NHS
Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC

BOARD OF DIRECTORS IN PUBLIC

1 May 2024

09:00 GMT+1 Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

Only PDFs are attached

- 0 Board of Directors Public Agenda.pdf
- 3 Board of Directors in Public Minutes - 3 Apr.pdf
- 4 Action Log - Public Board.pdf
- 7 Chief Executive Officer Report.pdf
- 8.1 WUTH IPR SPC Dashboard - April 2024 - 5 CFO.pdf
- 8.1.1 CFO Commentary M12.pdf
- 8.1.2 CIO Commentary.pdf
- 8.2 COO Report.pdf
- 8.3 BoD_2324 Integrated Performance Report - May 2024.pdf
- 8.3.1 WUTH IPR SPC Dashboard - April 2024 - Intro.pdf
- 8.3.2 WUTH IPR SPC Dashboard - April 2024 - 1 COO.pdf
- 8.3.3 WUTH IPR SPC Dashboard - April 2024 - 2 MD.pdf
- 8.3.4 WUTH IPR SPC Dashboard - April 2024 - 3 CN.pdf
- 8.3.5 CN Commentary.pdf
- 8.3.6 WUTH IPR SPC Dashboard - April 2024 - 4 CPO.pdf
- 8.3.7 CPO Commentary.pdf
- 8.4 BAF April 2024.pdf
- 8.5 Monthly Maternity Report May 2024 Final.pdf
- 8.5.1 Appendix 1 - Perinatal Clinical Surveillance Quality Assurance Report March 2024.pdf

- 8.5.2 Appendix 2 - Thematic Review Neonates.pdf
- 8.5.3 Appendix 3 - MIS Year 6 Summary for Trusts 2 March 2024.pdf
- 8.5.4 Appendix 4 - MIS-Year-6-guidance.pdf
- 8.5.5 Appendix 5 - SBLCBv3 Wirral Q4 2324 FINALISED March 2024.pdf
- 9 Health Inequalities Operating Model.pdf
- 9.1 Health Inequalty TOM final.pdf
- 10 Registers and FPP.pdf
- 10.1 Board Declarations of Interest.pdf
- 10.2 Governor Declarations of Interst.pdf
- 10.3 Gifts.pdf
- 10.4 Hospitality.pdf
- 11.1 People Comm.pdf
- 11.3 Estates and Capital Committee.pdf
- 11.4 Audit and Risk Committee.pdf

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 1 May 2024
Time	09:00 – 11:00
Location	Hybrid

Agenda Item			Lead	Presenter
1.	Welcome and Apologies for Absence		Sir David Henshaw	
2.	Declarations of Interest		Sir David Henshaw	
3.	Minutes of Previous Meeting		Sir David Henshaw	
4.	Action Log		Sir David Henshaw	
Items for Decision and Discussion				
5.	Patient Story		Dr Nikki Stevenson	
6.	Chairs Business and Strategic Issues – **Verbal**		Sir David Henshaw	
7.	Chief Executive Officer Report		Dr Nikki Stevenson	
8.	Board Assurance Reports			
	8.1)	Chief Finance Officer Report	Mark Chidgey	
	8.2)	Chief Operating Officer Report	Hayley Kendall	
	8.3)	Integrated Performance Report	Executive Directors	
	8.4)	Board Assurance Framework	David McGovern	
	8.5)	Monthly Maternity Report	Dr Nikki Stevenson	Jo Lavery
9.	Health Inequalities Operating Model		Matthew Swanborough/David McGovern	
10.	Declarations of Interest and Fit and Proper Persons Annual Update		David McGovern	Cate Herbert
Committee Chairs Reports				
11.	11.1)	People Committee	Lesley Davies	
	11.2)	Council of Governors – **Verbal**	Sir David Henshaw	
	11.3)	Estates and Capital Committee	Sir David Henshaw	
	11.4)	Audit and Risk Committee	Steve Igoe	
	11.5)	Charitable Funds Committee – **Verbal**	Sue Lorimer	

Closing Business

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

Date and Time of Next Meeting

Wednesday 5 June 2024, 09:00 – 11:00

Meeting	Board of Directors in Public
Date	Wednesday 3 April 2024
Location	Hybrid

Members present:

DH	Sir David Henshaw	Non-Executive Director & Chair
SI	Steve Igoe	SID & Deputy Chair
CC	Chris Clarkson	Non-Executive Director
SR	Dr Steve Ryan	Non-Executive Director
LD	Lesley Davies	Non-Executive Director
RM	Dr Rajan Madhok	Non-Executive Director
JH	Janelle Holmes	Chief Executive
NS	Dr Nikki Stevenson	Medical Director & Deputy Chief Executive
HK	Hayley Kendall	Chief Operating Officer
DS	Debs Smith	Chief People Officer
MS	Matthew Swanborough	Chief Strategy Officer (until 11am)
MC	Mark Chidgey	Chief Finance Officer

In attendance:

DM	David McGovern	Director of Corporate Affairs
CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.5
TC	Tony Cragg	Public Governor
EH	Eileen Hume	Deputy Lead Public Governor
LR	Lindsey Rowley	Member of the Public
RV	Dr Rose Vimala	Member of the Public

Apologies:

SL	Sue Lorimer	Non-Executive Director
SH	Sheila Hillhouse	Lead Public Governor
CM	Chris Mason	Chief Information Officer

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

	No interests were declared and no interests in relation to the agenda items were declared.	
3	**Minutes of Previous Meeting** NS requested the sentence regarding the coroner be amended to say, "*satisfied with the Trust's approach to coroners' referrals and death certification."* Subject to the amendment, the minutes of the previous meeting held on the 6 March were **APPROVED** as an accurate record.	James Jackson-Ellis
4	**Action Log** The Board **NOTED** the action log.	
5	**Staff Story** The Board received a video story from a junior doctor. The video story described the doctors positive experience of using Freedom to Speak Up and has subsequently decided to become a Freedom to Speak Up Champion because of this. DS commented the junior doctors story demonstrates the positives of the Freedom to Speak Up function, through providing guidance and support to seek a resolution independently. DS added it was also positive this junior doctor became a Champion as there were fewer Champions in the medical workforce. SR queried how this was being shared with the medical workforce so that staff understand the purpose of Freedom to Speak Up. DS stated the Freedom to Speak Up Guardian attends the induction meeting for new junior doctors and the video story would also be used to increase awareness. The Board **NOTED** the video story.	
6	**Chairs Business and Strategic Issues** DH provided an update on recent matters and highlighted the NHS Cheshire and Merseyside commissioned review into Wirral System was progressing as expected. DH commented the walkabouts held earlier in the morning were positive and confirmed support for these to take place at every meeting. NS agreed and explained her walkabout group went to two different wards to understand the estate limitations and how the different wards operate due to the capital constraints.	

	It was noted that the estates element will be discussed at Estates and Capital Committee as part of usual business. The Board **NOTED** the update.	
7	**Chief Executive Officer's Report** JH gave an industrial action update regarding the dispute with UNISON in relation to the Clinical Support Worker banding, noting discussions had taken place with UNISON and the Trust and a revised offer had been put to their members with the results due on or before 3 April. JH stated in February there was one Patient Safety Incident Investigation opened under Patient Safety Incident Response Framework and one Reporting of Injuries, Diseases and Dangerous Occurrences reported to the Health and Safety Executive. JH stated CQC undertook an unannounced visit to the Emergency Department on 14 March with a further unannounced follow up visit on 21 March. No immediate safety concerns were raised at the end of each visit during the high level feedback sessions. JH highlighted Amanda Doyle, NHSE National Director for Primary Care and Community Services visited the Trust on 21 March as part of a wider visit to Wirral system partners. Amanda visited the UECUP site, and the Transfer of Care Hub, before travelling to Wirral Community Health and Care Foundation Trust to continue her tour of the system. JH explained the Together Awards had been held on 22 March to celebrate the outstanding work of staff and teams throughout the past year and referenced the winners. JH summarised the recent meetings of the Cheshire and Merseyside Acute and Specialist Trust Board (CMAST) on 1 March and the Place Based Partnership Board on 21 March. Members congratulated the winners and thanked staff for their efforts in making the Trust a better place. SI commented he attended a CMAST chairs meeting on behalf of the Chair where there were discussions regarding funding to support efficiencies to drive integration of patient records. SI added it was important to ensure where integration of patient data was taking place all relevant system partners were involved. JH acknowledged this and agreed. The Board **NOTED** the report.	

8	**Board Assurance Reports** **8.1) Chief Finance Officer Report** MC highlighted at the end of February 2024, M11, the Trust was reporting a deficit of £23.1m against a plan of £17.8m, and the resultant variance of £5.3m was a deterioration on the M10 position (£4.50m). MC explained the key driver of the adverse variance related to the unmitigated impact of industrial action. MC provided an update on the statutory responsibilities and key financial risks, noting the RAG rating for each, highlighting that financial stability and financial sustainability were red, financial efficiency was amber, and agency spend, capital and cash were green. MC summarised the key drivers of variance to plan and corrective actions. MC sought approval for changes to the capital programme, noting these changes related to the removal of LIMS and the heating and chilled water pipework brought forward to this financial year. SR queried about the additional SPC graphs relating to cyber security. MC stated CareCERT alerts required a response within 72 hours and there was good assurance regarding this. MC added for supported serves there were a number of serves that were unsupported and corrective actions were in place to replace/upgrade those. SI queried about the additional funding made available and if the Trust was in a position to apply for this. MC stated this funding was for the ICS, however as Cheshire and Merseyside was reporting a non-complaint financial position this impacted on the ICS position to apply for the funding. The Board: • **NOTED** the report; and • **APPROVED** the increase in capital budget from £26.948m to £31.093m **8.2) Chief Operating Officer Report** HK highlighted in February the Trust attained an overall performance of 98.08% against plan for outpatients and an overall performance of 99.38% against plan for elective admissions. HK explained underperformance continues for inpatients due to the impact of large-scale cancellations for industrial action. Underperformance relating to the under-utilisation of the Surgical Centre by NHS system partners continues but has improved.	

	HK summarised referral to treatment, cancer performance and DM01 performance against the relevant trajectories. HK reported type 1 unscheduled care performance was 49.12%. HK explained the Trust has experienced attendances per day above 300, in a department that on average sees 260-270 patients and this causes significant flow issues as well as challenges to recover delivery against the UEC performance metrics. HK stated compliance with the national standard for 15-minute ambulance handovers has improved, averaging 61 minutes down from 92 minutes. Work continues to improve this standard, and improvements have been demonstrated since the middle of February 2024. HK highlighted demand for mental health beds remained constant and there was an increase in the number of patients requiring admission to acute mental health beds which was an increasing concern that the Board should be aware of. DH queried the current position for mental health patients in ED. HK stated the position remained challenged over the Easter weekend due to bed provisions and staff allocation, which was escalated to the ICB along with a mutual aid request. HK recommended waiting until Friday to see if the position improved. NS added there were concerns clinically and mitigation was in place as far as possible, but a Wirral system response was required to deliver safe care to patients and ensure staff were safe. HK stated that previous work had been undertaken to understand the mental health challenges in Wirral. DH requested that this be shared with the Board of Directors. SR queried about Right Care Right Person. HK stated this related to the reduction in the provision of police to support mental health patients. HK added the Trust was working with the relevant organisations and ensuring updated national guidance was understood by staff and local policies and education updated. RM queried the number of inpatients not meeting the criteria to reside and progress to reduce this. HK stated there had been an increase in the number of patients on pathway 2 resulting in a greater number of patients with complex requirements, who could then not be easily discharged. HK added the Trust continued to work well with Wirral Place partners to review patients with the longest length of stay and reduce this further.	Hayley Kendall

	CC queried if there had been any re-admissions following discharge of inpatients not meeting the criteria to reside. HK stated that we work with a third sector organisations, based in the Transfer of Care Hub, who check in on patients regularly post discharge and they have found no areas of concern including re-admission. The Board **NOTED** the report. **8.3) Integrated Performance Report** DS reported mandatory training and staff turnover continued to meet threshold. Sickness absence remained above Trust threshold, although had improved and appraisal was below compliance target due to strike action. NS explained the number of level 1 informal concerns raised was above Trust threshold and the Never Event related to the one mentioned at March Board. NS highlighted C Diff remained an area of focus and the Deputy Director for IPC was in the process of reviewing the C Diff improvement programme in light of the new thresholds for 2024/25. NS added the FFT for Maternity was increasing following this being an area of concern. The FTT for ED was below Trust threshold but remained above the national average. The Board **NOTED** the report. **8.4) Board Assurance Framework (BAF)** DM explained following the annual review, changes have been incorporated into the BAF as part of this annual refresh. DM noted this has included the addition of new risks, the removal of 1 risk and the merging of current risks. DM added work will now take place to set the current score and future targets for each risk which will be provided to the next Board meeting. DS clarified for risk 5, staff wellbeing would remain a separate risk and would not be merged into this risk. DM agreed to amend. SI commented the new risk relating to health inequalities was positive and there were significant opportunities to improve this across the Wirral population. LD noted although overall RAG rating may remain the same there may be scoring changes, and it would be helpful to demonstrate the direction of change on the BAF. DM agreed to review this as part of the scoring process.	David McGovern

	The Board: • **APPROVED** the proposed changes to the BAF for 2024; and • **NOTED** the current position in regard to Risk Appetite and Risk Maturity; and • **NOTED** the process for rescoring risks which will be reported from the next meeting. **8.5) Monthly Maternity and Report** JL provided the perinatal clinical surveillance data linked to quality and safety of maternity services and highlighted there were no areas of concern to raise this month. JL highlighted there remained an inability to benchmark against other providers for rates such as stillbirth and neonatal deaths. JL added there had been three still births in the later end of 2023 and six neonatal deaths. An update would be provided in the next quarterly report regarding this. NS reported the six neonatal deaths were reviewed promptly, noting there were no concerns regarding Maternity Services at the Trust, but joint learning had been shared with Wirral system partners. SR commented there had been reflection opportunities in the team regarding the three still births, noting there was good leadership and culture in place to encourage this. SR also commented about the continuity of carer model, explaining the national focus had changed on this and the Trust currently had a hybrid system in place currently. JL agreed and stated this was due to a national shortage of midwives, but the Trust was considering options and engaging with staff regarding this. LD queried the results from the 2023 Maternity Services Survey, particularly the lower-than-average score for questions relating to midwives and doctors being aware of the mother's medical history. JL stated these were two areas of focus and were included within the relevant action plan to improve. The Board **NOTED** the report.	
9	**Employee Experience** DS gave a presentation summarising the employee experience at the Trust through the seven People Promise areas using results from the 2023 NHS Staff Survey data and other internal data	

	sources. DS also gave examples of the Divisional staff experience against the People Promise and explained how at a Trust and Divisional level the employee experience information was being utilised. DS noted there was a national anomaly with the data for results relating to physical violence in work and bullying in work and therefore the results on these questions are not available. DS will bring back an updated presentation when the corrected results are provided. CC queried the statement regarding staff with disabilities or staff that are Black, Asian, or Minority Ethnic feeling they do not have the same career opportunities as their non-disabled or white colleagues. DS stated there was good representation of staff with disabilities and Black, Asian, or Minority Ethnic staff in lower Agenda for Change pay bands, but further work was required to increase this representation in higher bands. The Board **NOTED** the report.	Debs Smith
10	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards Update** HK highlighted in October 2023 Board received the annual self-assessment against the national EPRR core standards, resulting in a self-assessment score of 82% which was in line with previous submissions. HK explained that a new process was piloted in the region by NHSE, and therefore, following the submission of our self-assessment, there was a significant deterioration in the compliance score to 50% less than the self-assessment that was submitted. This is in line with what had been experienced in the first pilot in another region. HK added there had been several meetings with the ICB and NHS England and Chief Operating Officers to challenge the position and despite the challenge no scores were changed. An improvement plan has been developed that will be monitored through the Risk Management Committee. DH queried if this affected other Trusts regionally or nationally. HK stated this was a new approach being tested across Cheshire and Merseyside and affected only Trusts in the region. HK added the Trust's EPRR had been tested significantly through the pandemic and there was live test of the Major Incident Policy and response with the M53 incident in September 2023.	

	The Board **NOTED** the update and the change in levels of compliance and receive a future update on the action plan progress to improve the number of standards to full compliance.	
11	**Risk Management Strategy** DM reported the Risk Management Strategy was last refreshed and approved in November 2022 and would be subject to an annual review in April moving forward. DM added this refreshed version included minor changes and corrections regarding governance processes and had been updated with the new risk matrix framework. No changes were made to the risk appetite statement. The Board **APPROVED** the annual refresh of the Strategy.	
12	**Corporate Governance Manual** CH explained a review of the Corporate Governance Manual had been undertaken and requested specific approval of the Scheme of Reservation and Delegation and the Board Code of Conduct. CH added the manual will be reviewed annually going forward with any amends brought to Audit and Risk Committee and then the Board for final approval. **The Board:** • **APPROVED** the Scheme of Reservation and Delegation; and • **APPROVED** the Board Code of Conduct; and • **APPROVED** and the complete Corporate Governance Manual inclusive of the introductory document.	
13	**Committee Chairs Reports** **13.1) Finance Business Performance Committee** MC highlighted in the absence of SL that Committee noted further improvement to the 2023/24 financial plan was required and the risk around elective performance and achievement of cancer targets continued for certain medical specialities. The Board **NOTED** the report. **13.2) Audit and Risk Committee** SI explained there were no new risks or items for escalation identified and that the Committee was discussed and approved a number of key reports in relation to year end. The Board **NOTED** the report.	

	13.3) Quality Committee SR reported no new risks or items for escalation had been identified but Committee considered it would be useful to understand the potential impact, likelihood and mitigation for patient quality and safety related to restricted capital allocations for medical equipment. The Board **NOTED** the report. **13.4) People Committee** LD highlighted the Committee had been made aware induction compliance and apprenticeship levy spend had been areas of risk for the Trust. LD added good progress had been made and plans were on track to close the induction compliance risk by March 2024 and work continued to implement apprenticeships across the Trust. The Board **NOTED** the report.	
14	**Questions from Governors and Public** No questions were raised.	
15	**Meeting Review** No comments were raised.	
16	**Any other Business** No other business was raised.	

Action Log
Board of Directors in Public
1 May 2024

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	3 April 2024	3	To amend the minutes of the previous meeting	James Jackson-Ellis	Complete.	May 2024
2.	3 April 2024	8.2	To circulate the work that has been undertaken to understand the mental health challenges in Wirral.	Hayley Kendall	Complete.	May 2024
3.	3 April 2024	8.4	To review the presentation of increasing/decreasing scores on the BAF	David McGovern	Complete. The presentation has been altered to include Direction of Travel.	May 2024
4.	3 April 2024	9	To provide an updated presentation with the data for questions relating to physical violence and bullying in work are available	Debs Smith	In progress. To be provided once the data issue has been resolved by the NHS Staff Survey Coordination Centre.	TBC

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
1 May 2024

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

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

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

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

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

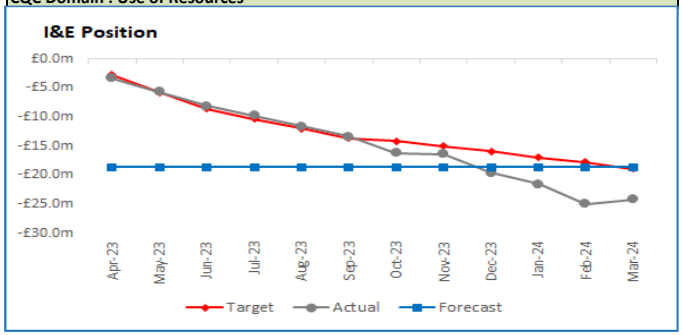
1	**Narrative**
1.1	**Industrial Action Update** Board members are aware that the dispute with UNISON in relation to the Clinical Support Worker (CSW) banding has been resolved and there will be no further strike action.

	There is an on-going dispute with Unite in relation to 23 staff members in Theatre Recovery regarding banding. The staff members in question have taken 4 days of action in April, and further action is planned in May 2024. The agreed Trust process for reviewing banding has been made available to the staff members in question. Unfortunately Unite members have declined to participate in that process to date. As the Trust's aim is to resolve the dispute, further flexible alternative options for staff to provide evidence of work at a higher grade have been offered. Meetings with Unite are on-going and talks have been productive. Comprehensive arrangements to plan for strike action have been put in place via the EPRR route and as such there have been no delays or disruptions to our patients.
1.2	**Specialised Commissioning Delegation** NHS England has confirmed that from 1st April 2024 the commissioning of the majority of services that are defined as specialised, has been delegated to NHS Cheshire and Merseyside Integrated Care Board (C&M ICB). For WUTH this means that an additional 5% of our services, including Neonatal, Renal, the Limbs centre and some specialised surgery, will be contracted, along with the majority of our services, by C&M ICB.
1.3	**Patient Safety Incident Investigations (PSIIs) and Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS)** There were no Patient Safety Incident Investigations (PSII) were opened in March under the Patient Safety Incident Response Framework (PSIRF). The Patient Safety Response Meeting report and investigate under the PSIRF to identify learning and improve patient safety. There were also no RIDDOR reportable events reported in March. All RIDDOR reportable events are subject to a Health and Safety Local Review investigation to ensure causes are identified and to ensure improvements are made to reduce the risk of a similar event occurring.
1.4	**Removal of Provider Licence Undertakings** The Trust received a letter from NHS England on 19th April, confirming that the undertakings imposed in 2018 on the Trust's provider licence, relating to financial sustainability and A&E performance, will be removed. NHSE has also determined it is appropriate to remove the additional licence condition imposed in 2015 (Section 111 Additional Licence Condition 1 – Additional Governance Requirements) relating to financial governance. This is extremely positive and provides further evidence of the progress the Trust has made on its improvement journey.
1.5	**CQC guidance to assessing the well-led key question** On 8 April, Care Quality Commission (CQC) published guidance for trusts on assessing the well-led key question under its new approach. The guidance has been developed jointly by CQC and NHS England. The guidance aims to provide a consistent understanding of what it means to be a well-led trust and reflects shared expectations across the regulators. It is structured around the eight quality statements for well-led, as set out under the new single assessment

	framework, and recognises the impact that good leadership has on staff morale and patient experiences of care. The guidance incorporates key developments in health and care policy and best practice, and includes expectations around system working, freedom to speak up and continuous improvement. CQC's new trust-wide well-led assessments will have a predominant focus on leadership, culture and governance and will result in new ratings for trusts. The full timeline for the assessments is expected to be published in the summer.
1.6	**System and Place Updates** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** The CMAST Leadership Board met on 5 April and discussed 3 significant areas of business. The first related to the policy of Right Care, Right Person and any consequential actions and impact this initiative could have on patient flow through the hospital and in particular emergency departments. The Leadership Board was next updated on the process of Trust decision making related to the Laboratory Information Management System (LIMS) Business Case. A Full Business Case and supporting documentation is due to be presented to the Boards of the five C&M 'core' Trusts in April and Wirral is one of the organisations. All present acknowledged the significant benefit and enabling impact of a LIMS system but also the challenging timing given operational and financial pressures. Finally, a significant portion of the meeting was used to discuss and explore current financial requirements, plans and risk mitigations for the 2024/5 C&M Plan. The group's discussion focussed on opportunities for significant further system savings in both the short and medium term.

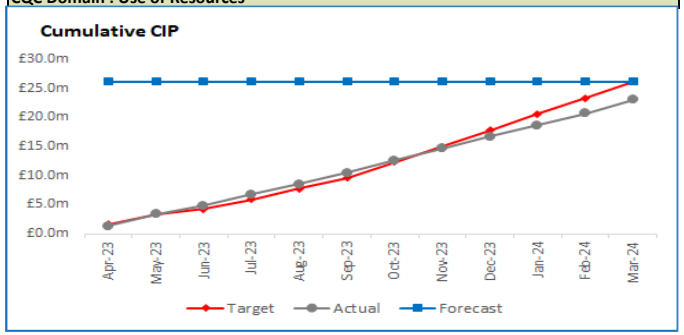
Chief Finance Officer (1)

CQC Domain : Use of Resources



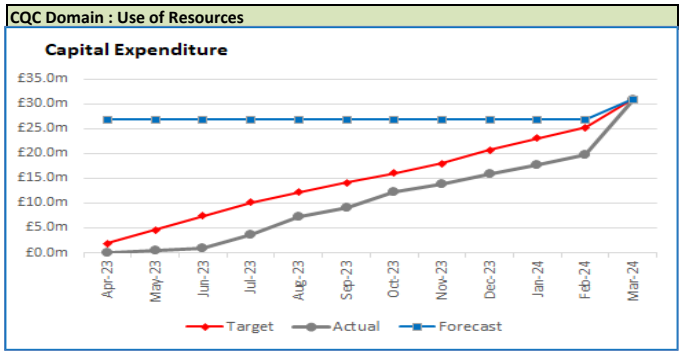
Mar-24
-£24.13m
Variance
Position worse than plan
Target
-£18.95m

CQC Domain : Use of Resources



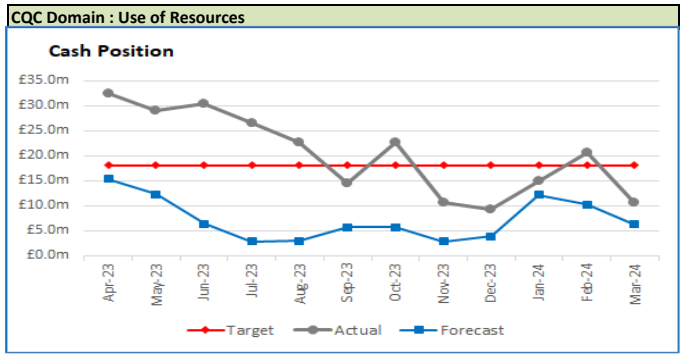
Mar-24
£23.00m
Variance
Position worse than plan
Target
£26.17m

CQC Domain : Use of Resources



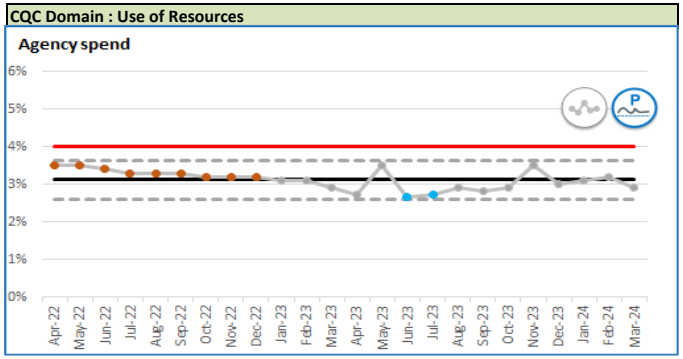
Mar-24
£30.96m
Variance
Position not worse than plan
Target
£31.0m

CQC Domain : Use of Resources



Mar-24
£10.58m
Variance
Position worse than plan
Target
£18.0m

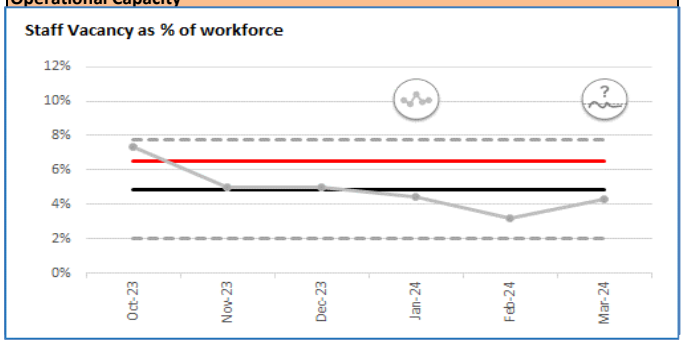
CQC Domain : Use of Resources



Mar-24
2.9%
Variance
Position better than threshold
Threshold
3.7%

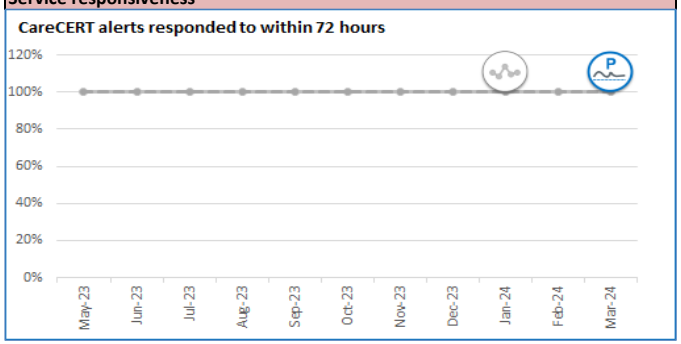
Chief Finance Officer (2) - Digital Healthcare Team

Operational Capacity



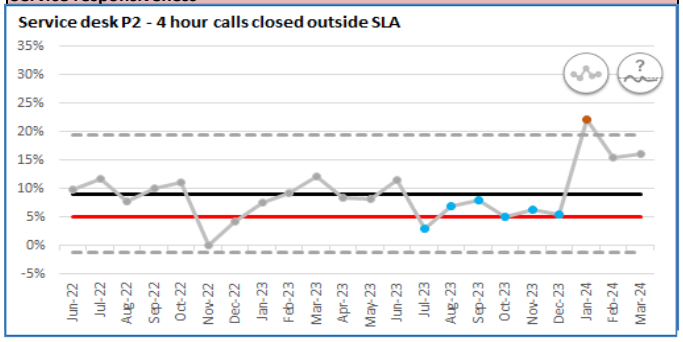
Mar-24
4.30%
Variance Type
Not enough data points yet
Threshold
<=6.5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



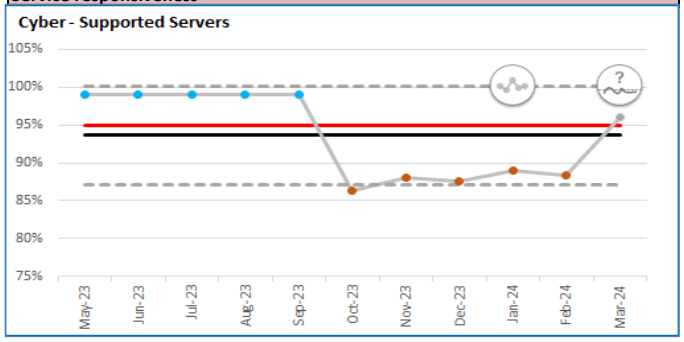
Mar-24
100%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently achieves the target

Service responsiveness



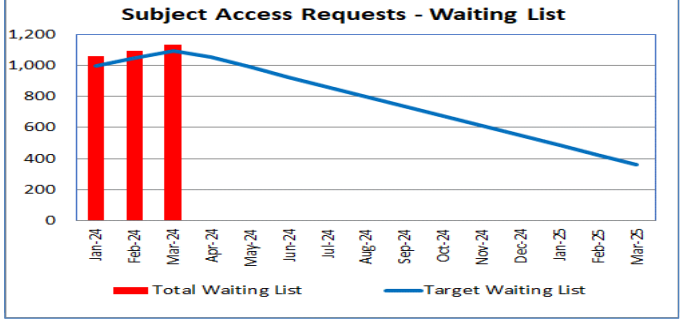
Mar-24
16.0%
Variance Type
Common cause variation
Threshold
<=5%
Assurance
Hit & miss target subject to random variation

Service responsiveness



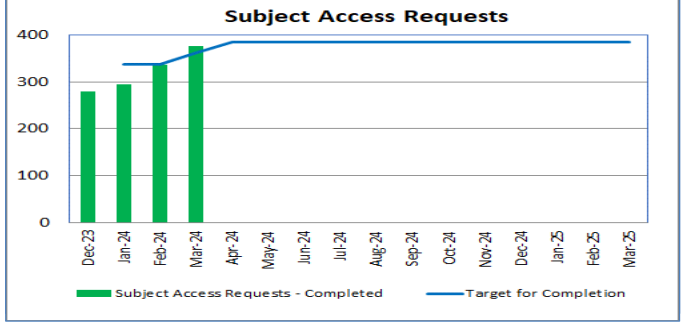
Mar-24
96%
Variance Type
Common cause variation
Threshold
>=95%
Assurance
Hit & miss target subject to random variation

Service responsiveness



Mar-24
1134
Variance
Total requests waiting worse than target
Threshold
1094

Service responsiveness



Mar-24
376
Variance
Completed requests better than target
Target
362

Chief Finance Officer

Executive Summary

At M12, the Trust has reported a deficit of £24.1m for 23/24, an adverse variance against plan of £5.1m. This £5.1m adverse variance relates to the unmitigated impact of Industrial Action with all other risks fully mitigated. This forecast variance to plan was included within the C&M ICS forecast position to NHSE at M11 and has been maintained in M12. Across 2023/24 financial risk has been managed between:

Internal risks - shortfalls in the value of elective activity, CIP achievement and overspends within Estates.
External risks – industrial action and under-utilisation of elective capacity by NHS partners.

The Trust's planned deficit and the unmitigated risk have placed significant pressure on both the Trust's cash position and compliance with the Public Sector Payment Policy (PSPP). Despite this the Trust has maintained a positive cash balance.

The significant financial improvement required for sustainability will be delivered through the medium-term finance strategy approved by the Board in April 2023. Quarterly updates are provided to the Board on progression of the strategy and the underlying financial position.

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

Statutory Financial Targets	RAG (M12)	RAG (Outturn)	Section within this report / associated chart
Financial Stability	🔴	🔴	I&E Position
Agency Spend	🟢	🟢	I&E Position
Financial Sustainability	🔴	🔴	N/A (quarterly update)
Financial Efficiency	🟡	🟢	Cumulative CIP
Capital	🟢	🟢	Capital Expenditure
Cash	🟢	🟢	Cash Position

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

The Board is asked to Note that:

- all statutory targets have been achieved with the exception of financial stability (I&E position).
- the risk rating against financial sustainability reflects the Trust's recurrent deficit and that the Trust has a medium term finance strategy to address this.
- all 2023/24 financial risk has been successfully mitigated with the exception of industrial action.

- as a result of industrial action the adverse variance to the I&E plan is £5.1m.
- this variance to plan was included within the ICS M11 forecast to NHSE.

I&E Position

Narrative:

At the end of March 2024, M12, the Trust has reported a deficit of £24.1m against a plan of £18.9m, the resultant adverse variance of £5.1m is an improvement on the M11 position (adverse £5.30m). The position includes all mitigations of the additional costs and reduced income due industrial action. It has been confirmed that no further mitigations are available.

The table below summarises the I&E position at M12:

Month 12	In Month			Year to Date		
Cost Type	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Clinical Income from Patient Care Activities	£37.4m	£35.9m	-£1.5m	£445.0m	£432.1m	-£12.8m
Other Operating Income	£3.4m	£5.1m	£1.7m	£40.0m	£43.1m	£3.1m
Total Income	**£40.8m**	**£41.0m**	**£0.1m**	**£484.9m**	**£475.2m**	**-£9.8m**
Employee Expenses	-£30.0m	-£30.6m	-£0.7m	-£355.3m	-£357.7m	-£2.4m
Operating Expenses	-£14.3m	-£11.4m	£2.9m	-£168.3m	-£164.1m	£4.3m
Non Operating Expenses	-£0.5m	-£0.6m	-£0.0m	-£6.4m	-£4.4m	£2.0m
CIP	£2.8m	£2.3m	-£0.5m	£26.2m	£23.0m	-£3.2m
B/S Release	£0.0m	£0.0m	£0.0m	£0.0m	£3.9m	£3.9m
Total Expenditure	**-£42.0m**	**-£40.3m**	**£1.7m**	**-£503.9m**	**-£499.2m**	**£4.7m**
Total	**-£1.2m**	**£0.7m**	**£1.8m**	**-£18.9m**	**-£24.1m**	**-£5.1m**

Key variances within the position are:

Clinical Income – £12.8m adverse variance relates to planned-care activity cancelled due to strike action, capacity at the CMSC not taken up by ICS partners prior to M10 and underperformance against the value of elective plan in Surgery. There has also been a reduction in PbR excluded drugs which is offset by operating expenses.
Operating expenses – The £4.3m underspend is partially due to the corresponding reductions in elective activity offset by adverse variances in Estates. The significant improvement in month reflects a full review of all non-pay commitments.
Non-operating expenses – PDC dividend payable was lower than expected and interest payable has reduced.
CIP – £23.0m of recurrent CIP has been delivered in-year which increases to £24.5m full year effect.

The Trust's agency costs were 2.9% of total pay costs in M12 compared to a maximum target of 3.7%. Plans have been agreed with Executives to further reduce agency costs from 1st April.

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

- The Trust fails to fully deliver the recurrent Cost Improvement Programme (see below and separate agenda item).
- Continuation of strike action, with a consequential impact on both expenditure and income (elective activity).
- The overspend in Estates continues and failure to implement mitigations.

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

Cumulative CIP

Narrative:
The Trust delivered £2.3m CIP in M12 which is an adverse variance to plan of £0.5m. The final position is £23.0m against a target of £26.2m. The full year effect of the schemes is £24.5m.

Risks to position:
- That the momentum on delivery of schemes is not sustained into 2024/25
- That the capacity of the Trust is not sufficient to deliver across all improvement agendas.

Actions:
- Continuation and refresh of the Productivity and Improvement Programme.
- Non recurrent measures to mitigate the recurrent shortfall.

Capital Expenditure

Narrative:
There have been no changes to the capital budget since M11 which remains at £30.961m. The capital budget is fully committed with no variance to plan.

Description	Approved Budget at M10	Reprioritisation	Proposed Revisions to Budget	Revised Budget
CDEL				
Internally Generated	£3.965m			**£3.965m**
Urgent Maintenance (ICB)	£2.920m		£2.920m	**£5.840m**
UECUP	£5.800m			**£5.800m**
UECUP - PDC	£10.000m			**£10.000m**
CDC - PDC	£4.108m			**£4.108m**
CDC - PDC P2	£0.146m			**£0.146m**
Diagnostics Digital - PDC	£0.049m			**£0.049m**
LIMS - PDC PROJECT DELAYED	£3.258m		-£3.258m	**£0.000m**
Endoscopy	£0.775m			**£0.775m**
Breast screening	£0.072m			**£0.072m**
Screening			£0.047m	**£0.047m**
IFRS16 - lease capitalisation			£0.159m	**£0.159m**
Confirmed CDEL	**£31.093m**	**£0.000m**	**-£0.132m**	**£30.961m**
Total Funding for Capital	£31.093m	£0.000m	-£0.132m	£30.961m
Capital Programme				
Backlog maintenance	£1.366m		£0.159m	£1.525m
Medical equipment	£1.916m			£1.916m
Heating and chilled water pipework replacement	£1.422m		£2.920m	£4.342m
Fire prevention works	£0.900m			£0.900m
IT equipment	£0.810m			£0.810m
UECUP - Trust funding	£5.800m			£5.800m
Contingency	£0.471m			£0.471m
Approved Capital Expenditure Budget	**£12.685m**	**£0.000m**	**£3.079m**	**£15.764m**
UECUP	£10.000m			£10.000m
CDC	£4.254m			£4.254m
Diagnostics Digital	£0.049m			£0.049m
LIMS - PDC PROJECT DELAYED	£3.258m		-£3.258m	£0.000m
Endoscopy	£0.775m			£0.775m
Breast screening	£0.072m			£0.072m
Screening			£0.047m	£0.047m
Confirmed PDC	**£18.408m**	**£0.000m**	**-£3.211m**	**£15.197m**
Total Anticipated Expenditure on Capital	£31.093m	£0.000m	-£0.132m	£30.961m

Risks to position:

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

Actions:

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

Cash Position

Narrative:

The underlying deficit position places increasing pressure on the Trust's ability to maintain a positive cash balance. At the end of March the cash balance was £10.6m. The large capital programme, a planned deficit of £18.9m and the unfunded impact of industrial action means that a positive cash balance is only possible by active daily management of the level of debtors and creditors. This arrangement is not sustainable but does mean the Trust has not had to draw upon additional borrowing from NHSE in 2023/24.

Risks to position:

- Achievement of the cash trajectory has placed delivery of the Public Sector Payment Policy at risk.
- Failure to achieve the full recurrent CIP plan has increased pressure on the cash trajectory.
- The low level of cash headroom that the Trust is working within increases the impact of any delayed payment of income due to the Trust.

Actions:

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

Chief Information Officer – Digital Healthcare Team

Overall position commentary

Strong performance is maintained in:

- Carecert alerts, which is a key control for cyber-security.

Improvements are highlighted in:

- Vacancy levels, which have reduced to 3.15%
- Cyber supported servers, again a key control for cyber-security

Key areas for improvement are:

- Subject Access Requests, where the importance of full recruitment is emphasised in delivering the agreed improvement trajectory.
- Service desk response times for Priority 2 incidents which are improved but remain too high. The focus is on issues relating to printing.

Service Responsiveness – Priority 2 calls closed outside of SLA

Narrative:

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

In February and March of 2024 15% and 16% of calls respectively exceeded the 4 hour SLA which shows a significant percentage increase compared to 2023 figures. The number of P2 calls being reported in February and March has increased from approximately 55 per month (experienced in previous months) to in excess of 85 calls per month. The vast majority of the increase can be attributed to printer related issues.

Actions:

- All printer calls are being collated to identify any underlying issues. Action plan will be put in place to address.
- In depth analysis of printer issues to validate the P2 classifications being placed on calls.

Risks to position and/or actions:

- Should no common underlying issues be discovered this may impact the ability to quickly return to target.

Service Responsiveness – Subject Access requests

Narrative:

The organisation has experienced a year on year increase in volume and complexity of Subject Access Requests (SARs) totaling 41% since 2016. Change in legislation, increase in request numbers, the complexity of the requests and the evolving attitudes towards information rights have had a significant impact on the standard of service delivery. This combination has led to a significant backlog of requests within the Access to Information

department. As at January 2024 there was a backlog of circa 1000 requests, with approximately 650 of those requests being outside of the regulatory 30 day response target.

The improvement trajectory is below target and current backlog has increased to 728 cases. This is due to the number of requests being above the monthly average figure predicted. For the previous 3 months it has been in excess of 400, which mirrors 2023 where January to March saw a similar increase. In conjunction with this rise, the team also currently has a vacancy.

Actions:

- The 2023 levels seen from January to March decreased in subsequent months, which we expect to be repeated this year.
- The current vacancy is being recruited to, with interviews being held week commencing April 15, 2024

Risks to position and/or actions:

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

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item No 8.2**
1 May 2024

Title	Chief Operating Officer's Report
Area Lead	Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Baily, Deputy Chief Operating Officer Kate Cooper, Directorate Manager Planned Care
Report for	Information

Executive Summary and Report Recommendations

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

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

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

The Board should note the ongoing improvements in reducing the number of patients with no criteria to reside in the hospital. The Trust is currently implementing the actions from the UEC Improvement Plan to ensure that the increase in demand can be met with adequate capacity to reduce the risk of corridor care and minimise the risk of daily overcrowding in ED.

Elective recovery remains a strong point and improvements continue, but medical industrial action remains the highest risk to the elective recovery programme.

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:

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

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

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

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

1	Introduction / Background
1.1	As a result of the large-scale cancellation of all but the most urgent elective activities aligned to the national Emergency Preparedness Resilience and Response (EPRR) to the COVID 19 pandemic, WUTH continues to progress elective care recovery plans to treat the backlog of patients awaiting their elective care pathway. There is national recognition of the significant disruption to elective services during the pandemic and more recently, the ongoing and prolonged industrial action. WUTH has full visibility of the volume of patients waiting at every point of care, enabling robust recovery plans which are reviewed on a weekly basis at the executive led Performance Oversight Group. The Trust has a strong elective recovery position within the region and continue to provide mutual aid to other organisations. Urgent and emergency care performance remains a challenge, and there is an internal improvement plan with steps to improve waiting time performance with a significant increase in internal scrutiny to ensure delivery of timely ambulance handover. This was presented to the Finance, Business Assurance Committee in April 2024.

2	Planned Care
2.1	**Elective Activity** In March 2024, the Trust attained an overall performance of 105.80% against plan for outpatients and an overall performance of 104.47% against plan for elective admissions as shown in the table below: Underperformance against plan continues for inpatients offset by an overperformance in daycase procedures. There continues to be an under utilisation of the Surgical Centre by another organisation.
2.2	**Referral to Treatment (RTT)** The national standard is to have no patients waiting over 104 weeks from March 2023 and to eliminate routine elective waits of over 78 weeks by April 2023 and 65 week waits by September 2024. The Trust's performance at the end of March against these indicators was as follows:

Activity Type	Target for March	Actual for March	Performance
Out pt New	11828	12459	105.33%
Out pt Follow up	28937	30692	106.06%
Total Out pts	40765	43151	105.80%
Day case	4259	4631	108.73%
Inpatients	757	609	80.45%
Total	5016	5240	104.47%

	• 104+ Week Wait Performance – 0 • 78+ Week Wait Performance – 2 (both patient choice) • 65+ Week Wait Performance - 378 • 52+ Week Wait Performance – 2116 • Waiting List Size - there were 43,819 patients on an active RTT pathway which is higher that the Trust's trajectory of 36,926. The main specialities challenged in delivering 65 weeks are Gynaecology, Upper GI and Colorectal all of which have plans in place to be compliant with the national expectation of no patients waiting longer than 65 weeks for treatment by September 2024.
2.3	**Cancer Performance** Full details of cancer performance are covered within the Trust dashboard, but exceptions also covered within this section for the end of year performance: • Faster Diagnosis Standard (FDS) – was 76.09% in February (latest available data) against a national target of 75% by March 2024. Although the final upload for March is not confirmed it is predicted that the 75% target is achieved, being the only acute trust to deliver against this indicator. • 62 day performance ended the year well ahead of trajectory with 121 patients waiting longer than 62 days against the agreed NHS England trajectory of 143. This is still longer than expected for cancer patients and there is a focus on reducing this number further during 2024/25. • 104 day long waiters – although not an official waiting time target the trust is monitored on long waits for treatment. The Trust ended the year with 41 patients waiting over 104 days. The Trust is achieving the National requirement to achieve 70% for 62-day waiters (by March 2024) and remains focussed on reducing the total number of 62 and 104 day long waiters to pre-covid levels. The continued multi-disciplinary approach to improving the efficiency of cancer pathways is working well and is being rolled out across the most challenged tumour groups.
2.4	**DM01 Performance – 95% Standard** At the end of March 97.70% of patients had been waiting 6 weeks or less for their diagnostic procedure for those modalities included within the DM01, a slight increase on last month's position of 97.61%. This is against the revised national standard of 95% and requirement for Trust's to achieve 90% by March 2024. WUTH remains on track to sustain above 95% by March 2024. The Trust has commenced providing mutual aid for a neighbouring Trust for endoscopy given the shorter waiting times at WUTH and significant waits elsewhere.
2.5	**Risks to recovery and mitigations** The clinical divisions are continuously working through options to reduce the backlogs of patients awaiting elective treatment and progress is being made to improve waiting times for patients.

	The major risk to the delivery of the elective recovery programme is the potential for ongoing medical staff industrial action as well as other staff groups. There continues to be risks on long waiting patients in Gynaecology and Upper GI, both are being closely monitored by the COO.

3.0 Unscheduled Care

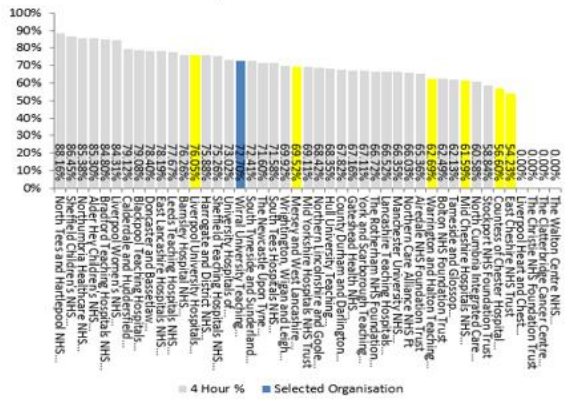
3.1 Performance

March Type 1 performance was reported at 46.53%, with the combined performance for the Wirral site at 73.31%:

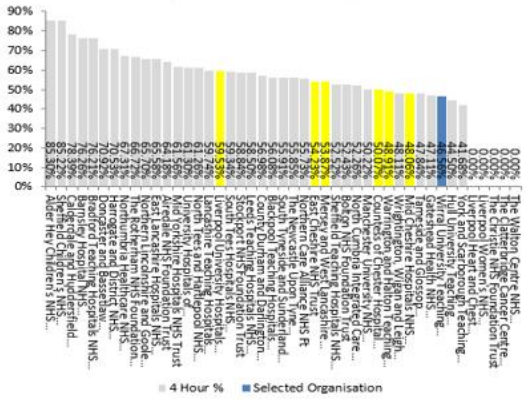
Type 1 ED attendances:	Type 3 ED attendances:
• 7,384 in February (avg. 238/day) • 8,204 in March (avg. 264/day) • 11% increase from previous month	• 3,149 in February • 3,268 in March • 3% increase from previous month

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

4hr performance weekly rank (all Types)	
Region	National
17 / 45	67 / 127

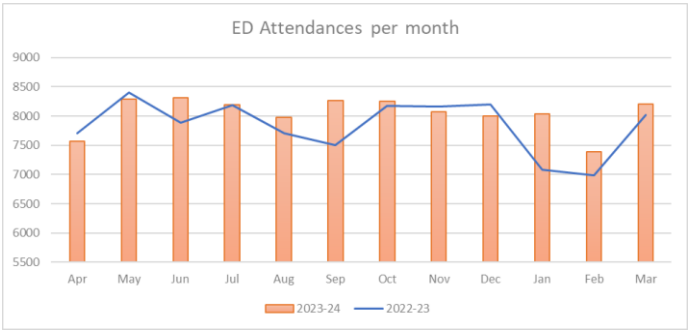


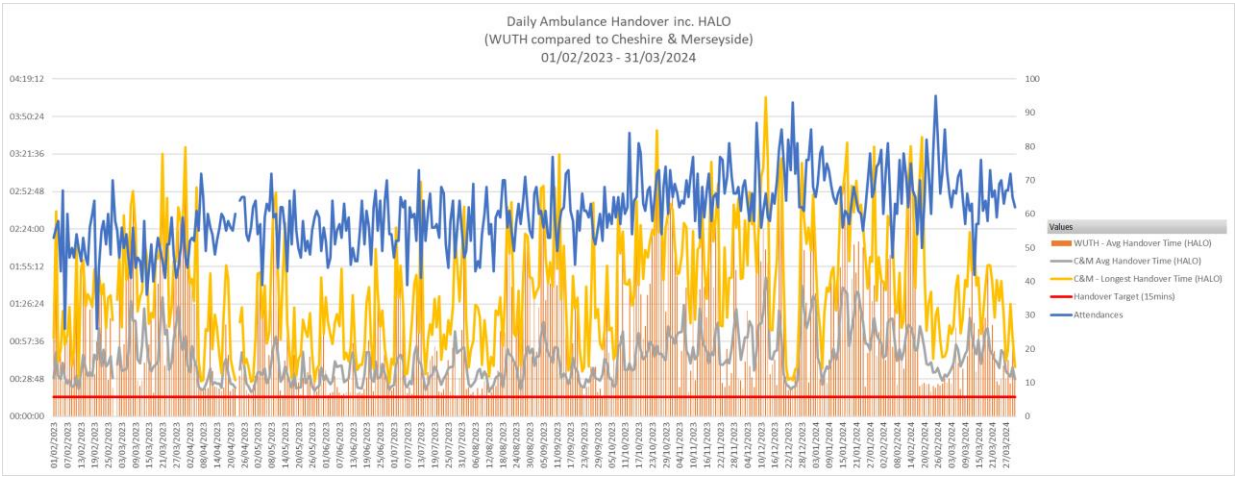
4hr performance weekly rank (Type 1)	
Region	National
38 / 45	112 / 127

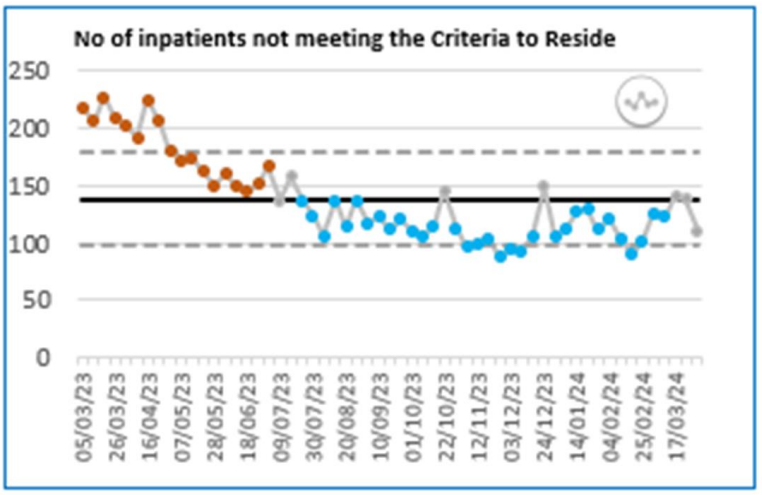


Type 1 performance remains the most significant challenge but during April improvements have been demonstrated linked to the UEC improvement plan.

A&E type-1 attendances remained high during the month of March 2024, continuing to remain above 2023-24.



	In March, compliance with the national standard for 15-minute ambulance handovers continued to see an improvement with an average daily handover of 43 minutes (46-minute average for Cheshire & Merseyside). The Trust averaged 5th out of the 9 Acute Trusts in Cheshire and Merseyside and further improvements have been demonstrated in April. In line with national guidance, compliance with ambulance handover at the Trust continues to be reviewed daily to ensure that delays to crew handover are kept to a minimum.  The Trust has completed work with AQuA which had focused on improving ambulance handover. Several good practices have been recognised, including the recent introduction of a continuous flow policy and the engagement of A&E nursing staff with improving the position. The project also identified a number of opportunities for improvement, including ensuring staff adhere to the handover process, updating the tracking screen, introducing a fit to sit model rather than keeping all patients on trolleys, increasing the Trust Same Day Emergency Care (SDEC) offer and reviewing how the Trust prioritises transfers out of ED. The findings also include recommendations for system partners, including expanding the ambulance conveyance avoidance offer with support from the local Community Trust. The actions from the AQuA recommendations will be incorporated into the UEC Improvement Plan, which is currently being revised and will be re-launched in April 2024, with a continued focus on the three targets of improving 4 hour waiting times, 15 minute ambulance handover and reducing the number of patients waiting more than 12 hours for admission.
3.2	**Transfer of Care Hub development and no criteria to reside.** As expected, the number of patients who do not meet the criteria to reside rose slightly to 110 at the end of March. The team continue to focus on the trajectory to reduce the position further to 75 by July 2024.



The Transfer of Care Hub working group is now working with system partners to focus on the four main reasons for complex delays in discharge. The pathways currently being reviewed are bariatrics, delirium, non-weight bearing patients and homelessness.

The Trust participated in the Cheshire and Mersey MADE event at the end of March to increase the number of NCTR discharges before the Easter weekend. Although the Trust did not see a significant reduction, the Trust has taken several actions with system partners to reduce the length of stay of patients through earlier intervention by community teams or social workers. The findings from the event will be presented to the Unscheduled Care Board in May 2024.

3.3 Mental Health

In March, the Trust saw a significant increase in demand for patients attending the ED with mental health conditions, with the highest number of patients attending ED on one day. The Trust worked with the local mental health provider to reduce the number of patients in ED as this posed a significant risk the safety of staff and patients. For two days there were 19 patients requiring mental health services in the ED which posed a significant risk to staff and patients which was also escalated to Cheshire and Merseyside ICB.

The refresh of mental health workstreams is also planned for April 2024 and will focus on staff training and development, improving the digital offer for mental health information capture and changes to the Mental Health Act with an improvement in the ED.

3.4 Risks and mitigations to improving urgent care performance

The Trust continues to make progress in implementing the actions from the improvement plans for each of the urgent care quality standards. The action plans have been shared with AQuA and it is anticipated that the refresh of the UEC programme will be shared in April 2024.

There remains a risk that the continued high level of attendances and acuity will challenge the improvement plans and actions. Added to this is the need to increase the number of nurses in the ED to support the requirement to release ambulance crews as soon as possible (which includes staffing corridors as required) and vacancies in junior medical staff is increasing the pressure in the department.

4 Implications

4.1	**Patients** • The paper outlines good progress with elective recovery but still waiting times for elective treatment are longer than what the Trust would want to offer but given the backlog from the Covid pandemic the Trust is in a strong position regionally in delivering reduced waiting times for patients. The paper also details the extra actions introduced recently to improve UEC performance.
4.2	**People** • There are high levels of additional activity taking place which includes staff providing additional capacity.
4.3	**Finance** • Cost of recovering activity from medical industrial action to ensure the Trust delivers against the national waiting time targets. The paper details additional resource agreed as part of the winter plan that has been introduced. The cost of providing corridor care is above the Trust's financial plan.
4.4	**Compliance** • The paper outlines the risk of not achieving the statutory waiting time targets in the main due to the impact of medical industrial action, relating mainly to 65 weeks by the end of March 2024 and 76% 4 hour performance.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.3**

01 May 2024

Title	Integrated Performance Report
Area Lead	Executive Team
Author	John Halliday - Assistant Director of Information
Report for	Information

Report Purpose and Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of March 2024.

It is recommended that the Board:

- notes performance to the end of March 2024.

Key Risks

This report relates to the key risks of:

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

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

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

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

1	Narrative
1.1	Following further discussion with the Executive Team and the Board, the performance metrics for inclusion, format and title of the report have been amended. The metrics are grouped under the responsible Executive Director, with the relevant CQC domain noted against each metric. Grouping the metrics by CQC domain shows the following breakdown for the most recently reported performance: **Summary of latest performance by CQC Domain:** Further metrics under the CFO have been added showing performance related to the Digital Healthcare Team.

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	4	3	7
Effective	0	1	1
Caring	2	2	4
Responsive	5	18	23
Well-led	2	1	3
Use of Resources	3	2	5
All Domains	16	27	43

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

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

Integrated Performance Report - April 2024

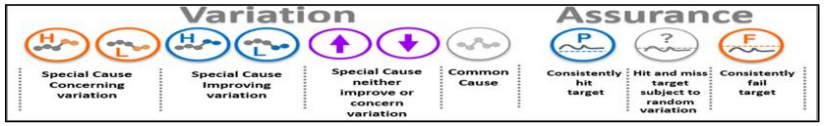
Approach

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

Summary of latest performance by CQC Domain:

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	4	3	7
Effective	0	1	1
Caring	2	2	4
Responsive	5	18	23
Well-led	2	1	3
Use of Resources	3	2	5
All Domains	16	27	43

Key to SPC Charts:



Issues / limitations

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

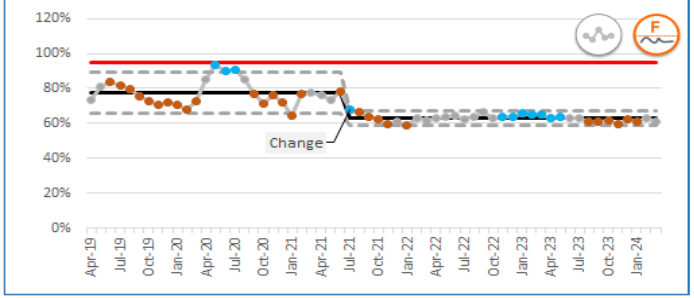
Changes to Existing Metrics:

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

Chief Operating Officer (1)

CQC Domain : Responsive

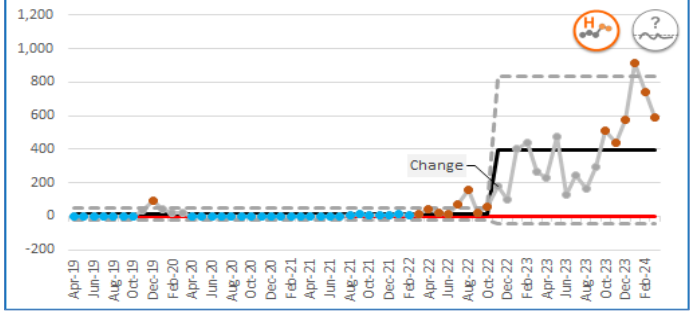
4-hour Accident and Emergency Target (including APH UTC)



Mar-24
61.1%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

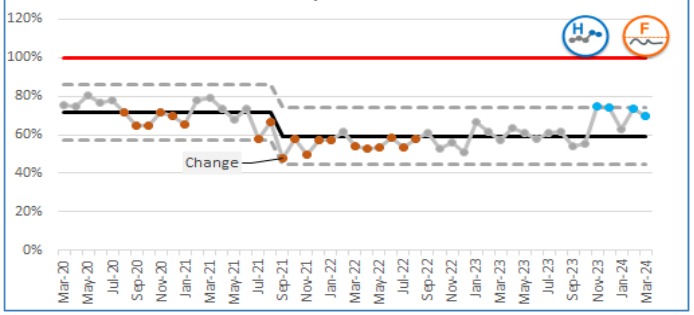
Patients waiting longer than 12 hours in ED from a decision to admit



Mar-24
587
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

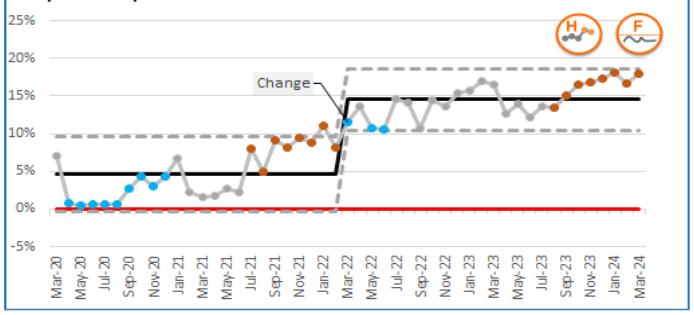
Time to initial assessment for all ED patients - % within 15 mins



Mar-24
69.6%
Variance Type
Special cause variation - improving
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

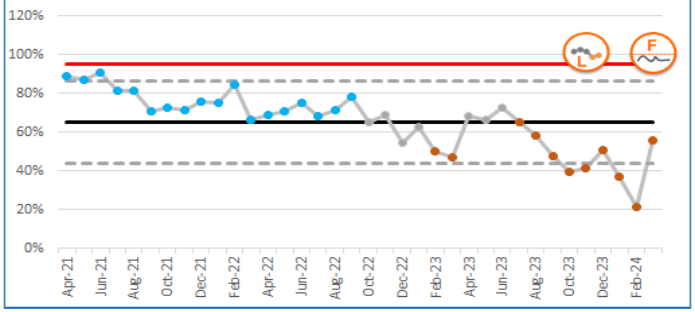
Proportion of patients more than 12 hours in ED from time of arrival



Mar-24
17.9%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

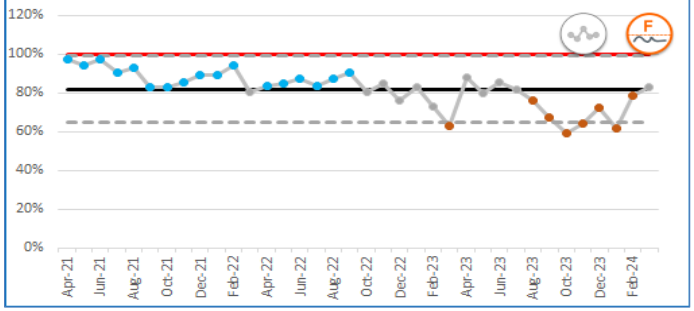
Ambulance Handovers: % < 30 mins



Mar-24
55.8%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

Ambulance Handovers: % < 60 mins

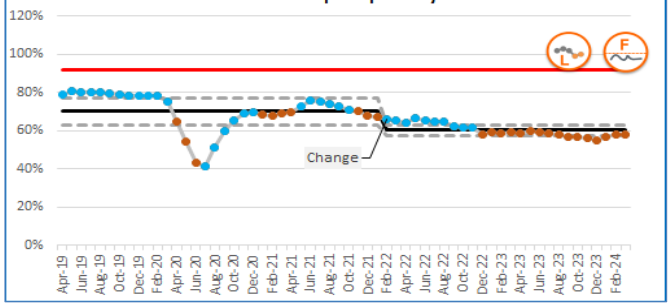


Mar-24
82.7%
Variance Type
Special cause variation - concerning
Threshold
100%
Assurance
Performance consistently fails to achieve the target

Chief Operating Officer (2)

CQC Domain : Responsive

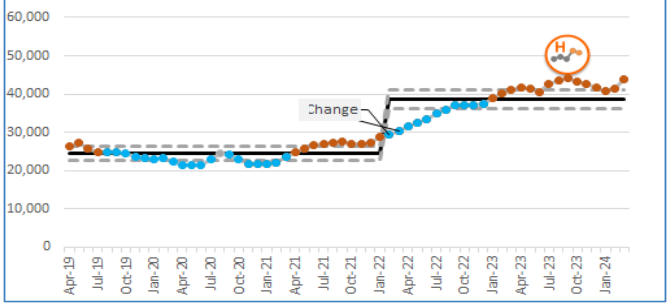
18 week Referral to Treatment - Incomplete pathways < 18 Weeks



Mar-24
58.19%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

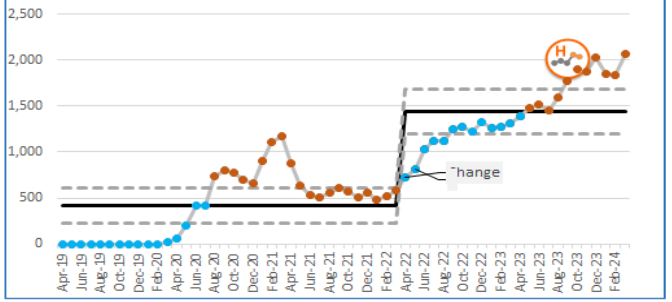
Referral to Treatment - total open pathway waiting list



Mar-24
43883
Variance Type
Special cause variation - concerning
Threshold
≤ 36926
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

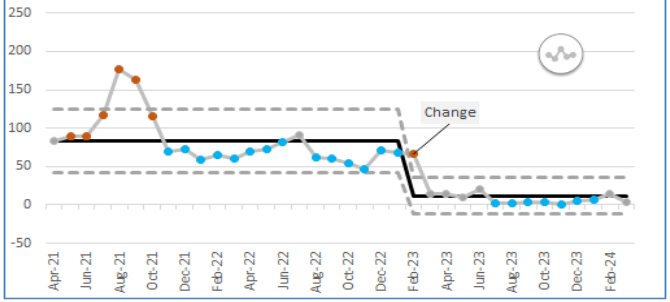
Referral to Treatment - cases exceeding 52 weeks



Mar-24
2065
Variance Type
Special cause variation - concerning
Threshold
1030
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

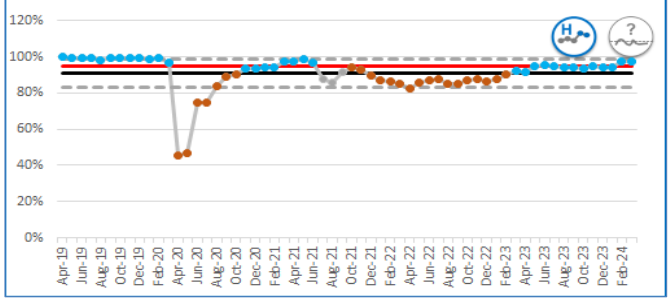
Referral to Treatment - cases waiting 78+ wks



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

CQC Domain : Responsive

Diagnostic Waiters, 6 weeks and over - DM01

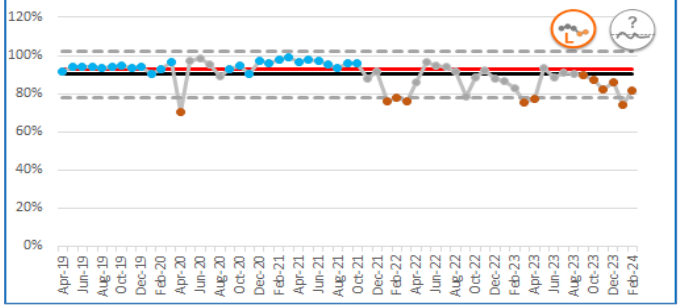


Mar-24
97.7%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

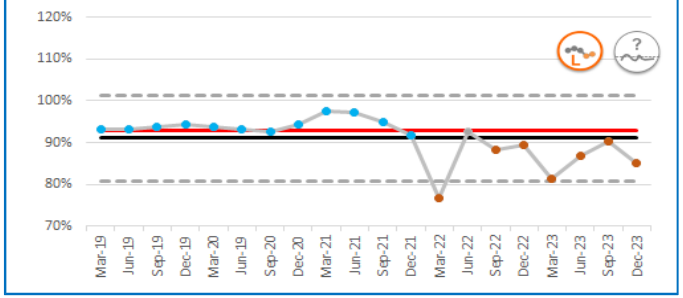
Cancer Waits - 2 week referrals (monthly)



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

CQC Domain : Responsive

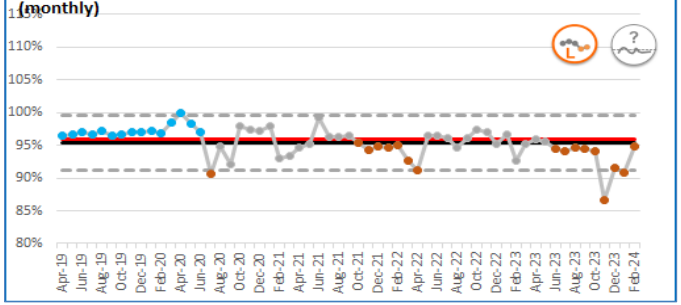
Cancer Waits - 2 week referrals (quarterly)



Dec-23
85.1%
Variance Type
Special cause variation - concerning
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

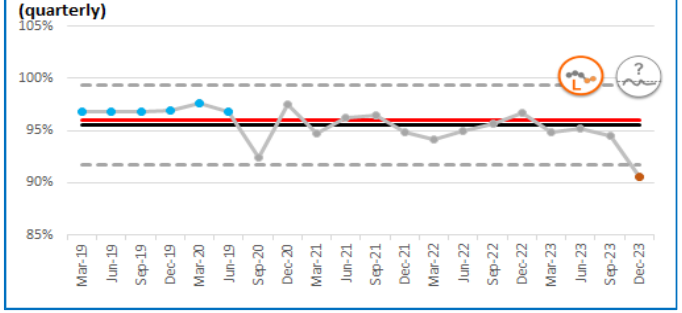
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



Feb-24
94.8%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

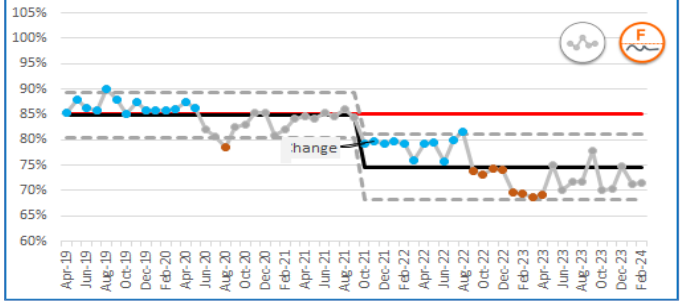
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



Dec-23
90.6%
Variance Type
Special cause variation - concerning
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

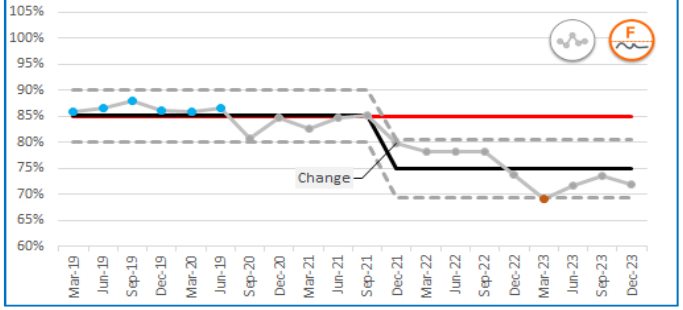
Cancer Waits - 62 days to treatment (monthly)



Feb-24
71.5%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

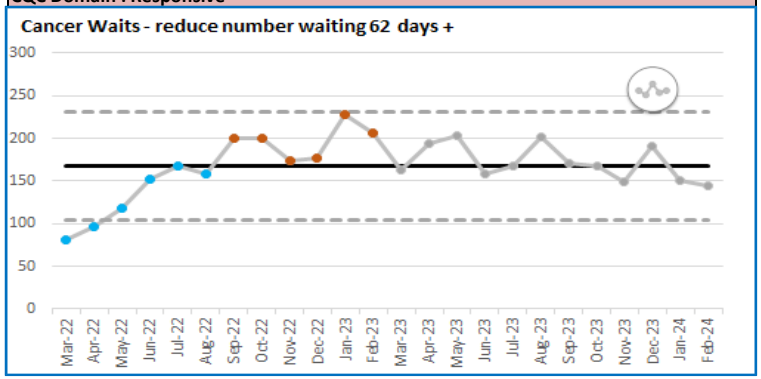
Cancer Waits - 62 days to treatment (quarterly)



Dec-23
71.8%
Variance Type
Common cause variation
Threshold
≥85%
Assurance
Performance consistently fails to achieve the target

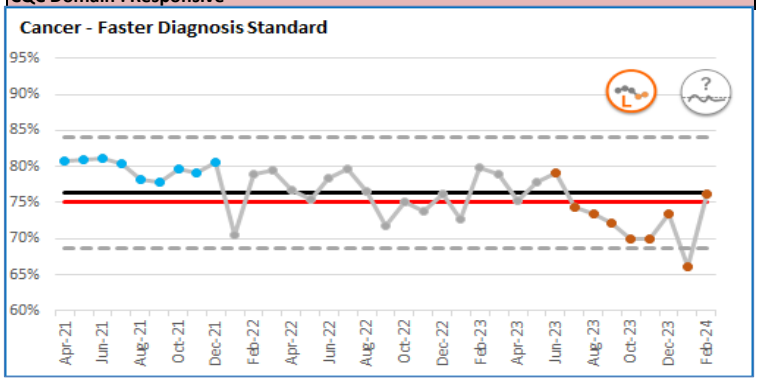
Chief Operating Officer (4)

CQC Domain : Responsive



Mar-24
115
Variance Type
Common cause variation
Threshold
143
Assurance
Trajectory target not appropriate for SPC Assurance reporting

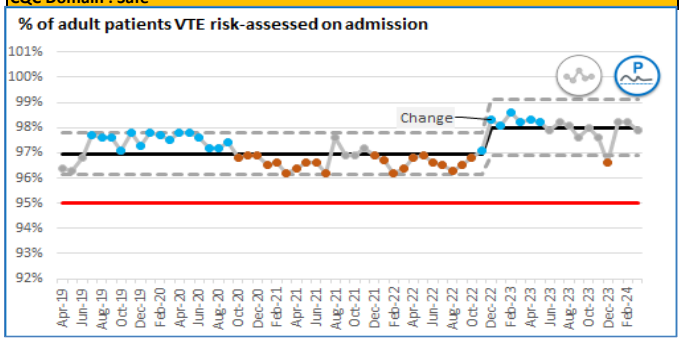
CQC Domain : Responsive



Feb-24
66.1%
Variance Type
Special cause variation - concerning
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

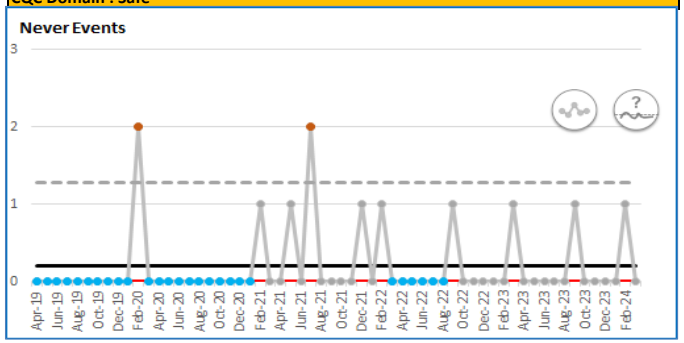
Medical Director (1)

CQC Domain : Safe



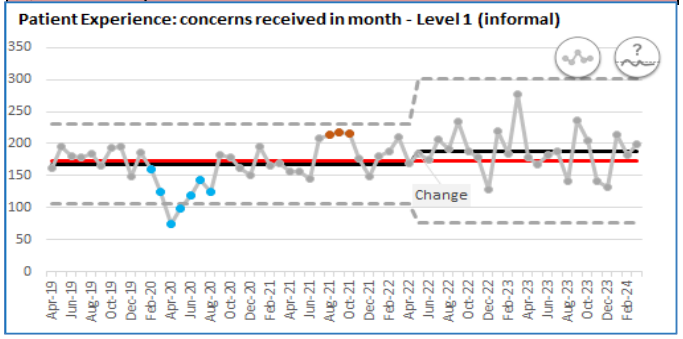
Mar-24
97.9%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



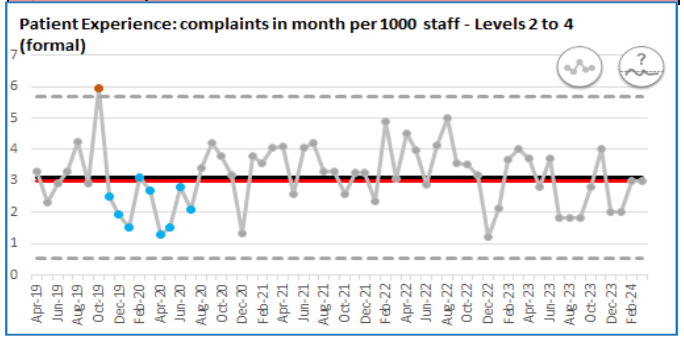
Mar-24
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



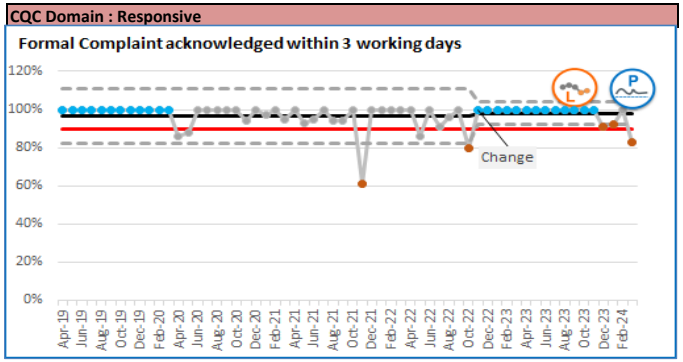
Mar-24
199
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



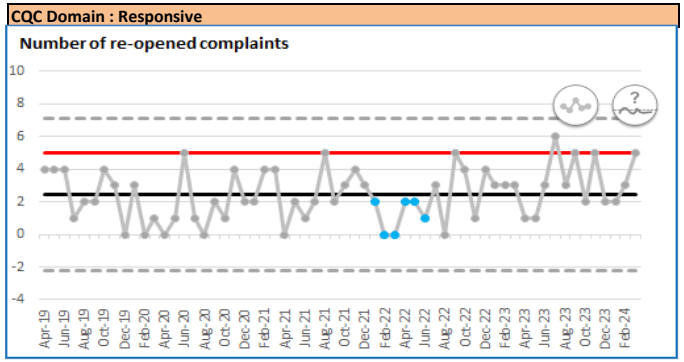
Mar-24
3.0
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



Mar-24
83.0%
Variance Type
Special cause variation - concerning
Threshold
≥90%
Assurance
Performance consistently achieves the target

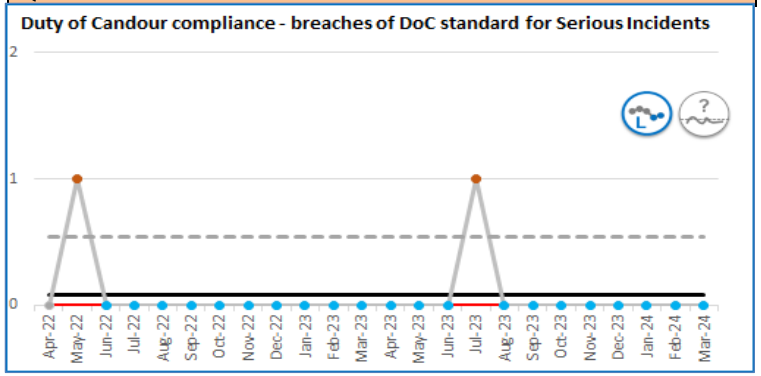
CQC Domain : Responsive



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

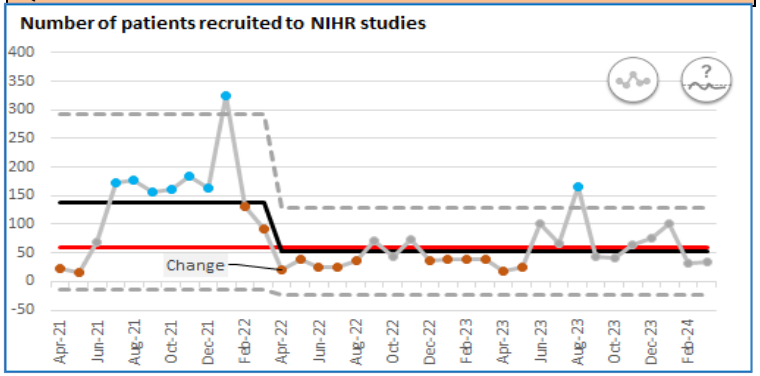
Medical Director (2)

CQC Domain : Well-led



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

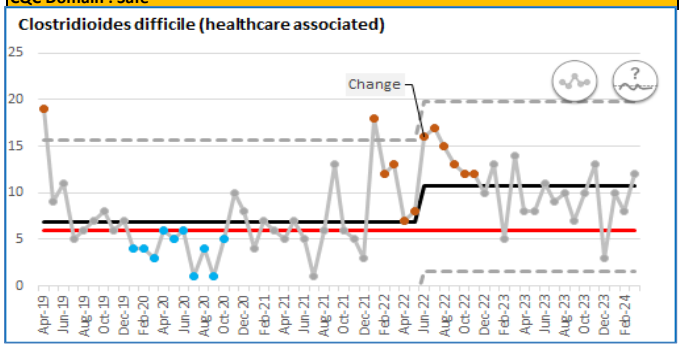
CQC Domain : Well-led



Mar-24
35
Variance Type
Common cause variation
Threshold
700 pa (trajectory)
Assurance
Hit & miss target subject to random variation

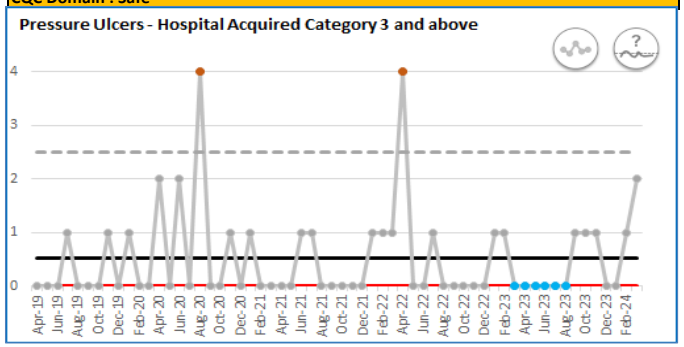
Chief Nurse

CQC Domain : Safe



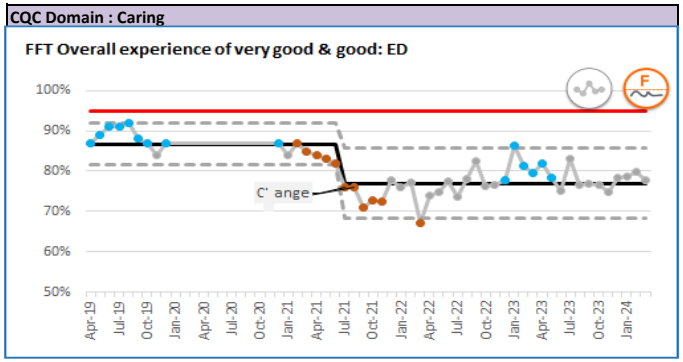
Mar-24
12
Variance Type
Common cause variation
Threshold
≤6
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



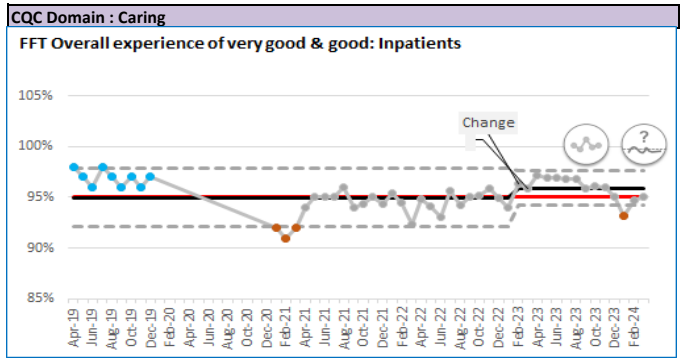
Mar-24
2
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



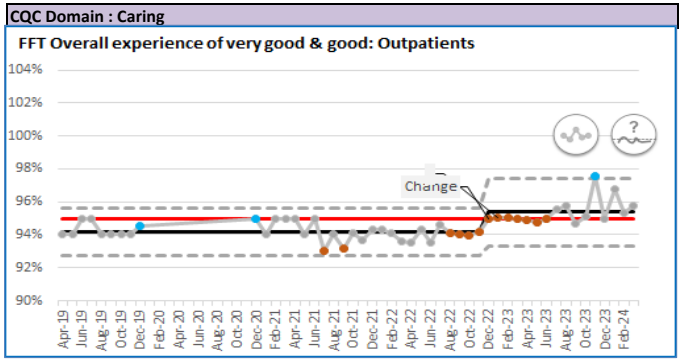
Mar-24
77.6%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring



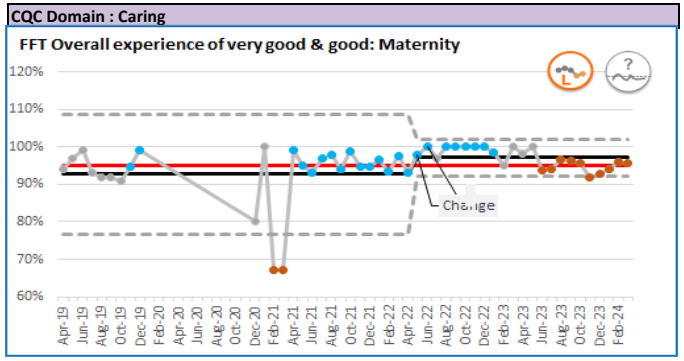
Mar-24
94.99%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



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

CQC Domain : Caring



Mar-24
95.5%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse

Overall position commentary

A local threshold of 6 / 5 *Clostridioides difficile* per calendar month has been set to achieve the year end ambition. In March, the threshold of 5 was exceeded by 6, having reported 12. Whilst this is 38 infections reported over the year end threshold it is a decrease of 33 when compared to the same period last year.

The 5 key priorities identified that underpin the CDT improvement work continue to be communicated weekly in The Trust bulletin with monthly related themes and newsletters to improve awareness to staff as per the agreed IPC communication and engagement strategy. The theme for March was hand hygiene.

Clostridioides difficile (healthcare associated)

Narrative:
The NHS standard contract for 2023-24 identifies the *C.difficile* threshold for each trust; our threshold for 2023-24 is 71.

Actions:

- The Bi-weekly DIPC MDT CDT improvement group continues with learning from *C difficile* rapid evaluations of care discussed and learning disseminated to the divisions.
- Yellow cards continue to be handed to staff who are observed not following the trust Hand hygiene policy, the cards detail the principles of the policy and reminds staff that effective hand hygiene helps to keep patients safe by protecting them from infection.
- Introduction of a Trust wide poster with a QR code requesting visitors to submit their opinions on staff hand hygiene and general cleanliness.

Risks to position and/or actions:

- Annual threshold has been exceeded by 38.
- Bed occupancy intermittently inhibits the ability to implement the HPV proactive and reactive cleaning schedule and the rapid isolation of infected patients.

FFT Overall experience of very good and good.

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

Inpatient FFT in March was 94.99% which is 0.01% below the local target analysis of the patient comments for inpatient services indicates that their reasons for providing a negative response is linked to their initial experience within ED, highlighting waiting times, delays and communication, these are also the reasons highlighted for negative responses in ED who's recommend rate was 77.6%.

Actions:

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

Risks to position and/or actions:

- Bed occupancy impacting on the length of time patients remain within ED: Processes are in place operationally to prevent this where possible.
- Whilst car parking continues to be a theme of negative feedback this has shifted from a subcategory of the inability to find a car parking space to frustrations related to pay machines and parking charges. These comments have been shared with the Capital Estates and Facilities Division

Pressure ulcers Hospital Acquired Category 3 and above

Narrative:

WUTH has a zero tolerance on Hospital Acquired HA Pressure Ulcers category 3 and above. During March there were two HA Category 3 pressure ulcer reported across Two wards within the Medical Division, both Pressure ulcers were on the sacral area. A Rapid Evaluation of Care REC has been requested however is awaiting presentation to identify the learning outcomes.

Actions:

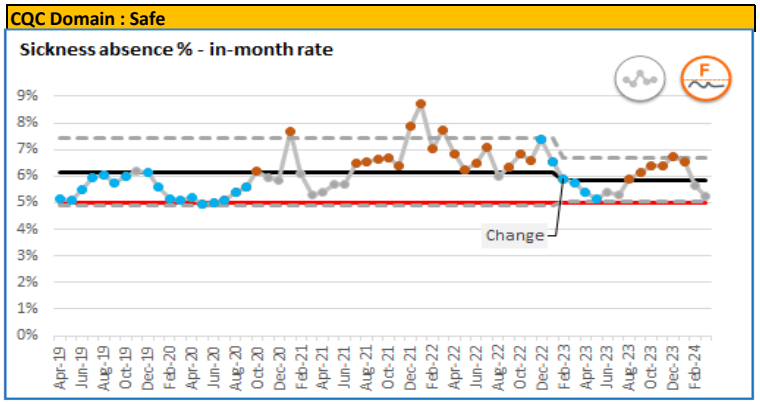
The Trust commenced with the implementation of Purpose T as its Pressure ulcer risk assessment replace Braden from the 1st April 2024.
The Trust has an overarching Trust Pressure Ulcer improvement plan with Divisional specific improvement plans identifying divisional themes and trends.
Review underway in relation to documentation provisions with Cerner system to streamline documentation.
Trust Wide Mattress Provision

Risks to position and/or actions:

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

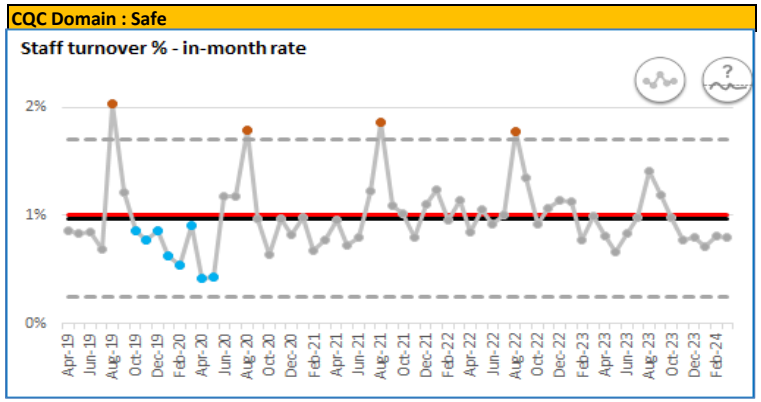
Chief People Officer

CQC Domain : Safe



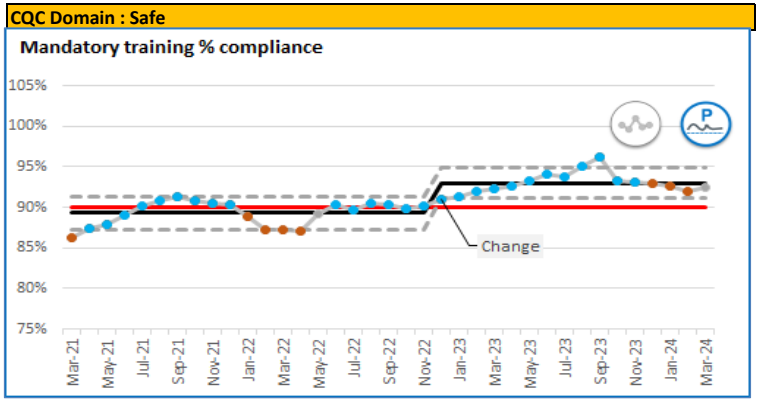
Mar-24
5.26%
Variance Type
Common cause variation
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Safe



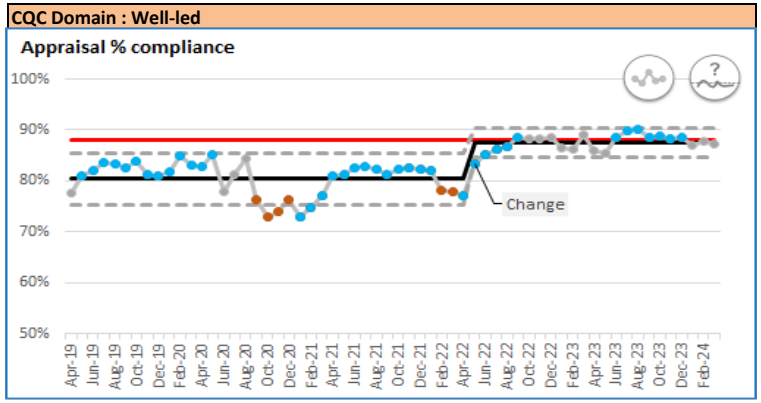
Mar-24
0.79%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



Mar-24
92.44%
Variance Type
Common cause variation
Threshold
≥90%
Assurance
Performance consistently achieves the target

CQC Domain : Well-led



Mar-24
87.27%
Variance Type
Common cause variation
Threshold
≥88%
Assurance
Hit & miss target subject to random variation

Chief People Officer

Overall position commentary

Despite operational pressures the Trust's People KPIs for mandatory training and turnover remain on target. Appraisal compliance was adversely impacted by strike action and remains slightly below target but with Divisional trajectories in place to achieve target. Sickness absence also remains above target but with a further improvement in month.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For March 2024 the indicator improved and is at 5.26%, which is a further improvement from the previous month.

The improvement in the position is driven by a decrease in short term sickness absence, and improvements across all Divisions.

Focus remains on supporting the health and wellbeing of our staff. A number of measures are in place to offer enhance support, boost morale, support mental and physical wellbeing, and help build resilience.

Actions:

- Ongoing delivery of Attendance Management Policy awareness sessions as part of the new policy launch.
- Wet work / HAVS (hand-arm vibration syndrome) policy ratified Trust wide (links to the Trust's Health Surveillance Policy).
- Check-Ins recording to increase uptake; focusing on staff contribution, development and wellbeing.
- Promotion of the Manager Essentials Programme.
- Vaccine programmes including measles and pertussis.
- Promotion of the clinician-led enhanced emotional resilience and staying healthy workshops throughout April. New bespoke Health Anxiety sessions commence in May.
- Additional counselling sessions to reduce waiting lists.
- Delivery of Health Surgeries to increase visibility supported by the EAP, Alcohol Team, Menopause Midwife and OH Nurses.
- Reduced OH Nurse and Dr waiting times.
- Increased focus on physical health with the promotion of bi-weekly staff Zumba sessions.

Risks to position and/or actions:

The management of sickness absence is primarily management led as they are responsible for monitoring employee attendance addressing sickness absence and ensuring that the policy is applied consistently, supported by the HR team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels and staff morale / engagement. Effective attendance management is critical and contributes to productivity and patient care. The Trust continues to promote a positive attendance culture by investing in, and focusing on, employee health and wellbeing initiatives to help mitigate this risk by preventing ill-health and supporting people to balance work whilst minimising the impact of any ill-health symptoms, where possible. Managing attendance can also help control costs related to overtime, absenteeism and temporary staffing.

Work continues on the agreed year 2 deliverables within the People Strategy with a number of workstreams that will support attendance across the Trust, this includes promotion of the new flexible working brochure, which is available to all staff, and the implementation of WUTH Perfect Start as part of the Trust-Wide Strategic Retention Group. Work has commenced on finalising year 3 deliverables which will include delivering against the Growing OH and Wellbeing together strategy as set out in the NHS People Plan to improve the health and wellbeing services for our people, to keep them safe and healthy and able to provide good care to our patients. This is part of our proactive culture of wellbeing across the trust.

Appraisal % compliance

Narrative:

The threshold for Appraisal compliance is 88% and for the month of March 2024 compliance remains below the threshold at 87.27%, demonstrating common cause variation.

Whilst the introduction of the new appraisal approach (launched in April 2023) has had a positive impact upon appraisal compliance overall, divisions are struggling to recover their position following the industrial action during the winter period. Divisional leaders have committed to restoring compliance by April 2024 and are working closely with HR Business Partners to ensure successful delivery of their trajectory.

Actions:

- Following a review of compliance data at Februarys Workforce Steering Board (WSB), and subsequent discussion and challenge to divisions tracking below target, Divisional Leaders have committed to achievement of their trajectory by April 2024. This will be reviewed at April's WSB meeting.
- Divisional leaders and HR business partners continue to identify areas of lower performance and work with service leads to address compliance gaps.
- The Learning and Development Team contacts all individuals that are out of compliance and due to become out of compliance with details about the appraisal process.
- Contact is also made with all line managers each month to actively highlight gaps in compliance and provide information and guidance on the process, note this is in addition to ESR automatic messages which are also issued.
- Development for managers continues with online resources and guidance made available together with formal management training.
- The intranet has a comprehensive suite of guidance and 'on-demand' learning resources that brief staff and managers on the new process.

- A new appraisal ‘portlet’ has been developed in collaboration with the national ESR Team. This makes recording appraisal easier for managers with a short step by step video to assist them in recording appraisals.
- The Learning and Development Team have offered short-term interim support to divisions to support with recording of appraisals during periods of significant system pressures and ongoing industrial action.

Risks to position and/or actions:

- Ongoing system pressures continue to be a risk to capacity for managers and staff to have quality appraisal discussions. To help mitigate this, the OD Team will work in collaboration with HR to provide targeted awareness sessions for teams / services that are particularly lower in compliance.

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Board Assurance Framework
April 2024

Item 8.4

Contents

1. Introduction

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

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

Baker Tilly 2021

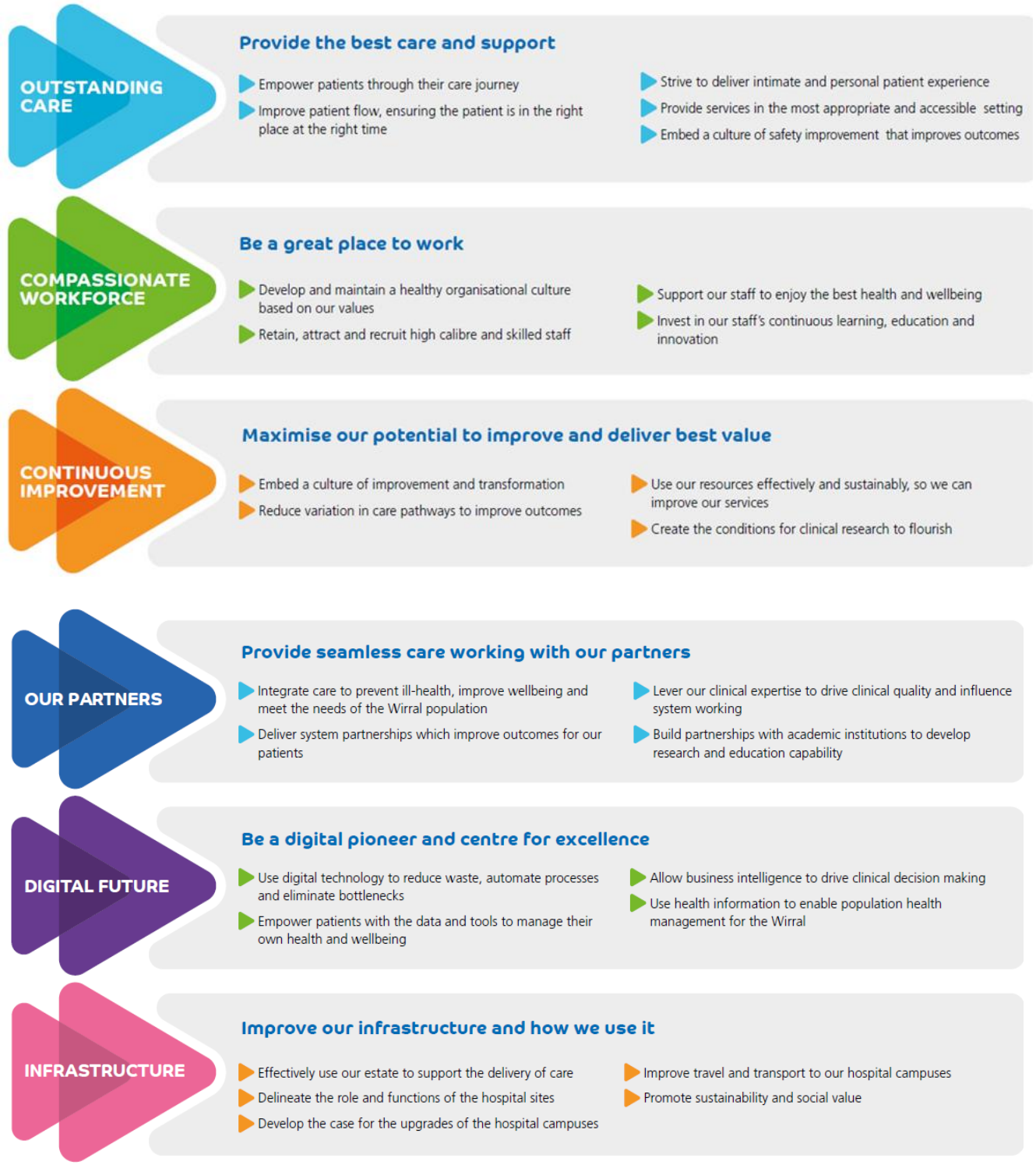
2. Vison, Strategy and Objectives

2.1 Our Vision

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

2.2 Our Strategic Objectives

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



3. Our Risk Appetite

3.1 Risk Appetite Statement

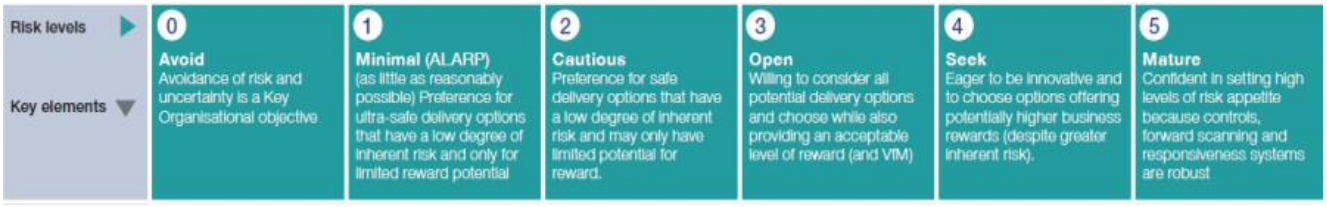
The Trust endeavours to establish a positive risk culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

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

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

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

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



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

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

4. Operational Risk Management

4.1 Operational Risk Management

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

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

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

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

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

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

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

The Trust shall achieve this by:

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

In order to support the Risk Management Process the Trust (via the Risk Management Committee) gives consideration to the latest set of significant risks at each meeting.

In order to further align this process the current list of significant risks is now included as an appendix to this BAF.

4.2 Risk Categorisation

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

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

5. Creating and Monitoring the BAF

5.1 Creation of the BAF

The original refreshed version of the BAF was created and approved in September 2021 following discussions and workshops with all Board members. The BAF is updated on a bi-monthly basis and subject to a full refresh on an annual basis.

5.2 Monitoring the BAF

It was agreed that the BAF would be subject to ongoing refreshment and that it would be subject to regular monitoring, it was noted that the schedule had been designed to help highlight the BAF and its content and widen engagement across the Trust. Having achieved this aim it is now proposed that the schedule will revert to that originally in place and in line with sector norms as follows:

- Reports to the Board at every other meeting.
- Reports to every other meeting of the Audit and Risk Committee with oversight of the Risk Management Framework and Strategy.
- Reporting to every other meeting of relevant Board Committees.
- Reporting to every other meeting of the Trust Management Board.
- Cyclical (at least yearly) circulation to Divisional Boards for information and to raise awareness; and
- Reporting to every other meeting the Risk Management Committee.

6. Update Report

6.1 Purpose

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

The controls, assurance, and actions for most of the current strategic risks have been, or are being, reviewed with Executive Team members and further iterations will be reflected in future reports to Board.

6.2 Changes to the previous version

Following the annual review of the BAF the Board has approved the strategic level risk that will be monitored for the year 2024/25. Work has commenced to update previous risks and populate newer risks. All updates will be fully completed over the coming month.

6.3 Risk Appetite and Risk Maturity

The report includes the current position of the Trust in relation to Risk Appetite and Maturity.

6.4 Recommendations

Board is asked to:

- Consider and Approve the proposed changes to the BAF.
- Note the current position in regard to Risk Appetite and Risk Maturity.
- Note the amendments to the frequency of BAF reporting which will be implemented from this meeting.

Board Assurance Framework Dashboard								
Strategic Priority	**Risk No**	**Risk Description**	**Lead**	**Committee**	**Original Score (I and L)**	**Current (I and L)**	**Direction of Travel**	**Target (I and L)**
Outstanding Care **R, O, C, F**	1	Failure to effectively manage unreasonable unscheduled care demand, adversely impacting on quality of care and patient experience.	Chief Operating Officer	Finance and Board	20 (4 x 5)	12 (4 x 3)	↔	12 (4 x 3)
Outstanding Care **R, O, C, F**	2	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	Chief Operating Officer	Finance and Board	16 (4 x 4)	12 (4 x 3)	↔	12 (4 x 3)
Outstanding Care **R, O, C, F**	3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	Medical Director	Quality and Board	16 (4 x 4)	12 (4 x 3)	↔	12 (4 x 3)
Compassionate Workforce **O, C, F**	4	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	↓	6 (3 x 2)
Compassionate Workforce **R, O, C, F**	5	Failure of the Trust to have the right culture, staff experience and organisational conditions to deliver our priorities for our patients and service users.	Chief People Officer	People	16 (4 x 4)	9 (3 x 3)	↓	6 (3 x 2)
Continuous Improvement **R, O, F**	6	Failure to embed the Trust's approach to planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans.	Chief Finance Officer	Finance	16 (4 x 4)	9 (3 x 3)	↓	8 (4 x 2)
Digital Future **R, O, F**	7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.	Chief Finance Officer	Finance	**TBD**	**TBD**	**N/A**	**TBD**
Continuous Improvement **R, F**	8	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.	Chief Strategy Officer	Board	16 (4 x 4)	9 (3 x 3)	↓	6 (3 x 2)
Our Partners **R, S, F**	9	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and Wirral review as a long term threat or opportunity to service sustainability.	Chief Executive Officer	Board	12 (4 x 3)	9 (3 x 3)	↓	6 (3 x 2)
Infrastructure **R, O, C, F**	10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.	Chief Strategy Officer	Capital and Board	16 (4 x 4)	12 (4 x 3)	↓	9 (3 x 3)
Infrastructure **R, O, C**	11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.	Chief Operating Officer	Board	**TBD**	**TBD**	**N/A**	**TBD**
Our Partners **R, O, C, F**	12	Failure to work with local partners to address and reduce health inequalities across the Wirral population.	All Directors	Board	**TBD**	**TBD**	**N/A**	**TBD**

12 Month Trend

Risk No	Risk Description	Initial Score	Target	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24		Apr 24 Current
1	Failure to effectively manage unscheduled care demand, adversely impacting on quality of care and patient experience.	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)		12 (4 x 3)
2	Failure to meet constitutional/regulatory targets and standards, resulting in an adverse impact on patient experience and quality of care.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)		12 (4 x 3)
3	Failure to ensure adequate quality of care, safety and patient experience resulting in adverse patient outcomes and an increase in patient complaints.	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)		12 (4 x 3)
4	Failure to effectively plan for, recruit, reduce absence of, retain and develop people with the right skills, this may adversely impact on the Trust's ability to deliver the Trust's strategy.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)		9 (3 x 3)
5	Failure of the Trust to have the right culture, staff experience and organisational conditions to deliver our priorities for our patients and service users.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)		9 (3 x 3)
6	Failure to embed the Trust's approach to planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans.	16 (4 x 4)	8 (4 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)		9 (3 x 3)
7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.	**TBD**	**TBD**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**		**TBD**
8	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.	16 (4 x 4)	6 (3 x 2)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)		9 (3 x 3)
9	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and Wirral review as a long term threat or opportunity to service sustainability.	12 (4 x 3)	6 (3 x 2)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)	8 (4 x 2)		9 (3 x 3)
10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)	9 (3 x 3)		12 (4 x 3)
11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.	**TBD**	**TBD**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**		**TBD**
12	Failure to reduce health inequalities for the Wirral population due to the absence of effective partnership working.	**TBD**	**TBD**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**		**TBD**

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

Strategic Priority	Outstanding Care				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	Chief Operating Officer	20 (4 x 5)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

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

Gaps in Control or Assurance	Actions
• The Trust continues to be challenged delivering the national 4 hour standard for ED performance. • The inability of the system to respond to the unprecedented UEC pressures and delivery of alternative care settings for patients that do not have a criterion to reside means the Trust occupancy is consistently above 95%, making the delivery of the four target very challenging.	• There is one overall Emergency Department Improvement Plan in place which focusses on ambulance turnaround times, time patients spend in the department and all other national indicators. Following the completion of several service improvements the operational plan for ED will be revised to include new areas of focus as the new leadership team for that area commence in post. • Develop with Wirral system partners a response to the Improving Urgent and Emergency Care Services released in January 2023. • Response to the national 10 high impact actions in preparation for winter • Design of a more streamlined UEC pathway • System 4 hour performance response to deliver 76% in March.

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

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

Strategic Priority	Outstanding Care				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	Chief Operating Officer	16 (4 x 4)	12 (3 x 4)	12 (3 x 4)	12 (4 x 3)

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

Gaps in Control or Assurance	Actions
• National challenge relating to medical staff rates of pay creating uncertainty with regards to additional capacity. • Industrial Action is creating a significant gap in plans to achieve the 2023/24 access targets • Impact of industrial action • 2 specialities are challenged in delivery of 65 and 75 weeks.	• Continue with delivery of mitigation plans for scheduled care, managing the risk with the utilisation of the national policy on clinical prioritisation. • Explore alternative avenues of providing additional core surgical capacity to reduce the backlog of long waiting patients. • **Utilisation of the LLP to deliver the gap in recurrent capacity.**

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

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

Strategic Priority	Outstanding Care				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	Medical Director	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	12 (4 x 3)

Controls	Assurance
• Patient Safety Governance Process. • CQC compliance focus on ensuring standards of care are met. • Embedding of safety and just culture. • Implementation of learning from PSIRF. • Development and implementation of Patient safety, quality and research and innovation strategies. • Monitoring and review of quality and safety indicators at monthly divisional performance reviews and bi-annual Corporate Service Performance Reviews. • WISE Accreditation Programme. • GIRFT. • Trust safety huddle.	• Patient Safety and Quality Board oversight and monitoring of quality and clinical governance themes and trends through the Quality and Patient Safety Intelligence Report at Quality Assurance Committee • Mortality Review Group Oversight Regular board review of Quality Performance Report, highlighting exceptions and mitigations • IPCG and PFEG • CQC engagement meetings • Cheshire and Merseyside ICB oversight of Trust clinical governance, including Sis, never events action plans. • Internal Audit – MIAA • PSIRF • Maternity self-assessment • Board focus on R and I • Clinical Outcomes Group • Trust led CQC mock inspections • Daily Safety Huddle • JAG accreditation • C and M Surgical Centre • LLP Assurance.

Gaps in Control or Assurance	Actions
• Fully complete and embedded patient safety and quality strategies • Industrial action impacts • Current operational impacts • Capital availability for medical equipment • Medical workforce gaps.	• Complete implementation, monitoring and delivery of the patient safety and quality strategies. • Monitoring Mental Health key priorities • Complete delivery of the Maternity Safety action plan • Ongoing review of IPC arrangements – SIT Review. • CQC preparedness programme and mock inspections

Progress
Key Changes to Note • Additional actions added.

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

Strategic Priority	Compassionate Workforce				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

Controls	Assurance
• International nurse recruitment. • CSW recruitment initiatives, including apprenticeship recruitment. • Vacancy management and recruitment systems and processes, including TRAC system for recruitment. • E-rostering and job planning to support staff deployment. • Strategic Retention Group in place and year 1 programme delivered. • Retention Task and Finish Groups in place for all relevant staff groups. • Facilitation in Practice programme. • Training and development activity, including launch of leadership development programmes aligned to the Trust LQF. • Utilisation of NHS England and NHS National Retentions programme resource to review and implement evidence based best practice. • Effective utilisation of the Trust's EAP has increased uptake across the organisation and is enabling staff to access support more quickly. • Clinical Psychotherapist led wellbeing sessions 'to help staff manage emotional adversity and stay healthy' have been delivered across the Trust. • Career clinics have recommenced within Nursing and Midwifery • Year 2 of flexible working policy. • Implementation of the Perfect Start. • Develop an Engagement Framework • Transform the delivery of our Occupational Health and Wellbeing Service to align to the Grow OH Strategy. • Leadership Qualities Framework and associated development programmes and masterclasses. • Bi-annual divisional engagement workshops • Staff led Disability Action Group.	• Workforce Steering board and People Committee oversight. • Internal Audit. • People Strategy.

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

Progress
Key Changes to Note • N/A

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

Strategic Priority	Compassionate Workforce				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	Chief People Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

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

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

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

BAF RISK 6	Failure to embed the Trust's approach to planning including CIP will impact on the achievement of the Trust's financial sustainability, service delivery and operational plans.

Strategic Priority	Continuous Improvement				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	Chief Finance Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	8 (4 x 2)

Controls	Assurance
• Formal budgets agreed for each Division and team, performance against budget subject to ongoing scrutiny by Finance. • Forecast of performance against financial plan updated regularly, with outputs included within monthly reports. • CFO and Deputy attend regional and national meetings to learn and interpret all forward guidance on future regime. • Implementation of Cost Improvement Programme and QIA guidance document.	• Monthly reports to Divisional Boards, TMB, FBPAC and Board of Directors on financial performance. • Programme Board has effective oversight on progress of improvement projects. • Finance Strategy approved by Board and being implemented. • External auditors undertake annual review of controls as part of audit of financial statements. • Annual internal audit plan includes regular review of budget monitoring arrangements. • FBPAC receive detailed monthly update from both Finance and Head of Productivity, Efficiency & PMO. Further assurances to be received from Divisions in relation to CIP. • Board receive update on CIP as part of monthly finance reports. • CIP arrangements subject to periodic review by Internal Audit. • Monthly COO checks and monitoring. • Recovery plan to achieve 23/24 financial plan and reset complete confirming no change to the plan. • Mitigations and Risk Plan Completed. • CFO presents quarterly forecasts to FBPAC and Trust Board. • H2 plans submitted and approved by Board.

Gaps in Control or Assurance	Actions
• Inherent variability within forecasting. • Limited capacity to identify savings within operational teams given ongoing pressures of service delivery. • Uncertainty of impact of industrial action • 2024/25 Plan not yet approved / not compliant.	• Continue delivery of CIP programme and maintain oversight of divisional progress. Ongoing. • Complete benchmarking and productivity opportunities review pack. • Develop 3 year CIP Plan to include all trust wide strategic and transformational plans. • Completion of submission of H2 plan to ICB. • Further review and challenge of 24/25 plan.

Progress
Key Changes to Note • Addition of controls.

BAF RISK 7	Failure to robustly implement and embed our Digital plans and ambitions will adversely impact on our service quality and delivery, patient care and carer experience.

Strategic Priority	Digital Future				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	Chief Finance Officer	TBD	N/A	TBD	TBD

Controls	Assurance
• Programme Board oversight. • Service improvement team and Quality Improvement team resource and oversight. • QIA guidance document implemented as part of transformation process. • Implementation of a programme management process and software to track delivery.	• Scale of projects versus resources. • Capital Committee. • Governance structures for key projects. • Capital Process Audit with significant assurance. • DSPT Audit with significant assurance.

Gaps in Control or Assurance	Actions
•	•

Progress
Key Changes to Note • Creation of Risk.

BAF RISK 8	Failure to deliver sustainable efficiency gains quality and improvements due to an inability to embed service transformation and change.

Strategic Priority	Continuous Improvement				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

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

Gaps in Control or Assurance	Actions
• Lack of protected time due to conflicting priorities in service delivery, particularly in relation to clinical staff. • Lack of clarity on H2 arrangements and financial arrangements for 2022/23 period. • Ability to deliver system wide change across Wirral NHS organisations and wider partners.	• Delivery of Cost Improvement approach through the WAVE programme. • Integration of Quality and Service Improvement function from 2024/25 • Strong Governance through PMO working of all schemes, risk and outputs. • Delivery of improvement projects to plan.

Progress
Key Changes to Note • N/A

BAF RISK 9	Failure to achieve strategic goals due to the absence of effective partnership working resulting in possible harm to patients, poor experience, damaged external relations, failure to deliver the transformation programme and Wirral review as a long term threat or opportunity to service sustainability.

Strategic Priority	Continuous Improvement				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	Chief Executive Officer	12 (4 x 3)	9 (3 x 3)	9 (3 x 3)	6 (3 x 2)

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

Gaps in Control or Assurance	Actions
• Function and role of C&M ICS working with the Trust and Formal.	• Development of PLACE governance arrangements with Wirral partners. • Completion of ICS and PLACE governance self-assessment. • Development of PLACE operating model.

Progress
Key Changes to Note • N/A

BAF RISK 10	Failure to robustly implement and embed infrastructure plans will adversely impact on our service quality and delivery, patient care and carer experience.

Strategic Priority	Infrastructure				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	Chief Strategy Officer	16 (4 x 4)	12 (4 x 3)	12 (4 x 3)	9 (3 x 3)

Controls	Assurance
• Implementation of capital programme, which includes remedial works at Clatterbridge. • Senior Clinician input in key decisions around key areas such as critical care. • Estates Strategy. • Agreed 3 year Capital Programme. • Business Continuity Plans. • Stock capital process. • Procurement and contract management. • Bespoke digital healthcare team. • Asset Assessments.	• Capital Committee oversight. • FBP oversight of capital programme implementation and funding. • Board reporting. • Internal Audit Plan. • Capital and Audit and Risk Committee Deep Dives. • Assessment of business continuity to address increasing critical infrastructure risks to be undertaken in August and September 2023. • Independent review of risks carried out. • Appointment of authorised engineers.

Gaps in Control or Assurance	Actions
• Delays in backlog maintenance. • Timely reporting of maintenance requests.	• Develop Arrowe Park development control plan and Prioritisation of estates improvements. • Asset audit. • Implementation of the new Capital Assets and Facilities system. • Heating and ventilation programme. • Replacement of generators. • Assessment of business continuity to address increasing critical infrastructure risks to be undertaken in August and September 2023. • Development and review of EPPR plans across all areas. • Delivery of 2024/25 Capital Programme to plan and budget allocation.

Progress
Key Changes to Note • N/A

BAF RISK 11	Risk of business continuity and the Trusts EPRR arrangements in the provision of clinical services due to a critical infrastructure, cyber, supply chain or equipment failure therefore impacting on the quality of patient care.

Strategic Priority	Infrastructure				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	Chief Operating Officer	TBD	N/A	TBD	TBD

Controls	Assurance
•	•

Gaps in Control or Assurance	Actions
•	•

Progress
Key Changes to Note • N/A

BAF RISK 12	Failure to reduce health inequalities for the Wirral population due to the absence of effective partnership working.

Strategic Priority	Our Partners				
Review Date	01/04/24	Initial Score	Last Month	Current	Target
Lead	TBD	TBD	N/A	TBD	TBD

Controls	Assurance
•	•

Gaps in Control or Assurance	Actions
•	•

Progress
Key Changes to Note • N/A

Appendix – Risk Scoring Matrix

Risk Scoring and Grading:

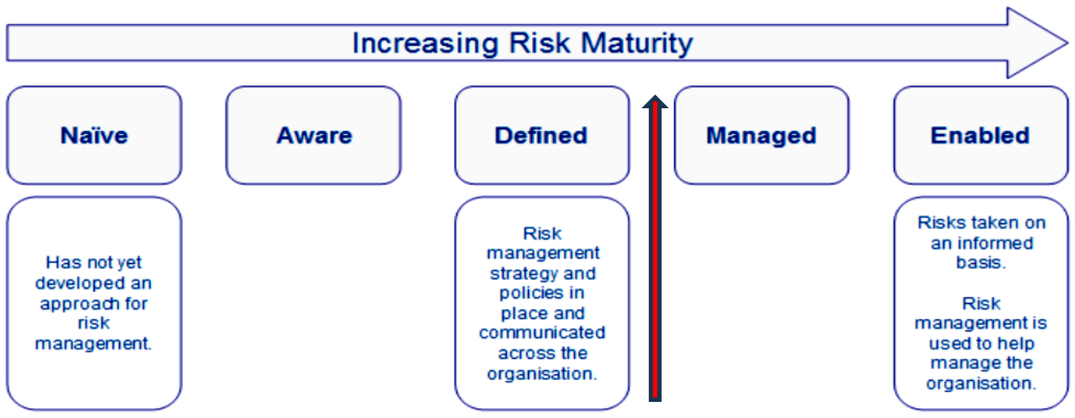
Use table 1 to determine the consequence score(s) (C)
Use table 2 to determine the likelihood score(s) (L)
Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score)
Assign grade of risk according to risk score.

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
5 Catastrophic	**5**	**10**	**15**	**20**	**25**
4 Major	**4**	**8**	**12**	**16**	**20**
3 Moderate	**3**	**6**	**9**	**12**	**15**
2 Minor	**2**	**4**	**6**	**8**	**10**
1 Negligible	**1**	**2**	**3**	**4**	**5**

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

Appendix – Risk Appetite

Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Outstanding Care – Provide the best care and support.	**Various**	The Trust has an **OPEN** risk appetite for risk, which balances the delivery of services and quality of those services with the drive for quality improvement and innovation. The Trust has **MINIMAL** risk appetite for any risk which has the potential to compromise the Health & Safety for patients, staff, contractors, the general public and other stakeholders, where sufficient controls cannot be guaranteed. We have a **SEEK** appetite for some financial risks where this is required to mitigate risks to patient safety or quality of care. We will ensure that all such financial responses deliver optimal value for money.
SO2: Compassionate Workforce – Be a great place to work.	**OPEN**	The Trust Board has an open risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Trust is an employer of choice.
SO3: Continuous improvement – Maximise our potential to improve and deliver best value.	**OPEN**	The Trust Board is prepared to accept risk in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and ensuring we deliver our goals and targets.
SO4: Our partners – Provide seamless care working with our partners.	**SEEK**	The Trust Board recognises there may be an increased inherent risk faced with collaboration and partnerships, but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.
SO5: Digital Future – Be a digital pioneer and centre for excellence.	**SEEK**	The Trust Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: Infrastructure - Improve our infrastructure and how we use it	**OPEN**	The Trust Board has an open risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.



Appendix – Significant Operational Risks

Clinical

87	W+C	Increasing numbers of children and young people with mental health disorders	(4 x 4) 16	⇔
877	Acute	Pressure on the emergency department with increasing numbers of patients experiencing a mental health crisis	(4 x 5) 20	⇔
1320	W+C	Risk related to the long-term proposal to condemn Theatre (G1) and not proceed with the recommended works	(5 x 3) 15	⇔
1329	D+CS	Inadequate patient flow due to the organisation bed occupancy being consistently above 90% impacting on patients' experience, quality and safety resulting in patient harm and poor outcomes.	(3 x 5) 15	⇔
1391	D+CS	Risks to patient safety within the transfusion process	(5 x 3) 15	⇔
1434	Surg	Aging Anaesthetic Machines - Gynaecology Theatres	(4 x 4) 16	⇔
1553	W+C	Risk of not being able to provide adequate sonography cover which is a requirement for our rapid diagnostic service for suspected endometrial cancer	(3 x 5) 15	⇔
1627	Acute	(UECUP) Construction impact on clinical service delivery	(3 x 5) 15	⇔
1674	W+C	IVF service provision not available from 1st October 2023 by Care Fertility	(4 x 4) 16	⇔
1776	Surg	Orthogeriatric Provision to Orthopaedic & #NOF patients	(3 x 5) 15	⇔

Environmental

1379	EF+C	APH Roof leaks	(3 x 5) 15	⇔
1673	EF+C	Identification of RAAC within Birch House CBH	(5 x 3) 15	⇔
1709	EF+C	Failing Building infrastructure. Potential falling masonry from roof height during high winds or storms to various roof locations below (Failing & loose brick-built roof tips to each external Emergency exit staircase).	(5 x 3) 15	⇔

Equipment

1004	D+CS	Risk of Transfusion service disruption	(4 x 4) 16	⇔
1112	Surg	There is a risk that Sterile Service Department may be subjected to increased downtime due to aged decontamination equipment. This may result in cancellation of surgical procedures.	(4 x 4) 16	⇔
1142	Surg	MAX FAX Equipment	(4 x 4) 16	⇔
1166	EF+C	Risk of the ventilation system which serves ITU at APH failing	(4 x 4) 16	⇔
1179	D+CS	Risk to patient treatment pathways due to the delay in supply of aseptically made medicinal products if the Aseptic Unit fails	(3 x 5) 15	⇔
1433	Surg	Management and transport of surgical specimens - current devices not fit for purpose	(3 x 5) 15	⇔
1502	Surg	Fisch type handpiece for ENT Surgery - lack of available equipment	(4 x 4) 16	⇔
1505	Surg	Flexible Cystoscopes availability	(4 x 4) 16	⇔
1514	EF+C	W&C Lifts failing resulting in inability to transport patients, or risk of life-threatening entrapment (only 2 lifts both of similar age)	(5 x 3) 15	⇔
1572	EF+C	Risk of failure to Pharmacy Aseptic Suite, Vent Plant 33 Theatre 10, and Vent Plant 33A Theatre 11 due to the age and condition of these units.	(4 x 4) 16	⇔
1635	D+CS	MRI Service unable to deliver timely care to emergency / urgent patients	(4 x 5) 20	⇔
1726	W+C	Olympus Stacker System Broken for 2nd time this year	(4 x 4) 16	⇔
1730	Surg	Sterilisers in SSD are over 13yrs and fail regularly which will impact service delivery due to the ability to reprocess surgical instruments.	(4 x 5) 20	⇔

Financial

1199	D+CS	Ageing Aseptic Services Unit (ASU) and Aseptic Air Handling Unit (AHU) - Financial risk of failure	(3 x 5) 15	⇔
1547	Corp	Cash management	(4 x 4) 16	⇔
1677	W+C	The Neonatal unit is not compliant with BAPM standards to deliver consultant cover for twelve hours daily Monday- Sunday.	(3 x 5) 15	⇔

Operational

941	EF+C	Unidentified Estates maintainable fixed assets within the organisation, which could result in patient/ staff harm, business disruption and breaches in legislative compliance (including Health & Safety at Work Act).	(5 x 3) 15	⇔
1041	D+CS	There is a risk that any patients requiring fluoroscopy examinations cannot have these examinations due to the breakdown of the machine	(4 x 4) 16	⇔
1056	EF+C	Passive fire protection at APH is not compliant with required standards for horizontal evacuation and therefore we may not be able to safely evacuate patients, visitors and staff in a timely manner increasing exposure to smoke and fire.	(5 x 3) 15	⇔
1365	W+C	Risks associated with essential works required on the Neonatal Unit for heating pipes	(3 x 5) 15	⇔
1453	D+CS	Medicines shortages- failure to deliver business objectives	(3 x 5) 15	⇔
1552	EF+C	Ward Based Horizontal and Vertical Evacuation training is not currently included in Mandatory Fire Safety Training	(5 x 3) 15	⇔
1704	W+C	Women's Directorate - Industrial Action (IA) impacting the ability to safely deliver patient care within national pathways.	(3 x 5) 15	⇔
1724	Surg	There is a risk to quality, complaints, and audit due to the patient backlogs and demand outstripping capacity in the Surgical Division	(4 x 4) 16	⇔
1728	Surg	SSD Washers/disinfector breakdown	(4 x 5) 20	⇔

Organisational

1628	Acute	Title: (UECUP) Contingency Budget Allocation	(3 x 5) 15	⇔
1781	Corp	Failure to deliver Quality Governance expectations due to operational pressure secondary to Industrial action	(3 x 5) 15	⇔

Staffing / Workforce

397	Corp	Sickness Absence	(4 x 4) 16	⇔
886	Med	There is a risk that Insufficient medical staffing capacity within the division will potentially result in poorer patient outcomes and harm.	(5 x 3) 15	⇔
1287	W+C	Risk of delays in reviews and poor patient experience caused by gaps in gynaecology middle grade doctors	(4 x 4) 16	⇔
1352	Corp	Industrial Action	(3 x 5) 15	⇔
1414	Med	Consultant Recruitment & Retention - Lack of consultant resource in Diabetes & Endocrinology	(4 x 4) 16	⇔
1529	Med	Lack of junior doctor cover and sufficient oversight of when gaps are occurring	(4 x 4) 16	⇔
1648	Med	Ongoing medical industrial action will compromise patient safety in the medical division	(4 x 4) 16	⇔
1794	Med	CSW Industrial action will compromise patient safety in the medical division	(4 x 4) 16	⇔

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.5**

01 May 2024

Title	Monthly Maternity and Neonatal Services Report
Area Lead	Dr Nikki Stevenson, Executive Medical Director, Deputy Chief Executive Officer (CEO)
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Information

Report Purpose and Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in March 2024, with the following paper providing a further update and oversight of the quality and safety of Maternity and Neonatal Services at Wirral University Teaching Hospital (WUTH).

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

Included in the paper is the monthly Perinatal Clinical Surveillance Quality Assurance Report providing an overview of the latest (March 2024) key quality and safety metrics.

The paper also provides updates on:-

- The Thematic review carried out on relating to neonatal deaths
- The details of the published MIS Year 6
- The Trusts position in achieving SBLv3

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks:

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

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

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
April 2024	Maternity & NNU Assurance Board	Monthly Maternity and Neonatal Services Report	For information

1	**Perinatal Clinical Surveillance Quality Assurance Report**
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (March 2024) key quality and safety metrics. The purpose of this report is to provide a monthly update to the Board of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services. The dashboard is provided for information and whilst there is no indication to escalate any of the metrics to the Board of Directors, it should be noted that since there is no longer a Northwest coast regional report being produced, WUTH is no longer able to report on the benchmarking against other providers for rates such as stillbirth and neonatal deaths. Assurance has previously been provided to the Board of Directors this was escalated via the Local Maternity and Neonatal System (LMNS) for a resolution. However, a Northwest Regional Dashboard Tool for use by Regional Maternity and Neonatal Teams is available to provide bespoke reports for Regional Operational Performance reporting. The Maternity Services Data Set publications have a lag of circa three months. On review of the dashboard the Board of Directors should be aware that concerns regarding the accuracy of the data sources have been raised regionally. Further escalating regionally, it remains WUTH is still unable to benchmark against other providers. Maternity has initiated in addition to Maternity and Newborn Safety Investigations (MNSI) an external review initiated there were three term still births in the later end of 2023. An update will be provided at the next quarterly Maternity and Neonatal Services report to the findings.

2	**Thematic Review Neonatal Deaths**
	Maternity and Neonates initiated a thematic review following six neonatal deaths in the postnatal period. The report and findings are included at **Appendix 2**.

3	**Maternity Incentive Scheme (MIS) Year 6**
	A detailed MIS update is included to Board of Directors Monthly Maternity Services update, which will further inform Trust declaration with the MIS due for submission before a deadline of 12 noon on 3 March 2025.

	Now in its sixth year, the Maternity Incentive Scheme (MIS) supports the delivery of safer maternity care through an incentive element to discount provider Trusts' contributions to the Clinical Negligence Scheme for Trusts (CNST). The MIS rewards Trusts that meet all ten safety standards designed to improve safety and the delivery of best practice in both Maternity and Neonatal care. NHS Resolution in conjunction with NHSE/I confirmed the relaunch of the Year 6 MIS published in March/April 2024 **(Appendix 3 and 4)**. The Women's & Children's Division has continued with its work to progress the 10 safety actions based on the previous requirements. NHS Resolution has made some amendments to how the MIS document is presented this year to try and simplify the requirements and improve clarity. The MIS document has also been published with an accompanying audit tool this year which whilst is not mandatory will be utilised by WUTH as a useful tool supporting the Trust to track progress with the actions and record when supporting evidence has been approved and where it is saved. The compliance will be monitored via a monthly Divisional Quality Assurance Meeting to provide the Board of Directors with an update on the position to meet the requirements of each safety action. A further compliance update will be included in the June Maternity quarterly update report utilising the audit tool. Provider compliance with the ten Safety Action Standards across C&M will be closely monitored by the LMNS and the declaration will also be required to be signed off by the ICB.

4	Saving Babies Lives Version Three
	The Saving Babies' Lives Care Bundle (SBLCB) launched in July 2023 provides evidence-based best practice, for providers and commissioners of maternity care across England to reduce perinatal mortality. The NHS has worked hard towards the national maternity safety ambition, to halve rates of perinatal mortality from 2010 to 2025 and achieve a 20% reduction by 2020 (DHSC 2017). ONS data showed a 25% reduction in stillbirths in 2020, with the rate rising to 20% in 2021 with the onset of the COVID-19 pandemic. While significant achievements have been made in the past few years, more recent data show there was more to do to achieve the ambition in 2025. Version 3 of the Care Bundle (SBLCBv3) was redeveloped to include a new, additional element on the management of pre-existing diabetes in pregnancy based upon data from The National Pregnancy in Diabetes (NPID) Audit. On final review of all the evidence as of 31 March 2024 the Trust achieved 97% compliance against the 6 elements included at **Appendix 5**.

5	Serious Incidents (SI's) & Maternity and Newborn Safety Incidents (MNSI)
	Patient Safety Incident Investigations (PSSI's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSSI's across the region.

	There were no Patient Safety Investigation Incidents (PSII's) for Maternity declared in March 2024 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date six cases are undergoing review. There were no Patient Safety Investigation Incidents (PSII's) declared in March 2024 for Neonatal services.

6	Implications
6.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
6.2	**People** • MIS Year 5 compliance has been met against all 10 safety actions demonstrating evidence delivering high quality care. • MIS Year 6 has been published and WUTH will continue to work towards achieving to demonstrate the continued delivery of high-quality care. • Saving Babies Lives v 3 has been achieved to a high level and will be monitored via the governance structures within the division and wider Trust. • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement.
6.3	**Finance** • In order to meet the compliance of MIS Year 6 neonatal workforce is required and a statement of case has been submitted to BDISC for consideration/approval. • Funding that has been awarded for specific initiatives has bene committed to and improvements programmes in progress.
6.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Appendix 1 - Perinatal Clinical Surveillance Quality Assurance Report March 2024

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	Yes	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to October 2023 and decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised; external review requested to support rise in still birth rate.
	Outlier for rates of neonatal deaths as a proportion of birth	na	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to May 2023 and decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised; thematic review commpleted as 6 NN deaths from Dec 2023 - March 2024
	Rates of HIE where improvements in care may have made a difference to the outcome	na	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of SI's	na	No PSSI's reported in March 2024
	Progress on SBL care bundle V3	no	SBLv3 launched and continued to be a key safety action of MIS Year 5 which was signed off as complaint meeting 81% (>70% was the requirement); Audits and evidencecontinue to be submitted for LMNS review and achieved complaince as at end of March of 97%
	Outlier for rates of term admissions to the NNU	na	The rate of avoidable term admissions; regular multi-disciplinary reviews of care take place; NW region outlier report no longer published and awaiting national guidance on monitoring processes
Service user and st	MNVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints; to date all complaints have been addressed for maternity in the target timeframesand there is nil to escalate
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey completed and divisional response has included staff engagement and continuation with the Pulse surveys; Score survey completed for MatNeo and cultural conversations commencing over x 4 sessions; Requirement to report to BOD Feb 2024
	CQC National survey	no	Published Feb 2024 and included within BoD report March 2024; action plan progressing; Sample provided for 2024 survey to be pulished early 2025
	Feedback via Deanery, GMC, NMC	no	Nil to esclate
	Poor staffing levels	no	Current vacancy rate is 7wte; predicted further 5wte between now and Nov 2024 due to leavers, retirements and maternity leave. Recruitment campaigns ongoing for Band 5 and Band 6 Midwives; Concern is will be reliant on newly quaified midwives in Sept 2024 leaving gaps between now and then;
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Nil of note; full establishment; governance structure review and revised structure implemented to meet requirements and maternity self assessment tool and continue to meet Ockenden Part 1
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates
	False declaration of CNST MIS	no	MIS Year 5 submission and declaration submitted by 12 noon on 1st February 2024 - complaince met; MIS Year 6 publication published April 2024 included within BoD report; Letter sent to advise what will not be included but no detail on additions
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month; funding options explored; 6 teams in total and two approach model in place; comparison data / research underway
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterly meeting held in Feb 2023; site visit May 2023; nil to escalate
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all PSSI's, local reviews, rapid evaluations of care, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. No exceptions to report. Three year single delivery plan for maternity and neonatal services published 31th March 2023 - gap analysis in progress and will monitored via WUTH CG structure and BoD
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework; PSIRF with effect from 1/9/2023
	Never Events which are not reported	no	No maternity or neonatal never events in March 2024
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales
Governanc e processes	Unclear governance processes		Clear governance processes in place that follow the PSIRF framework - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated. Additional quality assurance framework agreed with effect from June 2023 to give the BoD addiitonal assurances in monitoring of MIS, Three year delivery plan etc. Governance structure strengthened
	Business continuity plans not in place	no	Business continuity plans in place
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month
CQC inspection and DHSC or NHSE / request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	CQC reports published for maternity sites Seacombe Birth Centre and APH site for the domains Safe and Well led; both sites were rated 'GOOD'
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Thematic Review

Division(s):	Women's and Children's Division	**Service/Team/Ward(s):**	Obstetrics/Maternity/ Neonatology/ Paediatrics/ Safeguarding
Incident Date:	5/12/2023	**Incident Number/MRN**	CIF: 119796
Incident Date:	22/12/2023	**Incident Number/MRN**	CIF: 120850
Incident Date:	28/01/2024	**Incident Number/MRN**	CIF: 116040
Incident Date:	21/02/2024	**Incident Number/MRN**	CIF: 125987
Incident Date:	27/02/2024	**Incident Number/MRN:**	CIF: 125390
Incident Date:	03/03/2024	**Incident Number/MRN**	CIF: 125635
Incident Category:	Sudden infant death/Cardiac arrest	**Incident Harm Level:**	Major
Date of thematic review	5/3/24	**Location of thematic review:**	MS Teams
Staff Leading review:	Danielle Chambers, Quality and Safety Matron for Maternity Services		
Staff Participating in review:	• Hannah Blake, Bereavement Midwife • Jo Lavery, Director of Midwifery • Danielle Chambers, Quality and Safety Matron for Maternity Services • Nicola Denton, Named Nurse for Safeguarding Children and Children Looked After • Michelle Beales, Named Midwife for Safeguarding/Lead Specialist for Domestic Abuse and Harmful Practice • Karolyn Shaw, Assosciate Director of Nursing for Safeguarding and Complex Care • Lynsey Wileman, Neonatal Matron • The Thwin, Consultant Neonatologist • Elaine Mooney, Matron Paediatrics		

Background to thematic review

A local increase in reported sudden infant deaths has been recognized. There have been 5 reported cases of sudden infant death between 02/12/2023 and 05/03/2024. To note – there has also been a case of unexplained cardiac arrest in the community of a 13 day old infant on 27/02/2024. This baby is currently in receipt of palliative care at time of writing this report.

As all cases have been recently in receipt of maternity and/or neonatal care this review aims to assess if there are any common themes in order to extract any further learning and actions required.

All cases have been appropriately referred to the relevant agencies for further investigation. SUDIC protocol has been followed.

To note - 2 of the cases were eligible for referral to MNSI (Maternity and Newborn Safety Investigations) under the category of 'Early neonatal death' as the deaths occurred <7 days following birth. These cases have also been reported to MBRRACE UK and will undergo a full PMRT review once the final reports from MNSI have been received.

All cases will also be reviewed under the Child Death Overview Panel (CDOP). Coroners post-mortem findings are pending.

Scope of the thematic review

This thematic review will aim to identify any common themes amongst the cases, and generate any relevant additional actions and learning. It may also generate focus for further investigation.

Themes identified from discussions and analysis of data

Antenatal Risk Factors

5 out of 6 cases had identified antenatal risk factors. Smoking and SGA were found in 50% of cases.

To elaborate on this – out of the 3 smokers, 1 stopped smoking at 12/40 and was documented as vaping and the other 2 continued to smoke during pregnancy. Appropriate very brief advice (VBA) was documented and all had referrals to ABL. CO monitoring was also conducted in alignment with antenatal guidance. Range of CO readings for cases was 1-17ppm.

All cases had serial ultrasound scans in the antenatal period and SGA was detected in 3/6 (50%) of the cases.

Other antenatal risk factors identified are listed below:

- Previous small for gestational age baby (SGA) 2/6
- Previous caesarean section 2/6
- Gestational diabetes 1/6
- Short pregnancy interval (1/6)
- Previous intrauterine death (1/6)
- BMI >40 (1/6),
- Teen pregnancy (1/6)

Safeguarding/Social/Environmental Considerations

Only 1 case had a known safeguarding concern in the antenatal period. No threshold was met for intervention as was related to ex-partner.

All cases were residing in permanent accommodation. There was a housing issue identified in 1 of the cases. This was identified by the paramedics and police following the event. There was a strong smell of dog/cat urine, thick black mold in the bedrooms and this was noted to be close to the area of sleep for the baby. Police are performing air quality tests as part of their investigation.

During thematic review it was noted that the baby found in poor housing conditions had an admission to our paediatric ward on day 24 (5/2/24) with difficulty in breathing. IV antibiotics were administered, LP and blood cultures performed which were negative. Baby was discharged home from our paediatric ward and subsequently had a community midwifery visit on day 27 (8/2/24) where it was documented that baby appeared to be well. For completeness, a paediatric matron has conducted a review of care by paediatrics during this episode of care to the baby. This is included within Appendix 1.

5/6 cases would be considered to have been living in some element of socio-economic deprivation/austerity.

Looking at the geography of the cases there was no particular theme and areas are listed below:

- Upton 2/6
- Wallasey 2/6
- Birkenhead 2/6

Midwifery Care and Engagement

As per below list, 5/6 cases received care from midwifery continuity teams and 1/6 cases received care from the traditional community midwifery model. This would be expected given the continuity teams rollout being to areas of increased deprivation in the first instance.

- Willow team
- Lotus team
- Seaview team
- Queensway team
- Traditional midwifery model

Medications

There were no common maternal medication themes identified in the antenatal period. Medications administered included: Aspirin, Sertaline, Venlafaxine, Propranolol, Dexamethasone and Ferrinject.

Postnatally, the following commonly prescribed medications were noted to have been prescribed for mothers:

- Dihydrocodeine 4/6 cases
- Antibiotics 4/6 cases
- Enoxaparin 4/6 cases

To note - In terms of dihydrocodeine prescriptions in the postnatal period, our link pharmacist has already been actioned as part of a previous investigation to ensure there is a patient leaflet available to all postnatal patients. This will aim to improve the information surrounding the

postnatal pain relief pathway and to ensure the provision of informed choice inclusive of risks versus benefits.

Genders, Gestation and Birth Weight

4/6 babies were female and 2/6 babies were male. Gestations at birth were as follows, with 2/6 babies noted to be pre-term:

- 39/40
- 37+1/40
- 40+1/40
- 35+4/40
- 37/40
- 34+1/40

One of the pre-term births (34+1/40) occurred due to abnormal CTG with dopplers and SGA and the other pre-term birth was a spontaneous pre-term labour with PROM.

4/6 babies were born on normal birthweight centile and 2/6 babies were of low birth centile. To note of the babies born with low birthweights, 1 was a complicated pre-term baby and the other was a known SGA diagnosed on antenatal USS. Both low birthweight babies were of mothers who smoked.

Mode of Birth

3/6 of cases were spontaneous vaginal births and 3/6 of cases were emergency caesarean sections.

Of the vaginal births 1 was spontaneous labour and 2 were inductions of labour. Indications for induction were abnormal dopplers/SGA and reduced fetal movements at term.

Of the emergency caesarean sections 1 was an induction of labour and the other 2 cases were antenatal emergency cesarean sections.

Duration of Rupture of Membranes

Prolonged rupture of membranes (PROM) featured in 2 out of 6 cases (35.5 and 36 hours). IV antibiotics were administered to the mothers in the intrapartum period for this reason. Postnatally only 1 baby out of the 2 received complete PROM observations as per guidance. This learning was picked up in the initial rapid evaluation of care and there has since been an After Action Review to ensure a deeper dive into the reasons why PROM observations were not completed.

Timing of Death, Age at death and Co-Sleeping

The age of the infants at time of SUDIC/cardiac arrest was variable and was as follows:

- 3 days
- 5 days
- 38 days
- 29 days
- 13 days
- 49 days

5/6 cases occurred at night with 1/6 in day time hours.

In all 6 cases the parents reported that the babies usual place of sleep was in a moses basket or a next to me crib. However, 5/6 babies were noted to have been in their parents shared bed at the time of death.

All 6 cases had safer sleep advice documented as discussed at least once. In 2/6 cases there is no clear documentation of safer sleeping discussions prior to discharge, however this was then documented as discussed in the community during postnatal home visits. Interestingly, the 2 cases whereby this conversation is not documented prior to discharge are babies that had received transitional care (TC)/NNU care. This has been escalated to the neonatal matron who is currently reviewing this issue.

Neonatal Care/TC

3/6 of cases received NNU/Transitional care. 2 required IV antibiotics. The neonatal matron was therefore actioned to conduct a deep dive into these 3 cases along with a consultant neonatologist. This meeting took place on 6/3/24 and the findings of this review are attached and included within Appendix 2.

Mode of Feeding

Upon review there were no apparent commonalities with method of feeding and details are listed below:

- 1/6 exclusively breastfeeding
- 1/6 exclusively formula fed
- 2/6 mixed feeding (breastmilk and formula)
- 2/6 breastfeeding and also providing expressed breast milk via bottle.

All babies were documented to have established feeding at time of discharge from hospital.

Postnatal Visits

Age at discharge from hospital varied between 23-39 hours of age for the babies not receiving NNU or transitional care following birth. Those babies in receipt of NNU/TC care were discharged between days 8 and 11.

4/6 babies received a first day home visit as per guidance.

1/2 that did not have a first day home visit - no access was initially gained, but contact was made with parent and safety netting advice provided. This visit was successfully re-arranged. To note – access was gained twice further prior to the babies death and there were no concerns documented.

In the other case that did not receive a home visit this was missed due to an issue with the discharge not being called out to the community midwives. This learning has already been picked up as part of the initial rapid evaluation of care and this is also being reviewed further by MNSI.

Upon review, timings of discharge from midwifery community care were also examined as follows:

- 3/6 cases were not yet discharged/remained under midwifery community care.
- 3/6 were discharged from community midwifery care on days 16, 22 and 27

Summary of Review Findings

Key themes identified were smoking, co-sleeping, small for gestational age babies, socio-economi deprivation/austerity and babies that had been in receipt of TC/NNU care at some point.

The review has provided us with direction for further investigation including a deeper dive into the transitional care and neonatal care provided to 3 of the cases and a paediatric review into the previous admission of 1 of the babies with breathing difficulties.

All eligible cases have been appropriately referred to MNSI, MBRRACE and PMRT. SUDIC protocols have been followed and all cases will be reviewed at CDOP.

Post-mortem results and coroner's reports are outstanding and may provide further opportunity for learning.

Learning points identified

- The common theme from the cases was unintentional co-sleeping. Despite all cases receiving documented advice surrounding co-sleeping the reviewing group have generated a number of ideas and suggestions how we may strengthen this advice in future, and this requires improved standardization. Actions suggested to enhance safer sleeping advice have been captured within the actions log of this report.
- There is potential that austerity may be an issue and it is important that there is an assessment of home conditions documented in the antenatal and postnatal periods.
- Visual assessment of the sleeping conditions for babies should be recommended when confirming and advising upon safe sleeping practices.
- There appears to be differences in discharge processes and information given to parents between Transitional Care/NNU and maternity ward. This needs clarification going forward to ensure that all parents receive safer sleeping advice prior to discharge from hospital.

Recommendations

Recommendations are included within action plan below.

Action Plan

Action	Intended Outcome	Due Date	Action Lead
Safer sleep campaign with MNNVP, service users, families and birth partners. Ensure that this is actively promoted across all areas including: paeds ED, maternity areas, paeds outpatients, St Caths and social media platforms.	Safe sleep messages publicized greater to service users and staff. Address misinformation being publicized on social media by non-medical professionals. Look at ways in ensuring that partners and families are also provided with safer sleeping advice.	Ongoing	Rose Bellamy, Infant Feeding Midwife
Ensure lullaby trust leaflets are printed and available for all midwives to distribute and that	Midwives have the appropriate information leaflets and information	1/4/24	Community Manager Katie McCabe

information posters are printed and laminated for all community midwives kits to aid in discussions surrounding safer sleep.	posters to aid discussions surrounding safer sleep.		
Ensure staff involved in cases are receiving appropriate support	Staff feel supported and informed.	15/3/24	Hannah Blake, Bereavement Midwife
Obtain feedback regionally/nationally on the use of next to me cots	Identify if there has been an increase/theme of the use of next to me cots and be able to provide advice accordingly	1/4/24	Karolyn Shaw, ADN for Safeguarding and Complex Care
Re-introduce antenatal classes and ensure that these incorporate safer sleeping advice	Safer sleep advice is provided in the antenatal period as well as postnatally.	COMPLETE	Emma Rohlmann, Consultant Midwife
Improve current Cerner system to prompt more in depth documentation of discussions surrounding safer sleep both in the antenatal and postnatal periods. Make the assessment of the home/sleeping environment for baby a mandatory field on Cerner.	Improved documentation of safer sleep discussions and prompts will enhance the standardization of these discussions.	1/6/24	Tracy Wiltshire, IT Midwife
Ensure community discharge failsafe process in place.	Mitigation of risk of missed discharges	1/4/24	Kate McCabe, Community Team Leader
Work on standardizing the information provided at postnatal discharge with the development of a discharge information video. This can be shown to patients and families as part of the discharge process. Purchase iPads for this purpose.	Standardized discharge information.	1/6/24	Rosie Hoyle, Maternity Ward Manager
Adapt the slides on the waiting room TVs to incorporate clear messages about safer sleep and how patients can raise any issues surrounding housing.	Increased awareness surrounding safer sleep and how/who to contact surrounding housing issues	1/6/24	Dawn D'Arcy, Antenatal Clinic Manager
Publicize the offer of additional safeguarding supervision available.	Staff feel supported.	15/3/24	Michelle Beales, Named Midwife for Safeguarding/Lead Specialist for Domestic Abuse and Harmful Practice
Link in with universities on how we can improve education surrounding the provision of advice on safer sleeping and also the assessment of the home environment.	Student midwives and nurses receive appropriate education on providing safer sleep advice.	15/3/24	Sarah Weston, Practice Education Midwife

Review current preceptorship pack to ensure there is appropriate assessment of all new staff on their provision of safer sleep advice and the assessment of the home/sleeping environment.	All new starters receive appropriate training and assessment on their provision of safer sleep advice.	1/6/24	Jo Allen, Preceptorship and Retention Midwife and Rachel Hutton, Neonatal Practice Educator
Ensure all TC/NNU parents are receiving safer sleep advice prior to discharge and that there is a system in place for this to be documented.	All TC/NNU parents will received safer sleep advice prior to discharge.	1/4/24	Lynsey Wileman, Neonatal Matron
Conduct a deeper dive into the neonatal/transitional care provided to 3/6 of the cases	To identify any further learning.	7/3/24	Lynsey Wileman, Neonatal Matron
Clarify the follow-up process for babies who have been in receipt of NNU/Transitional care.	To clarify process and check that this is acceptable	7/3/24	Lynsey Wileman, Neonatal Matron
Conduct a review of the paediatric care of the baby who had an admission to paediatric ward with breathing difficulties.	To identify any further learning.	7/3/24	Elaine Mooney, Paediatric Matron
Ensure safer sleep advice is available and visible in all paediatric areas and part of the discharge process from paediatrics also.	To ensure consistent messages being reinforced across all areas that may be accessed by parents, families and their babies.	1/6/24	Elaine Mooney, Paediatric Matron
Feedback to Lynsey Costello (Service lead 0-19, Wirral Community Health. Paula Simpson (chief nurse of wirral community healthcare) re: cases and clarify their visiting schedule and the content of appointments	To identify any further learning/improvements required.	15/3/24	Jo Lavery, Director of Midwifery
Link in with ED to share learning from cases and offer any support	Shared learning	15/3/24	Jo Lavery, Director of Midwifery
Share thematic review with coroner as learning points identified.	Shared learning	12/3/24	Richard Crockford, Director of Quality
Explore the support and sign posting women, birthing people and their families receive on discharge from community midwifery and ongoing services available and feedback to director of midwifery.	Assessment of other support available and whether this is sufficient.	31/3/24	Kate McCabe, Community Manager
Share report with relevant stakeholders.	Shared learning.	18/3/24	Jo Lavery, Director of Midwifery
To share and discuss findings with LMNS forum, neonatal network, CDOP and cheshire &	Shared learning.	18/3/24	Jo Lavery, Director of Midwifery

Mersey neonatal senior nurse meeting.			
Link findings with CQC survey and include any relevant findings within CQC action plan.	Additional learning.	18/3/24	Jo Lavery, Director of Midwifery

Date completed:	**05/03/24**
Divisional Triumvirate Lead approving review:	**Jo Lavery, Director of Midwifery**

Appendices

Appendix 1

Overview of Paediatric Ward admission

Division Service/ Team/ Ward	Women's & Children's Division, Paediatrics	**Incident category**	-
Ulysses reference	Admission itself was not a reportable incident.	**Complaint reference**	-
Incident date & time	-	**Service user MRN**	5693981
Incident harm level	-	**Date of review**	7/3/24
Facilitator for Review	Asked to review admission to Paeds by Maternity Governance Matron	**Staff involved in review**	Elaine Mooney, Matron Paeds

Summary of incident

Patient - MRN 5693981

A deeper dive was requested into the admission of baby MRN 5693981 to paediatrics ward. This baby had been admitted to paediatric ward on 5/2/24 with difficulty breathing. Sadly baby RIP on 3/3/24.

Summary of key events in relation to the admission to paediatrics ward on 5/2/24 were reviewed and care was found to have been appropriate. No issues identified with this admission that would have been considered to have made a difference to the outcome.

Appendix 2

Review of Neonatal Care/Transitional Care for 3/6 Cases

Date of Review 6/3/24

Our neonatal matron and a consultant neonatologist have performed a deeper dive into the care provided to 3/6 cases on our neonatal unit and transitional care facility.

Data was collated in tabular format to identify any common themes below:

Case	1	2	3
Gestation	37+0	34+1	35+4
Weight	2000g	2020g	3080g
Reason for admission	Poor feeding/cold	Received NNU care for 4 days from birth for respiratory distress (CPAP/High flow) then admitted to TC on day 4 for gestational age to support feeding.	Born at 18:30 23/01/24 admitted to TC 22:00.
Neonatal alert?	Yes, family history (sibling) left isomerism. Antenatally scanned appropriately, plan made for outpatient appointment for ECHO at 6 weeks of age. All deemed appropriate.	No Gestational diabetes, Hypo pathway completed.	No Gestational diabetes, Hypo pathway completed.
Infection status	Maternal GBS risk factor. Sepsis pathway from birth, completed 36 hours 1st line antibiotics, cultures negative. Had rise in CRP to 19 so increased dosage of benpen given along with Gentamicin for complete 7 day course. LP carried out and negative.	Received 36 hours 1st line antibiotics for suspected sepsis, cultures negative. Antibiotics stopped at 36 hours.	PPROM/prem, sepsis pathway completed. Received 36 hours of antibiotics, cultures negative.
Feeding	EBM/cow and gate by bottle, received some NGT feeds on TC due to reluctant feeding. Gap in feeding record on ward from 13/02/24 23:15 until 11am 14/02/24 when admitted to TC.	DEBM, EBM, Formula (SMA 1st) via bottle and also breastfeeding.	Formula (Aptamil) bottle feeding
Medications during stay	Benzylpenicillin Gentamicin Vitamin K Clotrimazole Nystatin	Benzylpenicillin Gentamicin Vitamin K Glucose 10%	Benzylpenicllin Gentamicin Vitamin K Glucose 10%

Discharged from	Discharged from TC to PNW for a further 24 hours. Then discharged home from PNW. Discharge safety netting advice given including signs of sepsis and poor feeding from ANNP whilst on TC.	NNU from birth (12/01/24) to TC 15/01/24 Discharged to PNW 20/01/24 with a plan for further observation of feeding for24 hours on PNW and a reweigh, but advised that Baby could be weighed in the community and decision left to mum who decided to go home 20/01/24.	Born 23/01/24 Admitted to TC due to gestation but required NNU admission 25/01/24 for quad phototherapy and IV fluids for jaundice levels. Discharged to TC 26/01/24. Back to NNU for quad lights for jaundice 28/01/24 then back to TC 29/01. Discharged from TC following 48 hours observed bottle feeding.
Follow up	1st home visit 24/02 from community midwife for weight and had gained 20g and back to birth weight. Plan for further weight check in 48 hours 26/02. No weight/visit documented on cerner but Baby admitted via ED on 27/02.	Plan was to be weighed 25/01 by community midwife but this was missed out of the diary so mum chased up on 26th, plan made for weight in community 27/01. Weight monitored and discussed with medical team. Admitted to paediatric ward with difficulty breathing 05/02/24 when due for reweigh. Discharged from Paeds ward 07/02, discharged to health visitor from community midwife 08/02. Attended ED 03/03/24.	Discharged day 10 but no follow up recorded on cerner. Clarified with parents that seen in the community ? where is documentation kept?
Comments	Was there a visit/weight check 26th? No feeds documented on feeding chart from 23:15 13/02/24 until admission to TC 11am 14/02/24.		No cerner documentation for follow up. Baby had 2 x NNU admissions and 2 x TC admissions due to physiological jaundice requiring IV fluids and quad phototherapy. Required ambient/lfo2 for 11 hours. Gentamicin dosage given late and delay in IV fluid administration.

3 patient records reviewed and some findings as below:

- 2 of 3 patients were discharged home from postnatal ward, 1 of 3 patients were discharged home from Transitional Care.
- All patients had daily reviews completed.

- All patients had appropriate medical management.
- All feeds whilst on Transitional Care were appropriate- 12 hour gap with no feeds recorded for one patient prior to admission to TC (See review table).
- Follow up was not documented for one patient on Cerner but it was clarified that patient was followed up by community team.

There have been areas of improvement identified as below, and an action table has been produced to incorporate these recommendations.

Recommendations from review of neonatal/transitional care:

- Standardise discharge advice with PNW regarding safer sleep talk.
- Discharge planning board for Transitional Care service
- Babies discharged from Transitional Care to have resus talk (clarified and this is already the case).
- Pathway to be created between ANNP (NNU) and Hospital at Home team for follow up from Transitional Care. Currently babies are seen until day 28 by community midwifery. However as 2 out of 3 babies were 2kg we need to consider if some patients fall under Hospital at Home Team. Need to consider if there should be a weight criteria for Hospital at Home follow-up.
- Templates that are used on Cerner make it difficult to distinguish if patients are on Postnatal Ward or Transitional Care. This needs to be documented more clearly.
- The discharge template to be completed on Cerner for Transitional Care patients needs to include resus talk and safer sleep.

Neonatal Action Plan

Issue identified	Action	Progress	Owner	Due date	RAG
No discharge board for Transitional Care patients, difficult for staff to know what has been completed.	Discharge board to be put up on Transitional Care for staff to see what is outstanding for discharge.	Request to ward clerk to order whiteboard 27/02/24.	Lynsey Wileman/Vikki Bowden	31/03/24	
Medical team using wrong template for Transitional Care/Postnatal Ward review making it hard to see where baby has been cared for.	Education and training to medics to use correct review template.	New medics undergoing induction, learning to be shared with medical team.	Dr Thwin	31/03/24	
No standardisation of discharge for NNU and Transitional Care patients.	Discharge template to be added to cerner to include all aspects of discharge and include safer sleep.	Discussion with band 3 team to understand current discharge practice.	Lynsey Wileman/Dr Thwin/Rachel Hutton	31/03/24	
Not clear who is responsible to deliver safer sleep advice prior to discharge to parents on TC.	Discuss with maternity colleagues to devise a plan for ownership of safer sleeping advice.	Meeting to be arranged	Lynsey Wileman/Kirsty Chambers	11/03/24	

TC patients being followed up by community midwife at present.	Pathway to be devised regarding follow up required. HAH or community midwife depending on weight.	Lynne Jones ANNP is arranging a meeting with Nicky Cookson hospital at home to look at current practice.	Lynne Jones/Nicky Cookson	31/03/24	

Maternity Incentive Scheme (MIS)

Year 6

What to expect – An overview of changes

MIS Year 6 document – due for publication 2 April 2024

We have made some amendments to how the MIS document is presented this year to try and simplify the requirements and improve clarity. We hope this will help support Trusts and make it easier to focus on the safety standards in the scheme.
The primary requirements for each safety action are now at the front of the document, and the technical guidance can be accessed at the back. There is a clear index and links throughout the document enabling you to jump to other sections.

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	7	0	0	0	7
2	3	0	0	0	3
3	4	0	0	0	4
4	23	0	0	0	23
5	5	0	0	0	5
6	6	0	0	0	6
7	7	0	0	0	7
8	16	0	0	0	16
9	10	0	0	0	10
10	8	0	0	0	8
Total	89	0	0	0	89

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

The MIS document will be published with an accompanying audit/compliance tool this year. The tool has been designed to support you as you work towards compliance with the MIS safety actions.
It is not mandatory to use this tool, but we hope you will find it helpful.
The tool has been developed for your internal use only and is not intended for submission to NHS Resolution. It will allow you to track your progress with the actions and record when supporting evidence has been approved and where it is saved.

We anticipate that the Year 6 document will be published 2 April 2024. The compliance period will end 30 November 2024. The submission deadline will be 12:00 midday on 3 March 2025.

NHS Resolution will also be launching a Maternity Incentive Scheme workspace on the FutureNHS platform. We hope this will provide improved access to consistent information and guidance about the scheme in response to any queries. We will provide a series of webinars and resources that will be available on the platform. It will also offer the opportunity to share learning and tools that work well across the system, using examples of best practice / what good looks like. For those that do not wish to join the platform, information will continue to be provided by existing methods.

The MIS Team will be attending a number of local, regional and national meetings over the coming year to provide updates on the Maternity Incentive Scheme. Please contact them on nhsr.mis@nhs.net if this is something you feel would be helpful for your team.

The ten safety actions

We have worked with the Safety Action Leads to streamline some of the requirements of the safety actions where possible this year, while ensuring that this does not compromise the safety improvements that contribute to improved outcomes for women and families accessing maternity services.

To aid your forward planning, we have provided a very brief overview of any significant changes in this letter. Any aspects of safety actions not directly referenced below may be assumed to be essentially unchanged from Year 5 of the MIS. Further information will be available within the full published document in April 2024.

Please note: Where any elements have been removed from safety actions, this may not mean there is no requirement for this activity to continue in order to ensure best practice. However, it may be that it is no longer reportable as a requirement to meet full MIS compliance.

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 8 December 2023 30 November 2024 to the required standard?

- Compliance period commences immediately following MIS year 5 (in line with Safety Action 10).
- Removed requirement within MIS to demonstrate surveillance information completed within 30 days.
- Removed requirement within MIS to complete the review to the draft report stage by four months after the death.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

- Removed requirement within MIS to report on Midwifery Continuity of Carer pathway indicators.
- Removed requirement within MIS to demonstrate two people registered to submit MSDS data.

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

- Removed requirement within MIS to audit all 37+ week admissions to the neonatal unit (NNU).
- Focus on transitional care pathways for babies between 34+0 and 36+6.
- Introduce (any) quality improvement initiative to decrease admissions and/or length of stay to NNU.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Obstetric Workforce

- Removed requirement within MIS to demonstrate compliance with the Royal College of Obstetricians and Gynaecologists' (RCOG) guidance on compensatory rest.
- Removed option to demonstrate compliance with RCOG guidelines on engagement of locums with an action plan.

Neonatal Workforce

- Updated to reflect November 2022 BAPM Service Quality Standards.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

- An allocated midwifery coordinator in charge of the labour ward must have supernumerary status *at the start of every shift*. An escalation plan must include the process for providing a substitute coordinator in situations where there is no coordinator available.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives (SBL) Care Bundle Version Three?

- Removed requirement within MIS for providers to demonstrate implementation of a specific percentage of interventions.
- Agreement of a local improvement trajectory with the Local Maternity and Neonatal System (LMNS), and subsequently quarterly reviews to confirm progress against that trajectory, with optional use of the SBL implementation tool.
- Evidence of work towards full implementation / sustained improvement.
- Evidence of regionally shared learning.

Safety action 7: Listen to women, parents and families using maternity and neonatal services and co-produce services with users.

- Trusts should work with their LMNS/Integrated Care Board (ICB) to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place, with appropriate escalation if not.
- Provide evidence of MNVP infrastructure being in place.
- Provide evidence of MNVP Lead as a member of key Trust Safety and Governance meetings (working towards being a quorate member).

Safety action 8: Can you evidence the following three elements of local training plans and 'in-house', one day multi professional training?

- It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will no longer be measured in Safety Action 8.
- All anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric anaesthetic on-call rota *in any capacity* must attend maternity emergencies and multi-professional training.

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

- Discussions regarding safety intelligence must take place at the Trust Board *(or at an appropriate sub-committee with delegated responsibility),* as they are responsible and accountable for effective patient safety incident management in their organisation.
- Discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan using the Patient Safety Incident Response Framework (PSIRF).
- Removed requirement within MIS for Non-Executive Directors and Board Safety Champions to be registered with the dedicated FutureNHS workspace.

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

- Updated to reflect changes to MNSI reporting criteria.

NHS Resolution

Maternity (and perinatal) Incentive Scheme

Year Six

Conditions of the scheme

Ten maternity safety actions

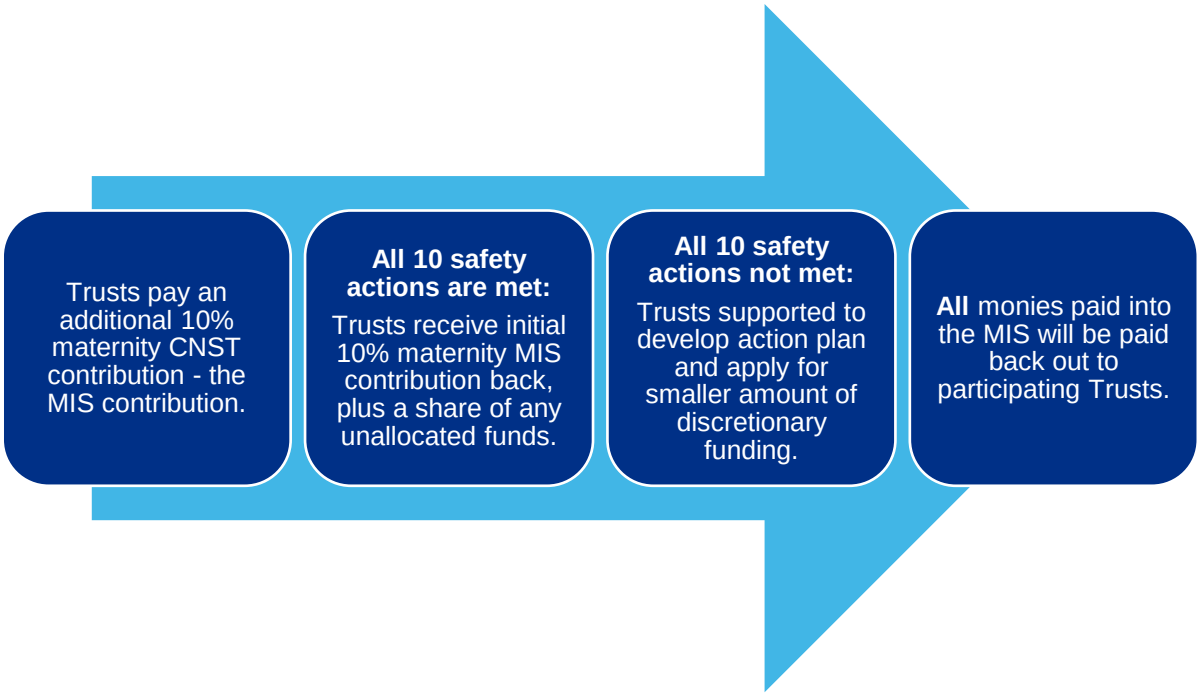
Additional guidance

Contents

Introduction

Now in its sixth year of operation, NHS Resolution's Maternity Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund:



The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC) and the Maternity and Newborn Safety Investigation Programme (MNSI).

Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover the element of their contribution relating to the CNST MIS fund and they will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the MIS fund and is subject to a cap decided annually by NHS Resolution.

MIS year six: conditions

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12 noon** on **3 March 2025** and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the director of midwifery/head of midwifery and clinical director for maternity services.
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- The Trust's CEO must sign to confirm that:

  ☑ The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

  ☑ There are no reports covering either year 2023/24 or 2024/25 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2025.

  ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates from Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the MIS results. See 'Reverification'.

NHS Resolution will publish the outcomes of the MIS verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

External verification

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

MBRRACE-UK data (safety action 1 standards a, b and c).

NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).

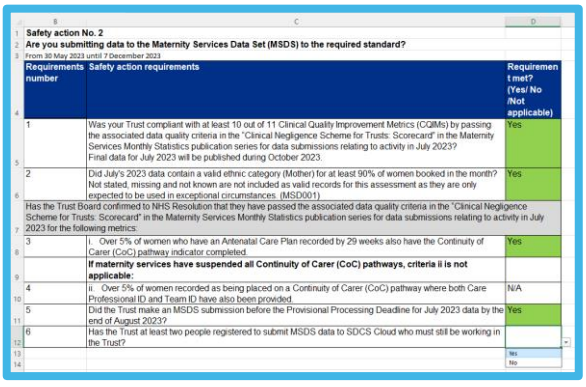
National Neonatal Research Database (NNRD), MNSI and **NHS Resolution** for the number of qualifying incidents reportable (safety action 10, standard a).

Trust submissions will also be sense checked with the **CQC**, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the maternity incentive scheme via the key lines of enquiry.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year.

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided internally in the Trust to support the Trust Board decision only. This will not be reviewed by NHS Resolution unless requested. See 'Reverification'.
- On the Board Declaration form Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.
- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.



Safety action No. 2
Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?
From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
	Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:	
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	N/A
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	

- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their maternity incentive scheme submission and that the MIS evidence has been discussed with commissioners.
- Trusts will need to report compliance with MIS by **12 noon 3 March 2025** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.

- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by AO of Clinical Commissioning Group/Integrated Care System.
- The Board declaration form will be made available on the MIS webpage during the MIS reporting period.

'What Good Looks Like'

Trusts are reminded to retain all evidence used to support their compliance position. In the event that NHS Resolution are required to review supporting evidence at a later date (as described below) it must be made available as it was presented to support Board assurance at the time of submission.

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net prior to the 3 March 2025.
- The Board declaration form must be sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2025 and 3 March 2025 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2025.
- Submissions and any comments/corrections received after 12 noon on 3 March 2025 will not be considered.
- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
    - Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation.
    - Technical errors outside the Trust's control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- The NHS Resolution MIS clinical team will review all appeals to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Appeals must be made in writing to NHS Resolution on the agreed template within two weeks of the final notification of results. Information on how to do this

will also be communicated to all Trusts when the confirmed MIS results are sent out.

Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a smaller amount of funding to support progress. To apply for funding, such Trusts must submit a completed action plan together with their completed Board declaration form by 12 noon on 3 March 2025 to NHS Resolution nhsr.mis@nhs.net.

Action plans submitted must be:

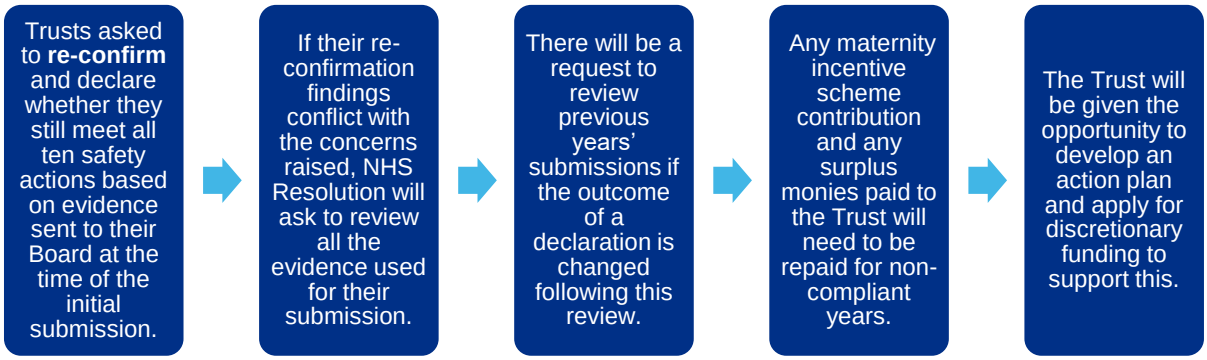
- Submitted on the action plan template in the Board declaration form.
- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- Details of each action should be SMART (specific, measurable, achievable, realistic and timely) and will enable the financial calculation of the funding requested.
- Any new roles to be introduced as part of an action plan must include detail regarding banding and Whole Time Equivalent (WTE).
- Action plans must be sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
- Action plans should not be submitted for achieved safety actions.

Ruth May, NHS England Chief Nursing Officer wrote to NHS Trusts on 8th April 2021 confirming that commissioners must ensure that any funding awarded to implement the agreed action plan for improvement is ringfenced for the maternity service to support the delivery of the action plan.

Reverification

Reverification is initiated if a concern is raised that a Trust Board may have incorrectly declared compliance with one or more of the ten safety actions' sub-requirements within the MIS. This may be identified through whistleblowing or following a CQC report that may call into question the original declaration. This concern may relate to any completed year of the MIS.

In the first instance, Trusts are asked to complete their own internal review of the evidence that was used to support their compliance for the relevant year at the time of submission. This must be the same evidence that was used to inform the Trust Board at the point of declaration. Trusts will be given the opportunity to downgrade their position at this point.



If following their own internal review, the Trust remains confident that their compliance declaration was correct, the Trust will be asked to provide all of their supporting evidence to NHS Resolution. A full review of the relevant evidence will then be undertaken by two members of the MIS clinical team.

Following this review, any Trusts found to have mis-declared compliance will be notified and will be required to repay the funds originally awarded to them for that MIS year. They will be asked to develop an action plan to introduce safety improvements and work towards full compliance, and they will be advised to bid for discretionary funding to support this action plan. Any discretionary funds agreed must be spent on the improvements in the agreed plan. Any amount of discretionary funding agreed will be deducted from the total MIS rebate amount repayable to NHS Resolution.

If a mis-declaration has been identified (as above), reverification of the previous MIS year will automatically be initiated. When a further mis-declaration is identified, this process will then be repeated for the previous year. This process will be limited to impact the current MIS year, and the two preceding historical MIS years only.

Any funds retrieved from non-compliant Trusts will be redistributed to all Trusts that achieved compliance for the applicable MIS year. This redistribution must take place within the same financial year that NHS Resolution receives the funds.

Need Help?

If you have any queries or concerns regarding any aspect of the MIS, please contact the MIS clinical team on nhsr.mis@nhs.net. There is a new FutureNHS MIS workspace where queries can be submitted and additional information and resources will be provided.

To ensure you receive all correspondence relating to the MIS, please add your name to the MIS contacts list.

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?

Required Standard
a) **Notify all deaths**: All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. b) **Seek parents' views of care:** For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards. c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months. d) **Report to the Trust Executive:** Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.
Minimum Evidence Requirement for Trust Board
Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see technical guidance regarding the introduction of the NHS Submit a Perinatal Event Notification system - SPEN). The PMRT must be used to review the care and reports about individual deaths should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.
Verification process
Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications. MBRRACE-UK/PMRT will take the data extract for verification on 1 February 2025.
Relevant Time period
From 8 December 2023 to 30 November 2024

Link to technical guidance

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required Standard
This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. 1. Trust Boards to assure themselves that at least 10 out of 11 MSDS-only (see technical guidance) Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024. Final data for July 2024 will be published during October 2024. 2. July 2024 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001).
Minimum Evidence Requirement for Trust Board
The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and undertaking quality improvement to minimise separation of parents and their babies?

Required Standard
a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice Or Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and present this to your Trust & LMNS Boards. b) Drawing on insights from themes identified from any term admissions to the neonatal unit, undertake at least one quality improvement initiative to decrease admissions and/or length of stay. Progress on initiatives must be shared with the Safety Champions and LMNS.
Minimum Evidence Requirement for Trust Board
Evidence for standard a) to include: **For units with TC pathways** • Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04. **For units working towards TC pathways** • An action plan signed off by Trust and LMNS Board for a move towards the TC pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.
Evidence for standard b) to include: 1. By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team. 2. By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required Standard
a) Obstetric medical workforce

1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas:

   a. currently work in their unit on the tier 2 or 3 rota
      or
   b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP)
      or
   c. hold a certificate of eligibility (CEL) to undertake short-term locums.

2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level safety champions and LMNS meetings.
   rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf

3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where consultants and senior Speciality, Associate Specialist and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.**
   rcog-guidance-on-compensatory-rest.pdf

4) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service
   roles-responsibilities-consultant-report.pdf when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

b) Anaesthetic medical workforce

A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)

c) Neonatal medical workforce

The neonatal unit meets the relevant BAPM national standards of medical staffing.

or

the standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

or

The standards are not met, but there is an action plan with progress against any previously developed action plans.

Any action plans should be shared with the LMNS and Neonatal ODN.

Minimum Evidence Requirement for Trust Board

Obstetric medical workforce

1) Trusts/organisations should audit their compliance via Medical Human Resources.

   Information on the CEL for short term locums is available here: www.rcog.org.uk/cel

   This page contains all the information about the CEL including a link to the guidance document:
   Guidance on the engagement of short-term locums in maternity care (rcog.org.uk)

   A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk

2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance.

3) Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that consultants/senior SAS

doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and senior SAS doctors about their ability to take appropriate compensatory rest in such situations.
NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG

4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.

Anaesthetic medical workforce

The rota should be used to evidence compliance with ACSA standard 1.7.2.1. This can be a representative month of the rota.

Neonatal medical workforce

The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce.

If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.

A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

Neonatal nursing workforce

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020).
For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies.
A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN.

Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Standard

a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years.

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.

c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift.

d) All women in active labour receive one-to-one midwifery care.

e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.

Minimum Evidence Requirement for Trust Board

The midwifery staffing report submitted will comprise evidence to support a, b, c and d progress or achievement.

It should include:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
- In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.
- Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.

- The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.

- Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.

    - The midwife to birth ratio.

    - The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.

- Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty at the start of every shift and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.

Relevant Time period

From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required Standard
Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of SBLv3 through quarterly quality improvement discussions with the ICB.
Minimum Evidence Requirement for Trust Board
Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate. *The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Required Standard

1. Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting:

   a) Engagement and listening to families.

   b) Strategic influence and decision-making.

   c) Infrastructure.

2. Ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.

Minimum Evidence Requirement for Trust Board

1.

a) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.

b) Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member, (Trusts should work towards the MNVP Lead being a quorate member), such **as:**

- Safety champion meetings
- Maternity business and governance
- Neonatal business and governance
- PMRT review meeting
- Patient safety meeting
- Guideline committee

c) Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as:

- Job description for MNVP Lead
- Contracts for service or grant agreements
- Budget with allocated funds for IT, comms, engagement, training and administrative support
- Local service user volunteer expenses policy including out of pocket expenses and childcare costs

- If evidence of funding support at expected level is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.

2. Evidence of review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as an action plan.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.

Relevant Time period

From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Required Standard
90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal Life Support Training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for MIS. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.
Minimum Evidence Requirement for Trust Board
*See technical guidance for details of training requirements and evidence.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 1 December 2023 to 30 November 2024

Link to technical guidance

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Required Standard

a) All Trust requirements of the PQSM must be fully embedded.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). With evidence of reporting/escalation to the LMNS/ICB/ Local & Regional Learning System meetings.

c) All Trusts must have a visible Maternity and Neonatal Board Safety Champion (BSC) who is able to support the perinatal leadership team in their work to better understand and craft local cultures.

Minimum Evidence Requirement for Trust Board

Evidence for point a) and b)

- Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop trusting relationships between staff, the frontline maternity, neonatal and obstetric safety champions, the perinatal leadership team 'Quad', and the Trust Board to understand, communicate and champion learning, challenges, and best practice.

- Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set at every meeting. This should be presented by a member of the **perinatal** leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.

- Evidence of collaboration with the LMNS/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

- Evidence of ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action

and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.

- Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.

Evidence for point c):

Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include:

- Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.

- Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025.
Relevant Time period
From 2 April 2024 to 30 November 2024

Link to technical guidance

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

Required Standard
a) Reporting of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024. b) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 8 December 2023 until 30 November 2024. c) For all qualifying cases which have occurred during the period 8 December 2023 to 30 November 2024, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.
Minimum Evidence Requirement for Trust Board
Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by 3 March 2025. Trusts' reporting will be cross-referenced against the MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard A) and B) have been met in the relevant reporting period. In addition, for standard B and C(i) there is a requirement to complete field on NHS Resolution's Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
Relevant Time period
From 8 December 2023 to 30 November 2024

Link to technical guidance

Technical Guidance

Technical Guidance for Safety Action 1	
Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the MBRRACE-UK/PMRT system to track your notifications and reviews: www.npeu.ox.ac.uk/pmrt/faqsmis; these FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk.	
SA 1(a) – Notify all eligible deaths	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal deaths must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that the Submit a Perinatal Event Notification system (SPEN) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through SPEN and this information will be passed to MBRRACE-UK. It will still then be necessary for reporters to log into the MBRRACE-UK/PMRT system to provide the surveillance information and to use the PMRT.
Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust.
What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK must be notified to MBRRACE-UK within seven working days.
What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification for neonatal deaths. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) with two working days of the death. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK are working with the National Child Mortality Database (NCMD) team to provide a single route

	of reporting for neonatal deaths that will be via MBRRACE-UK. Once this single route is established, MBRRACE-UK will be the mechanism for directly notifying all neonatal deaths to the local Child Death Overview Panel (CDOP) and the NCMD. At that stage, for any Trust not already doing so, a review completed using the PMRT will be the required mechanism for completing the local review for submission to CDOP. This will also be the required route for providing additional information about the death required by both CDOPs and the NCMD. Work is underway to provide this single route of reporting with plans to have this in place in 2024.
SA 1(b) – Seek parents' view of care	
We have informed parents that a local review will take place and they have been asked if they have any feedback or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' feedback, perspectives, and any questions can be considered during the review, this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' feedback and perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
We have contacted the parents of a baby who has died, and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their feedback and raise any questions and/or concerns they may subsequently have about their care.

	Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See especially the notes accompanying the flowchart.
Parents have not responded to our messages and therefore we are unable to discuss their feedback at the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information can be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials See notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
SA 1(c) – Review the death and complete the review	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: d) Late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) e) Stillbirths (from 24+0 weeks' gestation) f) Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) up to 28 days after birth While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet the safety action one standard.
What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session

	(which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: 
What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the Trust who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be selective as to which deaths are reviewed by the team including an external member. Bereavement care staff (midwives and nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for parents. It should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
What should we do if our post-mortem service has a long turn-around time?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than six months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death, complete and publish the report using the information you have available. When the PM results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than six months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review.

What is review assignment?	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review, the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided.
How does 'assigning a review' impact on safety action 1, especially on starting a review?	If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the PMRT verification process.
What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between 2 April 2024 and 30 November 2024 you should partner up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
What deaths should we review outside the relevant time period for the safety action verification process?	Trusts should review all eligible deaths using the PMRT as a routine on-going process, irrespective of the MIS timeframe and verification process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 6 MIS requirements.
What happens when an MNSI (formerly HSIB) investigation takes place?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by MNSI (formerly HSIB). Your local review using the PMRT should be started (to identify any early and immediate learning which needs to be actioned) but not completed until the MNSI report is complete. You should consider inviting the MNSI reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the MNSI review to be incorporated into the PMRT review. Depending upon the timing of the MNSI report completion achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an MNSI investigation is taking place, and this will be accounted for in the external verification process.

SA 1(d) – Report to the Trust Executive Board	
Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period of time defined by the user. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust maternity safety champions.
Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for the Trust Executive Board summarising the results from completed reviews over a period time which can be generated within the PMRT by authorised PMRT users for a user-defined period of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. Please note that these reports will only show summaries, issues and action plans for reviews that have been completed and published, therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
Guidance – technical issues and updates	
What should we do if we experience technical issues with using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on the PMRT for the maternity incentive scheme, where will they be published?	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action 1, will be communicated via NHS Resolution email and will also be included in the PMRT 'message of the day'.

Technical Guidance for Safety Action 2	
What are the 11 "MSDS-only" CQIMs in scope for this assessment?	These include: • Babies who were born pre-term • Babies with a first feed of breastmilk • Proportion of babies born at term with an Apgar score <7 at 5 minutes • Women who had a postpartum haemorrhage of 1,500ml or more • Women who were current smokers at booking • Women who were current smokers at delivery • Women delivering vaginally who had a 3rd or 4th degree tear • Women who gave birth to a single second baby vaginally at or after 37 weeks after a previous caesarean section • Caesarean section delivery rate in Robson group 1 women • Caesarean section delivery rate in Robson group 2 women • Caesarean section delivery rate in Robson group 5 women These do not include the following as they rely on linkages between MSDS and other datasets: • Babies breastfed at 6-8 weeks • Babies readmitted to hospital <30 days after birth
Some CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on those for three months?	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2024 data for these CQIMs. Due to this, Trusts are now directed to check whether they have passed the requisite data quality required for this safety action within the "CNST: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass CQIMs and other metrics specified above can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics

The monthly publications and Maternity Services Dashboard states that my Trusts' data has failed for a particular metric. Where can I find out further information on why this has happened?	Details of all the data quality criteria can be found in the "Meta Data" file (see 'CQIMDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: maternity-services-monthly-statistics The scores for each data quality criteria can be found in the "Clinical Negligence Scheme for Trusts: Scorecard" in the: Maternity Services Monthly Statistics publication series
The monthly publications and national Maternity Services Dashboard states that my Trusts' data is 'suppressed'. What does this mean?	Where data is reported in low values for clinical events, the published data will appear 'suppressed' to ensure the anonymity of individuals. However, for the purposes of data quality within this action, 'suppressed' data will still count as a pass.
Where can I find out more about MSDSv2?	maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Technical Guidance for Safety Action 3	
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
How can we evidence progress towards a transitional care service?	A current action plan with specified timescales and progress against these should be reviewed by the Trust and LMNS Boards before the submission deadline
How do we identify our themes of unplanned term admissions?	All term admissions will be reported through DATIX/LFPSE (as per local implementation of PSIRF) and themes identified through this intelligence. ATAIN proforma reviews are no longer mandated.
Who should be involved in the quality improvement initiatives?	The team should include members of maternity and neonatal multidisciplinary team including liaising with service user representative (MNVP) and support sourced from Trust quality improvement and service improvement teams if required.
How do we register our quality improvement initiative?	This will vary depending on local Trust policy. In the absence of any Trust policy, evidence of registering the quality improvement initiative, could be documented in the safety champion minutes.
What is considered as evidence of an update on the quality improvement initiative?	Evidence should include: 1) a presentation to the LMNS which includes an aim statement, measures, change actions and outcomes. 2) Discussion with safety champions and noted in the minutes at least once before the end of the reporting period.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk)

	Framework: Early Postnatal Care of the Moderate-Late Preterm Infant | British Association of Perinatal Medicine (bapm.org) B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk) The Handbook of Quality and Service Improvement Tools: the_handbook_of_quality_and_service_improvement_tools_2010-2.pdf (england.nhs.uk)

Technical Guidance for Safety Action 4	
a) Obstetric medical workforce guidance	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2024. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	No.
Where can I find the documents relating to short term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to long term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for 6 months after February 2024 and prior to submission to the Trust Board.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long term locums are employed who are not fully supported/supervised?	No.
Where can I find the documents relating to long term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG

How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors taking compensatory rest after non-resident on call?	Trusts should have documentary evidence of standard operating procedures and their implementation. Evidence of implementation/compliance could be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should have a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and have this as evidence that they are working towards compliance.
Can we self-certify compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Yes. However while this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to consultant attendance out of hours?	For example, departments can audit consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Departments may also wish to monitor adherence via incident reporting systems. Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.
Can we self-certify compliance with this	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans

element of safety action 4 if consultants have not attended clinical situations on the mandated list?	implemented to prevent subsequent non-attendances. These can be signed off by the Trust Board.
Where can I find the roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: nhsr.mis@nhs.net (MIS Team) or workforce@rcog.org.uk (RCOG).	
b) Anaesthetic medical workforce guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.
c) Neonatal medical workforce guidance	
Do you meet the BAPM national standards of junior medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication whether the standards not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps. This action plan should be submitted to the LMNS and ODN.
BAPM BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)	
NICU **Neonatal Intensive Care Unit**	All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics. Trusts that have more than one NNU providing IC or HD care should have separate cover at all levels of medical staffing appropriate for each level of unit. **Tier 1**

	Rotas should be European Working Time Directive (EWTD) compliant and have a minimum of 8 WTE staff Units with more than 7000 deliveries should have more than one Tier 1 medical support **Tier 2** EWTD compliant rota with a minimum of 8 WTE staff NICUs undertaking more than 2500 IC days per annum should augment their Tier 2 medical cover (more than one staff member per shift) **Tier 3** Minimum of 7 WTE consultants on the on-call rota with 24/7 availability of a consultant neonatologist NICUs undertaking more than 2500 IC days per annum should provide two consultant led teams during normal working hours. Neonatal consultant staff should be available on site in all NICUs for at least 12 hours a day, generally expected to include two ward rounds/handovers For units undertaking more than 4000 IC days per annum, consideration should be given to 24-hour consultant presence All NICU consultants appointed from 2010 should have CCT in Neonatal Medicine.
LNU **Local Neonatal Unit**	Where LNUs have a very busy paediatric/neonatal service and/or have neonatal and paediatric services that are a significant distance apart, the above staffing levels should be enhanced. The threshold should be judged and monitored on clinical governance grounds such as the ability consistently to attend paediatric or neonatal emergencies immediately when summoned. Units with more than 7000 deliveries should have more than one Tier 1 medical support.

	Tier 1 Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition. **Tier 2** Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff. **Tier 3** Consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification and substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN. At least one LNU Tier 3 consultant should have either a CCT in neonatal medicine or neonatal SPIN module (if this was available during training). All consultants covering the service must demonstrate expertise in neonatal care (based on training, experience, CPD and on-going appraisal).
SCU **Special Care Unit**	**Tier 1** Rotas should be EWTD compliant (58) and have a minimum of 8 WTE staff who may additionally cover paediatrics if this does not reduce safety and quality of care delivery. There should be a resident Tier 1 practitioner dedicated to the neonatal service during weekday day-time hours and an immediately available resident Tier 1 practitioner 24/7. **Tier 2** Shared rota with paediatrics comprising a minimum of 8 WTE staff. Tiers 1 and/or 2 may be able to be covered by appropriately skilled nursing staff

	Tier 3 A minimum of 7 WTE consultants on the on-call rota with a minimum of 1 consultant with a designated lead interest in neonatology. Tier 3 consultants should have a Certificate of CCT in paediatrics or Certificate of Eligibility for Specialist Registration (CESR) in paediatrics or an equivalent overseas neonatal or paediatric qualification. They must demonstrate knowledge, skills and CPD appropriate for the level of neonatal care through annual appraisal. Minimum of 1 consultant with a designated lead interest in neonatology, who should have completed a special interest (SPIN) module in Neonatology*. (if this was available during training)
Our Trust do not meet the relevant neonatal medical standards and in view of this an action plan, ratified by the Board has been developed. Can we declared compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.
When should the review take place?	The review should take place at least once during the MIS year 6 reporting period.
Please access the followings for further information on Standards	BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)
d) Neonatal nursing workforce guidance	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here:

	Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

Technical Guidance for Safety Action 5	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six-monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice.**	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or 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 two 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 one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for further details and definitions: safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	A supernumerary coordinator must be allocated for every shift and must start each shift with protected supernumerary status. It is accepted that there may be short periods when the coordinator is temporarily unavailable due to rapidly changing acuity on the labour ward to ensure safety for women, families and staff in the department. The co-ordinator should exercise professional judgement and escalate, if covering for breaks creates a safety risk to other women on labour ward. As long as there is clear evidence that the local escalation policy has been initiated in these circumstances, and this is not a recurrent daily event, Trusts may declare compliance with this standard.

	If the co-ordinator is regularly required to cover for breaks (more than 2-3 times a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.

Technical Guidance for Safety Action 6	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: saving-babies-lives-version-three/ An implementation tool is available for trusts to use if they wish at future.nhs.uk/SavingBabiesLives and includes a technical glossary for all metrics and measures. For any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to MSDS issues for this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net. Some data items are or will become available on the National Maternity Dashboard (Element 1); from NNAP Online (Element 5); and from NPID (Element 6). For any other queries, please email nhsr.mis@nhs.net
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. Where MSDS does not capture all process and outcome indicators given in the care bundle, this is indicated in the Implementation Tool.
What percentage performance is required to be compliant for a given intervention?	Where element process and outcome measures are listed in the evidence requirement of the SBLCB V3 a performance threshold is recommended. However, LMNS/ICBs are able to agree local performance thresholds with a provider in view of local circumstances, and the agreed local improvement trajectory.
How do we provide evidence for the interventions that have been implemented?	Trusts will need to verify with their LMNS/ICB that they have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBL e-learning for health modules have all been updated to reflect the changes in version 3. A new module for element 6 has also now been developed and published on the e-learning for health site.

Technical Guidance for Safety Action 7	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the LMNS. MNVPs ensure service user voice influences improvements in the safety, quality and experience of maternity and neonatal care.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
What advice is there for Maternity and Neonatal Voices Partnership (MNVP) leads when engaging and prioritising hearing the voices of neonatal and bereaved service users, and what support or training is in place to support MNVP's?	MNVPs should work in partnership with local specialist voluntary, community, and social enterprise (VCSEs) with lived experience to gather feedback. Engagement needs to be accessible and appropriate, particularly for neonatal and bereaved families. It is essential that you consider how you will protect people from being retraumatised through giving feedback on their experience. Training for MNVPs to engage with seldom heard or vulnerable communities may be required to ensure unintentional harm is avoided. MNVPs can also work in collaboration with their Trust bereavement leads to ensure adequate support is in place for themselves and the families they may engage with. Attendance at the Trust training could be beneficial.
What does evidence of MNVP engagement look like?	Engagement can include lots of different methods as detailed in the MNVP Guidance under the section *Engagement and listening to families*. Evidence for this includes: • 15 Steps for Maternity report. • MNVP Annual Report. • Engagement reports. • Expenses paid to service users. • List of organisations engaged. • Online surveys and feedback mechanisms. • Analysis of surveys by demographics of respondents.

Technical Guidance for Safety Action 8	
How will the 90% attendance compliance be calculated?	The training requires 90% attendance of relevant staff groups by the end of the 12-month period at: 1. Fetal monitoring training 2. Multi-professional maternity Emergencies training 3. Neonatal Life Support Training
Which maternity staff should be included for Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric consultants and SAS doctors. • All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor). • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • MSWs • GP trainees
Which maternity staff should be included for Maternity emergencies and multi-professional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants and SAS doctors. • All other obstetric doctors including obstetric trainees (ST1-7), sub speciality trainees, Locally Employed Doctors (LED), foundation year doctors and GP trainees contributing to the obstetric rota. • Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum). • Obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors. • All other anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) **who contribute to the**

	obstetric anaesthetic on-call rota <u>in any capacity</u>. This updated requirement is supported by the RCoA and OAA. • Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 6 compliance assessment. • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 6 compliance. At least one emergency scenario/drill should be conducted in a clinical area during the whole MIS reporting period, ensuring attendance from the relevant wider professional team, including theatre staff and neonatal staff. The clinical area can be any area where clinical activity takes place e.g. Delivery Suite, Clinic, A&E, theatre, a ward. This should not be a simulation suite.
Do non-obstetric anaesthetists that contribute to the obstetric rota need to attend obstetric emergency training?	Yes. However, it is recognised that the inclusion of anaesthetic staff who provide only intermittent or on-call coverage to the maternity unit may significantly extend the standards. Therefore, for the inaugural year of this standard, a threshold of 70% achievement is required as the minimum standard for this specific group.
Do non-obstetric anaesthetists need to attend the full day of obstetric emergency training?	It is the gold standard that all staff including non-obstetric anaesthetists that may find themselves responding to an obstetric emergency when on-call attend the full training day together, so that they can benefit from local learning and train alongside their multi-disciplinary colleagues, however it is appreciated that this may be a challenge for this group of staff. Therefore a minimum standard of attendance at half of the full day including obstetric skills drills will be accepted.
Training attendance for rotational clinical staff	It is the gold standard that all staff attend training in the unit that they are currently working in, so that they can benefit from local learning and training alongside their multi-disciplinary colleagues, however it is appreciated that this may be especially challenging for rotational staff. In the following circumstances, evidence from rotating medical trainees having completed their training in another maternity unit will be accepted: • Staff must be on rotation.

	• The training must have taken place in the previous Trust on their rotation during the MIS training reporting 12-month period. • Rotations must be more frequent than every 12 months. This evidence may be a training certificate or correspondence from the previous maternity unit.
Does the multidisciplinary emergency training have to be conducted in the clinical area?	Ideally at least one emergency scenario should be conducted in any clinical area as part of each emergency training day. You should aim to ensure that all staff attending emergency training participate in an emergency scenario that is held in a clinical area, but this will not be measured in year 6 of MIS.
Which staff should be included for Neonatal basic life support?	Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants/SAS doctors or Paediatric consultants/SAS Doctors covering neonatal units. • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives. The staff groups below are not required to attend neonatal basic life support training: • All obstetric anaesthetic doctors (consultants, SAS, LE Doctors and anaesthetic trainees) contributing to the obstetric rota. • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit). • Local policy should determine whether maternity support workers are included in neonatal basic life support training dependant on their role within the service. • If nursery nurses work within the service, this should also be recognised in your local training needs analysis.
I am a NLS instructor, do I still need to attend neonatal basic life support training?	No, if you have taught on a course within MIS year 6 you do **not** need to attend neonatal basic life support training

I have attended my NLS training, do I still need to attend neonatal basic life support training?	No, if you have attended a course within MIS year 6 you do **not** need to attend neonatal basic life support training as well.
Which members of the team can teach basic neonatal life support training and NLS training?	Registered RC-trained instructors should deliver their local NLS courses and the in-house neonatal basic life support annual updates.
What do we do if we do not have enough instructors who are trained as an NLS instructor and hold the GIC qualification?	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your LMNS to explore sharing of resources. It is recognised that for smaller hospitals, such as Level 1 units, there may be difficulty in resourcing qualified trainers. These units must provide evidence to their Trust Board that they are seeking mitigation across their LMNS and an action plan to work towards NLS and GIC qualified status. As a minimum, training should be delivered by someone who is up to date with their NLS training. Please see the RCUK website for the latest guidance regarding NLS GIC training
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined, however a minimum of 90% of paediatric/neonatal medical staff who attend neonatal resuscitations should have a valid resuscitation council NLS certification. Trusts that cannot demonstrate this for MIS year 6 should develop a formal plan demonstrating how they will achieve this for a minimum of 90% of their neonatal and paediatric medical staff who attend neonatal resuscitations by year 7 of MIS and ongoing.
The Core Competencies TNA suggests periods of time for each element of training, e.g. 9 hours for fetal monitoring. Is this a mandated amount of time?	We envisage that the fetal monitoring and obstetric emergencies training will require 1 whole day each. The hours for each element of training can be flexed by the individual Trust in response to their own local learning needs.

Technical Guidance for Safety Action 9	
Where can I find additional resources?	NHS England, Perinatal Quality Surveillance Model PSIRF (Patient Safety Incident Response Framework) Measuring culture in maternity services: Safety Culture Programme for Maternal and neonatal services Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board safety champions to access the culture and leadership programme, view wider resources and engage with a community of practice to support them in their roles. The Perinatal Culture and Leadership Programme - Maternity Local Transformation Hub - Maternity (future.nhs.uk) is a dedicated space for NHS England's Perinatal Culture and Leadership Programmes, with resources for senior leaders and their teams to support local safety culture work.
Perinatal Quality Surveillance Model	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local governance for sharing intelligence checked, and when needed, updated. • Describe the local governance processes in place to demonstrate how intelligence is shared from the ward to Board. • Formalise how Trust-level intelligence will be shared and escalated with the LMNS/ICB quality group and from there with regional quality groups which will include the Regional Chief Midwife and Lead Obstetrician.
Reporting to Trust Board	
What do we need to include in the dashboard presented to Board each month?	The dashboard should be locally produced, based on a minimum data set. It should include themes identified in line with PSIRF, and actions being taken to support; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. Themes and progress with culture

	improvement plans following local cultural surveys or equivalent should also be included. This may include the SCORE culture survey, NHS staff survey, NHS pulse survey, focus groups or suitable alternative. The dashboard can also include additional measures as agreed by the Trust.
Our Trust Board and / or sub-committee only meet 10 times a year. Is this acceptable?	If the Board or appropriate sub-committee do not meet monthly, it is the expectation that maternity and neonatal quality and safety will be discussed every time the Board or sub-committee meet.
Clarification as to what constitutes a Trust Board, can sub committees be categorised as a Board?	In year 6 the standard has been updated to reflect that an appropriate Trust Board sub-committee, chaired by a Trust Board member, can be delegated to undertake the monthly review of perinatal safety intelligence. If a sub-committee of the Board undertakes this work, an exception report or highlight report must still be provided to the Board and discussion evidence in the Board minutes.
Culture Surveys	
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will have participated in the Perinatal Culture and Leadership Programme. As part of this programme every service completed work to meaningfully understand the culture of their services. This diagnostic was either a SCORE culture survey or an alternative as agreed with the national NHSE team. Diagnostic insights and plans for improvement were to be shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the diagnostic findings. The expectation is that all maternity and neonatal services will understand how it feels to work in their services, either from the SCORE culture survey, or suitable alternative.
What if our maternity and neonatal services are not undertaking the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture survey was a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work.
Perinatal Culture and Leadership Programme	
Who is expected to have	Senior perinatal leadership teams from all Trusts that have a maternity and neonatal service in England have undertaken

undertaken the Perinatal Culture and Leadership Quad programme?	the PCLP. This will be representation from the midwifery, obstetric, neonatal, and operational professional groups, usually consisting of the DoM/HoM, clinical lead / CD for obstetrics, clinical lead for neonates and the operational manager.
Is there an expectation that the Board safety champions have undertaken the programme?	The Board Safety Champions should be supporting the perinatal leadership team 'Quad' and their work as part of the PCLP, but there is no expectation for them to attend the programme.
Safety Champions	
What is the rationale for the Board level safety champion safety action?	It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Do both the NED and Executive BSC and all four members of the 'Quad' have to be present at each meeting?	Ideally the meeting would have both Board Safety Champion (BSC's) and at least two members of the Quad present. If this is not always possible, it would be appropriate for either the Executive or NED BSC and at least one member of the quad to be present. However, the expectation is that each professional group is represented throughout the year, and that the nominated member attending brings all four voices to the conversation.
What are the expectations of the NED and Exec Board safety champion in relation to their support for the Perinatal Culture and Leadership Programme (PCLP), culture	As detailed in last year's MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provides an opportunity to share safety intelligence, examples of best practice, identified areas of challenge and need for support. The meetings should be conducted in an appreciative way, with the perinatal teams being open and transparent and the Board Safety Champions being curious and supportive. As a minimum the content should cover:

surveys and ongoing support for the Perinatal Leadership teams? **What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal Leadership teams?**	- Learning from the Perinatal Culture and Leadership Development Programme and how they are using this locally. - How they plan to continue being curious about their local culture. This may be in the form of pulse surveys, or team check ins. - Updates on recent local insight into their team's health, as gathered in the above bullet points. Updates on identified areas for improvement following the local diagnostic, along with any identified support required from the Board. NB, this plan will be fluid and iterative, based on continued conversations with perinatal teams. It is not a plan that can be completed and filed as culture is ever changing and something leaders continually need to be curious about. - Progress with interventions relating to culture improvement work, and any further support required from the Board.
Do the non-executive and executive maternity and neonatal Board safety champion not have to register to the dedicated FutureNHS workspace to access the resources available this year?	We encourage all NED and Exec Board Safety Champions to register on the FutureNHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace. New content and resources are added throughout the year, and we would encourage all BSC's to continue to access the page to benefit from these. You can also reach out to other Board Safety Champions and develop your own community of peer support. However, this will not be a formal requirement in year 6 of the MIS.
We had not continued to undertake feedback sessions with the Board safety champion, what should we do?	Parts a) and b) of the required standard builds on the year four and five requirements of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board level safety champions to raise concerns relating to safety and identify any support required from the Board. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions with staff as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three and four of the maternity

	incentive scheme and the expectation is that this should have been continued.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.
What are the expectations of the Board safety champions in relation to quality improvement work undertaken by the maternity and neonatal quality improvement programme?	The Board safety Champions will be expected to continue their support for continuous quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
Scorecards	
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here.
Why do we need to review the scorecard quarterly alongside current complaint and incident data?	The scorecard is a quality improvement tool that provides insight into claims in support of clinical governance and quality assurance in your organisation. It provides details of all CNST claims, combined with data from the EN scheme and can provide a full picture of maternity related claims in your organisation. The scorecard provides 10 years of claims experience allowing the impact of clinical effectiveness and safety interventions to be assess over time. It can be reviewed alongside other data sets to provide a fuller picture of safety. It highlights themes occurring in claims which can be addressed through staff education and training. The scorecard provides a number of speciality filtered views allowing quick access to the relevant data for your division/speciality. Where data sharing agreements exist, members may share scorecard data to support learning across partnerships, networks and regions.

	The safety and learning team at NHS Resolution can support you in accessing and using your scorecard, nhsr.safety@nhs.net . A short video on using your scorecard can be found here Videos (resolution.nhs.uk) (Extranet login required). The GIRFT/NHS Resolution Learning from Litigation Claims can be found here Best-practice-in-claims-learning-FINAL.pdf (gettingitrightfirsttime.co.uk) and includes advice on engaging with NHS Resolution Safety and Learning resources, including the scorecard.
Examples have been requested for the scorecards.	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historical claims on the scorecard and any action taken, then presenting these alongside current incidents and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows you to act quickly if any historical themes re-emerged. NHS Resolution have developed an example template to share, and this can be accessed via the FutureNHS platform Maternity Incentive Team workspace, or the MIS Team can send a copy out on request. NHS Resolution staff are always happy to talk through this process if it is helpful.

Technical Guidance for Safety Action 10	
Where can I find information on MNSI (previously HSIB)?	Information about MNSI and maternity investigations can be found on the MNSI/ website https://mnsi.org.uk
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website: • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: (i) when the baby was therapeutically cooled (active cooling only), or (ii) has been diagnosed with moderate to severe encephalopathy, consisting of altered state of consciousness (lethargy, stupor or coma) and at least one of the following: (aa) hypotonia; (bb) abnormal reflexes including oculomotor or pupillary abnormalities; (cc) absent or weak suck; (dd) clinical seizures Trusts are required to report their qualifying cases to MNSI via the electronic portal. Once MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury. * This definition was updated from 1 October 2023. Please see our website for further information, this does not change the cases referred to MNSI.
What is the definition of labour used by MNSI and EN?	The definition of labour used by MNSI and EN includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to)

	abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.
Changes in the EN reporting requirements for Trust <u>from 1 April 2022 going forward</u>	As in year 4 of MIS, in addition to reporting their qualifying cases to MNSI, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once MNSI have confirmed they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must input the MNSI reference number to confirm the investigation is being undertaken by MNSI (otherwise it is rejected). The Trust must share the MNSI report, along with the MRI report, with the EN team within 30 days of receipt of the final report by uploading the MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the MNSI report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where MNSI are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury and have a confirmed reference number. • Where a family have declined a MNSI investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution and advised of this reason for reporting. There is more information here: ENS Reporting Guide - December 2023 (for Member Trusts) - NHS Resolution
Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a MNSI investigation where the baby has a normal MRI. • Cases that MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to	If a baby has a clinical or MRI evidence of neurological injury and the case is being investigated by MNSI because of this, then the case should also be reported to NHS Resolution via the Claims Reporting Wizard along with the MNSI reference number (document the MNSI reference in the "any other comments box").

MNSI or NHS Resolution?	Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Should you have any queries, please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or MNSI maternity team maternityadmins@mnsi.org.uk
How should we report cases to NHS Resolution?	Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once they have been confirmed by MNSI as under investigation. They must also complete the EN Report form and attach this to the Claims Reporting Wizard: EN-Report-Form.pdf
What happens once we have reported a case to NHS Resolution?	On completion of the MNSI investigation, and on receipt of the MNSI report and MRI report, following triage, NHS Resolution will overlay an investigation into legal liability. Where families have declined an MNSI investigation, no EN investigation will take place, unless the family requests this.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. Regulation 20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by MNSI and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all qualifying cases to MNSI as soon as they occur and to NHS Resolution as soon as MNSI have confirmed that they are taking forward an investigation.

	Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to MNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme.
How can we confirm our cases have been reported to NHS Resolution?	We strongly advise making a note of the Claims Management System (CMS) reference number received once the matter is reported, as this will be confirmation that the case has been successfully reported to NHS Resolution.

MIS FAQ	
What do you mean by Trust Board?	Unless explicitly stated, Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion.
Why aren't we reporting everything directly to Trust Boards?	Trust Boards have a broad scope of responsibility, covering all aspects of the Trust's governance, strategy, and finances. They provide strategic direction and oversight, while sub-committees such as the Quality Governance Committee takes a more hands-on role in monitoring quality and safety performance reviewing and scrutinising operational detail. It is vital that the most pertinent information that is conveyed to Trust Boards is clearly recognised, and not lost in the operational detail of reporting. A sub-committee's in-depth examination of data, reports, and practices provides the Board with a clear understanding of the Trust's performance on quality and safety, including any immediate priorities or exceptions.
How can I evidence an appropriate sub-committee?	A Board Assurance Framework should highlight the decision-making processes within a Trust and detail those committees with delegated authority from the Board. Individual Terms of Reference from sub-committees should also contain this information. Minutes of sub-committee meetings should demonstrate that the required discussion around MIS standards have taken place, including any output which will be conveyed to the Trust Board. This must be recognised within Trust Board minutes.
What is a Quality Governance Committee, and how does it differ from a Trust Board?	A Quality Governance Committee (QGC) is a committee of the Trust Board responsible for overseeing the Trust's quality and safety governance arrangements. It provides assurance to the Trust Board that the Trust has robust systems in place to identify, assess, and mitigate risks to patient safety. The QGC also reviews the Trust's quality improvement initiatives and provides recommendations to the Trust Board. The information presented to a QGC will be more detailed and specific than the information presented to the Trust Board. They should receive regular updates on the Trust's performance in key quality and safety areas, as well as specific data on individual incidents and concerns. The QGC should also have the opportunity to discuss the Trust's quality improvement plans and provide feedback and recommendations. A QGC is appropriate to review evidence around safety actions, provide additional scrutiny **and then report to the**

	Trust Board, delivering a summary and highlighting any exceptions or particular areas of concern. **It is important to ensure that this process facilitates Trust Board oversight, rather than replaces it.**
Where can I find more information about Board Reporting via Quality Governance Committees?	NHS Providers Board Assurance Toolkit Quality Governance in the NHS
Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice for the Board notification form?	Trust Boards must self-certify the Trust's final MIS declaration following consideration of the evidence provided. It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the CQC for their consideration if any further action is required, and to the NHS England and NHS Improvement regional director, the Deputy Chief Midwifery Officer, regional chief midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the AO for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution. The declaration form must be signed by both CEO and the AO of Clinical Commissioning Group/Integrated Care System before submission.
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and

	AO (ICB). Where relevant, an action plan is completed for each action the Trust has not met. **Please send only the Board notification form to NHS Resolution. Do not send your evidence or any narrative related to your submission to NHS Resolution unless requested to do so for the purpose of reverification.** Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2024 and all Trusts will be notified. It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 3 March 2025, NHS Resolution will treat that as a nil response.
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 3 March 2025**. If not returned to NHS Resolution by 12 noon on 3 March 2025, NHS Resolution will treat that as a nil response.
Our Trust has queries, who should we contact?	Any queries prior to the 3 March 2025 must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The maternity incentive scheme outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated MIS link contacts via the link on the NHS Resolution website.
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results.

appeals this year?	The AAC will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal: • alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation. • technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated when final results are confirmed and sent to Trusts.
Merging Trusts	Trusts that will be merging during the year six reporting period (April 2024 – January 2025) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2024/25 and the reporting of claims and management of claims going forward.

Board Report and Action Plan on Implementation of the Saving Babies Lives Care Bundle (Version 3)

Implementation Report

Trust	**Wirral University Teaching Hospital NHS Foundation Trust**
Date of Report	**25-Sep-23**
ICB Accountable Officer	
Trust Accountable Officer	**Janelle Holmes, CEO**
LMNS Peer Assessor Names	**Debby Gould, LMNS Q&S Lead**

Background

Version three of the Saving Babies' Lives Care Bundle (SBLCBv3) published on 31 May 2023, aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The third version of the care bundle brings together six elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth
6. Management of diabetes in pregnancy

The Care Bundle is now a universal innovation in the delivery of maternity care in England and continues to drive quality improvement to reduce perinatal mortality. It has been included for a number of years in the NHS Long Term Plan, NHS Planning Guidance, the Standard Contract and the CNST Maternity Incentive Scheme, with every maternity provider expected to have fully implemented SBLCBv2 by March 2020.

ONS and MBRRACE-UK data demonstrate the urgent need to continue reducing preventable mortality. Developed 4 years after SBLCBv2, Version 3 of the Care Bundle (SBLCBv3) has been developed through a collaboration of frontline clinical experts, service users and key stakeholder organisations. All existing elements have been updated, incorporating learning from the Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (CNST MIS) and insights from NHS England's regional maternity teams. SBLCBv3 aligns with national guidance from NICE and the RCOG Green Top Guidelines where available but it aims to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. SBLCBv3 also includes a new element on optimising care for women with pregnancies complicated by diabetes.

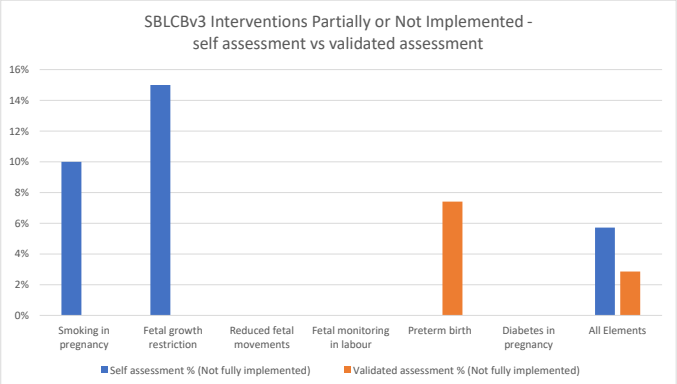
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

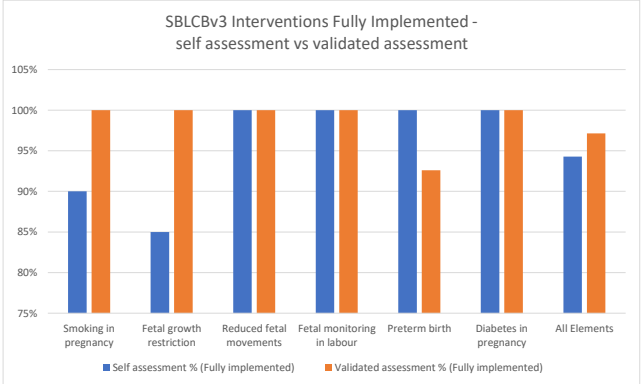
Implementation Grading

Limited Assurance - Activities and control are not suitably designed, or not operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	93%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	97%	CNST Met





Action Plan

Element 1

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. MSDS DQ check passed in November 23. Jan 24 data- 95% compliance of CO at booking. 89% compliance of CO at 36 weeks.
1.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. July-Sept audit noted and compliant at 92%
1.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. Smoking status at Booking noted at 100% in Jan 24. Smoking status at 36/40 noted at 89% in Jan 24. Audit noted for smoking status at every contact for pregnant
1.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. Opt-out referral rate noted at 100% in Jan 24 so therefore compliant
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
1.6	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	REF1.6N noted. 39% set quit date and 23% achieved a 4 week quit (includes Aug and Sept 23 data). These meet required compliance. Outcome indicator 1d- 40% in Jan 24 meets required compliance.
1.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. Audit noted as 100% compliant in REF1.7F (data from July-Sept 23)
1.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Updated Training compliance noted. Dec 23- 90% compliance for Midwives/MSW's and 100% compliance for Obstetric consultants working in ANC
1.9	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Updated Training compliance noted. Dec 23- 90% compliance for Midwives/MSW's and 100% compliance for Obstetric consultants working in ANC
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Please note, Pactitioners should complete NCSCT e-learning and assessments annually.

Element 2

INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in Q2 23/24
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in Q2 23/24
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in Q2 23/24
2.5	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.6	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	REF2.6- Guideline updated
2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in Q2 23/24
2.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline validadted by LMNS until June 2024
2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in Q2 (please note this is labelled as 2.7 in table of REF2.1D)
2.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Overall staff 90% compliance in March 2024
2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.18	Partially implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Q4 of 2023- 45% noted which meets required compliance at present
2.19	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Antenatal detection of SGA noted as 58% for Q4 of 2023 which meets compliance. GROW report shows babies born < 39 weeks is 11.1% in Q4 of 2023.
2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 3

INTERVENTIONS				
3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
3.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Computerised CTG audit in July/Aug/Sept 23 was 100% compliant. USS audit in July/Aug/Sept 23 was 94% compliant. IOL audit in July/Aug/Sept 23 was 2.2%. PMRT report from July-Sept 23 noted.

Element 4

INTERVENTIONS				
4.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Training compliance noted as 90% overall in December 23
4.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	80% compliant in September 2023 and 83% compliant in October 2023 (Audits remain valid as within previous 6 months).
4.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in December 23
4.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit 100% compliant in Decmber 23
4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 5

INTERVENTIONS				
5.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	JDs and Job Plans noted for all team members
5.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Births 16+0-23+6 was 0% in Oct 23 (data from MSDS) Births 24+0-36+6 was 6.3% in Oct 23 (data from MSDS) PMRT report- annual breakdown of cases in which preterm birth
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% compliance achieved July/Aug/Sept 23.
5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Twins trust audit demonstrates alignment with NICE. Re-audit document noted from September 2023.
5.7	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Evidence noted in 1.1. Progress with Early Pregnancy Intervention in C&M pathway
5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	60% compliance noted as per REF5.9 July/Aug/Sept 23.
5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline as REF5.3A (page 5). MSU audit 100% compliant in July/Aug/Sept 23.
5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit of 20 cases between Oct-Dec 23- 90% compliant
5.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisaton tool states 76% compliant for October 23
5.18	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.19	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Optimisaton tools states 100% compliance in October, November and December 2023.
5.20	Fully implemented	Partially implemented	Evidence not in place - improvement required.	52% compliance in 2023 (NNAP Powerpoint). 92% compliance noted in Q3 of 23/24 for babies born 22+0-29+6. Data also required for steroids >7days before birth
5.21	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	ODN Dashboard shows average compliance 97% for Oct,Nov, Dec 2023. 86% overall compliance in 2023 (NNAP Powerpoint). NNAP Powerpoint shows PVL- 7.7% in 2023. IVH- 12.2% in 2023.
5.22	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	ODN Dashboard shows average compliance 44% for Oct,Nov, Dec 2023
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	ODN Dashboard shows average compliance 85% for Oct,Nov, Dec 2023
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	ODN Dashboard shows average compliance 65% for Oct,Nov, Dec 2023

	5.25	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	ODN Dashboard shows average compliance 84% for Oct,Nov, Dec 2023
	5.26	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	NWODN Action Plan noted
	5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	ODN Dashboard shows average compliance 97% for Oct,Nov, Dec 2023
Element 6	INTERVENTIONS				
	6.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	6.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	CGM Audit 100% complaint July/Aug/Sept 23. Q3 CGM audit- please clarify audit 1 comments on page 6. Staff training certificates noted.
	6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	6.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	90% compliant in Q2 of 23/24. 100% compliant in Q3 23/24
	6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
	6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9**

01 May 2024

Title	Health Inequalities Operating Model
Area Lead	David McGovern, Director of Corporate Affairs / Matthew Swanborough, Chief Strategy Officer
Author	Mike Gibbs, Deputy Chief Strategy Officer
Report for	Approval

Executive Summary and Report Recommendations

This target operating model outlines our role in addressing health inequalities. The report provides a streamlined operating model and effective governance structure to optimise our efforts in addressing health inequalities. By enhancing organisational agility and accountability, we seek to strategically deploy resources, interventions, and initiatives with precision. This initiative is driven by a commitment to maximise our impact and promote health equity by ensuring that our strategies are well-executed, sustainable, and responsive to the diverse challenges posed by health inequalities.

The model has been crafted after a comprehensive examination of national, regional, and local contexts, incorporating an analysis of our Trust strategy, and enabling strategies. This report encompasses a review and assessment of existing initiatives currently targeting health inequalities, delineating our organisation's role and obligations. Moreover, the report presents a series of recommendations and provides a plan for implementation, monitoring, and evaluation.

It is recommended that the Board:

- Endorse and Embed the WUTH Health Inequality Model
- Endorse and Engage in Health Inequality Initiatives with Designated Leads
- Embeds Tools for Systematic Health Inequality Reduction

Key Risks

This report relates to these key risks:

- Our Partners - Risk No 12 BAF
  Failure to work with local partners to address and reduce health inequalities across the Wirral Population

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

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
12th March	Executives	Health Inequalities TOM	For Approval

1	Narrative
1.1	Against the backdrop of Wirral, a region distinguished by its unique characteristics and a vibrant community spirit, our organisation's commitment to addressing health inequalities assumes a localised emphasis. Wirral, situated within the fabric of England, is a community that thrives on its distinctiveness, confronting challenges and celebrating triumphs in a manner unique to its identity. Within Wirral, we are confronted with a stark reality: 35% of its population finds itself among the 20% most deprived in England. This statistic transcends mere numerical representation; it embodies the faces, narratives, and aspirations of our neighbours, underscoring the urgency of our mission. Acknowledging the profound impact of disparate health outcomes on individuals and communities, our organisation has pledged to play a pivotal role in driving positive change specifically tailored to the unique needs of Wirral. This targeted operating model unfolds as a bespoke blueprint for addressing health inequalities within the communities we serve. It delineates the strategies, initiatives, and ongoing endeavours that define our commitment to cultivating healthcare that is both accessible and equitable for all. Through a blending of research, community collaboration, and focused interventions, our organisation endeavours to affect a substantive reduction in health inequalities, thereby advancing health equity within Wirral. This report stands as a testament to our dedication to shaping a future wherein every service user accessing our organisation, regardless of their background or circumstances, can aspire to and attain the highest attainable standard of health.

2	Implications
2.1	**Patients** • Embedding the tools for systematic health inequality reduction and engaging in the initiatives outlined in this target operating model, maximises opportunities for inclusion and patient experience.

2.2	**People** • The initiatives outlined promotes EDI initiatives and maximises opportunities for inclusion • Implementing the systematic tools for reducing health inequalities will require familiarisation for some internal stakeholders • The recommendations within this report align and are in keeping with what other health and care partners are implementing
2.3	**Finance** • It is not anticipated implementing this report recommendations will have a financial impact.
2.4	**Compliance** • The target operating model for our role in addressing health inequalities supports the following statutory and/or regulatory compliance: • Human Rights Act 1998 • Equality Act 2010 • Public Sector Equality Duty 2010 • The Marmot Review 2010 / Health Equity in England: The Marmot Review 10 Years On 2020 • Health and Social Care Act 2022 • Health, public health and social care outcomes frameworks • CQC key inspection questions 2013 • The NHS Constitution – revised 2013 • Workforce Race Equality Standard WRES • Equality Delivery System (EDS-EDS 2) • Sexual Orientation Monitoring Standard 2017

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Our Role in Addressing Health Inequalities

Target Operating Model

Final

together we will

Foreword

Wirral University Teaching Hospital NHS Foundation Trust

As we introduce our Addressing Health Inequalities Model, our primary objective is to convey a compelling vision aimed at bridging the health disparity gap within the Wirral, fostering benefits for both our patients and communities. Health inequalities, characterised by unjust and avoidable health discrepancies among various groups, populations, or individuals, find their roots in the unequal distribution of social, environmental, and economic conditions within societies. These inequities has a profound influence on the opportunities for good health, shaping individuals' thoughts, emotions, actions, and, consequently, their susceptibility to illness. Moreover, they impede the proactive prevention of sickness and timely access to treatment, emanating from the conditions in which we are born, grow, live, work, and age.

The advent of the Covid pandemic has amplified challenges faced by our services, patients, and communities. Escalating waiting times, increased rates of missed appointments, and heightened mortality rates within our communities underscore the urgent need for a responsive and equitable approach. Importantly, these impacts exhibit variations in their distribution across communities.

In our commitment to addressing these challenges, we extend our collaboration to encompass our communities closely. By comprehending their priorities and understanding their experiences with the services we provide, we strive to collectively forge a path toward a more equitable and inclusive healthcare environment.

Recognising that the approach to addressing health inequalities must be system-wide and coordinated, we advocate for strategic collaboration between Trusts, local authority and neighbouring organisations. This local, system-level approach aligns with existing national frameworks and commitments, providing the foundation for this report. The report's purpose is to coordinate and contextualise existing efforts, supporting our strategic direction and concentrating on addressing health inequalities for the people of Wirral.

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Wirral University Teaching Hospital NHS Foundation Trust

Executive Summary

Wirral University Teaching Hospital NHS Foundation Trust

Background

Against the backdrop of Wirral, a region that resonates with unique characteristics and a vibrant community spirit, our organisation's commitment to addressing health inequalities takes on a localised focus. Wirral, nestled within the fabric of England, is a community that thrives on its individuality, facing challenges and celebrating triumphs in its own distinct way.

Within Wirral, we confront a stark reality – 35% of its population finds itself within the 20% most deprived in England. This statistic is not just a number; it represents the faces, stories, and aspirations of our neighbours, emphasising the urgency of our mission. In recognising the profound impact that disparate health outcomes can have on individuals and communities, our organisation has committed itself to playing a pivotal role in driving positive change specifically tailored to the unique needs of Wirral.

This target operating model unfolds as a tailored blueprint for addressing health inequalities for the communities we serve. It unravels the strategies, initiatives, and ongoing efforts that define our commitment to fostering a healthcare environment that is both accessible and equitable for all. Through a combination of dedicated research, community collaboration, and targeted interventions, our organisation endeavours to make a meaningful contribution to the reduction of health inequalities, thereby promoting health equity within Wirral.

This report stands as a testament to our dedication to crafting a future where every service user accessing our organisation, irrespective of their background or circumstance, can aspire to and attain the highest possible standard of health.

Purpose

Our aim is to develop a streamlined operating model and effective governance structures to optimise our efforts in addressing health inequalities. By enhancing organisational agility and accountability, we seek to strategically deploy resources, interventions, and initiatives with precision. This initiative is driven by a commitment to maximise our impact and promote health equity by ensuring that our strategies are well-executed, sustainable, and responsive to the diverse challenges posed by health inequalities.

Rationale

This initiative is grounded in the imperative to strategically enhance our organisational capabilities to address health inequalities. By refining our operating model and governance structures, we aim to optimise resource deployment, increase efficiency, and foster greater accountability. This strategic approach ensures that our efforts are impactful, sustainable, and responsive, aligning with our commitment to promoting health equity.

Executive Summary WUTH Health Inequality Model

Wirral University Teaching Hospital NHS Foundation Trust

STRATEGIC CONTEXT

- Health and Care Act 2022
- NHS Long Term Plan
- Marmot Review
- Core 20PLUS5
- ICS Legislation and Guidance
- The Cheshire and Merseyside Joint Forward Plan (2023-28)
- Wirral Public Health Annual Report
- NHSE Statement on information on health inequalities

INITIATIVES	DESCRIPTION
1 Core 20PLUS5	Core20PLUS5 is a national approach designed to reduce health inequalities by identifying a target population and 5 clinical areas of improvement. • **Core20**: The most deprived 20% of the national population • **PLUS**: Inclusion health groups identified at a local level • **5**: Clinical areas of focus: maternity, severe mental illness (SMI), chronic respiratory disease, early cancer diagnosis, hypertension
2 Anchor Institution	Anchor Institutions are large organisations which have a stake in their local area. Their assets can be used to address health inequalities. The key principles of Anchor Institutions focus on estates and land use, procurement, employment, professional development, sustainability and collaboration with local partners.
3 Social Value Charter and Award	The Social Value Charter is a model introduced to embed social value into procurement processes. Social Value priorities include tackling economic inequality, fighting climate change and providing equal opportunities. Organisations can gain accreditation from the Cheshire and Merseyside Social Value Award by uploading evidence of social, economic, environmental and innovative commitments. The award supports organisations to become Anchor Institutions.
4 NHS Prevention Pledge	The NHS Prevention Pledge is a Cheshire and Merseyside initiative which focuses on reducing preventable illness and inequalities in health. Core commitments include workforce development, promoting healthier lifestyles for patients, visitors and staff, enhancing Anchor Institution Practices and signing up to the C&M Social Value Award.
5 Fair Employment Charter	The Fair Employment Charter for Liverpool City Region encourages employers to improve their employment practices by celebrating fair employment practices. Its commitments focus on establishing a healthy workforce, fair pay and hours, inclusive workspaces and delivering justice in the workforce with opportunities for young people.

DELIVERY

- Tracking progress and delivery against Prevention Pledge, Anchor Institution, Social Value Award KPIs, and Green Plan
- Supported by WUTH Annual Operational Plans and Enabling Strategies
- Delivery of Marmot Principles
- Monitoring and Delivery through Health Inequality Committee
- Co-creation interventions and actions with communities
- Local/C&M/National Programmes Delivered in Place

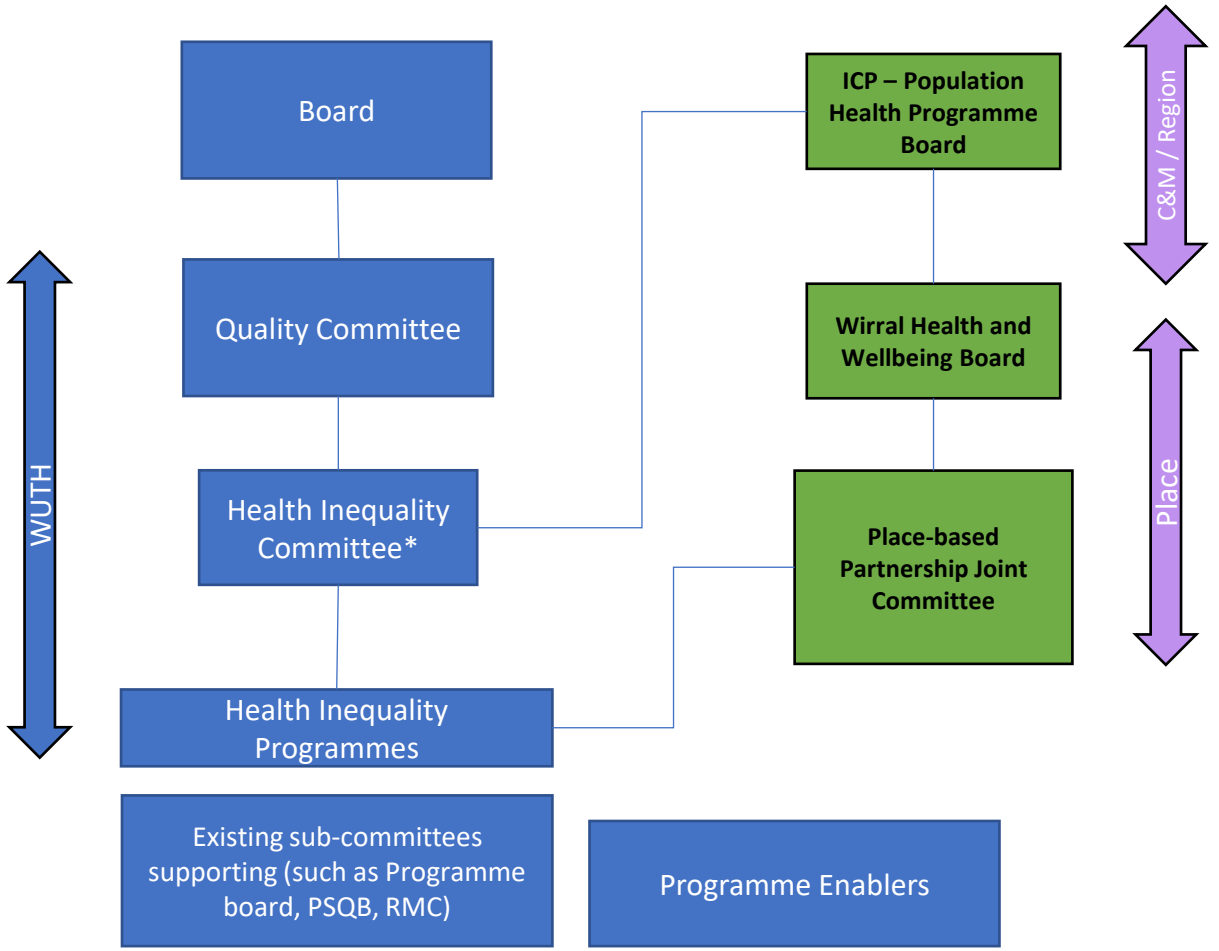
Executive Summary Proposed Governance Structure

Wirral University Teaching Hospital NHS Foundation Trust

Proposed Governance Structure

Recognising the critical need for robust governance and strategic oversight at the highest level, it is strongly recommended that we establish a dedicated 'Health Inequality Committee.' This committee will serve as an integral component of our governance structure, providing a direct link between our health inequality initiatives through Quality Committee and into the board.

The committee's primary functions will encompass board-level oversight, clear and comprehensive reporting, and strategic guidance. Comprising individuals with expertise in health inequalities, including leads of existing initiatives, the committee will ensure that our efforts align with the broader organisational goals and objectives. By bringing together diverse perspectives and skills at the board level, this committee will contribute significantly to coordinated actions, reinforcing our organisational commitment to addressing health inequalities with diligence and strategic intent.



*Establishment of new health inequality committee

Executive Summary – Key Steps and Plan

Wirral University Teaching Hospital NHS Foundation Trust

Key Steps and Plan

The operating model and key steps presented in this report satisfy the intended aim of addressing health inequalities. The following summary outlines the recommendations.

1) Endorse and Embed the WUTH Health Inequality Model:

Formally adopt and integrate the WUTH Health Inequality Model, tailored to our Trust's unique context. This strategic framework will guide understanding, assessment, and addressing of health inequalities. The model promotes consistency, coherence, and continuous improvement, aligning with our organisational values for effective health inequality reduction.

2) Trust Officially Endorse and Engage in Initiatives with Named Leads:

Officially endorse and engage in initiatives with designated leaders. Ensure ongoing success by appointing leaders for each initiative, formalising the Trust's dedication. These designated leads will play a pivotal role, overseeing implementation, monitoring progress, and aligning initiatives seamlessly with our overarching health inequality goals. The act of formally signing up to these initiatives not only emphasises our commitment but also enhances accountability, fosters collaboration, and contributes to a cohesive approach in addressing multifaceted health inequalities

3) Embedding Tools for Systematic Health Inequality Reduction:

Strengthen our commitment with systematic tools – integrate the NHS England Healthcare Inequalities Improvement Planning Matrix and the Health Inequalities Assessment Tool (HEAT). These tools provide a structured framework for identifying, prioritising, and addressing health inequalities, enhancing our capacity for evidence-based decision-making and transparent, accountable efforts.

4) Formation of a Health Inequality Committee:

Establish a dedicated 'Health Inequality Committee' for robust governance and strategic oversight. Comprising experts, including initiative leads, this committee ensures alignment with organisational goals. Its functions include executive-level oversight, comprehensive reporting, and strategic guidance, reinforcing our commitment to addressing health disparities at the highest level.

Plan for 2024/25

Obtain board approval for the WUTH Health Inequality Model and formulate a comprehensive implementation plan. Assign specific leaders for each initiative and establish a sub-committee within the health inequality committee.

Background and Context

Wirral University Teaching Hospital NHS Foundation Trust

As a Foundation Trust, we are acutely aware of the daily impact of a range of challenges, including poverty, low health literacy, homelessness, unemployment, lack of social support, and other factors. These challenges often create barriers for individuals in seeking support, comprehending and engaging with their healthcare, navigating available services, taking preventive measures, and pursuing long and healthy lives.

Within our healthcare and social support system, concerted efforts are underway to address these broader determinants of health at a population level. WUTH, as an integral component of this system, is committed to collaborating with partners across Cheshire & Merseyside to tackle these determinants in a unified and strategic manner.

However, it's imperative to acknowledge that healthcare inequalities are not the sole responsibility of those at the system level. Practitioners focusing on individual patient care also play a pivotal role. Irrespective of our specific roles, each of us can contribute to reducing these inequalities. This contribution might involve providing support during patient consultations, influencing service design, or advocating for comprehensive organisational and systemic changes, as articulated in the "My Role in Tackling Health Inequalities" framework by the King's Fund (D. Dougal & D. Buck, 2021).

Furthermore, WUTH recognises that its workforce is an integral part of the local community. The quality of patient experiences is intrinsically linked to the quality of staff experiences. Addressing workforce diversity inequalities is inseparable from addressing disparities in health outcomes.

What are Health Inequalities:
Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience and the care that is available to them (NHS England, 2023).

Background and Context

Wirral University Teaching Hospital NHS Foundation Trust

The Trust operates in some of the UK's most diverse and economically disadvantaged areas, where many face challenges in achieving a decent standard of living, including access to food, warmth, and shelter. Research consistently reveals a strong connection between poverty and health outcomes. Around 10% of an individual or community's health status is attributed to medical care, while a substantial 60% is shaped by social determinants and individual behaviours, closely intertwined with these social factors.

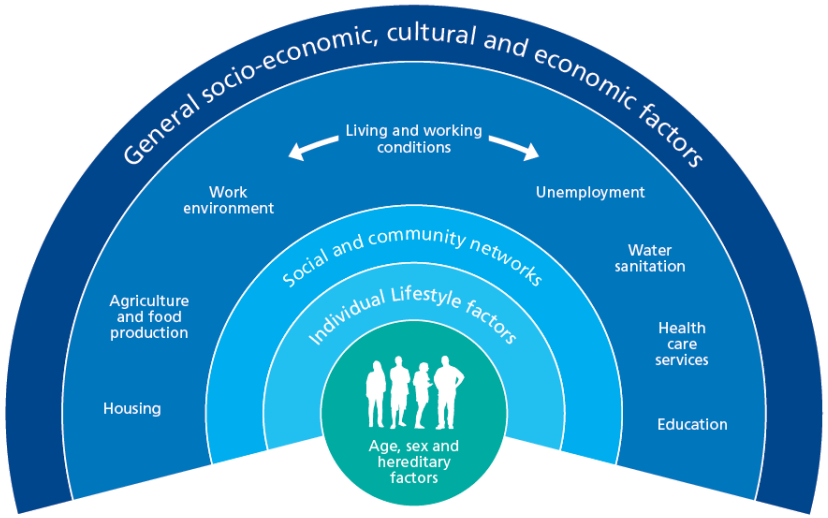
Certain communities, especially those with Black, Asian, or Minority Ethnic backgrounds and other protected characteristics, as well as individuals in "health inclusion groups" like vulnerable migrants, Gypsy Roma or Traveller communities, sex workers, and more, experience significant health disparities.

Health inequalities have persisted for a long time, with the pandemic emphasising these issues, particularly within Black, Asian, and Ethnic Minority communities. It is well-established that people in impoverished circumstances generally face worse health outcomes. In his 2011 review "Fair Society, Healthy Lives," Professor Sir Michael Marmot provided crucial recommendations to address these disparities.

The recently published NHS Race & Health Observatory Report on Ethnic Inequalities in Healthcare offers a detailed evidence review and recommendations for action, including mental health. A recent report from the King's Fund, titled "Equity and Endurance: Addressing Health Inequalities," discusses the historical focus on policy concerning health disparities and advocates for alternative approaches to ensure lasting change in the future.

Health disparities arise from inequalities in our birth circumstances, living conditions, work environments, and the aging process. These disparities are influenced by various factors that impact fair access to healthy choices. This encompasses the design, funding, and operation of services to ensure universal accessibility and the implementation of government policies that prioritise reducing health inequalities.

These challenges are deeply rooted in the broader determinants of health and demand our collective commitment, working alongside essential partners serving diverse populations, to effectively address them.



The Dahlgren-Whitehead Rainbow Model

Wirral University Teaching Hospital
NHS Foundation Trust

National Context

National Context

Wirral University Teaching Hospital NHS Foundation Trust

Context

In this section, we delve into the broader national landscape concerning initiatives aimed at addressing health inequalities. This includes elements such as the planning guidelines set forth by NHS England. Our examination extends to the overarching national strategy for tackling health inequalities, known as CORE20PLUS5. Furthermore, we explore the recently introduced inclusion health framework, shedding light on its implications and practical applications. To complement these perspectives, the section integrates a dedicated page focused on NHS England's recommended planning tools, providing valuable resources and guidance for strategic planning within the realm of health inequalities. Additionally, we provide an overview of the recent Statement on Information on Health Inequalities from NHS England, outlining the implications and requirements relevant to our Trust. We have also included the Care Quality Commission's equality objectives for comprehensive coverage.

National Context

Wirral University Teaching Hospital NHS Foundation Trust

NHS England Planning Guidance

The Health & Care Bill 2022 introduced an explicit requirement for Integrated Care Systems and NHS Trusts to focus on health equity, as part of delivering the statutory duty in delivering the triple aim of improving outcomes, quality and value for the populations we serve. NHS England operational planning guidance in response to the pandemic lays out the following national inequalities priorities for the NHS:

- **Priority 1: Restoring NHS services inclusively**: where performance reports will be broken down by patient ethnicity and Index of Multiple Disadvantage (IMD) quintile, focusing on unwarranted variation in referral rates and waiting lists for assessment diagnostic and treatment pathways, immunisation, screening and late cancer presentations.
- **Priority 2: Mitigating against 'digital exclusion'** – ensuring providers offer face to face care to patients who cannot use remote services; and ensure more complete data collection, to identify who is accessing face to face/telephone/video consultations is broken down by patient age, ethnicity, IMD, disability status etc.
- **Priority 3: Ensuring datasets are complete and timely** – to continue to improve data collection on ethnicity and other protected characteristics, across primary care/outpatients/A&E/mental health/community services, specialised commissioning and secondary care Waiting List Minimum Dataset (WLMDS).
- **Priority 4: Accelerating preventative programmes**; covering flu and Covid-19 vaccinations; annual health checks for people with severe mental illness (SMI) and learning disabilities; supporting the continuity of maternity carers and targeting long-term condition diagnosis and management.
- **Priority 5: Strengthening leadership and accountability** –Supporting PCN, ICS and Provider health inequalities SROs to access training and wider support offer, including utilising the Health Inequalities Leadership Framework, developed by the NHS Confederation.

National Approach in Reducing Health Inequalities

Wirral University Teaching Hospital NHS Foundation Trust

Core20PLUS5

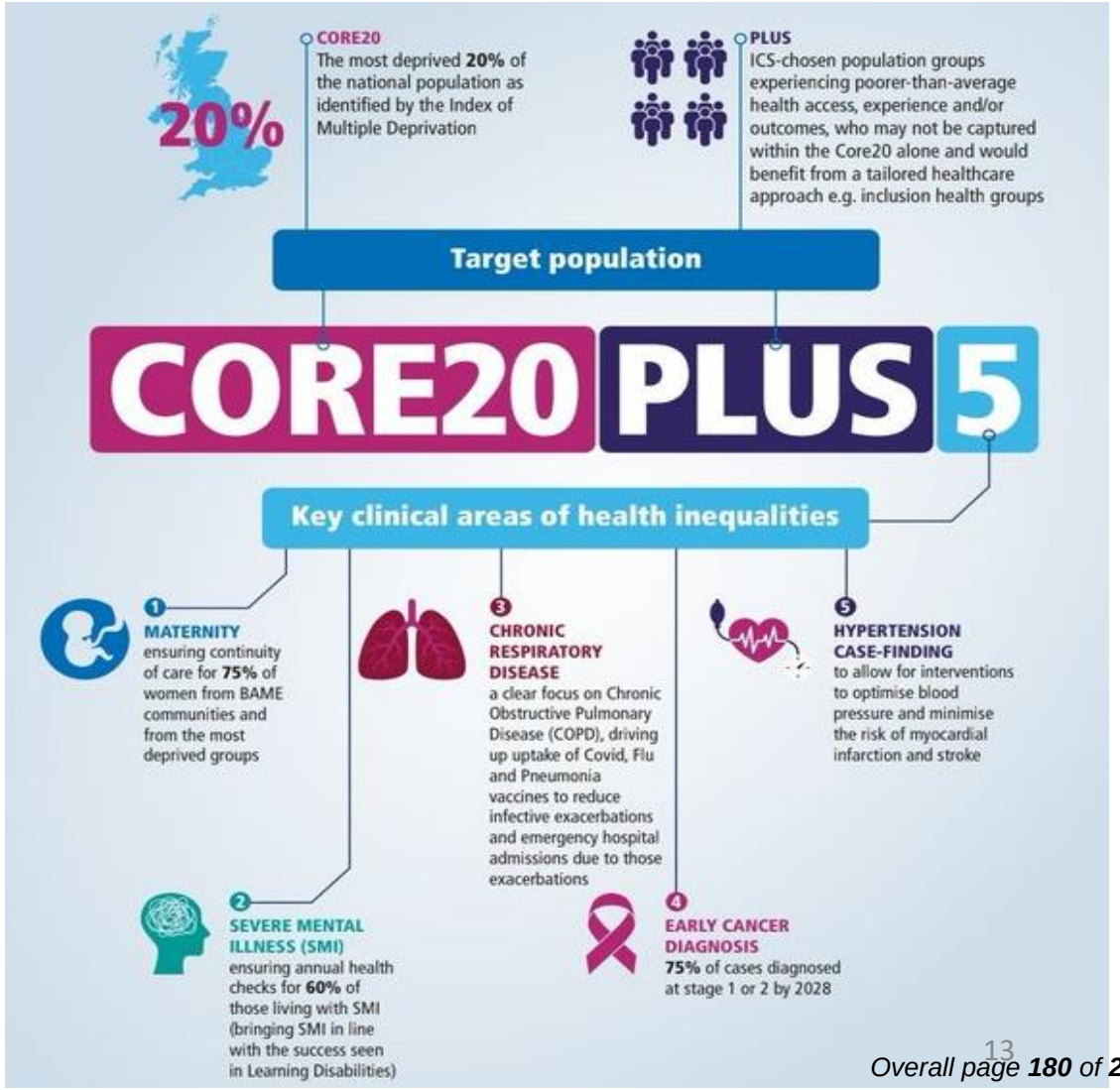
As part of planning requirements for 2022/23, NHS England introduced the Core20plus5 approach, supported by £200m national funding targeted at those areas with the greatest health inequalities.
The Core20PLUS5 approach is designed to support Integrated Care Systems to drive targeted action in health inequalities improvement and encompasses three key parts:

- **'Core20'** refers to the most deprived 20% of the population.
- **'PLUS'** refers to Integrated Care System identified populations or communities that are not thriving, and explicitly may include inclusion health groups.
- **'5'** refers to five clinical areas of focus, where there are inequalities, as described below.

5 key areas of health inequalities

1. **Maternity:** ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. **Severe mental illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
3. **Chronic respiratory disease:** a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.
5. **Hypertension case-finding:** to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

Figure 1: Core20PLUS5



Inclusion Health

Wirral University Teaching Hospital NHS Foundation Trust

Health Inclusion Groups

When addressing health inequalities, it is integral to understand the people who are most affected. Within the 'PLUS' groups of the Core20PLUS5 model are Inclusion Health Groups, which are determined at a local rather than national level. 'Inclusion Health Groups' or 'Inclusion Health', is an umbrella term used to describe people who are socially excluded, who typically experience multiple interacting risk factors for poor health, such as stigma, discrimination, poverty, violence, and complex trauma.

People in inclusion health groups tend to have poor experiences of healthcare services because of barriers created by service design. These negative experiences can lead to people in inclusion health groups avoiding future contact with NHS services and being least likely to receive healthcare despite having high needs. This can result in significantly poorer health outcomes and earlier death among people in inclusion health groups compared with the general population.

People in inclusion health groups include:

- People who experience homelessness
- People with drug and alcohol dependence
- Vulnerable migrants and refugees
- Gypsy, Roma, and Traveller communities
- People in contact with the justice system
- Victims of modern slavery
- Sex workers
- Other marginalised groups

Inclusion health groups often are a small number of individuals, but the implication of the care provided to these groups in relation to time, resource and cost to services is extensive. Therefore, Trusts must adopt a clear, targeted approach to improve the experiences of these individuals accessing services.

The NHS England National Framework for NHS Action on Inclusion

Introduced in October 2023, this framework aims to co-ordinate the focus on Inclusion health by focusing on the role that the NHS plays in improving healthcare, and how partnerships across sectors such as housing and the voluntary and community sector play a key role in addressing wider determinants of health.
The framework is based on five principles for action on inclusion health (Figure 1). It is focused on actions to address issues which are common across inclusion health groups.

Figure 2: Principles for action on inclusion health

Inclusion Health (continued)

Wirral University Teaching Hospital NHS Foundation Trust

Roles and Responsibilities

All elements of the health and care system must take action to improve health outcomes for inclusion health groups to address systematic health inequalities. Partners must work together to gain an understanding of the issues people face and develop knowledge skills and confidence to deliver change.

The NHS England National Framework for NHS Action on Inclusion sets out five principles for practical action and high impact changes that can be made to improve access and outcomes for inclusion health groups.

Table 1: Five principles for action on inclusion

1	**Commit to action on inclusion health**	Ensure the ICB has a named lead for inclusion health to ensure ICP strategies and ICB plans tackle inequalities of access, experience and outcomes for people in inclusion health groups.
2	**Understand the characteristics and needs of people in inclusion health groups**	Proactively improve data and insights on the needs of people in inclusion health in your population. Use this to drive improvement.
3	**Develop the workforce for inclusion health**	Develop the workforce so all staff understand inclusion health and trauma-informed practice. Develop specialists in inclusion. Support employment of people in inclusion groups as NHS anchor organisations.
4	**Deliver integrated and accessible services for inclusion health**	Use best practice to commission sufficient specialist services for inclusion health groups. Raise the quality of all services to ensure equitable access, experience and outcomes for all
5	**Demonstrate impact and improvement through action on inclusion health**	Evaluate the impact of changes made. Ensure people with lived experience inform improvement and evaluation

WUTH Responsibilities

The NHS England National Framework for NHS Action on Inclusion outlines the principles for action for different areas of the healthcare system and specifies that for Hospitals and Trusts are responsible for ensuring that frontline staff and team leaders have the skills and confidence needed to support socially excluded groups and provide adaptations for patients when needed. Trust roles and responsibilities in relation to inclusion health are to *" ensure inclusion health groups can access the best possible healthcare".*

Some examples highlighted for action are:

- Identify a named senior responsible officer for health inequalities and inclusion health in the organisation
- Report on progress delivering inclusion health activity at board level and provide opportunities for board members to spend time with people in inclusion health groups and understand their needs.
- Work collaboratively with wider system partners to use the various tools available and developing a research approach to improve the data and understanding of inclusion groups within the population the Trust serve
- Document how engagement with people with lived experience has informed service delivery, making this information publicly available.
- Build leadership for inclusion health into leadership programmes and training for all staff.
- Share best practice and learning across the system at national, regional, and local levels.
- Offer paid and voluntary employment opportunities to people from inclusion health groups.
- Develop integrated multidisciplinary teams which deliver proactive coordinated care which meet the needs of people in inclusion health groups.

National Context – Recommended Planning Tools

NHS Wirral University Teaching Hospital NHS Foundation Trust

NHS Providers are required to adopt a systematic approach to reduce healthcare inequalities, improve life expectancy and reduce disabilities. NHS England advocate the use of two tools:

1) NHS England Healthcare Inequalities Improvement Planning Matrix

The Healthcare Inequalities Improvement Planning Matrix aids NHS colleagues in assessing their work to reduce health disparities. Used by national and regional leads, it ensures programmes address seven key areas:

1) Equitable access: Consider accessibility for diverse groups, including those in deprived and socially excluded areas.

2) Data and modelling: Use data for targeted, proactive approaches, with agile models addressing emerging inequalities. The Healthcare Inequalities Improvement Dashboard consolidates indicators.

3) Co-produced delivery models: Engage individuals with lived experiences, guided by legal duties for public involvement.

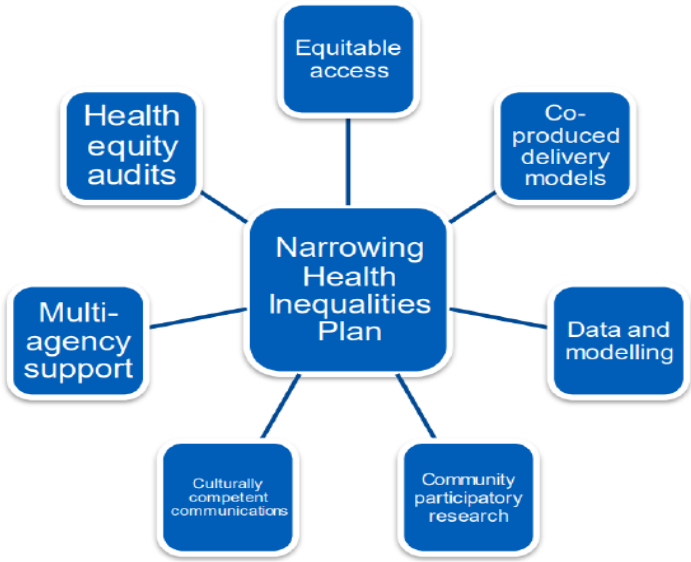
4) Community participatory research: Co-design research with diverse groups, avoiding exclusion in recruitment.

5) Culturally competent communication: Ensure authentic, culturally appropriate messages at all levels, engaging relevant groups.

6) Multi-agency support: Collaborate with the voluntary sector, local government, and NHS for improved care. Refer to The Health and Wellbeing Alliance for networks.

7) Health Equity Audits: Use audits to identify inequalities, conducting them at the project's start. The Equality and Health Inequalities Impact Assessment assists decision-makers.

Figure 3. NHS England Healthcare Inequalities Improvement Planning Matrix



2) The Health Inequalities Assessment Tool (HEAT)

Developed by Public health England. This aims to support the user to identify practical action in their work programme or service to address health inequalities and consequently improve health outcomes. NHS Providers are asked to introduce and apply the HEAT tool in their organisation to systematically address health inequalities and identify what action can be taken to reduce health inequalities and promote equality and inclusion.

National Context

Wirral University Teaching Hospital NHS Foundation Trust

Statement on information on health inequalities

In November 2023, NHS England released a statement on information on health inequalities (duty under section 13SA of the National Health Service Act 2006). This statement sets out a description of the powers available to relevant NHS bodies to collect, analyse and publish information.

Integrated care boards, trusts and foundation trusts should collect, analyse, publish and use information on health inequalities. Relevant NHS bodies have a legal duty to include in their annual report a review of the extent to which they have exercised their functions consistently with this Statement.

The duty to report information on health inequalities will encourage better quality data, completeness and increased transparency. The statement will help drive improvement in the provision of good quality services in reducing health inequalities, helping to ensure equitable access, experience and outcomes for all.

The statement outlines the legal powers and responsibilities of NHS bodies, as outline in the NHS Act (2006). NHS Foundation trusts have the following duties or powers that should enable and inform them collection, analysis and publication of information on inequalities:

1) Duties to provide goods and services as part of the health service
2) Powers to do anything which appears to it to be necessary or expedient for the purposes of or expedient for the purposes of or in connection with its functions
3) Duty to have regard to likely wider impacts of decisions, including on wellbeing
4) Public involvement duties
5) General duties under the public sector equality duty in the Equality Act (2010) (section 149) and the specific duties to create and report equalities information further to the Equality Act (2010) (Specific Duties and Public Authorities) Regulations 2017.

WUTH Responsibilities

The statement outlines that NHS Bodies should collect, analyse and publish specific information on health inequalities. A set of data indicators to be included, is overleaf, condensed for trust level reporting only.

It is recommended that health inequalities information is published in a report within or alongside the organisation's annual report. NHSE recommend that the report should distil the key messages in an accessible format, within approximately 10 pages. Alongside publishing the data in the report, trusts are expected to outline their reflections on the inequalities revealed, how the organisation will use the data and how they intend to improved and make progress to reducing health inequalities

At a minimum, annual report should contain a review of the extent to which the organisation has exercised their functions in line with NHSE's views set out in the statement. Trusts should publish information at a Trust level only.

National Context

Wirral University Teaching Hospital NHS Foundation Trust

Table 3: Information on health inequalities to be collected, analysed and published

Domain	Indicator	Indicator source	Variables to be published		Level available		Indicator alignment	
			Deprivation	Ethnicity	ICB	Trust	Healthcare inequalities priority	Core20Plus5 approach
Elective recovery	Elective activity vs pre-pandemic levels for under 18s and over 18s	SUS data and WLMDS Elective Recovery Dashboard (a) Elective Waiting List – Power BI CYP Elective Recovery – Power BI (a)	√	√	√	√	Priority 1: restore NHS services inclusively	
Urgent and emergency care	Emergency admissions for under 18s	SUS data CYP transformation dashboard (b)	√	√	√	√		
Mental Health	Rates of total Mental Health Act detentions	Mental Health Act Statistics, Annual Figures	√	√	√	√		
	Rates of restrictive interventions	Rates of restrictive interventions	√	√	√	√		
	NHS talking therapies (formerly IAPT) recovery	Psychological therapies, annual reports on the use of IAPT services	√		√	√	Priority 1: restore NHS services inclusively	
	Children and young people's mental health access	Mental Health Bulletin	√	√	√	√		
Smoking cessation	Proportion of adult acute inpatient settings offering smoking cessation services	Tobacco Dependence Patient-Level data set Future NHS Collaboration Platform: Prevention Site (a)				√	Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes	√
	Proportion of maternity inpatient settings offering smoking cessation services					√		√
Oral Health	Tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions not number of teeth extracted)	SUS / HES data	√	√	√	√		√

National Context

Wirral University Teaching Hospital NHS Foundation Trust

Care Quality Commission

Tackling inequalities in health and care is a core ambition of CQC's new strategy, and their equality objectives for 2021 to 2025 recognise the need to focus on the quality of care for people who are most likely to have poor experience or outcomes from care, including people detained under the MHA.

The five equality objectives:

1) Amplifying the voices of people most likely to have a poorer experience of care or have difficulty accessing care
2) Using data to understand and respond to equality risks
3) Working with others to improve equality of access, experience and outcomes
4) Using our independent voice to reduce inequalities
5) Our inclusive future: delivering on our diversity and inclusion strategy for our workforce

The CQC will use their monitoring and regulatory activity to make sure that health and social care services understand and are taking steps to tackle inequalities in care. This includes having an awareness of how characteristics such as a person's ethnicity, age and gender influence the quality of care they receive. In our equality objectives we highlight the following groups as an initial focus across the whole of CQC's work:

- people from Black and minority ethnic groups
- people with a learning disability and autistic people
- people with dementia
- people who need accessible communication including Deaf people and people who do not speak English
- Lesbian, gay, bisexual and transgender people.

WUTH Responsibilities

The Care Quality Commission (CQC) has a strategic aim to tackle health and care inequalities, which is evident in the forthcoming assessment framework. This framework will include quality statements assessing how care provision enhances outcomes and diminishes disparities. While this approach is not yet in effect, it is of great significance to the Trust. The Trust must prioritise consideration of its five equality objectives and the groups identified within these objectives. It is crucial for the Trust to demonstrate its awareness and initiatives in addressing inequalities.

National Summary

Wirral University Teaching Hospital NHS Foundation Trust

Summary

This section has delineated the national strategy for addressing health inequalities, captured in the CORE20PLUS5 initiative. This initiative operates at both systemic and localised levels, details of which will be explored further in subsequent sections. Additionally, the section has outlined the five principles for action on inclusion, including the responsibilities of the Trust.

NHS Providers are mandated to adopt a systematic approach to diminish healthcare disparities, enhance life expectancy, and mitigate disabilities. NHS England advocates the utilisation of two specific tools, as detailed within this section. It is advisable for the Trust to adopt and integrate these tools into its practices.

Given the heightened attention on health inequalities, there is an escalating necessity for Trusts to bolster their reporting mechanisms. The statement issued by NHSE delineates requirements for formal publication, covering the period from April 1, 2023, to March 31, 2025, subject to periodic reviews and updates. While the outcomes of data analysis may remain uncertain, they will undoubtedly inform a comprehensive action plan, facilitated through annual planning processes.

The Care Quality Commission's strategic ambition to address health and care inequalities is evident in the forthcoming assessment framework. This framework will incorporate quality statements evaluating how care provision enhances outcomes and diminishes inequalities. Despite the new approach not yet being implemented, it holds significant importance for the Trust.

Wirral University Teaching Hospital
NHS Foundation Trust

System Context

System Context

Wirral University Teaching Hospital NHS Foundation Trust

Context

This section offers a broad insight into the systemic context. It explores various initiatives currently in progress across Cheshire and Merseyside, each designed to address health inequalities, elevate employment standards, and enhance social value. Notable programs such as CORE20PLUS5, Marmot Community Programme, Fair Employment Charter, Prevention Pledge, Anchor Institutions, and the Social Value Charter are explored.

NHS Cheshire and Merseyside – the integrated care board (ICB) for the region is responsible for planning NHS services for our population, which includes the care you receive at your GP practice, local pharmacy, NHS dentist, NHS opticians, or at hospital.

Serving a population of over 2.7m people across Cheshire East, Cheshire West, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington and Wirral.

Working alongside the wider integrated care partnership, ICBs have four key aims:

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development

To support their vision, local health and care services are working together, as equal partners, to support seamless, person-centred care and tackle health inequalities by improving the lives of the poorest fastest.

CORE20PLUS5: C&M Priorities

Wirral University Teaching Hospital NHS Foundation Trust

Cheshire and Merseyside

Mounting evidence has identified disparities in the impact of the COVID-19 pandemic on different population groups, geographical regions and communities. The pandemic exacerbated pre-existing health inequalities and a concerted and targeted approach to improve population health outcomes is required.

Introduced in 2022, Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both the National and System level. The approach defines a target population cohort - the 'Core20PLUS' - and identifies '5' focus clinical areas requiring accelerated improvement.

CORE20

NHS Providers are expected to actively promote and target delivery of care to those patients in the most deprived 20% of the population based on the Index of Multiple Deprivation.

NHS Providers are required to analyse their waiting list data by relevant characteristics, including age, deprivation and ethnicity and by specialty with the aim to develop a better understanding of the local variations in access to and experience of treatment, in order to develop detailed clinical and operational action plans to ensure treatment is based on clinical need. This information is to be routinely shared with the Trust Board. NHS Providers must refer to national guidance to support the recovery of elective services.

WUTH Responsibilities

PLUS the population groups identified by the local Integrated Care Board

The Cheshire and Merseyside ICB has identified the following priority areas which providers are required to support and implement as required:
Cheshire and Merseyside Marmot Community programme: 'Building Back Fairer in Cheshire and Merseyside: Evidence for action and key approaches'

a) NHS Providers are required to support the implementation of the findings of the Cheshire and Merseyside Marmot Community report and Five-Year Strategy, detailing the key system priorities to reduce inequalities in health and to address social determinants of health. This aims to establish strategic systemwide leadership of system actions and to ensure effective capacity and roles of each system partner to achieve these actions.

b) NHS providers and partner organisations to adopt a Fair Employment Charter, to support fair employment policies and payment of the Real Living Wage to enhance workforce health and wellbeing.

c) All Cheshire and Merseyside NHS Trusts to adopt the NHS Prevention Pledge to drive upstream, ill-health prevention at scale for all NHS staff, patients, and visitors.

d) NHS providers, ICB and partner organisations providers to sign up the Social Value Charter, Social Value Award and Anchor Institute Framework, This will create Anchor systems at local place, increase community wealth (including through greater use of local suppliers) and address health and social care workforce shortages.

CORE20PLUS5: C&M Priorities

Wirral University Teaching Hospital NHS Foundation Trust

PLUS the population groups identified by the local Integrated Care Board

Other C&M ICB priority Programmes

To actively promote and support the ICB work programme to reduce health inequalities these include:

a) Alcohol harm reduction

b) Physical Activity Programme - to actively encourage and support delivery of the Physical Activity Strategy a whole-system approach with the aim to support 150,000 inactive people to become more active in areas of greatest need.

c) Work with Prevention Pledge lead (HEG); the nine NHS Trusts to train physical activity influencers within those settings.

Other Population Groups to be prioritised

a) Workforce: A diverse workforce that reflects the local population served is fundamental to striving towards equality. NHS Providers are required to ensure that their workforce is as diverse as it can be at all levels of the NHS, that the workforce is representative of the population that is served, and importantly that leadership is reflective of the workforce. It is expected that providers improve the Black, Asian and minority ethnic disparity ratio, delivering the six high impact actions to overhaul recruitment and promotion practices and implement plans to promote equality across all protected characteristics. Providers are expected to support the Cheshire and Merseyside Marmot community programme and adopt a Fair Employment Charter across the NHS and partner organisations, which will support fair employment policies and payment of the Real Living Wage to enhance workforce health and wellbeing.

3. FIVE Clinical Areas of Focus

NHS Providers will be required to participate as relevant to their area of delivery.

I. Maternity: All maternity providers to engage with the extensive work programme established by the C&M Local Maternity System to establish and embed models of care and improvement work to support the most disadvantaged women living in deprivation and/or from high-risk ethnic minorities
    I. Digital inclusion projects for women to improve access to health care (digital, language and confidence)

II. Hypertension Case Finding: C&M have a robust action plan to improve screening for and diagnosis of hypertension including BP monitoring at home. This is being led by our prevention & population health boards and delivered through our 9 places to ensure targeted action in communities with most inequalities.

III. Early Cancer Diagnosis: Targeted case finding to enable earlier diagnosis of cancer.

IV. Chronic Respiratory Disease through the DHSC Pilot: C&M involvement in the innovative DHSC Integrated Contact Tracing Pilot for COVID-19 has extended how we effectively manage acute respiratory infections and use the skilled workforce to increase vaccine uptake for Covid-19. The learning from this will allow us to understand how we can improve outcomes for respiratory vaccination in the future. Specifically considering factors of deprivation and ethnicity.

V. Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

Marmot Community Programme

Wirral University Teaching Hospital NHS Foundation Trust

What is the Marmot Review?

The Marmot Review into health inequalities in England was first published in 2010 and has been revisited in recent years with subsequent updates. It proposes an evidence-based strategy to address the social determinants of health, the conditions in which people are born, grow, live, work and age and which can lead to health inequalities. The review sets out a framework for action under two policy goals: to create an enabling society that maximizes individual and community potential; and to ensure social justice, health and sustainability are at the heart of all policies.

Central to the Review is the recognition that disadvantage starts before birth and accumulates throughout life. This is reflected in the 8 principles:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention
7. Tackle racism, discrimination and their outcomes
8. Pursue environmental sustainability and health equity together

What does the programme mean for Cheshire and Merseyside?

The Marmot Community Programme, led by Cheshire and Merseyside Health and Care Partnership and Directors of Public Health, working in partnership with the Institute of Health Equity (IHE) aims to systematically reduce health inequalities through action on the social determinants of health. 'All Together Fairer' is a landmark report on how public, private and third sector organisations in Cheshire and Merseyside can work together to tackle health inequalities. It sets out measurable actions for each Place as well as the region to create a fairer, more equitable society.

Routes for Action

The report sets out a set of routes for action in Cheshire and Merseyside:

- Increase and make equitable funding for social determinants of health and prevention
- Strengthen partnerships for health equity
- Create stronger leadership and workforce for health equity
- Co-create interventions and actions with communities
- Strengthen the role of business and the economic sector in reducing health inequalities
- Extend social value and anchor organisations across the NHS, public services and local authorities
- Develop social determinants of health in all policies and implement marmot indicators

Proposed Marmot Beacon Indicators

Additionally, All Together Fairer introduces 22 proposed marmot indicators against the 8 marmot beacon indicators, some of which should be met at System level, others at Place level, for example, life expectancy is a priority focus area for Wirral.

ALL TOGETHER FAIRER

Working as one to build a fairer, healthier Cheshire and Merseyside

Fair Employment Charter

Wirral University Teaching Hospital NHS Foundation Trust

What is the Fair Employment Charter?

Variations of Fair Employment and Work Charters, which aim to improve employment standards, exist across the country. The following page focuses on the Liverpool City Region Fair Employment Charter, which is supported by Wirral Council.

What does the Charter mean for Cheshire and Merseyside?

The Fair Employment Charter for the Liverpool City Region strives to raise employment standards in Halton, Knowsley, Liverpool, Sefton, St Helens and Wirral and is led by Steve Rotheram, Metro Mayor of the Liverpool City Region.

In their article about the Charter, the Wirral Intelligence Service highlights that more than a quarter of the Liverpool City Region's workforce earn less than the Real Living Wage and there are an estimated 19,000 workers on zero hours contracts. The Charter aims to tackle these challenges by supporting employers to deliver improved working conditions as they create jobs. The intention of the Charter is to celebrate good practice in fair employment and to build the case amongst other employers for them to consider changing their practices.

The Fair Employment Charter for the Liverpool City Region consists of Four Pillars:

- **Healthy**: Healthy workplaces are productive workplaces that are safe for those working in them, whilst recognising the importance of mental and physical health inside and outside of the workplace.
- **Fair**: Fairly paid, secure work is the foundation of good work and good workplaces.
- **Inclusive**: Good businesses and a successful economy can only be built if the talents of all are recognised and supported, barriers understood and removed, and talent maximised.
- **Just**: Workplaces that offer opportunities for all, a collective voice for all staff, and support the next generation to prosper underpin a more just present and an even better future for Liverpool City Region.

The Charter includes a criteria of how employers can demonstrate good practice and improve in these four areas, including through carrying out audits and creating policies.

Resources from the CIPD have been published to support employers to meet the Four Pillars.

WUTH

WUTH is not currently referenced as an organisation working with the Liverpool City Region towards the Fair Employment Charter. However, there is a strong focus on equitable, inclusive employment at the Trust, as highlighted in the Anchor Institution and Social Value Sections.

Prevention Pledge

Wirral University Teaching Hospital NHS Foundation Trust

What does the Prevention Pledge mean for Cheshire and Merseyside?

Despite dramatic improvements over the last 20 years, Cheshire and Merseyside continues to experience widespread preventable illness and inequalities in health.

It is widely acknowledged that a renewed focus on prevention measures is needed at scale to help address the gaps identified by the NHS Five Year Forward View, the NHS Long Term Plan, and the NHS Phase 3 COVID response.

To assist NHS Trusts in Cheshire and Merseyside to strengthen and scale up population-level prevention priorities, NHS Cheshire and Merseyside's Population Health Board has worked with public health charity Health Equalities Group to develop an NHS Prevention Pledge for Trusts in Cheshire and Merseyside.

The NHS Prevention Pledge is underpinned by 14 'core commitments' that have been developed through extensive consultation with representatives from provider trusts, NHS England, local authority public health teams, Office for Health Improvement and Inequalities, and third sector organisations across the region.

The core commitments cover the following key themes:

- Promoting workforce development, quality improvement, workplace health & wellbeing
- Embedding brief advice and making every contact count (MECC) across all services
- Promoting healthier lifestyles for patients & visitors, including:
  - healthier catering
  - smoke-free environments
  - active environments
- Enhancing anchor institution practices, engaging with the anchor framework & sign up to the C&M Social Value Charter and the C&M Social Value Award
- Using Marmot principles to address health inequalities
- Signing up to the C&M Concordat for Better Mental Health
- Embedding prevention within governance structures

WUTH Responsibilities

NHS Trusts in Cheshire and Merseyside have been engaged into three phases to adopt and embed the prevention pledge. WUTH were in the third phase which is the final cohort that started Sept 2022.
The requirements for WUTH are as follows:

- Intermediate adoption of pledge by Sept 2023 (adoption of 7 commitments)
- Attendance at Community of Practice meetings
- Progress captured through action trackers with KPIs aligned to the 14 commitments
- Full adoption of pledge Sept 2024

Intermediate adoption of the pledge is a pre-requisite to becoming Anchor Institutions.

Anchor Institutions

Wirral University Teaching Hospital NHS Foundation Trust

What are Anchor Institutions?

Anchor Institutions are large organisations which have a stake in their local area. They have large assets which can be used to address healthcare inequalities and improve the local population's health.

There are five principles of Anchor Institutions:

1.Purchasing locally and for social benefit

2.Using buildings and spaces to support communities

3.Widening access to quality work

4.Working more closely with local partners

5.Reducing environmental impact

NHS organisations can act as Anchor Institutions to improve the local economy and environment. Firstly, the introduction of Integrated Care Systems (ICSs) facilitates collaboration between NHS organisations, local authorities and the voluntary sector, meaning Anchor Institutions can have a large impact on the community. Secondly, creating local employment opportunities in NHS organisations can improve the economy and health of the community, whilst also addressing NHS workforce shortages.

What do Anchor Institutions mean to Cheshire and Merseyside?

The Cheshire and Merseyside Joint Forward Plan (2023-28) was published by the Integrated Care System (ICS) to outline their commitment to work with partners to benefit the population. The report highlights that developing Anchor Institutions in Cheshire and Merseyside is a key priority in supporting social and economic development. It is noted that in 2023-24, the Cheshire and Merseyside ICS aims to grow the number of anchor framework signatories to 25 and to engage with private sector organisations.

WUTH Responsibilities

The WUTH Green Plan refers to Anchor Institutions in its Green Place vision, noting the Trust's role as an Anchor Institution to accomplish social value. Key actions noted in the Plan include fulfilling the Trust's role as an Anchor Institution and enabling procurement to support Social Value and Anchor Institution NHS aims.

Other ongoing work at WUTH includes:

Purchasing locally and for social benefit

- Integrating the NHS Procurement Social Value Model *(currently for large tenders only but will eventually be for all of procurement)*

Using buildings and spaces to support communities

- Masterplans & Estates Strategy

Widening access to quality work

- Apprenticeships
- Teaching accreditation

Working more closely with local partners

- Wirral Place Sustainability Group (WUTH Chairs this group which reports into the Wirral Strategic Estates Group)
- Cool Wirral
- C&M Sustainability Board

Reducing environmental impact

- Board approved Green Plan, submitted to ICS
- Catering department reducing single use plastics & looking to introduce "On the Day" meal ordering system
- REGO electricity, LED Lighting replacement programme

Social Value Charter and Award

Wirral University Teaching Hospital NHS Foundation Trust

What is the Social Value Charter and Award?

The Social Value Charter is a model introduced by the UK government which highlights organisations' commitment to embed social value into their procurement processes. The purpose of the charter is to improve the social, environmental and economic wellbeing of communities. Areas of focus include COVID-19 recovery, addressing economic inequality, providing equal opportunity and fighting climate change.

The Social Value Awards recognise organisations which have provided value to their communities. The awards are held on a yearly basis and consist of a range of categories, including social value champions and private sector projects.

What do the Social Value Charter and Award mean to Cheshire and Merseyside?

Cheshire and Merseyside have published a Social Value Charter document, which outlines the requirement of the public sector as 'Anchor Institutions' to use their assets to improve overall wellbeing of the community and reduce inequalities. They define their vision as ensuring that "everyone recognises their contribution to Social Value" and highlight their commitments to improving social, environmental and economic wellbeing in line with the priorities outlined in the Marmot Review. By signing the Social Value Charter, organisations demonstrate their commitment to the principles of social value outlined in the document and to embed social value into the delivery of services.

The Cheshire and Merseyside Social Value Award defines its aims as supporting organisations achieve their staff and volunteer recruitment and retention strategy, Corporate Social Responsibility (CSR) and Social Value and enabling organisations to be recognised as 'Anchor Initiations'. Organisations can apply for the Cheshire and Merseyside Social Value Award by uploading evidence of their social, economic, environmental and innovative commitments.

WUTH Responsibilities

On the Social Value Business website, WUTH is one of the local organisations cited as recognising the Cheshire and Merseyside Social Value Award and Social Value Quality Mark.

WUTH is focussing on the following actions in line with the Cheshire and Merseyside Social Value Award:

Social - Creating healthier, more sustainable and more resilient places and communities

- Use of capital and estates as "Community Assets"
- Good mental health is promoted
- Community asset building and community health services are promoted

Economic

- Inclusive & non-discriminatory employers
- Local job creation and people in employment
- Employee wellbeing is supported Social Value embedded within the Supply Chain
- Service users & community are engaged and active co-design of future services

Environment – protecting & improving our environment

- Use of capital and estates as "Community Assets"
- Environmental impacts are reduced e.g – Home working policies, "Car miles" are reduced
- Sustainable travel is promoted
- Sustainable and ethical governance is promoted

Innovation – promoting social innovation

- Partnerships & collaboration between sectors and organisations
- Engagement in test bests or pilots is encouraged

System Summary

Wirral University Teaching Hospital NHS Foundation Trust

Summary

This section has outlined numerous initiatives and programmes in Cheshire and Merseyside dedicated to mitigating health inequalities. While these endeavours exhibit distinctive principles and focal points, overarching themes emerge, including targeted care delivery, the promotion of healthier lifestyles, elevation of employment standards, establishment of anchor institutions, infusion of social value into procurement processes, collaboration with local partners, and a commitment to reducing environmental impacts.

The initiatives directed by the Cheshire and Merseyside Integrated Care System hold particular significance for the Trust. The section has outlined several responsibilities for WUTH.

As this section transitions to the Place context, it becomes evident that while Wirral University Teaching Hospital is actively engaged in ongoing initiatives, there is room for further optimisation and coordination to streamline efforts in addressing the complex landscape of health inequalities.

Wirral University Teaching Hospital NHS Foundation Trust

Wirral Place Context

Wirral Place Context

Wirral University Teaching Hospital NHS Foundation Trust

Context

The section commences with an overview of the demographic profile of Wirral, detailing key indices of multiple disadvantage. It employs an infographic to visually present Wirral's life course statistics in comparison to England's. Furthermore, it delineates the existing healthcare provision offered by NHS providers within the region. Lastly, the section incorporates information regarding the Health and Wellbeing Strategy for Wirral.

Wirral Place

Wirral University Teaching Hospital NHS Foundation Trust

Wirral Place

Wirral is not in the 20% most deprived of authorities in 2019 overall, although there are many areas of severe deprivation across Wirral (largely in the East of the borough). It ceased being in the 20% most deprived of areas in the 2015 IMD. In previous IMDs, Wirral had been classed as being in the 20% most deprived authorities in England.

In 2019, Wirral was ranked the 77th most deprived authority (of 317 authorities) in England (1 the being most deprived, 317 the least deprived). Although the increase in rank appears to indicate Wirral has become less deprived (Wirral ranked 66 in the previous IMD in 2015 and 60 in the 2010 IMD), this is not necessarily the case.

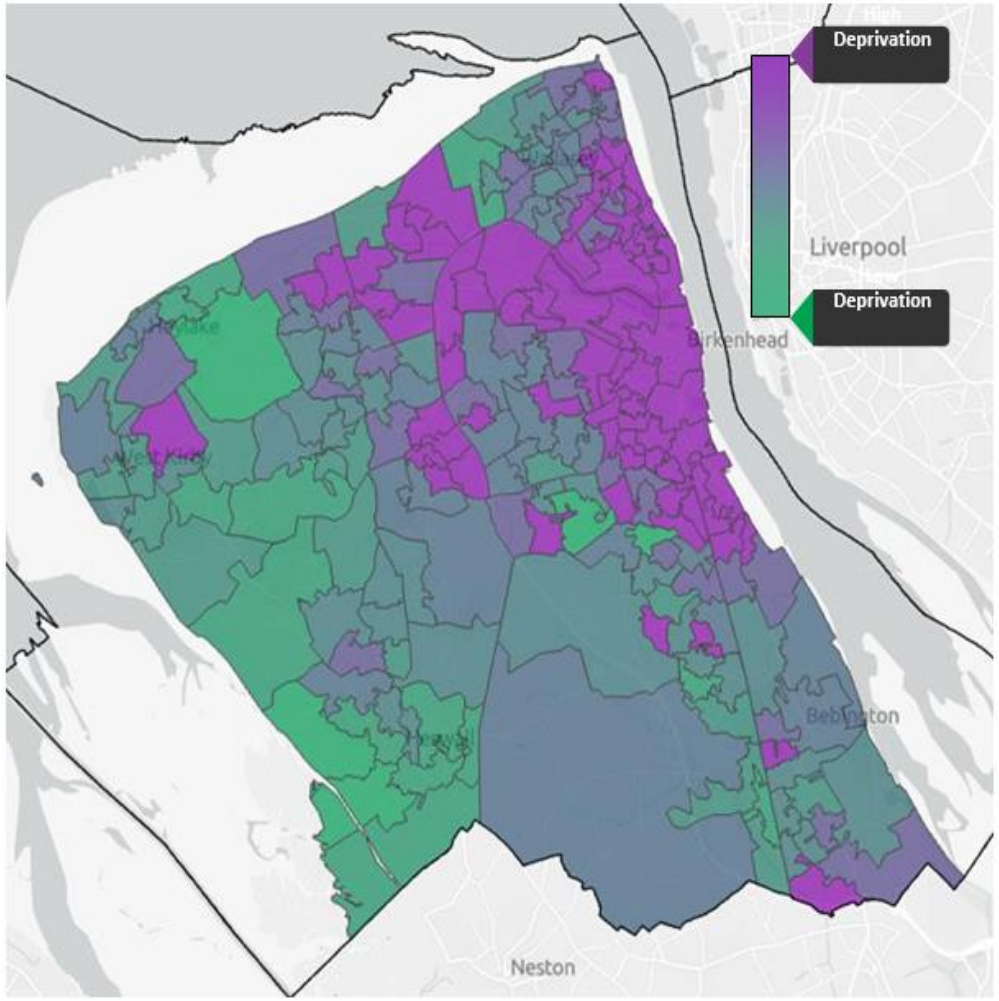
The number of Local Authorities has reduced from 326 in 2015, to 317 in 2019 and it is this factor which is likely to account for some of the change in rank. In fact, the overall number of Wirral LSOAs in the most deprived 20% of areas in England has increased to 72 in the 2019 IMD, from 62 in 2015 (an increase of 10 LSOAs).

Also, the number of LSOAs in the most deprived decile (10%) has been used as an indicator on how deprivation may have changed by the DLUHC, and in their main summary report on the IMD 2019, Wirral is specifically mentioned as one of the authorities which has become relatively more deprived in 2019 compared to 2015.

The population of those Wirral LSOAs (n=72) classified as being amongst the 20% most deprived nationally is around 115,500. In 2015, 95,500 people lived in the 62 LSOAs classified as being in the most deprived 20% in England - An additional 20,000 residents are now classed as living in deprivation, compared to 2015.

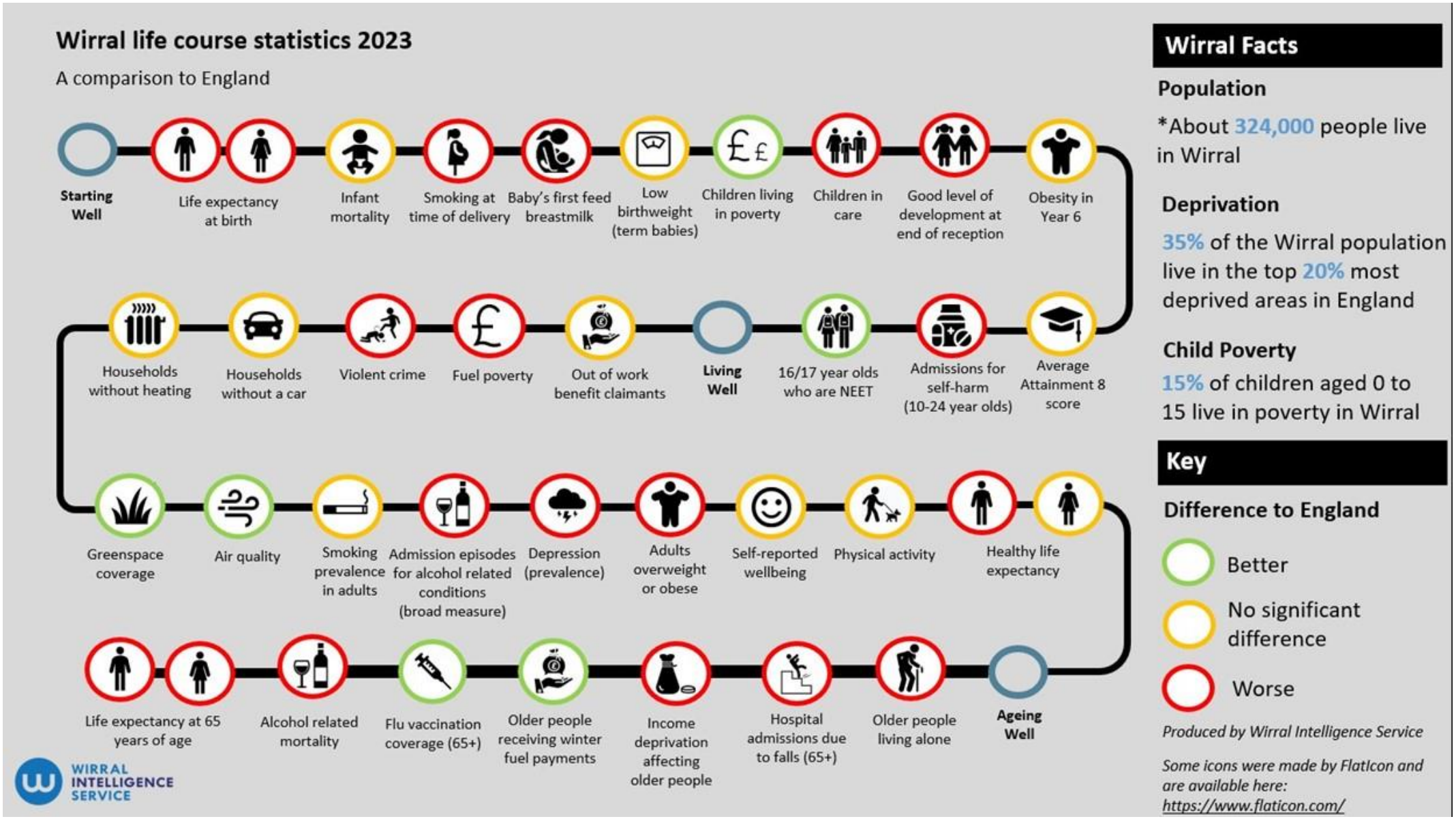
Area	IoMD score
Wirral	29.59
Cheshire & Merseyside	28.12
England	21.67
LCR	28.24

Figure 4. Indices of Multiple Deprivation Wirral



Wirral Place

Wirral University Teaching Hospital
NHS Foundation Trust



Wirral Place

Wirral University Teaching Hospital NHS Foundation Trust

Wirral Place

The initiatives led by the Cheshire and Merseyside ICS to tackle health inequalities are highly relevant to Wirral Place, given its demographics.

Within the Wirral Peninsula, there are 4 operating NHS Trust:

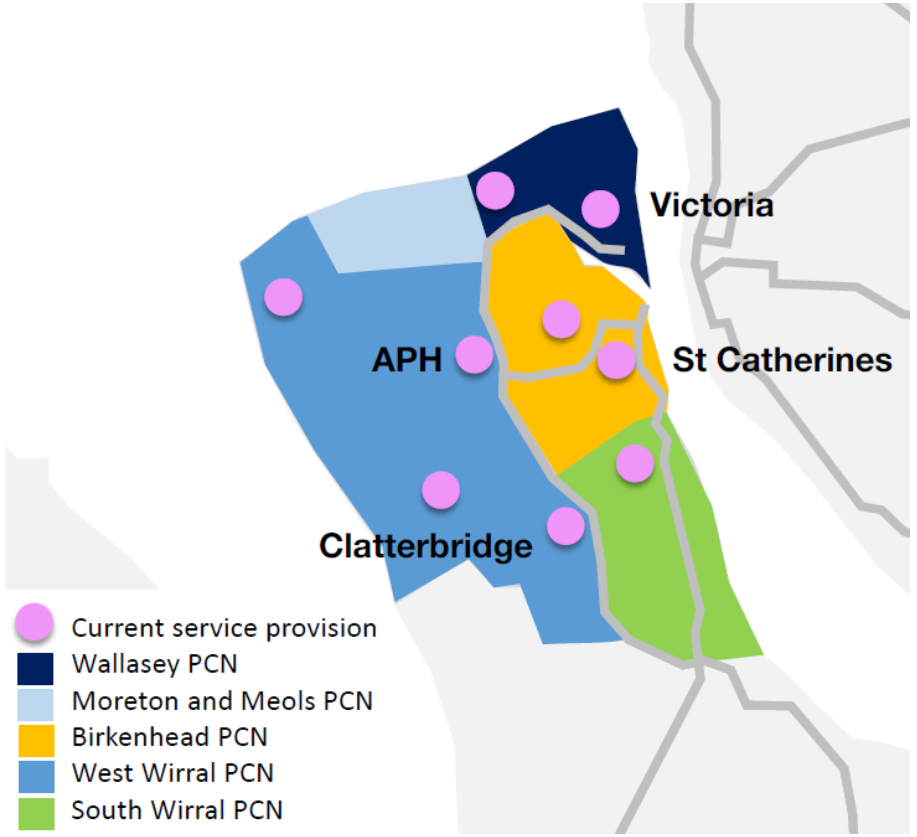
- Wirral University Teaching Hospital NHS Foundation Trust
- Wirral Community Health and Care NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Clatterbridge Cancer Centre NHS Foundation Trust

In addition, there are 49 GP practices and 5 primary care networks, as highlighted on the image, right.

WUTH alone is the largest employer in the region, with a 6500-person workforce.

The 'Healthy Wirral' Place Programme has established a clear vision for the region, based on wider National Initiatives, whilst informed by local contexts, and strategic visions of all partner organisations.

Figure 5. Current healthcare service provision Wirral



Wirral Place Context

Wirral University Teaching Hospital NHS Foundation Trust

Wirral Health and Wellbeing Strategy

The Wirral Health & Wellbeing Strategy 2022-27 emerges from the collaborative efforts of the Wirral Health and Wellbeing Board, a coalition comprising local entities such as the Council, NHS, Healthwatch, the Community, Voluntary and Faith Sector, Merseyside Fire and Rescue Authority, Merseyside Police, the Department for Work and Pensions, and Wirral Metropolitan College.

Mandated in every region, Health and Wellbeing Boards play a pivotal role in advancing the health and wellbeing of the local populace. Operating as a partnership committee, they produce a joint assessment of health needs and a cohesive health and wellbeing strategy.

This strategy, tailor-made for Wirral, zeroes in on shared priorities, resources, and assets that wield the greatest impact on enhancing health in the community. It articulates a collective ambition, presenting solutions and approaches that harness the combined strengths and capabilities of the borough.

Informed by the voices of Wirral residents and evidence-backed practices, the strategy aligns with and bolsters the Wirral Plan 2021-2026. It serves as a key component of the vision for the Cheshire & Merseyside Integrated Care System, establishing a duty to closely collaborate with the Health and Wellbeing Board. At a broader level, it contributes to the local implementation of All Together Fairer, the collaborative initiative in Cheshire and Merseyside aimed at reducing disparities in health outcomes.

The strategy is structured around five priorities:

Priority 1: Create opportunities to optimize health outcomes through economic and regeneration programmes.

Priority 2: Strengthen health and care initiatives to address disparities in health outcomes.

Priority 3: Ensure the best start in life for all children and young people.

Priority 4: Create safe and healthy living spaces that protect health and promote a good standard of living.

Priority 5: Foster a culture of health and wellbeing by listening to residents and fostering collaborative efforts.

Wirral Place Summary

Wirral University Teaching Hospital NHS Foundation Trust

Summary

This section has underscored the indices of multiple disadvantage, revealing that 35% of the population in Wirral resides in the top 20% most deprived areas in England. The life course statistics for Wirral demonstrate areas where Wirral fares comparatively worse than England, highlighting the crucial role of the Trust in addressing health inequalities. As the section shifts to the Trust context, it becomes apparent that while Wirral University Teaching Hospital is actively involved in ongoing initiatives, there is still scope for further optimisation and coordination to enhance efforts in addressing the intricate landscape of health inequalities.

Wirral University Teaching Hospital NHS Foundation Trust

Trust Context

Trust Context

Wirral University Teaching Hospital NHS Foundation Trust

Context

This section examines the specific context of the Trust, encompassing the organisational strategy, enabling strategies, and their interconnectedness with health inequalities. It offers insights into the ongoing initiatives and programmes, highlighting the progress made. We have included an assessment of where we are within this section. The concluding page of this section presents a summary of findings.

WUTH employs more than 6,500 staff serving a population of 400,000 across Wirral, Ellesmere Port and North Wales. The Trust generates an income of circa £500m. WUTH operates from 2 main sites: Arrowe Park Campus and The Clatterbridge Hospital Campus as seen in figure 6.

Figure 6. WUTH campuses

Trust Context

Wirral University Teaching Hospital NHS Foundation Trust

Our 2021-2026 Strategy

Developed in 2020 Our 2021-2026 Trust Strategy was launched in January 2021. The organisational strategy has six key objectives, with underpinning priorities. With focus on:

- Outstanding Care
- Compassionate Workforce
- Continuous Improvement
- Our Partners
- Digital Future
- Improving our infrastructure

Development and Delivery of Strategic Framework

The development and delivery of the strategic framework involved the creation of eight enabling strategies, aligned with the overarching Trust Strategy. This comprehensive approach extended to the design of clinical service strategies and priorities at the specialty level. The emphasis throughout was on the effective delivery of objectives and priorities, facilitated by an annual strategic priorities process that engaged both Divisional and Corporate Leadership Teams. This structured framework ensures a cohesive and strategic alignment between overall organisational goals and the specific priorities set at various levels within the Trust.

Trust Context

Wirral University Teaching Hospital NHS Foundation Trust

Existing strategic focus on health inequalities

We conducted a thorough examination of our organisation's strategy and accompanying strategies to assess and comprehend the connection between health inequality and its integration into each specific strategy. The findings indicate that the acknowledgment of health inequalities and strategies to address them is present in most organisational strategies.

However, there is a lack of evidence demonstrating how we are actively tackling health inequalities in the implementation of each strategy. The table on the right outlines the extracted information pertaining to these existing strategies.

Table 2: Existing strategic focus on health inequality

Strategy	Section	Extracted information	Health Inequality Link
WUTH Strategy	Health and Wellbeing Gap	There is a significant variation of over 12 years between Wirral wards, demonstrating health inequalities in neighbouring towns and boroughs… In line with the aspirations set in the Wirral Council Plan, it is vital that we work with our system partners and communities to close this gap and improve the life experience and outcomes for the Wirral population.	Discussion of the health inequalities within the Wirral Population in the introductory sections of the Strategy
	The Changing Health Landscape	NHS Long Term Plan: six key areas of the strategy, including 'Preventing illness and tackling health inequalities'.	Discussion of the partnerships that the Trust is part of and how health inequalities are outlined in our joint priorities
		Cheshire & Merseyside Health and Care Partnership: The Partnership's primary ambitions align to those described in the NHS Long term Plan: to improve health and reduce health inequalities.	
		Wirral Council Plan: A 2020 Vision; 'Strive to close the gap in health inequalities'.	
	Our Partners Strategic Objective	Integrate care to prevent ill-health, improve wellbeing and meet the needs of the Wirral population.	Trust 5 Year Strategy priority
	Digital future Strategic Objective	Use health information to enable population health management for the Wirral.	Trust 5 Year Strategy priority
Clinical Service Strategy	Outstanding Care Priorities	Embed a proactive population health approach.	Enabling Strategy Strategic Prioritiy
Digital Strategy	Digital Innovations Priorities	Work with our Health and Social Care partners to develop analytical capabilities improving access to information and appropriate information sharing to further enable population health management.	Enabling Strategy Strategic Prioritiy
Estates Strategy	Portfolio Development and Future Planning Priorities	Optimise the use of our estates through enhancements that are directed by population health needs and our understanding of capacity and demand of our clinical services, whilst preserving the synergies created through co location of specialist services.	Enabling Strategy Strategic Prioritiy
Research & Innovation Strategy	Partners and Place Priorities	Prioritise research at Place to address local population health needs and reduce health inequalities through collaboration.	Enabling Strategy Strategic Prioritiy
	Patient Experience	Ensure all patients have equal access to high quality, evidence-based and innovative care.	Enabling Strategy Strategic Prioritiy
Quality & Safety Strategy	Insight Priorities	Optimise from the benefits of working collaboratively and identify health inequalities by working with partners to develop better insight of quality and safety across Wirral Place and the wider system.	Enabling Strategy Strategic Priority
Green Plan	Green Plan 2022-2025	Take a systematic approach to reduce health inequalities and help the NHS to reach net zero.	Trust 3 Year Plan

Trust Context – Assessment of where we are

Wirral University Teaching Hospital NHS Foundation Trust

Initiative	Description	Formally Endorsed	Governance/Reporting	Progress to date	Requirements	Exec Lead
CORE20PLUS5 Steering Group	The Wirral Place Core20Plus5 Action Group's aims and objectives are focused on proactively tackling health inequalities for those groups of people that are contained within the three parts of the Core20Plus5 approach.	Agreed membership	WUTH are members of the steering group. Frequency – monthly. No formal internal reporting in place. This group reports into the Wirral Strategy and Transformation Group	Focus has been on the PLUS5 groups. Task and Finish Groups have been established. WUTH are attendees of the Did Not Attend (DNA) group where focus on reducing DNAs for PLUS groups is being developed.	Provide visible, and accountable system leadership for the health and care system in relation to tackling inequalities using the Core20Plus5 as the framework.	NS?
Prevention Pledge	NHS Trusts in Cheshire and Merseyside have been engaged into three phases to adopt and embed the prevention pledge. WUTH were in the third phase which is the final cohort that started Sept 2022.	Board Dec 23	Attendance at Community of Practice meetings Progress captured through action trackers with KPIs aligned to the 14 commitments	Intermediate adoption of the pledge is a pre-requisite to achieving the anchor institute charter.	Intermediate adoption of pledge by Sept 2023 (adoption of 7 commitments) Full adoption of pledge Sept 2024	DMc
Anchor Institution	Anchor Institutions are large organisations which have a stake in their local area. They have large assets which can be used to address healthcare inequalities and improve the local population's health.	Yes	No formal governance or reporting mechanism in place.	The ongoing work is currently undertaken between the workforce/OD directorate and the estates division. WUTH have applied for the anchor institute charter – outcome expected Q1 2024.	The key principles of Anchor Institutions focus on estates and land use, procurement, employment, professional development, sustainability and collaboration with local partners.	DS/MS?
Social Value and Award	The Social Value Charter is a model introduced by the UK government which highlights organisations' commitment to embed social value into their procurement processes.	No	No formal governance or reporting mechanism in place.	WUTH is focussing on the following actions in line with the Cheshire and Merseyside Social Value Award.	On the Social Value Business website, WUTH is one of the local organisations cited as recognising the Cheshire and Merseyside Social Value Award and Social Value Quality Mark.	DS
Fair Employment Charter	Variations of Fair Employment and Work Charters, which aim to improve employment standards, exist across the country. The following page focuses on the Liverpool City Region Fair Employment Charter, which is supported by Wirral Council	No	No formal governance or reporting mechanism in place.	Unclear on progress to date.	The Charter includes a criteria of how employers can demonstrate good practice and improve in these four areas, including through carrying out audits and creating policies.	DS

Trust Context – Summary

Wirral University Teaching Hospital NHS Foundation Trust

The Trust actively participates in several initiatives at the system and place levels, which demonstrates a dedicated commitment to addressing health inequalities. While organisational strategies acknowledge these disparities and outline strategies to tackle them, there is a noticeable absence of concrete evidence demonstrating active implementation of each strategy.

Progress has been made in initiatives such as the Core20Plus Steering group, Prevention Pledge, our role as an Anchor Institution, and the Social Charter. However, ongoing efforts are imperative to ensure continuous improvement, embedding, and sustainability. Challenges persist, including the absence of a clear formal reporting mechanism for initiatives, the lack of progress monitoring, and initiatives being compartmentalised across various executive director portfolios.

Moving beyond initiatives alone, it is evident that a substantial shift in our day-to-day business operations is essential to comprehensively address health inequalities. This necessitates integrating actions addressing health disparities as a fundamental aspect of every service delivery or transformation programme. Consequently, health inequality data should play a pivotal role in shaping our annual business planning, transformation efforts, productivity enhancements, and efficiency programmes. This approach ensures alignment with the evolving needs and expectations in health disparities.

In conclusion, as the Trust navigates the complex landscape of health inequalities, a comprehensive and integrated approach, coupled with robust reporting mechanisms, will be key to achieving sustained positive impacts on community health outcomes.

Wirral University Teaching Hospital
NHS Foundation Trust

Findings, Next Steps and Delivery

Our Findings

Wirral University Teaching Hospital NHS Foundation Trust

The findings from the previous sections in this report can be summarised as follows:

- CORE20PLUS5 serves as the national strategy for addressing health inequalities, operating at both systemic and local levels. Active engagement by the Trust in this initiative is crucial.
- The Trust is tasked with embedding the five principles for action on inclusion.
- NHS England advocates for the utilisation of two specific tools to ensure a systematic approach in tackling health inequalities.
- Formal publication requirements spanning from April 2023 to March 2025 necessitate the collection and analysis of specific information on health inequalities by the Trust.
- The forthcoming assessment framework by the CQC will include quality statements assessing how care provision enhances outcomes and diminishes inequalities. The Trust must be prepared to provide evidence supporting its efforts in reducing inequalities.
- It is imperative for the Trust to adopt the initiatives and programmes led in Cheshire & Merseyside, with appropriate governance mechanisms in place to ensure effective delivery, monitoring, and evaluation.
- 35% of the Wirral population resides in the top 20% most deprived areas in England.
- WUTH holds a critical role as the largest employer in Wirral, serving as an anchor institution with paramount importance.
- The Trust actively engages in various initiatives at both systemic and localised levels. While organisational strategies recognise inequalities, there is currently a lack of clear formal reporting, monitoring, and evaluation evidence.
- A significant transformation in our day-to-day business operations is imperative to effectively address health inequalities. This entails integrating actions aimed at tackling health inequalities as an integral component of every service delivery or transformation programme. Consequently, data on health inequalities should play a central role in shaping our annual business planning, transformation endeavours, productivity improvements, and efficiency initiatives.

Next Steps

Wirral University Teaching Hospital NHS Foundation Trust

Taken the findings into account and to drive our commitment in addressing health inequalities, the following four recommendations are proposed:

1) Endorse and Embed the WUTH Health Inequality Model:

In alignment with our approach to addressing health inequalities, it is strongly recommended that we formally endorse and embed the WUTH Health Inequality Model across our organisational framework. This model, tailored to the unique context of our Trust, serves as a strategic guide to understanding, assessing, and addressing health disparities within our community.

Embedding the WUTH Health Inequality Model will empower our teams with a shared framework for analysing and addressing health disparities, promoting consistency and coherence in our initiatives.

Additionally, this endorsement reinforces our dedication to interventions and continuous improvement in our efforts to reduce health inequalities. Through this recommendation, we acknowledge the importance of adopting a model that resonates with our organisational values and community context, contributing to a more tailored and effective strategy for improving health outcomes across the communities we serve.

2) Continuation of Existing Initiatives with Named Leads:

To ensure the continued success and impact of our ongoing initiatives dedicated to addressing health inequalities, it is recommended that we implement a structured approach by appointing named leads for each initiative. These designated leaders will serve as champions for their respective programmes, taking on the responsibility of overseeing implementation, monitoring progress, and ensuring that each initiative aligns seamlessly with our overarching health inequality goals.

The named leads will continue to play a pivotal role in enhancing accountability by providing focused leadership, fostering collaboration across departments, and ensuring that the initiatives remain on track. This strategic assignment of leadership will not only facilitate a more targeted and efficient execution of our programmes but also contribute to a cohesive and unified approach in addressing the multifaceted challenges of health inequalities.

3) Embedding Tools for Systematic Health Inequality Reduction:

To further support our commitment and ensure a systematic approach to reducing health inequalities, it is recommended that we embed the use of tools designed for this purpose. Specifically, we propose the integration of the NHS England Healthcare Inequalities Improvement Planning Matrix and the Health Inequalities Assessment Tool (HEAT) into our operational framework.

The NHS England Healthcare Inequalities Improvement Planning Matrix provides a structured framework for identifying, prioritising, and addressing health inequalities. By incorporating this matrix into our planning processes, we can systematically assess the impact of our initiatives on different population groups, ensuring a targeted and tailored approach. Additionally, the Health Inequalities Assessment Tool (HEAT) offers a comprehensive mechanism for evaluating the potential impact of policies, programmes, and services on health inequalities. Integrating HEAT into our decision-making processes will enable us to proactively identify areas where interventions are needed, assess the potential differential impacts on diverse communities, and refine our strategies to achieve equitable outcomes.

By embedding these tools into our day-to-day operations, we enhance our capacity to analyse, plan, and implement initiatives that effectively address health disparities. This approach not only facilitates evidence-based decision-making but also reinforces our commitment to transparency, accountability, and the continuous improvement of our efforts to reduce health inequalities within the communities we serve.

Next Steps

Wirral University Teaching Hospital NHS Foundation Trust

4) Formation of a Health Inequality Committee:

Recognising the critical need for robust governance and strategic oversight at the highest level, it is strongly recommended that we establish a dedicated 'Health Inequality Committee.' This committee will serve as an integral component of our governance structure, providing a direct link between our health inequality initiatives to the Quality Committee and into the board.

The committee's primary functions will encompass executive-level oversight, clear and comprehensive reporting, and strategic guidance. Comprising individuals with expertise in health inequalities, including leads of existing initiatives, the committee will ensure that our efforts align with the broader organisational goals and objectives. By bringing together diverse perspectives and skills at the board level, this committee will contribute significantly to coordinated actions, reinforcing our organisational commitment to addressing health inequalities with diligence and strategic intent.

WUTH Health Inequality Model

Wirral University Teaching Hospital NHS Foundation Trust

STRATEGIC CONTEXT

- Health and Care Act 2022
- NHS Long Term Plan
- Marmot Review
- Core 20PLUS5
- ICS Legislation and Guidance
- The Cheshire and Merseyside Joint Forward Plan (2023-28)
- Wirral Public Health Annual Report
- NHSE Statement on information on health inequalities

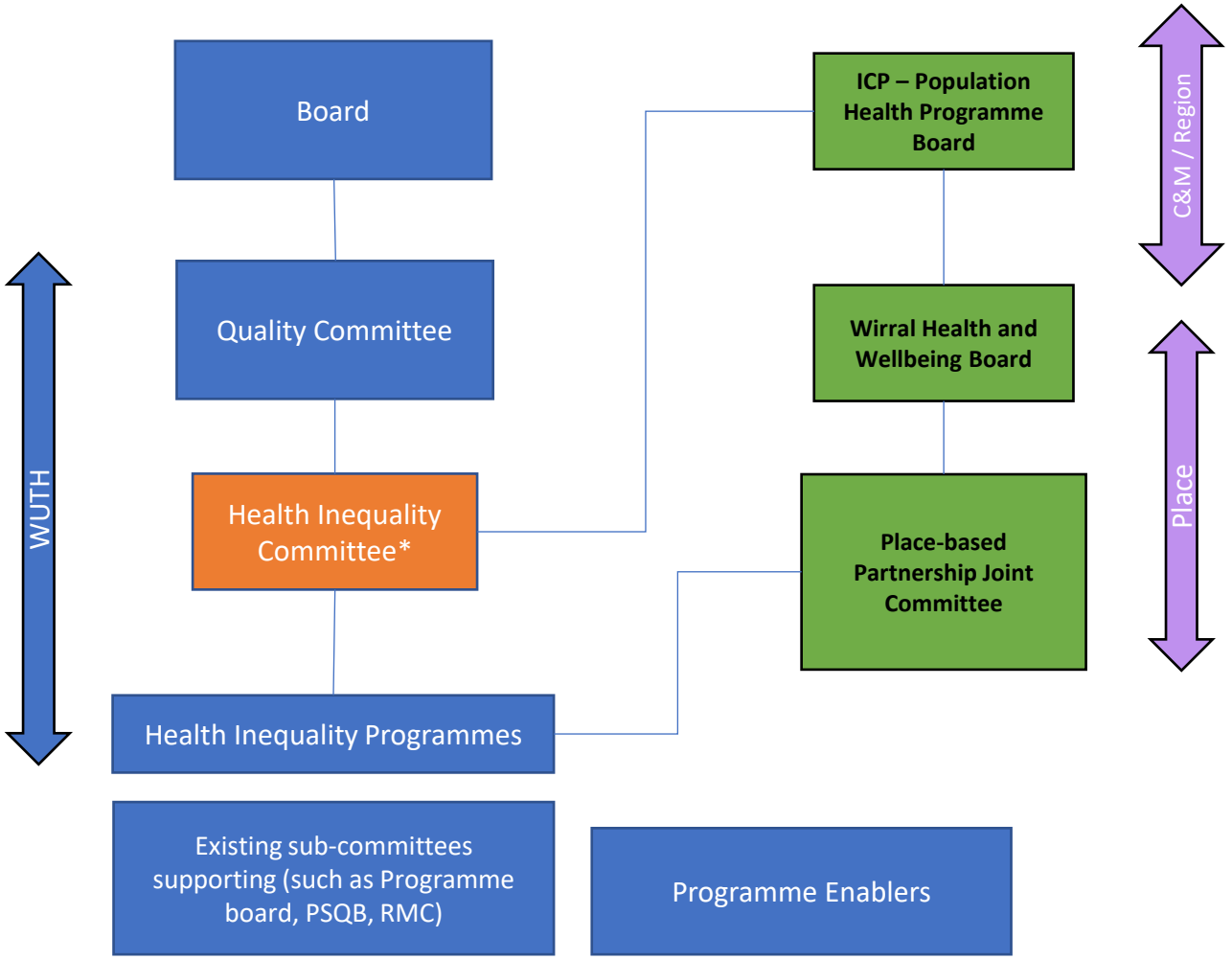
SYSTEM INITIATIVES	DESCRIPTION
1 Core 20PLUS5	Core20PLUS5 is a national approach designed to reduce health inequalities by identifying a target population and 5 clinical areas of improvement. • **Core20**: The most deprived 20% of the national population • **PLUS**: Inclusion health groups identified at a local level • **5**: Clinical areas of focus: maternity, severe mental illness (SMI), chronic respiratory disease, early cancer diagnosis, hypertension
2 Anchor Institution	Anchor Institutions are large organisations which have a stake in their local area. Their assets can be used to address health inequalities. The key principles of Anchor Institutions focus on estates and land use, procurement, employment, professional development, sustainability and collaboration with local partners.
3 Social Value Charter and Award	The Social Value Charter is a model introduced to embed social value into procurement processes. Social Value priorities include tackling economic inequality, fighting climate change and providing equal opportunities. Organisations can gain accreditation from the Cheshire and Merseyside Social Value Award by uploading evidence of social, economic, environmental and innovative commitments. The award supports organisations to become Anchor Institutions.
4 NHS Prevention Pledge	The NHS Prevention Pledge is a Cheshire and Merseyside initiative which focuses on reducing preventable illness and inequalities in health. Core commitments include workforce development, promoting healthier lifestyles for patients, visitors and staff, enhancing Anchor Institution Practices and signing up to the C&M Social Value Award.
5 Fair Employment Charter	The Fair Employment Charter for Liverpool City Region encourages employers to improve their employment practices by celebrating fair employment practices. Its commitments focus on establishing a healthy workforce, fair pay and hours, inclusive workspaces and delivering justice in the workforce with opportunities for young people.

DELIVERY

- Tracking progress and delivery against Prevention Pledge, Anchor Institution, Social Value Award KPIs, and Green Plan
- Supported by WUTH Annual Operational Plans and Enabling Strategies
- Delivery of Marmot Principles
- Monitoring and Delivery through Health Inequality Committee
- Co-creation interventions and actions with communities
- Local/C&M/National Programmes Delivered in Place

Proposed Governance Structure

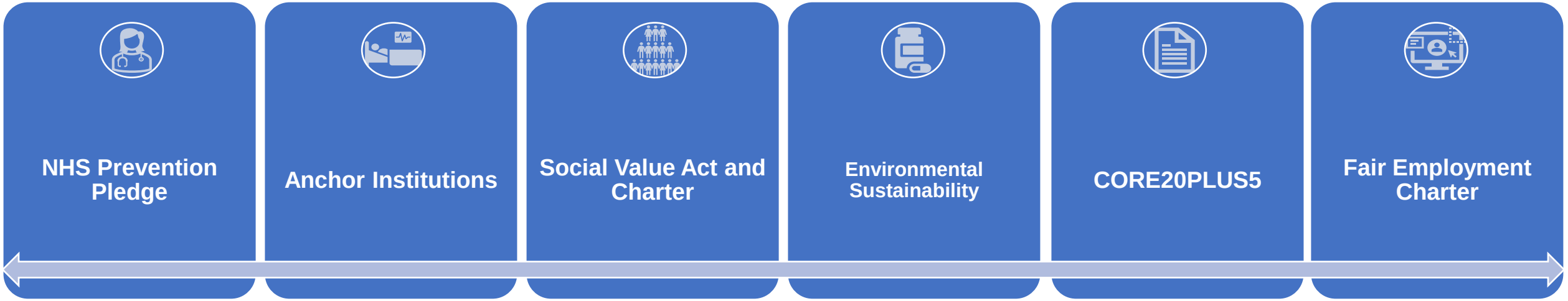
Wirral University Teaching Hospital NHS Foundation Trust



*Establishment of new health inequality committee

Current Health Inequality Initiatives

Wirral University Teaching Hospital NHS Foundation Trust



Delivery – Implementation and Monitoring

Wirral University Teaching Hospital NHS Foundation Trust

1. Endorse and Embed the WUTH Health Inequality Model:

Implementation Plan:

Establish a working group to assess the alignment of the WUTH Health Inequality Model with existing strategies and operational processes.
Develop a communication plan to introduce and explain the model to all relevant stakeholders.

Monitoring and Evaluation:
Regularly assess the integration of the model into operational practices.
Collect feedback from staff and stakeholders to identify areas for improvement.
Establish key performance indicators (KPIs) to measure the impact of the model on addressing health inequalities.

2. Continuation of Existing Initiatives with Named Leads:

Implementation Plan:
Identify and appoint named leads for each existing initiative, considering individuals with expertise in the respective areas.
Conduct orientation sessions for named leads to clarify roles, responsibilities, and expectations.

Monitoring and Evaluation:
Establish a reporting mechanism for named leads to regularly update on progress through the Health Inequality Sub-board Committee.
Conduct periodic reviews to ensure initiatives remain aligned with overarching health inequality goals.
Celebrate successes and address challenges through continuous improvement.

3. Embedding Tools for Systematic Health Inequality Reduction:

Implementation Plan:
Introduce the NHS England Healthcare Inequalities Improvement Planning Matrix and Health Inequalities Assessment Tool (HEAT) through training sessions.
Integrate these tools into existing planning processes and decision-making frameworks.
Develop guidelines and resources for staff to effectively use these tools.

Monitoring and Evaluation:
Regularly review the utilisation of tools in planning and decision-making.
Gather feedback from staff regarding the effectiveness and user-friendliness of the tools.

4. Formation of a Health Inequality Committee:

Implementation Plan:
Establish the committee with a diverse representation of expertise, including initiative leads and external health inequality specialists.
Define the committee's terms of reference, functions, and reporting mechanisms.
Initiate regular meetings and communication channels for efficient collaboration.

Monitoring and Evaluation:
Assess the committee's effectiveness in providing oversight and strategic guidance.
Solicit feedback from committee members and relevant stakeholders.
Adapt the committee's structure and processes based on evolving needs.

Delivery – Implementation and Monitoring

Wirral University Teaching Hospital NHS Foundation Trust

5. Communication and Stakeholder Engagement:

Develop a communication plan to regularly update staff, board members, and the wider community on the progress and impact of these initiatives.
Seek input and feedback from stakeholders at various stages to ensure inclusivity and transparency. Encourage a culture of open communication, where feedback is welcomed and acted upon.
Inclusion of health inequality work into bi-annual priority away day.

6. Capacity Building:

Provide training and resources for staff at all levels to ensure a shared understanding of the importance of addressing health inequalities.
Foster a culture of continuous learning and improvement, encouraging staff to engage with new tools, models, and governance structures.

7. Regular Reviews and Adjustments:

Establish a regular review cycle to assess the effectiveness of implemented initiatives.
Be responsive to emerging challenges and opportunities, adjusting strategies and processes accordingly.
Regularly update the organisation's leadership and stakeholders on the outcomes of these reviews.
By following this comprehensive plan, WUTH can systematically implement the proposed recommendations, ensuring that each initiative is seamlessly integrated into existing operations, and that the overall strategy remains dynamic and responsive to the evolving landscape of health inequalities.

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 10**
1 May 2024

Title	Registers of Interests and Gifts & Hospitality, and Fit and Proper Persons Update
Area Lead	David McGovern, Director of Corporate Affairs
Author	David McGovern, Director of Corporate Affairs Catherine Herbert, Board Secretary
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board with year end updates on the register of interests, the register of gifts and hospitality, and the fit and proper persons regime compliance.

It is recommended that the Board:

- Notes the Register of Interests at Appendix 1 and 2, the Register of Gifts at Appendix 3 and Hospitality at Appendix 4; and
- Notes the update on Fit and Proper Persons.

Key Risks

This report relates to these key Risks:

- Upholding standards of transparency and adhering to the standards set by NHS England to safeguard taxpayer monies.

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
April 2024	Audit and Risk Committee	As above	Information

1	Narrative
1.1	**Registers of Interests End of Year Update** Members will recall that the Trust's Managing Conflicts of Interest Policy was reviewed and approved in September 2022 by the Audit and Risk Committee and by the Board in October 2022. As set out in that policy, the Audit and Risk Committee have a responsibility of oversight for the register of interests and the register of gifts and hospitality. As of 31st March, there were 1539 staff who fall within the categories outlined in the Trust policy (compared to 1459 last year), and 1320 of those have completed their annual declaration/review. This is 86% of those required, and is compared to the position at last year end of 90%. This remains better than the sector best practice figure of 85%. However, the team continue to work towards full compliance, and will continue to make efforts to reach those who are non-compliant with this. The current list of Board and Senior Directors' Register of Interest is attached at Appendix 1, and the Governors' Register of Interest attached at Appendix 2. These are available to the public via the WUTH website.
1.2	**Registers of Gifts and Hospitality End of Year Update** The Managing Conflicts of Interest Policy lays out the requirements for declaring gifts and hospitality, and these are set in line with the model policy requirements. Gifts should be declared if valued over £50, and hospitality over £25 should be declared, with any hospitality over £75 requiring manager approval. Whilst the nature of gifts and hospitality is less straightforward than the register of interests, the team ensure regular communications are included in the bulletins and briefings sent out to staff to remind them to declare gifts and hospitality. This is escalated around key points of the year, such as Christmas and year end. As agreed in the internal audit that took place on this process, a guidance document has been produced and will be circulated when the first reminders of the new financial year are published. The Registers of Gifts and Hospitality are attached at Appendix 3 and 4.
1.3	**Fit and Proper Persons End of Year Update** In line with the Fit and Proper Person Policy the annual refreshment is being carried out. Following the implementation of the new guidelines published in August 2023, the number of roles which FPP applies to has been clarified as 25. In the period from April 2023 to March 2024 the process has been carried out in relation to 8 new starters and 1 leaver from eligible posts. The annual self-assessment process was carried out at the start of 2023 and successfully completed for all posts. The annual self-assessment process for 2024/25 has now commenced under the new requirements and will be completed by the deadline of 30th June 2024 as required by the guidance. The outcome of the process will be submitted to NHSE on that date.

	The new requirements mean that the annual self-assessment will include the following: • Each postholder to fill in the self-assessment form. • Checks to be made in relation to Insolvency, Company Directorships and social media activity. • Completed appraisals for all Board level roles (Execs and NEDs) in line with the requirements of the new Board Competency Framework.

2	Implications
2.1	**Patients** • No direct implications on patients
2.2	**People** • This report applies to all staff (gifts and hospitality), band 7+ staff (conflicts of interest), and the 25 roles identified for Fit and Proper Persons.
2.3	**Finance** • No financial implications.
2.4	**Compliance** • The Trust has an obligation to manage conflicts of interest and gifts/hospitality in a transparent way, with safeguards in place around the use of taxpayer funds. This is set out both in guidance from NHS England, and in the Trust's policies. • It is also a condition of the licence to ensure that Fit and Proper Persons tests have been carried out.

Interest Type	Employee	Date Arose	Date Updated	Date Ended	Role	Interest Description (Abbreviated)	Provider	Approval	Approver
Nil Declaration	Christopher Clarkson	03/07/2023			Non-Executive Director			N/A	
Loyalty Interests	Christopher Mason	01/01/2023			Chief Information Officer	This is a declaration of my friendship with Kyle Harrison who is an Account Executive of Cerner - the major supplier of WUTH's electronic patient record solution.	Kyle Harrison (Cerner)	N/A	
Outside Employment	David Henshaw	01/04/2020	07/05/2023		Chairman	Chair	Natural Resources Wales	N/A	
Shareholdings and other ownership int	David McGovern	31/10/2022	04/02/2024		Director of Corporate Affairs	Nil Board Trustee	Manchester Pride and Manchester Pride Events Limited	N/A	
Nil Declaration	Deborah Smith	02/07/2023			Chief People Officer			N/A	
Nil Declaration	Hayley Kendall	10/07/2023			Chief Operating Officer			N/A	
Loyalty Interests	Janelle Holmes	14/03/2023			Chief Executive	Husband working as Bank RGN at East Cheshire (Macclesfield General Hospital) part of C&M ICB Retired as Director of Ortivus (previous declaration)	Husband - Antony Homes	N/A	
Outside Employment	Lesley Davies	01/03/2023	08/10/2023		Non-Executive Director	National Leader for Governance	Department for Education	YES	David Henshaw
Loyalty Interests	Lesley Davies	02/01/2023	08/10/2023		Non-Executive Director	Chair Designate - voluntary role	Cheshire College South and West	N/A	
Outside Employment	Lesley Davies	01/06/2022	08/10/2023		Non-Executive Director	Education consultancy	Seymour Place Associates Limited	YES	Catherine Herbert
Outside Employment	Lesley Davies	01/06/2022	08/10/2023		Non-Executive Director	Education charity trustee	CVQO	YES	Catherine Herbert
Loyalty Interests	Mark Chidgey	12/02/2024			Chief Finance Officer	Melanie Andrew is a former colleague and friend who now works for Medinet. Medinet, as an Independent Sector Healthcare Provider, is a potential provider of services to the Trust.	Melanie Andrew, Medinet	YES	Janelle Holmes
Outside Employment	Mark Chidgey	01/06/2022	07/03/2023		Chief Finance Officer	Ad-hoc / occasional paid lecturing and education duties in support of healthcare courses for example the Elizabeth Garrett Anderson course. My input is minimal and probably averages 2 days per year. Preparation and delivery is undertaken either outside of core hours or by booking annual leave.	Alliance MBS Business School - The University of Manchester	YES	Janelle Holmes
Loyalty Interests	Matthew Swanborough	01/09/2021			Chief Strategy Officer	Partner employed in management position at Manchester University NHS Foundation Trust	NHS	N/A	
Loyalty Interests	Nicola Stevenson	22/03/2020	08/10/2023		Medical Director	Spouse is Consultant Intensivist at LUFT	Liverpool University Hospitals NHS Foundation Trust	YES	David McGovern
Outside Employment	Rajan Madhok	21/06/2023			Non-Executive Director	Governor, College Council	Coleg Cambria, North Wales	YES	David Henshaw
Outside Employment	Stephen Igoe	01/04/2000	08/10/2023		Non-Executive Director	Deputy Vice- Chancellor	Edge Hill University	N/A	
Outside Employment	Steven Ryan	03/05/2022	07/02/2023		Non-Executive Director	Sole trader providing professional advisory services in healthcare - typically to the NHS.	Steve Ryan Healthcare	YES	David McGovern
Outside Employment	Susan Lorimer	07/12/2023			Non-Executive Director	NED role for the above Trust	Northern Care Alliance NHS FT	YES	David Henshaw

Date Declared	Interest Type	Employee	Date Arose	Date Updated	Date Ended	Interest Description (Abbreviated)	Provider	Approval	Approver
06/04/2021	Loyalty Interests	Anand Kamalanathan	01/04/2020			Newborn and infant examination, is a national screening process. I am part of the advisory board	NIPE advisory board	N/A	
06/04/2021	Loyalty Interests	Anand Kamalanathan	01/04/2020			My wife is an Orthodontist by profession. She works at Alder Hey Children's Hospital and Arrowe Park Hospital. She has a private practice under the company 'Ellen Orthodontics'.	Ellen Orthodontics	N/A	
18/02/2021	Outside Employment	Ann Taylor	01/04/2020			Ad Hoc Training sessions re substance misuse to other Substance Misuse nurses	Vivari	N/A	
15/02/2021	Loyalty Interests	Eileen Hume	01/04/2010	07/03/2023		Member	Upton Group Practice Patient Participation Group	N/A	
03/05/2022	Loyalty Interests	Eileen Hume	01/04/2022	07/03/2023		member of Patient and Public Voice Group	Wirral Community Health and Care NHS Foundation Trust	N/A	
20/12/2023	Nil Declaration	Gary Bennett	20/12/2023					N/A	
14/09/2023	Outside Employment	John Brace	01/04/2023			Self-employed journalist mainly covering local government	Self-employed	YES	David Henshaw
17/10/2023	Loyalty Interests	John Brace	17/10/2023			I am a member of the Patient Participation Group (PPG) at the GP practice I am registered as a patient at (Devaney Medical Centre). The practice is based in Birkenhead, Wirral. The group meets regularly as a group of patients with practice staff. We also (as individual PPG members) choose our own officers annually (Chair, Secretary etc) who manage the group and have been asked to volunteer (collectively) outside the PPG meetings for the Devaney Medical Centre such as marshalling during vaccinations (although I haven't volunteered for this).	Patient Participation Group (Devaney Medical Centre)	N/A	
17/10/2023	Loyalty Interests	John Brace	17/10/2023			I am member of this trade union.	National Union of Journalists	N/A	
17/10/2023	Loyalty Interests	John Brace	17/10/2023			I am a member of this trade union.	Musician's Union	N/A	
17/10/2023	Loyalty Interests	John Brace	17/10/2023			I am a member of this charity (which is a charity and membership organisation for the promotion and advancement of organ playing and choral directing.	Royal College of Organists	N/A	
17/10/2023	Loyalty Interests	John Brace	17/10/2023			I am engaged to a current employee of Mersey Care NHS Foundation Trust who works as a health visitor (type of nurse). Her employer (Mersey Care NHS Foundation Trust) provide the health visitor service under contract to Liverpool City Council.	Mersey Care NHS Foundation Trust & Liverpool City Council	N/A	
17/10/2023	Loyalty Interests	John Brace	17/10/2023			My brother is a former employee of Wirral University Teaching Hospital NHS Foundation Trust where he worked as a physiotherapist.	Wirral University Teaching Hospital NHS Foundation Trust	N/A	
17/10/2023	Loyalty Interests	John Brace	17/10/2023			I am on the electoral roll of St Oswalds, Bidston which is in the Diocese of Chester and part of the Church of England.	Parish of Bidston, St Oswalds/Diocese of Chester/Church of England	N/A	
17/10/2023	Loyalty Interests	John Brace	17/10/2023			I am a member of the Wirral Community Health and Care NHS Foundation Trust.	Wirral Community Health and Care NHS Foundation Trust	N/A	
17/10/2023	Loyalty Interests	John Brace	17/10/2023			Member of the Wirral University Teaching Hospital NHS Foundation Trust	Wirral University Teaching Hospital NHS Foundation Trust	N/A	
17/10/2023	Loyalty Interests	John Brace	17/10/2023			Governor (Bidston and Claughton) starting from 18th October 2023 for 3 years.	Wirral University Teaching Hospital NHS Foundation Trust	N/A	
19/10/2023	Loyalty Interests	John Brace	18/10/2023			Court appointed administrator of a deceased person's estate (former spouse) who died at Arrowe Park Hospital on 15th January 2022 (Coroner ruled death cause was "accidental").	Leonora Brace (deceased)	N/A	
05/12/2023	Nil Declaration	Julie McManus	05/12/2023					N/A	
12/12/2023	Nil Declaration	Keith Johns	12/12/2023					N/A	
13/12/2023	Nil Declaration	Neil Wright	13/12/2023					N/A	
30/10/2023	Nil Declaration	Paul Dixon	30/10/2023					N/A	
01/05/2022	Outside Employment	Paul Ivan	01/04/2022	07/05/2023		I work as UK Medical Director of Accellacare which is part of the biggest Global Contract Research Organisation called ICON PLC . Accellacare currently does not have any competitive interests with WUTH or any other interactions with the Trust and there are no plans for any changes in this respect in future. However if I become aware of anything that would put myself in a conflict of interest in regards to Accellacare or ICON I will amend this declaration accordingly.	Accellacare/ ICON PLC	YES	Sheila Hillhouse

30/10/2023	Nil Declaration	Peter Peters	30/10/2023					N/A	
29/11/2022	Nil Declaration	Philippa Boston	29/11/2022					N/A	
18/02/2021	Loyalty Interests	Robert Thompson	22/01/2021	03/02/2023		Son-in-law an employee at WUTH - Dr Philip Lawrenson, Consultant in Acute Medicine	Wirral University Teaching Hospital	N/A	
15/02/2021	Loyalty Interests	Sheila Hillhouse	01/11/2018	03/09/2023		Trustee	Irish Community Care (Dale Street, Liverpool)	N/A	
14/04/2022	Loyalty Interests	Tony Cragg	01/04/2022			Non Executive director and trustee	Autism together ltd charity	N/A	

Interest Type	Employee	Year	Role	Date Incurred	Gift provider name	Provider Type	Interest Description (Abbreviated)	Single or multiple gifts in the same financial year	Value £'s	Declined	Gift donated to charity	Name of charity
Gifts	John Brace	2023/24	Governor	14/03/2024	Research for Action	Other	Note - type of organisation providing gift is a worker's co-operative Transport costs - travel by train (return) from Liverpool to London to a conference about local government accountability in London on 26th March 2024 - Estimated cost £81.00 (GBP) Provision of food at conference: Estimated cost: £10.00 (GBP)	Single	91	No	No	
Gifts	Ann Taylor	2023/24	Substance Misuse Nurse	27/01/2024	Overwritten for Data Protection	Patient	X was a patient I supported in my role, they were very isolated and previously refused hospital admission as they had a small dog, I agreed to care for the dog whilst they were an inpatient. Sadly the patient recently passed away and had requested I care for the dog permanently, they left a letter to this effect with their housing support officer. I have discussed with their relatives and they are happy to agree to this. I have informed my line manager of this	Single	0	No	No	
Gifts	Christopher Lloyd	2023/24	Organisational Development Practitioner	11/12/2023	The Trainer's Library	Other	The Trainer's Library are a company that the OD team use for training materials. In celebration of their birthday a small box of cakes were sent to all customers. Whilst the cakes were sent to me, they were for the team. I am the main contact on the account. An estimated value of the product is £8 - £10.	Single	8	No	No	
Gifts	Beverley Brewin	2023/24	Matron	10/12/2023	Narrinder (rep)	Supplier	M&S Vouchers	Single	100	No	Yes	
Gifts	Grace McGrath	2023/24	Clinical Nurse Specialist	05/12/2023	Overwritten for Data Protection	Patient	£25 GIFT VOUCHER FROM M and S	Single	25	No	No	
Gifts	Martin Kelly	2023/24	Consultant	01/04/2023	Overwritten for Data Protection	Patient	Approximate date this was a while ago and difficult to remember. Gift of a card, chocolate, coffee and preserve to myself and ODP colleague. Value estimated.	Single	40	No	No	
Gifts	Matthew Swanborough	2023/24	Chief Strategy Officer	29/09/2023	Walker Sime	Commercial Company	Box of Chocolates and Lollies	Single	4	No	No	
Gifts	Stanley Parikh	2023/24	Consultant	01/07/2023	Overwritten for Data Protection	Patient	6 bottles of red wine	Single	50	No	Yes	Youth with a mission

Date Declared	Interest Type	Employee	Year	Role	Date provided or offered	Hospitality provider name	Hospitality provider type	Hospitality description and circumstances	Value £'s	Declined	Was senior approval obtained for the hospitality?	Authorised by
19/03/2024	Hospitality	Patrick Rosser	2023/24	Consultant	17/03/2024	Intuitive	Commercial Company	Travel and accommodation to educational course at IRCAD, robotic training on anaesthetised animals	700	No	No	
28/02/2024	Hospitality	Mohammed Alam	2023/24	Consultant	23/02/2024	Kebomed UK	Commercial Company	Attended training session in Madrid to view & train on myoblate device. Company paid for transport accomodation & meals	1000	No	No	
25/02/2024	Hospitality	Jurgen Stamer	2023/24	Consultant	27/11/2023	PhysicaZUK cadaveric lab, Monday 27-Tuesday 28th Nov	Supplier	Cadaveric course on the use of new instruments for the implant we currently use for unicompartmental knee replacements.	75	No	No	
25/02/2024	Hospitality	Jurgen Stamer	2023/24	Consultant	14/02/2024	Zimmer Institute	Supplier	Return transfer from accommodation in Sydney to Hospital. This was a Visitation to see robotic surgery.	100	No	No	
08/02/2024	Hospitality	Mohammed Alam	2023/24	Consultant	07/02/2024	Besins pharmaceuticals uk	Commercial Company	Presentation to local primary care colleagues on HRT prescribing Hospitality & paid honorarium	550	No	No	
25/01/2024	Hospitality	Mohammed Alam	2023/24	Consultant	16/01/2024	Gedeon Richter pharmaceuticals	Commercial Company	Dinner at San Carlo restaurant Hale after planning meeting for 2024 NW consultants meeting	50	No	No	
25/01/2024	Hospitality	Mohammed Alam	2023/24	Consultant	16/01/2024	Gedeon Richter pharmaceuticals	Commercial Company	Dinner at San Carlo restaurant Hale after planning meeting for 2024 NW consultants meeting	50	No	No	
28/12/2023	Hospitality	Mohammed Alam	2023/24	Consultant	06/11/2023	Sonata/Gynaesonics	Supplier	Open house interactive presentation with food & drinks	50	No	No	
28/12/2023	Hospitality	Mohammed Alam	2023/24	Consultant	08/11/2023	Sonata/gynaesonics	Supplier	Clinical presentation with dinner at AAGl	50	No	No	
28/12/2023	Hospitality	Mohammed Alam	2023/24	Consultant	07/11/2023	Sonata/gynaesonics	Supplier	Peer to peer meeting with dinner at AAGL	50	No	No	
28/12/2023	Hospitality	Mohammed Alam	2023/24	Consultant	05/11/2023	Lina medical devices	Supplier	Dinner during AAGL meeting Nashville	75	No	No	
06/11/2023	Hospitality	Janelle Holmes	2023/24	Chief Executive	02/11/2023	Hill Dickinson	Supplier	Hospitality; Dinner & Networking Event. Invite from Hill Dickinson. We would be delighted if you could join us on 2 November 2023 for a roundtable discussion on provider collaboratives. This invitation-only evening event with attendees from across Cheshire and Merseyside will include dinner and networking and offers a forum in which to share successes and challenges experienced in the expanding provider collaborative arrangements over recent months. You will have the opportunity to hear from Mike Farrar, sharing his insight on progress in establishing collaboratives across the country and the benefits they could bring, as well as Hill Dickinson partner Rob McGough with legal perspectives on trends to date and potential future developments. Venue - Malmaison Liverpool, 7 William Jessop Way, Liverpool, L3 1QZ	50	No	Yes	Sir David Henshaw
26/10/2023	Hospitality	Sarah Doherty	2023/24	Highly Specialist Pharmacist	20/04/2023	Britannia Pharmaceuticals	Other	Apomorphine masterclass conference sponsored by Britannia pharmaceuticals. Refreshments provided + accepted. Accommodation and travel offered but not accepted as conference in Liverpool.	50	No	Yes	Sam Kirby
16/08/2023	Hospitality	Thomas Aust	2022/23	Consultant	22/03/2023	Inuitive surgical	Supplier	Flight and accomodation to Paris Charles de Gaulle airport hotel for meeting on gynaecological robotic laparoscopic techniques. i night in hotel and breakfast and lunch.	200	No	Yes	Sadiq
18/07/2023	Hospitality	Matthew Swanborough	2023/24	Director of Strategy & Partnership	11/07/2023	Wirral Council	Other	Ticket for the British Open Golf Tournament 2023 at Royal Liverpool Golf Club and meeting with Wirral Council Neighbourhood Director, Wirral Council Chief Executive and Wirral Council Leader to discuss benefits of British Open on Wirral communities.	95	Yes	No	
03/07/2023	Hospitality	Mohammed Alam	2022/23	Consultant	16/03/2023	Hologic UK	Commercial Company	dinner at SEUD conference in Abu Dhabi	50	No	No	
02/07/2023	Hospitality	Denise Langhor	2023/24	Consultant	02/07/2023	BMA	Other	At times travel to London is required for BMA work. Train travel and hotels paid for. This would usually be a maximum of £1500 a year, usually less.	1500	No	Yes	
12/06/2023	Hospitality	Christopher Mason	2023/24	Chief Information Officer	12/06/2023	Kyle Harrison	Supplier	Trip is due to take place on evening of 19th and day of 20th June. I will be travelling to and from Kyle's House and paying my own travel costs. I will be staying over at his house with my son and have an evening meal - which I am contributing towards. I will be spending a day fishing on the lake of one of one of Kyle's friends for which there is no cost to anyone.	0	No	Yes	David McGovern

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 11.1**
1 May 2024

Report Title	Committee Chairs Reports – People Committee
Author	Lesley Davies, Chair of People Committee

Overview of Assurances Received

- The Committee received an update on the ongoing dispute with Unison relating to the retrospective re-grading of Clinical Support Workers and which has been reported to the Board previously. Discussion between Unison and the Trust continue in order to work towards a resolution. The committee took good assurance of the management of safe working practices.

- The Equality Delivery system (EDS) has been part of the NHS contract since 2015 and a new framework was launched in 2022. The EDS is based on 11 outcomes and the last EDS assessment took place in February 2023 when the Trust agreed an overall rating of 'developing'. The Committee was assured to the progress made against the framework since 2023. This year the Trust has re-assessed it rating and has agreed an 'achieving' rating. The self-assessment findings are based on feedback from Health Watch, staff networks, trade union representatives, divisional triumvirates and the Executive Team.

- The Committee received good assurance on the progress being made against the year 2 deliverables of the People Strategy. Some progress has been hampered by industrial action but assurances were received that currently there are no areas of concern regarding non-delivery. Of note is the work being undertaken and the activities supporting the engagement of staff, continued work on the Just and Learning Culture and the role out of the Leadership training programme. At the end of the year the Committee will review the impact of this work.

- The Committee discussed the recent Staff Survey and although there are many positives to celebrate the response rate overall has dropped by 10% this year which is disappointing given the range of engagement activities being undertaken by the team. Local intelligence suggests that this is due to the impact of Industrial Action. The next steps include the dissemination of the responses at divisional team meetings in order to feedback directly to staff that their opinion matters and to discuss action the Trust is taking to address any concerns raised.

- The Committee was provided with a deep dive into Estates as this has been an area of ongoing concern with regard to the level of short-term sickness and lower levels of satisfaction demonstrated through staff feedback. This deep dive provided richness to the data that has been consistently reviewed and it was brought to the committee attention the lack of digital processes and the labour-intensive processes that staff carry out and also the structure of the division which relies on very few managers with a very wide span of control. The committee was assured that the division was reviewing ways of improving its processes, providing more support for appraisals and monitoring sickness absence and staff welfare and that work was being undertaken to review the structure of the division. The division is also looking at the opportunities of taking on apprentices.

- Despite seasonal pressures and strike action, the Trust's People KPIs for mandatory training and turnover remain on target and continues to be achieved. Appraisal compliance has been adversely impacted by strike action and remains slightly below target. Sickness absence also remains above target although there has been a significant improvement in month.

Areas of Risk

- The committee received the annual report on Workforce Education and Training. Focus was given to the two areas of risk highlighted in the paper: Induction Compliance and Apprenticeship Levy Spend. Assurance that induction compliance was now in target for both Corporate Induction and Local Induction was provided, and plans are on track to close this risk by end of March 24.

- Significant progress has been made to maximise the apprenticeship levy. Following a series of successful initiatives levy funding returned to HMRC has reduced from £45k (on average) in April 23 to £3k in March 24. Long-term plans were outlined in the paper which will fully mitigate return of apprenticeship levy to HMRC, and work continues to implement apprenticeships at WUTH and maximise all available apprenticeship levy funding. The greatest obstacle remains inability to fund backfill for apprentices. Apprenticeship Levy risk has reduced from 12 to 9 following progress.

Other comments from the Chair

- The Committee thanked the staff for their continued work and for providing good assurance on the areas reviewed

Wirral University Teaching Hospital
NHS Foundation Trust

Board of Directors in Public **Item No 11.3**
1 May 2024

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

Items for Escalation/Action

- The Committee received the quarterly performance report on the Estates functions across the Trust, with the Director of Estates providing assurance on delivery of statutory estates compliance, reactive maintenance, cleaning standards and health and safety.
- It was noted that Estates have made measurable progress to improve statutory and HTM Compliance, with 90.9% of in-date periodic inspections completed across statutory maintained assets.
- In terms of cleaning, the Trust has fully implemented the NHS National Standards of Healthcare Cleanliness, with full cleanliness audit scores report for all functional areas completed on a monthly basis. Trust Average Cleanliness Scores have been above their target of 95% for the previous 18 months, with the lowest score being 98.8% in September 2022.
- The Committee has now included non-clinical health and safety functions within its remit and received a report on health and safety incidents, training and audits across the Trust. This follows the transfer of the service into the Estates function in late 2023.
- The Committee was provided with assurances relating to capital expenditure across 2023/24 and the delivery of 23/24 £30.9m capital programme to budget.
- The Committee was also provided with an overview of the capital projects delivered across 23/24, including the modular theatres, community diagnostic centre, pipework replacement works, fire compartmentation and dry riser works, generator replacement, ward upgrades and clinical area flooring. The Committee were provided with an understanding of the lessons learnt from these major projects and the process undertaken by the Capital Team to improve project delivery and management.
- The A/Director of Estates also outlined the capital projects for 24/25 and demonstrated the alignment to the backlog maintenance risk and items on the Trust's risk register. These projects include lift replacement, ventilation replacement in ICU, pipework replacement, generator replacement and medical gas infrastructure.
- The Committee were also provided with an update on the UECUP (Urgent and Emergency Care Upgrade Programme), highlighting progress to date and dates for the completion of Phase 2. The Director also noted the management of delivery and handover of phases to the plan as well as the ongoing support provided to the principal contractor.
- The Deputy Director of Estates presented an approach to developing a site control plan for Arrowe Park Hospital, providing a plan for future developments on the campus.
- The Chief Strategy Officer provided un update on the meetings with Your Housing Group relating to the Frontis Building at Arrowe Park Hospital, with the Committee requesting that the Chief Strategy Officer meet with Hill Dickinson to consider mediation and legal options.

New/Emerging Risks

- A number of risks were identified and considered by the Committee:
  - The significant backlog maintenance risks across the Trust and mitigations in place to manage this risk, in light of the 24/25 capital (CDEL) allocation to the Trust.

- The ongoing support required to the Principal Contractor for the UECUP Programme and weekly meetings in place to manage delivery of the programme

Overview of Assurances Received

- A number of assurances were provided through reports from Committee members and members of the Estates Management Team including:
  - statutory estates compliance, reactive maintenance, cleaning standards and health and safety
  - Capital programme delivery
  - Capital expenditure to budget

Other comments from the Chair

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

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors **Item 11.3**
1 May 2024

Report Title	Committee Chairs Reports - Audit and Risk Committee
Author	Steve Igoe, Non-Executive Director & Deputy Chair

Overview of Assurances Received

This report updates on the work of the Audit Committee at its meeting on 18th April 2024.The work of the Audit Committee as well as being documented in its terms of reference is prescribed by Accounting /Auditing Standards and Regulatory requirements.

Items for Escalation

There are no items for escalation from the Committee to the Board.

Updates on issues raised at the Meeting on 29th February 2024

There was one item to be closed off from the previous meeting. This related to the bringing forward of a completion date from an internal audit report relating to HR. This was discussed further in the meeting.

Internal Control and Risk Management

The Committee discussed the Chair's report from the Risk Management Committee. The top 4 risks identified for discussion were:

- Pressure on the emergency department with increasing numbers of patients experiencing a mental health crisis.
- MRI service unable to deliver timely care to emergency/urgent patients.
- Sterilisers in SSD are over 13 years and fail regularly which impacts service delivery due to the inability to re process surgical instruments.
- SSD washers /disinfector breakdown.

The Risk Committee received reports in relation to significant risks, diagnostics & clinical support, Medicine and acute division risks, Finance, Medical devices and equipment, the Chairs report from the Health and Safety Committee and the Board Assurance Framework.

A detailed review of the Board Assurance Framework took place (BAF). It was noted that the BAF had been discussed at the relevant Board Sub Committees as well as at the Board .coring were that further work was to be undertaken in relation to Risk Appetite however The Audit and Risk Committee confirmed that the BAF suitably represented the key strategic risks impacting the Trust at the present time .A deep dive into BAF risk 2 (Failure to meet Constitutional/regulatory targets resulting in an adverse impact on patient experience and quality of care) was postponed due to the illness of the COO.

Key issues arising from the Information Assurance Group were presented and discussed. The Group provided updates and assurance on; Cyber security; Information Governance, Health records and data quality.

The Committee was updated on procurement including spend controls and waivers This report was presented by the Assistant Director of Finance – Procurement. It was noted that the Trust continues to perform strongly against NHS benchmarks. A detailed analysis of waivers was presented and discussed as usual. The Committee were assured that the Trust in relation to these waiver items was achieving value for money and that due consideration had been given to the relevant and appropriate levels of financial scrutiny and authorisation alongside the use of framework agreements and measured term contracts.

The Committee received a presentation on the development of a Trust-wide Procurement strategy. This was welcomed by the Committee who agreed to receive the detailed Strategy document for approval at the next meeting in June.

The Committee also scrutinised the standing report on financial losses and special payments. There were no material items of significance to report although there was some discussion on reimbursement for losses, particularly items such as teeth and hearing aids. Whilst these are not financially significant, they do have the potential to impact on the patient experience. This issue is currently under review by Trust staff.

Year End Accounting Matters

The Committee received papers in relation to the above covering Asset revaluations and material management estimates. The Committee discussed the items presented and approved the Trust's position in relation to those items. It was noted that these are areas already flagged by External Audit for detailed review and will be reported back on as part of the Auditor's ISA 260 end of audit report.

Anti-Fraud Progress Report

A Positive year-end report on Anti-Fraud matters was presented to the Audit Committee and discussed in detail.

In relation to the self-assessment for Government functional standard 013 for Counter Fraud the Trust assessed itself across all 13 headings as green (positive)

Internal Audit

MIAA provided an overview of recent activity undertaken across the Trust.

Due to timing movements, this Committee received a substantial number of reports, specifically:

- Management of Medical outliers - Moderate Assurance
- Limited Liability Partnerships – Substantial Assurance
- Cost Improvement Programme – Substantial Assurance
- ESR payroll review - Substantial Assurance
- HR and well-being Service ESR review – Substantial Assurance
- Ockenden Review – Substantial Assurance
- IT Infrastructure review – Substantial Assurance
- Assurance Framework report – Positive Outcome
- Risk Management (Core Controls Review) – Positive Outcome

Tracking Outstanding Audit Actions

Both the MIAA Audit Tracker and the Trust's own tracker report demonstrated good engagement with, and closure of, issues arising from Internal Audit reviews. This was confirmed orally by representatives from MIAA. There was strong evidence of items whose previous completion dates had slipped being actively completed. It was agreed that for 24/25 the Committee would push for

any Red (High Risk) actions to be completed with the aim that all such issues would not exist at the start of 25/26.

Internal Audit Annual Report and Head of Audit Opinion

A positive year end annual report was received from MIAA.

The overall opinion for the period 1st April 2023 to 31st March 2024 provides Substantial Assurance, that there is a good system of Internal Control designed to meet the Organisation's objectives, and that controls are generally being applied consistently.

External Audit

A progress statement was received form Azets. No specific issues were raised at this time with the external audit of the accounts being imminent. It was agreed that the management's detailing of material estimates and valuation matters was helpful.

Draft Annual Governance Statement

The above key constitutional and reporting document was discussed. Colleagues were asked to feed back any suggested amendments to the Board Secretary.

Register of Interests and Fit and Proper persons' annual update

The report from the Director of Corporate Affairs was discussed and the contents noted.

Annual Report of the Committee and Effectiveness review

The Committee approved the updated terms of reference and approved the outcome of its effectiveness review, specifically it confirmed that it is properly comprised with the appropriate skills and has met a sufficient number of times to conduct its business .The Committee has reviewed its work and confirms that it has discharged its duties in line with the Authority delegated to itby the Board via its terms of reference and is therefore operating effectively.

Emergent risks and Assurances

All such matters are included in the body of the report on the deliberations of the Audit Committee as set out above.