NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

5 June 2024

11:00 GMT+1 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 - 1 May.pdf
- 4 Action Log - Public Board.pdf
- 7 Chief Executive Officer Report.pdf
- 8.1 WUTH IPR SPC Dashboard - May 2024 - 5 CFO.pdf
- 8.1.2 CFO Commentary M1 24-25.pdf
- 8.2 COO Report.pdf
- 8.3 Integrated Performance Report - June 2024.pdf
- 8.3.1 WUTH IPR SPC Dashboard - May 2024 - Intro.pdf
- 8.3.2 WUTH IPR SPC Dashboard - May 2024 - 1 COO.pdf
- 8.3.3 WUTH IPR SPC Dashboard - May 2024 - 2 MD.pdf
- 8.3.4 WUTH IPR SPC Dashboard - May 2024 - 3 CN.pdf
- 8.3.5 CN Commentary.pdf
- 8.3.6 WUTH IPR SPC Dashboard - May 2024 - 4 CPO.pdf
- 8.3.7 CPO Commentary.pdf
- 8.3.8 WUTH IPR SPC Dashboard - May 2024 - 6 CIO.pdf
- 8.3.9 CIO Commentary.pdf
- 8.4 Productivity and Efficiency Update.pdf
- 8.5 Quarterly Maternity Report.pdf

- 8.6 Learning from Deaths Report Q3 2023-24.pdf
- 8.7 Guardian of Safe Working Annual Report Final 16th May 2024.pdf
- 9 Modern Slavery Statement.pdf
- 10 Annual Report of the BoD, including Effectiveness Review.pdf
- 10.1 Appendix 1 BoD.pdf
- 10.2 Appendix 2 Board of Directors TOR Review.pdf
- 11.1 FBPAC.pdf
- 11.2 People.pdf
- 11.3 Quality Committee.pdf

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 5 June 2024
Time	11:00 – 13:00
Location	Hybrid

Page	Agenda Item			Lead	Presenter
	1.		Welcome and Apologies for Absence	Sir David Henshaw	
	2.		Declarations of Interest	Sir David Henshaw	
5	3.		Minutes of Previous Meeting	Sir David Henshaw	
16	4.		Action Log	Sir David Henshaw	
	Items for Decision and Discussion				
	5.		Patient Story	Dr Nikki Stevenson	
	6.		Chairs Business and Strategic Issues – **Verbal**	Sir David Henshaw	
18	7.		Chief Executive Officer Report	Janelle Holmes	
	8.		Board Assurance Reports		
24		8.1)	Chief Finance Officer Report	Mark Chidgey	
30		8.2)	Chief Operating Officer Report	Hayley Kendall	
38		8.3)	Integrated Performance Report	Executive Directors	
57		8.4)	Productivity and Efficiency Update	Hayley Kendall	
66		8.5)	Quarterly Maternity Report	Dr Nikki Stevenson	Jo Lavery
72		8.6)	Learning from Deaths Report Q3 2023/24	Dr Nikki Stevenson	Dr Ranj Mehra
81		8.7)	Guardian of Safe Working Annual Report	Dr Nikki Stevenson	Dr Alice Arch
87	9.		Modern Slavery Statement	David McGovern	Cate Herbert
90	10.		Annual Report of the Board of Directors, including Effectiveness Review	David McGovern	Cate Herbert
	Committee Chairs Reports				
98	11.	11.1)	Finance Business Performance Committee	Sue Lorimer	
100		11.2)	People Committee	Lesley Davies	
102		11.3)	Quality Committee	Dr Steve Ryan	
	Closing Business				

12.	Questions from Governors and Public	Sir David Henshaw
13.	Meeting Review	Sir David Henshaw
14.	Any other Business	Sir David Henshaw

Date and Time of Next Meeting

Wednesday 3 July 2024, 09:00 – 11:00

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 1 May 2024
Location	Hybrid

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
CC	Chris Clarkson	Non-Executive Director
SL	Sue Lorimer	Non-Executive Director
SR	Dr Steve Ryan	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
RM	Dr Rajan Madhok	Non-Executive Director
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
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
CM	Chris Mason	Chief Information Officer
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.5
SH	Sheila Hillhouse	Lead Public Governor
EH	Eileen Hume	Deputy Lead Public Governor
JB	John Brace	Public Governor
TC	Tony Cragg	Public Governor

Apologies:

SI	Steve Igoe	SID & Deputy Chair
JH	Janelle Holmes	Chief Executive
JM	Julie McManus	Appointed Governor – Local Authority

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** DH welcomed everyone to the meeting. Apologies are noted above.	
2	**Declarations of Interest**	

	No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 3 April were **APPROVED** as an accurate record.	
4	**Action Log** DS clarified she anticipated providing an update in July when the NHS Staff Survey Coordination Centre had resolved the data issue. The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story from a bereaved husband whose wife passed away at Arrowe Park Hospital. The video story described his bereavement journey, which was both positive and negative. NS commented there had been significant learning following this video story and explained that in the new building there will be individual resus rooms. Ward folders had also been implemented to provide comprehensive information for patients and their families. DH queried the family leaving through ED instead of the main entrance once she had passed away. NS stated the main entrance shuts at 10pm and were unable to leave through this door after that time. NS added this would be the same when the new building was complete. SL queried if the concerns regarding GP misdiagnosis had been fed back to GPs. NS stated the Deputy Medical Director attended the local Medical Committee which included representatives from primary and secondary care, and this was raised there. LD suggested that charitable funds could be used to improve the patient relatives' experience. Members commented the patient story had been impactful and agreed to write a letter to the husband. The Board **NOTED** the video story.	
6	**Chairs Business and Strategic Issues**	

	DH provided an update on recent matters and highlighted the Wirral System Review continues to progress and the Trust had received positive feedback from the ICB regarding performance and recovery. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** NS reported the dispute with UNISON in relation to the Clinical Support Worker (CSW) banding has been resolved and that there will be no further strike action. NS added the dispute with Unite in relation to Theatre Recovery regrading remains ongoing and meetings continue to be held with Unite. NS explained from 1 April there had been specialised commissioning delegation changes resulting in certain services now being delegated to NHS Cheshire and Merseyside Integrated Care Board (ICB). NS added for the Trust this meant an additional 5% of services would be contracted by the ICB. NS stated in April there were no Patient Safety Incident Investigations opened under the Patient Safety Incident Response Framework and no Reporting of Injuries, Diseases and Dangerous Occurrences reported to the Health and Safety Executive. NS highlighted NHSE wrote to the Trust in April confirming that the undertakings imposed in 2018 and 2015 on the Trust's provider licence, relating to financial sustainability, controls, and A&E performance, will be removed. NS reference the guidance published in April for Trusts on assessing the CQC well-led key question under the new single operating framework. NS summarised the recent meetings of the Cheshire and Merseyside Acute and Specialist Trust Board (CMAST) on 5 April. SL queried the changes to the commissioning and if this was a risk or opportunity for the Trust. MC stated it was an opportunity for Cheshire and Merseyside to ensure certain pathways were aligned to population needs and the proximity of the ICB to services was a better position. Members commented the removal of the licence undertakings was extremely positive and a good sign of credibility for the Trust. The Board **NOTED** the report.	
8	**Board Assurance Reports**	

	8.1) Chief Finance Officer Report MC highlighted at the end of month 12 the Trust was reporting a deficit of £24.1m for 2023/24, an adverse variance against plan of £5.1m. MC explained the adverse variance relates to the unmitigated impact of industrial action and all other risks have been fully mitigated. MC reported this forecast variance to plan has been included within the Cheshire and Merseyside ICS forecast position to NHSE at M11 and has been maintained in M12. MC provided an update on the statutory responsibilities and key financial risks for month 12, noting the RAG rating for each, highlighting that financial stability and financial sustainability were red, financial efficiency was amber, and agency spend, capital and cash were green. MC summarised the key drivers of variance to plan and corrective actions. SL commented it was a significant achievement to deliver a £23m cost improvement programme, noting the Trust was one of the highest performance in the region and a reason for the Trust had a strong underlying financial position. The Board **NOTED** the report. **8.2) Chief Operating Officer Report** HK highlighted in March the Trust attained an overall performance of 105.80 against plan for outpatients and an overall performance of 104.47 against plan for elective admissions. HK explained underperformance against plan continues for inpatients offset by an overperformance in day case procedures, and there continues to be an underutilisation of the Surgical Centre by NHS partner organisations. HK summarised referral to treatment, cancer performance and DM01 performance against the relevant trajectories. HK reported type 1 unscheduled care performance was 46.53% and attendances remained high during the month. HK explained performance remains challenging but during April improvements have been made related to the UEC improvement plan. HK stated compliance with the national standard for 15-minute ambulance handovers continued to improve and averaged 43 minutes. HK highlighted there had been a significant increase in demand for patients attending the ED with mental health conditions. This concern continues to be escalated to the ICB.	

	RM noted the number of inpatients not meeting the criteria to reside had plateaued and queried the progress to achieve 75 inpatients by July. HK stated the focus was now on pathway 2 and 3 patients which were more complex to make improvements. A new permanent Discharge Director was now leading the Discharge Hub to deliver this. SR queried if there were still problems with children and young people residing at the hospital longer than necessary. HK stated the children and young people concerns previously reported had reduced and was currently not an issue. Members discussed the care of mental health patients and the impact this has on performance and the safety of staff and patients. Members acknowledged that following a CQC inspection of the local mental health provider, their staff had been requested to provide care for patients at the provider and this was significantly impacting on the delivery of mental health services at WUTH. DH queried how mental health services could be provided in a different way and if possible alternative solutions could be explored. DH requested HK provide data on ED performance when attendances of mental health patients was high and to quantify the impact this has. The Board **NOTED** the report. **8.3) Integrated Performance Report** NS explained the total number of C Diff cases in 2023/24 was an overall reduction compared to the previous year. NS added the Service Improvement Team would be providing support to embed actions from the IPC improvement plan. NS highlighted the method used to classify category 3 pressure ulcers had changed nationally and this was metric was likely to increase over the coming months. DS highlighted sickness absence continued to improve towards Trust target, although there had been a small increase in absences related to mental health. DS added appraisal compliance continued to be below Trust target which was key focus for Divisions. DS explained staff turnover continued to be below Trust target and this was evidence of a good employee experience. CC noted mandatory training compliance had been reducing since September and queried if this was an area of concern.	Hayley Kendall

	DS stated this was due to the impact of industrial action, but the compliance is above target (positive) and that Education Governance Group of Workforce Steering Board had a tight grip of this with no concerns being raised. SR commented certain training, notably level 4 CPR and PVP can take longer to deliver due to the in person delivery it required. NS agreed and explained each Division through Divisional Performance Reviews had a high level of focus on this due to medical compliance. CM reported for Digital Healthcare staff vacancies remained low and the Trust's cyber position remained strong, noting WUTH continued to play an active role in the relevant forums across Cheshire and Merseyside. CM added a recovery trajectory was in place to reduce the subject access requests (SARs) waiting list. LD noted the SAR position was challenged and queried the timescale to reduce this and if there were any emerging themes. CM stated the specific vacancy to respond to SARs had been filled and these would be expected to reduce within 3 months. CM added there had been no change in the themes emerging from SARs but there was a greater amount received. MC added the Information Assurance Group had a specific action to reduce the SAR waiting list. MC added Digital Healthcare assurance (including SARs and operational delivery) was provided to Finance Business Performance Committee and cyber security to Audit and Risk Committee. CC enquired if SAR themes should be provided to Quality Committee. It was agreed that the governance route for SAR reporting would be reviewed again and clarified. DH queried if the Surgical Centre still had additional capacity after NHS partner organisations had used the Centre. HK stated there was capacity and this had been offered to all providers in Cheshire and Merseyside. HK added at the point of referral for treatment patients were given the option to choose a location but waiting times were not shown. HK highlighted this had been raised with the ICB and communication about this was being improved. DH requested the Trust review how it could more widely publicise the lower waiting times at the Surgical Centre in comparison to other providers.	Mark Chidgey/ David McGovern Debs Smith/Hayley Kendall

	The Board **NOTED** the report. **8.4) Board Assurance Framework (BAF)** DM explained that, following the annual review of the BAF, the Board approved in April the strategic level risks that will be monitored for the year 2024/25. Work has commenced to update previous risks and populate newer risks, which will be completed over the coming month. DM added the frequency of BAF reporting will revert to the previous pattern. The Board: • **APPROVED** the proposed changes to the BAF; and • **NOTED** the current position in regard to Risk Appetite and Risk Maturity. • **NOTED** the amendments to the frequency of BAF reporting which will be implemented from this meeting. **8.5) Monthly Maternity and Report** JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were no areas of concern to raise this month. JL added one emerging area of concern related to midwifery staffing due to leavers, retirements, and maternity leave, noting the service would be reliant on newly qualified midwives in September 2024. Recruitment campaigns were ongoing for Band 5 and Band 6 Midwives. JL referenced the thematic review carried into the six neonatal deaths in the postnatal period, summarising the findings and recommendations for the Trust and Wirral system partners. JL provided the Maternity Incentive Scheme (MIS) Year 6 guidance for information and the Trust's position in achieving Saving Babies Lives Version 3. SR commented he recently undertook a maternity safety walkabout and noted the strong leadership and positive cultural within maternity services. SR added midwifery staffing was a national issue and the Trust was not an outlier. NS explained that the thematic review was a good example of learning, which had been shared with Wirral system partners and included recommendations to reduce health inequalities. The Board **NOTED** the report.	
9	**Health Inequalities Operating Model** DM and MS gave an overview of the presentation, summarising the rationale for the operating model and proposed governance	

	structures to optimise the Trust's efforts in addressing health inequalities. DM and MS explained the key next steps included endorsing and embedding the Health Inequality Model, engaging in health inequality initiatives with specific named leads, embedding tools for health inequality reduction and setting up a Health Inequality Committee. DM and MS added the Health Inequality Committee would report through to Quality Committee and Board. SL noted one of the CORE20PLUS5 priorities was to pay a real living wage to enhance workforce health and wellbeing. SL queried how feasible this was given the financial constraints. DS stated this would pose a challenge due to the requirements of Agenda for Change, and additional funding for pay could only be awarded by NHSE. RM commented about the regeneration of Birkenhead and the opportunities for the Trust to engage in health inequality reduction initiatives through the regeneration. LD queried the impact and commented about the importance of identifying 2 or 3 key areas of focus for the year. LD also commented about the timeliness of delivery and the impact of this by setting up governance structures. MS stated the impact would be measured similarly to other strategic priorities through twice yearly updates to Board. DH commented about ensuring Wirral system partners were also involved in the Trust's effort to reduce health inequalities. DH suggested the Health Inequality Committee identify 2 or 3 key areas of focus for the year and report these back to the Board. The Board: • **ENDORSED** the WUTH Health Inequality Model • **ENDORSED** the Health Inequality Initiatives with Designated Leads • **ENDORSED** the tools for Systematic Health Inequality Reduction	David McGovern
10	**Declarations of Interest and Fit and Proper Persons Annual Update** CH provided the year-end updates on the register of interests, the register of gifts and hospitality, and the fit and proper persons regime compliance, noting this had been provided to Audit and Risk Committee in April.	

	CH added an internal audit review had been conducted earlier in year on Managing Conflicts of Interest and received substantial assurance. DM noted the new requirement to submit a return providing detail on the successful completion of the Fit and Proper Persons annual tests and added that the self-assessments would be sent round shortly. The Board: • **NOTED** the Register of Interests at Appendix 1 and 2, the Register of Gifts at Appendix 3 and Hospitality at Appendix 4; and • **NOTED** the update on Fit and Proper Persons.	
11	**Committee Chairs Reports** **11.1) People Committee** LD explained she provided a verbal update at the last meeting and that the report summarised the meeting. The Board **NOTED** the report. **11.2) Council of Governors** DH gave a verbal update and explained the meeting had been positive with a good number of Governors attending. DH added there were had been detailed discussions on the Green and Sustainability plan and the employee experience of staff. The Board **NOTED** the report. **11.3) Estates and Capital Committee** DH highlighted at the last meeting an approach was discussed to develop a site control plan for Arrowe Park Hospital, providing a plan for future developments on the campus. DH added Committee also received an update on UECUP (Urgent and Emergency Care Upgrade Programme) and received assurance on the performance of estates function and capital programme financial/plan performance. The Board **NOTED** the report. **11.4) Audit and Risk Committee** DH noted SI had provided his apologies and that a report had been provided summarising the meeting.	

	The Board **NOTED** the report. **11.5) Charitable Funds Committee** SL gave a verbal update and highlighted at the last meeting it had been agreed to end the Tiny Stars appeal and once the Committee had oversight of the capital schemes being developed for the neonatal unit and confirmation on final costs/available funds, a recommendation would come back to Board. SL added Committee also agreed a process for the appointment of restricted fundholders and was given an update on the Charity activity and financial plans for the next financial year. **11.6) Finance Business Performance Committee** SL gave a verbal update and explained at the last meeting a review of consultant agency spend was discussed and exit plans in place each medical speciality. A Digital Healthcare update was now provided to each meeting and Committee heard about the plans for the Patient Portal. SL added the Committee also received a deep dive into backlog maintenance challenges, risk, and business continuity challenges. CC noted the long term financial risk of backlog maintenance and the impact of this on the Trust's long term financial position. CC queried if this could be discussed at the next Estates and Capital Committee meeting. MS agreed and indicated that he could develop projections on future backlog maintenance cost for the next ten years. The Board **NOTED** the report.	Matthew Swanborough
12	**Questions from Governors and Public** JB queried if there had been any nominations received for new monthly staff recognition awards. DS stated nominations opened today and the team were anticipating a good response. JB also queried if it was routine to conduct a thematic review into neonatal deaths. NS stated there had been a small increase in neonatal deaths within a short period and other nearby Trusts experienced similar increases. NS added it was national guidance that any neonatal deaths are reported to Board, which did not apply to other adult deaths.	

	No questions were raised.	
13	**Meeting Review** Members commented there had been good and transparent discussions. Members also commented that the patient story had been impactful.	
14	**Any other Business** No other business was raised.	

Action Log
Board of Directors in Public
5 June 2024

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	3 April 2024	9	To provide an updated presentation with the data for questions relating to physical violence and bullying in work are available	Debs Smith	In progress. To be provided once the data issue has been resolved by the NHS Staff Survey Coordination Centre.	July 2024
2.	1 May 2024	8.2	To provide data on ED performance when attendances of mental health patients was high and to quantify the impact this has	Hayley Kendall	Complete. Updated provided in the COO Report.	June 2024
3.	1 May 2024	8.3	To review and clarify the governance route for SARs.	Mark Chidgey/ David McGovern	Complete. The detail of the Trust's compliance with standards relating to SARs is reviewed at the Information Assurance Group with assurance from this group then reported to Audit and Risk Committee. SARs performance is also reported on the Integrated Performance Report, which is visible at the Trust Board and all Committees.	June 2024
4.	1 May 2024	8.3	To consider how the Trust could better publicise the lower waiting times at the Surgical Centre	Debs Smith/Hayley Kendall	Complete. Press release is drafted and ready to be issued.	June 2024
5.	1 May 2024	9	To ensure the Health Inequality Committee identify 2 or 3 key areas of focus for the year and report these back to the Board	David McGovern	Completed for action plan for first meeting when constituted. Forward plan will contain regular Board reporting.	June 2024
6.	1 May 2024	11.6	To discuss at the next Estates and Capital Committee the long term financial risk of backlog maintenance	Matthew Swanborough	Complete. Scheduled for July Estates and Capital Committee meeting.	July 2024

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
			and the impact of this on the Trust's financial position			

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
5 June 2024

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

Executive Summary and Report Recommendations
The purpose of this report is to provide Board with an update on strategic activity undertaken since the last meeting and draws the Board's attention to any local and national developments. It is recommended that the Board of Directors: • Note the report

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

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

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

1	**Narrative**
1.1	**Industrial Action** The national pay dispute relating to Specialty and Associate Specialist (SAS) Doctors and Junior Doctors is on-going. The BMA are currently balloting SAS doctors on the most recent

	pay offer. The ballot closes on 14th June 2024. The BMA has announced Junior Doctors strike action to take place beginning on Thursday 27 June and ending Tuesday 2 July. Board members are aware that there is an on-going dispute with Unite in relation to 23 staff members in Theatre Recovery regarding banding. The staff members in question have taken strike action in April and May, and further action is planned in June 2024. The agreed Trust process for reviewing banding has been made available to the staff members in question. Unfortunately Unite members have declined to participate in that process to date. As the Trust's aim is to resolve the dispute, further flexible alternative options for staff to provide evidence of work at a higher grade have been offered. Meetings with Unite are on-going. Comprehensive arrangements to plan for this local strike action have been put in place via the EPRR route and as such there have been no delays or disruptions to our patients.
1.2	**Health and Safety** There were no Patient Safety Incident Investigations (PSII) opened in April under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. There were two Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORs)s reportable events reported in April. All RIDDORs reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring.
1.3	**News and Developments** **Wirral System Review** In March 2024, Cheshire and Merseyside Integrated Care Board (C&M ICB) commissioned an independent review of collaboration and integration opportunities across NHS provider services on Wirral. This review is primarily focussed on identifying priorities for clinical, operational, and financial integration between Wirral University Teaching Hospital NHS FT (WUTH) and Wirral Community Health and Care NHS FT (WCHC). The review also will set out the integration delivery mechanisms and implementation roadmap for WUTH and WCHC. The review is a two stage process and commenced in late April 2024, with the aim of completing by August 2024. It is expected that the final report and recommendations will be shared, firstly, with the Cheshire and Merseyside ICB Board, then with the WUTH Board and WCHC Boards, for review and approval. **Wirral Community Diagnostic Centre** In early April 2024, the Trust commissioned and opened the new Wirral Community Diagnostic Centre (CDC) at Clatterbridge Hospital. The £13m new modular building construction includes new MRI and CT scanners and clinical rooms, ultrasound facilities and patient change areas. A link bridge has also been constructed, allowing direct access to Clatterbridge Hospital operating theatres.

	The new CDC will support diagnostic tests for hospital patients as well as direct access for primary care. **Martha's Rule Update** The Trust has been selected by NHS England to be a pilot site for the implementation of Martha's Rule. This will require the Trust to set up a process whereby patients, families and carers have 24/7 access to an urgent clinical review and second opinion if they have concerns around care or clinical deterioration. Care of the deteriorating patient is one of WUTH's key quality priorities for the coming year, and a Trust wide quality improvement project for care of the deteriorating patient is ongoing. **Publication of the Infected Blood Inquiry final report** Last month the Infected Blood Inquiry published its final report (www.infectedbloodinquiry.org.uk/reports). The Prime Minister subsequently issued an apology on behalf of successive Governments and the entire British state and on behalf of the NHS in England, now and over previous decades, Amanda Pritchard also issued a public apology. The Department of Health and Social Care has committed £19 million over five years to provide a bespoke Infected Blood Psychological Support Service which is expected to be rolled out later this summer. This service will include talking therapies, peer support, and psychosocial support, as well as access to other treatments or support for physical or mental health needs where appropriate.
1.4	**System Working** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** The CMAST Leadership Board met on 3 May and was a joint meeting with both Trust CEOs and Chairs in attendance. A key area of discussion was a review of the CMAST delivery priorities and commitments for 2024/25. The proposals are summarised below and were endorsed by the membership and are due to be reported to the ICB. The Board were also updated on Laboratory Information Management System (LIMS) decision making. At the time of meeting 4 of 5 Core Trusts had approved LIMS investment and delegation of implementation to the CMAST Leadership Board. Agreement from the remaining Trust is expected before the end of May. CMAST Programme deliverables for 2024/25 at a headline level are as set out below: **Elective Recovery and Transformation Programme:** 1. Reducing long waits, and improving waiting list management • Maintain zero 104 week position • Maintain zero 78 week position

- Eliminate 65 week waits
- Validation – meet national target

2. Reducing variation between providers
   - Achieve 85% theatre utilisation for all Trusts capped
   - Reduction in fallow theatres
   - Increase utilisation in elective hub theatre utilisation
   - Advice and guidance
   - Outpatient follow-up reduction
   - Maximising elective hub usage
   - Reduction in capacity-related insourcing & outsourcing

3. Improving productivity and efficiency within the providers
   Pre-referral specialist advice utilisation rate
   - Target: greater than 21% pre-referral specialist advice diversion rate.
   - Target: greater than 55% post-referral specialist advice utilisation rate.
   - Target: greater than 21% post-referral specialist advice diversion rate.

   PIFU utilisation rate
   - Targe: greater than 5%

A task and finish group has been established to review ad-hoc independent sector spend to ensure providers are not incurring costs for ad-hoc provision where there is local capacity available. CMAST will be working closely with high-spend trusts to support access to local capacity where possible before incurring unnecessary IS costs.

Diagnostics Programme

1. Reducing waiting times

   a. Productivity
   - Endoscopy - 95% lists utilisation
   - CT – 4 scans per hour
   - MRI – 2.5 scans per hour
   - NOUS - 3 scans per hour
   - Echos - 45 mins per test

This will mean 95% of patients seen within 6 weeks and no patient waits more than 13 weeks.

   b. Radiology
   - Deliver increased quality, reduced duplication, and reduced reporting waits.
   - Meet Royal College of Radiology (RCR) Guidelines:
     - CT - 95% urgent with 7 days
     - CT – 95% routine within 28 days
     - MRI – 90% of urgent within 7 days
     - MRI – 95% routine within 28 days

   c. Histopathology
   - Maximise our efficiency and resilience in histopathology
   - 80% cancer cell path samples reported within 10 working days

2. Digitise and innovate

- Reduce duplicate tests and ensure that patients don't need to attend repeat appointments - Save £10m over 10 years across the system.
- Ensure abnormal tests are prioritised - Save consultant reporting time enabling other images to be reported on quicker
- Potentially reduce appointment times from 45 minutes to 20 minutes - Increase capacity, reduce waiting times and reduce IS spend.
- Ensure abnormal tests are prioritised. Reducing the turnaround time for reports and the impact on urgent care.

3. Workforce resilience

    - Provide support and resilience for healthcare scientists - Ensure the 40+ Physiological Science tests have a strong workforce in place.
    - Do it 'once and well' attracting staff for the trust of their preference - Reducing vacancy rates.
    - Ensure we adjust to help staff to remain in post - Reducing use of bank and agency.
    - Ensure that we have a pipeline of staff coming into our system.
    - Ensure that we have resilience for years to come.

Clinical Pathways Programme

1. Improved access to services and health outcomes across C&M
2. Improving clinical pathways whilst actively supporting a reduction in health inequalities across C&M
3. Systems working collectively to improve service delivery, clinical outcome, patient experience, and where possible release efficiency savings.

Focus and clinical groups have been established across Dermatology, Cardiology, ENT, Ophthalmology, gynaecology.

Efficiency at Scale

Systems working collectively to improve service delivery and where possible release efficiency savings in 2024/5, this programme is targeting savings of £32.5m by focussing on:

- Reduction in fragile services across C&M
- Improved service delivery & quality
- Optimisation of assets/systems and expertise
- Improved productivity & value of money

Specific areas of work include:

1. Support a productive & efficient workforce
    - Support the continued reduction in agency costs
    - Optimisation of assets/systems and expertise

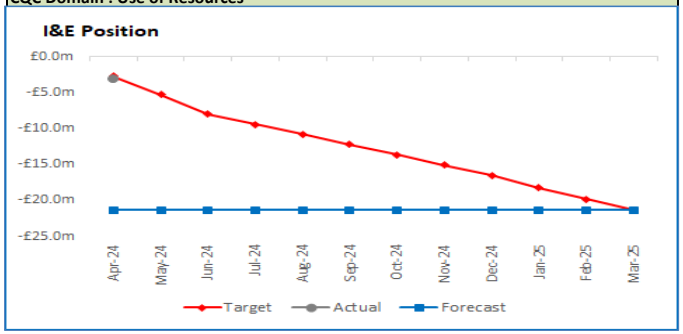
2. Reduce corporate running costs.
    - Simplification and standardisation of processes across the system
    - System collaboration where appropriate
    - Reduce corporate running costs.

3. Optimisations of purchase at scale opportunities across the C&M system
    - Reduce procurement and supply chain costs.

	• Improved inventory management across C&M • Optimisation of Value Based Procurement 4. Improved Medicines Optimisation across C&M • Improved patient outcomes • Support Health Inequalities and levelling-up agenda • Using best value biologic medicines • Optimisation of high-cost drugs (Blueteq & Homecare) • Purchase medicines at the most effective price point • Address problematic polypharmacy **Place Based Partnership Board (PBPB) Update** The PBPB met on the 7 May and discussed several standing reports on Place Quality and Performance, Finance and Unscheduled Care. Key among the reports was discussion surrounding the latest position on 2024/25 NHS Planning Guidance, specifically the approach being taken in Wirral by NHS Cheshire and Merseyside with Place partners to refresh the Wirral Health and Care Plan 2023/24 for 2024/25. Partners supported the approach being taken to update the Wirral Health and Care Plan for 2024/25 and agreed to receive this for approval at the June PBPB meeting.

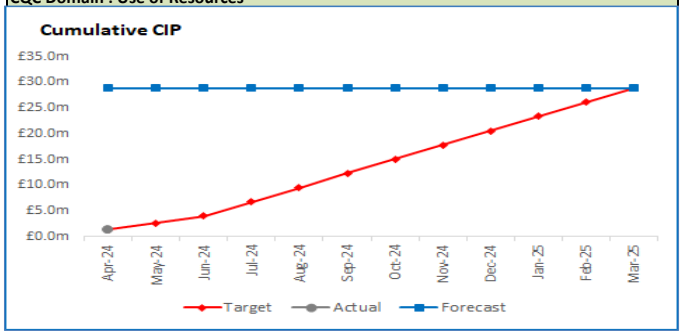
Chief Finance Officer

CQC Domain : Use of Resources



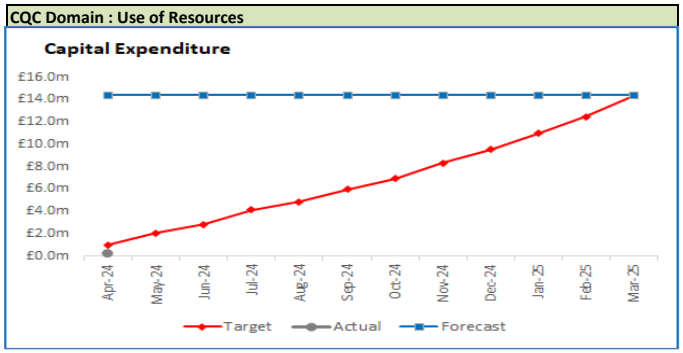
Apr-24
-£3.2m
Variance
Position worse than plan
Target
-£2.7m

CQC Domain : Use of Resources



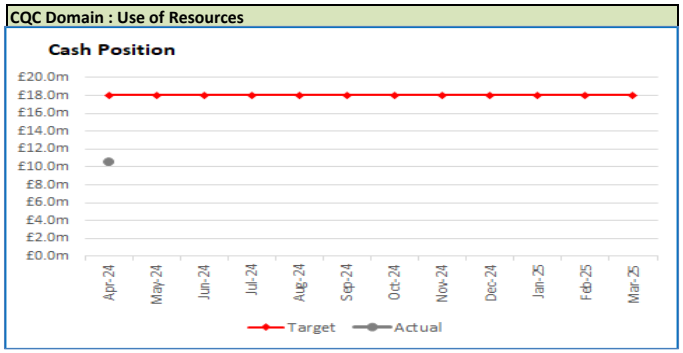
Apr-24
£1.3m
Variance
Position not worse than plan
Target
£1.3m

CQC Domain : Use of Resources



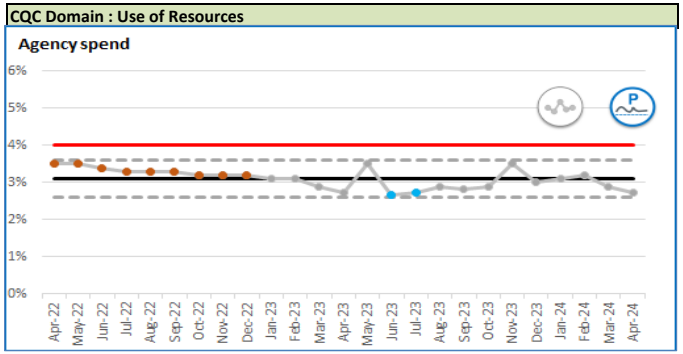
Apr-24
£0.2m
Variance
Position not worse than plan
Target
£1.0m

CQC Domain : Use of Resources



Apr-24
-£10.5m
Variance
Position worse than plan
Target
£18.0m

CQC Domain : Use of Resources



Apr-24
2.7%
Variance
Position better than threshold
Threshold
3.2%

Chief Finance Officer

Executive Summary

This report is based upon the draft annual plan which is in the process of being approved by the Board and NHS England.

The key internal risks to achievement of plan are full delivery of elective activity and the Cost Improvement Programme (CIP). 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).

At the end of April, month 1 (M1), the Trust has reported a deficit of £3.2m against a plan of £2.7m. This £0.5m adverse variance primarily relates to lower than planned levels of elective activity.

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

The risk ratings for delivery of statutory targets in 2024/25 are:

Statutory Financial Targets	RAG (M1)	RAG (Forecast)	Section within this report / associated chart
Financial Stability			I&E Position
Agency Spend			I&E Position
Financial Sustainability			N/A (quarterly update)
Financial Efficiency			Cumulative CIP
Capital			Capital Expenditure
Cash			Cash Position

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

The Board is asked to:

- Note the report.

I&E Position

Narrative:

At the end April, M1, the Trust has reported a deficit of £3.2m against a plan of £2.7m. The table below summarises this I&E position at M11:

	In Month			Year to Date		
Cost Type	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Clinical Income from Patient Care Activities	£37.7m	£36.8m	-£0.9m	£37.7m	£36.8m	-£0.9m
Other Operating Income	£2.6m	£2.8m	£0.2m	£2.6m	£2.8m	£0.2m
Total Income	**£40.3m**	**£39.6m**	**-£0.8m**	**£40.3m**	**£39.6m**	**-£0.8m**
Employee Expenses	-£29.8m	-£29.9m	-£0.0m	-£29.8m	-£29.9m	-£0.0m
Operating Expenses	-£13.6m	-£13.5m	£0.1m	-£13.6m	-£13.5m	£0.1m
Non Operating Expenses	-£0.5m	-£0.3m	£0.2m	-£0.5m	-£0.3m	£0.2m
CIP	£0.9m	£0.9m	-£0.0m	£0.9m	£0.9m	-£0.0m
Total Expenditure	**-£43.1m**	**-£42.8m**	**£0.3m**	**-£43.1m**	**-£42.8m**	**£0.3m**
Total	**-£2.7m**	**-£3.2m**	**-£0.5m**	**-£2.7m**	**-£3.2m**	**-£0.5m**

Key variances within the position are:

Clinical Income – £0.9m adverse variance relates to underperformance against the value of the elective plan in Surgery. This is discussed in more detail within the Elective Activity agenda item.
Non-operating expenses – interest receivable was higher than plan.
Cost Improvement Programme – CIP is in line with plan at M1, with savings for quarter 1 (Q1) transacted in full.

The Trust's agency costs were 1.5% of total pay costs in M1. This is below the 2024/25 target of 3.2%.

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).
- The Trust fails to fully deliver the Elective Activity plan (see below and separate agenda item).

Actions:
- Full identification and delivery of CIP schemes.
- Maximising elective capacity and recovery.

Cumulative CIP

Narrative:
The Trust delivered £0.9m CIP in M1 which is in line with plan. At the time of reporting the Trust has identified £20.3m of the 24/25 CIP target of £27.2m, a gap of £6.9m.

Risks to position:

- That the gap between target and identified schemes is not reduced.
- That the momentum on delivery of schemes is not sustained.
- That the capacity of the Trust is not sufficient to deliver across all improvement agendas.

Actions:
- Continuation of the Productivity and Improvement Programme.

Elective Activity

Narrative:
The Trust delivered elective activity to the value of £5.2m against a plan of £6.1m, a shortfall of £0.9m. This was driven in part by a shortfall of elective and day cases in Surgery but in the main by a lower case mix within the Division.

Risks to position:
- That the Trust fails to utilise the elective capacity in place.
- That the current case mix of cases continues.

Actions:
- Plans being developed within Surgery, with support from the Chief Operating Officer (COO) and Chief Finance Officer (CFO), to recover lost activity or to mitigate the income lost through further reductions in cost.

Capital Expenditure

Narrative:
Capital plan to be approved by the Board:

Description	Approved Budget at M1
CDEL	
Internally Generated	£12.870m
ICB/PDC/WCT	£6.284m
Charity	£1.000m
Confirmed CDEL	**£20.154m**
Total Funding for Capital	**£20.154m**
Capital Programme	
Estates, facilities and EBME	£5.000m
Heating and chilled water pipework replacement	£2.100m
Operational delivery	£2.750m
Medical Education	£0.080m
Transformation	£1.000m
Digital	£0.750m
UECUP	£6.010m
Charity	£1.000m
Approved Capital Expenditure Budget	**£18.690m**
Diagnostics Digital	£0.064m
LIMS - PDC	£1.400m
Confirmed PDC	**£1.464m**
Total Anticipated Expenditure on Capital	**£20.154m**
Under/(Over) Commitment	**£0.000m**

Whilst M1 spend on the capital programme is £0.78m below plan, no underspend is anticipated against plan by year end.

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

Risks to position:

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

Actions:

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

Cash Position

Narrative:

The underlying deficit position places increasing pressure on the Trust's ability to maintain a positive cash balance. At the end of April the cash balance was £10.4m. The Trust's capital programme and a planned deficit of £21.2m 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 and the Trust will need to draw upon additional borrowing by Q3 of 24/25.

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.
- Discussions with ICB around mitigations for cash position and process for applying for cash support.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 8.2**
5 June 2024

Title	Chief Operating Officer's Report
Area Lead	Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Baily, Deputy Chief Operating Officer Alistair Leinster, Divisional Director for Planning and Performance
Report for	Information

Report Purpose and Recommendations

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

For planned care activity volumes, it highlights the Trust's performance against the targets set for this financial year. The Board should note the ongoing positive performance with recovering elective waiting times, the achievement of the diagnostic 6 week waiting time and the 28 day faster diagnostic standard.

For unscheduled care, the report details performance and highlights the ongoing challenges with achievement of the national waiting time standards in the Emergency Department (ED).

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

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

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

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

1	Introduction / Background
1.1	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 the pandemic and more recently, the ongoing and prolonged industrial action. WUTH has 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. The Trust has a strong elective recovery position within the region and continue to provide mutual aid to other organisations, through the Cheshire and Merseyside Surgical Centre at Clatterbridge. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny to ensure delivery of timely ambulance handover. The Trust has engaged with AQUA improvement work and those observations have been incorporated into the improvement plan. The improvement plan was presented to the Finance, Business Assurance Committee in April 2024.

2	Planned Care
2.1	**Elective Activity** In April 2024, the Trust attained an overall performance of 103.5% against plan for outpatients and an overall performance of 98.1% against the plan for elective admissions, as shown in the table below:

Activity Type	Target for April	Actual for April	Performance
Outpatient New	12,671	12,428	98.08%
Outpatient Follow up	30,029	31,777	105.82%
Outpatients - Total	42,700	44,205	103.52%
Elective - Day case	4,438	4,547	102.46%
Elective - Inpatients	739	530	71.72%
Elective - Total	5,177	5,077	98.07%

Elective inpatients saw an under performance mainly in orthopaedics and also related to the underutilisation of the surgical centre via another organisation.

2.2	**Referral to Treatment (RTT)** The national standard is to have no patients waiting over 104 weeks from March 2023, to eliminate routine elective waits of over 78 weeks by April 2023, and to have no 65

week waits by September 2024. The timescale for elimination of 65 week waiters has moved nationally to September 2024, due to the impact of industrial action. The Trust having an internal stretch target of no 65 week waiters by the end of July 2024. The performance at end of April against these indicators was as follows:

- 104+ Week Wait Performance – 0
- 78+ Week Wait Performance – 3 (all patient choice)
- 65+ Week Wait Performance - 339
- 52+ Week Wait Performance – 1,985
- Waiting List Size - there were 44,710 patients on an active RTT pathway which is higher that the previously report Trust position of 41,440

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.

WUTH have continued to support Trusts across the North West by offering mutual aid to treat very long waiting patients through the Cheshire and Merseyside Surgical Centre.

2.3 Cancer Performance

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

Quarter	4
Period	01/01/2024 - 31/03/2024

National Standards:

Target	Indicator	Threshold	January-24		February-24		March-24		Quarter 4	
			Actual	Predicted	Actual	Predicted	Actual	Predicted	Actual	Predicted
28 Day Wait	GP or Screening Referral to Patient Informed of Cancer Diagnosis or Ruling Out of Cancer	75.00%	66.14%	N/A	76.09%	N/A	76.80%	N/A	73.17%	N/A
31 Day Wait	Decision to Treat/Earliest Clinically Appropriate Date to Treatment	96.00%	90.87%	N/A	94.83%	N/A	91.21%	N/A	92.21%	N/A
62 Day Wait	GP Urgent Referral, Screening Referral or Consultant Upgrade to First Definitive Treatment	85.00%	71.29%	N/A	71.48%	N/A	77.45%	N/A	73.68%	N/A

Sub Targets (Not National Standards):

Target	Indicator	Threshold	January-24		February-24		March-24		Quarter 4	
			Actual	Predicted	Actual	Predicted	Actual	Predicted	Actual	Predicted
28 Day Wait	Breast Expected to be >=90%	90.00%	93.44%	N/A	95.64%	N/A	94.83%	N/A	94.64%	N/A
28 Day Wait	Skin Expected to be >=90%	90.00%	88.12%	N/A	96.53%	N/A	94.88%	N/A	93.57%	N/A
62 Day Wait	Trust Position Expected to be >=70% by End March 2024	70.00%	71.29%	N/A	71.48%	N/A	77.45%	N/A	73.68%	N/A

- *2 Week Waits* – This national standard has now been stood down. However, the Trust continues to measure performance internally to support the delivery of the Faster Diagnosis Standard. At the end of March 2WW performance was 87.2%.

- *FDS* – The Trust saw an improvement in February and March, achieving the national target of 75% by March 2024, despite the impact of industrial action and subsequent inability to maintain the 2WW standard. During the period April 2023 – March 2024, WUTH was the 2nd best performing acute Trust in the region against this metric.

- *62 day* – performance improved in March 2024 compared to January and February. April position remains above trajectory, with 131 patients against a plan of 120.

	01/04	08/04	15/04	22/04	29/04	06/05	13/05	20/05	27/05	03/06	10/06	17/06	24/06	01/07	08/07	15/07	22/07	29/07	05/08	12/08	19/08	26/08
Actual 24/25	135	132	119	131																		
Trajectory	120	120	120	120	120	112	112	112	112	103	103	103	103	93	93	93	93	93	83	83	83	83
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

- *104 day long waiters* – performance is below trajectory for April, at 32 against a plan of 50.

	01/04	08/04	15/04	22/04	29/04	06/05	13/05	20/05	27/05	03/06	10/06	17/06	24/06	01/07	08/07	15/07	22/07	29/07	05/08	12/08	19/08	26/08
Actual 24/25	45	36	33	32																		
Trajectory	50	50	50	50	50	47	47	47	47	42	42	42	42	39	39	39	39	39	33	33	33	33
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

For 2024/25, the 62 day standard sees a previous national target of 85%, a national requirement to achieve 70% and a local trajectory to maintain 77% performance. The Trust is achieving the national requirement to achieve 70% for 62-day waiters (by March 2024) and remains focussed on reducing the total number of 62 and 104 day long waiters to pre-covid levels.

2.4 DM01 Performance – 95% Standard

At the end of April 97.73% of patients had been waiting 6 weeks or less for their diagnostic procedure for those modalities included within the DM01, maintaining the achievement of target seen in March. This is against the revised national standard of 95% and requirement for Trust's to achieve 90% by March 2024. Demand to endoscopy services has increased and thus future month's performance will be challenged to achieve the same level but it is predicted to remain above 90%.

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.

The major risk to the delivery of the elective recovery programme has been medical staff industrial action, given the significant volumes of patients cancelled during strike action. There is an emerging risk relating to the replacement of equipment in the sterile services department for which a business case is currently drafted and will be presented to Finance, Business Assurance Committee (FBPAC) in June 2024.

The main area of concerns in delivering 65 weeks by the end of September 2024 are Gynaecology and Colorectal both of which have significant backlogs of patients on the non-admitted pathway. Both services have recovery plans but there is no slippage built into the delivery plans.

3.0 Unscheduled Care

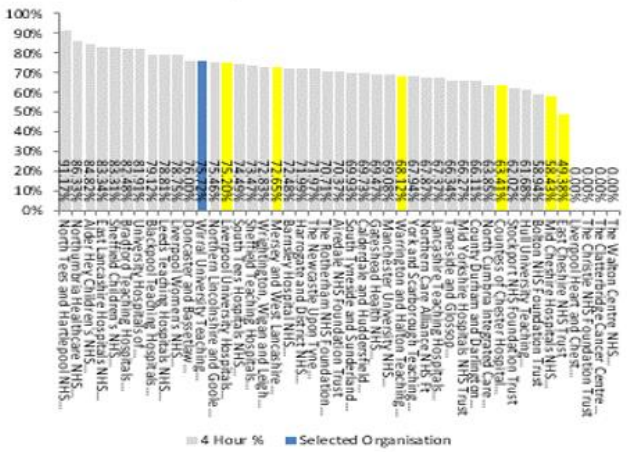
3.1 4 hour performance

April Type 1 performance was reported at 48.64%, with the combined performance for the Wirral site at 75.19%:

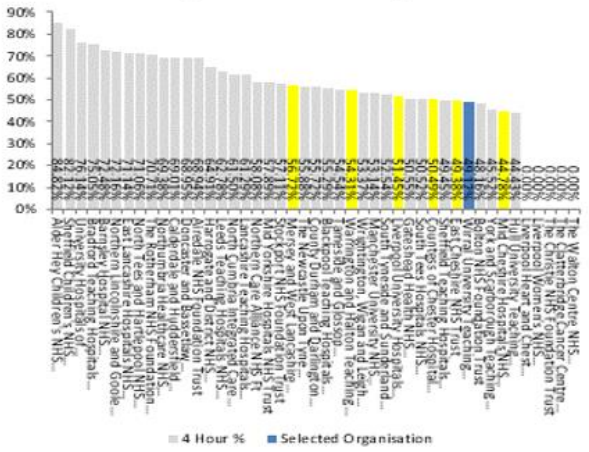
Type 1 ED attendances:	Type 3 ED attendances:
• 8,204 in March (avg. 264/day) • 7,720 in April (avg. 264/day) • 2% decrease from previous month, however 2% above April 23	• 3,268 in March • 3,268 • 2,822 in April • 14% reduction from previous month

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:

4hr performance weekly rank (all	
Region	National
12 / 45	40 / 127

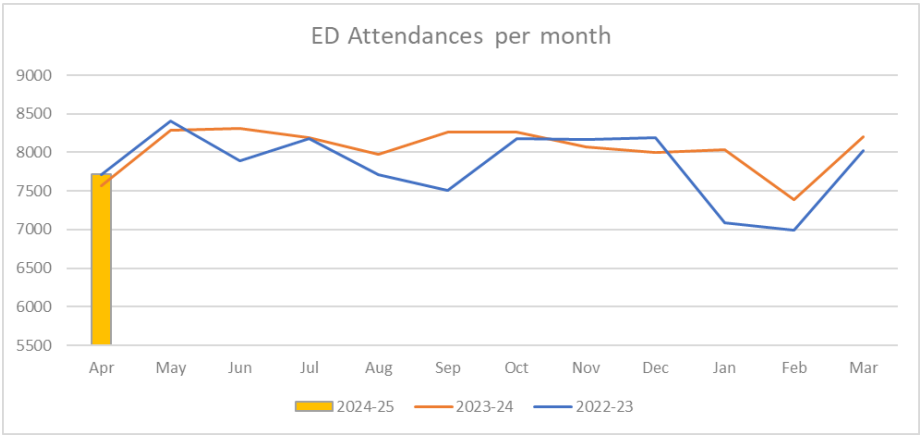


4hr performance weekly rank (Type	
Region	National
36 / 45	104 / 127



Type 1 performance remains the most significant challenge however as part of 2024-25 planning the Trust is working with system colleagues to agree the out of hospital response to support the improvement to achieve the recovery trajectory. Physical space within the department at peak times limit the ability to see patients in a timely manner that is compounded by the significant number of days where demand is between 50-100 patients in excess of what the department is designed for.

A&E type-1 attendances remained high during the month of April 2024 and although the activity dropped from March, attendances remain above the same month for the previous two years. As mentioned above, although in aggregate the demand per month is higher than previous years the department is experiencing attendances of 300-350 on Monday and Tuesday in particular, where last year this did not happen and puts significant pressure on the department delivering 4 and 12 hour improvements and recovering from the days of significant demand.

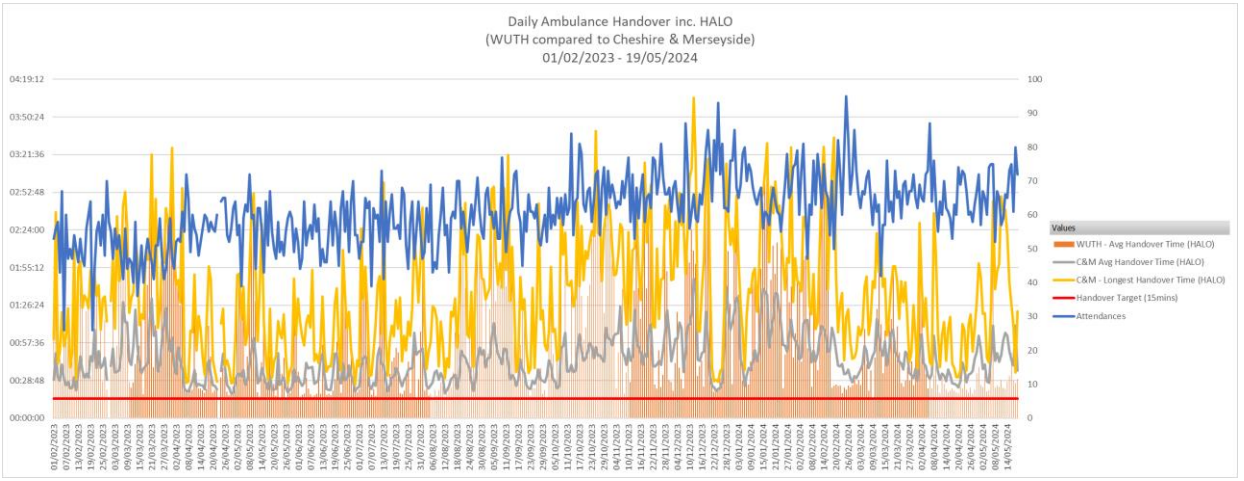


3.2 Ambulance handover performance

The Trust saw a significant improvement in ambulance handover times in April, performing 3rd out of the 9 acute Trusts within Cheshire and Merseyside.

	Dec-23	Rank	Jan-24	Rank	Feb-24	Rank	Mar-24	Rank	April	Rank
Aintree	00:56:25	5	00:46:11	3	00:51:43	5	00:43:35	4	00:48:52	9
Arrowe	01:15:24	8	01:31:22	8	01:07:09	9	00:48:17	7	00:32:56	3
Chester	01:19:07	9	01:43:38	9	00:48:14	3	00:46:04	6	00:44:47	8
Leighton	00:37:36	2	00:32:09	1	00:31:01	1	00:34:57	1	00:35:45	4
Macclesfield	00:51:39	4	00:39:05	2	00:39:29	2	00:44:01	5	00:28:57	1
Royal	00:57:32	6	01:03:42	5	00:51:48	6	01:04:01	9	00:38:42	5
Southport	00:51:26	3	01:14:38	6	00:57:08	7	00:40:51	3	00:40:52	7
Warrington	00:33:40	1	00:46:26	4	00:49:26	4	00:38:31	2	00:29:56	2
Whiston	01:00:42	7	01:29:53	7	01:00:18	8	00:53:54	8	00:38:51	6

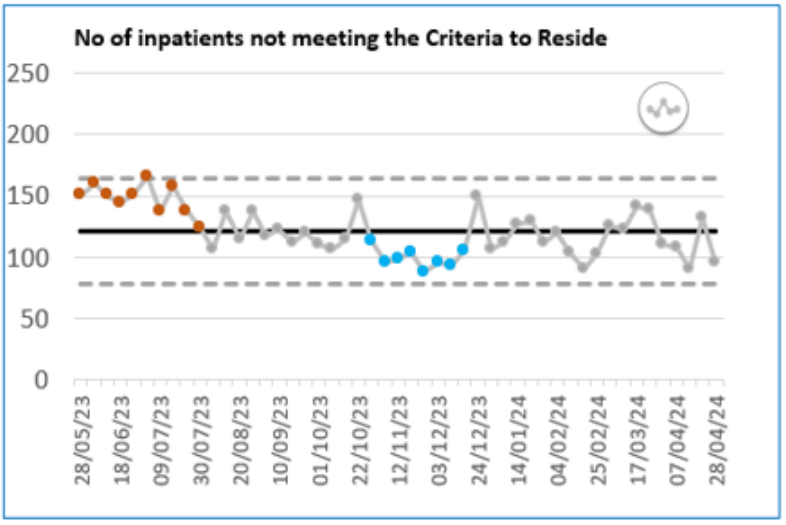
The improvement in performance can be seen month on month following several interventions implemented during February, including the continuous flow policy, increasing the staffing for ED corridors and direct oversight by the Chief Operating Officer, and particularly the Deputy Chief Operating Officer.



The actions taken following the work with AQuA have also been implemented, leaving only two recommendations outstanding. The emergency department is currently looking into the possibility of increasing the number of chair spaces for ambulatory care in order to be able to implement the fit2sit model. The model aims to identify patients arriving by ambulance who are well enough to sit in a chair and be treated rather than waiting on a trolley. It is expected that this model will be implemented after the next phase of the UECUP move, which is planned for June.

The greater part of the work is related to the expansion of same day emergency care (SDEC) provision, as currently many ambulance conveyances and emergency admissions could be redirected elsewhere on site should the appropriate pathways be available. A group has been set up to focus on the further development of pathways as a priority.

The Trust has recently led a meeting with system partners focusing on the information available to the Trust in recent weeks, including the GIRFT report on Alternative to Emergency Department (A-tED), the learning from the recent discharge event and the actions not completed from 2023-24 to develop an action plan for the areas that will have the greatest benefit in reducing A&E waiting times and ensure a improved outcome and patient experience for patients.

3.3	**Transfer of Care Hub development and no criteria to reside position** The Trust continues to be in a much-improved position as the number of patients not meeting the criteria for transfer has reduced. The Transfer of Care Hub is now identifying more complex reasons for delays, some of which are due to out of area placements, specialist step down beds and challenging social issues. The Trust is working with the local community Trust, local authority and commissioning colleagues to develop pathways or commission alternative provisions to support this cohort of patients.  There is a renewed focus on how the no criteria to reside position is reduced to the stretch target of 70 by the end of the financial year which focusses on improved pathway 3 transactions and improving the pace of patients transferred out to the home first service. This is monitored weekly through the executive discharge cell with all Wirral partners.
3.4	**Mental Health** The demand for patients attending the ED with mental health conditions remains high. The refresh of mental health working groups for 2024/25 annual planning is underway. The Trust's mental health groups have been re-established and the local mental health provider will launch the new Mental Health Board in early June, on which the Trust will be represented. The group is expected to monitor actions taken to prevent emergency admissions and present long-term plans to reduce conveyances to ED. The Unscheduled Care Board will have a mental health focus at the May meeting with a priority on frequent attenders at ED and the impact on ED when the department becomes overwhelmed by mental health demand. The board will be looking for additional support from the local mental health provider to mitigate the risk.
3.5	**Risks and mitigations to improving urgent care performance** There remains a risk that the continued high level of daily attendances and acuity will challenge the improvement plans and actions. Added to this is the need to increase the number of nurses in the ED to support the requirement to release ambulance crews as soon as possible (which includes staffing corridors as required) and vacancies in junior medical staff is increasing the pressure in the department.

4	Implications
4.1	**Patients** • The paper outlines good progress with elective recovery but still waiting times for elective treatment are longer than what the Trust would want to offer. The paper also details the extra actions introduced recently to improve UEC performance and the sustained improvement in ambulance handover performance.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • The cost of providing corridor care is above the Trust's financial plan and is provided at a premium. There are also additional costs of elective recovery in attaining 65 week performance.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets for elective and urgent care, although there are delivery plans in place to improve performance across these areas.

5	Conclusion
	The Board should note the ongoing improvements in reducing the number of patients with no criteria to reside in the hospital and the sustained improvements in ambulance handover performance. The Trust is currently implementing the actions from the UEC improvement plan to ensure that the increase in demand can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED. Elective recovery remains a strong point and improvements continue, but the delivery of 65 weeks is a risk in two specialities in the Trust given the significant backlogs from covid.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item 8.3**

05 June 2024

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 April 2024.

It is recommended that the Board:

- notes performance to the end of April 2024.

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:** Further metrics are shown under the Chief Information Officer (CIO) relating to the Digital Healthcare Team.

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	4	3	7
Effective	0	1	1
Caring	1	3	4
Responsive	6	17	23
Well-led	1	2	3
Use of Resources	3	2	5
All Domains	15	28	43

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

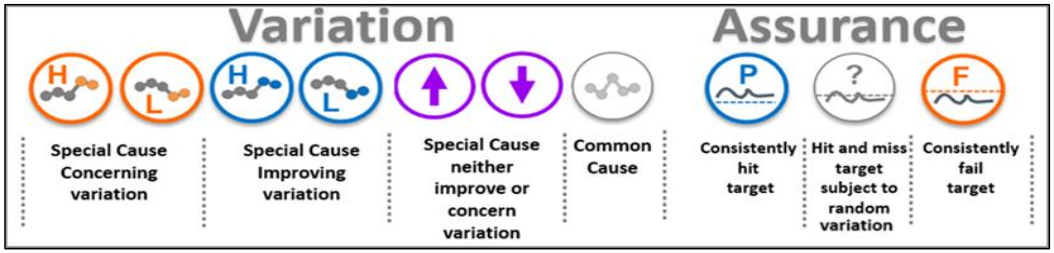
3	Conclusion
3.1	Monitoring of the key performance metrics will be continued monthly within the Integrated Performance Report, and at the regular operational meetings with the Clinical Divisions.

Integrated Performance Report - May 2024

Approach

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

Key to SPC Charts:



Summary of latest performance by CQC Domain:

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	4	3	7
Effective	0	1	1
Caring	1	3	4
Responsive	6	17	23
Well-led	1	2	3
Use of Resources	3	2	5
All Domains	15	28	43

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.

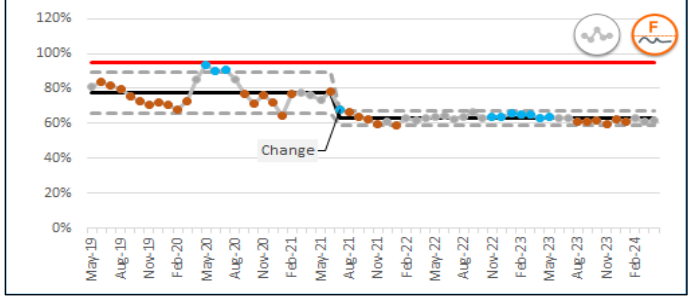
Changes to Existing Metrics:

Metric	Amendment
Clostridioides difficile (healthcare associated)	National threshold target for 2024/25 is not yet confirmed - internal maximum set at 108 cases for the year.
Ambulance handover	Metric calculation amended to show % within time-band

Chief Operating Officer (1)

CQC Domain : Responsive

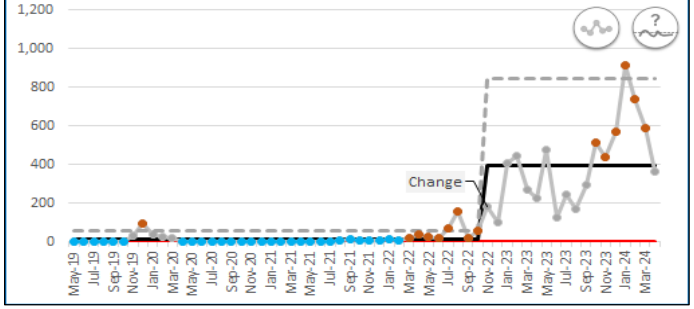
4-hour Accident and Emergency Target (including APH UTC)



Apr-24
61.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

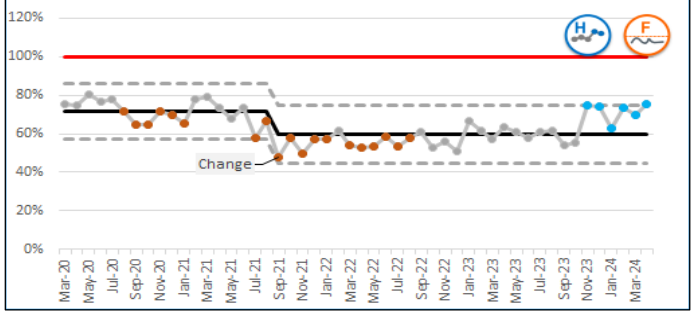
Patients waiting longer than 12 hours in ED from a decision to admit



Apr-24
362
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

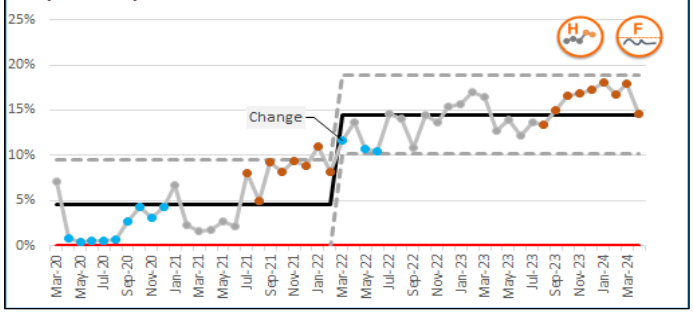
Time to initial assessment for all ED patients - % within 15 mins



Apr-24
75.5%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

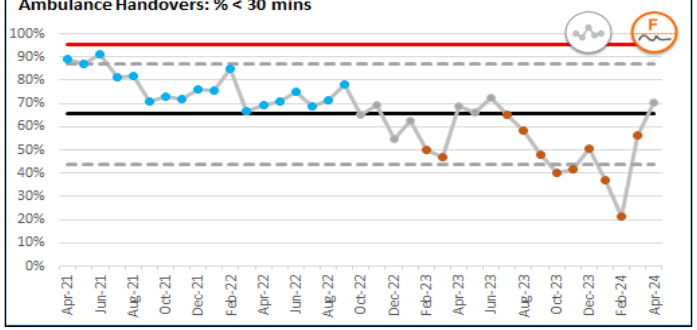
Proportion of patients more than 12 hours in ED from time of arrival



Apr-24
14.6%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

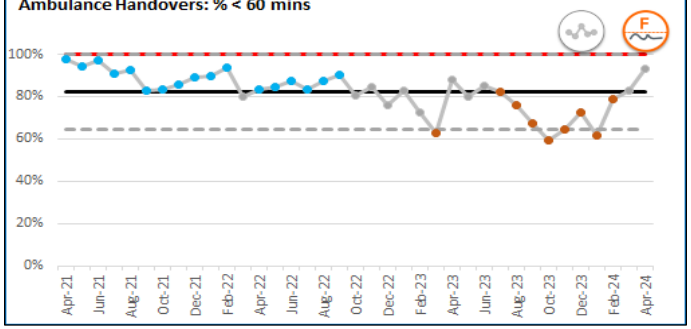
Ambulance Handovers: % < 30 mins



Apr-24
70.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

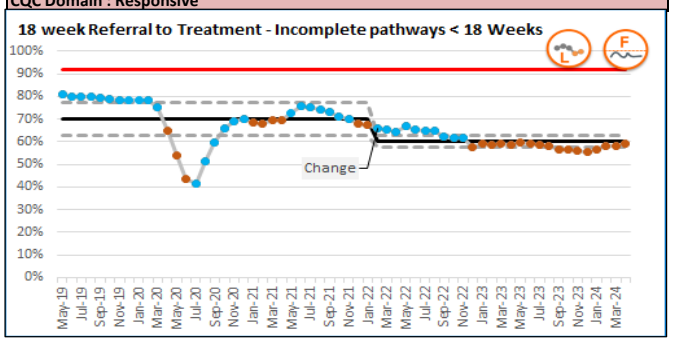
Ambulance Handovers: % < 60 mins



Apr-24
92.8%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

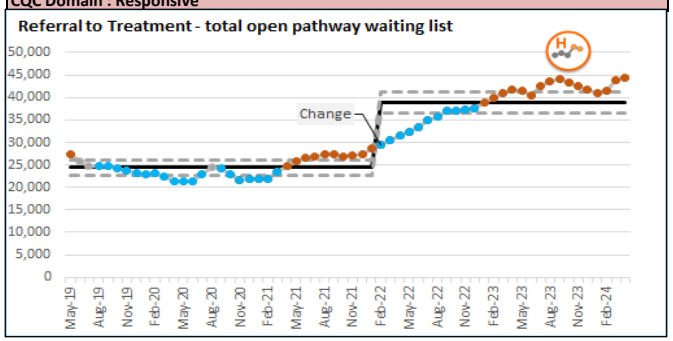
Chief Operating Officer (2)

CQC Domain : Responsive



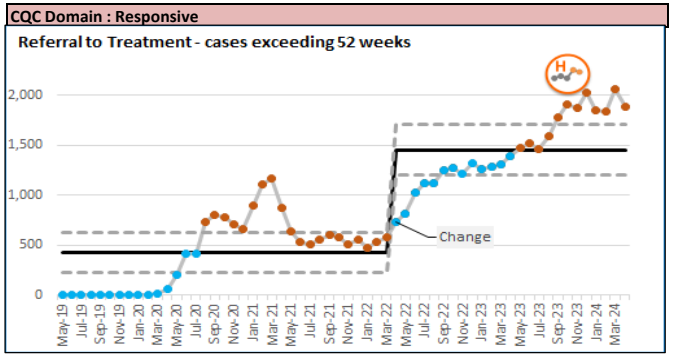
Apr-24
59.03%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



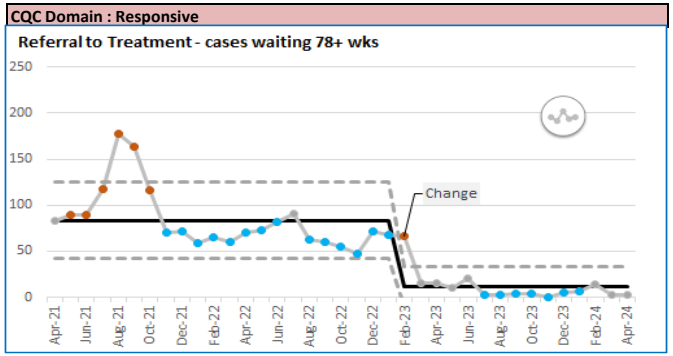
Apr-24
44384
Variance Type
Special cause variation - concerning
Threshold
≤ 38801
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



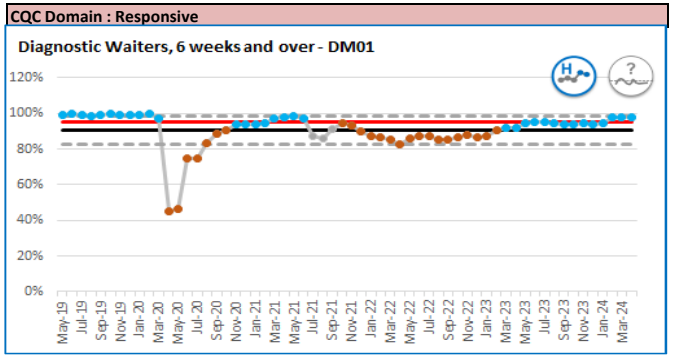
Apr-24
1884
Variance Type
Special cause variation - concerning
Threshold
≤ 1985
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



Apr-24
3 (pt choice)
Variance Type
Common cause variation
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

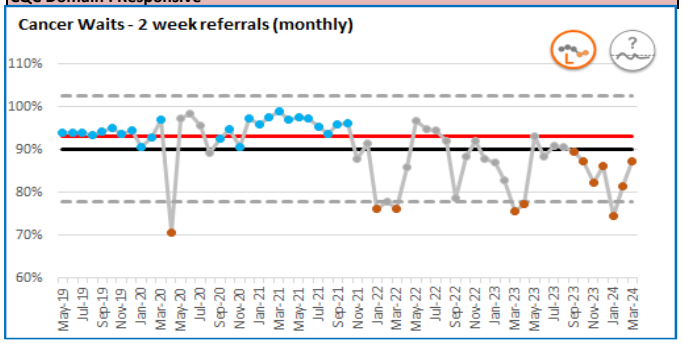
CQC Domain : Responsive



Apr-24
97.7%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

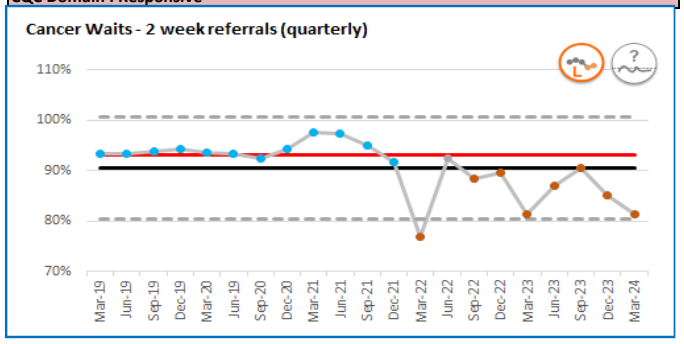
Chief Operating Officer (3)

CQC Domain : Responsive



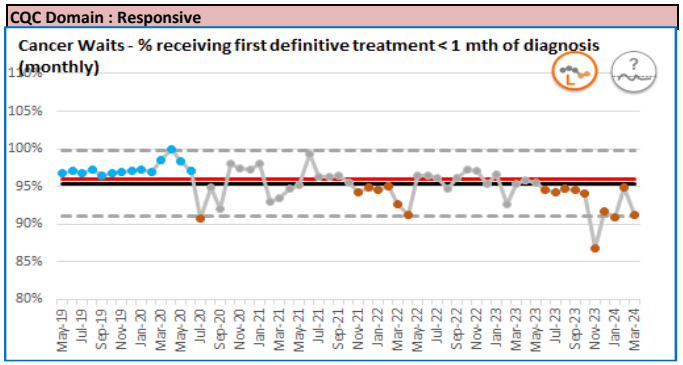
Mar-24
87.2%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



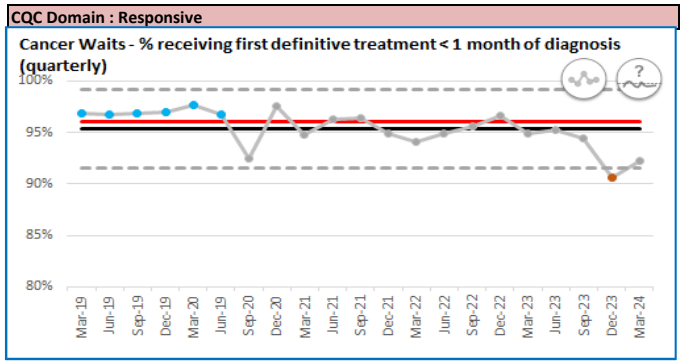
Mar-24
81.4%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



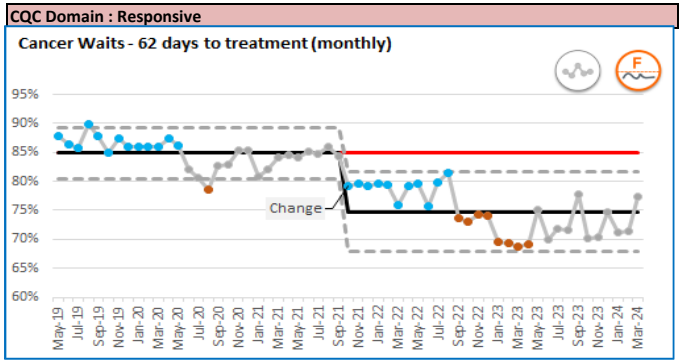
Mar-24
91.2%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



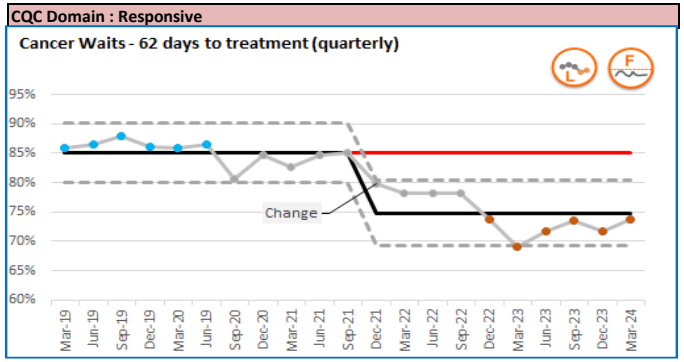
Mar-24
92.2%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Mar-24
77.5%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

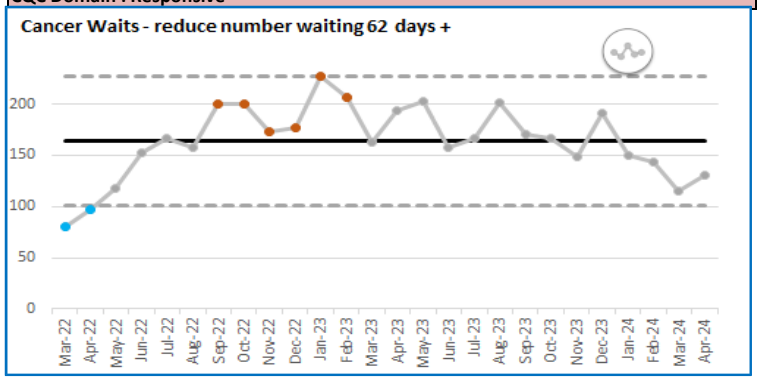
CQC Domain : Responsive



Mar-24
73.7%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

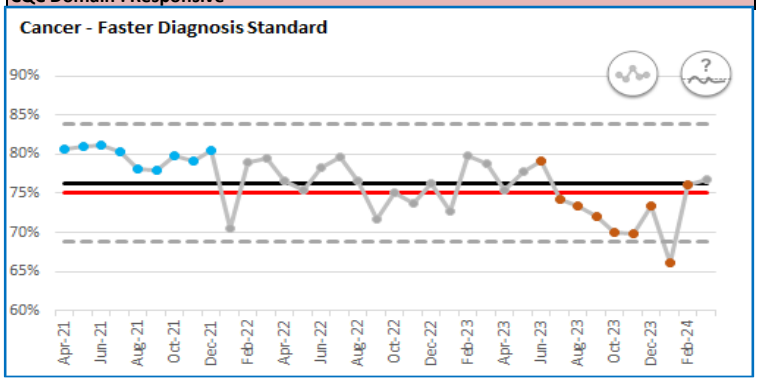
Chief Operating Officer (4)

CQC Domain : Responsive



Apr-24
131
Variance Type
Common cause variation
Threshold
120
Assurance
Trajectory target not appropriate for SPC Assurance reporting

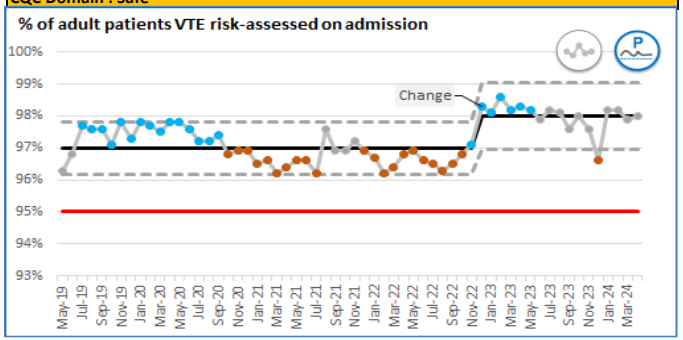
CQC Domain : Responsive



Mar-24
76.8%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

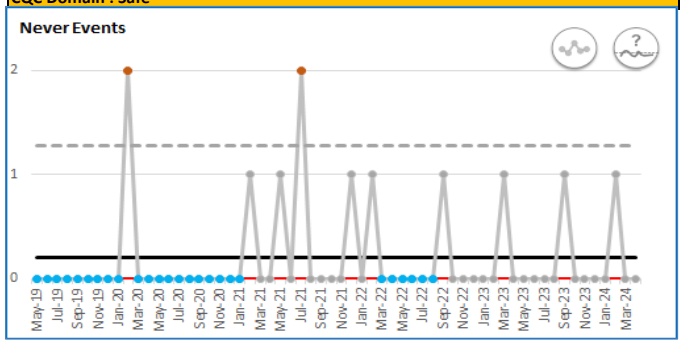
Medical Director (1)

CQC Domain : Safe



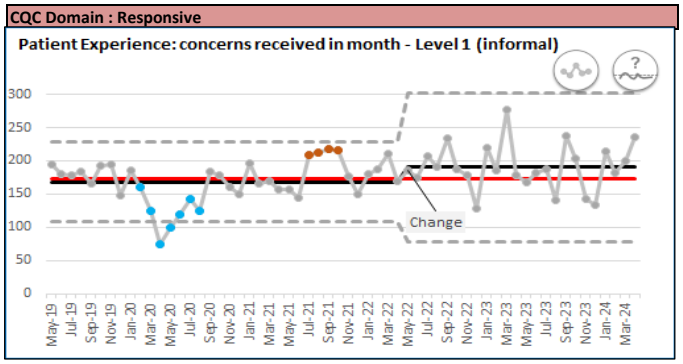
Apr-24
98.0%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



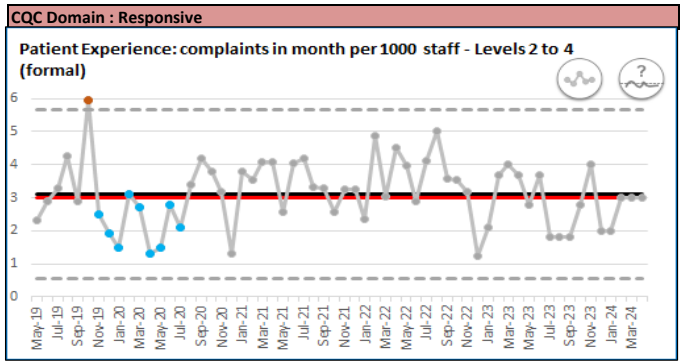
Apr-24
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



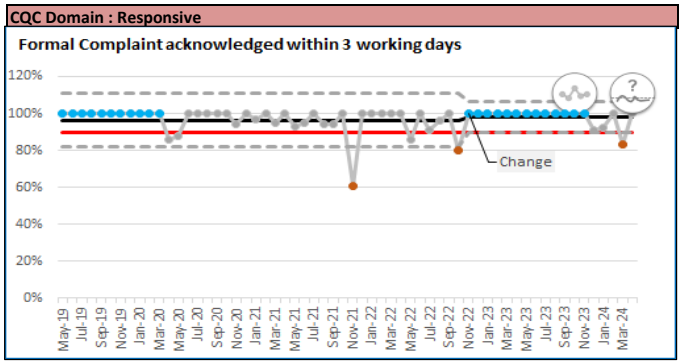
Apr-24
236
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



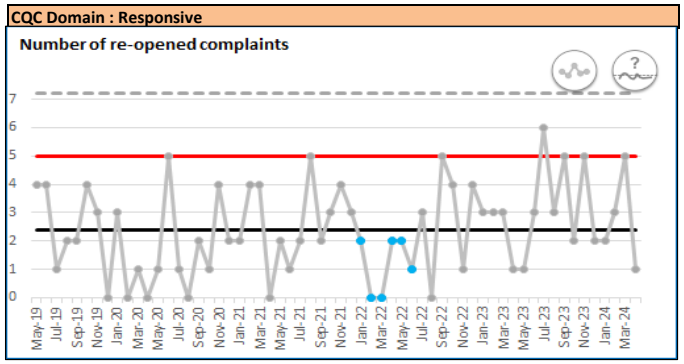
Apr-24
3.0
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Apr-24
100.0%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

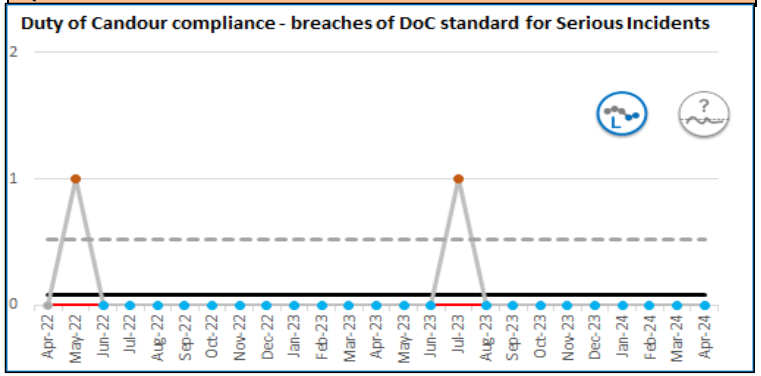
CQC Domain : Responsive



Apr-24
1
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

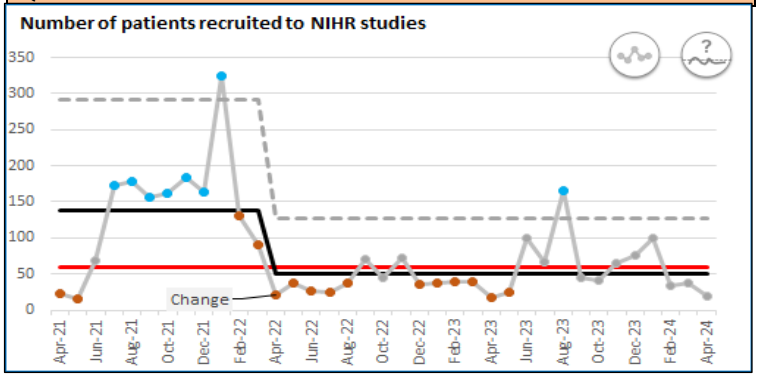
Medical Director (2)

CQC Domain : Well-led



Apr-24
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led

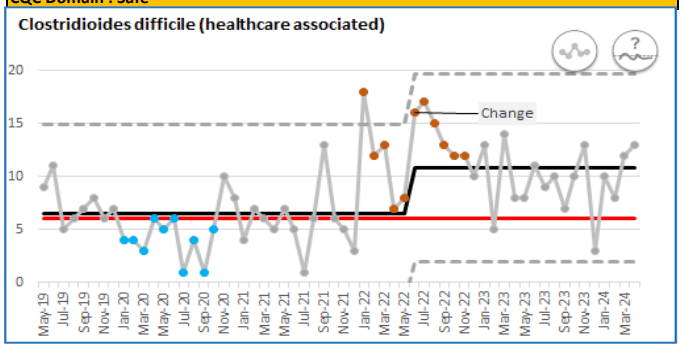


Apr-24
19
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

Chief Nurse

CQC Domain : Safe

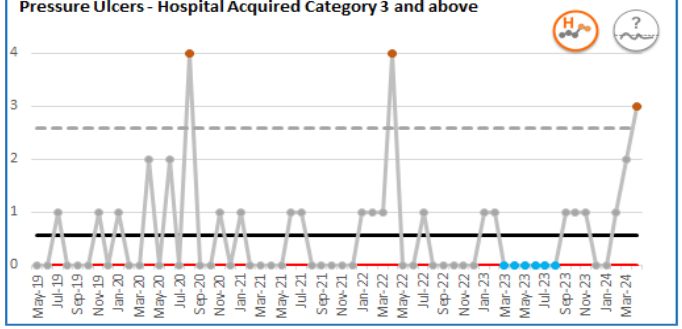
Clostridioides difficile (healthcare associated)



Apr-24
13
Variance Type
Common cause variation
Threshold
≤9
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe

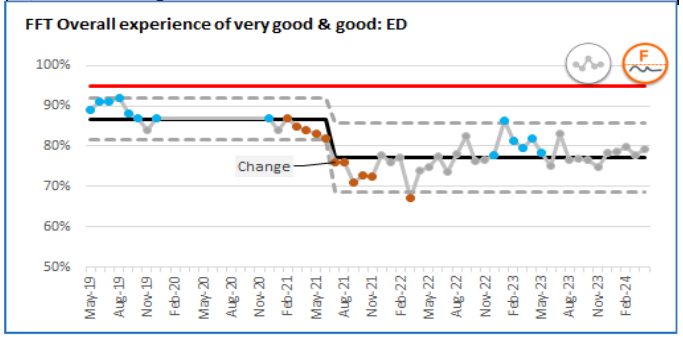
Pressure Ulcers - Hospital Acquired Category 3 and above



Apr-24
3
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

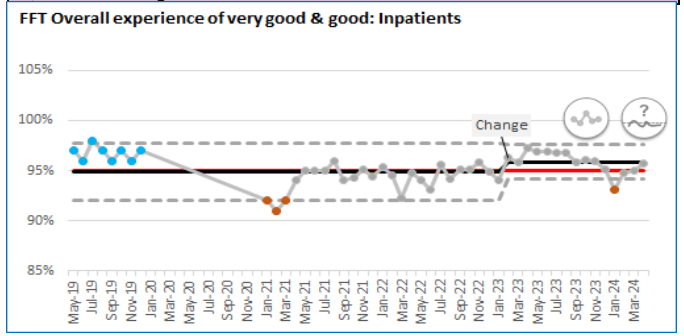
FFT Overall experience of very good & good: ED



Apr-24
79.2%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring

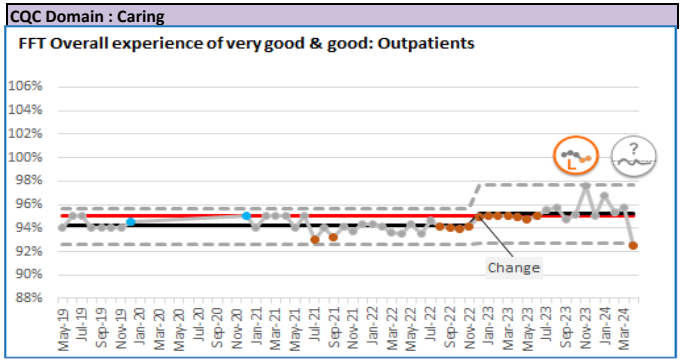
FFT Overall experience of very good & good: Inpatients



Apr-24
95.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

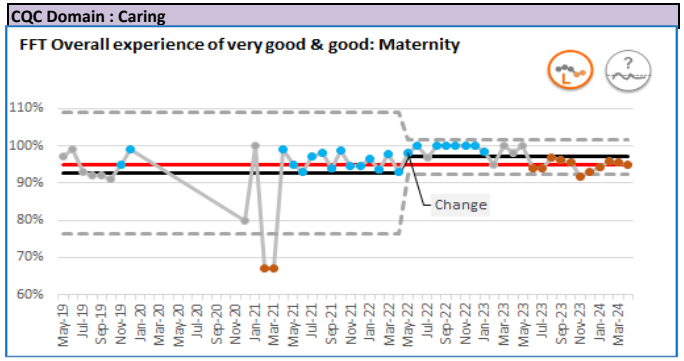
FFT Overall experience of very good & good: Outpatients



Apr-24
92.5%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring

FFT Overall experience of very good & good: Maternity



Apr-24
94.9%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse – April 2024 data

Overall position commentary

The NHS standard contract 2024/25 has replaced its Annual *Clostridioides difficile* and GNBSI objectives with the following quality statements.
The Provider must:

- comply with the Code of Practice on the Prevention and Control of Infections and put in place and implement an infection prevention programme in accordance with it.
- comply with, the National Infection Prevention and Control Manual.
- nominate an Infection Prevention Lead and ensure that the Co-ordinating Commissioner is kept informed at all times of the person holding this position.
- have regard to NICE guideline NG15 (Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use).
- have regard to the Antimicrobial Stewardship Toolkit for English Hospitals.

Infection Prevention and Control

Narrative:

The local Quality schedule requirement from Cheshire and Merseyside Integrated Care board is as follows

- An executive Summary
- Data relating to MRSA Blood-Stream Infections, Clostridium Difficile Infections, Klebsiella Bacteraemia, Nosocomial Covid-19 infections, Pseudomonas bacteraemia and E.coli bacteraemia,
- Learning from reviews of these cases
- How the organisation is addressing sepsis risks
- Outbreaks and Infection Related Incidents
- Lessons learnt from reviews undertaken and how the learning has been shared and what impact any changes have made on practice and quality/patient safety
- Antimicrobial Stewardship
- Multi-resistant Organisms
- Details of how the provider is maintaining compliance with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance.
- Comply with the National Infection Prevention and Control Manual
- Details of the Infection Prevention Lead and ensure that the Co-ordinating Commissioner is kept informed at all times of the person holding this position (and any changes)
- The report to include the priorities for the next quarter
- Submit evidence quarterly
- Trusts to share IPC Board Assurance Framework with ICB Place Quality Teams in Q2 and Q4.

Actions:

- Review the ToR and the cycle of business for the IPCG meeting to enable the required data to be agreed monthly prior to submission quarterly.
- Share the IPC BAF to key stakeholders in the organisation to ascertain local intelligence to gain assurances against meeting the criterion within the BAF.
- Support the development of local plans to identify further actions required to meet the requirements of the National IPC Board assurance framework

Risks to position and/or actions:

- Engagement with the Divisions and senior leaders to support the plan

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.

Analysis of the patient comments for ED identifies waiting times, delays and communication, as the main reasons for attributing a negative ED response. OPD had a recommend rate of 92.5% a review of the responses highlights that the recommend rate was significantly influenced by indifferent responses i.e., the largest proportions were for “neither good or poor” and “don’t know “rather than significant numbers of poor and very poor. Maternity score 94.9% there were no comments for poor or very poor responses to understand feedback.

Actions:

- 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
- Develop an ED orientation / information film to help support and manage patients expectations
- Continued focus on providing people with access to provide feedback via FFT:

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.

Pressure ulcers Hospital Acquired Category 3 and above

Narrative:

WUTH has a zero tolerance on Hospital Acquired HA Pressure Ulcers category 3 and above. From the 1st April WUTH implemented the national wound management classifications replacing previously classified PU of unstageable to a Cat 3, this has been socialised within the organisation and based on historical data will result in an increase of Trust HA cat 3 and above Pressure ulcers prevalence.

- During April there were 3 HA Category 3 pressure ulcers reported. One occurred in the Medical Division, one in the Clinical Support & Diagnostics division, and one in the Surgical Division. Two were located on the Sacral Area and the third was device-related. Each of these will be reviewed and presented at PSLRP 23rd May for learning outcomes.

Actions:

Trust wide implementation of Purpose T as its Pressure ulcer risk assessment has replaced Braden from the 1st April 2024.
The Trust has an overarching Trust Pressure Ulcer improvement plan with Divisional specific improvement plans identifying divisional themes and trends.
Review underway in relation to documentation provisions with Cerner system to streamline documentation.
Increase awareness on the importance of timely skin inspections to be shared at the safety huddle.
Trust wide mattress review

Risks to position and/or actions:

Changes to national reporting for wound classification will be implemented from 1st April 2024 which will remove the classification of Unstageable. These historical unstageable will automatically be classified as a Cat 3 which will result in an increased prevalence for the Trust.

Maternity FFT

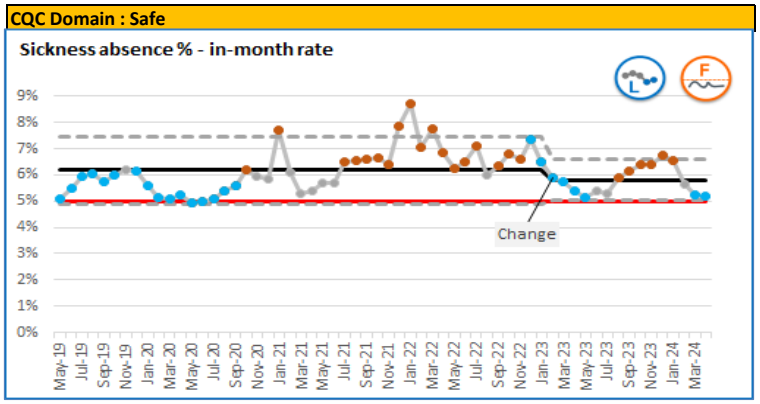
Whilst it is increasing still, it is not quite back to where it was mid-2023.

In March the response rate was 67 and April it was 92.

Each maternity area manager has been asked to put in sustainable measures to increase the compliance and a reflective position. This has included using housekeeper support as well as using the kiosk available, and we have reached out to our new MNVP lead Steph, to support too. Steph will help with visiting the unit, supporting with awareness and distribution of the cards/QR codes.

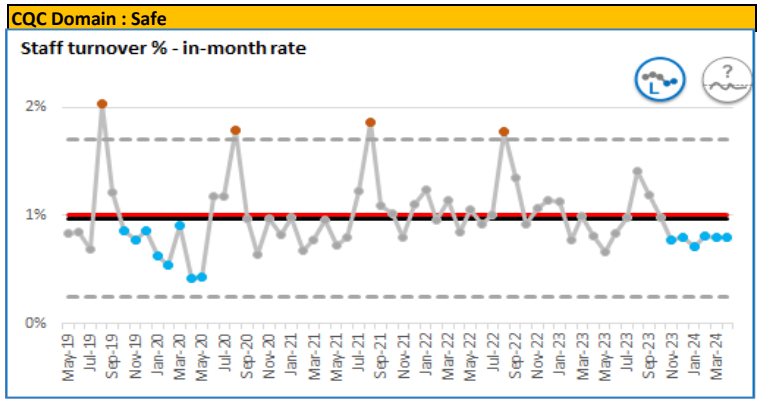
Chief People Officer

CQC Domain : Safe



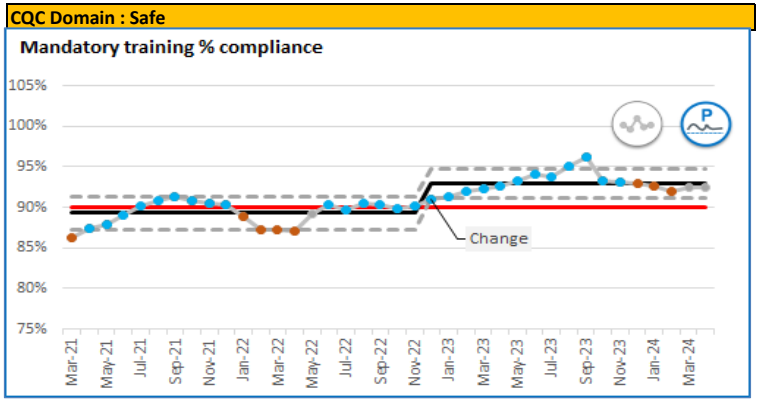
Apr-24
5.52%
Variance Type
Special cause variation - improving
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe



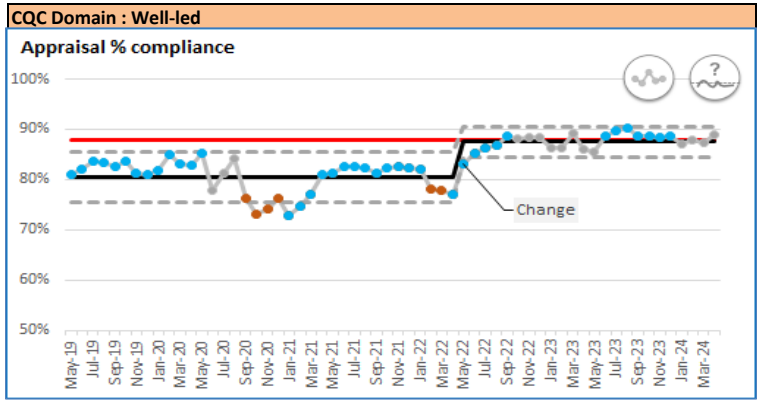
Apr-24
0.79%
Variance Type
Special cause variation - improving
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



Apr-24
92.39%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led



Apr-24
88.81%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer – for May 2024 BoD

Overall position commentary

The Trust's People KPIs for mandatory training and turnover remain on target. Appraisal completion was adversely impacted by operational pressures and industrial action but is back at compliance. Sickness absence remains above target at 5.52%; this is a slight decline of 0.26% this month.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For April 2024 the indicator was 5.52% and demonstrates special cause variation.

There have been sickness absence increases in both Acute and Women's & Childrens Divisions in April 2024.

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

Actions:

- Electronic flexible working application processed launched, to support continuous improvements in work life balance and staff experience.
- Additional counselling sessions provided to reduce waiting times.
- New quarterly Occupational Health Nurse drop in-sessions introduced.
- Reduction in OH Nurse and Dr waiting times.
- Targeted reactive psychological support.
- Health Surveillance implementation work extended.
- Psychotherapist clinician led 'How to Enhance Emotional Resilience and Stay Healthy' workshops throughout May.
- Additional Post Traumatic Stress Disorder (PTSD) session launched.
- Active promotion of national Carers Week and the June Carers Event

Risks to position and/or actions:

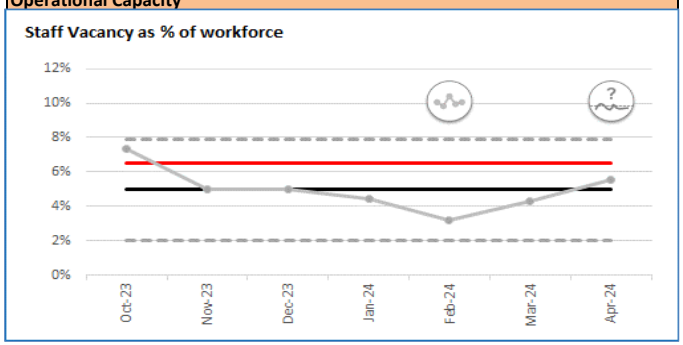
The management of sickness absence is primarily management led as they are responsible for monitoring employee attendance addressing sickness absence and ensuring that the policy is applied consistently, supported by the HR team. Sickness is multifaceted and adversely impacted by a range of factors including 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 the deliverables within the People Strategy with a number of workstreams that will support attendance across the Trust, this includes promotion of flexible working, which is available to all staff, transforming and modernizing Occupational Health and Wellbeing Service in line with the Growing OH and Wellbeing together strategy as set out in the NHS People Plan to improve the health and wellbeing services for our people, to keep them safe and healthy and able to provide good care to our patients. This is part of our proactive culture of wellbeing across the trust.

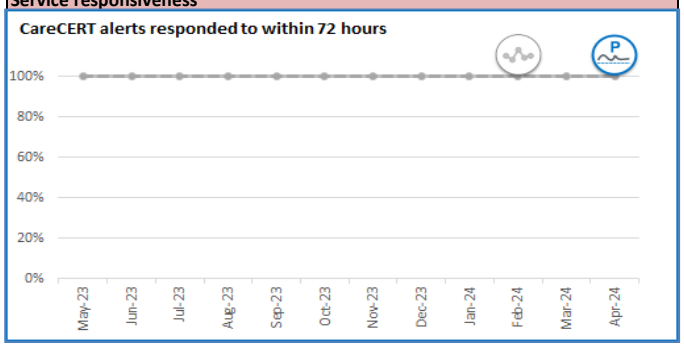
Chief Information Officer

Operational Capacity



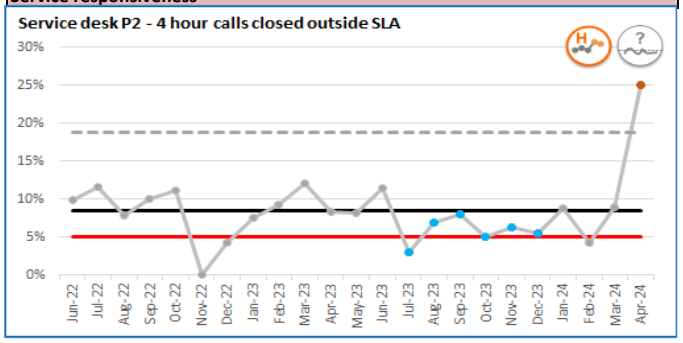
Apr-24
5.60%
Variance Type
Not enough data points yet
Threshold
<=6.5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



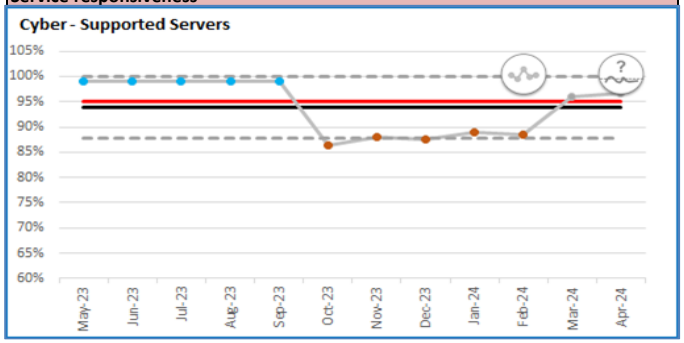
Apr-24
100%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently achieves the target

Service responsiveness



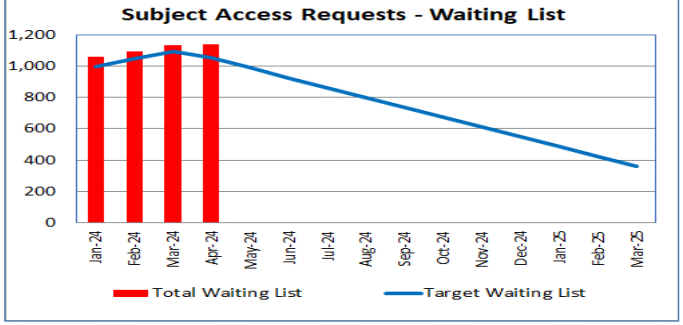
Apr-24
25.0%
Variance Type
Special cause variation - concerning
Threshold
<=5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



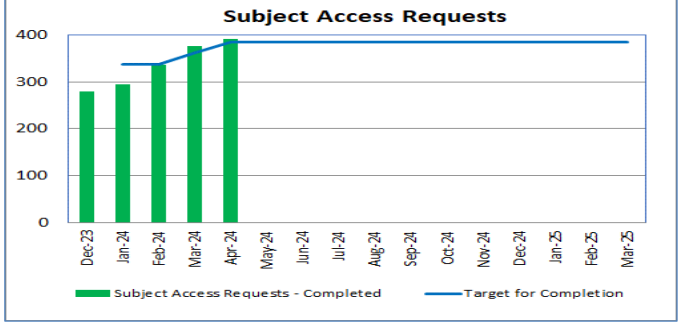
Apr-24
96.6%
Variance Type
Common cause variation
Threshold
>=95%
Assurance
Hit & miss target subject to random variation

Service responsiveness



Apr-24
1139
Variance
Total requests waiting worse than target
Threshold
1053

Service responsiveness



Apr-24
391
Variance
Completed requests better than target
Target
384

Chief Information Officer – for May 2024

Overall position commentary

Strong performance is maintained in:

- CareCERT alerts at 100% - a key control for cyber-security.

Improvements are highlighted in:

- Cyber supported servers, again a key control for cyber-security

Key areas for improvement are:

- Service desk response times for Priority 2 incidents deteriorated and remain too high.
- Subject Access Requests – completed requests are in line with the improvement trajectory, however the total backlog has increased.

Service Responsiveness – Priority 2 calls closed outside of SLA

Narrative:

All calls raised with the Digital Healthcare Team Service Desk are assigned a priority, based upon the perceived level of impact that a particular technical issue will have upon the continuity of operations and/or clinical care of our patients. Priority 2 (P2) calls are classified as clinical issue impacting patient care that needs direct action within 4 hours. The associated performance threshold in place is that no more than 5% of P2 calls should breach their SLA of 4 hours.

The KPI compliance has disappointed at 25%, significantly more than the previous months. The Trust and Cerner have added regular reboots to the infrastructure supporting the clinical printing solution to help reduce incidents. The KPI generated from the helpdesk solution “House on The Hill” have been investigated and it appears there has/is a reporting issue regarding breached calls. The helpdesk team have been investigating the P2 breached calls and found the helpdesk/other teams needed more guidance on processes and calls.

Actions

- Investigate the KPI reports with the House on the Hill supplier.
- Focus on P2 helpdesk SOP to ensure that the correct calls and processes are followed.
- Situation paper on P2 KPI position.

Risks to position and/or actions:

- Outcome from investigate may lead to re-examination of historical P2 compliance.

Service Responsiveness – Subject Access Requests

Narrative:

The organisation has experienced a year-on-year increase in volume and complexity of Subject Access Requests (SARs) totaling 41% since 2016. Change in legislation, increase in request numbers, the complexity of the requests and the evolving attitudes towards information rights have had a significant impact on the standard of service delivery. This combination has led to a significant backlog of requests within the Access to Information department. As at January 2024 there was a backlog of circa 1000 requests, with approximately 650 of those requests being outside of the regulatory 30 day response target.

The improvement trajectory for completing requests was again achieved in April. Total requests waiting however increased slightly to 1,139.
This is due to the number of requests received in April being higher than the monthly average figure expected and continuing in excess of 400 per month. The reduction in requests experienced in 2023 from April onwards has not yet materialised this year.

Actions:

- In 2023 requests received from January to March decreased in subsequent months, however as of April 2024 this has not yet occurred. Demand in May 2024 will be assessed against 2023 levels and against the trajectory assumptions.
- The vacancy in the Team was appointed to in April, currently awaiting confirmation of a start date.

Risks to position and/or actions:

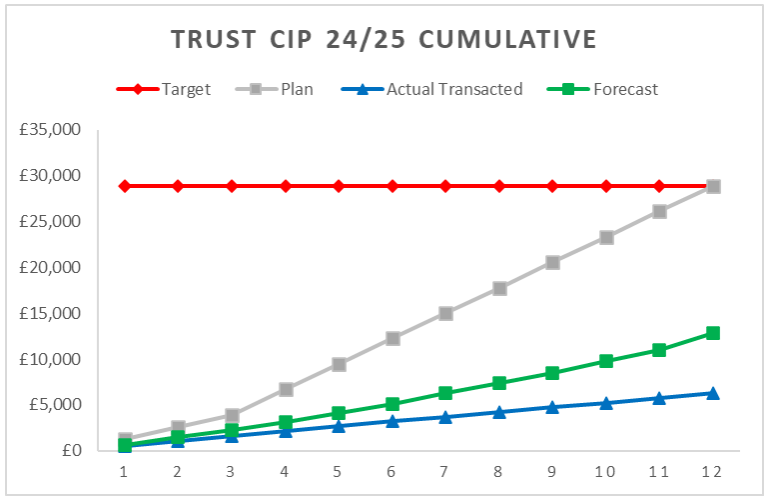
- Risk posed by any further increase in demand that is unaccounted for.
- Risk of trajectory slippage depending on any personnel issues such as sickness, staff turnover, recruitment etc.

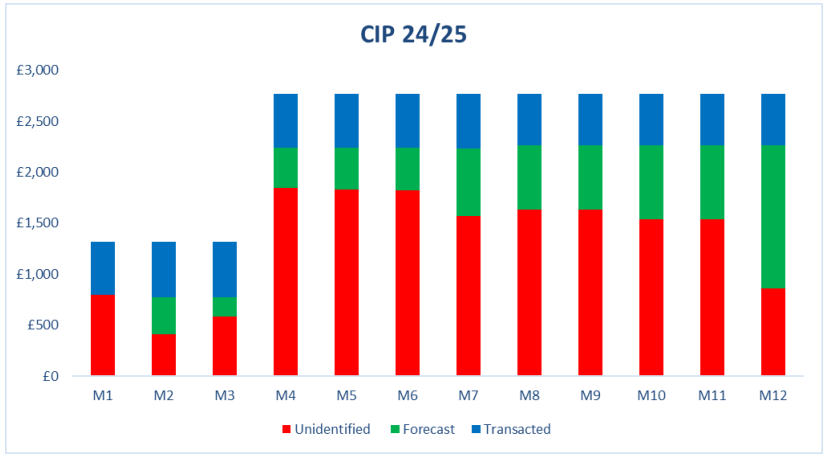
Productivity and Efficiency 2024/25 Position

Hayley Kendall, Chief Operating Officer
Board of Directors
June 2024

2024/25 M1 CIP – Divisional position

Wirral University Teaching Hospital NHS Foundation Trust





- Target £28.8m
- Forecast delivery £12.9m
- Gap to target £15.9m
- Transacted as at M1 £6.3m

Division	FY Target	FOT	Variance
Medicine	£5,253	£1,589	-£3,664
Acute	£1,533	£631	-£903
Surgery	£6,345	£3,984	-£2,361
DCS	£4,960	£2,096	-£2,864
W&C	£3,073	£1,273	-£1,800
Corporate	£2,560	£1,812	-£748
Estates	£3,455	£1,506	-£1,950
Central	£1,676	£0	-£1,676
Trust	£28,856	£12,890	-£15,966

Transacted CIP	
Division	Transacted 24/25
Medicine	£473
Acute	£86
Surgery	£208
DCS	£1,503
W&C	£660
Corporate	£1,812
Estates	£1,506
Central	£0
Total	£6,248

wuth.nhs.uk

Productivity & Efficiency Workstreams 2024/25

Wirral University Teaching Hospital
NHS Foundation Trust

R Chapman	H Kendall	D Smith	N Stevenson	N Stevenson	M Chidgey	M Chidgey	M Swanborough	H Kendall
								
Productivity £4m	Site Capacity £2m	Workforce £2m	Diagnostics & Reporting £1m	Medicines Optimisation £1m	Non-Pay Spend £1m	Digital Innovation £1.5m	Estates & Facilities £1m	Admin & Clerical £1.0m

Workstreams – update on tasks required to release the savings/efficiency

Wirral University Teaching Hospital
NHS Foundation Trust

90% complete | 51-85% complete | <50% complete

RAG Delivery Status

Productivity: £4m

- Improve efficiency in theatres, outpatients and endoscopy to utilise core sessions and reduce non-core costs.
- Optimise ward calibration and agree a target model of care to reflect national standards with robust e-rostering modelling and controls.
- Develop robust job planning policy to ensure alignment between demand and capacity and the delivery of annual activity targets.

Site Capacity: £2m

- Free up beds across the Trust by ensuring we treat patients in the right beds at the right time and closing escalation beds
- Improving discharges and delivering best in class Length of Stay (LOS) including assessment model
- Establishment of virtual wards and front door consultant delivered services to reduce G&A bed admissions

Workforce: £2m

- Utilising our existing workforce to address challenges of capacity and reducing the reliance on temporary staffing
- Reduction of medical bank and agency spend and embedding a sustainable workforce models
- Review of junior doctors rotas to ensure alignment between demand and resource requirements delivering fit for purpose rosters that do not rely on additional non-core spend

Workstreams

Wirral University Teaching Hospital NHS Foundation Trust

RAG Delivery Status

Medicines Optimisation: £1m

- Safely reduce our drug and prescribing spend
- Identify product switches in line with best practice and regional benchmarking
- Reducing spend on high-cost drugs in line with national guidance

Non-Pay Spend: £1m

- Reduce non-pay spend by standardising products across the Trust and improving quality at a lower cost.
- Increased use of data analytics to identify cost improvement opportunities.
- Collaborate with system partners to increase purchasing power and achieve greater economies of scale.
- Reduce waste identified by staff and patients.

Diagnostics & Reporting: £1m

- Ensure efficient use of our diagnostic service
- Reduce the reliance on outsourced support delivering improved value for money and quality
- Ensuring our capacity for internal services is maximised
- Maximise opportunities brought about by the Community Diagnostic Centre

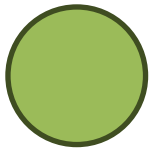
Workstreams

Wirral University Teaching Hospital NHS Foundation Trust

RAG Delivery Status

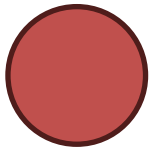
Digital Innovation: £1.5m

- Complete One Patient Record initiative to ensure clinicians are able to access all medical records digitally.
- Utilise digital technology to improve services and minimise manual processes and reduce cost.
- Improve data quality and reporting to enable better decision making.



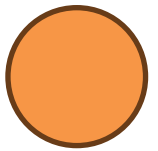
Estates & Facilities: £1m

- Ensuring our footprint is fully utilised and reduce the reliance on off site space and temporary accommodation



Admin & Clerical: £1.0m

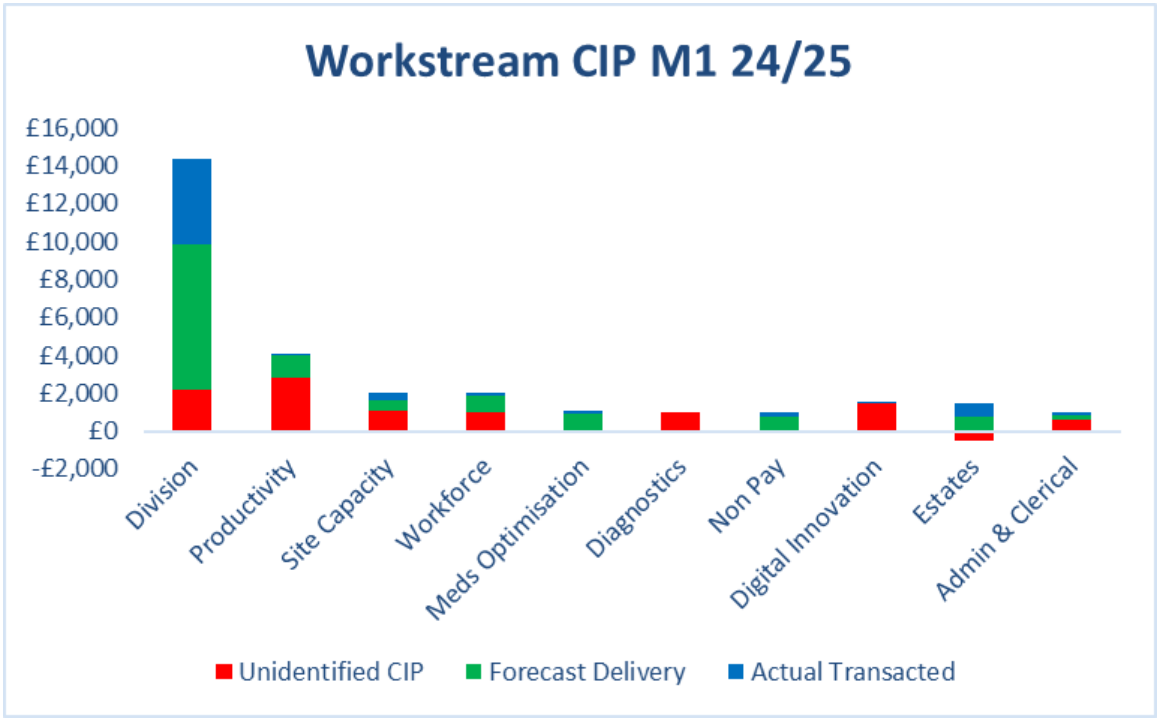
- Implementation of digital dictation and voice recognition
- Implementation of Robotic Process Automation
- Develop the optimal workforce model that embraces skill mix and delivers quality patient administration
- Deliver an outpatient scheduling solution that delivers maximum efficiency and use of staff



24-25 M1 CIP - Workstream

Wirral University Teaching Hospital NHS Foundation Trust

Workstream	FY Target	FOT	Variance
Division	£14,356	£7,640	-£6,717
Productivity	£4,000	£1,164	-£2,836
Site Capacity	£2,000	£597	-£1,403
Workforce	£2,000	£816	-£1,184
Meds Optimisation	£1,000	£903	-£97
Diagnostics	£1,000	£0	-£1,000
Non Pay	£1,000	£724	-£276
Digital Innovation	£1,500	£0	-£1,500
Estates	£1,000	£741	-£259
Admin & Clerical	£1,000	£306	-£694
Trust	**£28,856**	**£12,890**	**-£15,966**



together we will

Q1 Position at Month 1

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Division	Q1 Plan	Q1 Forecast	Variance
Medicine	£743	£275	-£468
Acute	£229	£43	-£186
Surgery	£913	£370	-£543
DCS	£730	£472	-£258
W&C	£440	£267	-£173
Corporate	£354	£453	£99
Estates	£518	£376	-£142
Central	£27	£1,698	£1,671
Trust	**£3,954**	**£3,954**	**£0**

Workstream	Q1 Plan	Q1 Forecast	Variance
Division	£2,154	£3,188	£1,034
Productivity	£600	£12	-£588
Site Capacity	£300	£152	-£148
Workforce	£300	£86	-£214
Meds Optimisation	£150	£155	£5
Diagnostics	£150	£0	-£150
Non Pay	£150	£138	-£12
Digital Innovation	£0	£0	£0
Estates	£150	£185	£35
Admin & Clerical	£0	£37	£37
Trust	**£3,954**	**£3,954**	**£0**

together we will

2024/25 Year end forecast following additional schemes

Wirral University Teaching Hospital NHS Foundation Trust

Workstream	FY Target	FOT	Variance
Division	£14,356	£7,640	-£6,716
Productivity	£4,000	£4,014	£14
Site Capacity	£2,000	£849	-£1,151
Workforce	£2,000	£1,216	-£784
Meds Optimisation	£1,000	£903	-£97
Diagnostics	£1,000	£10	-£990
Non Pay	£1,000	£1,074	£74
Digital Innovation	£1,500	£727	-£773
Estates Workstream	£1,000	£1,741	£741
Admin & Clerical	£1,000	£1,106	£106
Trust	**£28,856**	**£19,280**	**-£9,576**

together we will

wuth.nhs.uk

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.5**

05 June 2024

Title	Quarterly Maternity and Neonatal Services Report
Area Lead	Dr Nikki Stevenson, Executive Medical Director, Deputy Chief Executive Officer (CEO)
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 (BOD) was presented in March 2024 and monthly reports in April and May 2024.The following paper provides a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

Also included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (April 2024) key quality and safety metrics and the position of patient safety incidents.

This paper provides a specific update regarding MIS Year 6, Saving Babies Lives (SBLv3), Ockenden, the Three-Year Delivery plan, Ockenden, Maternity Continuity of Carer (MCoC) together with an update on the 24/25 Maternity and Neonatal Voices Partnership (MNVP) annual plan.

It is recommended that Board:

- Note the report.
- Note the Perinatal Clinical Surveillance Assurance report.
- Note the position of Patient Safety Incident Investigations (PSSI's) & Maternity and Newborn Safety Incidents (MNSI).
- Note the progress of the Trust's position with Maternity Incentive Scheme and Saving Babies Lives v3.
- Note the update on the NHSE three-year delivery plan for maternity and neonates incorporating Ockenden and East Kent 'Reading the Signals".
- Note the update to the Continuity of Carer model of maternity care and the Trusts position to implement this model as a default model of care subject to approval to improving the midwifery establishment.
- Note the 24/25 Maternity and Neonatal Voices Partnership (MNVP) annual plan.

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**
June 2024	Maternity & NNU Assurance Board	Quarterly Maternity and Neonatal Services Report	For information
June 2024	Patient Safety and Quality Board	Quarterly Maternity and Neonatal Services Report	For information

1	**Perinatal Clinical Surveillance Quality Assurance Report**
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (April 2024) 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 that WUTH is no longer able to report on the benchmarking against other providers for rates such as stillbirth and neonatal deaths since there is no longer a Northwest coast regional report being produced. Assurance has previously been provided to the Board of Directors that this was escalated via the Local Maternity and Neonatal System (LMNS) for a resolution. However, a Northwest Regional Dashboard Tool for use by Regional Maternity and Neonatal Teams is available to provide bespoke reports for Regional Operational Performance reporting. The Maternity Services Data Set publications have a lag of circa three months and at the time of the report (December 2023) data was unavailable to access. 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	**Patient Safety Incident Investigations (PSSI's) & Maternity and Newborn Safety Incidents (MNSI)**

	Patient Safety Incident Investigations (PSSI's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSSI's across the region. There were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in April 2024 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date two cases will undergo the independent safety investigation. There were no Patient Safety Investigation Incidents (PSII's) declared in April 2024 for Neonatal services.

3	**Maternity Incentive Scheme (MIS) Year 6**
	A detailed MIS update is included to Board of Directors Monthly Maternity Services update, which will further inform Trust declaration with the MIS due for submission before a deadline of 12 noon on 3 March 2025. Now in its sixth year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. The compliance is being monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors with an update on the position to meet the requirements of each safety action. An updated gap analysis is provided at **Appendix 2.** Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS and the declaration will also be required to be signed off by the ICB. The compliance will be monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors with an update on the position to meet the requirements of each safety action. A further compliance update will be included in the June 2023 Maternity quarterly update report utilising the audit tool. Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS/ICB.

4	**National Perinatal Mortality Maternity Incentive Scheme (MIS) Year 5**
	The Perinatal Mortality Reviews Summary Report (PMRT) is included in **Appendix 3 and 4**. The report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool for WUTH which occurred in the Quarter 3 and 4 23/24 period.

5	**Saving Babies Lives v Three (SBLv3) Safety Action 6 of the MIS year 5 Scheme**
	The Saving Babies' Lives Care Bundle (SBLCB) launched in July 2023 provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality.

	The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle (SBLCBv3) was redeveloped to include a new additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. On final review of all the evidence as of 31 March 2024 the Trust achieved 97% compliance against the 6 elements included at **Appendix 5**. The Trust continues to work towards full implementation and a further update will be in the next Board of Directors quarterly paper.

6	**Ockenden Review of Maternity Services: Final Report – Update on Trust compliance with the Immediate and Essential Actions / Recommendations**
	An initial gap analysis outlining compliance against these recommendations detailed within the 15 Immediate and Essential Actions (IEA's) was reported to the Board of Directors in December and updates have been provided quarterly. The gap analysis is included at **Appendix 6** and remains in the same RAG rated position as fully compliant.

7	**Three Year Delivery Plan – Maternity and Neonatal**
	An initial gap analysis outlining compliance against the recommendations is attached at **Appendix 7** and is RAG rated accordingly. The next three years the following four themes will be focused on: - • Listening to and working with women and families, with compassion • Growing, retaining, and supporting our workforce • Developing and sustaining a culture of safety, learning, and support • Standards and structures that underpin safer, more personalised, and more equitable care. Delivering this plan will continue to be a collaboration with maternity and neonatal services to support women and families and improve care. Progress is monitored via the Maternity and Neonatal Quality assurance board and WUTH continues to implement within the timescales. The equity and equality guidance for local maternity services is the pathway followed to address health equalities and is also part of the three-year delivery plan.

8	**Implementing a Continuity of Carer Model of Maternity Care**
	The Maternity Service continues to deliver care via two models of maternity care – one that is traditional in its approach, and the other a Continuity of Carer (CoC) Model of care. Women being cared for by a team of midwives under the Continuity of Carer model appreciate the benefits of improved outcomes and experience compared to those cared for by a traditional model. As a provider WUTH has six maternity continuity of carer teams and in line with upskilling programs and safe staffing levels. A further team was launched in February

	2024 and further teams were anticipated in 2024, subject to identifying additional funding. A comprehensive review of MCoC is being undertaken that will be presented to the Board of Directors on completion and data is being collated on the outcomes for women. There is a delay to this piece of work as there has been a regional request to broaden and publish the findings as research. An options appraisal is being developed with support of the regional team to consider recommendations for WUTH's future model of maternity care considering safe staffing levels and meeting the enhanced element of continuity which evidences better outcomes for women/birthing people.

9	Maternity & Neonatal Voices Partnership (MNVP)
	It is a requirement for MIS Year 6 to evidence via the LMNS all Trusts have produced an action plan developed with the MNVP Lead and local engagement network to address the issues and share it with their Trust Board included at **Appendix 8**.

10	Maternity and Neonatal Estates Survey
	NHSE are reviewing the maternity and neonatal estate, and all were requested to complete a detailed survey of their current environments. The outline for NHS was their commitment to making maternity and neonatal care safer, more personalised, and more equitable for women, babies and families. The condition of the estate can facilitate or frustrate that ambition therefore the survey will help to identify and better understand issues and inform action. NHS England's three-year delivery plan for maternity and neonatal services committed to "undertake a national maternity and neonatal unit infrastructure compliance survey and report, to determine the level of investment needed for an environmentally sustainable development of the maternity and neonatal estate across England. In addition to the survey the NWODN as part of the NHSE transformation programme visited the Neonatal Unit in May 2024 to review the footprint of estates. Forthcoming strategy and guidance will be shared with the Board of Directors on receipt in a future Board of Directors report.

11	Implications
11.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
11.2	**People** • Compliance and confirmation via the LMNS/ICB WUTH have that meet all 10 safety standards provides assurance of the improvements to high quality, safe care and the delivery of best practice in both Maternity and Neonatal services. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement. • Progress with the three-year delivery plan supports birthing people and their families with quality improvements to deliver safer, more personalised, and more equitable care.
11.3	**Finance**

	• In order to meet the continued compliance and sustainability of the Maternity Incentive Scheme (MIS) and deliver Maternity Continuity of Care as the default model, investment into the maternity and neonatal workforce is required and funding options continue to be explored.
11.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.6**

5 June 2024

Title	Learning from Deaths Report (Q3 2023-24)
Area Lead	Dr Nikki Stevenson, Executive Medical Director & Deputy CEO
Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Executive Summary and Report Recommendations

The purpose of this report is to provide the Board of Directors with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q3 23-24.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths within the Trust and escalates and deaths where there are potential concerns.
- The Trust SHMI for the latest available 12-month period (Sep 22- Aug 23) is 1.06 (within expected range)
- HSMR on the latest available data (Oct 22- Sep 23) is 95.7 (within expected range)
- The Mortality review group (MRG) meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner.
- The Medical examiner service continues to scrutinise all inpatient deaths within WUTH
- MRG continues to review Telstar Health data (formerly Dr Foster) to benchmark nationally and highlight areas of concern.
- Learning form mortality reviews is fed back to clinical areas by the Divisional Mortality leads.

It is recommended that the Board:

- Note the mortality indicators, ongoing Medical Examiner input and ongoing scrutiny of mortality through the Mortality Review Group.

Key Risks

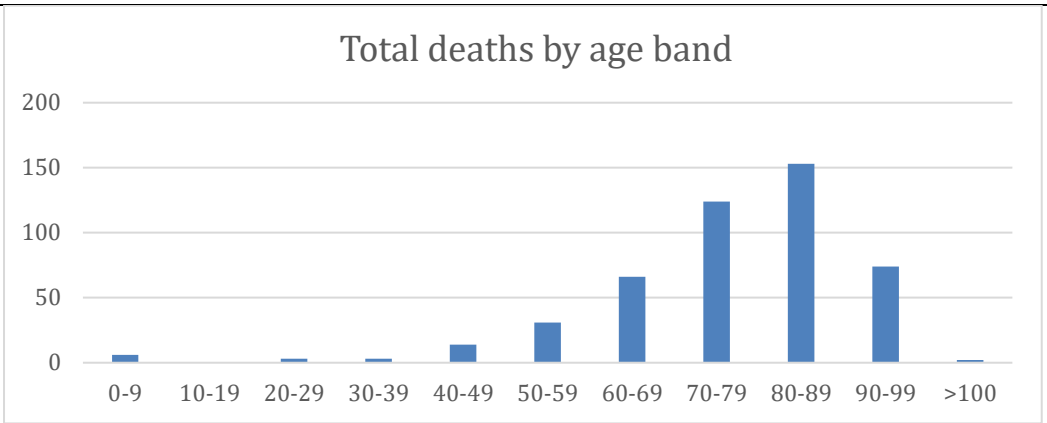
- BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes

Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
23 May 2024	Quality Committee	As above	Information
18 March 2024	Patient Safety Quality Board	As above	Information

1	**Narrative**
1.1	To provide a summary of the mortality review process, care issues, learning and current mortality comparator statistics. This paper is for Adult and perinatal mortality. Wirral University Teaching Hospital is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care. Reviewing mortality helps fulfil two of the five domains set out in the NHS Outcomes Framework: • Preventing people from dying prematurely. • Treating and caring for people in a safe environment and protecting them from avoidable harm. Wirral University Teaching Hospital uses mortality indicators such as the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) to compare mortality data nationally. This helps the Trust to identify areas for potential improvement. Although these are not a measure of poor care in hospitals, they do provide a 'warning' of potential problems and help identify areas for investigation. The Medical Examiner service provides independent scrutiny for all deaths that occur within WUTH, and escalates any concerns for a mortality review, coordinated through the Trust Mortality Group. Additionally, a random 5% of non-escalated deaths are selected for a "quality assurance" mortality review. Lessons learnt from mortality reviews are fed back to each clinical Division via the Divisional Mortality leads who attend the Mortality Review Group. **<u>Patient demographics</u>** There was a total of 477 deaths in Q3 23-24. As per previous trends most recorded deaths are in the over 60 age group and the vast majority fall into the "White British" Ethnic band.



Ethnicity	Number of deaths
White - British	417
White - Irish	3
White - Any other White background	7
Mixed - Any other mixed background	0
Asian or Asian British - Indian	1
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	0
Other Ethnic Groups - Chinese	3
Black/ Black British	1
Not stated/ Not known	45
Total	477

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

The overall SHIMI for WUTH on the latest available data (12 months to June 2023) is 1.06 which is within the “as expected” range. SHIMI for WUTH has been relatively stable in the “expected” range for several quarters now.

Factors impacting SHIMI.

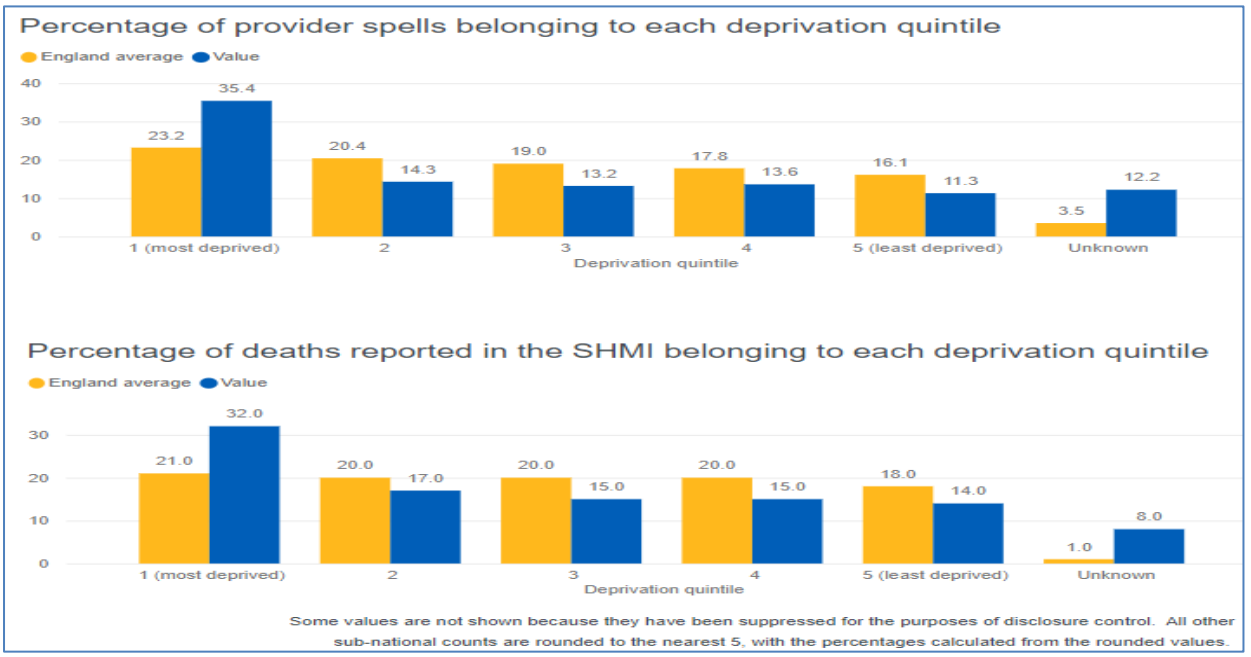
1. Specific diagnostic groups

SHIMI can be broken down into specific diagnostic groups to highlight any areas of concern.

There are no individual diagnostic groups that were statistical outliers during Q3 (when applying NHSE 95% confidence intervals).

2. Impact of deprivation on SHIMI

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

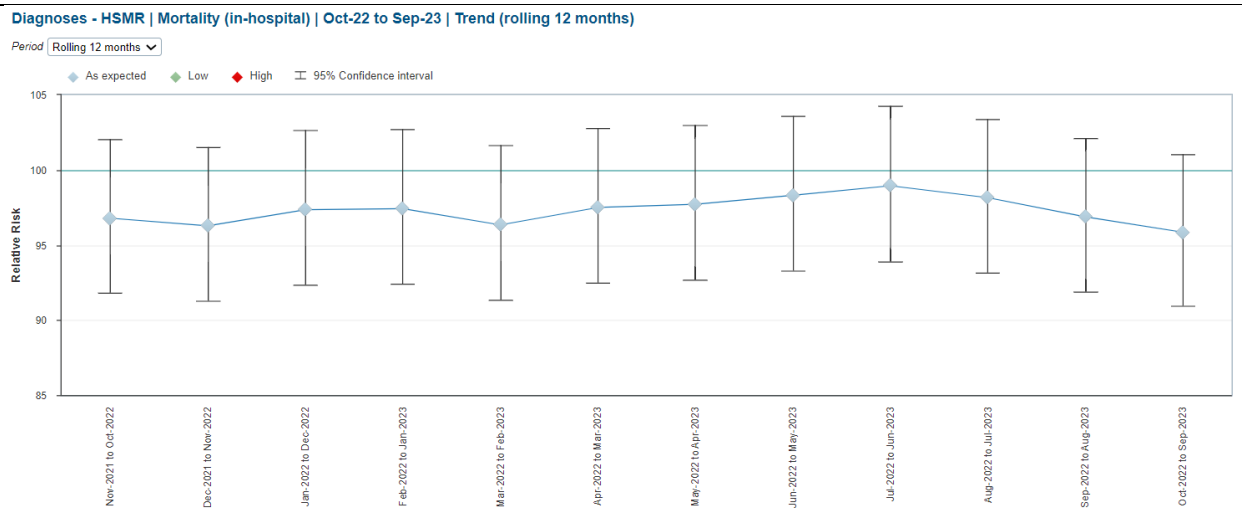


3. Palliative care coding

As discussed in previous reports WUTH continues to have a higher than average number of patients who have a palliative care code (after being reviewed by palliative care). A large number of patients with this code will impact on SHIMI as the SHIMI model does not exclude these patients (unlike HSMR). Recent reviews have shown that palliative care coding remains appropriate and is a reflection of a proactive palliative care service.

<u>Hospital Standardised Mortality Ratio (HSMR)</u>

The HSMR for the latest available is 95.9 on the latest 12 months rolling trend This is in the expected range.



Telstar Health is changing the HSMR model from 2025, with the main change being around inclusion of patients with a palliative care code. This group of patients have previously been excluded from HSMR and it is likely that including these patients will increase the Trust HSMR. There are other changes that may lower HSMR (eg, using deprivation index and expanding comorbidity groups). MRG have asked Telstart Health to undertake an impact analysis into this change and present findings at MRG in Q3 2024.

Mortality Dashboard

The medical examiners (MEs) continue to maintain scrutiny of all WUTH adult deaths and escalate cases where potential concerns are identified. From September 2024 the ME service will be required to undertake scrutiny of all deaths in the community as well as inpatient deaths. Plans are in place to ensure adequate capacity within the team to undertake this additional workload.

18 cases escalated by the ME to the mortality review group have undergone a review during Q3. These cases have been reviewed using a revised PMR template, or via the Royal College of Physicians Structured Judgement review tool.

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 16 deaths were reviewed in Q3 (3%) using the PMR template. None of these cases identified any cause for concern.

Summary of all Adult in patient deaths and case reviews

	Total Adult In-patients Deaths	Deaths reviewed by ME service (%)	Total No of cases escalated for review by Medical Examiner	Total No of SJR's opened from cases escalated	Quality assurance PMR's opened	Total number of case reviews opened by MRG
Q4 (22-23)	503	100%	17	2	15	32
Q1 (23-24)	456	100%	24	10	26	50
Q2 (23-24)	411	100%	16	7	13	29
Q3 (23-24)	477	100%	18	3	16	34

During Q3 19 mortality reports were discussed at MRG with the grading as below.

Grading of Adult Care and avoidability following review in Q3 (Includes reviews opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
Number of cases	6	13	0	0

During Q3 four (4) deaths were reported in patients identified as having a Learning disability. All of these deaths will be reviewed using the SJR template and have also been referred for external review through the national LeDeR programme.

Learning Disability Mortality Reviews				
	Total No. of LD Deaths	No. reviewed	Problems in Health care Identified in this Quarter	Referred to National LeDeR Programme
Q4 (22-23)	2	2	1	3
Q1 (23-24)	10	10	0	10
Q2 (23-24)	4	4	0	4
Q3 (23-24)	2	2	0	2

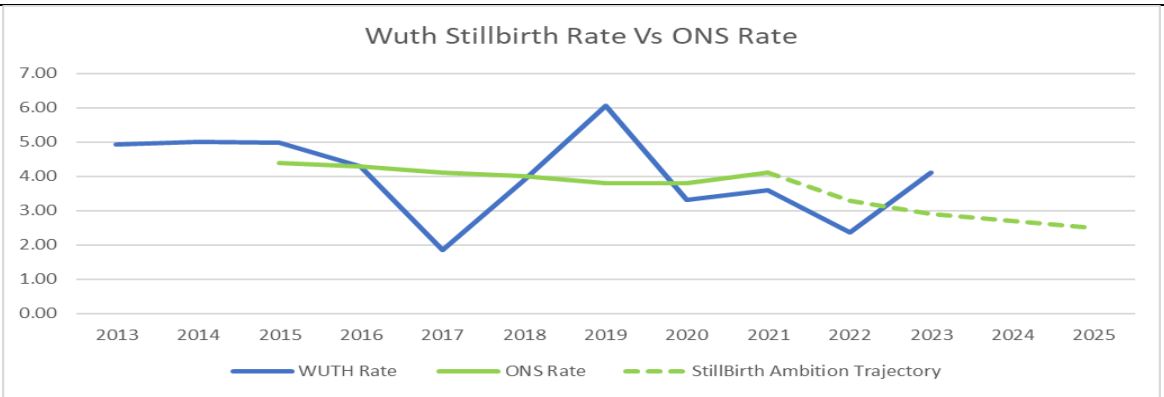
Perinatal and Neonatal deaths

All Neonatal deaths are discussed in a monthly neonatal mortality review meeting attended by Consultants, Nurse Managers, Advanced Neonatal Nurse Practitioners, trainee doctors and senior neonatal nurses. A standardised review template is used to collate information relating to the inpatient care. The deaths are then further reviewed using the PMRT which is a review that supports external attendance from Obstetricians, Neonatologists and Midwives.

	Stillbirths	Neonatal Deaths	Paediatric deaths	Cases sent for PMRT review
Q4 (22-23)	2	1	0	3
Q1 (23-24)	0	2	1	3
Q2 (23-24)	3	2	0	5
Q3 (23-24)	0	3	1	3

During Q3 there were 3 neonatal deaths and no stillbirths. There was 1 paediatric death that was an expected death in a child already known to Claire House hospice.

The stillbirth rate remains above the ONS average for WUTH, and the Division is closely monitoring this and working through several actions to provide assurance around care, as well as monitoring the feedback from PMRT reviews.



Outcome of PMRT reviews reported in Q3				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, likely affected outcome
	2	2	1	0

Learning Identified from PMRT reviews.

There were 5 PMRT case reports finalised during Q3. All but one of the cases were adjudged to have good care, or minor care issues that would not have affected the outcome.
One case was graded as “C”, where it was felt care issues may have affected the outcome. This related to a lack of senior review when the mother presented with abdominal pain during her pregnancy (not in line with national and local guidance). Learning from this case has been feedback to the department and triage processes strengthened.

Learning identified through review of mortality reviews during Q3.

Learning for mortality is derived from 3 main sources.

1. Mortality reviews (collated into a learning log)
2. Themes and trends escalated from the Medical Examiner
3. Learning identified through the SI process.

Specific learning and themes identified during Q3 as well as actions taken are listed in the table below.

Learning theme	Source	Action taken
Poor documentation/ copying and pasting of medical documentation	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads.
Issues around maternity Triage, not following	PMRT	Learning fed back to relevant clinicians. Compliance with guidelines to be reviewed by

national and local guidance		department and monitored through PSQB
Use of SLG2 inhibitors and patients presenting with DKA	Mortality Reviews	Medicines safety pharmacist is leading work across the Wirral system around prescription of this class of drug and complications
Trend of informal complaints against specific ward area	Medical Examiner escalated as theme	Specific cases reviewed for learning and feed back to families regarding concerns raised. Ward manager and lead clinician raising awareness amongst ward staff.

External Benchmarking Data

Dr Telstar Health (Dr Foster) Data

The Telstar Health (formerly Dr Foster) dashboard informs the Trust of any new CUSUM alerts and any diagnosis/ procedures with significantly high mortality.

Deaths in the diagnostic group "complication of device implant" was highlighted as an outlier this quarter. MRG has agreed to undertake a case note review for 16 deaths in this group.

The table below summarises ongoing as well as recently closed work resulting from Dr Foster data.

Diagnostic Group	Quarter Highlighted	Alert type	Work undertaken	Outcome/ Learning
Ovarian Malignancy	Q2 23-24	CUSM alert	Case note review	Small numbers of deaths (6). 2 cases were out of region patients who deteriorated while on holiday in Wirral. No care issues or themes found in other cases. This diagnostic group is no longer an outlier
Complication of device implant	Q3 23-24	CUSM alert	Case note review	16 cases to be reviewed

2	Implications
2.1	**Patients** • This report provides assurance around mortality statistics and shows that WUTH is not an outlier in terms of SHMI or HSMR when benchmarked against other Trusts.
2.2	**People**

	• Currently there is sufficient capacity in the Medical Examiner service to continue scrutiny of all inpatient deaths. From September 2024 the ME service will be required to scrutinse deaths in the community and plans are in place to ensure sufficient capacity to undertake this work.
2.3	**Finance** • Effective patient care will have a positive impact on the financial position of the Trust
2.4	**Compliance** • This report supports the Trusts requirements to provide safe and effective care as set out in the CQC framework

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.7**

05 June 2024

Title	Guardian of Safe Working Annual Report
Area Lead	Dr Nikki Stevenson, Executive Medical Director and Deputy CEO
Author	Dr Alice Arch, Guardian of Safe Working
Report for	Information

Executive Summary and Report Recommendations

This Annual Report on Safe Working Hours for doctors in training is presented to the Board with the aim of providing context and assurance around safe working hours for doctors working for WUTH on the 2016 Junior Doctors Contract for the last financial year; to provide an annual update on the work of the Guardian of Safe Working (GOSW); and to note areas of concern in terms of exception reporting, work schedules and fines paid.

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

- BAF Risk 3: 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	No

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	No
Our partners: provide seamless care working with our partners	No
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**

21 May 2024	People Committee	As above	Information

1	Narrative
	The 2016 Junior Doctors' Contract introduced the role of the Guardian of Safe Working (GOSW) in all organisations that employ or host these doctors. This includes: • being a champion for safe working hours, • attending induction to explain and promote the GOSW role to new doctors. • overseeing safety through exception reporting, • monitoring compliance, • escalating issues for actions when not addressed locally, • requiring work schedule reviews to be undertaken where necessary and • intervening to mitigate safety risk where issues are not being resolved satisfactorily. The five pillars of the Junior Doctors' Contract are: • Doctors/Dentists in Training (DiT) have a process for reporting safety concerns in the workplace which will reach senior leaders. • They have work schedules that describe their working patterns [more clearly than before]. • They should exception report if they work beyond their schedule hours. • Serious breaches of safe working limits can lead to fines for Trusts. • A Junior Doctor Forum (JDF) is established to discuss work and training issues and to decide how any money from fines should be spent. In 2019, the Junior Doctors' Contract was reviewed involving discussions between NHS Employers, the BMA and the Junior Doctors' Committee. Changes Included: • Maximum of 72 hours' work in any 7 consecutive day period. • Rest after nights. • Weekend frequency exemption in specified circumstances. • Maximum one in two frequencies on call. • Maximum of eight consecutive shifts rostered or worked over eight consecutive days. • Maximum of five consecutive long day shifts • Mandated breaks • Too tired to drive home provisions. • Payment for accommodation when non-resident on-call • Specification of breaches that attract a financial penalty. In WUTH, the current GOSW is Dr Alice Arch, who has been in post since 1st November 2023, supported by the Medical Resourcing Team and the Medical Education Lead. To monitor compliance with the working hours directive, Junior Doctors continue to submit exception reports via the appropriate process and in accordance with the 2016 Terms and Conditions of Service. DRS4, a specifically designed piece of software, is the current system through which these are reported and managed. This system enables Junior Doctors and their Supervisors to report and manage these exceptions, both Educational and Hours Compliance, and for oversight to be held by the GOSW.

High level data for Wirral University Teaching Hospital NHS Foundation Trust

Number of doctors / dentists in training (total): 283 (267.6 WTE)
Number of doctors / dentists in training on 2016 TCS (total): 283 (267.6 WTE)
Amount of time available in job plan for guardian to do the role: 1 PA/4 hrs per wk
Admin support provided to the GOSW: Access to 1.0 WTE
Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

Exception reports (regarding working hours)

Exception reports by department

Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E	0	25	25	0
General Medicine	0	230	227	2
General Surgery	0	56	56	0
Oral & Maxillofacial	0	4	4	0
Urology	0	1	1	0
T&O	0	20	20	0
Women & Children's	0	13	12	1
General Practice	0	12	12	0
Psychiatry	0	2	2	0
Total	0	363	360	3

Exception reports by grade

Grade	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	251	249	2
F2	0	18	0	0
SHO	0	85	84	1
SPR	0	9	9	0
Total	0	363	360	3

Exception reports by Rota

Rota	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E 20% Fellow	0	9	9	0
A&E F2 LIFT Weeks	0	5	4	0
A&E SHO	0	6	6	0
A&E SPR	0	5	5	0
DCT Rota	0	4	4	0
Gen Paeds SpR 0.6 WThF	0	1	1	0
Gen Paeds T1	0	11	10	1
Medicine F1	0	183	181	2
Medicine F1 LIFT MT	0	6	6	0
Medicine F1 LIFT WF	0	2	2	0
Medicine IMY2	0	4	4	0
Medicine IMY3	0	1	1	0
Medicine SHO	0	11	11	0
Medicine SHO LIFT MT	0	6	6	0
Medicine SHO 0.8 MTWTh	0	6	6	0
Medicine T1 General	0	1	1	0
Renal	0	8	8	0
Paediatrics Basic Hours	0	1	1	0
Psych F1 2023 LIFT MT	0	2	2	0
Surgical F1	0	46	46	0

Surgical F1 LIFT WF	0	8	8	0
Surgical T1 1:10	0	2	2	0
Stroke T1	0	1	1	0
Urology	0	1	1	0
Clatterbridge Fellow	0	1	1	0
GP F2	0	4	4	0
GP F2 LIFT MT Card WE	0	8	8	0
T&O Extra F1	0	4	4	0
T&O SHO	0	13	13	0
T&O SpR	0	3	3	0
Total	0	363	360	3

Exception reports (response time)						
	Addressed within 48 hours	Addressed within 7 days	Addressed in 8-14 days	Addressed in 15-30 days	Addressed in 31-50 days	Still open
F1	62	59	39	60	29	2
F2	8	6	1	3	0	0
SHO	16	11	18	13	25	1
ST3-8	7	1	2	0	0	0
Total	93	77	60	76	54	3

Exception reports (regarding training/academic issues)

Exception reports by department, grade or rota				
Department	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
A&E	0	1	1	0
General Medicine	0	6	6	0
General Surgery	0	1	1	0
Oral & Maxillofacial	0	0	0	0
Urology	0	0	0	0
T&O	0	0	0	0
Women & Children's	0	0	0	0
General Practice	0	0	0	0
Psychiatry	0	0	0	0
Total	0	8	8	0

Exception Reports

Most of the exception reports are from the Division of Medicine and particularly at Foundation Year 1 level. Many of these reports have been submitted by a smaller number of doctors and educational intervention to discuss these and assist these new doctors with learning the non-clinical skills needed to thrive in a medical career is vital to maintaining the safety of our patients and the wellbeing of those caring for them.

Additionally, several junior doctors raised exception reports due to covering the hour change on Sunday 27th October 2023 as advised by the British Medical Association. This is not specific to WUTH and the GOSW has sought specific advice and guidance on managing these reports.

Where exception reports are open beyond 14 days these are highlighted to the GOSW and are escalated for action by the supervisor. The overdue exception reports from the 2023/24 Financial Year have now been managed by the GOSW.

Exception reports regarding training/academic issues are managed by the Director for Medical Education. There are a much smaller number of exception reports entered for these reasons.

Work schedule reviews

There has been a Work Schedule Review in Paediatrics at Tier 1 (SHO) level and this is under review.

Vacancies

There are several vacant shifts which occur, for example, due to sickness or parental leave gaps on rotas which can contribute to exception reports.

Most of these vacant shifts were within the Emergency Department. Vacancies are covered by doctors on flexible contracts and via the collaborative bank to minimise risks to patients or doctors in training. Medical staffing reviews are underway in several specialities. Doctors working on a bank shift do not exception report for work on those shifts.

Fines

Fines are levied when working hours breach one or more of the following situations:

- The 48 hours average working week.
- Maximum 72 hours worked within any consecutive period of 168 hours.
- Minimum of 11 hours continuous rest between rostered shifts.
- Where meal breaks are missed on more than 25% of occasions.
- The minimum non-residential on call overnight continuous rest of 5 hours between 22:00 and 07:00 hours.
- The maximum 8 hours total rest per 24 hours non-resident on call shift.
- The maximum 13 hours shift length.
- The minimum 11 hours rest between resident shifts.

A proportion of the fine, apart from fines for breaks where payment is 100%, is aid to the GOSW fund, as specified in the 2016 TCS. The TCS also specifies that the Junior Doctors' Forum is the body that decides how accrued monies are spent within the framework identified within the TCS.

Several exception reports have been raised following handovers repeatedly running over and doctors understanding that they are required to attend the post-handover ward round. In addition to issuing the fines communication has been undertaken to ensure that this situation is not recurring. This position is being closely monitored.

Junior Doctors' Forum (JDF)

	The JDF is held every other month via a blended approach (face to face and via MSTeams). The JDF gives junior doctors the opportunity to discuss and jointly address rota and training issues as they arise. The GOSW has been actively encouraging attendance at JDF to encourage junior doctors to engage with improving their working experience and enhance communication between the junior doctors, Medical Resourcing, and the Senior Medical Education Team in partnership the the GOSW. **Doctors Mess** The Junior Doctors Mess is currently having modifications to extend and improve the facilities at WUTH.

2	Implications
2.1	**Patients** • The role of the safe working hours is designed to reassure junior doctors and the Trust that rotas and working conditions are safe for doctors and patients.
2.2	**People** • The GOSW ensures that issues of compliance with safe working hours are addressed by the doctor and the Trust as appropriate. It provides assurance to the board of the employing organization that doctors' hours are safe. • The GOSW works in collaboration with the Director of Medical Education and Local Negotiating Committee to ensure that the issues identified within exception reports, concerning both working hours and training hours, are properly addressed by the Trust.
2.3	**Finance** • The GOSW distributes monies received because of financial penalties to improve the training and working experience of all doctors in accordance with the 2016 TCS.
2.4	**Compliance** • This report provides assurance and compliance as per contractual obligations with NHSE and the NHS employers.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9**

05 June 2024

Title	Modern Slavery Statement
Area Lead	David McGovern, Director of Corporate Affairs
Author	Cate Herbert, Board Secretary
Report for	Approval

Report Purpose and Recommendations

The purpose of this report is to provide the Board of Directors with the annual update of the Modern Slavery Statement as required by the 2015 Act.

It is recommended that the Board:

- Approves the updated statement for 2024/25.

Key Risks

This report relates to these key Risks:

- Compliance with legislative requirements to publish a regularly reviewed and updated statement.

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

Governance journey

This is an annual report brought to the Board for approval.

1	Narrative

1.1	The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the act create a requirement for an annual statement to be prepared that demonstrates transparency both in the organisation and within its supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is also obliged to comply with the Act. The requirement for an annual statement is set out in Section 54 of the Act, specifically addressing the requirement for transparency in the supply chain. The statement should include the steps an organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The Act requires that the statement is approved annually by the Board of Directors. This year's statement has been updated in discussion with the Director of Corporate Affairs and the Assistant Director of Finance – Head of Procurement. The Board are asked to review the statement at section 1.2 and provide approval. Following this, it will be signed by the Chair and the CEO and published on the Trust website.
1.2	**Modern Slavery and Human Trafficking Act 2015 Annual Statement – 2024/25** Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps it has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business. The aim of this statement is to demonstrate that the Trust follows good practice, and all reasonable steps are being taken to prevent slavery and human trafficking. Wirral University Teaching Hospital NHS Foundation Trust provides a comprehensive range of high quality acute care services, our more than 6,200 strong workforce serves a population in excess of 400,000 people across Wirral, Ellesmere Port, Neston, North Wales and the wider Northwest footprint. We operate across two main sites, these being Arrowe Park Hospital in Upton and Clatterbridge Hospital in Bebington. We also provide a range of outpatient services from community locations at St Catherine's Health Centre in Birkenhead and Victoria Central Health Centre in Wallasey. The Trust has well established and robust recruitment and vetting procedures and seeks to ensure that suppliers operate in accordance with the provisions of the Modern Slavery Act. The Trust has a total non-pay spend of c.£130m on goods, equipment and services. The Trust aims to achieve value for money and to promote social values through its contracting and purchasing activity, and the effective utilisation of the Trust's spend contributes significantly to the quality of the patient environment and patient care. The Trust supports the eradication of Modern Slavery through its procurement procedures and processes and is clear that it expects all potential suppliers to be fully compliant with the provisions of the Modern Slavery Act. The Trust recognises that whilst there are laws in place to punish incidents of modern slavery, there is an opportunity to use its purchasing power to help prevent, identify and manage the risks of it occurring in its supply chain by adopting new processes and procedures in both its procurement activity and supplier management. The Trust has adopted a number of measures already, which include:

	• The use of Public Sector Frameworks where there is strong awareness of and monitoring for Modern Slavery in the supply chain. • The mandatory exclusion of any bidder that has been convicted of a human trafficking offence, and the Trust's contracts include • The inclusion of terms and conditions conferring a legal responsibility on Contractors to support that same objective to eradicate slavery and human trafficking. We acknowledge that these measures can be strengthened in line with the Procurement Policy Note PPN02/2023 (Tackling Modern Slavery in Government Supply Chains) so that: • There is a better and wider understanding of the risk and the sectors identified as being at high risk of modern slavery. • We identify and manage the risks when procuring new contracts-using a proportionate and risk assessed approach. • Risks are managed in existing contracts and arrangements. • Procurement staff are appropriately trained so that there is a consistent level of understanding of the issues; that they are able to recognise and effectively manage procurement activity where there is a potential risk and are able to deploy mitigating strategies to reduce the possibility of modern slavery occurring in the Trust's supply chain. Our approach will be monitored and reviewed in line with the provisions of the Trust's Procurement Strategy.

2	Implications
2.1	**Patients** • No direct impact on patients
2.2	**People** • No direct impact on staff, though ensuring that modern slavery does not exist throughout the supply chain supports an ethical approach and the fair treatment of everyone impacted by the Trust.
2.3	**Finance** • No financial implications
2.4	**Compliance** • Compliance with the requirements of the Modern Slavery Act 2015

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 10**
5 June 2024

Title	Annual Report of the Board of Directors, including Effectiveness Review
Area Lead	David McGovern, Director of Corporate Affairs
Author	Cate Herbert, Board Secretary
Report for	Approval

Executive Summary and Report Recommendations

The purpose of this report is to provide the Board of Directors with an overview of the work that it has undertaken and proposes a statement of effectiveness for approval. An assessment against the Terms of Reference has also been conducted and appended.

In line with the NHS Code of Governance, Trusts are encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years. Deloitte were recently commissioned to carry out the Well-led review and this effectiveness review was carried out prior to this. A separate action plan in is development to address any actions identified by Deloitte.

It is recommended that the Board:

- Approves the statement of effectiveness found at section 1.3; and
- Note both the outcomes of the effectiveness survey, and the self-assessment against the Terms of Reference.

Key Risks

This report relates to these key Risks:

- Ensuring the Trust has robust decision-making bodies that are regularly assessed.

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	No
Compassionate workforce: be a great place to work	No
Continuous Improvement: Maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	No

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

Governance journey
This is an annual report.

1	**Narrative**
1.1	**Overview of the Board of Directors** The general duty of the Board of Directors and of each Director individually is to act with a view to promoting the success of the Trust, so as to maximise the benefits for the members of the Trust and as a whole for the public. The Board leads the Trust by undertaking three key roles: 1. Formulating strategy; and 2. Accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable; and 3. Shaping a positive culture for the Board and the organisation. The membership of the Board of Directors in 2023/24 consisted of the following members: **Name** — **Position** Sir David Henshaw — Non-Executive Director & Chair Steve Igoe — SID & Deputy Chair Chris Clarkson — Non-Executive Director Sue Lorimer — Non-Executive Director Dr Steve Ryan — Non-Executive Director Lesley Davies — Non-Executive Director Dr Rajan Madhok — Non-Executive Director Janelle Holmes — Chief Executive Dr Nikki Stevenson — Medical Director & Deputy Chief Executive Tracey Fennell — Chief Nurse (to December 2023) Hayley Kendall — Chief Operating Officer Debs Smith — Chief People Officer Matthew Swanborough — Chief Strategy Officer Mark Chidgey — Chief Finance Officer There were no concerns over attendance of members through the year, and all meetings were quorate.
1.2	**Effectiveness Review** *Effectiveness Survey Results* This is the first internal effectiveness review of the Board of Directors carried out in some time and took two parts. The first was a survey sent out to all members of the Board, asking a series of questions around the operations of the Board. The responses received are attached at Appendix 1.

	All questions returned positive responses. Positively, several “Strongly agree” responses were seen across the survey, and particularly of note is the agreement that Non-Executive Directors and Executive Directors work effectively, and that both the scrutiny and discussion within the meeting is at the right level. Two areas for improvement were identified from the comments, which related to public attendance at meetings and an external stakeholder attending periodically to gain their perspective on key issues. The Corporate Governance team publish meeting dates on the Trust website and inform members of the public how to join should they wish, however other means to publicise this will be explored. The comment regarding an external stakeholder attending will be considered as part of the recommendations from the Deloitte Well-led review. *Self-Assessment against the Terms of Reference* The second part of the effectiveness review was formed of a self-assessment of the Terms of Reference, which has been undertaken against the activity of the Board during the year. This assessment is attached at Appendix 2. There are no areas recommended for amendment.
1.3	**Statement of Effectiveness** Building on the assessment of the Terms of Reference, and the outcomes of the survey, the following statement of effectiveness has been drafted and is recommended for approval. The Board of Directors confirms that it is properly comprised with the appropriate skills and has met a sufficient number of times to conduct its business. The Board has reviewed its work and confirms that it has discharged its duties in line its Terms of Reference and is therefore operating effectively.

2	**Implications**
2.1	**Patients** • No implications
2.2	**People** • No implications
2.3	**Finance** • No implications
2.4	**Compliance** • No implications

Board of Directors Effectiveness Self-Assessment responses

Does the Board of Directors have written terms of reference that has been approved?
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes
Yes

Do NED and Executive members work effectively together in a professional and constructively challenging manner?
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree

Are meeting papers distributed in sufficient time for members to give them due
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Agree
Agree

Has the Board of Directors established a plan of matters to be dealt with across the year?
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Agree
Agree
Strongly agree
Strongly agree
Strongly agree

Agree
Agree

Is the Board of Directors receiving sufficient quality of reports and information to make the decisions and recommendations asked of them?
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Agree
Strongly agree
Strongly agree
Strongly agree
Agree
Strongly agree
Strongly agree

Is the frequency of meetings sufficient to enable members to discharge their duties?
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Agree
Strongly agree
Strongly agree
Strongly agree
Agree
Strongly agree
Strongly agree

Is the discussion at the meeting at the right level?
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Agree
Strongly agree
Strongly agree
Strongly agree
Agree
Strongly agree
Strongly agree

Are members prepared, and able to provide scrutiny and challenge?
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Agree
Strongly agree
Strongly agree
Strongly agree

Strongly agree
Strongly agree
Strongly agree

Does the Board of Directors have the appropriate skillset to provide robust scrutiny and make sound decisions?
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Agree
Agree
Strongly agree

Is the meeting chaired effectively with clarity of purpose, allowing both members and attendees the opportunity to discuss and question?
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Strongly agree
Agree
Strongly agree
Strongly agree

Do you have any comments you would like to add based on questions 1-10?
The quality of reports is high and with sufficient detail to allow the development of effective scrutiny. Executive Directors and their reporting colleagues respond to scrutiny in a ver well informed and balanced way. This is impressive given the level of day-to-day intensity in their work in the Trust.
The Board is effective & well led
I think a strategic board can meet less frequently than monthly if there is provision for operational decisions not delegated.
The Board of Directors has developed into a strong forum with good challenge and support. The chief executive and executive directors have developed in their own contributions.

Is there anything that the Board of Directors could do to make the meeting more effective?
Continue to review balance of public vs private. There is rarely true public attendance in person so consider whether the public aspects can be communicated in a different way to reach a wider audience without the need for people to attend in person.
Goood team of Exec and non exec constructive challenge and good levels of assurance
Possibly an external stakeholder attending from time to time to gain their perspective on issues.

Board of Directors Terms of Reference Review

TOR Provision	Evidence/Commentary
The main duties of the Board of Directors are as follows:	
To set the strategic direction of the Trust within the overall policies both regionally and nationally, to define its annual and longer-term objectives, and to agree sufficiently resourced plans to achieve these	Strategic direction forms regular part of the Board discussions in all settings, via the Chair and CEO updates, planning exercises, and discussions in Board seminars. Formally, the strategic direction is set through biannual discussions on the strategic priorities and objectives, and as part of the yearly financial and operational planning exercise, taking account of NHSE guidance and national priorities.
To oversee the delivery of planned results by monitoring performance against objectives and ensuring corrective action is taken when necessary	Delivery of planned results is monitored through the integration of the Integrated Performance Report and completed via chair's reports from Committees.
To ensure effective financial stewardship through value for money, financial control and financial planning and strategy, and taking approvals in line with the Scheme of Reservation and Delegation.	Good financial stewardship is led through the Chief Finance Officer report to each Board meeting as well as quarterly updates on the long term financial sustainability of the Trust. The Board also have an Audit and Risk Committee to review and scrutinise internal controls, and a Finance Business and Performance Committee to monitor financial planning, strategy, and expenditure. Business cases and contract award recommendation reports are approved in line with the delegated limits.
To ensure that high standards of corporate governance are implemented and maintained, to support compliance with its statutory and regulatory requirements, and to support high standards of transparency, probity, and integrity in the conduct of the business of the whole Trust	High standards of corporate governance are maintained through following good corporate governance practices, including continual review of decision making processes, regular review and scrutiny of key documents and maintaining an awareness of statutory and regularly requirements to inform the Board's cycle of business.
To ensure that high standards of clinical governance are implemented and maintained, to ensure clinical services are effective and safe, and take into account patient experience	High standards of clinical governance are maintained through scrutiny of statutory clinical and nursing reporting requirements and fostering a culture centred on patient safety. Board also regularly receives a patient video story, providing a focus on areas of excellent patient care and/or experience, or highlighting areas for improvement to the

	Board. Board also receive an annual update on the Patient Experience Strategy and have a Quality Committee with delegated authority to drive this agenda. The Quality Committee Chair reports back to the Board after each Committee meeting.
To appoint, appraise and remunerate senior Executives	This is delegated to the Remuneration Committee.
To ensure that there is effective dialogue and partnership working between the Trust and the local community on its plans and performance and that these are responsive to the community's needs	Effective partnership working forms regular part of the Board discussions, and the Board recognise that working as a system is a key part of ensuring excellent patient care. Discussions take place regularly within all Board settings to consider how the Trust can best engage with these local partners.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 11.1**
5 June 2024

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

Items for Escalation and Action

- The Committee noted that financial performance to month 12 had continued to deteriorate with a deficit of £24m achieved against a planned deficit of £19m, an adverse variance of £5m. The variance relates to the costs and loss of activity connected to industrial action. This risk had been notified well in advance to the Committee and the Board.
- The Committee noted that the capital expenditure plan was achieved in full.
- The Chief Finance Officer updated the Committee on 2024/25 planning and the pressures on the ICB. The Trust has improved its planned deficit to £21.7m after achievement of a 5% CIP. This improvement means that there is no funding available to cover the significant risks in the plan and the ICB has been made aware of this. The ICB has a considerable deficit at present and there is a risk that it will come under pressure from NHSE to improve its plan further. This may impact on the Trust and the Trust plan is still not approved by the ICB.
- The Deputy Chief Operating Officer took the Committee through a report on agency medical spend and plans for safely exiting agency arrangements as soon as possible. The highest risk is in the Medical division where there are a number of fragile services including Stroke. Deputy Chief Operating Officer confirmed that options ae under review and the Chair of Quality Committee confirmed that no areas of concern had been raised at Quality Committee with regard to these services. The Committee requested an update at its August meeting.
- The Associate Director of Productivity, Efficiency & PMO informed the Committee that with regard to productivity and efficiency the year had started well, and the first month's target had been exceeded. However, there is a significant way to go to achieve the 5% target for the second year running. £16m has been identified to date from a target of £29m. She said there is still enthusiasm and that project plans and QIA's are in progress. It was agreed that it would be useful to have further presentations from Divisional Managers at the Committee.
- The Committee noted the strong performance in elective activity. The target of 0 for 78 week waiters had been achieved (other than a few related to patient choice) and the 65 week target is due to be achieved by August. Gynaecology is the biggest risk. The Deputy Chief Operating Officer assured the committee that Cancer performance is benchmarking well and Urology in particular has seen its waiting times halved. The Committee noted the strong performance on Diagnostics with achievement of the DM01 target of 95%.
- The Committee noted that despite the implantation of a recovery plan in the third quarter ED performance had not improved with performance against the 4 hour standard of 46.5% for Type 1 attendances and 73.1% for all attendances. However, performance on ambulance handovers had improved to 60 minutes. The team are now working with Aqua on non-admitted attendances in order to try to shift overall performance.
- The Chief Information Officer presented a report on Digital and Information activity and the Committee noted the backlog with regard to Subject Access Requests. A new appointment has been made to help reduce the backlog. Cyber security indicators were demonstrating good performance but there were issues with responses to service desk requests. Chief Information Officer said the team were going to focus on printer problems which were the bulk of the calls. The Committee were pleased to see that 22,000 patients had registered on

the new patient portal. The Committee requested an update on strategic digital developments for future meetings.

- The Chief Strategy Officer provided a presentation on backlog maintenance which had previously been presented to the Estates and Capital Committee. He highlighted the costs of bringing the estate up to standard and set out the mitigations which were in place for coping with poor quality infrastructure. The Committee requested a report on the cost to prevent the estate from further deterioration.
- The Committee noted that the Board Assurance Framework had been updated for the new financial year.

New/Emerging Risks

- Further improvement to the financial plan for the ICB s required by NHSE and that might provide a risk for the Trust. Additionally the Trust's financial plan now contains no funding to mitigate risk.
- The risk around lack of funding for backlog maintenance is significant.

Overview of Assurances Received

- The Trust has achieved the plan committed to with the ICB in H2.
- There are plans in place to reduce the use of agency medical staff.
- The Committee received a report from MIAA setting out its finding of Substantial Assurance on the key financial transaction processing controls.
- The Committee confirms that it is properly comprised with the appropriate skills, and has met a sufficient number of times to conduct its business. The Committee has reviewed its work and confirms that it has discharged its duties in line with the authority delegated to it by the Board via its Terms of Reference, and is therefore operating effectively.

Other comments from the Chair

- The Committee was pleased to see achievement of the Trust's plan for 2023/24 and the continued good work on CIP associated with service transformation.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 11.2**
5 June 2024

Report Title	Committee Chair's Report – People Committee
Author	Lesley Davies, Chair of People Committee

Overview of Assurances Received

- The staff story was a powerful reminder of how making adjustments, however small, for staff with unseen disabilities can have a huge impact both on staff members and patient care and demonstrated that we have more to do in this area of work. It served to reinforce the work that is already being carried out by the Trust to raise awareness of staff with disabilities and additional needs in order to improve the quality of their experience working at the Trust. A workstream to improve the experience of our staff with seen and unseen disabilities has been a key deliverable in our strategy for 2023/24. From the discussions valuable suggestions were made on how the Trust can further support staff with disabilities.

- The committee received the annual Guardian of Safe Working report. Good assurance was given on the embedding of the exceptional reporting process and the action that is followed up with divisions to resolve any issues arising from the exception reporting process. The Trust continues to build on the engagement of junior doctors through the junior doctors' forum. Good assurance was provided on the management of the exception reporting process however, to aid the committee's considerations it has requested that the total number of hours in excess of contractual requirements be included in the report alongside any individual or divisional exceptions.

- The trust reviewed the outcomes of the strategic priorities for 23/24 and recognised the considerable achievement that has been made in delivering the work with the majority of the key performance indicators delivered in full. The committee also reviewed and agreed the proposed priorities for 24/25 and was given good assurance on the likely impact these year 3 priorities will have on the Trust both in terms of the Trust's operational capacity and its culture.

- Good progress has been made in the development of workforce planning across the Trust. A new workforce planning standardised methodology has been implemented across all divisions and is aligned to the Trust's business and financial planning cycle. Based on feedback from divisions, the methodology is being revisited and simplified for 2023/24. There has been good engagement across the Trust and the early indications are that, given the support provided and the additional information made available to divisions on the age profile of existing staff, the planning tool will enable the Trust to more accurately identify the staffing needs of the future. The committee thanked the staff for their continued work in this area and acknowledged to goo progress that has been made to improve the Trust's workforce planning.

- The Committee received a report on the NHS Sexual safety Charter. The Trust has signed up to the NHS Sexual Safety Charter, which sets out a commitment to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our

workforce. The Charter details a range of actions that organisations can take to deliver this commitment. Workforce Steering Board has oversight of a detailed action plan, with initial actions to be delivered by July 2024. People Committee will receive a summary of delivery and priority areas of focus in its July meeting.

- The Northwest Black, Asian and Minority Ethnic Assembly and NHS England North West have published an Anti-Racism Framework. The Framework is based on 5 key principles, which will enable organisations to become 'unapologetically anti-racist':
    1. Prioritising anti-racism.
    2. Understanding lived experience.
    3. Growing inclusive leaders.
    4. Action to tackle inequalities.
    5. Reviewing progress.

  The Committee were informed that the Trust has applied for bronze status, and discussed the importance of thorough review of Trust status at each level as progress is made, to ensure that true impact is achieved.

Other Comments from the Chair

- The Committee confirms that it is properly comprised with the appropriate skills, and has met a sufficient number of times to conduct its business. The Committee has reviewed its work and confirms that it has discharged its duties in line with the authority delegated to it by the Board via its Terms of Reference, and is therefore operating effectively.
- The Committee thanked the staff for their continued work and for providing good assurance on the areas reviewed.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 11.3**
5 June 2024

Report Title	Committee Chairs Reports – Quality Committee
Author	Dr Steve Ryan, Chair of Quality Committee

Items for Escalation/Action

- Mental Health Key Priorities refresh. High attendance rates to the Emergency Department of patients presenting with acute mental health crisis, coupled with lack of access to inpatient mental health services remains a key clinical risk for the organisation. A review and refresh of our Mental Health Key Priorities has been undertaken to provide clear focus on 3 key priorities (reduced from 7) to help address issues that the Trust itself can deal with. The priority areas are, Training, Education and Communication; Mental Health Law Adherence and Service Development; Digital mental health – governance and case management. An enhanced organisation governance structure has been developed to support delivery of priorities, with reporting to the Trust Management Board.

- The Committee received a draft of the Annual Quality Account for 2023/2024. This contains a great deal of information and intelligence on the Trust's work across all areas of activity relating to quality. The Committee feels that it is assured that this is a fair account of the work, actions, challenges, and successes that it has scrutinised through the year. In approving the draft for further internal and external scrutiny and engagement, the Committee recommended that specific numerical metrics be developed for the 3 agreed quality priorities, to manifest the Trust's aspiration for improvement. The 3 areas are, reduction in rates of clostridioides difficile, identifying and responding to patients with clinical deterioration and supporting effective communication and accurate documentation during transfer of care. These areas have been developed after substantial staff engagement across the organisation.

- In receiving the wide-ranging and detailed information contained in the excellent Quality and Patient Safety Intelligence Report, the Committee had a significant discussion in how the golden thread on assurance on actions and "closing the loop" could be made more explicit. Many of the actions are implicit and referenced in other reports (such as the Learning from Deaths Report – see below).

New/Emerging Risks

- In receiving the NHE England North West Regional Report into Clostridioides difficile across the Wirral system, it was agreed that some residual risks remain relating to the lack of single rooms and isolation facilities. Mitigations are in place to minimise the impact. The Committee will receive an action plan to address the recommendations in the report. This will be shared with Wirral system partners at the Wirral Place Quality Group.

- Some infrastructure risks & issues that could impact quality and access were referenced in the committee papers (such as the MRI scanner and sterile services downtime). The Committee were assured that good sight of these risks existed in the Risk Management Committee and appropriate mitigation actions remained in place.

Overview of Assurances Received

- Mortuary services: A report was provided by the designated individual around the findings of and actions arising from an inspection by the Human Tissue Authority (HTA) carried out in June 2023, with the report being received in August 2023. No critical but seven major and six minor shortfalls were highlighted by the inspection. A corrective action plan was submitted to the HTA In October and December 2023 and the Trust is awaiting closure of the findings by the HTA. Key areas of findings related to wider staff awareness and training, ensuring the risk register is comprehensive, that mortuary staff themselves have full oversight of access records to permit audit of individuals accessing the mortuary facilities. Subsequent to the meeting the detailed action plan was shared with the Committee.

- Progress continues to be made with the development and implementation of the Patient Safety Incident Response Framework (PSIRF). In month there were 52 Rapid Evaluations of Care following a concern being raise. In 40, no issues of care delivery were found and in 8 thematic learning around care quality was identified around pressure ulcers, falls and infection control. The first Patient Safety report was provided by our first Patient Safety Response Partner, which highlighted that the induction, engagement, and training of partners is active, purposeful, and positive. It involves a range of activities including attending, governance meetings, observational visits, and leadership interviews. Recruitment for a further 5 partners has taken place. The diverse background of our Partners was noted and it is believed their fresh insights will bring much benefit to our safety agenda.

- The Learning from Deaths report provided assurance that mortality rates for the Trust remain within the expected range that a robust process exists for mortality reviews, supported by attendance of the senior medical examiner at the Mortality Review Group enabling “closing-the-loop” for case referred by them for scrutiny. There was also clear evidence of learning arising from the reviews at individual, service, and Trust levels.

- Medical Outliers (Internal Audit – moderate assurance) & Ockenden Report (Part 2) (Internal Audit – substantial assurance). Both these reports were seen at the Trust Audit Committee also. The level of assurance was as anticipated and in both cases action plans have been put in place to address the recommendations made. The Committee will continue to have oversight of these areas through its intelligence and other reports.

Other comments from the Chair

- The reports provided to the committee were high quality and contained the necessary detail for the committee to test the assurances that were provided. Additionally authors and area leads were able to respond to enquiries to assist the committee in formulating its opinion on assurance.

- It was noted that for 2024/2025 there are no externally identified trajectories for expected reductions in health care associated infections such as C diff or MRSA. Assessment of quality improvement will be based on the evidence of compliance with known control measures based on national authoritative guidance.

- The Committee confirms that it is properly comprised with the appropriate skills, and has met a sufficient number of times to conduct its business. The Committee has reviewed its work and confirms that it has discharged its duties in line with the authority delegated to it by the Board via its Terms of Reference, and is therefore operating effectively.