NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

1 November 2023

13:00 GMT Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

Only PDFs are attached

- 0 Board of Directors Public Agenda.pdf
- 3 Board of Directors in Public Minutes - 4 October.pdf
- 4 Action Log - Public Board.pdf
- 7 Chief Executive Officer Report.pdf
- 8.1 WUTH IPR SPC Dashboard - Oct 2023 - 5 CFO.pdf
- 8.1.1 CFO Commentary M6.pdf
- 8.2 Chief Operating Officer Report.pdf
- 8.3 Monthly Maternity Report.pdf
- 8.4 BAF.pdf
- 8.5.0 Integrated Performance Report - Nov 2023.pdf
- 8.5.1 WUTH IPR SPC Dashboard - Oct 2023 - Intro.pdf
- 8.5.2 WUTH IPR SPC Dashboard - Oct 2023 - 1 COO.pdf
- 8.5.3 WUTH IPR SPC Dashboard - Oct 2023 - 2 MD.pdf
- 8.5.4 WUTH IPR SPC Dashboard - Oct 2023 - 3 CN.pdf
- 8.5.6 CN Commentary - Sept figures for Nov 2023 BoD.pdf
- 8.5.7 WUTH IPR SPC Dashboard - Oct 2023 - 4 CPO.pdf
- 8.5.8 CPO Commentary - for Nov 23.pdf
- 9 Winter Plan 2023-24 BoD November 2023.pdf
- 10.1 Estates and Capital Committee.pdf

10.2 Finance Business Performance Committee.pdf

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 1 November 2023
Time	13:00 – 15:00
Location	Hybrid

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	
Items for Decision and Discussion			
5.	Staff Story	Debs Smith	
6.	Chairs Business and Strategic Issues – **Verbal**	Sir David Henshaw	
7.	Chief Executive Officer Report	Janelle Holmes	
8.	Board Assurance Reports		
	8.1) Chief Finance Officer Report	Mark Chidgey	
	8.2) Chief Operating Officer Report	Hayley Kendall	
	8.3) Monthly Maternity Report	Tracy Fennell	Jo Lavery
	8.4) Board Assurance Framework	David McGovern	
	8.5) Integrated Performance Report	Executive Directors	
9.	Winter Operational Plan	Hayley Kendall	
Committee Chairs Reports			
10.	10.1) Estates and Capital Committee	Sir David Henshaw	
	10.2) Finance Business Performance Committee	Sue Lorimer	
	10.3) Council of Governors – **Verbal**	Sir David Henshaw	
Closing Business			
11.	Questions from Governors and Public	Sir David Henshaw	
12.	Meeting Review	Sir David Henshaw	
13.	Any other Business	Sir David Henshaw	

Date and Time of Next Meeting

Wednesday 6 December 2023, 09:00 – 11:00

Meeting	Board of Directors in Public
Date	Wednesday 4 October 2023
Location	Hybrid

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Deputy Chair
SR	Dr Steve Ryan	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
RM	Professor Rajan Madhok	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
HK	Hayley Kendall	Chief Operating Officer
DS	Debs Smith	Chief People Officer
MS	Matthew Swanborough	Chief Strategy Officer
TF	Tracy Fennell	Chief Nurse
MC	Mark Chidgey	Chief Finance Officer

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
SS	Sally Sykes	Director of Communications and Marketing
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.3
RMe	Dr Ranj Mehra	Deputy Medical Director – item 8.4
JTG	Jay Turner-Gardner	Deputy Director Infection Prevention and Control – item 14
EH	Eileen Hume	Deputy Lead Public Governor
PI	Paul Ivan	Public Governor
TC	Tony Cragg	Public Governor
KJ	Keith Johns	Public Governor

Apologies:

SL	Sue Lorimer	Non-Executive Director

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed all present to the meeting. Apologies are noted above.	

2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 6th September were **APPROVED** as an accurate record.	
4	**Action Log** It was noted that the Research and Innovation Committee had been postponed and therefore the action relating to that Committee would be deferred. The Board **NOTED** the action log.	
5	**Patient Story** The Board viewed a story from a patient who received care at Arrowe Park for COVID and subsequent complications who required intensive treatment. She has since been diagnosed with PTSD, and received significant support from Helen Hardwick in Critical Care, and Rob Jones, Psychotherapist and Trauma Specialist. The patient thanked the staff for their care and support. The Board asked that their thanks be passed to Helen and Rob. It was noted that a staff story would come to the next Board. The Board **NOTED** the patient story.	
6	**Chairs Business and Strategic Issues** DH stated that there are currently good relationships and communications in place with the ICB, and noted the decrease in no criteria to reside (NC2R) patients to 113. SI attended the CMAST meeting recently and noted that there was significant focus there on HR and workforce processes, particularly on what is in place already vs what might be required. DH stated that there are a lot of policy changes proposed at the moment, and that the Trust should focus on ensuring it provides a streamlined and effective service. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report**	

	JH gave an overview of the report, highlighting the update on industrial action and the visit from Professor Tim Briggs to the modular theatres. JH also noted the topics of discussion from the CMAST Board, and the HPMA award recently won by Sharon Landrum. The Board asked that their congratulations be passed to Sharon on her achievement. DH enquired if the lines of communication are open and that there are good working relationships with the unions involved in the national disputes. DS confirmed this is the case. The Board **NOTED** the report.	
8	**Board Assurance Reports** **8.1) Chief Finance Officer Report** MC noted the risk ratings against each statutory target, and reported that the Trust has reported a deficit of £11.6m against a plan of £11.9m. The resultant favourable variance of £0.3m is a deterioration on the M4 position (£0.5m favourable variance). MC highlighted the key variances and risks to this position. It was noted that external risks consist of industrial action and lost income, as well as potentially unfunded pay awards. Internal risks are achievement of the CIP programme, an overspend on Estates, and achievement of the full elective plan. Recovery of the position is being managed by the Exec team and reported to FBPAC. MC added that the Q2 forecast will come to the November Private Board. SI enquired where liquidity would be sourced when the capital spend catches up to the cash availability. MC replied that there is a process for accessing cash but that it comes with a cost, similar to a loan process. Discussion continued around the potential national response when this is required for those Trusts requiring liquidity. It was noted that whilst WUTH is mid-table for acute trusts in the North West, the region remains the most challenged nationally. The Board **NOTED** the report. **8.2) Chief Operating Officer Report**	

	HK noted current elective activity figures and noted there were two 78 week wait breaches in August which have been treated in September. There was focus on the C&M Hub usage at the GIRFT visit from Professor Tim Briggs which has resulted in increased interest, which could help improve uptake of sessions. HK stated that cancer performance is off trajectory in August for 62 and 104 days but that this has been recovered in September. However, there has been an impact on cancer treatments due to medical industrial action. DM01 compliance has dipped slightly but is due to be back on track in October. In terms of unscheduled care, HK reported that Type 1 attendances and ambulance conveyances have increased, which has impacted performance. With a refocus on ED, these figures have improved and are likely to continue in this way from October. NC2R patient numbers have reduced, and progress is being made with care homes and partner organisations to continue this. HK highlighted the issues the Trust is facing around mental health patients, as there are 3 rooms for assessment but there are often 2 and 3 times that many mental health patients in ED which therefore means there is nowhere for other walk in patients to be assessed. This is being escalated with the mental health provider, and there is an issue with mental health patient transportation and observation which is being escalated to PLACE given the Trust has no replacement service from the mental health provider. This has been escalated to their CEO. DH commented that he recently visited A&E and noted the positive culture in that department despite the disruption and operational challenges. The Board **NOTED** the report. **8.3) Monthly Maternity Report** JL gave an overview of the report, noting the appendices which have been appended in line with MIS requirements. The NW outlier report is no longer available and therefore the Trust is unable to benchmark regionally, noting the Trust still monitors the maternity and neonates performance dashboard. JL noted that the ATAIN and Self Assessment tool appendices are also new to the Board and provided in line with MIS requirements.	Jo Lavery

	SR noted that culture is a critical part of the positive work in this department, and noted that future reports would benefit from highlighting some of this positive work and some of the thing we are doing above and beyond the requirements. Discussion took place around the continuity of carer implementation, both the risks and benefits, and it was noted that a risk assessment is due to be reported to Board in January. The Board **NOTED** the report and the additional reports and updates included as required to be reported to the Board of Directors in October 2023. **8.4) Learning from Deaths Q1 2023/24** RMe stated that the SHIMI and HSMR are stable and within acceptable ranges. Factors impacting the SHIMI were found to be pneumonia, sepsis, and cerebrovascular disease, and work is ongoing to ensure all coding is accurate and whether there is any learning arising from this. RM noted that initial findings on the high levels of pneumonia arose from a number of patients being in their last months of life, and therefore these should have been coded another way. RMe noted that the Medical Examiner reviews all deaths, and perinatal/neonatal deaths also have a monthly review. Board were informed of the learning identified through Q1, which included medication errors and delays, and poor documentation practices which are being addressed. NS noted the quality assurance aspect of this report, and the assurances that learning is constantly being fed back into the system. NS recently met with the coroner who provided further positive feedback and was assured by our processes. RM enquired about the autism category. TF required that this is included in line with national priorities. The Board **NOTED** the report, the mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group. **8.5) Integrated Performance Report** NS reported a never event that occurred in September and which will be seen in the next set of Board papers. This will be the first of the Patient Safety investigations in line with the new PSIRF guidance. DH enquired about the work ongoing around “One Wirral.”	

	MS replied that this is being led by the council and that a further update will be provided to the next Estates and Capital Committee. DS reported that turnover looks high because of the rotation of junior doctors, which is expected at this time in the year. DS stated that if these figures were removed, turnover would be on target. TF highlighted the C Diff figures, and stated that work is continuing to manage this and improve the current performance. The Board **NOTED** the report.	
9	**Emergency Preparedness, Resilience, and Response (EPRR)** **9.1) Annual Report** HK noted the arrangements in place across the Wirral, and stated that the 2021/22 assessment and core standards are included in the annual report for Board's information. The Board **APPROVED** the annual report. **9.2) Core Standards Assessment** HK stated that the core standards assessment for this year has been completed and is appended for information. This will be submitted to the ICB for a challenge session and then submitted to the national team. The Trust is assessing compliance at 1% higher than last year, which is a fair reflection given the work involved to reach compliance with the new EPRR business continuity toolkit that was released in April which required all business continuity plans in the Trust be refreshed. LD enquired about the timescales to achieve the amber actions. HK replied that this is held on another document and agreed to circulate to Board. The Board **NOTED** the report.	Hayley Kendall
10	**Elective Recovery Self Assessment** HK noted the national trajectory for no 65 week waiters by the end of March, and stated that this target should be achievable. However, there is also a push for all of these to have appointments by the end of October, and the achievement of this will be impacted by industrial action. SR enquired if an assessment of complaints around wait times are reviewed.	

	HK replied that every patient "clock stop" is reviewed and validated, though there are some risks given the size of the list. JH commented that she signs off on all complaints and the process for her sign off includes checks such as these. DH noted the Trust recently received substantial assurance by MIAA for the management of waiting lists and requested the review be circulated to members. The Board • **NOTED** the report; and • **SUPPORTED** the submission to Cheshire and Merseyside ICB.	Cate Herbert
11	**Fit and Proper Persons Policy** DM stated that the policy presented follows from the adopted framework provided to Board last month, and that it has been reviewed by the Audit and Risk Committee. The Board **APPROVED** the policy for implementation.	
12	**Organ Donation Annual Report** NS gave an overview of the report, noting that organ donation is monitored by NHS Blood and Transfusion, and that the Trust has an Organ Donation Committee which is chaired by Steve Ryan. The report provides a breakdown of donations, and NS noted the small number of missed donations which were predominantly in the ED. Learning is being disseminated in that and other key departments to ensure awareness. RM enquired about the figures in the table which make it look like some of those interviewed weren't eligible. NS replied that that is the case but that we are required to have this discussion with everyone. NS would ask the team to look at the table presentation to make this clearer. The Board **NOTED** the report	
13	**Patient Experience Annual Report** TF highlighted the metrics performance in the report and the outcomes of the Promise Groups so far, noting year to date has included initiatives around the Voice of the Child. TF also noted next steps, and the work ongoing this coming year towards further co-production. DH noted the positive nature of this report and the work being undertaken.	

	The Board **NOTED** the report.	
14	**Infection Prevention and Control Annual Report** JTG reported that the IPC team declared and managed 63 COVID outbreaks, along with 9 outbreaks of Clostridioides difficile and 12 outbreaks of Norovirus throughout 2022-2023 on in-patient wards. The team is now fully established and the report provides insight into the surveillance areas and the WISE audit for IPC. SR noted that there was a good discussion on this at the Quality Committee, and thanked the team for a comprehensive report. The Board **NOTED** the report.	
15	**Safeguarding Annual Report** TF gave an overview of the report, indicating the appointment of a second Adoption Medical Advisor, the improvements in Protecting Vulnerable People learning compliance, and improvements in the compliance using the Child Protection Information sharing tool. TF added that the hope boxes, as created and presented by Michelle Beale to the Board earlier in the year, was being rolled out in areas across the country. TF noted Michelle had won a safeguarding leadership away for this innovation. The Board **NOTED** the report and the actions being taken to rectify areas for improvement.	
16	**Committee Chairs Reports** **16.1 Quality Committee** SR highlighted the reports received by the Quality Committee around IPC and complaints, and stated that there was a technical breach of duty of candour due to missed paperwork, though the patient did receive this verbally. SR added that it was good to see the improvements in WISE Accreditation, and stated that the report on PSIRF provided assurances around the positive impact this new system would have. NS noted that the Governance Support Unit are working to improve the complaints responses, by implementing a new process for complaints with different complexity levels. PSIRF has also started well, with good engagement from staff, and the team will be collating feedback from staff over the coming months. The Board **NOTED** the report.	

16.2 Audit and Risk Committee

SI commented that it is good to see the improvements in recommendation implementation, as well as the deep dives into various areas of risk and internal control. SI noted that the NEDs are given the opportunity to meet with the internal and external auditors at the end of each Committee, and there was very positive feedback provided at this last meeting.

The Board **NOTED** the report.

16.3 People Committee – Verbal

LD stated that the team are continuing to implement the retention strategy, including exit interviews, though it is too early to determine the impact of these. The Committee discussed the Just and Learning culture, and Freedom to Speak Up, and specifically the responsibility of the organisation to listen to the concerns being raised. DS will be leading some work on Responsibility to Listen.

LD also noted the effective management of disciplinaries and grievances, and the positive outcomes from recent court cases which were based on the effectiveness of the policies in operation.

LD stated that the Committee also noted that staff were being supported over the Lucy Letby outcomes, given this is a live situation for many of them, and noted that the risks specifically highlighted by the Committee included the move to a new payroll provider and the industrial action.

NS commented that the Trust is running Executive led listening events to support staff affected by the Letby trial and subsequent knock on changes to patient behaviours. The last Leaders in Touch session as well reiterated the Trust's commitment to speaking up and listening.

CC noted that there have been recent press stories about inappropriate behaviours especially towards female members of staff.

NS stated that there are processes in place around this, and that the Trust continues to emphasise a culture of listening.

SR enquired if the GMC survey would include questions around inappropriate behaviours.

NS replied that the new set of questions for this year would include this, but that past years have not.

	The Board **NOTED** the report. **16.4 Research and Innovation Committee** This Committee had been deferred and as such, no update was required.	
16	**Questions from Governors and Public** No questions were raised.	
17	**Meeting Review** Members reflected on the journey of the Board over the past years, and Board effectiveness.	
18	**Any other Business** No other business was raised.	

The meeting closed at 11:00)

Action Log
Board of Directors in Public
1 November 2023

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	5 July 2023	8.1	To provide a breakdown of the number of open studies to understand the totality and spread	Dr Nikki Stevenson	In progress. An update will be provided to Board following the next meeting of the R&I Committee.	January 2024
2.	4th October 2023	8.3	Future maternity reports to include information on the positive work being conducted above and beyond requirements.	Jo Lavery	Complete. This will be factored into future reports.	October 2023
3.	4th October 2023	9.2	EPRR Core Standards dashboard to be circulated to Board to demonstrate timescales for compliance.	Hayley Kendall	Complete. Circulated on 6th October 2023.	October 2023
4.	4th October 2023	10	MIAA Waiting List Management report to be circulated to Board.	Cate Herbert	Complete. Circulated on 6th October 2023.	October 2023

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
1 November 2023

Title	Chief Executive Officer Report
Area Lead	Janelle Holmes, Chief Executive
Author	Janelle Holmes, Chief Executive
Report for	Information

Report Purpose and Recommendations
This is an overview of work undertaken and important recent announcements in October. It is recommended that the Board of Directors: • Note the report

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

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

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

1	**Narrative**
1.1	**Industrial Action Update** The national pay dispute relating to Consultants and Junior Doctors is on-going. Further joint strike action took place from 2nd October 2023 to 5th October 2023. In a separate matter, the UNISON industrial dispute relating to retrospective re-banding for Clinical Support Workers continues. Strike action took place from 23rd to 27th October

	2023 and a further ten days of action is planned between 6th and 17th November 2023. Planning and mitigating actions take place via the Trust's EPRR route and impact across the Trust is carefully monitored.
1.2	**Serious Incidents and Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS)** The Trust declared no serious incidents in September. There were three incidents reported to the Health and Safety Executive (HSE) in September. All RIDDOR incidents are subject to a local review investigation to ensure appropriate action is taken to prevent a similar reoccurrence.
1.3	**Laboratory Information Management System (LIMS)** Following the Board approval to engage and commence with the regional move to a standardised LIMS platform the Diagnostics and Clinical Services Division has been engaging with the process. Tender evaluation documents are currently being developed and the clinical leads from laboratory services at WUTH are engaged in the process. Following the October Board discussion feedback has been given to the Cheshire and Merseyside Pathology Network that the Board requires assurance on the mobilisation and implementation of the new system, given the magnitude of change that is being proposed. Work continues with system finance leads to develop a solution to manage any revenue impact of the new system.
1.4	**MRI Team wins Radiography Award** The MRI Department have been selected as the North West Region Team of the Year 2023 in the Society of Radiographers 2023 Radiography Awards. The award nomination will also go forward to be judged for the overall UK award. The awards ceremony will take place in London on 8 November.
1.5	**UK Covid-19 Inquiry module 2 public hearings** The public hearings for module 2 of the UK Covid-19 Inquiry began on 3 October 2023 and will conclude on 14 December 2023. Module 2 is focused on core political and administrative governance and decision-making for the UK. It will examine the initial response, central government decision making, political and civil service performance as well as the effectiveness of relationships with governments in the devolved administrations and local and voluntary sectors. It will also assess decision-making on non-pharmaceutical measures and the factors that contributed to their implementation. Key political decision makers including Rt Hon Rishi Sunak MP, Rt Hon Boris Johnson and Rt Hon Matt Hancock MP are expected to give evidence in November and December 2023.
1.6	**System and Place Updates** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** CMAST Leadership Board met on 6th October and included member Trust Chairs. The purpose of the meeting was twofold: to provide an update to the Board on progress in delivery against CMAST Programme's workplan commitments; and to

reflect on the potential for system learning and approaches to assurance in response to incidents.

Diagnostics Programme

2023/4 delivery headlines:

- Against a backdrop of an overall increase in activity there has been a reduction in waiting times across specialities, including 100% reduction in patients waiting 79 wks+ and 74% reduction in patients waiting 26 wks+
- Increased productivity has been achieved through the introduction of single guidelines and productivity tools meaning performance can be monitored more accurately across C&M
- System first thinking is enabling innovation across C&M through increased:
    - capital investment
    - screening opportunities
    - cost avoidance through efficiency
- A number of key decisions on significant direction of travel issues have been taken in the first part of the year to further the following workstreams within the diagnostics programme:
    - Pathology target operating model
    - Pathology LIMS (Laboratory Information System)
    - Endoscopy transformation

Anticipated 2023/4 next steps and delivery milestones:

- Enhanced mutual aid offer to harmonise waiting times
- Continued development of shared digital systems
- Workforce – interventional radiology, workforce growth and development
- Development and testing of risk and gain share mechanisms
- Increased use of AI deployment across diagnostics

Elective Recovery

2023/4 delivery headlines:

- Waiting lists and PTL management:
    - C&M were one of the only ICBs in the country to eliminate 104 week waits in line with deadlines
    - C&M ERF performance has tracked 2% higher than the England average since May
- Reducing variation in care:
    - Mutual aid for over 6500 patients from 8 different trusts throughout C&M has been facilitated
- System resources:
    - C&M theatre utilisation performance started in the 2nd quartile a year ago, and rose to 4th best in the country during August
    - Over 2,600 patients have been treated in the shared elective hub

Anticipated 2023/4 delivery milestones:

- Waiting lists and PTL management
    - C&M are on track to eliminate 65 week waits by the end of March 2024

- Over 110,000 patients have been cleared from the potential breach cohort since April
- System resources:
  - The second cohort of attendees will be starting Theatre Academy to ensure the spread of best practice techniques throughout C&M

Clinical Pathway

2023/4 delivery headlines:

- The CPP Programme continues to follow its established methodology while continuing to follow identified road maps for orthopaedics, dermatology and ENT
- A current state assessment has been undertaken for gynaecology with the first workshop held over the summer

Anticipated 2023/4 next steps and delivery milestones:

- Orthopaedics - C2Ai risk stratification project currently ongoing in all Trusts that deliver orthopaedic services will conclude and further pathway standardisation will be progressed
- Dermatology – Continued focus on exploring the potential use of technology within the specialty, through establishment of pilots and stocktaking existing projects
- ENT – Further development of the collaborative alliance with key focus on workforce with support from the workforce programme
- Gynaecology – Prioritisation and evaluation of opportunities to agree an improvement roadmap
- Connecting with other workstreams to maintain connection when identifying and scoping of further specialties for inclusion in the programme

Finance, Efficiency & Value – Efficiency at Scale

2023/4 delivery headlines:

- Programme Director is in place and funding for the programme has been secured for 2023/4 and 2024/5
- Principles and a workplan for 2023/24 have been established for efficiency at scale. The workplan is aligned to the National Corporate Services Transformation Programme
- Highlights from workstreams include:
  - Funding for the medicines optimisation workstream has been secured for 2023/4 and 2024/5, a single governance structure is now in place for medicines to support this
  - A full procurement governance structure is in place and ICB Chief Procurement Officer commenced in September
  - An additional indemnity insurances review has been completed and £2.1m identified for review across C&M
  - A business case in under development for a single financial ledger and is supported by all trusts in C&M

Anticipated 2023/4 key targets include system delivery and contribution to:

- Medicines management will deliver an estimated £10m of savings in 2023/4, subject to continuation of ICB investment in infrastructure
- Procurement initiatives will deliver a £5m full year effect although the full value will not be realised until 2024/5
- Planning to support finance and legal workstreams to potentially release up to £1m in savings in 2024/25

Workforce

2023/4 delivery headlines:

- A detailed analytical review of workforce and benchmarking exercise has been completed with all C&M providers in conjunction with the ICB and the efficiency at scale programme
- AHP Faculty has been established with a robust system wide workplan
- Clear priorities and strategic workforce plan have been developed and aligned to support focus areas for the elective recovery and clinical pathway programmes
- A number of pilot sites have been identified to facilitate testing of a career pathway aimed at Band 6 ward nurses to support retainment and career progression
- After undertaking scoping exercises and in conjunction with system partners it has been agreed not to pursue projects at this time around developing a HCA collaborative bank or midwifery trainee nursing associate role

Anticipated 2023/4 delivery milestones will support delivery of objectives by:

- Ongoing funding will not be provided for the workforce programme in 2024/5
- A refocusing of the programme to identify commitments moving beyond 2023/4 has commenced

A planned discussion on the ICS Digital Strategy has been rescheduled to a future meeting.

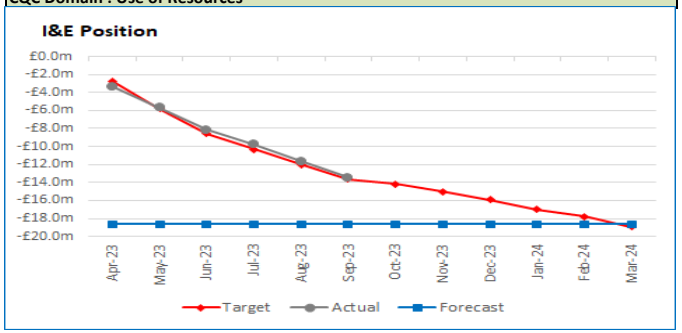
Place Based Partnership Board (PBPB) Update

The Place Based Partnership Board (PBPB) met on the 19th October, and discussed a number of reports, including quality and performance, finance, and risk reports from a Place perspective. Key among the reports was a proposal from Cheshire and Wirral Partnership NHS Foundation Trust for the creation of a new Urgent Response Centre (URC), to delivery and support modern models of care for service users in mental health crisis. The Board discussed the business case and approved that work should continue in creating this URC.

It is also worth noting that the PBPB has adopted WUTH's templates for future reporting on risk, assurance, and performance.

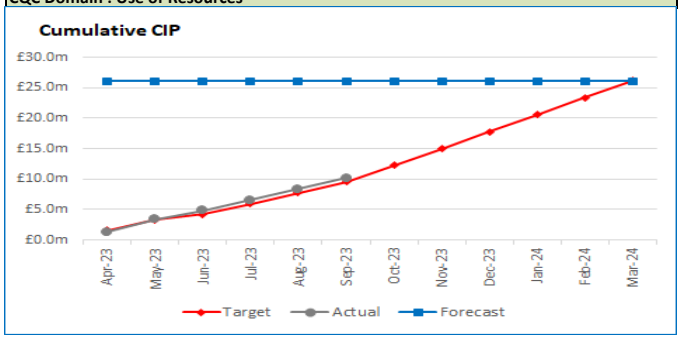
Chief Finance Officer

CQC Domain : Use of Resources



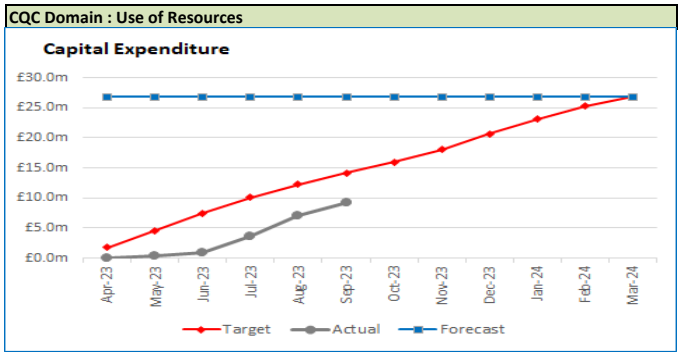
Sept-23
-£13.44m
Variance
Position better than plan
Target
-£13.65m

CQC Domain : Use of Resources



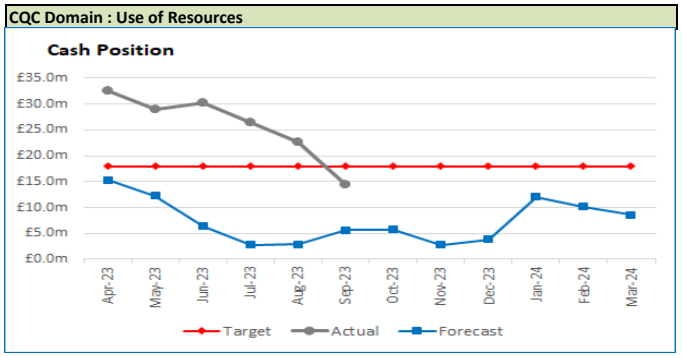
Sept-23
£10.20m
Variance
Position better than plan
Target
£9.58m

CQC Domain : Use of Resources



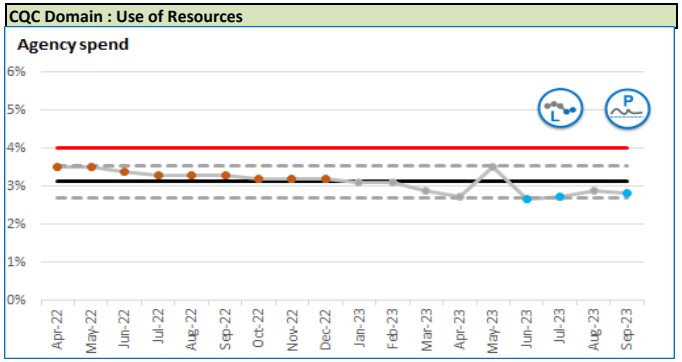
Sept-23
£9.2m
Variance
Position not worse than plan
Target
£14.1m

CQC Domain : Use of Resources



Sept-23
£14.5m
Variance
Position worse than plan
Target
£18.0m

CQC Domain : Use of Resources



Sept-23
2.83%
Variance
Position better than threshold
Threshold
3.70%

Chief Finance Officer

Executive Summary

In summary, the Trust is forecasting, with risks, that the financial plan for 2023/24 will be achieved. The key internal risks are CIP achievement, maximising elective activity and overspends within Estates. The main external risks are the impact of continued strike action and underfunded national pay awards. Failure to achieve the financial plan would place significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP).

As the Trust annual plan is a deficit of £18.9m, management of risks against this plan alone do not deliver long-term financial sustainability. The significant financial improvement required for sustainability will be delivered through the medium-term finance strategy approved by the Board in April 2023. Quarterly updates will be provided to the Board on progression of the strategy and the underlying financial position.

The risk ratings for delivery of statutory targets in 2023/24 are:

Statutory Financial Targets	RAG (M3)	RAG (Forecast)	Target Measure
Financial Stability			Achieve in-year financial plan
Agency Spend			Agency spend <= 3.7% of total pay
Financial Sustainability			Medium term financial recovery plan
Financial Efficiency			Variance from efficiency plan
Capital			Capital spend on track and within CDEL limit
Cash			Positive Trust cash balance

Note – Financial stability is an in-year measure of achievement of the (deficit) plan whereas financial sustainability reflects the longer-term financial position of the Trust and recovery of a break-even position.

The Board is asked to approve the increase in capital budget from £26.842m to £26.948m. This has been reviewed and endorsed by the Estates and Capital committee.

I&E Position

Narrative:

At the end of September 2023, Month 6, the Trust has reported a deficit of £13.4m against a plan of £13.6m, the resultant variance of £0.2m is a deterioration on the M5 position. The position assumes £3.2m of income to mitigate lost activity caused by industrial action. This is based on guidance from NHSE and the ICB but this has yet to be finalised.

The table below summarises this I&E position at M6:

Month 6	In Month			Year to Date		
Cost Type	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Clinical Income from Patient Care Activities	£37.3m	£36.5m	-£0.8m	£220.0m	£216.7m	-£3.3m
Other Operating Income	£2.6m	£2.0m	-£0.7m	£19.9m	£19.2m	-£0.7m
Total Income	**£39.9m**	**£38.5m**	**-£1.5m**	**£239.9m**	**£235.9m**	**-£4.0m**
Employee Expenses	-£29.4m	-£29.1m	£0.2m	-£177.2m	-£177.3m	-£0.1m
Operating Expenses	-£13.5m	-£12.5m	£1.0m	-£82.7m	-£80.3m	£2.3m
Non Operating Expenses	-£0.5m	-£0.4m	£0.1m	-£3.2m	-£2.0m	£1.2m
CIP	£1.8m	£1.8m	-£0.0m	£9.6m	£10.2m	£0.6m
Total Expenditure	**-£41.6m**	**-£40.3m**	**£1.3m**	**-£253.4m**	**-£249.3m**	**£4.1m**
Total	**-£1.6m**	**-£1.8m**	**-£0.2m**	**-£13.6m**	**-£13.4m**	**£0.2m**

Key variances within the position are:

Clinical Income – £3.3m adverse variance relates to planned-care activity cancelled due to strike action, capacity at the CMSC not taken up by ICS partners and lower than planned case mix in Surgery. There has also been a reduction PbR excluded drugs but this is offset by operating expenses.
Operating expenses – The underspend mirrors the variances within clinical income.
Non-operating expenses – our PDC dividend payable was lower than expected and interest payable has increased due to our high cash balance.
CIP – CIP is currently ahead of profile but delivery of the remaining plan will be very challenging.

It is confirmed that the Trust's agency costs were 2.8% of total pay costs compared to a maximum target of 3.7%.

Risks to position:
The main risks to the I&E position are:

- The Trust fails to fully deliver the recurrent Cost Improvement Programme (see below and separate agenda item).
- Continuation of strike action, with a consequential impact on both expenditure and income (elective activity).
- The overspend in Estates continues and no mitigations are identified.
- That the reducing trajectory of patients with no criteria to reside is either not maintained and/or reverts to previous levels.

Actions:
- Full identification and delivery of CIP schemes.
- Maximising elective capacity and recovery.
- Minimising the financial consequences of strike action whilst maintaining the safety of services.

Cumulative CIP

Narrative:

M6 continued our strong performance with £1.8m delivered in month against a plan of £1.8m. The Trust is ahead of the year-to-date plan of £9.6m by £0.6m.

Risks to position:

- That the momentum on identification and delivery of schemes is not sustained.
- That the capacity of the Trust is not sufficient to deliver across all improvement agendas.

Actions:

- Continuation of the Productivity and Improvement Programme.

Capital Expenditure

Narrative:

As per the table below, Board approval is requested to increase the capital budget from £26.842m to £26.948m. This reflects both additional PDC of £0.106m and virement between schemes; the most significant of which is to re-prioritise £0.869m of ICB backlog maintenance funding from pipework replacement into fire prevention.

Capital Plan 2023/24

Description	Original budget	Reprioritisation	New PDC for approval	Revised budget
CDEL				
Internally Generated	£3.965m			**£3.965m**
Urgent Maintenance (ICB)	£2.920m			**£2.920m**
UECUP	£5.800m			**£5.800m**
UECUP - PDC	£10.000m			**£10.000m**
CDC - PDC	£4.108m			**£4.108m**
CDC - PDC P2			£0.106m	**£0.106m**
Diagnostics Digital - PDC	£0.049m			**£0.049m**
Confirmed CDEL	**£26.842m**	**£0.000m**	**£0.106m**	**£26.948m**
Total Funding for Capital	£26.842m	£0.000m	£0.106m	£26.948m
Capital Programme				
Backlog maintenance	£1.397m	£0.869m		£2.266m
Medical equipment	£1.818m	£0.096m		£1.916m
Heating and chilled water pipework replacement	£2.920m	-£0.900m		£2.020m
IT equipment	£0.750m			£0.750m
UECUP - Trust funding	£5.800m			£5.800m
Approved Capital Expenditure Budget	**£12.685m**	**£0.065m**	**£0.000m**	**£12.752m**
UECUP	£10.000m			£10.000m
CDC	£4.108m		£0.106m	£4.214m
Diagnostics Digital	£0.049m			£0.049m
Confirmed PDC	**£14.157m**	**£0.000m**	**£0.106m**	**£14.263m**
Total Anticipated Expenditure on Capital	£26.842m	£0.065m	£0.106m	£27.015m
Under/(Over) Commitment	£0.000m	-£0.065m	£0.000m	-£0.067m

At month 6 the Trust has spent £9.2m against a cumulative target expenditure of £14.1m, an underspend of £4.9m. This is primarily driven by delays in respect of the UECUP and CDC schemes. We do not anticipate any underspend against plan at year end.

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

Risks to position:

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

Actions:

- CFO, with executive team to continue to work with divisions to manage re-prioritisation of schemes within the agreed budget.
- Estates and Capital Committee to continue to monitor progress and risks from capital projects.

Cash Position

Narrative:

The underlying deficit position places increasing pressure on the Trust's ability to maintain a positive cash balance. At 30/09 our cash balance was £14.5m. With our large capital programme and a planned deficit of £18.9m means that a positive cash balance is only possible by active daily management of the level of debtors and creditors. This arrangement is not sustainable but does mean the Trust does not need to draw upon additional borrowing from NHSE.

Positive progress has been made with Barclays in enabling access to the bank account for the Charity.

Risks to position:

- Achievement of the cash trajectory will place delivery of the Public Sector Payment Policy at risk.
- Failure to achieve the full recurrent CIP plan would mean that the cash trajectory cannot be achieved.
- The low level of cash headroom that the Trust is working within increases the impact of any delayed payment of income due to the Trust.

Actions:

- Continued daily monitoring and forecasting of the Trust cash position and PSPP performance.
- Monitoring and escalation of any aged debt delays.
- Confirmation of NHSE process should the Trust be required to request additional cash resource.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 8.2**
1 November 2023

Title	Chief Operating Officer's Report
Area Lead	Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Baily, Deputy Chief Operating Officer Nicola Cundle-Carr, Head of Business Improvement
Report for	Information

Report Purpose and Recommendations

This paper provides an overview of the Trust's current performance against the elective recovery programme for planned care and standard reporting for unscheduled care.

For planned care activity volumes, it highlights the Trust's performance against the targets set for this financial year. The Board should note that industrial action has had a significant impact on the ability to deliver the elective plan and a high number of patients cancelled for planned care, with the year to date activity position being behind plan.

For unscheduled care, the report details performance and highlights the ongoing challenges with achievement of the national waiting time standards and the significant impact of mental health demand on the Emergency Department (ED).

It is recommended that the Board of Directors

- Note the report

Key Risks

This report relates to these key risks:

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

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

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes

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

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

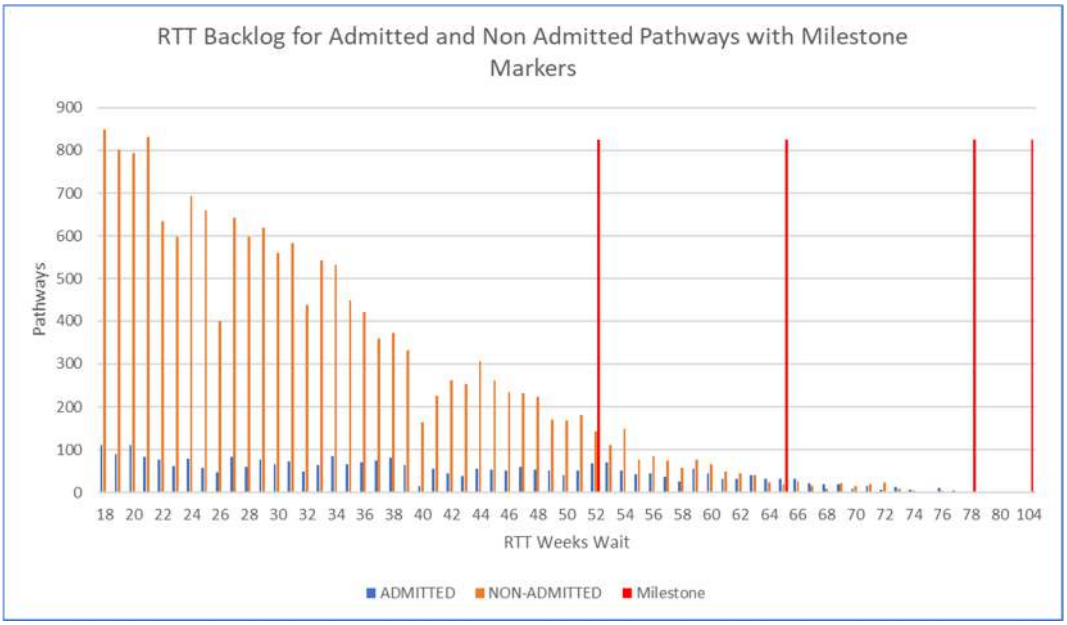
1	Introduction / Background
1.1	As a result of the large scale cancellation of all but the most urgent elective activities aligned to the national Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway. There is national recognition of the significant disruption to elective services during that pandemic. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny from September 2023.

2	Planned Care
2.1	**Elective Activity** In September 2023, the Trust attained an overall performance of 96% against plan for outpatients and an overall performance of 85% against plan for elective admissions as shown in the table below: **2023/24 Plan** **Activity Type** | Target for Sep | Actual for Sep | Performance **Outpatient New** | 12,058 | 11,474 | 95% **Outpatient Follow Up** | 30,322 | 29,070 | 96% **Total outpatients** | **42,380** | **40,544** | 96% **Day case** | 4,390 | 3,733 | 85% **Inpatients** | 671 | 561 | 84% **Total** | **5,061** | **4,294** | 85% The reasons for underperformance against plan relates predominantly to the impact of large scale cancellations for medical industrial action. There are a number of other areas of underperformance relating to the under utilisation of Surgical Centre sessions (relating to another NHS Trust), and two across medical specialities, both of which have recovery plans in place monitored by the Chief Operating Officer.
2.2	**Referral to Treatment (RTT)** The national standard is to have no patients waiting over 104 weeks from March 2023 and to eliminate routine elective waits of over 78 weeks by April 2023 and 65 week waits by March 2024. The Trust's performance at the end of September against these indicators was as follows: • 104+ Week Wait Performance – 0 • 78+ Week Wait Performance – 3 • 65+ Week Wait Performance - 347

- 52+ Week Wait Performance - 1781
- Waiting List Size - there were 44,147 patients on an active RTT pathway which is higher that the Trust's trajectory of 39,114.

An in-depth analysis of waiting list size has been undertaken and key actions to address are underway across the divisions, including early escalation to clinical teams and proactively managing patient pathways ahead of breach dates.

The graph below illustrates current RTT Backlog for admitted and non-admitted patients at the key milestones of 52, 65, 78 and 104 weeks:



WUTH have continued to support neighbouring Trusts by offering mutual aid to treat very long waiting patients through the Cheshire and Merseyside Surgical Centre and this will continue throughout the year.

2.3 Cancer Performance

Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for Quarter 2 to date:

- 2 Week Waits – performance at the end of September is 89.9% which is below the required standard of 93%. Outliers being Gynaecology and Upper GI. This performance is still positive when benchmarking across C&M although medical industrial action is having a significant impact on performance.
- Faster Diagnosis Standard (FDS) – was 73.37% in August (latest available data) against a National target of 75% by March 2024, marginal underperformance that is expected to be recovered from next month given the good track record over the last 6 months.
- 31 day treatment numbers - above trajectory and expected to continue.
- 62 day performance is currently below trajectory with 170 patients against a plan of 182.

	03/04	10/04	17/04	24/04	01/05	08/05	15/05	22/05	29/05	05/06	12/06	19/06	26/06	03/07	10/07	17/07	24/07	31/07	07/08	14/08	21/08	28/08	04/09	11/09	18/09	25/09
Actual 23/24	177	193	193	194	182	175	175	182	203	191	162	155	158	161	163	165	167	176	191	183	196	201	184	175	164	170
Recovery Trajectory	210	210	210	210	205	205	205	205	205	200	200	200	200	194	194	194	194	194	188	188	188	188	182	182	182	182
Pre-COVID Average	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51	51

- 104 day long waiters – performance is above trajectory at 57 against a plan of 37 for September:

	03/04	10/04	17/04	24/04	01/05	08/05	15/05	22/05	29/05	05/06	12/06	19/06	26/06	03/07	10/07	17/07	24/07	31/07	07/08	14/08	21/08	28/08	04/09	11/09	18/09	25/09
Actual 23/24	65	68	59	55	54	49	58	58	64	56	46	48	59	57	57	56	47	42	43	41	45	48	54	57	50	57
Recovery Trajectory	55	55	55	55	52	52	52	52	52	49	49	49	49	45	45	45	45	45	41	41	41	41	37	37	37	37
Pre-COVID Average	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12

As with all Trusts across C&M delivery of the 31and 62 day indicators remains a priority but given the increases in demand the recovery of performance against the targets remains a focus for 2023/24. The Trust is performing well when compared to other units but remains focussed on improving waiting times further for patient experience.
There continues to be a multi-disciplinary approach to improving the efficiency of cancer pathways and expect that this will support decreased waiting times over the next six months. It should be noted that medical industrial action is significantly impacting the ability to maintain

2.4 DM01 Performance – 95% Standard

In September 93.94% (pre-submission) of patients waited 6 weeks or less for their diagnostic procedure for those modalities included within the DM01. This is against the national standard of 95% and requirement for Trust's to achieve 90% by March 2024. The Trust has managed to achieve compliance for two months and plan to be back on track with the standard in October 2023 following a challenge in CT and ECHO over the summer months.

The Trust has commenced providing mutual aid for neighbouring Trusts for patients waiting longer than 6 weeks for diagnostic tests.

2.5 Risks to recovery and mitigations

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

The major risk to the delivery of the elective recovery programme is medical staff industrial action, given the significant volumes of patients cancelled during this action. On strike days, elective activity is being managed patient by patient to ensure minimal disruption to our patients whilst maintaining safe standards of care across the hospital sites, with a focus to keep patient cancellations to an absolute minimum.

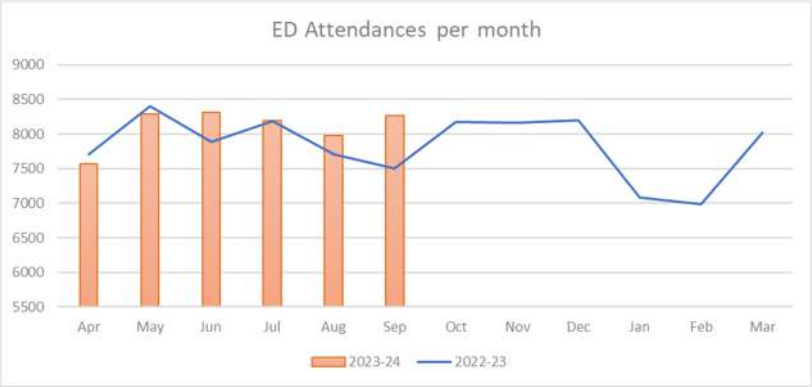
3.0 Unscheduled Care

3.1 Performance

September Type 1 performance was reported at 47.15%, which is below the 4-hour improvement trajectory. The combined performance for the Wirral site was 74.47%:

Type 1 ED attendances:	Type 3 ED attendances:
• 7,973 in August (avg. 257/day) • 8,264 in September (avg. 266 /day) • 4% increase from previous month	• 3,012 in August • 2,942 in September • 2% reduction from previous month

ED Attendances by month 2023/24 compared to 2022/23:

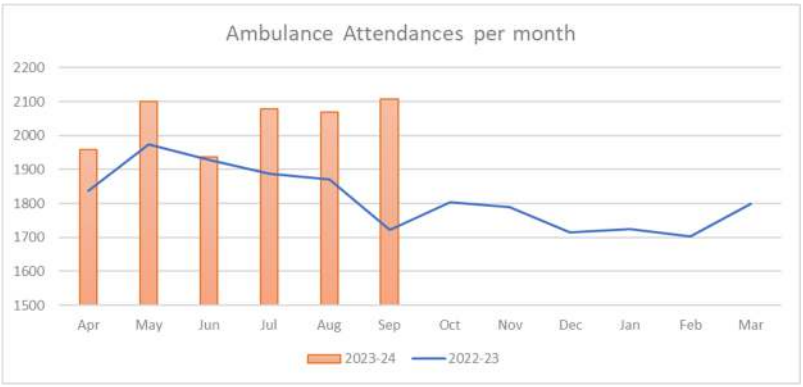


September was a significantly challenged month for Unscheduled Care with high level of demand from both walk-in attendances and ambulance conveyances. The increase in demand had a negative impact on Type 1 performance due to overcrowding in the emergency department and the lack of space to see and treat patients when demand peaks occur.

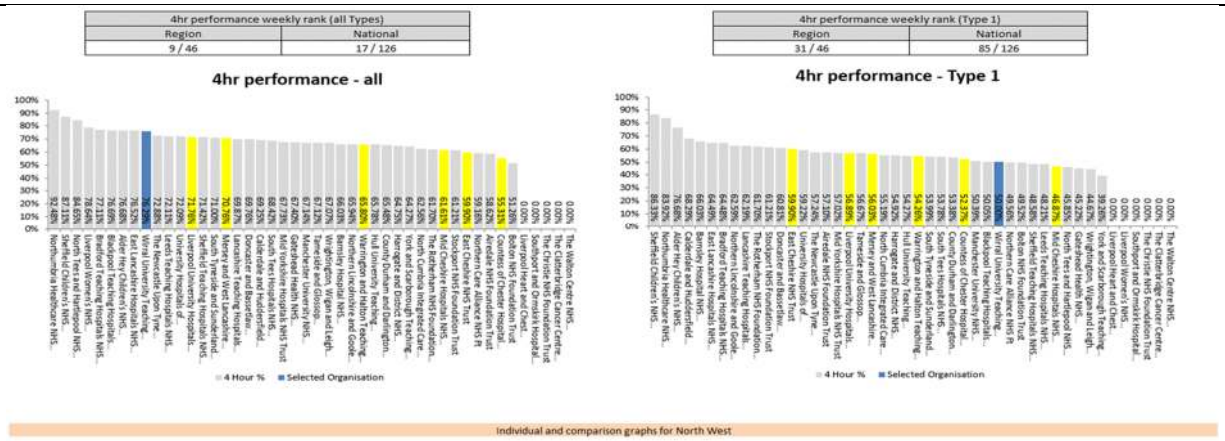
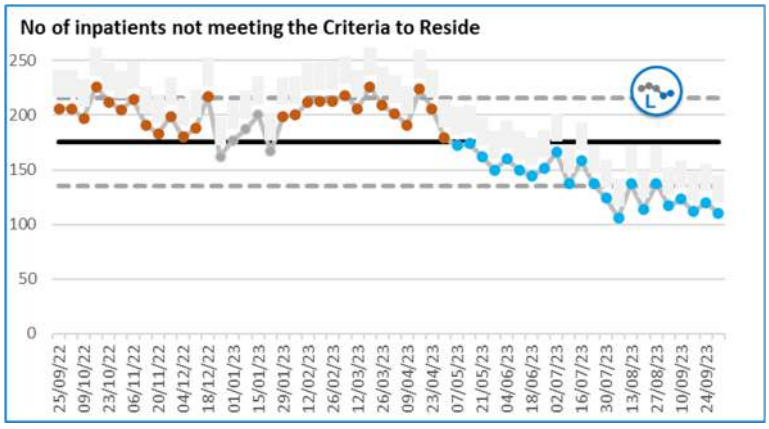
Earlier this year, the Trust invested in the opening of the Ambulance Arrival Zone (AAZ) to reduce the number of patients being cared for in the corridors and ensure timely handover from crews. In recent months, the pressures with increasing demand through ambulance conveyances has meant that the AAZ has reached its capacity limits, resulting in patients being cared for in the corridor and remaining in the care of the paramedic. This has had a negative impact on the handover times and the ability to release crews back into the community.

To improve the position, the Trust has met with colleagues from the Northwest Ambulance Service (NWAS) and agreed some key actions to be implemented in November. These include reviewing the ability to staff the first corridor and improving access to our UMAC area.

The graph below shows the ambulance attendances per month compared to the previous year.



The graphs below demonstrate Wirral's 4-hour performance for all attendances (blue bar) plotted against other acute providers in C&M (yellow bars) and Type 1 performance only:

	 The Trust also remains focused on the improvement work with achieving the 4-hour standard for Type 1 attendances. Recent improvements have been seen with changes to the alignment of the medical workforce across majors and minor departments and an increase in visibility of wait times for triage and medics. The Divisions have also contributed to improving the performance by developing their local action plans.
3.2	**Transfer of Care Hub development and no criteria to reside** Improvement with the reduction of the number of patients with no criteria to reside continues through the month of September. The reduction can be seen in the SPC graph below.  The weekly Executive Discharge Cell chaired by the Trust, remains in place, and continues to address difficult discharge pathways with support from system partners. Several winter schemes are due to come online from November, this includes the expansion of the Home First Service hosted by the local Community Trust. The service expansion in November which will provide an increase in capacity going into winter, with a focus on all patients on Pathway 1.
3.3	**Mental Health** Mental health continues to be a significant risk to the Trust and is considered the greatest risk to the Trust going into Winter. The Emergency Department continues to have patients waiting for an extended period of time for a bed from a mental health specialist or out of hospital community services. The Trust has raised concerns in relation to the removal of the mental health support for patients admitted under Section 136 of the Mental Health Act 1983 when the Prometheus contract expires on October 31st. The matter was raised with ICB and the Trust has since

	received confirmation from ICB that funding has been approved to cover the gap in service; this is being worked through and any further risks will be flagged to Board. The Trust continues to work with the local mental health provider regarding the reconfiguration of ED during the next phase of UECUP, which is expected in February 2024. The Trust has requested urgent action from them to support the Trust in ensuring the flow from ED from February onwards due to insufficient capacity to support patients with mental health conditions outside of the Mental Health Unit in ED.
3.4	**Risks and mitigations to improving performance** Mental health demand and the gap in provision for Wirral is the highest risk at present to delivering an effective UEC service to the local population. Industrial action continues to challenge ED capacity and flow across the hospital, however, the Trust continues to ensure robust plans are in place to ensure patient and staff safety is maintained.

4	**Implications**
4.1	**Patients** • The paper outlines challenges with waiting times for elective treatment longer than what the Trust would want to offer, but given the backlog from the Covid pandemic the Trust is in a strong position regionally in delivering reduced waiting times for patients.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • Cost of recovering activity from medical industrial action to ensure the Trust delivers against the national waiting time targets.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets in the main due to the impact of medical industrial action.

5	**Conclusion**
	The Board should note the ongoing improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the Trust's Winter Plan to ensure that the increase in demand over the winter can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED. Elective recovery remains a strong point and improvements have been seen in the 62 and 104 day wait cancer metrics and in achieving the FDS, but medical industrial action remains the highest risk to the elective recovery programme.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.3**

01 November 2023

Title	Monthly Maternity and Neonatal Services Report
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and AHPs Director of Infection Prevention and Control
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Information

Report Purpose and Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in September 2023 and an extended monthly report in October 2023, with the following paper providing a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

The purpose of this report is to provide a monthly update to the Board of Directors of key metrics reported to the Local Maternity and Neonatal System (LMNS) via the Maternity Dashboard.

Included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (September 2023) key quality and safety metrics.

This paper provides a specific update regarding Year 5 of the Maternity Incentive Scheme (MIS), together with all the identified reporting requirements required to the Board of Directors in the month of November 2023 which will be part of the evidence to support sign off for compliance.

Updates will be provided on the Trust position: -

- Avoiding Term Admissions in Neonates (ATAIN) action plan
- Transitional care action plan
- Maternity and Neonatal Voices Partnership (MNVP) annual report

It is recommended:

- Note the report
- Note the additional reports and updates included within the report required to be reported to the Board of Directors in November 2023

Key Risks

This report relates to these key Risks:

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

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
Nov 2023	Maternity & NNU Assurance Board	Monthly Maternity and Neonatal Services Report	For information

1	Perinatal Clinical Surveillance Quality Assurance Report
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (September 2023) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services. The dashboard is provided for information and whilst there is no indication to escalate any of the metrics to the Board of Directors, it should be noted since there is no longer a Northwest coast regional report being produced WUTH is no longer able to report on the benchmarking against other providers for rates such as stillbirth and neonatal deaths. Assurance has previously been provided to the Board of Directors this was escalated via the Local Maternity and Neonatal System (LMNS) for a resolution. However, a Northwest Regional Dashboard Tool for use by Regional Maternity and Neonatal Teams is available to provide bespoke reports for Regional Operational Performance reporting, this data is reported as of May 2023. On review of the dashboard the Board of Directors should be aware concerns regarding the accuracy of the data sources have been raised regionally, further escalating regionally it remains WUTH is still unable to benchmark against other providers.

2	Serious Incidents (SI's) & Maternity and Newborn Safety Incidents (MNSI)
	Serious incidents (SI's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). SI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity SI's across the region. There was one serious incident and Maternity and Newborn Safety Investigation (MNSI (previously HSIB)) case declared in September 2023 for maternity services. There were no serious incidents declared in August 2023 for Neonatal services.

3	Maternity Incentive Scheme (MIS) Year 5
	A detailed MIS update is included to Board of Directors Quarterly Maternity Services update, which will further inform Trust declaration with the MIS due for submission before a deadline of 1 February 2024. The compliance is being monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors an update on the position to meet the requirements of each safety action. A further compliance update will be included in the December 2023 Maternity and Neonatal monthly update report. There are several additional items included within the November monthly report which are a requirement to be reported to the Board of Directors and will be part of the evidence submitted within the MIS submission. An updated gap analysis is provided at **Appendix 2.** Provider compliance with the Ten Safety Action Standards across C&M is being monitored closely by the LMNS and there is a requirement for the declaration to be signed off by the ICB.

4	Avoiding Terms Admissions in Neonates (ATAIN) and Transitional Care (TC) Services
	The main objectives of the ATAIN and TC action plans are to have oversight and a programme of improvements in reducing avoidable term admissions into neonatal care and transitional cares services. The action plan is included at **Appendix 3** providing an update on the Trusts position and are requirements of the Maternity Incentive Scheme.

5	Maternity and Neonatal Voices Partnership (MNVP)
	As reported to the Board of Directors in the last monthly report in October 2023 and in line with the Maternity Incentive Scheme (MIS) Year 5 included at **Appendix 4** is the annual report of the Maternity and Neonatal Voices Partnership.

6	Implications
6.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
6.2	**People**

	• The proposals particularly around compliance with MIS Year 5 outline the safety action we aim to meet in order to deliver high quality care and demonstrate all safety measures. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement.
6.3	**Finance** • In order to meet the compliance of MIS Year 5 and deliver Maternity Continuity of Care as the default model, investment into the maternity and neonatal workforce is required and funding options are being explored.
6.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework

October/November 2023

Item 8.4

Contents

1. Introduction

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

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

Baker Tilly 2021

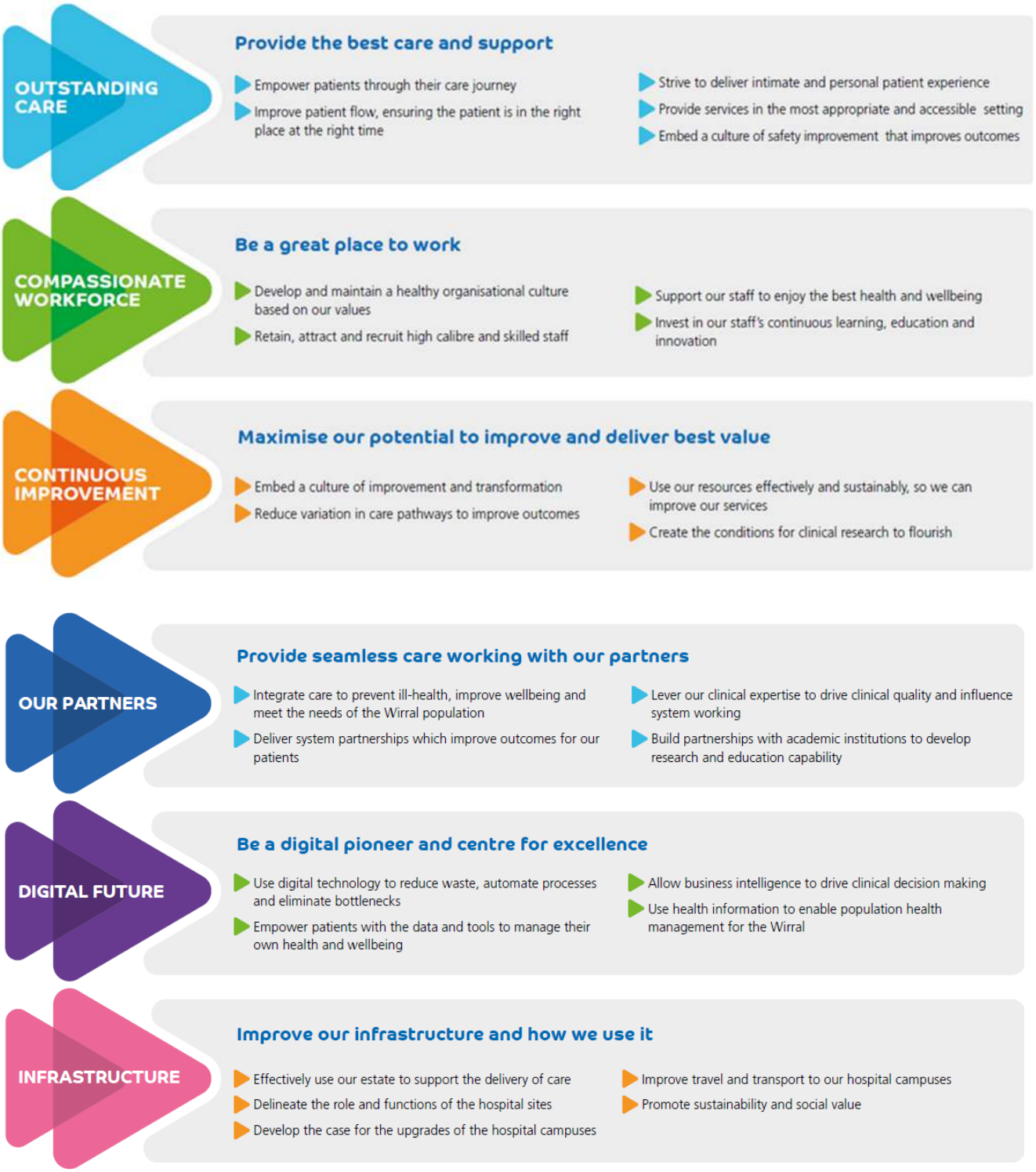
2. Vison, Strategy and Objectives

2.1 Our Vision

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

2.2 Our Strategic Objectives

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



3. Our Risk Appetite

3.1 Risk Appetite Statement

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

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

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

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

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

Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Outstanding Care – Provide the best care and support.	Various	The Trust has an OPEN risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation. The Trust has MINIMAL risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed. We have a SEEK appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.
SO2: Compassionate Workforce – Be a great place to work.	OPEN	The Trust Board has an open risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Trust is an employer of choice.
SO3: Continuous improvement – Maximise our potential to improve and deliver best value.	OPEN	The Trust Board is prepared to accept risk in relation to innovation and ideas which may affect the reputation of the

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

4. Operational Risk Management

4.1 Operational Risk Management

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

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

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

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

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

- All risks are identified that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust.
- Priorities are determined, continuously reviewed and expressed through objectives that are owned and understood by all staff.
- Risks to the achievement of objectives are anticipated and proactively identified.
- Controls are put in place, effective in their design and application to mitigate the risk and understood by those expected to use them.

- The operation of controls is monitored by management.
- Gaps in control are rectified by management.
- Management is held to account for the effective operation of controls.
- Assurances are reviewed and acted on.
- Staff continuously learn and adapt to improve safety, quality and performance.
- Risk management systems and processes are embedded locally across divisions, directorates and within corporate services including business planning, service development, financial planning, project and programme management and education.

The Trust shall achieve this by:

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

4.2 Risk Categorisation

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

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

5. Creating and Monitoring the BAF

5.1 Creation of the BAF

The original refreshed version of the BAF was created and approved in September 2021 following discussions and workshops with all Board members.

5.2 Monitoring the BAF

It was agreed that the BAF would be subject to ongoing refreshment and that it would be monitored as follows:

- Reports to the Board at each meeting.
- Reports to each meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy.
- Additional Audit and Risk Committee focus on 2 risks at each meeting.
- Reporting to every meeting of relevant Board Committees.
- Reporting to each meeting of the Trust Management Board; and
- Reporting to each meeting the Risk Management Committee.

5.3 Annual Refresh

The Risk Management Strategy outlines that the BAF will be subject to annual refreshment that will take place in March each year for approval in April.

6. Update Report

6.1 October/November 2023

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

The controls, assurance, and actions for each of the current strategic risks have been reviewed with Executive Team members and these changes will be reflected in the next iteration to Board.

6.2 Changes to the previous version

Following the last report, changes have been incorporated into the BAF where scorings have changed, or actions been completed/added.

It should also be noted that changes have now been made in relation to the frequency of BAF reporting across all fora.

6.3 Recommendations

Board is asked to:

- Note and approve the changes to the BAF.
- Note the changes in the frequency of BAF reporting across all fora.

Board Assurance Framework Dashboard							
Strategic Priority	**Risk No**	**Risk Description**	**Lead**	**Committee**	**Original Score 2022/23**	**Last Month**	**Current**
Outstanding Care **R, O, C, F**	1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	Chief Operating Officer	Quality and Board	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)
Outstanding Care **R, O, C, F**	2	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	Chief Operating Officer	Quality and Board	16 (4 x 4)	12 (3 x 4)	12 (3 x 4)
Outstanding Care **R, O, C, F**	3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	Medical Director	Quality	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)
Compassionate Workforce **O, C, F**	4	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Compassionate Workforce **R, O, C, F**	5	Failure of the Trust to have the right culture and organisational conditions/structure to deliver our priorities for our patients and service users.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Compassionate Workforce **R, O**	6	Failure to maintain our positive staff experience will adversely impact on staff motivation, engagement and satisfaction.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Continuous Improvement **R, O, F**	7	Failure to embed the Trust's approach to value and financial sustainability and Planning may impact on the achievement of the Trust's financial, service delivery and operational plans.	Chief Finance Officer	FBP	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)
Continuous Improvement **R, F**	8	Failure to deliver sustainable efficiency gains due to an inability to embed service transformation and change.	Chief Strategy Officer	Board	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)
Continuous Improvement **R, O, S**	9	Failure to have strong leadership and governance systems in place.	Chief Executive Officer	Board	12 (4 x 3)	8 (4 x 2)	8 (4 x 2)
Our Partners **R, S, F**	10	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability.	Chief Executive Officer	Board	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)
Digital Future and Infrastructure **R, O, C, F**	11	Failure to robustly implement and embed infrastructure plans including digital and estates will adversely impact on our service quality and delivery, patient care and carer experience.	Chief Strategy Officer	FBP and Board	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)
Infrastructure **R, O, C**	12	Risk of business continuity in the provision of clinical services due to a critical infrastructure or supply chain failure therefore impacting on the quality of patient care.	Chief Strategy Officer	Capital, FBP and Board	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)

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

Strategic Priority	Outstanding Care			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Chief Operating Officer	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)

Controls	Assurance
• Annual preparation and presentation of a system wide Winter plan in line with the National UEC Recovery Action. • Full participation in the Unscheduled Care transformation programme which includes working with Wirral Community Trust to reduce the numbers of patients attending the ED department who can have their care needs met away from ED. • Onsite support from Wirral Community Trust with the Chief Operating Officer focusing on admission avoidance and supporting early and timely discharge. • Monitoring of ED improvement plan and Wirral system urgent care plan by system Chief Operating Officers including Director of Adult Social care. • Health Economy CEO oversight of Executive Discharge Cell. • Additional spot purchase care home beds in place. • Participation in C&M winter room including mutual aid arrangements. • NWAS Divert Deflection policy in place and followed. • Rapid reset programme launched with a focus on hospital flow and discharge. • Continued communications out to primary care and to Wirral residents around only use A+E for urgent care requirements. • Regular meetings with the divisional leadership teams to ensure actions for improvement are delivered. • Business Continuity and Emergency Preparation planning and processes in place	• Trust Management Board (TMB) Assurance • Divisional Performance Review (DPR) • Executive Committee • Wirral Unscheduled Care Board • Weekly Wirral COO • Board of Directors • Finance Business and Performance Committee • Full unscheduled care programme chaired by CEO

Gaps in Control or Assurance	Actions
• The Trust continues to be challenged delivering the national 4 hour standard for ED performance. • The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criterion to reside means the Trust occupancy is consistently above 95%, making the delivery of the four target very challenging.	• There is one overall Emergency Department Improvement Plan in place which focusses on ambulance turnaround times, time patients spend in the department and all other national indicators. Following the completion of several service improvements the operational plan for ED will be revised to include new areas of focus as the new leadership team for that area commence in post. • Develop with Wirral system partners a response to the Improving Urgent and Emergency Care Services released in January 2023. • Response to the national 10 high impact actions in preparation for winter • Design of a more streamlined UEC pathway

Progress
Key Changes to Note • Additional action added relating to a system wide response required on delivering against the new national measures for improving urgent and emergency care, released in January 2023.

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

Strategic Priority	Outstanding Care			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Chief Operating Officer	16 (4 x 4)	12 (4 x 3)	12 (3 x 4)

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

Gaps in Control or Assurance	Actions
• There are several specialities whereby recovery plans do not achieve reasonable waiting times in year. These are subject to a full service review with the COO and action plans as required. • National challenge relating to medical staff rates of pay creating uncertainty with regards to additional capacity. • Industrial Action is creating a significant gap in plans to achieve the 2023/24 access targets • Impact of industrial action	• Continue with delivery of mitigation plans for scheduled care, managing the risk with the utilisation of the national policy on clinical prioritisation. • Explore alternative avenues of providing additional core surgical capacity to reduce the backlog of long waiting patients.

Progress
Key Changes to Note • Further gaps in controls identified relating to the impact of Industrial Action • Additional action added.

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

Strategic Priority	Outstanding Care			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Medical Director	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)

Controls	Assurance
• CQC compliance focus on ensuring standards of care are met. • Embedding of safety and just culture. • Implementation of learning from incidents. • Development and implementation of patient safety, quality, and research strategies. • Initiative-taking monitoring and review of quality and safety indicators at monthly divisional performance reviews. • WISE Accreditation Programme.	• Patient Safety and Quality Board oversight and monitoring of quality and clinical governance themes and trends through the Quality and Patient Safety Intelligence Report at Quality Assurance Committee • Review of modified harm review Trust process Mortality Review Group Oversight Regular board review of Quality Performance Report, highlighting exceptions and mitigations • GIRFT and GIRFT Monitoring • Quality and Clinical audits • IPCG and PFEG • CQC engagement meetings • Cheshire and Merseyside ICB oversight of Trust clinical governance, including Sis, never events action plans. • Internal Audit – MIAA • PSIRF introduced – 14 month project plan from September • Maternity self-assessment • Clinical Outcomes Group • CQC Maternity inspection

Gaps in Control or Assurance	Actions
• Fully complete and embedded patient safety and quality strategies • Industrial action impacts	• Complete implementation, monitoring and delivery of the patient safety and quality strategies. • Implementation of PSIRF • Monitoring Mental Health key priorities • Complete delivery of the Maternity Safety action plan • Ongoing review of IPC arrangements • CQC preparedness programme and mock inspections • Appointment of patient safety champions

Progress
Key Changes to Note • Additional actions added.

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

Strategic Priority	Compassionate Workforce			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives, including apprenticeship recruitment. • Vacancy management and recruitment systems and processes, including TRAC system for recruitment. • E-rostering and job planning to support staff deployment. • Strategic Retention Group in place and year 1 programme delivered. • Retention Task and Finish Groups in place for all relevant staff groups. • Facilitation in Practice programme. • Training and development activity, including launch of leadership development programmes aligned to the Trust LQF. • Utilisation of NHS England and NHS National Retentions programme resource to review and implement evidence based best practice. • Effective utilisation of the Trust's EAP has increased uptake across the organisation and is enabling staff to access support more quickly. • Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy' have been delivered across the Trust. • Career clinics have recommenced within Nursing and Midwifery	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy.

Gaps in Control or Assurance	Actions
• National shortages in certain roles and full rollout of clinical job planning are pending workforce planning processes. • Availability of required capabilities and national shortage of staff in key Trust roles. • Talent management and succession planning framework is yet to be implemented.	• Monitor impact of retention and recruitment initiatives. • Retention working group action plan. • Identification and review in progress of workforce data sources: ESR reporting, Exit Surveys and Staff Survey to determine priorities and inform the delivery action plan. • Roll out of clinical job planning. • Transfer of OH Services. • Actions from National Staff Survey. • Incorporation of NHS workforce plan into Strategy. • A 3-month pilot of the internal transfer for band 5 Registered Nurses and Clinical Support Workers has been launched • The electronic resignation and exit interview pilot has been completed and is in the process of review.

Progress
Key Changes to Note • N/A

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

Strategic Priority	Compassionate Workforce			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Just and Learning Culture Group in place and year 1 programme of work delivered. • Leadership Qualities Framework and associated development programmes and masterclasses. • Just and Learning culture associated policies. • Revised FTSU Policy. • Triangulation of FTSU cases, employee relations and patient incidents. • Lessons Learnt forum.	• Workforce Steering board and People Committee oversight. • Internal Audit. • PSIRF Implementation Group. • Lessons Leant Forums. • Increased staff satisfaction rates relating to positive action on health and wellbeing.

Gaps in Control or Assurance	Actions
• The potential for national and local industrial action	• Just and learning Communications Plan. • Provision for mediation and facilitated conversations. • SOP for supporting staff affected by unplanned events. • Launch Patient and Syllabus Training. • Embed the new approach to coaching and mentoring • Embed new supervision and appraisal process • Develop and implement the WUTH Perfect Start • Targeted promotion of FTSU to groups where there may be barriers to speaking up. • Completion of national FTSU Reflection and Planning Tool •

Progress
Key Changes to Note • Addition of controls. • N/A

BAF RISK 6	Failure to maintain our positive staff experience will adversely impact on staff motivation, engagement and satisfaction.

Strategic Priority	Compassionate Workforce			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Year 2 of flexible working policy. • Implementation of the Perfect Start. • Develop an Engagement Framework • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • Leadership Qualities Framework and associated development programmes and masterclasses. • Bi-annual divisional engagement workshops • Staff led Disability Action Group.	• Workforce Steering board and People Committee oversight. • Internal audit.

Gaps in Control or Assurance	Actions
	• Year 2 of flexible working policy. • Implementation of the Perfect Start. • Develop an Engagement Framework • Embed the WUTH LQF and associated development offer • Deliver year 2 of the flexible working programme • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • Launch of new CEO Award • Launch 'Employee of the Month' and 'Team of the Month' awards • Development of staff stories library.

Progress
Key Changes to Note • Addition of controls.

BAF RISK 7	Failure to embed the Trust's approach to value and financial sustainability may impact on the achievement of the Trust's financial, service delivery and operational plans

Strategic Priority	Continuous Improvement			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Chief Finance Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document.	• Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • Monthly COO checks and monitoring. • Execs to agree recovery plan to achieve 23/24 financial plan.

Gaps in Control or Assurance	Actions
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Limited assurance on delivery as plans are in early stages and timelines for delivery still subject to change. • Uncertainty of impact of industrial action	• CFO to present a full review of Forecasting to the FBPAC. • Continue delivery of CIP programme and maintain oversight of divisional progress. Ongoing. • Complete benchmarking and productivity opportunities review pack. • Develop 3 year CIP Plan to include all trust wide strategic and transformational plans.

Progress
Key Changes to Note • Wording of the Risk altered. • Additional actions identified.

BAF RISK 8	Failure to deliver sustainable productivity gains due to an inability to embed service transformation.

Strategic Priority	Continuous Improvement			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Chief Strategy Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• Programme Board oversight. • Service improvement team and Quality Improvement team resource and oversight. • QIA guidance document implemented as part of transformation process. • Implementation of a programme management process and software to track delivery. • Quality impact assessment undertaken prior to projects being undertaken.	• Quarterly Board assurance reports, Monthly Programme Board chaired by CEO to track progress. • COO monthly tracking of individual projects with scrutiny at programme board meetings. • Rotational presentations by divisions to FBPAC meetings with effect from October 2021. Monthly CIP report to FBPAC. • MIIA internal audit review of Cost Improvement Programmes, which highlighted an audit opinion of moderate assurance. • External audit report.

Gaps in Control or Assurance	Actions
• Lack of protected time due to conflicting priorities in service delivery, particularly in relation to clinical staff. • Lack of clarity on H2 arrangements and financial arrangements for 2022/23 period. • Historic estate infrastructure system working. • Lack of clarity on financial arrangements for 2022/23 period. • Historic estate infrastructure. • Ability to deliver system wide change across Wirral NHS organisations. • Lack of clarity on H2 arrangements and financial arrangements for 2022/23 period, limits level of assurance in board and committee reports.	• Implementation and delivery of Cost improvement and Transformation Programmes for 22/23 and delivery of 22/23 Improvement Programme to plan. • Implementation of revised Cost Improvement approach.

Progress
Key Changes to Note • N/A

BAF RISK 9	Failure to have strong leadership and governance systems in place.

Strategic Priority	Continuous Improvement			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Chief Executive Officer	12 (4 x 3)	8 (4 x 2)	8 (4 x 2)

Controls	Assurance
• Board oversight and governance reporting. • Board Development Programme. • Well led and maturity assessments in place. • Board Appraisal and Development Plans. • Clear recruitment process. • NHS Code of Governance. • Forward plan and work programme.	• Board and Committee reporting. • Development Programme. • Assessment and Adoption of the NHS Code. • Internal Audit.

Gaps in Control or Assurance	Actions
• N/A	• Continuous review of Governance structure and reporting. • CQC Inspection readiness programme.

Progress
Key Changes to Note • Additional control added.

BAF RISK 10	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and a long term threat to service sustainability.

Strategic Priority	Our Partners			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Chief Executive Officer	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)

Controls	Assurance
• WUTH senior leadership engagement in ICS. • Wuth Strategic intentions are aligned with the ICS, for example ensure master plans and decisions are taken as a system to optimise the way we use public estate across Wirral to deliver organisation and ICS objectives. • National guidance on PLACE based partnerships Legislation framework. • ICS design framework. • ICS Body governance. • Input of Trust CEO and Director of Strategy into Outline of the ICP Structure.	• CEO and Director of Strategy updates to Board and Executive Director meetings. • Chair, CEO and Chief Strategy Officer attendance at Healthy Wirral Partners Board. • Secondment of Head of Strategic Planning to develop ICP/Place operating model. • ICS Chair updates, ICS meetings, ICS Self-assessment submission. • CMAST CEO and Directors of Strategy meetings. • Healthy Wirral Partners Board.

Gaps in Control or Assurance	Actions
• Time to establish C&M ICS accountability and governance infrastructure, Delays in the consolidation of CCGs to ICS. • Place lead appointment for Wirral. • Function and role of C&M ICS working with the Trust and Formal.	• Development of PLACE governance arrangements with Wirral partners. • Completion of ICS and PLACE governance self-assessment. • Development of PLACE operating model.

Progress
Key Changes to Note • Additional actions identified.

BAF RISK 11	Failure to robustly implement and embed infrastructure plans including digital and estates will adversely impact on our service quality and delivery, patient care and carer experience, and our ability to transform services in line with our aspiration to be a leader in our ICS.

Strategic Priority	Digital Future and Infrastructure			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Chief Finance Officer and Chief Strategy Officer	16 (4 x 4)	16 (4 x 4)	16 (4 x 4)

Controls	Assurance
• Assessment of Capital requests. • Capital bid process. • Capital Contingency. • Risk management via Ulysses. • Reporting to Capital and Estates Committee.	• Funding approvals. • Scale of projects versus resources. • Capital Committee. • Governance structures for key projects.

Gaps in Control or Assurance	Actions
• N/A	• Continue to track delivery of 23/24 schemes through Capital Management Group and Capital Committee • Prepare for 24/25 capital schemes as part of 3 year capital programme • Further develop reporting to Capital Committee • Deep dive of Estates risks related to backlog maintenance, through Capital Committee • Continual reassessment of requests through Capital Management Group

Progress

Key Changes to Note

- Delays in completion of all phases of the Urgent and Emergency Upgrade Programme (UECUP), with notification made to Trust Board and NHS England.
- Assessment of potential future delays to the UECUP Programme undertaken by Trust
- Deep dive completed on risk related to Lifts across Arrowe Park Hospital campus

BAF RISK 12	Risk of business continuity and the provision of clinical services due to a critical infrastructure supply chain failure therefore impacting on the quality of patient care.

Strategic Priority	Infrastructure			
Review Date	01/10/23	Initial Score	Last Month	Current
Lead	Chief Strategy Officer	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

Controls	Assurance
• Implementation of capital programme, which includes remedial works at Clatterbridge. • Senior Clinician input in key decisions around key areas such as critical care. • Estates Strategy. • Agreed 3 year Capital Programme. • Business Continuity Plans. • Stock capital process. • Procurement and contract management. • Bespoke digital healthcare team. •	• Capital Committee oversight. • FBP oversight of capital programme implementation and funding. • Board reporting. • Internal Audit Plan.

Gaps in Control or Assurance	Actions
• Delays in backlog maintenance.	• Develop Arrowe Park master plan and Prioritisation of estates improvements. • Asset audit. • Implementation of the new Capital Assets and Facilities system. • Deep dive of Estates risks related to backlog maintenance, through Capital Committee • Heating and ventilation programme. • Replacement of generators. • Assessment of business continuity to address increasing critical infrastructure risks to be undertaken in August and September 2023.

Progress
Key Changes to Note • Additional actions identified.

Appendix – Risk Scoring Matrix

Risk Scoring and Grading:

Use table 1 to determine the consequence score(s) (C)
Use table 2 to determine the likelihood score(s) (L)
Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score)
Assign grade of risk according to risk score.

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
5 Catastrophic	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	□	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Negligible	**1**	**2**	**3**	**4**	**5**

Risk Grading	Risk Score
Low risk	1 to 3
Moderate risk	4 to 6
High risk	8 to 12
Significant risk	15 to 25

Appendix – Risk Appetite Scoring Matrix

Risk levels ▶ / Key elements ▼	0	1	2	3	4	5
	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	**Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	**Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	**Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	**Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	**Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.5**

01 November 2023

Title	Integrated Performance Report
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 September 2023 It is recommended that the Board: • notes performance to the end of September 2023

Key Risks
This report relates to the key risks of: • Quality and safety of care • Patient flow management during periods of high demand

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

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

1	**Narrative**
1.1	Following further discussion with the Executive Team and the Board, the performance metrics for inclusion, format and title of the report have been amended. The metrics are grouped under the responsible Executive Director, with the relevant CQC domain noted against each metric.

	Grouping the metrics by CQC domain shows the following breakdown for the most recently reported performance: **Summary of latest performance by CQC Domain:**

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	3	4	7
Effective	0	1	1
Caring	2	2	4
Responsive	4	18	22
Well-led	3	0	3
Use of Resources	4	1	5
All Domains	16	26	42

2	Implications
2.1	Implications for patients, people, finance, and compliance, including issues and actions undertaken for those metrics that are not meeting the required standards, are included in additional commentaries and reports.

Integrated Performance Report - October 2023

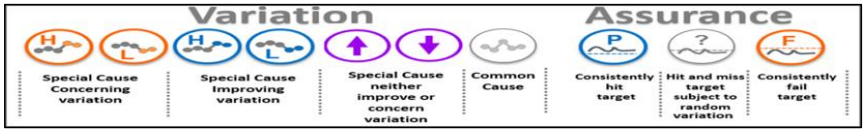
Approach

The metrics for inclusion have been reviewed with the Executive Director team.
Performance is represented in SPC chart format to understand variation, and a summary table indicating performance against standards.
The metrics are grouped into Executive Director portfolios, with individual metrics showing under their CQC Domain.
Commentary is provided at a general level and by exception on metrics not achieving the standards set.

Summary of latest performance by CQC Domain:

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	3	4	7
Effective	0	1	1
Caring	2	2	4
Responsive	4	18	22
Well-led	3	0	3
Use of Resources	4	1	5
All Domains	16	26	42

Key to SPC Charts:



Issues / limitations

SPC charts should only be used for 15 data points or more. Some of the reported metrics only apply from 2022, so will take time to build up.
SPC format does not support including a target where it is variable over time, eg a reducing trajectory for long waiters.
Alternative formats of charts are included where they are more appropriate.

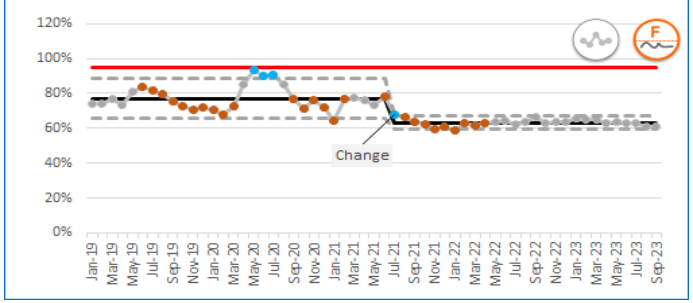
Changes to Existing Metrics:

Metric	Amendment
Clostridioides difficile (healthcare associated)	Threshold target for 2023/24 is now confirmed - maximum 71 cases for the year.
% Appraisal compliance	Likely change of the target threshold to 90% from Q3 2023/24

Chief Operating Officer (1)

CQC Domain : Responsive

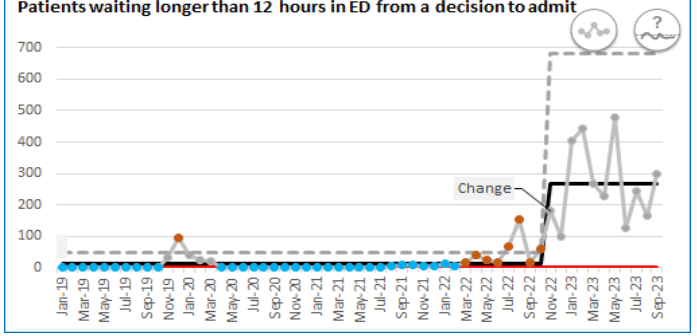
4-hour Accident and Emergency Target (including APH UTC)



Sept-23
61.3%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

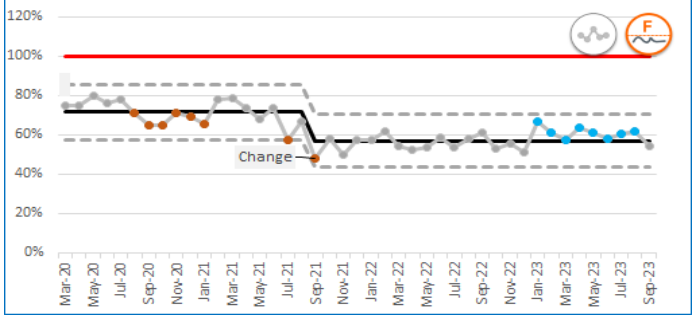
Patients waiting longer than 12 hours in ED from a decision to admit



Sept-23
297
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

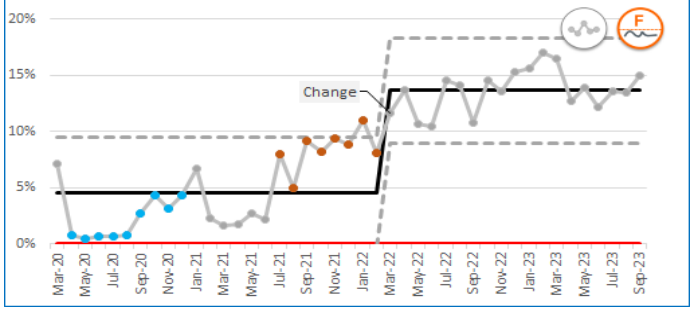
Time to initial assessment for all ED patients - % within 15 mins



Sept-23
54.1%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

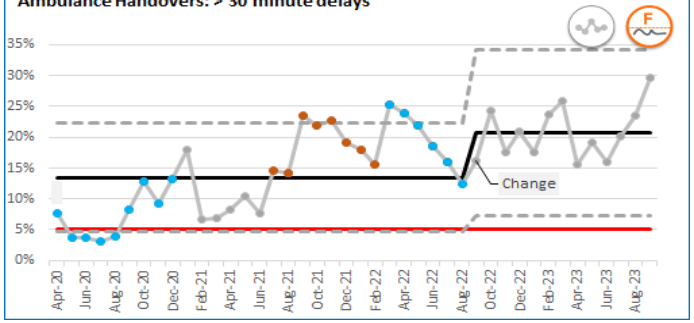
Proportion of patients more than 12 hours in ED from time of arrival



Sept-23
15.0%
Variance Type
Common cause variation
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

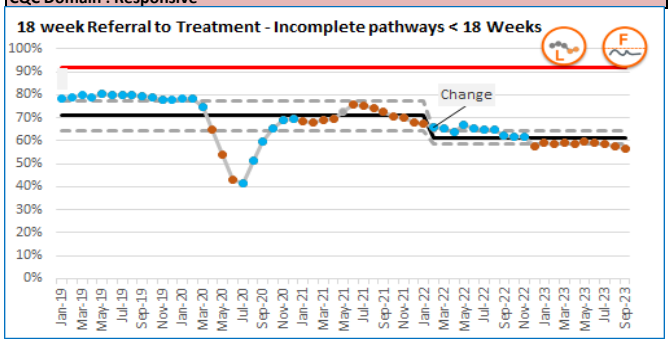
Ambulance Handovers: > 30 minute delays



Sept-23
29.6%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

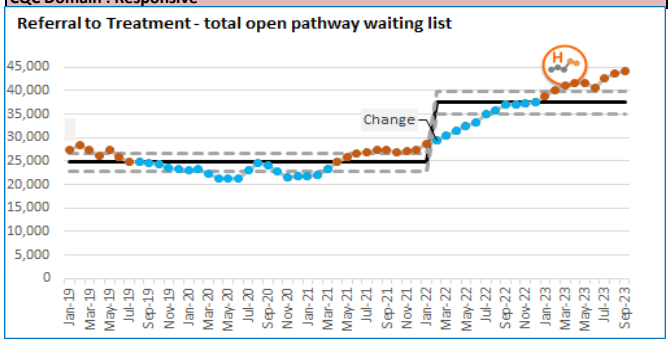
Chief Operating Officer (2)

CQC Domain : Responsive



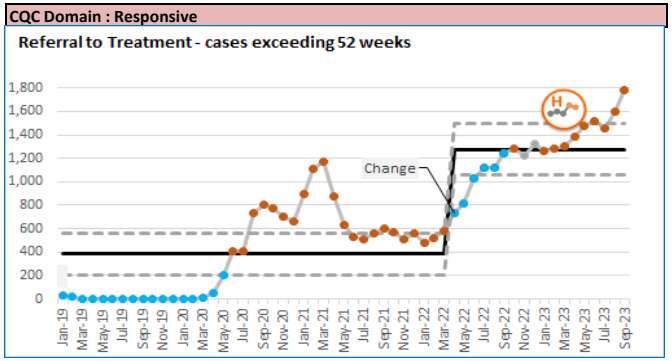
Sept-23
56.68%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



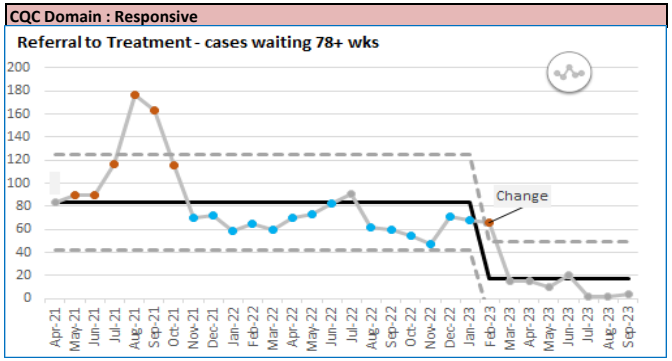
Sept-23
44147
Variance Type
Special cause variation - concerning
Threshold
≤ 39104
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



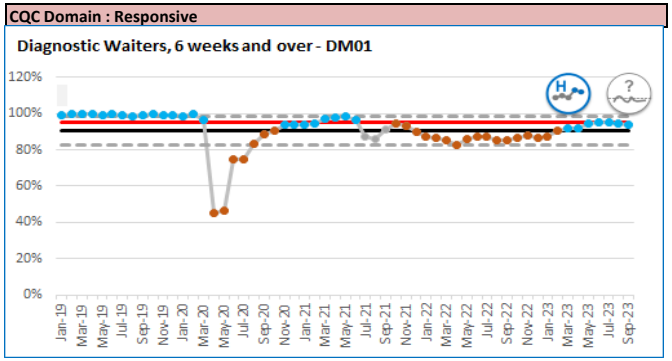
Sept-23
1781
Variance Type
Special cause variation - concerning
Threshold
1330
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



Sept-23
4
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

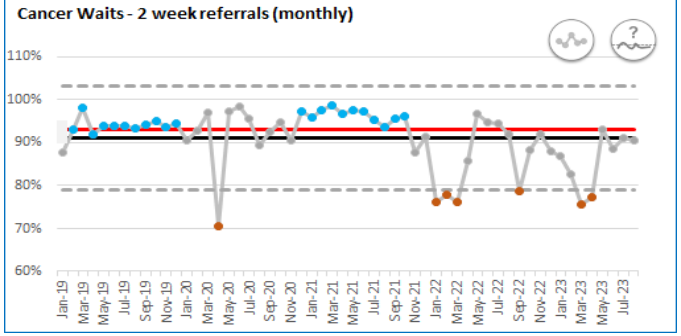


Sept-23
93.9%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

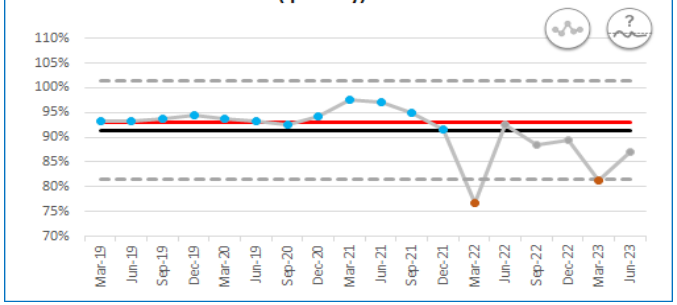
Cancer Waits - 2 week referrals (monthly)



August-23
90.6%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

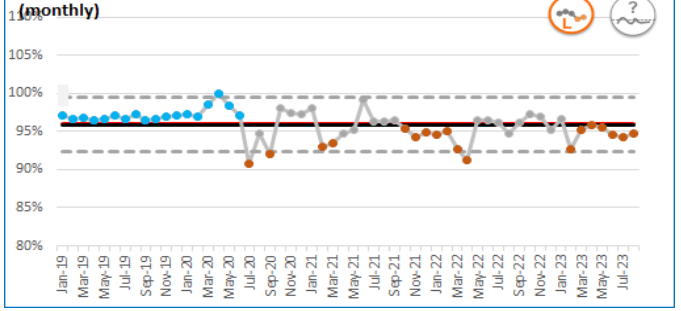
Cancer Waits - 2 week referrals (quarterly)



June-23
86.9%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

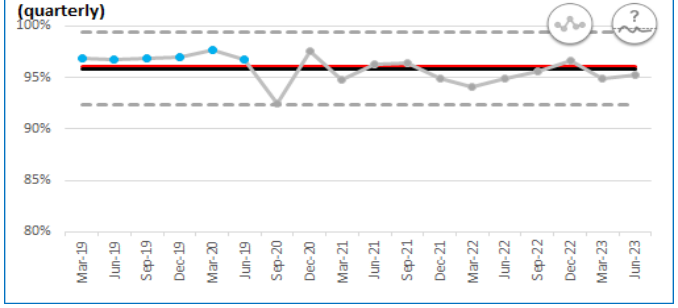
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



August-23
94.7%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

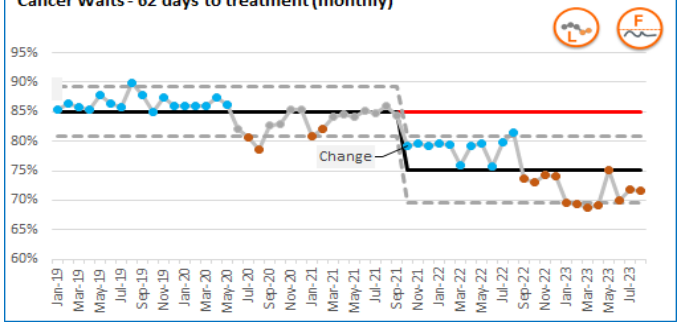
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



June-23
95.2%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

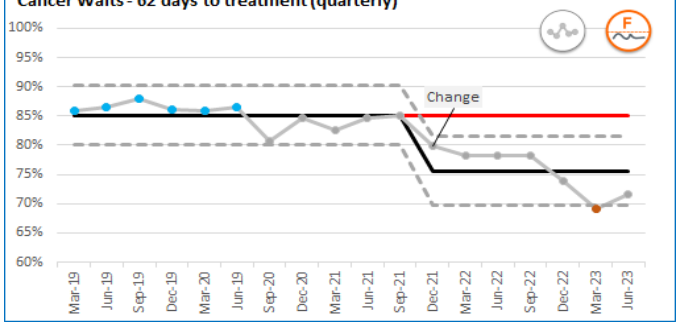
Cancer Waits - 62 days to treatment (monthly)



August-23
71.6%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

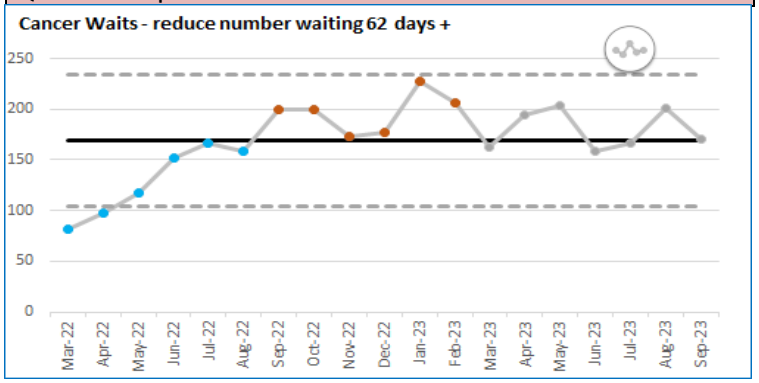
Cancer Waits - 62 days to treatment (quarterly)



June-23
71.7%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

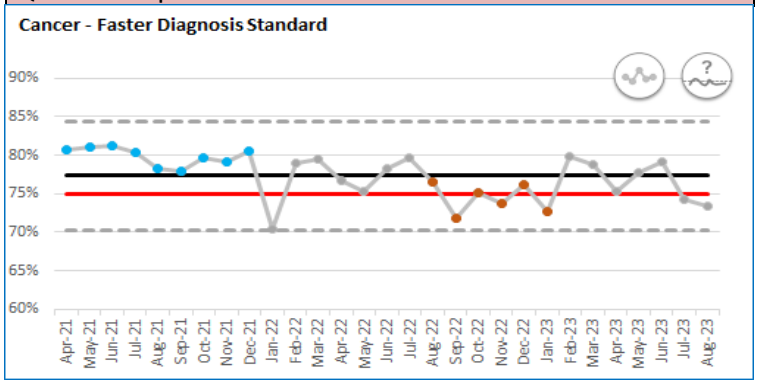
Chief Operating Officer (4)

CQC Domain : Responsive



Sept-23
170
Variance Type
Common cause variation
Threshold
176
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

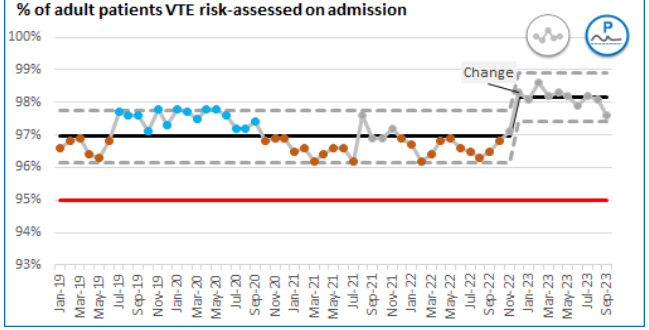


August-23
73.4%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

Medical Director (1)

CQC Domain : Safe

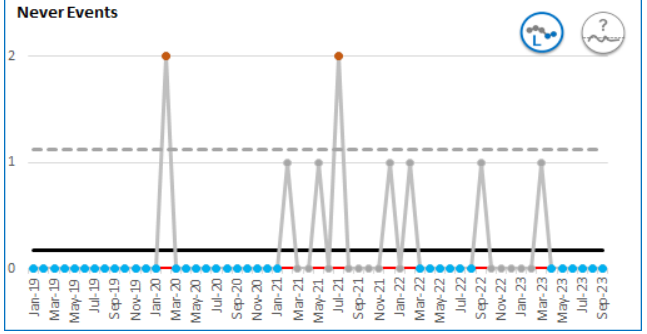
% of adult patients VTE risk-assessed on admission



Sept-23
97.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe

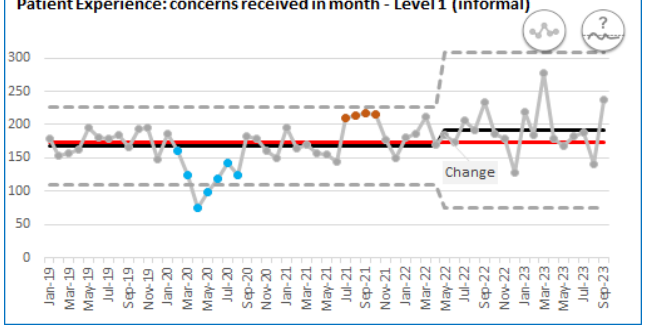
Never Events



Sept-23
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

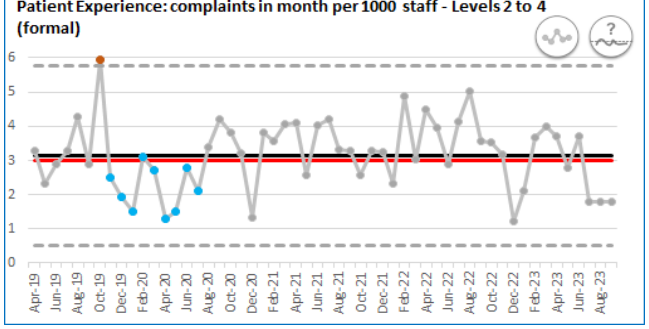
Patient Experience: concerns received in month - Level 1 (informal)



Sept-23
237
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

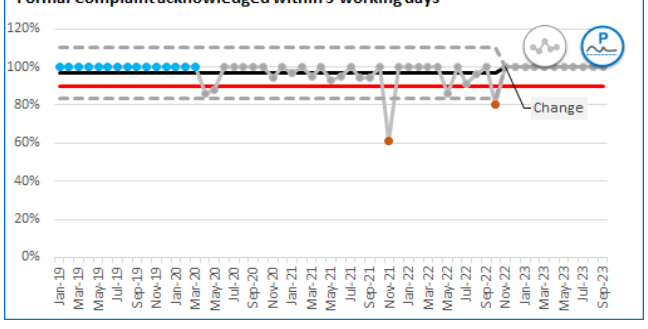
Patient Experience: complaints in month per 1000 staff - Levels 2 to 4 (formal)



Sept-23
1.8
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

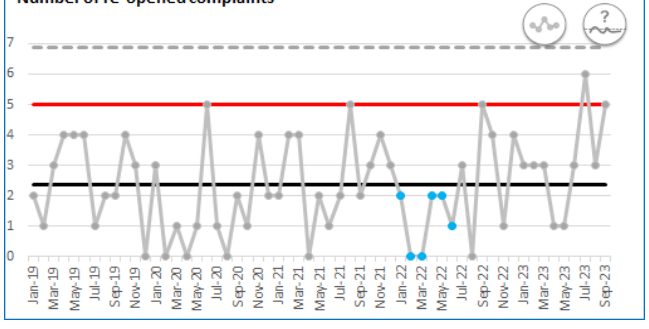
Formal Complaint acknowledged within 3 working days



Sept-23
100%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Responsive

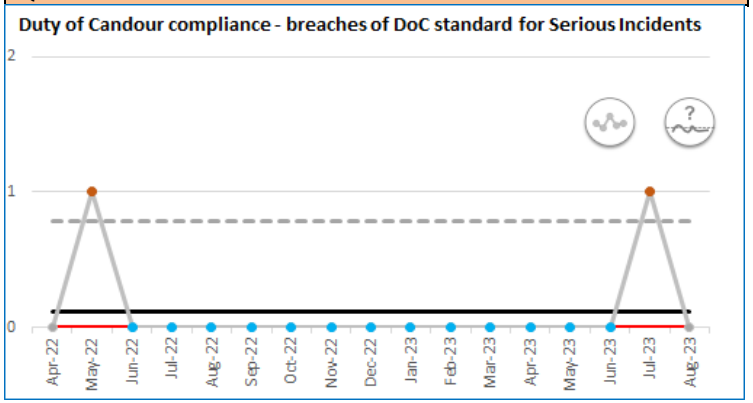
Number of re-opened complaints



Sept-23
5
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

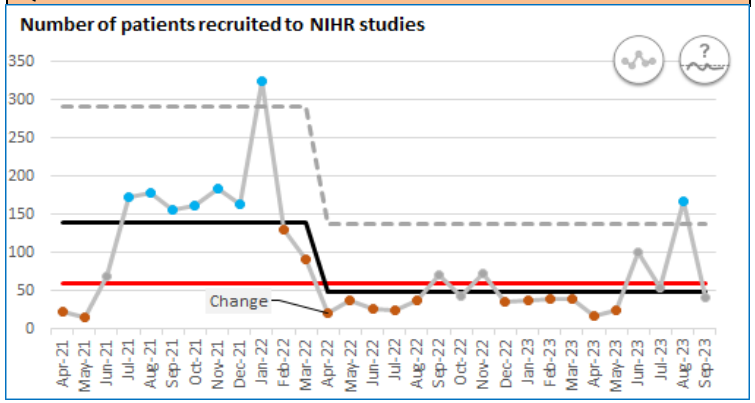
Medical Director (2)

CQC Domain : Well-led



Sept-23
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led

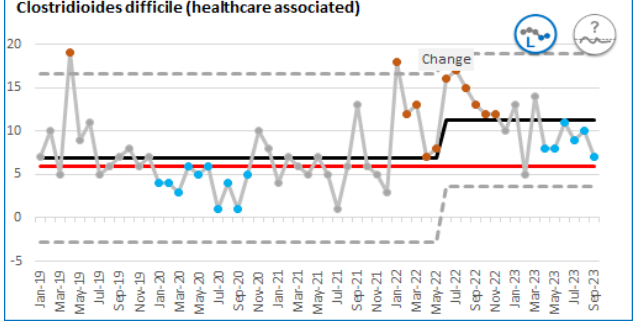


Sept-23
41
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse

CQC Domain : Safe

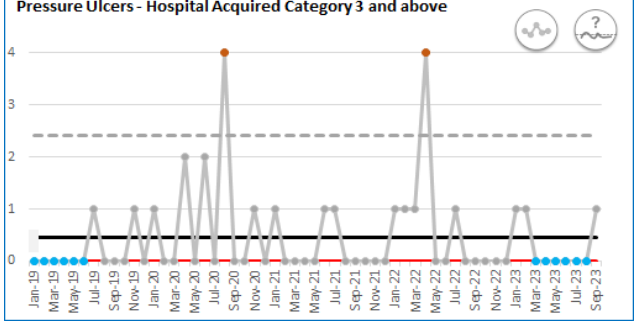
Clostridioides difficile (healthcare associated)



Sept-23
7
Variance Type
Special cause variation - improving
Threshold
≤6
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

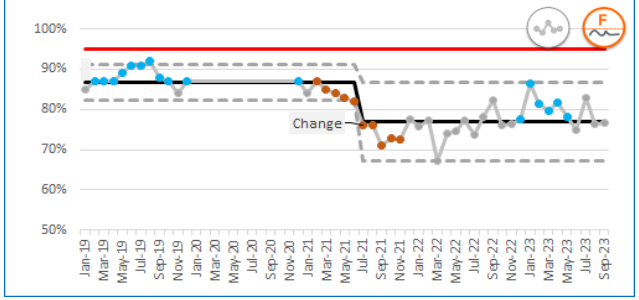
Pressure Ulcers - Hospital Acquired Category 3 and above



Sept-23
1
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

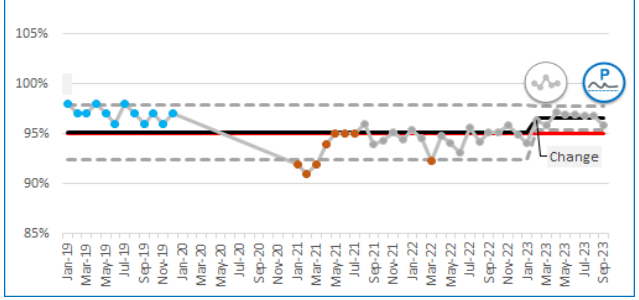
FFT Overall experience of very good & good: ED



Sept-23
76.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

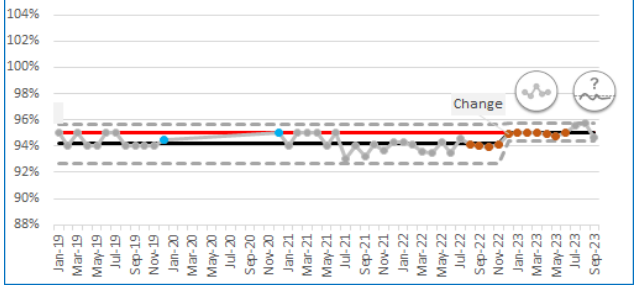
FFT Overall experience of very good & good: Inpatients



Sept-23
95.8%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Caring

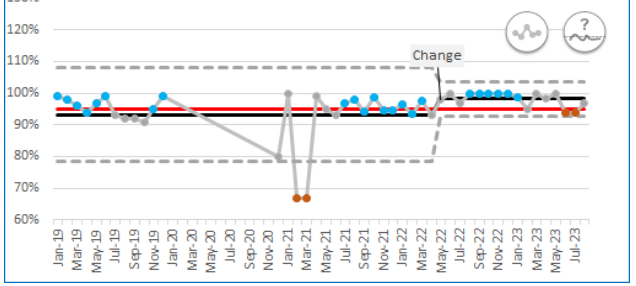
FFT Overall experience of very good & good: Outpatients



Sept-23
94.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

FFT Overall experience of very good & good: Maternity



Sept-23
96.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse – for Nov 2023 BoD

Overall position commentary

The Trust exceeded its monthly *Clostridioides difficile* threshold by 3 in September 2023. This is a decrease of 23 cases when compared to 2022/23 and the downward trend in the number of positive cases reported over the past 12 months continues. In line with the IPC annual plan, the 5 key priorities identified, that underpin the Trust CDT priorities work plan, that aim to further reduce the incidence of CDT over the forthcoming months, is incorporated into the IPC communication and engagement strategy.

For Pressure ulcers, category 3 and above, that have developed in our care there was a single case in September 2023.

The Friends and Family Test (FFT) for Inpatients and Maternity have exceeded the required threshold. Emergency Department (ED) has not achieved target in month at 76.8%, very similar to August's 76.5%, and Outpatients was very slightly below the target threshold at 94.69%. During August, all areas were above the national benchmark for FFT except for ED which was slightly below the national average. September's benchmarking data has not yet been released by NHSE.

***Clostridioides difficile* (healthcare associated)**

Narrative:

The NHS standard contract for 2023-24 identifies the *C.difficile* threshold for each trust; our threshold for 2023-24 is 71. To meet this, we have set internal monthly threshold of 5 or 6 each month. In September 2023 there were 7 patients diagnosed with CDT, exceeding the monthly threshold by 3.

Actions:

- Dynamic CDT improvement plan is in place, with mechanisms to cross reference learning from *C difficile* investigations to instigate actions from learning outcomes.
- A proactive and reactive decant programme has commenced to enable HPV cleaning of the whole site.
- Improved processes regarding the use of side rooms to enable prompt isolation.
- Priority focus on cleaning, decluttering, hand hygiene and re-introduction of the 'gloves off' campaign
- Use of newly developed IPC dashboard that incorporates local intelligence to highlight priority areas where targeted work can be focused to improve patient outcomes.

Risks to position and/or actions:

- Annual threshold may be exceeded.
- Bed occupancy levels may inhibit the ability to implement the HPV cleaning schedule and the rapid isolation of infected patients.

FFT Overall experience of very good and good.

Narrative:

The Trust monitors FFT experience across a range of care settings, with a target rating of a minimum 95% for good or very good.

Performance against the 95% threshold for September 2023 was:

- Emergency Department (ED) – 76.79% (below threshold) - slightly below the national average of 82% (using August's Benchmarking)
- Inpatients – 95.83% (above threshold) - above national average of 94% (using August's Benchmarking)
- Outpatients – 94.69% (below threshold) – above national average of 94% (using August's Benchmarking)
- Maternity 96.15% (above threshold) - above national average of 92% (using August's Benchmarking)

Actions:

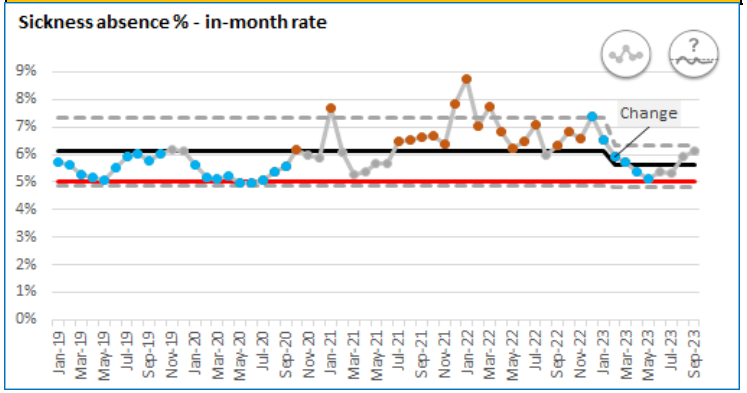
- Continued focus on providing people with access to provide feedback via FFT: volunteers are visiting ED and out-patient areas at varied times and days.
- Monitor FFT performance against national average: we perform similar or above the national average since December 2022.
- Proactively respond to feedback, making immediate rectifications when able to and encourage patient and carer participation through Patient Experience Promise groups.
- Continue coproduction with patients via Patient experience strategy

Risks to position and/or actions:

- Bed occupancy impacting on the length of time patients remain within ED: Processes are in place operationally to prevent this where possible.
- Car parking facilities impacting on patients' ability to easily access outpatients' appointments on time at the Arrowe Park Hospital site: Actions have been taken to address this.

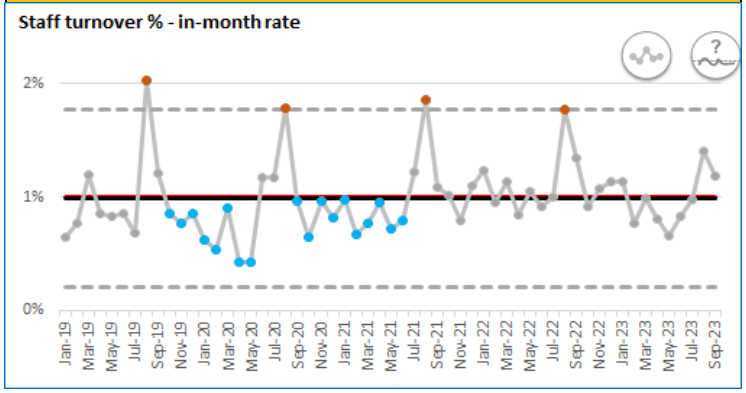
Chief People Officer

CQC Domain : Safe



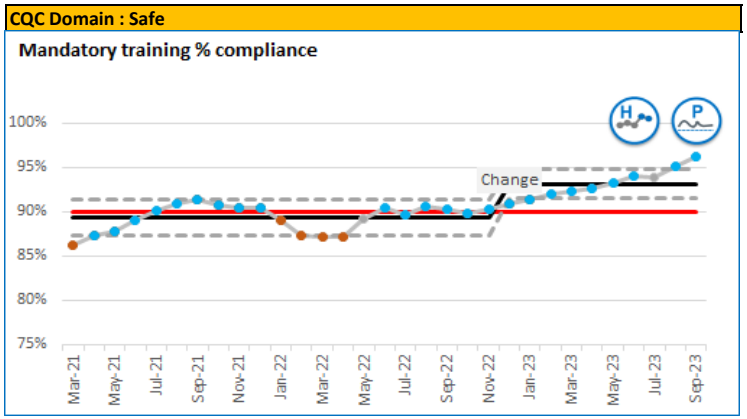
Sept-23
6.15%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



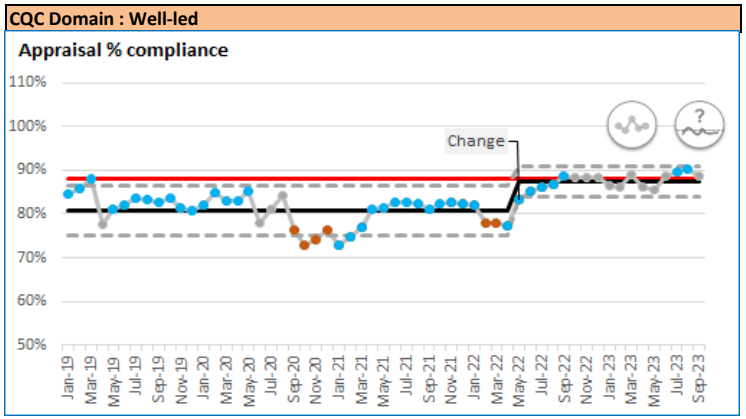
Sept-23
1.19%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



Sept-23
96.26%
Variance Type
Special cause variation - improving
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led



Sept-23
88.57%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – for Nov 2023 BoD

Overall position commentary

Mandatory training and appraisal compliance continues to be achieved.

Sickness absence has increased to 6.15%. Whilst turnover has reduced this month, it is over target, this aligns with Additional Clinical services staff leaving to undertake further / higher education.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For September 2023 the indicator was 6.15% and demonstrates common cause variation.

The position is mainly driven by short term sickness absence. Gastrointestinal problems, cold/flu, COVID and anxiety/stress/depression are the most commonly occurring reasons for short term sickness absence amongst the workforce. An increase in sickness absence during September is typical.

Actions:

- HR continue to provide ongoing and targeted support for example a deep dive into Periop accompanied with a 12-week support plan.
- The Staff Flu Vaccination programme and campaign has started well with 16.26% of all staff vaccinated and 9.53% of all staff have received the COVID-19 Booster Vaccination.
- Additional psychological support capacity has been put in place.
- Active promotion and use of the MIND Wellness Action Plan for staff experiencing stress, anxiety and depression.
- Training continues to be delivered to managers and supervisors on attendance management, emphasising the importance of consistent adherence of policies and communication with staff.
- Virtual Wellbeing week was promoted 9-13th October with a theme around 'get ready for winter'.
- Active promotion of October Menopause Awareness month and the dedicated menopause intranet page.
- Implementation of the new Appraisal and Check-in process continues; not only does the process focus upon an individual's contribution but places wellbeing at the center of the conversation.

Risks to position and/or actions:

The management of sickness absence is primarily management led as they are responsible for monitoring employee attendance, addressing sickness absence and ensuring that the policy is applied consistently, supported by the HR team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels and staff morale / engagement. Effective attendance management is critical and contributes to productivity and patient care. The Trust continues to promote a positive attendance culture by investing in, and focusing on, employee health and wellbeing initiatives to help

mitigate this risk by preventing ill health and supporting people to balance work whilst minimising the impact of any ill health symptoms, where possible. Managing attendance can also help control costs related to overtime, absenteeism and temporary staffing.

Work continues on delivering the agreed year 2 deliverables within the People Strategy with a number of workstreams which will support attendance across the Trust – such as transforming and the modernisation of Occupational Health and Wellbeing service to align to the GROW OH Strategy, development of the Trust's flexible working offer, developing and embedding our Just and Learning Culture and the development and implementation of the WUTH employee perfect start.

Staff Turnover % compliance

Narrative:

The Trust threshold for turnover is 0.83%. In September 2023 the indicator has decreased 1.19%. This demonstrates a common cause variation.

Higher than average turnover in September is common and is driven by staff moving on to further education or training.

Actions:

Focusing on how we can sustain a valuable workforce continues through the Strategic Retention Group. Some examples of the work underway include:

- Digitalisation of the resignation and exit interview form remains ongoing. A target date of January 2024 has been set to pilot the new process.
- A library of staff stories and career pathway films has been launched.
- New approaches to promoting development opportunities to non-PC based staff.
- The 2023 Staff Survey has been launched with an emphasis on listening to staff.
- This coincides with FTSU 'Listen Up Month' with an increased FTSU guardian presence across the Trust to promote speaking up and create a culture of psychological safety.
- Just and Learning is now included at the WUTH Welcome which not only outlines what is Just and Learning culture but also encourages staff to speak up and draw upon the fact that they are new and with 'fresh eyes' to highlight areas of good practice / raise concerns if they notice something.

Risks to position and/or actions:

The impact of the work outlined above will achieve a downwards trend towards the <10% turnover target, the number or % of staff leaving within the first 12 months and voluntary turnover.

Risks to Trust financial management, quality, patient safety and operational performance due to the cost of high Turnover and the expense of bank and agency cover should also reduce as Turnover improves over time.

Work continues delivering the agreed year 2 deliverables within the People Strategy with a number of workstreams which will help support retention across the Trust – such as the development of the Trust's flexible working offer and launch of the FW brochure, the development of the WUTH employee perfect start, delivering a programme of work to improve the experience of our disabled staff and embedding our just and learning culture.

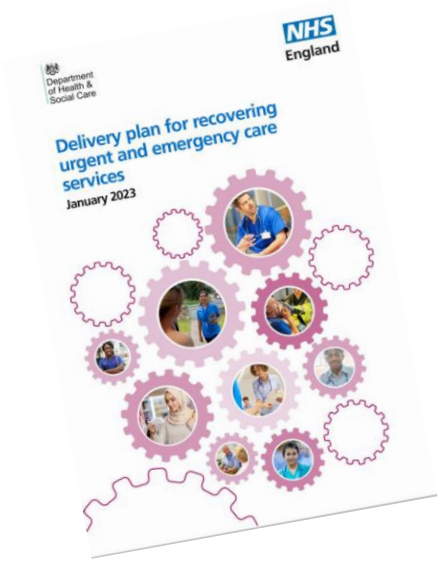
Winter Plan 2023/24

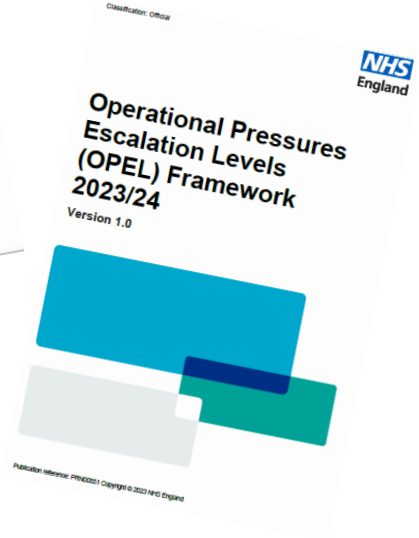
Hayley Kendall, Chief Operating Officer

Board of Directors

1 November 2023

National Context





Capacity and Demand

Arrowe - Adult G&A Beds	Division / Specialty / Description	Core	Escalation	Total
AMU	Medical - Acute Medical Unit	27		27
OPAU	Medical - Older Persons Assessment Unit	24	4	28
MSSW	Medical - Medical Short Stay Ward	16		16
Ward 10	Surgical - T&O	22		22
WAFFU	Surgical - T&O	8		8
Ward 11	Surgical - T&O	25		25
Ward 12	Surgical - Orthopaedic unit (elective)	13		13
Ward 14	Surgical - Colorectal Unit (elective)	37		37
SEU / ward 17	Surgical - Mixed	20		20
Ward 18	Surgical - Mixed	30		30
Ward 20	Surgical - Urology	29		29
Ward 21	Medical - DME	30		30
Ward 22	Medical	31		31
Ward 23 stroke	Medical - DME / Stroke	26		26
Ward 24	Medical	23		23
Ward 25	Medical	22		22
Ward 26	Medical - Mixed	29	4	33
Ward 27	Medical - DME	29		29
Ward 30	Medical - Haematology	22		22
Ward 32	Medical - Cardiology	17		17
Ward 32 - HAC	Medical - Heart Assessment Unit	12		12
Ward 33	Medical	26		26
Ward 36	Medical - Gastroenterology	24		24
Ward 37	Medical - Respiratory	9		9
Ward 38	Medical - Respiratory	37		37
CCU	Medical - Coronary Care Unit	7		7
Ward 54	W&C - Gynaecology Ward	16		16
Total		611	8	619

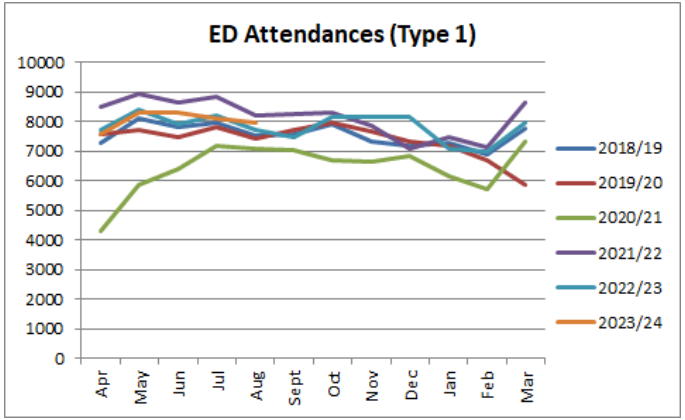
Clatterbridge - G&A Beds		Core	Escalation	Total
Ward M2 Surg	Surgical - General Surgery (elective)	6		6
Ward M2 Ortho	Surgical - Orthopaedics (elective)	20		20
Ward M3	Medical	0		0
Ward M1 CGH	Medical - DME / Rehabilitation	20	10	30
CRC	Medical - Rehabilitation	30		30
Total		76	10	86

Critical Care	Specialty / Description	Core	Escalation	Total
ITU	Critical Care	12		12
HDU	Critical Care	6		6

Total Adult Beds		705	18	723

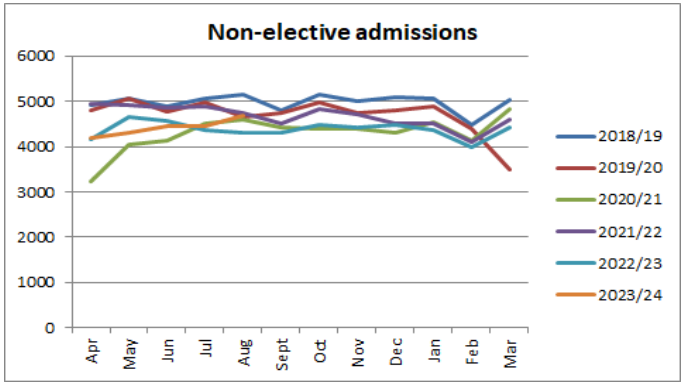
- Ward configuration as at 3rd October 2023
- Exclusions: Dermatology ward, Maternity, Neonates, Paediatrics, ITU, Wirral Neuro Rehab
- Total adult bed base across both sites = 723
- Acute beds excluding ring fenced areas = 636

Demand



ED Attendances

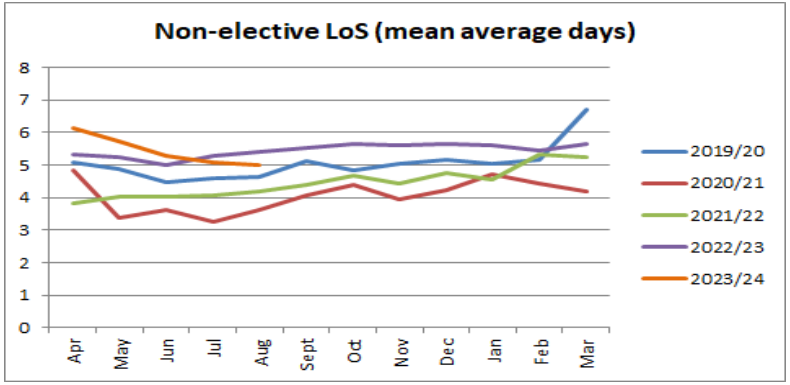
The first five months of 2023/24 ED attendances are very similar to the same period in 2022/23, with a cumulative slight increase of 0.9%.



Non-elective admissions

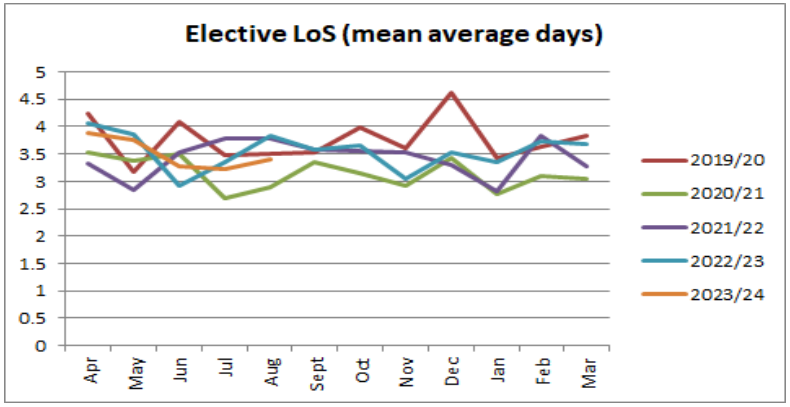
Non-elective admissions across the first five months of 2023/24 were similar to 2022/23 levels.
Though there is slight split with the early months of May and June being lower than last year, and July and August subsequently being higher

Demand



Non-Elective Length of Stay (LOS)

Mean average non-elective LOS for patients discharged in 2023/24 has been reducing from the high point in April 2023. This may be reflective of the reducing number of patients that no longer meet the criteria to reside



Elective LOS

Mean average LOS for elective patients discharged in 2023/24 has been slightly below the 2022/23 average for most months

Bed Requirements

Non-Elective Inpatient Requirements

- Forecasted non-elective admissions is based on 2022-23 levels, with an expected increase.
- Average mean non-elective LOS has been applied to forecasted admission rates to predict non-elective bed days and calculate bed requirements based at 95% and 98% occupancy.
- Forecast required beds demonstrate the requirement for a winter escalation plan to: enhance bed capacity resilience, avoid bedding in assessment areas which further compounds ED waiting times and maintains patient safety.
- On this starting model the months of November and December would require additional bed capacity to maintain 95% occupancy.

Forecast non-elective bed requirements

Month 23-24	Forecast Non-elective Occ Beddays Demand	Current Non-elective Bed Base Capacity	Total Beds to maintain 95% Occ	Additional Beds for 95% Occ	Total Beds to maintain 98% Occ	Additional Beds for 98% Occ
October	20,727	639	704	65	682	43
November	21,033	639	738	99	715	76
December	21,815	639	741	102	718	79
January	20,767	639	705	66	684	45
February	18,368	639	691	52	669	30
March	21,285	639	723	84	701	62

Non-elective model only, and excluding Obstetrics, Neonatology & Paediatrics admissions:

- Non-elective admissions based on 2022-23 levels for October to March, plus anticipated 4% growth
- This is similar to combined April to August growth in 2023-24 over 2022-23, though individual months have varied considerably

Bed Requirements

- Model has been updated to reflect the potential impact of the Virtual Ward schemes as per the Virtual Ward plan at the end of August
- Two Virtual Wards (Frailty and Respiratory) have been modelled into the plan
- Home first capacity is still under review with Wirral Community Trust
- The Virtual ward numbers shown below can be varied by month as the operational plans and timescales become more understood

Month 23-24	Admissions 2022/23	Growth 4%	LoS	Occ Beddays	Minus ITU/HDU	Bed capacity created - Frailty	Bed capacity created - AHF	Bed capacity created - Respiratory	Bed capacity created - Home First	Additional Beds - Ward M1	Additional Beds - W44, W36, W20	Add net beds for 95% occ	Add net beds for 98% occ
October	3,112	3,236	6.5	21,037	20,727	4		4	10		10	37	15
November	3,033	3,154	6.8	21,333	21,033	4		12	10		20	53	30
December	3,161	3,287	6.7	22,125	21,815	8		12	10	0	20	52	29
January	3,025	3,146	6.7	21,077	20,767	12	5	12	10	0	26	1	-20
February	2,782	2,893	6.4	18,648	18,368	12	6	12	10	0	26	-14	-36
March	3,049	3,171	6.8	21,595	21,285	12	6	12	10	0	26	18	-4

Assumptions:

Home First - currently 5 patients discharged per day into 70 HF spaces. This to increase to 170 spaces capacity from Nov, ie 2.5 times increase. Assume 2 days saved per patient

LoS - variance from Sept 2022 to 2023 applied to 2022 numbers for Oct to Mar (reduction of 0.68)

Escalation Capacity Plan

		Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Requirement		18	18	18	28	28	28
Plan	Ward 36	10	10	10	10	10	10
	Ward 31	0	10	10	16	16	16
	Total	10	20	20	26	26	26
	Timescale	From 23rd Oct	From 13th Nov		1st Jan 2024		

- Prioritise opening capacity on the APH site for Medicine – more flexibility on acuity and patient selection
- Gastroenterology to move to Ward 33 and have 24 specialty beds
  Ward 33 including Renal beds to move to Ward 36 and open ward back up to 36 beds (GIM and Renal)

Other available beds that could be utilised:
- Ward 44 (6)
- Ward M1 (10)

No financial provision in for the staffing of these beds and no staffing plan

Winter Additionality

- Frailty Virtual Ward expansion up to 25 beds by mid November and 30 beds in December
- Home First expansion to 150 patients
- Ambulatory Heart Failure Service reducing the need for admission, maximising use of Medical Day Unit (MDU)
- Frailty at the Front Door expansion increased hours and workforce to provide a more consistent service and strong links with Frailty at the Front Door
- Maximising the use of the Medical Day Unit to support early discharge
- Implementation of the new post take model to increase the number of patients seen by a consultant within 12 hours
- Paediatric Hospital at Home – additional resource to prevent admission during times of peak demand

System Partner Response

Mental Health

- Significant risk for Winter given current challenges and demands in ED
- Discussions with local mental health provider – currently no additionality for Winter
- Further risk with UECUP changes from February which limit capacity to just the Mental Health Suite in ED

Community Services

- Home First expansion reducing patients awaiting discharge on pathway one
- Collaboration/coordinate the works on frailty across Wirral ensuring smooth pathways
- Seamless streaming to the Urgent Treatment Centre (UTC)

Summary

- Robust plans in place to deal with expected winter pressures
- Recent peaks in demand has led us to think we need plan for worst case scenario
- There are 3 months where demand outstrips capacity available (based on scenario modelling)
- Concern that we will still be providing corridor care and have elongated handover times given the levels of occupancy / CQC risk also
- No additionality from Mental Health provider to cope with the current levels of demand
- Other considerations to go further:
    - Plan for the worst case scenario including all escalation beds being opened
    - Staff the first corridor from ED (£150k) to ensure quicker ambulance handover times
    - Paramedic on site during winter period – in discussions with NWAS
    - Quantify the potential cost pressures enacting the worst case scenario
- It is recommended that the Board of Directors note the report.

Appendices: Divisional Plans

Acute Division Objectives

a. ED Objectives

- No corridor waits
- Patients receive ED triage within 15 minutes
- Diagnostics orders completed within 30 minutes
- Patients seen by an ED Doctor in 60 minutes
- Specialty Doctor advice within 120 minutes
- ED bed requests made within 180 minutes
- Patients leaving ED within 240 minutes
- Ambulance Handover within 15 minutes

b. Assessment Areas Objectives

- Patients assessed by Senior Doctor in Assessment Unit within 180 minutes
- 80% of same day discharges in an ambulatory setting
- Patient LOS within Assessment unit target (AMU, SEU, GAU = 48hours, OPAU = 72 hours, CDU = 12 hours)
- Avoid bedding assessment areas

c. Services/Initiatives Already in Place

- 24/7 front door patient streaming, to navigate patients away from ED to most appropriate healthcare providers including access to UTC
- Frailty at the front door - OPAU escalation beds
- Implementation of Older Person's Rapid Access Clinic (OPRA)
- ATN in place to support the handover from NWAS and have oversight of patients on the corridor
- AAZ to accommodate 12 trolley spaces

Acute Division Proposed Winter Schemes 2023

Scheme	Benefit Impact of non-delivery RAG	High-Impact Interventions	Lead	By	Status
Majors/Minors Split	Dedicated rota to focus on each side of the department	2 & 3	Divisional Director Divisional Director of Nursing Clinical Lead ED	Oct 2023	
Working in conjunction with Medical Division to implement the new post take model	Improve timely review of patients refer	2 & 3	Divisional Director Associate Medical Director	TBC with Medicine	
NWAS Direct Access to UMAC	Attendance avoidance to ED	1, 2 & 3	Divisional Director Clinical Lead ED	Nov 2023	
Simplify access to HOT clinic and increase HOT clinic offer/capacity from other Divisions	Reduce attendances to ED	1 & 3	Divisional Director	Nov 2023	
Frailty area on OPAU – direct pull from ED with frailty score	Reduce LoS Admission Avoidance Direct Access to Virtual Ward	2, 3 & 7	Divisional Director Division Director of Nursing	Nov 2023	
Implementation of reverse cohort model	Ensuring that clinical risk is reduced by early review	3	Divisional Director Clinical Lead ED	Oct 2023	
Work with WCT to implement Home First on the first floor	Reduce admissions, length of stay and improve patient experience	2, 3 5 & 6	Divisional Director Divisional Director of Nursing	Nov 2023	
Review the working model of the substance misuse team including joint working with CWP	Reduce Admissions/Readmissions Improve Patient Experience	1 & 3	Divisional Director of Nursing	Nov 2023	
Review opportunity to increase ED capacity by the opening of green majors	Reduce number of patients on corridor Support the implementation of reverse Cohorting	3	Divisional Director Divisional Director of Nursing Clinical Lead	TBC - estates	
Implement outcome following MH service provision review	Reduce Patient Risk Reduce Risk to Staff Improve Patient Experience	3	Deputy COO Divisional Director Clinical Lead	Dec 2023	

Diagnostics & Clinical Support Winter Plan

DCS Division Objectives

- Provide timely inpatient and outpatient diagnostics and therapy to support admission avoidance and Trust discharge processes
- Provide timely inpatient and outpatient pharmacy to support Trust processes
- Maintaining 100% outpatient activity against plan
- Delivery of DM01 targets
- 24/7 critical care outreach provision
- Full implementation of critical care staffing

Services/Initiatives already in place

- 7 day working for all therapy teams
- Participate in daily board rounds
- Participate in point prevalence's during periods of high demand
- Home First expansion to promote early discharge
- Maximising DHC capacity
- Discharge hub coordinating complex discharges

Diagnostics and Clinical Support Winter Actions

- Escalation bed cover – Therapies and Pharmacy
- Dispensary capacity
- Dietetic / SLT assistant post
- Inpatient weekend scanning capacity
- Expansion of night vehicle service
- Extended respiratory panel testing capacity
- Offer additional therapy hours 4-6 to support late discharges
- Divisional support for Trust wide vaccination programme

DCS Division Proposed Winter Schemes 2023

SCHEME	BENEFIT IMPACT OF NON-DELIVERY RAG	ALIGNMENT TO NHSE HIGH-IMPACT INTERVENTIONS	LEAD
Therapies - OT/ Physio escalation bed cover	Improved rate of discharge Support transfer of patients who no longer meet the criteria to reside	Inpatient flow and LOS (acute)	Deputy Divisonal Director DCS
Pharmacy - escalation bed cover	Support increased demand over winter	Inpatient flow and LOS (acute)	Deputy Director of Pharmacy
Pharmacy - Dispensary capacity	Support increased demand over winter	Inpatient flow and LOS (acute)	Deputy Director of Pharmacy
Therapies - Front Door Therapy capacity (UPC Team)	Support increased demand over winter	Inpatient flow and LOS (acute) SDEC	Deputy Divisional Director DCS
Therapies - Over-recruitment B5 OT/ Physio	Support increased demand over winter	Inpatient flow and LOS (acute)	Deputy Divisonal Director DCS
Therapies - SALT/ Dietetic Assistant post	Support increased demand over winter	Inpatient flow and LOS (acute)	Deputy Divisonal Director DCS
Radiology - Inpatient weekend capacity CT/ MR	Support increased demand over winter and patient flow.	Inpatient flow and LOS (acute)	DM Radiology
Patient Flow - Expansion of night vehicle	Improve patient flow and discharge	Inpatient flow and LOS (acute)	DM Patient Flow
Radiology - Virtual ward- Diagnostic flows	SDEC	Virtual wards	DM Radiology
Extended respiratory panel testing capacity	Support increased demand over winter	Acute Respiratory Infection Hubs	Head of Pathology

Women and Children's Winter Plan

a. Women and Children's Objectives

- Maintain safe Maternity Unit access
- Maintaining 100% planned elective programme (subject to Industrial Action)
- Delivery of cancer access targets
- Zero >78 week open RTT pathways
- 50% discharges by 4pm

b. Services/Initiatives Already in Place

- Daily board rounds
- Point prevalence's being undertaken during periods of high demand
- Daily scheduling review meeting to review elective demand during periods of high non-elective demand
- Regional pathways and escalation for Maternity, Neonates and Acute Paediatrics

Women and Childrens Division Proposed Winter Schemes 2023

Scheme	Benefit Impact of non-delivery RAG	High-Impact Interventions (no.)	Lead	By	Status
Pregnant Women vaccination programme	3	8	DD of N&M	September 23 onwards	
Discharges by 4pm; uplift performance to best performing ward (Gynae)	1	3	DD of N&M	Ongoing	
Paediatric System and Divisional Winter resilience structures in place from August 23	2	8	DD	August 23	
Utilise Paediatrics network command structure for escalation and mutual aid, ensure regional bronchiolitis pathway followed	2	8	DD	Ongoing	
Utilise winter surveillance data for C&YP to assess capacity and demand regularly, e.g. increased risk of Flu and Measles	2	7	DD	October 23	
Comms plans for primary care and public to promote Big 6 initiative for most common paediatric conditions	2	8	DD	September 23 onwards	
Paediatric Day case unit to be utilised if required using IPC cohorting guidelines i.e. RSV –ve and Rhinovirus cohort, RSV +, COVID, Pertussis, FLU A and Flu B can only be cohorted with same patients.	3	3	DD of N&M	September 23 onwards	

Women and Childrens Division Proposed Winter Schemes 2023

Scheme	Benefit Impact of non-delivery RAG	High-Impact Interventions (no.)	Lead	By	Status
Move of Gynaecology October to January bed reduction from 16 to 11 – mitigation by use of Day Case area 6 beds and GAU capacity increased from 4 beds to 6 beds and Day case recovery through SEAL and 3 stage recovery. Contract has a break clause if need to release W31 to general bed base after phase 1.	2	3	DD of N&M	October 23 – January 24	
24/7 SDEC provided through CED/PAU following successful recruitment and training – review frequent attenders	2	1	DD of N&M	November/ December 23	
Paeds Rapid Access Clinic capacity reviewed to meet changes in demand.	3	9	DD	Ongoing	
Paeds Hospital @home to be supported by additional resource to prevent admission if peaks in demand	3	7	DD	Ongoing	
Maximise use of CGH to protect elective programme	3	3	DD	October onwards	
In OPEL 4 escalation and agreed with COO review relocation of PAU to Childrens ward with Risk assessment.	3	1	DD	Ongoing	

Surgery Division Winter Plan

Surgical Division Objectives 22/23

a. Deliver outpatient & elective plan

b. Increase activity through the Clatterbridge Surgical Centre

c. Deliver cancer standards

Services/Initiatives already in place

- Think Big Programme
- SEU SDEC GP & ED
- Early supported discharge with MyMobility app
- Updated VRE swabbing to support flow
- Daily point prevalence
- Weekly LLOS
- Robust staffing plan (ward and theatre)
- Workforce wellbeing - Ensure staff are supported to have resilience throughout winter. Use of staff “check-in’s” whilst encouraging staff to utilise any support offered by the Trust.

Surgical Division Proposed Winter Schemes 2023

Scheme Emergency pathways	Benefit Impact of non-delivery RAG	High-Impact Interventions (no.)	Lead	By	Status
Streaming from ED front door – review of ED SOP as needs updating. Relaunch & embed	Support 4 hour standard & reduce admissions	1 & 3	Divisional Director	October	
Embed interprofessional standards across all specialities	Support 4 hour standard & reduce admissions	1 & 3	Associate Medical Director	October	
Review of hot clinic processes & capacity	Support 4 hour standard & reduce admissions	1 & 3	Divisional Director	October	
SEU – create more capacity clinic & chairs to improve flow	Support 4 hour standard & reduce admissions	1 & 3	Divisional Director & CL EGS	October	
SEU – protect SDEC nursing from bed base to improve flow	Support 4 hour standard & reduce admissions	1 & 3	Divisional Director & CL EGS	October	
SEU – protect from medical outliers to improve flow	Support 4 hour standard & reduce admissions	1 & 3	Divisional Director & CL EGS	October	
Review of OOHs Urology SHO cover	Support 4 hour standard & reduce admissions	1 & 3	DM & CD Urology	October	
Review of NOF Pathway – to ensure knowledge across trust & compliance. Ensure #NOF nurse is pulling from ED	Support 4 hour standard	2 & 3	DM& CD Orthopaedics	November	

Surgical Division Proposed Winter Schemes 2023

Scheme Elective & Emergency Pathways	Benefit Impact of non-delivery RAG	High-Impact Interventions (no.)	Lead	By	Status
Improved co-ordination with IDT/documentation on when patient are MFFD – improving documentation via specific ward round template	Reduce LOS	3 & 4	DM & CD Orthopaedics	October	
Convert in patient stay to day case (urology, EGS)	Reduce LOS	3	Divisional Director, DM & CD Urology, CL EGS	November	
Further develop M3 ambulatory village	Reduce admissions	3	DM & CD Urology	November	
Review of Biliary pathway	Reduce LOS	1 & 3	CL General Surgery elective & EGC lead	December	
Caude Equina Pathway to be agreed in line with ED colleagues	Reduce LOS	1 & 3	DM & CD Orthopaedics	December	
Orthopaedic Orthogeriatric ward cover review with medicine to increase	Reduce LOS	1 & 3	DM Orthopaedics	December	
Maintain & maximise effectiveness of LLOS Reviews	Reduce LOS	3	Divisional Director of Nursing	On going	
Reinstate Colorectal Ward MDT Meeting which took place before Covid with ward sister, stoma, nutrition, ANP and Consultant.	Reduce LOS	1 & 3	CD General Surgery	October	
Colorectal Stoma – implement 6 day service & review of community provision	Reduce LOS	1 & 3	DM & CD General surgery	December	

Surgical Division Proposed Winter Schemes 2023

Scheme Elective Pathways	Benefit Impact of non-delivery RAG	High-Impact Interventions (no.)	Lead	By	Status
Establish a sit in service at home following elective surgery day case	Reduce admissions	3	Divisional Director	October	
Consider shrinking of Orthopaedic Elective Bed Base on APH if necessary and not expected to have material impact on Elective programme.	Protect elective capacity & Achieve activity plans	3	Divisional Triumvirate with COO	December	
Elective standby patient (Opthal, urology, UGI)	Achieve activity plans	3	Divisional Director & DM Urology	Complete opthal – Urology & UGI November	
Protect Elective flow by utilising CBH	Protect elective capacity & Achieve activity plans	3	Divisional Director with CDs	October	
Protect cancer capacity theatre & W14	Achieve national standards	3	Divisional Director	September	

Medicine Division Winter Plan

Medicine Specialties Division Objectives

a. Medicine Specialty Objectives

- Each base ward pulls one patient from an Assessment Unit by 10:00
- 50% of Discharges by 4pm
- 100% of patients with CTR recorded during the inpatient spell
- 100% of patients with EDD recorded during inpatient spell
- 30% of patients discharged from DHC

b. Services/Initiatives Already in Place

- Daily board rounds and discharge focused afternoon huddle
- Daily documentation of CTR
- Daily Senior patient reviews
- Documented estimated date of discharge
- Outlier ward rounds
- Point prevalence's being undertaken during periods of high demand
- Post take support
- Shadow rota for specialties to provide daily Consultant reviews in unplanned escalation areas

c. Medicine Winter Actions

- Maximise use of Respiratory ESD Assessment Service to provide COPD Virtual Ward
- Expansion of Frailty Virtual ward
- Discharges by 4pm; uplift performance to best performing ward supported by Discharge Nurse
- Optimised utilisation of Discharge Hospitality Centre
- System wide discharge cell attendance to support review of long length of stay patients
- Weekly Divisional long length of stay reviews
- Provision of sustained inpatient bed base and surge plan
- Robust Christmas and February half term staffing plans
- Restricted annual leave and study leave during January and February as predicted most challenging months

Actions are detailed further within the Medicine Specialty Division action plan

Winter themes: Annex A Annex A — 10 high impact interventions 10 high impact interventions

High Impact Intervention	Medicine Plan
Inpatient flow and length of stay (acute): Reducing variation in inpatient care and length of stay for key iUEC/conditions/cohorts by implementing hospital efficiencies and bringing forward discharge processes for pathway 0 patients.	• Optimise use of DHC • Maintain weekly LLOS reviews • Develop MDU pathways for early discharge • Ensure consistent approach to discharge clinics across Division • Refine role of Discharge Lead Nurse to support discharge • Agree escalation processes with Medicine Manager of the Day and Patient Flow • Review / audit of practice against RCP ward self assessment and Integrated urgent and emergency care pathway maturity self-assessment
Virtual wards: Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.	• Increase capacity of Virtual Frailty Ward • Increase use of Virtual Respiratory Ward
Same Day Emergency Care: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.	• Review of consistent approach to discharge clinics and hot clinic availability across Medical Specialties
Frailty: Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.	• Work with Acute on model for staffing for Frailty

Medicine Specialties Division Action Plan

Theme	General Actions	Benefit Impact of non-delivery RAG	Alignment to NHSE/I Operational Priorities	Lead	By	Status
Bed capacity	Expand capacity and workforce of Frailty Virtual ward	Support admission avoidance & reduce LOS		DD	15 Oct 23	
	Maximise use of Respiratory ESD Assessment Service to include COPD Virtual Ward	Support admission avoidance & reduce LOS	C	DD	1 Oct 23	
	Increase in Ambulatory Heart Failure service capacity	Support admission avoidance & reduce LOS		DD	1 Oct 23	
	Plan for increase in bed base to meet demand (accounting for increased demand versus impact of bed reduction schemes)	Increase in capacity		DD	1 Oct 23	
Escalation	Develop a robust Influenza cohorting and surge plan, co-produced with Surgery Division and IPC	Maintain patient safety	C	DD	1 Oct 23	
	Robust Christmas and February half term staffing and activity plans	Maintain patient safety			1 Oct 23	

Theme	General Actions	Benefit Impact of non-delivery RAG	Alignment to NHSE/I Operational Priorities	Lead	By	Status
Discharge / Patient Flow	Maintain weekly LLOS reviews - continue to focus on stranded and super stranded patients within Divisional LLOS meetings	Reduce LOS		DD	1 Oct 22	Ongoing
	Optimise use of DHC	Improve Flow & Discharge before 4pm		DD	1 Oct 23	Ongoing
	Strengthening of Board Rounds & Huddles to support earlier discharge	Improved Flow Discharge before 4pm	C	DD DDN	1 Sept 23	Ongoing
	Refine the role of Discharge Lead Nurses to maximise value	Improved Flow Discharge before 4pm		DD	1 Oct 23	Ongoing
	Post take - Implement sustainable model for Cardiology post take, maintain interim support for Respiratory post take, agree model for other Medical Specialties	Improve rate of discharge		DD		Ongoing
	Ensure consistent approach to discharge clinics and hot clinic availability across Medical Specialties	Improve rate of discharge		DD	Nov 23	Live
	Agree escalation processes in Medicine through Manager of the Day and Patient Flow	Improve Flow		DD		
Staffing	Robust staffing plans during winter period (including Christmas and February half term)	Support Trust during winter increased winter demand	A	DDN	1 Oct 22	

Medicine Specialties Division Financial Summary - Approved

General Actions	Funding	Impact of non-delivery RAG	Lead
Virtual Ward Funding (Frailty & Resp) Acute & Medicine joint approach for the integration of pathways between Virtual Ward, Frailty at the Front Door and OPAU	ICB Funding 337k recurrent 120k non recurrent	Approved	Divisional Director Associate Medical Director Acute & Medicine Division

Transfer of Care Hub Winter Plan

Transfer of Care (Discharge) Hub Objectives

a. Reduce the number of patients with no CTR in the hospital to 100 and below by 1st November 2023

b. Ensure patients who will need support on discharge are identified on admission and have minimum delay when ready to leave the hospital

c. Ensure patients and their families are involved in discharge planning

c. Assure a good patient experience on discharge with clear information on agreed pathway

Services/Initiatives already in place

The Transfer of Care Hub is embedding new processes to enable timely decision making and discharge including:

- Daily validation of patients with no criteria to reside
- Attendance at ward Board Rounds and Huddles
- Social Care implementing 3 conversations to reduce assessment complexity with patients/ families
- Daily workflow processes to progress chase all complex patient discharges
- Tracking and reporting of the discharge planning stages in Cerner (go live 25/9/23)
- A Safe Transfer of Care Referral form, replacing N2A/Ds, launch anticipated mid October 2023
- Standard Operating Procedures clearly documented by 1st November 2023

Transfer of Care (Discharge) Hub Division Proposed Winter Schemes 2023

Wirral University Teaching Hospital NHS Foundation Trust

Scheme	Benefit Impact of non-delivery RAG	High-Impact Interventions (no.)	Lead	By	Status
Monitor the daily/ weekly discharge activity required to assure progress initially 10% of the bed base with NC2R over winter. (Overall aim is to reduce to 5%)	Ensure sufficient discharges by pathway each day and avoid additional unnecessary bed days	5	Angie Nisbet	1st November	
Work with divisions and especially pharmacy and DHC to ensure transport and TTHs are ready for early in day discharge of patients on Pathways1-3	Ensure earlier in day discharges for patients on pathways 1 3 reducing risk of avoidable delay	5	Angie Nisbet	1st October	
Second Trusted Assessor recruited enabling timely support for patients admitted from care homes in ED; AMU; OPAU; MSSU and joint working with Tele Triage, Virtual Frailty Ward Team	Increase working with Care Homes to minimise time residents spend in hospital and coordinating wrap around support in the homes.	5	Graeme Lambert	1st December	
Ensure ToCH team are actively involved in making Home First and Care Market Sufficiency projects to assure the hub fulfil its role to make schemes successful	close working with Home First team and Care commissioners & providers to improve Pathway 1 discharges	5	Angie Nisbet	ongoing	
Monitor P1-3 readmissions within 48 hours of discharge and commence planning in assessment areas and re discharge with appropriate wrap around support	Rapid reassessment of discharge pathway	5	Graeme Lambert	ongoing	

Key: Blue = Complete; **Green** = On Track; **Amber** = Minor delays but with manageable risk; **Red** = Major delays against plan

together we will

ToCH Daily Activity Model

Anticipated future flow required (November)

Daily Incoming

Total: 21

P1: 13
P2: 5
P3: 3

Daily Discharges

	Daily (Mon-Fri)	Daily Wknd (Sat-Sun)	Weekly Total
HomeFirst	6	2	34
STAR	4	1	22
POC	3		15
CICC/D2A	5	1	27
P3 (24hr)	2		10
Fast track (POC & 24hr)	1		5
OOA			4
	21	4?	117

Minimum number of packages circulating (Patient status - *Assessment Complete*)

Estates, Facilities & Capital Division Winter Plan

Estates, Facilities and Capital Division Objectives

a. Estates/Capital Management Objectives

- Estates/Capital Management structures and processes are developed to ensure 365days, 24/7 support to the Trusts Divisions, patients, partners and visitors, across WUTH sites.
- 24/7 maintenance of all assets.
- Provision of capital project delivery
- Minor works programme

b. Facilities Objectives

- Protect our patients and staff through maintaining a clean environment via our Cleanliness service
- Support Trust patient flow through timely cleaning of ward areas, in line with IPC guidance
- Portering service to support the timely transfer of patients across our hospital sites
- Provide a catering service for our patients and staff

c. Estates, Facilities and Capital Winter Actions

- Increase the Band 2 HCP Environmental cleaning team shift pattern capacity ratio to support periods of additional IPC activity
- Increase Band 3 HCP Cleanliness Services Supervisor provision to support additional IPC activity and auditable assurance of cleanliness standards
- Additional Band 2 Porters to support increased activity demand in ED throughout the Winter period
- Robust Christmas and February half term staffing plans
- 1x Additional Band 5 and 1x Additional Band 3 Trade Technician.

Actions are detailed further within the Estates, Facilities and Capital proposed winter schemes.

Services/Initiatives Already in Place

- HCP Environmental cleaning team

Estates, Facilities and Capital Division Proposed Winter Schemes 2023

Scheme	Benefit Impact of non-delivery RAG	High-Impact Interventions (no.)	Lead	By	Status
Additional Porters 1.4 WTE B2	Support increased demand over winter	3,4	ASD Facilities and Support Services	1 September 23	Out for advert/secondment
HCP provision for additional Environmental Team capacity to support IPC agenda - APH 4.73 WTE B2	Support increased demand over winter	3,4	ASD Facilities and Support Services	1 September 23	Out for advert
Increase Band 3 HCP Cleanliness Services Supervisor provision to support additional IPC activity and auditable assurance of cleanliness standards 1 WTE B2	Support increased demand over winter	3,4	ASD Facilities and Support Services	1 September 23	Secondment
Robust staffing plans during winter period	Support Trust during winter increased winter demand	3,4	Director of Capital Planning	TBC	Ongoing
Additional Skilled technician 1 WTE B5	Support increased winter demand on our assets	3,4	APH Maintenance Mgr.	1 October 23	Trac TBC
Additional Trade Assistant 1 WTE B3	Support increased winter demand on our assets	3,4	APH Maintenance Mgr.	1 October 23	Trac TBC

Board of Directors in Public **Item No 10.1**
1 November 2023

Report Title	Committee Chairs Reports – Estates and Capital Committee
Author	Sir David Henshaw, Chair of Estates and Capital Committee

Items for Escalation/Action

- The Chair noted that the Wirral Place and ICB Strategic Estates Group should be taken through the Wirral Place Partnership Board for discussion and agreement of next stapes.

New/Emerging Risks

- The Committee noted the increasing backlog maintenance risks and requested ongoing monitoring through the Committee, along with a request for the Chief Strategy Officer to examine plans for staged redevelopment of Arrowe Park Hospital.

Overview of Assurances Received

- The Director of Estates provided assurance to the Committee on the performance and risks related to Capital and Estates. This included the Estates Divisions performance against key metrics and indicators, such as maintenance, financial performance, and statutory compliance.
- This highlighted the improvements made across the Division in relation to Hard and Soft FM safety, patient experience, efficiency, effectiveness, and governance, which were evaluated as part of the annual NHS England Premises Assurance Model (PAM).
- The Director of Estates also provided an overview of the Wirral Place and ICB Strategic Estates Group and analysis undertaken to understand NHS and Council estate across Wirral. This will be used by the Wirral Place Partnership Board to discuss and agree ways to improve estate and estate investment.
- The Associate Director of Estates detailed the progress with the 23/24 Capital Programme, which includes 15 capital (infrastructure) project with a value of ~£19m. This included information on the completion of the Phase 2 Modular Theatres construction in early October 2023.
- As part of this update, the A/Director also provided an analysis of backlog maintenance challenges across the Arrowe Park Clatterbridge Hospital campuses. Detailing the levels of risk and estimated costs of replacements and repairs to eradicate the backlog. For 23/24, this totalled approximately £46.5m.
- The COO provided an update on the Urgent and Emergency Care Upgrade Programme (UECUP) and detailed progress with the construction as well as highlighting the programme status and steps taken to reduce completion delays.
- The Committee noted the following reports:
    - Estates Division Performance Report
    - Capital Programme Financial Position
    - UECUP Progress Report
    - Backlog Maintenance Report
    - MIAA Capital Programme Governance Audit

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 10.2**
1 November 2023

Report Title	Committee Chairs Reports – Finance Business Performance Committee
Author	Sue Lorimer, Chair of Finance Business Performance Committee

Items for Escalation/Action

- Financial performance to month 6 was reviewed by the Committee and it was pleasing to see that the trust continues to perform ahead of plan with a deficit of £13.4m against a plan of £13.6m. Elective activity has continued to underperform due principally to the impact of industrial action and underutilisation of the Countess of Chester's planned sessions in the Cheshire and Merseyside Surgical Hub. It was noted that the Countess of Chester is still sending work to the private sector, and this has been raised with the ICB.
- The Committee received an overview of elective activity performance to date. It was noted that as in other trusts, performance had been adversely affected by industrial action, but the trust could demonstrate good performance compared to regional peers. The trust has lost 1345 cases due to industrial action and this has had an impact on waiting times and list size. Urology and Colorectal remain the specialties causing most concern but while there is a recovery plan in place for Urology, Colorectal is a longer-term project.

New/Emerging Risks

- The Committee noted the increasing risk to activity plans due to industrial action and underperformance in external referrals to the C&M Surgical Hub.
- Increasing risk to forecast financial performance.

Overview of Assurances Received

- The Committee considered a revenue business case to increase the establishment of the Pharmacy Aseptic Unit by 7 staff at a cost of £307,366. This would enable the unit to better meet demand by implementing Saturday working. It would also mean that the unit could accommodate demand from other units which is currently unmet and is likely to achieve profit of some £600,000. The team confirmed that current staff were positive and supported the proposal. The Committee commented on the good quality of the case and were happy to recommend to the Board of Directors for approval.
- The quarterly financial plan update was provided to the Committee and a risk of £8.8m to forecast performance was flagged. Of this, £2.4m had arisen outside of initial planning assumptions and £6.4m was within planning assumptions. The latter sum comprises a variance in financial performance of Estates and Facilities, a shortfall on the CIP target and underperformance on elective activity. The senior team continue to seek mitigations to enable an outturn much closer to plan.
- The Estates and Facilities team with Finance have conducted a deep dive into their negative variance from plan of £1m to month 6 and a forecast negative variance of £2.6m for the year. The Committee were informed that a number of budget lines such as Gas had experienced increases outside of Estates management control, but it had been determined that the sum of £1.3m was within management control and of this £1.2 million was a shortfall on CIP. The Committee received a very detailed review of the mitigations proposed by the

division and this had been risk rated. The total mitigations identified amounted to £0.8m and the team were charged with the delivery of mitigations of that sum as a minimum.

- The Committee received a report on cost and productivity and while performance has been extremely good there remains a forecast CIP shortfall of some £3m. However, the Committee noted that the forecast delivery of £23.2m was a significant achievement at 4.4% of operating expenditure. The Committee were assured that work will continue to identify the shortfall. The team also set out initial CIP plans for 2024/25.
- The Committee approved the revisions to its terms of reference but requested that the business case approval limits were noted explicitly.
- A cycle of business was presented to the Committee, and this was approved subject to inviting a division to attend every other meeting and a presentation of the performance of the Limited Liability Partnership (LLP) at the next meeting.