Wirral University Teaching Hospital
NHS Foundation Trust

BOARD OF DIRECTORS IN PUBLIC - 4TH OCTOBER 2023

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4 October 2023

09:00 GMT+1 Europe/London

AGENDA

1. BOARD OF DIRECTORS IN PUBLIC

REFERENCES

Only PDFs are attached

- 0.1 Board of Directors Public Agenda.pdf
- 3 Board of Directors in Public Minutes - 6 September.pdf
- 4 Action Log - Public Board.pdf
- 7 Chief Executive Officer Report.pdf
- 8.1 WUTH IPR SPC Dashboard - Sept 2023 - 5 CFO.pdf
- 8.1.1 CFO Commentary M5 Final.pdf
- 8.2 COO report for Sept 23.pdf
- 8.3 Monthly Maternity Services Report Oct FINAL Public.pdf
- 8.3.1 Appendix 1 - Perinatal Clinical Surveillance Quality Assurance Report August 2023.pdf
- 8.3.2 Appendix 2 - MIS Year 5 Compliance Table updated Sept 2023.pdf
- 8.3.3 Appendix 3 - ATAIN Report.pdf
- 8.3.4 Appendix 4 - Maternity Self Assessment Toolfinal updated Sept 2023.pdf
- 8.4 - LFDQ1 23-24.pdf
- 8.5 BoD_2324 Quality Performance Dashboard - Oct 2023.pdf
- 8.5.1 WUTH IPR SPC Dashboard - Sept 2023 - Intro.pdf
- 8.5.2 WUTH IPR SPC Dashboard - Sept 2023 - 1 COO.pdf
- 8.5.3 WUTH IPR SPC Dashboard - Sept 2023 - 2 MD.pdf
- 8.5.4 WUTH IPR SPC Dashboard - Sept 2023 - 3 CN.pdf
- 8.5.5 CN Commentary - Aug figures for Oct 2023 BoD - draft.pdf

- 8.5.6 WUTH IPR SPC Dashboard - Sept 2023 - 4 CPO.pdf
- 8.5.7 CPO Commentary - for Oct REVISED.pdf
- 9.1 EPRR Cover Sheet.pdf
- 9.1.1 WUTH EP Annual Report 2022-23.pdf
- 9.2 Core Standards Annual Submission Cover Sheet 2022 2023 October 23.pdf
- 9.2.1 WUTH Return NHS Core Standards Template V2.1 19 September 2023.pdf
- 10 Elective Recovery Self-Assessment -.pdf
- 10.1 Appendix 1.pdf
- 11 Fit and Proper Persons.pdf
- 11.1 Fit Proper Persons Policy - 2023.pdf
- 12 Organ Donation Annual Report.pdf
- 13 Patient Experience Strategy Annual Report.pdf
- 14 Infection Prevention and Control Annual Report.pdf
- 14.1 Infection Prevention and Control Annual Report.pdf
- 15 Safeguarding Annual Report.pdf
- 16.1 Quality Committee.pdf
- 16.2 Audit and Risk Committee 20th Spetember 2023.pdf

Wirral University Teaching Hospital
NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 4 October 2023
Time	9:00 – 11:00
Location	Hybrid

Agenda Item		**Lead**	
1.	Welcome and Apologies for Absence	Sir David Henshaw	
2.	Declarations of Interest	Sir David Henshaw	
3.	Minutes of Previous Meeting	Sir David Henshaw	
4.	Action Log	Sir David Henshaw	
Items for Decision and Discussion			
5.	Patient Story	Tracy Fennell	
6.	Chairs Business and Strategic Issues – **Verbal**	Sir David Henshaw	
7.	Chief Executive Officer Report	Janelle Holmes	
8.	Board Assurance Reports		
	8.1) Chief Finance Officer Report	Mark Chidgey	
	8.2) Chief Operating Officer Report	Hayley Kendall	
	8.3) Monthly Maternity Report	Tracy Fennell	Jo Lavery
	8.4) Learning from Deaths Q1 2023/24	Dr Nikki Stevenson	Dr Ranj Mehra
	8.5) Integrated Performance Report	Executive Directors	
9.	Emergency Preparedness, Resilience and Response (EPRR)	Hayley Kendall	
	9.1) Annual Report		
	9.2) Core Standards Assessment		
10.	Elective Recovery Self-Assessment	Hayley Kendall	
11.	Fit and Proper Persons Policy	David McGovern	
Annual Reports			
12.	Organ Donation Annual Report	Dr Nikki Stevenson	
13.	Patient Experience Strategy Annual Report	Tracy Fennell	
14.	Infection Prevention and Control Annual Report	Tracy Fennell	

15.	Safeguarding Annual Report	Tracy Fennell

Committee Chairs Reports

16.	16.1) Quality Committee	Dr Steve Ryan
	16.2) Audit and Risk Committee	Steve Igoe
	16.3) People Committee - **Verbal**	Lesley Davies
	16.4) Research and Innovation Committee - **Verbal**	Sir David Henshaw

Closing Business

17	Questions from Governors and Public	Sir David Henshaw
18	Meeting Review	Sir David Henshaw
19	Any other Business	Sir David Henshaw

Date and Time of Next Meeting

Wednesday 1 November 2023, 09:00 – 11:00

Wirral University Teaching Hospital NHS Foundation Trust

Meeting	Board of Directors in Public
Date	Wednesday 6 September 2023
Location	Hybrid

Members present:

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

In attendance:

CH	Cate Herbert	Board Secretary
JJE	James Jackson-Ellis	Corporate Governance Officer
SS	Sally Sykes	Director of Communications and Engagement
JL	Jo Lavery	Divisional Director of Nursing & Midwifery (Women's and Children's Division) – item 8.5
SH	Sheila Hillhouse	Lead Public Governor
EH	Eileen Hume	Deputy Lead Public Governor
PI	Paul Ivan	Public Governor

Apologies:

DH	Sir David Henshaw	Non-Executive Director & Chair
SR	Dr Steve Ryan	Non-Executive Director
CC	Chris Clarkson	Non-Executive Director
DM	David McGovern	Director of Corporate Affairs

Agenda Item	Minutes	Action
1	**Welcome and Apologies for Absence** SI welcomed all present to the meeting. Apologies are noted above.	
2	**Declarations of Interest** No interests were declared and no interests in relation to the agenda items were declared.	

3	**Minutes of Previous Meeting** The minutes of the previous meeting held on the 5 July were **APPROVED** as an accurate record.	
4	**Action Log** The Board **NOTED** the action log.	
5	**Patient Story** The Board received a video story from a transgender woman. The video described her experience of transitioning, the support available and the importance of having a supporter listener available throughout the process. RM queried what was meant by a supportive listener. TF stated the patient felt “talked at” by clinicians and doctors and the individual did not feel listened to. TF added the Women and Children’s Division have launched the Voice of the Child project, whereby children and young people have a voice in designing their care and can identify if they want the opportunity to speak on their own with a healthcare professional. DS commented it was important to thank the patient for sharing her story and the changes made in the Trust following her experience. The Board **NOTED** the patient story.	
6	**Chairs Business and Strategic Issues** SI stated DH had not provided any issues to raise on this occasion. The Board **NOTED** the update.	
7	**Chief Executive Officer’s Report** JH highlighted Maternity Services at Trust rated had been 'Good' by the Care Quality Commission with areas of 'Outstanding' practice following an inspection conducted in April. JH also highlighted in August Wirral Council CEO and Wirral Council Leader visited the Trust to view the progress on the new Urgent Emergency Upgrade (UECUP) site and to hear about the improvements being made in the Operational Centre for Patient Flow. JH reported the Trust had been selected as a finalist for another Health Service Journal Award in the Provider Collaborative of the Year category for the Cheshire and Merseyside Surgical Centre at Clatterbridge.	

	JH gave an industrial action update and summarised the latest position as well as the ongoing dispute with Clinical Support Workers (CSWs) regarding retrospective re-banding. JH stated the Trust declared 5 serious incidents in July and 0 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS). JH referenced the submission made to the UK Covid-19 Public Inquiry regarding the Trust's procurement of equipment and supplies during the pandemic and the updated NHSE enforcement guidance. JH summarised the recent meeting of the Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board on 4 August. SL commented the Trust had been shortlisted for several Health Service Journal awards this year and proposed displaying this at future meeting. SI suggested this be scheduled for a future meeting. SL also queried the rationale by UNISON to backdate to 2018. DS stated UNISON were using the precedent that in April 2018 several Trusts in Greater Manchester backdated re-banding, following UNISON raising the issue in that region in 2019. JH stated there is evidence of impact on elective activity due to industrial action. Each period required significant planning across teams to ensure staff and patient safety, with a subsequent impact on managing business as usual. The Board **NOTED** the report.	Hayley Kendall
8	**Board Assurance Reports** **8.1) Integrated Performance Report** NS highlighted the number of patients recruited to NIHR studies was below threshold and would be discussed further at the Research and Innovation Committee in September. NS added a new Research and Innovation Manager was in the process of being recruited. TF stated the number C diff cases was above threshold, and this continued to be monitored closely. DS reported sickness absence was above threshold in month and was driven by short term sickness. Staff turnover in month was above threshold and a review of thematic exit interview data would be discussed at Workforce Steering Board in September.	

	The Board **NOTED** the report. **8.2) Chief Finance Officer Report** MC highlighted at the end of July 2023, month 4, the Trust was reported a deficit of £9.8m against a plan of £10.3m; the resultant variance of £0.5m is an improvement on the month 3 position. The position assumes £1.7m of income to mitigate lost activity caused by industrial action. This has been agreed with the ICB as a planning assumption but will not be transacted ahead of national guidance. MC provided an update on the month 4 statutory financial targets and the RAG rating for each, highlighting that financial stability, agency spend financial efficiency, capital and cash were all rated green, and financial sustainability was red. MC summarised the risks to position and actions for the I&E position, CIP, capital expenditure and cash position. SL queried if there was an update regarding Countess of Chester not fully utilising their allocated time for orthopaedic work in the Cheshire and Merseyside Surgical Centre. HK stated the Countess of Chester were conducting 1 session a week instead of the 6 initially planned. HK added there were staffing challenges and they were focussing on their targets. HK highlighted the concern has been raised with the ICB and other partners. The Board **NOTED** the report. **8.3) Productivity and Efficiency Update** HK provided an overview of the report, summarising the current 2023/24 Productivity and Improvement Programme and identified plans to date, along with the ongoing work to identify further schemes to deliver a programme that supports the financial sustainability of the Trust. HK added at the end of month 4 £17.689m had been transacted from budgets as recurrent savings. This is 68% of the full year target of £26.1m at less than halfway through the financial year. SL noted Estates was the only Division not achieving the target set out at the start of the year and queried this. MS stated the original target had since been revised owing to several schemes taking longer to deliver. MS added there had also been a rephasing of the programme in Estates. SI queried the red and amber RAG rated schemes.	

	HK stated the red and amber schemed would be transacted in 2024/25 and planning had already started with teams to identify opportunities. SI also queried how the Trust was engaging with Wirral system partners to drive system efficiencies. JH stated the ICB was holding Wirral Place to account, and a meeting was being held in September with CEOs of Wirral system partners in September regarding financial sustainability. The Board **NOTED** the report. **8.4) Chief Operating Officer Report** HK highlighted in July the Trust attained an overall performance of 96% against plan for outpatients and an overall performance of 84% against plan for elective admissions. The Trust was on plan to achieve the activity plan in July but was impacted by industrial action. HK stated cancer performance for 2 week waits in July was 89.2% which is below the required standard of 93% but still positive given the challenges in that area, with two main areas of underperformance in gynaecology and colorectal. The Faster Diagnosis Standard was 79.12% against a national target of 75% by March 2024. HK reported type 1 unscheduled care performance was 50.51, which was below the 4hr improvement trajectory. HK also reported there were circa 115 inpatients not meeting the criteria to reside, down from 250 in April. HK stated the risks to improving performance continued to be the impact of industrial action and the increasing number of mental health patients, which often exceeds the capacity of the mental health unit, posing an increased risk to patients and staff. HK added an urgent meeting was being held with Cheshire Wirral Partnership regarding this. RM noted the good progress in addressing the number of inpatients not meeting the criteria to reside and queried if there had been a streamlining of processes. HK stated there was a number of processes involved in matching patients to care packages. HK added NHSE were due to visit the Trust to understand how the Care Hub could implemented elsewhere. SI noted the total bed capacity had reduced due to fewer inpatients not meeting the criteria to reside and queried if this was translating into improved patient experience.	

HK stated there had been zero corridor care of patients and faster discharge. However, industrial action was impacting this.

SI also queried the hidden cost of industrial action through planning as well as the impact on efficiency, and if this was being captured.

HK stated the new Divisional Director of Acute was capturing this intelligence.

The Board **NOTED** the report.

8.5) Quarterly Maternity Report

JL provided an overview of the report, noting the update regarding Year 5 of the Maternity Incentive Scheme (MIS), together with an update on Saving Babies Lives (SBLv3) and the outcome of the recent Care Quality Commissioner (CQC) inspection of Maternity Services.

JL also updated on the three-year delivery plan, maternity continuity of carer implementation, the workforce position and the staffing requirements to continue to pursue this model.

DS queried if staff in Maternity Services would feel confident raising concerns.

JL stated there was good evidence that midwives and neonatal staff were confident raising concerns. JL added the Division regularly held listening events and there were other mechanisms for staff to communicate concerns. JL stated the CQC commented on the positive culture in Maternity Services.

Members congratulated the Maternity Services for achieving the good rating and acknowledged the continued and sustained improvements.

The Board **NOTED** the report.

8.6) Learning from Deaths Report

NS provided an overview of the report, highlighting the Trust's Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) data. The Trust was within the expected range of mortality data.

NS added a review of palliative care coding was conducted and this was shown to be appropriate and a reflection of a proactive palliative care team. NS added for patients who were under palliative care and subsequently died in hospital, 91% had documented evidence that their preferred place of death was in hospital.

	The Board **NOTED** the report. **8.7) Guardian of Safe Working Report** NS provided assurance that doctors and dentists in training were safely rostered and that their working hours were compliant with the Terms and Conditions of Service (TCS). NS summarised the number of doctors in training, exception reports submitted for the Q1 by specialty and grade and the number of breaches of safe working hours and fined incurred. SL queried the process for closing an exception report. NS outlined the process as well as the questions asked. NS added it was dealt with in real time. SI noted the Guardian of Safe Working had stepped down and queried when a replacement would be appointed. NS stated in the interim the Deputy Medical Director was acting as the Guardian of Safe Working. NS added there had been no applications initially and this was a risk. NS agreed to provide an update at the next meeting regarding the appointment of the Guardian of Safe Working. Members thanked the Guardian of Safe Working who was stepping down. The Board **NOTED** the report. **8.8) Board Assurance Framework (BAF)** CH provided the BAF covering strategic risks and the scores for the period July/September 2023. CH added the display of the scoring had been updated to reflect the rolling 12 month period. SI commented it was good to see the risk scoring moving in the right trajectory. The Board **NOTED** the report.	
9	**2022-23 Annual Submission to NHS England North West: Appraisal and Revalidation** NS provided the annual submission to evidence assurance about the governance arrangements in place in relation to appraisal, revalidation and managing concerns of senior medical staff employed at the Trust during April 2022 to March 2023. NS highlighted upon approval the statement would be signed by the Chief Executive and submitted before 31 October. NS added	

	the annual submission was presented to and ratified by the People Committee in July. The Board **APPROVED** the report.	
10	**Employee Experience Update** DS highlighted the approach taken to understanding employee experience at the Trust and provided an overview of the feedback received from employees about their experience in Q1 and Q2 through the National Quarterly Pulse Survey. SL queried if employee experience information by Division was available and if this differed between each. DS stated the key themes remained the same for each Division and there were no outliers. DS agreed to include an overview of Divisional employee experience in the next report. RM suggested including information in the next report regarding patient experience and if this mirrored similar experience of staff. DS agreed to speak with TF regarding this. LD acknowledged the response rate was 17% across the Trust and it was positive to see the improvement in Q1 and Q2. LD commented it was important to understand the rationale for why staff were not completing the Pulse Survey and if there were any barriers to completion. DS stated mangers and senior leaders were promoting the Pulse Survey to their teams and HR colleagues were also. DS added where there were lower response rates approaches were being taken to encourage more responses. The Board **NOTED** the report.	Debs Smith Debs Smith
11	**Biannual Report for Estates, Facilities and Capital** MS provided assurance on the Estates, Facilities and Capital service provision performance, which align to the strategic objectives of the Trust and the Division. MS also provided an overview of capital works undertaken in 2023/24. LD sought an update on telephony and the impact on patient experience. MS stated an update regarding this was provided to the Council of Governors in July. MS added there was a 12 month improvement project, a review of the directory had been undertaken and the number of extensions reduced. LD also queried the inpatient meal wastage.	

	MS stated the model for inpatient meal provision was being reviewed, noting Clatterbridge produce the meals and were transferred to Arrowe Park. The Board **NOTED** the report.	
12	**Freedom to Speak Up and Fit and Proper Persons** CH and DS provided an update in relation to the outcome of the trial of Lucy Letby and provided assurance in regard to the Trust's focus on patient safety, Freedom to Speak Up (FTSU) and Fit and Proper Persons (FPP). CH stated the Trust's FPP Policy had previously been enhanced to include additional roles beyond what had been specified in the guidance. CH added the new framework was launched on 2 August and the revised policy would be provided at the October meeting. DS stated the FTSU Policy had been updated in 2022 and guidance documents were relaunched by NHSE in 2022. DS added the Board also receive a biannual FTSU Report and work was ongoing to embed a Just and Learning Culture through the new quarterly Lessons Learnt Forum. LD commented as People Committee Chair, she attends the Responsible Officer's Advisory Group, and any concerns are dealt with promptly. LD added the Board receive good assurance through reporting and walkabouts and if there were any concerns the Board would seek further assurance were required. The Board: • **NOTED** the report; and • **ADOPTED** the new framework for Fit and Proper Persons	
13	**NED Engagement Proposals** CH presented a proposal for NED engagement within the Trust, with each NED partnering with a different Division and working with the Divisional Triumvirate to ensure visibility and involvement. HK stated it was a positive mechanism for building relationships with each Divisional Triumvirate and commented managing unannounced visits was important for staff and patient safety. SL welcomed the proposal and commented it was a helpful structure to have in place. SI commented the CQC would welcome this approach by ensuring members of the Board were visible to all staff.	

	LD suggested after conducting each visit verbal feedback could be provided to future Board meetings. LD also suggested if there were specific theme that needed exploring NEDs could also focus on this during each visit. NS stated it was important for any feedback on themes be captured through the usual governance processes. The Board **APPROVED** the proposal.	
14	**Board of Directors' Terms of Reference.** CH presented the Terms of Reference for the Board of Directors for approval. SL queried the delegated responsibilities around financial approvals in line with the Scheme of Reservation and Delegation. CH stated delegated responsibilities and approvals were set out in section 3 and had been mapped against that document. CH agreed to enhance the responsibility around financial approvals, and added the Scheme of Reservation and Delegations was in the process of being reviewed and updated where necessary. NS queried membership in section 5. CH stated the membership was set out in the Constitution and would need to be amended and approved if changes to the membership were required. However, additional layers of requirements could be added to the Terms of Reference if Board felt that was required. CH agreed to provide an update at the next meeting regarding this. The Board **APPROVED** the Terms of Reference, subject to assessing the implications impacting on section 5.	Cate Herbert
15	**Committee Chairs Reports** **15.1 Quality Committee** The Board **NOTED** the report. **15.2 Charitable Funds Committee** The Board **NOTED** the report. **15.3 People Committee** The Board **NOTED** the report. **15.4 Estates and Capital Committee**	

	The Board **NOTED** the report. **15.5 Council of Governors** The Board **NOTED** the report. **15.6 Finance Business Performance Committee** The Board **NOTED** the report.	
16	**Questions from Governors and Public** No questions were raised.	
17	**Meeting Review** Members commented about the comprehensive level of information in the reports that was clear and concise. Members also commented it was positive the Trust was continuing with business as usual despite the disruption caused by industrial action. No other comments were made.	
18	**Any other Business** No other business was raised.	

(The meeting closed at 11:20)

Action Log
Board of Directors in Public
4 October 2023

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
1.	5 July 2023	8.1	To provide a breakdown of the number of open studies to understand the totality and spread	Dr Nikki Stevenson	A verbal update will be provided at the meeting.	October 2023
2.	6 September 2023	7	To provide a presentation showcasing the shortlisted applicants for the Health Service Journal awards	Hayley Kendall	Complete. Scheduled for November meeting.	November 2023
3.	6 September 2023	8.7	To provide an update at the next meeting regarding the appointment of a new Guardian of Safe Working	Dr Nikki Stevenson	A verbal update to be provided at the meeting.	October 2023
4.	6 September 2023	10	To provide an overview of Divisional employee experience in the next report	Debs Smith	Complete. To be provided as part of the next Employee Experience Report.	October 2023
5.	6 September 2023	10	To speak with Tracy Fennell about including patient experience metrics alongside staff metrics in the next report	Debs Smith	Complete. To be provided as part of the next Employee Experience Report.	October 2023
6.	6 September 2023	14	To agree whether specific roles should be added to the Board Terms of Reference	Cate Herbert	Specific reference to financial approvals outlined in the Scheme of Reservation and Delegation has been added. The membership section of the Terms of Reference has been updated with the following: “The Trust chooses to interpret these four constitutional roles to mean the Chief Executive, Medical	October 2023

No.	Date of Meeting	Minute Ref	Action	By Whom	Action status	Due Date
					Director, Chief Finance Officer, and Chief Nurse.”	

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 7**
4 October 2023

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

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

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

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

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

1	**Narrative**
1.1	**Industrial Action Update** The national pay dispute relating to Consultants and Junior Doctors is on-going, resulting in discontinuous strike action taken by both staff groups. There have been several episodes of strike action. In September 2023 the first period of joint strike

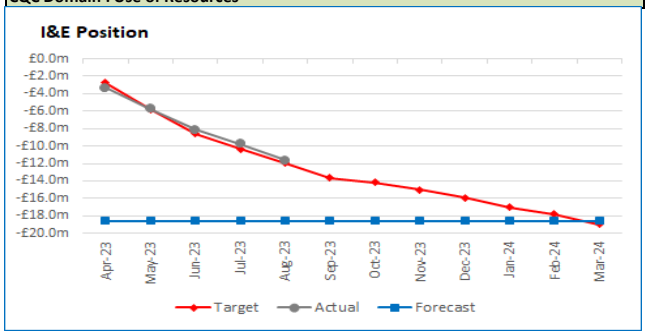
	action took place. Further joint strike action is planned for 2nd October 2023 to 5th October 2023. Planning and mitigating actions take place via the Trust's EPRR route. During the period of Industrial Action the Trust has seen a decrease in elective activity due to the redeployment of staff to other areas in the Trust to ensure patient safety. Activity that did continue was in relation to patients requiring priority treatment, such as maternity services and patients undergoing cancer treatment. In a separate matter, the UNISON industrial dispute relating to retrospective re-banding for Clinical Support Workers continues. In September 2023 a revised offer was made to UNISON. The offer set out a simplified process for those staff members involved in the dispute and was based on an offer accepted by UNISON in another NHS Trust. Unfortunately, UNISON rejected the offer without putting it to its members for a vote. We have again asked UNISON to agree to engaging ACAS to support negotiations. UNISON have declined. Further strike action took place on 27th and 29th September 2023. Strike action relating to the same issue took place in Warrington and Halton NHS Foundation Trust on 28th and 29th September 2023.
1.2	**Clinical Strategy Advisory Group** The Clinical Strategy Advisory Group has been established to provide oversight and governance of the Trust's Clinical Service Strategies and provide the Board of Directors with advice on the Trust's strategic direction in relation to collaboration, developments and partnerships. The Clinical Strategy Advisory Group will meet three times per year and includes clinical leadership and Executives from across the Trust. The Trust held the first meeting of the Clinical Strategy Advisory Group chaired by the Chief Executive, in September 2023. This was well attended and focussed on collaborative working across the Integrated Care System and with system partners, with a number of areas of focus agreed for the coming months. Outputs and recommendations from the first meeting will feed into the next Board of Directors away day.
1.3	**Cheshire and Merseyside Surgical Centre Phase 2 construction** Professor Tim Briggs, the national GIRFT lead, visited the hub as part of the national accreditation programme on 25th September. The visit went extremely well, with formal feedback expected at the end of October. Significant progress has been made with the Cheshire and Merseyside Surgical Centre Phase 2 construction project at Clatterbridge Hospital. This £14.9m construction includes two new operating theatres, recovery unit expansion, education and training facilities and expansion and refurbishment of consultation and pre-operative assessment rooms. The construction project will be completed in late September and handed over the Trust to allow operations to commence from October 2023.
1.4	**Community Diagnostic Centre (CDC) construction**

	The construction of the new Community Diagnostic Centre (CDC) at Clatterbridge Hospital has made significant progress across the summer, with the modular building being delivered to site in early September 2023 and internal fit out commencing in mid-September 2023. The Unit will provide additional MRI and CT scanning facilities and consultation rooms for patients across Wirral, improving access to diagnostics. The £10.3m construction is on track for completion in late March 2024, to allow the Trust to commission and operate the Unit from April 2024.
1.5	**Serious Incidents and Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDORS)** The Trust declared no serious incidents in August. The Serious Incident Panel report and investigate under the Serious Incident Framework to identify learning. Duty of Candour has been commenced in line with legislation and national guidance. There were two incidents reported to the Health and Safety Executive (HSE) in August. All RIDDOR incidents are subject to a local review investigation to ensure appropriate action is taken to prevent a similar reoccurrence.
1.6	**System and Place** **Cheshire and Merseyside Acute and Specialist Trust (CMAST) Board Update** The Leadership Board met on 1 September and considered a number of important issues which included an update on specialised commissioning and programmes of work related to clinical leadership and LIMS. The issues discussed included: • Specialised Commissioning: discussions included an update on a NW review of Women and Childrens' Services in line with national standards and service specifications, and upcoming engagement on the emerging proposals with ICS partners through the autumn and spring. The programme of work currently has a targeted outcome by spring / summer 2024. The Board also received an update on the process of delegation of some functions to ICBs. In the NW a number of functions will be delegated to ICBs, some will be retained by NHSE and a third category will be jointly discussed with all the NW ICBs in a shared forum. CMAST are represented by Alder Hey in these discussions. • ICS Clinical Leadership. A request was made for Trusts to consider funding of clinical time for ICB Transformation Programme funding and bids. The Board recognised the need to engage with the ICB on this and to establish a more sustainable approach however the challenge for Trusts to delivery consistently more system contributions while also delivering heightened levels of efficiency was noted to be a challenge. • A further update on the recommended system approach to Laboratory Information Management Systems (LIMS) and imminent delivery of an OBC for the 5 'host' Trust Boards (WHHT, WUHT, MWL, LUHFT and COCH) to support the next step in a consolidated C&M approach and the proposed delegation of the ITT process to CMAST. • The Board noted the recent conclusion of the Lucy Letby trial and recommended opportunities for future system learning.

	• The Board also noted the development of a quarterly Cancer Alliance report for use by stakeholders. • The Board also received the C&M ICS Activity Summary Repot and C&M ICS Finance Report. The Board's next meeting will include Trust Chairs where business is expected to include a review of programme delivery - year to date.
1.7	**Sharon Landrum wins HPMA Award** Sharon Landrum, Workforce Engagement and Inclusion Lead won the Ward Hadaway Star Award at the Healthcare People Management Association (HPMA) Excellence in People Awards at the Royal Armouries Museum in Leeds on 19 September. The Star Award recognises workforce practitioners that do their role brilliantly well.

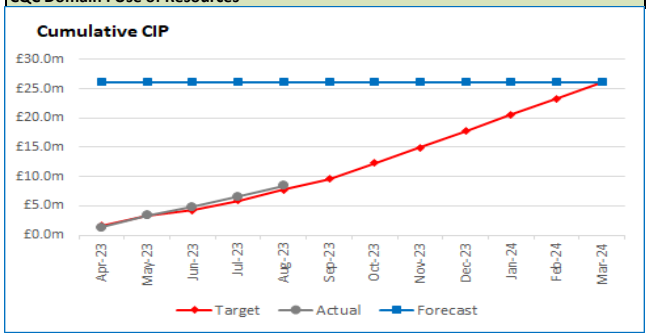
Chief Finance Officer Report

CQC Domain : Use of Resources



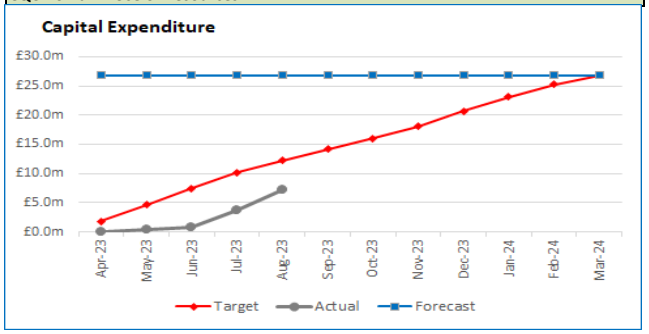
August-23
-£11.64m
Variance
Position better than plan
Target
-£11.99m

CQC Domain : Use of Resources



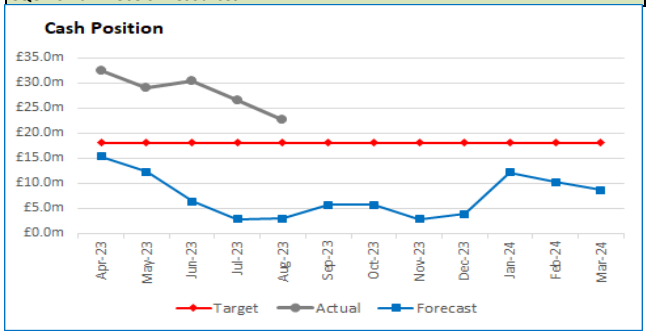
August-23
£8.40m
Variance
Position better than plan
Target
£7.73m

CQC Domain : Use of Resources



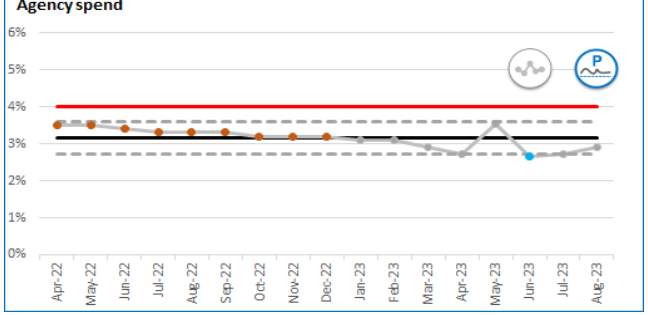
August-23
£7.2m
Variance
Position not worse than plan
Target
£12.2m

CQC Domain : Use of Resources



August-23
£22.6m
Variance
Position better than plan
Target
£18.0m

CQC Domain : Use of Resources



August-23
2.90%
Variance
Position better than threshold
Threshold
3.70%

Chief Finance Officer

Executive Summary

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

As the Trust annual plan is a deficit of £18.6m, management of risk against this plan alone is not sufficient to deliver long-term financial sustainability. The significant financial improvement required for sustainability will be delivered through the medium-term finance strategy approved by the Board in April 2023. Quarterly updates will be provided to the Board on progression of the strategy and the underlying financial position.

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

Statutory Financial Targets	RAG (M5)	RAG (Forecast)	Target Measure
Financial Stability			Achieve in-year financial plan
Agency Spend			Agency spend <= 3.7% of total pay
Financial Sustainability			Medium term financial recovery plan
Financial Efficiency			Variance from efficiency plan
Capital			Capital spend on track and within CDEL limit
Cash			Positive Trust cash balance

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

I&E Position

Narrative:

At the end of August 2023, month 5, the Trust has reported a deficit of £11.6m against a plan of £11.9m, the resultant favorable variance of £0.3m is a deterioration on the M4 position (£0.5m favorable variance). The position assumes £2.4m of income to mitigate lost activity caused by industrial action. This is based on guidance from NHSE and the ICB but is yet to be finalised.

The table below summarises this I&E position at M5:

Month 5	Annual Plan	In Month			Year to Date		
Cost Type	23/24	Plan	Actual	Variance	Plan	Actual	Variance
Clinical Income from Patient Care Activities	£440.1m	£36.4m	£37.2m	£0.8m	£182.7m	£180.2m	-£2.5m
Other Operating Income	£28.4m	£4.5m	£4.4m	-£0.1m	£17.2m	£17.2m	-£0.0m
Total Income	**£468.5m**	**£40.9m**	**£41.6m**	**£0.7m**	**£199.9m**	**£197.4m**	**-£2.5m**
Employee Expenses	-£339.0m	-£30.5m	-£30.9m	-£0.4m	-£147.8m	-£148.1m	-£0.3m
Operating Expenses	-£168.5m	-£13.4m	-£14.0m	-£0.6m	-£69.1m	-£67.8m	£1.3m
Non Operating Expenses	-£5.9m	-£0.5m	-£0.4m	£0.2m	-£2.7m	-£1.6m	£1.1m
CIP	£26.2m	£1.8m	£1.8m	-£0.0m	£7.7m	£8.4m	£0.7m
Total Expenditure	**-£487.2m**	**-£42.5m**	**-£43.5m**	**-£0.9m**	**-£211.9m**	**-£209.1m**	**£2.8m**
Total	**-£18.6m**	**-£1.7m**	**-£1.9m**	**-£0.2m**	**-£11.9m**	**-£11.6m**	**£0.3m**

Key variances within the position are:

Clinical Income – £2.5m adverse variance relates to planned-care activity cancelled due to strike action, capacity at the CMSC not taken up by ICS partners and lower than planned case-mix in Surgery. There is also a reduction in PbR excluded drugs income which is offset within operating expenses.
Operating expenses – The underspend reflects lower than planned surgical capacity and reduced PBR excluded drugs costs but then also estates overspends.
Non-operating expenses – Actual Public Dividend Capital payments are lower than budgeted due to improvements in the initial planning assumptions on which the plan was based.
CIP – CIP remains ahead of profile but with an increasingly challenging target across the year.

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

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

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

Actions:
- Full identification and delivery of CIP schemes.
- Maximising elective capacity and recovery.
- An estates recovery plan is being produced for execs and will be assured through FBPAC.
- Minimising the financial consequences of strike action whilst maintaining the safety of services.

Cumulative CIP

Narrative:
M5 continued our strong performance with £1.8m delivered in month against a plan of £1.8m. The Trust is ahead of the year-to-date plan of £7.7m by £0.7m.

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

Actions:
- Continuation of the Productivity and Improvement Programme.

Capital Expenditure

Narrative:
The Trust has spent £7.2m against a cumulative target expenditure of £12.2m, an underspend of £5m. This is primarily driven by delays in respect of the Urgent and Emergency Care Upgrade Programme (UECUP) and Clinical Diagnostic Centre (CDC) schemes.

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

Risks to position:

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

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

Cash Position

Narrative:

The underlying deficit position places increasing pressure on the Trust's ability to maintain a positive cash balance. At M5 achieving a cash balance of £22.6m has only been possible because not all accrued expenditure from 2022/23 has been transacted as payments and there is continued daily management of working capital balances.

Risks to position:
- Reductions in cash balances place delivery of the Public Sector Payment Policy (PSPP) at risk.
- Failure to achieve the full recurrent CIP plan will negatively impact 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.
- The Trust has registered a formal complaint relating to Barclays Bank with the Finance Ombudsman. Barclays has not transacted requested changes to the approved signatories and this means that the Trust cannot access in excess of £1m of charitable funds for schemes for premature babies, cancer patients and NHS staff.

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.
- Continue to seek resolution of the Barclays Bank complaint directly and through the Finance Ombudsman.
- Provide short-term cash support to ensure charitable funds schemes are not delayed.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
04 October 2023

Item No 8.2

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

Report Purpose and Recommendations

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

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

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

It is recommended that the Board of Directors note the report.

Key Risks

This report relates to these key risks:

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

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

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

Governance journey
This is a standing report to Board

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

2	Planned Care
2.1	**Elective Activity** In August 2023, the Trust attained an overall performance of 92% against plan for outpatients and an overall performance of 86% against plan for elective admissions as shown in the table below:

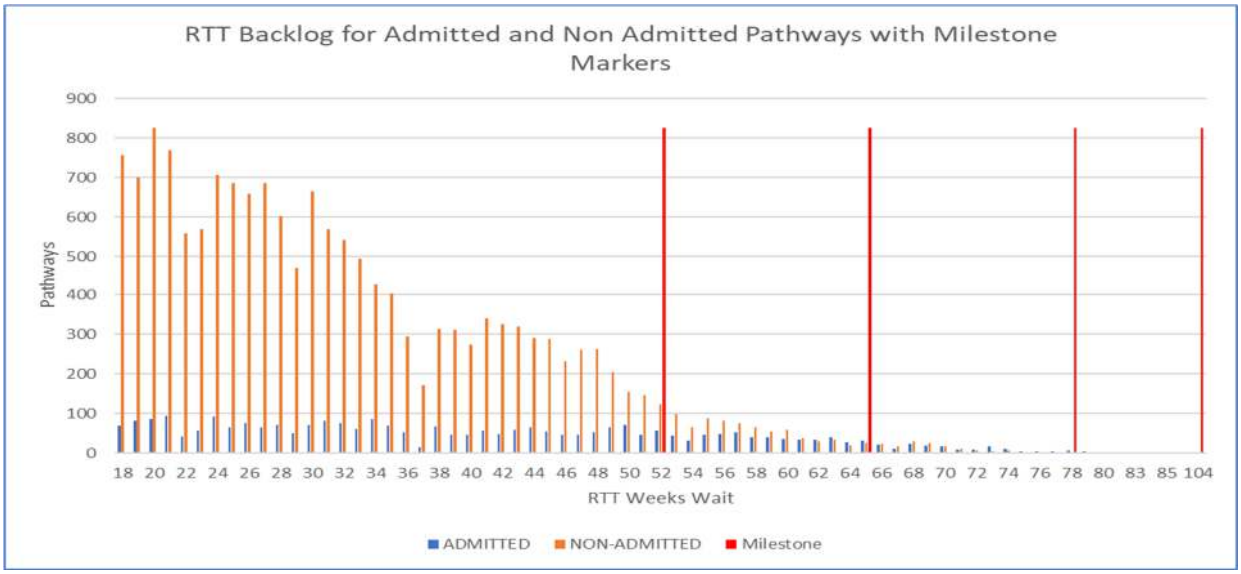
2023/24 Plan Month To Date			
Activity Type	Target for Aug	Actual for Aug	Performance
Outpatient New	12,626	11,436	91%
Outpatient Follow Up	31,842	29,501	93%
Total outpatients	**44,468**	**40,937**	92%
Day case	4,571	3,924	86%
Inpatients	700	624	89%
Total	**5,271**	**4,548**	86%

	The reasons for underperformance against plan relates predominantly to the impact of large scale cancellations for medical industrial action. There are a number of other areas of underperformance relating to the under utilisation of Surgical Centre sessions (relating to another NHS Trust), and two across medical specialities, both of which have recovery plans in place monitored by the Chief Operating Officer.
2.2	**Referral to Treatment (RTT)** The national standard is to have no patients waiting over 104 weeks from March 2023 and to eliminate routine elective waits of over 78 weeks by April 2023 and 65 week waits by March 2024. The Trust's performance at the end of August against these indicators was as follows: • 104+ Week Wait Performance – 0 • 78+ Week Wait Performance - 2 • 65+ Week Wait Performance - 345 • 52+ Week Wait Performance - 1598

- Waiting List Size - there were 43,560 patients on an active RTT pathway which is higher that the Trust's trajectory of 39,312.

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

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



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

2.3 Cancer Performance

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

- 2 Week Waits – performance at the end of August is 90.2% which is below the required standard of 93%. Outliers being Gynaecology and Upper GI. This performance is still positive when benchmarking across C&M.
- Faster Diagnosis Standard (FDS) – was 74.29% in July (latest available data) against a National target of 75% by March 2024, marginal underperformance that is expected to be recovered from next month given the good track record over the last 6 months.
- 31 day treatment numbers - above trajectory and expected to continue.
- 62 day performance id currently above trajectory with 201 patients against a plan of 188. This is expected to recover during September and be back in line with plan:

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

- 104 day long waiters – performance is above trajectory at 48 against a plan of 41 for August:

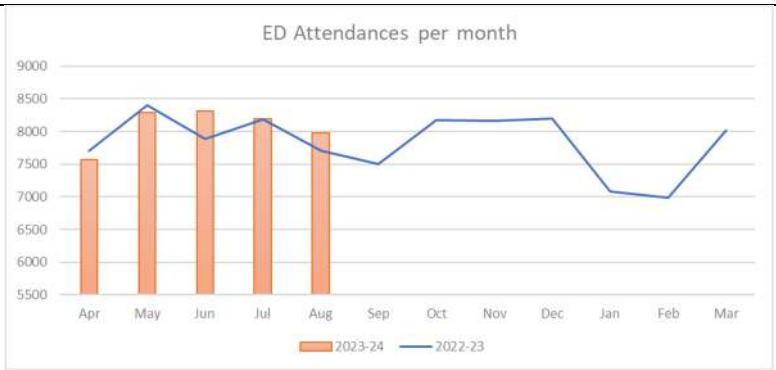
	03/04	10/04	17/04	24/04	01/05	08/05	15/05	22/05	29/05	05/06	12/06	19/06	26/06	03/07	10/07	17/07	24/07	31/07	07/08	14/08	21/08	28/08
Actual 23/24	65	68	59	55	54	49	58	58	64	56	46	48	59	57	57	56	47	42	43	41	45	48
Recovery Trajectory	55	55	55	55	52	52	52	52	52	49	49	49	49	45	45	45	45	45	41	41	41	41
Pre-COVID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

	As with all Trusts across C&M delivery of the 31and 62 day indicators remains a priority but given the increases in demand the recovery of performance against the targets remains a focus for 2023/24. The Trust is performing well when compared to other units but remains focussed on improving waiting times further for patient experience. There continues to be a multi-disciplinary approach to improving the efficiency of cancer pathways and expect that this will support decreased waiting times over the next six months. It should be noted that medical industrial action is significantly impacting the ability to maintain
2.4	**DM01 Performance – 95% Standard** In August 94.28% of patients waited 6 weeks or less for their diagnostic procedure for those modalities included within the DM01. This is against the national standard of 95% and requirement for Trust's to achieve 90% by March 2024. The Trust has managed to achieve compliance for two months and plan to be back on track with the standard in October 2023 following a challenge in CT and ECHO over the summer months. The Trust has commenced providing mutual aid for neighbouring Trusts for patients waiting longer than 6 weeks for diagnostic tests.
2.5	**Risks to recovery and mitigations** The clinical divisions are continuously working through options to reduce the backlogs of patients awaiting elective treatment and progress is being made to improve waiting times for patients. These include the recruitment of new staff, with a focus on consultants, additional activity outside of core capacity to ensure reductions in elective waiting times continue. The major risk to the delivery of the elective recovery programme is medical staff industrial action, given the significant volumes of patients cancelled during this action. On strike days, elective activity is being managed patient by patient to ensure minimal disruption to our patients whilst maintaining safe standards of care across the hospital sites, with a focus to keep patient cancellations to an absolute minimum.

3.0	**Unscheduled Care**
3.1	**Performance** August Type 1 performance was reported at 46.40%, which is below the 4-hour improvement trajectory. The combined performance for the Wirral site was 60.84%:

Type 1 ED attendances:	Type 3 ED attendances:
• 8,192 in July (avg. 264/day) • 7,973 in August (avg. 257 /day) • 2.6% reduction from previous month	• 2,906 in July • 3,012 in August • 3.6% increase from previous month

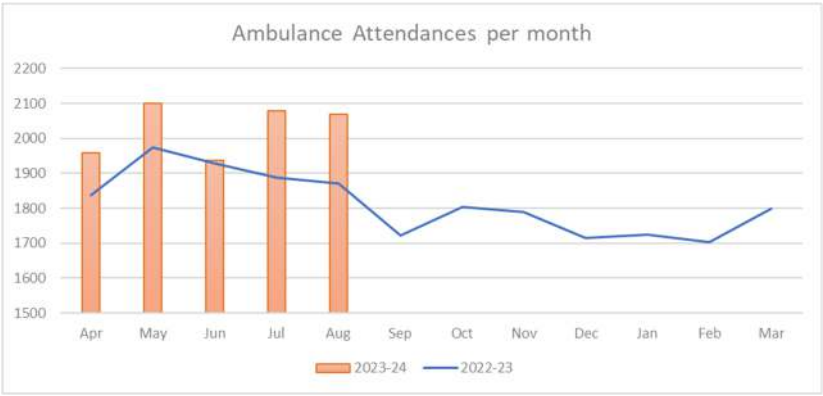
ED Attendances by month 2023/24 compared to 2022/23:



For the month of August, the Trust saw a slight decrease in Type 1 but an increase in Type 3 attendances compared to the previous month, although both figures were higher than the previous year. The increase in ambulances attendances from 2022/23 continues, with a 9% increase in August compared to previous year.

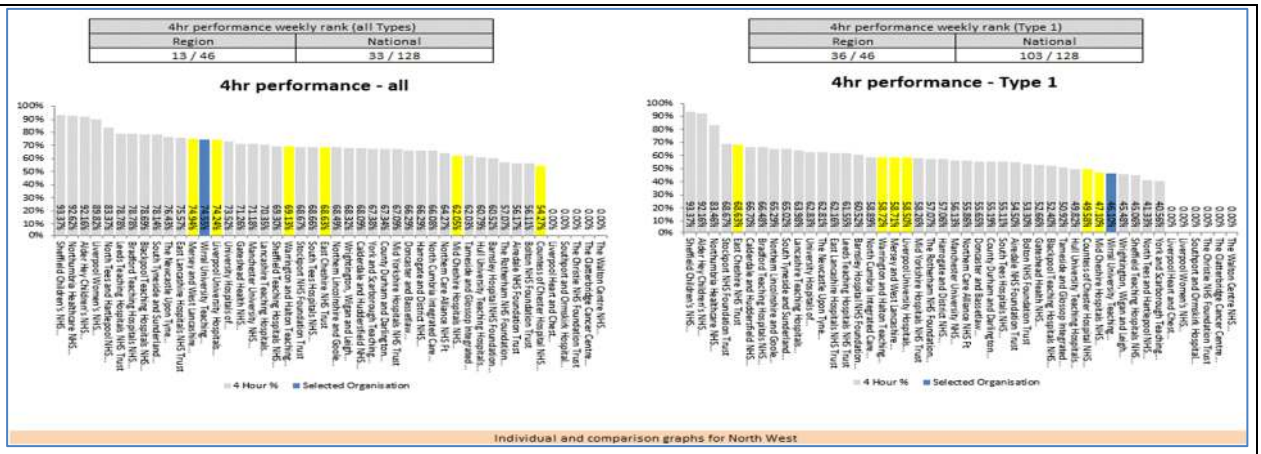
The Trust continues to work in partnership with the Northwest Ambulance Service on improving ambulance handover at the Trust in line with national improvement. However, the increase is linked to an increase in acuity in the region. Increased demand and acuity challenges were noted in August, particularly in Wirral and Cheshire. August saw an increase in corridor waits towards the end of the month as the Ambulance Arrival Zone was at full capacity given the increase in acuity of attendances.

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



Increased pressure in the Trust in August has led to a reduction in performance in the 15 minute handover. Although this remains a challenge, the Trust continues to focus on improvement actions and is working with PLACE to avoid attendance by accessing other services and to increase the Trust's provision of Same Day Emergency Services (SDEC) ahead of winter. In addition, there is a focussed piece of work on regular attenders to look at other options for accessing healthcare.

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

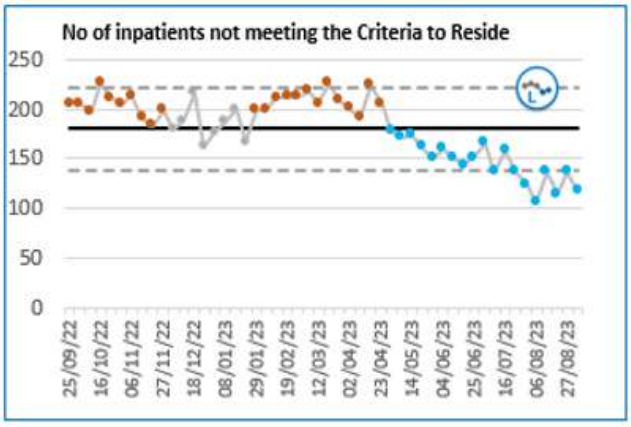


The Trust will continue to focus on improving the achievement of the 4-hour standard for Type 1. The Division continues to work through the action plan in place covering staffing, estates and streamlining clinical pathways and will have a focussed action on engagement with staff to understand the challenges with achieving the standard.

Although the Trust's has seen an improved position with a reduction in the number of patients waiting longer than 12 hours for a bed following a decision to admit, due to demand and poor egress from ED, the number did increase in month. Escalation and clinical care for patients is assured so there is no risk to patients waiting for a bed given care is provided in the ED.

3.2 Transfer of Care Hub development and no criteria to reside

The Transfer of Care Hub continues to see progress with reducing the number of patients with no criteria to reside and the positive results progress through the months. The reduction can be seen in the SPC graph below.



The Trust continues to work with local authorities and Care Homes to improve the transfer of patients from the Trust to a more appropriate place of care for our patients. The meetings have been productive and identified areas for improvement with both the Local Authority and the Trust which are being taken up through the Hospital Wide Flow Improvement Group.

It is anticipated that the expansion of the Home First Service will lead to an increase in capacity before winter, with a focus on patients on Pathway 1. This would support patients to be discharged in a timely manner and prevent the risk of a prolonged stay in the acute setting.

	Following the success of the Care Home engagement sessions, the Trust has planned to hold discussions with Domiciliary Care Providers in September.
3.3	**Mental Health** There has been a sustained increase in the number of patients that remain in ED that require mental health service provision. This increase has presented significant challenges and risks to patients and staff and has now been formally escalated through to the Trust's mental health provider, given the current position is not sustainable. A formal assessment of the current demand and capacity has been produced by the Deputy Chief Operating Officer and Deputy Chief Nurse and demonstrates the urgent need to resolve the current challenges. At present the Trust has not had sight of the additionality provision required for the winter period and remains the highest risk to delivery of ED services during winter. For noting on regular occasions the mental health demand exceeds the formal capacity available ranging from 1 to 6 but mainly at 3 to 4 patients. An urgent response has been requested by the WUTH Chief Executive Officer on mitigations for the current level of risk. The Trust has requested a service review with the need for urgent action from the mental health provider, in response to the current challenges with demand, the increase in pressure expected to see over winter and the next phase of UECUP that is due to start in February 2024. The Trust is working with PLACE to ensure urgent action is taken.
3.4	**Risks and mitigations to improving performance** Mental health demand and the gap in provision for Wirral is the highest risk at present to delivering an effective UEC service to the local population. Industrial action continues to challenge ED capacity and flow across the hospital, however, the Trust continues to ensure robust plans are in place to ensure patient and staff safety is maintained.

4.0	**Conclusion**
	The Board should note the positive improvements in the no criteria to reside position in the hospital and that hospital occupancy remains the focus. Whilst there is a refreshed Hospital Flow Improvement Programme aiming to deliver improved patient pathways and reduced time for patients in ED, there are still challenges with delivering a number of the UEC metrics. Elective recovery remains a strong point and improvements have been seen across the cancer metrics of 62, 104 day waits as well as achievement of the FDS but industrial action remains the highest risk to the elective recovery programme.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.3**

04 October 2023

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

Report Purpose and Recommendations

The last Quarterly Maternity Services update report to the Trust Board of Directors was presented in September 2023, 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 (August 2023) key quality and safety metrics.

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

Updates will be provided on the Trust position: -

- Avoidable Term Admissions in Neonates (ATAIN) Quarter 1 report.
- Maternity Self-Assessment tool.

It is recommended: -

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

Key Risks

This report relates to these key Risks:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes

Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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

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

1	**Perinatal Clinical Surveillance Quality Assurance Report**
	The Perinatal Clinical Surveillance Quality Tool dashboard is included in **Appendix 1** and provides an overview of the latest (August 2023) key quality and safety metrics. The purpose of this report is to provide a monthly update to BOD of key metrics reported to the Local Maternity and Neonatal System (LMNS) and NHSE/I via the Northwest regional Maternity Dashboard which are linked to the quality and safety metrics of Maternity and Neonatal Services. The dashboard is provided for information and whilst there is no indication to escalate any of the metrics to the Board of Directors, it should be noted since there is no longer a Northwest coast regional report being produced WUTH is no longer able to report on the benchmarking against other providers for rates such as stillbirth and neonatal deaths. Assurance can be provided to the Board of Directors this has been escalated via the Local Maternity and Neonatal System (LMNS) for a resolution.

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

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

4	Avoiding Terms Admissions in Neonates (ATAIN)
	The main objectives of Term Admissions quarterly reports is to review the antenatal, intrapartum and immediate postnatal care of neonates that were born after 37 weeks gestation, and were admitted to the neonatal unit. This is line with national guidance for ATAIN. The report is included at **Appendix 3** providing an update on the Trusts position at Quarter 1 and is a requirement of the Maternity Incentive Scheme.

5	Maternity Self-Assessment Tool
	There is a requirement by NHSE and the Care Quality Commission (CQC) to report the Maternity Self-Assessment tool 6 monthly to the Board of Directors included at **Appendix 4**.

6	Conclusion
	The next BOD paper will continue to update on the delivery of safe maternity and neonatal services to include an update on progress with the Maternity Incentive Scheme Year 5. An update will be provided on the Maternity and Neonate Voices Partnership (MNVP) and the annual report will be included in line with the requirements of MIS Year 5.

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	na	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and awaiting national guidance on monitoring processes
	Outlier for rates of neonatal deaths as a proportion of birth	na	No escalation from SCN / LMNS on outlier report; NW region outlier report no longer published and awaiting national guidance on monitoring processes
	Rates of HIE where improvements in care may have made a difference to the outcome	no	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of SI's	no	No serious incidents reported in August 2023 (x 1 on 1 Sept 2023) included to inform Board of Directors
	Progress on SBL care bundle V3	no	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP. SBLv3 launched and will continue to be a key safety action of MIS Year 5 with an additional element 6: mgt of pre-existing diabetes; nataional toolkit available and quarterley meetings with ICB to monitor to be set up; update will be provided via the national toolkit at the next quarterley meeting
	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 inititaive underway for MatNeo
	CQC National survey	no	Included within monthly report
	Feedback via Deanery, GMC, NMC	no	Nil to report this month
	Poor staffing levels	no	All vacacnies have been recruited into for Band 5 and Band 6 midwives; further retirements anticipated later and in the year. New starters have start dates in Sept/Oct 2023. >2% vacancy rate
	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 underway
	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	Externally audited by MIAA. MIS Year 4 submission and declaration submitted by 12 noon on 2nd February 2023; MIS Year 5 published 31/5/2023 and submission cycle will be Feb 2024
	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; no further MCoC teams to be launched until recruited midwives in post
Safety and learning culture	Lack of engagement in HSIB 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 SI's, local reviews, rapid reviews, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress. Trust wide lessons learnt forum has commenced reviewing themes from SI's, complaints and audits
	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
	Never Events which are not reported	no	No maternity or neonatal never events in August 2023
	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 SI 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. Awaiting further guidance re: PSIRF and maternity services
	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/I 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

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
a)	a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.		On review to date all deaths meeting the relevant criteria have been r eported to date.To ensure that the process is robust there is a need to introduce a failsafe/audit process to ensure compliance is consistently being met. Two cases require review (to confirm compliance) therefore need to look at cases 88579 and 88576 (DC to action)See evidence in emails re complaince to date (12/09)
b)	b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.		To further evidence - DC to upload evidence of bereavement care presentation/evidence of parents involvement to MIS folder.
c)	c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 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 to the draft report stage within four months of the death and published within six months.		Standard is currently being met but process to be further improved. To introduce failsafe/audit process to ensure compliance being met (can pull data direct from MBRRACE system) JS - Analyst to action. Same actioned - evidence on mat dashboard moving forwards.
d)	d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.		Robust process established. To upload evidence of quarterly reports to the folder. These are sent to trust mortality group.
Minimum evidential requirement for Trust Board			
	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter from 30 May 2023 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.		Actions are added to the regional lessons learned templates. These templates are shared at audit meetings, added to CG Gems Newsletters and bereavement bulletin. Going forward -
Validation process			
	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.	No Change	Dates for Board paper/s and sign off reviewed. JL to update progress in BoD paper/s.
What is the relevant time period?			
	From 30 May 2023 until 7 December 2023	Note date	
What is the deadline for reporting to NHS Resolution?			
	12 noon on 1 February 2024	Note date	
Technical guidance - FOR INFORMATION PURPOSES ONLY			
Which perinatal deaths must be notified to MBRACE-UK?	Details of which perinatal death 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 a single notification portal (SNP) will be released by NHS England in 2024. Once this is released notifications of deaths must be made through the SNP and this information will be passed to MBRRACE-UK. It will then be necessary for reporters to log into the MBRRACE-UK surveillance system to provide the surveillance information and 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 from 30 May 2023 onwards 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 with plans to have this in place in the forthcoming months		
Are there any exclusions from completing the surveillance information?	If the surveillance form needs to be assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.		
We have informed parents that a local review will take place and they have been asked if they have any reflections 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' perspectives and 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' 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 perspective 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 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 also 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.		
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: • All late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) • All stillbirths (from 24+0 weeks' gestation) • 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 happens when an 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 HSIB. Your local review using the PMRT should be started but not completed until the HSIB report is complete. You should consider inviting the HSIB reviewers to attend these reviews to act as the external members of the review team, thereby enabling the learning from the HSIB review to be automatically incorporated into the PMRT review. Depending upon the timing of the HSIB report completion achieving the MIS standards for these babies may therefore be impacted by time frames beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an HSIB INVESTIGATION is taking place, and this will be accounted for in the external validation process.		
What is meant by "reviews should be completed to the draft report stage"?	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 is meant by "reviews should be completed to the draft report stage"?	A multidisciplinary review team should have used the PMRT to review the death, then the review progressed to at least the stage of writing a draft report by pressing 'Complete review'. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details of assistance in using the PMRT to complete a review.		
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 unit 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 turn-around time in excess of four months?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than four months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death and complete it with the information you have available. When the post-mortem 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 four months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review.		We recognise that there is a delay in PM results due to shortage of perinatal pathologists. This is a recognised issue nationally.
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 external validation 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 30 May 2023 and 7 December 2023 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 validation process?	Trusts should review all eligible deaths using the PMRT as a routine process, irrespective of the MIS timeframe and validation process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 5 MIS requirements.		
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, within the PMRT for user-defined time periods. 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 reviews over a period time which have been completed can be generated within the PMRT by authorised PMRT users for a user-defined periods 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 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.		
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'.		

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
1)	Trust Boards to assure themselves that at least 10 out of 11 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 2023. Final data for July 2023 will be published during October 2023.		Meeting arranged with data analyst to review latest scorecard to confirm current compliance with data submission/s. Standard met for April and June - further work ongoing but no issues anticipated re meeting 10/11 standards for MIS submission.
2)	July 2023 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)		Ethnicity confirmed as datafield evident in records.
3)	Trust Boards to confirm 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:		Await July scorecard review.
4)	Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.		Meeting arranged to conifrm same. MSDS submission before end July - outcome awaited I nOctober.
5)	Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.		Compliance evidenced
Continuity of carer (CoC)	Midwifery Continuity of carer (MCoC) Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable. i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.		Await review of July 2023 scorecard
	These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be		Await review of July 2023 scorecard
Personalised Care and Support Planning (PCSP)			
Minimum evidential 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.		
Validation process			
	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.		
What is the relevant time period?			
	From 30 May 2023 until 7 December 2023		
What is the deadline for reporting to NHS Resolution?		Note dates	
	1 February 2024 at 12 noon	Note dates	
Technical guidance - FOR INFORMATION ONLY			
The following CQIMs use a rolling count across three separate months in their construction. Will my Trust be assessed on these three months? **• 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 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**	No. For the purposes of the CNST assessment Trusts will only be assessed on July 2023 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 "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series, as the national Maternity Services Dashboard will still display these data using rolling counts.		
My maternity service has currently suspended Midwifery Continuity of Carer pathways. How does this affect my data submission for CNST safety action 2?	If maternity services have suspended Midwifery Continuity of Carer (MCoC) pathways, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102. This is a satisfactory response for safety action 2 criteria 3i. If your Trust has suspended all MCoC pathways, criteria 3ii is not applicable and does not need to be completed. If your Trust is continuing with some provision of MCoC pathways, then criteria 3ii does still apply.		
Will my Trust fail this action if women choose not to receive continuity of carer?	No. This action is focussed on data quality only and therefore Trusts pass or fail it based upon record completeness for each metric and not on the proportion (%) recorded as the metric output. If women choose not to be placed onto a MCoC pathway, MSDS submissions should explicitly report that women are not being placed on MCoC pathways in MSDS table MSD102.		
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		
What is the Data Quality Submission Summary Tool? How does my Trust access this?	The Data Quality Submission Summary Tool has been developed by NHS England specifically to support this safety action. The tool provides an immediate report on potential gaps in data required for CQIMs and other metrics specified above after data submission, so Trusts can take action to rectify them. It is intended to be used alongside other existing reports and documentation in order for providers to be able to create a full and detailed picture of the quality of their data submissions. Further information on the tool and how to access it is available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/data-quality-submission-summary-tool		

For the Data Quality Submission Summary Tool, what does "sustained engagement" mean for the purposes of passing criteria 3?	By "sustained engagement" we mean that Trusts must show evidence of using the tool for at least three consecutive months prior to the submission of evidence to the Trust Board. For example, for a submission made to the Board in November, engagement should be, as a minimum, in August, September and October. This is a minimum requirement, and we advise that engagement should start as soon as possible. To evidence this, Trusts should save the Excel output file after running the report for a given month. Three files representing each of the three consecutive months should be provided to your Trust Board as part of the assurance process for the scheme. Note – this only becomes a requirement in the event your Trust fails the requisite data quality for the continuity of carer metrics in criteria 3.		
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/CoCDQ Measures construction' tabs) which accompanies the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/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?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/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		

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?			
	Year 5	**Complaince with Standards**	**Comments / Evidence**
Standard Required			
a)	Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		Revised pathway ratified.
b)	A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.		Atain meetings are multidisciplinary with input/leads from amternity and neonatal services. Action plan/s to be signed off by Director of Midwifery. Action plan from Atain meetings to go to Mat Neo Q&S Assurance Board for sign off in October.
c)	Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.		Revised pathway ratified and is in use clinically.
Minimum evidential requirement for Trust Board			
standard a)	Evidence for standard a) to include: Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.		
Standard b)	Evidence for standard b) to include: • Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. • Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks. 21 • Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. • Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan.		
Standard c)	Evidence for standard c) to include: Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.		
Validation process			
	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form	No Change	
What is the relevant time period?			
	30 May 2023 to 7 December 2023		
What is the deadline for reporting to NHS Resolution?			
	01-Feb-24	Note date	
Technical guidance - FOR INFORMATION ONLY			
Does the data recording process need to be available to the ODN/LMNS/ commissioner?	The requirement for a data recording process from years three and four of the maternity incentive scheme was to inform future capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review. This should be in place and maintained in order to inform ongoing capacity planning of transitional care to minimise separation of mothers and babies. This could be captured through existing systems such as BadgerNet or alternatives such as paper based or electronic systems. These returns do not need to be routinely shared with the Operational Delivery Network (ODN), LMNS and/or commissioner but must be readily available should it be requested.		
What members of the MDT should be involved in Atain reviews?	The expectation is that this is a multi-professional review, as a minimum the care should be reviewed by representation from both maternity and neonatal staff groups. This should include as a minimum; a member of the maternity team (a midwife and / or obstetrician and /or trainee from maternity services) and a member of the neonatal team (neonatal nurse and / or neonatologist/paediatrician and/or trainee from neonatal services).		
We have undertaken some reviews for term admissions to NICU, do we need to undertake more and do all babies admitted to the NNU need to be included?	Maintaining oversight of the number of term babies admitted to a Neonatal Unit (NNU) is an important component of sustaining the Avoiding Term Admissions into Neonatal Units (ATAIN) work to date. The expectation is that reviews have been continued from year 4 of the scheme. If for any reason, reviews have been paused, they should be recommenced using data from quarter 4 of the 2022/23 financial year (beginning January 2023). This may mean that some of the audit is completed retrospectively. We recommend ongoing reviews, at least quarterly of unanticipated admissions of babies equal to or greater than 37 weeks to the NNU to determine whether there were modifiable factors which could be addressed as part of an action plan. A high-level review of the primary reasons for all admissions should be included, with a focus on the main reason(s) for admission through a deep dive to determine relevant themes to be addressed. For example, if 60% of babies are admitted for respiratory problems, then focus on this cohort of babies and complete a deep dive into identified themes or if 40% of babies were admitted with jaundice and 35% of babies were admitted with hypothermia then focus on these two cohorts of babies. In addition to this, the number of babies admitted to the NNU that would have met current TC admission criteria but were admitted to the NNU due to capacity or staffing issues and the number of babies that were admitted to or remained on NNU because of their need for nasogastric tube feeding, but could have been cared for on a TC if nasogastric feeding was supported there should be reported on.		
What do mean by quarterly?	Occurring every three months. This would usually mirror the 4 quarters of the financial year and should cover the period of the MIS 30 May 2023 – 7 December 2023.		
TC audit – what should the audit include and is there a standard audit tool?	An audit tool can be accessed below as a baseline template; however, the audit needs to include aspects of the local pathway. ATAIN-CASE-NOTE-REVIEW-PROFORMA-Revised-2022-converted.pdf We recommend that Trusts refer to the auditable standards included in their local TC pathway guideline/policy.		
How long have the neonatal safety champions been in place for?	Trust Board champions were contacted in February 2019 and asked to nominate a neonatal safety champion. The identification of neonatal safety champions is a recommendation of the national neonatal critical care review and have been in place since February/March 2019.		
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.		
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://improvement.nhs.uk/resources/reducing-admission-full-term-babies-neonatal-units/ https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/Illness-in-newborn-babies-leaflet-FINAL-070420.pdf 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-		

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
	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 Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.		Meeting arranged to further review compliance against the standard. No locum used in last 12 months who hasn't worked at WUTH. Rotas will provide further evidence of this.
	2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in 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		Guidance in place but compliance against standard o be confirmed. Rota's to further evidence. Audit to be undertaken to further support.
	3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality 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. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf		Guidance in place but compliance against standard o be confirmed.
	4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 26 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ 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.		Policy detailing requirements reviewed, updated and ratified. Audit against standards to be undertaken September 2023.
	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)		Anaesthetic cover in place - audit against standard to confirm complaince awaited. Rotas further evidence meeting standard as Obstetrics is prioritised at a cost to other specialities - same to be added to Risk Register for surgery.
	c) Neonatal medical workforce The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).		Gap analysis undertaken and service is partially compliant against standard - Neonatal ODN are aware and are working with service to support complaince. Action plan being developed to mitigate risk and to identify current shortfall in neonatal consultant cover. Action plan resulted in submission of statement of case/business being developed and will be presented to Board in October 2023.
	d) Neonatal nursing workforce The neonatal unit meets the BAPM neonatal nursing standards. If the requirements have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed 27 and include new relevant actions to address deficiencies. If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).		Neonatal nurse staffing reviewed with Neonatal ODN and additional funding has supported the recruitment of additional nursing staff. BAPM Guidance in November 2022 outlines severla roles required for the service. Gap analysis undertaken and paper identifying shortfall to be presented to Board in October 2023.
Minimum evidential requirement for Trust Board			
a)	Obstetric medical workforce 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (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		
b)	2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS.		
c)	3) Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working 28 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 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		
d)	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. 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 Operational Delivery Network (ODN).		
Validation process			
	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.		
What is the relevant time period?			
	Obstetric medical workforce 1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023 Anaesthetic medical workforce Trusts to evidence position by 7 December 2023 at 12 noon Neonatal medical workforce A review has been undertaken of any 6 month period between 30 May 2023 – 7 December 2023 a) Neonatal nursing workforce Nursing workforce review has been undertaken at least once during year 5 reporting period 30 May 2023 – 7 December 2023		
What is the deadline for reporting to NHS Resolution?			
	01-Feb-24		

Technical guidance - FOR INFORMATION ONLY			
	Obstetric workforce standard and action		
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 2023. 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?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.		
Where can I find the documents relating to short term locums?	Safe staffing | RCOG All related documents are available on the RCOG safe staffing page.	For Information	
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 2023 and prior to submission to the Trust Board and have a plan to address any shortfalls in compliance.	For Information	
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?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans implemented to prevent subsequent non -compliance.		
Where can I find the documents relating to long term locums?	https://rcog.org.uk/careers-and-training/starting-your-og-career/workforce/safe-staffing/#:~:text=RCOG%20updates%2C%20guidance%20and%20position%20statements%20on%20safe,indirect%20supervision%20from%20a%20consultant%20who%20is%20non-resident. All related documents are available on the RCOG safe staffing page.		
How can the Trust monitor adherence with the standard relating to Standard operating procedures for consultants and SAS doctors acting down?	Trusts should provide 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 produce 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 assure the Board this is in place and being addressed.		
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?	Trusts cannot self-certify if they have no evidence of any standard operating procedures by October 2023. They can self-certify if they have been unable to achieve appropriate compensatory rest in individual circumstances such as excessive staffing pressure have prevented the doctor accessing this. They should, however, demonstrate that they have an action plan to ensure future compliance and provide assurance to the Board that this is place.		
Where can I find the documents relating to compensatory rest for consultants and SAS doctors?	https://rcog.org.uk/careers-and-training/starting-your-og-career/workforce/safe-staffing/#:~:text=RCOG%20updates%2C%20guidance%20and%20position%20statements%20on%20safe,indirect%20supervision%20from%20a%20consultant%20who%20is%20non-resident. All related documents are available on the RCOG safe staffing page.		
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 element of safety action 4 if consultants have not attended clinical situations on the mandated list?	Trusts can self-certify compliance with safety action 4 provided they have agreed strategies and action plans 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 and RCOG		
	Anaesthesia Clinical Services Accreditation (ACSA) standard and action		
	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.	For Information	
	Neonatal Workforce standards and action		
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.	For Information	
	BAPM "Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021 or "Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018		
	Neonatal Intensive Care Unit (NICU) Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have completely separate cover at each level of staff during office hours and out of hours. Tier 1 Resident out of hours care should include a designated tier one clinician - Advanced Neonatal Nurse Practitioner (ANNP) or junior doctor ST1-3. NICUs co-located with a maternity service delivering more than 7000 deliveries per year should augment their tier 1 cover at night by adding a second junior doctor, an ANNP and/or by extending nurse practice. Tier 2 A designated experienced junior doctor ST 4-8 or appropriately trained specialty doctor or ANNP. NICUs with more than 2500 intensive care days should have an additional experienced junior doctor ST4-8 or appropriately trained specialty doctor or ANNP. (A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative) Tier 3 Consultant staff in NICUs should be on the General Medical Council specialist register for neonatal medicine or equivalent and have primary duties on the neonatal unit alone. NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day. NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal daytime hours. NICUs undertaking more than 4000 intensive care days per annum should consider the presence of three consultant led teams during normal daytime hours.	For Information	
	Local Neonatal Unit Tier 1 At least one resident tier 1 practitioner immediately available dedicated to providing emergency care for the neonatal service 24/7. In large LNUs (>7000 births) there should be two dedicated tier 1 practitioners 24/7 to support emergency care, in keeping with the NICU framework. Tier 2 An immediately available resident tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit e.g. between 09.00 - 22.00, seven days a week. LNUs undertaking either >1500 Respiratory Care Days (RCDs) or >600 Intensive Care (IC) days annually should have immediately available a dedicated resident tier 2 practitioner separate from paediatrics 24/7. Tier 3 Units designated as LNUs providing either >2000 RCDs or >750 IC days annually should provide a separate Tier 3 Consultant rota for the neonatal unit. LNUs providing >1500 RCDs or >600 IC days annually should strongly consider providing a dedicated Tier 3 rota to the neonatal unit entirely separate from the paediatric department; a risk analysis should be performed to demonstrate the safety & quality of care if the Tier 3 is shared with paediatrics at any point in the 24 hours in these LNUs. All LNUs should ensure that all Consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system and no consultant should undertake fewer than 4 'consultant of the week' service weeks annually. No on-call rota should be more onerous than one in six and all new appointments to units with separate rotas should either have a SCCT in neonatal medicine or be a general paediatrician with a special interest in neonatology or have equivalent neonatal experience and training.	For Information	
	Special Care Unit Tier 1 A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. Tier 2 A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit. Tier 3 In SCUs there should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology).	For Information	
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.	For Information	

When should the review take place?	The review should take place at least once during the MIS year 5 reporting period.		
Please access the followings for further information on Standards	BAPM Optimal Arrangements for Neonatal Intensive Care Units in the UK (2021). A BAPM Framework for Practice https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2021 Optimal arrangements for Local Neonatal Units and Special Care Units in the UK (2018). A BAPM Framework for Practice https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018	For Information	
	Neonatal Workforce standards and action		
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) https://www.bapm.org/resources/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: https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/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?	If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to meet the recommendations. The action plan and related progress, signed off by the Trust Board, should be shared with the Royal College of Nursing (doreen@crawfordmckenzie.co.uk) and Neonatal ODN Lead. This will enable Trusts to declare compliance with this sub-requirement.	For Information	

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
a)	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	No Change	Updated review of midwifery staffing completed in 2022 using Birthrate+.
b)	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.		Budget partially identifies budgetary requirements. Presentation of workforce paper to Board in October 2024.
c)	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.		Compliance evidenced.
d)	All women in active labour receive one-to-one midwifery care.		1:1 midwifery care calculated monthly demonstrating compliance.
e)	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.		Midwifery staffing paper to be presented to Board in September/October 2023. This will demonstrate shortfall in meeting staffing requirements for continuity of carer.
Minimum evidential requirement for Trust Board			
	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. o The midwife to birth ratio o 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 status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.		
Validation process			
	Self-certification to NHS Resolution using the Board declaration form		
What is the relevant time period?			
	30 May 2023 – 7 December 2023	Note dates	
What is the deadline for reporting to NHS Resolution?			
	1 February 2023 at 12 noon	Note dates	
Technical guidance - FOR INFORMATION PURPOSE ONLY			
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 details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637 https://www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637	For Information	
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	The Trust can report compliance with this standard if this is a one off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once 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. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to 40 midwives at birth when required, supporting junior midwives undertaking suturing etc. This should not be counted as losing supernumerary status.		
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. As stated above, completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 5 of MIS.	For Information	
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.	For Information	

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
1	Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.		~~Implementation plan agreed within the~~ Division and work ongoing to implement all required standards. Partial complaince met. Detailed report to next Board
2	Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.		No formal arrangement regarding meeting structure with ICB in place. Meeting with LMNS and ICB to be arranged to confirm. Process for discussion c larified by LMNS - NO ICB meetings being introduced as agreed with LMNS who will act as the ICB sign off. Concerns re ICB oversight communicated at meeting on 04/09/23.
Minimum evidential requirement for Trust Board			
1	1) The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. A new implementation tool is now available to help maternity services to track and evidence improvement and compliance with the requirements set out in version three. The tool is based on the interventions, key process and outcome measures identified within each element, and is available at https://future.nhs.uk/SavingBabiesLives Providers should use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. These percentages will be calculated within the national implementation tool.		Previous presentation at Board of 3 Year Single Delivery plan.
2	2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust, using the implementation tool and includes the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. 42 • 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 and neighbouring Trusts.		Progress meetings in place and delegated to LMNS from ICB
Validation process			
1	Self-certification to NHS Resolution using the Board declaration form.	For information	
2			
3			
What is the relevant time period?			
		Note date	
What is the deadline for reporting to NHS Resolution?			
Technical guidance - FOR INFO ONLY		Note date	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: https://www.england.nhs.uk/publication/saving-babies-lives-version-three/ The implementation tool is available at https://future.nhs.uk/SavingBabiesLives and includes a technical glossary for all data items referred to in MSDS Additional resources are in production and will be advertised on this page. Any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to the digital aspects of 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 or from NNAP Online For any other queries, please email nhsr.mis@nhs.net	For information	
What is the rationale for the change in evidential requirements to SA6 in Year 5?	The broad principles that will apply to the implementation of the standards detailed in the Saving Babies' Lives Care Bundle (version 3) are: The use of the implementation tool will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle (for some elements this may only require evidence of a protocol, process, or appointed post). These data will form the basis of compliance with safety action 6 of this version of the maternity incentive scheme. This approach acknowledges the increased number and/or size of elements in this new version of the care bundle.	For information	
What are the indicators for Element 1	Process Indicators 1a. Percentage of women where there is a record of: 1.a.i. CO measurement at booking appointment 1.a.ii. CO measurement at 36-week appointment 1.a.iii. Smoking status** at booking appointment 1.a.iv. Smoking status** at 36-week appointment 1b. Percentage of smokers* that have an opt-out referral at booking to an in-house/in-reach tobacco dependence treatment service. 1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date. Outcome Indicators 1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. 1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks. *a "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). **Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.		
What are the indicators for Element 2	Process Indicators 2a. Percentage of pregnancies where a risk status for Fetal Growth Restriction (FGR) is identified and recorded at booking. (This should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital once the primary data standard is in place.) 2b. Percentage of pregnancies where a Small for Gestational Age (SGA) fetus (between 3rd to <10th centiles) is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital. 2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT). Outcome Indicators 2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). 2e. Percentage of live births and stillbirths >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected.		
What are the indicators for Element 3	Process Indicators 3a. Percentage of women who attend with Reduced Fetal Movements (RFM) who have a computerised Cardiotocograph (CTG). 3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan by the next working day to assess fetal growth. Outcome Indicators 3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT. 3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation. *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation.		

What are the indicators for Element 4	Process Indicators 4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors, and situational awareness. 4b. Percentage of staff who have successfully completed mandatory annual competency assessment. 4c. Fetal monitoring lead roles appointed. Outcome Indicators 4d. The percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 201848.		
What are the indicators for Element 5	Process Indicators 5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU). 5b. Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. 5c. Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. 5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive intravenous (IV) intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. 5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. 5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. 5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. 5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (5a – 5g above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation). To minimise the need for local data collection to support these improvements the formal collection of process measure data can be restricted to the seven interventions listed in this section, the use of volume targeted ventilation and caffeine is recommended but these data are not currently recorded or presented with national datasets. In addition, the gestational limits for some of the indicators and/or the groups studies have been adjusted to align with current nationally collected data (e.g., data on babies born only below 34 weeks or data on the number of babiesreceiving antenatal corticosteroids rather than the number of mothers) Outcome Indicators 5i. Mortality to discharge in very preterm babies (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner). 5j. Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: ✓ Germinal matrix/ intraventricular haemorrhage ✓ Post haemorrhagic ventricular dilatation ✓ Cystic periventricular leukomalacia 5k. Percentage of perinatal mortality cases annually (using PMRT for		
What are the indicators for Element 6	Process Indicators 6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). 6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes. 6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. 6d. Demonstrate compliance with Continuous Glucose Monitoring (CGM) training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. 6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with Diabetic Ketoacidosis (DKA) during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities, and availability of expertise. Outcome Indicators 6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the National Pregnancy in Diabetes (NPID) dashboard (aiming for >95% of women). 6g. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women). Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.		
What considerations need to be made to ensure timely submission of data to evidence implementation and compliance with locally agreed progress measures?	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.		
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. MSDS does not capture all process and outcome indicators given in the care bundle. A summary of this appears in the technical appendix for version 2 of the care bundle, available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/tools-and-guidance 49 Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.		
Would a Trust be non-compliant if <60% of smokers set a quit date?	As stated in SA6, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. The implementation tool will set out the evidence requirement for demonstrating compliance with each intervention. Where element process and outcome measures are listed in the evidence requirement, a performance threshold is recommended, but this is for agreement between a provider and their ICB in view of local circumstances.		
The SBLCBv3 that was published on the 31st May 2023 included a typo in Appendix D Figure 6 with BMI as >18.5kg/m and it is not clear what "other features" mean	This has now been amended and states <18.5kg/m with further clarity provided regarding "other features".		
How do we provide evidence for the interventions that have been implemented?	The evidence requirements for each intervention are set out within the implementation tool. You will need to verify that you have an implemented service locally.		

Will the eLfH modules be updated in line with SBLCBv3?	The SBLCB eLearning for Health modules is currently being updated in line with the latest iteration, Version 3 of the Care Bundle and will include a new section to support implementation of element 6. We have asked for the ultrasound element to be reviewed for its relevance, this was developed separately, and we will make sure the completion of the e learning is focussed on elements 1-6.		

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users			
	Year 5	**Complaince with Standards**	**Comments / Evidence**
Standard Required			
1	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 (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.		Fully complaint and work ongoing to further improve partnership
2	Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.		Action plan in place and recent CQC result has hilighted the outstanding work that is ongoing with the MNVP.
3	Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.		MNVP Chair is a safety champion and attends all meetings.
Minimum evidential requirement for Trust Board			
	Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support. • The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.		
Validation process			
	Self-certification to NHS Resolution using the Board declaration form		
What is the relevant time period?			
	Trusts should be evidencing the position as 7 December 2023		
What is the deadline for reporting to NHS Resolution?			
	1 February 2023 at 12 noon		
Technical guidance - FOR INFORMATION ONLY			
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 local maternity and neonatal system (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.		
When will the MNVP guidance be published?	We are working with our stakeholders to publish the MNVP guidance as soon as possible. As it is not yet published, it is acknowledged that there may not be enough time ahead of the reporting period for full implementation of all the requirements of the MNVP guidance. Where an element of the guidance is not yet fully implemented, evidence must be presented that demonstrates progress towards full implementation within 12 months.		

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?			
	Year 5	**Complaince with Standards**	**Comments / Evidence**
Standard Required and minimum evidential requirement			
1	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.		Training Needs Analysis in place and follows national guidance set out on NHSE Future Platform. Training compliance trajectory on track to meet target. On track
2	The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.		Sign off to be discussed and agreed at Maternity and Neonatal Assurance Board -
3	The plan is developed based on the "How to" Guide developed by NHS England.		See above narrative
Validation process			
	Self-certification to NHS Resolution using the Board declaration form.		
What is the relevant time period?			
	12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review. It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1		
What is the deadline for reporting to NHS Resolution?			
Technical guidance - FOR INFORMATION ONLY			
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A training plan should be in place to implement all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. NHS England » Core competency framework version two Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.		
How will the 90% attendance compliance be calculated?	The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups by the end of the 12 month period.		
Where can I find the Core Competencies Framework and other additional resources?	https://www.england.nhs.uk/publication/core-competency-framework-version-two/ • Includes links to the documents: o Core competency framework version two: Minimum standards and stretch targets o 'How to' guide - a resource pack to support implementing the Core Competency Framework version two o Core competency framework: training needs analysis • NHS England V1 of the Core Competency Framework https://www.england.nhs.uk/publication/core-competency-framework/ • https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth		
What training should be included to meet the requirements of the Core Competency Framework Version 2?	All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. Trusts must be able to evidence the four key principles: 1. Service user involvement in developing and delivering training. 2. Training is based on learning from local findings from incidents, audit, service user feedback, 55 and investigation reports. This should include reinforcing learning from what went well. 3. Promote learning as a multidisciplinary team. Promote shared learning across a Local Maternity and Neonatal System.		
Which maternity staff should be included for Module 2: 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 • 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 Module 3: Maternity emergencies and multiprofessional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric consultants. • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors 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. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota. 56 • 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 5 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 5 compliance • At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff		
Does the multidisciplinary emergency scenarios described in module 3 have to be conducted in the clinical area?	At least one emergency scenario needs to be conducted in the clinical area or at point of care. You need to ensure that 90% of your staff attend a minimum of one emergency scenario that is held in the clinical area, but not all of the scenarios have to be based in a clinical area.		

Which staff should be included for Module 6: Neonatal basic life support?	Staff in attendance at births should be included for Module 6: Neonatal basic life support. This includes the staff listed below: • Neonatal Consultants or Paediatric consultants 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, staff grades and anaesthetic trainees) contributing to the obstetric rota and • 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.		
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 5 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 5 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. A detailed response to this can be found on the CCF futures page.		
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 Local Maternity and Neonatal System (LMNS) to explore sharing of resources. There may be difficulty in resourcing qualified trainers. Units experiencing this 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 by 31st March 2024. As a minimum, training should be delivered by someone who is up to date with their NLS training.		
Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally determined.		
How do we involve services users in developing and delivering training?	Please refer to the “How To” guide for ideas on how to involve service users in the developing and delivering of training. This is Principle 1 of the CCFv2 that recommends MNVP leads could be a member of the multidisciplinary educational teams (MET) to support the planning and selection of themes/local learning requirements to reflect in the training. Ways in which service users and service user representatives can support the delivery of training include with video case studies, inviting service users to tell their story or inviting charitable/support organisations for example local Downs Syndrome groups; LGBTQIA+ Communities; or advocates for refugees. NHS England will be sharing examples of practice over the year and on their NHS Futures page.		
The TNA suggests periods of time required for each element of training, for example 9 hours for fetal monitoring training. Is this a mandated amount of time?	The TNA has been inputted with example times to demonstrate how the calculations are made for the backfill of staff that is required to put a training plan in place. The hours for each element of training can be flexed by the individual trust in response to their own local learning needs.		
Do all the modules within the CCF require a multidisciplinary attendance?	Multidisciplinary team working has an evidence-base and has been highlighted in The Kirkup Report (2022). Key Action 3 (Flawed Team working) was a significant finding with the recommendation to improve teamworking with reference to establishing common purpose, objectives, and training from the outset. It is therefore a requirement that there is a strong emphasis on multidisciplinary training throughout the modules in response to local incidents. The staff groups within the multidisciplinary teams being trained may also vary, depending on the incident/emergency being covered.		

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?			
	Year 5	**Compliance with standards**	**Comments / Evidence**
Standard Required			
a)	All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.		Perinatal Quality Surveillance model (PQSM) enbedded and same is presented to Board monthly however traditionally (up until March 2023) outlier report presented quarterly to Board which is no longer submitted due to no regional dashboard being produced.
b)	Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.		Maternity processes for investigation are embedded in practice eg HSIB and PMRT> PSIRF training taking place prior to September deadline however further work is required to ensure PSIRF process is appropriately implemented into maternity and neonatal service. Trust SI policy to also include reference to maternity and neonatal sprocesses - comments re same submitted prior to ratification of policy. Concerns re PSIRB escalated regionally and nationally by Regional team. Process introduced at WUTH which will be reviewed in December 2023.
c)	Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.		Work ongoing to ensure this process is embedded. Training date arranged for the Quadumvirate in Birmingham this month (Sept 2023).
Minimum evidential requirement for Trust Board			
	Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically: • Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. • Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs). • To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.		
	Evidence for point b) • Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. This should continue to be undertaken quarterly as detailed in MIS year 4. These discussions 60 must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.		
	Evidence for point c): Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include: • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.		
Validation process			
	Self-certification to NHS Resolution using the Board declaration form	No Change	
What is the relevant time period?			
	Time period for points a and b) • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st December 2023. • The expectation is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly. If for any reason they have been paused, they should be reinstated no later than 1 July 2023. • The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • 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 the 17th July 2023. • Evidence that a review of 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) quality meeting by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan. This should continue to be undertaken quarterly as detailed in MIS year 4. Time period for points c) • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available no later than 1 August 2023. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of quarterly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 2 meetings held by 1 February 2024	Note dates	
What is the deadline for reporting to NHS Resolution?			
	By 1 February 2024 at 12 noon	Note date	
Technical guidance - FOR INFORMATION			
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should: - Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board - Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician		
What do we need to include in the dashboard presented to Board each month?	The dashboard can be locally produced, based on a minimum data set as set out in the Board level measures. It must include the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashboard can also include additional measures as agreed by the Trust.		

We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do?	Parts a) and b) of the required standards build on the year three and four requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions 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 of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 1 July 2023.		
We are a Trust with more than one site. Do we need to complete the same frequency of walkabouts 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 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		
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 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.		
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will be involved in the Perinatal Culture and Leadership Programme. As part of this programme every service will be undertaking work to meaningfully understand the culture of their services. This diagnostic will either be a SCORE culture survey or an alternative as agreed with the national NHSE team. It is expected that diagnostic findings are 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.		
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 is 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.		
What are the expectations of the NED and Exec Board safety champion in relation to As detailed in previous years MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provide an opportunity to share their support for the Perinatal Culture and Leadership Programme (PCLP), culture surveys and ongoing support for the Perinatal 'Quad' Leadership teams? / What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal 'Quad' Leadership teams?	As detailed in previous years MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provide an opportunity to share their support for the Perinatal Culture and Leadership Programme (PCLP), culture surveys and ongoing support for the Perinatal 'Quad' Leadership teams? / What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal 'Quad' Leadership teams? safety intelligence, examples of best practice and identified areas of challenge. 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: - Learning from the Perinatal Culture and Leadership Development Programme so far - Plans to better understand their local culture. This will be use of the SCORE culture survey, or suitable alternative as agreed by the national NHS England team. - Updates on the SCORE survey, or alternative when undertaken. - Updates on identified areas for improvement following the local diagnostic, along with any identified support required from the Board. NB, a formal report following this work should be presented at Board by the Perinatal leadership team. Progress with interventions relating to culture improvement work, and any further support required from the Board		
Clarification as to evidence required to meet the standard: Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available.	The NED and Exec Board Safety Champion will be able to evidence they have registered on the FutureNHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace through minutes of a trust board meeting providing confirmation of specific resources accessed and how this has been of benefit. This will be reported as part of the board submission to NHS Resolution.		
How often should the Board Safety Champions be meeting and engaging with the perinatal 'Quad' team?	Meetings between the Board Safety Champion(s) and Quad member(s) should be occurring a minimum of quarterly. We would expect a minimum of two meetings during this reporting period.		
Who is expected to have undertaken the Perinatal Culture and Leadership Quad programme?	The expectation is that the senior perinatal leadership team (the Quad) have undertaken 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 Quad and their work as part of the PCLP, but there is no expectation for them to attend the programme.		

Evidence that a monthly review – Most Trust meet bi-monthly (every other month) & are unable to meet this requirement	A review must be undertaken at every board meeting. If this is bi-monthly that will be sufficient, but this is the minimum requirement.		
Examples have been requested for how to review the data from scorecards	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historic 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 historic themes re-emerged. An example is now available from the MIS team at NHS Resolution, and staff are happy to talk through this process if it is helpful.		
The perinatal quality surveillance model requires review in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife to provide evidence of trust-level intelligence being shared and actions reported on areas of concern. This needs to happen before 1st July and therefore does not give trusts enough time to carry out this review	The expectation is that this process should already be in place as it was a requirement in previous years, with the year 4 requirement for this to be in place by 16th June 2022. However, in recognition of the challenges of embedding a new quality surveillance model the timeframe of the 1st July has been amended to 1st December 2023 to allow additional time for trusts.		
Clarification as to what constitutes a trust board, can sub committees be categorised as a board?	This refers solely to the Board of the trust, and it is a requirement that the board oversees the quality of their perinatal services at every meeting.		

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?			
	Year 5	**Compliance with standard**	**Comments / evidence**
Standard Required			
a)	Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to 7 December 2023.		Compliance evidenced to date.
b)	Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023.		Compliance evidenced to date.
c)	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:		
i	the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and		Compliance evidenced to date.
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.		Compliance evidenced to date.
Minimum evidential requirement for Trust Board			
	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution.		
	Trust Board sight of evidence that the families have received information on the role of HSIB/MNSI and EN scheme.		
	Trust Board sight of evidence of compliance with the statutory duty of candour.		
Validation process			
	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB/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 C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.		
What is the relevant time period?			
	Reporting to HSIB – from 6 December 2022 to 7 December 2023 Reporting period to HSIB and to NHS Resolution – from 6 Decemb		
What is the deadline for reporting the NHS Resolution?			
	By 1 February 2024 at 12 noon		
Technical guidance - FOR INFORMATION			
Where can I find information on HSIB	Information about HSIB and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/ From October 2023 this website will no longer be available and the HSIB maternity programme will be hosted by the CQC. Further details will be circulated once available.		
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 HSIB/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: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [or] • Was therapeutically cooled (active cooling only) [or] • Had decreased central tone AND was comatose AND had seizures of any kind. Once HSIB/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.		
What is the definition of labour used by HSIB and EN?	The definition of labour used by HSIB 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 Trusts from 1 April 2022 going forward	With effect from 1 April 2022, Trusts have been required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed 1 April 2022 going forward they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB//MNSI report with the EN team within 30 days of receipt of the final report by uploading the HSIB/MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB/MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB/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 HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution. There is more information here: ENS Reporting Guide - July 2023 (for Member Trusts) - NHS Resolution		
Cases that do not require to be reported to NHS Resolution	Cases where families have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a HSIB/MNSI investigation where the baby has a normal MRI. • Cases that HSIB/MNSI are not investigating.		
What if we are unsure whether a case qualifies for referral to HSIB/MNSI or NHS Resolution?	For cases from 1 April 2022, if the baby has a clinical or MRI evidence of neurological injury and the case is being investigated by HSIB/MNSI because of this, then the case should also be reported to NHS Resolution via the claims wizard along with the HSIB/MNSI reference number (document the HSIB reference in the "any other comments box"). 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 HSIB/MNSI maternity team (maternity@hsib.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 HSIB/ MNSI as under investigation. They must also complete the EN Report form and attach this to the Claims Reporting Wizard: https://resolution.nhs.uk/wp-content/uploads/2023/05/EN-Report-Form.pdf		
What happens once we have reported a case to NHS resolution?	Following the HSIB/MNSI investigation, and on receipt of the HSIB/MNSI report and MRI report, following triage, NHS Resolution will overlay an reported a case to NHS Resolution investigation into legal liability. Where families have declined an HSIB/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. https://www.legislation.gov.uk/ukdsi/2014/9780111117613/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 HSIB 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 incidents to HSIB/MNSI as soon as they occur and to NHS Resolution as soon as HSIB/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 HSIBMNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and HSIB/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.		

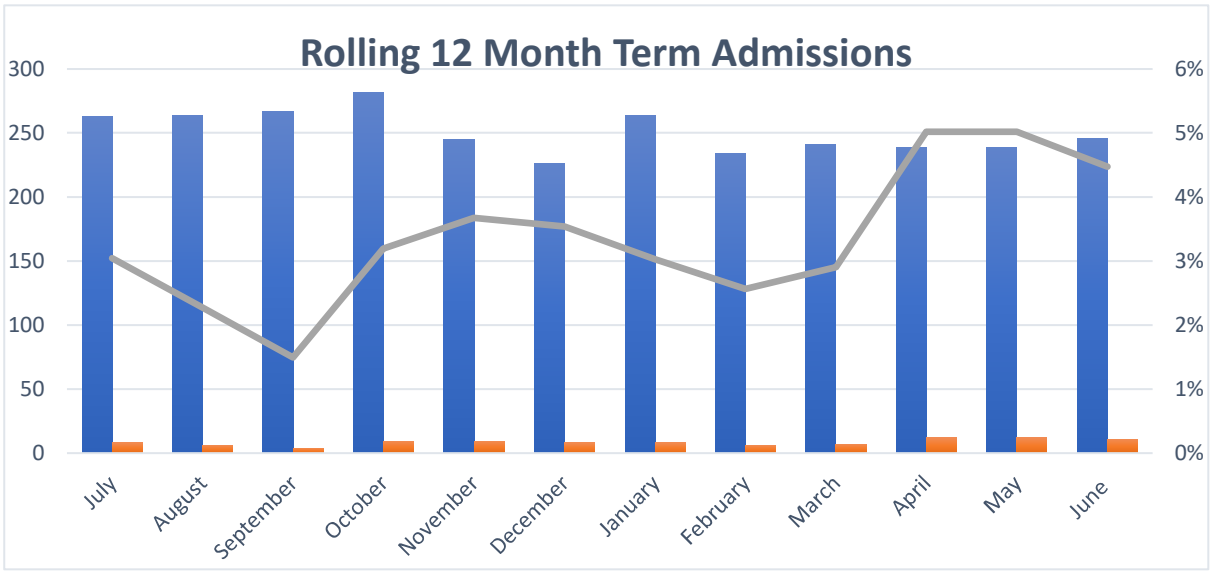
Board of Directors in Public **Item 8.3 – Appendix 3**

04 October 2023

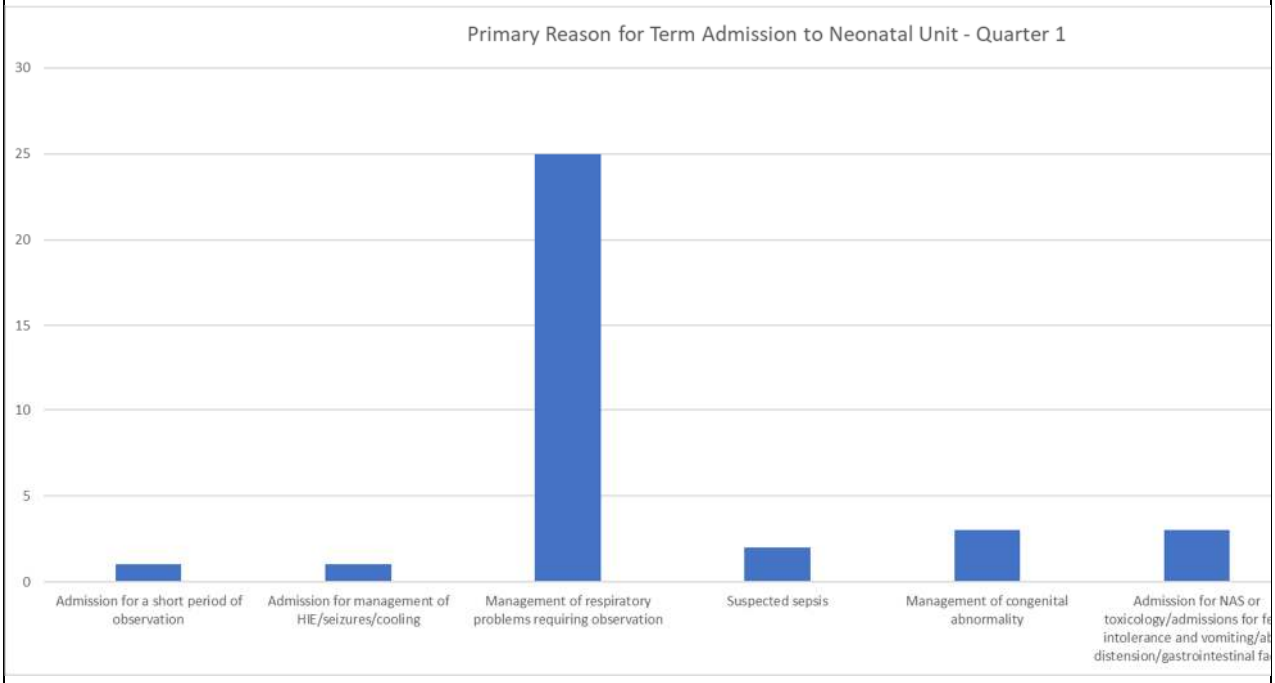
Title	Avoiding Term Admissions into Neonatal Unit (ATAIN), Quarterly Report (Q1)
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and AHPs Director of Infection Prevention and Control
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Information

Report Purpose and Recommendations
The purpose of this report is to provide an update on the Trusts position with Avoiding Term Admissions into Neonatal Unit (ATAIN) It is being presented for information and a requirement of the Maternity Assessment Scheme (MIS) for the Board of Directors to receive regular updates with an update required within the timeline in October 2023. It is recommended that the Board: • Note the report

1	**Narrative**
1.1	**Introduction** The main objectives of Term Admissions Meeting is to review the antenatal, intrapartum and immediate postnatal care of neonates that were born after 37 weeks gestation, and were admitted to the neonatal unit. This is line with national guidance for ATAIN. ATAIN stands for 'Avoiding Term Admissions into Neonatal Units'. It is a programme of work to reduce harm leading to avoidable admission to a neonatal unit (NNU) for infants born at term, i.e. ≥ 37 +0 weeks gestation. A central aim of the work is to prevent harm leading to separation of mother and baby (NHS England 2022 – online). For full terms of reference (TOR) for this meeting please see Appendix 1. As per Terms of Reference the meetings are conducted by a multidisciplinary panel with members from each speciality in attendance (Obstetrics, Neonatology and Midwifery). The meeting is also advertised to all staff with the option to attend either in person or virtually via MS teams. Reviews of these cases are standardised and measurable through the utilisation of a review template. Data from cases is collated on a spreadsheet for ease of thematic oversight. To ensure that all term admissions into neonatal unit have been reported and captured, there is a failsafe process in place whereby the Women's and Children's Clinical Governance Team check neonatal badger net records against the Ulysses incident

	reporting system. If there are any term admissions identified as not been reported via Ulysses these are then inputted retrospectively by the Women's and Children's Clinical Governance Team. This provides assurances that all neonatal term admissions are being reported and allows learning and actions from any reviews to be logged centrally in an auditable format. Learning from ATAIN meetings is shared in a variety of different forums including: on the midwives learning and development group, ward safety huddles, the CG Gems Newsletter, at study days, audit meetings and clinical governance meetings. Actions from ATAIN reviews are captured via Ulysses and also fed into the ATAIN Action Plan. This provides evidence towards the achievement of MIS Safety Standard 3. Quarterly reports generated from ATAIN will be fed back through the Quality Assurance Report and The Obstetrics and Neonatal Clinical Governance Meeting
1.2	**Data Collection: Number of Admissions** Below is a graph containing rolling 12 months of term admissions.  **Key:** **Blue Column** - monthly births. **Orange Column** - Term admission to neonatal unit. a. Primary Reasons for Term Admission to Neonatal Unit

Tabled below are the primary reasons for term admission to neonatal unit for quarter 1. Management of respiratory problems requiring observation was the leading primary

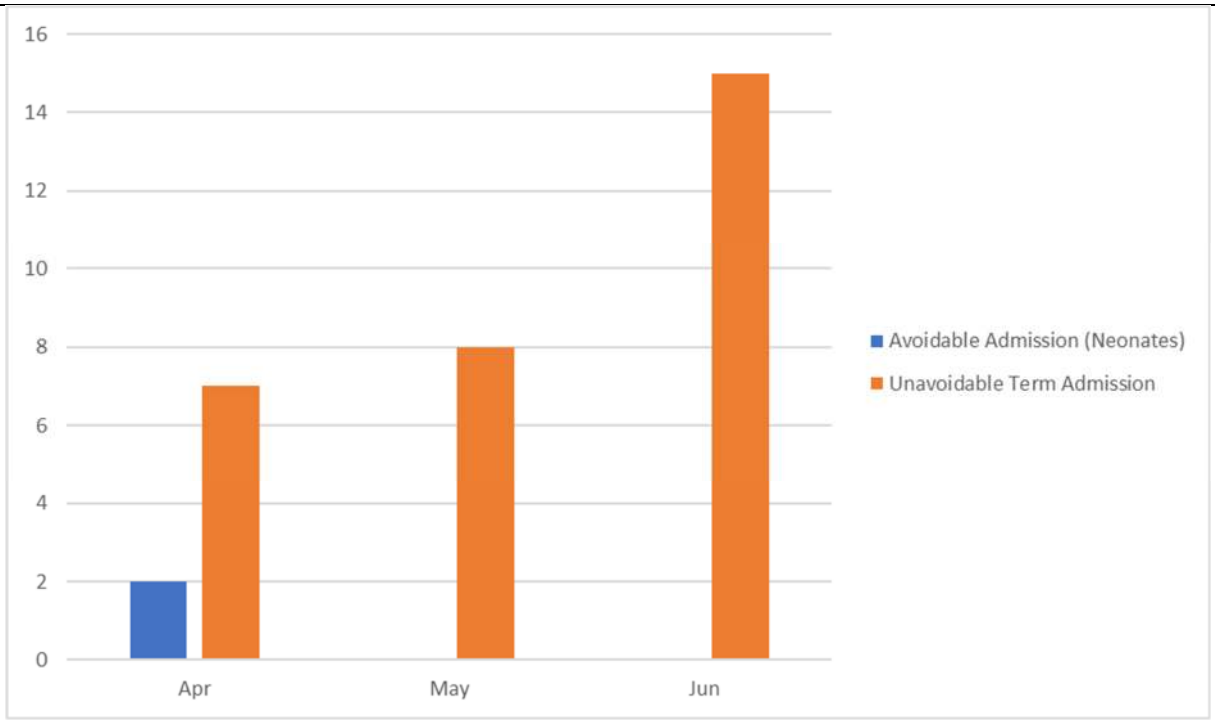


reason for term admission into neonatal unit in Quarter 1 (2023). All of the cases of respiratory problems were deemed unavoidable admissions.

In recent years nationally there has been an increase in caesarean section births, and caesarean section birth can increase the risk of respiratory issues in the newborn. Trust ATAIN leads have recognised that the standardised ATAIN review tool was not capturing the mode of birth, hence adjustments have been made to this to ensure that data on mode of birth is also monitored in relation to term admissions going forward.

Due to a change in national guidance on administration of steroids in the antenatal period, there may be less babies receiving steroids than in previous years. Going forward the team have agreed that this requires audit in order to obtain some further deeper thematic learning on the impact that this change may have had on term admissions to neonatal unit.

<u>Avoidable Versus Unavoidable Term Admissions to Neonatal Unit</u>



Two of the cases were considered avoidable admissions in Quarter 1 2023. One case was a baby that had fell out of bed whilst co-sleeping with the mother on maternity ward. This was deemed potentially avoidable as there was no documented evidence of any conversations surrounding safe sleeping in the immediate postnatal period within the patient records. A 72 hour review was conducted under CIF number 105207 at the time by the ward manager in order to conduct an in-depth review of the case and identify any deeper learning. The ward manager has since added safe sleeping advice to the ward welcome pack. Visual aids were also improved in patient rooms surrounding the importance of keeping beds at a minimum height.

The other case that was deemed potentially avoidable was a case whereby a baby with an NGT developed pneumonia. Again a 72 hour review was conducted for this case. This was reported under CIF number 106611. There were some discrepancies surrounding the documentation and management of the NGT. 72 hour review identified that we were unable to establish whether the pneumonia was caused by issues with the management of the NGT or whether the baby was developing pneumonia anyway. Nevertheless, learning was shared with staff surrounding NGT management and the importance of clear documentation surrounding this.

There was a spike in cases noted in June 2023 therefore there was a thematic review meeting conducted in order to have oversight on these. 2 of the June cases were admitted due to congenital abnormalities, and all cases in month were deemed to be unavoidable

1.3 **Summary of Findings**

All cases of term admissions except 2 were deemed unavoidable for Quarter 1. The potentially avoidable cases were both appropriately actioned for 72-hour review and learning was shared.
The identification of the primary cause for admission to neonatal unit being for the management of respiratory issues has provided direction of audit plans going forward and also in adjustments to the review tool. This may provide us with further insight into the admissions for respiratory issues – in particular as to whether the changes in national

	guidance on steroid admission and increase in caesarean section have had an impact upon respiratory related admissions.

3	Conclusion
3.1	**Summary of Findings** All cases of term admissions except 2 were deemed unavoidable for Quarter 1. The potentially avoidable cases were both appropriately actioned for 72-hour review and learning was shared. Themes from term admissions will continue to be monitored and feed into the ATAIN action plan and also the audit agenda going forward.

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Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups		Organogram updated and reflects this.
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes		Role/s of Triumvirate clear and established
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined		 DOM jd final 2021.docx
		Agenda for change banded at 8D or 9		Went through panel with agreement from Chief Nurse
		In post		
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate		
		Clinical director to executive medical director		Regular Clinical Leads meeting with Medical Director
		DoM to executive director of nursing		Senior Nurse Management Team (SNMT) weekly meeting in addition to monthly 1:1
		General manager to executive chief operating officer		Divisional Director has line of sight to COO.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity services standing item on trust board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, Attain, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions		Board papers can be accessed via the website as public. Quarterly update to Board by DoM. NED Safety Champion feeds back to Board monthly by exception.
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Perinatal Quality Surveillance report goes to Board monthly.
		There should be a minimum of three PAs allocated to clinical director to execute their role		Initially 2 PA's allocated but 3 allocated in new job plan
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team		Clear structure in place
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		Effective relationship with HR Business Partner and Senior HR advisors – Divisional Surgeries in place as well as regular catch ups with DoM.
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate		In place, support at monthly Divisional Surgery

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area		In place from an establishment perspective . Finance attend Divisional Surgeries.
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways		Directorate Manager in post supported by Triumvirate.
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups		Agreed actions from CG meetings, LWSG etc. Evidence of stakeholder engagement throughout
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, e.g. senior midwifery leadership assembly		Senior Midwifery meeting; Consultant meeting; DM meetings in place and chaired appropriately. 7 Features of Safety supported and demonstrated within the Division. Training – MDT reinforces a leadership culture.
		Leadership culture reflects the principles of the '7 Features of Safety'.		
	Leadership development opportunities	Trust-wide leadership and development team in place		L&D Team, top leaders programme, effective managers etc. Leadership Masterclasses supported by the Trust.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Inhouse or externally supported clinical leadership development programme in place		Top Leaders programme, plus externally supported programmes for Midwifery Leaders.
		Leadership and development programme for potential future talent (talent pipeline programme)		Aspiring HOM's programmes completed regionally and nationally.
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		Directory of Learning & Development opportunities further supports professional development.
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy		Organisational structure defines clear lines of accountability from ward to Board.
		Organisational vision and values in place and known by all staff		Trust Values in place, known and respected by the teams. Staff held to account to deliver against the values.
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]		As above.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years		In place and can be evidenced. Regional Strategy being reviewed currently.
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan		In place and can be evidenced.
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MNVP, service users and all staff groups.		MDT approach to strategy production supported. Can be evidenced on request. MNVP Partnership active and meets all requirements of Safety Action in Maternity Incentive Scheme.
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]		
		Maternity strategy aligned with trust board LMNS and MNVP's strategies		Maternity Strategy aligned to that of the National Five Year Forward View and other national objectives.
		Strategy shared with wider community, LMNS and all key stakeholders		Completed but not shared widely as separate regional strategy. Trust strategy available on request by external stakeholders including LMNS..

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		In place – Mr Steve Ryan.
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		Bi-monthly meetings take place. Job description in place and Safety Champion work log updated with key actions.
		All Safety champions lead quality reviews, e.g. 15 steps quarterly as a minimum involving MNVPs, service users, commissioners and trust governors (if in place)		Regular walkabouts from safety champions, 15 steps repeated in December 2022 and included maternity neonatal and Seaccombe birth, Reports available and action plans in progress
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		Can be evidenced as part of public board papers.
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMNS) and MatNeoSIP Patient Safety Networks. [MIS]		Pathway in place and included as evidence for Ockenden.
Multi-professional team dynamics	**Multi-professional engagement workshops**	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality improvement plans		Monthly audit days, multi-professional encouragement to attend.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Record of attendance by professional group and individual		Record of attendee's held by clinical governance teams.
		Recorded in every staff member's electronic learning and development record		Initially not recorded on ESR however project undertaken with Trust L&D Team to pilot reporting onto ESR in Maternity Services which is now in place.
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		Within ESR and on PROMPT, Block C. TNA in place and shared with LMNS with reporting template.
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority		Recently updated as required for Ockenden
		All staff given time to undertake mandatory and job essential training as part of working hours		As Prompt/Block C plus additional 4 hours to undertake K2
		Full record of staff attendance for last three years		Can be produced on request
		Record of planned staff attendance in current year		Can be produced on request
		Clear policy for training needs analysis in place and in date for all staff groups		As above, updated in 2021

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Compliance monitored against training needs policy and recorded on roster system or equivalent		Discussed and monitored monthly at DMB
		Education and training compliance a standing agenda item of divisional governance and management meetings		As above, in addition also monitored at PSQB, DPR etc.
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		Can evidence if required – PROMPT supports this requirement. TNA in place outlining requirements of Competency Framework. Quarterly reporting to the LMNS.
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation		Structure/ line of accountability included in the template of each job description.
		Compliance with annual appraisal for every individual		Sustained >90% consistently. Same monitored through DPR.
		Professional validation of all relevant staff supported by internal system and email alerts		In place within ESR

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		Robust appraisal system which includes objectives
		Schedule of clinical forums published annually, e.g. labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings		In place within monthly clinical governance gems newsletter
	Multi-professional clinical forums	HR policies describe multi-professional inclusion in all processes where applicable and appropriate, such as multi-professional involvement in recruitment panels and focus groups		Stakeholder panels take place in all
	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place		Vales based questions asked at interview
		Multi-professional inclusion in clinical and HR investigations, complaint and compliment procedures		In place
		Standard operating procedure provides guidance for multi-professional debriefing sessions following clinical incidents or complaints		HOT debrief or After Action Reviews based on NHSE template in place
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		As above.
		Schedule of attendance from multi-professional group members available		Record of attendance kept for all debrief sessions
	Multi-professional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multi-professional attendance.		Bi-weekly sessions
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design		Abundance of evidence available on request

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users		Improvement plan in place
	Collaborative multi-professional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, i.e. senior responsible officer and delegated responsibility		QI lead in post. Evidence of QIP – MatNeo collaboration.
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		Evidenced in MatNeo work.
		Identification of the source of evidence to enable provision of assurance to all key stakeholders		Evidenced according to QIP – both locally and regionally.
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access		Divisional Governance team use/store all evidence on shared drive. Same accessible to key staff.
		Clear communication and engagement strategy for sharing with key staff groups		Trust strategy recently updated and staff engagement plan updated within the Division.
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements		Maternity Transformation agenda outlines specific requirements – further supported by NHSE/I regional team and the LMNS.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Weekly/monthly scheduled multi-professional safety incident review meetings		Weekly for all specialities within W&C
	Multi-professional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS		In place prior to Covid, not reintroduced face to face yet, however Teams Safety Summit held x2 regionally.
		Positive and constructive feedback communication in varying forms		SCORE survey previously undertaken. Repeat underway. Staff engagement survey undertaken annually and gaps actioned accordingly. PULSE survey also quarterly
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach		Audit day and CIF learning. Clinical Gems newsletter for sharing.
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]		In place – same led by Governance team, CI's and ADN/HoM. Trust Vision / Values structure supports standards framework.
		Schedule of focus for behavioural standards framework across the organisation		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month		In place as described above
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]		In place as described above
		All policies and procedures align with the trust's board assurance framework (BAF)		
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance		In place within the Division with clear structure / oversight of maternity services.
		Staff across services can articulate the key principles (golden thread) of learning and safety		Participated in the EBC learn and support work – also discussed on PROMPT and Block C.
		Staff describe a positive, supportive, safe learning culture		Evidenced through staff engagement survey / feedback.
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		In place as described above. Maternity Structure Graph 17.04.2023.doc

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support		Maternity Governance structure being reviewed to strengthen and incorporate the workload to deliver MIS Year 5, Three Year Delivery Plan and SBLv3
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		Job descriptions clearly articulate roles and responsibilities.
		Team capacity able to meet demand, e.g. risk register, and clinical investigations completed in expected timescales		Difficult at times however clear Trust oversight process through weekly SI panel.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF		Maternity specific Risk Management Strategy not currently approved; drafted and awaiting GSU – same escalated to LMNS re potential of regional Risk Management Strategy. Trust Risk Management Strategy which includes Maternity has been updated. and is awaiting approval from GSU
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF		BAF updated but does not include Maternity specific risk management strategy although aspects are included in a broader sense that relate to maternity services.
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board		Dashboard in place in addition to Quality Assurance report that goes quarterly to Board of Directors.
		Mechanism in place for trust-wide learning to improve communications		CG Gems, audit day, CIF learning etc,

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication		Perinatal meeting and sharing of joint learning
		Governance communication boards		In place in all clinical areas.
		Publicly visible quality and safety board's outside each clinical area		Q&S Boards outside all areas – visible to the public.
		Learning shared across local maternity system and regional networks		Submit to LMNS and regional attendance at all SIG's to share learning
		Engagement of external stakeholders in learning to improve, e.g. CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups		Trust has number of staff who Chair these regional meetings/groups
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.		Communication Strategy in place and maternity included
		Multi-agency input evident in the development of the maternity specification	N/A due to ICB introduction / PLACE	CCG outlined service specification historically however this will change in April 2022 with the introduction of the ICB. National Maternity Service specification in place.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process		Process in place between CCG/WUTH. LMNS and ICS will lead from April 2022.
		In date and reflective of local maternity system plan		Specification in place and links in with LMNS plan/Deliverables.
		Full compliance with all current 10 standards submitted		Externally audited by MIAA for assurance
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.		Ongoing action plan in place to meet requirements of all ten safety actions. Trust Board updated re progress of same.
		Clear process defined and followed for progress reporting to LMNS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance		LMNS have oversight of compliance with MIS safety actions and were provided with Board declaration forms in 2021.
		Clear process for multi-professional, development, review and ratification of all clinical guidelines		Process in place within the Division.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multi-professional meetings for a rolling 12 months programme.		The process if for MDT discussion at weekly Risk meeting – same are circulated for input from all stakeholders and ratified as per Trust policy.
		All guidance NICE complaint where appropriate for commissioned services		NICE Guidance monitored and gap analysis undertaken with any newly published guidance.
		All clinical guidance and quality standards reviewed and updated in compliance with NICE		Process in place and evidenced.
		All five elements implemented in line with most updated version		
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.		Fully implemented and monitored through LMNS.
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan		On target and monitored as safety action in MIS.
		All four key actions in place and consistently embedded		Evidence to support same.
	Application of the four key action points to reduce inequality for	Application of equity strategy recommendations and identified within local equity strategy		Gap analysis undertaken and action plan in place and completed.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	BAME women and families	All actions implemented, embedded and sustainable		LMNS – ongoing work regarding LMNS requirements. Any amendments to be added to existing plan. Consultant Midwife leading on same.
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE		In post
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs		In post with required number of PA's
		Plan in place for implementation and roll out of A-EQUIP		A-Equip model – Professional Midwifery Advocates in place.
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team		Plan in place which has had further update.
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered		PMA team developed – additional training sourced when required.
		Service provision and guidance aligned to national bereavement pathway and standards		WUTH piloted national pathway and have led / implemented regionally agreed pathway.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity bereavement services and support available	Bereavement midwife in post		1.0wte equivalent. Work ongoing to further progress support to women/families.
		Information and support available 24/7		Butterfly team in place providing support as required.
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities		Butterfly and ApplePip Rooms available 24/7.
		Quality improvement leads in place		Minimal hours currently – same being reviewed in conjunction with MatNeo work.
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation		QIP in place linked to Maternity Transformation Programme.
		Recognised and approved quality improvement tools and frameworks widely used to support services		Evidenced through MatNeo work
		Established quality improvement hub, virtual or otherwise		In place as part of MatNeo but same to be further developed.
		Listening into action or similar concept implemented across the trust		LIA type processes in place – use of MatNeo plans/hub.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Continue to build on the work of the MatNeo Sip culture survey outputs/findings.		Regular meetings with Lead progressing work.
	MatNeo Sip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan		Evidence of same – regional Lead progressing further work with providers.
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)		Plan in place and evidenced. Ockenden evidence further supports this requirement.
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees		Maternity agenda on cycle/s of business. Not on all agendas but is included on relevant meetings including BoD agenda. Decision taken to implement Mat Neo Assurance Board
		FTSU guardian in post, with time dedicated to the role		In place and evidenced.
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post		Lead within Division and L&D leading on work throughout the Trust to further support.
	Human factors training available	Human factors training part of trust essential training requirements		Included in PROMPT training.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Human factors training a key component of clinical skills drills		In PROMPT and is evidenced.
		Human factors a key area of focus in clinical investigations and formal complaint responses		Key point included on template used.
		Multiprofessional handover in place as a minimum to include. Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas e.g., antenatal/postnatal ward/triage.		Handover processes updated and in place further supported by twice daily ward rounds on Delivery Suite.
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern		Evidence of twice daily ward rounds in place. Further evidence supports Ockenden requirements.
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's		In place.
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date		SOP developed and huddles taking place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Audit of compliance against above		Evidence of audit undertaken. No continuous audit process in place – same to be reviewed/updated. Daily audit tool in place
		Annual schedule for Swartz rounds in place		Pre Covid this was in place.
	Trust wide Swartz rounds	Multi-professional attendance recorded and supported as part of working time		Process in place Trust wide.
		Broad range of specialties leading sessions		Inclusive of all Divisions.
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse		Pre Covid this was in place.
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit		Process in place – oversight from Governance team.
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		World Patient Safety Day evidenced learning Trust wide.
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes		In place and story shared.
		In date business plan in place		Cycle of business in place for each meeting.
		Meets annual planning guidance		In place Trust wide.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Comprehension of business/ contingency plans impact on quality. **(i.e. Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively**	Business plan supports and drives quality improvement and safety as key priority		Trust wide processes in place
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups		Compliance with BR+ given current model of care
		Consultant job plans in place and meet service needs in relation to capacity and demand		In place following review
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans		There was disparity in the allocation of PA's – same reviewed as part of the job planning work.
		Business plans ensures all developments and improvements meet national standards and guidance		Operational plan and Strategy supports the MTP and National agenda.
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.		Strategy updated and reflects same.
		Business plans include dedicated time for clinicians leading on innovation, QI and Research		Dedicated research and audit lead. Oversight and Lead for QI. Plans in place to reduce inequalities – further work ongoing to improve same.
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidance's.	**That Employment Policies and Clinical Guidance's meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.		Employment procedures/processes in place.
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.		Complaint with same and evidenced through Consultant Midwife lead on Public Health agenda.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public
04 October 2023

Item 8.4

Title	Learning from Deaths Report (Q1 2023-24)
Area Lead	Dr Nikki Stevenson, Executive Medical Director
Author	Dr Ranjeev Mehra, Deputy Medical Director
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide the Board of Directors with Wirral University Teaching Hospitals (WUTH) Learning from Deaths Report and reports on deaths observed in Q1 23-24.

Key points:

- The medical examiners continue to provide independent scrutiny of all deaths
- The Trust SHMI for the 12 months (April 2022to March 2023) is 105.26 (within expected range)
- HSMR on the latest available data is 95.2 (within expected range)
- The Mortality review group (MRG) meets every 2 weeks and provides scrutiny and assurance around mortality metrics as well as reviewing cases escalated from the Medical Examiner.
- MRG continues to review Telstar Health data (formerly Dr Foster) to benchmark nationally and highlight areas of concern.
- Learning form mortality reviews is fed back to clinical areas by the Divisional Mortality leads.

It is recommended that the Board:

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

Key Risks

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

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	No

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

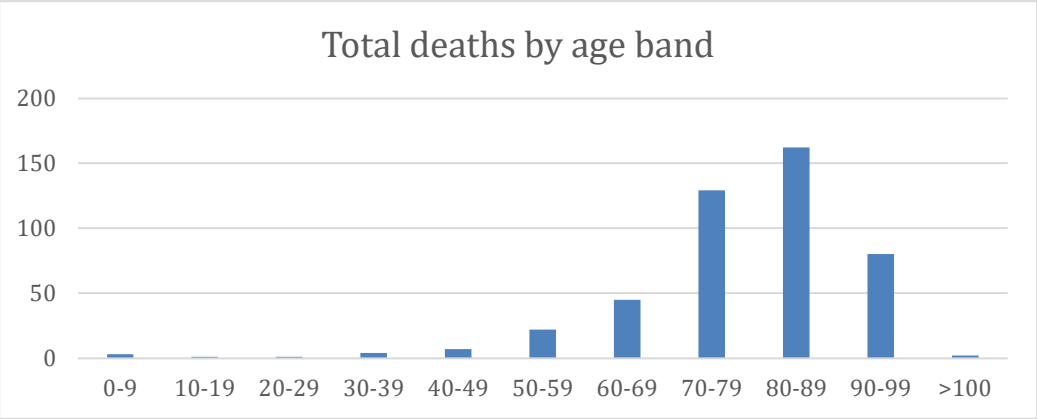
Governance journey
This is a standing report.

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

Patient demographics

There was a total of 456 deaths in Q1 23-24.

As per previous trends most recorded deaths are in the over 60 age group and the vast majority fall into the “White British” Ethnic band.



Ethnicity	Number of deaths
White - British	405
White - Irish	2
White - Any other White background	4
Mixed - Any other mixed background	0
Asian or Asian British - Indian	0
Asian or Asian British - Pakistani	0
Asian or Asian British - Any other Asian background	1
Other Ethnic Groups - Chinese	2
Black/ Black British	0
Not stated/ Not known	42
Total	456

Mortality Comparators

Summary Hospital Level Mortality Indicator (SHIMI)

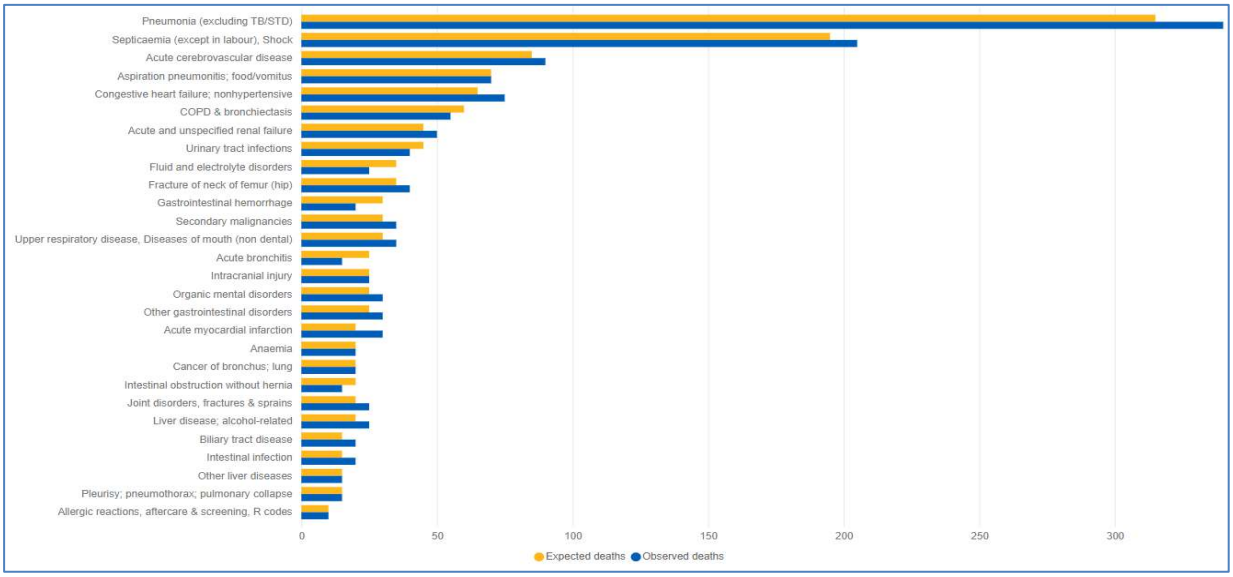
The overall SHIMI for WUTH on the latest available data (12 months to March 2023) is 105.26 which is within the “ as expected” range. SHIMI for WUTH has been relatively stable in the “expected” range for several quarters now.

Factors impacting SHIMI

1. Specific diagnostic groups

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

There are no individual diagnostic groups that were statistical outliers during Q1



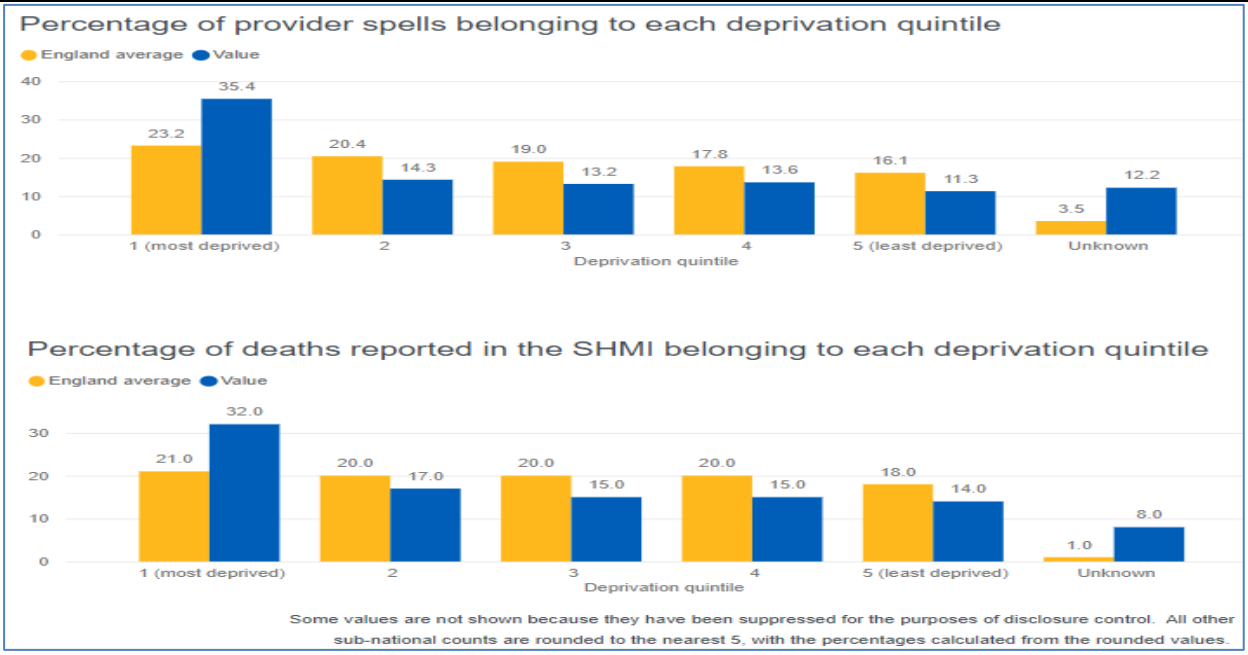
Deaths in the diagnostic group Pneumonia remain higher than expected (more observed deaths than expected deaths) as in previous quarters, but still in the " as expected" range statistically. A audit of 100 pneumonia deaths has recently been completed and showed learning around recording of Curb scores and sputum sample completion. The major finding was that a majority of pneumonia deaths were in patients that were in the last months of life , and in retrospect should have been coded under another diagnostic group.

Deaths in the diagnostic group Sepsis are higher than expected, but not statistically significant, and sepsis remains in the " as expected" range for mortality. A sepsis improvement group has been set up to focus on sepsis care and to drive improvement in KPI's.

Deaths in the diagnostic group Cerebrovascular Disease are higher than expected (when compared to similar stroke units). The Stroke service are currently reviewing this data and comparing with other data sources (SSNAP data).

2. Impact of deprivation on SHIMI

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



3. Palliative care coding

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

Hospital Standardised Mortality Ratio (HSMR)

The HSMR for the latest available is 95.2. This is in the expected range, and slightly lower than the previous quarter.

Mortality Dashboard

The medical examiners (MEs) continue to maintain scrutiny of all WUTH adult deaths and escalate cases where potential concerns are identified.

24 cases escalated by the ME to the mortality review group have undergone a review during Q1. These cases have been reviewed using a revised PMR template (cases) or via the Royal College of Physicians Structured Judgement review tool (cases). One case was escalated to the Serious Incident Review Panel and subsequently declared as a Serious Incident. This will be reviewed as per SI process and a SI report will be signed off by the SI panel in due course.

MRG have reviewed a random selection of deaths that were not referred by the ME office. This is to provide assurance around the ME processes. A total of 26 deaths were reviewed in Q1 (5%) using the PMR template. None of these cases identified any cause for concern.

Summary of all Adult in patient deaths and case reviews							
	Total Adult In-patients Deaths	Deaths reviewed by ME service (%)	Total No of cases escalated for review by Medical Examiner	Total No of SJR's opened from cases escalated	Serious Incidents opened following MRG review	Quality assurance PMR's opened	Total number of case reviews opened by MRG
Q2 (22-23)	446	100%	19	4	2	26	45
Q3 (22-23)	533	100%	19	6	0	22	41
Q4 (22-23)	503	100%	17	2	1	15	32
Q1 (23-24)	456	100%	24	10	0	26	50

During Q1 11 mortality reports were discussed at MRG with the grading as below.

Grading of Adult Care and avoidability following review in Q1 (Includes reviews opened in previous quarters)				
	Grade 0	Grade 1	Grade 2	Grade 3
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues, definitely affected outcome
	1	10	0	0

During Q1 10 deaths were reported in patients identified as having a Learning disability. All of these deaths will be reviewed using the SJR template and have also been referred for external review through the national LeDeR programme.

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

Perinatal and Neonatal deaths

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

During Q1 there were 2 neonatal deaths. There was also one paediatric death. All these cases will undergo a PMRT review as per the usual process. Internal review through Si panel has not identified any cause for concern in these cases.

	Stillbirths	Neonatal Deaths	Paediatric deaths	Cases sent for PMRT review
Q2 (22-23)	0	1	0	1
Q3 (22-23)	1	4	1	6
Q4 (22-23)	2	1	0	3
Q1 (23-24)	0	2	1	3

Outcome of PMRT reviews reported in Q1				
	Grade A	Grade B	Grade C	Grade D
Description	No care issues	Care issues, would not have affected outcome	Care issues, may have affected outcome	Care issues,likely affected outcome
		0	0	0

Learning Identified from PMRT reviews.

There were no PMRT case reports finalised during Q1

Learning identified through review of mortality reviews during Q1

Learning for mortality is derived from 3 main sources

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

Specific learning and themes identified during Q1 as well as actions taken are listed in the table below.

Learning theme	Source	Action taken
Medication delays and errors	Mortality reviews	All cases are feedback via the Medications safety Pharmacist (who is a member of MRG) to relevant areas and MSOP committee that has oversight of medication safety across the Trust.
Poor documentation/ copying and pasting of medical documentation	Mortality reviews	Specific examples feedback to relevant clinical teams. General themes feedback to Divisions through Divisional Mortality leads.
Poor documentation	Mortality reviews	Continues to be a theme, although less frequent than in previous quarters. All these cases are

around MCA and DNACPR decisions		feedback to individual teams and the Trust CPR committee. MCA training and has been refreshed across all areas recently and audits of DNACPR forms strengthened to ensure better compliance.
Confusion around swabbing requirements for Covid-19	Mortality reviews	Guidance has been re-circulated to all clinical areas

External Benchmarking Data

Dr Telstar Health (Dr Foster) Data

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

There were no CUSUM alerts identified in Q1.

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

Diagnostic Group	Quarter Highlighted	Alert type	Work undertaken	Outcome/ Learning
Pneumonia	Q2 22-23	High SHIMI	Case note audit	Audit completed. Only 30% of patients in this group were felt to have pneumonia. Issues identified around sputum culture and smoking cessation advice. Audit to be discussed at Respiratory team meeting and action plan to address issues identified will be developed.
Secondary Malignancy	Q3 22- 23	High SHIMI	Case note audit	Ongoing
Non-Infective Gastroenteritis	Q4 22-23	High SHIMI	Case note review	Small numbers, but 6 of the 7 cases had different final diagnosis. No concerns in care identified.

AQUA

The AQUA mortality report for Q1 was not available at the time of completing this report.

2	Implications
2.1	**Patients** • Reviewing patient outcomes, such as mortality, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care.
2.2	**People** • No direct implications for staff, though learning supports a culture of openness, and good patient care.
2.3	**Finance** • No implications
2.4	**Compliance** • Independent scrutiny from Medical Examiner supporting good practice. This report also is provided in line with National Guidance on Learning from Deaths.

3	Conclusion
3.1	Mortality indicators (SHIMI and HSMR) are both within the “as expected” range. There are no individual diagnostic groups that are statistical outliers during Q1, although Pneumonia, sepsis and deaths due to cerebrovascular disease have more observed deaths than expected. The Medical Examiner continues to provide scrutiny for all death and helps to identify learning and escalate concerns to the Mortality Review group. The Mortality Review Group continues to meet every 2 weeks to review appropriate cases and ensure learning themes and trends are captured and fed back to clinical areas. Benchmarking form Telstar Health has not identified any areas of concern during Q1

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 8.5**

04 October 2023

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

Report Purpose and Recommendations

This report provides a summary of the Trust's performance against agreed key quality and performance indicators to the end of August 2023

It is recommended that the Board:

- notes performance to the end of August 2023

Key Risks

This report relates to the key risks of:

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

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

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

Governance journey

Date	Forum	Report Title	Purpose/Decision
April 2022	Board Seminar – Development Session	Proposed 2022/23 Quality and	Discussion on results of review and agreement on next steps

		Performance Dashboard	
April 2023	Executive Director Team	Proposed Integrated Performance Report	Further discussion on metric inclusion and format of report
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:**

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	4	3	7
Effective	0	1	1
Caring	3	1	4
Responsive	4	18	22
Well-led	2	1	3
Use of Resources	5	0	5
All Domains	18	24	42

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

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 - September 2023

Approach

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

Summary of latest performance by CQC Domain:

CQC Domain	Number achieving	Number not achieving	Total metrics
Safe	4	3	7
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Responsive	4	18	22
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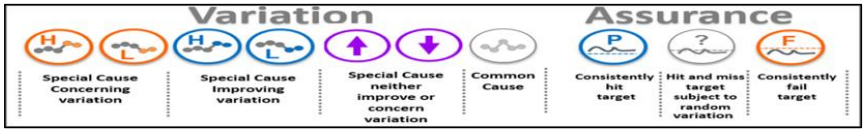
All Domains	18	24	42

Key to SPC Charts:



Issues / limitations

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

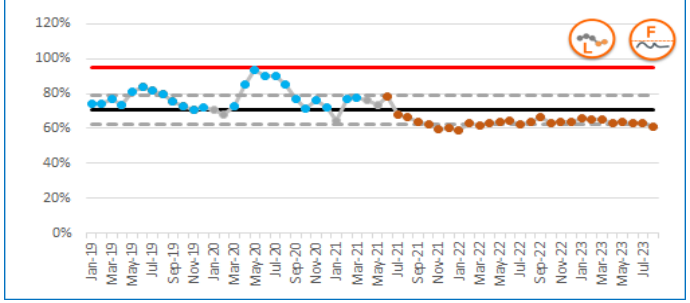
Changes to Existing Metrics:

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

Chief Operating Officer (1)

CQC Domain : Responsive

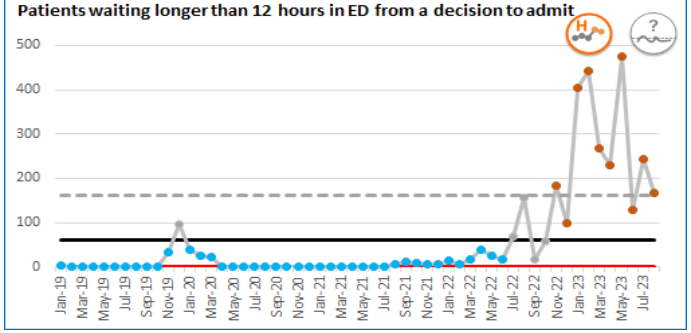
4-hour Accident and Emergency Target (including APH UTC)



August-23
60.8%
Variance Type
Special cause variation - concerning
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

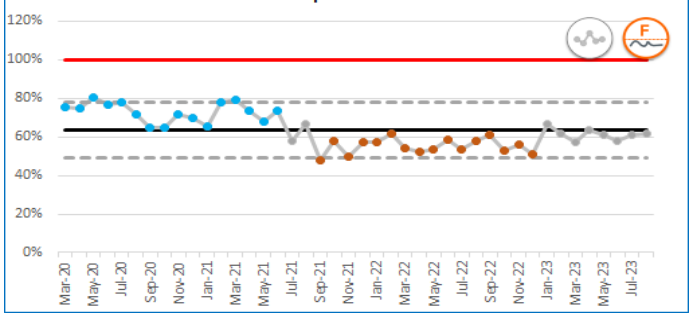
Patients waiting longer than 12 hours in ED from a decision to admit



August-23
167
Variance Type
Special cause variation - concerning
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

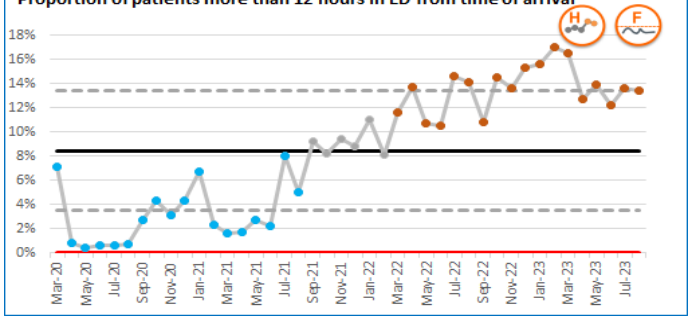
Time to initial assessment for all ED patients - % within 15 mins



August-23
61.7%
Variance Type
Common cause variation
Threshold
100%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

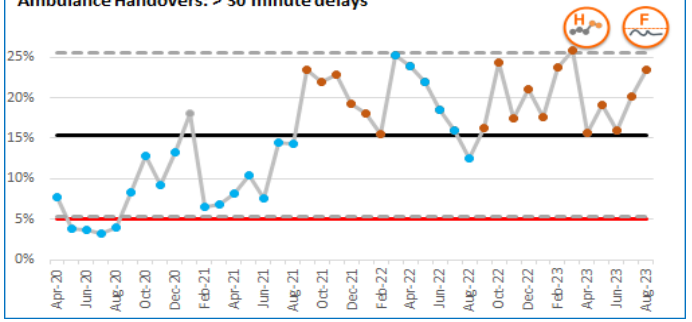
Proportion of patients more than 12 hours in ED from time of arrival



August-23
13.4%
Variance Type
Special cause variation - concerning
Threshold
0%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive

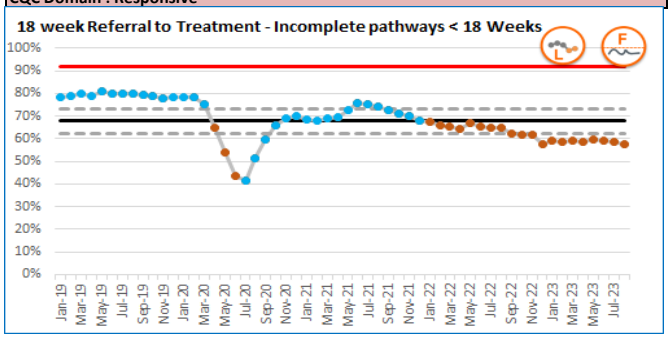
Ambulance Handovers: > 30 minute delays



August-23
23.5%
Variance Type
Special cause variation - concerning
Threshold
≤5%
Assurance
Performance consistently fails to achieve the target

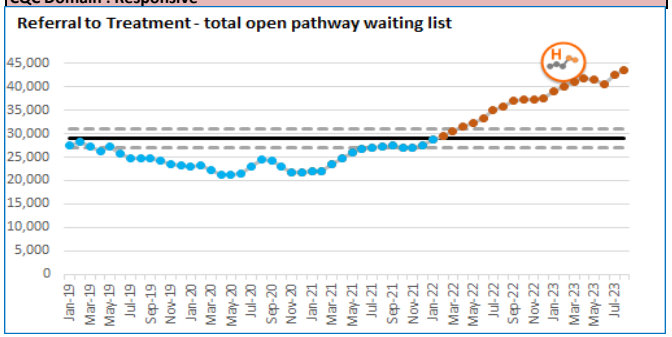
Chief Operating Officer (2)

CQC Domain : Responsive



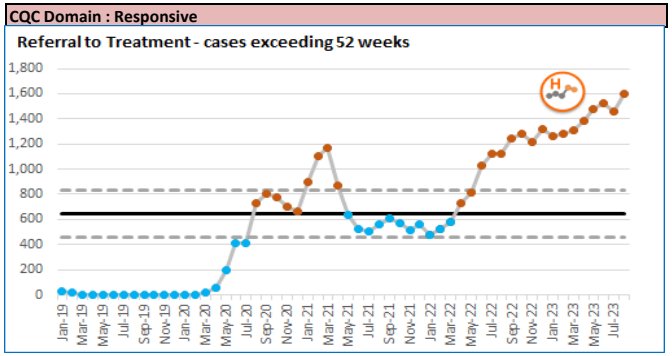
August-23
57.82%
Variance Type
Special cause variation - concerning
Threshold
≥92%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Responsive



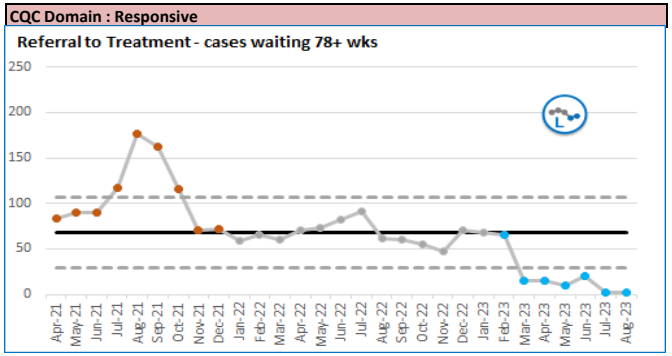
August-23
43560
Variance Type
Special cause variation - concerning
Threshold
≤ 39104
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



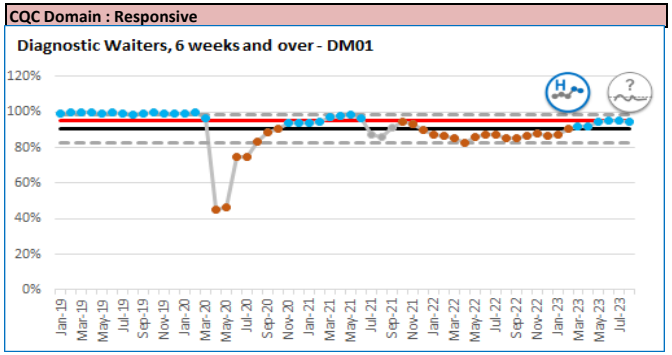
August-23
1598
Variance Type
Special cause variation - concerning
Threshold
1330
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive



August-23
2
Variance Type
Special cause variation - improving
Threshold
0 (exc choice / complex)
Assurance
Trajectory target not appropriate for SPC Assurance reporting

CQC Domain : Responsive

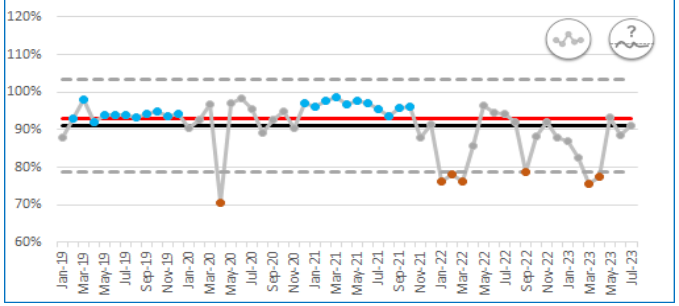


August-23
94.2%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Operating Officer (3)

CQC Domain : Responsive

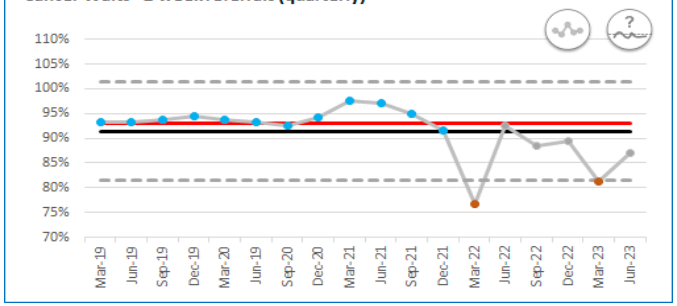
Cancer Waits - 2 week referrals (monthly)



July-23
91.0%
Variance Type
Common cause variation
Threshold
≥93%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

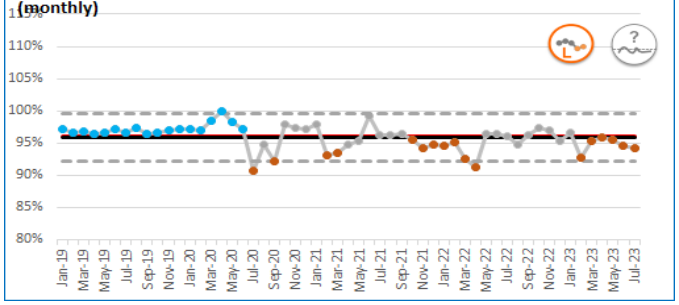
Cancer Waits - 2 week referrals (quarterly)



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

CQC Domain : Responsive

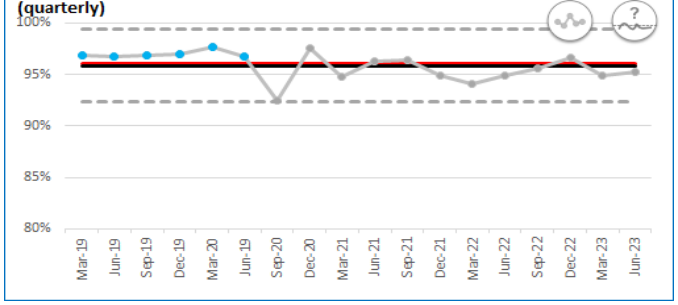
Cancer Waits - % receiving first definitive treatment < 1 mth of diagnosis (monthly)



July-23
94.2%
Variance Type
Common cause variation
Threshold
≥96%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

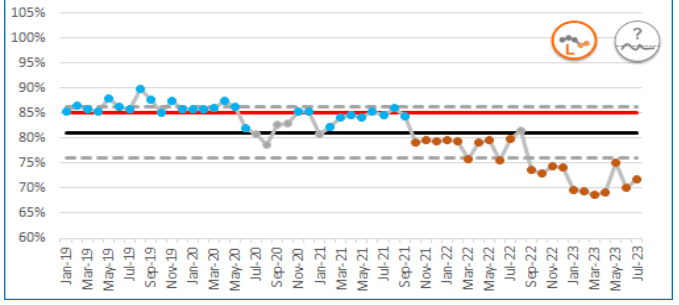
Cancer Waits - % receiving first definitive treatment < 1 month of diagnosis (quarterly)



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

CQC Domain : Responsive

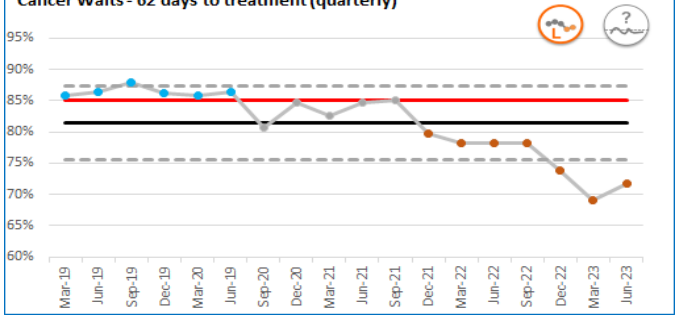
Cancer Waits - 62 days to treatment (monthly)



July-23
71.8%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive

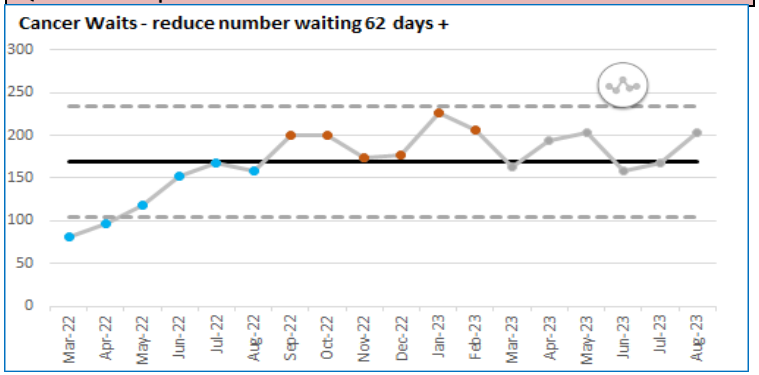
Cancer Waits - 62 days to treatment (quarterly)



June-23
71.7%
Variance Type
Special cause variation - concerning
Threshold
≥85%
Assurance
Hit & miss target subject to random variation

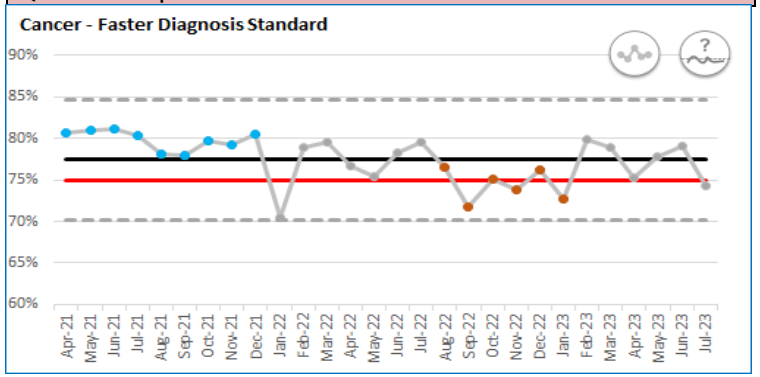
Chief Operating Officer (4)

CQC Domain : Responsive



August-23
203
Variance Type
Common cause variation
Threshold
100
Assurance
Trajectory target not appropriate for SPC Assurance reporting

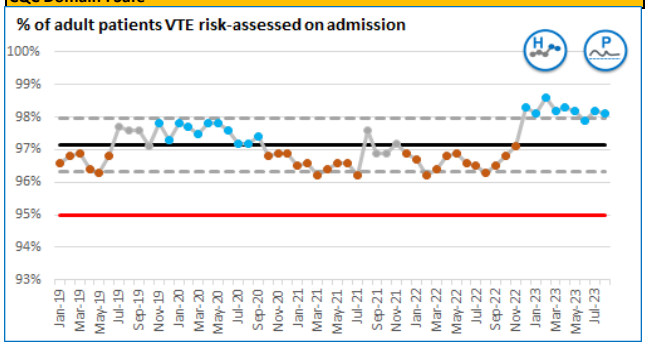
CQC Domain : Responsive



July-23
74.3%
Variance Type
Common cause variation
Threshold
≥75%
Assurance
Hit & miss target subject to random variation

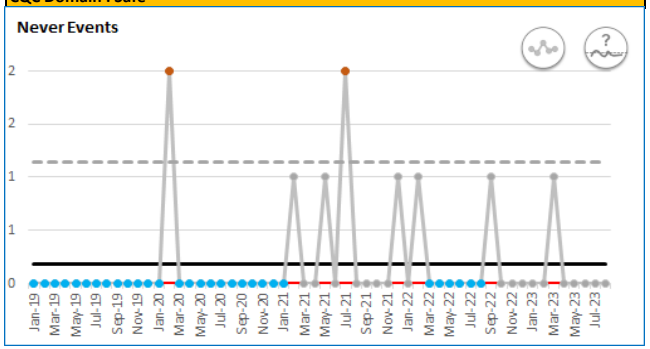
Medical Director (1)

CQC Domain : Safe



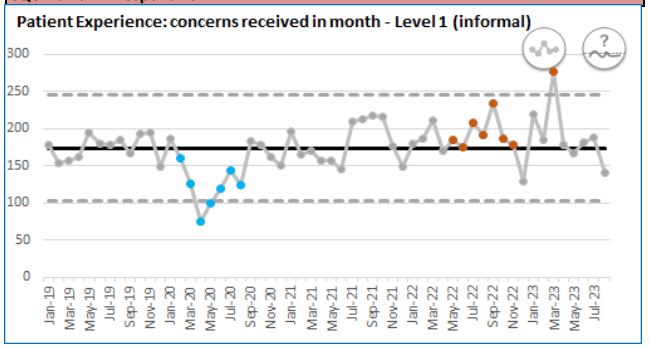
August-23
98.1%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Performance consistently achieves the target

CQC Domain : Safe



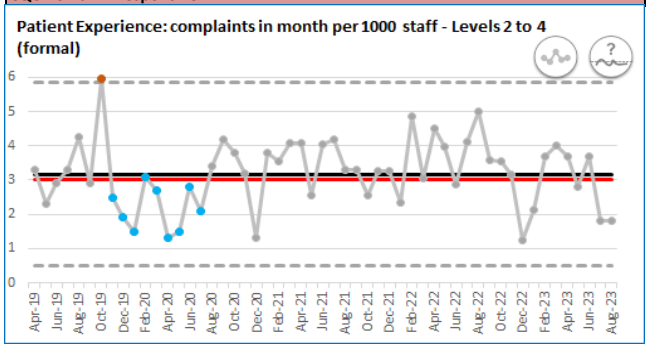
August-23
0
Variance Type
Common cause variation
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



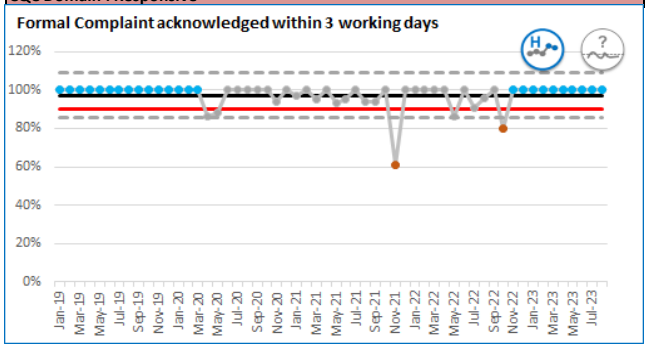
August-23
141
Variance Type
Common cause variation
Threshold
≤173
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



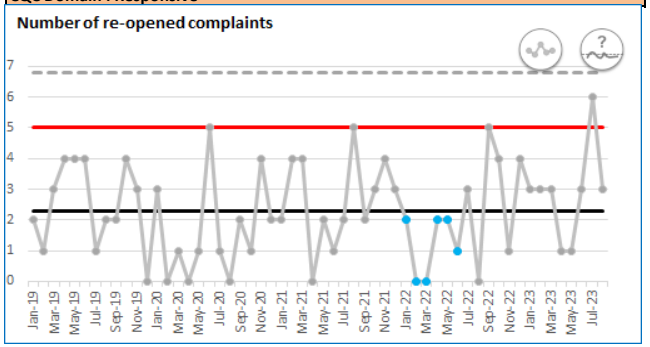
August-23
1.8
Variance Type
Common cause variation
Threshold
≤3.1
Assurance
Hit & miss target subject to random variation

CQC Domain : Responsive



August-23
100%
Variance Type
Special cause variation - improving
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

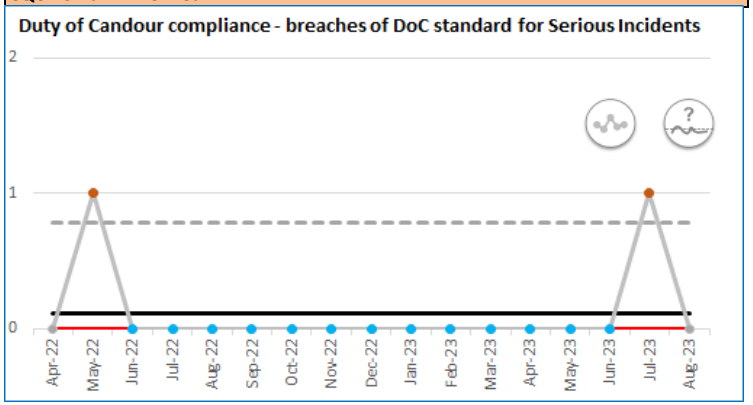
CQC Domain : Responsive



August-23
3
Variance Type
Common cause variation
Threshold
≤5
Assurance
Hit & miss target subject to random variation

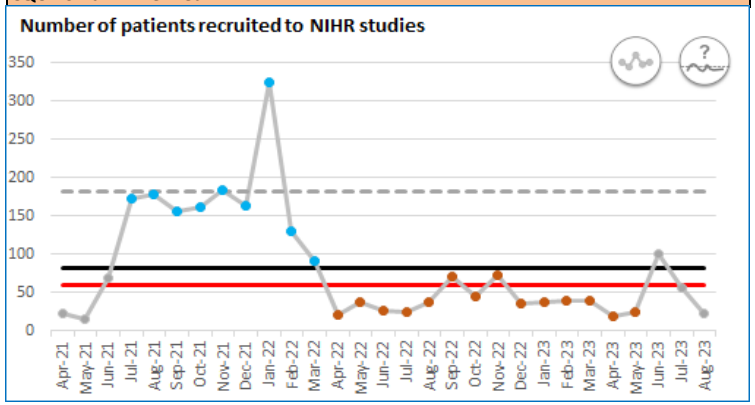
Medical Director (2)

CQC Domain : Well-led



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

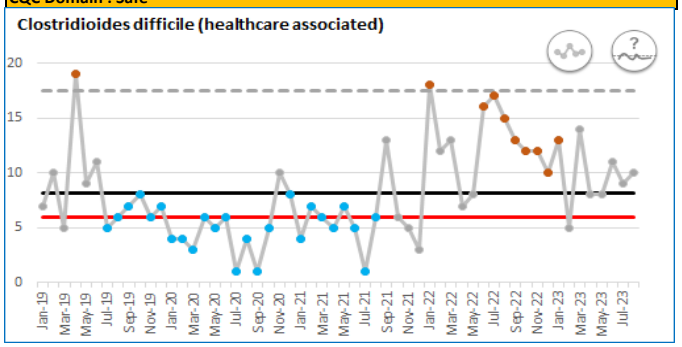
CQC Domain : Well-led



August-23
23
Variance Type
Common cause variation
Threshold
59 per mth (700 pa)
Assurance
Hit & miss target subject to random variation

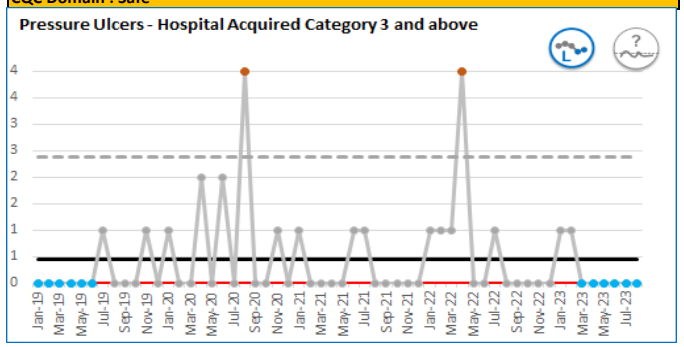
Chief Nurse

CQC Domain : Safe



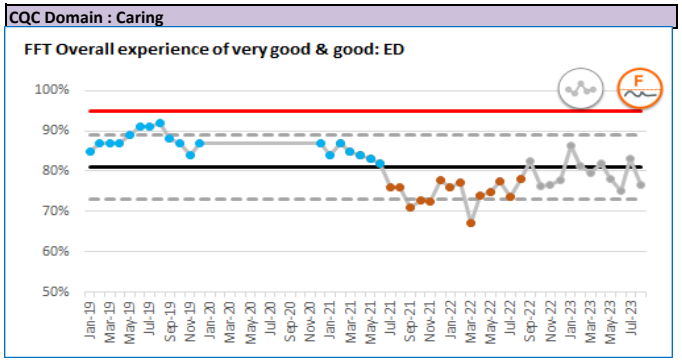
August-23
10
Variance Type
Common cause variation
Threshold
≤6
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



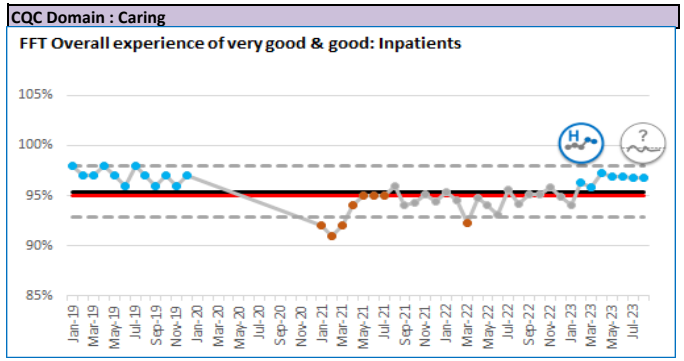
August-23
0
Variance Type
Special cause variation - improving
Threshold
0
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



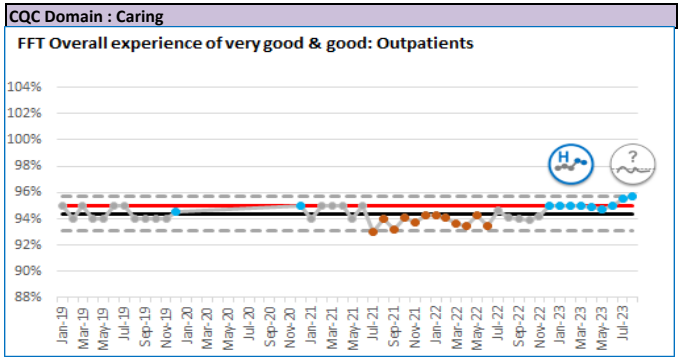
August-23
76.5%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Performance consistently fails to achieve the target

CQC Domain : Caring



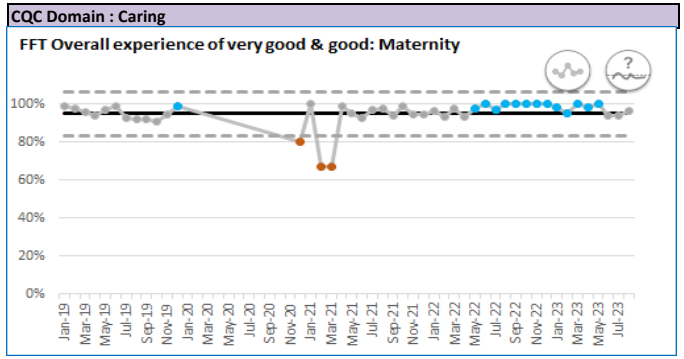
August-23
96.8%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



August-23
95.7%
Variance Type
Special cause variation - improving
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

CQC Domain : Caring



August-23
96.7%
Variance Type
Common cause variation
Threshold
≥95%
Assurance
Hit & miss target subject to random variation

Chief Nurse – for Oct 2023 BoD

Overall position commentary

The Trust exceeded its monthly *Clostridioides difficile* threshold by 4 in August 2023. This is a decrease of 17 cases when compared to 2022/23 and the downward trend in the number of positive cases reported over the past 12 months continues. In line with the IPC annual plan, 5 key priorities have been identified that underpin the Trust CDT priorities work plan which is aimed to further reduce the incidence of CDT over the forthcoming months. The development of an IPC dashboard within BI portal has taken place enabling visibility of key metrics aligned to the IPC improvement plan to further enhance trust wide assurance mechanisms.

Pressure ulcers, category 3 and above, that have developed in our care has not exceeded the threshold for exception reporting this month having achieved no pressure ulcers being reported in August 2023.

The Friends and Family Test (FFT) for Inpatients, Outpatients and Maternity have all exceeded the required threshold. Emergency Department (ED) has not achieved target in month at 76.50%, a deterioration from July's 83%. All areas are above the national benchmark for FFT except for ED that is slightly below the national average for this month.

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

Narrative:

The NHS standard contract for 2023-24 identifies the *C.difficile* threshold for each trust; our threshold for 2023-24 is 71. To meet this, we have set internal monthly threshold of 5 or 6 each month. In August 2023 there were 10 patients diagnosed with CDT, exceeding the monthly threshold by 4. The Trust has reduced its rate from 66 per 100,000 bed days in Q2 2022 to 39 per 100,000 bed days.

Actions:

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

Risks to position and/or actions:

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

FFT Overall experience of very good and good.

Narrative:

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

Performance against the 95% threshold for July 2023 was:

- Emergency Department (ED) – 76.5% (below threshold) - slightly below the national average of 80%
- Inpatients – 96.8% (above threshold) - above national average
- Outpatients – 95.73% (above threshold) – above national average
- Maternity 96.7% (above threshold) - above national average

Actions:

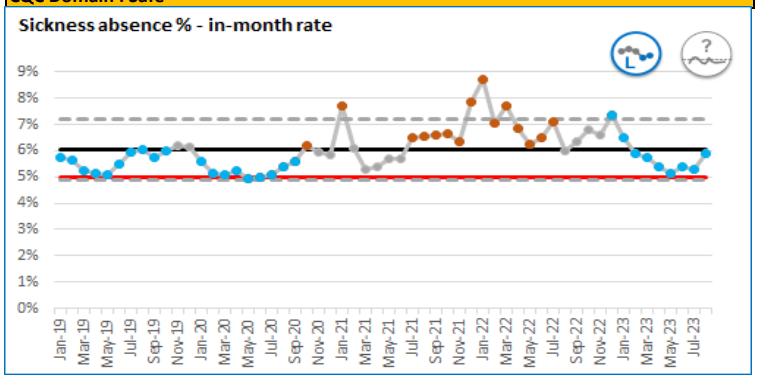
- Continued focus on providing people with access to provide feedback via FFT: volunteers are visiting ED and out-patient areas at varied times and days.
- Monitor FFT performance against national average: we perform similar or above the national average since December 2022.
- Proactively respond to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

Risks to position and/or actions:

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

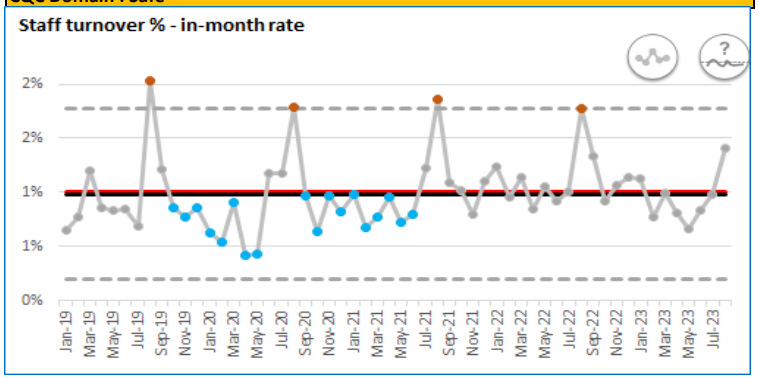
Chief People Officer

CQC Domain : Safe



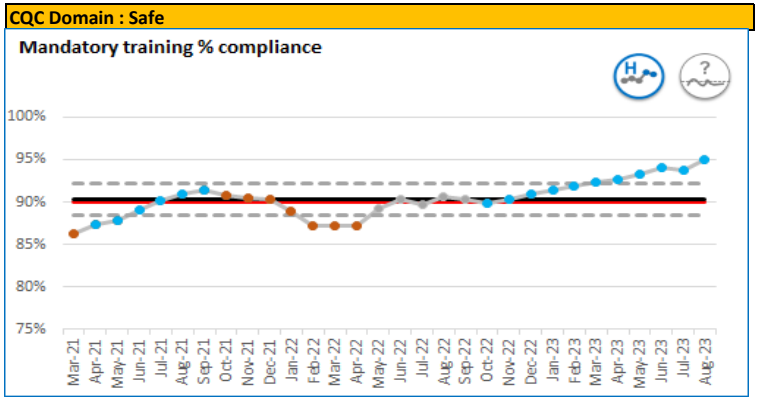
August-23
5.90%
Variance Type
Special cause variation - improving
Threshold
≤5%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



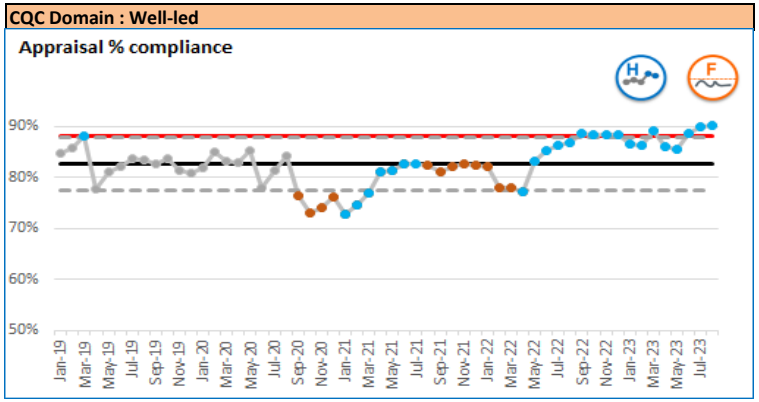
August-23
1.41%
Variance Type
Common cause variation
Threshold
≤0.83%
Assurance
Hit & miss target subject to random variation

CQC Domain : Safe



August-23
95.04%
Variance Type
Special cause variation - improving
Threshold
≥90%
Assurance
Hit & miss target subject to random variation

CQC Domain : Well-led



August-23
90.19%
Variance Type
Special cause variation - improving
Threshold
≥88%
Assurance
Performance consistently fails to achieve the target

Chief People Officer – for Oct 2023 BoD

Overall position commentary
Mandatory training and appraisal compliance continues to be achieved. Whilst turnover has spiked in August 2023, this relates to the expected turnover of junior doctors. Sickness absence has increased to 5.9%.

Sickness absence % in month rate

Narrative:

The Trust threshold for sickness absence is 5%. For August 2023 the indicator was 5.90% and demonstrates special cause variation – improving.

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

The Trust position is slightly above the Cheshire and Wirral average.

Actions:

- Estates and Facilities have experienced a rise in long term sickness. A deep dive of all cases is underway to ensure compliance with policy, and to identify any further interventions to facilitate an earlier return to work.
- Additional support has been put in place for staff who may have been affected by the events at the Countess of Chester Hospital NHS Foundation Trust.
- Flu Vaccination Programme has been launched, to be enhanced by the COVID Vaccination Programme as soon as possible.
- Promotion of the Trust's wellbeing offer continues, including the development of a Trust intranet Wellbeing Self Help Hub to be launched in Quarter 3.
- Further Clinical Psychotherapist led wellbeing sessions are planned to be delivered across the Trust based on anxiety, social anxiety, health anxiety and managing moods; these are currently in development.
- The Trust's EAP utilisation has increased, enabling staff to access support more quickly.

Risks to position and/or actions:

The management of sickness absence is primarily management led, supported by the HR team. Sickness is multifaceted and adversely impacted by a range of factors including vacancy levels and staff morale / engagement. 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.

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

Staff Turnover % compliance

Narrative:

The Trust threshold for turnover is 0.83%. In August 2023 the indicator has risen for the second month to 1.41%. This demonstrates a common cause variation. The spike in turnover relates to expected junior doctor rotations. Turnover excluding junior doctor rotation is on target at 0.81%

A thematic review of exit interviews was reported to Workforce Steering Board in September 2023. The most commonly occurring known destination on leaving is for employment in other NHS Organisations and, whilst the reasons for leaving vary, career development/promotion, dissatisfaction, management relationships and staffing are the commonly occurring themes. Pleasingly we are seeing a reduction in staff leaving due to flexible working and work life balance, demonstrating the impact of the Flexible Working programme of work delivered as part of the Trust People Strategy.

Actions:

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

- The ongoing 3-month internal transfer pilot for band 5 Registered Nurses and Clinical Support Workers who are seeking new opportunities internally, if successful it may be expanded to other roles.
- HCSW and registered nurse career pathways have been reviewed and development work on underpinning training is being identified.
- The Recruitment Team continue to improve the visibility of Trust vacancies and use of QR codes to improve access.
- 'Celebrating Success' graphic developed to showcase improvements made to support retention and increase engagement.
- Inclusion Week will promote inclusion targeted at all staff to support belonging at WUTH.
- Targeted support in place for Estates and Facilities staff to respond to concerns around computer literacy in relation to the move to paperless pay slips in October and low eLearning compliance.
- Second round of Division led Engagement Events launched to feedback progress from 2022 staff survey and Q1 & Q2 pulse survey. These were also celebration events and an opportunity for increased senior leadership visibility.

Risks to position and/or actions:

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

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

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

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9.1**

04 October 2023

Title	2022/2023 Emergency Preparedness, Resilience and Response Annual Report (EPRR)
Area Lead	Hayley Kendall, Chief Operating Officer
Author	Steve Povey, Head of EPRR
Report for	Approval

Report Summary and Recommendations

The purpose of the annual report is to:

- Provide an overview of the emergency preparedness arrangements within Wirral University Teaching Hospital NHS Foundation Trust (WUTH).
- Describe the Trust's responses to incidents that have occurred during 2022-23.
- Outline the work that has been undertaken in this area during the past 12 months.
- Outline the improvement and annual work programmes from last financial year and this.

It is recommended that the Board

- Approves the annual report.

Key Risks

This report relates to these key risks:

- Compliance with NHS England Core Standards for EPRR
- Statutory EPRR arrangements in place as a category 1 responder under the Civil Contingencies Act.

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
This is an annual report provided to the Board.

1	Narrative
1.1	The annual report for Emergency Preparedness, Resilience and Response (EPRR) details the Trust's approach and arrangements for meeting the requirements of the national Framework for EPRR and the NHSE Core Standards. The report details the: • Staff and meeting structure for EPRR • Out of hours arrangements • Risk register • Exercises and training • Communication testing • External review – NHS Core Standards • Reporting structure • Event planning • Annual work plan Over the course of most of the reporting period the Trust has responded to a series of Industrial Action strikes involving paramedics, nurses and medical staff which has involved having a command and control structure in place to support the hospital management structure. In addition the Trust was in full command and control structure for the financial year due to the COVID-19 pandemic and operated all responses to the pandemic via the EPRR structure. During the course of the year a new Head of EPRR came into post to continue the work done previously. Work will include the maintenance of the annual plan, exercising and delivering training across the Trust and assurance that robust business continuity processes are in place.

2	Implications
2.1	**Patients** • Maintaining robust EPRR plans supports patient safety, and ensures service provision can continue in the event of a crisis or other business continuity scenario
2.2	**People** • EPRR, and the training required by the new guidance, supports staff's ability to continue to provide services in an emergency scenario and provides a structure for a measured response.
2.3	**Finance** • There may be financial impact due to an EPRR event, though ensuring appropriate mechanisms for planning and management can mitigate this.
2.4	**Compliance** • This report is provided in line with reporting guidance on an annual basis.

Wirral University Teaching Hospital
NHS Foundation Trust

Emergency Preparedness Resilience and Response (EPRR)

Annual Report

2022/23

Report date:
September 2023

Author: Steve Povey, Head of EPRR/EPO

Sponsor: Hayley Kendall, Chief Operating Officer, and Accountable Emergency Officer

Contents

Appendices

1. Executive Summary

The Civil Contingencies Act (CCA) (2004) requires category one responders, to show that they can deal with incidents while maintaining services to patients. As a category one responder under the Act, the Trust has a duty to develop robust plans to respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of our services in the event of a disruption.

The Trust has the required Accountable Emergency Officer (AEO), supported by the Emergency Preparedness Officer (EPO) along with the appropriate emergency planning meeting structure.

All of the mandated emergency plans to respond to a major incident are in place and published on the Trust emergency planning intranet page.

2. Introduction

The NHS needs to be able to plan for, and respond to, a wide range of incidents that could impact on health or patient care. These could be anything from extreme weather conditions, an outbreak of an infectious disease, or a major transport accident. A significant incident or emergency is any event that cannot be managed within routine service arrangements. It requires the implementation of special procedures and involves one or more of the emergency services, the NHS or a local authority.

The Civil Contingencies Act (CCA) (2004) requires category one responders, to show that they can deal with such incidents while maintaining services to patients. As a category one responder under the Act, the Trust has a duty to develop robust plans to respond effectively to emergencies, to assess risks and develop plans in order to maintain the continuity of its services in the event of a disruption.

3. Purpose

The purpose of the annual report is to:

- Provide an overview of the emergency preparedness arrangements within Wirral University Teaching Hospital NHS Foundation Trust (WUTH)
- Describe the Trust's responses to incidents that have occurred during 2021-22
- Outline the work that has been undertaken in this area during the past 12 months
- Summarise the planned work streams and priorities for the year ahead

4. Emergency Preparedness Structure

4.1 Lead Officers

Accountable Emergency Officer (AEO)
The NHS Act 2006 (as amended) places a duty on providers to appoint an individual to be responsible for discharging their duties. This individual is known as the AEO. For the period covered in this report, the AEO was:

Hayley Kendall Chief Operating Officer	**01/04/22 – 31/03/23**

Emergency Planning Officer
The AEO is supported in this role with the role of Emergency Planning Officer (EPO). For the period covered in this report, the EPO was:

Steve Povey	**27/07/22 – 31/03/23**

4.2 Meeting Structure

In order to discharge the Trust's responsibilities effectively under the Civil Contingencies Act (2004), emergency preparedness arrangements have been embedded into the Trust's operational structure.

Trust wide ad-hoc planning meetings are initiated for any required emergency planning such as large scale community events, planned IT downtime planning, bank holiday planning, service/ward change or other operational pressure where services may be affected. Section 9 details the events that have been formally planned for during this period.

4.2.1 EPRR meeting structure:

- The Local Health Resilience Partnership (LHRP) meetings provide a forum to ensure that planning is not be conducted in isolation by a single organisation, but is undertaken in partnership with other local responders and commissioners. There are 2 levels of LHRP meetings; Strategic and Practitioner.
- The AEO, or their representative, attends the Strategic LHRP meetings for Merseyside. These meetings are held three times a year at Strategic Level.
- A Deputy Executive Director, Deputy Chief Operating Officer or the EPO attends the Merseyside LHRP Strategic LHRP meetings on behalf of the AEO should they be unavailable.
- The EPO attends the Merseyside LHRP Practitioner level meeting.
- Both the Strategic and Practitioner Level LHRPs meetings were re-instated from June 2021 and were regularly attended by a WUTH representative.
- Attendance at these meetings is required to comply with NHS Core Standards for EPRR.

4.3 Out of Hours Arrangements

4.3.1 On-call rota
The Trust operates an on-call rota which is on a 24/7/365 basis and ensures that senior managers and Executive Directors are contactable at all times and are able to respond quickly to a major or serious incident at any given time. This structure is supported by specific clinical and departmental on-call rotas which are designed to respond to local service-related operational issues. There is central coordination of these rotas.

4.3.2 On-call booklet
The Hospital Manager/Executive On-call booklet is regularly reviewed and updated to ensure that current information is to hand for any operational issue and risk assessment forms for major incidents.

4.3.3 On-call training
1:1 induction meetings are in place for members of the on-call executive director and manager rota, this includes major incident training. The on-call managers hold quarterly on-call forums where on-call issues, new guidance, updates and major incident refresher training is held.

NHS England and the Cheshire and Mersey ICB host Principles of Health Command Training throughout the year. Attendance on this course is mandatory for all oncall managers and directors with compliance measurable and part of the NHS England Cores Standards for EPRR response.

5. Risk Register (LHRP)

The Cheshire & Merseyside LHRP maintains a register of risks which are likely to present a threat to the wider community. These risks are updated at the LHRP quarterly meetings and provide the basis for setting the planning agenda and establishing emergency preparedness work plans for the Cheshire & Merseyside region.

2023/24 sees a scheduled update of the LHRP Risk Resister and the Trust Head of EPRR/EPO is part of the working group for this having also sat on the previous update.

6. Exercises and Training

The Civil Contingencies Act (2004) outlines the organisational responsibility to exercise plans. Under the Act, all NHS organisations are required to undertake:

- Live exercises (or incident) every three years
- Table top exercises annually
- Communications exercises every 6 months

Given the Trust and the NHS has been operating in an emergency state for the last two years through the COVID-19 pandemic, in line with national guidance, all EPRR exercises and training were stood down and have only recently commenced to be planned again. It should be noted that as the Trust was under a command structure for the entirety of the pandemic the Trust's EPRR was thoroughly tested.

6.1 Live exercise (or incident)

6.1.1 COVID 19 Pandemic

The Trust continued to run in a command and control structure in response to the national Level 4 incident - COVID-19 Pandemic. This meets the requirements of the three yearly live exercise. It is anticipated that an EMERGO exercise to coincide with the new Emergency Department opening will be the next live exercise.

6.1.2 Level 1 Business Continuity Incident

During the year the Trust experience a major failure of theatre ventilation of six theatres in the main theatre complex. Given the significant disruption to services, and impact on patients, this incident was run as a formal level 1 business continuity incident, through the Trust command and control structure. The incident ran from the 1st April 2022 through to the 20th April 2022.

Incident	Overview	Declared Date	Stepped Down Date
Theatre Ventilation	Failure of ventilation system in 6 theatres	01/04/2022	20/04/2022

6.2 Table top exercise

In line with the national guidance, exercises were stood down during this period, however the Trust continued to run in line with command and control structure for the COVID Pandemic. The National Emergency was stepped down in May 2023 and have subsequently begun planning for the re-introduction of exercises.

6.3 Communications

The major incident contact list for in and out of hours was successfully tested during 2022/23 as outlined in the table below:

OUT OF HOURS
02/12/2022
IN HOURS
22/04/2022 17/11/2022

7. External Review

7.1 NHS England Assurance for EPRR

The NHS England Core Standards for EPRR are the minimum standards which NHS organisations and providers of NHS funded care must meet.

The Trust self-assessed against these standards between July and September 2022. Following assessment, the organisation self-assessed as demonstrating partial compliance level. The assessment level is confirmed by NHS England as providing 'substantial' compliance (see appendix 1):

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address **six to ten** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address **11 or more** core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

A copy of this assessment along with the declaration of the level of compliance achieved was taken to the Public Board of Directors in September 2022.

8. Reports to Committee and Public Board

EPRR Reports to Board/Committee were presented on the following dates:

Item	Risk Management Committee	Public Board of Directors
EPRR Annual Report 2021/22		September 2022
EPRR Core Standards 2021/22 Compliance Report	October 2022	
Quarterly EPRR Report to Risk Management Committee	August 2022	
Quarterly EPRR Report to Risk Management Committee	November 2022	
Quarterly EPRR Report to Risk Management Committee	February 2023	

9. Event Planning

During 2022-23 planning meetings supported by EPRR have taken place to ensure that safe robust plans were in place for the following events:

Event	Summary
Half Term/Bank Holiday Planning **Easter, early and late May, August, October Half-term, Christmas/New Year period, February Half-term**	Trust wide plans are developed to outline the arrangements that are put in place in the Trust and within key partner organisations in preparation for the Bank Holiday and selected Half Term periods. They provide assurance to the Wirral system and describe initiatives that have been put in place to maintain safe patient flow during a period of known increased demand. They provide robust plans for internal oncall teams to follow through the oncall structure. The planning also ensures that the process for bank holiday reporting to NHSE/I (NHSE daily operational pressures and NHSI SITREP) is in place during the bank holiday weekend period.
Trust wide Wirral Millennium planned upgrades/downtime:	Planned Wirral Millennium 'downtime' and system upgrades requires trust wide planning to ensure that issues/risk and actions have been identified and that staff in all areas are aware of the formal downtime process to follow to maintain patient safety. The EPO coordinates all such responses with leads from the specialty area. The EPO agrees all potential disruption plans with the AEO.
Multiple estates planning events: **Projects supported during this period included the Trust UECUP programme surveys, planned power outages at APH and CBH.**	Planned Estates projects that affect the Trust operationally require careful planning with key stakeholders to ensure that risk is identified and mitigation put in place to ensure patient and staff safety. The EPO is involved in the planning of all such events and approves the progression of such events with the AEO.

10. Work undertaken in 2022-23

The following work-streams were completed during the year under review:

- Provided 'partial assurance' for NHS England Core Standards for EPRR
- Facilitated internal communication exercises, plus continued to experience a pandemic, that tests alerting procedures as part of incident response procedures
- Delivered major incident training to new on-call managers and directors
- Developed Trust wide plans for planned events such as IT planned downtime, Bank Holiday/Half Term periods and multiple estate projects

11. Progress with work programme for 2022-23

All actions are complete as detailed in appendix 2, these were the improvement actions from the 2021/22 plan.

12. Work programme for 2023-24

Work streams have been developed using recommendations from the Local Health Resilience Partnership. They will be undertaken during the 2023/24 financial year. Please refer to the plan in appendix 3.

EPRR Statement of Compliance

Cheshire & Mersey Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

Wirral University Teaching Hospital has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Wirral University Teaching Hospital will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

22/09/2022
Date signed

Appendix 2

Progress with 2021/2022 Improvement Plan

Lead: Steve Povey, Head of EPRR

Recommendation /Issue (in line with EPPR Framework)	By end of Quarter 2020-21	Progress
Produce an annual report on Emergency Preparedness 2021/221 to Risk Management Committee September 2021	Q2	Complete
Undertake the self-assessment for the 2021/22 EPRR assurance process	Q2	Complete
Undertake a 'Deep Dive' into the preparedness of the Trust for the specified subject	Q2	Complete
Ensure RMC and the Public Board of Directors (BoD) has sight on the level of compliance against the 2020/21 revised process for the revised EPRR assurance	Q3	Complete
Carry out a Communication Exercise at a 6-month interval	Q2 & Q4	Complete
Plan for a mass casualty tabletop exercise to take place by the end of 2020/21 *N/a for this period*	Q4	N/a
Carry out the 3-yearly review of all relevant emergency plans and note at BoD	Q4	N/a
Develop and deliver strategic refresher Major Incident Training to on-call Hospital Managers, Hospital Clinical Coordinators and Executives	Q4	Complete
Participate in multi-agency EPRR training and exercises in collaboration with partner organisations and the Cheshire & Merseyside LHRP – *N/a for this period*	Q4	N/a
Develop specific plans for all relevant local events in order to address potential demand management pressures in the health care system	Q4	Complete

Appendix 3

2023/24 Work Plan

Lead - Steve Povey, Head of EPRR

Recommendation /Issue (in line with EPPR Framework)	By end of 2023/24
Undertake an evacuation table top exercise	Q4
Produce an annual report on Emergency Preparedness 2022/23 to Risk Management Committee (RMC) September 2022 and ensure noted at the Public Board Meeting	Q3
Undertake the self-assessment for the 2023/4 EPRR assurance process	Q2
Undertake a 'Deep Dive' into the preparedness of the Trust for the specified subject	Q2
Carry out a communication exercise at a 6-month interval	Q1& Q3
Ensure the Board of Directors (BoD) has sight on the level of compliance achieved, the results of the 2022/23 self-assessment and the improvement plan for the forthcoming period	Q3
Carry out the 3-yearly review of all relevant emergency plans and note at BoD, where required	Due 2025
Update and deliver strategic refresher major incident training to on-call hospital managers, hospital clinical coordinators and executives	All Quarters
Participate in multi-agency EPRR training and exercises in collaboration with partner organisations and the Cheshire and Merseyside LHRP	Q4
Develop specific plans for all relevant local events in order to address potential demand management pressures in the health care system	Q4

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 9.2**

04 October 2023

Title	2022/2023 Annual Core Standards for Emergency Preparedness, Resilience and Response (EPRR)
Area Lead	Hayley Kendall, Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Steve Povey, Head of EPRR
Report for	Ratification

Report Purpose and Recommendations

This covering paper sets out the requirement for the Trust to undertake an annual EPRR self-assessment against the core standards, in line with the Department of Health and Social Care and NHS England. The self-assessment has been completed by the Chief Operating Officer, as the Accountable Emergency Officer (AEO) and the Head of EPRR as the Emergency Planning Officer (EPO).

The output of the self-assessment as partially compliant with a percentage compliance of 82%.

The two main themes of partial compliance relates to the newly required centrally led Principles of Health Command training that all oncall managers and directors must undertake. This is still in progress and internal portfolios need to be gathered to provide assurance. Secondly the new NHS Business Continuity Toolkit was released at the end of April 2023 and requires a full re-write of all Business Continuity Plans (BCPs). Given the requirement to respond to industrial action this is work in progress, but training has commenced with divisions to redraft all BCPs.

An action plan will be developed to ensure that partial compliance indicators are progressed to full compliance in readiness for next year's core standards self-assessment.

The Board is asked to note the self-assessment of partial assurance which in the main is caused by minor requirements to update internal processes and BCP processes following the release of the new BCP Toolkit.

Key Risks

This report relates to these key risks:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	No
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
This is an annual report submitted to the Board.

1.	Overview
	On an annual basis the Department of Health and Social Care and NHS England require all Trusts to undertake an annual assessment of their Core Standards for EPRR. This takes the form of a self-assessment against each applicable standard and requires a response to be documented and evidenced and an action plan for any standard that is not fully compliant put in place to achieve that compliance. In addition, annually, a specific work area is selected for a 'deep dive' focus on its arrangements. For 2023/24 this area is 'EPRR responder training'. These deep dive standards are answered in the same way but do not count towards the overall compliance rating. To assist with compliance, for 2023 guidance has been provided on the expectations for each standard to achieve full compliance. The guidance is very prescriptive about what must be in place for each standard and the Midlands trial in 2022 saw most Trust's compliance rating drop in a process being described as 're-setting the baseline'. The process so far has identified some new or additional requirements for some of the standards which will see the Trust rating drop whilst additional requirements move to the action plan. For 2023 Trusts are required to complete their core standards assessment and submit to a central repository by the 29th September 2023 following which NHSE and the ICB will review submissions and evidence and issue a compliance rating. The timeline for the standards is as follows: • 29th September – deadline for providers to upload all documents to the central repository. • October – NHSE and ICB Review Trust returns. • October/November – Challenge period for requests for additional information, Trusts have 3 weeks to respond and provide additional supporting evidence as required. • 29th December – Regional teams submission deadline to national team. It should be noted that the review process may change the scoring of the self-assessment, but the Trust will provide information to the ICB as required.

2. Self-assessment Outputs

The self-assessment has been completed in line with the guidance and the output score is 82% partially compliant. This is a similar position to the self-assessment last year (81%) and is more of an achievement given the new guidance and standards that have been included in this year's core standards.

Percentage Compliance	82%
Overall Assessment	Partially Compliant

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core Standards.

The table details the areas of compliance by domain and highlights the main area that requires improvement is business continuity, which links directly to the release of the new BCP Toolkit at the end of April 2023:

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	5	1	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	11	0	0	0
Command and control	2	1	1	0	0
Training and exercising	4	3	1	0	0
Response	7	7	0	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	3	7	0	1
Hazmat/CBRN	12	11	1	0	7
Total	**62**	**51**	**11**	**0**	**11**

The Board should note that the Trust has 1 WTE that leads the EPRR response for the Trust alongside the Chief Operating Officer. Industrial action has placed significant demands on the EPRR portfolio and thus to achieve this level of compliance given the other pressures has been quite an achievement.

3. Recommendation

The Board should note the self-assessment of compliance of 82% against the core standards and that an action plan will be developed to improve compliance in readiness for next year's self-assessment.

4 Implications

4.1 **Patients**

- Maintaining robust EPRR plans supports patient safety and ensures service provision can continue in the event of a crisis or other business continuity scenario.

4.2 **People**

- EPRR, and the training required by the new guidance, supports staff's ability to continue to provide services in an emergency scenario and provides a structure for a measured response and ensure for their own health and safety.

4.3	**Finance** • Currently, there is no impact on finance, however ensuring plans are in place will support cost aversion in the event of an EPRR event.
4.4	**Compliance** • This report is in line with the NHSE Guidance and supports compliance with EPRR requirements.

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	In accorance with the NHSE EPRR Framework, the Trust has assponited Hayley Kendall, Chief Operating Officer as the Accountable Emergency Officer. Details of the responsibilities associated with the role are in Section 3 of the Trust EPRR Policy including LHRP Representation.	Fully Compliant
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	The Trust EPRR Policy, last reviewed May 2022, contains the roles and responsibilities for key positions and references its approval to the Trust Risk Management Committee and Trust Board. Note that the Trust does not have a dedicated Emergency Planning Committee as the EPRR portfolio refers through to the Risk Management Committee. Section 6.1 of the Policy references the BCM process for departments internally and also for utility and consumable providers	Partially Compliant
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	EPRR Annual Report & Core Standard Assurance Statement approved at Risk Management Committee and noted in Chair's RMC Report to Board of Directors in March 2022. Standard achieved The EPRR Annual Report must go to the Trust Board (Public Board) and also a statement appear in the Trust Annual Report & Accounts (Statement of readiness ith possibly Core Standards arting?)	Fully Compliant
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	The trust has an Annual Work Plan that is published each year and updated throughout the year.	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Major Incident Plan (reviewed March 2022) and action cards describe resourcer and roles and responsiblities. The Trust CBRNE & HAZMAT Response Plan (Reviewed March 2022) is also relevant. The response for decontamination events is suitable resourced and is included in the new build ED plans to provide permanent connections and a designated area for wet decontamination. Current arrangemnts are in place utilising a generator and temporary water supply. Items are services in accordance with the manufacturers requirements. the Trust has a two tier On Call System with Hospital Managers supported by a Manager on Call and Director On Call who are available 24/7.	Fully Compliant
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	The Trust has in place; Major Incident Plan,, Annual Report, Risk Register entries, Debriefs from exercises and incidents which detail learning. Learning from debriefs following training, exercising or a live incident are documented and have an action owner. Where appropriate lessons are sahred with partners at L:HRP Meetings.	Fully Compliant
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	The Trust has a Risk Management Policy and EPRR Risks are included on the trust risk register. Signifcant/major incidents are recorded on the trust BAF. Trust attendance at LHRP Strategic and Practitioner meetings where EPRR risks are considered and recorded. Trust EPO is part of the working group for the LHRP Risk Register.	Fully Compliant
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	EPRR policy references the Trust risk management policy and risks are reviewed on a monthly basis. AEO and Head of EPRR attends Risk Management Committee.	Fully Compliant
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	The Trust Policy structure sees all policies apporved at local level and then sent to a parent committee (Risk Management for EPRR), all policies are then published fro consultation before being formally approved.The Trust liaises with other Acute Networks and with other trusts, ICB and NHSE via the LHRP structure at both Practitioner and Accountable Director level	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Plans reviewed 3 yearly in line with EPRR framework. WUTH has been involved in several major incidents in previous years. No significant command issues highlighed by the subsequent debriefs and command framework has been used for pandemic response.	Fully Compliant
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The Trust has a Severe Weather Plan in place which was reviewed in March 2022. The plan references hot and cold weather extremes and also covers flooding. The trust has a MoU with North West 4x4 to assist in extreme conditions. Communications arrangements are in place that utilise internal and external communications. the trust has a group set up for |CLimate Adaptation Planning with its first meeting being scheduled.	Fully Compliant
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Policies and procedures as detailed in the health & Social care act. COVID Board assurance framework IPC Team Outbreak policy Fit testing service PPE policy Isolation policy Ongoing surveillance Infection Prevention & Control Group that is chaired by the DIPC and signs of all relevant policies and procedures Annual work plan 3 yr IPC strategy Trust intranet has current guidelines	Fully Compliant
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fit testing service for FFP3 masks Local COVID policy reflecting national guidelines. Local monkey pox plan Weekly Clinical Advisory group that oversees all new and emerging pandemics Trust intranet has current guidelines IPC COVID BAF Collaborative flu preparedness meetings	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	MOU in place between our community/partner organisations to work in collaboration as and when needed. Monthly collaborative meetings between partner organisations Nerve agent information and other resources in an emergncy details in MS Teams On Call Group and within ED.	Fully Compliant
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	NHS England Concept of Operations for managing Mass Casualties incorporated into the Trust Major Incident Plan. Patient identification included in the ED major incident plan/action cards. Mass casualty action card (Plato Action Card) included in the Hospital on-call booklet and Major Incident Plan. NWAS regional casualty allocations agreed with ED and agreed by AEO. Full Capacity Protocol available to assist onboarding and discharge. Plan in place for unidentified patients.	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evacuation Plan in place. NHSE Evacuation and Shelter guidance incorporated into plane. Shelter is the responsibility of the Local Authority Evacuation Policy review undertaken with NWAS & MFRS Evacuation Workshop held with On-call managers, Hospital Clinical Coordinators & Executive Directors on-call	Fully Compliant
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lockdown Policy in place, currently under review following incient at CGH site that required multi agency response. Alternative ICC nominated. Staff communications route updated following incidnet at CGH. Plan is scalable dpending on locaation and risk.	Fully Compliant
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Referred to in the Major Incident Plan. Referred to the Communications Plan.	Fully Compliant
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust engages and contributes to the LHRP via the Deaths Management Working Group and Mersyside Mass Fatalities Plan. Mortuary Action Card details storage arrangements for Major Incident/Mass Caualty Incident, wider Merseyside plan activated when capacity reached, in accordance with ICB/NHSE.	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	24/7 Manager & Executive Director level on-call in place, SPOC via Trust switchboard 24hr/7 days Major Incident Plan Switchboard cascade In & out of hours plan in place, tested every 6 months On-call booklet in place for all managers and directors WUTH has been involved in 3 major incidents with no significant issues highlighted • Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff."	Fully Compliant
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	1st and 2nd On Call staff are undertaking Principals of Health Command Training on an ongoing basis delivered centrally by NHSE. Internal training for on call and training checklist. Sessions throughout the year for new staff and existing staff as a refresher. All staff transferring to NHSE Portfolios, final versions received late July. Training being formulated to meet this requirement.	Partially Compliant

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22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Training records maintained centrally by Emergency Planning. Transfer to NHSE Training Portflios under Principles of Health Command to take place from Q4 2023 onwards. Record of 1:1 induction checklist sent to delegate Certificate of attendance for training sent to delegates for their portfolios Attendance sheets for training/on-call fourm saved centrally by Emergency Planning Matrix of training for on-call maintaing centrally by Emergency Planning • Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for all on call staff, new requirement and will be delivered through the year	Partially Compliant
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Evidenced in EPRR Annual Report Debrief Reports produced and shared at LHRP for shared learning • Exercising Schedule • Evidence of post exercise reports and embedding learning. Exercising administration to be updated to include aims/objectives in planning stage, link with ICB for local COMAH Participation. CBRN traning and exercise commencing following re training of trainers in July 2023. EMERGO course in planning stage for new ED Department opening.	Fully Compliant

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24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	Training records maintained centrally by Emergency Planning Record of 1:1 induction checklist sent to delegate Certificate of Attendance for training sent to delegates for their personal portfolios. Attendance Sheets for training/on-call fourm saved centrally by Emergency Planning Matrix of training for on-call maintained centrally by Emergency Planning - Training records - Evidence of personal training and exercising portfolios for key staff. - Personal portfolios to be included in PADR process for On Call staff.	Fully Compliant
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	On call and key responder staff receive training for their specific rsponse roles. All staff receive introductory induction training on the role of EPRR. Incident action cards are clear on roles.	Fully Compliant
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Radiology Conference Room is the Major Incident Room The Boardroom is the back up room All on-call forums and 1:1 inductions are held in the Major Incident Room to ensure on-call are clear on where the room is and what is available in the room Site Maps, action cards and plans etc are in a locked cupboard in the room. The key located and door codes for Radiology are described on the on-call major incident action card which is inlcuded in the on-call booklet. Major Incident Room used a number of times for major and critical incidents etc and no significant issues highlighted.Resilient phone lines in Radiology Conference Room.	Fully Compliant
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	All polices are verision controlled under the Trust document control processes. Digital copies are available vis MS Teams and Resilience Direct with hard copies present in the Major Incident Room. External partners are issued with digital versions but will be replaced in future with access to Partners page on Resilience Direct.	Fully Compliant

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28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Business Continuity response plans in place and available on the Emergency Planning Intranet page. Trust is moving to the recently issued NHSE Business Continuity Toolkit and has commenced training within Directorates.	Fully Compliant
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	List of volunteers for trainined Loggists kept in the Major Incident Room (out of hours)and the Quality & Safety Department (in hours) Request of Loggist included in the Commander's action card (out of hours) and Quality & Safety Action Card (in hours) Record of training maintained centrally by Emergency Planning. Trust has a supply of MI Log Books in the MI Room. • Documented processes for accessing and utilising loggists • Training records	Fully Compliant
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	METHANE Template inlcuded in the on-call booklet and MS Teams Groups for On Call Managers and Directors Information Team, Infection Control Team and Emergency Preparedness able to upload SitReps via Strategic Data Collection Service (SDCS).	Fully Compliant
31	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	ED access to UKHSA ED access to Toxbase Access to Trust clinical pathways and guidance Specific guidance on nerve agents, EPRR blood transfusion guidance are available on the On Call Teams groups	Fully Compliant
32	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	Trust CBRN policy ED access to UKHSA ED access to Toxbase Access to Trust clinical pathways and guidance	Fully Compliant

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33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Trust communications and media policy Major Incident Plan Social Media Policy Inclusion of communicaitons Lead in the Command Team Information tracking sheets held in the Major Incident Room WUTH has been involved in 4 major incidents in the past 4 years that have been noted as being well managed	Fully Compliant
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Trust communications and media policy Major Incident Plan Social Media Policy Inclusion of communicaiton lead in the Command Team Information tracking sheets held in the Major Incident Room Action Card in place for Comms Suppport including Out Of Hours SPOC via On Call System	Fully Compliant

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35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Trust communications and media policy Major Incident Plan Section 5 Social Media Policy Inclusion of communicaitons lead in the Command Team Information tracking sheets held in the Major Incident Room MRF Contacts Directory in On Call Teams Group to ensure latest partnet contact detils are available.	Fully Compliant
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	The Trust Major Incident Plan details the forms of response during a business continuity/major incident, in particular Section 5. Trust executive team has recently completed media training to ensure a good pool of people available as spokespeople.	Fully Compliant
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	The Trust AEO attends LHRP Strategic Meetings, in their absence, another Director or the Trust EPO will attend with delegated authority. The Trust EPO is a member of the Energy Resilinence Group and ha soffered to continue on the Risk Register Group.	Fully Compliant

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38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	The Trust is represented at both the Cheshire and Mersey Resilience Forums by the ICB with support from NHS England. LRF business is fed through the LHRP meetings.	Fully Compliant
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Mutual Aid arrangements are contained in Section 3 of Major Incident Plan. Muitual Aid requests would be made by the COO, Deputy COO or On Call Manager. A MACA Request would be made via the On Call Director to NHSE with a request for the appropriate form. Mutual aid is coordinated via the C&M SCC structure.	Fully Compliant
40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all	This standard is not applicable to the Trust	
41	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency	This standard is not applicable to the Trust	
42	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas	This standard is not applicable to the Trust	
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Major Incident Plan Code of Conduct - handling personal identifiable information Information Governence Policy Information Security Policy EPRR data sharing protocols with Trust IG Lead. Data Protection and sharing information in emergencies guidance is available in the On Call Teams Groups	Fully Compliant
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	The Trust EPRR Policy is in place, however, this is to be reviewed as a result of the Trust adopting the NHSE Business Continuity Toolkit, thereofre, all policies are to be re-written to follow this format.	Fully Compliant

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45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	This is included in revised BCP Policy currently being rolled out, the existing Policy is in place whilst the new training is rolled out and meets the requirements. The Trust is expected to be compliant once the policy has been re-written.	Partially Compliant
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	EPRR policy BIAs available on the Trust intranet, the response to Covid-19 resulted in plans being used in earnest and a review is now required as part of the opeartional debrief. NEW NHSE Toolkit rolled out to divisions	Partially Compliant

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47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	BCPs available on the Trust intranet Policies are available for departments but reviews range from 2019 to 2022. BCPs are currently being reviewed against the new guidance and thus it would no tbe possible for the Trust to be compliant given the timescales since the new guidance was released. Review needed to ensure that column D subjects are covered by all plans.	Partially Compliant
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	Testing and Exercising elements are included in the re-writing of the BC Plan following the adoption of the NHSE Business Continuity Toolkit. To date the Trust has tested its BCPs under digital downtime, COVID-19 and power outage.	Fully Compliant
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved	Revised DPST for 2022 has one action for WUTH. CHECK	Fully Compliant
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	The trust has in place policies and regular Board Reports and an Annual Report. This is to be fully updated following the adoption of the NHSE Business Continuity Toolkit.	Partially Compliant

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51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	EPRR policy Annual Report Major Incident debriefs The Trust has reviewed its own performance via the completion of Core Standards	Partially Compliant
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	EPRR Policy Ref debrief Millennium - during Covid regular reporting and testing BCPs postponed in line with national policy. Trust re-establish the annual planned reviewed of the effectiveness of the BCMS and the adoption of the NHSE Business Continuity Toolkit.	Partially Compliant

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53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	The Procurement Department seek assurance from Suppliers, this process will be re-inforced by the adoption of the NHSE Business Continuity Toolkit.	Partially Compliant
54	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning	This standard is not applicable to the Trust	
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	CBRN Plan Major Incident Plan, additional training completed for PRPS trainers with a revised training plan being implemented	Fully Compliant
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	CBRN Plan ED Training Trust Waste Policy	Fully Compliant
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Rotas are available in ED. Each shift has at least one trained member of staff: Shift Leader/ Band 6. More trained staff are needed to strengthen capability. The Trust Ed has indicated that more training is eeded including train the Trainer for staff cascade	Fully Compliant

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58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing	Equipment checklist is wall mounted within external container at the front of ED. Equipment held is reviewed against the checklist annually	Fully Compliant
59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Y	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Completed and available in the ED external container at the front of ED. PRPS suits serviced as per manufacturers requirements.	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Y	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Suits Serviced 22nd September 22 full check, Generator serviced September 2022. Arrangements in place to replace expired or contaminated/used suite.	Fully Compliant
61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	PPM in place. Suit Servicing 22nd September	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
62	**Hazmat/CBRN**	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Y	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultaion with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	NHSE guidance followed. Kit destroyed in line with NHSE guidance. In the event of wet decontamination, water stored pending disposal, new ED decon area ha s drain interceptor requested by EPRR	Fully Compliant
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment	6 x staff have undertaken a PRPS Train the Trainer course to allow full roll out of training across staff.	Fully Compliant
64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Training programme commencing and Policy around training to be updated.	Partially Compliant
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Records maintained by CBRN leads in ED. 6 staff are trained decontamination trainers. Fit Test training available via IPC	Fully Compliant

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	CBRN Plan and ED action cards. Training for new staff and refresher training taking place with wet decontamination exercise planned for post strike period	Fully Compliant
67	**CBRN Support to acute Trusts**	**Capability**	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response. The support provided by NHS Ambulance Services must include, as a minimum, a biennial (once every two years) CBRN/HazMat capability review of the hospitals including decontamination capability and the provision of training support in accordance with the provisions set out in these core standards.		Evidence predominantly gained through assessment and verification of training syllabus (lesson plans, exercise programme), ensuring all key elements in "detail"" column are expressed in documentation. This will help determine: -If IOR training is being received and is based on self-presenters to ED. -Whether PRPS training is being delivered. -Training re: decontamination and clinical care of casualties. Specific plans, technical drawings, risk assessments, etc. that outline: -The acute Trusts' CDU capability and how it operates. -Its provision of clinical radiation monitoring. -How scientific advice is obtained (this could also be an interview question to relevant staff groups, e.g., ""what radiation monitoring equipment do you have, and where is it?" Any documentation provided as evidence must be in-date, and published (i.e., not draft) for it to be credible. Documented evidence of minimum completion of biannual reviews (e.g., via a collated list).	This standard is not applicable to the Trust	
68	**CBRN Support to acute Trusts**	**Capability Review**	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.		Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. -Evidence of progress/close-out of actions.	This standard is not applicable to the Trust	
69	**CBRN Support to acute Trusts**	**Capability Review Frequency**	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).		Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. Evidence of progress/close-out of actions.	This standard is not applicable to the Trust	

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.
70	CBRN Support to acute Trusts	Capability Review report	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.		Evidence of those reports and that the designated hospital and NHSE EPRR Lead are in receipt of those. Dip sample of last 10 years of reports, e.g., please provide reports from 2015, 2018, and 2022 to show adherence to the retention of reports for 10 years.	This standard is not applicable to the Trust	
71	CBRN Support to acute Trusts	Train the trainer	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.		Written statement as to how this is achieved, which can then be further investigated during inspection. Evidence of training records and/or a documented training schedule. Provision of suitable training documentation – syllabus, lesson plans, etc., that shows the detail of training delivered.	This standard is not applicable to the Trust	
72	CBRN Support to acute Trusts	Aligned training	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.		NARU can provide the latest version number of associated training packages. This can then be cross-referenced against lesson plans and training packages in acute Trusts to ensure up-to-date national training is being delivered.	This standard is not applicable to the Trust	
73	CBRN Support to acute Trusts	Training sessions	Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.		Clear evidence of documentation (e.g., a contract, MoU, or equivalent, that details how training is delivered to acute Trusts, how often, etc.).	This standard is not applicable to the Trust	

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 10**
04 October 2023

Title	Elective Recovery: Protecting and expanding elective capacity letter, Board self-assurance
Area Lead	Chief Operating Officer
Authors	Hayley Kendall, Chief Operating Officer Nicola Cundle-Carr, Head of Business Improvement
Report for	Information

Report Purpose and Recommendations

This paper sets out the Trust response to NHS England's letter of the 4th August 2023 relating to the protection of elective capacity, and specifically outpatients. The report will provide an overview of the self assessment that has been undertaken with the full assessment also included within this paper.

The Board should note the positive position against the required domains outlined by NHS England relating to the management of patients on the outpatient waiting list.

It is recommended that the Board

- Note the report; and
- Support the submission to Cheshire and Merseyside ICB.

Key Risks

This report relates to these key risks:

- Delivering timely and safe care for patients awaiting elective treatment

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.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
12th September 2023	Executive Leadership Team Meeting	Elective recovery – protecting and expanding elective capacity self-assessment	Information

1	Introduction / Background
	NHS England published a letter to all acute trusts on the 4th August 2023 titled "protecting and expanding elective capacity". The letter focussed on transforming outpatient services and maintaining an accurate and validated waiting list with parameters for validation. The letter requested that Boards have oversight and approve a self-certification against the standards set out in the letter. The self-certification has been carried out by the Head of Business Improvement and the Chief Operating Officer and provides a transparent and robust position for the Trust.

2	Self-certification overview
	The full self-certification is attached as Appendix 1 to this paper but for the Board this section will provide an overview of the trust performance against the standards set out by NHS England by assurance area.
2.1	**Validation** The Board should be assured that the Trust has in place a thorough validation process that validated every patient after each clinical episode which is more than what is required in the guidance. There are live reports available to support all staff in this process. There is a full text message service in place and all patients waiting over 12 weeks will have been contacted by the end of October 2023 to ensure the patients are validated. All patient responses will be recorded on the Patient Target Lists (PTL). The Trust has a Patient Access Policy that describes the rules and regulations of the national RTT guidance and how this should be applied internally. There is also a comprehensive RTT training package that all staff must complete. The Trust recently received substantial assurance by Mersey Internal Audit (MIAA) for the management of waiting lists. Non-RTT patients receive the same level of scrutiny as RTT live patients. This is through a suite of reports available to the operational and management team to manage patients through their pathway. This is monitored via the weekly performance meeting chaired by the Chief Operating Officer and attended by all clinical divisions.
2.2	**First appointments** The Trust has an agreed trajectory to achieve zero patients waiting longer than 65 weeks by the end of March 2024 and has set an ambition to have all patients in this category with an outpatient appointment prior to the 31st October 2023. There is a significant challenge to achieving the ambition due to the impact of Industrial Action on elective activity.

	The Trust has approached the Independent Sector and C&M mutual aid for specialities where the plans to achieve the national standards look challenging. Unfortunately to date there has been no additional support available for the areas where the backlog of patients waiting treatment is high.
2.3	**Outpatient follow ups** The recent guidance from NHS England has placed significant emphasis on developing alternative models of care to manage the increasing number of patients that require a follow up appointment. The Trust is currently rolling out partial booking to all specialities for patients that are overdue their follow up appointment, with the aim of ensuring that unnecessary follow ups are reduced. Patient Initiated Follow-up (PIFU) was introduced in the Trust earlier in the year and has been rolled out across most specialities successfully. There is further work required to increase the volumes but there is also the need to balance the backlog of patients that are waiting a follow up, as an output of the delays during the Covid pandemic. The Trust has embarked on a programme to reduce missed appointments (DNAs) in outpatients with the implementation of text reminders to all patients. In addition, the introduction of partial booking, where patients have to confirm they require the appointment and agree a date, has seen unnecessary appointments cancelled prior to the date due reducing wasted appointments by up to 10% in some specialities from the information to date. Advice and guidance is available in most of the clinical specialities and provides a system for GPs to gain advice on patients without patients being referred into the Trust. There is a plan in place to roll out to all specialities over the next quarter. This is monitored via the weekly performance meeting chaired by the Chief Operating Officer. There are a number of specialities that have transformational plans to deliver outpatient services differently. These include development of one stop shops, utilisation of technology to manage patients remotely and high volume elective pathways for routine operations. Shared care is also being implemented for a pathway in Community Paediatrics.

3	**Summary**
	The Trust is reporting a compliant position against the domains set out by NHS England for the management of patients on the outpatient waiting list. The Board should note that MIAA has recently reported strong assurance following an audit of waiting list management and practice within the Trust.

4	**Implications**
4.1	**Patients** • The backlog will intrinsically have an impact on patient outcomes, though any harms that may arise from delays in care are reviewed by the Quality Committee. The Trust is committed to ensuring patient safety and providing excellent care and works consistently towards minimising the backlog despite the operational pressures and demands including industrial action.

4.2	**People** • There is no direct impact on our staff at this time.
4.3	**Finance** • The Board approved budget includes the achievement of elective recovery trajectories, and the income provided from that activity. Whilst backlog work continues, anything that impacts the ability to deliver elective recovery could in turn impact the achievement of that element of the budget, although the cost of recovery will inevitably increase due to industrial action lost activity.
4.4	**Compliance** • Whilst no statutory or regulatory mandate surrounds the reduction of the backlog, it is clear that both from a system and central perspective, work on elective activity is of significant importance. It is anticipated that letters such as the one attached to this paper will continue to come through, and the Trust will be asked to demonstrate the controls and measures it has in place to tackle this issue.

C&M Provider / Elective Recovery Programme - Protecting and expanding elective capacity letter Board self-assurance summary
Wirral University Teaching Hospital NHS Foundation Trust - 8th September 2023

Assurance Area	Board Requirement	Assurance RAG	Narrative
1. Validation	a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation.		*The Trust validates after every clinical episode as part of BAU. This continued throughout COVID . It has a full suite of live reports available that are available to all managers across divisions.*
	b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation.		*TheTrust has plans to expand it's existing service and send text messages to every GP referred patient 12+ weeks referral on the outpatient waiting list and ASI PTL. This will be completed by 31.10.23 and patient responses will be updated on the PTL's to aid operational management and audit trail.*
	c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.		*The Trust has a comprehensive RTT training package for all service users. There are live PTL's for all patient cohorts which are monitored weekly. There is also a live patient tracker that is updated after every clinical episode and validated by the central team. Assurance audits are undertaken to ensure accurate clock stops. The Trust has RTT super-users to monitor compliance against the RTT Rules Suite and was recently awarded "Substantial Assurance" by MIAA for the Management of Waiting Lists. There is an Access Policy in place that sets out all rules for the management of the patient pathway.*
	d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.		*The Trust has a full suite of PTL's to manage non-RTT patients including: Outpatient Waiting List, Follow Up Waiting List, Diagnostic Waiting List and Inpatient Waiting List These are monitored as part of BAU at the COO's weekly Performance Oversight Group. Activity plans include non-RTT patients and this cohort of patients has the same level of focus as RTT live patients. There are recovery plans in place across Colorectal, Gastroenterology, Dermatology and Gynaecology to provide additional clinic capacity to reduce the backlog of patients awaiting outpatient appointments.*
2. First Appointments	a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.		*The Trust has an agreed trajectory to have no patient waiting longer than 65 weeks by the end of March 2024 complete with monthly speciality targets. Both 65 weeks and First OPA are closely monitored at the COO's Performance Oversight Group with remedial mitigation actions for any speciality with long first OPA waits or behind plan for 65 weeks.*
	b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers.		*The Trust access's Independent Sector, Mutual Aid, Insourcing/Outsourcing where available. It also has an Outpatient Workstream that includes digital enablers for outpatient solutions.*
3.Outpatient Follow-ups	a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan.		*The Trust has live reports on current performance against follow up activity plans/trajectory. A pilot is underway within Colorectal Surgery for partial booking of overdue follow ups which has had a positive impact on reducing waiting times and unnecessary follow up appointments. It is planned to roll out across all specialities.*

	b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty.		*The Trust is currently rolling out PIFU across all specialities. Current live specialities are: ANAESTHETICS, CARDIOLOGY, COLORECTAL SURGERY, COMMUNITY PAEDIATRICS, DERMATOLOGY, DIETETICS, ENT, GYNAECOLOGY, OCCUPATIONAL THERAPY, OPHTHALMOLOGY, PAEDIATRICS, PAIN MANAGEMENT, PHYSIOTHERAPY, RHEUMATOLOGY, TRAUMA & ORTHOPAEDICS, UPPER GASTROINTESTINAL SURGERY, UROLOGY PIFU uptake is monitored weekly at the COO's Performance Oversight Group and Divisions are working with clinical colleagues to increase uptake and a patient information video has been developed to play in all OP areas.*
	c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments.		*The Trust sends text reminders for OPA's. Patients are tracked after every clinical episode and adherence to the Trust's Patient Access Policy as BAU. A partial booking pilot is underway across Gastro, Dermatology and Pain for new OP appointments and Colorectal for Follow up appointments. As part of this process there is a PIFU element (Colorectal) and patients who are moved across to a PIFU queue are also given a follow up telephone call as standard operational process using a protocol reference guide. Partial booking will be rolled out to all specialities with a drive to reduce DNAs.*
	d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking data (via the Model Health System and data packs) to identify further areas for opportunity.		*A&G is live in: CARDIOLOGY, COLORECTAL SURGERY, ENDOCRINOLOGY, ENT, GYNAECOLOGY, OPHTHALMOLOGY, PHYSIOTHERAPY, RESPIRATORY, , UPPER GASTROINTESTINAL SURGERY, UROLOGY with plans to roll out to all specialities within the next 3 months. A&G is monitored via the COO's weekly Performance Oversight Group. Clinical capacity is flexed to meet demand.*
	e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focusing on maximising clinical value and minimising unneccesary touchpoints for patients, utilising the wider workforce to maximise clinical capacity		*An ambulatory village for Urology and Gynaecology on the cold site (CBH) is in progress. It will include one stop services for patients and increase the nurse led ambulatory clinics. Having both services together will reduce the amount of times patients visit for an apptointment.* *Orthopaedics have commenced my mobility app which will reduce clinic visits for post op elective joints.* *Community Paediatrics have an agreement to implement shared care with primary care for children solely on a melatonin pathway. This will apply to between 500- 700 children on the Trust's 7000 caseload and will estimate a reduction of 1000 – 1400 follow ups a year.*
4. Support Required	The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.		*Yes, no further support required*

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 11**

04 October 2023

Title	Fit and Proper Persons Test Policy
Area Lead	David McGovern, Director of Corporate Affairs
Author	David McGovern, Director of Corporate Affairs
Report for	Approval

Report Summary and Recommendations

This report provides the revised Fit and Proper Persons Test (FPPT) Policy, following changes implemented by the new Framework, and the recommendations from internal audit. This policy was approved by the Audit and Risk Committee at its meeting on the 20th September.

It is recommended that the Board:

- Approve the policy for implementation.

Key Risks

This report relates to these key risks:

- Failure to have strong leadership and governance systems in place.
- Failure of the Trust to have the right culture and organisational conditions/structure to deliver our priorities for our patients and service users.

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	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**
6th September 2023	Board of Directors in Public	Freedom to Speak Up and Fit and Proper Persons	Noting and adoption of the FPPT Framework
20th September 2023	Audit and Risk Committee	Fit and Proper Persons Test Policy	Approval

1	Narrative
1.1	NHSE published a new Fit and Proper Persons Test (FPPT) Framework on 2nd August, which, on top of current requirements, introduces standardised board member reference, and requires FPPT checks to be part of an individual's Electronic Staff Record (ESR). Board will recall adopting this framework formally at its September meeting.
1.2	WUTH's current Fit and Proper Persons Test Policy has now been reviewed in light of this framework, and is attached at Appendix 1 for approval. The new policy includes the amends recommended by the internal audit (provided on the agenda today), and brings the document in line with the requirements of the new framework, including several revisions to the list of those required to undertake a FPPT both on appointment and annually. As per the framework, the policy will now require that Executive and Non Executive Directors, and anyone who could stand in their stead, will be required to undertake FPPT. The policy was approved by the Audit and Risk Committee at its meeting on the 20th September and is recommended for approval to the Board.

2	Implications
2.1	**Patients** • No direct implications for patients, though the new policy will contribute towards ensuring directors are of good character, and in turn make decisions with integrity.
2.2	**People** • The main implications will be those listed as required to complete FPPTs, but overall will contribute to a culture of transparency and probity.
2.3	**Finance** • No direct implications from a financial perspective.
2.4	**Compliance** • The policy has been drafted in line with the new framework, and the internal audit undertaken by MIAA.

Wirral University Teaching Hospital NHS Foundation Trust

Policy Reference: 282

FIT AND PROPER PERSONS POLICY

Version: 3

Name and Designation of Policy Author(s)	Director of Corporate Affairs
Ratified By (Committee / Group)	Trust Board
Date Ratified	
Date Published	
Review Date	31st November 2025
Target Audience	All directors
Other Associated Strategies, Policies, Procedures, etc	Disciplinary Policy Conflicts of interest guidance and policy Professional Codes of Conduct relevant to registered nurses, allied health professionals, medical staff and others

1 Introduction

1.1 All Executive and Non-Executive Director appointments are subject to the Fit and Proper Persons Test ("FPPT") as laid out in Regulation 5 of the Health and Social Care Act 2008 (Regulations of Regulated Activities) (Amendment) (Regulated Activities) Regulations 2014 (the "Regulations") which came into force on 27th November 2014. This Policy also incorporates the requirements of the refreshed framework introduced in August 2023.

1.2 Individuals in these roles must meet the requirements on appointment and continue to meet these requirements whilst holding office as a director.

1.3 The Trust will regularly review the ongoing continuing fitness of a director to hold a Directorship with the Trust. In the event that the Trust determines on reasonable grounds that the Director has ceased to be a "fit and proper person" within the meaning of the Regulations then the appointment may be terminated with immediate effect. (Subject to Trust HR processes for executive directors)

1.4 This policy applies to permanent and interim positions, whether the individual is employed directly or via a third party. The Trust will retain responsibility for carrying out checks on all interim staff, as well as maintaining the relevant evidence.

1.5 The word "Director" is used throughout this policy to include all individuals within this wider definition with autonomy & authority to act in the capacity of a director when required in a manner comparable to an executive director of the Trust.

2 Purpose

The purpose of this policy is to inform those outlined in the scope of their responsibilities in relation to the Fit and Proper Persons Test and to outline the processes that will ensure the test is correctly applied and regularly monitored.

The policy is to set out the required standards based on the guidance issued by the Care Quality Commission (CQC) which emphasises the importance of the Fit and Proper Persons Test in ensuring the accountability of directors of NHS providers.

To ensure the Trust meets its statutory and regulatory requirements, this policy defines the way in which areas of responsibility have been determined, together with processes for assessment checking and compliance monitoring.

The policy for Fit and Proper Persons Tests is based upon the following key principles:

a) The Trust complies with its statutory and regulatory obligations when appointing directors to the Trust Board.
b) The Trust meets the requirements of its Governance framework.
c) The Trust has in place a robust process for the assessment of directors in meeting the requirements of the Fit & Proper Persons Test at the point of recruitment and on an on-going basis.
d) The Trust is prepared for external monitoring and assessment undertaken by regulatory bodies.

3 Scope

3.1 This policy and procedure applies to all Board level appointments, whether on an interim or permanent basis.

The Trust regards the following posts as subject to the 2014 regulations:

a) The Chairman, Non-Executive Directors and Associate Non-Executive Directors
b) The Chief Executive and Executive Directors and those officers required to act as substitutes for Executive Directors in the presentation of reports to Board.

A list of the positions covered by this policy (as defined by the Board) is contained in appendix D.

4 Meeting the Requirements of Regulation 5

4.1 The Regulations places the ultimate responsibility on the Chair to discharge the requirement placed on the Trust, to ensure that all relevant post holders meet the FPPT and do not meet Chief Executive's letter to Executive Directors should include a paragraph to confirm this responsibility. Further detail is provided in the CQC Guidance for NHS Bodies: Fit and Proper Persons: Directors, November 2014,NHS Provider Fit and Proper Persons Regulations in the NHS February 2018 and NHS England Fit and Proper Person Test Framework for Board Members 2023.

4.2 Web links

Fit and proper person requirements: adult social care services | Care Quality Commission (cqc.org.uk)

http://nhsproviders.org/fit-and-proper-persons-regulations-in-the-nhs

4.3 The Trust will make every reasonable effort to assure itself about existing post holders and new applicants and to make specified information about board directors available to CQC on request.

All Directors falling within the scope of the policy as set out in sections (3.1 and 1.4) must provide evidence that they:

- are of good character
- hold the required qualifications and have the competence, skills and experience required for the relevant office for which they are employed
- are capable, by reason of their physical and mental health, after any necessary reasonable adjustments, of properly performing their work
- can supply relevant information as required by schedule 3 of the Regulations
- Have not have been responsible for or privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on regulated activity (or providing a service elsewhere which if provided in England would be a regulated activity).

Regulations a person is deemed "unfit" if:

- The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged.
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986.
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.

- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland.
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

4.4 In accordance with part 2 of the Regulations a person will fail the good character test if they:

- Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom would constitute an offence.
- Have been erased, removed, struck off a register of professionals maintained by a regulator of health care or social work professionals

4.5 **Serious misconduct or mismanagement**

Serious misconduct:

- Misconduct is defined by CQC as a breach of "a legal or contractual obligation imposed on the director," for example an employment contract, regulatory requirements, criminal law or engaging in activities which are morally reprehensible or likely to undermine public confidence. Examples of serious misconduct include assault, fraud and theft.

Mismanagement:

- Mismanagement is defined by CQC as "being involved in the management of an organisation in such a way that the quality of decision-making and actions of the managers falls below any reasonable standard of competent management." Examples of serious mismanagement include any dishonest conduct, continued failure to develop and manage business, financial or clinical plans, and having no regard to appropriate standards of governance.
- While serious misconduct tends to be a single incident, serious mismanagement is likely to refer to actions over a period of time.

Privy to" - misconduct or mismanagement

- "Privy to" means that there is evidence that the director was aware
- Of serious misconduct or mismanagement but did not take the appropriate action to ensure it was addressed. This action could include making a formal complaint or drawing the matter to the attention of the appropriate senior member of staff or a suitable person outside the organisation.
- "Responsible for, contributed to or facilitated" means that there is evidence that a person has intentionally or through neglect behaved in a manner, through action or omission, which would have led to, assisted or enabled serious misconduct or mismanagement.

5 Process for New Appointments

5.1 The Trust's comprehensive pre-employment checking processes are determined by the NHS employment standards and include the following:

- Employment history and reference checks, one of which must be the most recent employer (including validation of a minimum period of three consecutive years of continuous employment or training and details of any gap) and including reasons for leaving;

- Qualification and professional registration checks (as relevant to post).
- Right to work checks.
- Proof of identity checks.
- Occupational Health Assessment.
- Different types of criminal record check, including the Disclosure and Barring Service (DBS), where relevant to the post and where eligibility criteria are met.

5.2 In addition, the following checks shall be carried out for Director appointments:

- Search of the insolvency and bankruptcy register by individual's name
- Search of the insolvency and bankruptcy register by individual's company name, where appropriate
- Search of the disqualified directors register and the removed trustee register.

5.3 The Regulations introduce the requirement to complete a FPP Declaration form for new employees. This form and a copy of this policy will be included within the application pack and form part of the application process, regardless of whether the Trust is employing the individual on a temporary or permanent basis, directly or indirectly.

5.4 While the Trust will have regard to information on when convictions, bankruptcies or similar matters are considered 'spent,' there is no time limit for considering serious misconduct or responsibility for failure in a previous role.

5.5 The Chair of the appointments panel will be responsible for ensuring compliance supported by the relevant recruitment support, with input from the Director of Corporate Affairs. No offers of employment shall be met until this process has been complied with and evidenced.

A detailed checklist will be completed and will be retained on the post holder's personal file for the purposes of audit.

5.6 Any executive or non-executive appointment will take into account the Trust's obligations under the Regulations. Where the Trust makes a decision on the suitability of an individual, the reasons will be appropriately documented.

5.7 Where the Trust deems that the individual who is to be appointed is suitable, despite not meeting the characteristics outlined in Schedule 4, Part 2 of the Regulations (Good Character), and the reasons will be recorded in the minutes of the relevant meeting and the information about the decision will be made available to those that need to be aware. The appointment process will include an evaluation against the Trust's values, and any relevant external guidance. External advice will be sought as necessary.

5.8 Where specific qualifications are deemed by the Trust as necessary for a role, the Trust will make this clear and will only appoint those individuals that meet the required specification; including any requirements to be registered with a professional Regulator.

5.9 The Trust will carry out employment checks (as far as reasonably practicable) on a candidate's qualifications and employment records. The recruitment process will necessarily include a qualitative assessment and values based assessment.

5.10 If the Director has a physical or mental health disability, wherever possible, reasonable adjustments will be made to enable the individual to carry out the role that they have been appointed to.

6 Process for Existing Staff and Ongoing Fitness

6.1 Every year there will be a requirement for post holders to complete a further form of declaration confirming that they continue to be a fit and proper person.

6.2 Individuals will be required to make the Trust aware as soon as practicable of any incident or circumstances which may mean they are no longer to be regarded as a fit and proper person, and provide details of the issue, so that the Trust can consider this.

6.3 If concerns are raised at the pre-employment stage, then the matter will be raised with the Director of Corporate Affairs who undertakes the Fit and Proper Persons checks. The Director of Corporate Affairs will then inform the Chairman who will decide whether the candidate is to be appointed or rejected. It should be noted that any process in relation to the recruitment of the role of Director of Corporate Affairs will be carried out by the appointing person e.g. Chief Executive of Chief People Officer with approval to be received via the Board SID.

6.8 Should the Director fail the Insolvency, Bankruptcy, and Disqualified Directors checks or any other necessary check under the Regulations (post-employment /appointment), or if concerns about the Directors "fitness" are raised by a member of the public or otherwise, the Chief People Officer will notify the Director of Corporate Affairs, who in turn will then take appropriate action. In light of the evidence that is obtained following an investigation, the Chairman will decide whether the individual has ceased to be a "fit and proper person" within the meaning of the Regulations. Any investigation should be undertaken as soon as reasonably practicable.

6.9 The Trust reserves the right to suspend a director or restrict them from duties on full pay / emoluments (as applicable) to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the interests of service users or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

6.10 Should there be sufficient evidence to support the allegation(s), then the Trust will consider terminating the appointment of the Director with immediate effect (in line with the Trust's Disciplinary policy).

6.11 When a director no longer meets the requirements of Paragraph 3 of the Regulation and is a health care professional, or other professional registered with a health or social care regulator, then the Trust will inform the regulator in question.

7. Concerns regarding an individual have continued FPP compliance

7.1 If, either at the time of appointment or later, it becomes apparent that circumstances exist or have arisen whereby an Executive Director may not be considered to meet all the requirements of a 'fit and proper person', the Director of Corporate Affairs shall inform the Chair. If this concern relates to the Director of Corporate Affairs then the CEO will inform the Chair and oversee the matter.

7.2 The Chair will lead on addressing these concerns on a case by case basis and will need to consider whether an investigation is necessary or appropriate given the allegation.
Where it is necessary to investigate or take action, the Trust's current processes will apply using the Trust's Capability Policy and Procedure or the Attendance Management Policy (managing performance or sickness absence), Trust's Disciplinary procedure or afforded a similar process to this if the potential discontinuation could be due to 'some other substantial reason'.

7.3 The Trust reserves the right to suspend a director or restrict them from duties to allow the Trust to investigate the matters of concern. Suspension or restriction from duties will be for no longer than necessary to protect the interests of patients or the Trust and/or where there is a risk that the Director's presence would impede the gathering of evidence in the investigation.

7.4 Should the Chair consider the individual to be suitable, despite existence of information relevant to issues identified in Schedule 4, Part 2, the Chair's reasons should be recorded for future reference and made available.

7.5 If an investigation concludes that an individual carrying out an identified position under this policy may no longer meet the requirements of the "fit and proper person test" the following two-stage procedure will be applied:

7.6 **Fit & Proper Person Hearing** - If there is sufficient evidence that an individual carrying out one of the identified positions under this policy may no longer be a fit and proper person, and the evidence is such that formal action may be required, then that person will be invited to a hearing to give them the opportunity to test the evidence and/or offer an explanation for consideration.

7.7 **Fit & Proper Person Appeal Hearing** - If an individual carrying out one of the identified positions under this policy has been determined to no longer be a fit and proper person, then that person may appeal that decision in writing within fourteen calendar days of receipt of notification of the Trust's decision.

7.8 Should there be sufficient evidence to support the allegation(s), then the Trust may terminate the appointment of the Director with immediate effect, in line with the Trust's Disciplinary policy. Where an individual who is registered with a professional regulator (General Medical Council (GMC), Nursing & Midwifery Council (NMC) etc.) no longer meets the fit and proper person's requirement the Trust must inform the regulator and take action to ensure the position is held by a person meeting the requirements.

7.9 The criteria and process around the removal of Non-Executive Directors, including the Chair, is outlined in NHS Improvement's "Arrangements for the Removal or Suspension of NHS Trust Chair and Non-Executive Directors and NHS Charity Trustees" (or for a Foundation Trust within the Trust's Constitution)

8 Annual Review Process

8.1 The Trust is responsible for ensuring the continued "fitness" of those persons who the requirements apply. The Trust will therefore undertake the following on an annual basis:

a) The completion of an annual self-declaration form by all those named within the Scope of this policy, the process for this will be managed and co-ordinated by the Director of Corporate Affairs after the end of each financial year, 31st March. A copy of the signed self-declaration form should be returned to the Director of Corporate Affairs and subsequently placed on the director's personal file. It is the responsibility of the Director of Corporate Affairs to escalate any non-compliance to the Chair.

b) The Director of Corporate Affairs will undertake annual checks of the insolvency, bankruptcy and disqualified directors register after the end of the financial year, 31st March. It is the responsibility of the Director of Corporate Affairs to escalate any non-compliance to the Chair.

c) The formal appraisal process, enhanced to address the Fit & Proper Persons requirements, will be undertaken by the appropriate person with line management responsibility.

d) In the case that there is a non-compliance matter relating to the Director of Corporate Affairs then this matter will be overseen by the CEO in liaison with the Chair.

11 Duties & Responsibilities

Individual Roles

Chair	The Chair is ultimately responsible to discharge the requirement placed upon the Trust to ensure that all directors meet the requirements of the Fit and Proper Persons Test and do not meet any of the 'unfit' criteria. The Chair is also subject to the requirements of the test. The Chair is responsible for taking the necessary action to ensure existing directors who no longer meet the regulations of the FPPR (i.e., are deemed 'unfit') do not continue in their role
Senior Independent Director/Vice Chair	The Senior Independent Director or Vice Chair is responsible for undertaking independent verification on Fit and Proper Persons checks
Chief Executive	The Chief Executive although subject to the requirements of the test is also accountable to the Board for the Trust's compliance with statute and regulation.
Chief People Officer	The Chief People Officer is responsible for ensuring that all employment checks are undertaken in accordance with Trust policy and procedures for new appointments and that the annual checking process is adhered to for all those directors in post.
Director of Corporate Affairs	The Director of Corporate Affairs is responsible for ensuring that all checks are undertaken in accordance with the Fit and Proper Persons policy and that the Trust complies with its statutory and regulatory requirements.
Executive and Non-Executive Directors	All Executive and Non-Executive Directors as outline in the scope of this policy are accountable for ensuring they meet the requirements of the Fit and Proper Persons Test on appointment and complete annual self-declarations. They are also responsible for informing the Chair if during the course of employment or term of office they no longer meet the requirements of the Fit and Proper Persons Test and therefore are deemed "unfit."

Committee Roles

Board	The Board is responsible for the performance management of this policy.

12 References

Acts of Parliament
Health & Social Care Act 2008 (Regulated Activity) Regulations 2014: Regulation 19.
Regulations
Care Quality Commission (CQC) Guidance for NHS bodies November 2014 - Regulation 5: Fit and proper persons: Directors.

Websites
Care Quality Commission - www.cqc.org.uk

NHS Sources
NHS Employers - www.nhsemployers.org

NHS Improvement
Trust Licence No. 130142 section G4 – Fit and Proper Persons

Regulatory Bodies
Care Quality Commission (CQC)

Appendix A – Fit and Proper Persons Declaration – Non Executive Director

1. Non-executive roles in the NHS are positions of significant public responsibility and it is important that those appointed can maintain the confidence of the public, patients and NHS staff. NHS Improvement has a duty to ensure that those we appoint to NHS boards are of good character, will ensure an open and honest culture across all levels of the organisation. The "Fit and Proper Person" requirements are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2. By signing the declaration below, you are confirming that you are a "fit and proper person" outlined at (2), that you do not fall within any of the categories outlined at (4) or (5) below and that you are not aware of any pending proceedings or matters which may call such a declaration into question in the future.

3. The regulations require you are:

   (a) of good character.
   (b) have the necessary qualifications, competence, skills and experience; and
   (c) are able by reason of your health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position.

4. Do any of the following conditions apply to you? You are asked to confirm that you are not:

   (a) a person who has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence.
   (b) a person who has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.
   (c) an undischarged bankrupt, or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged.
   (d) the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland.
   (e) a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40).
   (f) a person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it.
   (g) included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern

Ireland.

(h) a person who has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

5. In addition, the following conditions disqualify you from appointment as a chair or non-executive director of an NHS Trust. You are asked to confirm that you are not:

(a) an employee of the NHS Trust with the vacancy.
(b) a chair or member of the governing body of a clinical commissioning group, or employees of such group.
(c) a serving MP nor MEP or a candidate for election as MP or MEP.
(d) a person who has been dismissed (except by redundancy) by any NHS body.
(e) a person whose earlier appointment as chair or chair or non-executive director of an NHS trust was terminated.
(f) under a disqualification order under the Company Directors Disqualification Act 1986. and / or
(g) a person who has been removed from trusteeship of a charity.

DECLARATION

☐ I confirm that I do not fit within any of the categories listed at (4) or (5) and that there are no other grounds under which I would be ineligible for appointment. If appointed, I undertake to notify NHS Improvement immediately of any change of circumstances that may affect my eligibility to remain in post.

☐ I wish to declare the following information which may be relevant to my eligibility for this role:

Signature: **Name:** **Date**

Disclosure of wider interests

Role:	Organisation:	Detail:	Paid/Unpaid:

Appendix B – Fit and Proper Persons Declaration (Executive Director)

1. Executive roles in the NHS are positions of significant public responsibility and it is important that those appointed can maintain the confidence of the public, patients and NHS staff. The Trust has a duty to ensure that those we appoint to the board are of good character, will ensure an open and honest culture across all levels of the organisation. The "Fit and Proper Person" requirements are set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

2. By signing the declaration below, you are confirming that you are a "fit and proper person" outlined at (2), that you do not fall within any of the categories outlined at (4) or (5) below and that you are not aware of any pending proceedings or matters which may call such a declaration into question in the future.

3. The regulations require you are:

   (a) of good character.
   (b) have the necessary qualifications, competence, skills and experience; and
   (c) are able by reason of your health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position.

4. Do any of the following conditions apply to you? You are asked to confirm - Yes or No:

	Questions	**Y**	**N**
4a	a person who has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if omitted in any part of the United Kingdom, would constitute an offence		
4b	a person who has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals		
4c	an undischarged bankrupt, or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged		
4d	the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland		
	Questions	**Y**	**N**
4e	a person to whom a moratorium period under a debt relief order		

	applies under Part VIIA (debt relief orders) of the Insolvency Act 1986(40)		
4f	a person who has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it		
4g	included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland		
4h	a person who has been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (Whether unlawful or not) in the course of carrying on a regulated activity or discharging any functions relating to any office or employment with a service provider.		

5. In addition, the following conditions may disqualify you from being an Executive Director of an NHS Trust.

You are asked to confirm - Yes or No:

	Questions	**Y**	**N**
5a	a person who has been dismissed (except by redundancy) by any NHS body		
5b	under a disqualification order under the Company Directors Disqualification Act 1986; and/or		
5c	a person who has been removed from trusteeship of a charity		

You are asked to confirm that you have - Yes or No:

	Questions	**Y**	**N**
5d	the qualifications, skills and experience necessary for the relevant position		

You are asked to confirm that you are - Yes or No:

	Questions	**Y**	**N**
5e	capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010		

DECLARATION

☐ I confirm that I do not fit within any of the categories listed at (4) or (5) and that there are no other grounds under which I would be ineligible for appointment. If appointed, I undertake to notify the Trust immediately of any change of circumstances that may affect my eligibility to remain in post.

☐ I wish to declare the following information which may be relevant to my eligibility for this role:

Signature: **Name:** **Date:**

Disclosure of wider interests

Role:	Organisation:	Detail:	Paid/Unpaid:

Appendix C - Pre-Employment Fit and Proper Persons File Check List

Name:	
Position:	
Date of Commencement:	

Criteria for checking:	**Evident on file:**
Disclosure and Barring Service (DBS) disclosure	Yes/No If no state reason:
2 Satisfactory References (3 for Medical Director)	Yes/No If no state reason:
Employment History – application form or CV	Yes/No If no state reason:
Occupational Health Clearance	Yes/No If no state reason:
Relevant qualification(s) e.g., Professional Body (if applicable)	Yes/No/NA If no state reason:
ID Documentation	Yes/No
Fit & Proper Persons Test – Self Declaration Form	Yes/No If no state reason:

Has the insolvency, bankruptcy and disqualified directors register been checked by the Director of Corporate Affairs?	Yes, no concerns □	Yes, concerns escalated □	Register not checked: □
			Reason for not checking:

Authorising Signatory:

Signed:
Name:
Position: Senior Independent Director/Vice Chairman
Date:

A copy of this form should be retained on the individual's personnel file.

Appendix D – 25 Roles currently covered by the enhanced FPP Policy

ROLE
Chair of the Board
Senior Independent Director (SID)
NEDs x 5
Chief Executive Officer
Medical Director
Chief Nurse
Chief Operating Officer
Chief People Officer
Chief Finance Officer
Chief Strategy Officer
Director of Corporate Affairs
Chief Information Officer
Director of Communications and Engagement
Director of Estates and Facilities and Capital Planning
Deputy Medical Director (Professional Standards)
Deputy Medical Director (Quality and Patient Safety)
Deputy Chief Nurse
Deputy Chief Operating Officer
Deputy Chief People Officer
Deputy Chief Finance Officer
Board Secretary

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 12**

4 October 2023

Title	Organ Donation Annual Report
Area Lead	Dr Nikki Stevenson, Medical Director/Deputy CEO
Author	Dr Rosie Holmes (Clinical Lead for Organ Donation) Angela Campion-Sheen (Specialist Nurse Organ Donation)
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide a detailed account of organ donation activity within Wirral University Teaching Hospital (WUTH) for the period 1st April 2022 – 31st March 2023. Organ donation activity is monitored via the Potential Donor Audit (PDA) through NHS Blood and Transplant (NHSBT) and overseen locally by the Organ Donation Committee (ODC) which meets on a quarterly basis. Lead members of the committee are:

- Dr. Steve Ryan - Chair (Non-Executive Director) WUTH
- Dr. Rosie Holmes - Clinical Lead for Organ Donation (CLOD) WUTH
- Angela Campion-Sheen - Specialist Nurse – Organ Donation (SNOD) NHSBT/WUTH

Organ donation activity takes place predominantly within the Critical Care Unit, with some activity within the Emergency Department at WUTH. There are two groups of patients who can donate solid organs after death:

1) patients who have been pronounced dead using neurological criteria and are ventilated on a life support machine. This is known as Donation after Brain Stem Death (DBD).
2) patients who are mechanically ventilated with overwhelming single organ failure (usually brain) and a decision has been made to withdraw life-sustaining treatment (WLST). This is known as Donation after Circulatory Death (DCD).

Organ donation is a complex process requiring multi-disciplinary co-operation. Potential organ donors are identified by medical and nursing staff in the above units and subsequently referred to the on-call organ donation team. It is imperative that potential donors are identified and referred in a timely manner.

All organ donor activity, including potential donors, is monitored via the PDA. This is a national audit that commenced in 2003 as part of a series of measures to improve the rates of organ donation. The principle aim of the audit is to determine the number of potential solid organ donors in the UK, and to provide information about the hospital practices surrounding donation and how local teams are contributing to this. It provides a breakdown of information, including reasons why some potential donors do not go on to become solid organ donors. All deaths in the Critical Care Unit and Emergency Department are included in the audit which is input to the NHSBT databases for analysis.

It is recommended that the Board:

- Note the report

Key Risks
This report relates to these key Risks: • Maintaining compliance with reporting guidelines and regulations regarding organ donation.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	No

Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	No
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**
August 2023	Patient Safety Quality Board	As above	Information

1	Narrative
1.1	**Introduction** Donation activity data is obtained via the NHSBT PDA. This is collected and collated by our dedicated embedded SNOD who inputs the data into the national audit. The SNOD is essential for the success of the organ donation program. The global COVID-19 pandemic caused a significant negative impact on organ donation (OD), not only within WUTH but the NHS as a whole. Fortunately, numbers have increased again and are close to levels of OD seen pre-pandemic. This has coincided with the return of WUTH's embedded SNOD, meaning WUTH is engaging well with the organ donation process, and it has data to present for the year April 2022 – March 2023. All Trusts within the UK are categorised into different Levels according to their donation activity and specifically the number of proceeding donors per year over a three-year period. In November 2022 the National Organ Donation Committee made the decision to re-categorise hospitals based on previous years donation activity up until 31st March 2022. The aim of this is to group together hospitals with similar donor activity to ensure that like for like data can be compared, and at annual UK OD meetings, hospitals with similar donor activity levels can share information and experiences. WUTH falls into the

	Level 3 category: an average of more than 3 but less than 6 proceeding donors per year.
1.2	**Key Issues** The following statistics represent data obtained from local records within WUTH. It includes all audited deaths within the Critical Care Unit and Emergency Department for adult patients up to the age of 85. It also includes patients that have died outside the critical care unit following non proceeding donations because of prolonged asystole. The column on the right of the table shows comparator data from the National PDA across the whole of the UK. Please note that this data excludes patients over 80 years of age, despite patients aged up to 85 (but not actually 85) being eligible. **Key Figures: Key numbers comparison with National Rates, 1st April 2022 – 31st March 2023**

	DBD	DCD	UK wide PDA data 2022 - 2023
Patients meeting OD referral criteria	11	38	6910
Referred to NHSBT	10	31	6482
Referral rate %	91%	82%	94%
Neurological death tested	5 (5 became unsuitable for testing)	-	
Testing rate %	100%	-	
Eligible donors	5	23	4906
Family approached	4 (1 unsuitable for approach)	4	2935
Collaborative approach	4	4	2716
% collaborative approaches	100%	100%	93%
Consent ascertained	2 (2 known opt-out)	2 (1 opt-out, 1 opt-in but family override)	1805
Consent rate	50%	50%	61%
Actual donors	2	0 (1 prolonged time to asystole, 1 screened out)	1419
% of consented that became actual donors	100%	-	79%
Missed potential	1	1 (late referral after withdrawal of life sustaining treatment)	
Number of patients receiving organ transplants	8		

The table above shows that for 49 patients who were potential donors, 2 patients' end of life decisions to donate were honoured and facilitated. This resulted in 9 organs being donated and 8 patients receiving life-saving transplants.

- 1 person received a heart transplant
- 2 people received liver transplants
- 4 people received kidney transplants
- 1 person received a pancreas transplant

	- 1 person donated heart valves - 1 person donated their pancreas for research The figures include all possible patients from the Critical Care Unit and Emergency Department; all referrals came via the critical care team. The numbers highlight the successful collaboration between the Critical Care Unit, SNOD and Transplant Teams. In particular, the introduction of a referral reminder in the ICU morning safety huddle has improved our referral rate, achieving a high referral rate since. Local consent rate figures are adjusted to account for known decisions not to donate which gives us an approach rate of 100%. The low referral rate for our DCD patients was due to 1 patient having an absolute contraindication (≥85 years), 3 patients were clinically unsuitable and although 3 patients were missed required referrals, they would all have been excluded from DCD for clinical reasons. The seemingly large difference between the number of those eligible to donate and those where the family are approached is for a variety of reasons, including known decisions to opt-out, clinical instability post referral and patient death prior to approach. In the last year there were 2 missed potential donors, one DBD and one DCD; unfortunately, both these occurred within the footprint of the Emergency Department. The missed DCD was due to a late referral from the Critical Care team once withdrawal of life sustaining treatment (WLST) had already been implemented; they did not think the patient would be medically suitable for donation. Alas, in this instance, the patient had opted in on the Organ Donor Register (ODR) and the family were keen to honour their wishes, however this was not possible. Apologies were made to family and the patient did go on to successfully donate tissues. The incident occurred in the Emergency Department on a very busy shift and the missed potential has been discussed with those involved. The missed DBD was a patient who had had a severe intra-cranial bleed. Despite absent cranial nerve reflexes, neurological death testing was not considered. This occurred whilst our embedded SNOD was away and was investigated by the visiting SNOD looking after the PDA. There are no specific learning points, however it is felt that both the Critical Care Unit and Emergency Department would benefit from an update to recent changes in Organ Donation, including when and how to refer. The Critical Care update is planned for the next Audit Meeting.
1.3	**Organ Donation Committee** The Organ Donation Committee meets quarterly and is chaired by Dr Steve Ryan, Non-Executive Director. This gives strategic direction to organ donation activity. In January 2023, Angela, our SNOD, recruited new OD link nurses from the Critical Care Unit, Emergency Department and theatres to raise awareness, promote organ donation and collaboration. We continue to raise the public profile of organ donation at WUTH mainly through the ongoing efforts of Paul Dixon, our volunteer. He has continued to help increase the numbers of people signing up to the Organ Donor Register on the Wirral. Organ Donation Week runs from Monday 18th to Sunday 24th September 2023. There will be a stall in the main entrance for the duration of the week, we have purchased a flag to be raised on the hospital's flagpole and the front of the hospital will be lit up pink.

	We are liaising with Wirral Borough Council to have the lighthouse in New Brighton lit up pink too. As a committee, we will continue to work collaboratively with Wirral Borough Council to design and create a permanent memorial that publicly recognises and acknowledges the patients and their families that have generously given the gift of life through organ donation within WUTH. This is a progressive piece of work supported by the Trust's Chief Executive.
1.4	**Clinical Guidelines** The WUTH Organ Donation Guidelines are up to date and reflect current national guidance.
1.5	**Conclusion** Performance in organ donation is compliant with CG135 and is within acceptable national targets in many of the key metrics measured. There continue to be missed a small number of potential donors; however, we hope that with continuing education and raising awareness, these missed opportunities will continue to decline.

2	Implications
2.1	**Patients** • At the heart of every potential donation there is a patient. Their, and that of their family's journey and care remains the top priority even after referral to the Organ Donation team. The process is clearly explained, and the family are involved from the very start. They receive support not only from the Critical Care team but also the SNOD involved in the case. They are free to change their mind about whether or not they would like to explore organ donation at any point, and their wishes are always honoured and respected. • A safety huddle occurs every morning on the Intensive Care Unit. It is usually at this point that any patients who may fulfill Brain Stem Death criteria or whom may have treatment withdrawn are identified. Nursing staff as well as doctors are closely involved in the process and if someone requests not to be involved, that is facilitated.
2.2	**People** • Organ donation is acknowledged to be a difficult process for staff to go through. It can be extremely lengthy and is usually highly emotive. As such, support is given throughout the entire process by the SNOD involved in each case. There is an opportunity for a debrief after donation and the SNOD and/or CLOD endeavour to liaise with individual members involved in the process. • It is recognized that from referral to donation can be well over 24 hours. This in itself is a huge resource requirement as it requires a dedicated Critical Care nurse and bed for the duration, as well as time in theatre if the donation proceeds. The Critical Care Unit and Trust support and help facilitate every donation.
2.3	**Finance** • Funding is currently through NHSBT; the SNOD is employed through NHSBT and the CLOD's PAs are funded by NHSBT. The Trust receives a donation from

	NHSBT for proceeding donors. Funds are currently held in a separate account, spending from which is authorized by the Organ Donation Committee.
2.4	**Compliance** • WUTH continues to follow Best Practice Guidance for organ donation and is audited annually via the NHSBT PDA.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 13**

4 October 2023

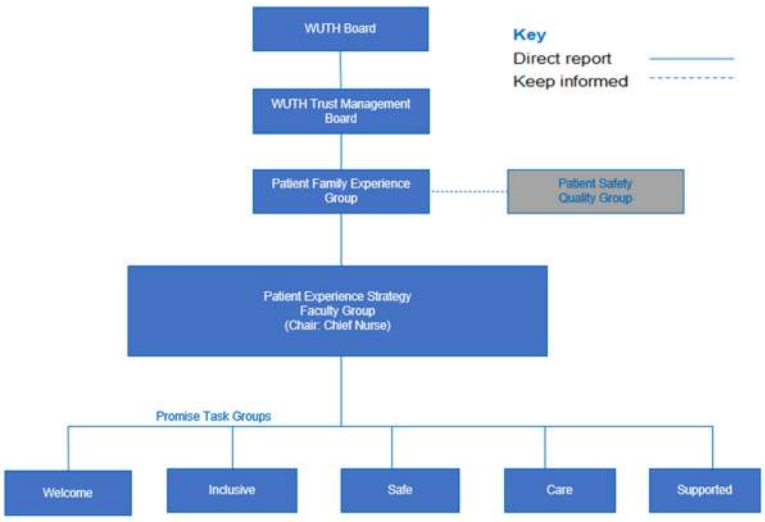
Title	Patient Experience Strategy Annual Report
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and AHPs Director of Infection Prevention and Control
Author	Johanna Ashworth-Jones, Programme Developer Patient Experience and Nurse Quality Indicators
Report for	Information

Report Purpose and Recommendations
The purpose of this report is to provide an annual overview of the implementation of the patient experience strategy since its implementation April 2022, initial achievements, and general objectives for 2023/24 including workstreams identified to date. It is recommended that Board: • 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

1	**Background**
1.1	WUTH launched its strategies framework for 2021 – 2026 with the goal of delivering against seven enabling strategies. Patient Experience, Quality and Safety Strategy was originally a combined strategy however, to ensure that there were clear intentions set, measurable outcomes, and that the strategy could be easily followed and embedded the patient experience element was separated out into its own enabling strategy. For the strategy to be meaningful and have ownership across the community that WUTH serves, the strategy was co-produced by patients, carers, staff, Voluntary Charity Faith groups VCF and Healthwatch.

	The methodology used to co -produce this consisted of a series of 14 workshops where participants were asked to develop the key aspects of the strategy. These were consolidated into three potential options as there was significant synergy across the 14 submissions. The three options were then put out to public vote on all aspects of the strategy, the vision, the promise statements, and the visuals. A total of 1915 votes were received, and the winning strategy option was launched publicly April 2022. 
1.2	**Structure & Governance** The strategy consists of 5 key promises, Welcome, Inclusive, Safe, Care and Supported. These "Promise" groups consist of a Chair, Deputy Chair and representations from, Patients, VCF, Health watch, Carers, WUTH Governors and WUTH staff. Chairs and Deputy Chairs are expected to present progress against their promise at the Patient Experience Faculty group meeting Chaired by the Chief Nurse, governance structure diagram below.  The establishment of each promise group has a structured format as follows, • Quality framework, this allows the group to compare external, internal, and combined metrics such as CQC experience survey ratings, Friends and Family test feedback etc. • Agreed self-assessment criteria set against the CQC quality ratings. • Terms of Reference • A scheduled two month focus on the promise which includes. ▪ An interactive public workshop

- A Trust promise group walk around.
- A focused promise questionnaire
- Group pen portraits
- Staff Pledges – This was launched September 2022

- Identified workstream based on service user feedback.
- Co production or engagement approach

Whilst the promise groups have a consistent approach to support deliverability and governance, the identified workstreams are fluid and clearly aligned to service user feedback, including new workstreams and priorities identified outside of the focused intel periods. Within year one the overarching strategy objectives focused mainly on the development and implementation of this structure as displayed in table one below. All these objectives have been achieved.

	Strategic Priorities	Progress with Strategic Plans and Priorities (Measurable KPIs and Trajectories)	KPI of Delivery RAG rating	Evidence of Outcome- business case, performance improvement etc.
	Patient Experience Vision Priorities			
1	Establish promise groups & faculty group	Completed		Group action notes, Social media, focus months
2	Establish promise group assurance frameworks	Completed		Frames utilised by Promise group to provide promise self rating
3	Establish rating dashboard	Completed		Presented to TMB, PFEG, PSQB
4	Run promise group double focus months to include engagement workshops, walk arounds and focused surveys for 3 of Promise groups	Completed 4 which is an additional one over objective target		Promise group awareness coms, work streams established form workshops, meet the promise group, social media
5	Collaborative work designing feedback forms for children and young people	Completed		Feedback form created and available for order
6	Establish social media forums	Completed		Facebook = approx. 3.5k, Twitter = approx. 1K, Instagram = approx. 700. You tube channel & tik tox launched
7	Develop a Patient experience Newsletter	Completed		Quarterly newsletter , circulated to partnership VCF groups, posted on social media

The other fundamental element to the deliverability and success of the strategy was to develop communication avenues that would also promote engagement. In year one these consisted of the development of a newsletter both digital and paper versions, and the creation of social media platforms. Of the social media platforms Facebook as been the most successful with approx. 3.5k followers/friends, this has also been successful in providing engagement and feedback opportunities. @patientwuth which is the strategies social media handle is also active on Twitter, Instagram and has launched its own you tube channel and tick toc as part of several promotional avenues for associated workstreams.

Social media holds significant benefits as a communication enabler such as reaching a wide and diverse audience instantly, this can also work from a negative perspective where members of the public can comment adversely in an open domain. Whilst this was considered an initial risk it has been a positive outcome, demonstrating an open and transparent approach from WUTH and providing an opportunity to listen and act. Year two will focus on widening communication and engagement opportunities with community-based stalls and presentations to ensure that the strategy is receiving feedback that is reflective of the population it serves and is communicating in a variety of ways that does not exclude those who are not digitally enabled.

1.3 **NHSI / E Patient Experience Improvement Framework**

In 2018 NHSI/E launched its patient experience improvement framework. Dissemination throughout the NHS at a Trust level was understandably delayed due to the Covid pandemic. As we learn to live with Covid the expectation is that Trust will demonstrate their performance again the framework on a self-assessment basis. The framework consists of 23 overarching domains and a total of 53 indicators. These domains span a variety of operational and strategic aspects including workforce,

leadership, external partnership working and internal processes to respond to and include patient experience feedback. One of the most significant requirements is that NHS Trust's should have a patient experience strategy. The progression and monitoring of the NHSI/E framework is undertaken via the patient experience strategy faculty group, reporting into the Patient Family Experience Group which has external partners within its membership to provide external scrutiny. Detailed below is the self-assessment ratings progression from its baseline April 2022 compared with January 2023.

	Organisational Self Assessment Score					
	5	4	3	2	1	0
Apr-22	14	15	20	4	3	0
Jan-23	16	17	19	2	2	0

The self-assessment evaluation will be repeated in June 2023 and presented to the patient experience strategy faculty group 12th July 2023.

There has also been a noted improvement in FFT, with the Trust consistently above the national average since December 2022.

Feb-23	ED	Inpatients	Outpatients	Maternity
National Average	80%	94%	93%	93%
Wirral University Teaching Hospital	81.42%	96.26%	95.01%	95.45%
Countess of Chester	No Data	No Data	No Data	No Data
Liverpool University Hospitals/Liverpool Women's	69%	92%	93%	80%
St Helens & Knowsley - Whiston Hospital	78%	96%	95%	100%
Mid Cheshire	90%	95%	94%	100%

1.4 Co production

In year one it was anticipated that most of the engagement within the strategy would be from Wirral's adult population. A conscious decision was therefore taken to ensure that children and young people had an opportunity to contribute with targeted workstreams. NHS England requires hospitals to undertake a patient experience questionnaire known as the friends and family test FFT. WUTH have an inclusive approach to this FFT collection with different methodologies available including paper questionnaires. The paper questionnaire is available in different formats, general, easy read, maternity services, and children & young people.

The children and young people version was out dated and required a change of wording format to meet with NHS England guidance. This required update, provided an opportunity to engage with children and young people to co – produce a FFT questionnaire that encourages them to capture the voice of the child. This co production design task also provided the opportunity to meet with children and young people and socialise the patient experience strategy, including various elements aligned to the promise focus months.

The co – produced children's and young person's FFT card has been implemented across the Trust and will be evaluated in September 2023. The FFT card is displayed below along with a couple of photos from one of the co- production and engagement events.

2	Promise groups
2.1	**Welcome Promise *"Being made to feel at ease and reassured"***

The Welcome promise group was launched May 2022 and has had a total of 6 meetings to date. Welcome has a current self-assessment rating of "Good" which has improved from its initial rating of "Requires Improvement".

Focus months for Welcome were held September and October 2022 and consisted of each of the elements described within the outlined focus month structure. The collection and review of service user feedback focused predominantly on a celebration of WUTH staff and how they routinely adhere to the Welcome promise, areas where improvement requirements were identified centered on orientation which has been broken down into several orientation domains as detailed below. Service users explained that their experience journey starts long before being seen by a healthcare professional and in some cases, areas identified as requiring improvement can increase for some, additional anxiety, and nervousness.

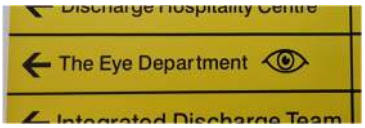
Orientation

- Signage
- Site maps
- Ward / unit information leaflets
- Way finding volunteers
- Patient information videos

In addition to orientation the group were also asked to look at staff smoking policy / cessation, as service users reported that being attended too by staff that smell of tobacco smoke did not put them at ease.

Co-production and engagement are at the core to ensuring that the patient experience strategy is successful. The Welcome group have incorporated this into their workstreams with examples evident including two way finding events, where current and potential patients joined people supported by Wirral Mencap and WUTH staff to navigate to departments across the Arrowe park hospital site.

As a result of these wayfinding events several changes to signage have been made and temporary stair well and lift directories created and displayed. The group has further plans to complete additional way finding events on the Clatterbridge site and other Arrowe park areas.

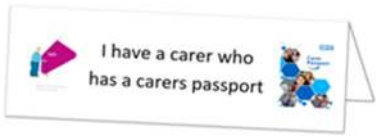


Patient / service users indicated that they wanted to receive information in a more accessible format, that meets a higher level of expectation in terms of information required that may not be easily conveyed in writing, and that could also support patients with complex needs or anxiety. It was suggested that short information films / videos should be considered as this format would meet several requirements, such as desensitisation techniques, digital communications, reasonable adjustments such as average reading age, environmental impact of leaflet production etc. Since establishing the workstreams two orientation videos have been produced based on service users' requests and a review of Trust activity data to maximise the need. These orientation films are for the SEAL unit, preparing people coming in for minor surgery and the Endoscopy Department which prepares people for this investigative procedure.

Both of these orientation films have been very successful in terms of feedback, with other NHS providers contacting WUTH in relation to the process so that they can also undertake a similar approach. The Welcome group will be responsible for reviewing requests for other orientation films to ensure that these meet the needs of the service

	users. The next orientation film has been commissioned and will focus on needle phobia and will include some of WUTH's service users taking part in the filming. The Welcome group were the first group to launch staff pledges as part of raising awareness of the patient experience strategy and ways for everyone to get involved. This was very popular with all designations of staff as it is felt that all staff can relate to making service users feel welcome, at ease and reassured.    Challenges around car parking have been raised via the welcome group and via numerous other patient experience feedback opportunities. Given that estate and facilities is a significant theme within each of the promises there is departmental representation on each promise group. In addition, the Environmental Matron has been identified as the main link between the patient experience strategy and the estate & facilities department with a formal process put in place to monitor progress and updates.
2.2	**Inclusive Promise group** "***Listening to me and respecting me as an individual"*** The inclusive promise group was established September 2022 and has had a total of 3 meetings. Focus months are planned for June & July 2023 however service user feedback has been very evident in relation to this promise and an initial two workstreams have been established as follows: • Deaf and hearing-impaired awareness • Trans and non-binary It is well documented that the Covid Pandemic has widen the health equalities gap for deaf and hearing-impaired service users, whilst IPC transparent face masks were introduced towards the end of the pandemic service users reported challenges with these such as glare, positioning and fogging inhibiting lip reading for those that can ultise this to support communication. WUTH have responded to this feedback through the strategy and arranged an engagement session where service users who are deaf or have a hearing impairment were invited to vote on the best transparent IPC approved face mask reviewing all the available options. The group unanimously voted on a product and as part of the strategy this will be the mask used across the Trust. Samples and stock ordering details will be circulated to all areas early June 2023. WUTH is working closely with the Merseyside society for deaf People MSDP to capture experiences and develop an improvement plan. Feedback focuses on the following areas: • Identification – Accessible information standard • Translation and interpretation provision • External communication e.g., phone services • Staff awareness and support • Practical solutions – Reasonable adjustments

	May 1st -5th 2023 is Deaf awareness week and WUTH will utilise this opportunity to highlight the challenges faced by service users and provide practical support to staff on communication tips this will also include most commonly used British Sign Language BSL. The trans and non-binary group have had a total of two meetings. Feedback and improvement suggestions has focused on two main domains, forms of address / demographical documentation and staff awareness. Formulation of the improvement plan for these areas is in progress.
2.3	**Safe Promise Group *"Feeling safe and having Trust in the staff"*** Safe is a very emotive word especially in the NHS, as healthcare professionals there is significant focus on delivering safe care, with scrutiny on clinical outcomes and harms. Service users however report that the feeling of safe is based on trust and confidence creators which demonstrates the importance of listening to service users to understand their perspective. The Safe Promise group was established July 2022 and has had a total of 5 meetings. Focus months were completed during November and December 2022, months that are historically associated with high operational demands when patients having trust in staff and feeling safe is paramount and served as a great reminder and opportunity to raise awareness amongst staff. Patients and Carers have raised frustrations in relation to the provision and sharing of information that is pertinent to their care with examples shared of staff being unaware and or services users having to repeat the information to each new staff member. Across Wirral and within the Trust the provision of health information passports is available for patients and Carers but are not widely known or utlised, these include, health passport for learning disabilities, Carers passports, catheter passports, veterans passports etc. The need to raise awareness of these passports was identified as the Safe promise groups first workstream. Given the number of different passports in use this was proposed as a phased approach with Carers and LD health passports being in phase 1. This workstream has consisted of general awareness raising and the development of alert signs that patients can display and show staff to promote the use of their passport, this was initially piloted on two wards and subsequently rolled out to a total of 6 wards. The pilot will be formally evaluated in June 2023 and potentially rolled out across the Trust.



The safe promise group have chosen a further two workstreams based on service user feedback, these will be, empowering patients to keep safe whilst in hospital and a reinvigoration of the “Hello my name is campaign”.

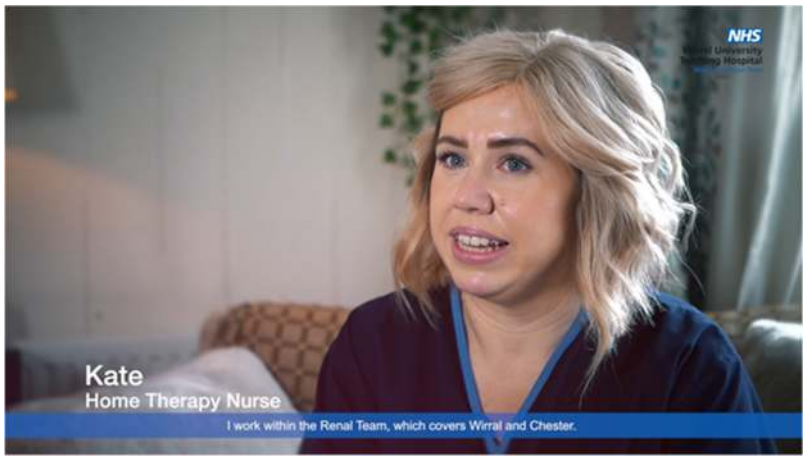
The original Hello my name is campaign launched by Dr Katie Granger following her cancer treatment 2013, was hailed as the first rung on the ladder to providing truly person centered, compassionate care and was extremely successful. Feedback from patients has suggested that the importance of staff introducing themselves has lessened and that this is an important factor in building trust and rapport with staff to make them feel safe. Whilst this is the fundamental of the originally campaign additional feedback from staff members and service users has suggest a 3-part approach to the reinvigoration.

Part 2: Staff and patients who have names that are not considered traditional or more popularly known in English culture have reported that they have been persuaded or felt obliged to use a name that is more familiar or that others have indicated is more easily pronounceable. Every individual has a right to be called by their preferred name as part of their own identity, from a safe aspect if people are using an alternative name that is not recorded this could cause potential errors in appropriate identification. There is a national racial discrimination campaign and software available with resources that can be utilized to split out the syllables / pronunciation groupings which will be an option to explore to support this element.

Part 3: Preferred name, patients have indicated that sometimes they have a preferred name which is often their middle name rather than their first name, but that they are frustrated in having to explain this and would like their preferred name or known as name captured. Also, this applies to forms of address eg Professor Jones instead of being called by their first name without the patients permission.

Throughout the focus months the safe promise group attend engagement events and or invited VCF to participate in aspects to support the promise. These event included attendance at the girl guides to explore what the safe promise meant to them and people who are supported by Mencap attending the hospital to conduct a passport knowledge question with staff. This questionnaire provided an additional opportunity for

	these service users to explain to staff why the LD passport is important to them and how it should be used through their lived experience.  
2.4	**Care "*Designing my care with me and for me*"** The Care Promise was the first promise to be established and commenced in April 2022, it has had a total of 7 meetings. Focus months were held May & June 2022. As the focus months were at the start of the strategy launch the Care promise group have continued to hold additional walk abouts to ensure that feedback and progression of the identified workstreams is reflective.     Feedback from service users in relation to the delivery of care and how caring WUTH staff are has been overwhelming and is a real area of celebration and aligns to the CQC rating of Good within the Care domain. The aligned promise of involving patients in their healthcare journey and the designing of their healthcare however has been rated as requires improvement by the group. Feedback has centered around discharge planning and process, and this is aligned to a key Trust priority. The care promise group have identified two elements to support improvements in this area (1) Discharge checklist. (2) Discharge information leaflets. The discharge checklist is a co-production workstream, service users reported that they wanted to have more ownership of discharge information and a way that they could challenge staff about next steps. A group of service users, VCF groups, Healthwatch and staff designed a list of prompts / questions, these were then circulated to a wider group including the patient panel, VCF group members for comments and feedback. Once an agreed checklist was finalised it was discussed that this should be presented in a patient friendly format rather than a formal NHS style template. In true co – production style the design of the checklist has

	been put out to the public to design, design entries will then be put out to public vote and feedback for final creation and launch, voting will commence June 2023. In addition to the two discharge workstreams further areas of improvements and workstreams have also been identified for support from the Care promise group. • Discharge: (1) Patient Checklist (2) Discharge information leaflets (3) Take home medication • Design and delivery of empathy training - *understanding a person's disability and reasonable adjustment needs, will support the ability to design care with individuals* • Order on the day menus • Young Carers (1) Admission identification within children's and young peoples services (2) admission identification on adult general wards (3) Care planning / young Carers passport design (this will be undertaken in conjunction with the supported promise)
2.5	**Supported Promise Group *"Working together to plan my aftercare"*** The supported promise group was the last of the promise groups to be established with its first meeting September 2022 and a total of two meetings within the strategy's first year. Focus months were held February & March 2023. During the workshop and via social media, participants were asked what aftercare meant to them. As anticipated, this was very varied however a there was a clear direction from service users that those with lifelong conditions felt that there is partnership between WUTH and the patients in enabling them to stay well and supporting them to take ownership of their health. This feedback has helped strength the group membership from specialist services such as respiratory and renal. Workstreams have been identified following the focus months as follows. • Self medication education • Support specialist services to raise awareness of service provide and patient self help to stay well and avoid hospital admission • Hidden disabilities (1) awareness raising (2) hospital facilities. As part of the specialist services a home hemodialysis awareness video has been created and will be launched June 2023 this will be promoted via the Supported promise group as part of the wider patient experience strategy. 

3	**Next steps – year 2** 2023/ 24 operational and strategic priorities have been presented formally as part of the enabling strategies update to the Executive Board and Divisional leads. As highlighted earlier in the report the patient experience strategy is unique in that its operational objectives will be fluid dependent upon experience feedback. Overarching objectives for the strategy have been set to provide additional structure and support the sustainability of the implementation. These objectives are tabled below and are RAG rated against the deliverability. Progress will be monitored and presented through the governance channels highlighted in appendix 1.

	Strategic Priorities	Progress with Strategic Plans and Priorities (Measurable KPIs and Trajectories)	KPI of Delivery RAG rating	Evidence of Outcome- business case, performance improvement etc.
	Patient Experience Vision Priorities			
1	Develop and launch public facing patient experience strategy webpages	Staff member trained to create web page items, build commenced.		Web page and access count. Service user evaluation
2	Increased community interface to ensure patient experience strategy messages are being received by the wider community and increase opportunities to be involved. This will ensure that the strategy is fully representative and inclusive of the population WUTH serves	Agreement to join Healthwatch community bus trips Programme of dates scheduled to host stands at local supermarkets Non digital communication plan developed		Increased participation
3	Develop and launch patient ward information folders			
4	Establish a patient experience strategy awards / recognition system			
5	Integrate the patient experience strategy promises into level 4 wise accreditation			
6	Run promise group double focus months to include engagement workshops, walk arounds and focused surveys for the 2 remaining Promise groups	Supported Promise group completed Feb & Mar 23 , Inclusive Promise group scheduled June & July 23		

4	Conclusion
4.1	The Patient experience strategy has had a successful first year and achieved its year one objectives to provide the strategy with a structure and format to gain regular insight, build relationships with the community it serves and create a sense of ownership across all staff designations. Year two will require a dedicated focus on sustainability, outcomes and a comprehensive communications plan that demonstrates that the Trust is responding to service user feedback. A key element will be increasing participant and engagement across the Wirral community to ensure that the priorities and feedback gained is fully representative of the local community. The Trust has been commended for its open and transparent approach to the development of the strategy and its feedback response. It is recognised that although the patient experience is part of the Trust's enabling strategies the essence of the strategy means that its objectives will be fluid to align to the reflective feedback gained and therefore does not naturally fit into the usual three-to-five-year objective strategy setting.

5	Implications
5.1	**Patients** • The patient experience strategy has been created in coproduction, with patients, carers, voluntary care and faith sectors, Healthwatch and staff. The purpose of the strategy is to create a positive experience and widen communication, engagement and coproduction opportunities to respond to feedback.

	• The engagement structure maximises opportunities for inclusion by the variety of methodologies in place to gather feedback. The Trust has actively reached out to VCF & Health watch groups to ensure representation, and involvement. The Patient experience strategy has a focused promise on inclusion.
5.2	**People** • The patient experience strategy provides extensive flexible opportunities for a wide variety of staff to get involved and have their voice heard. • The structure also actively encourages staff participation in areas of personal development with staff being supported to take the lead of task and finish groups whom may not ordinarily have this type of expose in their current roles. • WUTH also has a unique profile whereby for the majority of staff, WUTH is their local hospital, where their friends and family also receive treatment providing a vested personal interest in making improvements. • A significant focus of the strategy is on patient feedback which predominantly highlights staff for their excellent care and treatment, providing a public mechanism to celebrate and reinforce staff recognition within the organization.
5.3	**Finance** • Whilst there are no direct financially aligned outcomes for the Patient Experience strategy apart from specific staffing resources and some project resource requirements, the strategy does support cost improvements to the trust such as promotion of services aligned to reducing admission and appointments, improvements in experience should also support reductions in the volume of complaints to aligned workstreams, there by reducing Trust staffing input requirements. Positive promotion of the Trust will also potentially support and influence charitable income.
5.4	**Compliance** • The ouputs and delivery of the patient experience strategy underpins most of the evidence aligned to the new CQC quality statements. In addition, patient experience is one of the fundamental areas of focus for CQC including demonstration of responding to feedback. • NHS organisation are also required to partake in the friends and family test as part of its contractual requirements, WUTH is fully compliant in this and use this as part of the feedback mechanisms that feed into the strategy promise groups.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 14**

04 October 2023

Title	Infection Prevention & Control Annual Report 2022-2023 and IPC Priorities for 2023-2024
Area Lead	Tracy Fennell, Chief Nurse, Executive Director of Midwifery and AHPs, Director of Infection Prevention and Control
Author	Jay Turner-Gardner, Deputy Director of Infection Prevention & Control
Report for	Information

Report Purpose and Recommendations

The purpose of this report is to provide assurance to Board on compliance with:

I. The Health & Social Care Act 2006 (updated 2008, 2012, 2015 and Dec 2022): Code of Practice on the prevention and control of infections and related guidance (commonly known as the hygiene code); and
II. The CQC regulations

It is recommended that the Board:

- Note the report

Key Risks

This report relates to these key Risks that were active during the year of the report:

I. Risk 609
- Patients who have their first positive specimen 8-14 days after admission are categorised as Hospital-Onset Probable Healthcare-Associated (HO-pHA). Patients who have their first positive specimen 15 or more days after admission are classified as Hospital-Onset Definite Healthcare-Associated (HO-dHA).

II. Risk 799
- The demand on the Trust for beds is resulting in decisions having to be made that compromise our own Outbreak guidelines which is putting our staff and patients at an increased risk of acquiring COVID whilst in our care.

III. Risk 1300
- The risk of breaching our annual threshold set by NHSE/I for patients being diagnosed with *Clostridioides difficile* infections.

And the Trust overarching risk

IV. PR4 – Catastrophic failure in standards of care.

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	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	Yes
Infrastructure: improve our infrastructure and how we use it.	Yes

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
26th July 2023	IPCG	Infection Prevention & Control Annual report 2022-2023	Information
21st August 2023	PSQB	Infection Prevention & Control Annual report 2022-2023	Information
6th September 2023	Quality Committee	Infection Prevention & Control Annual report 2022-2023	Information

1	Narrative
1.1	Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are developed and maintained. The purpose of this report is to provide assurance to the Board of Directors on compliance with the Health & Social Care Act 2008: code of Practice on the prevention and control of infections and related guidance, last updated 13th December 2022. The past 3 years have seen many necessary restrictions imposed on everyday life to manage COVID-19, but these have come with a huge toll on wellbeing and economic output. Scientists and the Government now understand more about COVID-19, how it behaves and how it can be treated which has resulted in the government in 2022-2023 moving away from deploying regulations and requirement and instead replaced them with specific interventions for COVID-19 with public health measures and guidance. During this challenging time the Infection Prevention and Control (IPC) Team continued to work and support the wards and departments in promoting the health, safety, and well-being of not only patients and visitors but also themselves to deliver the clean, safe, and effective care deserved by all. The infection control programme aims to continuously review and build on existing activity, driven by local needs, while incorporating and complying with the latest NHSE/I and UKHSA guidance and other relevant strategies and regulations pertaining to IPC.

2	Implications
2.1	Whilst acknowledging the '*Living with COVID* 'methodology the IPC team declared and managed 63 COVID outbreaks, along with 9 outbreaks of *Clostridioides difficile* and 12 outbreaks of Norovirus throughout 2022-2023 on our in-patient wards.

	The Trust this year was one of 17 Trusts out of 24 in the Northwest who breached their annual objective for patients being diagnosed with CDT although noting a reduction in cases has been seen over the past 12 months. Whilst promoting a 'zero tolerance' approach to MRSA bacteraemia the Trust reported 2 patients diagnosed with MRSA bacteraemia in 2022/23 which is the same as the previous year

3	Conclusion
3.1	The Annual IPC report 2022-2023 details the annual infection prevention and control activities during the year as reported at the monthly IPCG and is a testimony to the hard work of the IPC Team and the divisions; together they have shown commitment in the delivery of excellent infection prevention practices by managing our infection risks together in a caring and competent manner. Following a review of the 2022-2023 work, the Trust will over the next 12 months focus on 5 key priorities: • Cleaning • The Environment • Patient Isolation • Sampling compliance • Bare below the elbows With an increased scrutiny in our investigative procedures to further inform practice, we will continue to work in collaboration with partners across the whole health economy to keep a focus on prevention of infections and compliance with good working practices to maintain the health, safety and wellbeing of staff, patients, and the residents of Wirral and beyond.

4	Implications
4.1	**Patients** • IPC is crucial to ensuring patient safety
4.2	**People** • Significant work has been undertaken with the team and wards, both in updating working practices with the IPC team and working with wards to educate and train. • The team is now fully staffed and there is a good culture of IPC in the Trust.
4.3	**Finance** • No direct impact on finance
4.4	**Compliance** • Compliance with the Health & Social Care Act 2008: code of Practice on the prevention and control of infections and related guidance, last updated 13th December 2022.

Wirral University Teaching Hospital
NHS Foundation Trust

INFECTION PREVENTION & CONTROL ANNUAL REPORT

2022/2023

Contents

1.0 Executive Summary

Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are developed and maintained. The purpose of this report is to provide assurance to the Board of Directors on compliance with the Health & Social Care Act 2008: code of Practice on the prevention and control of infections and related guidance, last updated 13th December 2022.

The past 3 years have seen many necessary restrictions imposed on everyday life to manage COVID-19, but these have come with a huge toll on wellbeing and economic output. Scientists and the Government now understand more about COVID-19, how it behaves and how it can be treated which has resulted in the government in 2022-2023 moving away from deploying regulations and requirement and instead replaced them with specific interventions for COVID-19 with public health measures and guidance.

Whilst acknowledging the '*Living with COVID* 'methodology IPC declared and managed 63 COVID outbreaks, along with 9 outbreaks of *Clostridioides difficile* and 12 outbreaks of Norovirus throughout 2022-2023.

During this challenging time the Infection Prevention and Control (IPC) Team continued to work and support the wards and departments in promoting the health, safety, and well-being of not only patients and visitors but also themselves in order to deliver the clean, safe and effective care deserved by all.

The Trust this year was one of the 17 Trusts out of 24 in the Northwest who breached their annual objective for CDT although noting we have seen figures reduce over the past 12 months due to delivery of the IPC work plan.

Whilst promoting a 'zero tolerance' approach to MRSA bacteraemia the Trust reported 2 MRSA bacteraemia in 2022/23 which is the same as the previous year.

The Trust continues to report its quarterly mandatory laboratory data and the surgical division continue to report mandatory surveillance of SSI following orthopaedic surgery for every quarter and voluntary surveillance of large bowel surgery for every quarter.

This report is testimony to the hard work of all the teams in WUTH and acknowledges the incredible results that can be achieved when an organisation shares the same vision and values and how when we get the basics right, we become better and then can progress through to best.

In conclusion, I would like to acknowledge the hard work of the IPC Team and the divisions; together they have shown commitment in the delivery of excellent infection prevention practices by managing our infection risks together in a caring and competent manner. Over the next 12 months the Trust will focus on 5 key priorities to further reduce CDT incidence. Furthermore, we will continue to further review existing work and projects to develop an increased scrutiny in our investigative procedures to further inform practice, we will also continue to work in collaboration with partners across the whole health economy to keep a focus on prevention of infection and compliance with good working practices.

Tracy Fennell
Chief Nurse/Director of Infection and Prevention and Control (DIPC)

2.0 Description of Infection Prevention

2.1 Nursing Team

Tracy Fennell, the Chief Nurse is the Director of Infection Prevention & Control and has overall responsibility for leading the organisations IPC team, strategy and improvement plan.

Jay Turner-Gardner the Infection Prevention & Control Specialist is the Deputy Director of Infection Prevention and Control provides expert IPC advice and is managed by and professionally accountable to the DIPC and deputises in her absence for all matters relating to Infection Prevention.

The Infection Prevention & Control Matron has managerial responsibility for the Infection Prevention Team.The Infection Prevention Nursing Team establishment consists of:

- 3 x band 7 (3.0 WTE) Senior Infection Prevention Specialist Nurses.
- 3 x band 6 (3.0 WTE) Infection Prevention Specialist Nurses
- 1 x band 4 (1.0 WTE) Secretary.
- 1 x band 3 (1.0 WTE) Infection Prevention assistant

The IPC analyst role (1 x band 5, 1.0 WTE) moved under direct responsibility of the Programme Developer in the Corporate Nursing Team in 2021 for further development of the role.

The team for the first time in many years was fully established throughout 2022/23.

2.2 Infection Prevention on-call

The Infection Prevention on call nursing advisory service ceased in Q4 following a period of consultation.

2.3 Medical Staff

The IPC team is supported by a microbiology team of which there are 2 x 1.0 WTE consultant microbiologists. This includes the infection control doctor (3 PAs). Due to the inability to fill consultant vacancies, the team now comprises of 1.0 WTE specialty doctor. There are 2 WTE clinical scientists in the department, one of whom continues to lead on the Water and Ventilation safety aspects of IPC.

The out- of- hours consultant microbiologist service is a shared between three Trusts, defined by an SLA. (Chester, Warrington) This support is available on call from 5pm – 9am, including weekends and bank Holidays for Microbiology. The on-call Consultant Microbiologist service does not provide standalone IPC advice unless related to aspects of care related to Microbiology advice.

2.4 The Infection Prevention and Control Team

The Team meets regularly with the IP Doctor and led by the Deputy DIPC they provide the Infection Prevention service to the Trust. The Deputy Director of Infection Prevention & Control is responsible for producing the 3-year IP strategy, delivering the Infection Prevention annual plan and annual audit

plan on behalf of the DIPC, who reports with the Non - Executive Director for Quality to the Trust Board on behalf of the Quality Committee that oversees Patient Safety Quality Board where Infection Prevention & Control Group reports.

2.5 Microbiology Laboratory Services

Chester and Wirral Microbiology Service (CWMS) is the Medical Microbiology laboratory providing high quality diagnostic bacteriology and virology services to Wirral and West Cheshire and it is in Bromborough, Wirral. It provides the majority of the lab diagnostics for WUTH including routine cultures, Infection screening tests (MRSA, VRE screens) and molecular testing for organisms such as Influenza, C. difficile, Norovirus, CPE and SARS-CoV -2. This is a 24/7 service, and an out of hours service restricted to urgent samples including blood cultures, CSF and COVID tests.

The on-site testing for COVID/ FLU, which was located in the Blood sciences labs ceased in early 2023. The Point of care testing (POCT) for Covid/ Flu continues in the admission areas. Off-site services included tests done in CWMS and some referrals to Liverpool clinical laboratories.

2.6 Reporting Line to the Board of Directors

A schematic of the reporting arrangements for the Infection Prevention Control group within the Trust can be found in **Appendix 1**

2.7 The Infection Prevention and Control Group

This group continues to meet monthly, and each directorate provides representation. The group is chaired by the DIPC; the deputy chair is the Deputy DIPC. Its purpose is to provide a two-way communication channel between the Trust Board/Quality Committee via the Patient Safety and Quality Board (PSQB). The IPCG has an assurance/management role and is authorised to approve Infection Prevention policies and to formulate recommendations for Infection Prevention and Control conveying these to the PSQB via a chairs report.

The Trust Infection Prevention & Control Terms of Reference can be found in **Appendix 2**. These are reviewed bi-annually.

2.8 Departmental/Divisional Infection Prevention and Control groups

The following groups meet monthly supported by the IPCT, discussing IPC related issues and incidents whilst developing assurance reports for the Infection Prevention and Control Group (IPCG).

- Medicine
- Acute Specialties
- Orthopaedics
- Specialist Surgery/ Surgery
- Theatres
- Women's and Children's

- Diagnostics

2.9 The weekly 'HCAI oversight' meeting'

This meeting has been chaired throughout 2022/2023 by the Deputy DIPC and is accountability based reviewing all incidences of CDI, concentrating on lessons learnt during the review of the patient pathway and how these were captured, and their implementation progressed. Nosocomial COVID ceased to be investigated at the start of the year however all patients who have COVID on part one or part 2 of their death certificates have a mini review completed for assurance purposes.

2.10 The weekly 'Patient Safety Learning Review Panel'

This meeting is chaired by the Associate Director of Nursing-Corporate Nursing and is accountability based, reviewing all 'patient harms' including Falls, Pressure damage and incidences of Bacteraemia, concentrating on lessons learnt during the review of the patient pathway and how these are captured. This meeting also determines avoidability status.

3.0 Reports to the Trust - Summary

Reports written and/or coordinated by the Deputy DIPC include:

- Daily IPC update including outbreak and surveillance summary for the patient flow team, senior management, the nursing teams and facilities detailing all patients with alert organisms including any areas under increased surveillance due to an increase in prevalence of any specific organism.
- Daily Outbreaks in the community which could have an impact on our service by the WCT.
- Monthly Infection prevention data summary of activities for the IP divisional meetings and the IPCG.
- Monthly IPC chairs reports and updates for the PSQB/ Clinical Advisory Group
- Annual Infection Prevention Report once per year which includes the Annual Infection Prevention plan and Annual Infection Prevention audit plan.
- Ad hoc updates in relation to the Infection prevention board assurance framework
- Weekly Executive Team update for DIPC
- IPC BI portal
- Monthly IDA's - if required
- Guidance reports for Clinical Advisory Group based on changes in national guidance.

4.0 Budget Allocation to Infection Prevention

4.1 Microbiology and Laboratory Services

The medical microbiologists and the Laboratory are funded from the Pathology Directorate, which is within the Division of Diagnostics and Clinical Support.

4.2 Funding for Outbreaks of Infection

Funding for outbreaks of infection (excluding laboratory costs as detailed above), are funded locally by the Divisions.

4.3 The Infection Prevention and Control Nursing Team (IPT)

The IPC Team are funded from Corporate Nursing and the Deputy DIPC is the budget holder for the Infection prevention service, the budget funds the nursing team and any Infection prevention initiatives identified during the year. This includes Infection Prevention signage, posters, study days and campaigns.

4.4 Investments in Infection Prevention at WUTH

In the year 2022/23 the Trust continued in its investment of

- MRSA screening for all admissions
- CPE and VRE screening for all Orthopedic patients
- Hydrogen Peroxide Vapor (HPV) 'fogging' following incidences of CDI, COVID, VRE, CPE when capacity/patient flow allows.
- Ongoing HPV programme when bed capacity allows.
- EvaluClean – A simple system utilised by the IPC team that uses a UV marker which is invisible to the human eye to mark objects, following environmental cleaning a UV torch is then used to see if the mark has been removed during the cleaning process.
- Adenosine triphosphate (ATP) – ATP is the energy carrying molecule used in cells and we use it to detect the presence of organic matter (contamination) by way of swabbing certain objects to determine if organic matter is detected to measure the effectiveness of cleaning.
- Increased cleaning in addition to the base line clean to support the increase in C.diff infections.
- Disposable curtains throughout the trust
- Deployment of Air purifiers in collaboration with Facilities.
- Daily cleanliness monitoring checklists introduced and completed on Tendable by the cleanliness Supervisory team.

5.0 Health Care Associated Infection (HCAI)

Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment or from being in contact with a healthcare setting. The term HCAI covers a wide range of infections. The most well-known include those caused by Meticillin-resistant *Staphylococcus aureus* (MRSA), *Clostridoides difficile* (C. difficile) and more recently COVID – 19.

HCAIs pose a serious risk to patients, staff, and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention is a key priority for the NHS. The 3-year IP strategy and annual plan for 2022/2023 focuses on revising and updating present arrangements, strengthening, and building on the work that has already been achieved in the previous year and planning for the new and continuing challenges ahead.

6.0 Surveillance/ Mandatory reporting

UK Health Security Agency's Data Capture System provides an integrated data reporting and analysis system for the mandatory surveillance of *Staphylococcus aureus*, *Escherichia coli*, *Klebsiella* spp., *Pseudomonas aeruginosa* bacteraemia and *Clostridioides difficile* infections. The monthly quality check of the mandatory data introduced in 2019 continues between the IPC analyst and Deputy DIPC prior to it being 'signed off' by the DIPC on behalf of the Chief Executive.

Carbapenemase Producing *Enterobacteriaceae* (CPE) bacteraemia are reported locally as are VRE bacteraemia.

COVID-19 data continued to be captured daily throughout the year and published monthly, weekly, and daily using specified admission indicators via NHSE/I.

6.1 Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia

There remains a zero tolerance for a patient to acquire an MRSA bloodstream infection (MRSA BSI) while receiving care in a healthcare setting. The Joint Healthcare Infection Society (HIS) and Infection Prevention Society (IPS) published new guidelines for '*the prevention and control of meticillin-resistant Staphylococcus aureus (MRSA) in healthcare facilities'* in 2021. The WUTH guidelines were last reviewed pre COVID and the decision made at that time was to continue to complete screening for MRSA as per existing local policy, the Trust intends to reevaluate this in a further review to reflect the 2021 guidelines to ensure the best cost-effective approach whilst continuing to promote patient safety. The proposed review highlighted as a priority in the 2023/2024 annual plan.

6.2 Reporting and monitoring arrangements for MRSA bacteraemia

All Laboratory reported incidences are entered into the UKHSA data capture system (HCAI DCS) and a Post Infection Review (PIR) is completed by the MDT. There is no longer a mandatory requirement to enter these PIR reports into the DCS reporting system unless requested so by UKHSA as a high outlier.

Completed PIR reports are available to be shared with the Integrated care system* (ICS) and discussed at their quality meetings.

Following a laboratory confirmed MRSA bacteraemia a Multi-disciplinary Team, incorporating the patient's clinician, Microbiologist, Deputy DIPC, Matron and Pharmacist meet to complete the investigation to determine the causative factors of the MRSA bacteraemia and identify and learning to support the development of a local action plan, it is the responsibility of the directorate to achieve the action plan. Causation is determined once the information is gathered.

MRSA Bacteraemia are apportioned according to the DOH guidelines below:

- Day 0 = Day of admission community attributed (pre day 2)
- Day 1 = community attributed (pre day 2)
- Day 2 = Trust attributed (on or post day 2)

This year 2 MRSA bacteraemia were reported on or after day 2 of admission (post) and 1 reported pre day 2.

*Clinical commissioning groups (CCGs) were established as part of the Health and Social Care Act in 2012 and replaced primary care trusts on 1 April 2013. On 1 July 2022, integrated care systems (ICSs) became legally established through the Health and Care Act 2022, and CCGs were closed.

6.3 The incidence of MRSA bacteraemia since 2014/15.

SPC Chart 1 below provides a breakdown of **MRSA bacteraemia** by month.

Chart 1

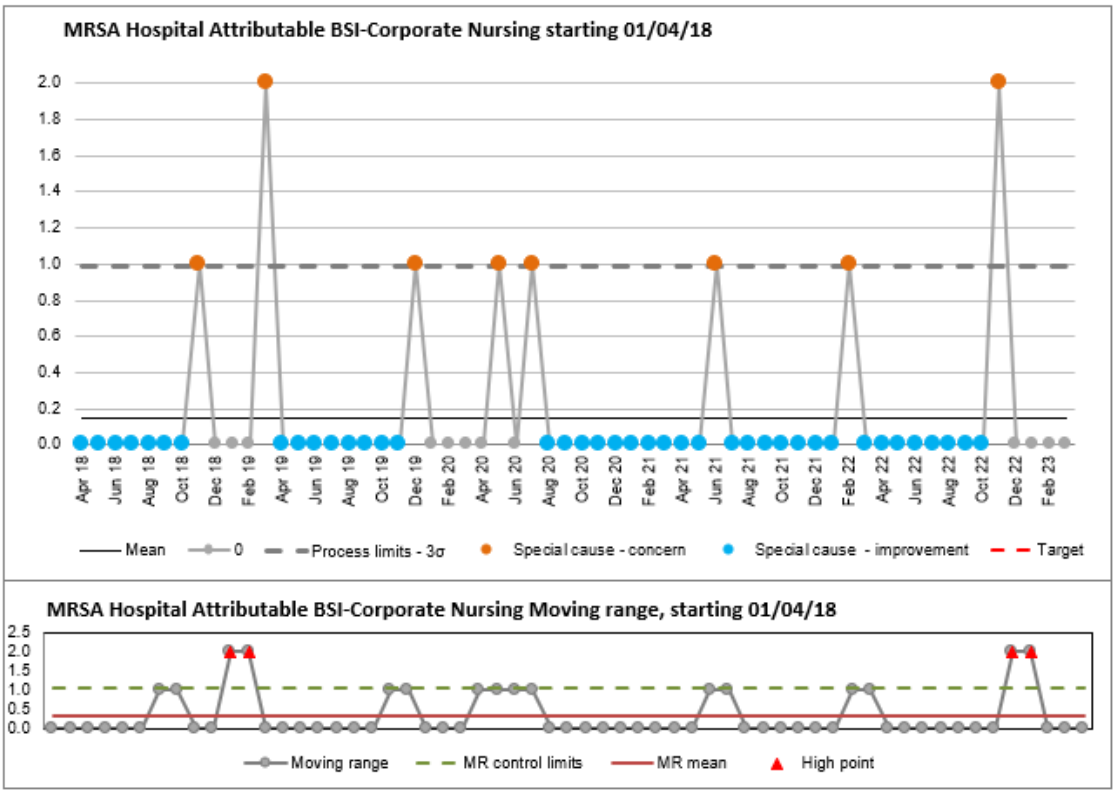


Table 1 below provides a breakdown of **MRSA bacteraemia** by year since 2014/15

Table 1

The incidence of MRSA Bacteraemia since 2014/15									
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Pre day 2 for WCT	4	5	3	0	3	2	0	3	2
Post day 2 for WUTH	3	1	1	2	3	1	2	2	1
Total for Wirral CCG	7	6	4	2	6	3	2	5	3

There has been no increase in the incidence of MRSA bacteraemia with the Trust during the previous two years, reporting 2 hospital onset, hospital associated (HOHA) cases for the past 3 years.

Table 2 below table provides a breakdown of Hospital onset and Community onset, Hospital Associated and Community Associated **MRSA bacteraemia** by month.

Table 2

Breakdown of MRSA cases in 2022/23													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	0	0	0	0	0	0	0	2	0	0	0	0	2
CO-HA	0	0	0	0	0	0	0	0	0	0	0	0	0
Community Associated	0	0	0	0	0	0	0	0	0	0	1	0	1

6.4 Themes from Post Infection review

The first MRSA bacteraemia was thought to be potentially contaminated during collection as the patient's presenting symptoms were not that of a true MRSA infection and the patient was presenting as 'well'. The PIR did not identify any superficial or deep focus of potential infection. Due to the patient's risk factors, including diabetes it was decided to manage the patient as if it was a true infection. The review identified that the team who took the blood cultures had not updated their ANTT training and as the annual competency assessment since then could not be determined, the review advised that this MRSA bacteraemia was avoidable.

The second MRSA bacteraemia was detected in a patient who was known to have a history of MRSA which was confirmed once again on admission by screening, however not all screening sites were swabbed as per policy, suppression therapy was delayed, and antimicrobials prescribed on admission did not consider MRSA status. The patient had multiple indwelling devices and documentation of some aspects of the patient's management was found to be poor. It was determined that the source was probable urinary catheter or cannula related and deemed avoidable.

6.5 Meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia

Methicillin-sensitive *Staphylococcus aureus* (MSSA), is a skin infection that is not resistant to certain antibiotics. MSSA normally presents as pimples, boils, abscesses, or infected cuts, but also may cause pneumonia and other serious skin infections. MSSA affects people of all ages and has been known to cause outbreaks among sports teams, families, prison inmates and people who live and work in close quarters, such as military recruits.

MSSA colonises the skin, causing no symptoms and without causing infection, but then may later lead to infection. The infection spreads via direct skin-to-skin contact and may spread via contact with contaminated items or surfaces. The sharing of contaminated personal items with someone who has MSSA — towels, sheets, razors, clothes, or sports equipment — increases the likelihood of spreading the infection.

All Laboratory reported incidences of MSSA are entered into the UKHSA data capture system (HCAI DCS) and a Route cause Analysis (RCA) is completed by the MDT.

There are no national or local objectives set against these at present and many are related to skin and soft tissue infections.
Table 3 below provides a breakdown of **MSSA bacteraemia** by year and month.

Table 3

The incidence of MSSA Bacteraemia since 2016/17													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2016/17	4	2	4	1	1	1	1	3	0	1	4	1	23
2017/18	1	1	1	1	1	2	4	1	3	2	3	2	22
2018/19	2	1	5	1	1	2	0	4	1	3	0	3	23
2019/20	3	5	1	0	2	1	1	2	1	3	3	2	24
2020/21	4	1	1	0	0	2	2	3	0	1	4	0	18
2021/22	1	2	2	0	0	0	4	0	3	5	4	4	25
2022/23	2	1	4	2	5	2	4	2	1	2	2	5	32

The Trust has increased its incidence of MSSA bacteraemia by 28% from the previous year. A proposed review will be in the 2022/2023 annual plan.

SPC Chart 2 below provides a breakdown of **MSSA bacteraemia** by month.

Chart 2

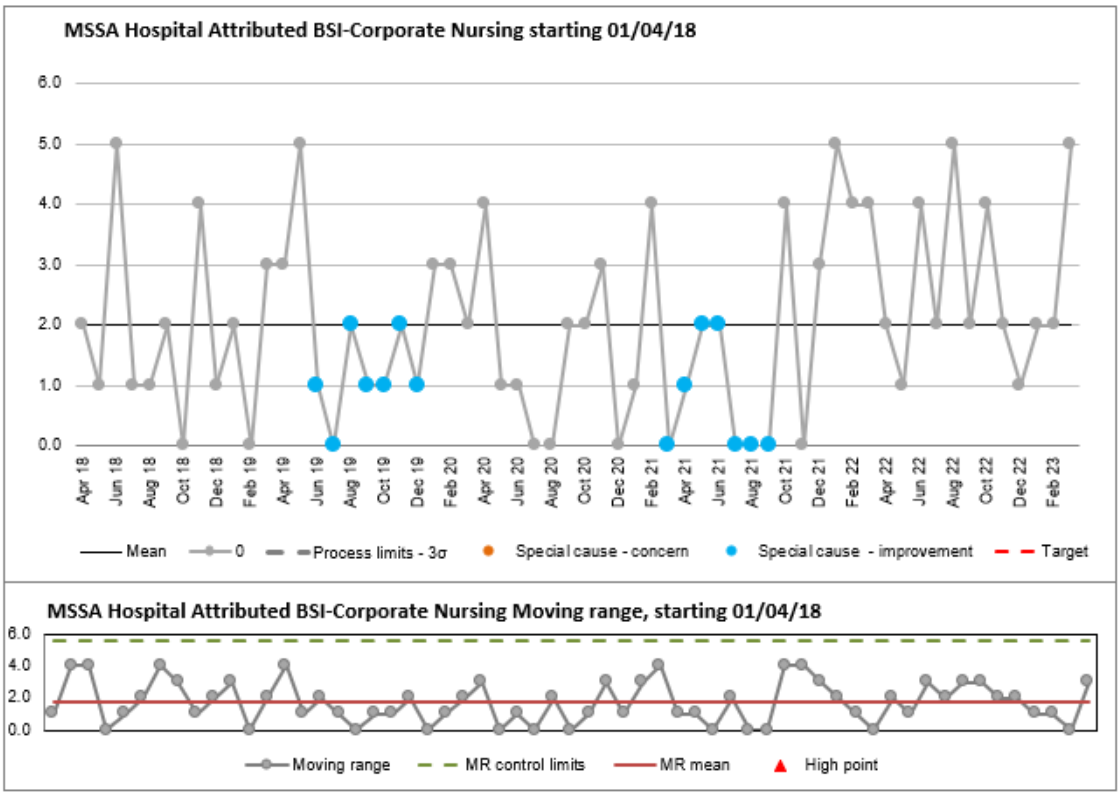


Table 4 below table provides a breakdown of Hospital onset and Community onset, Hospital Associated and Community Associated **MSSA bacteraemia** by month.

Table 4

Breakdown of MSSA cases in 2022/23													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	2	1	2	1	5	1	4	1	0	2	2	1	22
CO-HA	0	0	2	1	0	1	0	1	1	0	0	4	10
Community Associated	3	2	4	7	5	2	2	2	2	2	3	4	38

6.6 *Clostridioides difficile* Infection (CDI)

Clostridioides difficile (C. Difficile) is a bacterium found in the intestine. It can be present in healthy people and cause no symptoms, however C. difficile can cause imbalance in the bacteria within the gut and this can occur when people are taking antibiotics. *Clostridioides difficile* infection (CDI) is highly infectious and will spread through contact with a contaminated environment or person and is estimated to cause 20 to 30% of antibiotic-associated diarrhoea. The annual incidence of CDI has been relatively stable in the UK since 2013 and was 22.2 per 100,000 population between April 2020 and March 2021.CDI carries considerable risk of morbidity and 30-day all-cause mortality is estimated to be between 9 and 38%. As a significant healthcare associated infection, multiple infection control measures and treatment modalities have been explored and this remains an evolving field. Crucially, the management of severe CDI should be considered a medical emergency and urgently assessed and reviewed regularly to ensure that patients receive prompt and optimised care.

6.7 Reporting and Surveillance of *Clostridioides difficile*

Trusts are required under the NHS standard contract 2022/23 to minimise *C.difficile* infections so that they are no higher than the threshold levels set by NHS England and Improvement.

Objectives for this year are derived from a base line of the 12 months ending November 2021, as this is the most recent available data at the time that NHSE/I was calculating the figures.

If a trust had fewer than or equal to 10 cases during the 12 months ending November 2021, the threshold will be equal to that count. If a trust had more than 10 cases, the threshold will be one less than that count.

All thresholds were rounded down to the nearest whole number and pertain to healthcare-associated cases (i.e., HOHA and COHA cases).

NHS acute providers use the case assignment definitions:

- **Hospital onset healthcare associated**: (HOHA) Specimen date is ≥3 days after the current admission date (where day of admission is day 1)

- **Community onset healthcare associated**: (COHA) Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date(where day 1 is the specimen date)

6.8 *Local reporting for CDI in 2022/23*

The national objective set for WUTH for healthcare associated *Clostridioides difficile* infections (CDI) this year was 72, which proved to be very challenging, and a decrease from the previous year's objective of 115 by 43.

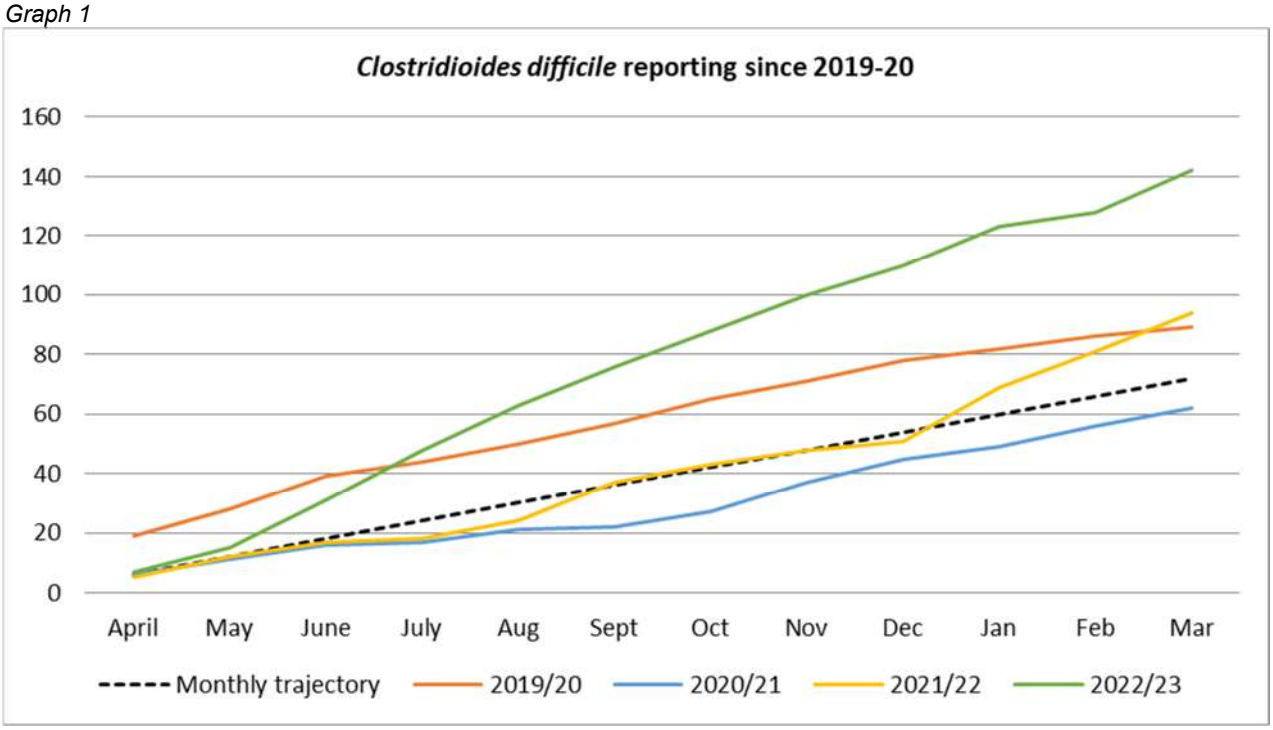
Table 5 below provides a breakdown of ***Clostridioides difficile*** by year and month.

Table 5

The incidence of *Clostridioides difficile* since 2019/220													
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	19	9	11	5	6	7	8	6	7	4	4	3	89
2020/21	6	5	5	1	4	1	5	10	8	4	7	6	62
2021/22	5	7	5	1	6	13	6	5	3	18	12	13	94
2022/23	7	8	16	17	15	13	12	12	10	13	5	14	142

Graph 1 below provides ***Clostridioides difficile*** reported infections since 2019/20 and annual trajectory.

Graph 1



SPC Chart 3 below provides a breakdown of ***Clostridioides difficile*** **infections (CDI)** by month.

Chart 3

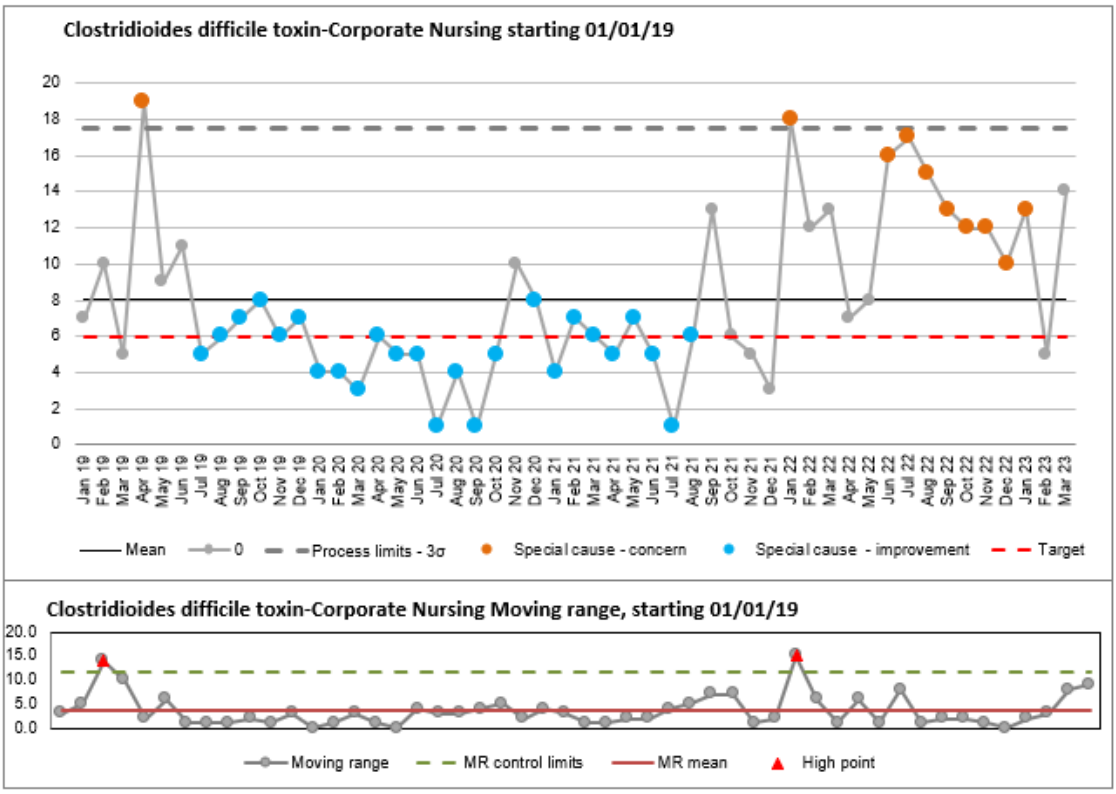


Table 6 below table provides a breakdown of Hospital onset Hospital Associated, Community onset Hospital Associated, Community onset Indeterminate Associated, Community onset Community Associated, ***Clostridioides difficile*** **infections (CDI)** by month.

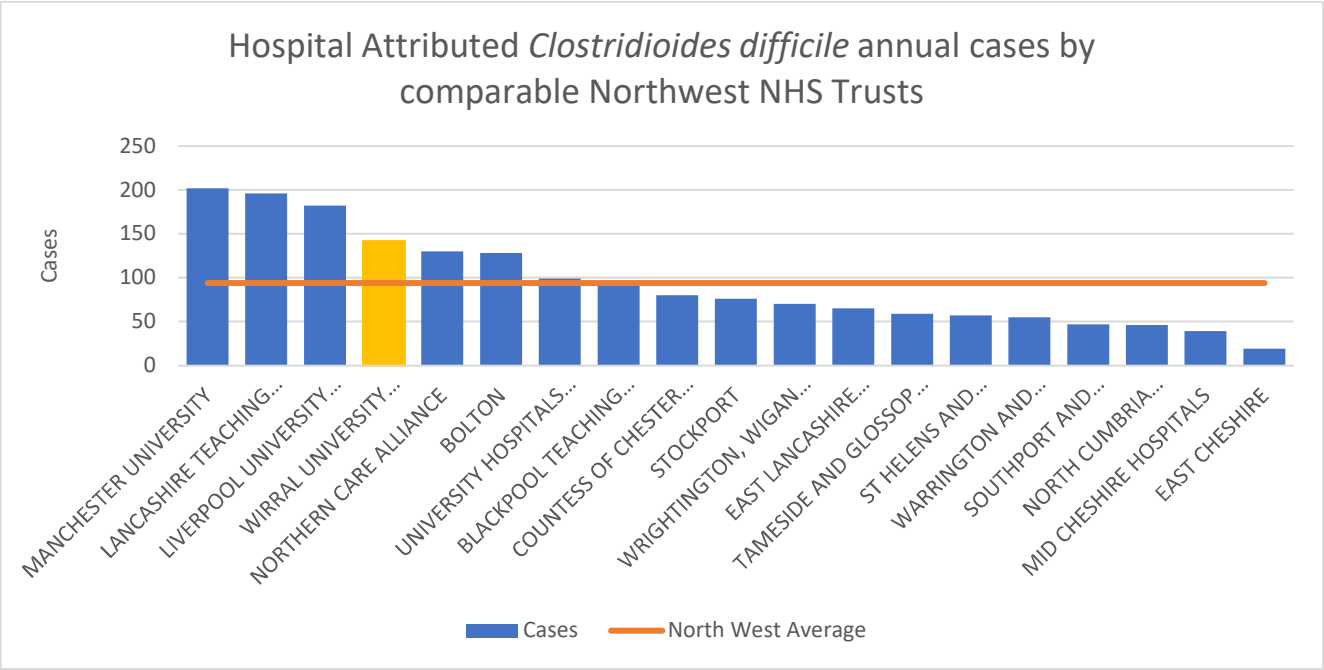
Table 6

Breakdown of *Clostridioides difficile* cases in 2022/23													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	7	8	14	15	13	11	8	9	7	9	4	12	117
CO-HA	0	0	2	2	2	2	4	3	3	4	1	2	25
CO-IA	1	3	0	2	2	4	1	3	0	0	0	2	18
CO-CO	5	3	0	2	1	1	4	6	2	5	2	1	32

Wirral PLACE/CCG rates of *Clostridioides difficile* infection cases have been significantly higher than the national average since 2014. Whilst rates increased dramatically in 2019 the start of the pandemic in 2020 saw a huge reduction. Since January 2021 the rates started to increase again and reached a similar level as to what they were 2011. At year end (2022/2023), the Wirral system reported the highest case rate per 100,000 population across Cheshire and Merseyside

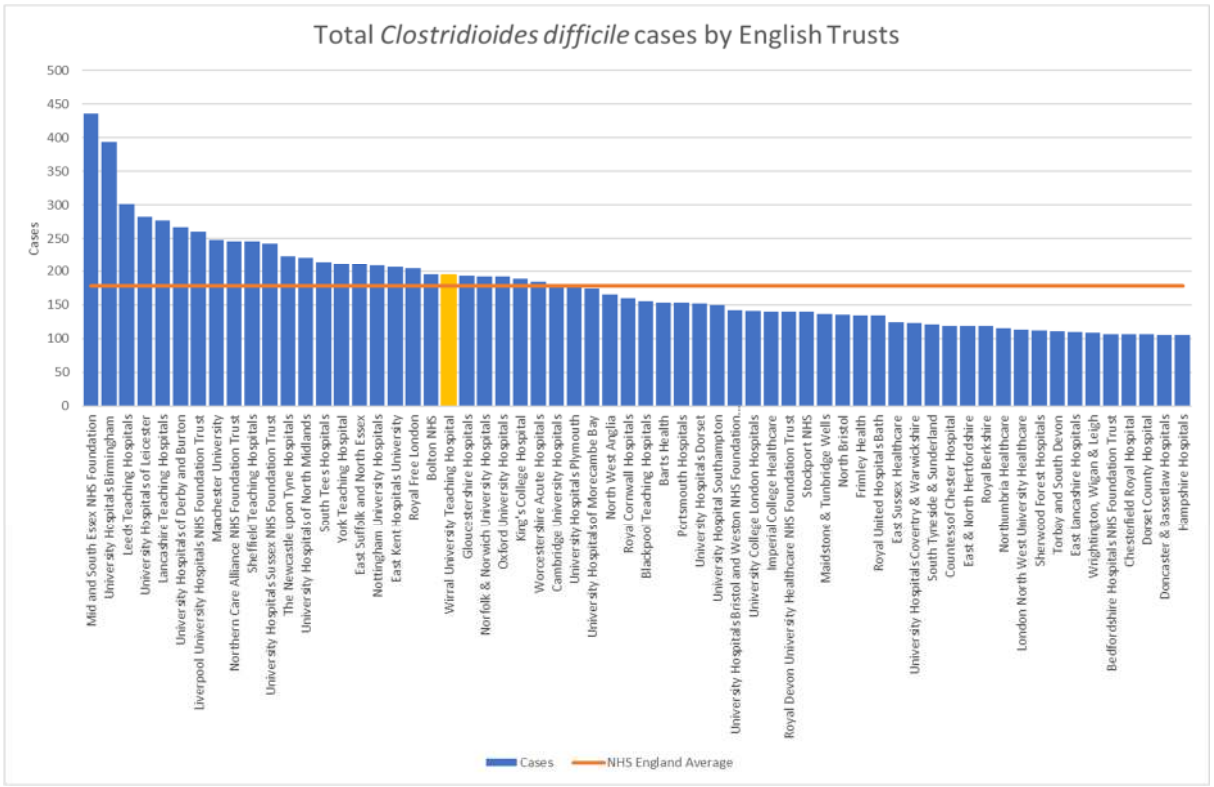
Graph 2 below shows Hospital attributed ***Clostridioides difficile*** annual cases by comparable Northwest NHS Trusts

Graph 2



Graph 3 below provides ***Clostridioides difficile*** reported by English Trusts for 2022/23.

Graph 3



Wirral PLACE sits within Cheshire and Merseyside ICB and has a population of 330,00 with recognised challenges and inequalities in parts of the borough. WUTH is the only acute Hospital Trust, there is also a community care trust which delivers services elsewhere and a Mental Health Trust providing services for Wirral. There are over 300 GP's in over 40 GP practices and 120 Care/residential settings.

Discussions surrounding the causes for the rise in case rates started in July 2022 when the Deputy DIPC introduced a quarterly CDI report and a Trust wide improvement plan, this was shared with the regional IPC lead. It was agreed that a more thorough investigation of the entire Wirral system, to include Primary, secondary and community care would take place to help identify and support further initiatives that would support an improvement in the rates of *Clostridioides difficile*. Unfortunately, due to external factors the visit was not able to take place within the 2022-2023 year.

In 2022/23 we have reported 142 *Clostridioides difficile* infections. This is an increase of 48 cases when compared to 2021/22. We were 70 cases over local trajectory for 2022/23.

6.9 Themes from CDI RCA investigation

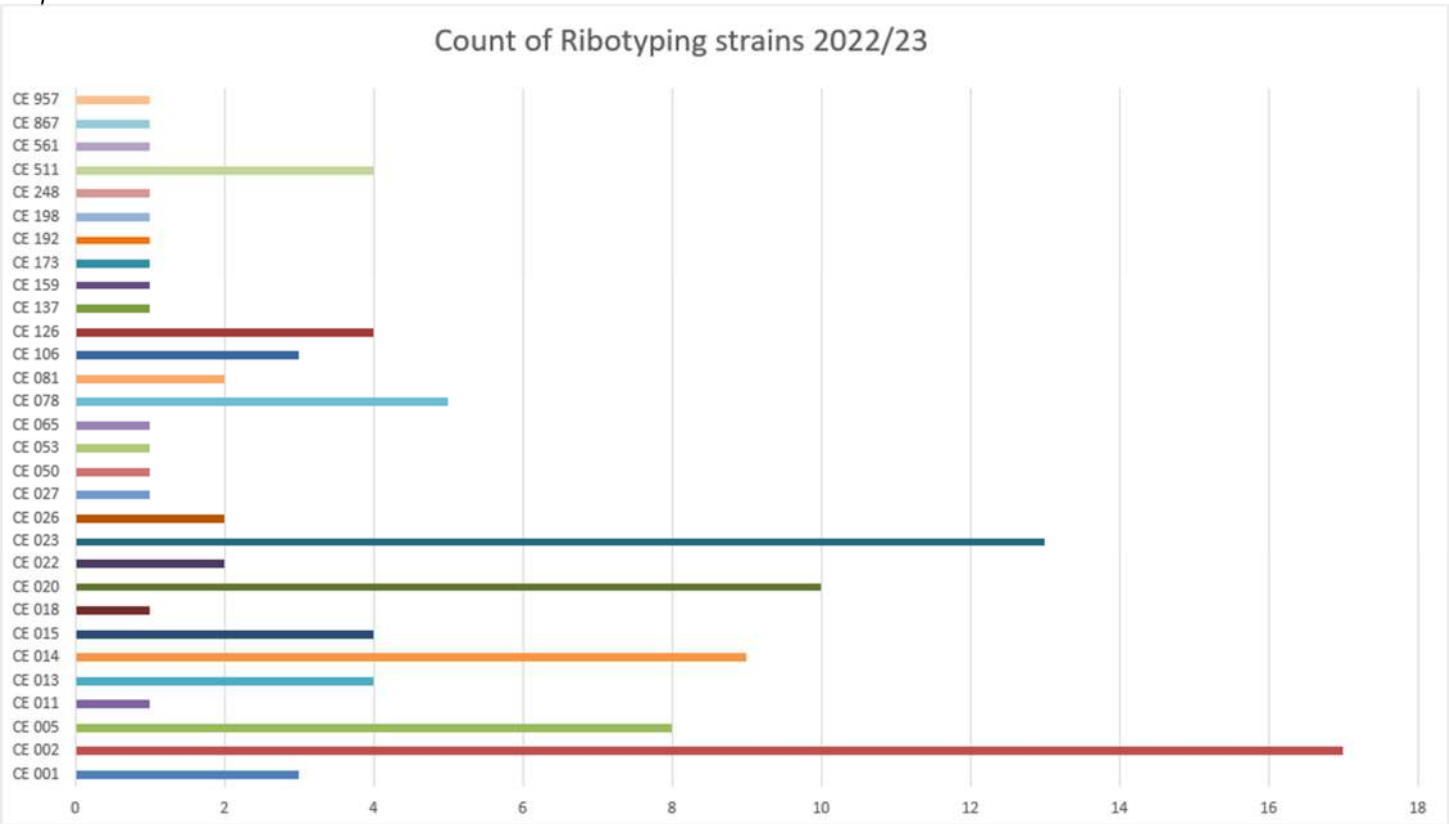
Although it is not always possible to ascertain the cause, some of the common themes and learning outcomes from the RCAs completed between 1st April 2022 – 30th November 2022 (100) are listed below in table 7.

Table 7

Themes	count	Percentage
Delayed sample collection	41	44%
Delay in suspicion of infection	29	31%
Delayed isolation (> 2 hours since positive result)	27	29%
Inadequate Documentation of bowel habit	25	27%
Inadequate cleaning	25	27%
Delayed Prescription of CDI treatment (> 2 hours of test result)	18	19%
Delayed testing	10	11%
Delayed availability of CDI medication	10	11%
Inappropriate handover on patient transfer	5	5%
Inappropriate non - CDI antibiotics use / dose / Duration*	4	4%
Patient movements between bays/ ward > 2 in 2 days?	3	3%
No senior ward manager oversight	2	2%

Graph 4 below provides a count of ***Clostridioides difficile*** ribotyping results in 2022/23.

Graph 4



Molecular typing is an important infection control tool to monitor the prevalence of certain strains within a healthcare institution or to investigate if a cluster of infections are unrelated or part of an outbreak. Typing results since April 2022 show no particular C. difficile strain beyond those detected within specific outbreaks (CE 002, CE 020 and CE 023).

6.10 Gram-negative bloodstream infections (BSIs)

Since April 2020, reporting trusts were asked to provide information on whether patients with Gram-negative bloodstream infections had been admitted to the reporting trust within one month prior to the onset of the current case. This allows a greater granulation of the healthcare association of cases.

- **Hospital onset healthcare associated**: (HOHA) Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
- **Community onset healthcare associated**: (COHA) Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date(where day 1 is the specimen date)

For 2022/23, as for 2021/22, trust-level thresholds comprise total healthcare-associated cases (i.e., HOHA and COHA).

All thresholds are derived from a baseline of the 12 months ending November 2021, as this is the most recent available data at the time of calculating the figures.
Objectives for this year are derived from a base line of the 12 months ending November 2021, as this is the most recent available data at the time that NHSE/I was calculating the figures.

For each of the three Gram-negative bloodstream infection types specified, if a trust had fewer than or equal to 10 cases during the 12 months ending November 2021, the threshold will be equal to that count. If a trust had more than 10 cases, the threshold will be 5% less than the count.

All thresholds were rounded down to the nearest whole number and pertain to healthcare-associated cases (i.e., HOHA and COHA cases).

Gram-negative bacteria - *Escherichia coli (E. coli)*, *Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella* spp.) are the leading causes of healthcare associated bloodstream infections. The national ambition was to deliver a 25% reduction of healthcare associated Gram-negative blood stream infections by 2021-2022 with 50% by 2023-2024, (Jan 16 - Dec 16 data values). In 2021/2022 Trusts were given individual objectives for each organism.

E.coli

Escherichia coli (*E. coli*) bacteria are frequently found in the intestines of humans and animals and can survive in the environment. There are many different types of *E. coli*, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. *E. coli* bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E. coli bacteraemia (blood stream infection) may be caused by primary infections spreading to the blood.

Community-acquired E. coli bacteremia is most frequently the result of urinary tract infections in older adults, while hospitalised patients likely develop bacteremia because of lower respiratory tract infection.

Escherichia coli causes more than one-third of the bacteraemia cases in England each year, and the incidence of these infections is increasing.

Table 8 below provides a breakdown of Hospital attributed ***E.coli*** **bacteraemia** by month against the trajectory.

Table 8

The incidence of *E.coli* bacteraemia since 2021/22													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021/22	4	4	7	3	3	5	4	4	6	5	6	8	59
Trajectory 2022/23	5	5	4	5	5	4	5	5	4	5	5	4	56
2022/23	8	4	9	12	10	6	5	5	11	5	6	8	89

We were 33 cases over our trajectory for 2022/23.
Graph 5 below provides ***E.coli*** bacteraemia reported infections by month against the trajectory.

Graph 5

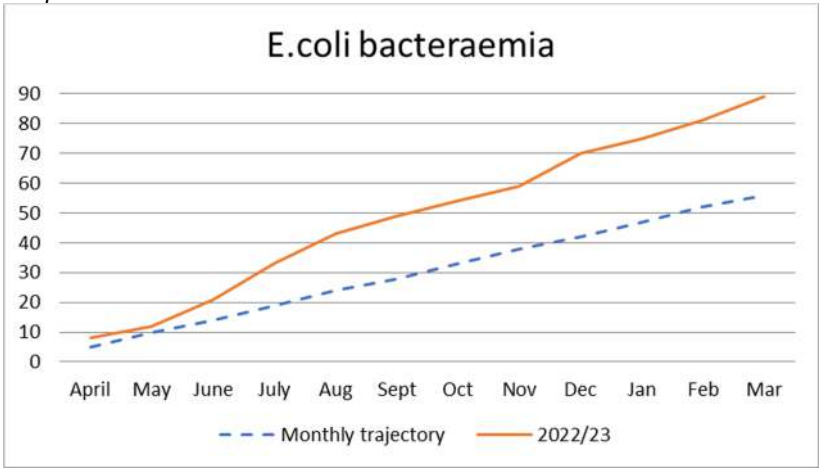


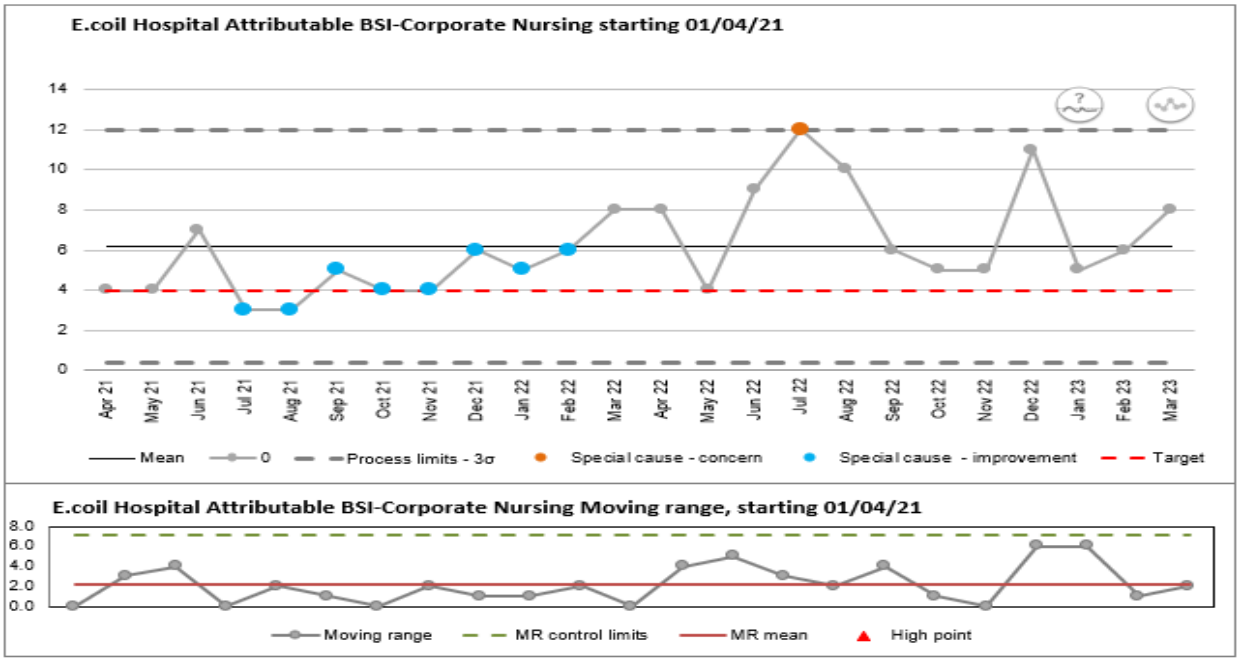
Table 9 below table provides a breakdown of Hospital onset and Community onset, Hospital Associated and Community Associated ***E.coli*** **bacteraemia** by month.

Table 9

Breakdown of E.coli cases in 2022/23													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	5	0	5	6	4	3	3	2	10	2	3	6	49
CO-HA	3	4	4	6	6	3	2	3	1	3	3	2	40
Community Associated	12	11	15	10	16	17	10	17	9	10	14	17	158

SPC chart 4 below provides a breakdown of *E.coli* bacteraemia by month.

Chart 4



Klebsiella

Klebsiella bacteria are normally found in the human intestines (where they do not cause disease). They are also found in human faeces. In healthcare settings, *Klebsiella* infections commonly occur among sick patients who are receiving treatment for other conditions. Patients whose care requires devices like ventilators (breathing machines) or intravenous (vein) catheters, and patients who are taking long courses of certain antibiotics are most at risk for *Klebsiella* infections. Healthy people usually do not get *Klebsiella* infections.

Table 10 below provides a breakdown of Hospital attributed ***Klebsiella* bacteraemia** by month against the trajectory.

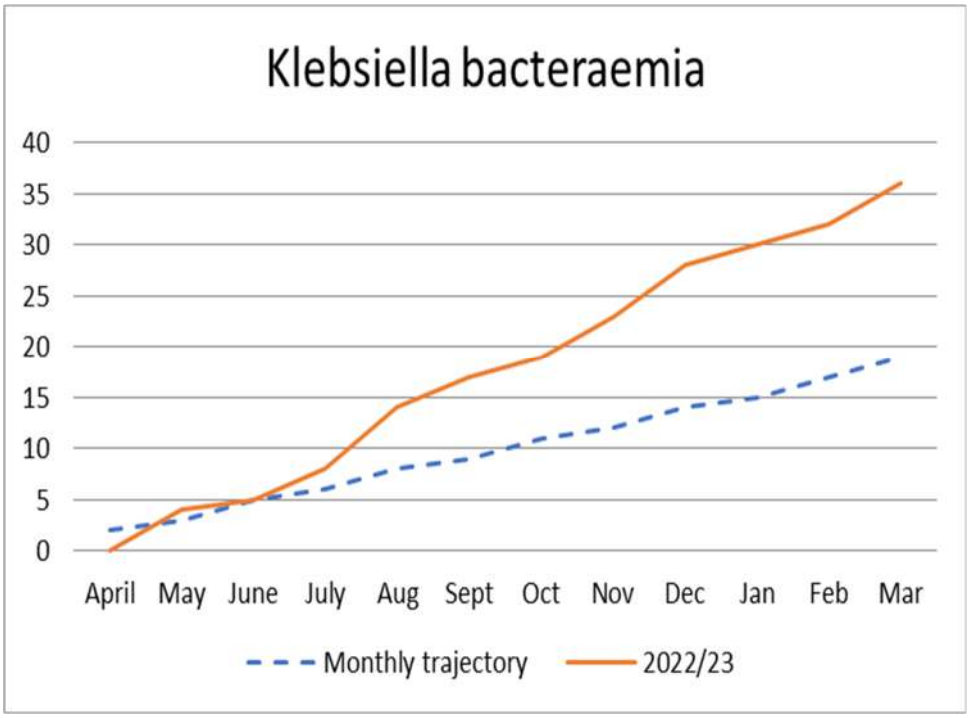
Table 10

The incidence of Klebsiella bacteraemia since 2021/22													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021/22	1	3	4	1	3	0	3	2	2	2	1	3	25
Trajectory 2022/23	2	1	2	1	2	1	2	1	2	1	2	2	19
2022/23	0	4	1	3	6	3	2	4	5	2	2	4	36

We were 17 cases over our trajectory for 2022-2023.

Graph 6 below provides ***Klebsiella* bacteraemia** reported infections by month against the trajectory.

Graph 6



SPC chart 5 below provides a breakdown of *Klebsiella* bacteraemia by month.

Chart 5

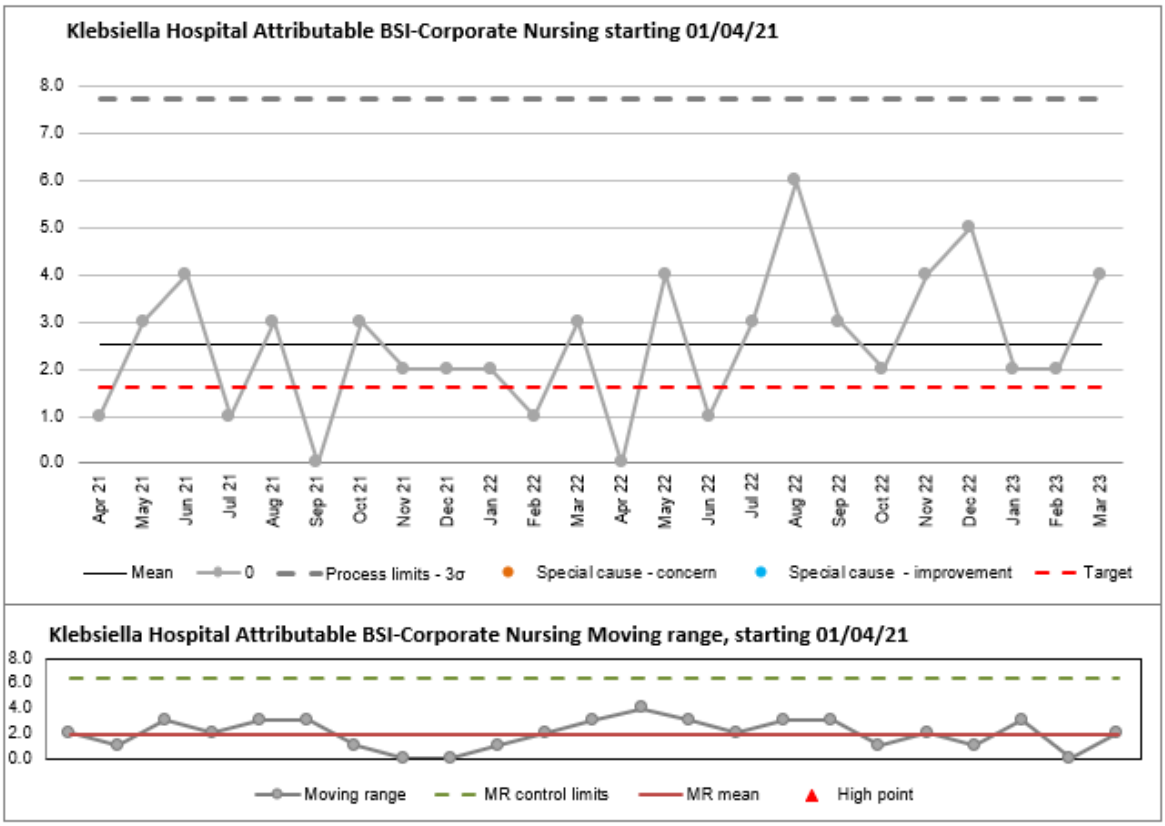


Table 11 below table provides a breakdown of Hospital onset and Community onset, Hospital Associated and Community Associated ***Klebsiella* bacteraemia** by month.

Table 11

Breakdown of Klebsiella cases in 2022/23													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	0	3	1	2	3	2	1	4	4	1	1	3	25
CO-HA	0	1	0	1	3	1	1	0	1	1	1	1	11
Community Associated	3	0	2	3	3	3	1	3	7	3	2	2	32

Pseudomonas

Pseudomonas aeruginosa lives in the environment and can be spread to people in healthcare settings when they are exposed to water or soil that is contaminated with these germs. Resistant strains of the germ can also spread in healthcare settings from one person to another through contaminated hands, equipment, or surfaces.

Table 12 below provides a breakdown of Hospital attributed ***Pseudomonas* bacteraemia** by month. against the trajectory.

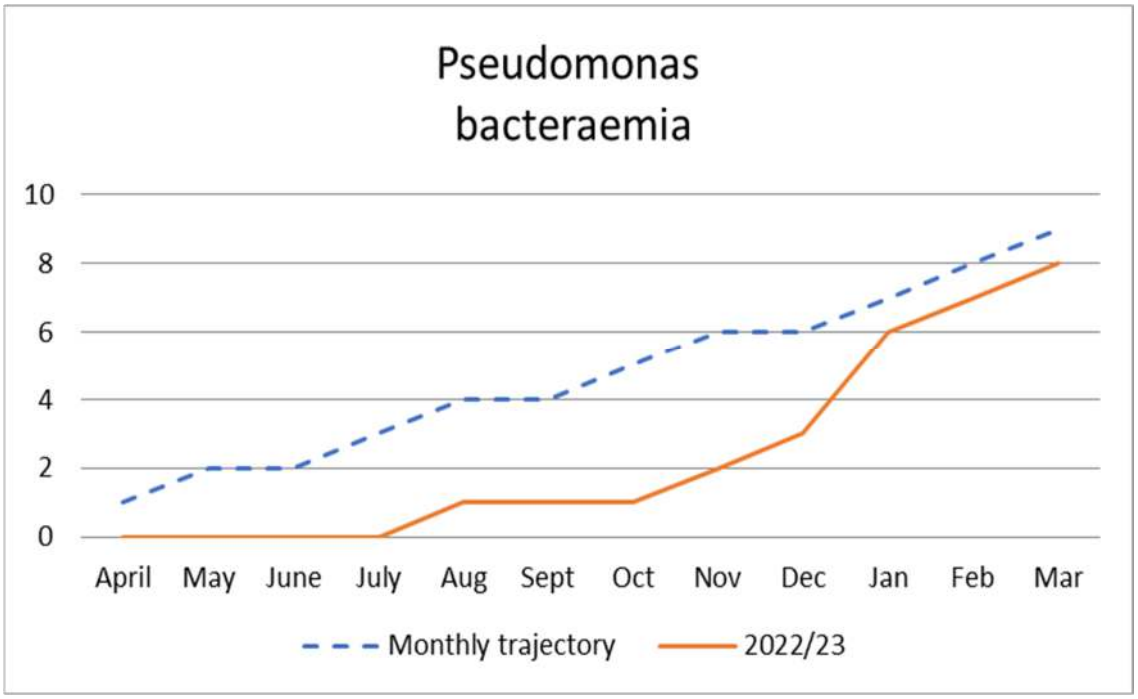
Table 12

The incidence of Pseudomonas bacteraemia since 2021/22													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2021/22	1	0	0	0	2	3	0	1	0	0	0	1	8
Trajectory 2022/23	1	1	0	1	1	0	1	1	0	1	1	1	9
2022/23	0	0	0	0	1	0	0	1	1	3	1	1	8

We were 1 case under our trajectory for 2022-2023.

Graph 7 below provides Pseudomonas bacteraemia reported infections by month against the trajectory.

Graph 7



SPC chart 6 below provides a breakdown of ***Klebsiella*** **bacteraemia** by month.

Chart 6

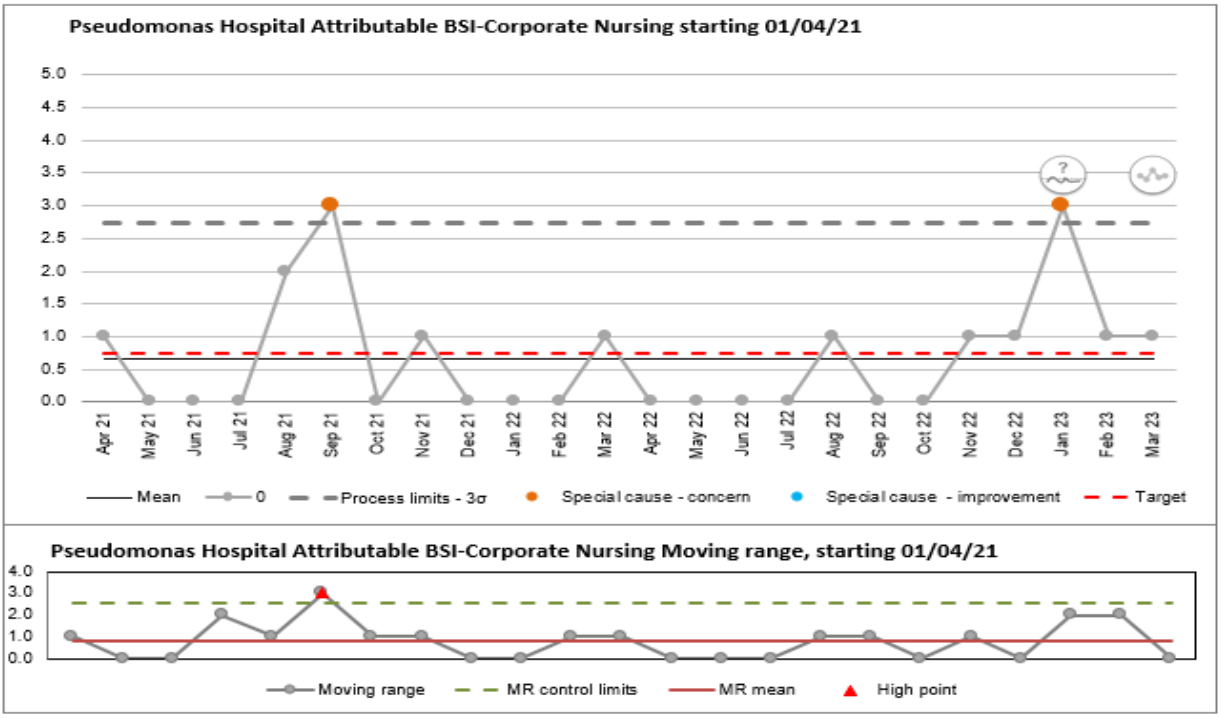


Table 13 below table provides a breakdown of Hospital onset and Community onset, Hospital Associated and Community Associated ***Pseudomonas*** **bacteraemia** by month.

Table 13

Breakdown of Pseudomonas cases in 2022/23													
Incidence	*April*	*May*	*June*	*July*	*Aug*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*Mar*	*Total*
HO-HA	0	0	0	0	1	0	0	1	1	1	1	1	6
CO-HA	0	0	0	0	0	0	0	0	0	2	0	0	2
Community Associated	0	0	0	1	1	0	3	1	1	0	2	1	10

6.11 Themes from gram negative RCA investigation

E- mail notifications are sent to the divisions to request for the RCA investigation to be undertaken for all hospital onset gram negative BSIs. These are then required to be presented at the weekly patient safety review panel with any resulting actions developed from lessons learnt monitored at the monthly divisional IPC meetings and presented at the monthly IPCG. Below are the themes that have been identified from the completed investigations.

- Delay in taking blood cultures/sepsis pathway not being followed.
- Not known if staff taking blood culture have received/compliant with ANTT training.
- Surgery in the previous 30 days or 12 months if a prosthetic implant
- ERCP/MRCP in previous 28 days

- Diabetic foot ulcer
- Open wounds

The 2023-2024 annual plan proposes as more in depth look at Gram Negative Bacteraemia and gathering assurance from lessons that have been learnt have been embedded in the Teams to sustain improvements.

6.12 Carbapenemase-producing Enterobacteriaceae (CPE)

The spread of antibiotic resistance in gram-negative organisms continues to be an increasingly significant public health threat and a matter of national and international concern. They are an emerging cause of healthcare-associated infections, which represent a major challenge to healthcare systems.

Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. These organisms are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Environmental and surface contamination plays a significant role in transmission. Bacteria can survive on dry surfaces for extended periods, increasing the risk of cross contamination between patients.

Table 14 below provides a breakdown of all CPE **bacteremia** by year and month.

Table 14

The incidence of CPE Bacteraemia since 2019/20													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	0	0	0	1	0	0	0	0	0	0	0	0	1
2020/21	0	0	0	1	0	0	0	0	0	0	0	0	1
2021/22	0	0	0	0	0	0	0	1	0	0	0	0	1
2022/23	0	0	0	0	0	1	0	0	0	0	0	0	1

As a result of the ongoing challenges faced in 2022-2023 the review of the current arrangements and introduction of a CPE policy, reflecting the national guidance was put on hold for 2 years, this will now be part of the annual plan for 2023.24.

6.13 Mandatory Glycopeptide resistant Enterococci (VRE) bacteraemia

Enterococci bacteria are frequently found in the bowel of normal healthy individuals. There are many different species of enterococci, but only a few have the potential to cause infections in humans. They can cause a range of illnesses including urinary tract infections, bacteraemia (blood stream infections) and wound infections.
There has been 1 incidence of VRE bacteraemia reported at WUTH during the period April 2022 - March 2023. This is a decrease of 3 from the previous year. Unlike other organisms under mandatory surveillance, Public Health England (PHE) employs a reporting year which runs from October – September to publish national G/VRE data. There is no requirement to apportion cases, only report incidences.

Table 15 below provides a breakdown of VRE **bacteremia** by month.

Table 15

The incidence of *VRE bacteraemia since 2019/20*													
Incidence	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	0	0	1	0	1	0	1	1	0	0	1	0	5
2020/21	1	0	0	0	0	0	0	0	0	0	0	0	1
2021/22	0	2	0	0	0	1	0	1	0	0	0	0	4
2022/23	0	0	0	0	0	1	0	0	0	0	0	0	1

6.14 Quarterly Mandatory Laboratory Reporting (QMRL)

The Quarterly Mandatory Laboratory Reporting data continues to be submitted via the laboratory to the UKHSA Health Care Associated Infection (HCAI) Data Capture System.

This data includes:

- Total number of blood culture sets examined.
- Total number of glycopeptide resistant enterococci (GRE) positive blood culture episodes
- Total number of positive blood culture sets
- Total number of S. aureus positive blood culture sets
- Total number of *Clostridioides difficile* toxin positive reports in people aged 2 - 64 years.
- Total number of *Clostridioides difficile* toxin positive reports results in people aged >=65 years
- Total number of stool specimens tested for diagnosis of C. difficile infection.
- Total number of stool specimens examined.
- Total number of faecal specimens and rectal swabs taken for carbapenemase-producing *Enterobacteriaceae* (CPE) screening

6.15 Coronavirus (COVID-19)

The Government's aim throughout the COVID-19 pandemic has been to protect the lives and livelihoods of citizens across the United Kingdom (UK). In May 2022, the Government published Guidance, *'COVID-19 Response: Living with COVID-19'.* This document set out how the Government would continue to protect and support citizens by enabling society and the economy to open up more quickly than many comparable countries; using vaccines; and supporting the National Health Service (NHS) and social care sector. It also set out how England would move into a new phase of managing COVID-19.

The document acknowledged that vaccines have enabled the gradual and safe removal of restrictions on everyday life over the past year and remain at the heart of the Government's approach to living with the virus in the future. It also identified that the Government and the NHS, with the help of volunteers delivered one of the largest vaccination programs in history.

The emergence of new variants will be a significant factor in determining the future path of the virus as new variants of COVID-19 will continue to emerge. This could include variants that render

vaccines less effective as they become resistant to antivirals or cause more severe disease. The pathway to greater stability will be supported by utilising vaccines and other available treatments.

Whilst the past 3 years have seen many necessary restrictions imposed on everyday life to manage COVID-19, these came with a huge toll on wellbeing and economic output. Scientists (including virologists, epidemiologists, clinicians, and many others) and the Government now understand more about COVID-19, how it behaves and how it can be treated. As the virus continues to evolve, it will be important to continue to add to this understanding.

Living with and managing the virus will mean maintaining the population's wall of protection and communicating safer behaviours that the public can follow to manage risk. The Government will move away from deploying regulations and requirements in England and replace specific interventions for COVID-19 with public health measures and guidance.

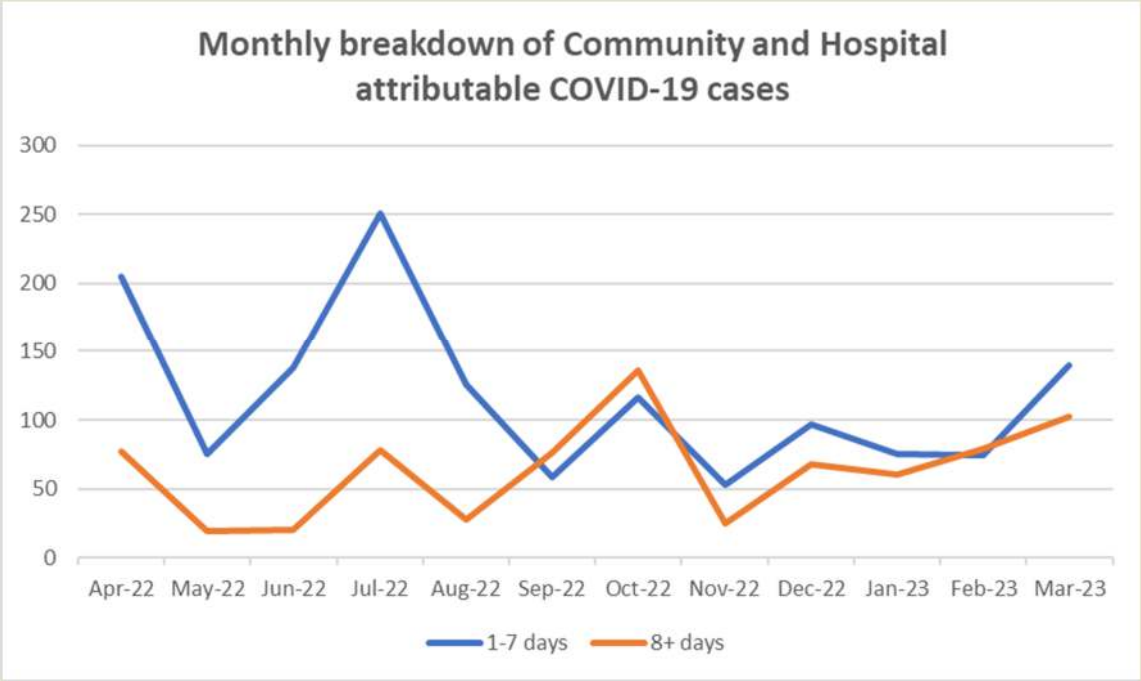
As a result of new National guidance released on 31st August 2022, WUTH stopped all admission screening and day 3 and day 6 screening on 2nd September 2022, it then became a challenge to determine nosocomial status, community screening also became unavailable. Visiting also resumed. at this time. In September/October 2022 completion of root cause analysis stopped for all COVID infections The only RCA's that continued to be completed by the IPC team were those following a death of patient with COVID on part 1 or 2 of their death certificate. The table 16 below provides a breakdown of COVID-19 by month.

Table 16

	No. of COVID-19 cases				Total No. of cases per month
	Community Onset		Hospital Onset		
Month	1-2 days	3-7 days	8-14 days	15+ days	
Apr-22	179	26	32	45	282
May-22	69	6	7	12	94
Jun-22	128	10	4	16	158
Jul-22	231	20	20	58	329
Aug-22	113	13	10	18	154
Sep-22	44	15	26	50	135
Oct-22	92	24	42	94	252
Nov-22	46	7	6	19	78
Dec-22	76	21	19	49	165
Jan-23	63	12	12	48	135
Feb-23	61	13	25	54	153
Mar-23	105	35	45	57	242
Total	1207	202	248	520	

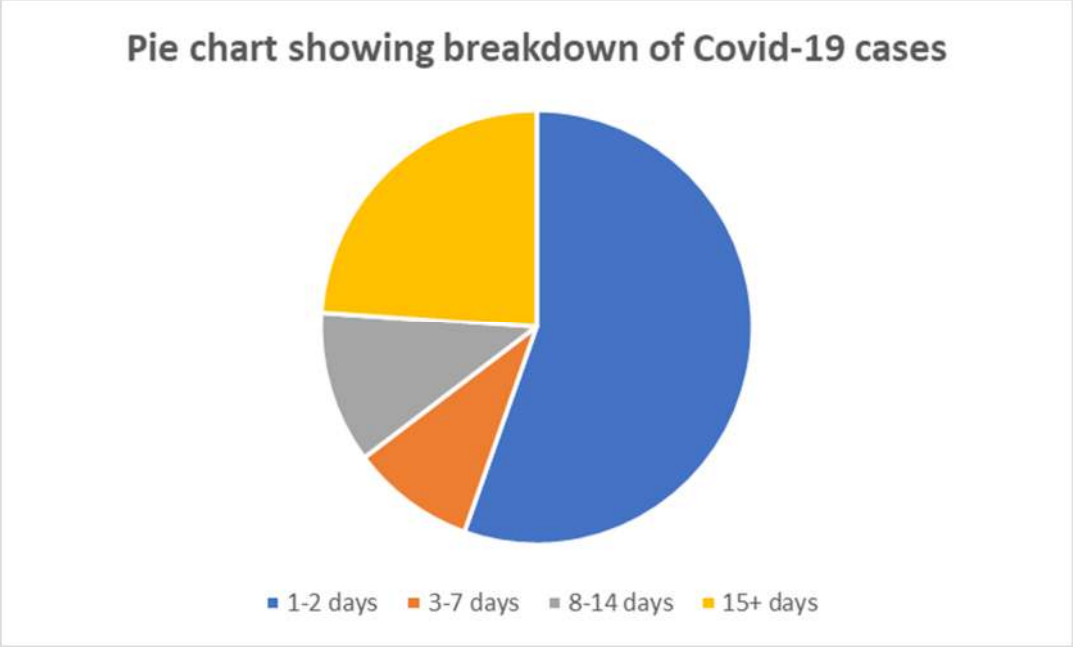
Graph 8 below shows the incidence of patient COVID-19 results in 2022/2123

Graph 8



The Pie chart 1 below provides a breakdown of COVID-19 in 2022-2023

Pie chart 1



Effective infection prevention and control remained fundamental in the way in which WUTH for the third year running rapidly adapted to the response to the COVID pandemic and the ongoing waves.

of the disease. Improvements and initiatives continued throughout 2022/23 to strengthen IPC practices across the trust; this activity continued to be captured in the Infection Prevention & Control Board Assurance Framework (IPC BAF) which was introduced at the beginning of the pandemic and is now on version 11. This assurance document is updated to reflect current Trust guidelines and is reviewed by the Quality Committee as delegated by the Board of Directors.

Over time, though hard to predict, it is likely that COVID-19 will become a predominantly winter seasonal illness with some years seeing larger levels of infection than others. This may take several years to occur, and waves of infection may occur during winter or at other times in the year.

6.16 Seasonal Influenza

WUTH participates in the Unify2 influenza surveillance scheme for reporting cases occurring in level two and level three care settings (ICU and HDU). Table 71 below shows the summary of Influenza Cases in Augmented Care areas reported through Unify2 Surveillance Scheme since 2019-2020

Table 17

	Influenza A, H1N1pdm09	Influenza A (H3N2)	Influenza A, unknown subtype	Influenza B	Influenza other/unknown subtype
April 2019 -March 2020	3	4	3	0	0
April 2020 -March 2021	0	0	0	0	0
April 2021 -March 2022	0	0	0	0	0
April 2022 -March 2023	2	2	12	0	0

Throughout the rest of the Trust there were 538 positive flu patients admitted in 2022/23, of these there were 527 Flu A positives and 11 Flu B positives. Some cases were an incidental finding due to the type of test that was performed for COVID-19; as can be seen above 16 patients required level two and level three care settings (ICU and HDU)

These numbers reflect a return to levels experienced pre-COVID-19 pandemic.

Of the reported cases of Influenza, 37 patients passed away during their inpatient stay, of these all but 9 came into hospital with Influenza. Of the 9 patients who caught flu whilst an in-patient, flu was not listed as Part 1 a on their death certificate as direct cause of death.

6.17 Surgical Site Infection (SSI)

There is a mandated requirement for all NHS Trusts in England to submit data with regards to Surgical Site Infections (SSI) to Public Health England (PHE) comprising of at least 1 quarter per year for one orthopaedic category as a minimum.
Throughout the year the Trust has been completing ongoing surveillance and reporting on five surgical categories, as listed below:

Orthopaedic

- *Hip replacement* - Replacement of the hip joint including resurfacing of the joint, acetabulum replacement and revision of previous replacement and conversion from a previous hemiarthroplasty or bone fixation.
- *Repair of neck of femur* - Replacement of the head of femur, including revision of a previous hemiarthroplasty (but *excluding conversion to total joint replacement)* and reduction of a fractured neck of femur using open fixation e.g., dynamic hip screw.
- *Reduction of Long bone fracture* - Open or closed reduction of fracture of long bones requiring surgical incision to apply internal or external fixation. *Excludes replacement or open fixation of hip fracture, of small bones or intraarticular fracture*.

Colorectal

- *Small bowel surgery* - Incision, excision or anastomosis of small intestine, *excluding procedures which involve anastomosis of small to large bowel.*
- *Large Bowel* - Incision, excision or anastomosis of the large bowel, including procedures which involve anastomosis of small to large bowel.

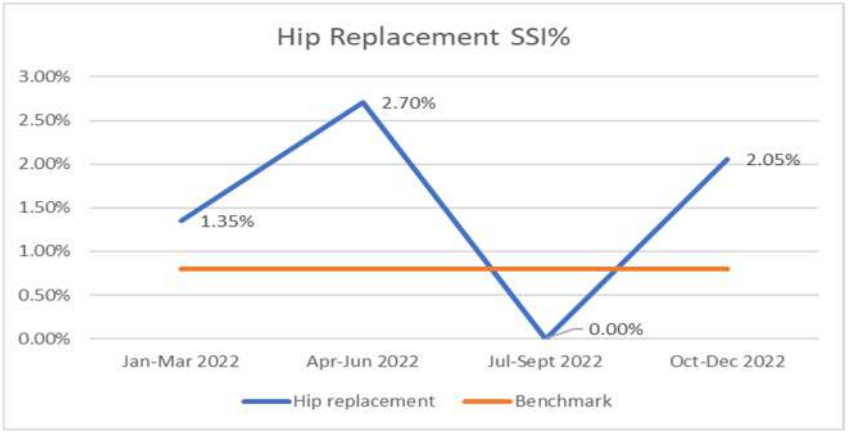
The surgical division completed a year of small bowel surveillance (June 2021 to June 2022), then moved onto large bowel surveillance (July 2022 to July 2023) and then started surveillance on Long Bone surgery. Tables 18 and 19 below shows the data submission for January to December 2022. The data submission for January to March 2022 is not due until the end of June 2022 and is therefore not included within this report.

Table 18

Category	Jan-Mar 2022		Apr-Jun 2022		Jul-Sept 2022		Oct-Dec 2022	
	Total No	SSI	Total No	SSI	Total No	SSI	Total No	SSI
Hip replacement	74	1	111	3	132	0	146	3
Repair neck of femur	71	1	80	0	73	2	84	1
Long bone	na	na	na	na	56	1	59	0

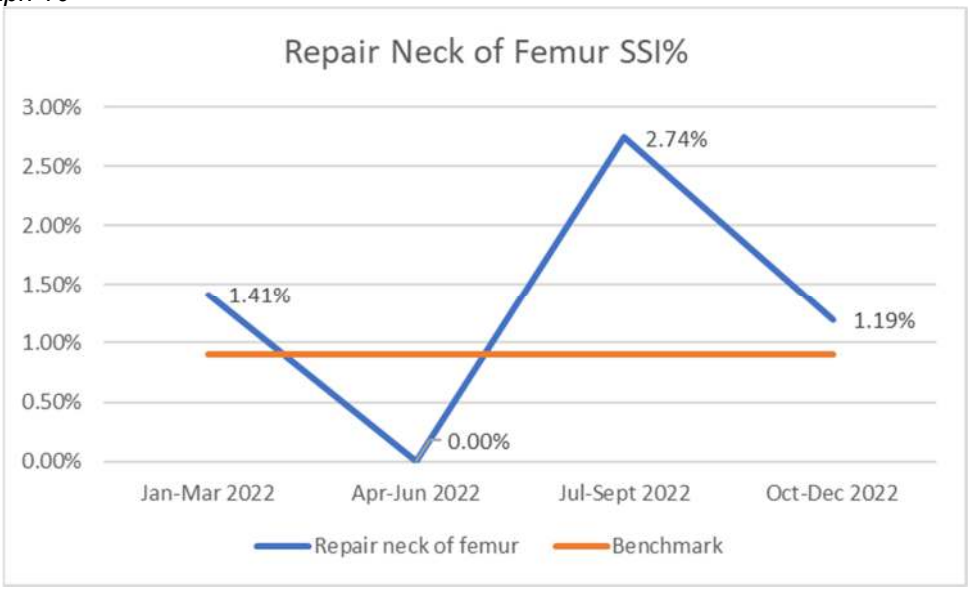
All suspected SSIs are reviewed by the multidisciplinary team to agree if it is a confirmed SSI and identify learning. Below are graphs for each surgical category comparing percentage of SSIs compared with the benchmark of all hospitals data over 5 years. Graph 9 below shows SSI rates for hip replacement.

Graph 9



Graph 10 below shows SSI rates for repair of neck of femur.

Graph 10



Graph 11 below shows SSI rates for reduction of long bone fracture.

Graph 11

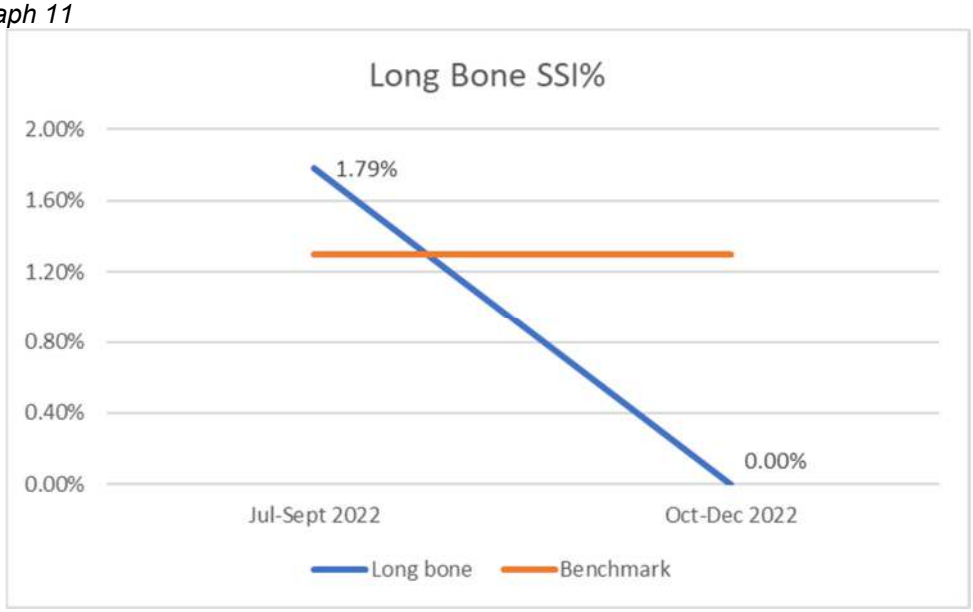
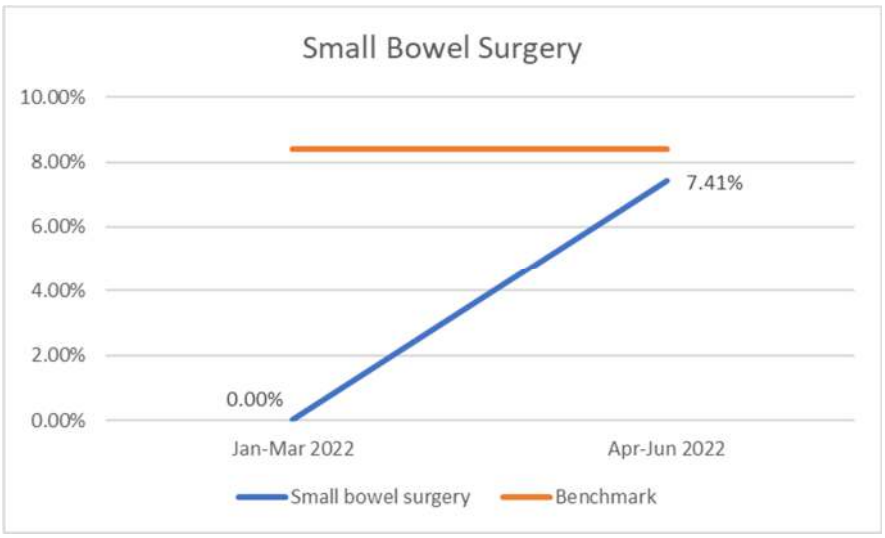


Table 19

Category	Jan-Mar 2022		Apr-Jun 2022		Jul-Sept 2022		Oct-Dec 2022	
	Total No	SSI	Total No	SSI	Total No	SSI	Total No	SSI
Small bowel surgery	30	0	27	2	na	na	na	na
Large bowel	na	na	na	na	76	7	94	6

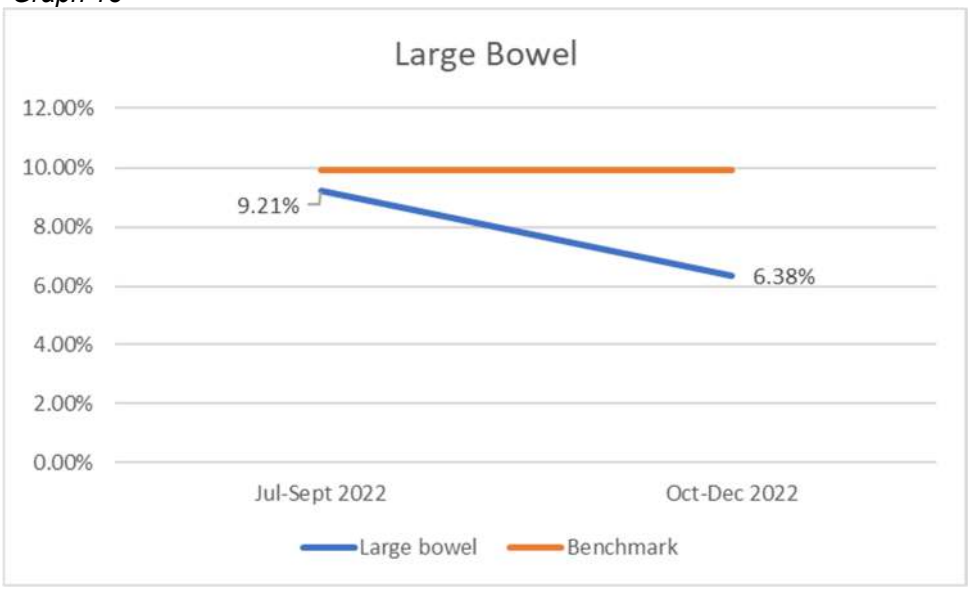
Graph 12 below shows SSI rates for small bowel surgery.

Graph 12



Graph 13 below shows SSI rates for large bowel surgery.

Graph 13



Weekly MDT SSI RCA meetings are being held, whereby incidents are reviewed, key learning is identified, and action plans are developed. The RCAs and action plans are shared with the ward areas and clinicians for comments and learning. Action plans developed with the ward areas are being reviewed regularly to monitor progress. This is fed into divisional IPC for assurance. SSI has also been added to directorate clinical governance meetings and any issues are being escalated via divisional quality board (DQB).

Learning identified from the RCAs include:

- Lack of consistency of post operative wound education to patients on discharge
- Gaps in documentation with regards to wound care post-operatively and on discharge
- Inconsistencies in completion of the wound assessment tool on Cerner
- Inconsistencies in post operative wound care management
- Body temperature monitoring and maintenance intra-operatively is not standard.
- Lack of MDT involvement regarding prevention
- Lack of ward engagement and knowledge of SSI
- Inconsistencies with wound swabbing and information when wound is swabbed.
- Inappropriate prescribing of antibiotics by GPs

Actions that have been identified from the RCAs include:

- MDT SSI task group to be established within orthopaedic division with key focus to be prevention and reducing number of SSIs within the division.
- Surgical wound SOP to be developed, through an MDT approach to standardised wound care management, with TVNs, IPC, clinicians, SSI nurse.
- Ward based level involvement, ward managers to attend RCA meetings, to discuss lapses in care and share key learning with staff. Action plans to be completed and regularly updated and monitored in ward areas with SSIs – to raise SSI awareness.
- Wound swabbing clarification and guidance.
- Education to staff regarding information inputted when swabbing a wound.
- SSI to be added to directorate CG meetings and issues/ concerns raised at DQB.
- SSI RCA and action plans to be added to incident forms to ensure monitored through clinical governance.
- Theatre leads to be invited to RCA meetings to discuss key findings and learnings.
- Education to be provided to ward areas regarding SSIs, prevention and early recognition. SSI link nurse to attend ward safety huddles.
- Education regarding utliisation of wound assessment tool, to ensure standardised care, ensure wounds are checked each shift and information regarding wound obtained.
- SSI role and RCA process to be reviewed with the aim to report on SSIs the month before so information and key learning/issues are addressed in real time.

7.0 Outbreaks /Increased Incidences/Clusters of Infection

Infection surveillance supports the early detection of outbreaks which enables control measures to be instigated early to avoid escalation. An outbreak, as defined in the National Infection Prevention manual is.

- Two or more linked cases with the same infectious agent associated with the same healthcare setting over a specified time period.

Or

- A higher than expected number of cases of HAI in a given healthcare area over a specified time period.

Once an Outbreak has been identified the senior IPC Team arrange outbreak meetings on a regular basis with the divisional teams to give support and advice until the outbreak is determined to be closed. Due to Trust operational pressures during 2022-23 regular meetings once outbreaks were declared were not as frequent and as a result updates were often given from the IPC team via e-mail to divisions.

7.1 Norovirus

Between 1st April 2022 and 30th March 2023 there were 12 confirmed Norovirus outbreaks, with some wards experiencing more than one outbreak. 8 wards were fully closed, and 4 wards were partially closed/restricted. The length of outbreaks ranged from 3 days, when symptomatic patients had been able to be accommodated in single rooms; up to 39 days, when a ward had been partly reopened to support operational pressures, and new patients admitted to the ward unfortunately acquired Norovirus.
In total, 227 patients experienced D&V symptoms, of these 76 patients were confirmed to have Norovirus, although not all patients were sampled. When Norovirus is confirmed on a ward it is presumed that any patients' further patients on the ward with symptoms are likely to have Norovirus.
There were 68 staff who also reported symptoms during these outbreaks, however 3 outbreaks had no staff affected.
N.B. It is rare to receive samples from staff into the Lab for testing.

7.2 *Clostridiodes difficile*

There were 9 wards that were identified as having a period of increased incidence of *C.difficile*:

- Ward 32 - 4 patients identified with CDT between May and June 2022; 3 patients were identified as having ribotype 023, indicating transmission of infection and meeting the definition of an outbreak.
- Ward 22 - 11 patients identified with CDT between June and August 2022; 4 patients were identified as having ribotype 511 and 2 patients had ribotype 023, indicating likely cross transmission and two separate outbreaks. The other patients had distinct ribotypes.
- Ward 33 - 10 patients identified with CDT between June and September 2022; 2 patients were identified as having ribotype 002, however these were 3 months apart and all other patients had distinct ribotypes.
- Ward 11 - 3 patients identified with CDT in July 2022; all patients had distinct ribotypes.
- Ward 27 - 4 patients identified with CDT in November 2022; 2 patients were identified as having ribotype 005 indicating likely cross transmission and meeting the definition of an outbreak.
- Ward 18 - 3 patients identified with CDT in October 2022; 2 patients were identified as having ribotype 002 indicating likely cross transmission and meeting the definition of an outbreak.
- Ward 21 – 3 Patients identified with CDT between December 2022 and January 2023; all patients were identified as having ribotype 002, with identical fingerprinting, indicating cross transmission and meeting the definition of an outbreak.
- WAFFU had a number of patients identified with CDT in February 2023; all patients had distinct ribotypes.

Once an Outbreak is declared all wards are required to implement the Trust CDI improvement plan, enhanced cleaning is initiated and increased attention to outstanding Estates issues addressed. HPV of the ward is also required however this was not always possible due to operational pressures. Once

outbreaks are over all documentation is advised to be attached to the incident form which is commenced when the outbreak is declared.

7.3 COVID-19

COVID-19 outbreaks continued to be submitted throughout the year to the NHSE/I online reporting system. Wards and departments remained in 'outbreak' until 15 days have passed since the last positive COVID-19 case had been identified. Outbreaks became protracted following the change to National Guidance advising that COVID exposed patients did not need be isolated or cohorted. Therefore, new patients admitted into bays where known patients had been cared for could potentially become exposed when a contact subsequently tested positive for COVID-19.

Due to significant operational pressures during the winter, attendance at outbreak meetings was sporadic, therefore the IPCT provided an email notification of outbreaks with a list of mitigating actions that needed to be implemented, this was supported with regular visits by the IPCT to the outbreak wards.

Between April 2022 and March 23 there were 63 outbreaks declared.

In total 714 patients tested positive for COVID-19:

- 120 patients tested positive between day 3 and 7;
- 202 patients tested positive between day 8 and 15;
- 401 patients tested positive after day 15 of admission.

There were

- 3 staff only outbreaks,
- 28 patient only outbreaks
- 32 outbreaks that involved both patients and staff.

From these Outbreaks a total of 186 staff were reported to be COVID-19 positive. However, staff reporting declined after the Trust Contact Tracing stopped in November 2022.

Most of the outbreaks in 2022-2023 were in March 2023, with 9 outbreaks identified, followed by April 2022, with 8 outbreaks identified . There were 9 outbreaks ongoing at the end of 2022-23.

7.4 *Pseudomonas*

Between August and October 2022 there were 4 babies who acquired *Pseudomonas aeruginosa* on the Neonatal Unit that had been identified from routine weekly screening. Regular outbreak meetings were held to ensure that mitigating actions were in place, and all guidelines and SOPs were reviewed. Samples were sent for typing with two reported as identical. Environmental sampling was also undertaken, and although *Pseudomonas aeruginosa* was grown from one isolate the typing did not match.

7.5 MRSA

An MRSA outbreak was declared on the Neonatal Unit in February 2023 when one baby was identified with a MRSA bacteraemia from a receiving Trust following transfer, screening of the babies on the unit identified one neonate colonized with MRSA, followed by a further neonate identified in March 2023. Outbreak meetings were held, and an improvement plan was implemented. This outbreak remained ongoing into April 2023.

8.0 Incidents of communicable disease

Communicable diseases, also known as infectious diseases or transmissible diseases, are illnesses that result from the presence and growth of pathogenic (capable of causing disease) biologic agents in an individual human or other animal host. There may be occasions when patients or staff have been exposed to a specific infection e.g., scabies, Group A Streptococcus, identified by either the IP&CT or PHE which results in the need for either staff and Patient screening / treatment or both. When these situations have been identified the IP&C team support the ward teams to complete contact tracing and screening, if exposed patients / staff are identified immunisation records are checked by patients clinician and occupational health for verification of immunity and vaccination offered as required.

8.1 *Group A streptococcus*

Group A Streptococcus (also known as GAS, group A strep, strep A, and Streptococcus pyogenes) is a bacterium which can colonise the throat, skin and anogenital tract. Strep A infections are more common in children, but Adults can also sometimes get them. Most strep A infections are not serious and can be treated with antibiotics. But rarely, the infection can cause serious problems, this is called invasive group A strep (iGAS) It is spread by close contact between individuals, through respiratory particles and direct skin contact. It can also be transmitted environmentally, for example through contact with contaminated objects, such as towels or bedding, or ingestion of food prepared by someone with the infection.

At the end of 2022 there was an increase in GAS in children and NHS England published interim clinical guidance on the diagnosis and treatment on 9th December 2022. Subsequently there was an increase in patients being admitted with GAS; 22 patients had GAS in blood cultures and 4 patients had GAS within clinical samples during 2022-23 which were treated as iGAS. As this is only diagnosed post admission, ‘warn and inform’ letters were regularly issued to staff who may have been exposed, prior to confirmed diagnosis, without wearing a FRSM. There were no cases of healthcare workers who acquired GAS reported by Occupational Health or transmission to other patients identified.

8.2 Mpox

Mpox (previously known as monkeypox) is a rare disease that was first discovered in 1958 when outbreaks of a pox-like disease occurred in monkeys kept for research. The first human case was recorded in 1970 in the Democratic Republic of Congo (DRC), and since then the infection has been reported in a number of central and western African countries. Since May 2022, cases of Mpox have

been reported in multiple countries that do not usually have Mpox virus in animal or human populations, including the UK. Prior to 2022, cases identified in the UK had been either been imported from countries where Mpox is endemic or contacts with documented epidemiological links to imported cases. Since May 2022 detection of Mpox infection, acquired within the UK, were confirmed in England. Between 6 May 2022 and 31 March 2023 there have been 3,555 cases reported in England. The outbreak has mainly been in gay, bisexual, and other men who have sex with men without documented history of travel to endemic countries.

During this time there were patients admitted to the Trust who were suspected of having Mpox. Meetings were held to ensure that the correct precautions were implemented, and details of contacts were collected as a precaution if the cases were confirmed. Testing has confirmed that there were no patients admitted to WUTH with Mpox.

8.3 Tuberculosis

Tuberculosis (TB) is an infectious disease caused by the organism Mycobacterium Tuberculosis. It usually presents as a chronic disease of the respiratory tract but may also affect other organ systems. TB is spread by inhalation of infectious droplets, which may be coughed or sneezed by a patient with respiratory TB. People with TB in organs other that the respiratory tract or with latent TB are rarely infectious to others.
In December 2022 a patient was diagnosed with TB who had been in hospital for 48 hours prior to TB being suspected, appropriate precautions were then implemented. A multi-disciplinary meeting was held which included Microbiology, Occupational Health, TB Specialist Nurse, UKHSA and Divisional Representatives. Contact tracing was undertaken, and notification letters were sent to all staff who had exposure and 2 patients who were deemed to have had more than 8 hours contact within the bay. There have been no other confirmed cases as a result of this.

8.4 PVL-MRSA

Panton Valentine Leukocidin (PVL) is a toxin produced by certain types of *Staphylococcus aureus.* The toxin can kill white blood cells and cause damage to skin and deeper tissues, causing cellulitis, abscesses, boils and carbuncles. It usually spread from close contact, including close contact sports.

In March 2023, a child with cystic fibrosis was admitted to WUTH who tested positive for PVL-MRSA on admission screening. The child's family were noted to be staying in a local immigration hotel. A multi-disciplinary team (MDT) meeting was held which included members of WUTH, Public Health Wirral Council, Wirral Community, UKHSA, the Integrated Care Board and SERCO (immigration providers). Arrangements were made for the child and family to be decolonised at the same time and through multi-disciplinary working the child was able to be discharged safely. There was no onward transmission of PVL-MRSA identified.

9.0 Antimicrobial Stewardship

Antimicrobial resistance resulting from infections with multidrug resistant organisms (MDROs) is a major public health concern. If MDROs continue to increase at the current rate, coupled with a limited pharmaceutical company pipeline of novel agents, even simple infections will become untreatable

soon and most elective surgical procedures, such as joint replacements will become prohibitively dangerous. Common lifesaving operations and treatment regimens such as Caesarian sections and chemotherapy will carry a high risk of mortality.

One of the ways the rate of potentiation of MDROs is accelerating is through inappropriate use of broad-spectrum antimicrobials. Good antimicrobial stewardship practices limit their use to as short a duration as is clinically appropriate and promote use of narrower spectrum agents where possible.

NHS England and regulatory bodies such as the Care Quality Commission (CQC) expect secondary care organisations to be able to demonstrate adherence to guidance such as Start Smart Then Focus, a toolkit for antimicrobial stewardship in secondary care. Additionally, they must be able to demonstrate good performance against other measures of effective antimicrobial stewardship such as consumption as well as the relevant indicators of the Commissioning for Quality and Innovation (CQUIN) framework.

9.1 Antibiotic Stewardship Team (AST)

The Antimicrobial Stewardship Team develops and support the implementation of policies, procedures and guidelines to ensure the safe and effective use of antimicrobials throughout the Trust. The AMS team meet quarterly and report to the Trust Medicines Safety and Optimisation Group (MSOP) and Trust Infection Prevention and Control group (IPCG). Membership consists of Consultant Medical Microbiologist (CMM), Consultants from each Division, Antimicrobial Pharmacists, Advanced Nurse Practitioners and junior doctors. The Committee is well represented by the CMM and pharmacists, Acute Care, Critical care, Elderly care and Respiratory Consultant. Wider attendance remains a challenge however, the team engages directly with specific teams when required for certain pieces of work.

The AMS Team has the following strategies to improve AMS at WUTH:

- Prescriber education training program
- Specialist annual training for F1s, F2s, and pharmacists which is delivered by the AMS pharmacy team. Microbiology team also provide annual training for F1s, F2s, IMTs and Medical Students.
- All newly qualified Non-Medical Prescribers (NMP) attend a training session on AMS.
- Training also provided on an ad hoc basis when necessary.
- Maintaining an evidence-based antimicrobial formulary
- Audit program to monitor antimicrobial prescribing, consumption and identify areas for improvement.

9.2 Ward – focused Antimicrobial Stewardship Team

The ward-based AMS team consists of a CMM or Specialty Doctor or Clinical Scientist for microbiology and a specialist antimicrobial pharmacist to undertake ward rounds to provide patient specific interventions and prescribing feedback directly to prescribers.

The team also leads on service improvements to improve antimicrobial prescribing, such as new treatments, diagnostic tests and developments to the e-prescribing system.
Areas which are high-users of broad-spectrum antibiotics or high incidence of *C.difficile* infections and areas with patients with critical or complex infections requiring long-courses of treatment have been identified by audits and prioritised for visitation by the ward focused AMS Team:

- Critical care (five times weekly)
- Acute Care (five times weekly) – AMU, MSSW, UMAC
- Older Persons Assessment Unit (weekly)
- Gastroenterology ward (weekly) – W36
- Elderly Care wards (weekly) W21, 22, 23 (new in 22/23) and 27
- Respiratory Unit (weekly) – W37 and 38
- Orthogeriatric wards/T&O x 3 (weekly) – W10,11,12 and WAFFU
- SEU (weekly)
- Colorectal unit (weekly)
- General medicine W20 (weekly) (new in 22/23)

The AMS ward-focused team are also available to attend all other areas in response to positive culture results from the microbiology lab and referrals from medical colleagues.
The AMS team also initiated targeted AMS ward rounds on wards with increased incidence of *C.difficile* cases, such as ward 33.

Microbiology +/- AMS Pharmacist also attend the following weekly MDTs:

- Renal
- Haematology
- Endocarditis
- OPAT MDT and “virtual” ward round
- *C,difficile* infection MDT
- Prosthetic Joint MDT

9.3 Antibiotic Safe Prescribing Indicators Report (ASPIRE) and Point Prevalence Survey (PPS)

As part of the audit and feedback program, providers should monitor adherence to SSTF principles regularly in all clinical areas to show:

- Evidence of documenting indication and duration (or review date) on the prescription
- Evidence of antimicrobial stewardship review of antibiotics at 48-72 hours after initiation and documentation of the antimicrobial prescribing decision (stop, change, switch, continue, OPAT) on the prescription or in the notes.
- Adherence with local guidance on the choice of antibiotic therapy (or documented reason for non-compliance)

At WUTH these parameters are audited quarterly as part of the Antibiotic Safe Prescribing Indicators Report (ASPIRE) audit which analyses antibiotic prescribing for 10 patients selected at random on each ward. The results are displayed as a dashboard demonstrating performance Trust wide as well as at a Divisional and Directorate level.

Results from Q1-Q3 22/23 as seen below in table 20 demonstrate that average trustwide performance across the year was as follows (no data for Q4 due to reduced resource within the Pharmacy AMS team):

Table 20

ASPIRE Quality indicators (target >95% for all)	Q1-Q3
Compliance with antibiotic formulary	97%
Documentation of indication for antibiotics on prescription	96%
Stop / review date on antibiotic prescription	100%
Antibiotic clinical review undertaken within 72 hours of initiation	96%

These parameters are reported quarterly trust-wide (via IPCG & MSOP Antimicrobial Stewardship Assurance Report) and divisionally via Lead Divisional Pharmacist Reports.

Additionally, an antibiotic point prevalence survey reviews every antibiotic prescription for inpatients on the day of the audit. Data was collected in March 2023 and will be reported to MSOP later in 2023.

Although ASPIRE indicates that antibiotic prescriptions consistently have a documented review within 72 hours in line with national guidance, the outcome of these reviews is most frequently “continue”. Evidence from AMS ward rounds indicated this was frequently suboptimal, so the AMS Team set the objective to reduce the number of antibiotic prescriptions continued at 72hrs as measured by ASPIRE data, see table 21 below:

Table 21

Objectives to monitor quality of 72-hour review	**Baseline**	**Target**	**Q1**	**Q2**	**Q3**	**Q4**	**Avg.**
Reduce percentage of antibiotic courses “continued” at clinical review by 5% from current average measure by monthly ASPIRE audit.	63.1%	≤58.1%	64.1%	51.1%	50.8%	No data	55.3%

Changes to intravenous antibiotic order sentences were implemented on 3rd May 2022 to promote timely review on prescriptions at 72 hours and has had an impact in reducing the consumption of intravenous antibiotics and the number of antibiotic courses “continued” at clinical review. See section 9.7 for audit results.

9.4 Restricted Antibiotic Use

Certain broad-spectrum antibiotics are restricted and should only be prescribed when recommended in the formulary for specific indications or on the advice of a microbiologist. The Pharmacy

Department limits where these are stocked and receives a daily automated electronic report to allow follow up of these prescriptions to ensure this is the case. Restricted antibiotics which are not prescribed as per formulary or on microbiologist advice are referred to the ward pharmacist for discussion with the prescriber.
During 22/23 (no data was collected for January & February due to reduced resource within the pharmacy AMS team), 2857 restricted antibiotics were audited, 98.5% of which were prescribed as per formulary, authorised by Microbiology or otherwise appropriate.

9.5 Antibiotic Consumption

SSTF requires Trusts to understand their antibiotic consumption patterns. Antibiotic consumption is measured as defined daily doses (DDDs) which is the standard dose of that agent for an adult in a single day. Antibiotic consumption data is skewed by hospital occupied bed days and to introduce consistency is often measured by DDDs per 1000 admissions. National data analysis is also available on the RXInfo DEFINE and PHE Fingertips websites.

A service condition of the NHS Standard Contract for 2022/23 was to reduce consumption of broad-spectrum antibiotics (from the Watch & Reserve categories) by 4.5% by the end of March 2023 against the baseline figure of consumption for calendar year 2018. DEFINE website has shown WUTH has met this target reduction, achieving a 7.5% reduction when compared to baseline (however, once official HES admissions data is released, this figure is expected to improve, for example, official data from Q3 22/23 show a 13% reduction at WUTH compared to 2018 baseline).

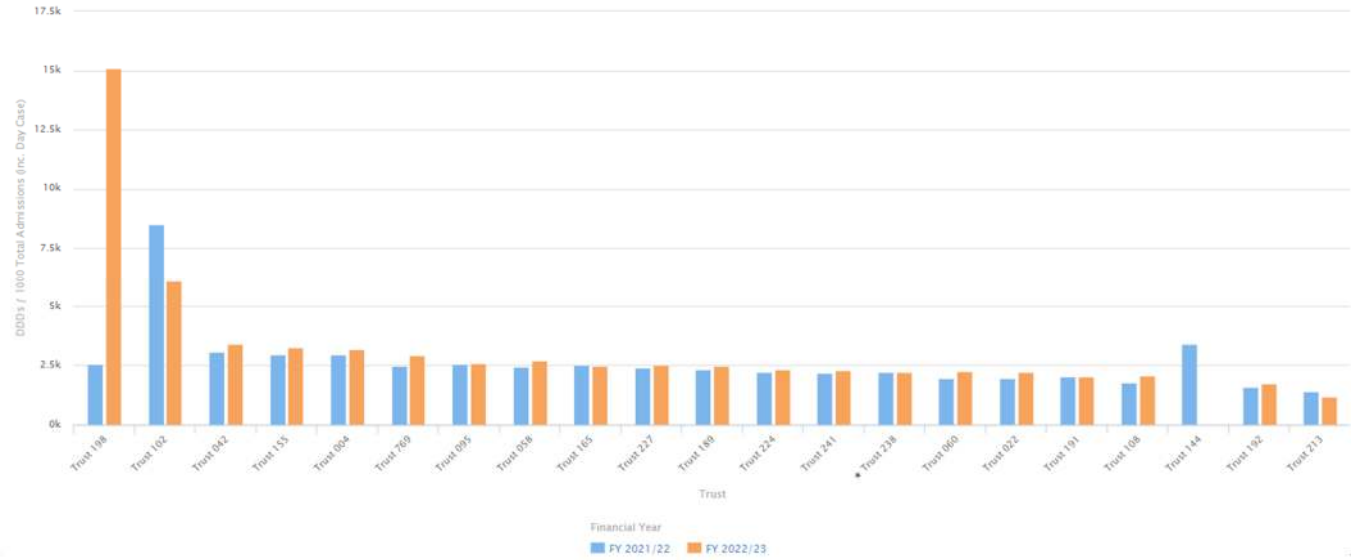
In addition, the AMS team set a local target to reduce consumption of intravenous antibiotics by 1% compared to previous year. The Trust has met this target with a 1.75% reduction (in DDDs per 1000 total admissions). This has been helped by the implementation of 3-day default durations on intravenous antibiotics mid-way through Q1.
The consumption data is collated using the national benchmarking software package DEFINE and displayed in table 22 below. Official figures are provided by UKHSA (with a 3–4-month delay) and may differ slightly to those reported on DEFINE due to differences in admissions data, this is being investigated nationally.

Table 22

Performance against locally agreed AMS objectives:	**Baseline**	**Target by Q4**	**22-23**
Reduce consumption of broad-spectrum antibiotics from WHO "Watch" and "Reserve" categories (DDDs/1000 admissions reported quarterly) compared to calendar year 2018.	2399	2291 G ≥4.5% reduction A 1-4.5% reduction R <1% reduction	2220 (7.5% reduction)
Reduce consumption of intravenous antibiotics by 1% compared to previous year (DDDs/1000 admissions reported quarterly)	1148	1137 G ≥1% reduction A 0-1% reduction R <0% reduction	1128 (1.75% reduction)

Although the Trust has met the target to reduce broad-spectrum antibiotics compared to 2018, usage of broad-spectrum antibiotics compared to last year has largely stayed the same. Graph 14 below shows prescribing of Watch & Reserve antibiotics for the last 2 financial years compared to similar Northwest NHS Trusts.

Graph 14

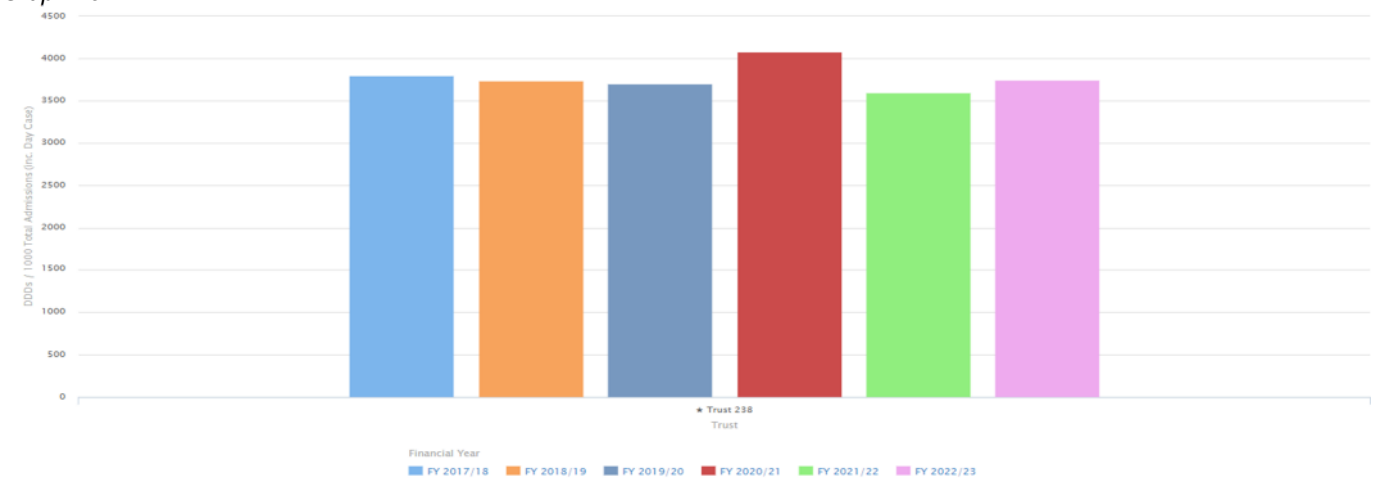


9.5.1 <u>Total Antibiotic Consumption</u>

Total antibiotic consumption no longer forms part of the national targets; however, usage is still benchmarked nationally. Data from DEFINE has shown an increase in total antibiotic consumption (DDDs per 1000 admissions) compared to the previous financial year 21/22.

There is a time-lag in reporting accurate data on PHE Fingertips webiste which is currently showing only Q2 data but regardless of this increase, as of Q2 22/23, the Trust remained in the best quintile in England for total antibiotic consumption (data from PHE Fingertips website, delayed reporting of official figures).Graph 15 below shows WUTH Total antibiotic usage (DDDs per 1000 admissions) over the past 6 years.

Graph 15

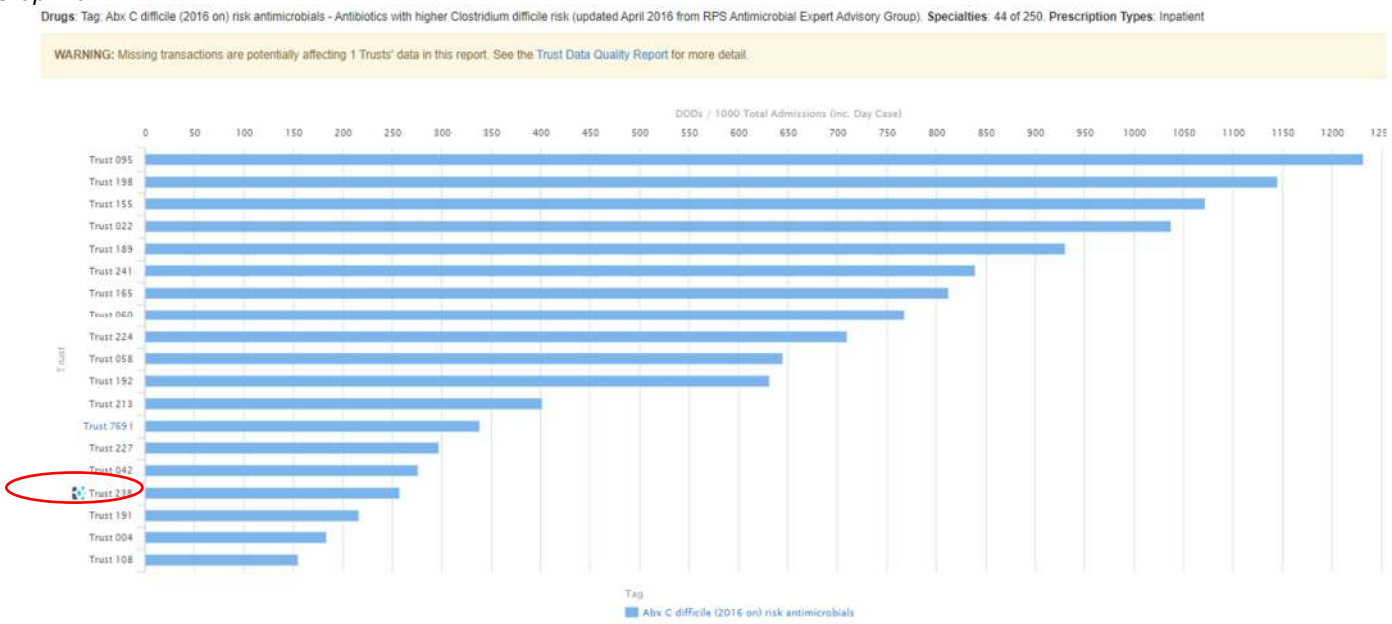


9.5.2 Consumption of antibiotics with higher *C.difficile* risk

Data from DEFINE suggests WUTH consumption of antibiotics considered high-risk for *C.difficile* is below average when benchmarked against other Trusts of similar type and size and it is reassuring that consumption is reducing in the long term, see graph 16 and 17 below:

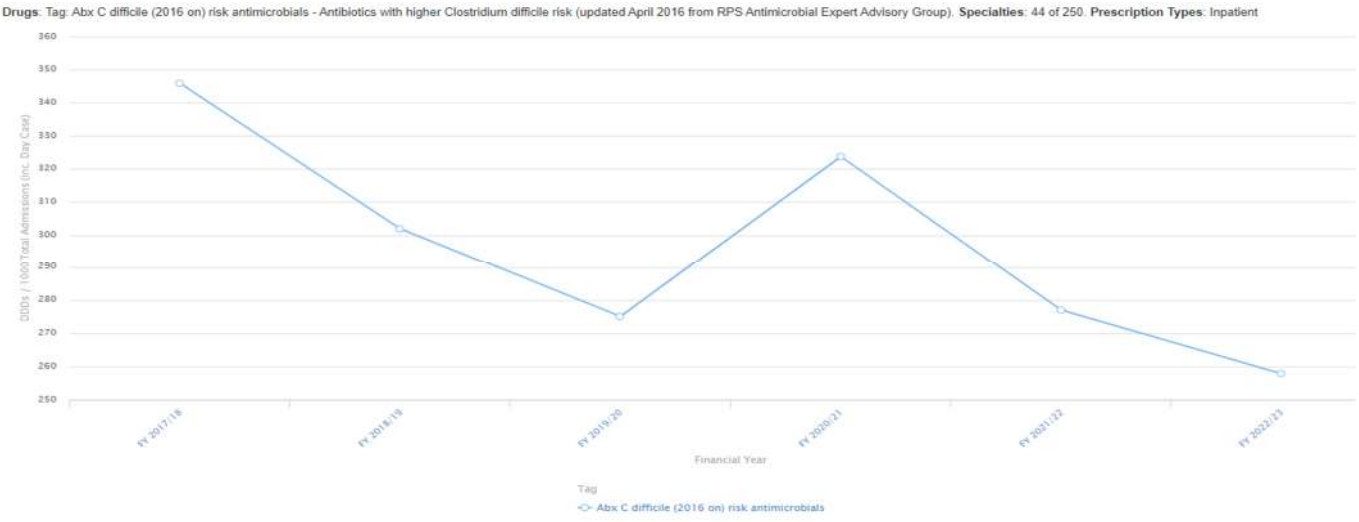
Consumption of antibiotics with higher *C.difficile* risk by Trusts of similar size and type (WUTH is Trust 238) in previous 12 months.

Graph16



Graph 17 below shows the consumption of antibiotics with higher *C.difficile* risk has been on a downward trend since 2017/18 with the exception of 2020/21 when prescribed trends were most affected by the coronavirus pandemic. (WUTH is Trust 238)

Chart 17



9.6 Appropriate antibiotic prescribing for UTI in adults *(Antimicrobial Resistance CQUIN CCG2)*

WUTH achieved an overall compliance of 52% across all the quality measures (target≥60%).

Table 23

	Q1	Q2	Q3	Q4
Compliance with all indicators: • Diagnosis of UTI based on documented clinical signs or symptoms in accordance with local guidance and/or UKHSA UTI Diagnosis Guidelines. • If >65yrs old or CAUTI, urine dip stick was NOT used to diagnose the UTI. • Antibiotic treatment compliant with NICE / local Guidelines. • Urine sample sent at time of diagnosis and sent to microbiology in line with UKHSA/NICE guidance. • For CAUTI- documented review of urinary catheter use in the patient record.	52%	47%	55%	54%

The delivery plan for this CQUIN was the development of a Cerner 'Powerform' to aid clinicians towards appropriate diagnosis and management of UTI. Along with education delivered to F1s, F2s, NMPs and IMTs, education for nursing staff regarding catheters and a Trustwide communications plan.

The Cerner development work was delayed due to no clinical lead identified and then paused due to a "build-freeze" associated with the Cerner upgrade. Work wasn't ready for completion until the end of March 2023. The powerform 'decision aids' are not able to 'fire' at the appropriate time within the prescriber's workflow and therefore usage will be low and have little impact. However, a UTI powerplan built by the pharmacy informatics team, went live on 4th April 2023 and should aid prescribers to prescribe appropriate antibiotics in line with the formulary. Unfortunately, the powerplan is not mandatory and prescribers need to choose to prescribe via the powerplan, so the AMS team are undertaking education to different staff groups, along with trust wide communications.

A clinical consultant lead was assigned 8 months into the financial year to advocate and lead for this project. Whilst work on the Cerner developments had been paused/delayed, learning points from the CQUIN CCG2 audit data were used in education sessions delivered to the following prescribers in Q3; FY1, FY2, ANPs, elderly care consultants and medical board.

The newly established continence care clinical practice educator has also initiated education for nursing staff around the appropriate management of urinary catheters, appropriate dipping and taking urine samples.

9.7 New developments/improvement strategies

On 3rd May 2022 a default duration of 3 days for most IV antibiotic prescriptions for adults was implemented to promote the timely review of IV antibiotic prescriptions within 72hrs as per NICE guideline NG15: Antimicrobial Stewardship and the recently published ARK trial.

There was concern that this change in practice may result in antibiotic prescriptions stopping earlier than intended. So, the Pharmacy AMS team carried out audits to provide data to quantify the risk of

this type of incident occurring before the change was implemented, one month after implementation and seven months after implementation. The key findings were:

The risk of IV antibiotic prescriptions expiring earlier than intended has significantly reduced. Table 4 shows that the proportion of antibiotic prescriptions stopping earlier that intended over a weekend period was approximately 6% prior to the change in practice and seven months following implementation, the proportion of antibiotic prescriptions expiring earlier than intended has reduced to 0.5%.

The risk of antibiotic prescriptions expiring earlier than intended in the earliest stages of treatment has been significantly reduced. Table 5 shows that there were no examples of antibiotics stopping within the first 3 days of treatment in either of the post-implementation audits. Whereas there were three examples prior to implementation.Table 24 below shows the drop-off rate when total number of IV antibiotic prescriptions of any duration on Friday used as the denominator.

Table 24

	Nov 21 (Before change in practice)		Jun 22 (One month following change in practice)		Dec 22 (Seven months following change in practice)	
Outcome following stop date	No of prescriptions N=180	No of patients N=162	No. of prescriptions N=221	No. of patients N=182	No. of prescriptions N=187	No of patients N=157
Prescription expired earlier than intended	11 (6.1%)	10	11 (5.0%)	10	1 (0.5%)	1
Unable to confirm	2* (1.2%)	2*	3 (1.5%)	2	2 (1%)	2

Table 25 below shows the prescribed duration of prescriptions that expired earlier than intended over a weekend.

Table 25

	Nov 21	Jun 22	Dec 22
Prescribed duration (days)	No of prescriptions	No of prescriptions	No of prescriptions
1	1	0	0
2	2	0	0
3	3	8	1
4	0	1	0
5	5	2	0
7	1	0	0
Total	**11**	**11**	**1**

An “Antibiotic Stop Alert” was proposed by the Clinical Advisory Group (CAG) to reduce the risk of antibiotics stopping inadvertently, but after the audit findings were presented, CAG advised the stop alert was not required.

Next steps:

- The behavioural change from prescribers and clinical pharmacists around ensuring that antibiotic prescriptions are reviewed in a timely basis is crucial for patient safety and requires ongoing prescriber and pharmacist education is necessary to be sustained.
- The Antimicrobial Stewardship mPage was designed to improve the quality of antimicrobial reviews by highlighting antibiotic prescriptions which are due for review alongside relevant

microbiology cultures. Technical fixes are required before its use can be promoted. Prioritisation of these fixes would also support the new 23/24 IV to oral switch CQUIN.

9.8 AMS Team response to rise in CDT infections.

With regards to reducing CDI cases, the AMS team has focused on overall AMS improvement across the Trust, with some specific strategies targeted at CDI. The contribution made by the AMS Team is summarised below:

The AMS Pharmacist and Microbiology team continue to be involved in RCAs related to *C.difficile* infection to identify AMS learning points for the clinical teams.

Overall, AMS improvement:

- 3-day default duration on IV antibiotics
- UTI CQUIN support
- Audit of carbapenem usage on OPAT
- Audit of neutropenic sepsis treatment
- Additional AMS ward rounds

Strategies targeted at CDI:

- Gap Analysis of 'How to Deal with a Problem Like *C.difficile*' document.
- Reviewed antimicrobial formulary to ensure broad-spectrum antibiotics are only indicated where necessary.
- Additional targeted AMS ward rounds on wards with increased incidence
- Reviewed usage of antibiotics with higher risk for *C.difficile* on wards with increased incidence
- Audit of themes from RCAs 21/22 by Microbiology team
- Education - IPC Newsletter for *C.difficile*, pharmacist clinical presentation, ward rounds.

10.0 Decontamination

10.1 Decontamination Arrangements

The Care Quality Commission and the Health and Social Care Act 2008 requires healthcare organisations to keep patients and visitors safe by having procedures and systems in place to ensure that all reusable medical devices are properly decontaminated prior to use, and that all single use devices are not re-used. (Criterion 9).

Effective decontamination of reusable medical devices and equipment (including surgical instruments) is essential in minimising the risk of transmission of infectious agents to patients and staff.

Decontamination may involve a combination of processes (including cleaning, disinfection, and sterilisation) to render an item safe for further use on patients and for handling by staff. Any company supplying medical devices or equipment must offer clear instructions on suitable decontamination methods and it is essential that decontamination processes comply with manufacturers' guidelines and are available within the Trust. Failure to follow manufacturer's guidance may result in damage to items, invalidate warranties and transfer liability to the user, or the person authorising the decontamination process.'

WUTH has a standard Trust wide approach for decontamination and any queries regarding decontamination of any medical equipment was directed to the Deputy DIPC during 2022/23 owing to a vacant post for the Decontamination Lead. The Decontamination Group met several times, chaired by the deputy DIPC with possible actions/resolutions agreed with the support of the Trust Microbiology representative, AE(D) and other group members. Actions remaining unresolved were escalated to IPCG in the chairs report.

10.2 Sterile Services

Sterile Services sits within the directorate of perioperative medicine and is situated at the APH site. The unit provides decontamination services to both Wirral University Teaching Hospital NHS Foundation Trust and to other NHS trusts and private facilities. The services include washing, decontamination, assembly packing and sterilisation of surgical instruments, theatre trays, soft packs, procedure packs and supplementary items. The service also provides an endoscopy decontamination unit at the CGH site providing sterilisation and decontamination of flexible endoscopes used at the site through wet sterilisation and dry holding.

The unit is committed to developing a comprehensive policy that gives assurance regarding the quality of the services provided to its customers, both internal and external to the organisation.

The unit conforms to the requirements of the Quality System Standard BS/EN/ISO 13485: 2016 and relevant requirements of European Directive 93/42/EEC through effective implementation of the department procedures.

The unit updates and reviews their protocols on a regular basis to ensure improvements in quality and customer service and their effectiveness is monitored through internal audits, complaints, and non-conformities. Assurance is provided to the directorate of perioperative medicine Infection Control Group, IPCG and Safety & Quality Boards.

11.0 Cleaning Services

Wirral University Teaching Hospital NHS Foundation Trust have adopted a Domestic Service Cleanliness model that fully conforms to the Department of Health guidelines on the specification for the planning, application, measurement, and review of cleanliness services in hospitals and our cleanliness standards are governed by the following legislation:

- National Standards of Healthcare Cleanliness 2021 has replaced the National Specification for Cleanliness in the NHS 2007

In April 2021, NHS England and NHS Improvement launched the new National standards of healthcare 2021 that set out several key changes to how we perform and audit cleanliness to provide assurance of safe cleanliness standards across all our functional areas.

11.1 Management arrangements

The new standards set out to achieve the following ethos:

- Collaboration: A collaborative approach is essential to continuously improve cleanliness. The standards state that organisations should involve a board nominee, clinical colleagues, partner organisations and patients in setting and monitoring cleaning standards for consistently high levels of service.

- Transparency and Assurance: The standards emphasise transparency to assure patients, the public and staff that safe standards of cleanliness have been met. The transparency of audit and reporting methods, display of audit results and the commitment to cleanliness charter provides assurance that an organisation is serious about cleaning.

- Infection Prevention and Control: Cleaning is a vital part of the overall infection prevention and control process which aims to provide a clinically clean and safe environment for delivering safe patient care. Safe standards of cleanliness minimises risk to patient safety from inadequate cleaning. The new standards will be the measure by which we deliver cleaning services into the future.

- Continuous Improvement: To encourage continuous improvement the standards combine mandates, guidance, recommendations, and good practice. The new standards will allow organisations to measure performance in a uniform way and to benchmark it against similar organisations. They seek to drive improvements while being flexible enough to meet the different and complex requirements of all healthcare organisations.

- The Facilities Department provides a once daily baseline clean and an additional rapid response infection control cleaning service, which fully conforms and complies to all current legislation and recommendations. This service is audited using a recognised auditing tool to provide assurance of safe cleanliness standards.

11.2 Cleaning Programme

Domestic Services Team continues to provide a comprehensive range of cleanliness services to support the Trusts IPC agenda. These services include:

- Rapid Response
- Enhanced Cleans
- Hydrogen Peroxide Vaporisation (HPV) programme

Over the past 12 months there has been a significant impact on the continuity and standard of cleanliness achieved due to a more focused scrutiny on the outcomes. Improvements in the overall condition, appearance and maintenance of the environment and improved responsibility and collaboration across the multi-disciplinary groups has resulted in progress that has now started to show results across the hospitals.

During the challenges over the winter period the cleanliness service remained adaptable and high quality. It was recognised the requirement for further development of systems and processes to manage the impact of COVID-19 and to maintain safe cleanliness standards throughout the

pandemic and winter period. Therefore, measures were put in place to support the organisation with the significant challenges ahead and provided assurance of cleanliness outcomes during 2021/22 which was as follows:

- Maximise staffing capacity to provide flexibility to meet the demand and needs of operational service delivery.
- Allocation of domestic hours to support additional enhanced cleaning throughout the Trust when patients with infections have been identified.
- Increased cleaning frequency to twice daily cleaning and HPV of sluice areas and patient equipment in areas that have higher environmental contamination rates as set out in the PHE and other national guidance.
- Cleaning frequencies of the Care environment C.diff care areas were enhanced and single rooms, cohort areas and clinical rooms cleaned twice daily.
- Patient Flow continued to allocate the Terminal cleaning required to assist with patient flow.

11.3 Performance Monitoring

To support the assurance of our cleanliness standards the Facilities Department use an industry approved Micad auditing software. It provides our quality control in the form of a visual inspection audit that monitors the quality of cleanliness of all our functional areas across all the responsibility groups of Domestics, Nursing and Estates. These technical audits involve the scoring of 50 elements within each area assessed and generate a score reflecting the standard of cleanliness achieved.

The mandatory efficacy audits are a management tool to provide assurance that the cleaning standards are met using good practice and that the correct cleaning procedures are consistently delivered to satisfy IPC and safety standards by checking the efficacy of the cleaning process at the point of service delivery. Each patient facing functional area should be audited at least once a year and multidisciplinary attendance is key to providing a more rounded view of our cleanliness standards. Efficacy audits were introduced in 2022/23 on a rolling monthly programme with 7-8 functional areas randomly selected each month.

The Trust has adopted a multidisciplinary approach to technical and efficacy auditing periodically, to assess the cleaning from different perspectives and validate the audit score at ward/department level.

During 2022/23, daily cleanliness monitoring checklists were introduced and are now completed by the cleanliness Supervisory team on the Trust recognisable Tendable audit system to provide additional assurance of our cleanliness standards and to support quality improvement.

11.4 Patient-Led Inspection Programme (PLACE)

The Patient-led assessment of the care environment (PLACE) is an annual national inspection self-assessment programme, which is managed by NHS Digital on NHS England and NHS Improvement's behalf. The assessments mainly apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors, but other providers are encouraged and helped to participate in the programme. PLACE replaced the longstanding PEAT (patient environment action team) programme in 2013.

Under PLACE, organisations make an in-depth assessment of the non-clinical, patient-related aspects of the care environment for all qualifying inpatient settings. Responses contribute to scores across six domains, including one specifically for 'cleanliness'.

Questions within some of the other domains also relate to cleaning and associated services.

PLACE scores are released as an official statistic, and the results are published to help drive improvements in the care environment. The results show how healthcare organisations are performing both nationally and in relation to similar service providers.

We operated a full PLACE assessment within 2022/23 which was a full review with external and patient assessment. The cleanliness result for Wirral University Teaching Hospital was published as 99.32%

11.5 New cleaning standards

The new National Standards of Healthcare Cleanliness 2021 were implemented within 2022-2023 and they primarily will encompassed all cleaning tasks throughout the NHS regardless of which department is responsible for it. They are based around being easy to use; freedom within a framework; fit for the future; efficacy of the cleaning process; cleanliness which provides assurance; and transparency of results.

The new standards are an update on the previously available guidance and provide a new framework within which healthcare establishments set out details for providing cleaning services and assessing 'technical' cleanliness. This will ensure that Wirral University Teaching Hospital has a sustainable, effective healthcare cleaning service that will:

- be patient focused.
- be achieved through collaboration of all responsibility groups.
- provide clarity for all cleanliness responsibility groups to ensure our healthcare environment is clean and safe.
- be consistent with infection prevention and control standards and requirements.
- have clear objectives that will provide a good foundation for service improvements.
- provide a culture of continuous improvement.
- provide an agreed and recognisable auditing and monitoring framework.

Compliance with these standards will enhance quality assurance systems, meet the requirements of CQC outcome standard Regulation 15, provide benchmarks and output indicators and offer a recognisable auditing and monitoring system and more importantly will be future proof. As an Acute Trust we started implementation from April 22 and the new standards are now fully in place across the organization.

11.6 The Decontamination Unit (Central Equipment Library)

The Decontamination Unit at Wirral University Teaching Hospital Foundation is under the Facilities Management Department covering Arrowe Park and Clatterbridge Hospital Sites.
The service is responsible for the cleaning, decontamination, and processing of non-invasive medical devices alternating mattress cells, covers and cushions.

Recent Capital Investment involving a structural upgrade and new equipment has increased IPC assurance reducing the risk of cross infection and improved environmental hygiene.

The investment has improved redesign in collaboration with Deputy Director of IPC based on HBN 001 Infection Control in the built Environment, areas of improvement are:

- Flow Design- Separate Entry/ Exit
- Delineated work areas for Decontamination and Clean Processing
- Stainless steel decontamination tables and bespoke shelving for devices
- Improved standard operating procedures for staff to follow within defined work areas.
- Improved cleaning guidance of medical devices in line with Medical Devices Policy
- Labelling, processing, and storage of medical devices
- Re-introduction of ATP swabbing following mattress decontamination

11.7 New Initiatives

Installation of Otex Decontamination Laundry System was successful in

April 2022.This system is HTM 01-04 compliant and provides a validated chemical disinfection process by injecting a continuous flow of ozone into every wash cycle. Ozone disinfection system is effective against micro-organisms such as MRSA E-Coli and C.difficile spores. The Otex system shows a reduction in water and energy costs by 35% in line with NHS Plan for Carbon Reduction and provides validated assurance of Ozone with each wash cycle.

11.8 Service Improvements

- Education and Training of the Central Equipment Library Team to support the inspection, cleaning of foam mattresses in line with BHTA 2012.
- Identification of criteria for condemning of foam mattress supporting assurance for audit and working collaboratively with all ward staff.
- Purchase of new Trolleys for the safe transportation of foam mattress
- Central Equipment Library deploys Air Purifying Units on request to all areas to assist in the reduction of respiratory viruses.
- All exposed soft foam mattresses identified are processed for decontamination using the Otex Laundry System to support IPC with the reduction in transmission of C-Difficile.

11.9 Water Safety Group (WSG)

A multidisciplinary Water Safety Group (WSG) including Estates & Facilities in conjunction with Microbiology and Infection Prevention continue to meet monthly. The Water safety plan (WSP) is a risk-management approach to water safety and provides assurance that systems are in place to control/minimise the risk of morbidity and mortality due to infections related to water systems. This is achieved through control, monitoring, maintenance and testing of water outlets and water systems as required.

The WSP encompasses all areas of potential risk (*Pseudomonas aeruginosa* and Legionella) about water safety; this includes potable water, hot and cold-water systems, endoscopy waters (AER final rinse waters), hydrotherapy pool, birthing pool waters and renal waters. By employing innovative engineering and risk prevention strategies, leading to local reconfiguration of water system design, the WSG is working to reduce the risks and hazards at the point of provision of the water supply.

The WSG continue to give advice on remedial action when required where water systems or outlets. are found to be contaminated and the risk to susceptible patients is increased. This includes an escalation procedure and convening extra ordinary meetings to trouble shoot and instigate remedial actions to reduce risks to patients and staff. This group reports into the Health and Safety Management committee and the Infection Prevention and Control Group.

11.10 Ventilation Safety Group (VSG)

The multidisciplinary Ventilation Safety Group (VSG) comprising of Estates & Facilities in conjunction with Microbiology and Infection Prevention meet monthly to look at the legal and mandatory requirements of ventilation systems in healthcare premises, this includes the design, maintenance, and the operation of ventilation systems. This group reports into the Health and Safety Management committee and the Infection Prevention and Control Group

11.11 Ventilation

Ventilation systems provide thermal comfort to patients and staff, enable the removal of pollutants and odours, provide protection from infection for vulnerable patients and reduce the risk of spread of infection. Patients and staff have a right to expect that it will be designed, installed, operated, and maintained to standards that will enable it to fulfil its desired functions reliably and safely.

Specialist ventilation systems are used extensively in healthcare premises in many areas to closely control the environment and air movement of the space that it serves to contain, control, and reduce hazards to patients and staff from airborne contaminants. This includes operating departments, intensive care units, isolation suites, pharmacy and sterile supply departments and laboratories.

The sophistication of ventilation systems in healthcare premises is increasing and their importance has been further highlighted at the beginning of the COVID-19 pandemic in 2020.

Good indoor ventilation can reduce the risk airborne transmission of SARS-CoV-2 beyond 2 meters. CO2 air monitoring can be used as a proxy to indicate areas of poor ventilation. It can give an of effectiveness of ventilation in a multi-occupancy setting by monitoring levels of Co2 that can build up through exhaled air. It does not provide a direct measure of infection risk, or a direct measurement of ventilation rates. Co2 rates were first measured back in 2021 and to mitigate risk a total of 30 air purifiers were purchased. These air purifiers purchased use HEPA filters which can reduce the number of potentially infectious particles in the air, thereby reducing the risk of transmission of infection. It must be noted that this intervention does not reduce transmission via close range aerosols and droplets or via fomites.

These Air purifiers are now used when a patient who is nursed in a bay is diagnosed with COVID, this helps to clean the air within the bay to reduce the risk to others in the bay. When the patient gets isolated, the air purifier remains in the bay as that is where the risk remains. SOPs were developed to support their use .

Air purifier(AIRVIA AERO 100)

The IPC team acknowledge their use on the daily IPC report and the devices are held and distributed via the Central Equipment Library (CEL).

A longer-term trust wide ventilation improvement plan is awaited from the Estates and Facilities directorate.

The Water & Ventilation safety groups promote Trust compliance to Criterion 1 and 2 of the Health and Social care Act 2008 which includes 1) Systems to manage and monitor the prevention and control of infection and 2) To provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

12.0 Training Activities

12.1 Infection Prevention Link Practitioners

The IPC Link Practitioner programme was re-introduced during 2022-23 with the first meeting held in November 2022 and the second meeting held in January 2023. There were two replicated sessions on each of these dates to allow staff to attend either in the morning or afternoon. The primary purpose of the meeting was educational with time set aside for discussion and to share good practice.
Educational topics included:

- *Clostridioides difficile*
- ANTT
- Gloves off campaign
- Perceptions of IPC
- Norovirus
- Alert organisms

The sessions were well attended and there was positive feedback received by attendees.

12.2 IPC and Matrons Collaborative

To replace the Matrons Development programme, monthly IPC and Matrons collaborative meetings were arranged, with the exception of December and January. The purpose of this collaborative is to support Matrons with their development, share good practice and discuss new initiatives. Dates were shared in advance and diary invites circulated. There has been limited attendance at these meetings however for those who have attended it was well received.

12.3 Student Nurse Training

Student nurses have continued to shadow the IPC team on an ad hoc basis for either a morning or afternoon. Student inductions arranged by the Practice Educator Facilitators have also been supported by IPC to provide basic IPC training. These sessions are arranged on an ad hoc basis.

12.4 Mandatory Training for Trust Staff

Infection prevention training is mandatory every 18 months for all WUTH staff based in the hospital and the community. Training is accessed online via the E-learning hub, which includes an e-learning Infection Prevention package for all clinical and non-clinical staff. The e-Learning package covers general principles of infection prevention, hand hygiene, the use of PPE and decontamination. The clinical package identifies more detailed information regarding alert organisms and standard precautions.

Evidence of completion of Infection Prevention and Control mandatory training is confirmed at appraisal and monitored at the Monthly IP performance meetings and reported to the Trust Board. Compliance is also monitored at the Subject Matter Expert meetings chaired by Workforce Development.

12.5 Trust Induction Training

Face to face Induction Training was reinstated in July 2022 with IPC attending one afternoon, twice per month, to provide a 5-minute talk to new staff on IPC basic principles and being available to answer any specific questions. From November 2022 the IPC team also provided an Induction Newsletter to provide to new starters.

12.6 Wirral Enhanced Preceptorship Programme (WEPP)

WEPP is a 2-day development programme for all newly qualified staff that is held monthly. IPC provide a 90-minute session which covers the chain of infection, standard Ipc precautions and alert organisms.

12.7 Care Support Worker Training

This is a 2-day programme of Clinical Support Workers Core Skills Course, which is part of the National Care Certificate that is held at least monthly. The IPC provide an hour session which covers general IPC update, hand hygiene, swab and specimen collection, diarrhoea management and mattress check.

12.8 Clinical Champions

This is a 1-day programme to provide senior staff with an update on ANTT, peripheral cannulation, urinary catheterisation, care of PICC lines and blood culture collection. IPC provide a 90-minute session which covers an update on HCAIs, learning from RCAs and the importance of correct management of invasive devices.

12.9 Specific Training

The IPCT have supported bespoke training to departments including Critical Care, Radiology, Gynaecology, and pharmacy. As well as providing ad hoc training when visiting wards and departments as required. Specific training has also been delivered to Facilities staff, as part of the *C.difficile* Improvement Plan, to provide an understanding of the important role that this group of staff have to play in providing a clean and safe environment for patients and visitors.

12.10 Aseptic Non-Touch Technique (ANTT)

The ANTT framework provides a clinical guideline for aseptic technique and is based on a theoretical evidence-based framework (Rowley 2001). Its purpose is to standardise practice and raise clinical standards. It can be applied to any aseptic procedure, such as intravenous therapy, wound care and urinary catheterisation. ANTT is recognised as the 'gold standard' for aseptic practice and is followed throughout WUTH by members of staff who are required to undertake invasive clinical procedures, including those members of staff who work in the community. Training is provided by Clinical Skills and Divisional Clinical Educators.
The ANTT Policy was updated in November 2022 and introduced 3 Tiers:

- Tier 1 – Hand Hygiene
- Tier 2 – Standard ANTT
- Tier 3 – Surgical ANTT

Competency assessments for ANTT are required to be completed annually and compliance is monitored by Divisions at their monthly IPC meetings and reported monthly at the IPCG. However, there is limited availability of ANTT competencies for doctors. Table 26 below shows the results of the ANTT training in 2021/22 compared to the previous year.

Table 26

Training	Number of staff trained			Method of delivery
	2022/23	2021/22	2020/21	
ANTT Train The Trainer	**45**	40	40	Face to Face training 2-hour session
ANTT theory	**183**	250	817	e. Learning video
ANTT practical	**1725**	77	742	Practical training either in Clinical Skills or on wards via Train the Trainers- e.g., 50 mins for theory & practical and demonstration on WEPP

				programme. Staff are assessed and competency signed on the Tier/s that applies within their role.
Blood cultures	**61**	7	18	Face to face training 2 hrs
Catheterisation	**202**	247	90	Face to face training 1.5 hrs

12.11 Monthly IPC Newsletter

During 2022-23 the IPC team published 7 newsletters to promote various topics related to IPC:

- *Clostridioides difficile*
- Hand Hygiene
- Personal Protective Equipment
- Antimicrobial Stewardship
- Urinary Tract Infections CQUIN
- Infection Prevention and Control Week
- ANTT and 'Without Gloves'

Regular newsletters will continue to be published during 2023-24 to promote topical issues and aid learning and awareness for all staff.

12.12 IPC Campaigns

World Hand Hygiene Day on 5th May 2022 was celebrated with the IPCT visiting wards and departments throughout the week to promote hand hygiene and the role of bare below the elbow. The UV light box was used to assess how well staff cleaned their hands, as well as asking staff to remove gloves which were covered with paint to demonstrate how hands can become contaminated even when wearing gloves.

Infection Prevention and Control Week in October 2022 celebrated 50 years of Infection Prevention. The IPCT visited wards and departments throughout the week promoting various topics including *C.difficile*, cleaning, use of Tristel duo and management of invasive devices. A wordsearch competition was held which hid a secret IPC related message when all the words were found and three winners were given a goodie bag.

Health and Safety Awareness Week in November 2022 was supported by the IPCT who provided virtual sessions on Microsoft Teams for Sharps Safety and Personal Protective Equipment.

ANTT and 'Without Gloves' Campaign was launched in December 2022 with the support of Dr Sam Clarke who had introduced 'Without Gloves' initially in Critical Care. Various posters had been designed which were circulated by the IPCT when they visited all wards and departments throughout the week, including specific staff groups such as porters and facilities. This campaign was also supported by Clinical Skills and IV access / OPAT.

13.0 Audit

13.1 Audit programme for 2022/23

The audit programme continued to focus on key policies which aim to prevent Health Care Associated Infection (HCAI), based on the Health and Social Care Act (2015).

13.2 IPC Environmental audit

The IPC Environmental Audit programme is aligned the with Wirral Individualised Safecare Everytime (WISE) Accreditation Plan. During 2022-23, 67 wards and departments had an IPC Environmental Audit undertaken with some areas receiving more than one audit. If a ward scores below 70% (red) a reaudit will be undertaken within 3 months; if a ward scores between 70% and 89% (amber) a reaudit will be undertaken within 6 months if capacity / workload permits. The Senior Nurses within the Divisions also undertake regular audits to ensure there is improvement, and when a green score is achieved, this is maintained. A monthly report is provided to IPCG with progress to date as well as the audit scores from the Divisional audit results. Exceptions to the standards are captured in action plans which are managed locally by the Divisions and reported via their monthly IPC Divisional meeting. Table 27 below is a breakdown of the ward category scores by Division for 2022-23

Table 27

Division	Green	Amber	Red
Medicine	5	14	0
Acute	5	1	0
Surgery	5	12	0
Women's & Children	4	5	0
Clinical Support	2	10	1
Corporate	0	3	0
Total	**21**	**45**	**1**

13.3 Hand Hygiene Audit

The Hand Hygiene audit in Tendable was updated to provide additional information on which moment for hand hygiene was being audited, what agent was used, was the correct process used and was the staff member bare below the elbow. All wards / clinical departments are expected to undertake weekly hand hygiene audits which are increased to daily during an outbreak or increased incidence of infection.

The IPCT have also undertaken hand hygiene audits, however these have been recorded manually on paper so a comparison with the ward-based audits from Tendable can be done. The results have been submitted to IPCG and provide a breakdown of staff groups for the Divisions to review and act accordingly. The IPC audits demonstrate a more realistic compliance of hand hygiene than is provided by the wards. The IPCT have provided additional support to the auditors to ensure the correct process for auditing is undertaken.

13.4 Sluice Audit

An audit was undertaken by the Vernacare Rep in September 2022 which covered the macerators, commodes and racking for pulp items. In total 43 wards / departments were reviewed across Arrowe Park and Clatterbridge sites:

- 4 areas only had a bedpan washer available and 2 areas had a bedpan washer and macerator.
- At the time of the audit there were 2 macerators that were not working
- 12 macerators were recommended to be replaced.
- There was a mixture of Clinell and Vernacare commodes available.
- 23 commodes were recommended to be replaced.
- Pulp racking was only available in 22 areas.

The audit results were shared with Estates.

13.5 Commode audit

Audits are completed on a regular basis via the Tendable app by the ward staff. Ad hoc audits are completed by the IPC team following a patient being diagnosed with *C.difficile* toxin or a CD equivocal result. Audit results are fed back real time for immediate improvement and reported by the Divisions in their exception report at the monthly IPC meetings.

13.6 Sharps audit

A Sharps Audit was undertaken by WUTH sharps bin supplier 'Daniels' in March 2023. In total 44 areas were visited, and 228 sharps containers were audited, no bins were found to have protruding sharps, none were more than three quarters full, and all were at the correct height, which is a significant improvement from the previous audit. The following non-compliance was identified.

- 4 containers were not assembled correctly.
- 12 containers were not signed or dated after being assembled.
- 6 containers had inappropriate contents.
- 17 containers did not have the temporary closure in place when left unattended.

The audit findings have been shared with health & safety.

13.7 Other Audits via Tendable app

The following audits are undertaken by the staff on the wards and departments via the Tendable App:

- CPE Checklist – as required when there is a CPE patient on the ward.
- Personal Protective equipment – this audit has been updated to specifically review what PPE is used and if it donned and doffed correctly and is required to undertaken at least monthly.
- Daily First Impression Audit – has replaced the Quick COVID-19 Assessment
- High Impact Interventions (care bundles) for:

- Central Venous Catheter Insertion
- Central Venous Catheter ongoing care
- Peripheral Vascular Insertion
- Peripheral Vascular ongoing care
- Surgical Site Infection Preoperative / Perioperative
- Ventilator Associated Pneumonia ongoing a
- Urinary Catheter Insertion
- Urinary Catheter Ongoing Care
- Chronic Wounds
- *Clostridioides difficile*
- ANTT

14.0 External Assurance Assessments

There have been none related to Infection Prevention & Control during 2022-2023.

15.0 Policy Development

The Policy Review Group supported an IPC Policy Development Plan using a risk-based approach. As part of this plan the following policies have been updated and ratified in 2022-23:

- Tuberculosis – Prevention and Control of Infection in the Hospital
- Norovirus Outbreak Policy
- Blood Culture Collection Policy
- Aseptic Non-Touch Technique Policy

The National IPC Manual for England, an evidence-based practice manual for all those involved in England, was published in April 2022. There have been various updates provided with version 2.4 being the most current. WUTH has adopted this guidance and its principles as approved by IPCG. The manual has replaced the following policies:

- Hand Hygiene Policy
- Standards Precautions Policy

A link to the Manual is available on the WUTH Intranet and ensures that the most up to date version is available for staff to access.

The following policies are due to be ratified early in 2023-24:

- Infection Prevention and Control Policy
- Water Coolers and Ice Makers
- Pets as Therapy (PAT) and Assistance Dogs Visiting
- MRSA

16.0 Infection Prevention & Control Board Assurance Framework

NHSE/I published the first version of the Infection Prevention and Control Board Assurance Framework in 2020. Since this time there have been several published that are updated and refined to reflect the increased learning around COVID-19. The framework, structured around the existing 10 criteria set out in the Infection Prevention Control Code of Practice (2008) that was updated in Dec 2022 to reflect changes to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and the role of infection prevention and control (IPC) (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance. The new document takes account of changes to the IPC landscape and nomenclature that have occurred since the COVID-19 pandemic and link directly to Regulation 12 of the Health and Social Care Act (2008).

The Trust added one additional criteria of 'leadership' in recognition of the important part that this plays in hospital management arrangements.

Table 28

	IPC BAF Standard
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and risks their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial stewardship to optimise service user outcomes to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care, or treatment nursing/medical in a timely fashion.
5	Ensure prompt identification of individuals who are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation precautions and facilities.
8	Provide secure and adequate access to laboratory/diagnostic support as appropriate.
9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infection.
10	Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

	IPC BAF local Standard
11	The Trust can demonstrate effective and knowledgeable leadership in relation to IPC at all levels, relevant to roles.

The reporting arrangements for each version have been via the Infection Prevention & Control Group, into PSQB and the Quality Committee, and onto the Board of Directors.

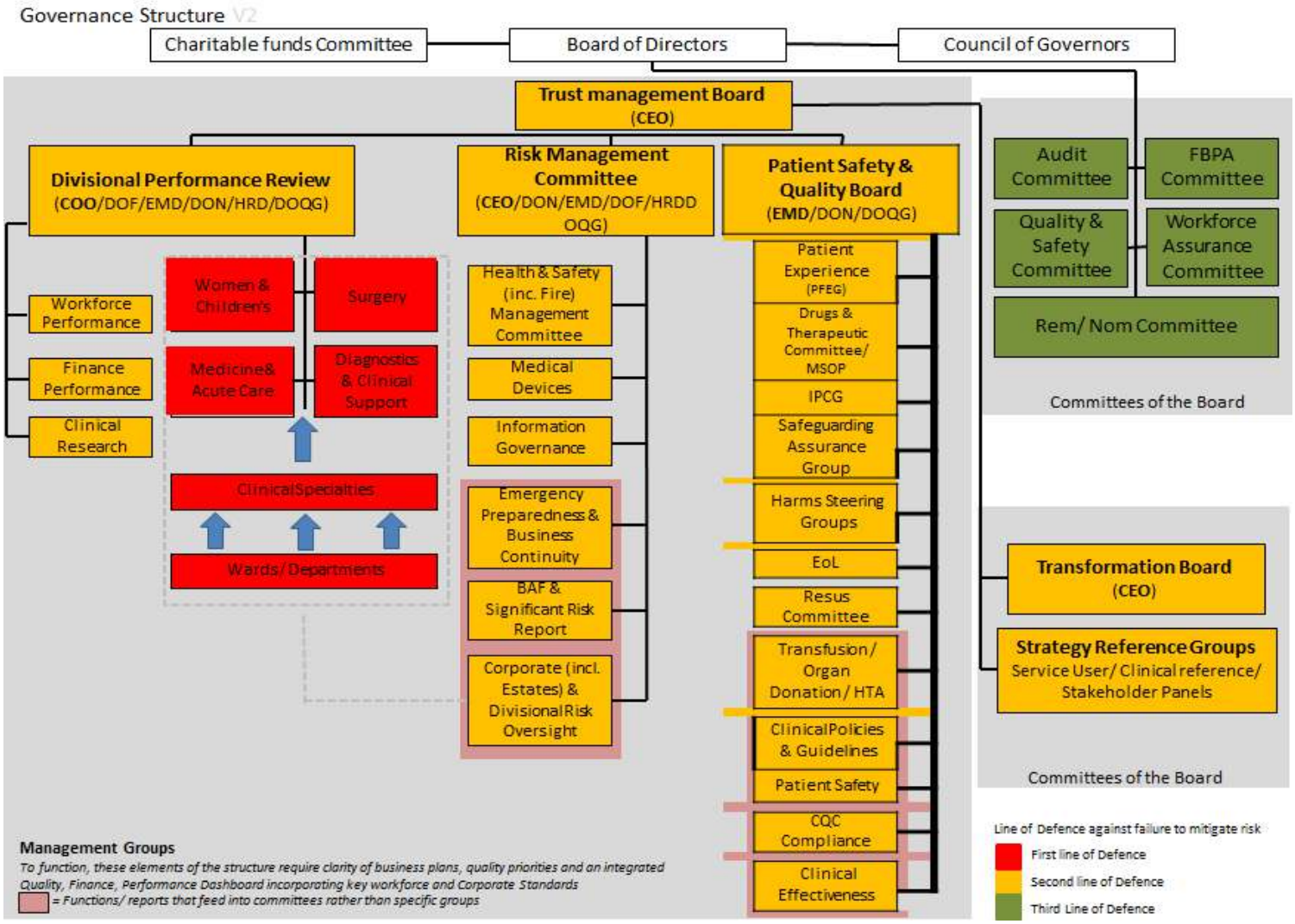
18.0 Conclusion

The above report details annual infection prevention & control activities in 2022/23 as reported to the monthly IPCG, it also details the forward Infection Prevention & Control plan for 2023/24. The infection control programme aims to continuously review and build on existing activity, driven by local needs, while incorporating and complying with the latest NHSE/I and UKHSA guidance and other relevant strategies and regulations pertaining to IPC.

Jay Turner-Gardner
Deputy Director of Infection and Prevention and Control

APPENDIX 1

Governance Structure



APPENDIX 2

Infection Prevention and Control Group
Terms of Reference

1. CONSTITUTION

The Infection Prevention & Control group is authorised to formulate recommendations for Infection Prevention and Control within the Trust and reports to Trust board via the Quality Assurance Committee. The Infection Prevention & Control Group is chaired by the Director of Infection Prevention and Control (DIPC), who is the Chief Nurse. The deputy chair is the Deputy DIPC and/or the Deputy Chief nurse.

2. MONTHLY CORE MEMBERSHIP

- Chief Nurse / Director of Infection Prevention and Control (DIPC) (Chair)
- Deputy Director of Infection Prevention & Control
- Consultant Microbiologist/Infection Control Doctor
- Clinical Scientist – Environmental microbiology
- Occupational health representative
- Antimicrobial Pharmacist
- Associate Director of Estates
- Associate Director of Facilities
- Consultant in Public Health (PHE)
- Divisional Directors of Nursing

CLINICAL LEADS/MEDICAL REPRESENTATION FROM DIVISIONS ON A QUARTERLY BASIS

- Surgery
- Women & Children
- Medicine
- Acute
- Diagnostics and Clinical support

Members of the IPCG are expected to actively participate in discussions pertaining to IPCC ensuring that solutions and action plans have Multidisciplinary perspectives and have considered the impact across all the Directorates and departments.

Members have a responsibility to disseminate the minutes from this meeting within the relevant departments and organisations and inform them of issues discussed.

Members have a responsibility to share the learning gained from IPCG within their divisions and departments to ensure that organisational learning occurs.

Members have a responsibility to Communicate to the IPCG risk issues and solutions discussed in the departments/organisational meetings to support the organisational learning.

3. QUORUM

For decisions taken by the committee to be valid, the meeting must be quorate. This will consist of a minimum of 8 members from the core including the Director of Infection Prevention and control (or nominated deputy) and the Infection Prevention and control Doctor, the Associate Director of Nursing Infection Prevention and Control (or nominated deputy) , and 1 representative from each division.

4. ATTENDANCE AT MEETINGS

The Infection Control Group may require from time to time, the attendance of any Trust employee (or agent of the Trust) to attend the committee at the request of the Chair.

5. FREQUENCY OF MEETING

The Infection Prevention and Control Group will meet every month.

6. OVERVIEW

The Infection Control Group is a subcommittee of the Patient Safety and Quality Board (PSQB) and monitors the Infection Prevention and Control strategic objectives. The 3-year IPC Strategy is agreed by the Trust Board and is based on WUTH organisational priorities. The Trust IPCG oversee and monitor the annual IPC plan in meeting the 3-year Strategy.

7. SCOPE AND DUTIES

Oversee and directs all Infection Prevention and Control activity within the Trust and provide the Chief Executive and trust board with relevant information and advice.

Approve the Strategic plan and interpret and advise on the National Infection Prevention and Control manual.

Provide assurance that the NHS core standards and Department of Health recommendations on infection prevention and control are implemented.

Receive assurance and escalations that infection surveillance data and performance is monitored with appropriate action being taken within the divisions.

Approve Infection prevention and control policies and guidelines that enable implementation of the National Infection Prevention and Control manual.

Advise the Trust on its statutory requirements in relation to Infection Prevention and Control inclusive of the decontamination of medical and surgical devices equipment, e.g., Health Act 2008 and receive assurance as such from the Divisions.

Receive assurance from the divisions that training and supervision systems regarding Infection Prevention and Control is in place for all staff and contractors working within the Trust and that those systems are regularly monitored by their management Teams.

Approve the annual infection prevention and control plan and monitor and review progress.

8. ORGANISATION

Administration support is provided by the Deputy Director of Infection Prevention and Control's Secretary who organises the meetings and provides minutes.

The Deputy Director of Infection Prevention and Control will on behalf of the DIPC be responsible for the compilation of an agenda prior to each meeting.

A chairs report will be submitted to the PSQB monthly prepared by the Deputy DIPC

A chairs report will be presented from the Decontamination group, Antimicrobial Stewardship group, the Ventilation safety group, Water safety group, the WIVAT group and Monthly Divisional IP&C meetings be exception.

The Terms of Reference for the group will be reviewed every 2 years.

10. VERSION CONTROL

Version Control	Date	Comments
V1	August 2020	
V1.2	November 2022	Reviewed the membership and clarified reporting mechanisms.

11. DOCUMENT OWNER

Infection Prevention and Control Secretary/Team Administrator

APPENDIX 3

Annual Infection Prevention Audit Programme
2023/2024

Delivery of this audit plan is to support the Trust in meeting the

- NHS Commissioning Boards delivery of a 'zero tolerance' to MRSA bloodstream infections
- Provider objectives for *Clostridioides difficile* as set out in the NHS Standard Contract 2023/24: Minimising *Clostridioides difficile* and Gram-negative bloodstream infections.
- National Infection Prevention & Control Board assurance framework which provides an assurance structure for boards against which the system can effectively self-assess compliance with the 10 criteria outlined in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

	Audit topic	*Frequency*	*Where identified*	*Where reported*	*Responsibility*	*Lead*
1	Hand Hygiene (Compliance & technique)	Weekly increasing to daily if required	IP Audit plan Directorate Action Plan Tendable app	Directorate Governance meetings Monthly Infection Prevention & Control Group meetings *Clostridioides difficile* & Bacteraemia RCA proforma	Directorate	Ward/ Departmental Managers
2	Environmental audit	Annual by IPC As required by Directorate	IP Audit plan Directorate Action Plan Tendable app PLACE	Directorate Governance meetings Monthly Infection Prevention Control group meetings *Clostridioides difficile* &, Bacteraemia RCA proforma	IPC and Directorate	Ward/ Departmental Managers

3	Patient shared equipment	Monthly	IP Audit plan Directorate Action Plan Tendable app PLACE	Directorate Governance meetings Monthly Infection Prevention & Control Group meetings *Clostridioides difficile* & Bacteraemia RCA proforma	Directorate	Ward/ Departmental Managers
4	Food safety	Monthly	IP Audit plan Tendable app PLACE	Monthly Infection Prevention performance meetings Directorate Governance meetings	Directorate	Ward/ Departmental Managers
5	*'Saving Lives'* High Impact Interventions Numbers 1-7	Monthly/as and when required	IP Audit plan Directorate Action Plan	Monthly Infection Prevention & Control group meeting Directorate Governance meetings *Clostridioides difficile* & Bacteraemia RCA proforma	Directorate	Ward/ Departmental Managers
6	Antimicrobial point prevalence audit	Monthly	IP Audit plan Directorate Action Plan Antimicrobial audit plan	Monthly Infection Prevention & Control group meeting Directorate Governance meetings	Pharmacy	Antimicrobial pharmacist
7	External Commode audit	Annual or more frequently	IP Audit plan Directorate Action Plan	Directorate Governance meetings Monthly Infection Prevention & Control group meeting *Clostridioides difficile* RCA	Infection Prevention Team	Infection Prevention Team
8	Personal protective equipment	Monthly or more frequently	IP Audit plan Directorate Action Plan	IP Audit plan Directorate Action Plan	Directorate	Ward/ Departmental Managers
11	Mattress audit	Weekly/after discharge of a patient	Tendable app	Infection Prevention & Control group meeting Directorate Governance meetings	Directorate	Ward/ Departmental Managers

APPENDIX 4

Infection Prevention Annual Plan 2023/2024

The 2023-2024 IPC annual plan describes the methods that will be used to accomplish the objectives as set out in the IPC strategy which reflects the

- NHS Commissioning Boards delivery of a 'zero tolerance' to MRSA bloodstream infections
- Provider objectives for *Clostridioides difficile* as set out in the NHS Standard Contract 2023/24: Minimising *Clostridioides difficile* and Gram-negative bloodstream infections.
- National Infection Prevention & Control Board assurance framework which provides an assurance structure for boards against which the system can effectively self-assess compliance with the 10 criteria outlined in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

Strategic objective	Action
Objective 1 Training and Education Regulation 12 & 7 (CQC) Criterion 1 (The Hygiene Code)	• Monthly newsletter on HCAI data and themes identified from RCA's for GNBSI and CDI. • Support and contribute to the induction programme and the ongoing learning and development of the Healthcare cleaning professional. • Introduce and support Trust wide patient safety initiatives pertinent to IPC i.e., 'Gloves are off' campaign.

Objective 2 **Audit & Surveillance** Regulation 9(CQC) Criterion 4 (The Hygiene Code)	• Complete mandatory surveillance of all alert organisms (Infections) • Complete the annual IPC audit plan on tendable to support W.I.S.E accreditation. • Support further development of the SSI programme, promoting ownership at divisional level of the lessons learnt from the themes identified contributing to infections. • Provide screening data in line with screening policies to promote compliance. • Work in partnership with commissioners/providers across Wirral to reduce the incidents of all alert organisms
Objective 3 **Policies & Procedures** Regulation 12 (CQC) Criterion 1 & 9 (The Hygiene Code)	• Develop a Carbapenemase producing *enterobacteriaceae* (CPE) policy based on national guidance v risk-based benefits to patients. • Review the existing MRSA policy to ensure that it meets with the current national guidelines. • Ongoing review of the new National IPC manual against WUTH local policies • Scheduled review of all IPC policies to ensure they reflect national guidance and are current.
Objective 4 **Care Environment** Regulation 15(CQC) Criterion 2 & 7(The Hygiene Code)	• Appropriate IPC representation at the beginning and throughout all scheme's meetings • Support MDT attendance at facilities efficacy audits. • Develop training tools to support the training needs of the Trusts Healthcare cleaning professionals. • Support the review of current cleaning equipment and solutions to ensure cost effective results
Objective 5 **Communication & Information**	• Ongoing review of the IPC patient information leaflets • Work with the communications team to ensure IPC updates are communicated trust wide.

Regulation 17(CQC) Criterion 5 (The Hygiene Code)	• IPC representation at IPC Divisional meetings • Work with information to develop the IPC BI portal. • Support the use of data to identify and deliver improvements. • Work in collaboration with the Directorate governance teams to strengthen the reporting process of HCAI's and the resulting investigations and findings.
Objective 6 Research & Innovation Criterion 9 (The Hygiene Code)	• To review and investigate any IPC innovations that can be introduced to support the teams with IPC improvements. • Support the introduction of new technologies. • Work in collaboration with procurement to promote cost effective care delivery. • Support ward led quality improvement projects based on the learning outcomes from GNBSI investigations
Objective 7 Antimicrobial Stewardship Regulation 12(CQC) Criterion 3 & 9(The Hygiene Code)	• Attendance at local and regional antimicrobial groups • Review antimicrobial practice as part of the CDI RCA programme.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 15**

04 October 2023

Title	Safeguarding Annual Report 2022-2023
Area Lead	Tracy Fennell Chief Nurse (Executive Lead for Safeguarding) Executive Director of Midwifery and Allied Health Professionals, Director of Infection Prevention and Control)
Author	Karolyn Shaw, Associate Director of Nursing for Safeguarding
Report for	Information

Report Purpose and Recommendations

The Safeguarding Annual Report provides the Board of Directors with an overview of the national and local context of safeguarding and the current Trust position by providing assurance that the Trust is meeting its statutory obligations and national safeguarding standards. Analysis of the annual safeguarding activity including progress made against the objectives set out in the Safeguarding Annual Report 2022/23 and an overview of the Trust safeguarding priorities for 2023/24.

The report provides an end of year position of compliance against the following areas:

1. Protecting Vulnerable People (PVP) training against the target of 90%
2. Care Quality Commission updates:
    - Child Protection Information Sharing (CP-IS)
    - Children Looked After (CLA) and Initial Health Assessment's (IHA)
    - Deprivation of Liberty Safeguards (DoLS) expiry dates
3. Trust safeguarding activity

Improvements are evident in the following areas:

- Appointment of a second Adoption Medical Advisor (AMA) in line with the recommendations set out in the Somerset Ruling 2022. Progress of pre-adoption medicals in accordance with the Somerset Ruling through the appointment of an additional AMA, alignment with the Named Dr for Children Looked After (CLA), all outstanding cases completed.
- Protecting Vulnerable People (PVP) compliance has been a challenge, however, trust wide improvements have been noted through quarterly improvements in compliance during the year. Q4, below, figures provide overview of each PVP level from end of year position 2021/22 to 2022/23:
  Level 1 improvement from 87.33% to 92.16% (4.83% increase)
  Level 2 improvement from 84.97% to 86.93% (1.96% increase)
  Level 3 improvement from 72.2% to 85.9% (13.7% increase)
  Level 4 improvement from 77.74% to 85.57% (7.83% increase)
- Improvements noted to the compliance for CP-IS checks by staff in the Emergency Department (ED) 80.5% an improvement from Q4 last year (79.8%).

- Annual compliance for CP-IS for Children's Outpatient Department was 98%, however improvements are required for the Children's ward (85%) and Paediatric Assessment Area 84.25%.
- Presentation of an NHS Star award to Safeguarding Named Midwife relating to contributions to the embedment of the HOPE project within the Trust and wider partnership.
- Evidence that staff have a good understanding and awareness of 'Think Family Approach' and professional curiosity in the wider context continues to be evidenced through referrals highlighting parental concerns, mental health, and assaults.
- Slight improvement of timely applications for DoLS within 3 days of admission/and or identification mapped against internal benchmark since data collection commenced (70.7%) 2021/22 to 79.6% (2022/23).
- Development of an escalation process to ensure a multi-disciplinary team approach and senior oversight when managing complex care patients and Mental Capacity Act (MCA).
- Introduction of a discharge MCA framework.
- In line with MIAA recommendations safeguarding question has been added to the Cerner Millennium referral and is expected to go live in early 2023/24.
- Development and embedding of a process to enable guardians to be recorded on CLA health care records alongside the NOK identifying who has parental responsibility.

Priority areas for 2023/24:

- To focus on domestic abuse and further embedment and strengthening of the Domestic Abuse Act (2022) once further guidance and regulations are confirmed.
- Continue to work in collaboration with the ICB and ensure the organisational responsibilities and requirements for the new SAAF and safeguarding contract are embedded and delivered.
- To sustain positive partnership engagement with key stakeholders, to ensure the continuation of robust and transparent conversations in addressing and identifying solutions to rapidly evolving safeguarding issues.
- Support the Trust to recognise and understand the impact of adverse childhood experiences (ACEs) and how this can impact on future, physical and mental health to support trauma informed practice in care provision.
- Moving forward in 2022/23 collaborative working is planned with the Named Nurse for Children and Children Looked After and LA to ensure further integration of IHA systems to reduce system delays in achieving statutory timeframes.
- Support the Tissue Viability service with the implementation of the Department of Health and Social Care Safeguarding Adult's Protocol - Pressure Ulcers and the interface with a safeguarding enquiry into the tissue viability clinical incident forms.
- Reach the 100% compliance for supervision to ensure that all professionals are supported in their competence, assume responsibility for their own practice and enhance patient protection and safety in complex situations.
- Achieve the 90% and above compliance for all PVP mandatory training and sustain this compliance providing further assurance that staff can make every contact count to prevent all forms abuse.
- As a key priority work with divisional leads to make improvements in compliance of CP-IS checks completed by practitioners within Acute and Women's and Children's divisions.
- Review understanding of staff awareness of the interaction of MCA and Mental Health Act to improve practice for those patients requiring restrictive practice intervention when in crisis.

- Development of phase 2 of the HOPE boxes to extend the offer to support wider family members (fathers) within the Trust.
- Sustainment of improvements in the Deprivation of Liberty Safeguards applications inclusive of next of kin details and provision of information booklet.

Recognition is given to the hard work and commitment of the safeguarding team and all Trust staff who work tirelessly in ensuring, 'Safeguarding is Everyone Business'.

It is recommended that the Board:

- Note the report and the actions being taken to rectify the areas for improvement

Key Risks
This report relates to these key risks: • Trust Risk 612 - PVP mandatory training is a statutory requirement for the organisation and remains under the mandatory 90% compliance rate • Trust Risk - 0221 - FGM screening Cerner – FGM routine enquiry is currently only asked in Maternity and Gynecology services

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.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
July 2023	Patient Safety Quality Board	As above	Information

Contents

Glossary

ACE	Adverse Childhood Effects
ADNS	Associate Director of Nursing for Safeguarding
AMA	Adoption Medical Advisor
BI	Best Interests
CDOP	Child Death Overview Panels
CSPR	Child Safeguarding Practice Review
CLA	Children Looked After
CMICB	Cheshire and Merseyside Integrated Care Board
CP-IS	Child Protection information sharing
CQC	Care Quality Commission
DNA	Did Not Attend
DoLS	Deprivation of Liberty Safeguards
ED	Emergency Department
FGM	Female Genital Mutilation
IFD	Integrated front door
IHA	Initial Health Assessments
IDVA	Independent Domestic Violence Advisor
HV	Health visitors
KPI	Key performance indicators
LA	Local Authority
LPS	Liberty Protection Safeguards
MAR	Multi Agency Referral
MARAC	Multi Agency Risk Assessment Conference
MCA	Mental Capacity Act
MSP	Making Safeguarding Personal
NOK	Next of Kin
NRLS	National Reporting and Learning System
OPD	Out Patients Department
PBL	Pre-Birth Liaison

PiPoT	People in Positions of Trust
PVP	Protecting Vulnerable People Training
PSQB	Patient Safety Quality Board
RPR	Relevant Persons Representative
RRM	Rapid Response Meeting
SAG	Safeguarding Assurance Group
SARs	Safeguarding Adults Reviews
SIRG	Serious Incident Review Group
SJR	Structured Judgement Review
SOP	standard operating procedure
SUDIC	Sudden Unexpected Deaths of Child
WSAPB	Wirral Safeguarding Adults Partnership Board
WISE	Wirral Individual Safe Care Every Time Accreditation Programme
WLSSG	Wirral Local Safeguarding Strategy Group
WRAP	Workshops to Raise Awareness of Prevent
WSCP	The Wirral Safeguarding Children Partnership

1	Background and Statutory Legislation
1.1	**Introduction** Wirral University Teaching Hospital NHS Foundation Trust, thereafter, referred to as the Trust, is committed to ensuring that the safeguarding of our patients, their families, our staff, and our communities is at the foundation of our 'Together we will' Trust values. We strive to improve and build upon the safeguarding practices we offer by promoting the Trust ethos that safeguarding is everyone's business in the drive to continuously make improvements to the service we provide. The term "safeguarding" covers everything that assists children, young people, and adults at risk to live a life that is free from abuse and neglect, which enables them to retain independence, wellbeing, dignity, and choice. Safeguarding encompasses prevention of harm, exploitation, and abuse through provision of high-quality care, effective responses to allegations of harm and abuse that are in line with multi-agency procedures. Importantly safeguarding embraces the use of learning to improve services for our patients, their families, and carers. The Trust Safeguarding Team continues to provide a range of activities to support key areas of safeguarding work, embrace change and respond to emerging themes both local and nationally and strive to ensure all safeguarding processes are robust and effective. The team safeguarding structure and further definitions have been elaborated on in appendix 1 and 2. Effective safeguarding of adults, young people, and children is heavily reliant on the development of robust professional relationships and multi-agency working arrangements. This can only be effective when all staff are knowledgeable, confident, and equipped with the skills to deal with process and procedures when concerns arise relating to safeguarding and patient safety. There is a culture of 'Think Family' that is embedded throughout the Trust as it is recognised that children, young people, and adults do not exist or operate in isolation of one another. This report provides assurance that the Trust is fulfilling the duties and responsibilities in relation to promoting the welfare of children, adults and families who come into contact with our services. This report reflects the high level of activity across all work streams to improve internal and multi-agency processes and build on existing systems and procedures. We continue to strive to further improve and achieve strong compliance against all our safeguarding standards internally and externally to safeguard the most vulnerable in our society.
1.2	**Statutory Framework and National Policy Drivers** Whilst safeguarding shares the same agendas and principals for adults and children, there are significant differences in the laws and policies that shape how we safeguard these groups. The legal framework to protect children is contained in Working Together to Safeguard Children (2020) and the Care Act 2014 for adults. However, the

	overarching objective for both is to enable children and adults to live a life free from harm, abuse, or neglect. The Children Act (1989) and Section 11 of the Children Act (2004) places a statutory duty on all NHS Trusts to make arrangements to ensure that it has regard for the need to safeguard and promote the welfare of children when exercising its functions. The statutory guidance 'Working Together to Safeguard Children (2018) supports the multi-agency safeguarding arrangements set out in the Children and Social Work Act (2017). The Care Act 2014 set out a clear legal framework for how local authorities and other agencies should protect adults at risk of abuse or neglect. The focus is on personalised and outcome focused care with an emphasis on making adult safeguarding 'personal', Adults should therefore be seen as experts in their own lives and safeguarding means working 'with the adult' and not a process that is done to or for an adult. Trust Safeguarding policies, procedures and training are up to date with current child and adult safeguarding legislation and includes new LSCP definitions and arrangements and how the Trust discharges its statutory safeguarding duties in relation to: • Children Act (1989, 2004) • Children and Social Work Act (2017) • Working Together to Safeguard Children (2020) • Promoting the Health and Well-being of Looked after Children (2015) • Safeguarding Adults at risk in line with the Care Act (2014) • The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007 • The Domestic Abuse Act (2021) • The Counter Terrorism and Security Act (2015) • CQC Regulation 13: Safeguarding service users from abuse and improper treatment
1.3	**Safeguarding children** **Wirral Safeguarding Children Partnership** The Wirral Safeguarding Children Partnership (WSCP) is led by three statutory partners Local Authority (LA), Police, and Cheshire and Merseyside Integrated Care Board (ICB). Structure can be found in appendix 3. The Children Act (1989) and Section 11 of the Children Act (2004) in conjunction with Working Together to Safeguard Children (2018) places a statutory duty on all NHS Trusts to ensure organisational policy and practice is in place to safeguard and promote the welfare of children. **Section 11 audit** Section 11 audit is monitored through the WSCP and provides evidence of effective safeguarding arrangements by demonstrating compliance with relevant legislation, provides evidence of reflective practice, identifies areas of good practice, and highlights organisational development and improvement. Collectively the review of organisation section 11 and cross triangulation of other areas of intelligence can enable local partnership developments to be identified.

Multi agency reviews

There has been 2 statutory Child Safeguarding Practice Reviews (CSPR). Child Noah tragically died at home, and although his death was not suspicious the case highlighted the complexities of working with families with multiple issues. Child Ollie died because of injuries sustained by co-sleeping. This case highlighted the importance of safe sleep messaging.

There has been 1 local Learning Review (LR) - Matthew who tragically took his own life shortly after his 18th birthday. This case highlights the sometimes-overlooked vulnerabilities of older teenagers.

There has been a total of 4 chronology requests from the partnership and the Trust await further direction if these meet the thresholds for either LR or CSPR.

Trust Position

- The Trust is represented at the WSCP by the Associate Director of Nursing for Safeguarding, Named Nurse for Safeguarding Children and Children Looked After, and the Named Midwife for Safeguarding the unborn.
- In 2022/23 there has been 12 recorded deaths within the sudden unexpected deaths infant and child (SUDIC) process; 6 of these deaths were unexpected, 6 were expected deaths and required co-ordination as per process to partner agencies.
- 24,181 children attended the Emergency Department (ED) during 2022/23 and of this total 1851 were 16/17 age group. 93% of all children who attended ED had their status as a child recognised (until their 18th birthday) and appropriate paediatric assessments and treatment offered. The outstanding 7% have been identified as those children who have booked into ED and left prior to any assessments of treatment.
- Child Protection Information Sharing (CP-IS) compliance continues to remain a priority. Responsibility for the monitoring and reporting of quarterly CP-IS data has now been handed over to the divisions (Q4) and will be monitored via the Safeguarding Assurance Group (SAG). Below illustrates the annual compliance (%) of those areas who are utilizing the system.

Ward/Area	**Annual % compliance**
Emergency Department	80.5%
Children's ward (including Day case)	85%
Paediatric Assessment Unit	84.25%
Children's Outpatient Department	98%
Maternity	*Data collection beginning in Q1*
Gynaecology Ward	*Data collection beginning in Q1*
Neonatal Ward	*Data collection beginning in Q1*

- Multi agency information continues to be shared via the Trusts ED Children's Liaison Coordinator, accidental injury is highlighted as the main reason to share information with partner agencies (971 cases) highlighting the 34 top themes being, head injury 32%, ingestion (21%), burns (15%) and dog bites (10%). In terms of parental concerns raised it has not been any surprise to note that mental health (88%) and parental substance misuse (14%) continue to be the top theme in referrals made by staff when utilising the "think family approach" and professional curiosity.
- Themes and trends in data continue to be shared with the WSCP Contextual Safeguarding Committee to assist in preventative work within communities, data during 2022/23 highlights an upwards trend of the number of children that have attended ED due to being assaulted.

	• There have been 5 challenging cases involving children who are open to the LA that have attended ED for support with emotional health and well-being. These cases were required to be escalated to the Trust executive team, operational leads within the appropriate LAs and the ICB due to placement issues, delayed discharge, or the requirement of other services to maintain the safety of these children. ➢ 2 were subject to a Court of Protection Deprivation of Liberty Safeguard (DoLS). • There are still many children who attend ED with mental health concerns which include low mood, deliberate self-harm and suicidal ideation and a noted increase in those attending following an overdose of medications. Information continues to be shared via the ED liaison coordinator and to the WSCP. • In Q2 Risk 347 failure to safely update details of Next of Kin, Parent/Guardian or Emergency due to process for recording guardian not being followed correctly for CLA. A standard operating procedure in now place developed together with the information governance team and Named Nurse. Assurances are in place for any lapse that trigger an investigation to understand how and why the issue occurred.
1.4	**Children Looked After (CLA) and Initial Health Assessments (IHAs)** Children coming into care must have a high-quality initial health assessment (IHA) within 20 working days of becoming a Child Looked After (CLA). The Trust has a statutory and contractual responsibility to provide this service. Assurance of compliance is monitored via the quarterly Safeguarding Accountability and Assurance Framework (SAAF) data submissions against a set of key performance indicators (KPIs) which cover Adults, Children and CLA. **Trust Position.** • Delays continue in receiving referrals from the LA outside of the agreed 48hrs time scale which subsequently impacts on the Trust's ability to complete within the statutory timeframes. Monthly escalation reports are completed to the LA and the Designated Nurse for Children and CLA. As a result of these delays the Trust continues to remain below the statutory compliance rate of 100%. • Further delays have been identified through the process of quality assurance due to partial or no information regarding the child's birth history or family history being provided by the LA. • A multi-agency working group consisting of WUTH, LA and the Community Trust (inclusive of named professionals began meeting monthly (Q4) to begin working collaboratively to address gaps and improve processes including our own internal processes and KPIs. • A review of the Coram BAAF (British Agencies Adoption and Fostering) framework is set to be reviewed nationally in 2023/24 which will enable a timelier and streamlined service for patients and agencies.
1.5	**Somerset Ruling March 2022** The Somerset Ruling identified a procedural flaw in the creation of adoption medical reports, particularly that an Adoption Medical Advisor (AMA) must take responsibility for the advice given in the pre-adoption medical reports completed, which in effect means that they must provide advice and a signature. **Trust Position** • The Trust have appointed 2 members of staff to fulfil the role of AMA in line with the requirements highlighted in the ruling. As a result all 42 cases escalated by

	the LA as outstanding have been completed with oversight by the Designated Doctor for CLA. • The Somerset Ruling is now embedded in practice as business as usual.
1.6	**Unborn** The Wirral Pre Birth Liaison meeting (PBLM) is a pathway to share information to develop a coordinated plan to safeguard children and unborn babies; this multiagency group is chaired by the Trust's Named Midwife. The main purpose is to obtain multiagency information and develop a support plan for the unborn. The threshold and criteria are women who are known to services, for reasons such as safeguarding, mental health issues, substance misuse and those who disclose any form of domestic abuse. • 140 referrals were submitted for consideration to PBLM by midwives, 130 met the criteria/thresholds to progress. 16 cases were referred into PBLM by Integrated Front Door (LA). The most consistent reasons for referrals into PBLM were previous social care involvement followed by known domestic abuse concerns. • The HOPE (Hold on Pain Eases) boxes pilot launched in October 2022 within Maternity and Children's Social Care. HOPE is a national pilot to support women when babies have been removed from their care, HOPE utilises a trauma informed approach and the Trust is included alongside 24 other organisations. This builds on the Always and Forever boxes which were created by the Trusts Named Midwife and launched in 2020. • The HOPE boxes have been positively received throughout the Trust and the wider partnership. The Trusts Named Midwife for Safeguarding has been awarded an NHS Safeguarding Star award for work relating to the HOPE project and had the opportunity to present the project to the Trust Board.
1.7	**Safeguarding Adults** The Care Act (2014) states that adult safeguarding is established as a core function of every LA's care and support system. The Care Act sets out the statutory framework for safeguarding adults. The Care Act (2014) requires each LA to have a Safeguarding Adults Board (SAB) with core membership from the LA, police, NHS, alongside members from other emergency services, probation services and the voluntary sector. One of SAB's key functions is to ensure that policies and procedures governing adult safeguarding are fit for purpose and can be translated into effective adult safeguarding practice. Wirral Safeguarding Adults Partnership Board (WSAPB) was re-established in July 2021, following the disbandment of the Merseyside Safeguarding Adults Board. The primary responsibility of the WSAPB is to ensure that adults in Wirral, who may be at risk, are able to live fulfilling lives, free from abuse and neglect. The WSAPB has a statutory responsibility to monitor and evaluate what is done by partner agencies individually and collectively to safeguard and promote the welfare of adults who live in Wirral (appendix 4). The WSAPB meets quarterly with 2 development days a year with members representatives of agencies across Wirral, including representation from the Trust by the Associate Director of Nursing for Safeguarding. The Named Nurse for Safeguarding Adults represents the Trust at the 4 WSAPB subgroups.

	The WSAPB works collaboratively with 3 other adult boards across Merseyside to undertake work in relation to Safeguarding Adult Reviews (SARs). During the annual reporting in year 2022/23 the Trust were requested to provide information for 2 SAR considerations, both met the thresholds as SARs and are remain ongoing reviews. Findings and learning will be shared across agencies to provide assurance of actions taken to improve practice once finalized, any learning for the Trust will be monitored via the SAG. **Trust Position** • During 2022/23 there have been no legislative changes in policy or guidance in respect of safeguarding adults. • Learning identified through an externally raised concern saw the development of guidance for staff when considering non-accidental injuries in patients who are non-mobile/communitive adults. This has been included in the Trust's Safeguarding Adults procedure and guidance policy. • External concerns raised against the Trust directly from the LA continue to follow the governance process and are managed through the governance divisional leads using the safeguarding rapid review template. Oversight is provided by the Named Nurse for Safeguarding Adults with any learning identified, and subsequent actions monitored by the divisions involved. Themes and trends are reported through the Quality & Patient Safety Intelligence Report feeding into the PSQB for wider learning and assurance. • The Safeguarding Adults Procedure and Guidance policy was updated in December 2022/23 to include the divisional 'Safeguarding Rapid Review' template and standard operations procedure (SOP) for externally raised concerns. • Externally raised identified themes throughout 2022/23 were discharge and/or poor care concerns. Over 60% of concerns were discharge related issues such as, package of care provision, general poor communication, and poor communication of skin condition and/or wound care advice. • Concerns progressed to a safeguarding section 42 (S42) enquiry has further decreased from 31% in 2021/22 to 15% in 2022/23. This is due to the process allowing for the Named Nurse for Adults to work in collaboration with the LA to identify which concerns are progressed as S42, any concerns not identified as a meeting the thresholds for a S42 are managed as clinical incidents. Where no concerns are identified following an initial enquiry then no further action is required. • S42 enquiries are to be completed within 28 days as per Statutory framework thus review to be complete by division within 7 days. During 2022/23 a total of 11 section 42 enquires were initiated however only 5 were complete within the required 7-day timeframe. 2 were agreed that they did not need to follow the rapid review process as 1 had originally been to SIRG and would have been a duplication and the other was discussed by the division at a statutory safeguarding strategy meeting within 7 days and therefore report not required. The remaining 4 rapid reviews had delays of between 2-16 days mainly due to capacity and availability issue to identify leads. • Named Nurse for Safeguarding Adults is working alongside the Governance Support Unit (GSU) to ensure reports can be created through Ulysses with automatic reminders to division to monitor robust reporting in line with statutory requirements. • As part of a review of the tissue viability (TV) referral form a question has been added to identify if a safeguarding referral has been completed following an action

	MIAA, the referral form has been built and is planned to go live in Cerner Millennium early 2023/24. • Work continues to add the adult safeguarding decision guide for severe pressure ulcers as a questionnaire to the TV incident form as a tool to support staff to determine if pressure ulcers require safeguarding processes to be followed. The Governance Support Unit to build and embed the decision support tool into the clinical incident form as a questionnaire and will continue into the coming year.
1.8	**The Mental Capacity Act (2004) and Deprivation of Liberty (2007)** The Mental Capacity Act (2005) (MCA) protects and empowers individuals who are unable to make decisions for themselves. It applies to everyone working in health and social care providing support, care, and treatment to people aged 16 and over who live in England and Wales. The five principles of the MCA are: • Assume a person has the capacity to make a decision themselves, unless it's proved otherwise • Wherever possible, help people to make their own decisions. • Don't treat a person as lacking the capacity to make a decision just because they make an unwise decision • If you make a decision for someone who doesn't have capacity, it must be in their best interests • Treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms The MCA allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf should they lack capacity in the future. Any individual is deemed to lack capacity to make a decision if they are unable to: • Understand the information relevant to the decision • Retain that information • Use or weigh up that information as part of the process of making the decision The MCA (2005) allows restraint and restrictions to be used – but only if they are in a person's best interests. Extra safeguards are needed if restraint and restrictions are used to deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards (DoLS). Plans to replace DoLS by Liberty Protection Safeguards (LPS) were due 1st October 2020, however deferred in response to COVID 19 pandemic with no confirmed launch date. The combined draft code of practice was released in March 2021/22 and the Trust provided feedback as part of this consultation exercise. However, in April 2023 the Department of Health and Social Care (DHSC) provided an update that implementation of LPS has been delayed beyond the life of this Parliament however feedback will be provided of the consultation by DHSC in due course. The Trust will therefore continue to make applications in line with the Mental Capacity Act 2005 to ensure that the rights of those who may lack the relevant capacity are protected. **Trust Position** • Trust policy is in place 'Role of the Mental Capacity Act 2005 in Acute Healthcare – policy reference 237' and was reviewed in February 2025. • Trust policy for Deprivation of Liberty Safeguards – policy reference 217 is in place, and will be reviewed in December 2025.

- A total of 2313 referrals were received for 2022/23, 2006 referrals were processed as DoLS 7-day urgent authorisations and standard applications which was an increase of 19 compared to 2021/22 (1987). 307 (13.2%) applications were not progressed to standard applications due to either duplicate application, discharged prior to the referral being valid or within 24 hours of receiving it, fluctuating/regained capacity, application of a mental health section used or due to relevant case law. This is a decrease from last year by 12. Duplicate and discharged patients was the most common theme.
- Statutory 7 day urgent and standard DoLS applications are made by staff via the Ulysses incident reporting system. Quality assurance of all DoLS applications inclusive of MCA and Best Interests (BI) is completed by the Lead Nurse for MCA and DoLS. The below chart highlights the compliance percentages for DoLS applications by staff.

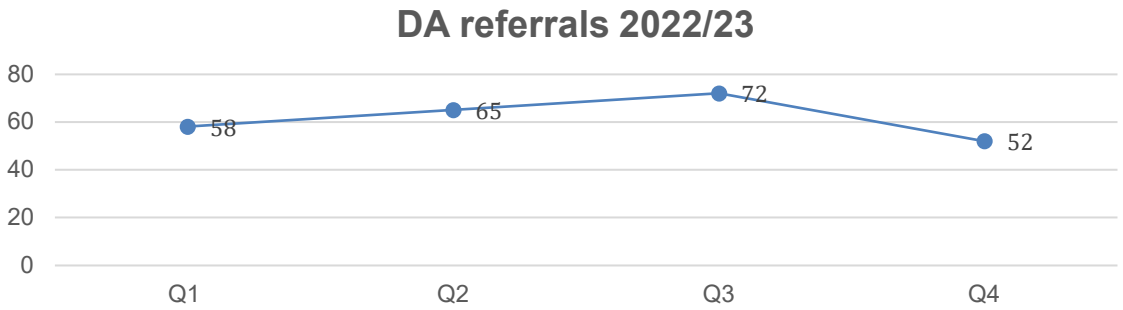
DoLS application compliance	**20/21**	**21/22**	**22/23**
*RPR details included (NOK details)	61%	61%	66.8%
RPR booklet provided	56.4%	57%	59%
DoLS applications requiring further information	n/a	**70%	58%

Identification and consent for a Relevant Persons Representative (RPR) and provision of a RPR booklet (statutory obligation) informing the RPR of their duties/responsibilities. **DoLS applications requiring further information data commenced in August 21.

- Best interest (BI) completion for DoLS MCAs continues to be 100%, 5.3% (108) of BI documentation are delayed being completed on average for 1.8 days, delaying DoLS from being valid.
- Delayed DoLS applications are monitored on a case-by-case basis. There are no other known organisations that monitor this KPI and the trust internal practices exceed the requirements to measure when a delay occurs. Monitoring of this KPI during 2022/23 has enabled the Trust to understand a position of compliance for DoLS applications and accepted risk as highlighted below:
  - 79.6% (1598) of DoLS were received either within 3 days of admission or when a deprivation of liberty was identified further into the patient's journey in 2022/23, a slight increase from 2021/22 (70.7% - 1406).
  - Deep dives are completed for delayed applications and if a valid reason to mitigate the delay is not identified then a clinical incident report is completed for significant delays and learning shared, commenced in Q3 2021.
- Gaps in MCA compliance continue to be identified. Themes highlighted outside of unlawful deprivation of liberty are:
  - Lack of MCA/BI completion for falls intervention, Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), refusal of medications/medications given covertly, procedures/investigations such as catheter insertion or nasogastric (NG) tube insertion.
  - Interpreter not used as per Principle 2 of the MCA 2005,
  - Not obtaining the Lasting Power of Attorney/Advanced Decision to Refuse treatment documents.
  - Inappropriate/prolonged use of restraint/restraint (physical and chemical) without legal authorisation/seclusion.
  - Statutory IMCA referral not completed.

	• Multiple bespoke MCA training sessions have been offered throughout the year highlighting learning from Trust cases. Additionally, DoLS: how to guide was produced and disseminated along with variety bulletins/ 7 minute briefings covering a wide range of MCA and its interaction including communication,16–17-year-olds, Refusal of medications/treatment and restrictive practices including bed rails, consent and supervision inclusive of documentation requirements. • There is representation by safeguarding at both the weekly Serious Incident Review Group (SIRG) and the Patient Safety Learning Review Panel providing expertise to any incidents including MCA. • Following an action from SIRG a Complex Case Standard Operating Procedure (SOP) in managing and escalation of complex patients has been developed and shared trust wide. • Lead for MCA continues to work with divisional Clinical Practice Facilitators as well as those for Patient Safety and Harms Prevention, Continence Care, Medicines Management and Leads for DNACPR to ensure MCA continues to remain on their agenda. • Safeguarding is represented on the Trust's Mental Health Transformation Group (MHTG) and sub groups looking at MCA and its interaction with Mental Health. Following the delivery of MCA/Mental Health scenario-based and complex patients training in ED (Q2 and Q3) audit findings highlighted a significant increase in staff knowledge and confidence to follow the MCA process, however case review highlights that process are not always followed with restrictive practice and restraint/seclusion is being is used without evidence of legal authorisation. • Development of an MCA discharge framework was undertaken by staff and supported by Wirral Community Health and Care (WCHC) NHS Foundation Trust which included MCA for discharge bespoke training and examples of documentation to increase knowledge and support Allied Health Professionals (AHPs) and integrated Discharge Team (IDT) nurses. Again, feedback has been positive highlighting staff have improved confidence and knowledge when putting MCA 2005 into practice. Positive assurance has been received from IDT professional lead in relation to the assessments being completed. This has now been extended to ward teams and further training will be offered moving forward in Q1 2023/24. ** Wirral Individual Safe Care Every Time Accreditation Programme (WISE) continues to audit staff's understanding of the different levels of patients' supervision options and knowledge when to contact the Safeguarding Team for any changes in restrictions or updates.
1.9	**The Counter Terrorism and Security Act (2015)** The threat of terrorism continues locally, nationally and globally and the strategy aims to ensure that the UK has the best response to the heightened threats from terrorism moving forwards. CONTEST is the framework that enables the government to organise work to counter all forms of terrorism and has four key components: • Pursue - to disrupt terrorist activity and stop attacks • Prevent - to stop people becoming or supporting violent extremists and build safer and stronger communities • Protect - strengthening the UK's infrastructure to stop or increase resilience to any possible attack • Prepare - should an attack occur then ensure prompt response and lessen the impact of the attack

	The NHS and its partners have a role in the 'PREVENT' section of this strategy. Whilst the Trust continues to be a non-priority site, the reporting mechanism is required via NHS Digital and via the SAAF to CMICB. The Counter Terrorism and Security Act (2015), places a specific duty on statutory bodies including the police, LA's and health organisations to have 'due regard' to help prevent people being drawn into terrorism. The Channel process (a standardised voluntary multi-agency programme for people at risk of radicalisation) is a legal requirement for public bodies across the country. **Trust position** • Trust policy 'PREVENT Policy and Guidance protecting those who are vulnerable to exploitation and radicalisation through a multi-agency approach' (policy reference 305) is in place; due review in December 2022/23. • There have been no recent changes to legislation or guidance regarding Prevent during 2022/23. • The Trust monitors the number of Channel panel requests for information received from CMICB. The Trust received 20 requests for information to be shared with the Channel panel, 16 for children and 4 for adults, 6 were for routine 6 or 12 monthly reviews. • The Trust has not had any cases that required a Prevent referral during 2022/23. • Quarterly data submissions for Prevent continue to NHS Digital and via the SAAF to CMICB; this includes referral numbers and training data. • Prevent mandatory awareness and Workshop to Raise Awareness of Prevent (WRAP) training continues as part of all levels of PVP training. The Department of Health and Social Care has set compliance for Prevent at 85%. Compliance is monitored via PVP through the SAG and PSQB, the Trust have finished 2022/23 is a positive position and have achieved compliance for all levels of Prevent training.
1.10	**The Domestic Abuse Act (2021)** The Domestic Abuse Act (2021) aims to ensure that victims have the confidence to come forward and report their experiences, safe in the knowledge that the state will do everything it can, both to support them and their children and pursue the abuser. Most of the provisions in the Act will be brought into force by commencement regulations, once the necessary preparatory work has been completed, for example, the making of court rules or the issue of guidance. **Trust Position** • Domestic abuse and harmful practices is included across all levels of PVP training which supports staff in the completion of risk assessing victims of domestic abuse. • The Trust has 2 policies in place; 1 to support staff with patients and 1 for support for staff that may experience domestic abuse: ➢ Domestic Violence and Abuse policy reference 035 due for review in July 2023/24

	➢ Domestic Abuse Workplace Policy: Support for Staff policy reference 344 and due for review in June 2023/24 • The Trust has an identified lead for Domestic Abuse and Harmful Practices (Named Midwife for Unborn) and supports both patients and staff following any disclosures or concerns. • In 2022/23 the Safeguarding Team received 247 referrals (a further decline) relating to domestic abuse in comparison to 289 in 2021/22 and 377 in 2020/21. A steady increase was noted Q1 – 3 and then declined in Q4. Further analysis of the data to evidence the reasons for this ongoing trend is required.  • In 2022/23 the Safeguarding team supported 5 staff members following disclosure of domestic abuse which was an increase in comparison to supporting 8 staff members in 2020/21. • The domestic abuse routine enquiry questions were embedded within Cerner in 2019/20, prompting all patients 16yrs and above to be given the opportunity to disclose concerns to staff. Compliance of this question is monitored through daily IT reports and using the WISE audit programme. Compliance within ED remains requiring improvement and is now monitored by the division and reported into the Safeguarding Assurance Group. • The domestic abuse CAADA-DASH risk assessment is embedded within Cerner supporting practitioners to identify high risk cases of domestic abuse, stalking and 'honour' based violence. This assessment assists decision making of cases that require referral to MARAC and enables support mechanisms to be identified. The trust have referred 34 cases of high risk domestic abuse victims to MARAC in 2022/23. • The Trust has contributed towards 4 new Domestic Homicide Reviews (DHRs) in Wirral. Reviews await approval from the Home Office and publication, identified learning specific to the Trust will be shared, implemented and monitored through the SAG and mandatory/bespoke training. **Harmful Practices Trust Position** • 1 referral was received relating to Harmful Practice for 2022/23. • The Safeguarding team received 18 referrals relating to identified cases of Female Genital Mutilation (FGM). 16 were identified through midwifery services at the point of women booking into midwifery care and 2 were identified through gynecology services and these women were not pregnant. There has been a total increase from 12 cases in 2021/22. • Consultation remains ongoing with the Urology department in respect of the implementation of the FGM routine enquiry questions. There is an aim to have this embedded into a pilot area within Urology within 2023/24.
1.11	**People in Positions of Trust (PiPOT) (Staff allegations)**

	All incidents or allegations of abuse are taken seriously by the Trust and are treated in accordance with WSCP and WSAPB procedures. **Trust position** • Allegations against staff continue to be raised to the Safeguarding team following the People in Positions of Trust (PiPOT) policy and process. 63 were received during 2022/23, 6 less compared to 2021/22. • Allegations that do not require safeguarding involvement are managed via the divisions and/or Human Resources. Regular bi-weekly meetings continue to monitor progress of any cases to ensure all required actions have been completed. • Any allegations requiring safeguarding reporting processes to be initiated are also reported to the Designated Nurse/Professional Lead for Adults/Children and to the Local Authority Designated Officer (LADO) for children's concerns. • Staff allegations data and information is reported via the Quality and Patient Safety Intelligence Report into PSQB for wider learning and assurance.

2	Inspections/Reviews
2.1	**Care Quality Commission (CQC) of Health Services for Children Looked After (CLA) and safeguarding across Wirral – May 2019 (update)** Ensure children and young people receive care and treatment from suitably trained medical and nursing staff in line with national guidance for emergency paediatric care (CQC Safeguarding Wirral Wide Action Plan 2019). The business case for the integration of Children's ED and Paediatric Assessment Unit (PAU) has been approved (April 2023). Transformation work will continue into 2023/24 with the recruitment of registered nurses with the appropriate paediatric training to care for children in the ED. This will minimise the significant risk to the Trust, which is currently reflected on the Women's and Children's divisional risk register. Upon completion the Trust will meet national standards ensuring children are cared for by appropriately trained staff in a suitable environment 24/7 with revised extended opening of PAU. Monitoring and assurances will be reported quarterly to the SAG by the Women's and Children's division.
2.2	**Joint Targeted area inspection (JTAI) December 2022** The Trust participated in a Joint Targeted area inspection (JTAI) regarding the multi-agency response to children and families who need help in the Wirral. This inspection took place from 12 - 16 December 2022 and was carried out by inspectors from Ofsted, the Care Quality Commission (CQC) and His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS). A full report was published 14 January 2023 the overall summary of the inspection identified that agencies: Strengths included: • Senior leaders in partner agencies have a shared and well-developed vision for early help in the Wirral. • There is a broad range of locality-based early help and family support services available to children and their families that are making a positive difference. • A strong commitment to co-production and to engaging children and their families means that both the overall range of services and individual children's

packages of support are increasingly well matched to the needs of children and families.

Improvements required include:

- Better co-ordination of services and
- Improvements to meet the early help needs of children with special educational needs and/or disabilities.

The Trust await an action plan to be formulated by the WSCP to direct partner agencies to required multi agency and single agency improvements.

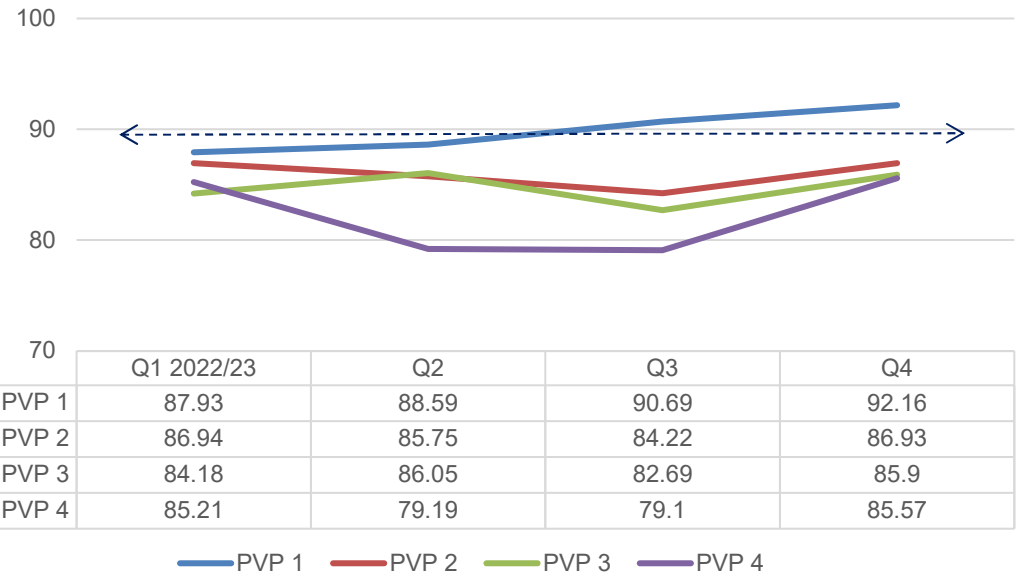
3 Protecting Vulnerable People Mandatory Training (PVP)

The Trusts PVP Strategy outlines the pathway for staff to access appropriate safeguarding education relevant to their role and competencies required written within the legislative framework and which reflects the findings and recommendations from the Safeguarding Children and Young People: roles and competencies for health care staff. Intercollegiate Document (2014) and the Safeguarding Adults: roles and competencies for health care staff Intercollegiate document (2018).

Trust Position

- PVP training level 1-3 is delivered through an eLearning package and the additional hours aspects of level 3 requirements set out in the safeguarding Intercollegiate documents is delivered as a face-to-face package (including MCA and DoLS).
- The Trust did not reach the mandatory training compliance target of 90% for PVP by the end of the year 2022/23 for levels 2-4. In comparison to Q4 2021/22 the Trust has seen an overall improvement across all levels:

Trust PVP compliance 2022-23



	Q1 2022/23	Q2	Q3	Q4
PVP 1	87.93	88.59	90.69	92.16
PVP 2	86.94	85.75	84.22	86.93
PVP 3	84.18	86.05	82.69	85.9
PVP 4	85.21	79.19	79.1	85.57

- Despite a drop in compliance during Q2 – 3 the Trust has finished Q4 with in a positive position compared to Q4 2021/22. Level 1 PVP remains within compliance requirement of 90% and above, noting levels 2-4 all above 85% mark.

- Divisionally 13 areas are noted to have achieved compliance compared to only 6 areas last year (Q4). Divisional compliance can be seen in the chart below.

Divisional position – Q4

Division	PVP 1	PVP 2	PVP 3	PVP 4
Acute	84.22	78.26	97.3	76.33
Surgery	92.38	90.43	86.79	94.12
Women's & Children	88.24	96.8	91.53	92.86
Medicine	87.67	84.11	83.28	N/a
Clinical Support	91.69	86.75	95.57	100
Corporate	90	80	69.12	71.43
Estates & Facilities	95.33	75	100	N/a

- Throughout the year visibility and bespoke training has continued to multiple departments and wards. Bespoke sessions are implemented for various reasons such as identified learning from incidents, lessons learnt following multi agency reviews, following WISE audit or requests made from managers.
- Assurance of safeguarding knowledge is monitored through WISE. 26 clinical areas have been audited during 2022/23 and the provision of bespoke training is completed in areas identified as requiring improvement. The average score for all audits completed during this period is 90.4% highlighting that staff have a good understanding and knowledge base for safeguarding and MCA (2005).

4 Governance Arrangements for Safeguarding

4.1 **Safeguarding Assurance Group (SAG) and Patient Safety and Quality Board (PSQB)**

The Safeguarding Assurance Group (SAG) provides opportunity for challenge and assurance regarding safeguarding arrangements within the Trust, monitor compliance and benchmarking with external standards, clinical effectiveness indicators including CQC outcomes and addresses any areas requiring improvement.

The SAG meets quarterly which allows for a defined and joint approach to safeguarding across all divisions within the Trust. The group has divisional representation alongside the named/lead professionals and is attended externally by the designated professionals for adults, children and CLA from the Cheshire and Merseyside Integrated Care Board (CMICB) to allow scrutiny and oversight.

SAG agenda includes the compliance with safeguarding standards, including the safeguarding assurance framework and mandatory safeguarding training compliance.
The Associate Director of Nursing for Safeguarding provides a quarterly report into the PSQB and yearly annual report.

Trust Governance structure arrangements are detailed in appendix 5.

Trust Position

- 4 SAG meetings were planned for 2022/23: November 2022 SAG was unfortunately cancelled due to operational pressures. A Chair's review with key people was conducted and a safeguarding oversight report was shared with PSQB by way of assurance and escalation.

4.2	**Safeguarding Accountability and Assurance Frameworks (SAAF) for Children, Children Looked After and Adults** The purpose of the SAAF is to set out clearly the safeguarding roles and responsibilities of all individuals working in providers of NHS funded care settings and NHS commissioning organisations, which is submitted quarterly. The responsibilities for safeguarding form part of the core functions for each organisation and therefore assurance regarding compliance of safeguarding responsibilities is provided to Cheshire and Merseyside ICB. In Q3 the Trust engaged in a wider review of the new proposed Safeguarding KPI's and Commissioning Standards across the Cheshire and Merseyside ICB footprint, to support a consistent approach to quality assurance. Reporting using the new proposed SAAF template is required to begin in Q1 2023 / 24, with the expectation of full compliance by Q3 2023 / 24.
4.3	**Safeguarding Incident Reporting** Safeguarding incident notifications are integrated into the Trust's Safeguard database to record all safeguarding incidents both internally and externally. Following receipt of the incident documentation received by the safeguarding team, it is recorded in Cerner to ensure all staff has access to all safeguarding information. The Safeguard system then automatically reports relevant safeguarding incidents to the National Reporting and Learning System (NRLS). Any alerts required are escalated to Cheshire and Merseyside ICB and the CQC as required. The Associate Director Nursing for Safeguarding or a deputy attends the weekly Trust's Serious Incident Review Group (SIRG) to provide safeguarding expertise and MCA (2005) expertise and advice and overview of any incidents with MCA involvement. Clinical incident forms are be raised by the safeguarding team when concerns have been raised that do not meet the thresholds for safeguarding investigations highlighting potential gaps in processes directly to the divisions.
4.4	**Safeguarding Supervision and Support** Safeguarding supervision is a term used to describe a formal practice of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance patient protection and safety in complex situations. There are 2 mechanisms for safeguarding supervision: • Advice on individual case management • Ensuring that those working with cases with safeguarding issues have sufficient knowledge, skills, and appropriate attitude. The requirement for Trust employees to have access to safeguarding supervision is explicitly stated in Working Together to Safeguard Children (2018): *"Effective practitioner supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support practitioners to reflect critically on the impact of their decisions on the child and their family."* The Care Act (2014) dictates the requirement for safeguarding supervision: *"Skilled and knowledgeable supervision focused on outcomes for adults is critical in safeguarding work. Managers have a central role in ensuring high standards of practice and that practitioners are properly equipped and supported. It is important to recognise that dealing with situations involving abuse and neglect can be stressful and distressing for staff and workplace support should be available."*

	Trust Position • Safeguarding supervision is provided to all health practitioners who case hold safeguarding cases. • Safeguarding Supervision Policy – policy reference 247 is in place, to be reviewed March 2024. • In line with recommendations from The Care Act (2014) safeguarding supervision sessions continue to be delivered via monthly drop-in sessions within the ED. This allows staff opportunity to access supervision for both adults and children. Records of supervision are recorded and kept securely by the safeguarding supervisors on a case-by-case basis. 122 members of staff have been recorded as being offered supervision, 50 member of staff accessed safeguarding supervision and 72 staff did not have any concerns/cases they wanted to discuss. The safeguarding team use these opportunities to also educate staff, discuss safeguarding processes and promote training, CP-IS and domestic abuse questions. • ED Paediatric Peer Review continues to be delivered on a quarterly basis to share learning and identify how to improve practice. • The Trust Named professionals all access safeguarding supervision from Designated professionals and are 100% compliant with the agreed KPIs of the agreed SAAF. • Within 2022/23 it was noted that the compliance of safeguarding supervision had fluctuated throughout the year between 60-70% for case holding staff accessing supervision. This was escalated as an area of concern to the Divisional Director for Women's and Children's. Management and responsibility to improve compliance is aligned to the divisional leadership team and improvements will be expected from Q1 2023/24. Furthermore, the division have approved for a further 3 midwifery safeguarding supervisors to be trained in 2023-24 to support the continued development of the Continuity of Carer model within midwifery services.

5	**Looking forwards into 2022/2023**
	Safeguarding remains a priority area of work for the Trust and this section defines the strategic priorities and work plan within safeguarding as we move forward into 2023/24. The strategic safeguarding aims related to the Trusts workforce are: • To focus on domestic abuse and further embedment and strengthening of the Domestic Abuse Act (2022) once further guidance and regulations are confirmed. • Continue to work in collaboration with the ICB and ensure the organisational responsibilities and requirements for the new SAAF and safeguarding contract are embedded and delivered. • To sustain positive partnership engagement with key stakeholders, to ensure the continuation of robust and transparent conversations in addressing and identifying solutions to rapidly evolving safeguarding issues. • Support the Trust to recognise and understand the impact of adverse childhood experiences (ACEs) and how this can impact on future, physical and mental health to support trauma informed practice in care provision. • Moving forward in 2022/23 collaborative working is planned with the Named Nurse for Children and Children Looked After and LA to ensure further

	integration of IHA systems to reduce system delays in achieving statutory timeframes. • Support the Tissue Viability service with the implementation of the Department of Health and Social Care Safeguarding Adult's Protocol - Pressure Ulcers and the interface with a safeguarding enquiry into the tissue viability clinical incident forms. • Reach the 100% compliance for supervision to ensure that all professionals are supported in their competence, assume responsibility for their own practice and enhance patient protection and safety in complex situations. • Achieve the 90% and above compliance for all PVP mandatory training and sustain this compliance providing further assurance that staff can make every contact count to prevent all forms abuse. • As a key priority work with divisional leads to make improvements in compliance of CP-IS checks completed by practitioners within Acute and Women's and Children's divisions. • Review understanding of staff awareness of the interaction of MCA and Mental Health Act to improve practice for those patients requiring restrictive practice intervention when in crisis. • Development of phase 2 of the HOPE boxes to extend the offer to support wider family members (fathers) within the Trust. • Sustainment of improvements in the Deprivation of Liberty Safeguards applications inclusive of next of kin details and provision of information booklet.

6	Conclusion and Recommendations
6.1	The Trust continues to actively respond and contribute to regional and national developments. This Annual Report demonstrates that safeguarding vulnerable people remains a significant priority for the Trust and provides assurance that the statutory duties are met. Safeguarding provision is proactively and continuously developed and implementation of learning from adverse events into frontline practice is evident. We recognise there is much more to achieve and to this end the development and delivery of the future priorities will help ensure that the Trust is fully engaged in the effective prevention of and response to safeguarding concerns. The underpinning message, however, remains the same in that safeguarding is everyone's business irrespective of role or position. It is everyone's responsibility to safeguard and protect the most vulnerable adults and children in our society. The child and adult at risk must remain at the center and be the motivation of our actions.

Appendix 1

Definitions

Safeguarding: The Care Quality Commission (CQC) states; ‘Safeguarding means protecting people's health, wellbeing, and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to high-quality health and social care’ (CQC, 2022).

Safeguarding Children: A child is defined within the Children Act 1989 as “an individual who has not reached their 18th birthday”, the fact that a child may:

- Live independently
- Is a parent themselves
- Is in custody
- Is a member of the armed forces

does not change their entitlement to protection under The Children Act (1989). This is important because young people aged 16 and 17 years with safeguarding needs access, ‘adult’ services in the Trust and are seen and treated by adult trained and registered staff who may not acknowledge this entitlement.

Safeguarding Adults: An adult is an individual aged 18 years or over.

The Care Act (2014) defines an ‘adult at risk’ as:

- An adult who has care and support needs (whether the needs are being met or not).
- Is experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

All Wirral University Teaching Hospital NHS Foundation Trust (WUTH) all staff have a statutory responsibility to safeguard and protect those who access their care regardless of their position in the organisation. However, some defined named safeguarding roles exist, they include:

Named Professionals.

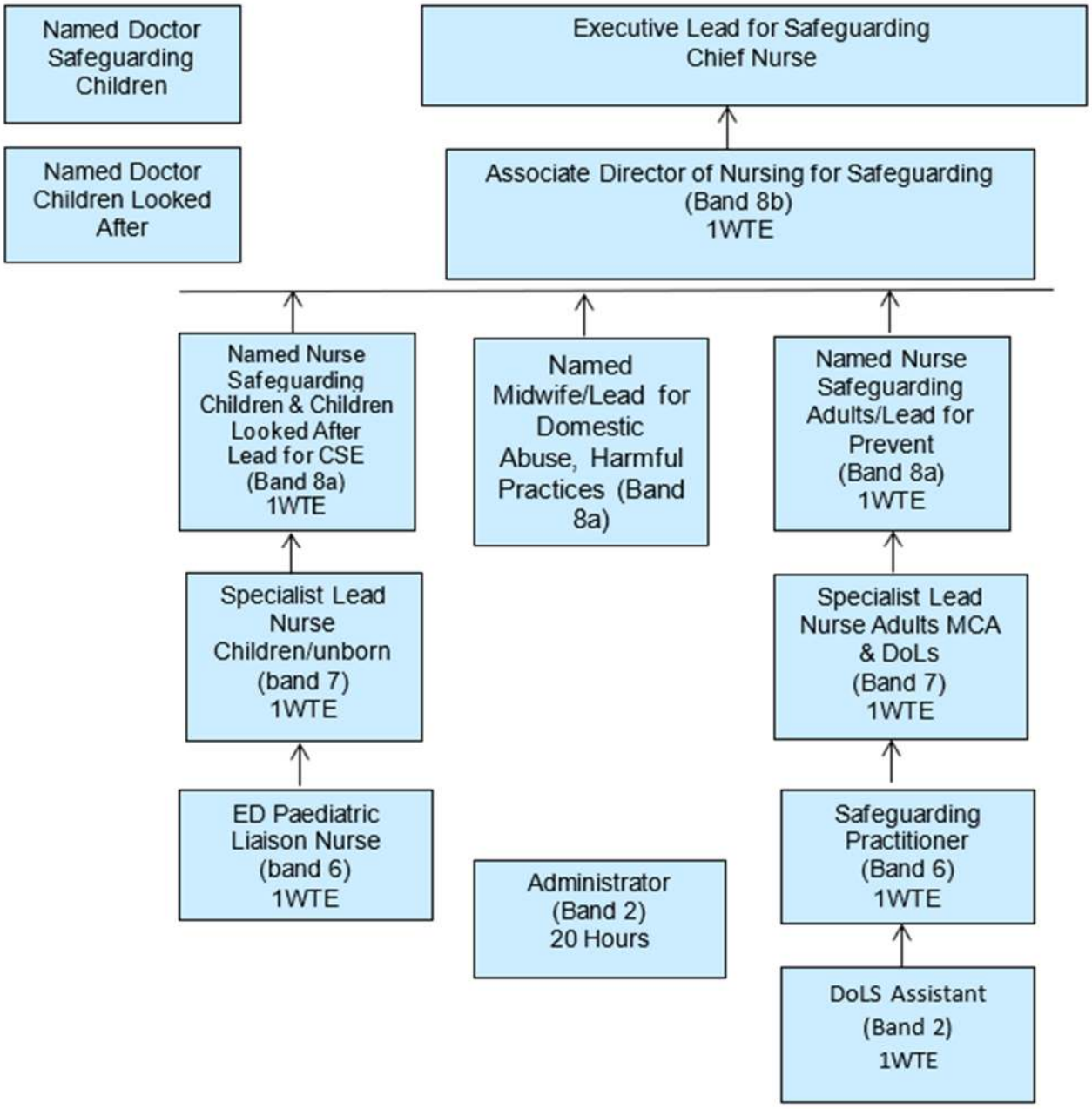
Named professionals have specific roles and responsibilities for Safeguarding Children and Adults, as described in the Intercollegiate Safeguarding Competencies for Adults (2018) and Children (2019).

All NHS providers must identify a Named Doctor, a Named Nurse for Safeguarding Children and Young People, a Named Professional for Adults and a Named Midwife (if the organisation provides maternity services) to provide expert advice and support to Trust employees and promote good practice within their organisation as per Children Act (1989/2004) and the Care Act (2014).

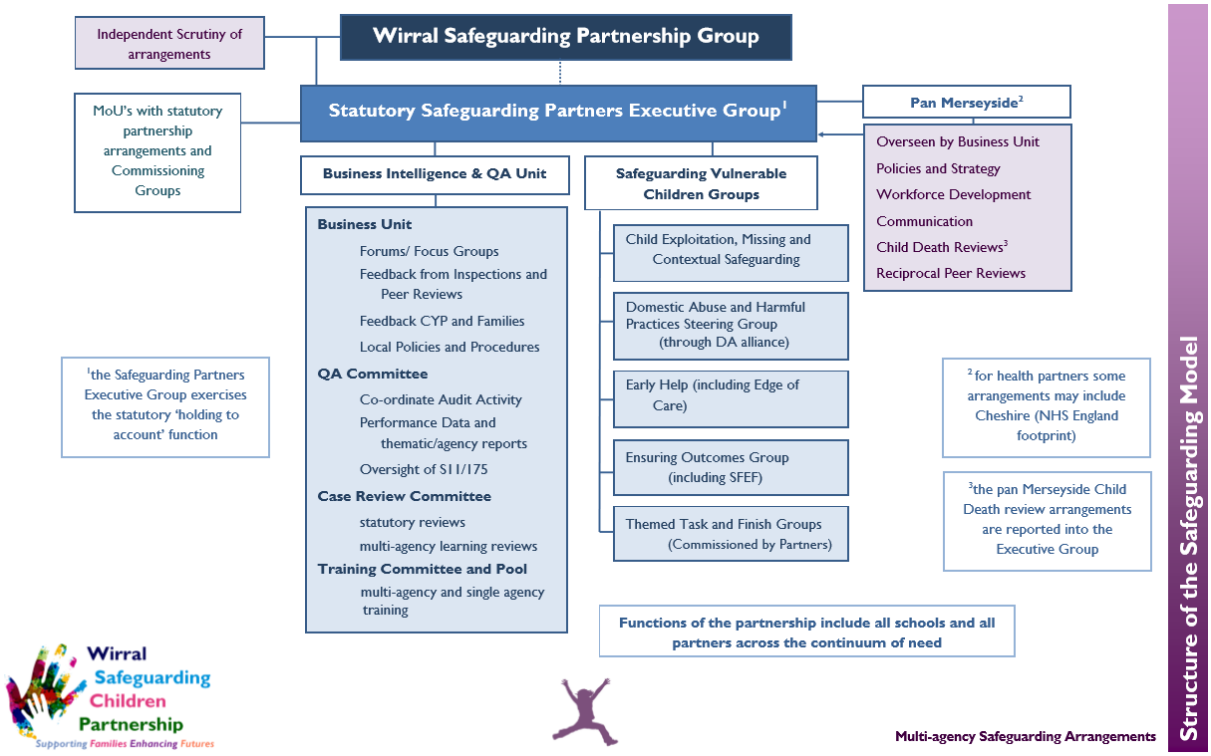
From April 2021 - March 2022 the WUTH named professionals were:

- Named Doctor for Children and Young People – Dr Elizabeth Thompson
- Named Doctor for Children Looked After – Dr Vidya Raghavan
- Named Nurse for Children and Children Looked After – Nicola Denton
- Named Professional (Nurse) for Adults – Helen Brookes
- Named Midwife – Michelle Beales-Shaw

Appendix 2
Safeguarding Structure



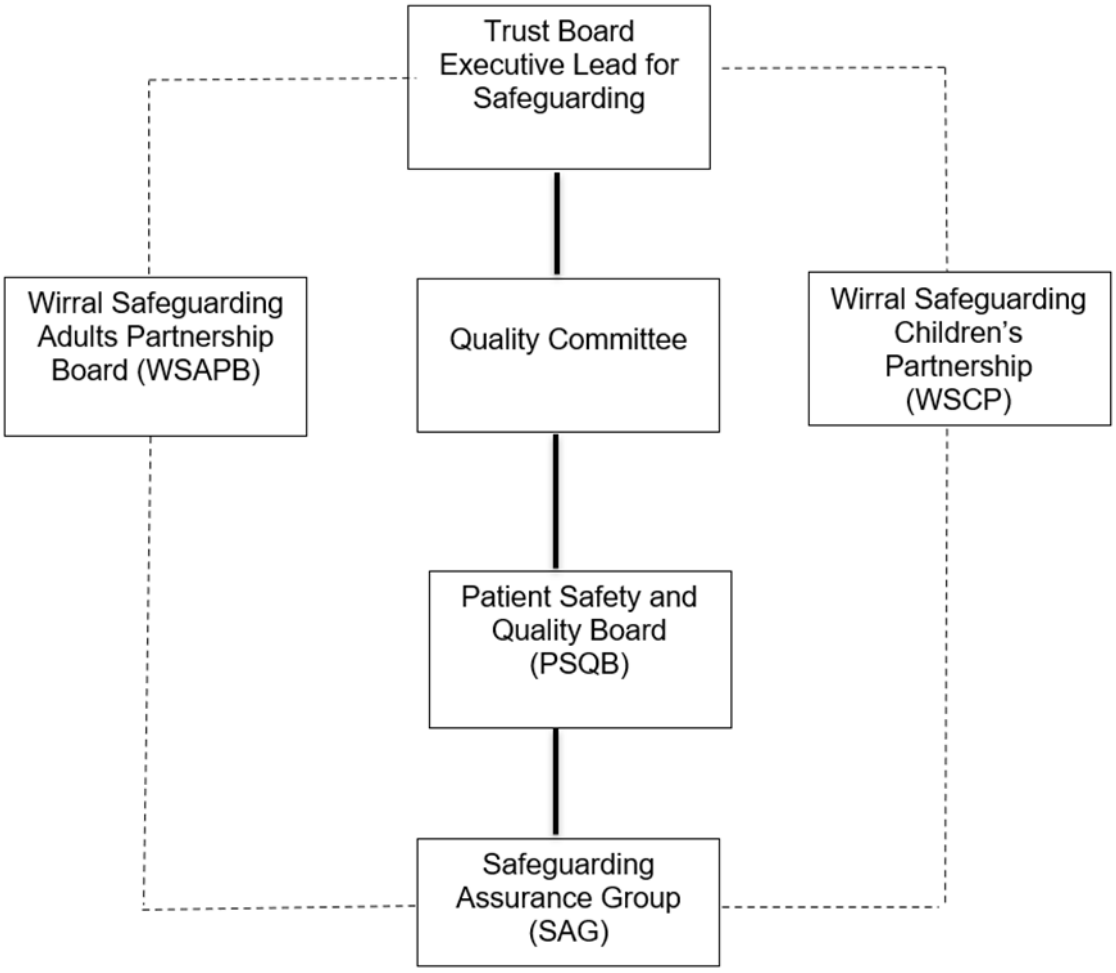
Appendix 3
Wirral Safeguarding Children's Partnership Structure



Appendix 4
Wirral Safeguarding Adults Partnership Board Structure

Appendix 5

WUTH Governance Structure



Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors in Public **Item 16.1**
4th October 2023

Report Title	Chair's Report: Quality Assurance Committee 7th September 2023
Author	Dr. Steven Ryan

Items for Escalation/Action

- There remains an issue with levels of infection with *clostridioides difficile* and gram-negative bacteria (e.g. *escherichia coli*) being above our planned trajectories. Despite the assurances provided on the prevention and control measures seen in the annual infection and prevention control report (which the Board will see today), the impact of lack of isolation facilities and high levels of bed occupancy increase the risk of health-care associated infection and require continued vigilance and attention. We await the final report by NHSE/I of *c difficile* control measures across the Wirral health and care system, following their inspection earlier in the year. Measures were enacted following informal feedback of this inspection & our own after-action reviews. The areas of action include isolation, environment, bare below the elbows, cleaning strategy and sampling.

- Compared to the previous year progress continues to be made in dealing with delays in responding to complaints beyond our 40-day Trust deadline during the first two quarters of 2023/2024. Work continues with the divisional teams to address more quickly complaints where patients have been receiving complex multispecialty care. The number of complaints made in 2022/23 (240) represents a small proportion of our more than 1 million patient episodes, though each an important issue for the patient and their carers/family. Seventy-nine of these were reported from our Emergency Department, which remains under sustained pressure with prolonged waiting times.

- A technical breach in Duty of Candour had occurred in quarter. Although the patient had received direct verbal feedback and an apology – this had not been followed up with a letter. Review had indicated that an extant informatics process would likely have prevented the issue and feedback and sharing of this has therefore been undertaken.

New/Emerging Risks

- The industrial action by several staff groups is having an increasingly acknowledged impact on access times for elective and emergency care. In the latter case it is having we believe a material impact on the need for corridor care, the ability to mobilise escalation capacity and move patients at the right speed along their care inpatient pathway. Coinciding industrial action between staff groups will likely have an even greater impact.

Overview of Assurances Received

- The Annual Infection Prevention and Control (IPC) Report provides a coherent and comprehensive description of our IPC measures. Positive assurances provided included that the IPC central team was fully staffed, after previously carrying long term vacancies and a number of metrics demonstrated that our leadership and delivery on antimicrobial stewardship is progressing well. Assurance was sought and provided that changes to on-call IPC advice systems had good oversight and issues arising had been solved

appropriately. Of note during the year, 1,725 staff had received aseptic non-touch technique training. Assurance was also sought on how IPC input was played into decisions about planned preventative maintenance by the estates team. An example was given of how a risk-base approach was used to design a maintenance schedule to protect patients at high-risk of infection (ward 30).

- Assurance was received that despite the known issues with high pressure and prolonged wait-times in our emergency department, resulting in 79 complaints (see above), the CQC Urgent and Emergency Care patient Experience Survey demonstrated that using regional benchmarking, WUTH was the top organisation regionally for 5 of the 9 sections reported and within the top 9 for the remaining 4. This is a testament to professionalism and patient-centeredness of our staff working in the department.

- The Committee received assurance that the WISE accreditation programme continues itself to be reviewed and improved. Developments include a increasing focus on patient outcomes as well as care-delivery processes and a move from an individual assessor to assessment by a team.

- The Committee received the Annual Organ Donation Report and gained assurance that the Trust benefits from a high level of commitment from its leaders and clinical teams and from its donor champions. Metrics show a high level of compliance with agreed processes in our two key areas – Critical Care and the Emergency Department, but 100% compliance is sought. Where this is not the case, feedback, education and support are provided.

- The comprehensive Annual Safeguarding Report showed good progress had been made in improving rates of mandatory training at all 4 levels and also that action to appoint an additional Adoption Medical Adviser had meant that all outstanding overdue assessments had been completed.

- The Trust has now gone live with the processes and systems of the National Patient Safety Incident Response Framework, following appropriate engagement and learning. Feedback was given that this was as much a cultural shift, as a change of system. There is already a feeling that this paradigm shift that would align well with the Trusts values and ambitions. It was suggested that a seminar for the Board, in learning about the nature and impact of this change would be beneficial.

Other comments from the Chair

- The reports provided to the committee were high quality and contained the necessary detail for the committee to test the assurances that were provided. Each was an honest account outlining (often substantial) progress but also highlighting areas for continued focus and need for improvement. High quality leadership is clearly displayed within these reports. The preparation and assembly of the QAC papers is also a very high standard.

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors
4 October 2023

Item 16.2

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 20th September 2023.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.

Internal Control and Risk Management

- The Committee discussed the Chair's report from the Risk Management Committee. Many of the items raised in the report were the subject of debate and discussion by the Committee in other items and indeed the People risks were the subject of a report and deep dive on previously reported recommendations and risks. It was noted that 40% of the significant risks in the report related to Estates and Facilities, and as a result the Committee requested a deep dive into those risks and mitigations in the area to come to a future meeting of the Audit Committee. It was however noted that there is a strong risk management culture in the Trust, and this was evident in the report and responses.
- The Committee was updated on procurement spend controls and waivers. It was noted that the Trust continues to perform strongly against NHS benchmarks. A detailed analysis of waivers was presented and discussed with the vast majority of spend related to specific capital projects and specialist staffing requirements. Discussion confirmed that whilst the report was thorough and detailed it might benefit from further work to minimise repetition of detail included therein. 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.
- The Committee scrutinised the standing report on financial losses and special payments. Much of these losses were immaterial however the Committee did note and discuss the protracted nature of the recovery of sums owed by WBC. It would appear that there continues to be a dispute over these sums which constitute over 73% of outstanding debt at £566k. Finance colleagues were asked to review a pragmatic solution to achieving a negotiated settlement on these disputed items and to report back to Audit Committee at its next meeting.

Anti-Fraud Progress Report

MIAA provided their regular update on Anti-Fraud issues and work being undertaken. The Trust reported 12 green outcomes against the 12 return standards. A positive position. The AFS will review the Anti-Fraud policy to reflect the new standard, and this will come to the Committee for ratification in due course.

Work continues on the National Fraud Initiative matching process which must be completed by the end of the current financial year.

Internal Audit

- MIAA provided an overview of recent activity undertaken across the Trust.
- A review of medical devices received a moderate assurance outcome primarily as a result of one high risk action relating to “patching”. Positively this issue and recommendation was responded to in a timely manner with the issue being rectified by the 31st August 2023.
- A review of e-rostering was also rated as moderate assurance again due to the inclusion of one high risk recommendation. As with medical devices, the Trust responded to this in a timely manner with associated actions being completed in August 2023.
- A review of “fit and proper persons” activity and processes was undertaken again resulting in moderate assurance. The updated detailed policy was discussed later in the agenda with associated actions being dealt with in advance of the meeting and an updated policy subsequently ratified later in the discussions.
- Audits against the data security and protection toolkit standards and capital programme governance both yielded substantial assurance. Excellent outcomes given the size and importance of both of these areas and colleagues are to be commended for these positive results.

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 verbally by representatives from MIAA. There was strong evidence of items whose previous completion dates had slipped being actively completed. The Committee were assured that the final few items related to people issues would be completed by various policy ratification processes to be completed by the end of the month.

People related actions deep dive

- At the request of the Committee, colleagues in the HR and Workforce Directorate updated on the completion of actions arising from the work of the extraordinary audit committee previously and the outcomes of ongoing business as usual activity now being reported through the People committee and Risk committee. Assurance was taken that previous issues had been resolved, for example in relation to “right to work” checks and system developments. The Committee were appraised that some recommendations previously made, for example in relation to payroll processing, had now been superseded through the decision to terminate the SLA with the Countess of Chester and tender for payroll services. The Committee welcomed the presentation and assurances from the Deputy Director and agreed to review the BAF risks on workforce later in the year.

Board Assurance Framework (BAF)

- A refreshed version of the Trust’s BAF was presented and discussed. The Committee confirmed the key risks being managed and in particular noted positive movements in the overall risk profile of the Trust reflecting continued work to manage risk and apply mitigations where possible.

Fit and Proper Persons Policy

In the light of the changes to the Fit and Proper Persons Test published by NHSE on 2nd August, a revised and updated version of the Trust's Fit and Proper Persons Policy in line with this new guidance was presented and approved.

Managing Conflicts of Interest

- The Committee was assured of continuing good progress in identifying and recording matters in relation to the management of conflict of interest. This is a substantial exercise given the number of staff covered by the regulations. At the time of the meeting 57% of affected staff had responded although it was noted that the date at which compliance would be judged was 31 March 2024.

Terms of Reference and cycle of Business

The Terms of Reference for the Committee were approved as was the cycle of business for 23/24 subject to the addition of further items in relation to deep dives on estates and facilities risks and workforce risks during the year.

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.

S J Igoe

Chair of Audit Committee

22nd September 2023