Committee meeting. The Trust would likely secure a managed service contract option instead of a replacement programme, with a provider recommendation being presented to the Board next April. The Board **NOTED** the update.	
10	**Operational Plan for 2022/23** HK commented that the report provides the Annual Operational Plan that incorporates all elements of activity and operational performance, workforce plans to deliver the annual activity plans, quality plans that outline the key priorities and a financial plan that ensures the Trust remains financially sustainable. The Board **NOTED and APPROVED** the report.	
11	**NHS Staff Survey 2021** DS noted that the results of the survey have been shared with the Workforce Assurance Committee since the embargo was lifted, and highlighted the next steps for disseminating both the results and our plans following those results. The Board **NOTED** the report.	
12	**Modern Slavery Statement** CH noted that this report provides the annual statement that the Board must approve in line with the Modern Slavery and Human Trafficking Act 2015. The Board **APPROVED** the updated statement for 2022/23.	
13	**Communications and Engagement**	

	SS gave an overview of the report and highlighted some of the key activity, including the upcoming leadership conference and the return to in person awards for staff side. The Board **NOTED** the report.	
14	**Committee Chairs Reports** **14.1 Audit Committee** The Chair of the Audit Committee provided a verbal report to the Board on recent proceedings of the meeting held on 23 May. The Committee had received the draft 2021/22 Quality Accounts as well as the draft 2021/22 Annual Report and Accounts and an external audit progress report. The Committee had approved each ahead of the Board of Directors meeting on 8 June whereby the Board would sign off each. The Board **NOTED** the report. **14.2 Quality Committee** The Chair of the Quality Committee provided a report to the Board on recent proceedings of the meeting held on 25 May. The Committee subsequent to the Audit Committee approved the draft 2021/22 Quality Accounts. The Committee received the Q4 2021/22 Learning from Deaths Report and the Serious Incident Review Panel's Chair's Report. The Committee also received an update on the Care Quality Commission Action Plan. The Board **NOTED** the report. **14.3 Workforce Assurance Committee** The Chair of the Workforce Assurance Committee provided a verbal report to the Board on recent proceedings of the meeting held on 26 May. The Committee received a staff story which highlighted the value of the Trust's Equality, Diversity, and Inclusion work. The Freedom to Speak Up processes continue to work well and there had been zero anonymous reports, which provided assurance that the reporting culture was changing positively. The Trust's People Strategy was moving to detailed implementation planning and success measures were being defined. The 2021 Staff Survey results was now with Divisions for detailed improvement planning.	

	The Board **NOTED** the report.	
15	**Questions from the Public** No questions from the public were raised.	
16	**Any other Business** No other business was raised.	

(The meeting closed at 12:15)

6 July 2022

Chair **Date**