Mersey and West Lancashire Teaching Hospitals NHS Trust

Trust Board Meeting (Public)
To be held at 10.00 on Wednesday 31 July 2024
Boardroom, Level 5, Whiston Hospital / MS Teams Meeting

Time	Reference No	Agenda Item	Paper	Presenter
Preliminary Business				
10.00	1.	**Employee of the Month (July 2024)** *Purpose: To **note** the Employee of the Month presentation for July 2024*	Film	Chair *(10 mins)*
10.10	2.	**Patient Story** *Purpose: To **note** the Patient Story*	Presentation	Chair *(15 mins)*
10.25	3.	**Chair's Welcome and Note of Apologies** *Purpose: To record apologies for absence and confirm the meeting is quorate*	Verbal	Chair *(10 mins)*
	4.	**Declaration of Interests** *Purpose: To record any Declarations of Interest relating to items on the agenda*	Verbal	
	5.	**TB24/049 Minutes of the previous meeting** *Purpose: To **approve** the minutes of the meetings held on 26 June 2024*	Report	
	6.	**TB24/050 Matters Arising and Action Logs** *Purpose: To consider any matters arising not included anywhere on agenda, review outstanding and **approve** completed actions*	Report	
Executive Committee Assurance Report				
10.35	7.	**TB24/051 Executive Committee Assurance Report** *Purpose: To **note** the Executive Committee Assurance Report*	Report	A Marr *(10 mins)*
Performance Reports				
10.45	8.	**TB24/052 Integrated Performance Report**	Report	

		8.1. Quality Indicators 8.2. Operational Indicators 8.3. Workforce Indicators 8.4. Financial Indicators *Purpose: To **note** the Integrated Performance Report*		L Barnes L Neary M Szpakowska G Lawrence *(30 mins)*
Committee Assurance Reports				
11.15	9.	**TB24/053 Committee Assurance Reports** 9.1. Audit Committee (24/06 report and 30/07 verbal) 9.2. Quality Committee 9.3. Strategic People Committee 9.4. Finance and Performance Committee *Purpose: To **note** the Committee Assurance Reports*	Report	I Clayton/ S Connor G Brown L Knight S Connor *(30 mins)*
Other Board Reports				
11.45	10.	**TB24/054 Corporate Risk Register** *Purpose: To **note** the Corporate Risk Register*	Report	N Bunce *(10 mins)*
11.55	11.	**TB24/055 Board Assurance Framework** *Purpose: To **approve** the Board Assurance Framework*	Report	N Bunce *(10 mins)*
12.05	12.	**TB24/056 Informatics Reports** 12.1. Data Security and Protection Toolkit (DSPT) 12.2. Information Governance Annual Report *Purpose: To **note** the Data Security and Protection Toolkit (DSPT) and the Information Governance Annual Report*	Report	M Gandy *(10 mins)*
12.15	13.	**TB24/057 Learning from Deaths Quarterly Report** *Purpose: To **note** the Learning from Deaths Quarterly Report*	Report	P Williams *(10 mins)*
12.25	14.	**TB24/058 Learning from Deaths Annual Report 2023/24** *Purpose: To **note** the Learning from Deaths Annual Report for 2023/24*	Report	P Williams *(15 mins)*

12.40	15.	**TB24/059 Maternity and Neonatal Services Assurance Report Quarter 1** *Purpose: To **note** the Maternity and Neonatal Services Assurance Report*	Report	L Barnes *(15 mins)*
Concluding Business				
12.55	16.	**Effectiveness of Meeting**	Verbal	Chair *(5 mins)*
13.00	17.	**Any Other Business** *Purpose: To **note** any urgent business not included on the agenda*	Verbal	Chair *(5 mins)*
		Date and time of next meeting: Wednesday 25 September 2024 at 09:30		**13.05 close**
15 minutes lunch break				

Chair: Gill Brown

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	31 July 2024
Agenda Item	**Agenda Item 2**				
Report Title	Patient Story				
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance				
Presenting Officer	Yvonne Mahambrey, Quality Matron Patient Experience				
Action Required		**To Approve**	X	**To Note**	

Purpose

To present to the Board the difference that a patient experience questionnaire has made to a patient at the point of care and the care of future patients.

Executive Summary

At Mersey and West Lancashire Teaching Hospitals NHS Trust, we know that patient experience is more than just meeting our patient's physical needs, but also about treating each patient as an individual with dignity, compassion, and respect. We do not want to just meet expectations; we want to exceed them. This means we are committed to working in partnership with our patients to improve the quality of care that we provide, and we commit to actively seek, listen, and act on feedback received from our patients. One method that patients can provide feedback is face to face with the Patient experience and inclusion team, this is when the Quality Matron first met E.

E, a 21-year-old lady, who was studying a Law degree when she suffered a brain haemorrhage and spent a total of 23 weeks in hospital. The Patient Experience Matron met her on Seddon Suite, spending some time chatting with E and her best friend going through the survey questions.

When E shared a photo prior to the brain haemorrhage, it was clear that her hair was an important physical feature in her overall body image. E's hair had been cut quickly prior to brain surgery and as E described was a "shadow of its former glory". With assistance from the Hairdressing team, we were able to help E feel and look a bit more like herself. E also showed the team the protective helmet that must be worn when E goes outside. The helmet in E's words is really "ugly and embarrassing". Following a conversation with the physiotherapy team, the decoration of the helmet was incorporated into her therapy sessions.

Lessons learned

- In addition to the benefits seen here for E, through her ongoing feedback, the Patient Experience Matron has worked with the Volunteer Service Manager to provide an ad-hoc service that will provide a young volunteer who can be available to provide some "young person distraction" for our long-term younger patients at the Whiston, St Helens and Newton sites.
- The Patient Experience tendable audit has been mandated for all in-patient wards to ensure that evidence of listening to and responding to feedback is documented. The Patient Experience champion role has been developed. Champions will lead on the ward audits as part of their role.

Financial Implications

None as a direct result of this paper.

Quality and/or Equality Impact

Not applicable

Recommendations	
The Board is asked to note the Patient Story	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
	SO2 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

Minutes of the Trust Board Meeting
Held at Boardroom, Level 5, Whiston Hospital / on Microsoft Teams
Wednesday 26 June 2024
(Approved at Trust Board on Wednesday 31 July 2024)

Name	Initials	Title
Richard Fraser	RF	Chair
Ann Marr	AM	Chief Executive Officer
Anne-Marie Stretch	AMS	Deputy Chief Executive Officer
Geoffrey Appleton	GA	Non-Executive Director & Deputy Chair
Lynne Barnes	LB	Acting Director of Nursing, Midwifery & Governance
Gill Brown	GB	Non-Executive Director
Nicola Bunce	NB	Director of Corporate Services
Steve Connor	SC	Non-Executive Director
Rob Cooper	RC	Managing Director
Malcolm Gandy	MG	Director of Informatics
Paul Growney	PG	Associate Non-Executive Director
Lisa Knight	LK	Non-Executive Director
Gareth Lawrence	GL	Director of Finance and Information
Hazel Scott	HS	Non-Executive Director
Carole Spencer	CS	Associate Non-Executive Director
Malise Szpakowska	MS	Acting Director of Human Resources
Rani Thind	RT	Associate Non-Executive Director
Peter Williams	PW	Medical Director

In Attendance

Name	Initials	Title
Angela Ball	AB	Halton Council Representative (Stakeholder Representative) (via MS Teams)
Michelle Henshall	MH	Care Quality Commission (CQC) Operations Manager, Cheshire & Merseyside (via MS Teams)
Juanita Wallace	JW	Executive Assistant (Minute Taker via MS Teams)
Richard Weeks	RW	Corporate Governance Manager

Apologies

Name	Initials	Title
Ian Clayton	IC	Non-Executive Director
Lesley Neary	LN	Chief Operating Officer
Sue Redfern	SR	Director of Nursing, Midwifery and Governance

Agenda Item	Description
Preliminary Business	
1.	**Employee of the Month**
	1.1. The Employee of the Month for June 2024 was Lesley Brant, Patient Advise and Liaison Service (PALS) Officer, Southport Hospital), and the Board watched the film of LB reading the citation and presenting the award to Lesley.

	RESOLVED: The Board **noted** Employee of the Month film for June 2024 and congratulated the winner.
2.	**Chair's Welcome and Note of Apologies**
	2.1. RF welcomed all to the meeting, in particular MS who was attending her first Board meeting in her role as Acting Director of Human Resources. Additionally, RF welcomed MH who was attending the meeting as an observer as part of the Care Quality Commission's (CQC) routine engagement with the Trust. . 2.2. RF noted the apologies of IC and wished him well on behalf of the Board. 2.3. RF acknowledged the following awards and recognition that the Trust had recently received: 2.3.1. Helen Day, Paediatric Nurse, Ormskirk was named the 'Paediatric Nurse of the Year' at the National Diabetes Nursing Awards 2024. 2.3.2. MWL Procurement were shortlisted for two awards at the Health Care Supply Association (HCSA) Excellence in Supply North : • Procurement Excellence • Procurement Transformation Award 2.3.3. The 5 Star Nursing Conference took place on Friday 21 June 2024 and the work of the fantastic nursing teams was recognised as they took part in a poster presentation competition which was judged by the Chief Executive, Ann Marr, OBE. Congratulations to the following: • Winner - Nurse-led Macmillan Team • Highly Commended - Ophthalmology Team • Highly Commended - Nutrition Hydration Champions 2.3.4. The IT Service Desk was awarded the Service Desk Institute (SDI) Level 4 certification. Apologies for absence were **noted** as detailed above
3.	**Declaration of Interests**
	3.1. There were no declarations of interests in relation to the agenda items.
4.	**TB24/044 Minutes of the previous meeting**
	4.1. The meeting reviewed the minutes of the meeting held on 29 May 2024 and approved them as a correct and accurate record of proceedings. **RESOLVED:** The Board **approved** the minutes from the meeting held on 29 May

5.	**TB24/045 Action Log and Matters Arising**
	5.1. The meeting considered the updates to the Action Log, which reflected the progress made in discharging outstanding and agreed actions. 5.2. Action 6 was noted as completed and the other outstanding actions were not due until July. **RESOLVED:** The Board **approved** the action log.
Performance Reports	
6.	**TB24/046 Integrated Performance Reports**
	The Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) Integrated Performance Report (IPR) for May 2024 was presented.
6.1.	**Quality Indicators**
	6.1.1. LB and PW presented the Quality Indicators. 6.1.2. LB highlighted the following: 6.1.2.1. The nurse fill rate was 99.1% and LB reported that there were no individual areas of concern. LB advised that the legacy trusts had reported nursing staff fill rates differently and this was now being aligned to reflect NHS England guidance, so the fill rates would look slightly different in the future. 6.1.2.2. There were four cases of Clostridioides difficile (C.diff) reported in May which was a reduction from ten cases in April 2024 and the main root cause analysis (RCA) findings were the need for a focus on diarrhoea management. 6.1.2.3. There had been an outbreak of Carbapenemase-producing Enterobacteriaceae (CPE) on the Whiston site and the Infection Control and Prevention (ICP) team were providing advice to manage the outbreak. 6.1.2.4. There were 12 cases of Escherichia coli (E.coli) reported in May and actions focused on the hydration of patients, especially during the warmer weather. 6.1.2.5. There had been a reduction in the number of pressure ulcers reported in May. Policies and the strategy had now been aligned across MWL 6.1.2.6. There had been an increase in the number of falls with harm in month. LB referred to the recent deep dive into falls and the differences between sites that had highlighted the need to share good practice and understand the impact of the environment on falls. 6.1.2.7. The inpatient Friends and Family Test (FFT) recommendation rate in May was 94.6% against the target of 90%, despite lower recommendation rates from the maternity areas. LB advised that this was not unique to the Trust and was mainly due to the number of touch points for patients from maternity services which led to some repetition and reported an action plan was in place to try and address the response rates.

	6.1.2.8. The number of complaints responded to within 60 days was 65.8% against a target of 80% which was an improving position. LB advised that the two legacy PALS teams were now working together to share best practice and mutual support. 6.1.3. PW reported that there had been a Never Event at Whiston Hospital in May 2024 (retained guidewire in unwell patient in the operating theatre). A rapid Patient Safety Incident Investigation (PSII) review had been completed and several human factor and environmental issues that may have contributed to the never event had been identified. PW assured, that whilst there had been no harm to the patient as a direct result of the incident, they did remain unwell and were being cared for in the Intensive Care Unit (ICU). Immediate action taken included the re-sharing of the Central Venous Catheter (CVC) checklist, the guidelines for safe vascular access and the Trust policy for placement of indwelling intravenous catheters with all anaesthetic staff. There had also been changes to the handover process to reduce the human and environmental factors that might have contributed to the never event. PW assured that, following the outcomes of the full PSII, the lessons learnt, and action plan would be shared. 6.1.4. There had been one neonatal death recorded at the Ormskirk Maternity unit (pre-term delivery for a woman who attended in spontaneous labour at extreme premature gestation). PW noted that despite a long resuscitation attempt the baby had not survived. A Perinatal Mortality Review Tool (PMRT) review had been undertaken and PW advised that, the review had not found anything that could have been done differently that would have changed the outcome in this case. The findings would be presented at the Patient Safety meeting and the departmental governance meeting. 6.1.5. PW confirmed that the latest data released for Hospital Standardised Mortality Ratio (HSMR) was up to December 2023 and therefore the Trust's position remained unchanged from the April IPR. The Trust's HSMR remained low at 93, which was below the expected level, legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK) had an HSMR of 91 and legacy Southport and Ormskirk (S&O) Hospital NHS Trust had an HSMR of 98. PW advised that following the review of historic HSMR reporting at the S&O sites actions had been taken to standardise coding practice across MWL. 6.1.6. PG reflected on the recent media coverage of E.coli and asked what the Trust was doing to reduce the incidence. LB responded that the numbers were following the same seasonal pattern that had been experienced the previous year, with numbers rising in the warmer weather. PW added that the focus of the actions remained on ensuring patients did not become dehydrated, as this increased the risk.
6.2.	**Operational Indicators**

	6.2.1. RC, on behalf of LN, presented the operational indicators and highlighted the following: 6.2.1.1. Urgent Care performance remained pressured and 4-hour performance (mapped) had reduced from 75% in April to 74.1% in May 2024, national performance was 74% and Cheshire and Merseyside (C&M) was 71.1%. RC noted that, whilst the Trust was in line with national performance, this was not accepted and there was a lot of work to be undertaken to improve performance which had been discussed at the Finance and Performance (F&P) Committee. 6.2.1.2. The number of Non-Criteria to Reside (NCTR) patients had increased to 22% (0.5% increase from April 2024). 6.2.1.3. Bed occupancy across all sites was 106% in May which equated to an additional 99 patients, and this was an increase from 104% in April 2024. RC noted the impact on Emergency Department (ED) performance and ambulance handover times. 6.2.1.4. A collaborative meeting had taken place with the North West Ambulance Service NHS Trust (NWAS) and system partners to establish what could be done collectively to improve ambulance handover times and this had included the expansion of the ambulance triage areas. 6.2.1.5. The Trust continued to utilise all escalation capacity across both acute sites and to implement the internal improvement plans. 6.2.1.6. There had been a discussion at the F&P Committee around the C&M Integrated Care Board (ICB) Urgent and Emergency Care (UEC) recovery programme that had been established and RC noted that there was a focus on Mid Mersey recovery which included Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL). There were three key workstreams for admission avoidance, reduction in acute length of stay and improved discharge. RC noted that LN was the Senior Responsible Owner (SRO) for the acute length of stay workstream. 6.2.1.7. The Trust had 2,629 52 +week waiters at the end of April 2024 and zero 78 +week waiters. Plans were in place to achieve zero 65 +week waiters by the end of August 2024, ahead of the national deadline of September 2024. 6.2.1.8. 18-week RTT performance for May 2024 was 61.4% and this was ahead of national performance of 58.3% (April 2024) and C&M performance of 57%. RC noted that the Trust continued to risk stratify all patients to ensure that the most clinically ill patients were seen and treated first. 6.2.1.9. The Trust had seen a significant improvement in overall diagnostics 6-week performance from 66.4% in September 2023 to 93.5% in May 2024. It was noted that the Trust was the best performing Trust nationally and this was following the work undertaken with the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST). RC noted that there were several modalities, namely endoscopy, non-obstetric ultrasound and DEXA scans that remained below target, however, there had been a significant improvement in the endoscopy and non-obstetric ultrasound waiting lists. DEXA scans remained an issue, but improvements were expected once the planned additional capacity became available at the end of June 2024.

	6.2.1.10. The cancer faster diagnosis standard performance had decreased from 75.3% in March to 70.3% in April 2024 against a target of 75%. The 62-day cancer pathway performance was 80.1% against a target of 85%, compared to national performance at 66.6% and C&M performance at 70.9%. RC noted that MWL had treated more patients on the 62-day pathway than any other C&M Trust and more patients within 62-days. The cancer teams across both legacy trusts had been combined with one patient tracking list and this had demonstrated benefits in levelling up performance across sites. RC noted that there were tumour specific improvement action plans in place to achieve the 28 and 62-day pathways. 6.2.1.11. There had been a significant improvement with the production of GP letters following an outpatient appointment within seven days to 72.8% towards the target of 90%. 6.2.2. RT asked if there had been an increase in breast cancer referrals to Whiston Hospital following the transaction. Traditionally breast cancer referrals from Southport had been made to Aintree Hospital and RT wondered if this had now changed. RC advised that there had always been a percentage of patients referred to Whiston Hospital and that this was dependant on where the patient lived. Additionally, there were several GP practices that had always referred patients to Whiston Hospital, however, there had not been a significant increase in the number of referrals. RC noted that there were plans in place to develop the breast cancer service at Southport and Ormskirk Hospitals. 6.2.3. NB reflected on the upcoming industrial action by junior doctors and asked whether this would impact on the delivery of elective targets. RC advised that the practical planning for the industrial action was at an advanced stage to ensure that urgent and emergency care rotas were covered as a priority, however, it was expected there would be an impact on elective activity, but everything was being done to keep this to a minimum. 6.2.4. GB reflected on the phenomenal improvement in diagnostics 6-week performance and felt that the teams involved should be congratulated. 6.2.5. GB also reflected on the system UEC recovery programme and commented that, whilst the system partners had got together and the governance arrangements were in place, there had not yet been any visible results and asked who had overall responsibility for this. RC confirmed that the PLACE Director for St Helens was the SRO for the Mersey and West Lancashire footprint under the overall ICB programme. GB asked whether feedback had been provided to the SRO and the ICB about the lack of progress to date. RC responded that there was a group of senior people from across the system who had recently met to discuss metrics and noted that the stated objective of the UEC programme was to eradicate corridor care in ED. The programme was working to a goal of putting in place improvements from September / October 2024 (in readiness for the traditional winter period) and

	RC felt it would be important to test some of the plan prior to this to ensure that they were effective. 6.2.6. GB asked if learning would be shared if actions were successful. RC reflected that the Super Multi Agency Discharge Event (MADE) held at Easter had demonstrated that reducing the NCTR patients was possible, which in turn had a positive impact on patient flow and reduced the number of patients in ED. The current meetings with NWAS and the system partners coordination group were focusing on how these could be replicated this winter. 6.2.7. RF confirmed that GB had been nominated as the MWL NED to attend the St Helens and Sefton PLACE board meetings, to help strengthen system working. 6.2.8. CS asked about virtual wards and whether these had contributed to patient flow as expected. RC responded that legacy STHK had embraced virtual wards, particularly for respiratory and frailty patients. RC noted that there had not yet been as strong performance from Southport and Ormskirk areas, however, the virtual ward beds had been commissioned later. Additionally, RC noted that it would be important to utilise all virtual ward capacity and a proposal for a total of 68 virtual equivalent beds for MWL covering respiratory, frailty and urgent cancer care had been submitted to the ICB via CMAST. 6.2.9. RF commented that, in addition to the challenges that all trusts were experiencing, MWL was also in the middle of an integration which created both challenges and opportunities and this was an underlying element of the reports presented and the questions raised.
6.3.	**Workforce Indicators**
	6.3.1. MS presented the Workforce Indicators and highlighted the following: 6.3.1.1. The core mandatory training compliance was 87.7% against a target of 85%. The Executive Committee continued to receive a monthly update on compliance with compulsory training and each Executive was responsible for reviewing overall compliance at a departmental level. 6.3.1.2. The Trust was currently in the second month of the appraisal window which had been adopted across all MWL sites. It was noted that there had been a reduction to 72.6% in May 2024, but this was expected at this point in the cycle. 6.3.1.3. In May sickness absence was 5.6% against the target of 5%. Stress, anxiety, and depression remained the highest causes of sickness. MS noted that for the same period in 2023/24 the sickness absence rate had been 5.5%. 6.3.2. RT asked if the monthly reporting to the Executive Committee identified if there were pockets of non-compliance. MS confirmed that the reports included breakdowns by subject and staff groups, so it was possible to

	pinpoint areas where additional support was required, such as the medical and dental workforce which was currently on an improvement trajectory.
6.4.	**Financial Indicators**
	6.4.1. GL presented the Financial Indicators and highlighted the following: 6.4.1.1. The Board had approved the final MWL financial plan for 2024/25 of £26.7m deficit which had assumed: • Payment of £12m funds in line with the transaction business case • A Cost Improvement Programme (CIP) target of £47m (£36.2m recurrent and £11.8m non-recurrent) • Delivery of the 2024/25 activity plan 6.4.1.2. At month 2 the Trust had reported a deficit of £8.6m in line with plan. 6.4.1.3. The Trust had achieved £12.6m (25%) of the overall CIP target. 6.4.1.4. The cash balance at month 2 was £3.1m and the Trust would require cash support through the year. The application for cash support in Q2 had been submitted in line with the plan. 6.4.1.5. Agency spend was 3.8% against the national target of 3.2% and work was ongoing through the People Performance Council (PPC) to reduce this. 6.4.2. GB reflected on the financial position and the achievement of CIP and commented that not many trusts were in this position. GL commented on the team work and ownership across the whole organisation. RF commented that the achievements of the staff every year should not be taken for granted. 6.4.3. GA reflected on the ownership of CIP by all the staff teams that has been displayed at the F&P Committee meetings and noted that in other organisations that he had been involved in this had been very top down. The delivery of recurrent CIP was not easy, and GA commented that he had been impressed in the quality of the presentations delivered at F&P Committees. Additionally, GA commented that if the culture was right performance would follow and MWL had achieved this. 6.4.4. AM agreed and commented that she was due to give a talk about how to achieve financial control and she felt that one of the most important aspects was culture, technical controls were important, but ownership of an issue was key. **RESOLVED:** The Board **noted** the Integrated Performance Report.
Committee Assurance Reports	
7.	**TB24/047 Committee Assurance Reports**
7.1.	**Executive Committee**
	7.1.1. AM presented the Executive Committee Assurance report covering the meetings held in May 2024. AM highlighted the following:

	7.1.1.1. The Committee had received the CQC report following a recent inspection of Medicine and Spinal Injuries at Southport Hospital which had focused on nutrition. The feedback received had been positive, but with some 'should do' actions, and an action plan had been developed to address these. It was noted that the recruitment of additional dieticians would be a challenge and AM commented that this was a niche role for spinal injuries patients and there was a national shortage. 7.1.1.2. Following the recent spot check audits that had been undertaken on all wards a back-to-basics Nursing Conference had been arranged for 21 June. Seven-minute safety briefing sessions had been developed and would be rolled out for delivery during the daily safety huddles on each ward. Additionally, a new ward accreditation programme had been developed and AM noted that several wards had already been assessed. 7.1.1.3. The Committee had received the Southport Hospital HSMR review which examined the reasons for the fluctuations in HSMR from 2017/2018 and it was noted that this was mainly due to changes in coding and there had been an increase in the expected death rate because of this. The deep dive had concluded that some of the fluctuations were due to a real improvement in the crude mortality. AM noted that she was assured that the HSMR was now correctly reported. 7.1.1.4. The Sterile Services contract for Whiston and St Helens Hospitals was due to end in 2025 and following a review of the business case the Committee approved the preferred option to recontract with an external supplier, which also allowed for future expansion. 7.1.1.5. The proposed SMART actions for board members to support the Trust's Equality, Diversity, and Inclusion (EDI) and health inequality reduction aspirations had been discussed and the Committee had agreed to work with the EDI team to identify the appropriate EDI objectives for each Director. 7.1.1.6. As part of the 2023/24 winter escalation plan the number of beds in a ward bay had been increased to five beds and the impact of this had been discussed. The IPC concerns had been noted when the additional beds had been opened, however, to date no direct link had been found between the number of beds per ward bay and rates of hospital acquired infections. The additional staffing and other non-pay costs required to support the additional beds had been acknowledged. 7.1.1.7. The Committee received a report from the Service Improvement team which detailed the work undertaken with theatres at St Helens Hospital to optimise utilisation. 7.1.1.8. The Health Work and Wellbeing Occupational Health system business case had been approved and a single contract would be implemented across all sites. 7.1.1.9. The Appraisal, Mandatory and Compulsory Training report was discussed. It was noted that Mandatory and Compulsory training was reviewed in detail monthly for each Director's area of responsibility and deep dives were being undertaken into any departments and staff groups that were below the required target.

	7.1.2. AM noted that the following new investment decisions had been taken during May 2024: 7.1.2.1. Approval of the sterile services business case with the authority to negotiate a contract with the supplier. 7.1.2.2. The approval of the business case to procure a single occupational health records system for the Trust. 7.1.3. RF asked if all the acute C&M Trusts had now approved the Laboratory Information Managements System (LIMS) business case, and AM confirmed that they had. 7.1.4. RT asked whether the quality spot checks audits and action plans would be reported to the Quality Committee. LB advised that initially the quality checks were taking place weekly, however, this had now been amended to monthly, as improvements had been noted. An update on the action plan was due to be presented at the Executive Committee in the next few weeks and would be shared with Quality Committee for assurance. GB commented that she recognised that the changes would take a little time to become embedded and anticipated an improvement by Quarter 3. 7.1.5. GB was supportive of the actions being taken to reduce corridor care but asked if the Trust opened more escalation beds to improve patient flow would this result in patients being redirected to MWL. AM agreed that there was always a risk of redirection, however, the Trust had to do the right thing for patients. RC commented that ambulance attendances by area were tracked, and this was discussed at the weekly meetings with NWAS, and any movement of activity not related to a specific pathway would be identified and raised. RF commented that he had discussed this with the Chair of NWAS who had noted that MWL and several other trusts did the right thing by the patients and carried more of the burden. The remainder of the report was **noted.**
7.2.	**Audit Committee**
	7.2.1. RF expressed his thanks to SC for chairing the Audit Committee on behalf of IC. 7.2.2. SC, presented a verbal assurance report following the Audit Committee that had been held on 24 June and highlighted the following: 7.2.2.1. The meeting consisted of two parts and part one covered the part year accounts for S&O from April to June 2023 and the following was noted: 7.2.2.2. The Head of Internal Audit Opinion had provided substantial assurance. 7.2.2.3. The S&O final accounts, the Letter of Representation and the Value for Money (VFM) report from Mazars were reviewed, and the Committee had accepted the findings and recommended the financial statements to Board for approval.

	7.2.2.4. The External Auditors Completion Report was reviewed, and SC noted that S&O had received a clean report from the external auditors which was a credit to GL and the team. 7.2.2.5. The Annual Governance Statement and Annual Report had been audited and were reviewed and recommended to the Board for approval. 7.2.3. The second part of the meeting covered 2023/24 for STHK and then MWL from 01 July 2023 and SC highlighted the following: 7.2.3.1. The External Auditors (Grant Thornton) provided a verbal update which included the key field work undertaken to date as well as the regular meetings with the finance team. The VFM team had been engaged and it was noted that there were currently no areas of concern. An update would be provided at the end of July and the final audit report would be ready in August 2024. 7.2.3.2. The Committee had noted the External Audit timetable which had been issued and approved outside of the meeting. 7.2.3.3. The Head of Internal Audit Opinion was confirmed as substantial assurance. 7.2.3.4. The Committee had received the Annual Meeting Effectiveness Review which was a summary of individual Committee meetings, and it was noted that whilst, there were improvements that could be made, the report had been positive in terms of the effectiveness of the Board and Committee meetings. 7.2.3.5. The MWL draft Annual Governance Statement and Annual Report were presented, and SC commented that this covered the 12 months for the Trust (three months as STHK and nine months as MWL) and this was a well set out report, considering this complexity. There were some minor amendments identified that would be actioned and it was noted the report still needed to be audited and would be presented again at a future Audit Committee. 7.2.4. SC alerted the Board to the changes in the external audit reporting timetable for MWL. 7.2.5. SC noted that the Committee had acknowledged the effort and hard work of everyone involved in producing the draft accounts and draft annual report. 7.2.6. NB noted that the Audit Committee would not usually be held two days prior to Board but this was due to the national audit timetable for the submission of the accounts. NB also confirmed that a further Audit Committee meeting may need to be arranged prior to the July Board to approve the MWL accounts. 7.2.7. The Board accepted the Audit Committee recommendation to approve the part year S&O final annual report and accounts.
7.3.	**Charitable Funds Committee**

	7.3.1. GA presented the Charitable Funds Committee Assurance Report for the meeting held on 11 June 2024 and paid tribute to the Head of Charity who had done phenomenal work in the six months since her appointment. This included the amalgamation of the accounts for the two legacy trusts' Charitable Funds as well as staff engagement across MWL to create awareness of the new Charity. Additionally, the Head of Charity has created a new brand for the Charity which included a website, merchandise, colour schemes and a mascot, Scrubs the Bear. 7.3.2. GA reported that the new MWL NHS Charity would be launched in July , and various activities had been planned across all the hospital sites. 7.3.3. The Committee had noted that further brand development was planned, and this included donation envelopes, newsletters, and boards at the entrances to the hospitals. Additionally, a fundraising event was being planned for Christmas. 7.3.4. GA commented that whoever took over from him as Chair of the Charitable Funds Committee would have a strong foundation on which to build to capture the organisation as well as the public's imagination. 7.3.5. GA paid tribute to PG who had chaired the Committee for several years. Additionally, GA thanked PG for his recent fundraising effort which involved walking 26 miles between Southport, Ormskirk, Whiston and St Helens Hospitals whilst carrying a log weighing more than 30kg to highlight the hidden weight experienced by dementia patients and their carers. 7.3.6. The Committee had received the latest fundraising financial report and noted the charitable fund applications received and approved since the last meeting. 7.3.7. RF thanked PG and his friends for raising funds for the MWL Hospital Charity. The report was noted.
7.4.	**Quality Committee**
	7.4.1. GB presented the Quality Committee Assurance Report for the meeting held on 18 June 2024 and highlighted the following: 7.4.1.1. The Committee had requested that the Corporate Performance Report (CPR) narrative include more detail about any never events. 7.4.1.2. The Committee had noted the 10% overall reduction in pressure ulcers reported year on year and acknowledged the work of the Tissue Viability Team in this achievement. 7.4.1.3. The slight increase in patient falls with moderate or above harm in month was noted, however, there had been a decrease in overall numbers. The Committee had recognised the differences in the number of falls recorded

between sites which were potentially associated to the patient environment and that the Executive Committee would be undertaking a thematic review.

7.4.1.4. The national/regional 2024/25 Infection, Prevention and Control (IPC) targets thresholds were outstanding; however, internal improvement plans were in place to meet the Trust's objectives and would be subject to ongoing review.

7.4.1.5. There had been a CPE outbreak, and this was being managed with support from regional NHSE and UKHSA.

7.4.1.6. There had been zero Methicillin-Resistant Staphylococcus Aureus (MSRA) reported in May.

7.4.1.7. The Committee continued to monitor the complaints and PALS improvement actions and supported the mutual aid being offered within MWL to achieve a consistently high response rate.

7.4.1.8. The Committee continued to monitor the maternity Friends and Family Test (FFT) response rates and recommendation rates as one of the Trust's Quality Improvement Objectives for 2024/25.

7.4.1.9. The Committee had noted that the draft reports following the CQC inspection for the Emergency Departments at Southport and Whiston Hospitals had not been received.

7.4.1.10. The Committee had suggested that additional metrics relating to sepsis and the deteriorating patient, should be added to the CPR. LB and PW had agreed to review this.

7.4.2. The Committee had received assurance reports from the reporting councils and noted that the Clinical Effectiveness Council (CEC) was now a single council for MWL.

7.4.3. The following points were highlighted from the specific reports reviewed by the Committee:

<u>Clinical Effectiveness Council Report</u>:

7.4.3.1. The Intensive Care National Audit and Research Centre (ICNARC) audit provided assurance that the commissioned critical care bed base was sufficient.

7.4.3.2. The successful recruitment of consultant Histopathologists had been noted.

7.4.3.3. MWL would be standardising on the AQUA metrics to monitor Sepsis.

7.4.3.4. The Committee had noted the plans for the recruitment to Gynaecology Consultants and the gynaecology productivity review that had been undertaken.

<u>Clinical Audit Programme Progress</u>:

7.4.3.5. Six audit posters had been accepted for the national audit conference and the Paediatric Consultant was congratulated for the winning poster (Ormskirk Team, Improving 14hour paediatric consultant review). The poster presentation from a junior doctor on Catheter Knowledge Quality Improvement Programme would be shared for learning.

<u>Clinical Research – 6 Monthly Update</u>:

	7.4.3.6. The Trust was the top recruiting site for 2023/24 across numerous research studies and GB reflected on the importance of research to improve patient outcomes. 7.4.3.7. The Committee had been disappointed to note the static funding received from the National Institute for Health and Care Research (NIHR). <u>Patient Safety Council Report</u>: 7.4.3.8. The Hospital Acquired Pressure Ulcers (HAPU) processes had been aligned across MWL. 7.4.3.9. The Patient Safety Incident Response Framework (PSIRF) had been implemented across MWL. 7.4.3.10. The Council had highlighted the vacant antimicrobial prescribing pharmacist post at Southport Hospital and the mitigations that were in place. <u>Patient Experience Council</u>: 7.4.3.11. The Committee had received the quarterly complaints report and requested an additional breakdown of the issues covered by the theme of communication. 7.4.4. RF reflected that the amalgamation of the legacy trusts provided an opportunity to adopt the best practice reporting and agreed that the CPRs would continue to evolve and develop and was assured that the members of the Quality Committee continued to challenge the data they received. The remainder of the report was **noted**.
7.5.	**Strategic People Committee**
	7.5.1. LK presented the Strategic People Committee Assurance report for the meeting held on 17 June 2024 and highlighted the following: 7.5.1.1. The Committee received an update on Health Care Assistant (HCA) absence levels from the HCA Task and Finish Group and were assured by the work that was ongoing in several key areas to support the HCA workforce. 7.5.1.2. The Committee received the Improving Working Lives of Doctors in Training report which provided an overview of the priority areas being focused on for improvement, including duty rosters, reducing pay errors and mandatory training. 7.5.1.3. The Committee received the Recruitment and Retention Operational Annual Assurance update which included an overview of the actions being taken to improve recruitment and retention. A better understanding of the reasons for staff resigning was required as this would assist with the identification of ways to improve retention. It was noted that a new resignation form had been developed and implemented to do this. The use of robotics to increase efficiencies around the time to hire was also discussed. 7.5.1.4. An update on Clinical Coder staffing was received and this included feedback following a deep dive on the challenges around recruiting clinical

	coders. LK noted that there was a workforce gap of 10.5 Whole Time Equivalent (WTE) in contrast to the monthly average workload demand. A new working model was being developed to ensure that there was a clear career structure, development and succession planning in place to maximise retention. 7.5.1.5. The Committee had received the Safe Working report and LK advised that there were no issues to note. The remainder of the report was **noted**.
7.6.	**Finance and Performance Committee**
	7.6.1. SC presented the Committee Assurance report for the meeting held on 20 June 2024 and noted that key points had already been discussed in other reports presented at the meeting. Other points to highlight were: 7.6.1.1. The Committee received the Benefits Realisation Report and SC noted that historically the public sector was not good at tracking benefits realisation. The report had also set out the benefits pipeline from the Frontline Digitisation programme and the Committee approved the Benefits Realisation Strategy. 7.6.1.2. The CIP target for 2024/25 was £48m and this included £36.2m recurrently. The Trust had already delivered £19.6m (41% of target). SC reflected on an earlier discussion about the impact of culture on CIP delivery and commented that this was evident in the Human Resources CIP presentation. 7.6.1.3. The Committee received the Diagnostic Target Review which had set out the plans for sustained improved performance and the sharing of learning across all sites to further improve performance. 7.6.1.4. The Committee received a report which outlined the WTE changes against plan which provided an overview of the workforce plan and monitoring that was in place for the new workforce submissions to NHSE. 7.6.2. The Committee received the assurance reports from the Procurement Council, the CIP Council, the Capital Planning Council, the Estates & Facilities Management Council, and the IM&T Council Update. The remainder of the report was **noted**. **RESOLVED:** The Board **noted** the Committee Assurance Reports
Other Board Reports	
8.	**TB24/048 Fit and Proper Person Chair's Annual Declaration**
	8.1. RF presented the Fit and Proper Person Chair's Annual Declaration which provided assurance to the Board that the Trust met the requirements of the NHS England Fit and Proper Person Test Framework for board members

	and was compliant with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 8.2. It was noted that as part of the annual process, the Chair had ratified the declarations and checks for all board members and the Deputy Chair had ratified the declarations and checks for the Chair. **RESOLVED:** The Board **noted** the Fit and Proper Person Chair's Annual Declaration
Concluding Business	
9.	**Effectiveness of Meeting**
	9.1. In response to RF's question about the effectiveness of the meeting MS commented that the meeting had been engaging and there had been a balanced contribution from all members. The assurance reports had been concise and clear, with accessible language which was important as the documents were in the public domain. Additionally, MS commented that sharing the Employee of the Month video at the start of the meeting set the tone for the meeting and reinforced the Trust values. RF thanked MS for the feedback and commented that he felt it was very important for a unitary board that both NEDs and Executives were prepared to challenge one another. Additionally, RF commented that all Board members were working together to achieve the Trust's goal to deliver five star patient care.
10.	**Any Other Business**
	10.1. GB reflected on the 5 Star Nursing conference that had been arranged by LB and the nursing team and commented that the timing, location of venue, and engagement of staff had been excellent. GB suggested that the Critical Care Pause Presentation be shared at a future Board meeting. GB also reflected on the presentation by two of the matrons from the Whiston and Southport Hospital Emergency Departments who spoke about their experience with the recent CQC inspections and this had demonstrated the Trust's values of being open and honest. 10.2. RF advised that he and GB had attended the two Long Service Awards events and reflected on how humbling it had been to meet staff that had given 25 or 40 years' service to a single Trust. 10.3. RF advised that it was GA's last Board meeting as he was retiring and extended his personal thanks to GA for all his support during his tenure as Deputy Chair and commented that the Trust had benefitted from his experience as well as his vast network of contacts. GA reflected on his career and commented that he had worked for six NHS organisations over a period of 21 years. GA commented that it had been a pleasure and a privilege to work with the MWL team.

	10.4. RF asked MH if she would like to comment on the meeting and MH responded that it had been an interesting meeting, and, whilst she had previously engaged with some of the members, it was good to attend a Board meeting to see how the Board maintained oversight of the Trust as well as the challenges by members as part of obtaining assurance. Additionally, MH congratulated the Employee of the Month. There being no other business, the Chair thanked all for attending and brought the meeting to a close at 11.21. The next Board meeting would be held on **Wednesday 31 July 2024 at 10:00**

Meeting Attendance 2024/25												
Members	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Richard Fraser (Chair)	✓	✓	✓									
Ann Marr	✓	✓	✓									
Anne-Marie Stretch	A	✓	✓									
Geoffrey Appleton	✓	✓	✓									
Lynne Barnes	✓	✓	✓									
Gill Brown	✓	✓	✓									
Nicola Bunce	✓	✓	✓									
Ian Clayton	✓	✓	A									
Steve Connor	✓	✓	✓									
Rob Cooper	✓	✓	✓									
Malcolm Gandy	✓	✓	✓									
Paul Growney	✓	✓	✓									
Lisa Knight	✓	✓	✓									
Gareth Lawrence	✓	✓	✓									
Lesley Neary	✓	A	A									
Sue Redfern	A	A	A									
Hazel Scott	✓	✓	✓									
Carole Spencer		✓	✓									
Malise Szpakowska			✓									
Rani Thind	✓	✓	✓									
Peter Williams	✓	✓	✓									
In Attendance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Angela Ball	A	A	✓									
Richard Weeks	✓	✓	✓									
✓ = In attendance A = Apologies												

Trust Board (Public)
Matters Arising Action Log
Action Log updated 26 July 2024

Mersey and West Lancashire Teaching Hospitals NHS Trust

Status	
Yellow	On Agenda for this Meeting
Red	Overdue
Green	Not yet due
Blue	Completed

Agenda Ref	Meeting Date	Agenda Item	Action	Lead	Deadline	Forecast Completion *(for overdue actions)*	Status
12	31/01/2024	**MWL TB24/010 Learning from Deaths Quarterly Report** 12.1 STHK sites	The Board requested a summary of the themes, learning and actions plans from the Quarterly Learning from Deaths Report be brought together in to an annual report each year. PW agreed to do this for July and NB to update the Board workplan to include this. Update (April 2024) Board workplan updated	PW	Jul-24		**Included in Agenda Item 13 (TB24/057)**
8	29/05/2024	**TB24/039 Committee Assurance Reports** 8.1 Executive Committee	RT reflected on the item about the introduction of the long day shifts for nursing on the legacy STHK sites asked whether this was the same for maternity services. LB commented that she was not aware of any different issues in maternity services who had also implemented the 12-hour shifts and had personally only received positive feedback. It was noted that questions about the long day shifts were part of the quality walkabouts. RT agreed that the feedback she had received had also been positive but asked if this allowed for sufficient staffing at times of high demand. AM agreed that the Executive Committee would review this. July Update This was reviewed at a Whiston Safety Champion walkabout on 16 July 2024. Staff were much happier with new shift pattern. Staffing numbers on 2E raised by staff. Sue Orchard (SO) completing skill mix review across maternity and will be reported in the Q2 maternity report. The units use bank and overtime to flex staffing during activity peaks.	LB	Jul-24		**Completed**

8	29/05/2024	**TB24/039 Committee Assurance Reports** 8.1 Quality Committee	The number of closures of the Whiston neonatal unit seemed to be a cause for concern, although it had been noted that additional staff had been allocated to support the transitional care plan and this might make a difference. AM agreed that the issue needed to be examined further and suggested the executive undertake a deep dive to examine the causes and any recurrent themes. The Executive Team to undertake a deep dive in to the Q4 neonatal unit closures at Whiston Hospital <u>July 2024</u> Q4 NNU diverts presented to Executive Committee alongside the Neonatal ODN capacity and demand for C&M. HD/IC cots well utilised compared to peer. All diverts appropriate to maintain safety of the department. Internal capacity and demand to be completed to ensure adequate staffing numbers. Further report to be presented at Executive Committee.	LB	Jul-24		**Completed**
9	29/05/2024	**TB24/040 Aggregated Incidents, Complaints and Claims Report**	A review of the PALs service to be undertaken and feedback to be presented at Executive Committee. <u>July Update</u> PALs review completed and presented to Executive Committee. Backlog noted at the time of report but now fully resolved. Update presented at Quality Committee in July 2024.	LB	Jul-24		**Completed**

Completed Actions

Agenda Ref	Meeting Date	Agenda Item	Agreed Action	Lead	Deadline	Outcome	Status
6	24/04/2024	**TB14/030 Integrated Performance Report** 6.2 Operational Indicators	RT commented that non-obstetric ultrasound was not included on the Corporate Risk Register (CRR) and asked if additional capacity was planned or if the Trust would continue to outsource this. LN responded that outsourcing had been used to overcome the backlog, but once again there was sufficient internal capacity to cope with the predicted levels of growth once a steady state was achieved. LN suggested the capacity and demand modelling for each diagnostic modality be presented at the Finance and Performance Committee to provide assurance	LN	Jun-24	**June Update:** The follow up Diagnostics Report was presented at the Finance and Performance Committee on 20 June 2024	**Closed**

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	31 July 2024
Agenda Item	**TB24/051**		
Committee being reported	Executive Committee		
Date of Meeting	This report covers the five Executive Committee meetings held in June 2024		
Committee Chair	Ann Marr, Chief Executive Officer		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
There were four Executive Committee meetings held during June 2024. At every meeting bank or agency staff requests that breached the NHSE cost thresholds were reviewed, and the Chief Executive's authorisation recorded. At each meeting the weekly vacancy control panel decisions were also reported.		
06 June 2024		
June Trust Board Agenda and Employee of the Month	• The Director of Corporate Services presented the draft Trust board agendas which were reviewed and agreed. • The Employee of the Month (EOTM) nominations received in May were reviewed and a winner selected.	Approval
Falls Reduction Assurance.	• The Acting Director of Nursing, Midwifery and Governance presented a revised report with additional data, following previous discussion at the Committee. • There had been an increase in falls in December 2023, but this had not continued and year on year there had been a reduction in the number of falls per 1,000 bed days. • Further work was being undertaken to understand the impact of the environment on falls, particulary the falls that took place in a side room compared to a bay and the differences between MWL sites.	Assurance
Review of locum consultant and SAS assignments	• The Managing Director presented the report which detailed for each division the senior medical posts filled by locums and the plans to convert these to substantive appointments. • It was noted that some of the fragile services at the legacy S&O sites relied on locum staff due to national shortages in some specialities, and the solutions were not immediate.	Assurance

	• Quarterly progress reports would be brought to the Committee to provide assurance that the planned actions were effective.	
Quality Ward Rounds – New format	• The Acting Director of Nursing, Midwifery and Governance introduced the presentation. • The benefits of Quality Ward Rounds (QWRs) for board to ward connection were recognised and the objective was to adapt the former STHK process for the whole of MWL. • Feedback had been obtained from a number of sources and used to help develop the proposal. • The plan was to link the QWRs with the ward acreditation and the Committee supported this approach. • The ward visit was regarded as the most important part of the QWR and this was to be re-instated following suspension during COVID. The face to face visits would also utilise the 15 step challenge. • Members of the Corporate Nursing team would continue to capture actions and feedback from the QWR which would be collated to identify any themes. There would be bi-annual summaries of the QWR activity and feedback to the Quality Committee. • The Committee approved the proposal.	Approval
13 June 2024		
Integrated Risk and Incident Management System Business Case	• The Director of Informatics introduced the paper which detailed the options to a single MWL Risk and Incident Management System as the current legacy contract ended. • There was a requirement to move to a system that could meet the NHS England (NHSE) Learning From Patient Safety Events (LFPSE) reporting requirqirements. • The Committee supported the need to move to a single MWL wide system and the selected preferred supplier but had further questions about the level of project support to implement and manage the new system. • The team were therefore asked to further review this aspect of the case and return to the committee with a revised proposal. • The business case was not approved.	Approval
Risk Management Council Assurance Report	• The Director of Corporate Services presented the report.	Assurance

	• There were 1,066 risks on the risk register, with 41 escalated to the Corporate Risk Register (CRR). • Many of the CRR risks were being reviewed by the new divisional management teams. • No new CRR risks had been approved during May. • The Claims Governance Group and Emergency Preparedness, Resilience and Response (EPRR) Operational Group had not met in May, so there were no assurance reports.	
Infection Prevention Control	• The Managing Director provided an update on the Carbapenemase-producing Enterobacteriaceae (CPE) outbreak on ward 1D and the work that was proposed to shut and deep clean the ward when the current patients could be discharged. • Committee supported this approach despite the operational difficulties this would cause for patient flow.	Assurance
Improving working lives for doctors in training	• The Acting Director of Human Resources (HR) provided a briefing on the recent letter from NHSE about action that could be taken to improve the experience of doctors in training. • The lead employer model was recognised nationally as helping to reduce payroll errors and the reported errors were very low for the doctors in training employed via the MWL lead employer service. • A lead had been selected to work on the development of eight week rotas and aligning core skills training. • Further guidance was awaited from NHSE about the proposed NHS Digital Staff Passport, but this would also been implemented once the guidance was available. • The Committee noted the action plan and the areas of additional focus to meet the NHSE requirements.	Assurance
Integrated Performance Report (IPR) – May 2024	• The Director of Finance and Information presented the IPR for review prior to circulation to the Committees. • Committee discussed mortality and Infection, Prevention and Control (IPC) metrics and agreed additional commentary to be added to the report	Assurance
Premium Payment Scrutiny Council	• The Director of Finance and Information reported on the latest review of dermatology and the actions being taken, which would be monitored via	

	the monthly divisional Finance and performance review meetings.	
20 June 2024		
Patient Engagement Portal (PEP)	• The Director of Informatics provided an update on the implementation of the PEP for MWL. • The system was procured in October 2023 and has been operationalised for waiting list validation, with full roll out of phase 1 functionality including "E-Meet and Greet" by August 2024. • Work was also being undertaken with the the operational teams who were transforming out patient booking and appointment letters. • Committee welcomed this development on the basis that it would make access easier for patients who were able to engage with the technology, but were assured that all patients would still have a choice of how they communicated with the Trust and would not be excluded.	Assurance
Mandatory Training Compliance	• The Acting Director of HR presented the compliance for May. • MWL compliance was above target at 87.7% • All Divisions and departments were reporting compliance above the 85% target except Women and Children which was at 83.1% • All staff groups were above 85% except medical and dental staff which was 76.2%, with an improving trajectory.	Assurance
Appraisal Compliance	• The Acting Director of HR presented the performance for May. • The 2024/25 appraisal window for AfC staff now ran for April to September across the whole of MWL. • The compliance rate in May reflected staff dropping out of compliance at the start of the appraisal window and was 72.6%, which was expected to improve significantly in June and July.	Assurance
Cyber Incident Briefing	• The Director of Informatics provided a briefing on the recent cyber attack on the NHS in London. • The paper detailed the actions MWL was taking to enhance protections against cyber attacks and adapt as the threats evolved.	Assurance
Laboratory Information System (LIMS) - Update	• The Director of informatics provided an update on the procurement process for the Cheshire and Merseyside collaborative LIMS.	Assurance
27 June 2024		

Vacancy Contol Panel Terms of Reference (ToR)	• The Acting Director of HR presented the draft ToR for the panel for review and approval. • It was confirmed that the ToR matched the suggested ToR produced by C&M Integrated Care Board (ICB). • The ToR were approved	Approval
Provider Workforce Return - April	• The Acting Director of HR introduced the report which explained the new monthly workforce reporting requirements. • The data would be brought to the committee each month. • The report demonstrated that in April the Trust had not exceeded its planned workforce profile for either substantive or bank /temporary staff.	Assurance
Action plan to reduce HCA agency spend	• The Acting Director of Nursing, Midwifery and Governance presented an update on the agreed action plan. • Changes to bank pay rates had taken effect on 01 July and the impact would be assessed over the coming months. • Recruitment to the internal staff bank had increased and this would reduce reliance on agency staff. • The controls and approval process for authorising agency bookings had been reviewed and additional information was required before shifts could be approved. • The impact of the planned actions would continue to be closely monitored.	Assurance
Cannular Care Improvement Plan	• The Acting Director of Nursing, Midwifery and Governance introduced the report which detailed the actions being taken to improve cannular care and reduce hospital acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteremia infections. • There was an focus on Aseptic Non Touch Technique (ANTT) to ensure all staff had the fundamtal knowledge and skills required. • The routine use of Hydrogen Peroxide fogging for deep cleans had also been proposed, and Committee discussed the operational impact on patient flow due to the amount of time required. • The improvement plan was noted.	Assurance
Safer Staffing Report - April	• The Acting director of Nursing, Midwifery and Governance presented the nurse safer staffing report for April, noting that from May the reporting methodology across MWL would be fully aligned	Assurance

	against the planned staffing levels rather than actual and would all be reported one month in arrears. • The overall RN/M fill rate was 99.2% and HCA was 117.1% with overall CHPPD recorded at eight hours. The HCA figures included supplementary care.	
ICB – Urgent and Emergency Care (UEC) recovery programme	• The Director of Integration presented the final agreed governance structure of the Cheshire and Merseyside UEC recovery programme. • Opportunity modelling for the MWL footprint was due to be completed by the Place leads by the end of July. • There was concern that actions had not yet commenced that would impact on winter 2024/25.	Assurance
Ward 1A Business Case	• The Managing Director introduced the proposal from the Medical Division to agree a substantive medical staffing model for ward 1A, which would also create capacity for post take ward rounds in the Emergency Department to "pull" patients into appropriate speciality care. • There were further opportunities for additional respiratory consultant capacity to re-patriate some activity and develop the service to meet currently unmet demand. • Committee noted no additional funding was required and the proposed substantive staffing model would be more sustainable. • The committee approved the business case.	Approval
Alerts:		
None		
Decisions and Recommendations:		
<u>Investment decisions taken by the Committee during June 2024 were:</u> • Recruitment of three WTE respiratory consultants to support ward 1A		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	31 July 2024
Agenda Item	**TB24/052**			
Report Title	Integrated Performance Report			
Executive Lead	Gareth Lawrence, Director of Finance, and Information			
Presenting Officer	Gareth Lawrence, Director of Finance, and Information			
Action Required		**To Approve**	X	**To Note**

Purpose

The Integrated Performance Report provides an overview of performance for MWL across four key areas:

1) Quality
2) Operations
3) Workforce
4) Finance

Executive Summary

Performance for MWL is summarised across 30 key metrics. Quality has 10 metrics, Operations 13 metrics, Workforce 4 metrics and Finance 3 metrics.

Financial Implications

The forecast for 2023/24 financial outturn will have implications for the finances of the Trust.

Quality and/or Equality Impact

The 10 metrics for Quality provide an overview for summary across MWL

Recommendations

The Board is asked to note performance for assurance.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care – Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care – Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Overview

Mersey and West Lancashire Teaching Hospitals ("The Trust") has in place effective arrangements for the purpose of maintaining and continually improving the quality of healthcare provided to its patients.
The Trust has an unconditional CQC registration which means that overall its services are considered of a good standard and that its position against national targets and standards is relatively strong.
The Trust has in place a financial plan that will enable the key fundamentals of clinical quality, good patient experience and the delivery of national and local standards and targets to be achieved. The Trust continues to work with its main commissioners to ensure there is a robust whole systems winter plan and delivery of national and local performance standards whilst ensuring affordability across the whole health economy.

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Dec-23	84.1	100	93.0	Best 30%
FFT - Inpatients % Recommended	Jun-24	94.6%	90.0%	94.6%	Worst 50%
Nurse Fill Rates	Jun-24	94.2%	90.0%	96.7%	
C.difficile	Jun-24	6		20	
E.coli	Jun-24	12		38	
Hospital Acq Pressure Ulcers per 1000 bed days	Mar-24	0.05	0.00	0.09	
Falls ≥ moderate harm per 1000 bed days	May-24	0.08	0.00	0.19	
Stillbirths (intrapartum)	Jun-24	0	0	0	
Neonatal Deaths	Jun-24	1	0	3	
Never Events	Jun-24	0	0	1	
Complaints Responded In 60 Days	Jun-24	74.5%	80.0%	71.4%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	May-24	73.5%	75.0%	71.9%	Worst 30%
Cancer 62 Days	May-24	80.2%	85.0%	80.1%	Best 10%
% Ambulance Handovers within 30 minutes	Jun-24	48.8%	95.0%	51.4%	
A&E Standard (Mapped)	Jun-24	77.6%	78.0%	75.5%	Best 40%
Average NEL LoS (excl Well Babies)	Jun-24	4.2	4.0	4.1	Best 30%
% of Patients With No Criteria to Reside	Jun-24	22.3%	10.0%	22.0%	
Discharges Before Noon	Jun-24	18.8%	20.0%	18.3%	
G&A Bed Occupancy	Jun-24	97.4%	92.0%	97.6%	Worst 40%
Patients Whose Operation Was Cancelled	Jun-24	0.9%	0.8%	0.9%	
RTT % less than 18 weeks	Jun-24	61.1%	92.0%	61.1%	Best 40%
RTT 65+	Jun-24	511	0	511	Worst 40%
% of E-discharge Summaries Sent Within 24 Hours	Jun-24	84.3%	90.0%	82.8%	
OP Letters to GP Within 7 Days	May-24	71.5%	90.0%	72.2%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jun-24	74.4%	85.0%	74.4%	
Mandatory Training	Jun-24	88.5%	85.0%	88.5%	
Sickness: All Staff Sickness Rate	Jun-24	5.7%	5.0%	5.6%	
Staffing: Turnover rate	Jun-24	0.7%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jun-24		6,700	2,700	
Cash Balances - Days to Cover Operating Expenses	Jun-24	1.4	10		
Reported Surplus/Deficit (000's)	Jun-24		-13,687	-14,727	

Board Summary - Quality

Quality

Friends and Family Test – achieved the overall target despite lower recommendation rates within Maternity areas. An extensive action plan is in place for the Whiston Maternity Unit which will extended across the Ormskirk site.

Clostridium difficile infection – a CDI Improvement Plan is being implemented, incorporating the key elements of environmental cleanliness, appropriate antimicrobial prescribing and staff awareness and training. The Consultant Nurse IPC is also representing the Trust at an NHSE-led Cheshire and Merseyside IPC Provider Collaborative. The first improvement project was agreed to focus on C difficile, which is a common challenge facing acute Trusts in the region.

E coli -The E coli Improvement Plan remains on track, and the Trust is also collaborating on an ICB-led North Mersey IPC/AMR action plan, with a focus on reducing E coli BSIs and hydration.

Pressure Ulcers - Pressure Ulcers per 1,000 bed days for MWL has shown a 10% improvement from 2022/23 to 2023/24. The TVN team are continuing to align pathways and processes for pressure ulcer prevention across the MWL organisation. The TVN teams are working to ensure pressure ulcer prevention training aligns across the organisation and is in accordance with a standard curriculum from NHS England and NHS national wound care strategy. The Trust has a unified risk assessment tool -Maelor risk assessment, with legacy S&O sites adopting paper-based risk assessment documentation. Work is currently underway to digitalise nursing admission and risk assessment documentation. This will ensure data is captured in a timely manner. Processes have been developed to review Pressure ulcers incidents under PSIRF process.

Patient Falls –From 2022/2023 to 2023/2024 there was an overall reduction of 5.3 % in the number of falls and a 6.7% reduction in the falls per 1,000 bed days. The Falls leads at both sites continue to work on trust-wide actions, including daily walkarounds, ward audits and support and education. The Bi-monthly Falls Improvement Group continues to share themes/trends, lessons learned and Trust-wide audit compliance. Decaffeinated drinks are being piloted on 3 wards as an initiative to reduce falls.

Never Events – No Never Events were reported in June (YTD 1). The Never Event reported in May is currently going through the PSII process.

Neonatal death –this was a baby born at 23 weeks and 1 day gestation via normal vaginal delivery. There had been a diagnosis of a fetal abnormality antenatally.
The Baby was transferred to a Level 3 neonatal intensive care unit and sadly died there 10 days later. MBRRACE assignment from WUTH completed. An MDT Review is arranged and a Learning Review is underway.

HSMR - Latest data available up to and including Dec-23. YTD the Trust HSMR remains low at 93.0, with both sites below 100 (STHK site 91.0 and S&O 98.0). The YTD S&O HSMR has increased from 22-23. The factors driving the rise in HSMR have been reviewed and this appears to be driven by a fall in palliative care coding and a drop in patients recorded as having septicaemia. Action has been taken to ensure that patients are coded as accurately as possible to ensure an accurate HSMR. The Trust continues to monitor and investigate any alerting diagnosis groups. Crude mortality remains unchanged. The SHMI remains within expected levels

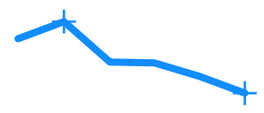
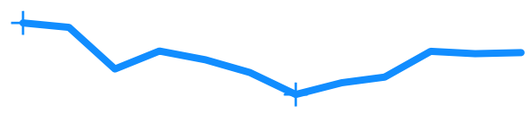
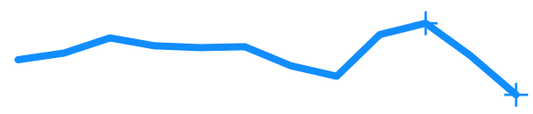
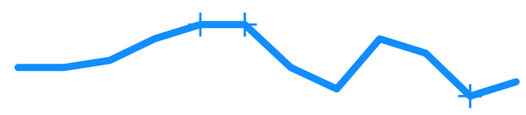
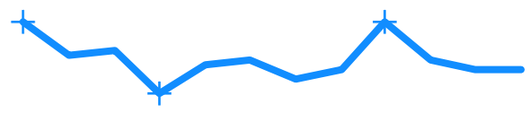
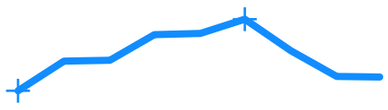
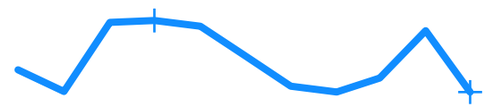
Complaints - % of stage 1 complaints resolved in 60 working days – there has been an improvement in complaints responsiveness in June. Every effort is made to increase and maintain the response time.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Quality

Quality	Period	Score	Target	YTD	Benchmark	Trend
Mortality - HSMR	Dec-23	84.1	100	93.4	Best 30%	
FFT - Inpatients % Recommended	Jun-24	94.6%	90.0%	94.6%	Worst 50%	
Nurse Fill Rates	Jun-24	94.2%	90.0%	96.7%		
C.difficile	Jun-24	6		20		
E.coli	Jun-24	12		38		
Hospital Acq Pressure Ulcers per 1000 bed days	Mar-24	0.05	0.00	0.09		
Falls ≥ moderate harm per 1000 bed days	May-24	0.08	0.00	0.19		
Stillbirths (intrapartum)	Jun-24	0	0	0		
Neonatal Deaths	Jun-24	1	0	3		
Never Events	Jun-24	0	0	1		
Complaints Responded In 60 Days	Jun-24	74.5%	80.0%	71.4%		

Board Summary - Operations

Operations

A&E - 4-Hour performance increased in June, achieving 72.7% (all types), national performance 74.6% and providers across Cheshire & Merseyside averaging 72.7%. The Trusts mapped 4-Hour performance achieved 77.6%. The Trust continue to utilise all escalation capacity across both sites. The Trust is involved in a regional UEC improvement programme focussing on 3 elements; admission avoidance, inpatient length of stay and acute discharges. The Trust is leading on the inpatient length of stay programme, with SRO's from community and PLACE, leading on the other elements.

Patient Flow - Bed occupancy across MWL averaged 105% in June equating to 93 patients - a small decrease from 105.8% in May. There was a peak of 122 patients (43 at S&O, 79 at StHK), which includes patients in G&A beds, escalation areas and those waiting for admission in ED. Average length of stay for emergency admissions is high, at 9.7 at S&O and 7.7 at StHK, with an overall average of 8.3 days, the impact of non CTR patients being 22.3% at Organisation level, 0.3% higher than May - (26% StHK and 17% S&O).

18 Weeks - The Trust had 2,728 52-week waiters at the end of June (287 S&O and 2,441 StHK) and 3 78 week waiters. The 52-week position is an increase of 99 from May. 18 Week performance in June for MWL was 61.1%, S&O 68.2% and StHK 58.4%. MWL performance remains ahead of national performance (latest month May) of 59.1% and C&M regional performance of 57.7%.

Cancer - Cancer performance for MWL in May increased to 73.5% for the 28 day standard (target 75%), with Southport achieving 71.5% and St Helens performance being 74.8%. Latest published data (May 24) shows National performance of 76.4% and C&M regional performance of 74.1%. Performance for 62-day increased to 80.2% (target 85%), with Southport achieving 69.9% and St Helens 84.8%. C&M performance was 71.8% and National 65.8%. Tumour site specific improvement plans are in place which set out the key actions being taken to achieve the 28 day and 62 day standards for 2024/25.

Diagnostics - Diagnostic performance achieved target in June, increasing to 96.1% for MWL, S&O 94.6% and StHK 96.9%. MWL performance is ahead of national performance (latest month May) of 77.9% and C&M regional performance of 90%.

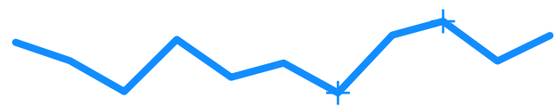
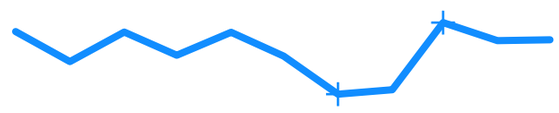
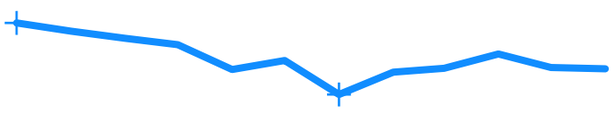
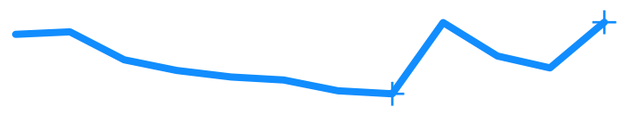
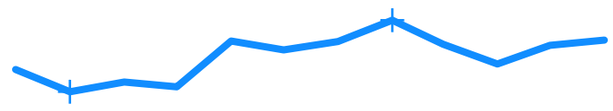
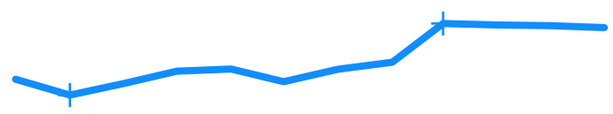
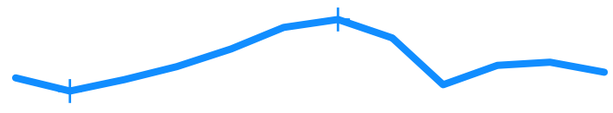
Letters - The Trust had a significant improvement in performance in letters sent to GP's within 7 days. The interim solution will continue to be rolled out. Urgent letters are being produced within 48 hours of appointment.

Integrated Performance Report

Integrated Intelligence & Improvement Service

NHS
Mersey and West Lancashire Teaching Hospitals
NHS Trust

Board Summary - Operations

Operations	Period	Score	Target	YTD	Benchmark	Trend
Cancer Faster Diagnosis Standard	May-24	73.5%	75.0%	71.9%	Worst 30%	
Cancer 62 Days	May-24	80.2%	85.0%	80.1%	Best 20%	
% Ambulance Handovers within 30 minutes	Jun-24	48.8%	95.0%	51.4%		
A&E Standard (Mapped)	Jun-24	77.6%	78.0%	75.5%	Best 50%	
Average NEL LoS (excl Well Babies)	Jun-24	4.2	4.0	4.1	Best 30%	
% of Patients With No Criteria to Reside	Jun-24	22.3%	10.0%	22.0%		
Discharges Before Noon	Jun-24	18.8%	20.0%	18.3%		
G&A Bed Occupancy	Jun-24	97.4%	92.0%	97.6%	Worst 40%	
Patients Whose Operation Was Cancelled	Jun-24	0.9%	0.8%	0.9%		
RTT % less than 18 weeks	Jun-24	61.1%	92.0%	61.1%	Best 30%	
RTT 65+	Jun-24	511	0	511	Worst 30%	
% of E-discharge Summaries Sent Within 24 Hours	Jun-24	84.3%	90.0%	82.8%		
OP Letters to GP Within 7 Days	May-24	71.5%	90.0%	72.2%		

Board Summary - Workforce

Workforce

Mandatory Training - The Trust continues to exceed its mandatory target at 88.5% against a target of 85%.

Appraisals - The Trust is currently in its annual appraisal window achieving 74.4% against a target of 85%. There has been an in month increase in compliance across both legacy sites with the lower compliance on legacy S&O sites achieving 72.6% and legacy STHK sites achieving 75.3%.

Sickness - In-month sickness remains above target, at 5.7% against the 5% target. This is a 0.1% in month increase. The top reason for absence is Anxiety, Stress and Depression. This is consistent with the top reason for absence across the NHS. The Trust continues to focus on supporting all employees who are absent due to Anxiety/Stress/Depression by ensuring that all supportive actions have been undertaken. Further targeted work has also been undertaken as part of our overall absence management approach:

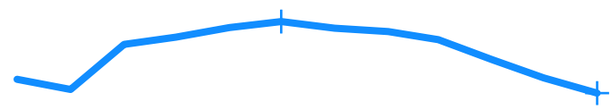
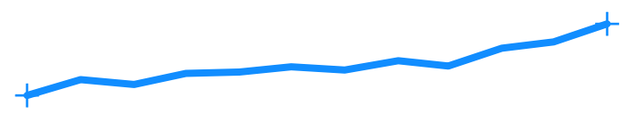
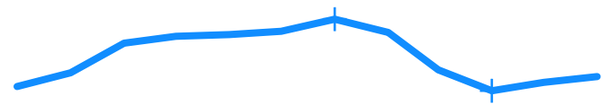
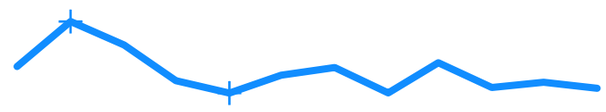
• Ensuring that welcome-back conversations (renamed from return to work), welfare meetings and trigger meetings are being undertaken
• Carrying out internal audits of areas to ensure the processes are being followed and providing support and training to line managers
• Delivering Attendance Management training sessions to new and existing managers.
• Holding bi-weekly review of Trust absences by HR Operations Team and HWWB Team.
• Facilitating early engagement of all employees who are absent due to musculoskeletal problems.
• Holding bi-weekly review of Trust absences by HR Operations Team and HWWB Team.
• Facilitating early engagement of all employees who are absent due to musculoskeletal problems.

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary - Workforce

Workforce	Period	Score	Target	YTD	Benchmark	Trend
Appraisals	Jun-24	74.4%	85.0%	74.4%		
Mandatory Training	Jun-24	88.5%	85.0%	88.5%		
Sickness: All Staff Sickness Rate	Jun-24	5.7%	5.0%	5.6%		
Staffing: Turnover rate	Jun-24	0.7%	1.1%	0.8%		

Board Summary - Finance

Finance

The final approved MWL financial plan for 24/25 gives a deficit of £26.7m, which assumes:

- Payment of £12m funds in line with transaction business case
- Delivery of £36.2m recurrent CIP
- Delivery of £11.8m non-recurrent CIP
- Delivery of the 24/25 activity plan, in order to achieve planned levels of income including ERF/API variable funding
- Contract agreements in line with planned values

Surplus/Deficit – At Month 3, the Trust is reporting a year to date deficit of £14.7m which is a £1m negative variance from plan due to the impact in month from industrial action. This position includes underperformance from month 1 against the activity plan which is currently mitigated by non recurrent underspends elsewhere in the position.

CIP - The Trust's CIP target for financial year 2024/25 is £48.0m, of which £36.2m is to be delivered recurrently and £11.8m non-recurrently. As at Month 3, the Trust has successfully transacted CIP of £27.4m in year of which £24.8m is recurrent, with a further £1.1m of recurrent CIP at finalisation stage.

Cash - At the end of M3, the cash balance was £3.5m, the Trust will require cash support throughout the year and will need to provide significant assurance to receive this. The application for M5 has been submitted in line with plan. Trust will continue to monitor Lead Employer cash balances to ensure no detrimental impact to the Trust.

Capital - Capital expenditure for the year to date (including PFI lifecycle) totals £2.7m. This is below plan due to timing of projects and will be fully utilised by the end of the year. The capital plan will require external PDC cash support, this is forecast to be required after M7.

Integrated Performance Report

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Board Summary - Finance

Finance	Period	Score	Target	YTD	Benchmark	Trend
Capital Spend £ 000's	Jun-24		6,700	2,700		
Cash Balances - Days to Cover Operating Expenses	Jun-24	1.4	10			
Reported Surplus/Deficit (000's)	Jun-24		-13,687	-14,727		

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy Southport & Ormskirk

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Dec-23	81.4	100	98.0	
FFT - Inpatients % Recommended	Jun-24	93.5%	90.0%	93.9%	
Nurse Fill Rates	Jun-24	91.0%	90.0%	94.1%	
C.difficile	Jun-24	2		6	
E.coli	Jun-24	2		14	
Hospital Acq Pressure Ulcers per 1000 bed days	Mar-24	0.15	0.00	0.07	
Falls ≥ moderate harm per 1000 bed days	May-24	0.08	0.00	0.19	
Stillbirths (intrapartum)	Jun-24	0	0	0	
Neonatal Deaths	Jun-24	0	0	1	
Never Events	Jun-24	0	0	0	
Complaints Responded In 60 Days	Jun-24	70.0%	80.0%	76.0%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	May-24	71.5%	75.0%	68.2%	
Cancer 62 Days	May-24	69.9%	85.0%	68.4%	
% Ambulance Handovers within 30 minutes	Jun-24	61.2%	95.0%	64.3%	
A&E Standard (Mapped)	Jun-24				
Average NEL LoS (excl Well Babies)	Jun-24	5.7	4.0	5.4	
% of Patients With No Criteria to Reside	Jun-24	17.0%	10.0%	17.6%	
Discharges Before Noon	Jun-24	18.5%	20.0%	19.6%	
G&A Bed Occupancy	Jun-24	96.9%	92.0%	97.4%	
Patients Whose Operation Was Cancelled	Jun-24	1.2%	0.8%	1.0%	
RTT % less than 18 weeks	Jun-24	68.2%	92.0%	68.2%	
RTT 65+	Jun-24	9	0	9	
% of E-discharge Summaries Sent Within 24 Hours	Jun-24	84.8%	90.0%	80.6%	
OP Letters to GP Within 7 Days	May-24	71.3%	90.0%	75.0%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jun-24	72.6%	85.0%	72.6%	
Mandatory Training	Jun-24	90.1%	85.0%	90.1%	
Sickness: All Staff Sickness Rate	Jun-24	5.8%	5.0%	5.9%	
Staffing: Turnover rate	Jun-24	0.8%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jun-24				
Reported Surplus/Deficit (000's)	Jun-24				

Integrated Performance Report

Integrated Intelligence & Improvement Service

Mersey and West Lancashire Teaching Hospitals NHS Trust

Board Summary

Legacy St Helens & Knowsley

Quality	Period	Score	Target	YTD	Benchmark
Mortality - HSMR	Dec-23	84.9	100	91.0	
FFT - Inpatients % Recommended	Jun-24	95.1%	94.0%	94.9%	
Nurse Fill Rates	Jun-24	97.6%	90.0%	99.5%	
C.difficile	Jun-24	4		14	
E.coli	Jun-24	10		24	
Hospital Acq Pressure Ulcers per 1000 bed days	Mar-24	0.00	0.00	0.11	
Falls ≥ moderate harm per 1000 bed days	May-24	0.08	0.00	0.18	
Stillbirths (intrapartum)	Jun-24	0	0	0	
Neonatal Deaths	Jun-24	1	0	2	
Never Events	Jun-24	0	0	1	
Complaints Responded In 60 Days	Jun-24	77.8%	80.0%	68.1%	

Operations	Period	Score	Target	YTD	Benchmark
Cancer Faster Diagnosis Standard	May-24	74.8%	75.0%	74.3%	
Cancer 62 Days	May-24	84.8%	85.0%	85.4%	
% Ambulance Handovers within 30 minutes	Jun-24	42.5%	95.0%	44.6%	
A&E Standard (Mapped)	Jun-24				
Average NEL LoS (excl Well Babies)	Jun-24	3.7	4.0	3.7	
% of Patients With No Criteria to Reside	Jun-24	25.5%	10.0%	24.5%	
Discharges Before Noon	Jun-24	19.0%	20.0%	17.1%	
G&A Bed Occupancy	Jun-24	97.6%	92.0%	97.7%	
Patients Whose Operation Was Cancelled	Jun-24	0.7%	0.8%	0.8%	
RTT % less than 18 weeks	Jun-24	58.4%	92.0%	58.4%	
RTT 65+	Jun-24	502	0	502	
% of E-discharge Summaries Sent Within 24 Hours	Jun-24	84.2%	90.0%	83.4%	
OP Letters to GP Within 7 Days	May-24	71.7%	90.0%	70.6%	

Workforce	Period	Score	Target	YTD	Benchmark
Appraisals	Jun-24	75.3%	85.0%	75.3%	
Mandatory Training	Jun-24	87.7%	85.0%	87.7%	
Sickness: All Staff Sickness Rate	Jun-24	5.6%	5.0%	5.4%	
Staffing: Turnover rate	Jun-24	0.7%	1.1%	0.8%	

Finance	Period	Score	Target	YTD	Benchmark
Capital Spend £ 000's	Jun-24				
Cash Balances - Days to Cover Operating Expenses	Jun-24				
Reported Surplus/Deficit (000's)	Jun-24				

Committee/Council/Group Assurance Report			
Title of Meeting	**Trust Board**	**Date**	31 July 2024
Agenda Item	**TB24/053 (9.1)**		
Committee being reported	Audit Committee		
Date of Meeting	24 June 2024		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
AC24/018 Southport & Ormskirk NHS Hospital Trust Internal Audit Opinion Quarter 1 2023/24	The Internal audit opinion for the period 01 April 2023 to 30th June 2023 was Substantial Assurance.	Assurance
AC24/018 Southport & Ormskirk NHS Hospital Trust Accounts adoption	Committee reviewed and approved the annual accounts for Southport & Ormskirk NHS Hospital Trust M1-3 2023/24	Approval
AC24/019 Southport & Ormskirk NHS Hospital Trust External Audit Completion Report	Mazars provided an overview of the external audit findings and shared the completion report.	Assurance
AC24/020 Southport & Ormskirk NHS Hospital Trust Annual Report and Annual Governance Statement	Committee reviewed and approved the annual governance statement for Southport & Ormskirk NHS Hospital Trust M1-3 2023/24	Approval
AC24/024 MWL External Audit Report	Grant Thornton (GT) provided a verbal update following their appointment as MWL external auditors for 23/24. An overview of the audit plan was given, and GT confirmed the audit was underway.	Assurance
AC24/025 MWL Head of Internal Audit Opinion	The Internal audit opinion for the period 01 April 2023 to 31 March 2024 was Substantial Assurance	Assurance/
AC24/026 Audit Committee Annual Effectiveness Reviews	The Committee noted the conclusions following the annual reviews of effectiveness.	Assurance

AC24/027 MWL Annual Report and Annual Governance Statement	Committee reviewed and approved the draft annual governance statement for MWL 2023/24.	Approval

Alerts:

None

Decisions and Recommendation(s):

AC24/018 Southport & Ormskirk NHS Hospital Trust Accounts adoption
AC24/020 Southport & Ormskirk NHS Hospital Trust Annual Report and Annual Governance Statement

- The final 2023/24 accounts, annual report and annual governance statement were approved by the Committee and recommended for approval by Board.

AC24/027 MWL Annual Report and Annual Governance Statement

- The draft Annual Report and Annual Governance Statement were approved by the Committee subject to ongoing external audit and will be brought back to the next Committee.

Committee Assurance Report

Title of Meeting	**Trust Board**	**Date**	31 July 2024
Agenda Item	**TB24/053 (9.2)**		
Committee being reported	Quality Committee		
Date of Meeting	23 July 2024		
Committee Chair	Gill Brown, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
Minutes of the previous meeting	• Minutes of the meeting held on 18 June 2024: Following a few minor clarifications the minutes were approved as a correct and accurate record of the proceedings.	Approved
Matters arising/Action Log	• Noted actions aligned to agenda items on the meeting with remaining actions due at future meeting and within the meeting pack. • Action 46, 55, 56, 57, 58, 59, 60, 61 completed. • Terms of Reference for 3 councils to be reviewed and presented to the Quality Committee in September. • Quality Committee effectiveness review 2023/24 - action plan to be shared to Quality Committee September. • Committee agreed additional metric for deteriorating patients to be added to Corporate Performance Report.	Assurance
Quality Committee Corporate Performance Report (CPR)	• **Nutrition –** Interventions in place with further reporting into the committee end of Quarter 2. Review of metric within CPR for recording of patients at high risk requiring referral to dietician. • **Pressure Ulcers:** Continuous improvement. Assurance provided regarding validation data reporting update by July 2024. • **Patient Falls (with moderate harm or above):** Continuous improvement. Thematic review completed and assurance provided against ongoing actions. • **Infection Prevention and Control:** One Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteraemia-Learning review panel with report to September Quality Committee.	Assurance

	• Carbapenemase-producing Enterobacteriaceae (CPE) - Controlled re-opening of ward area following outbreak with supportive guidance in place from regional NHS England (NHSE.) • **Complaints:** Complaint numbers risen, maintaining positive improvement in response times. Patient Advise and Liaison Service (PALS) backlog Whiston site complete. Recognised pre-action requests impacting on Trust complaints and claims position with potential for this to decrease in October 2024. • **Friends and Family Test (FFT):** Assurances provided for Maternity recognising challenges against the four touch points taking positive comparison across the region with the Trust being first in the region for the second touch point. Work continues with response rate improvements. • **Maternity:** Induction of Labour increased in month with-in depth audit commissioned. Assurance provided against year-to-date third- and fourth-degree tears against expected benchmark. Noted work ongoing with Local Maternity and Neonatal System (LMNS) to agree regional targets with future reporting. Assurance provided against improvement plan to deliver improved compliance and data capture at booking in for referral to stop smoking Ormskirk site. Expected improvement in September reporting to the Committee. • **Hospital Standardised Mortality Ratio (HSMR):** Delay with data released. Trust-wide HSMR remains below 100. Accuracy of coding ongoing. One neonatal death in month. In month variation against mortality rate at Southport and Ormskirk (S&O) Hospital sites at weekends. Committee agreed for mortality outcomes group to review trend. • **Staffing:** Assurance provided against recording of MWL safe staffing and drop-in rate reported in month. Historical reporting remained in month with expected improved fill rate going forward.	

	• **Sepsis:** Review of metric with AQUA and sepsis team aligned to National Institute for Health and Care Excellence (NICE) guidance. Updated data reporting expected timeframes to be confirmed.	
Clinical Strategy Annual Review	• Committee updated on development of Clinical Strategy following formation of MWL. Four clinical objectives outlined within the strategy. Strategy review 2026. Expected launch of the Strategy over the next few weeks. • MWL Nursing & Midwifery Strategy in development and expected to be presented to Committee in September 2024 to supplement the Clinical Strategy. • Assurance provided on programme of work to deliver stabilisation of fragile and high-risk services and timelines for change/integration are being managed.	Assurance
Maternity and Neonatal Services Quarterly Report (inc latest maternity patient experience data).	• MWL Quarter 1 report • Maternity Incentive Scheme (MIS) - Assurance provided regarding accurate data capture regarding mandatory training. Oversight and scrutiny in place for MWL MIS year 6 submission due March 2025. Clarity also provided through agreed actions against timeframes/parameters and accurate data collection to assure consistency for future reporting to Care Quality Commission (CQC) and NHS Resolution (NHSR). • Monthly reporting on training data confirmed within divisional governance process going forward. • Clarity on timeframes for compliance provided with agreement for each Clinical Negligence Scheme for Trusts (CNST) MIS Safety Action timeframe in next report to the Committee. • Oversight of training at Executive level with future reporting through Electric Staff Records (ESR) noted. • Two reportable deaths in the Quarter. Full Perinatal Mortality Review Tool (PMRT) process noted, and lessons learnt taken forward recognising these wouldn't have affected the outcomes. Committee requested future reports provide further clarity on lessons learnt that don't affect negatively on outcomes and to provide clarity on care continued until decision to withdraw care and timelines to assure prompt actions were taken.	Assurance

	• Assurance provided that parents' views of care is included in PMRT process with request for this to be included in future reporting. • Quarterly report to Executive Committee when PMRT initiated. • Neonatal medication incident's key themes presented, and improvement plans for assurance noting positive collaboration with pharmacy colleagues for ongoing delivery against medication safety. • Future reporting to provide clarity on harms and comparisons/benchmarking/themes to assure actions are effective. • MWL compliance with all elements of Saving Babies Lives (SBL) Care Bundle 2 with continued work towards SBL version 3. Progress acknowledged by LMNS with assurance provided via regular meetings to monitor and review action plan progress. • Governance processes to be included in future reporting. • Noted 100% compliance is not a required target within SBL metrics. Committee requested detail on ongoing concerns/actions in future report. • CQC action plan requested in next report to assure updates against Must and Should Do's. Mini assessment agreed to support assurance request and embedding into action plan. • Final Maternity and Neonatal Voices Partnership (MNVP) 15 Steps reports to be circulated as appendices on next report for assurance. • Training data to be added to Perinatal Quality Surveillance Model (PQSM) report for assurance. • Assurance provided against Neonatal closures/diverts noting ongoing work through executive committee on local acuity, activity and staffing based on Trust activity until regional strategic work is delivered on neonatal cot configuration. Confidence provided against safe levels of staffing and appropriate divert policy.	
Patient Experience Council Report	• Animal and Pet Therapy Policy agreed with separate policy to be developed for service animals/guide dogs. • Patient story highlighted the positive reflection of effective communication, expectations and kindness. • Development of MWL End of Life Strategy.	Assurance

	• Chaplaincy - harmonisation of chaplaincy policy, Standard Operating Procedure (SOP) for emergency marriages. • Dementia and Delirium Steering Strategy Group relaunched. • Ongoing development of MWL food and drink strategy. • Committee requested review of weekend opening times for the coffee shop Southport Site. Committee requested review of support to the Southport Site for enquiries at the reception inclusive of the volunteer services.	
Clinical Effectiveness Council Report	• Assured against actions to update Policies. • Whiston Hyper-acute Stroke Unit (5c) and Acute stroke Unit (5D) Highest performing units in the country. • Structured Medication Reviews (SMR/HSMR) - small diagnosis alerts for review. • Learning from deaths report to Trust board in July. • Assured on robust governance for non-medical prescribers.	
Complaints, PALs, Claims and FFT Quarter 1 2024/25 Report	• Assured against work to improve response times against increase numbers of complaints received noting complexities. • Peer networking ongoing to support improvement work within complaints/PALS services. • Claims-Orthopaedic deep dive and findings to be presented at next committee meeting. • Assured and noted zero PALS backlog Whiston site. • Ongoing collaboration with Divisional leads to resolve complaints timely. • Committee requested future reporting of the subcategories within communication themes aligned to complaints and FFT to provide greater assurance.	Assurance
Patient Safety Council Report	• Assured on work to reduce outstanding policies and procedures. • Assured on future divisional reporting. • Medical devices team commended.	Assurance
Safeguarding Quarterly Report	• First MWL report. • Improved visibility of the Safeguarding Team and ward visits with focus on reporting of Deprivation of Liberty Safeguards (DOLs). • Evidence of assurance via external scrutiny from the Integrated Care Board (ICB) and MIAA in relation to safeguarding process and compliance. • Revision of patient access policy to support patients with Learning Disabilities.	Assurance

	• Training compliance particularly level 3 Children and Adults remains ongoing focus.	
Infection Prevention Control Quarterly Report	• One Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia - assurance through cannula improvement plan and part of Trust Quality Objectives. • MWL Aseptic Non Touch Technique (ANTT) harmonised training proposal to Mandatory Training Steering Group August 2024. • ANTT Training – improvement required. • Controlled re-opening of ward following Carbapenemase-producing Enterobacteriaceae (CPE) outbreak on Whiston site with assurance of extensive deep cleaning and estates work. • Infection, Prevention and Control (IPC) policy and audit harmonisation plans continue. • Antimicrobial stewardship – positive ongoing recruitment actions and mitigations in place in the interim.	Assurance
CQC Quarterly Report	• Reports awaited for Urgent and Emergency Care for both Whiston and Southport sites with queries still being received. • Maternity reports with one action plan - on track with further audits proposed. • Medicine/Spinal Injuries reports - assurance provided against three actions. • Additional enquires noted and assurance against Trusts timely responses and monitoring given. • Monthly CQC Assurance Group Terms of Reference under revision aligning to the new Divisions. • Ward Accreditation aligned to the CQC requirements and commenced in June 2024. • Re-establishment of the Quality Ward rounds to commence end of August 2024.	Assurance
Mandatory Training Compliance Report and Action Plans	• Assurance against Mandatory Training project - Standardisation of Mandatory training -deadline for full alignment by April 2025 for Core and Compulsory subjects. • Mandatory Training Project Group providing improved governance reporting into the People Performance Council. • Involvement in national projects and alignment to Core Skills Framework and standardisation of E-Learning packages to support passporting of training. • MIAA audit Feb-March 2024 – Substantial assurance for mandatory training with three actions.	Assurance

	• Further improvement required for priority compulsory training subjects – Executive Oversight / Action Plans included in the report.	
Any Other Business	• None	
Alerts:		
• Nil		
Decisions and Recommendation(s):		
The Board is recommended to note the report.		

Committee Assurance Report			
Title of Meeting	Trust Board	**Date**	31 July 2024
Agenda Item	TB24/053 (9.3)		
Committee being reported	Strategic People Committee		
Date of Meeting	22 July 2024		
Committee Chair	Lisa Knight, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items		
Title	**Description**	**Purpose**
SPC 0724/03 – Minutes of the previous meeting	The Committee reviewed the minutes of the meeting held on the 22 July 2024 and approved them as a correct and accurate record of proceedings.	Decision
SPC 0724/04 Action Log and Matters Arising	The Committee reviewed the outstanding and approved the completed actions.	Assurance
SPC 0724/05 – Workforce Dashboard	The CPR dashboard was presented focusing on the key indicators for the SPC. The following points were noted: • Mandatory training exceeded target 88.5% (June) against 85% target. • Appraisal – the Trust is currently in its annual appraisal window achieving 74.4% against a target of 85%. There has been an in month increase in compliance across both legacy sites with the lower compliance on legacy S&O sites achieving 72.6% and legacy STHK sites achieving 75.3%. The Trust is on target to achieve its 85% target by the end of the appraisal window. • Sickness - In-month sickness remains above target, at 5.66% against the 5% target. The Committee will receive a deep dive into sickness absence. • Turnover in month and over a rolling 12-month period is positively below target (0.7% and 12.6% respectively).	Assurance
SPC 0724/06 Deep dive into Sickness Absence	A Sickness Absence Deep Dive presentation was received which included a comprehensive analysis of sickness absence data for the years 2019/20 and 2023/24, comparing metrics across various protected	Assurance

	characteristics, staff groups, and national and regional levels. The report aims to identify statistically significant findings and trends, providing insights into the drivers of sickness absence within the organisation. The Trust aims to reduce sickness absence rates through targeted interventions, improved policy compliance, and enhanced support for staff, particularly those facing mental health challenges and other significant stressors. The key findings noted were as follows: National Trends: • There has been a 34% increase in sickness absence per employee from 2019 to 2023 across all sectors. • Nationally, sickness absence is at its highest since 2010, with 7.8 days per employee in 2023 compared to 5.8 days in 2010. • Mental health issues, particularly anxiety and depression, have become leading causes of long-term illness, with significant spikes observed during the COVID-19 pandemic. Sickness Absence Trends in the Trust: • Although sickness has reduced in 2023/24 compared to previous years, it remains above the Trust target of 4.5%. • Long-term sickness decreased from 2022/23 to 2023/24 but increased compared to 2021/22, likely influenced by COVID-19. • The Trust's sickness rate is slightly higher than both the Cheshire and Merseyside (C&M) average and the national average. Absence Reasons and Patterns: • Anxiety/stress/depression accounts for 33% of absences, aligning with regional data. • Musculoskeletal problems are notably higher than the national average, particularly among clinical staff. • Gastrointestinal issues have remained stable but are higher than regional averages. • There is a significant increase in colds, coughs, and flu, attributed to reduced COVID-19 testing and more resilient viruses. Demographic Analysis: • A significant increase in sickness absence was	

	noted among Band 2 staff, especially Healthcare Assistants (HCA) and Healthcare Support Workers (HCSW). • Staff aged 21-25 and 56-60 showed the highest increases in sickness absence, primarily due to stress and anxiety. • Disabled staff reported a higher percentage of absences due to mental health issues, though these were not always directly linked to their declared disabilities. The report outlined several targeted actions to address the identified issues which were noted as follows: Short Term Absences: • Implement 'return to work' audits and update the attendance management policy. • Identify interventions for colds and musculoskeletal-related short-term sickness. • Targeted Support for Specific Age Groups: • Conduct deeper dives into sickness absence for ages 21-25 and 56-60 to identify appropriate interventions. Support for Disabled Staff: • Conduct specific analyses to understand and address the increased absences among disabled staff. Addressing Mental Health Issues: • Implement stress risk assessment audits and identify interventions to support staff dealing with anxiety, stress, and depression. Band 2 Sickness: • Undertake detailed analysis and interventions for Band 2 staff to reduce sickness absence. Mandatory Training and Compliance: • Review and ensure mandatory training compliance in areas with high sickness rates. Reducing Turnover and Vacancy Rates: • Analyse exit interview data and implement strategies to reduce turnover and vacancies, particularly in high-absence areas.	

	Promoting Health and Wellbeing: • Collaborate with Infection Prevention and Control (IPC) and Health, Work, and Wellbeing (HWWB) teams to reduce sickness due to gastrointestinal issues and colds/flu.	
SPC 0724/07 – Trust Objectives 2024/45 Q1 update	A paper and presentation were received on the Trust Human Resources Objectives for 2024/25 with a Q1 update specifically relating to Developing organisational culture and supporting our workforce. The objectives that underpin this overachieving objective are aligned to the NHS People Plan pillars. The objectives for 2024/25 focus on culture, careers development including mandatory training, compassionate leadership, and future workforce models along with our ambitions for digitalisation. Good progress has been made on the objectives so far, with the following key achievements noted to date: • The launch of the MWL values and behaviours • Introduction of the MWL appraisal window • Implementation of the Sexual Safety Charter	Assurance
SPC 0724/08 – People Plan Update Q1 (Trust)	The paper and presentation provided information on the Q1 2024/25 position for achievement of the NHS People Plan objectives relating to the Trust mapped against the four pillars of the NHS People plan. The People plan sets out practical actions that employers and systems should take, and the Trust has utilised these actions to develop objectives and practical deliverables focussing on the following: **Pillar One: Looking After Our People** • Continuing to champion and support the HWWB Operational Plan • Continuing to advocate for the Wellbeing Network • Check and challenge MWL on our ambitions and achievements. • Rolling out the internal transfer scheme across MWL • Running BAME Career Workshops. 16 workshops are planned this year and three workshops have been delivered to circa 30 staff. **Pillar Two: Belonging in the NHS** • Trust Values and Behaviours have been reviewed as part of an engagement and communication	Assurance

	programme with the new values going live in April 2024 • MWL continues to offer a range of leadership and management apprenticeships to all staff groups at all levels up to Level 7. In Q1 there are 17 staff undertaking L7 in Senior Leadership, ten staff completing L6 in Chartered Manager and seven staff completing L3 the Team Leader programme. • Staff have been supported during formal employee relations cases resulting in ten cases being closed between March and June 2024 **Pillar 3: Growing for the Future** • The Medical Leadership Development Programme has been developed and to launch in September 2024 offering a blended development approach of face to face, distance, and e-learning offerings covering leadership and transactional management skills bespoke to medical leadership roles. • There has been a continued focus on reduction of Band 5 Registered Nurses (RN) and Band 2 HCA vacancies including undertaking centralised recruitment, bank recruitment and enhancing manager training packages. • The Trust has attended careers fairs and recruitment events focussing on roles with the greatest workforce gaps. 18 events held/ attended in total with 180 HCA and 92 Theatre Roles recruited. • In addition, the Trust has recruited 16 substantive and ten bank HCAs at the St Helens Place Health and Social Care event held in early April 2024. **Pillar 4: New Ways of Working and Delivering Care** • Secured funding to train 27 additional ACPs across MWL in Autumn 2024. • Working towards agency staff use reduction to 3.2% for 2024/25. Actions underway to reduce HCA agency including bank recruitment, bank rate alignment and changing of casual worker agreement to one in three. • Review of full recruitment process to identify where robotics and technology can create efficiencies to improve time to hire – specific focus on Nursing & Midwifery and HCA roles.	

SPC 0724/09 – People Plan Update Q1 (LE)	**Pillar One: Looking After Our People** • Trainees have 24/7 access to services through the website/app and helpdesk support Monday to Friday 9am-5pm. A dedicated absence support team is in place to support with access to wellbeing resources. • Launch of the **Sexual Safety Charter** supported by promotion through social media feeds – attended by 154 external stakeholders across all NHSE regions. • Implementation of the **IWL agenda** – focussing on reducing the repetition of StatMand Training by facilitating the passport of training records and competency sign off – we have already seen an increase to 81% in April 2024 from 12% in 2019 **Pillar Two: Belonging in the NHS** • Supporting our trainees - formal **case activity** has decreased – a total of seven formal cases were concluded this month, average days open was 139 days a reduction of 40 days from May. • **Preemployment** - the onboarding team are processing pre-employment checks for **3,328** trainees for August 2024. • Communication is key - 21 email bulletins shared with hosts and trainees in June, with 36 social media stories and four website news articles shared. **Pillar 3: Growing for the Future** • New Topdesk helpdesk system will allow for greater more automated Key Performance Indicators (KPI) measurements to be obtained. • Improving work schedule compliance - increase in **code of practice compliance** from 35% to 60% aiming for a target of 75% by the end of Q4. • Reducing pay errors - total overpayment in June were 51, with only six being attributed to Lead Employer (LE). **Pillar 4: New Ways of Working and Delivering Care** • Utilising RPA, confirmation of employment forms have been automated resulting in 750 letters and 32 e-forms processed automatically without human intervention.	Assurance

	• £1.2m of the LE Apprenticeship has been spent by NHS partners in the last 12 months. • There has been an increase the number of DITs joining the Collaborative Bank and more Northwest (NW) Trusts have been encouraged to use the bank to reduce agency spend with 1,365 shifts being filled by the bank in June 2024. • LE are exploring the potential to extend the bank to qualified medical workforce to support retention when they complete trainee and continue to support reduction in agency spend.	
SPC 0724/10 – Volunteers Operational Plan annual assurance Update	A paper and presentation were received outlining important role that Volunteers play in the provision of outstanding service, to enhance patient experience and support our staff. At MWL we have over 300 volunteers across all sites in a wide range of roles that support our patients, visitors and staff including meet and greet, dining companions and discharge support. The following key points were noted: • The Trust's Volunteers offer their time, experience, enthusiasm, and commitment as part of wanting to give something back to the organisation. In turn the Trust aims to provide quality programmes and rewarding and beneficial opportunities that make a difference. • Each legacy organisation had a Volunteers Service which was led by a Volunteer Services Manager. The services, until recently, have sat in different parts of the organisation and reported independently to both Workforce and Patient Experience councils and committees. • The intention to align the two legacy teams. • Updates from each of the legacy teams and the STHK Operational Plan which is on track to deliver objectives. • An NHS Volunteering Taskforce was set up in 2022 with the key drivers for the taskforce being to optimise the impact of volunteers on services and ensuring the volunteers have the best experience possible. • In June 2023 a set of recommendations were published as part of a 32-page report. The report is focussed on NHS volunteering, but the authors believe the principles can be applied more widely. There were 4 overarching recommendations: • Data and Measurement	Assurance

	• Leadership • Volunteer Experience • NHS Resilience and Emergency Support • NHS England have pledged to invest £10m over three years to drive forward the positive impact of volunteering on health services. They have stated that the funds will be used to help Integrated Care Systems develop innovative approaches to volunteering and uncovering untapped potential to bring together community and healthcare volunteering. • Moving forwards Volunteer Services will be delivered as part of the Workforce Development Team and as part of this transition the team will come together as one. • During 2024/25 a review will be undertaken to develop a new 2025-28 operational plan to be launched in March 2025. • Recognition was given to some of the Trust's volunteers to highlight their amazing contribution including positive feedback received regarding Jack the Therapy Dog.	
SPC 0724/11 Workforce Operational Plan (Provider Workforce Return 2024/25)	The paper and presentation detailed the planning guidance and outlined expectations of Trusts regarding their submissions as follows: • National expectation is that there is no growth in funded whole time equivalent (WTE) included within plans and contracted staffing growth should come with commensurate and demonstrable reductions in temporary staffing use. • There is a focus on the triangulation of workforce, finance and activity data as part of the planning process. • Workforce productivity CIPs to be triangulated with overall productivity. • A diagnostic tool to support analysis of triangulation was produced and was mandatory for all organisations to complete in C&M and submit alongside final plan submissions in March 2024. • Trusts are monitored through the submission of monthly Provider Workforce Returns (PWRs) which is designed to capture workforce information within month at Trust level including WTE of staff by workforce group (Contracted, Bank and Agency) and Workforce KPIs including. vacancy levels by specific workforce. Trusts are	Assurance

	required to prepare the data in accordance with the Provider Workforce Return Guidance. It was noted that the Trust's submission takes account of the following: • Theatre expansion business case • Increased recruitment of HCAs to reduce the existing vacancy gap alongside reducing the use of HCAs via bank and agency. • Planned reduction in sickness absence across staff groups to Trust target (4.55%) to support the reduction in use of bank. • Planned reduction in the use of agency across staff groups to meet the target of 3.2% that has been set for agency spending. On a monthly basis the Workforce and Finance Teams work together to review the Trust's Workforce position utilising the PWR submissions alongside other workforce information. The outputs of these reviews will be reported through People Performance Council on a bi-monthly basis along with the Executive Committee on a monthly basis.	
SPC 0724/12 Staff Survey Action Plan Q1 Update	A paper and presentation were received on the findings from the 2023 Staff Survey, which alongside a range of other staff, safety and patient experience measures, including any residual 2022 staff survey actions are being used to drive a range of actions identified and supported through the proposed Divisional Workforce and HR Groups. The report included updates on the Trusts ongoing staff engagement tools, Team Talks with details of activity since 1 April 2024, proposed activity for the remainder of 2024, outcomes and engagement noting the challenge of releasing staff and poor engagement at S&O sites, for whom this is a new activity. The key areas for focus have been identified as: • Speak Out Safely • Flexible Working • Compassionate Leadership • We are always Learning • Equality, Diversity & Inclusion The Departmental areas for focus in 2024 are:	Assurance

	• Community Nursing • Pharmacy • Care of the Elderly • Frailty • Critical Care (Whiston) • Medical Secretaries • Maternity/ Obstetrics/ Paediatrics • Spinal Injuries • Estates & Facilities/ Medirest • Lead Employer	
SPC 0724/13 Workforce/ HR Corporate Risk Register Q1 update	This paper summarised the risk dashboard in terms of a snapshot of the data that has been presented to the relevant Councils. For HR Commercial Services risks are being monitored through the HR Commercial Services Council and all other Trust HR risks are being monitored through the People Performance Council and the relevant Groups that report into these Councils. All risks are reported through to the Risk Management Council on a monthly basis and are monitored and managed by the HR Governance & Performance departmental meetings. These are summarised as follows: • Total number of risks being managed on the Divisional HR risk register - 80 • New risks added in month - 1 • Risks closed in month - 6 • Risk scores changed (increased/decreased) in month – 1 • Risks overdue for review – 24 (mainly related to CIP tripartite sign off which will be completed by the 31 July 2024)	Assurance
SPC 0724/14 - Assurance Reports from Subgroup(s)	The Strategic People Committee noted the Assurance Report from the Employee Relations oversight Group. A discussion took place about the increasing complexity of employee relations cases, particularly those involving safeguarding matters and impact on sometimes over an extensive period of time on HR colleagues who are supporting these cases. It was suggested that some sort of peer/other supervision should be explored to support the wellbeing of the HR Advisory teams and it was confirmed that staff are able to step away from a case should they need to. Feedback will be gained in this regard from HR teams to enable appropriate support to be provided.	Assurance

SPC 0724/15 - Items for Escalation to Trust Board	Feedback from the Committee indicated, this meeting has been effectively chaired.	Assurance
SPC 0724/16 Any Other Business	The Strategic People Committee were requested to consider a topic that they would like to hear about in September/October for the next Staff Story topics.	Assurance

Alerts:

None

Decisions and Recommendation(s):

- Additional support to be explored to support HR Advisory teams with the impact of complex employee relations cases.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Committee Assurance Report			
Title of Meeting	**Trust Board**	**Date**	31 July 2024
Agenda Item	**TB24/053 (9.4)**		
Committee being reported	Finance and Performance Committee		
Date of Meeting	25 July 2024		
Committee Chair	Steve Connor, Non-Executive Director		
Was the meeting quorate?	Yes		

Agenda items

Title	Description	Purpose
MWL FC24/125 – Director of Finance Update	• Cheshire and Merseyside (C&M) system reporting off plan for Q1, excluding the impact of industrial action however no external funding to cover industrial action. • Committee discussed current controls and updates	Assurance
MWL FC24/126 – System recovery plan and external financial improvement support	• Update on progress • Large volume of supporting information shared with a focus on governance, controls and efficiencies. • Director of Finance, Chief Executive and Chair are meeting in the coming weeks.	Assurance
MWL FC24/127 – Integrated Performance Report Month 3 2024/25	• Bed occupancy across MWL averaged 105% in June equating to 93 patients – a decrease from 105.8% in May. • Average length of stay for emergency admissions is high at 8.3, 9.7 at S&O and 7.7 at STHK, the impact of non-criteria to reside (NCTR) patients has increased by 0.3% in June, being 22.3% at Organisation level (26% STHK and 17% S&O). • 4-Hour performance increased in June achieving 72.7% (all types), national performance 74.6% and providers across C&M averaging 72.7%. • 18 Week performance in June for MWL was 61.1%, S&O 68.2% and STHK 58.4%. National Performance (latest month March) was 59.1% and C&M regional performance was 57.7% • Diagnostic performance in June for MWL achieved target at 96.1%, S&O 94.6% and STHK 96.9%. C&M was top in the country for June	Assurance

	• The Trust had 2,728 52-week waiters at the end of June (287 S&O and 2,441 STHK) and three 78-week waiters. • Cancer performance for MWL in May increased to 73.5% for the 28-day standard and 80.2% for the 62-day standard.	
MWL FC24/128 – Finance Report Month 3 2024/25	• The Trust is reporting a deficit of £14.7m which is £1m worse than plan due to the impact of industrial action. • The Trust's combined 2024/24 Cost Improvement Programme (CIP) target is £48m of which £11.8m is non-recurrent. As at Month 3, the Trust has transacted CIP of £27.4m in year and £24.8m recurrently. • At Month 3, agency spend is £6.1m to date, 4% of total pay costs. Premium Payment Scrutiny Council review and address the drivers of agency costs with actions taken through executive committee. • The Trust has a closing cash balance of £3.5m at Month 3 with a planned requirement of £38.9m revenue support for 24/25 which is yet to be approved. Cash approvals are now being reviewed monthly by NHSE. • Better Payment Practice Code (BPPC) has not been achieved but has been impacted by a large volume of small value agency invoices, the Trust is working with suppliers and the position reflects an 11.3% improvement. • The capital plan for the year is £48.4m (including Public Finance Initiative (PFI) Lifecycle). Spend to date is £2.7m in line with plan. The plan requires external Public Dividend Capita (PDC) support (£17m) which has not yet been drawn down.	Assurance
MWL FC24/129 – National benchmarking update	• Committee reviewed the results of the 2022/23 National Cost Collection which was the last collection for the two legacy trusts. • Scores are against an average of 100 with scores below 100 demonstrating lower than average costs and above 100 higher than average costs. • STHK achieved a score of 90 for 2022/23 an improvement of 4 from 2021/22 which was 94. • S&O achieved a score of 104, an improvement of 6 from 2021/22 which was 110.	Assurance

	• Both sites achieved high scores for the quality of costing (measured using a national tool).	
MWL FC24/130 – Month 3 2024/25 CIP Programme Update Alongside: MWL FC24/132 – Medicine and Urgent Care Division CIP Presentation	• Total targets for 2024/25 is £48m in year and £36.2m recurrently. • There is currently a delivered/low risk value of £28.7m in year (60% of the £45.2m target) and £25.9m recurrently (72% of the £36.2m target). • Focus on completing outstanding Quality Impact Assessments (QIAs) with training provided to support completion. • Presentation included update to the committee on progress for 2024/25 along with examples of CIPs identified and cost controls in place to ensure effective use of existing resources. • Committee noted the update and was assured by the report and presentations.	Assurance
MWL FC24/131 – Urgent Care Performance delivery review	• Overview provided of the internal Urgent and Emergency Care (UEC) improvement projects and how they link into the C&M UEC improvement programme. • Performance varies across sites and internal improvement programme established to standardise good practice. • C&M programme has three areas of focus; Admission avoidance, Acute Length of Stay (LoS), Acute Discharge. Steering groups made up of partners from across the system.	Assurance
Assurance Reports from Subgroups:	• 13.1 MWL FC24/133 – Procurement Council • 13.2 MWL FC24/134 - CIP Council • 13.3 MWL FC24/135 - Capital Planning Council • 13.4 MWL FC24/136 –Estates & Facilities Management Council • 13.5 MWL FC24/137 – IM&T Council Update	Assurance
Alerts		
None		
Decisions and Recommendation(s):		
None		

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	31 July 2024
Agenda Item	**TB24/054**			
Report Title	Corporate Risk Register (July 2024)			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required		**To Approve**	X	**To Note**

Purpose

To inform the Board of the risks that have currently been escalated to the Corporate Risk Register (CRR) via the Trust's risk management systems

Executive Summary

1. Risk Management Systems

There is an MWL Risk Management Framework that has been approved and implemented. The risk management and reporting mechanisms continue to rely on the legacy trusts separate DATIX systems, until a new single system is implemented which is expected later in 2024/25. The reporting structures within the current Datix systems are now being aligned to the new divisional structure of the Trust.

The Corporate Services are managing integrated risk registers (within the confines of the two reporting systems) and the new divisional triumvirate teams have also now started the work of reviewing all the risks reported for the services they manage and setting up their internal divisional review meetings, to align the risks, remove duplicates and ensure consistency of scoring. Via this process several of the CRR risks are being challenged (with the support of the lead director for each risk) and it is expected that there will be some changes to the CRR before the next report to Board in October.

Any member of staff can still easily report a new risk wherever they work in the organisation.

This report provides an overview of the risks reported across MWL, and those risks that have been escalated to the CRR.

The CRR is reported to the Board four times a year to provide assurance that the Trust is operating an effective risk management system, and that risks identified and raised by front line services can be escalated to the Executive and Board, if necessary. The risk management process is overseen by the Risk Management Council, which reports to the Executive Committee providing assurance that risks;

- Have been identified and reported
- Have been scored in accordance with the standard risk grading matrix.
- Risks initially rated as high, or extreme have been reviewed and approved by the relevant divisional triumvirate and a director.
- Have an identified target risk score, which captures the level of risk appetite and has a mitigation plan that will realistically bring the risk to the target level.

2. Risk Registers and Corporate Risk Registers

This report is based reflects a snapshot of the risk registers on 01 July 2024 and reflects all risks reported and reviewed during June 2024.

Risk Register Summary (Appendix 1)

- The total number of risks on the MWL risk register was 1,068 compared to 1,055 in April.
- 39 of these risks had been escalated to the CRR compared to 44 in April.
- Two new escalated risks are reported on the CRR in July compared to April and eight risks have been closed or de-escalated from the CRR reported in April.

Financial Implications
None as a direct result of this report

Quality and/or Equality Impact
Not applicable

Recommendations
The Board is asked to note the Corporate Risk Register for assurance

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Appendix 1

July 2024 – Corporate Risk Register Quarterly Board Report

1. Risk Register Summary for the Reporting Period

This table provides a high-level overview of the "turnover" in the risk profile of the legacy trust sites compared to previous reporting periods.

RISK REGISTER STHK SITES	Current Reporting Period (July 2024)	Previous Reporting Period (June 2024)	Previous Reporting Period (May 2024)
Number of new risks reported	31	35	72
Number of risks closed or removed	26	40	72
Number of increased risk scores	9	2	1
Number of decreased risk scores	10	14	6
Number of risks overdue for review	165**	41	83
Total Number of Datix risks	**845***	**853**	**858**

*829 scored risks, 16 new risks awaiting scoring and approval

RISK REGISTER S&O SITES	Current Reporting Period (July 2024)	Previous Reporting Period (June 2024)	Previous Reporting Period (May 2024)
Number of new risks reported	10	5	13
Number of risks closed or removed	0	3	13
Number of increased risk scores	1	2	
Number of decreased risk scores	2	0	
Number of risks overdue for review	53**	51	45
Number of tolerated risks	16	16	17
Total Number of Datix risks	**223***	**213**	**211**

*185 scored risks, including 16 tolerated risks and 38 new risks awaiting scoring and approval.

** the reporting date in July was Monday 1st July and most of the outstanding reviews had been completed prior to the RMC meeting on 9th July

2. Risk Profiles

Legacy STHK risk profiles

Risk Profile

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
23	**47**	**16**	**79**	**10**	**160**	**67**	**159**	**35**	**203**	**13**	**10**	**7**	**0**
86 = 10.37%			**249 = 30.04%**			**464 = 55.97%**				**30 = 3.62%**			

829 risks that are scored and approved.

The risk profiles for each clinical area and for the collective Corporate Services are:

Surgery* – 234 risks reported 28.23% of the total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
1	**21**	**3**	**16**	**5**	**41**	**23**	**52**	**10**	**55**	**4**	**1**	**2**	**0**
25 = 10.68%			**62 = 26.50%**			**140 = 59.83%**				**7 = 2.99%**			

*includes maternity

Medicine and UEC – 124 risks reported 14.95% of the total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
6	**6**	**3**	**11**	**1**	**15**	**8**	**26**	**11**	**25**	**5**	**3**	**4**	**0**
15 = 12.10%			**27 = 21.77%**			**70 = 56.45%**				**12 = 9.68%**			

Clinical Support Services – 129 risks reported 15.56% of the total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
5	**5**	**4**	**14**	**0**	**19**	**8**	**26**	**7**	**35**	**3**	**3**	**0**	**0**
14 = 10.85%			**33 = 25.58%**			**76 = 58.91%**				**6 = 4.65%**			

Primary Care and Community Services – 43 risks reported 5.2% of the total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
2	**1**	**0**	**1**	**1**	**11**	**1**	**9**	**3**	**14**	**0**	**0**	**0**	**0**
3 = 6.98%			**13 = 30.23%**			**27 = 62.79%**				**0**			

Corporate (Finance, Health Informatics/Health Records, Facilities, Nursing/Governance/Quality & Risk, HR, and Medicines Management) – 299 risks reported 36.1% of the total

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk			
1	2	3	4	5	6	8	9	10	12	15	16	20	25
9	**14**	**6**	**37**	**3**	**74**	**27**	**46**	**4**	**74**	**1**	**3**	**1**	**0**
29 = 9.69%			**114 = 38.12%**			**151 = 50.50%**				**5 = 1.67%**			

The highest proportion of the Trust's risks continues to be identified in the corporate services. The split of the risks across the corporate departments is:

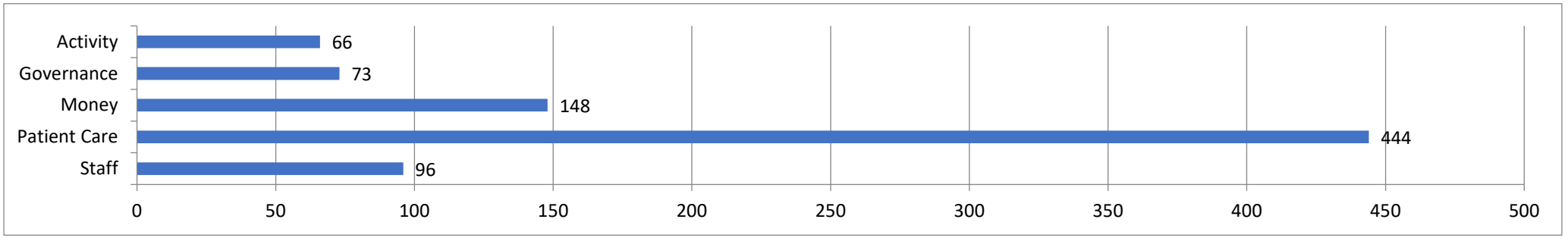
	High	Moderate	Low	Very low	**Total**
Health Informatics/ Health Records	3	17	11	4	**35**
Facilities (Medirest/TWFM)	0	26	11	4	**41**
Nursing, Governance, Quality & Risk	0	23	13	4	**40**
Finance	0	11	29	11	**51**
Medicines Management	0	21	21	4	**46**
Human Resource	2	53	29	2	**86**
Total	**5**	**151**	**114**	**29**	**299**

Legacy S&O risk profiles

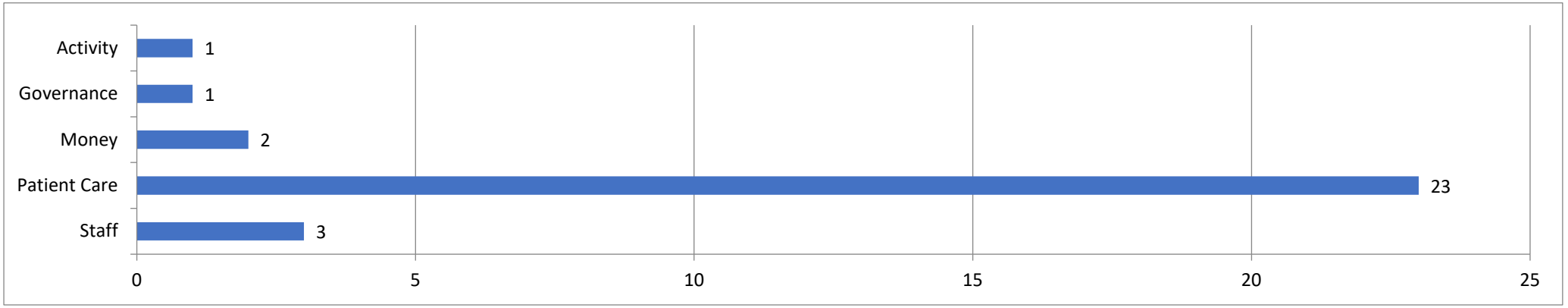
Division	Very Low Risk			Low Risk			Moderate Risk				High/Extreme Risk			
	1	2	3	4	5	6	8	9	10	12	15	16	20	25
Clinical Support & Community Services	0	0	3	5	0	8	8	11	4	11	1	5	1	0
	3 = 5.26%			13 = 22.81%			34 = 59.65%				7 = 12.28%			
Corporate Services	0	0	1	4	0	9	6	1	1	8	2	2	1	0
	1 = 2.86%			13 = 37.14%			16 = 45.71%				5 = 14.29%			
Medicine & Urgent Care	0	0	3	0	0	8	8	14	2	10	0	2	0	0
	3 = 6.38%			8 = 17.02%			34 = 72.34%				2 = 4.26%			
Surgery	0	0	1	2	0	4	3	12	2	15	4	4	2	0
	1 = 2.04%			6 = 12.24%			32 = 65.31%				10 = 20.41%			
Women & Children	0	0	1	0	1	4	6	5	1	17	0	0	0	0
	1 = 2.86%			5 = 14.29%			29 = 82.85%				0 = 0.00%			
Trust (Inclusive of tolerated and unapproved risks)	**0**	**0**	**9**	**11**	**1**	**33**	**31**	**43**	**10**	**61**	**7**	**13**	**4**	**0**
	9 = 4.04%			**45 = 20.18%**			**145 = 65.02%**				**24 = 10.76%**			

3. **Categories of risk (MWL)**

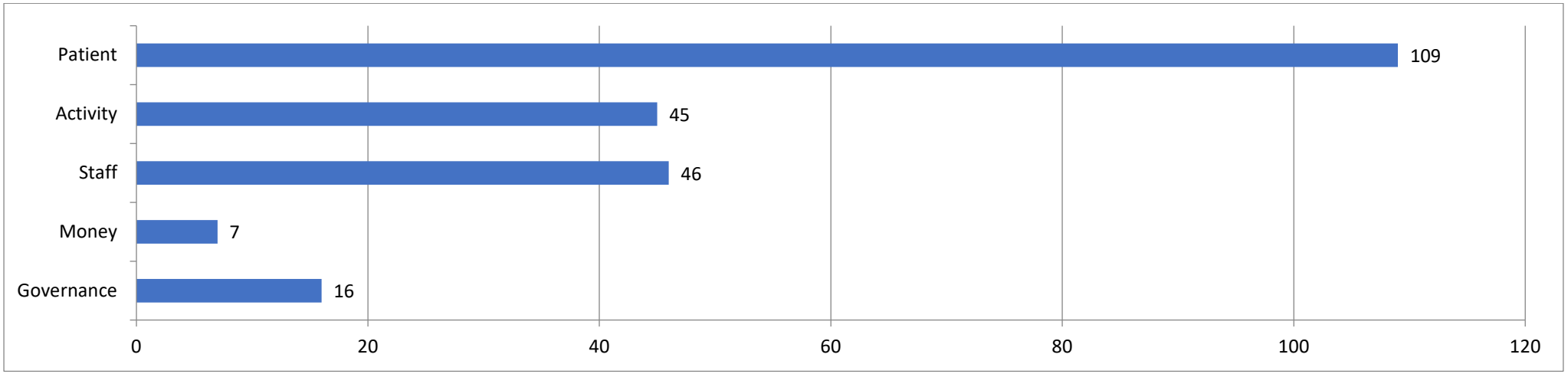
MWL Risk Register
Legacy STHK



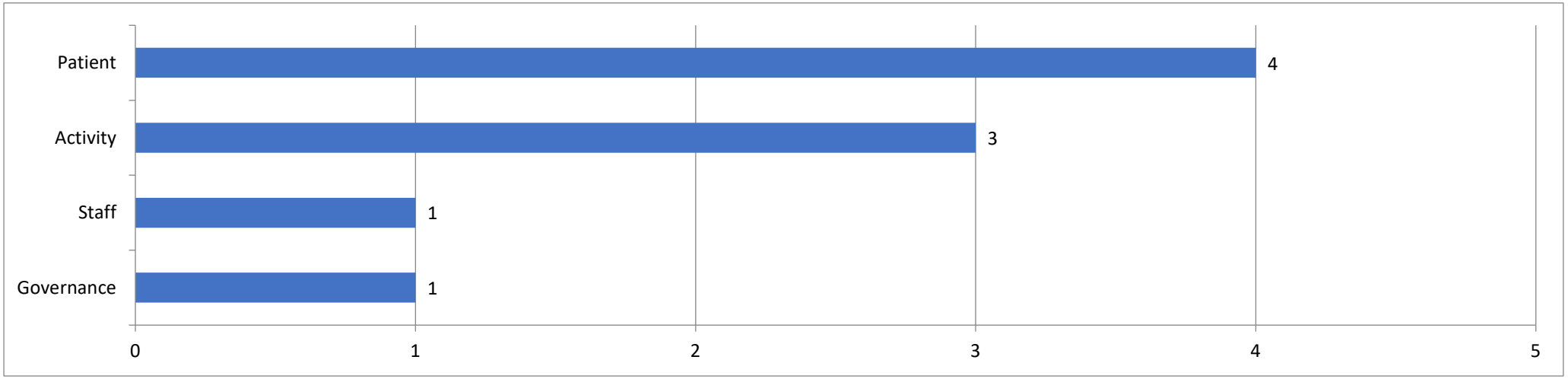
MWL Corporate Risk Register
Legacy STHK



Legacy S&O



Legacy S&O
Corporate Risk Register



4. Corporate Risk Register

The risks highlighted in yellow have specifically been queried with the divisional management teams and are being reviewed and will be discussed with the lead directors.

Risk 3043 has been reviewed and deescalated from the CRR with a score of 9 (after 1st July) reflecting the recruitment of new consultant microbiologists.

Risk 2996 has been reviewed and reduced to a score of 16 (after 1st July) reflecting the current vacancy position

No	ID	Exec Lead	Division/Service	LEGACY SITE	Title	Next review date	Rating (current)	Last updated
1	762	Malise Szpakowska	Human Resources	STHK	Potential risk of the Trust not being able to provide safe levels of staffing	31/07/2024	**16**	26/06/2024
2	1152	Malise Szpakowska	Human Resources	STHK	Potential impact for the Trust on quality of care, contract delivery and finance due to increased use of bank and agency	31/07/2024	**16**	26/06/2024
3	1263	Rob Cooper	Medicine & Urgent Care	STHK	If the numbers of planned patient discharges and transfers cannot be achieved, this will impact on patient flow	15/10/2024	**15**	12/06/2024
4	1772	Malcolm Gandy	Informatics	STHK	Risk of malicious cyber attack	31/07/2024	**16**	19/03/2024
5	2082	Peter Williams	Medicine & Urgent Care	STHK	Medical Provision post take consultant reviews for patient whose stay in ED is delayed	30/08/2024	**20**	15/02/2024
6	2083	Lesley Neary	Medicine & Urgent Care	STHK	If medical bed occupancy increased above 95% there will be no capacity to admit patients from ED	12/08/2024	**15**	13/05/2024
7	2223	Rob Cooper	Medicine & Urgent Care	STHK	If ED attendances and admissions increase beyond panned levels, there will not be sufficient inpatient beds to meet demand	15/07/2024	**20**	12/06/2024
8	2750	Malcom Gandy	Informatics	STHK	Data quality and patient mismatch errors	30/09/2024	**15**	31/05/2024

9	2985	Lesley Neary	CSS & Community	STHK	If there are not sufficient Phlebotomy Staff recruited and retained to meet demand this will impact waiting times	31/07/2024	**15**	25/03/2024
10	2996	Lynne Barnes	Medicine & Urgent Care	STHK	If the Medical Division cannot maintain safe nurse staffing levels there is a risk to patient safety, patient experience, and the quality of care	22/08/2024	**20**	05/06/2024
11	3013	Lesley Neary	CSS & Community	STHK	The X ray equipment at Newton Community Hospital is end of life and needs to be replaced.	16/09/2024	**16**	18/06/2024
12	3043	Rob Cooper	CSS & Community	STHK	Shortage of Microbiology Consultants	30/06/2024	**16**	12/03/2024
13	3178	Lesley Neary	CSS & Community	STHK	High turnover rates and national shortages resulting in a risk that there may not be sufficient substantive staff to meet demand	15/09/2024	**16**	16/05/2024
14	3251	Malcolm Gandy	Informatics	STHK	Trust solution for outpatient letter printing – current system end of life / no longer supported	30/06/2024	**20**	04/06/2024
15	3349	Lesley Neary	Medicine & Urgent Care	STHK	Olympus managed endoscopy scope equipment contract due to end.	30/09/2024	**20**	12/06/2024
16	3371	Lynne Barnes	Medicine & Urgent Care	STHK	Ward areas having to accommodate an extra patient during times of heightened capacity demands	14/10/2024	**16**	13/06/2024
17	3475	Lesley Neary	Medicine & Urgent Care	STHK	Delays in NWAS transport for patients requiring neuro radiology thrombectomy / surgical intervention at a tertiary centre	10/09/2024	**16**	03/06/2024
18	3527	Rob Cooper	Surgery	STHK	Delivery of care for plastic surgery patients in North Wales	23/07/2024	**20**	23/05/2024
19	3532	Rob Cooper	Surgery	STHK	ENT equipment, for nasoendoscopy does not meet BAHNO recommendations for photo-documentation and digital storage	28/06/2024	**15**	16/04/2024
20	3535	Lesley Neary	Surgery	STHK	Potential requirement to add a 5th surgical patient into bays within surgical wards	27/06/2024	**20**	16/04/2024
21	3574	Malcolm Gandy	CSS & Community	STHK	Risk that Careflow waiting list functionality will not always automatically link open referrals to future activity, until the clinic reconfiguration is completed	**29/03/2024**	**15**	09/01/2024
22	3598	Rob Cooper	Surgery	STHK	If Orthopaedic Desouter drills are not replaced, then there will be an impact on some surgical procedures	01/09/2024	**15**	18/06/2024

23	3624	Lesley Neary	Surgery	STHK	Out of hours endoscopy assistance	12/09/2024	**15**	17/04/2024
24	3647	Lesley Neary	Medicine & Urgent Care	STHK	St Helens endoscopy re-design	31/12/2024	**15**	05/06/2024
25	3748	Lesley Neary	Medicine & Urgent Care	STHK	Increased risk of not meeting dermatology 2ww target	13/08/2024	**15**	17/04/2024
26	3795	Lesley Neary	Medicine & Urgent Care	STHK	Endoscopy waiting lists for urgent or 2WW appointments	30/09/2024	**16**	05/06/2024
27	3850	Lesley Neary	CSS & Community	STHK	Paediatric Dietetics	15/07/2024	**15**	22/05/2024
28	3872	Peter Williams	Medicine & Urgent Care	STHK	Quality of advice and guidance requests for lesions	13/08/2024	**15**	06/06/2024
29	3959	Rob Cooper	CSS & Community	STHK	Risk that Patients having more than one hospital number (from the legacy EPR systems) could not be identified by Pathology	16/09/2024	**20**	28/06/2024
30	4018	Lesley Neary	Surgery	STHK	Admissions department staffing issues	28/06/2024	**16**	23/05/2024
31	2432	Nicola Bunce	Estates & Facilities	S&O	Critical estate infrastructure	31/07/2024	**20**	01/07/2024
32	2590	Lesley Neary	Surgery	S&O	ENT Provision Service	01/07/2024	**16**	10/06/2024
33	2230	Rob Cooper	Executive	S&O	Fragile Services	07/11/2023	**16**	28/05/2024
34	2601	Peter Williams	Surgery	S&O	Inability to provide out of hours anaesthetic support for a 2nd time critical emergency at Ormskirk Hospital	15/07/2024	**20**	21/06/2024
35	2572	Rob Cooper	CSS & Community	S&O	Malfunction and failure of the ADS (Automatic Dispensing System) Pharmacy Robot	14/08/2024	**16**	01/07/2024
36	1528	Rob Cooper	CSS & Community	S&O	Risk of medication errors and patient harm due to lack of an Electronic Prescribing and Administration of Medicines (EPMA) system at legacy S&O sites	11/09/2024	**16**	25/06/2024
37	1603	Rob Cooper	Surgery	S&O	Replacement of aging Autoclaves	22/07/2024	**20**	26/06/2024

38	2031	Lesley Neary	Medicine & Urgent Care	S&O	Risk to Patient Flow and Capacity on Southport site	01/07/2024	**16**	29/05/2024
39	2545	Lesley Neary	CSS & Community	S&O	Temperature Monitoring and Control - Ward/Department drug storage areas	21/08/2024	**20**	01/07/2024

Blue text designates new CRR risks added since the last board report.

5. Risks closed or de-escalated from the CRR since the last quarterly board report.

ID	Division/Service	LEGACY SITE	Title
1874	CSS & C	STHK	Trust RTT incomplete position against the 92% national standard is at risk of failure
1913	CSS & C	STHK	Delay in receipt of tertiary referrals in PBS department
3199	Medicine	STHK	Patients 'forward waiting' medical wards creates a risk to patient safety, dignity, and experience
3496	Medicine	STHK	Staffing establishment in operational site management team to meet activity requirements overnight
3600	Surgery	STHK	Replacement of surgical diathermy machines in PDSU
3770	Surgery	STHK	Capacity to reduce the backlog of clinic letter typing
3790	CSS & C	STHK	Risk of patient harm from ascitic drains due to specialist care knowledge across the Trust
3847	CSS & C	STHK	Paediatric Dietetics capacity

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	**31 July 2024**
Agenda Item	**TB 24/055**			
Report Title	Board Assurance Framework, (July 2024)			
Executive Lead	Nicola Bunce, Director of Corporate Services			
Presenting Officer	Nicola Bunce, Director of Corporate Services			
Action Required	X	**To Approve**		**To Note**

Purpose

For the Board to review and agree updates to the Board Assurance Framework (BAF).

Executive Summary

The BAF is reviewed four times a year, the last review was in April 2024, and this review captures the changes that have occurred during Q1 (2024/25).

The BAF is the mechanism used by the Board to ensure it has sufficient controls in place and is receiving the appropriate level of assurance in relation to the delivery of its statutory duties, strategic plans and long-term objectives.

Each BAF risk is assigned a lead Executive, who is responsible for ensuring the risk is updated at each quarterly review.

The Executive Committee then review the proposed changes to the BAF in advance of its presentation to the Trust Board and proposes changes to ensure that the BAF remains current, that the appropriate strategic risks are captured, and that the planned actions and additional controls are sufficient to mitigate the risks being managed by the Board, in accordance with the agreed risk appetite.

Key to proposed changes (appendix 1):
~~Score through~~ = proposed deletions/completed
Blue Text = proposed additions
Red = overdue actions

Proposed changes to risk scores.

No changes to the risk scores are proposed this quarter.

Financial Implications

None directly because of this report

Quality and/or Equality Impact

Not applicable

Recommendations	
The Board is asked to approve the changes to the Board Assurance Framework.	
Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Appendix 1

Board Assurance Framework Quarterly Review – Q1 2024/25

BOARD ASSURANCE FRAMEWORK 2024-25									
BAF Dashboard 2024-25 – Quarter 1 Review									
BAF	**Risk Description**	**Exec Lead**	**Risk Score**						
			Inherent	**Jan 24**	**April 24**	**July 24**	**Oct 24**	**Target**
1	Systemic failures in the quality of care	Medical Director/ Director of Nursing	**20**	**20** ↑	**20** ↔	**20** ↔		**5**
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	Director of Finance and Information	**20**	**20** ↑	**20** ↔	**20** ↔		**10**
3	Sustained failure to maintain operational performance/deliver contracts	Chief Operating Officer	**16**	**20** ↔	**16** ↓	16 ↔		**12**
4	Failure to protect the reputation of the Trust	Director of Human Resources	**16**	**12** ↔	**12** ↔	**12** ↔		**8**
5	Failure to work in partnership with stakeholders	Director of Human Resources/ Managing Director	**16**	**12** ↔	**12** ↔	**12** ↔		**8**
6	Failure to attract and retain staff with the skills required to deliver high quality services	Director of Human Resources	**20**	**15** ↔	**15** ↔	**15** ↔		**10**
7	Major and sustained failure of essential assets and infrastructure	Director of Corporate Services	**16**	**12** ↔	**12** ↔	**12** ↔		**8**
8	Major and sustained failure of essential IT systems	Director of Informatics	**20**	**16** ↔	**16** ↔	**16** ↔		**16**

Strategic Risks – Summary Matrix

Vision: 5 Star Patient Care

Mission: To provide high quality health services and an excellent patient experience

BAF Ref	Long term Strategic Risks	Strategic Aims					
		We will provide services that meet the highest quality and performance standards	We will work in partnership to improve health outcomes for the population	We will provide the services of choice for patients	We will respond to local health needs	We will attract and develop caring highly skilled staff	We will work in partnership to create sustainable and efficient health systems
1	Systemic failures in the quality of care	✓		✓	✓	✓	✓
2	Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners	✓		✓		✓	✓
3	Sustained failure to maintain operational performance/deliver contracts	✓	✓		✓	✓	✓
4	Failure to protect the reputation of the Trust			✓			✓
5	Failure to work in partnership with stakeholders	✓	✓	✓	✓		✓
6	Failure to attract and retain staff with the skills required to deliver high quality services	✓				✓	✓
7	Major and sustained failure of essential assets, infrastructure	✓	✓	✓			✓
8	Major and sustained failure of essential IT systems	✓	✓	✓			✓

Risk Scoring Matrix

Impact Score	Likelihood /probability				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible (very low)	1	2	3	4	5

Likelihood – Descriptor and definition
Almost certain - More likely to occur than not, possibly daily (>50%)
Likely - Likely to occur (21-50%)
Possible - Reasonable chance of occurring, perhaps monthly (6-20%)
Unlikely - Unlikely to occur, may occur annually (1-5%)
Rare - Will only occur in exceptional circumstances, perhaps not for years (<1%)
Impact - Descriptor and definition
Catastrophic – Serious trust wide failure possibly resulting in patient deaths / Loss of registration status/ External enquiry/ Reputation of the organisation seriously damaged- National media / Actual disruption to service delivery/ Removal of Board
Major – Significant negative change in Trust performance / Significant deterioration in financial position/ Serious reputation concerns / Potential disruption to service delivery/Conditional changes to registration status/ may be trust wide or restricted to one service
Moderate – Moderate change in Trust performance/ financial standing affected/ reputational damage likely to cause on-going concern/potential change in registration status
Minor – Small or short term performance issue/ no effect of registration status/ no persistent media interest/ transient and or slight reputational concern/little financial impact.
Negligible (very low) – No impact on Trust performance/ No financial impact/ No patient harm/ little or no media interest/ No lasting reputational damage.

Key to proposed changes:

~~**Score through**~~ **= proposed deletions/completed**

Blue Text = proposed additions

Red = overdue actions

BAF 1 Systemic failures in the quality of care

Exec Lead: Medical Director/Director of Nursing

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	5	20	1	5	5

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver the Clinical and Quality standards and targets • Failure to deliver CQUIN element of contracts, if required • Breach of CQC regulations • Unintended CIP impact on service quality • Availability of resources to deliver safe standards of care • Failure in operational or clinical leadership • Failure of systems or compliance with policies • Failure in the accuracy, completeness or timeliness of reporting • Failure in the supply of critical goods or services **Effect:** • Poor patient experience • Poor clinical outcomes • Increase in complaints • Negative media coverage **Impact:** • Harm to patients • Loss of reputation • Loss of contracts/market share	• Clinical Strategy • Nursing and Midwifery Strategy • Quality metrics and clinical outcomes data • Complaints and claims • Incident reporting and investigation • Risk Assurance and Escalation policy • Contract monitoring • CQPG meetings • NHSE Single Oversight Framework • Staff appraisal and revalidation processes • Clinical policies and guidelines • Mandatory Training • Lessons Learnt reviews • Clinical Audit Plan • Quality Improvement Action Plan • Clinical Outcomes/Mortality Surveillance Group • Ward Quality Dashboards • CIP Quality Impact Assessment Process • IG monitoring and audit • Medicines Optimisation Strategy • Learning from deaths policy • Emergency Planning Resilience and Recovery • Ockenden Report action plan • Maternity Incentive Scheme. • CNST premium • Patient Safety Incident Response Framework (PSIRF) • Safer staffing/ establishment and Birth Rate + staffing reviews	**LEVEL 1** Operational Assurance • Staff Survey • Friends and Family scores • Quality Ward Rounds **LEVEL 2** Board Assurance • IPR/CPR • Patient stories • Quality Committee • Audit Committee • Finance and Performance Committee • Infection control, Safeguarding, H&S, complaints, claims and incidents annual reports • Nursing & Midwifery Strategy • Learning from Deaths Mortality Review Reports • Quality Account • Internal audit programme • IPC Board Assurance Framework **LEVEL 3** Independent Assurance • National clinical audits • Annual CQUIN Delivery (if required) • External inspections and reviews • GIRFT Reviews • PLACE Inspections Reports • CQC Insight and Inspection Reports • Learning Lessons League & NSIB reports • IG Toolkit results • Model Hospital	~~Standardised approach to Quality Improvement for MWL (Revised to June 2024)~~ ~~Single approach to ward accreditation for MWL (Revised to May 2024)~~	Routinely achieve 30% of discharges by midday 7 days a week to improve patient flow. Single set of key clinical and quality policies for MWL ~~Incident reporting framework to still include reports all incidents and learning points, in parallel to PSIRF.~~ Fully integrated MWL quality governance structure (revised to December 2024) Single risk and incident reporting system for MWL (October 2024)	Phase 1 of the deteriorating patient improvement project completed by July 24 phase 2 commenced to align processes across all MWL sites (Update report to executive Committee September 2024) Alignment of key clinical and quality policies across the new organisation (September 2024) Achieve new complaints response time of 60 days (Revised to September 2024) Achieve quality improvement objectives for 2024/25 (March 2025). Implement changes agreed in the Nurse Establishment Review (September 2024). Implement the new incident and risk reporting system for MWL (August 2024) Implement actions from the Maternity CQC inspections (November 2024) Provide assurance on ED safety to ICB following NHSE letter (December 2024) Evaluate new MWL 5 star ward accreditation process (August 2024)

BAF 2 Failure to develop or deliver long term financial sustainability plans for the Trust and with system partners

Exec Lead: Director of Finance

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	4	5	20	2	5	10

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to achieve the Trusts statutory breakeven duty. • Failure to develop a strategy for sustainable healthcare delivery with partners and stakeholders. • Failure to deliver strategic financial plans. • Failure to control costs or deliver CIP. • Failure to implement transformational change at sufficient pace. • Failure to continue to secure national PFI support. • Failure to respond to commissioner requirements. • Failure to respond to emerging market conditions. • Failure to secure sufficient capital to support additional equipment/bed capacity. • Failure to obtain sufficient cash balances. • Failure to obtain on going transaction support. • Failure to deliver financial plans. **Effect:** • Failure to meet statutory duties. • NHSE/I Single Oversight Framework rating. **Impact:** • Unable to deliver viable services. • Loss of market share • External intervention	• Operational Plan and STP financial modelling • Annual Business Planning • Annual budget setting • CIP plans and assurances processes • Monthly financial reporting • Service line reporting • 3-year capital programme • Productivity and efficiency benchmarking (ref costs, Carter Review, model hospital) • Contract monitoring and reporting • Activity planning and profiling • IPR • NHSI annual provider Licence Declarations • PMO capacity to support delivery of CIP and service transformation • Signed Contracts with all ICBs and Spec Comm • Premium/agency payments approval and monitoring processes • Internal audit programme • Compliance with contract T&Cs • Standards of business conduct • SFIs/SOs • Conflict of interest declarations • Benchmarking and reference cost group • Workforce vacancy panel ToR	**LEVEL 1** Operational Assurance • Monthly CBU Finance and Performance Meetings • CIP Council Meetings • Agency and locum spend approvals and reporting process • Operational planning • Premium Payment Scrutiny Council • Vacancy panel **LEVEL 2** Board Assurance • Finance and Performance Committee and reporting Councils • Annual Financial Plan • Audit Committee • Integrated Performance Report • Benchmarking and market share reports (inc. GIRFT) • Internal Audit Programme • CQUIN Monitoring **LEVEL 3** Independent Assurance • ICB & NHSE monthly reporting and review meetings • Contract Review meetings • Place Based Partnership Boards • Financial sustainability self-assessment • External Audit reports including VfM Assessment • Head of Internal Audit Opinion • NHSE scrutiny of cash applications	Continue collaboration across C&M to deliver transformational CIP contribution. Medium and long-term financial plan, taking into account current position and savings from any reconfiguration, that addresses drivers of the underlying financial position of services at legacy S&O sites. Complete the review of financial controls so they are standardised across MWL (September 2024) ~~Implement a vacancy control process in line with ICB system requirements (May 2024)~~	Develop capacity and demand modelling and a consistent approach to service development business case approval. Foster positive working relationships with health economy partners to help create a joint vision of the future of health services. Continue to achieve cash flow and prompt payment of invoices from other NHS providers e.g. as lead employer to maintain cash balances. At the earliest opportunity move back to longer term financial planning with rolling plans for 3 – 5 years.	Continue to track the activity and financial impact of continued Industrial Action and national guidance/direction on how the impact will be funded or activity plans revised (on-going for Junior Doctors) Deliver the agreed 2024/25 financial and activity plans, including CIP targets, reduction in bank and agency spend and delivery of minimum national activity targets (March 2025) Deliver the agreed 2024/25 capital programme. Complete review of financial position with PWC as part of NHSE support (September 2024)

BAF 3 Sustained failure to maintain operational performance/deliver contracts

Exec Lead: Chief Operating Officer

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	~~5~~ 4	4	16	3	4	12

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. **Effect:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand. **Impact:** • Failure to deliver against national performance targets (ED, RTT, and Cancer etc.) or PSF improvement trajectories. • Failure to reduce LoS. • Failure to meet activity targets. • Failures in data recording or reporting • Failure to create sufficient capacity to meet the levels of demand.	• NHS Constitutional Standards • Divisional ~~Care group~~ activity profiles and work plans • System Winter Plan • Divisional ~~Care Group~~ Performance Monitoring Meetings • Team to Team Meetings • ED RCA process for breaches • Tumour specific cancer waiting time recovery plans • Exec Team weekly performance monitoring • Waiting list management and breach alert system • ECIP Improvement Events • A&E Recovery Plan • Capacity and Utilisation plans • CQUIN Delivery Plans • Capacity and demand modelling • System Urgent Care Delivery Board Membership • Internal Urgent Care Action Group (EOT) • Data Quality Policy • MADE events ~~re DTOC patients~~ • Bed occupancy rates • Number of super stranded /patients who no longer meet the criteria to reside	**LEVEL 1** Operational Assurance • Winter resilience plans • Divisional Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • IA EPRR response and recovery plans • Weekly performance review meetings **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance monthly oversight meetings	Implementation of routine capacity and demand modelling A defined preferred option and capital secured for Shaping Care Together programme. Implementation of CDC at Southport and Ormskirk sites.	Assurance that there is sufficient system response to operational pressures ~~and delayed discharges~~ and reducing the number of patients who no longer meet the criteria to reside. ~~Progress against 2023/24 waiting list reduction and recovery targets.~~ Progress against 2024/25 waiting list reduction and recovery targets. ~~Tumour pathway specific recovery plans to reduce cancer waiting times and consistently achieve the national access standards.~~	~~Deliver 2023/24 combined STHK & S&O waiting list reduction and elective recovery targets (April 2024)~~ ~~Implementation of Diagnostics Improvement Plans across MWL (April 2024)~~ Deliver the agreed 2024/25 activity and access time performance improvements (April 2025) Develop new non-elective winter strategy to achieve 2024/25 targets (~~June 2024~~ Revised to September 2024) Implement cancer performance improvement plans across MWL (April 2025) Work with the Mid Mersey UEC improvement programme, aligned to the MWL footprint, to reduce corridor care and reliance on escalation beds, in support of the NHS C&M 2024/25 priorities (September 2024)

BAF 4 Failure to protect the reputation of the Trust

Exec Lead: Deputy CEO

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements. • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information. • Failure of FPPT procedure **Effect:** • Loss of market share/contracts • Loss of income • Loss of patient/public confidence and community support • Inability to recruit skilled staff. • Increased external scrutiny/review. **Impact:** • Reduced financial viability and sustainability. • Reduced service safety and sustainability • Reduced operational performance. • Increased intervention	• Communication, Media and Public Engagement Strategy & action plan • Workforce/ People Plan and action plan • Publicity and marketing activity/proactive annual programme • Patient Involvement Feedback • Patient Power Groups • Annual Board effectiveness assessment and action plan • Board development programme • Internal audit • Data Quality • Scheme of delegation for external reporting • Social Media Policy • Approval scheme for external communication/ reports and information submissions • Well Led framework self-assessment and action plan • NED internal and external engagement • Trust internet and social media monitoring and usage reports • Complaints response times monitoring and quarterly complaints reports • Compliance with GDPR/FOI	**LEVEL 1** Operational Assurance • Winter resilience plans • Divisional Finance and Performance meetings • Community services contract review meetings • ICB CEO meetings • Extraordinary PTL for long wait patients • Daily/weekly media briefings and board flash reports for urgent issues **LEVEL 2** Board Assurance • Finance and Performance Committee • Integrated Performance Report • Annual Operational Plan **LEVEL 3** Independent Assurance • Contract review meetings • NHSE & ICB monitoring and escalation returns/sit-reps • System winter resilience plan • CQC System Reviews • Cancer Alliance oversight of pathways • Provider representative at Place quarterly ICB performance meetings		Creation of good working relationships with new Healthwatch/PBP areas post transaction	~~Communications programme to launch new trust values and 2024/25 objectives to deliver 5 star patient care (April 2024)~~ Develop the MWL Communications, Media, and Public Engagement strategy for approval by the Trust Board (September 2024) MWL stakeholder newsletter (revised to September 2024 due to timing of the general election) Monthly media activity reports to Executive Committee (revised to September 2024) With partners deliver the communications and engagement programme for the Shaping Care Together pre consultation business case (September 2024) Launch of the MWL Hospital Charity (July 2024)

BAF 5 Failure to work effectively with stakeholders

Exec Lead: Director of HR/ Managing Director

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Failure to respond to stakeholders e.g. Media • Single incident of poor care • Deteriorating operational performance • Failure to promote successes and achievements • Failure of staff/ public engagement and involvement • Failure to maintain CQC registration/Outstanding Rating • Failure to report correct or timely information **Effect:** • Lack of whole system strategic planning • Loss of market share • Loss of public support and confidence • Loss of reputation • Inability to develop new ideas and respond to the needs of patients and staff **Impact:** • Unable to reach agreement on collaborations to secure sustainable services • Reduction in quality of care • Loss of referrals • Inability to attract and retain staff • Failure to win new contracts • Increase in complaints and claims	• Communications and Engagement Strategy • Membership of Health and Wellbeing Boards • Representation on Urgent Care Boards/System Resilience Groups • JNCG/LNG • Patient and Public Engagement and Involvement Strategy • Place Director Meetings • Staff engagement strategy and programme • Patient power groups • Involvement of Healthwatch • St Helens Cares Peoples Board • Involvement in Halton and Knowsley PBP development • Membership of specialist service networks and external working groups e.g. Stroke, Frailty, Cancer • Cheshire and Merseyside Integrated Care Board governance structure • Exec to Exec working • MWL Hospitals Charity annual objectives • Regular meetings with local MPs, OSCs etc. • Equality impact assessments • Anchor institution development plan	**LEVEL 1** Operational Assurance • LUHFT Partnership Board • North Mersey Ophthalmology Steering Group • Shaping Care Together Programme • Membership of CMAST • Capital Assurance Group • ED&I Steering Group • Monitoring of NHS Choices comments and ratings • Review of digital media trends • Healthwatch feedback **LEVEL 2** Board Assurance • Quality Committee • Charitable Funds Committee • CEO Reports • HR Performance Dashboard • Board Member feedback and reports from external events • Quality Account • Annual staff engagement events programme **LEVEL 3** Independent Assurance • NHSE review meetings • Participation in C&M ICB leadership and programme Boards • Collaborative working with Place Directors to develop plans for PBPs • Membership of St Helens People Board • OSC attendance/presentations	Health inequalities improvement objectives to be agreed with each Place and the ICBs	**C**&M Integrated Care System performance and accountability framework ratings and reports Development of good working relationships with each Place and their Primary Care Networks Maintain or improve NHS Operating framework segment 2 (April 2024)	Re start the Shaping Care Together Programme to develop a new PCBC for the configuration of services between the Southport and Ormskirk Hospital sites (revised to November 2024 due to timing of the general election) Work with NHSE/ICB post transaction to continue to support fragile services for MWL as required (September 2024)

BAF 6 Failure to attract and retain staff with the skills required to deliver high quality services — Exec Lead: Director of HR

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	3	5	15	2	5	10

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Loss of good reputation as an employer • Doubt about future organisational form or service sustainability • Failure of recruitment processes • Inadequate training and support for staff to develop • High staff turnover • Unrecognised operational pressures leading to loss of morale and commitment • Reduction in the supply of suitably skilled and experienced staff **Effect:** • Increasing vacancy levels • Increased difficulty to provide safe staffing levels • Increase in absence rates caused by stress • Increased incidents and never events • Increased use of bank and agency staff **Impact:** • Reduced quality of care and patient experience • Increase in safety and quality incidents • Increased difficulty in maintaining operational performance • Loss of reputation • Loss of market share	• Trust brief live ~~Team Brief~~ • MWL News ~~Staff Newsletter~~ • Mandatory training • Appraisals • Staff benefits package • H&WB Provision • Staff Survey action plan • JNCC/LNC • ~~Education and~~ Workforce & Development Operational Plan • Learning and Organisational Development Operational Plan • People Policies • Exit interviews • Staff Engagement Programme – Listening events • Involvement in Academic Research Networks • Values based recruitment • Daily nurse staffing levels monitoring and escalation process • 6 monthly Nursing establishment reviews and workforce safeguards reports • Recruitment and Retention Operational ~~Strategy action~~ plan • Career leadership & talent development programmes • Agency caps and usage reporting • Speak out safely policy • ~~ACE Behavioural standards~~ • Trust Values • Medical Workforce OD plan • Talent Management action plan • Equality, Diversity, and Inclusion Operational plan	**LEVEL 1** Operational Assurance • Premium Payments Scrutiny Council • Monitoring of bank, agency and locum spend • Workforce operational plans **LEVEL 2** Board Assurance • Strategic People Committee • People Performance Council, Valuing Our People Council and HR Commercial Services Council • Finance and Performance Committee • Committee Performance Report • Staff Survey • Monthly monitoring of vacancy rates Labour stability and staff turnover • WRES, WDES, EDS3 and Gender Pay Gap, EDI reports and action plans • Quality Ward rounds • Employee Relations Oversight Group **LEVEL 3** Independent Assurance • HR Benchmarking • Nurse & Midwifery Benchmarking • Freedom to Speak Up Guardian reports • Guardian of Safe Working Hours report	Improve ease with which staff can move roles internally (March 2025). Integration of education structure across MWL (revised to September 2024) Monthly Provider Workforce Returns (PWR) MDT approach to HR support to Divisions including recruitment, retention, staff engagement and wellbeing. (October 2024) Optimise utilisation of the apprenticeship levy to attract and retain staff (March 2025) Delivery of the NHS EDI Improvement Plan high impact actions (March 2025) Achieve bronze level North West Anti-Racism Framework (March 2025)	Specific strategies and targeted campaigns to overcome recruitment hotspots e.g., international recruitment and working closely with NHSE. CDC recruitment campaign continues with recruitment events and new training opportunities for Physician Associates, Phlebotomy, international recruitment, and use of apprenticeships (On-going) C&M Endoscopy bank pilot now extended to October 2024 and piloting the hybrid employment model. Achieve 2023/24 targets for international medical recruitment and Nurse Associate expansion (March 2025)	Continue to provide the necessary support for organisational change to implement the remaining management structure for the MWL integrated operating model (revised to September 2024) Achieve the mandatory and compulsory training target of 85% (April 2025) Achieve 85% compliance with staff appraisals (April 2025) Implement the NHS Sexual Safety Charter (March 2025) Delivery the 2023 staff survey action plan (March 2025) Deliver the HR Operational plans for 2024/25 (March 2025)

BAF 7 Major and sustained failure of essential assets or infrastructure

Exec Lead: Director of Corporate Services

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	4	12	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Poor replacement or maintenance planning • Poor maintenance contract management • Major equipment or building failure • Failure in skills or capacity of staff or service providers • Major incident e.g. weather events/ fire • Insufficient investment in estates capacity to meet the demand for services **Effect:** • Loss of facilities that enable or support service delivery • Potential for harm as a result of defective building fabric or equipment • Increase in complaints **Impact:** • Inability to deliver services • Reduced quality or safety of services • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share/contracts	• New Hospitals / Vinci /Medirest Contract Monitoring • Equipment replacement programme • Equipment and Asset registers • 5-year Capital programme • PFI lifecycle programme • PPM schedules and reports • Procurement Policy • PFI contract performance reports • Regular accommodation and occupancy reviews • Estates and Accommodation Strategy • H&S Committee • Membership of system wide estates and facilities strategic groups • Membership of the C&M HCP Strategic Estates work programme • Access to national capital PDC allocations to deliver increased capacity • Compliance with national guidance in respect of waste management, ventilation, Oxygen supply, cleaning, food standards • Compliance with NHS Estates HTMs • Green Plan	**LEVEL 1** Operational Assurance • Major Incident Plan • Business Continuity Plans • Planned Preventative Maintenance Programme • Issues from meetings of the Liaison Committee escalated as necessary to Executive Committee to capture ▪ Strategic PFI Organisational changes ▪ Legal, Financial and Workforce issues ▪ Contract risk ▪ Design & construction ▪ FM performance ▪ MES performance • S&O safety groups and E&F Governance Group **LEVEL 2** Board Assurance • Finance and Performance Committee • Finance Report • Capital Council • Audit Committee • Integrated Performance Report • ERIC returns/data **LEVEL 3** Independent Assurance • Authorising Engineer Appointments • Authorising Engineer Audits • Condition surveys • Premises Assurance Model benchmarking • Model Hospital • PLACE Audit Results and benchmarking	Maintain up to date 10-year strategic estates development plans for MWL n to support the Trusts service development and integration strategies. ~~Create strategic site development plans for the S&O hospital sites when transaction completed (February 2024)~~ Development of an Estates Strategy in response to Shaping Care Together preferred service configuration option (aligned to SCT timetable)	Develop the final business case to fully implement National Standards of Cleaning across MWL and present to the Executive Committee for approval (revised to August 2024) Implementation of the national Hospital Food Review recommendations and mandatory standards (Gap analysis being undertaken) Compliance with the new Protect legislation for premises security – Consultation closed in July 2022 and draft legislation not yet published. Commission up to date 6 facet survey of the Southport and Ormskirk Hospital sites (October 2024)	3-year capital programme to deliver the Same Day Ambulatory care capacity and UEC schemes (on going to 2024/25) ~~Delivery of the Whiston Additional Theatres Scheme (June 2024)~~ ~~Complete review of Estates and FM systems, processes, and policies across all MWL sites (revised to June 2024)~~ Deliver the S&O sites backlog maintenance programme for 2024/25. Deliver the MWL capital works plans for 2024/25. Review impact of Building Safety Act on planned schemes (December 2024)

BAF 8 Major and sustained failure of essential IT systems

Exec Lead: Director of Informatics

Inherent Risk			Current Risk			Target Risk		
Likelihood	Impact	Score	Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	4	4	16	2	4	8

Risk	Key Controls	Sources of Assurance	Additional Controls Required	Additional Assurance Required	Action Plan (with target completion dates)
Cause: • Inadequate replacement or maintenance planning • Inadequate contract management • Failure in skills or capacity of staff or service providers • Major incident e.g. power outage or cyber attack • Lack of effective risk sharing with HIS shared service partners • Inadequate investment in systems and infrastructure **Effect:** • Lack of appropriate or safe systems • Poor service provision with delays or low response rates • System availability resulting in delays to patient care or transfer of patient data • Lack of digital maturity • Loss of data or patient related information **Impact:** • Reduced quality or safety of services • Financial penalties • Reduced patient experience • Failure to meet KPIs • Loss of reputation • Loss of market share contracts	• MMDA Management Board and Accountability Framework • Procurement Framework • MMDA Strategy • Performance framework and KPIs • Customer satisfaction surveys • Cyber Security Response Plan • Benchmarking • Workforce Development • Risk Register • Contract Management Framework • Major Incident Plans • Disaster Recovery Policy • Disaster Recovery Plan and restoration procedures • Engagement with C&M ICS Cyber group • Business Continuity Plans • Care Cert Response Process • Project Management Framework • Change Advisory Board • IT Cyber Controls Dashboard • Information asset owner/administrator register • Service improvement plans • MWL Digital Strategy 2024-2027 • Microsoft Defender for Endpoints • MFA protection for confidential data • Annual DSPT self-assessments	**LEVEL 1** Operational Assurance • Information security dashboard • Information asset owner register • Information security dashboard • IT On Call (including network specific cover provided by MMDA) • Benefit realisation framework monitoring • Monthly cyber security operational meeting **LEVEL 2** Board Assurance • Board Reports • IM&T Strategy delivery and benefits realisation plan reports • Audit Committee • Executive committee • Risk Management Council • IM&T Council • Information Security Assurance Group • MMDA Service Operations Board • MMDA Strategy Board • Programme/Project Groups • Information Governance Steering Group **LEVEL 3** Independent Assurance • Internal/External Audits • CareCert, Cyber Essentials, External Penetration Test to identify cyber threats and vulnerabilities. • Support contracts for core systems • Quarterly NHS Digital simulated phishing attack reports • Digital Maturity Assessments	Annual IT Corporate Governance Structure review Technical Development of staff	Compliance with ISO27001 – with gap analysis being in progress (March 2025) IT communications strategy Digital Maturity assessment Cyber Essential Certification/Accreditation – achieve by January 2026 Migration from end-of-life operating system at S&O sites Multi-factor authentication to provide additional protection for confidential data	Achieve HIMMS Level 5 2018 standards and core digital capabilities and WGLL standards (March 2025) Decommission Windows 12 Servers (October 2024). Windows Server 2008 Servers are gradually being retired and will be fully replaced (March 2025). Delivery of the Frontline Digitisation Programme to optimise Careflow EPR and implement new functionality to meet the core digital capability standards (March 2025) Delivery of Community EPR (revised to September 2024 due to system issues) Respond to cyber threat alerts and update systems as required (on going) ~~Test major incident and data recovery plans for MWL (Revised to June 2024)~~ ~~Implement multi-factor authentication (MFA) to end users (June 2024)~~ Deliver the 2024/25 IT capital expenditure plan (March 2025)

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**			**Date**	31 July 2024
Agenda Item	TB24/056 (12.1)				
Report Title	Data Security and Protection Toolkit (DSPT) - Final Submission Report 2023/24 for Mersey and West Lancashire Teaching Hospitals NHS Trust.				
Executive Lead	Malcom Gandy, Director of Informatics (SIRO)				
Presenting Officer	Malcom Gandy, Director of Informatics (SIRO)				
Action Required		**To Approve**	X	**To Note**	

Purpose

To provide the Trust Board with assurance that Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) operates within the parameters defined in the Data Security and Protection Toolkit (DSPT) and has completed the annual submission to demonstrate such compliance.

Executive Summary

This Report summarises MWL's status of the Data Security and Protection Toolkit (DSPT) for its 2023/24 submission. The DSPT is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's ten data security standards.

All organisations that have access to and process patient / personal data and systems must use this toolkit to provide assurance that they are practising good data security, and that personal information is handled correctly and in line with data protection legislation.

When considering data security as part of the 'Well Led Key Line of Enquiry' as part of the Care Quality Commission (CQC) inspections, they will consider how organisations are assuring themselves against these standards.

The submission date for the DSPT is now the end of June and there are no plans to move it back to the month of March (as it was up until 2020).

MWL submitted the DSPT assessment at the end of June 2024 for the 2023/24 submission and was able to submit evidenced items for all the assertions as required as part of the submission, this included non mandatory items. MWL achieved a "standards met" rating for the submission.

Mersey Internal Audit Agency (MIAA) have audited a number of the assertions and evidenced items. MWL has received the rating of 'Substantial Assurance' against its DSPT.

Financial Implications

None directly from this report

Quality and/or Equality Impact

N/A

Recommendations

The Board is asked to note Data Security and Protection Toolkit (DSPT) report for assurance.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care – Safety

X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care – Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Introduction

The Data Security and Protection Toolkit (DSPT) enables organisations to measure their performance against Data Security and Information Governance requirements set out in legislation and Department of Health policy. It is based on the National Data Guardian ten data security standards (covering topics such as staff responsibilities and continuity planning (National Data Guardian Review (Review of Data Security, Consent and Opt-Outs) and legal rules relevant to IG and personal data (UK General Data Protection Regulation 2016 and the Data Protection Act 2018).

All organisations that have access to and process patient / personal information must provide assurances that they are practising good information governance and use the DSPT to evidence this by the publication of annual assessments. It is also a contractual requirement in the NHS England standard conditions contract that relevant providers publish DSPT assessments on an annual basis:

> *"The Provider must complete and publish an annual information governance assessment and must demonstrate satisfactory compliance as defined in the Data Security and Protection Toolkit, as applicable to the Services and the Provider's organisation type."*

It remains Department of Health policy that all bodies that process NHS patient information for whatever purpose should provide assurance via the DSPT.

The DPST this year contained 108 mandatory 'assertions' that required evidencing. Each mandatory requirement has to be addressed in order to submit a successful assessment - if this was not achieved MWL would have been considered non-compliant.

The DSPT submission date up until 2020 had always been the end of March, this has now changed and is the end of June. MWL submitted a successful DSPT before the deadline and met all mandatory requirements.

Larger organisations, such as Acute Trusts, are also required to have their DSPT submission externally audited to ensure the accuracy of their submission. The objective of this exercise is to provide independent assurance over a nationally determined sample of evidence items and to highlight areas for improvement to inform the following years DSPT submission.

Failure to complete the DSPT can have serious implications for organisations. As this is a contractual obligation with Commissioners, non-compliance could incur financial penalties or impact MWL's ability to bid for new services in the future. In addition could place MWL's reputation at risk. The Information Commissioner has also indicated that satisfactory completion of the DSPT can act as a strong mitigation against regulatory fines imposed should an incident be reported to them.

Summary of 2023/24 Submission

Evidence has been provided for the self-assessment against the 10 National Data Guardian Standards and the associated assertions that sit under each standard. These items are recorded under assertions and represent an indicator of maturity in that area. There are in 108 mandatory assertion items that require evidence.

For example, in order to comply with Standard 1 for 'Personal Confidential Data', MWL has to provide evidence for the assertions as detailed below:

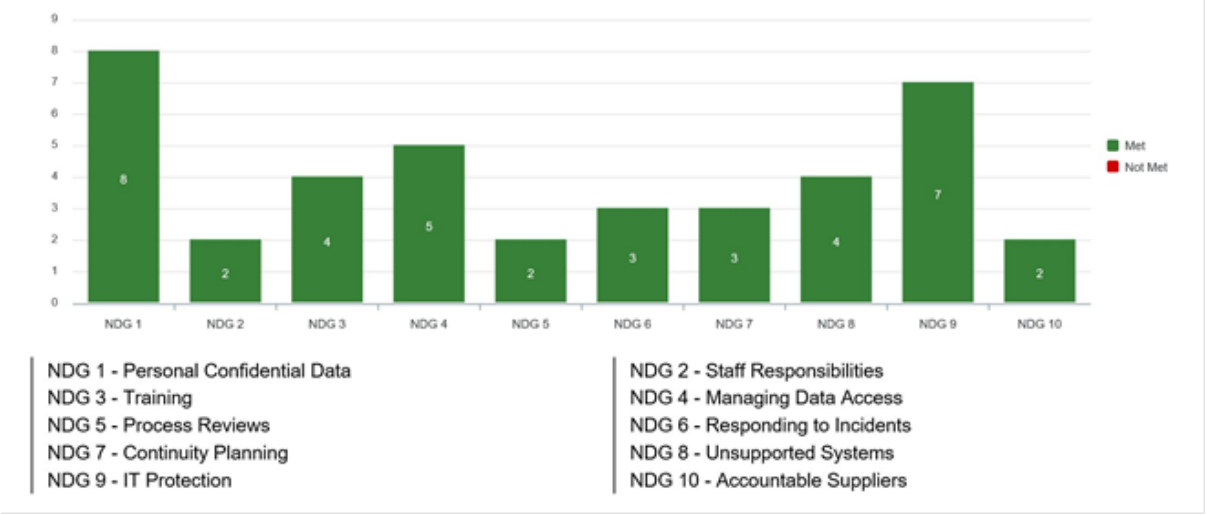
1.1	The organisation has a framework in place to support Lawfulness, Fairness and Transparency		
1.1.1	State your organisation's Information Commissioner's Office (ICO) registration number.	Mandatory	**COMPLETED**
1.1.2	Your organisation has documented what personal data you hold, where it came from, who you share it with and what you do with it.	Mandatory	**COMPLETED**
1.1.3	Transparency information (e.g. your Privacy Notice and Rights for individuals) is published and available to the public.	Mandatory	**COMPLETED**
1.1.4	Your business has identified, documented and classified its hardware and software assets and assigned ownership of protection responsibilities.	Mandatory	**COMPLETED**
1.1.5	List the names and job titles of your organisation's key staff with responsibility for data protection and data security.	Mandatory	**COMPLETED**
1.1.6	Your organisation has reviewed how it asks for and records consent to share personal data.	Mandatory	**COMPLETED**
1.1.7	Data quality metrics and reports are used to assess and improve data quality.	Mandatory	**COMPLETED**
1.1.8	A data quality forum monitors the effectiveness of data quality assurance processes.	Mandatory	**COMPLETED**

1.2	Individuals' rights are respected and supported		
1.2.2	Your organisation has processes in place to deliver individuals rights including to handle an individual's objection to the processing of their personal data.	Mandatory	**COMPLETED**
1.2.3	Your organisation has a process to recognise and respond to individuals' requests to access their personal data.	Mandatory	**COMPLETED**
1.2.4	Your organisation is compliant with the national data opt-out policy.	Mandatory	**COMPLETED**

1.3	**Accountability and Governance in place for data protection and data security**		
1.3.1	There are board-approved data security and protection policies in place that follow relevant guidance.	Mandatory	**COMPLETED**
1.3.2	Your organisation monitors your own compliance with data protection policies and regularly reviews the effectiveness of data handling and security controls.	Mandatory	**COMPLETED**
1.3.3	SIRO responsibility for data security has been assigned.	Mandatory	**COMPLETED**
1.3.4	There are clear documented lines of responsibility and accountability to named individuals for data security and data protection.	Mandatory	**COMPLETED**
1.3.5	Your organisation operates and maintains a data security and protection risk register (including risks from supply chain) which links to the corporate risk framework providing senior visibility.	Mandatory	**COMPLETED**
1.3.6	List your organisation's top three data security and protection risks.	Mandatory	**COMPLETED**
1.3.7	Your organisation has implemented appropriate technical and organisational measures to integrate data protection into your processing activities.	Mandatory	**COMPLETED**
1.3.8	Your organisation understands when you must conduct a Data Protection Impact Assessment and has processes in place, which links to your existing risk management and project management, to action this.	Mandatory	**COMPLETED**
1.3.9	Data security and protection direction is set at board level and translated into effective organisational practices.	Mandatory	**COMPLETED**
1.4	**Records are maintained appropriately**		
1.4.1	The organisation has a records management policy including a records retention schedule.	Mandatory	**COMPLETED**

In order for MWL to have achieved "**standards met**", all of the mandatory items with the DSPT had to be completed. Our baseline assessment was submitted to NHS Digital in February 2024.

MWL successfully completed the DSPT in time for the end of June 2024 submission date. A summary of how the 2023/24 submission looked is shown below:

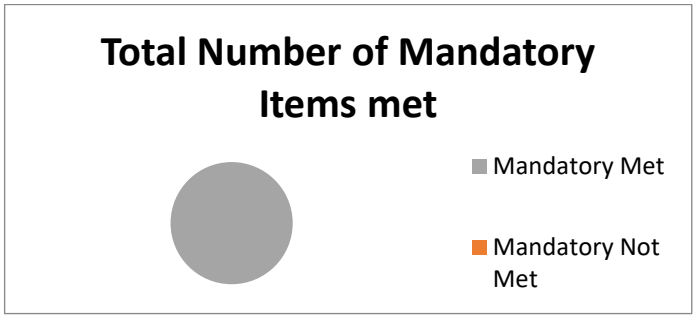


The table below shows the status of **Mandatory** evidence items met applicable for MWL:

Data Standard	Number of Requirements	IT Sec Owner	IG Owner	DQ Owner	Total Evidence item provided
1	**21**	**4**	**15**	**2**	**21/21**
2	**2**	**0**	**2**	**0**	**2/2**
3	4	0	**4**	**0**	**4/4**
4	**12**	**12**	**0**	**0**	**12/12**
5	**1**	**1**	**0**	**0**	**1/1**
6	**13**	**10**	**3**	**0**	**13/13**
7	**9**	**9**	**0**	**0**	**9/9**
8	**15**	**15**	**0**	**0**	**15/15**
9	**28**	**28**	**0**	**0**	**28/28**
10	**3**	**2**	**1**	**0**	**3/3**
Total	**108**	**81**	**25**	**2**	**108**

Evidence was required from MWL's IT Security, Information Governance (IG) and Data Quality (DQ) teams. The table above showing that IT Security were required to provide 81 mandatory items of evidence, IG – 26 and finally DQ providing 2 items.

The chart below shows the Mandatory evidence items met:



Summary of Results:

Total Number of Data Standards = 10

Total Number of Mandatory Evidence Items required = 108

Total Number of Mandatory Evidence Items achieved = 108

MWL also completed the Non-Mandatory Evidence Items, this table shows the number of these items per Data Standard:

Data Standard	Number of Requirements	IT Sec Owner	IG Owner	DQ Owner	Total Evidence item provided
1	0	0	0	0	0
2	0	0	0	0	0
3	2	2	0	0	2/2

4	**6**	**6**	**0**	**0**	**6/6**
5	**1**	**1**	**0**	**0**	**1/1**
6	**1**	**1**	**0**	**0**	**1/1**
7	**3**	**3**	**0**	**0**	**3/3**
8	**1**	**1**	**0**	**0**	**1/1**
9	**2**	**1**	**1**	**0**	**2/2**
10	**4**	**2**	**2**	**0**	**4/4**
Total	**20**	**17**	**3**	**0**	**20**

In total 128 evidence items have been provided, 108 Mandatory items and 20 non-mandatory items.

DSPT Approval

In order to submit and publish the DSPT once all evidence has been provided the SIRO must provide final approval. On the 27th June, the IG Team presented the SIRO with the evidence that had been provided for MWL's DSPT. The SIRO has approved the submission of the DSPT for 2023/24, subject to recommendations from MIAA being actioned.

Internal Audit

Mersey Internal Audit Agency (MIAA) carried out an audit of MWL's DSPT submission (as required of larger NHS organisations) during two visits in April and May 2024 to assess the Trust's compliance against these standards. MIAA audited assertions which covered each data security standard of the DSPT including, Personal Confidential Data, Staff Responsibilities, Business Continuity Planning and Unsupported Systems. These areas cover thirteen assertions (see below) which this year have been selected by NHS Digital. Due to the involvement of NHS Digital the audits have changed significantly with additional evidence and assurance required in all areas being reviewed. The scope of the review included mandatory elements only.

Area	Description
1.1	The organisation has a framework in place to support Lawfulness, Fairness and Transparency
2.2	Staff contracts set out responsibilities for data security

3.1	Staff have appropriate understanding of information governance and cyber security, with an effective range of approaches taken to training and awareness
3.2	Your organisation engages proactively and widely to improve data security, and has an open and just culture for data security incidents
4.4	You closely manage privileged user access to networks and information systems supporting the essential service
5.1	Process reviews are held at least once per year where data security is put at risk and following DS incidents
6.2	All user devices are subject to anti-virus protections while email services benefit from spam filtering and protection deployed at the corporate gateway
7.1	Organisations have a defined, planned and communicated response to Data security incidents that impact sensitive information or key operational services
8.4	You manage known vulnerabilities in your network and information systems to prevent disruption of the essential service
9.2	A penetration test has been scoped and undertaken
9.5	You securely configure the network and information systems that support the delivery of essential services
9.6	The organisation is protected by a well-managed firewall
10.2	Basic due diligence has been undertaken against each supplier that handles personal information

The Trust received the audit report from MIAA in June which has confirmed a rating of '**Substantial Assurance**.'

Substantial Assurance

The Trust was also assessed against the risk rating score at the National Data Guardian Standard level.

National Data Guardian Standard level	Overall assurance rating at the National Data Guardian level
1. Personal Confidential Data	Substantial
2. Staff Responsibilities	Substantial
3. Training	Substantial
4. Managing Data Access	Substantial
5. Process Reviews	Substantial
6. Responding to Incidents	Substantial
7. Continuity Planning	Substantial
8. Unsupported Systems	Substantial
9. IT Protection	Substantial
10. Accountable Suppliers	Substantial

An assessment as to the veracity of the organisation's self-assessment / DSPT submission and the assessor's level of confidence that the submission aligns to their assessment of the risk and controls.

As a result of the above, the overall assurance level across all 10 National Data Guardian Standards is rated as:

Substantial Assurance

Areas of Good Practice received from MIAA Audit Report

Assertion	Areas of Good Practice
	The Trust demonstrated its framework in relation to data security and protection with clear commitment and support by senior management and a defined structure for internal reporting.
1.1.1 1.1.3	The Trust's registration with the Information Commissioner's Office was up to date and privacy notices were published and accessible via the website home page.
2.2.1	Employment contracts incorporated data security and protection responsibilities.

3.1.1 3.1.2 3.1.3	There was a specialist IG Training Needs Analysis (TNA) in place which had been approved by the SIRO and included how the Trust would measure its effectiveness and the reporting in place to provide assurance to the xxx (IGSG) training was in place.
4.4.2	Controls were in place to manage privileged users across both infrastructures that were in place at the time of the review.
5.1.1	Up to date policies and procedures were in place and operating for managing data security and protection incidents. Testing on a sample of incidents identified no issues in relation to data security and protection incident management.
6.2.1 6.2.3 6.2.4	Technical controls were in place for the management of antivirus solutions deployed, including updates and scanning of files downloaded or opened.
6.2.5	Technical controls were demonstrated as in place to prevent connections to malicious websites.
6.2.8 6.2.9	The Trust was able to demonstrate that Domain-based Message Authentication Reporting and Conformance (DMARC), Domain Keys Identified Mail (DKIM) and Sender Policy Framework (SPF) were enabled.
7.1.1 7.2.1	The Trust had undertaken dependency mapping across all key services and there was evidence of Business Continuity Plans (BCPs) being in place for a sample of services.
8.4.1 8.4.2 8.4.3	Standard operating procedures were in place for the management of security patches and threat and vulnerability management.
9.5.1 9.5.2 9.5.3 9.5.5 9.5.6 9.5.7	The Trust evidenced secure configuration and change management for its infrastructure and systems, including restrictions relating to installation of software and autorun, device encryption and centrally deployed and managed standard builds.
9.5.8 9.6.2	Conditional access was in place for authenticating remote access and for accessing administrative interfaces.
9.6.1 9.6.3 9.6.5 9.6.6	Boundary and local firewalls were in place with firewall rules subject to change management, quarterly review and configured to block all unauthenticated inbound traffic by default.

Recommendations received from MIAA Audit Report

MIAA have identified the following areas that will require further attention in 2024-25. An action plan is in place with assigned owners and dates to ensure these areas are actioned. Please note all the recommendations

were rating as low. The action plan will be presented to the SIRO at the Information Governance Steering Group in September:

Assertion	Recommended Areas of Improvements
1.1.2 1.1.4	Improvements to the Information Asset Register (IAR) and data flow mapping processes could be made including developing a mechanism to update register(s) following a new or change in processing activities, formalising a strategy / process to maintain registers, and ensuring ownership of all assets are assigned and maintained.
1.1.6	The Trust should consider documenting a specific policy for consent in respect of data processing activities.
1.1.7 1.1.8	The Trust should develop a Terms of Reference (ToR) for the Data Quality Forum which should include the reporting route to the Information Governance Steering Group (IGSG) and publish a schedule for data quality audits.
2.2.1	Confirm that all employment contract templates contain the relevant data security requirements including volunteer, student, locum / temporary, and legacy.
3.1.1 3.1.2 3.1.3	Confirm Caldicott Guardian / DPO training has been completed and document plans for how the Trust will evaluate the effectiveness of training activities and evidence reporting of outcomes to the relevant committees as planned.
3.2.1	As planned, the Trust should ensure the IGSG and IMT Council ToRs are approved ahead of submission.
4.1.1	Continue to review logging and monitoring policies and procedures to ensure retention periods are sufficient to enable investigation of incidents.
4.4.1 4.4.2	The Trust should ensure that, where there are differences in the controls and processes of each infrastructure being managed that there is a consistent level of management and oversight prior to full integration of the environments.
6.2.3 6.2.4 6.2.5 8.4.2 9.5.9	Continue to perform regular reviews across the estate.
7.1.1 7.1.2	Formalise a process for regularly reviewing / approving the list of key operational services and confirm Business Continuity plans (BCPs) are in place for all critical systems.
9.2.3	The results of the penetration test should be reported to the IGSG, as planned, including provision of assurance that any actions have been remediated

9.5.9	The Trust should consider documenting within a medical device policy (or similar) the controls that would be placed upon devices that are connected to the Trust's network but do not have the capability to connect to the internet
10.2.1	The Trust should ensure that due diligence processes are undertaken on an annual basis for all suppliers in scope and that evidence is retained of any certifications that the suppliers have maintained.
10.2.4	Formalise an assurance strategy for the lifetime of the contract and contract solution, and mature and embed assurance processes for Information Asset Owners (IAOs). Continue to review all critical service contracts contain clear roles and responsibilities.

Conclusion

MWL will continue to build and improve on the Information Governance and IT Security foundations which have been embedded. MWL has demonstrated they have excellent IG and IT Security processes in place by successful completion of the Data Security and Protection Toolkit and a positive audit.

Report Ends.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board Meeting**			**Date**	31 July 2024
Agenda Item	**TB24/056 (12.2)**				
Report Title	Information Governance Annual Report (including Freedom of Information Annual Report) 2023/24				
Executive Lead	Malcom Gandy, Director of Informatics (SIRO)				
Presenting Officer	Malcom Gandy, Director of Informatics (SIRO)				
Action Required		**To Approve**	X	**To Note**	

Purpose

To provide the Trust Board with assurance that Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) has an effective Information Governance Agenda and Framework in place.

Executive Summary

This report is designed to inform and give assurance to the Board of progress made against the Information Governance (IG) work programme for 2023/24.

IG is a framework that not only provides a consistent way for staff to deal with the many different information handling requirements but brings together all of the requirements, standards and best practice that apply to the handling of information, specifically information that contains personal confidential information, now referred to as personal data.

IG has four fundamental aims:

- To support the provision of high-quality care by promoting the effective and appropriate use of information in a secure manner
- To encourage staff to work closely together, preventing duplication of effort and enabling more efficient use of resources.
- To develop an information management structure to provide staff with appropriate tools and support to enable them to discharge their responsibilities to consistently high standards.
- To enable organisations to understand their own performance and manage improvement in a systematic and effective way.

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) has a duty to ensure that it complies with its legal and regulatory obligations, for IG this is data protection legislation, more specifically the UK GDPR and Data Protection Act 2018. MWL is committed to conducting frequent reviews and improvements of its services; this includes Information Governance (IG).

This report details the progress that has been made against the IG work programme for 2023/24 (since the formation of MWL July 2023 to the end of the financial year March 2024) and provides a 'year ahead' programme of work on areas that are necessary to achieve IG compliancy and to further embed IG within MWL.

Financial Implications

None directly from this report

Quality and/or Equality Impact

Not applicable

Recommendations

The Trust Board is asked to note the Information Governance Annual Report for assurance.

Strategic Objectives	
X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care – Safety
X	**SO3** 5 Star Patient Care – Pathways
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care – Systems
X	**SO6** Developing Organisation Culture and Supporting our Workforce
X	**SO7** Operational Performance
X	**SO8** Financial Performance, Efficiency and Productivity
X	**SO9** Strategic Plans

Introduction

The NHS Information Governance (IG) Framework is the means by which the NHS handles information about patients and employees, specifically personal identifiable information. This Framework allows MWL to ensure that all personal, sensitive and confidential data is being handled legally, securely, efficiently and effectively. IG is an ongoing process which covers many different areas including records management, data quality, legislative compliance, risk management and information security.

MWL has a duty to comply with data protection legislation such as the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 (DPA 2018), the Freedom of Information Act 2000 (FOIA 2000), and to meet IG / Information Security / NHS specifications and requirements mainly relating to the National Data Guardians Data Security Standards and other related legislation, guidance and contractual responsibilities to support the assurance standards of the Data Security and Protection Toolkit (DSPT).

MWL has its own IG Strategy which sets out the approach it takes in developing and implementing a robust IG Framework for future management, setting out the arrangements, policies, standards and best practice to support the effective management and protection of personal information. A range of policies and procedures further support the IG work including the Records Management Policy and Procedure, Confidentiality Code of Conduct Policy, Data Security & Protection Breaches / Incident Reporting Policy and Procedure, Freedom of Information Policy, Data Protection Impact Procedure, Data Quality Policy, these have been approved since the formation of MWL. All of which have been made available to staff via the MWL intranet.

MWL will complete and submit the Data Security and Protection Toolkit (DSPT) on an annual basis. The DSPT enables organisations to measure their performance against Data Security and IG requirements set out in legislation and Department of Health policy. MWL have completed the DSPT for 2023-24 and to provide assurance that the evidence provided was of a good standard it was audited by Mersey Internal Audit Agency. For 2023-24 MWL received the rating of '**Substantial Assurance**'.

Senior Information Risk Owner Update (SIRO)

This section of the paper is designed to inform and give assurance to the Board of progress made against the IG work programme for 2023-24.

This section will provide assurance, from the SIRO, that MWL:

- Has a sufficient framework in place to ensure compliance with all elements of the IG Agenda.
- Has an active and effective IG Steering Group forum, meeting regularly.
- Manages and investigates any IG / Confidentiality incidents and issues.

Roles and Responsibilities

The Role of the SIRO

Malcolm Gandy, Director of Informatics, is MWL's registered SIRO. The role of SIRO at all NHS Trusts has been mandated since 2007, following significant data losses in the public sector.

A SIRO is required to be an Executive Director, Chief Information Officer or a Senior Manager with access to a Trust Board. The SIRO is expected to understand how the strategic business goals of the organisation may be impacted by information risk.

The key responsibilities of the SIRO are to:

- Take ownership of the risk assessment process for information and cyber security risk, including review of an annual information risk.
- Review and agree action in respect of identified information risks.
- Ensure that the organisation's approach to information risk is effective in terms of resource, commitment and execution and that this is communicated to all staff.
- Provide a focal point for the resolution and / or discussion of information risk issues.
- Ensure the Board is adequately briefed on information risk issues.
- Ensure that all care systems information assets have an assigned Information Asset Owner.

The SIRO also takes overall ownership of the organisation's Information Risk Policy (incorporated within the Network & Information Security Risk Policy); acts as a champion for information risk on the Board and provides written advice to the Accountable Officer on the content of the Trust's Statement of Internal Control in regard to information risk.

The SIRO will implement and lead the NHS IG risk assessment and management processes within the Trust and advise the Board on the effectiveness of information risk management across the Trust**.**

The SIRO has a responsibility for ensuring there are robust IG systems and processes in place to help protect patient and corporate information. The focus of the DSPT is on setting standards and providing tools to achieve them. The SIRO authorises the DSPT Self-Assessment annual submissions once the relevant assurances have been provided by the IG and IT Security Teams. The data security standards provide assurance across ten areas:

1 Personal Confidential Data
2 Staff Responsibilities
3 Training
4 Managing Data Access
5 Process Reviews
6 Responding to Incidents
7 Continuity Planning
8 Unsupported Systems
9 IT Protection
10 Accountable Suppliers

The Role of the Caldicott Guardian

Mr Alex Benson is MWL's registered Caldicott Guardian. Mr Benson is tasked with ensuring that the personal information about those who use its services is used legally, ethically and appropriately, and that confidentiality is maintained. Mr Benson provides leadership and informed guidance on complex matters involving confidentiality and information sharing. Caldicott Guardianship is a key component of the broader IG agenda.

NHS organisations have been required to appoint a Caldicott Guardian since 1999, when it was mandated by NHS England. The Caldicott Guardian has a key role in ensuring that all NHS organisations achieve the highest practical standards for handling patient information. This includes

representing and championing confidentiality requirements and appropriate information sharing at the highest level of the Trust.

The purpose of this section is to provide assurance to the Trust Board that the Caldicott Guardian function within MWL operates at a satisfactory level and that it is appropriately supported within the existing IG structure.

MWL's Caldicott Guardian is supported by MWL's Director of Informatics in his role as Senior Information Risk Owner (SIRO) and MWL's Head of Information Governance & Data Protection Officer and her team.

Data Protection Officer

Camilla Bhondoo is MWL's Data Protection Officer. Data Protection Officers (DPOs) are part of data protection legislation, UK General Data Protection Regulation 2018 (UK GDPR) and Data Protection Act 2018.

DPOs are therefore at the heart of this legal framework for many organisations, facilitating compliance with the provisions of the UK GDPR. It is therefore mandatory for certain Data Controllers and Processors to designate a DPO (Article 37, UK GDPR).

This will be the case for all public authorities and bodies (irrespective of what data they process). MWL is therefore required to appoint a DPO.

The named DPO must be:

- Independent
- An expert in data protection
- Adequately resourced
- Report to the highest management level

As per Article 39 of the UK GDPR the DPO tasks are to:

- inform and advise you and your employees about your obligations to comply with the UK GDPR and other data protection laws.
- monitor compliance with the UK GDPR and other data protection laws, and with your data protection polices, including managing internal data protection activities; raising awareness of data protection issues, training staff and conducting internal audits.
- advise on, and to monitor, Data Protection Impact Assessments
- cooperate with the supervisory authority and
- be the first point of contact for supervisory authorities and for individuals whose data is processed (employees, customers etc).

Camilla Bhondoo reports into the Director of Informatics/SIRO.

Information Governance Steering Group

The Information Governance Steering Group (IGSG) is a standing committee which is accountable to MWL's IM&T Council and ultimately MWL's Board. The Group oversees the implementation of the IG Agenda throughout the organisation.

Its main purpose is to support and drive the broader IG Agenda and provide MWL's Board with the assurance that effective IG best practice mechanisms are in place within MWL.

The IGSG is chaired by MWL's SIRO Mr Malcolm Gandy, with MWL's Deputy SIRO, Rob Howorth as Deputy Chair. Core membership includes MWL's Directors and Assistant Directors, Heads of Quality, Heads of Service and Senior Managers.

This year the remit of the IGSG saw the Group address the following topics in addition to achieving DSPT compliance –

- Implementation of an IG Workplan for 2023-24 that detailed the IG tasks that were required for the year, not only listing DSPT requirements but areas that are required as part of the data legislation (not included in the DSPT). The aim was to provide assurance to the Group (including the SIRO, Caldicott Guardian and DPO) that all areas of data protection law were being addressed and therefore MWL were complying with this law. For this IG Workplan 21 workstreams were listed and there were 77 individual tasks – all requiring completing before DSPT submission (end of June).

- Review the membership for the IG Steering Group to be more inclusive and representative of the departments across the Trust. Enabling key IG messages to be filtered to the right places. This has been reflected in an updated and approved Terms of Reference for the group.

- Create and approve the following IG policies as MWL:

    - Information Governance Strategy
    - Information Governance Policy
    - Data Protection Impact Assessment (DPIA) Procedure
    - Records Management Policy and Procedure
    - Confidentiality Code of Conduct Policy
    - Freedom of Information Policy
    - Data Security & Protection Breaches / Incident Reporting Policy and Procedure

- Introduction of a new area via a policy – Individual Rights Policy. The purpose of this policy is to re-enforce the Trust's commitment to complying to the Individual Rights as outlined in the UK General Data Protection Regulation. The Trust is familiar with Subject Access Requests (also known as Right to Access) however there are 9 others which need to be processed should a patient / service user request so. They are:

    - The right to be informed (Articles 13 & 14)
    - The right of access (Article 15)
    - The right to rectification (Article 16)
    - The right to erasure (Article 17)

- The right to restrict processing (Article 18)
- The right to data portability (Article 20)
- The right to object (Article 21)
- Rights in relation to automated decision making and profiling (Article 22)
- The right to withdraw consent (Article 7)
- The right to complain (Article 77)

This policy was approved at May's (2024) IG Steering Group.

- A patient / public Privacy Notice and a staff Privacy Notice created and approved for MWL. Important notices that are available on MWL's public website describing to MWL's service users how the Trust processes their personal data in line with the law.

- Implementation of the Data Security & Protection Breaches / Incident Reporting Policy and Procedure. Since the formation of the MWL in July 2023 to the end of March 2024 895 data breaches have been reported on the Trusts Incident Reporting System, Datix. Each data breach has been investigated by the IG Team. Where data breaches have been classed as near miss data breaches or where key actions have been required the IG Officers have completed an IG Incident Proforma which details the data breach, score, findings and an action plan. These are reviewed by the Directorate Manager and sent to the DPO for approval. Where data breaches are classed as serious there is a process in place to escalate to the SIRO and Caldicott Guardian (if patient data involved) via the DPO. A report is presented to the IG Steering Group which also provides assurance that the Trust have a robust data breach procedure and policy in place.

- Review the Training assertion within the DSPT via the IG Training Needs Analysis (TNA) document and agree that the Trust will need to gain 85% compliance for the IG Mandatory Training to bring this in line with the rest of the Mandatory training across the Trust. Previously the DSPT mandated that all organisations had to achieve 95% - after a review by the DSPT Team the compliance is no longer set nationally but locally. MWL's IG TNA was approved in November's (2023) IG Steering Group.

- Establishment of key MWL Information Asset Owners (each Exec) and Information Asset Managers and Administrators (delegated responsibility from the Exec to a senior member/s of their team) to support the Information Asset Register workstream and IG agenda for their area to understand what key Information assets each area may have and what securities are in place around them. Where a system is in use i.e., ESR this linked into the IT System Register. IAO's report to the SIRO on any information related risks in their area.

- Establishment of MWL's IT System Register, in particular focusing on the critical IT Systems with assigned Information Asset Owners. The IG Team have now handed this over to IT colleagues to ensure it is kept up to date with key IT movements such as back-ups, upgrades, IG will continue to feed into the register on the governance arrangements i.e., completed DPIA, Due Diligence Questionnaire, Contracts, Sharing Agreements.

- Review of CCTV Signage across the sites following an audit that was undertaken by IG and alongside work established by Estates and Facilities to merge signage across the Trust. In conjunction with the IG Team the information on the signs has now been updated to ensure it aligns with data protection legislation in terms of advising individuals that CCTV is in use and where to find out more information.

- The Data Protection Impact Assessment (DPIA) Procedure become embedded within MWL continuing from the legacy of STHK and S&O. Since becoming MWL 57 DPIAs have been completed concerning new projects / systems / initiatives that require personal data to be processed. This alongside the completion of Due Diligence Questionnaires (29) which provides Supplier Assurance demonstrates the Trust have an effective process in place to assess any IG and IT Security risks where personal data is concerned.

- Establish close working relationship with the IT Security Team to ensure that the DPIA process becomes robust, and the evidence required for the DSPT is of high quality and relevant.

- Carry out walk around confidentiality audits around all hospital sites to provide the IG Steering Group with assurance that MWL are acting in accordance with IG principles when on-site i.e., identification badges are worn, clear desk policies are adhered to, secure areas are kept locked when unoccupied, and so on. In addition, where information differs across the sites ensure this is raised so that the same message is being used across MWL – key example CCTV signage and more recently the signage for not using mobile phones on site.

- Trialling the FOI service with a dedicated Senior IG Officer to focus on raising compliance.

Reportable Incidents

MWL has a duty to report any incidents regarding breaches of the Data Protection Act that score highly to the Information Commissioner's Office (ICO) and for the financial year 2023/24 there was one incident. The Trust is yet to hear from the ICO.

A breakdown of the reported incident to the ICO is below:

April 2024	At 20:00 on the 16/04/2024 the Radiology department at Mersey and West Lancashire Teaching Hospital NHS Trust (MWL) received a telephone call from an individual stating to be the husband of a patient who had recently undergone an obstetric scan. The call was taken by the Radiographer. The caller stated that their partner had asked them to call regarding the results. The Radiographer then informed the caller of the results of the scan over the telephone. An hour later the patient came to the Radiology department to report that the caller was her ex-partner and that safeguarding measures where currently in place. It was also reported that the man purporting to be the patient's husband had covertly recorded the telephone conversation with the Radiographer and posted this on his social media channels.
Outcome	ICO advised of action plan, at the time of writing this report no comments have been received by the ICO. Action Plan included: Immediate Actions Taken

	The Radiology Manager has spoken to and apologised to the patient. Established that the patient was safe and police. The MWL Safeguarding Team also informed as were Human Resources and Information Governance. The incident was recorded on the Datix incident Management System at 16:08 on 17/04/2024. Further Actions: Initial incident grading matrix completed. IG incident investigation report started. IG Training compliance checked (department is compliant). IG contacted senior department lead to establish the process they have in place for releasing information. Audit of department arranged, with particular attention to how telephone calls are managed. IG to attend team meeting to discuss how these calls should be handled. Lessons learnt to be circulated to the Trust via internal comms. Upcoming face to face training delivered by IG will include a stronger emphasis on the importance of confirming the right to access information and confirming ID over the telephone. IG to review Radiology Staff Handbook to see if content is appropriate and there are no gaps in the content. Radiology team are working with HR around the staff disciplinary process.

There have been no fines issued by the ICO to MWL in 2023-24. However, due to a number of complaints made directly to the ICO concerning the processing of Subject Access Requests (SARs) in October 2021, the former STHK had been notified that they were on an ICO Infringement list, and should further concerns have arisen, another review would have been undertaken by the ICO. This Infringement notification has been carried across to MWL, however the Access Team is now under IG Management as of January 2024, a move which was agreed by the Executive Team in 2021 but not carried out under STHK, it has since happened under MWL in January 2024. The Executive Team wanted assurance that all SAR processing across the Trust would be subject to the relevant IG checks to try and reduce further similar breaches. The ICO have been notified of the move. The IG Team are now working with the Access Team to review all processes and have in May 2024 process mapped the service with the help of a Business Change Manager. Work is ongoing.

Reporting & Monitoring

Progress against MWL's DSPT and compliance with relevant legislation is monitored by the Head of Risk Assurance & Data Protection Officer (DPO) and the IG Steering Group.

Progress reports are presented to the IG Steering Group and subsequently to the IM&T Council, then ultimately to the MWL's Board by the Senior Information Risk Owner (SIRO).

Any standards or areas of compliance not being met require action plans to be prepared, which will be monitored to ensure improvement and compliance.

The Year Ahead

The next 12 months will see MWL continue to build upon it's IG Strategy and will ensure it remains compliant with the DSPT, data protection legislation and its own IG Framework. Maintaining compliance will occur through planning and day to day activities, which will need to be balanced against the needs of the organisation.

In 2023-24 an IG Workplan was introduced, which was monitored by the IG Steering Group and highlighted the progress in each area required to ensure MWL's adherence to not only the DSPT but Data Protection law as a whole. It was presented at the IG Steering Group in June 2024 to show the final status of each area for 2023-24 – all complete. The IG Workplan details what work the Trust will need to carry out during the course of this year to ensure it remains on track with its compliancy. A new IG Workplan for 2024-25 for MWL will be in place as of July.

This year the following areas will be of primary focus:

- **To create and implement an MWL IG Workplan for 2024-25** – The IG Workplan details what work the new Trust will need to carry out during the course of this next year to ensure it remains on track with its compliancy. This will keep the new Trust in line with the DSPT and data protection legislation. The former IG Workplan contained 21 workstreams, the new IG Workplan will contain 22 as it will include the processing of Subject Access Requests which now comes under IG Management. The IG Team will ensure there is a continuous review of the IG Workplan throughout the year and provide assurance via the IG Steering Group.

- **Complete the DSPT recommendations** – There are recommendations that have been produced by the Internal Auditors after their assessment of the MWL's DSPT. An action plan will be produced identifying action owners. This action plan will be monitored under MWL's IG Steering Group.

- **To fully embed the Access Team into IG and support this workstream** – The Access Team who process Subject Access Requests (SARs) moved into the IG Team in January 2024 following a notification from the ICO, previously they were part of Legal Services. The IG Management Team along with the Access Lead have started a full review of this service which has included a current state process mapping session. It is important that the SARs are being processed in line with data protection legislation, which previously was not happening and to ensure that the team are processing 'pure' SARs which again has not been happening, for example CCTV footage which is not a classed as SAR as third-party information is required. There is work to streamline the service and make it more efficient whilst adhering to our legal obligations. Progress will be reported to the IG Steering Group.

- **To implement the Individual Rights Policy** – A new area to the Trust, the IG Management Team must train up the IG Team including the Access Team on what these Individual Rights and

how they need to be processed. Logbooks will need to be created and statistical information fed into the IG Steering Group.

- **Establish Face to Face IG Mandatory Training Sessions** - The IG Team have seen the benefits of being on site through walk around audits and meeting members of staff when guiding them through data breaches. The IG Team will look to introduce the option of attending face to face IG Mandatory training sessions, where possible and in conjunction with 'Training Needs Analysis - TNA', for staff. This will be alongside the online module and IG workbook and hopefully open up more options to staff. The aim is to ensure compliance remains buoyant and that key IG messages are brought to life, making them memorable – instilling 'think before you act' in order to reduce data breaches.

- **Continue with Due Diligence Checks - It** is important that checks are in place where systems and initiatives process personal data. The IG Team do this through reviews of Data Protection Impact Assessments, Due Diligence Questionnaires, Data Sharing Agreements and Contracts. The IG Team must know if a 'project' is still live, if any changes have been made and if the documentation needs updating or retiring. This allows the team to check that the data is still being processed in line with the law. Often project managers / service leads forget to link in with the team and so the IG Team are looking at conducting regular reviews, ideally annual reviews on the documentation they hold through their logbooks. Due Diligence Questionnaires also enable the supplier to update and refresh their information if they still hold a contract with the Trust. Checks have been paused due to resourcing issues; these do need to continue following the DSPT audit.

- **Continue to work with the IT Security Team** – there are key workstreams that require close working with the IT Security Team, these are completion of the DSPT, Data Protection Impact Assessments, Due Diligence Questionnaires, Risk Assessment forms (i.e., Working Abroad), email searches for Subject Access Requests, training (specifically phishing, ransomware) and general advice. It is important this relationship is maintained in order to provide the Trust with assurance that all data security areas are being looked at, reducing silo working and demonstrating a collaborative approach to support staff members in achieving their end goal.

- **Continue to implement Information Asset Registers (IARs) across the Trust** –. There is a need to understand where in MWL personal data is processed and to ensure this data can be processed legally, is being held as securely as possible and to identify any risks. With the coming together of departments its even more important to understand where the data sits and who can access it. The completion of IARs will continue and any high risks will be highlighted to the SIRO. This work will sit alongside Data Flow Mapping which ensures that any outflows of data are done via a secure manner, i.e., secure email. Required by the DSPT.

- **Continued use of the Data Breach Investigation Report** – Following on from the success of MWL's first year of implementing the data breach policy which saw 895 data breaches being investigated and the completion of IG Incident proformas when required, the IG Team want to ensure this good work is continued and action plans are drawn up to support the data breach and are supported by the IG Team. The proformas not only provide all management that a

serious / near miss data breach is being managed but also provides the individual affected with assurance that is has been investigated thoroughly. These proformas have fed into wider complaints received by the Trust.

Conclusion

As MWL's first year comes to a close the IG Team can confirm that the Trust has implemented the key IG foundations which are required to ensure the Trust is meeting its data protection obligations and IG Framework and Strategy. This has been demonstrated by the completion of MWL's first Data Security and Protection Toolkit (DSPT). Not only were the Trust able to provide evidence on all assertions (even non-mandated) but this evidence was verified by the Trust's external auditor who have awarded the Trust's DSPT '**substantial assurance**.' The DSPT looks at the robustness of the processes that have been put in place such as; the reporting and investigation of data breaches, the completion of Data Protection Impact Assessments (DPIAs), data sharing agreements, data processor agreements, the delivery and monitoring of IG training and awareness, providing advice and guidance on a range of data protection queries to name a few areas.

This year as MWL, we will continue to build on these foundations and continue to work with internal departments across the Trust to raise awareness of IG, what it is about and what we are here to do. This will also include picking up on DSPT recommendations made by auditor which will further strengthen what we have in place. In addition, as an IG Team we will continue to work closely with our partner organisations such as Cheshire and Merseyside ICB and Cheshire and Mersey Health Care Partnership to ensure any commissioned services / projects processing personal data which link us as a commissioner and / or provider are fully IG assessed and supported before implementation. This is welcomed and required for cross organisational and collaborative working.

The MWL's IG Steering Group will continue to monitor the progress of MWL's IG Agenda, to ensure the IG Team receive full support, so that compliance can be maintained, processes are embedded and improved upon and proactive involvement occurs as a new organisation.

Freedom of Information Act - Annual Report 2023/24

Summary: This report is designed to give the Trust Board assurances that MWL was compliant with the Freedom of Information Act. This report summarises the key points of FOI compliance for 2023-24.

Since the formation of MWL in July 2023 till the end of March 2024, 824 FOI requests were received, at the time of writing this report, 88% of the requests received were completed, of those completed requests, 56% were completed within the 20-working daytime frame.

	2023 (July) / 2024 (March)
Requests received	824
Requests completed	88%
20 working day compliance	56%

Introduction

As a public authority MWL is required to action and respond to Freedom of Information (FOI) Requests under the legislation 'the Freedom of Information Act 2000.' The public are able to request non personal information about MWL and its activities.

Anyone can make an FOI request and the organisation must respond to the request within 20 working days. Failure to do so could result in a fine or warning from the Information Commissioners Office.

The Chief Executive who has overall responsibility in MWL for the FOI Act delegates the responsibility for the implementation and monitoring of the Act to Anne-Marie Stretch, who is the Deputy Chief Executive (also known as the Executive FOI lead) at MWL. The Executive FOI Lead ensures that MWL complies with the legislation and takes overall ownership of MWL's FOI Policy, making sure systems and procedures that are established are reviewed to support the FOI process.

The Information Governance (IG) Team through dedicated resources, process, coordinate, monitor and report all FOI requests. This includes following all administration procedures and record keeping in line with MWL's FOI policy and the FOI Act.

This report is designed to provide the Trust Board with assurance that MWL is compliant with Freedom of Information legislation. Statistical analysis of the requests and responses for July 2023 – March 24 will be shown here.

Further analysis is available on request if members of the Board would like more information on anything not discussed in this report.

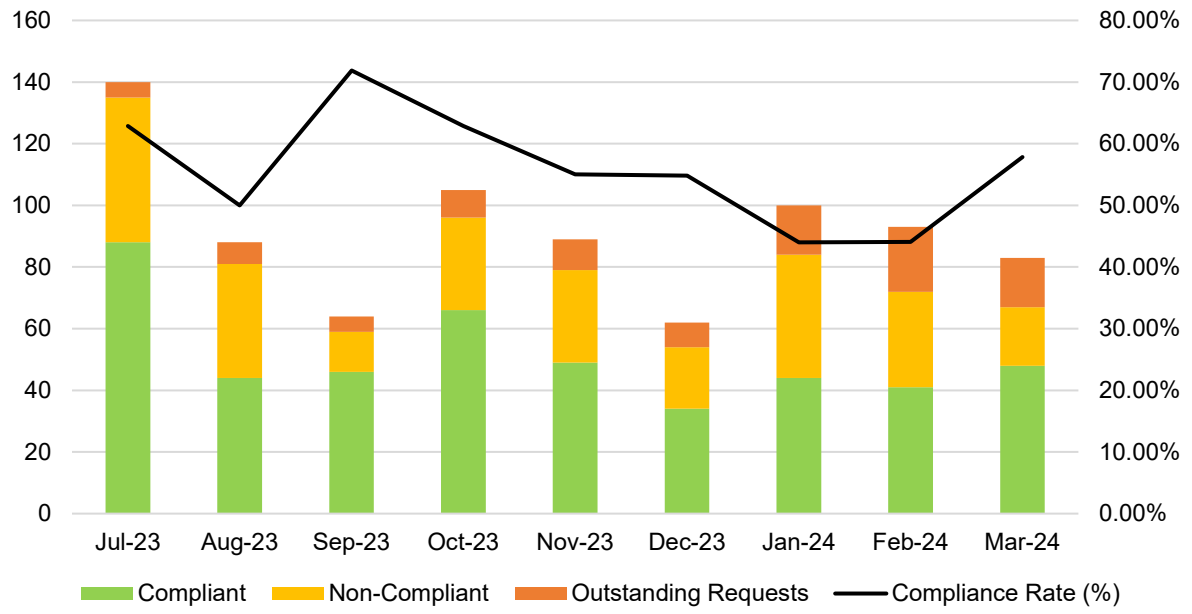
Performance

The overall compliance figure shows a slight decrease on the previous year's compliance levels in terms of completing the requests.

- The areas of MWL that received the most requests to answer were Human Resources (174), Finance (147), Business Intelligence / Information (141), Procurement (95), Pharmacy (83), IT Services (68), Estates (64), and Radiology (53).
- 56% of requests were answered within the 20-working day timescale.
- September 2023 saw the highest rate of compliance with 72% of requests responded to within 20 working days.
- 88% of all requests received in the financial year have been responded to, the remaining 12% of requests are still open.
- Requests originated predominately from the commercial sector (330, 40%), members of the public (141, 17%), and media organisations (109, 13%).
- The top 3 categories of requests that were received were: “About the Trust” (233), “What and How we Spend” (204), and “Lists & Registers” (176).

Table 1 below shows the requests completed throughout the year and the monthly compliance with the 20-working daytime scale.

Table 1 – Update (July 2023 – March 2024)



Areas to Note

- The nature of the requests that are being received have become more complex which often results in 1 FOI request having multiple questions for different departments. The majority of FOIs contain at least 1 finance question which increases the number of FOIs receive, far more than any other department. This means that the approval process is taking longer.

- Although there is work ongoing to bring departments together across MWL most requests are still being sent to 2 departments to get the information as MWL for example Radiology that sat under STHK and Radiology that sat under S&O.

- Staff movement within departments has delayed FOIs been answered as the IG Team locate the correct staff member.

- Since October 2023 the IG Team have allocated a Senior IG Officer to work solely on the FOI workstream to drive up compliance. This IG resource has not been backfilled and although has provided assurance to the Exec FOI Lead that the IG Team is doing everything they can to move the FOIs along some IG duties have had to be paused which is not sustainable.

Areas of Improvement in 2023-24

- As staff movement across MWL settles the IG Team will work with each department to gain a list of contacts who can support the Freedom of Information requests. The IG Team will ensure FOI training and further guidance is provided so that responders are comfortable with the process and understand the approval process before information is released to the requestor.

- The IG Team will liaise with the key departments such as HR, Finance, and IT to get publication schemes in place which will provide the information that is most frequently asked. This will mean that the IG Team can signpost requestors, easing pressure on teams across MWL.

- The FOI publication to be moved to the main MWL website as a section of the 'About the Trust' section – again to enable the IG Team to redirect.

- To work with IT Apps and Development Team on a new FOI Logging System which will allow the IG Team to manage each FOI at the question level instead of viewing the FOI as a whole. Staff will only be sent the questions relevant to their area. This will mean that FOIs that cover several areas will be more efficiently managed.

- To address the recruitment / resource pressures within the IG Team to ensure the FOI workstream is sufficiently resourced.

Conclusion

MWL's FOI process has seen each Executive Lead reviewing and approving FOIs for their respective areas which certainly has resulted in the process becoming more streamlined by making each Executive Lead aware of what information was being requested and released. This approval process will continue.

The FOI requests being received by the Trust are considered not 'straight forward' and result in multiple departments having to contribute to just one, combine this with legacy STHK & S&Os departments

coming together and in a lot of cases still having to go to two sources to pull the information as the information is yet to be merged has meant that the Trust's overall compliance is a fair representation.

As MWL, the IG Team will continue to implement the FOI process and work with the departments to see where information can be published. All members of the IG Team have been trained in the FOI process and there is daily cover.

The IG Team will continue to report compliance at the IG Steering Group and at the IM&T Council, where risks will be raised if required.

Report Ends.

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	31 July 2024
Agenda Item	**TB24/057**			
Report Title	Learning from Deaths 2023/24 Q2/Q3/Q4 report			
Executive Lead	Dr Peter Williams, Medical Director			
Presenting Officer	Dr Peter Williams, Medical Director			
Action Required		**To Approve**	X	**To Note**

Purpose

To describe the mortality reviews which have taken place throughout the Trust and provide assurance that deaths occurring in hospital undergo a robust review to identify lessons which can be learned.

Executive Summary

At legacy St Helens and Knowsley Teaching Hospitals NHS Trust (STHK), of 1,064 deaths in Q2 and Q3 of 2023/24, 201 have undergone a Structured Judgement Review (SJR) with 40 outstanding. Of those cases reviewed, three were rated Amber (subject to detailed review and discussion at Mortality Surveillance Group) and none as Red.

At legacy (Southport and Ormskirk Hospital NHS Trust) S&O, all 251 deaths in Q4 of 2023/24 underwent Medical Examiner review. In 42 cases, learning was identified, and 13 cases underwent a Structured Judgement. Of those cases undergoing SJR, one case was rated as Poor/Amber. Of those cases reviewed by the Medical Examiner which are awaiting SJR, four provisionally had their care rated as “Poor” and two as “Red” (subject to detailed review and discussion at Mortality Operational Group).

Financial Implications

None

Quality and/or Equality Impact

Learning from Deaths contributes to the Trust’s continuous learning and patient safety cultures

Recommendations

The Board are asked to note the Learning from Deaths 2023/24 Q2/Q3/Q4 report

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care - Pathways
	SO4 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. **Outcome from reviews undertaken**

STHK - Number of reviews carried out Q2 2023/24 – July/September 2023 (492 deaths in Quarter)

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
108 *(23)*	42	15	25	3	0

STHK - Number of reviews carried out Q3 2023/24 – October/December 2023 (572 deaths in Quarter)

No. of reviews *(outstanding)*	Green	Green with Learning	Green with positive feedback	Amber	Red
93 *(27)*	24	17	14	1	0

S & O Number of reviews carried out Q4 2023/24 – January /March 2024 (251 Deaths in Quarter)

No. of reviews *(outstanding)*	Excellent	Good	Adequate	Poor	Red
13 SJRS	3	5	4	1	0
ME reviews with identified learning	0	37	0	3	2

	Summary	SJR Rating	Comments
STHK SJR	68 year old female, post op death following small bowel ischaemia, caecal perforation, and small bowel obstruction	AMBER	Reviewed at June Mortality Surveillance Group (MSG) – feedback and review from Radiology. Further detailed surgical review has been requested.
STHK SJR	51 year old female, Respiratory failure, pneumonia, spina bifida	AMBER	Went to January MSG – referred to Incident review Group– action contained in update 22 below

STHK SJR	74 year old female post op death. Pulmonary embolism, #NOF, pneumonia	AMBER	Went to June MSG – awaiting information from Critical Care
STHK SJR	57 year old male, cardiac arrest death. CAP	AMBER	To be discussed at July MSG
S&O SJR	Patient with NG Tube inserted but delay noted in starting feed (Not contributing to death)	AMBER	Nutrition provision and end of life care

2. Key learning points

Update 22	Patients on home ventilation There is a new protocol on EPMA for patients who receive home ventilation (CPAP or NIV/BiPAP). This should be prescribed on admission for patients who have their own machine at home. This will prompt nursing staff to assist the patient to use their own machine whilst they are a hospital inpatient. This protocol is only to be used for patients who are stable from their respiratory condition. Patients who usually use home ventilation but have developed a respiratory acidosis should be discussed with the on-call respiratory consultant before using this protocol or if their respiratory condition changes during their inpatient stay. To prescribe home ventilation in EPMA: ADD DRUG > Protocol > Home Ventilation	Thoracic imaging in older patients with suspected chest trauma All patients with a high-risk mechanism of injury or a penetrating chest injury require CT chest. If the patient is >65 years, they also require CT chest if they have any of the following: 1. COPD/chronic lung disease 2. Anticoagulation 3. Hypoxia (sats <94% or <88% with chronic lung disease) The Thoracic Injuries Pathway can be found on the Intranet/A-Z of services/A&E/Major Trauma / Chest
Update 22 continued	PICC (Peripherally inserted central catheter) learning PICC lines are rapidly becoming an acceptable alternative to traditional central venous catheters and tunnelled catheters, with advantages of patient comfort, reduced insertion complications, reduced infection rates and ease of placement. They have the potential to provide continuous venous access for patients throughout the duration of a treatment episode. Once inserted, the PICC must not be used until the position of the catheter has been confirmed by x-ray using the radiological anatomical landmarks of the	Respect of patients DNACPR This was a LD patient with complex underlying medical conditions who had previously expressed that he would not wish to receive CPR in the event of a cardiac arrest because he felt he had lived a good life already and didn't feel there was any reason to attempt to prolong it. Although the patient did not bring his DNACPR form into hospital with him, a new form was completed in accordance with Trust policy. When he had an unexpected cardiac arrest, his wishes were respected, and he was allowed to die peacefully as per his request. Patient autonomy is one of the

	carina/shadow of the pericardiac sac, and the tip should not me more than 2.5 vertebrae below the carina at that point. The x-ray should be reviewed by a competent staff member to determine correct positioning of device. This does not need to be a member of the MET team. For further details please see the Policy for the placement and care of all indwelling intravenous and subcutaneous catheters on the intranet.	core principles of medical ethics, and we must respect this at all times.
Update 21	Neurological assessment in the confused patient Patients presenting with acute confusion should have a neurological assessment carried out and documented in their medical notes at the time of their initial assessment. This will result in earlier identification of those with a focal neurological deficit and prompt earlier stroke team involvement where appropriate. It also provides a baseline assessment that can be used for comparison later in the hospital admission.	Assessment of Pain Patients who are confused cannot reliably indicate whether they are in pain. The Abbey Pain Scale is a tool that is validated for use in patients who cannot verbalise their level of pain. It is available via the trust intranet and should be used as an alternative to the standard 1-10 scoring system used in other patient groups. Click Here for the Abbey Pain Score Tool
Update 20	Adopting a "comfort first" approach There have been some excellent examples of end-of-life care in recent months, particularly in frail older patients who may benefit from a "comfort first" approach. In frail patients with a limited life expectancy, carefully consider the burdens of treatment as well as the benefits. Communication with the patient and their family is vitally important to establish patient wishes.	Management of the delirious patient Delirium can be challenging to manage, particularly in the patient with an underlying dementia diagnosis. The delirium bundle can be found on the trust intranet. Further advice can be sought by contacting Marie Honey, Nurse Consultant for Older People, psychiatry liaison team or referring to the Department of Medicine for Older People for specialist advice.
Further updates can be found on the intranet Learning from Action		

Learning into Action

- Following each quarterly submission to Board, examples of learning are reported and shared throughout the organisation to ensure that all staff are given the opportunity to determine how this could impact on their practice and try and make things better. The leaning is shared at team brief and via all Trust councils. The learning also appears on the intranet. http://nww.sthk.nhs.uk/about/learning-into-action

Coroners Case (Incident occurred in March 2023 but Inquest concluded in April 2024)

Failure to recognise an unexpected post-operative deterioration until emergency laparotomy was performed, with ensuing delay in transfer to critical care.

Lessons Learned:

- Clinical deterioration can be reflected in:
    - Worsening laboratory tests
    - NEWS score
    - Worsening pain scores
    - A prolonged length of stay for elective patients
    - General concern, from patients or relatives.
- Ward staff should escalate any patient who they have concerns about in the absence of NEWS triggers and scores via the MET
- Wards which do not routinely manage critically unwell patients should be targeted for training in recognition and treatment of the deteriorating patient

Actions Taken:

- Gynae Consultant of the week has oversight of all in-patients ensuring consistent senior doctor ward round with clear escalation plans and discussion with operating team as necessary
- Deteriorating patient policy and proforma education for nursing and medical teams in gynaecology wards
- Pilot of “Martha’s Rule” at Southport Hospital with a view to rollout at Whiston Hospital

Appendix 1

Total Deaths in Scope –Mortality Surveillance Group

Check against NWB downloaded LD List **'Learning Disability Death'**	LeDeR Death Review[2]
Check against MHA and DOLS list **'Severe Mental Illness Death'**	SJR[3]
Check if age < 18 yrs., but > 28 days **'Child Death'**	SIRI & Regional Child Death Overview Panel (CDOP)
Check if < 28 days and > 24 weeks gestation **'Neonatal death or Stillbirth'**	Joint Perinatal Audit Meeting (SJR), & C&M 'Each Baby Counts' Panel
Check if spell includes obstetric code (501) **'Maternal Death'**	PSIRF/SIRI & National EMMBRACE system (also perinatal)
Check against current year 'Alert List' **'Alert Death'**[5]	SJR
Check DATIX for Safety Incidents with "Death" recorded as outcome **'Incident Death'**	SJR or PSII
Check DATIX for complaints/PALS/staff concerns **'Concern Death'**	SJR
Check against Surgical Procedures List **'Post-op Death'**	SJR
Random Sample, include all low risk deaths[4] **'Sample Deaths'**	SJR
Cardiac Arrests that result in death **'Cardiac Arrest Deaths'**	SJR

1. All inpatient deaths at STHK, transfers to other hospitals or settings not included
2. LeDeR – nationally prescribed process for reviewing LD deaths
3. Structured judgement review, currently STHK tool
4. Low risk deaths as defined by Dr Foster/HED grouping
5. Alert deaths; include any CQC alerts or internal monitoring alerts from the previous year
6. Random sample to ensure monthly we cover at n30 or 25% whichever is the greater
7. Cardiac Arrests that result in death

Appendix 2

Forums and channels were learning is shared within the Trust

Forum/Communication Channel	Chair	Support
Trust Board	Richard Fraser	Juanita Wallace
Clinical Effectiveness Council	Peter Williams	Helen Burton
Patient Safety Council	Rajesh Karimbath	Kim Jeffrey
Patient Experience Council	Anne Rosbotham-Williams	Francine Daly
Team Brief	teambrief@sthk.nhs.uk	
Intranet Home Page	Lynsey Thomas	
Global Email	Elspeth Worthington	Jane Bennett
Medical Division Safety and Governance Meeting	David Snow/Gemma Causer	Joy Woosey
Surgical Division Safety and Governance Meeting	John McCabe/Helen Hurst	Gina Friar
Women and Children's Division Safety and Governance Meeting	Kevin Thomas/Sue Orchard	Julie Rigby
Community and Clinical Support Division Safety and Governance Meeting	Vinod Gowda/Tracy Greenwood	Sam Barr
ED and AMU Teaching	Ragit Varia/Sarah Langston/Michael Aisbitt	Ann Thompson
Foundation Year Teaching	Sue Priestley (W&StH)/Ann Holden (S&O)	

ENDS

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	31 July 2024
Agenda Item	**TB24/058**			
Report Title	Learning from Deaths Annual Report 2023/24			
Executive Lead	Dr Peter Williams, Medical Director			
Presenting Officer	Dr Peter Williams, Medical Director			
Action Required		**To Approve**	X	**To Note**

Purpose

To summarise the work of the Learning from Deaths Team at Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) over the last 12 months and the learning which has been made following the review of deaths which have occurred across the Trust

Executive Summary

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) has well-established processes at both legacy trusts to review deaths occurring in hospital and identifying areas of learning where practice can be improved.

The teams involved in review and learning from deaths (LFD) are now working together to ensure that the processes of review are robust and consistent, and that learning is shared across the whole Trust. Where concerns have been identified these have received further peer review and escalated as appropriate via the Trust's Patient Safety processes.

The predominant themes were around care at the end of life and improving flow through the Emergency Department. Lessons were learned around the reversal of anticoagulation and administration of medication and the importance of communication (including use of translation services) for patients reaching the end of their life. Lessons learned are shared widely throughout the Trust and Divisions will create action plans and evidence their completion to address any concerns.

Financial Implications

None

Quality and/or Equality Impact

The Learning from Deaths process promotes continuous learning in order to foster a culture which leads to ongoing improvement of care, pathways and services.

Recommendations

The Board is asked to note the Learning from Deaths Annual Report 2023/24 for assurance.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
	SO5 5 Star Patient Care - Systems

	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance
	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

1. Introduction

Learning from deaths of people in their care can help providers improve the quality of the care they provide to patients and identify where they could do more.

A CQC review in December 2016, *"Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England*" found some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care.

In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. We are now helping trusts to meet the requirements of the new guidance.

Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL) has embraced the Learning from Deaths (LFD) Process to encourage continuous improvement and enable lessons to be learned when patients die in hospital.

2. Approach to Mortality Review across the Trust

Both legacy Trusts at MWL have different process for reviewing and learning from deaths. Although there are differences in the approach, both provide robust, consistent and transparent review of deaths in hospital.

	Process	**Reporting to**
Legacy S&O	Merged ME and LFD process All deaths in hospital reviewed by Medical Examiner Team. Outcome recorded on Careflow system. Any concerns around lapses in care are logged on DATIX, cases with learning are referred directly to clinical directors. SJR requests are made for those without concerns but meet NQB definitions. Mortality Outcomes Group reviews learning from ME reviews, SJRs as well as SMR analysis	Clinical Effectiveness Council
Legacy STHK	Separate ME and LFD process Deaths in hospital within scope (Appendix 1) referred for SJR and review at Mortality Surveillance Group. Any concerns around lapses in care logged on DATIX.	Clinical Effectiveness Council

The process to merge the two review groups (Mortality Outcomes Group and Mortality Surveillance Group) has begun in order to have a single Trust-wide group for review of in-hospital deaths. Both groups work closely with Specialist Palliative Care Teams to identify actions which can be taken to improve End of Life Care.

3. Annual Review of Deaths across MWL

In 2023/24 at legacy STHK there were 2174 deaths, of which 328 were identified for Structured Judgement Review. Of these, 237 have been completed, the outcomes of which are detailed below.

	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4*	Total
RED	0	0	0	0	0
AMBER	1	2	1	0	4**
GREEN	46	42	35	1	124
GREEN - WITH LEARNING	17	17	16	0	50
GREEN WITH LEARNING - POSITIVE FEEDBACK	20	25	14	0	59
Total	84	86	66	1	237

**Q4 has not yet been reported in full*
*** all 4 cases have been managed via the patient safety incident framework process*

In 2023/24 at legacy S&O there were 937 deaths of which 48 of which have been identified for SJR with 42 completed. the outcomes of which are detailed below.

	23/24 Q1	23/24 Q2	23/24 Q3	23/24 Q4	Total
Very Poor Overall	0	0	0	0	0
Poor Overall	0	0	1	1	2*
Adequate Overall	2	0	5	5	12
Good Overall	7	3	3	3	16
Excellent Overall	6	0	3	4	13
Total	15	3	12	13	43

** both cases have been managed via the patient safety incident framework process*

4. Themes identified in Mortality Reviews in 2023/24

<u>End of Life Care</u>

Usual medication at the end of life

When patients are reaching the end of their life (and may not be able to take oral medication) it is still important to ensure that essential medication is given, if this will help to alleviate symptoms or prevent distress

- Methadone should not be stopped in patients who are already prescribed this drug but can be given via syringe driver if required
- Parkinson's Disease medication can be converted to a patch for patients at the end of life to prevent worsening of symptoms.
- A patient's usual Anti-epileptic medication should not be stopped at the end of life and can be given via syringe driver if required.
- Fentanyl patches must not be removed and should continue to be replaced as patients are dying

Anticipating death and advanced care planning.

Awareness and acknowledgement that patients are reaching the end of their life can ensure that advanced care planning can take place, allowing patients to die in their preferred place of care. Unfortunately in some circumstances, advanced care plans are not followed as intended, resulting in avoidable hospital admission. Close working between Primary, Secondary and Community Care providers ensures that the wishes of patients and their loved ones are followed wherever possible at the end of life.

For patients where death can be anticipated, investigations or interventions with minimal benefit to the patient should be carefully considered, with the involvement of patients and their loved ones in these discussions. Cases have highlighted where supportive treatments for those who were dying were delayed while the patient awaited other interventions. In some of those cases, families have also not felt listened to when their loved one has been ill or deteriorating.

<u>Emergency Department flow</u>

Long waits for admission to a ward for patients seen in the Emergency Department have been noted across the Trust due to increased inpatient length of stay. This leads to ED crowding and delays for patients awaiting a bed. The Royal College of Emergency Medicine estimates that harm can be caused to patients once the delay to admission exceeds 8h. The Trust is working closely with system partners to reduce hospital length of stay which is the main driver of ED overcrowding, with additional resource allocated to maintain safety and quality of care for patients as they wait in the ED.

Mortality reviews frequently identify long waits for patients in ED with an associated impact on the quality of care. Thus far no deaths have been directly attributed to delays in the ED however clinical teams should continue to ensure that patients waiting an inpatient bed receive the same level of care of those in inpatient areas.

5. Lessons Learned from Mortality Reviews in 2023/24

GKI (Glucose/Potassium/Insulin regime)

- This should only to be used with patients who have a definite diagnosis of diabetes. If used in patients that are non-diabetic, this may lead to a detrimental outcome.
  Action – Communication to all clinicians and discussion at junior doctor training.

Palliative Care and End of Life Care

- Blood glucose monitoring may still be required in patients who are diabetic to prevent the distress of a hypoglycaemic episode during the final stages of life
- Prior to using sedating drugs, other causes of agitation should be considered (eg. Constipation, urinary retention, nicotine or alcohol withdrawal)
  Action – Communication to all clinicians in trainee education and clinical governance meetings

Preventing harm from falls

- Following a death in a patient who had suffered a fall in the hospital, a change to the process and guidance for the emergency reversal of anticoagulants in patients with Head Injury has been made
  Action – Update of policy on reversal of anticoagulation and ensure treatments are easily accessible across all sites

Dealing with health inequalities in patients whose first language is not English

- Following a death in ED for a patient whose first language is not English it was identified that some staff members were not clear how to access translation services in emergency situations (A relative helped to translate for the patient in this case)
  Action - A Task and Finish group has been established to review the availability and suitability of translation services both for emergency and elective situations across the Trust. Communication to all staff in Medicine and Emergency Care Division on how to access translation services.

Learning from coroner's cases

Cases which are referred by the Medical Examiner's Team to the Coroner also undergo Trust review and implementation of actions to prevent similar incidents. Inquests into the cases concluded in 2023/34 .

Case 1

Death following an elective procedure

Failure to recognise an unexpected post-operative course and ongoing deterioration until emergency laparotomy was performed, with ensuing delay in transfer to critical care which may have contributed to a patient's death.

Lessons Learned:

- The frequency of consultant review of gynaecology inpatients or for the post operative review by the operating surgeon should be clearly identified
- Clinical deterioration can be reflected in:
    - Worsening laboratory tests
    - NEWS score
    - Worsening pain scores
    - A prolonged length of stay
    - General concern, from patients or relatives.
- Ward staff need to feel empowered to escalate patients who they have concerns about in the absence of NEWS triggers and scores
- Wards which do not routinely manage critically unwell patients should be targeted for training in recognition and treatment of the deteriorating patient

Actions Taken:

- Consultant (hot) of the week has oversight of all in-patients
    - Consistent senior doctors ward round with clear escalation plans and discussion with operating team as necessary
- Deteriorating patient policy and proforma education for nursing and medical teams in gynaecology wards

Case 2

A patient suffered complications following a ruptured uterus. A caesarean section was originally planned electively but had been postponed due to emergency cases taking priority on a single list. The patient re-presented as an emergency and was taken to theatre urgently out of hours. Despite resuscitation from major haemorrhage and eventual transfer to ICU, the lady died from a hypoxic brain injury in the subsequent days.

Actions Taken:

- A clinically led process for planning elective caesarean sections with identification of clinical urgency.
- Separation of the elective and emergency processes so that emergency work does not impact on the ability to do planned elective cases.
- Dedicated elective maternity theatre lists

The Lancashire coroner agreed that death could have been avoided if surgery had proceeded electively but commended the trust for the changes that had been put in place, commenting that 'these will save lives'.

Case 3

A patient was admitted with chest pain at home and a INR >8 on admission. They suffered an unwitnessed fall in hospital sustaining a subdural haematoma. There was suboptimal coagulation reversal and falls risk assessment before and after fall. Following a second fall, CT showed a worsening subdural haematoma which was not suitable for intervention.

Coroner found that the cause of the fall was collapse due to medical causes but that death could have been avoided if reversal of anticoagulation had been completed following the first fall.

Actions Taken:

- Work with nursing teams to ensure falls risk assessments are completed accurately and reviewed following any change in the patient's condition
- Review of the guidance on emergency reversal of anticoagulation to ensure clarity of guidance and availability of reversal agents across Trust

Appendix 1

Total Deaths in Scope – Legacy STHK Mortality Surveillance Group

Check against NWB downloaded LD List **'Learning Disability Death'**	LeDeR Death Review[2]
Check against MHA and DOLS list **'Severe Mental Illness Death'**	SJR[3]
Check if age < 18 yrs., but > 28 days **'Child Death'**	SIRI & Regional Child Death Overview Panel (CDOP)
Check if < 28 days and > 24 weeks gestation **'Neonatal death or Stillbirth'**	Joint Perinatal Audit Meeting (SJR), & C&M 'Each Baby Counts' Panel
Check if spell includes obstetric code (501) **'Maternal Death'**	STHK STEIS/SIRI & National EMMBRACE system (also perinatal)
Check against current year 'Alert List' **'Alert Death'**[5]	SJR
Check DATIX for Safety Incidents with "Death" recorded as outcome **'Incident Death'**	SJR or PSII
Check DATIX for complaints/PALS/staff concerns **'Concern Death'**	SJR
Check against Surgical Procedures List **'Post-op Death'**	SJR
Random Sample, include all low risk deaths[4] **'Sample Deaths'**	SJR
Cardiac Arrests that result in death **'Cardiac Arrest Deaths'**	SJR

1. All inpatient deaths at STHK, transfers to other hospitals or settings not included
2. LeDeR – nationally prescribed process for reviewing LD deaths
3. Structured judgement review, currently STHK tool
4. Low risk deaths as defined by Dr Foster/HED grouping
5. Alert deaths; include any CQC alerts or internal monitoring alerts from the previous year
6. Random sample to ensure monthly we cover at n30 or 25% whichever is the greater
7. Cardiac Arrests that result in death

Appendix 2

Forums and channels were learning is shared within the Trust

Forum/Communication Channel	Chair	Support
Trust Board	Richard Fraser	Juanita Wallace
Clinical Effectiveness Council	Peter Williams	Helen Burton
Patient Safety Council	Rajesh Karimbath	Kim Jeffrey
Patient Experience Council	Anne Rosbotham-Williams	Francine Daly
Team Brief	teambrief@sthk.nhs.uk	
Intranet Home Page	Lynsey Thomas	
Global Email	Elspeth Worthington	Jane Bennett
Medical Division Safety and Governance Meeting	David Snow/Gemma Causer	Joy Woosey
Surgical Division Safety and Governance Meeting	John McCabe/Helen Hurst	Gina Friar
Women and Children's Division Safety and Governance Meeting	Kevin Thomas/Sue Orchard	Julie Rigby
Community and Clinical Support Division Safety and Governance Meeting	Vinod Gowda/Tracy Greenwood	Sam Barr
ED and AMU Teaching	Ragit Varia/Sarah Langston/Michael Aisbitt	Ann Thompson
Foundation Year Teaching	Sue Priestley (W&StH)/Ann Holden (S&O)	

ENDS

Mersey and West Lancashire Teaching Hospitals NHS Trust

Title of Meeting	**Trust Board**		**Date**	31 July 2024
Agenda Item	**TB24/059**			
Report Title	Maternity and Neonatal Services Assurance Report Quarter 1			
Executive Lead	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Presenting Officer	Lynne Barnes, Acting Director of Nursing, Midwifery and Governance			
Action Required		**To Approve**	X	**To Note**

Purpose

To provide assurance on the quality and performance of the maternity and neonatal services across Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL).

Executive Summary

The report details the Q1 position on -:

- Maternity Incentive Scheme (MIS) Year 5 and preparation for MIS year 6
- Perinatal Mortality.
- Incidents, complaints, and Maternity red flags
- Neonatal medication incidents
- Saving Babies Lives (SBLv3). Continuous improvement noted and working towards full compliance supported and monitored by the LMNS.
- Care Quality Commission (CQC) inspection improvement plan update
- Workforce: six monthly staffing papers and one to one care in labour
- Suspension of maternity services and neonatal closures.
- Maternity survey and patient experience update following deep dive presented to Executive Committee.
- Ockenden and three-year delivery plan update

Financial Implications

None as a direct result of this report.

Quality and/or Equality Impact

Not applicable

Recommendations

The Board is note the Maternity and Neonatal Quarter 1 Update.

Strategic Objectives

X	**SO1** 5 Star Patient Care – Care
X	**SO2** 5 Star Patient Care - Safety
X	**SO3** 5 Star Patient Care – Pathways`
X	**SO4** 5 Star Patient Care – Communication
X	**SO5** 5 Star Patient Care - Systems
	SO6 Developing Organisation Culture and Supporting our Workforce
	SO7 Operational Performance

	SO8 Financial Performance, Efficiency and Productivity
	SO9 Strategic Plans

This standardised report template has been developed by the Cheshire and Mersey Local Maternity and Neonatal System (LMNS) and includes the key reporting issues identified for Maternity and Neonatal Services.

1. Maternity Incentive Scheme (MIS)

MIS Year 5 declaration was submitted in February 2024 with feedback initially received that all 10 safety actions have been accepted as compliant.

On 04/06/24 NHS Resolution (NHSR) informed the Trust that they had identified some areas of concern which suggested some contradictions between the Ormskirk MIS declaration and the CQC report which was published on 05 April 2024.

The Trust was requested to review the MIS year 5 evidence with specific reference to Safety Action 8. Compliance for obstetric doctors at maternity emergency / multi professional training and fetal monitoring and surveillance training was identified within the CQC report as being below the required compliance at the Ormskirk maternity unit in contrast to the declaration for compliance to MIS Year 5.

The data provided to the CQC ahead of the inspection on the 07 December 2023 was incomplete and did not include a preceding 12-month compliance data set.

Upon review of the evidence, it was confirmed that the training compliance was higher than that reported to the Quality Committee and Trust Board at the time and met the MIS requirements. The review identified several areas for improvement in the management and governance arrangements for the MIS process which will be addressed as art of the single MWL process and submission for MIS year 6.

A formal response was provided on 20 June 2024 and a response was received on 22 July 2024 confirming that NHSR had reviewed the additional evidence provided and this was sufficient to confirm the Trust had met the requirements of safety action 8.

MIS year 6 was published in April 2024 and the final submission will be due on 03 March 2025. One Clinical Negligence Scheme for Trusts (CNST) premium will be paid for the MWL maternity services and therefore combined evidence from both maternity units will be required.

Leads have been identified for all 10 safety actions and a process put in place to collect and monitor the evidence throughout the year. Updates, assurance reports and the relevant approvals have been mapped to the corporate governance timetable throughout the year.

Current training compliance for MIS year 6.
The requirement is for 90% attendance of each relevant staff group for both emergency/MDT training and fetal surveillance for the period 01 December 2023 to 31 November 2024. The 12-month rolling compliance at the end of June 2024 is: -

PROMPT Emergency and MDT Training Figures for the 12 previous consecutive months up to 30/06/24.

The maternity service has rated compliance as green if over 90%, amber between 80-90% and red if below 80%.

Staff Group (PROMPT)	% Compliance Whiston	Compliance RAG	% Compliance Ormskirk	Compliance RAG
Midwives	94.97%		93.2%	
Maternity Support Staff	90.47%		100%	
Consultant Obstetricians: with	94.44%		92.35	
All other Obstetric Doctors	100%		88.9%	
Obstetric Consultant Anaesthetists	91.66%		58.3%	
All other Anaesthetic Doctors	70.83%		92.9%	
All other Theatre Staff	80%		63.2%	Theatre staff are not required to attend the training for MIS compliance, but it is considered good practice and we continue to include them as part of the maternity MDT.
Midwives	94.97%		92.2%	
Neonatal Consultants	90%		100%	
All other Neonatal Doctors	86.36%		100%	
Neonatal Nurses	77.77%		97%	
Neonatal ANNP	100%		100%	

There are five staff groups that are not currently complaint to the 90% requirement. A trajectory improvement plan is in place to ensure staff are allocated to training dates before the end of November. Changeover of junior medical staff and staff turnover can all impact the compliance levels reduce compliance. All new staff are allocated a training date as part of their induction.

Fetal Surveillance in the Antenatal and Intrapartum Period for the 12 previous consecutive months up to 30/06/24:

Staff Group	% Compliance Whiston		% Compliance Ormskirk	
Midwives	97%		62%	
Consultant Obstetricians	89%		45%	
All other Obstetric Doctors	94%		77%	

Compliance for attendance at fetal surveillance training at Ormskirk is currently below the required target. The fetal surveillance midwife had been on long term sick which affected the provision of training earlier in 2024. Support from the Whiston site has been provided to increase resilience. Additional training dates have been arranged to ensure compliance by November, if not sooner.

2. Quality and Safety

2.1 Clinical Outcomes/ Dashboard

Maternity and Neonatal Dashboards
Performance is monitored via our local and regional dashboards. Regional and local clinical dashboards are monitored via local governance and presented via the Corporate Performance Report (CPR) at Quality Committee.

Current areas of focus include:

- Carbon monoxide (CO) screening at 36 weeks gestation is a process indicator for Element 1 of Saving babies lives Care bundle. Trust performance was an outlier but we have reported improvements since and this will be monitored through internal and external dashboards.
- Smoking - A continued focus for referral of women who smoke at booking aimed at supporting a smoke free pregnancy and reducing the percentage of smokers at the time of delivery. The Whiston service commenced an inhouse model in January 2024 following the appointment of two tobacco dependant advisors on fixed term contracts and alongside changes to the maternity information system in March 2024 has resulted in 100% compliance in May for the first time. Ormskirk has seen a reduction in compliance to 78.6% and focussed work to improve compliance in progress.

2.2 Perinatal Mortality

Perinatal mortality includes any fetal loss from 22-week gestation, stillbirths, and neonatal deaths in the first 28 days of life. MBRRACE-UK is notified of all eligible perinatal deaths and these deaths are reviewed using the national Perinatal Mortality Review Tool (PMRT).

All perinatal mortality incidents have an initial multidisciplinary review to determine the degree of harm caused, to identify if there is any immediate learning or if the incident is required to be externally reportable.

Quarter 1: 2024/25	
April 2024	0
May 2024	1 early neonatal death
June 2024	1 Stillbirth

For the Q1 reporting period (2023/24) there were two reportable deaths.

Both cases have undergone a multidisciplinary review, commencement of the PMRT review process which includes seeking parents' views of care to ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments. Care was reviewed and assessed for all cases using the MBRRACE categorisation.

MIS Safety Action 1 relates to the requirement to use National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths for the period 08 December 2023 to 30 November 2024 to the required standard.

2.3 Serious Incidents

Never Events
There have not been any never events for this reporting period.

STEIS Reportable Incidents
Serious incidents (SIs) are reported as they occur, evidenced on the regional dashboard which is updated monthly and reported to Board via the serious incident reports

	Maternity Q1 2023/24	
	Whiston	**Ormskirk**
April 2024	No Incidents	No Incidents
May 2024	No Incidents	No Incidents
June 2024	No Incidents	No Incidents

2.4 Maternity and Neonatal Safety Investigations (MNSI, formerly HSIB)

MNSI undertake independent investigations into incidents within Maternity Services which fall under a defined criteria that includes maternal deaths, stillbirths and babies that require cooling.

MNSI triage reported cases following a Trust referral based on the following criteria:

- Baby's MRI result.
- Family concerns regarding the care given.
- Trust concerns regarding the care given.

All investigations accepted by MNSI are reported on STEIS as a serious incident. Cases not accepted by MNSI are investigated at the Trust with a full MDT review including an external representative from the Cheshire and Merseyside system.

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

MNSI Cases April 2019 to June 2024	STHK	S&O	MWL Total
Total Referrals	51	16	67
Referrals / Cases Returned to the Trust / Rejected	20	6	26
Total Investigations to Date	31	10	41
Total Investigations Accepted	31	10	41
Total MNSI Investigations Completed	29	10	39
Current Active Cases	2	0	2

There have not been any new reported cases in Q1.

2.5: Neonatal medication Incidents

MWL Neonatal Medication Errors (as identified via DATIX systems) Q1 (2024-2025)

During Q1 there have been 14 medication incidents within the Neonatal Units (NNU).

Neonatal medication incidents Q1 (2024-2025)	
Location	Number of medication incidents reported
Ormskirk	10
Whiston	4
Total	14

Category of incident	Number	% of incidents
Medication - storing	1	7.1%
Medication - prescribing	2	14.2%
Medication - administration	7	50%
Medication - delivery	2	14.2%
Medication - preparing	2	14.2%

Key findings/themes during this period:

- Missed gentamicin levels.
- Unintentional omission or delay of medicines
- Prescribing errors
- Communication between ward areas in relation to medicine administration

Action log:

Location	Action	Due date
Ormskirk and Whiston	**Introduction of new prescription chart for NNU.**	October 24
Ormskirk	**Review current neonatal sepsis pathway**	December 24
Ormskirk	**Introduction of drug library on NNU**	October 2024
Ormskirk	**Introduction of IV drug monographs**	October 2024

Pharmacy continues to be involved in MDT induction and training e.g.

- Ormskirk site, Pharmacy supports induction and specific educations sessions at staff study days.
- Whiston site, Pharmacy delivers Paediatric Prescribing Teaching every couple of months as new prescribers join the Trust.

Paediatric Pharmacist education sessions are also delivered to the Pharmacy team through ‘ten-minute teach’ and weekly pharmacist education meetings. This is to support learning, to reinforce good prescribing and to keep staff engaged with medication safety.

2.6 Saving Babies Lives (SBL) Care Bundle

SBL is one of the actions in MIS.

MWL are fully compliant with all the elements of Saving Babies Lives Care Bundle 2 and continuing to work towards Saving Babies Lives Version 3.

Elements 1 to 5 remain the same as version 2 below with the addition of a sixth element relating to diabetes.

The KPIs for the care bundle are –

- Element 1: Reducing Smoking in Pregnancy
- Element 2: Risk Assessment and Surveillance of Fetal Growth Restriction
- Element 3: Raising Awareness of Reduced Fetal Movements
- Element 4: Effective Fetal Monitoring in Labour
- Element 5: Reducing Preterm Birth
- Element 6: Management of pre-existing diabetes

Progress in implementing the care bundle for Q1 as validated by the LMNS is :

Whiston site

	Baseline assessment	Assessment 1	Assessment 2	Assessment 3
Review Quarter	Q2	Q3	Q4	Q1
Assurance review date	17/11/23	07/12/23	07/03/24	06/06/2024
Element 1	10%	50%	60%	90%
Element 2	70%	75%	80%	85%
Element 3	50%	50%	100%	100%
Element 4	60%	100%	80%	60%
Element 5	37%	74%	93%	93%
Element 6	33%	67%	83%	100%
Total	40%	71%	83%	88%

Ormskirk site

	Baseline assessment	Assessment 1	Assessment 2	Assessment 3
Review Quarter	Q2	Q3	Q4	Q1
Assurance review date	16/11/23	08/12/23	22/03/24	27/06/2024
Element 1	60%	100%	100%	100%
Element 2	60%	75%	95%	100%
Element 3	0%	50%	100%	100%
Element 4	80%	100%	60%	80%
Element 5	26%	85%	96%	96%
Element 6	67%	83%	100%	100%
Total	47%	84%	94%	97%

2.7 Care Quality Commission CQC Review

The maternity service received the final CQC report on 05 April following its inspection on 07 and 08 December 2023.

The report rated the services as:

- Whiston: Good overall and good for being safe and well-led
- Ormskirk; Good overall and for being well-led. It was rated requires improvement for being safe.

Whiston unit had three should do actions. Ormskirk Unit had three must do actions and five should do actions. There is a CQC action plan to deliver the improvement which is monitored via the Women and Children Divisional management team and assurance is provided via the CQC Assurance Group and Quality Committee. The action plan has made good progress and is on target to deliver the improvements.

2.8 Safety Champions

The aim of Safety Champions is to ensure seamless communication from 'floor to Board' with a focus on Maternity and Neonatal issues and improving safety and outcomes.

Safety champions and Maternity and Neonatal Maternity Voices Partnership (MNVP) relate to MIS safety action 7 and 9 with a reporting period from 02/04/24 to 30/11/24.

Schedules for Safety Champion Walkarounds for both sites for 2024 are in place and they will meet frontline clinical and non-clinical staff alongside women and their families to enable to an additional opportunity for feedback about any safety concerns to be raised, which are then reported at the Maternity safety champions meetings.

The Maternity Safety Champions review the Perinatal Quality Surveillance Model (PQSM) tool monthly which is attached in Appendix 1.

The NED and Executive Safety Champions additionally undertake walkarounds with feedback also presented at the Maternity Safety Champions meetings.

Both sites have MNVP leads in post with feedback into the Safety Champions meetings.

A 15 steps Maternity and Neonatal event took place 9th Feb on the Ormskirk site which is a review of maternity and neonatal services from a service user perspective led by the MNVP lead. The review looks at four key themes: welcoming and informative, friendly, and personal, safe and clean and organised and calm. The Ormskirk report is attached in Appendix 2 with many areas of positive feedback reported.

A 15-step event for Whiston was undertaken in Q1 2024/25 on 16 May. The preliminary feedback was positive. The full report is pending from the MNVP lead and will be shared when available.

The MVNP also visits the NNUs regularly engaging with families and obtaining feedback from them in relation to their experience.

2.9 Complaints and Claims.

Maternity: There have been eight formal maternity complaints in Q1. The complaints received in Q1 are on track to be answered within the target timeframes. There was one late response for a complaint in Q4 2023/24 which has now been finalised.

	April 2024		May 2024		June 2024		Total	
	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston	Ormskirk	Whiston
Number of Complaints	0	0	4	2	0	2	4	4

The Ormskirk complaints relate to clinical care with one case being a historic complaint from 2014. The issues raised relate to a third-degree tear, cancelled ultrasound scan and two concerns relating to labour and birth which includes the historic complaint. All complaints responses are in progress.

The Whiston complaints relate to an early pregnancy loss, care in labour, attitude of staff within maternity triage and an historic complaint from 2012 which is a joint complaint between maternity and gynaecology relating to birth via caesarean section and subsequent gynaecology management. One response completed and three in progress with no anticipated delays to timeframes.

Neonatal: There were no complaints in Q1 for neonatal services.

2.10 Maternity Red Flags

NICE Safe Midwifery Staffing guidance recommends utilising nationally recognised red flag indicators.

A Midwifery Red Flag event is considered as a potential early indicator warning sign. These incidents must be reported to the Maternity Shift Leader to identify and address and identify any immediate actions.

The following are the recommended red flags which require documenting via the Datix Incident Reporting System.

- Delayed or cancelled time critical activity.
- Missed or delayed care (delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (e.g., diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 15 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (e.g., sepsis or urine output).
- Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

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Theme	Total for Q1 2024/25							
	April 2024		May 2024		June 2024		Total	
	Whi	Orm	Whi	Orm	Whi	Orm	Whi	Orm
Delayed or cancelled time critical activity	1	0	0	4	1	0	**2**	**4**
Missed or delayed care	0	0	0	1	0	0	**0**	**1**
Missed medication	0	0	0	0	0	0	**0**	**0**
Delay of more than 30 mins in pain relief	0	0	0	0	0	0	**0**	**0**
Delay of 15 minutes or more between presentation and triage	0	4	0	0	3	0	**3**	**4**

Theme	Total for Q1 2024/25							
	April 2024		May 2024		June 2024		Total	
	Whi	Orm	Whi	Orm	Whi	Orm	Whi	Orm
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	**0**	**0**
Delay of 2 hours or more between admission for induction	0	1	0	2	0	0	**0**	**3**
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	**0**	**0**
Any occasion when 1 Midwife is not able to provide continuous 121 care in labour	0	0	0	0	0	0	**0**	**0**
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	0	0	0	**0**	**0**
TOTAL	**1**	**5**	**0**	**7**	**4**	**0**	**5**	**12**

3. Workforce

The Women and Children division became operational in April 2024 with a dedicated divisional structure of a triumvirate consisting of a Divisional Director of Operations, Divisional Director of Midwifery, and a Divisional Medical Director. The Division consists of maternity, gynaecology services, paediatric and neonatal services.

The Division will be undertaking a staffing review to support harmonisation of the approach to roster management and establishment planning.

Maternity staffing is identified within MIS safety action 5 with a requirement to review staffing and report the results twice a year.

Ormskirk Maternity Staffing:
The number of births at Ormskirk between January to June 2024 was 1,073 which is an increase of 103 births (10.62%) compared to the previous year with an increase in booking from the same reporting period of 4.1%.

The overall funded establishment is128.01WTE which is separated into 115.99WTE direct clinical staff and 12.02WTE non direct care staff.

Midwife to birth ratio for this reporting period has been recorded as 1:24.

There has been 100% compliance noted for the provision of 1-1 care in labour and the availability of a supernumerary delivery suite shift coordinator for this 6-month reporting period.

The Ormskirk Unit staffing review for the period January – June 2024 is included as appendix 3.

Whiston Maternity Service:
The number of births at MWL (Whiston site) between January to June 2024 was 1,862 which is a 3% increase compared to the same reporting period in 2023.

Bookings have increased by 1.8% compared to the same reporting period in 2023.

The BR+ report identified that the required WTE for the provision of direct maternity care was 160.98 WTE and the current funded establishment is 168.22 WTE (166.22 WTE excluding externally funded fixed term midwifery posts). Agreement to recruit above establishment by 6 WTE to cover maternity leave is maintained and the service is therefore in line with the recommendations of the Birthrate plus assessment.

Midwife to birth ratio for this reporting period has been recorded as an average of 1:27.

There has been 100% compliance noted for the provision of 1-1 care in labour and the availability of a supernumerary delivery suite shift coordinator for this 6-month reporting period.

The Whiston staffing review paper for January – June 2024 is included as Appendix 4.

The LMNS have been asked to support in looking at a review across Cheshire and Merseyside to ensure that the calculation of the midwife to birth ratio is standardised and consistent relating to non-direct care giving staff, DS shift coordinator and ward manager giving are included or excluded in the calculation**.**

Ormskirk Neonatal service:

Neonatal staffing relates to MIS safety action 4 with a timeframe of 02 April 2024 to 30 November 2024.

Ormskirk neonatal service is currently staffed to British Association of Perinatal Medicine (BAPM) requirements with the only current vacancy being a 0.3 WTE Band 5 neonatal nurse.

Whiston Neonatal service:

The service is currently BAPM compliant. A high-level review of the staffing has recently been undertaken as part of the divert deep dive and identified vacancy issues at Band 6. Recruitment is ongoing for Band 6 neonatal nurses alongside over recruitment of band 5 nurses to enable internal development of existing band 5 staff.

Currently band 2 HCAs undertake an element of the Nursery Nurses roles. A workforce review is underway to the support worker bandings and roles which would support the trained staff within the unit.

There is currently a gap of neonatal nurses who are ‘Qualified in Speciality.’ The current

number of staff who are QIS trained on the unit is currently 8.56 WTE against a requirement of 11 WTE, with plans in place to resolve this by August 2024.

Family Integrated (FiCare) Accreditation:

Ormskirk neonatal unit achieved FiCare Green accreditation January 2023 and are working towards stage two accreditation which is expected to be achieved by the end of 2024. The unit provides emotional support for staff and families for 1.5 days a week, through a qualified psychologist. There is a FiCare teaching timetable which runs throughout the week over seven days. There is a plan to commence annual staff training. The FiCare Lead and Baby Friendly Initiative (BFI) Lead are currently working together to try and implement this.

The Whiston site neonatal service has successfully achieved FiCare Accreditation in December 2023.

A clinical in reach Psychologist provides fortnightly counselling/support sessions for families on the unit (supporting FiCare standards). The Trust Chaplain continues to undertake weekly walk-arounds which is well received by families.

3.1 Sickness Absence (Including COVID)

Sickness is being managed according to the MWL policy, with monthly oversight and support from Human Resources.

3.2 Continuity of Carer (CoC)

Ormskirk maternity currently has one team (Sapphire Team) providing continuity, the plan will be to launch two teams based on the Sapphire Team model for women and babies of Black, Asian and mixed ethnicity and those living in the most deprived neighbourhoods. Preparation for the roll out of CoC has been paused until full staffing levels achieved.

Whiston currently have a homebirth team that provides full continuity of care to women once a decision has been made to birth at home which can be undertaken at any stage of a woman's antenatal pathway. The Amethyst Team continues to provide continuity to the most vulnerable women although they are currently unable to provide the intrapartum element of the model currently with the intrapartum support coming from the Delivery suite.

The current Whiston CoC plans are currently on hold which has previously been agreed at Executive level, in response to the Ockenden Report recommendations. A revised plan in line with 'Maternity Continuity of Carer Model at Full-Scale' guidance is being developed which utilises a mixed risk model providing enhanced midwifery care to women and babies of Black, Asian and mixed ethnicity and those living in the 10% decile of deprivation.

3.3 Maternity suspension of services.

For the reporting period of April to June 2024 there were two suspensions of maternity services on the Ormskirk site both occurring in May. A closure on the 04 May 2024 was due to high activity leading to insufficient midwifery staff and beds. Five women were diverted

to other hospitals however they did not birth there and subsequently birthed at Ormskirk as planned and two women were transferred to other units for induction of labour. Apology letters were sent to all affected women and no harms occurred. The second closure on the 19 May 2024 was predominantly due to a midwifery staffing deficit against planned staffing levels due to sickness compounded by high activity that day. No women were transferred or diverted.

3.4 Neonatal Unit Closures

Whiston neonatal unit closed to external admissions on 31 occasions: 15 occasions in April, three in May and 13 in June. All closures were attributed to increased acuity and/or staffing/skill mix and were reported to ODN. Whiston remains a negative outlier for its number of closures because of not having sufficient cots to meet the sustained demand. Ormskirk neonatal unit closed on two occasions due to lack of cot capacity.

An overview of the Neonatal closures and actions from the previous quarter was presented to the Executive Committee in July 2024. The Acting Director of Nursing, Midwifery and Governance was assured regarding the decision making and escalation in each scenario. Further work is being undertaken to address the issue identified regarding acuity of babies, until a regional cot configuration piece of work is complete in 2025.

3.5 One to One Care in Labour

Maternity Services aim to achieve 100% of one-to-one care to women in established labour and this is monitored and reported within the safe staffing report and the monthly dashboard. For the Q1 period there have not been any occasions when one to one care in labour was not provided.

4. Patient experience.

Relates to MIS safety action 7 with a time frame of 02 April 2024 to 30 November 2024.

A deep dive into patient experience which included Friends and Family, National Maternity Survey and MNVP presentation was presented to the Executive Committee on 11 July 2024 and the Quality Committee on 23 July 2024.

Friends and Family
MWL is currently above national average for satisfaction rates for all touch points in the FFT.

National Maternity Survey action plan update
Following receipt of the National survey responses an action plan was developed to look at ways to improve patient experience and feedback.

Themes at Ormskirk:

- Not enough antenatal information to support the decision on where to have their baby.
- Being aware of service user's medical history during antenatal checkups.
- Having enough time during antenatal checkups to ask questions.
- Service users do not feel listened to during antenatal checkups.
- Not being provided with feeding information throughout pregnancy.

- Those involved in care were able to stay as long as they wanted.

The action plan consisted of 27 actions. ten have been completed, ten in progress and six slightly delayed which were added in May 2024 following an MNVP co-production event. There was one significantly delayed action which is due to change in procurement plans to introduce new maternity digital system.

Themes at Whiston:

- Antenatal care (time to ask questions, concerns raised taken seriously, not asked enough about mental health)
- Not being aware of medical history -antenatal and postnatal
- Delays in discharge
- Partner involvement and not being able to stay as long as they wished.
- Mothers feeling listened to.

The action plan consisted of 43 actions. 26 have been completed, 13 in progress and five significantly delayed actions which are due to change in procurement plans to introduce a new maternity digital system and CoC.

MNVP

MNVP leads additionally have an action plan which has a strong focus on the national maternity survey findings, including issues identified from the narrative responses included in the survey. There are mmonthly feedback meetings with Maternity services and commissioners.

Feedback has been gathered via:

- Online surveys
- 'Walk the patch'
- Virtual listening events
- In person listening events ('World Café' event, 'Pizza and Planning', '15 Steps', attendance at libraries, family hubs, playgroups, and attendance in person within maternity and neonatal areas to talk to women and families.)
- Social media
- 1:1 conversation with MNVP Chair

A virtual event was held at Ormskirk on 17 June 2024 in collaboration with the MNVP, 'An evening with your local Obstetrician'. This was attended by over 20 service users and helped understand what it is that service users need to know in relation to birth choices and what obstetricians can do to develop closer connections and communication channels with our local birthing community.

5. Ockenden Final Report Update

Following receipt of the Ockenden 2 Report, the Maternity Service undertook a comprehensive gap analysis against the 92 individual actions. Actions outstanding relate to

- **Essential Action 1: Workforce Planning and Sustainability Including Training**
  This is being reviewed post transaction to develop a single plan for MWL.

- **Essential Action 4: Clinical Governance and Leadership**

Every Trust must ensure they have a patient safety specialist, specifically dedicated to Maternity Services. National guidance on the requirements of this role have not yet been published.

Progress is monitored at the Divisional governance meetings for both Maternity and Neonatal guidelines.

The LMNS will be undertaking a second Ockenden visit during 2024/25.

6. NHSE: Three-Year Delivery Plan for Maternity and Neonatal Services

This plan developed by NHSE sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families.

Whiston and Ormskirk sites both have a three-year delivery action plan and gap analysis documents. The Delivery Plan identifies four themes with 12 objectives incorporating 73 individual actions, 58 of which are Trust specific actions and 15 being ICB actions. Both sites have completed 45 actions with 13 in progress.

There is one red action which relates to systems being required to be able to disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds. The current maternity system disaggregates some data but does not have the functionality to capture and analyse more data. The new Trust Electronic Patient Record (EPR) will be able to meet these requirements but is not due to be implemented until October 2026.

Monitoring of the action plan continues by the division, the LMNS and regular meetings with the commissioner.

8. Recommendations
The Board asked to note the report.

9. Appendices
Appendix 1: Perinatal Quality Surveillance Model Tool: May 2024.

Appendix 2: Ormskirk MNVP 15 steps report

Appendix 3: Ormskirk staffing paper.

Appendix 4: Whiston staffing paper.

APPENDIX 1

Mersey and West Lancashire Teaching Hospitals NHS Trust

	Safe	Effective	Caring	Well-Led	Responsive
Maternity CQC Maternity Ratings - Whiston Hospital	Good	Good	Good	Good	Good
Maternity CQC Maternity Ratings - Ormskirk Hospital	Requires Improvement	Good	Good	Good	Good

	May-24			Apr-24			Mar-24			Feb-24			Jan-24			Dec-23			Nov-23			Oct-23			Sep-23			Aug-23			Jul-23			Jun-23		
	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total	Whiston	Ormskirk	Total
The Number of Incidents Reported Graded as Moderate or Above	0	1	1	0	2	2	0	0	0	1	0	1	0	1	1	1ǂ	1	2	1tǂ	0	1	0	2	2	2ǂ	1	3	3#	1	4	0	0	0	2ǂ	0	2
Healthcare Safety Investigation Branch / Maternity and Newborn Safety Investigations (HSIB/MNSI) / NHS Resolution (NHSR) / CQC or Other Organisation with a Concern or Request for Action Made Directly with Trust	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Coroner Reg 28 Made Directly to Trust	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Term Admission to NICU from DS	13	2	15	22	5	27	15	5	20	14	4	18	23	8	31	5	8	13	13	13	26	7	4	11	10	10	20	8	7	15	10	3	13	12	4	16
Number of StEIS Reportable Incidents / HSIB/MNSI Cases	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	0	0	0	1	0	1	1	0	1	0	0	0	0	0	0
Number of Cases Reported to HSIB/MNSI	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	1	0	1	0	0	0	0	0	0	1	0	1	1	0	1	0	0	0	0	0	0
PMRT	0	1	1	0	0	0	0	0	0	1	1	2	0	0	0	1	2	3	2	0	2	0	0	0	1	0	1	1	2	3	0	2*	2	1	0	1
Number of Intrapartum Stillbirths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of Neonatal Deaths before 28 days at MWL	0	1	1	0	0	0	1	0	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1*	0	1
Number of Neonatal Deaths before 28 days Elsewhere	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	1	0	0	0	1	0	1	0	0	0	0	0	0
No Babies Born with HIE Grade 2 +3	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0
Number of Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1:1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Supernumeray Shift Co-ordinator	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Consultant Delivery Suite Cover (Hrs)	98		N/A	98		N/A	98		N/A	98		N/A	98		N/A	98		N/A	98		N/A	98		N/A	98		N/A	98		N/A	98		N/A	98		N/A

Whiston Staff Survey Results:	Update Date	Results
Proprtion of midwives responding with agree / strongly agree on whether they would recommend Whiston Hospital as a place to work	Oct-22	47%
Proportion of Specialty Trainees in Obstetrics responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours	No data	No data

Ormskirk Staff Survey Results:	Update Date	Results
Proprtion of midwives responding with agree / strongly agree on whether they would recommend Ormskirk Hospital as a place to work		
Proportion of Specialty Trainees in Obstetrics responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours	No data	No data

* 21/40 termination due to maternal medical condition, born with signs of life

ǂ 1. Stillbirth where there was a breakdown of the perineum postnatally, 2. 2,000ml PPH.

1. 3.8l PPH. 2. 32/40 Stillbirth. 3. 5 Day neonatal death of a baby born at STHK , at another hospital

ǂ 1. Therapeutic Cooling. 2. Bladder injury at LSCS requiring return to theatre.

tǂ Fetal death in-utero .

ǂ Maternal death
February 1 therapeutic cooling

15 Steps for Maternity & Neonatal Ormskirk Hospital 2024

SOUTHPORT ORMSKIRK SEFTON

Maternity & Neonatal Voices

Working in partnership to improve maternity & neonatal services

CHAIR'S SUMMARY

About the Research

The National Maternity Review, Better Births and subsequent implementation guidance emphasises the responsibility of Local Maternity & Neonatal Systems to ensure they co-design services with service users. In a maternity context, the best way of instating service user co-production is through a 'Maternity & Neonatal Voices Partnership' (MNVP). These are independent formal multidisciplinary committees which come together to influence and share in the decision making of the Local Maternity & Neonatal System and its constituent parts. They are underpinned by practical support from local commissioners and providers, including appropriate financial support. The 15 Steps for Maternity toolkit is an approach to service/quality improvement designed for MNVPs that focuses on ward/service ''walkarounds'' considering first impressions from a service user perspective. The outcomes should inform improvement actions at a ward/service and organisational level.

"Alone we can do so little; together we can do so much" - Helen Keller

KEY FINDINGS & RECOMMENDATION

For Sefton Place

- Ensure appropriate ringfenced, annual funding is in place and accessible to MNVPs.
- Work with providers and service users to develop and support co-production through local MNVPs and ensure there is a commissioner responsible for maternity available to participate.
- Use your MNVP to drive service improvement. Undertaking service development and transformation without ensuring it will meet the needs of local families' risks money being wasted on inappropriate services.

For the Provider

- Share positive aspects from your 15 Steps Report with all staff and look at reports from other providers to see where you can learn from what they do well.
- Work with commissioners, staff and service users to develop and support co-production through the local MNVP.
- Use your 15 Steps Report to evidence CNST (Clinical Negligence Scheme for Trusts) Safety Action 7 demonstrating action on patient feedback.

For the MNVP

- Ensure responsibility for 15 steps actions are assigned with timescales and followed up at regular MNVP meetings becoming part of ongoing workplans.
- Work with commissioners and providers to ensure the MNVP is well supported and well attended by staff.
- Repeat the 15 steps challenge periodically or visit areas not covered by the work.

Aims of the project

- Continue with local co-production in maternity and neonatal services in Ormskirk Hospital
- Work collaboratively to make simple improvements within maternity care settings.
- Highlight gaps in coproduction of maternity services.
- Suggest environmental changes to maternity spaces.

INTRODUCTION

Better Births describes how maternity services should be co-produced with Maternity & Neonatal Voices Partnership (MNVPs). MNVPs are local teams of service users/user reps, midwives, obstetricians and commissioners, who meet regularly and work together to review, co-design and co-produce local maternity services.

Ormskirk Hospital asked Southport, Ormskirk & Sefton Maternity & Neonatal Voices Partnership to deliver the co-production toolkit ''The 15 Steps for Maternity''. It looks at quality from the perspective of people who use maternity services. This involved working collaboratively with our MNVP Chair, volunteers and service users across our network.

What is the 15 Steps for Maternity?

The 15 Steps for Maternity is a toolkit published by NHS England which has been developed with Maternity & Neonatal Voices Partnerships (MNVPs) in mind. The toolkit aligns with the NHS priorities for maternity care as outlined in Better Births and local objectives from the Cheshire and Merseyside Local Maternity and Neonatal System.

The toolkit supports collaborative working between all those involved with using, reviewing, designing and delivering maternity services. It is an observational approach whereby small teams of service users and maternity staff explore local maternity settings to get a 'feel' for the space. It is not a performance management tool, nor does it take the place of a formal audit (clinical, quality, safety, or otherwise).

The toolkit has been co-created with maternity service users who identified four themes which were important to them in the place where their maternity care is being provided. These are:

- Welcoming & Informative
- Safe & Clean
- Friendly & Personal
- Organised & Calm

Special care was taken to consider the needs of seldom heard voices and minority groups, being particularly mindful that if maternity services are experienced in the above ways by these groups, they are likely to be these things for all people on a maternity journey.

Our 15 Steps for Maternity Event

Our 15 Steps for Maternity Event took place on Friday 9th February 2024, and it was attended by:

- MNVP Chair
- Director of Nursing
- Associate Director of Nursing & Midwifery
- Consultant Obstetrician
- Lead Quality Midwife
- Directorate Manager for Radiology
- Neonatal Sister
- Student Nurse
- LMNS Community Engagement Officer
- Northwest Neonatal ODN Family Engagement Lead
- Healthwatch Sefton
- Breastfeeding Support Sefton
- Families and Babies West Lancashire
- 7 x Service Users

On the day, we split into small groups and were shown around the different Maternity and Neonatal settings in Ormskirk Hospital and were asked to give our opinions on the following areas:

- Antenatal Clinic (including Scanning areas)
- Maternity Assessment Unit (PAU & Triage)
- Delivery Suite
- Maternity Ward
- Neonatal Unit

The small teams walked around their allocated areas, using the 15 steps observation guides as a prompt. Positive feedback and suggested actions were then shared with the Maternity provider and Sefton Place.

FINDINGS & RECOMMENDATIONS

Antenatal Clinic (including scanning areas)

Upon entering the Antenatal Clinic, it feels to be a safe, clean, clutter free space with access to toilet facilities. The space felt calm and quiet. Groups were not greeted by staff upon arrival and receptionists were hidden behind a large desk. There was no access to free drinking water.

Information about trust values were displayed and the visions and values board were well received. Information was available on SIDs, Mental Health, Safe Sleep, Smoking Cessation, CQC the MNVP and PALS. However, placement of the information could be improved; many posters were placed behind seating areas (not facing service users) or hidden behind doors. Feedback boxes were available, but pens were not provided, and it was felt that this could be updated and replaced with a simple QR code.

The Antenatal Clinic waiting area is a shared space with service users attending Gynaecology and Early Pregnancy Assessment Unit. This was raised as a concern and potential trigger for service users who were attending clinic under sad circumstance and having to share the waiting area with pregnant families who were attending clinic under happy circumstances. The walk from the scan room to the room that is used for breaking bad news was also felt to be too far away for service users who were upset and having to walk past several other service users to get there.

Recommendations:

- *Ensure pens are provided by feedback stations.*
- *Consider the placement of patient information to ensure that is accessible.*
- *Consider the use of Hospital Volunteers to support with welcoming service users into the department and navigating the estate.*
- *Consider removing the glass Perspex in front of the reception desk (this was installed during the Covid-19 pandemic).*
- *Consider providing free drinking water via a fountain and/or replacing unhealthy options with healthy ones in the department vending machine.*

Maternity Assessment Unit (PAU/Triage)

Upon arriving at the Maternity Assessment Unit, the door was answered promptly, and visitors were welcomed in by nice, friendly staff. It was difficult to navigate the department and unclear if and where to report to reception. Information displayed was inconsistent and unclear, there were opportunities for wall and board space to better utilised to include information on the likes of reduced foetal movements, information for birth partners and staff photos/'who's who uniforms. It was also noted that there appeared to be no information available in different languages.

Generally, the setting felt clean, and staff could be seen cleaning. The scan room was a pleasant cool temperature and felt clean. In one of the bays, there was a hole in the ceiling and in the bathroom, it was noted that there were no handrails near the bath as well as hooks placed at an odd height.

Tea and coffee facilities were provided with decaf and dairy free options available too. Positive affirmations and birthing equipment such as peanut balls were well received. It was suggested that mural could be painted in the bathroom to make the space feel more friendly. MAU is home to the 'butterfly suite', a facility for bereaved families. The colour of the butterfly room was described as 'sad' but the mural on the wall, the double bed, and the self-sufficient design of the space felt very positive.

Recommendations:

- *Review patient information and ensure boards are utilised to maximise awareness raising around reduced topics such as reduced foetal movements, information for birth partners etc.*
- *Consider displaying 'staff photos' or a 'guide to staff uniforms' so service users know who is entering the room and why.*
- *Complete repairs/maintenance work (e.g., hole in ceiling, placement of hooks, bath rails)*

Delivery Suite

Upon arriving at Delivery Suite, visitors were welcomed in by smiling staff. There was lots of welcoming signage and information, with clearly displayed visiting times. Visitors noticed visual information that was both useful and encouraging of informed choice. The Delivery Suite was bright and well maintained. Birth rooms were set up to promote active birth with equipment such as birthing pools and birthing balls provided. In general, the Delivery Suite felt to be a calm, peaceful and relaxed atmosphere.

There were no recommendations for Delivery Suite at this time.

Maternity Ward

Groups were greeted by welcoming and friendly staff upon arrival at the Maternity Ward. The Quality board was well received and displaying information in this way felt open and honest. The Maternity Ward lacked useful information and it was felt the day room and bare walls could be better utilised to display clear information on topics such as infant feeding, safe sleep, pelvic health, mental health, the MNVP and PALS. Some information leaflets were found on the bookshelf but mixed up with staff Unison leaflets. It was suggested the Television screen could also be utilised for information sharing.

In general, the Maternity ward felt clean and at a comfortable temperature though cluttered with equipment in some parts of the corridor. Whilst the ward was full, it felt calm, and staff appeared to be in control. The purple and green décor and orange floors felt off putting. Room 13 was nicely decorated with matching curtains and cot; however, it was suggested that its name could be considered unlucky by superstitious service users and could it be renamed or renumbered.

Of note, it was concerning to hear that partners were typically not able to stay over unless extenuating circumstances were present. The majority of visitors expressed that they would have wanted their partners to be able to stay. It is worth considering that one father felt that *not* being able to stay gave him a reason to go home to rest and destress.

Recommendations:

- *Reinstate patient information board (these had been removed whilst the unit was redecorated).*
- *Reorganise the bookshelf, ensure it has relevant, up to date patient information displayed on it.*
- *Consider renaming/renumbering 'Room 13'.*
- *Consider changing the bathroom flooring.*

Neonatal Unit

Upon arrival at the Neonatal Unit, there was no wait to be let into the area by friendly staff. The entrance into the Neonatal Unit was incredibly welcoming, with signage and information available in a variety of formats and different languages. In general, the information displayed on the walls and boards was excellent. Information included a staff photo board, signs of achievements, positive feedback, information about community-based support and activities (e.g., Dads Matters). Unfortunately, the QR code to take you to a Padlet of information was situated too high and also did not work. It was difficult to leave feedback as the suggestion box had no pen, and there was also no information about the local MNVP. Not only did the staff appear to be warm, friendly and personable with women and families, they appeared to be caring of one another too.

The Neonatal Unit provided a family kitchen and family room, with plenty of comfortable seating, space to prepare meals and snacks and available drinking water. There were also overnight rooms available for families. The Unit felt calm, quiet and peaceful.

Recommendations:

- *Consider adding signposting in different languages as well as access to information in different languages via a QR code.*
- *Rebranding and placement of the 'MVP' information to include Neonatal Voices ('MNVP') to encourage Neonatal families to provide feedback and have the opportunity to get involved in coproduction of services.*
- *Check that the Padlet QR code is up to date.*
- *Improve information for Partners (e.g., DadPad Neonatal)*

CONCLUSION

The 15 Steps for Maternity Challenge was seen as a useful, enjoyable and worthwhile undertaking by staff and service users alike and we received lots of positive feedback from all involved.

This report will be shared with the Maternity Provider and Sefton Place. The actions will be added to the MNVP programme of work and will work with the provider to co-design solutions to some of the issues raised. It also recommended that the MNVP repeats the 15 Steps Challenge yearly for all maternity settings within Ormskirk Hospital.

The work has helped to embed co-production with staff and Sefton Place. It has enabled them to experience first hand the important role MNVPs contribute to improving care and experience for people using maternity services.

The NHS Long Term Plan reported that women's experiences of maternity care are improving as evidenced by the latest CQC report. It states ''Involving Service Users has been at the centre of these improvements with over 100 Maternity Voices Partnerships in place across England to ensure that maternity services are rooted and responding to, what women and their families need and want.

REFERENCES

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2. NHS England (2017) Implementing Better Births: A resource pack for Local Maternity Systems | Link: nhs-guidance-maternity-services-v1.pdf (england.nhs.uk)

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4. NHS London Clinical Networks (2018) Effective co-production through local Maternity Voices Partnerships: A resource for commissioners | Link: mat-mvp-coproduction-052018.pdf (nationalmaternityvoices.org.uk)

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Mersey and West Lancashire Teaching Hospitals NHS Trust

Ormskirk Maternity staffing report January – June 2024

Background

Maternity services in the NHS have seen significant change and development in the last decade, driven by an ambition and vision to deliver the best care to women, babies and families. Central to the development of safe maternity staffing has been the overarching policy publications; '*Safe Midwifery Staffing for Maternity Settings'* (NICE 2015), '*Better Births'* (NHS England 2016) and '*Safe, Sustainable and Productive Staffing 'An Improvement Resource for Maternity Services'* (NQB 2018).

Critical to delivering this is the safe, sustainable, and productive staffing in maternity services, NHS boards hold individual and collective responsibility for making judgements about staffing and the delivery of safe, effective, compassionate and responsive care within available resources (NQB 2016).

NICE 2019 "*Safe Midwifery Staffing for Maternity Settings'* recommendations are for registered midwives (or other authorised people) who are responsible for determining the midwifery staffing establishment. Determine the midwifery staffing establishment for each maternity service (for example, preconception, antenatal, intrapartum, and postnatal services) at least every 6 months. Undertake a systematic process to calculate the midwifery staffing establishment which meets CNST's MIS minimal evidential requirement relating to Safety Action 5 regarding effective midwifery workforce planning.

Birth rate at Ormskirk Maternity Unit

The number of births at Southport and Ormskirk Hospitals NHS Trust between the 6 months January to June 2024 was 1073 which is an increase of 103 births compared to a year ago. Ormskirk Maternity Services utilises scenario-based forecasts based upon the previous years projected births as per National Recommendations (NICE 2015). The rationale for utilising projected birth rates to plan for midwifery staffing is to estimate the potential resource impact associated with recommendations regarding midwifery staffing ratios and provide a woman in established labour with supportive one-to-one care that are essential for safe midwifery care.

Comparing the two years the births for January to June 2024 have increased by approximately 10.62%, there has also been an increase in bookings of 4.1%.

Births

Month	Jan	Feb	March	April	May	June	Total
Q4 2023 and Q1 2024 Birth	174	191	189	176	182	161	1073
Q4 2022 and Q1 2023 Births	169	154	157	168	153	169	970
Difference per month	-22	+17	-20	-18	-19	-30	+103

Month	Jul	Aug	Sept	Oct	Nov	Dec	Total
Q2 2023 and Q3 2023 Births	180	180	173	171	158	174	1036
Q2 2022 and Q3 2022 Births	206	187	210	204	177	162	1146
Difference per month	-26	-7	-33	-33	-19	+12	-110

Bookings

Month	Jan	Feb	March	April	May	June	Total
Q4 2023 and Q1 2024 Bookings	229	195	203	220	192	189	1228
Q4 2022 and Q1 2023 Bookings	218	176	209	191	203	183	1180
Difference per month	+11	+19	-6	+29	-11	+6	+48

Month	Jul	Aug	Sept	Oct	Nov	Dec	Total
Q2 2023 and Q3 2023 Bookings	227	206	200	204	178	191	1206
Q2 2022 and Q3 2022 Bookings	194	201	160	197	211	206	1169
Difference per month	+33	+5	+40	+7	-33	-15	+37

Birthrate Plus® + Staffing

The most recent BR+ report was completed on 9th January 2022 and was based on the births and forward bookings for 2020/2021 which was 2387 births. The recommendation for the funded establishment for the provision of direct midwifery care included a 25% uplift for annual leave, sickness, and study leave.

The Maternity funded establishment for the provision of direct midwifery care at the time of this staffing report is above the recommendations of the 2022 Birthrate plus assessment. Following publication of the report and a serious incident within the Maternity service the Trust Board agreed to increase the funded establishment by 5.55 WTE to provide separate cover for elective caesarean section lists, increased training as a result of Ockenden and a number of externally funded posts. A staffing review in 2023 also resulted in increasing the funded establishment for direct midwifery care to include an average uplift representative of the last 3 years annual leave, sickness, training, and maternity leave as per Ockenden essential safety action one. The previous uplift for midwifery staffing of 25%, was subsequently increased to 30%. The increase costs for this were covered by reallocating the maternity bank budget to the appropriate funded posts. As part of this review the support staff budget was realigned to provide funded posts where these were previously covered by NHSP.

A recent report from the Maternity Healthroster analysing data from April 2021 to March 2024 showed that the average unavailability due to annual leave, sickness, parenting, study, and special leave equated to 30.63%. This demonstrates that the 30% uplift for clinical staff (excludes clinical lead posts) is appropriate.

The below table demonstrates the funded and contracted establishment for the midwives providing direct and non-direct clinical midwifery care.

Direct Care

Midwives	Funded establishment	Contracted	Difference
Band 7	17.54	19.92	+2.38 (1wte mat leave cover, 1wte LTS cover and .38 WTE shift leader development)
Band 5/6 (includes 1wte post reg student mw	92.97	78.04	Vacancy 14.93 WTE
Band 3 MSW	5.48	5.48	0
Total	115.99	103.44	14.93wte vacancy excluding 2.38 band 7 sickness and mat leave cover Total vacancy = 12.55WTE

Non direct clinical care

Senior management and specialist midwives	Funded establishment	Contracted	Difference
8 and above	4.00	4.00	0
Band 7	7.32	7.32	0
Band 5/6	.7	.7	0
Total currently	12.02	12.02	0.

The above band 7 posts include externally funded posts which are a 0.4wte additional hours for the Bereavement midwife, 1wte preceptorship/ workforce midwife, .11wte perinatal trauma midwife, 0.4wte pre-term birth and multiple pregnancy midwife, 0.4wte pelvic health midwife. In addition, there is 0.6wte externally funded band 6 hours for MSW retention.

Birthrate Plus is a framework for workforce planning based on an understanding of the total midwifery time required to care for women with a minimum standard of the provision of one-to-one midwifery care to women throughout their established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

Birthrate Plus® is the only nationally endorsed tool for calculating maternity staffing levels. The Birthrate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during the antenatal period, labour, birth, the immediate post-delivery period and the postpartum period utilising the accepted standard of 1 Midwife to 1 woman in labour. This determines the total midwife hours needed and therefore the staffing required, to deliver midwifery care to women across the whole maternity pathway using NICE guidance and acknowledged best practice.

Each individual service will have their case mix identified using 5 different categories (Cat 1- V) with the lower the score the more normal the processes are for labour and birth and the higher scores indicating when a mother and/or baby require a very high degree of support or intervention. Together with the case mix, the number of midwife hours per patient/client category plus extra midwife time needed for the complicated categories of III, IV & V and calculates the clinical staffing for the annual number of women delivered.

Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

S&OHT	% Cat I	% Cat II	% Cat III	% cat IV	% Cat V
2021 DS % case mix	4.1%	14.1%	23.6%	27.5%	30.7%
2018 DS % case mix	4.1%	14.1%	30.8%	23.2%	27.8%

The report identified that the Delivery Suite case mix for 2021 indicated that 58.2% of women were in the 2 higher categories IV and V which was in keeping with the average for England of 58%. This was an increase of 7% compared with the 2018 report of 51%, which reflected the increase of induction rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

The workforce review considered in addition to the intrapartum areas:

- 172 babies requiring enhanced care and extended lengths of stay on the postnatal wards
- 1700 babies who have their Examination of the newborn screening undertaken by a midwife rather than a paediatrician
- The staffing for the Maternity Assessment Unit which is staffed to the BSOTS model and covers Triage activity and planned day unit work, plus midwife sonography hours. There are in total 9170 episodes annually. The hours for the day unit work provide 12-hour cover, 7 days a week.
- Outpatient clinic services
- Inpatient ward activity.
- Community services which include all women receiving community care including 289 who chose to birth at another trust but which antenatal and/ or postnatal care is provided. A further 411 women who birthed at Ormskirk General Hospital but lived outside the catchment area received their community care from their home Trust.

The BR+ report was inclusive of a 25% uplift for annual leave, sickness and study leave and based on the births and forward bookings for 2020/2021 which was 2387 births.

The BR+ report identified that 9.51wte is recommended as the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical whole time equivalent (WTE). This has been increased to 12.02wte with the externally funded posts. The contracted establishment is 12.02wte and aligns to the recommendations and therefore no variance is noted.

The report concluded that the required whole time equivalent for the provision of direct maternity care was 107.89wte with a recommended ratio split between midwives and maternity support workers working on the postnatal ward.
The BR+ report identified a variance of 2.26wte midwives that were needed to provide direct clinical care. The funded clinical establishment at the current time is 115.99wte which is a variance of +8.1wte to the birthrate plus recommendation. However, this includes the 30% uplift, designated staff for elective caesarean lists and some externally funded posts.

A staffing position at the end of June 2024 identified that the Unit was not in deficit to the BR+ funded recommendations for the maternity workforce based on our current modelling ratio of midwife to MSW. There is a current and expected vacancy of 15.24wte midwives

with 9.96wte midwives in the recruitment process. Recruitment is ongoing to achieve the 30% uplift, in the interim shortfalls are covered by NHS professionals.

The BR+ report highlights the required additional support for Band 2 support workers whose roles are essential to the service but are not included in the midwifery ratio calculations the requirement for these support staff to be decided by professional judgement. Currently there are sufficient band 3 support workers working across the service to provide support for midwives however there was a deficit of band 2 housekeepers on the antenatal and postnatal ward. This was considered as part of a review of the maternity staffing budget and funding is in place. Recruitment to commence once a maternity housekeeper JD is approved. In the interim is being covered by NHSP.

The report analysed data and acuity for the current model of care provided within SOHT, whilst staffing for BSOTS was included it does not reflect any other future plans or continuity of carer caseload teams. The maternity service will need to utilise the National Continuity of workforce tool to determine the required additional number of midwives needed to deliver MCoC at full scale as we progress through the revised MCoC action plan. The findings will be shared with the Committee and Trust Board following completion, with a view to moving forward once midwifery staffing is in place with an adequate uplift to cover all absences.

The maternity service currently has additional midwives in post that are funded by the LMNS or NHSE with an expectation of continuation of these roles which include a workforce/ preceptorship midwife, MSW support midwife, 0.4WTE Pre-term birth and multiple pregnancy midwife, 0.11WTE perinatal trauma midwife and 0.4wte Perinatal Pelvic health midwife and 0.4wte bereavement midwife which were not included within the BR+ workforce report. Recurrent funding has not been formally approved to date.

The BR+ report identifies that if the Trust adopted the establishment recommendations the midwife to birth ratio would be 1:22.6 based on the different care setting ratios across the entire maternity settings and is the recommended staffing ratio to be utilised. The BR + recommendations were accepted in full by the Trust Board at the time of the report.

There is an ongoing rolling recruitment programme in an attempt to address any deficits in vacancies as early as possible and be proactive in an attempt to cover prospective maternity leave and retirements.

The Maternity Inpatient Matron and Preceptorship Midwife have revised the pathway for band 5 midwives to support an earlier transition to band 6 for those that are ready.

Our first International recruited midwife commenced within the Trust in March 2023 with a 2nd international midwife joining the Maternity Service in January 24. The IR Midwives' have required an enhanced level of support and bespoke training plans in addition to the standard orientation and induction plan. The midwives are supported by our preceptorship and pastoral support midwife and all members of the team.

Sickness

	January 24	February 24	March 24	April 24	May 24	June 24
Sickness	**8.95%**	**8.52%**	**9.23%**	**7.47%**	**8.58%**	**Stats not available until 18th July**

Midwifery sickness has remained at around 8.5% on average. Staff shortages have been mitigated by offering extra shifts and bank hours. Enhanced rates for NHSP were in place since June 2023 up until the end of March 2024. Maternity staffing and activity are monitored frequently every day with staff being redeployed to the clinical area of greatest need.

The maternity service utilises E roster for staffing which is monitored daily by the maternity managers, matrons and roster co-ordinator to identify and deficits in actual staffing compared to planned staffing. The use of bank is utilised to cover deficits, where necessary specialist midwives and midwifery managers are used to cover shortages not fulfilled by the bank.

A 24/7 maternity bleep holder is available who is a senior midwife of Band 7 and above who has oversight of the staffing and clinical activity and oversees any redeployment additionally as required which includes members of the Senior Management Team, Specialist Midwives and utilisation of the escalation process as required. The bleep holder is an additional role 07:30-20:00hrs with the Delivery Suite shift coordinator covering the bleep 19:30-08:00hrs. Maternity bleep holder documentation contains documentation of planned versus actual staffing which is completed daily identifying the staffing and activity status. Any redeployment or escalation is recorded on this documentation by the bleep holder. Three times daily an escalation document is submitted which is discussed at patient flow meetings within the acute Trust. A daily C+M sit rep is also completed by 11am each day and submitted to the LMNS. This identifies current activity, escalation undertaken and hot spots with the ability to request a 'Gold' command meeting and formally request or offer mutual aid.

From 1st July Ormskirk Maternity will be adopting the maternity bleep holder format and policy used at STHK. Plans are under review to extend the maternity bleep holder to a role additional to the shift leader across the 24hours.

Midwife to birth ratio

Month	Ratio
January 24	1:24.71
February 24	1:24.55
March 24	1:24.56
April 23	1:24.13
May 24	1:24.48
June 24	Stats not available until 18th June

Currently the midwife to birth ratio is calculated by clinical midwives available for work. The LMNS have been asked to support in looking at a review across C+M to ensure the calculation of midwife to Birth ratio is standardised and clear about non direct care giving staff included in this monthly calculation.

Continuity of Carer

The Trusts current position for Continuity of carer remains on hold due to staffing provision and has been discussed at Board level. The Sapphire Team, our current CoC team was launched in 2017 and has remained fully operational. The Team consists of 8 WTE midwives providing antenatal, parent education, hypnobirthing, intrapartum and postnatal care for women living outside the West Lancs area but choosing to deliver at ODGH, there are 4 teams of 2 midwives located at childrens centres, their caseload calculated at 1:36 Working pattern: 9-5 community days and long day/night on Delivery suite to provide intrapartum care for women booked under the care of the team.

Data January- June 2024

METRIC	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24
% of women at 29 weeks on a CoC pathway	13.3%	9.8%	8.4%	12.6%	10.1%	Not available until 10th July
% of Asian, Black or Mixed women at 29 weeks on a CoC pathway	0.0%	0.0%	0.0%	0.0%	0.0%	Not available until 10th July
% of women in bottom decile of deprivation at 29 weeks on a CoC pathway	26.9%	26.7%	20.6%	14.8%	28.6%	Not available until 10th July

Age Profile of Midwifery Staffing

The table below indicates the age profile for midwifery staffing with the largest staff group currently being aged 56-60 years of age. The majority of staff are between the age of 36 and 60 years.

Age Band	% of Staff
21-25	**7.14%**
26-30	**7.14%**
31-35	**8.73%**
36-40	**15.07%**
41-45	**13.49%**
46-50	**8.73%**
51-55	**13.49%**
56-60	**18.25%**
61-65	**6.34%**
66-70	**2%**

The changes to the NHS pension scheme have led to an increase in midwives wishing to access their pension fund and remain in work on reduced hours. Whilst this has helped with retention the released hours have added to the staffing deficit.

One to One Care in Labour

Safe Staffing for Maternity Setting (NICE 2015) stipulates that care should be provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same Midwife for the whole of labour). Compliance is monitored monthly on the maternity dashboard and compliance for the period January to June 2024 was 100%.

Midwifery Red Flag Events

NICE Safe Midwifery Staffing guidance recommends utilising nationally recognised red flag indicators. A midwifery red flag event is considered as a potential early indicator warning sign. These incidents must be reported to the maternity shift leader to identify and address and identify any immediate actions. The following are the recommended red flags which require documenting via the Datix incident reporting system.

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).

- Missed medication during an admission to hospital or Midwifery-Led Unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 Midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

A Datix is required if there is any occasions that the DS shift coordinator is unable to maintain a supernumerary status. Red flags are also reported on the Birthrate+ acuity tool which is completed 4hrly on Delivery Suite.

Theme	Month						Total
	January 24	February 24	March 24	April 24	May 24	June 24	
Delayed or cancelled time critical activity	0	0	0	0	4	0	**4**
Missed or delayed care	0	0	0	0	1	0	**1**
Missed medication	0	0	0	0	0	0	**0**
Delay of more than 30 mins in pain relief	0	0	0	0	0	0	**0**
Delay of 15 minutes or more between presentation and triage	17	12	2	4	0	0	**35**
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0	**0**
Delay of 2 hours or more between admission for induction	0	3	4	1	2	0	**10**
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0	**0**
Any occasion when 1 Midwife is not able to provide continuous 121 care in labour	0	0	0	0	0	0	**0**
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	0	0	0	**0**
TOTAL	**17**	**15**	**6**	**5**	**7**	**0**	**50**

Between January to June there were 50 Midwifery Red Flag Events reported. 35 of these related to a delay in initial triage. 10 related to a delay in commencing the induction process. The remaining 5 red flags related to a delay in care.

In May diverts were requested on 2 occasions. The closure on the 4th May was due to high activity on the Unit leading to insufficient midwifery staff and beds. On the 19th May the

predominant factor was a midwifery staffing deficit against planned staffing levels, and this was also compounded by high activity.

On the first occasion 5 women were diverted to other hospitals however they did not deliver and later were admitted at Ormskirk as planned for the birth. 2 women were transferred to other units for induction. Letters were sent to all affected women. During the 2nd divert no women were transferred or diverted. The 7 red flags in May were on days that the unit was on divert.

The role of the Delivery Suite Shift Coordinator is a key role in the intrapartum area and are present 24/7 and are a recommendation within the Ockenden Report. The Delivery Suite Coordinator is supernumerary which is a pivotal role to enable them to undertake their role effectively in providing an overarching view, effective leadership, clinical expertise and facilitating communication between professionals whilst overseeing appropriate use of resources. No red flags have been reported in this reporting period due to compliance. A monthly audit is also undertaken which has confirmed 100% compliance to the Shift Coordinator being supernumerary and has been presented at the Labour Ward Maternity Forum and Governance meetings.

The Red Flags are all Datix incidents, and any learning from Red Flag and Datix incidents is disseminated via ward meetings, safety huddles and the Obstetrics & Gynaecology Clinical Governance & Quality meetings.

Summary

Births within Ormskirk Maternity for the period January to June 2024 was 1073 which is an increase of approximately 6 births per month compared to the average of the previous 6 months. Bookings for the 6-month period were 1228, for comparison this is an increase of 4 bookings per month

The Maternity funded establishment at the time of the previous staffing report was in line with the previous Birthrate plus assessment with the additional funded roles agreed by the Trust, this continues to be the case. The Maternity Unit is now compliant with Ockenden for the funded establishment including an uplift based on the past 3-year absences. An updated review of the past 3 years up to April 2024 confirmed that an uplift of 30% was appropriate to maintain compliance with Ockendon.

The increased uplift as per Ockendon has resulted in a higher vacancy rate which the Department has been trying to fill. To avoid the midwifery staffing becoming bottom heavy the preceptorship programme has been revised to facilitate an earlier transition to band 6 for those that are ready at 12 months. The current vacancy is 15.24 with 9.96wte midwives in the recruitment process.

The Birthrate plus report identified that the DS case mix was that 58.2% of women are in the 2 highest categories of care required which is in line with the average for England of 58%. which is an increase of 7% from the previous Birthrate plus assessment in 2018. This reflects the increase in induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

The establishment figures provided to Birthrate plus were correct at the time of submission of data however changes to the funded establishment occurred in 2022 following the introduction of designated staffing for elective caesarean section lists and additional roles funded by Ockenden monies.

The BR+ report highlights the recommendation of the need for Band 2 Health care workers whose roles are essential to the service but are not included in the midwifery ratio calculations. This was included in the staffing review and will be recruited to once a Job Description for a Maternity Housekeeper is agreed. In the interim shifts are being covered by NHSP.

The BR+ report does not reflect any future plans for the service or continuity of carer caseload teams.

The maternity service currently has additional midwives in post/ under recruitment that are funded by the LMNS or NHSE with an expectation of continuation of these roles which include a workforce/ preceptorship midwife and bereavement midwife which were not included within the BR+ workforce report.

Sickness has fluctuated over the past 6 months with the highest rates during school holidays. Daily monitoring to identify any deficits in actual staffing compared to planned staffing is in place. The use of NHS professionals bank is utilised to cover deficits. Nonclinical midwives are utilised if staffing and acuity indicate insufficient staffing.

A 24/7 maternity bleep holder is available who has oversight of the staffing and clinical activity and overseas any redeployment as required which includes members of the Senior Management Team, Specialist Midwives and utilisation of the escalation process as required. The bleep holder role is separately staffed 07:30-20:00 and held by the Delivery Suite Shift Coordinator overnight.

The Birthrate over the past 2 years has been lower than the 2387 that the Birthrate + assessment was based on 2212, and 2077 respectively. However, bookings have increased by 85 comparing July 2022 to June 2023 with July 2023 to June 2024. Fluctuations in birth rates can be expected year to year. The unfilled vacancy and reduced overall demand may present an opportunity to identify monies from within the maternity staffing budget to fund the additional band 7 shift coordinator posts required to provide a designated maternity bleep holder across the night shift.

There has been 100% compliance noted for the provision of 1-1 care in labour and the availability of a supernumerary Delivery suite shift coordinator for this 6-month reporting period.

Between January to June 2024 there were 50 Midwifery red flags events. The majority of these were for a delay of 15 minutes or more between presentation and triage however the majority were seen within 30 minutes. A programme of work has been done to improve escalation on Triage and this has resulted in 0 red flag incidents for triage delays in May and June. Seven incidents occurred in May related to delays during the induction process and these were related to the two times that the Maternity Unit closed to admissions.

There were two diverts requested during this reporting period on the 4th and 19th May. The closure on the 4th May was due to high activity on the Unit leading to insufficient midwifery staff and beds. On the 19th May the predominant factor was a midwifery staffing deficit against planned staffing levels and this was also compounded by high activity.

Whiston Maternity staffing report January to June 2024

BACKGROUND

Maternity services in the NHS have seen significant change and development in the last decade, driven by an ambition and vision to deliver the best care to women, babies and families. Central to the development of safe maternity staffing has been the overarching policy publications; '*Safe Midwifery Staffing for Maternity Settings'* (NICE 2015), '*Better Births'* (NHS England 2016) and '*Safe, Sustainable and Productive Staffing 'An Improvement Resource for Maternity Services'* (NQB 2018).

Critical to delivering this is the safe, sustainable and productive staffing in maternity services, NHS boards hold individual and collective responsibility for making judgements about staffing and the delivery of safe, effective, compassionate and responsive care within available resources (NQB 2016).

NICE 2019 "*Safe Midwifery Staffing for Maternity Settings'* recommendations are for registered midwives (or other authorised people) who are responsible for determining the midwifery staffing establishment. Determine the midwifery staffing establishment for each maternity service (for example, preconception, antenatal, intrapartum, and postnatal services) at least every 6 months. Undertake a systematic process to calculate the midwifery staffing establishment which meets CNST's MIS minimal evidential requirement relating to Safety Action 5 regarding effective midwifery workforce planning.

Birth rate at Whiston site maternity service

The number of births at MWL (Whiston site) between January to June 2024 was 1862 which is a decrease of 86 births (4.4%) compared to the previous six months (Q2 and Q3 2023/24) but a 3% increase compared to the same reporting period in 2023.

MWL Maternity Services utilises scenario-based forecasts based upon the previous years projected births as per National Recommendations (NICE 2015). The rationale for utilising projected birth rates to plan for midwifery staffing is to estimate the potential resource impact associated with recommendations regarding midwifery staffing ratios and provide a woman in established labour with supportive one-to-one care that are essential for safe midwifery care.

Births (Whiston site)

Month	Jan	Feb	March	April	May	June	Total
Q4 2023/24 and Q1 2024/25 Births	336	292	334	312	310	278	1862
Q4 2022/3 and Q1 2023/24 Births	286	259	312	315	309	326	1807
Difference per month	+50	+33	+22	- 3	+1	- 48	+55

Bookings for this reporting period were 2076 which identifies a slight increase of 37 bookings (1.8%) compared to the previous six month reporting period with a 2.7% decrease compared to the same reporting period in 2023.

Month	Jan	Feb	March	April	May	June	Total
Q4 2023/24 and Q1 2024/25 Bookings	367	370	336	357	337	309	2076
Q4 2022/23 and Q1 2023/24 Bookings	371	341	393	318	352	360	2135
Difference per month	-4	+29	-57	+39	-15	-51	-59

BIRTHRATE PLUS® + STAFFING

A full Birth rate plus workforce review was commissioned with a final report being received in October 2022 using the data for 2020.
The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.

Birthrate Plus® is the only nationally endorsed tool for calculating maternity staffing levels. The Birthrate Plus® methodology is based on an assessment of clinical risk and the needs of women and their babies during the antenatal period, labour, birth, the immediate post-delivery period and the postpartum period utilising the accepted standard of 1 Midwife to 1 woman in labour. This determines the total midwife hours needed and therefore the staffing required, to deliver midwifery care to women across the whole maternity pathway using NICE guidance and acknowledged best practice.

Each individual service will have their case mix identified using 5 different categories (Cat 1- V) with the lower the score the more normal the processes are for labour and birth and the higher scores indicating when a mother and/or baby require a very high degree of support or intervention. Together with the case mix, the number of midwife hours per patient/client category plus extra midwife time needed for the complicated categories of III, IV & V and calculates the clinical staffing for the annual number of women delivered.
Included in the workforce assessment is the staffing required for antenatal inpatient and outpatient services, ante and postnatal care of women and babies in community birthing in either the local hospital or neighbouring ones.

STHK	% Cat I	% Cat II	% Cat III	% cat IV	% Cat V
2020 DS % case mix	0.5%	6.5%	32.1%	27.9%	33%
	39.1%			60.9%	
2016 DS % case mix	7.7%	17%	23.4%	29.2%	22.7%
	48.1%			51.9%	
2020 Generic % case mix	3.7%	11.2%	29.5%	25.6%	30%
	44.4%			55.6%	

There was no data for the generic % case mix in the 2016 report

The report identifies that the generic case mix for 2020 indicates that 55.6% of women are in the 2 higher categories IV and V which is slightly below the average for England of 58%.
The 2020 DS case mix indicates that 60.9% of women are in the higher 2 categories for care within the DS environment which is an increase of 9% from the previous Birthrate plus assessment in 2016 which reflects the increase in induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

The workforce review considers in addition to the intrapartum areas:

- 310 babies requiring enhanced care and extended lengths of stay on the postnatal wards
- 2525 babies who have their Examination of the newborn screening undertaken by a midwife rather than a paediatrician
- Staffing required within Maternity triage to provide the BSOT's model to the 6166 women who had attended
- Staffing within the fetal maternal assessment Unit which undertook 5973 attendances
- Outpatient clinic services
- Inpatient ward activity.
- Community services which include all women receiving community care including those who chose to birth at another trust but which antenatal and/ or postnatal care is provided.

The establishment figures provided to Birthrate plus were correct at the time of submission of the data however changes to the funded establishment occurred in 2022 following the TUPE transfer of staff from the Bridgewater community Trust that increased staff, activity, and the respective budgets. Additional changes were implemented in 2023 thereby increasing the funded budget as a result of adding 5.86 Ockenden funded monies following this transfer and by reorganisation and realignment of existing vacancies.
These realignment changes have therefore reduced the variance between the current funded establishment and the BR+ recommended establishment.

The BR+ report is inclusive of a 22% uplift for annual leave, sickness and study leave and based on the birth rate for 2020 which was 3748 births.

The below table provides the funded and contracted establishment for the midwives/ MSW providing direct and non-direct clinical midwifery care as of 30th June 2024.

Direct clinical care

Midwives	Funded establishment	Contracted	Difference
Band 7	19.80	23.91	4.11
Band 5/6	123.26	123.76	0.50
Band 3 MSW	25.16	14.52	-10.64
Total	168.22	162.19	-6.03

Non-direct clinical care

Senior management and specialist midwives	Funded establishment	Contracted	Difference
8 and above	6.00	4.40	-1.6
Band 7/6	8.39	8.59	0.2
Total currently	14.39	12.99	1.4

The non-direct care band 7 posts indicated above include three fixed term externally funded posts which are a 0.6 Bereavement midwife, 1 WTE preceptorship/ workforce midwife and 0.4 preterm birth midwife which have been included in the contracted figures but are not in the funded establishment.

There is an expectation of continuation of these roles once external funding is discontinued and a business case in preparation needs to be considered before the end of 2024.

The non direct care identifies a 1.60WTE vacancy in the 8a + roles. This includes a legacy deputy head of Midwifery post which was on hold pending the management structure review and the transactional process of transitioning to MWL and will require further evaluation under the new structure and a matron post which has been recruited to with a start date of 02/09/24.

The BR+ report identified that 14.49 WTE is recommended as the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment is 14.39 WTE and aligns to the recommendations and therefore no variance is noted.

The report concluded that the required WTE for the provision of direct maternity care was 160.98 WTE with a recommended ratio split between midwives and Maternity support workers working on the postnatal ward and community.

The current funded establishment is 168.22 WTE (166.22 WTE excluding the externally funded fixed term midwifery posts).

The Trust Board has agreed to substantively over establish by 6 WTE to cover maternity leave which is maintained and therefore the maternity funded establishment for the provision of direct midwifery care as of the 30th June 2024 is in line with the recommendations of the Birthrate plus assessment.

The BR+ report however identified a deficit of 3.59 WTE midwives to provide direct clinical care if the current ratio of midwives to maternity support workers was changed. If the model was changed there would be an over establishment to the Band 3 Maternity support workers within the inpatient areas and a deficit of midwives. The suggestion was to reduce to 1 MSW per shift instead of the current ratio of 2 per shift. If the current model remained the same there was no variance.

A reduction in the MSW staffing based on clinical opinion does not take into account the requirement for 1 MSW per day to be within Maternity theatres for elective caesarean sections and therefore would not be possible.

The BR+ report highlights the required additional support for Band 2 support workers whose roles are essential to the service but are not included in the midwifery ratio calculations and recommends increasing their establishment by 9.28 WTE. A current antenatal clinic review will be commencing, and the findings of this review will inform a business case to increase the band 2 support staff.

The BR+ report analysed data and acuity for the current model of care provided within the Whiston maternity service and did not reflect any future plans or continuity of carer caseload teams. The maternity service will need to utilise the National Continuity of workforce tool to determine the required additional number of midwives needed to deliver MCoC at full scale as we progress through the revised MCoC action plan which is currently paused following executive agreement.

In this reporting period 15.45 WTE midwifery posts were appointed to resulting from vacancies, retirements and maternity leaves including leavers who have handed in their resignation or date of retirement. 11.65WTE will be newly qualified midwives who will commence Sept/ October following qualification and 3.8WTE band 6 midwives who have commenced in post

There is an ongoing rolling recruitment programme in an attempt to address any deficits in vacancies as early as possible and be proactive in covering prospective maternity leave and retirements.
Senior midwifery roles that have been recruited to in this reporting period include an extension to the externally funded pastoral support and preceptorship midwife for a further 12-month period, WOPD manager due to promotion of the previous manager, 1 WTE matron and 1WTE community manager due to retirement. A Deputy Director of Midwifery has been appointed on a six-month secondment who is due to commence on the 14/08/24 to cover the secondment of the Head of Midwifery to the Director of Midwifery post.

6 Internationally recruited midwives have joined the Trust since November 22 with 1 midwife returning home within this reporting period due to personal reasons. All of the IR Midwives are at various stages since arrival and have required an enhanced level of support and bespoke training plans in addition to the standard orientation and induction plan. The Midwives are supported by our Workforce and Pastoral Support Midwife and all members of the team.

Sickness

	January 24	February 24	March 24	April 24	May 24	June 24
Sickness	**6.5%**	**6.71%**	**8.07%**	**7.47%**	**8.58%**	**Data not available until 18th July**

There has been a consistent reduction in the level of sickness in 2023 since the 13.62% rate in January 2023 for all Maternity staff including Covid-19 related sickness figures which continued in January and February 2024; however an increase is noted from March 24. Sickness and absence management is monitored in accordance with policy supported by HR and HWWB
Staff shortages were mitigated by offering extra shifts and bank hours. Maternity staffing and activity are monitored frequently every day with staff being redeployed to the clinical area of greatest need. Redeployment additionally includes members of the senior management team, specialist midwives and utilisation of the escalation process as required in redeploying staff to the required clinical area.

A 24/7 maternity bleepholder is available who is a senior midwife of Band 7 and above who has oversight of the staffing and clinical activity and overseas any redeployment additionally as required which includes members of the senior management team, specialist midwives and utilisation of the escalation process as required. Maternity bleepholder documentation contains documentation of planned versus actual staffing which is completed daily identifying the staffing and activity status. Any redeployment or escalation is recorded on this documentation by the bleepholder. A daily C+M sit rep is also completed by 11am each day and submitted to the LMNS. This identifies current activity, escalation undertaken and hot spots with the ability to request a 'Gold' command meeting and formally request or offer mutual aid.

Midwife to birth ratio

Midwife to birth ratio for this reporting period has been recorded as:

Date	Midwife to Birth ratio
January 24	1:28
February 24	1:26
March 24	1:27
April 24	1:28
May 24	1:27
June 25	1:26

The LMNS have been asked to support in looking at a review across C+M to ensure that the calculation of the midwife to Birth ratio is standardised and consistent relating to non-direct care giving staff, DS shift coordinator and ward manager giving are included or excluded in the calculation.

Continuity of Carer

The Trust has developed a revised plan for the delivery of a Maternity Continuity of Carer model in line with delivering 'maternity continuity of carer model at full-scale' guidance, which has previously been submitted to Quality committee, Trust Board and to the LMNS. This guidance outlines and supports Trusts to develop and deliver continuity of carer as the default model for the provision of maternity services when building blocks are in place and safe staffing allows.

Following this guidance, the maternity service reviewed the whole model of care as this was required and identified that we needed to utilise a mixed risk model delivering continuity of carer to all eligible women. As this is a totally revised model staff consultation and engagement is needed to be recommenced. The plan sets out the phased approached to achieving this and identifies the significant resources implications, recruitment, estate, training, and consultation requirements.

The Trusts current position for Continuity of carer is currently on hold which has been discussed at Board level. The current homebirth team provides full continuity of care to women once a decision has been made to birth at home which can be undertaken at any stage of a woman's antenatal pathway. The amethyst team continues to provide continuity to the most vulnerable women although they are currently unable to provide the intrapartum element of the model currently with the intrapartum support coming from the Delivery suite.
The Birthrate plus report reflects the current model of care and does not provide any recommendations for the delivery of CoC. A full review using the National CoC workforce tool will be required to determine what additional staffing will be required to fully implement CoC going forward.

Age Profile of Midwifery Staffing

The table below indicates the age profile for midwifery staffing with the largest staff group currently being aged 26-30 and 56-60 years of age. The maternity service has seen an increased number of leavers recently in this retiring age group which impacts on staffing and the experienced skill mix.

Age Band	% of Staff
21-25	7.88%
26-30	17.73%
31-35	10.34%
36-40	13.79%
41-45	10.34%
46-50	9.85%
51-55	9.85%
56-60	17.24%
61-65	2.96%

One to One Care in Labour

Safe Staffing for Maternity Setting (NICE 2015) stipulates that care should be provided for the woman throughout labour exclusively by a midwife solely dedicated to her care (not necessarily the same Midwife for the whole of labour). Compliance is monitored monthly on the maternity dashboard and compliance for the period January to June 2024 was 100% and there have not been any occurrences where this has not been achieved in the previous 12 months.

Midwifery Red Flag Events

NICE Safe Midwifery Staffing guidance recommends utilising nationally recognised red flag indicators.
A midwifery red flag event is considered as a potential early indicator warning sign.
These incidents must be reported to the maternity shift leader to identify and address and identify any immediate actions.
The following are the recommended red flags which require documenting via the Datix incident reporting system.

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or Midwifery-Led Unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 Midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

A Datix is required if there are any occasions that the DS shift coordinator is unable to maintain a supernummary status.

Theme	Month					
	Jan 2024	Feb 2024	March 2024	April 2024	May 2024	June 2024
Delayed or cancelled time critical activity	0	0	0	1	0	1
Missed or delayed care	0	0	0	0	0	0
Missed medication	0	0	0	0	0	0
Delay of more than 30 mins in pain relief	0	0	0	0	0	0
Delay of 30 minutes or more between presentation and triage	0	0	1	0	0	3
Delay of 15 minutes or more between presentation and triage (BSOT standard)	0	1	1	0	0	0
Full clinical examination not carried out when presenting in labour	0	0	0	0	0	0
Delay of 2 hours or more between admission for induction	0	0	2	0	0	0
Delayed recognition of and action on abnormal vital signs	0	0	0	0	0	0
Any occasion when 1 Midwife is not able to provide continuous 121 care in labour	0	0	0	0	0	0

Theme	Month					
	Jan 2024	Feb 2024	March 2024	April 2024	May 2024	June 2024
If Delivery Suite Coordinator was not supernumerary and the reason why?	0	0	0	0	0	0
TOTAL	**0**	**1**	**4**	**1**	**0**	**4**

Between January to June 2024 there were ten Midwifery Red Flag Events reported. There were 4 Red Flags reported for triage breaches of delay of 30 minutes or more between presentation and triage as per NICE standards. The maternity service undertakes BSOTs and have identified that there were 2 delays of 15 minutes or more between presentation and triage. All delays were due to a high acuity and capacity and numerous women attending simultaneously.

The role of the Delivery Suite Shift Coordinator is a key role in the intrapartum area and are present 24/7 and are a recommendation within the Ockenden Report. The Delivery Suite Coordinator is supernumerary which is a pivotal role to enable them to undertake their role effectively in providing an overarching view, effective leadership, clinical expertise and facilitating communication between professionals whilst overseeing appropriate use of resources. No red flags have been reported in this reporting period due to compliance. A monthly audit is also undertaken which has confirmed 100% compliance to the Shift Coordinator being supernumerary and has been presented at the Labour Ward Maternity Forum and Governance meeting.

The Red Flags are all Datix incidents, and any learning from Red Flag and Datix incidents is disseminated via ward meetings, safety huddles and the Obstetrics & Gynaecology Clinical Governance & Quality meetings.

SUMMARY

The number of births at MWL (Whiston site) between January to June 2024 was 1862 which is a decrease of 86 births (4.4%) compared to the previous six months (Q2 and Q3 2023/24) but a 3% increase compared to the same reporting period in 2023.

There was a slight increase of 37 bookings (1.8%) compared to the previous six month reporting period with a 2.7% decrease compared to the same reporting period in 2023.

The BR+ report identified that the generic case mix was that 55.6% of women are in the 2 highest categories of care required which is slightly below the average for England of 58% with the DS case mix indicating that 60.9% of women are in the highest 2 categories for care within the DS environment which is an increase of 9% from the previous Birthrate plus assessment in 2016. This reflects the increase in induction of labour rates, delivery methods, post-delivery problems and increases in obstetric and medical conditions.

The BR+ report is inclusive of a 22% uplift for annual leave, sickness and study leave and identified that 14.49 WTE is the staffing requirement for non-clinical midwifery roles based on 9% of the total clinical WTE. The funded establishment is 14.39 WTE and aligns to the recommendations and therefore no variance is noted.
There is a 1.60WTE vacancy in the 8a + roles which includes a legacy deputy head of Midwifery post which was on hold pending the management structure review and the transactional process of transitioning to MWL and a matron post which has been recruited to with a start date of 02/09/24.

The non-direct care band 7 posts include three fixed term externally funded posts (2.0WTE) which are included in the contracted figures but not in the funded establishment and a business case will be required before the end of 2024 as the expectation is that these post will be substantive once the external funding ends. .

The BR+ report concluded that the required WTE for the provision of direct maternity care was 160.98 WTE and the current funded establishment is 168.22 WTE (166.22 WTE excluding externally funded fixed term midwifery posts). Agreement to substantively over establish by 6 WTE to cover maternity leave is maintained and the service is in line with the recommendations of the Birthrate plus assessment.

Business cases will be required in 2024 to consider increasing the number of Band 2 support staff within antenatal clinic follow an antenatal clinic review, funding for midwives on fixed term externally funded posts and staffing requirements using the National Continuity of workforce tool to determine number of midwives needed to deliver MCoC at full scale as we recommence, he revised MCoC action plan.

15.45 WTE midwifery posts were appointed to with 3.8WTE midwives commenced in post and 11.65WTE newly qualified midwives due to commence in Sept/ October following qualification. Ongoing rolling recruitment programme to reduce any deficits in vacancies as early as possible and be proactive in covering prospective maternity leave and retirements.

The midwife to birth ration at the ned June 2024 was 1:26.

There has been 100% compliance noted for the provision of 1-1 care in labour and the availability of a supernummary Delivery suite shift coordinator for this 6-month reporting period.

Between January to June 2024 there were ten Midwifery Red Flag Events reported. There were 4 red flags reported for triage breaches of delay of 30 minutes or more between presentation and triage as per NICE standards. The maternity service undertakes BSOTs and have identified that there were 2 delays of 15 minutes or more between presentation and triage. All delays were due to a high acuity and capacity and numerous women attending simultaneously.